



# State Medical Board of Ohio

## Report of RU-486 Event MEDICAL BOARD

(Required pursuant to R.C. 2919.123)

MAR 8 2016

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 2 / 22 / 16  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:  
3255 E Main St. Columbus OH 43213

4. Date post RU-486 complication began:

5. Event(s) (Please check all that apply):

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized

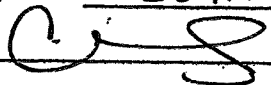
Patient received a transfusion       Severe bleeding

Other serious event (specify) \_\_\_\_\_

6. Duration of event: na Hours \_\_\_\_\_ Days

7. Remarks: failed M&B (non viable IUP) due to FDA regimen

8. a. Name of physician who provided RU-486: Catherine Romanos

8. b. Physician's signature:  MD/DO

Date: 3/3/16

Send completed forms to: **State Medical Board of Ohio**  
 Legal Department  
 30 E. Broad St., 3<sup>rd</sup> Floor  
 Columbus, OH 43215-6127



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	April	11	2016
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <i>Planned Parenthood East Surgical Center</i>			
3. Address of medical practice or facility at which RU-486 was provided: <i>3255 E Main St., Columbus OH 43213</i>			
4. Date post RU-486 complication began: <i>4/25/16</i>			
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: _____ Hours _____ Days			
7. Remarks: <i>Failed medication abortion, continuing pregnancy</i>			
8. a. Name of physician who provided RU-486: <i>ROMANOS</i>			
8. b. Physician's signature: _____			
Date: _____ <i>4/25/16</i>			

Send completed forms to: State Medical Board of Ohio

Legal Department  
30 E. Broad St., 3<sup>rd</sup> Floor  
Columbus, OH 43215-6127

MEDICAL BOARD

APR 26 2016



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>April</u> <u>21</u> <u>2016</u> <small>Month                      Day                      Year</small>
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 E. Main St. Columbus OH 43213</u>
4. Date post RU-486 complication began:	<u>4/22/16</u>
5. Event(s) (Please check all that apply):	<input checked="" type="checkbox"/> Incomplete abortion <u>em 4/27/16</u> <input type="checkbox"/> Adverse reaction to RU-486 <input type="checkbox"/> Patient hospitalized <input type="checkbox"/> Patient received a transfusion <input checked="" type="checkbox"/> Severe bleeding <input type="checkbox"/> Other serious event (specify) _____
6. Duration of event: _____ Hours _____ Days	
7. Remarks:	<u>DIC for bleeding.</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	
Date	<u>4/27/16</u> <u>MB/DO</u>

Send completed forms to:                      State Medical Board of Ohio  
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MEDICAL BOARD  
MAY 2 2016



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: June 3 2016  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
Planned Parenthood East Surgical

3. Address of medical practice or facility at which RU-486 was provided:  
3255 E. Main St Columbus OH 43213

4. Date post RU-486 complication began: 6/7/16

5. Event(s) (Please check all that apply):

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized

Patient received a transfusion       Severe bleeding

Other serious event (specify) \_\_\_\_\_

**MEDICAL BOARD**  
**JUN 13 2016**

6. Duration of event: 24 Hours \_\_\_\_\_ Days

7. Remarks: incomplete expulsion of POC due to severe fibroid uterus.

8. a. Name of physician who provided RU-486: Catherine Romanos

8. b. Physician's signature: [Signature] M.D./D.O.

Date: 6/9/16

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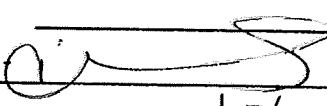
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# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	June	10	2016
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood East Surgical Center		
3. Address of medical practice or facility at which RU-486 was provided:	3255 E. Main St. Columbus OH 43213		
4. Date post RU-486 complication began:	6/15/16		
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:	_____ Hours	_____ Days	
7. Remarks:	failed medication abortion sp D-C		
8. a. Name of physician who provided RU-486	ROMANOS		
8. b. Physician's signature			
	MD/DO		
Date	6/15/16		

Send completed forms to: State Medical Board of Ohio

Legal Department  
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Columbus, OH 43215-6127

MEDICAL BOARD

JUN 17 2016



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: July 05, 2014  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
YPGH

3. Address of medical practice or facility at which RU-486 was provided:  
3255 East Main St. Columbus, OH 43213

4. Date post RU-486 complication began:  
07/14/2016

5. Event(s) (Please check all that apply):  
 Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized  
 Patient received a transfusion       Severe bleeding  
 Other serious event (specify) \_\_\_\_\_

6. Duration of event: 2 Hours \_\_\_\_\_ Days

7. Remarks: Failed medical abortion completed surgically

8. a. Name of physician who provided RU-486: Romanos

8. b. Physician's signature: [Signature] MD./D.O.  
Date: 7/15/2016

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MEDICAL BOARD  
JUL 18 2016

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# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: August 16 2016  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
PPG OH

3. Address of medical practice or facility at which RU-486 was provided:  
3255 W. Main St.  
Columbus, OH 43213

**MEDICAL BOARD**  
**AUG 29 2016**

4. Date post RU-486 complication began: 8/24/2016

5. Event(s) (Please check all that apply):

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized

Patient received a transfusion       Severe bleeding

Other serious event (specify) Failed medical abortion

6. Duration of event: 2 Hours \_\_\_\_\_ Days

7. Remarks:  
Surgical completion of abortion

8. a. Name of physician who provided RU-486 C. Romanos

8. b. Physician's signature *[Signature]* MD/DO

Date 8/24/2016

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**Legal Department**  
**30 E. Broad St., 3<sup>rd</sup> Floor**  
**Columbus, OH 43215-6127**



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: September 27 2016  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:  
3255 E. Main St Columbus OH 43213

4. Date post RU-486 complication began: 10/5/16

5. Event(s) (Please check all that apply):

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized

Patient received a transfusion       Severe bleeding

Other serious event (specify) \_\_\_\_\_

**MEDICAL BOARD**

**OCT 17 2016**

6. Duration of event: \_\_\_\_\_ Hours \_\_\_\_\_ Days

7. Remarks:  
incomplete mib required suction procedure

8. a. Name of physician who provided RU-486 ~~Lisa Kuder~~ @ Catherine Romanoski

8. b. Physician's signature \_\_\_\_\_ [Signature] MD/DO

Date 10/27/16

Send completed forms to: **State Medical Board of Ohio**  
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Prescribed: 5/--/2011, Rev. 12/13/12





# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: November 3 2016  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
Planned Parenthood

3. Address of medical practice or facility at which RU-486 was provided:  
3255 East Main Street  
 Columbus, OHIO 43213

4. Date post RU-486 complication began: 11/10/16

5. Event(s) (Please check all that apply):

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized

Patient received a transfusion       Severe bleeding

Other serious event (specify) \_\_\_\_\_

6. Duration of event: \_\_\_\_\_ Hours 19 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature  MD/DO

Date 11/22/16

Send completed forms to: **State Medical Board of Ohio**  
 Legal Department  
 30 E. Broad St., 3<sup>rd</sup> Floor  
 Columbus, OH 43215-6127

**MEDICAL BOARD**  
 NOV 25 2016

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# State Medical Board of Ohio

## Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: November 17 2016  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
Planned Parenthood - East Surgical

3. Address of medical practice or facility at which RU-486 was provided:  
3255 East Main St  
 Columbus, OH 43213

4. Date post RU-486 complication began:  
12/15/16

5. Event(s) (Please check all that apply):

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized

Patient received a transfusion       Severe bleeding

Other serious event (specify) Failed Medication Abortion

6. Duration of event: \_\_\_\_\_ Hours 33 Days

7. Remarks:  
D.C performed - uncomplicated.

8. a. Name of physician who provided RU-486 Catherine Romanos

8. b. Physician's signature \_\_\_\_\_ MD/DO

Date 12/29/16

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 30 E. Broad St., 3<sup>rd</sup> Floor  
 Columbus, OH 43215-6127

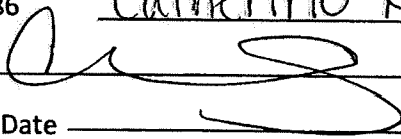
**MEDICAL BOARD**  
**JAN 03 2017**



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>November 22 2016</u> <small>Month Day Year</small>
2. Name of medical practice or facility at which RU-486 was provided:	<u>Planned Parenthood East Surgical</u>
3. Address of medical practice or facility at which RU-486 was provided:	<u>3255 East Main St Columbus, Ohio 43213</u>
4. Date post RU-486 complication began:	<u>12/6/16</u>
5. Event(s) (Please check all that apply):	<input 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 checked="" type="checkbox"/> Other serious event (specify) <u>Failed Abortion</u>
6. Duration of event:	_____ Hours <u>12</u> Days
7. Remarks:	<u>FDA medication abortion @ 9w3d failed. DIC for ongoing IUP on 12/13/16.</u>
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	<u></u>
	<small>M.D./D.O.</small> <u>12/13/16</u> Date _____

Send completed forms to: State Medical Board of Ohio  
 Legal Department  
 30 E. Broad St., 3<sup>rd</sup> Floor  
 Columbus, OH 43215-6127

**MEDICAL BOARD**  
**DEC 16 2016**



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 11 29 2016  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
Planned Parenthood East Surgical

3. Address of medical practice or facility at which RU-486 was provided:  
3255 East Main St., Columbus, Ohio 43213

4. Date post RU-486 complication began: 1/3/17

5. Event(s) (Please check all that apply):  
 Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized  
 Patient received a transfusion       Severe bleeding  
 Other serious event (specify) Failed Medication Abortion

6. Duration of event: \_\_\_\_\_ Hours 45 Days

7. Remarks: Failed Medication Abortion with D&C procedure

8. a. Name of physician who provided RU-486: Catherine Romanos  
 8. b. Physician's signature: [Signature] M.D./D.O.  
 Date: 1/17/17

Send completed forms to: State Medical Board of Ohio  
 Legal Department  
 30 E. Broad St., 3<sup>rd</sup> Floor  
 Columbus, OH 43215-6127

MEDICAL BOARD

JAN 19 2017



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 12 / 6 / 2016  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
Planned Parenthood East Columbus Surgical

3. Address of medical practice or facility at which RU-486 was provided:  
3255 East Main St, Columbus, OH 43213

4. Date post RU-486 complication began: 1/5/17

5. Event(s) (Please check all that apply):

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized

Patient received a transfusion       Severe bleeding

Other serious event (specify) Failed Medication Abortion

6. Duration of event: \_\_\_\_\_ Hours 35 Days

7. Remarks: Failed Medication Abortion with D&C procedure

8. a. Name of physician who provided RU-486: Catherine Romanos

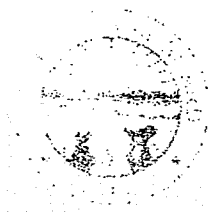
8. b. Physician's signature: [Signature] MD/DO

Date: 1/17/17

Send completed forms to: State Medical Board of Ohio  
 Legal Department  
 30 E. Broad St., 3<sup>rd</sup> Floor  
 Columbus, OH 43215-6127

MEDICAL BOARD

JAN 19 2017



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 12 / 13 / 16  
Month Day Year

2. Name of medical practice or facility at which RU-486 was provided:  
Planned Parenthood - East surgical

3. Address of medical practice or facility at which RU-486 was provided:  
3255 East Main St  
Columbus, OH 43213

4. Date post RU-486 complication began:  
12/21/16

5. Event(s) (Please check all that apply):

Incomplete abortion       Adverse reaction to RU-486       Patient hospitalized

Patient received a transfusion       Severe bleeding

Other serious event (specify) Failed Medication Abortion

6. Duration of event: \_\_\_\_\_ Hours 9 Days

7. Remarks:  
D.C performed uncomplicated

8. a. Name of physician who provided RU-486 Catherine Romanas

8. b. Physician's signature [Signature] MD/DO

Date 12/29/16

Send completed forms to: State Medical Board of Ohio  
 Legal Department  
 30 E. Broad St., 3<sup>rd</sup> Floor  
 Columbus, OH 43215-6127

**MEDICAL BOARD**  
 JAN 03 2017



# State Medical Board of Ohio Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>December</u> <u>15</u> <u>2016</u> <small>Month Day Year</small>
2. Name of medical practice or facility at which RU-486 was provided:	Planned Parenthood - East Surgical
3. Address of medical practice or facility at which RU-486 was provided:	3255 East Main St., Columbus, OH 43213
4. Date post RU-486 complication began:	12/22/16
5. Event(s) (Please check all that apply):	<input 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 checked="" type="checkbox"/> Other serious event (specify) <u>Failed Medication Abortion</u>
6. Duration of event: _____ Hours <u>15</u> Days	<b>MEDICAL BOARD</b> <b>JAN 10 2017</b>
7. Remarks:	failed medication abortion resolved with D:C - uncomplicated
8. a. Name of physician who provided RU-486	<u>Catherine Romanos</u>
8. b. Physician's signature	 <small>MD/DO</small>
Date	<u>1/9/17</u>

Send completed forms to: State Medical Board of Ohio  
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