State Medical Board of Ohio

Report of RU-486 Event

MEDICAL BOARD

MAR 8 2016

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 2 (Month) 22 (Day) 16 (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: N/a Hours _____ Days

7. Remarks: failed MTB (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., 3rd Floor
Columbus, OH 43215-6127

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: April (Month) 11 (Day) 2016 (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: 4/25/16

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

X Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: failed medication abortion, continuing pregnancy

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

8. b. Physician's signature _____ MD / D.O.

Date 4/25/16

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

MEDICAL BOARD
APR 26 2016

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: April (Month) 21 (Day) 2016 (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: 4/22/16

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

X Incomplete abortion ERC 4/27/16 ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ✓ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: D.C for bleeding.

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

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

Date 4/27/16

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

MEDICAL BOARD
MAY 2 2016

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: May 12, 2016 (Month / Day / Year)

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

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:
5/19/2016

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: _____ Hours 6 Days

7. Remarks: Incomplete Medical abortion manage surgically

8. a. Name of physician who provided RU-486 _____

8. b. Physician's signature _____ M.D./D.O.

Date 5/25/16

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

MEDICAL BOARD
MAY 27 2016

Prescribed: 5/--/2011, Rev. 12/13/12

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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 (Month) 3 (Day) 2016 (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 _____ M.D. / D.O

Date 6/9/16

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

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: June (Month) 10 (Day) 2016 (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):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days

7. Remarks: failed medication abortion
s/p D&C

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

8. b. Physician's signature _____ MD/D.O

Date 6/15/16

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

MEDICAL BOARD
JUN 17 2016

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: July (Month) 05 (Day), 2016 (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:
325 East Main St. Columbus, OH 43213

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

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

X 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 _____ M.D./D.O

Date 7/15/2016

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

MEDICAL BOARD
JUL 18 2016

Prescribed: 5/--/2011, Rev. 12/13/12

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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 (Month) 16 (Day) 2016 (Year)

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

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

X 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 _____ M.D./D.O.

Date 8/24/2016

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

Prescribed: 5/--/2011, Rev. 12/13/12

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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: 08 (Month) 24 (Day) 16 (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:
3755 E. Main St. Columbus OH 43213

4. Date post RU-486 complication began:
9/6/16

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 _____ Days

7. Remarks: failed medication abortion completed surgical

8. a. Name of physician who provided RU-486 Lisa Keder

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

Date 9/14/2016

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

MEDICAL BOARD
SEP 19 2016

Prescribed: 5/--/2011, Rev. 12/13/12

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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: 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 MAB required suction procedure

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

8. b. Physician's signature _____ M.D./D.O.

Date 10/12/16

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

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: 11 (Month) 28 (Day) 2016 (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: 11/8/16

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 11 Days

7. Remarks:

8. a. Name of physician who provided RU-486 Michelle Isley

8. b. Physician's signature _____ M.D. / D.O.

Date 11/18/16

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

MEDICAL BOARD
NOV 21 2016

Prescribed: 5/--/2011, Rev. 12/13/12

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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 (Month) 3 (Day) 2016 (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):

X 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 _____ M.D. / D.O

Date 11/22/16

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

MEDICAL BOARD
NOV 25 2016

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 (Month) 17 (Day) 2016 (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

X 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/D.O

Date 12/29/16

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

MEDICAL BOARD
JAN 03 2017

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: 12 (Month) 6 (Day) 2016 (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

X 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 _____ MD/DO

Date 1/17/17

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

MEDICAL BOARD
JAN 19 2017

Prescribed: 5/--/2011, Rev. 12/13/12

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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: 12 (Month) 13 (Day) 16 (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

X 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 Romanos

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

Date 12/29/16

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

MEDICAL BOARD
JAN 03 2017

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: December (Month) 15 (Day) 2016 (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: 12/22/16

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

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Medication Abortion

MEDICAL BOARD
JAN 10 2017

6. Duration of event: _____ Hours 15 Days

7. Remarks:
failed medication abortion resolved with D:C - uncomplicated

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

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

Date 1/9/2017

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

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 (Month) 22 (Day) 2016 (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:
12/6/16

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

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

X Other serious event (specify) Failed Abortion

6. Duration of event: _____ Hours 4 Days

7. Remarks:
FDA mudication abation @ 9w3d faild. DiC for ongoing IUP on 12/13/16.

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

8. b. Physician's signature _____ MD/D.O

Date 12/13/16

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

MEDICAL BOARD
DEC 16 2016

Prescribed: 5/--/2011, Rev. 12/13/12

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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: 11 (Month) 29 (Day) 2016 (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

X 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 _____ M.D. / D.O

Date 1/17/17

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

MEDICAL BOARD
JAN 19 2017

Prescribed: 5/--/2011, Rev. 12/13/12