

000156



TERMINATED PREGNANCY REPORT
State Form 36526 (R4 / 12-11)
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.) Planned Parenthood of Indiana		City or town, of pregnancy termination Merrillville		County of pregnancy termination Lake	
Patient's age** 15	Married <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Date of pregnancy termination (month, day, year) 1/16/14		Education (Enter highest grade completed.) 9-12th grade	
Race (Select one or more.) <input checked="" type="checkbox"/> Black or African American		<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	Ethnicity <input type="checkbox"/> Hispanic or Latino <input checked="" type="checkbox"/> Not Hispanic or Latino	
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> White	<input type="checkbox"/> Other		
Live Births: <input checked="" type="checkbox"/>	Number now living (enter number or check None) <input checked="" type="checkbox"/> None		Number now deceased (enter number or check None) <input checked="" type="checkbox"/> None		
Other Terminations: <input checked="" type="checkbox"/>	Number of spontaneous terminations (enter number or check None) <input checked="" type="checkbox"/> None		Number of induced terminations (enter number or check None) <input checked="" type="checkbox"/> None		
Dates of terminations (Do not include this termination.)					
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
7. _____ 8. _____ 9. _____ 10. _____ 11. _____ 12. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:	
Pathological examination performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		If yes, results: Procedure Complete			
Procedure that Terminated pregnancy (check one only)		Type of Termination Procedures		Complication(s) of Pregnancy Termination (Check all that apply.)	
<input type="checkbox"/> Medical (nonsurgical) Mifepristone / Misoprostol		Additional Procedures used for this termination, if any (check all that apply)		<input checked="" type="checkbox"/> None <input type="checkbox"/> Uterine Perforation	
<input checked="" type="checkbox"/> Suction Curettage		<input type="checkbox"/>		<input type="checkbox"/> Hemorrhage <input type="checkbox"/> Cervical Laceration	
<input type="checkbox"/> Menstrual Aspiration		<input type="checkbox"/>		<input type="checkbox"/> Infection <input type="checkbox"/> Retained Products	
<input type="checkbox"/> Medical (Nonsurgical) Specify Medication(s) _____		<input type="checkbox"/>		<input type="checkbox"/> Other (Specify): _____	
<input type="checkbox"/> Medical (Surgical) Other (Specify) _____		<input type="checkbox"/>		Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Date last normal menses began (month, day, year) 11/2013		Physician estimate of gestation (in weeks) 9W		Postfertilization age of the fetus (in weeks) 7W	
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 Marshall Levine, M.D
Address of physician performing termination (number and street, city, state, and ZIP code) 8645 Connecticut Street Merrillville Indiana 46410	

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

JAN 21 2014