

Rpt 19



State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2119.123)

To be completed by the physician who provided RU-486

| | | | |
|---|-----------|-----------|-----------|
| 1. Date RU-486 was provided: | <u>08</u> | <u>15</u> | <u>12</u> |
| | Month | Day | Year |
| 2. Name of medical practice or facility at which RU-486 was provided: <u>Preterm</u> | | | |
| 3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleve. OH 44120</u> | | | |
| 4. Date post RU-486 event began: <u>09/08/12</u> | | | |
| 5. Event(s) (Please check all that apply): | | | |
| <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized | | | |
| <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding | | | |
| <input type="checkbox"/> Other serious event (specify) _____ | | | |
| 6. Duration of event: <u>2</u> Hours _____ Days | | | |
| 7. Remarks: <u>Abortion completed surgically 9/8/12, no further complication.</u> | | | |
| 8. a. Name of physician who provided RU-486 <u>Rebecca Lowenthal, M.D.</u> | | | |
| 8. b. Physician's signature <u>[Signature]</u> <u>9/12/12</u> <u>M.D.</u> D.O. | | | |

Send completed forms to:

State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

MEDICAL BOARD

SEP 24 2012

Sept 20



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To be completed by the physician who provided RU-486

| | | | |
|--|--------------------|------------------|---------------------|
| 1. Date RU-486 was provided: | <u>08</u> Month | <u>30</u> Day | <u>2012</u> Year |
| 2. Name of medical practice or facility at which RU-486 was provided: <u>Arcterm</u> | | | |
| 3. Address of medical practice or facility at which RU-486 was provided: <u>12000 Shaker Blvd. Cleve. OH 44120</u> | | | |
| 4. Date post RU-486 event began: <u>9/12/12</u> | | | |
| 5. Event(s) (Please check all that apply): <input checked="" type="checkbox"/> Incomplete abortion <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____ | | | |
| 6. Duration of event: <u>2</u> Hours _____ Days | | | |
| 7. Remarks: <u>Abortion completed surgically 9/12/12, no further complication.</u> | | | |
| 8. a. Name of physician who provided RU-486 <u>Lisa Perricci, M.D.</u> | | | |
| 8. b. Physician's signature <u>[Signature]</u> <u>9/14/12</u> <u>M.D. / D.O.</u> | | | |

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