004387

TERMINATED PREGNANCY REPORT

State Form 36526 (R3 / 6-11)
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

☐ PLEASE CHECK IF AN AMENDED FORM.

Mail completed form to: Indiana State Department of Health
P. O. Box 7125
Indianapolis, IN 46204

**** If the patient is less than fourteen (14) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov.
Further, this **report shall also be mailed** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be mailed to the Indiana State Department of Health **no later than July 30 for each termination performed in the first six (6) months of that year** and **no later than January 30 for each termination performed for the last six (6) months of the preceding year.**
Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5-(b).

Facility name *(If not a hospital or clinic, please enter address.)*	City or town, of pregnancy termination	County of pregnancy termination
PPIN 8590 Georgetown Road	Indianapolis	Marion

Patient's age**	Married	Date of pregnancy termination *(month, day, year)*	Education *(Enter highest grade completed.)*
23	☐ Yes ☒ No	8-7-13	16

Race *(Select one or more.)*
☐ Black or African American ☐ American Indiana or Alaska Native ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☒ White ☐ Other

Ethnicity
☐ Hispanic or Latino ☒ Not Hispanic or Latino

Live Births:	Number now living *(enter number or check None)* ☒ None	Number now deceased *(enter number or check None)* ☒ None
Other Terminations:	Number of spontaneous terminations *(enter number or check None)* ☒ None	Number of induced terminations *(enter number or check None)* ☒ None

Dates of terminations *(Do not include this termination.)*
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____

Fetus delivered alive?	Fetus viable?	If viable, medical reason for termination:
☐ Yes ☒ No	☐ Yes ☒ No	

Pathological examination performed?	If yes, results:
☐ Yes ☒ No	

Type of Termination Procedures

Procedure that Terminated pregnancy *(check one only)*	Additional Procedures used for this termination, if any *(check all that apply)*
☒ Medical (nonsurgical) Mifepristone / Misoprostol	☐
☐ Suction Curettage	☐
☐ Menstrual Aspiration	☐
☐ Medical (Nonsurgical) Specify Medication(s) _____	☐
☐ Medical (Surgical) Other *(Specify)* _____	☐

Complication(s) of Pregnancy Termination *(Check all that apply.)*

☒ None ☐ Uterine Perforation
☐ Hemorrhage ☐ Cervical Laceration
☐ Infection ☐ Retained Products
☐ Other *(Specify)*: _____

Did this termination of pregnancy result in a maternal death?
☐ Yes ☒ No

Date last normal menses began *(month, day, year)*	Physician estimate of gestation *(in weeks)*	Postfertilization age of the fetus *(in weeks)*
6-9-13	9+0	6+0

How determined:
Ultrasound

My signature certifies this termination was performed according to IC 16-34-2.

Signature of physician performing termination	Full name of physician performing termination
Cashman	Casandra Cashman

Address of physician performing termination *(number and street, city, state, and ZIP code)*
8590 Georgetown Road Indianapolis, IN 46268

[redacted]

DATE RECEIVED BY ISDH *(month, day, year)*: _____

RECEIVED
AUG 15 2013