

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to ORC 2919.123)
To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>10</u> Month	<u>21</u> Day	<u>2021</u> Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood Of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St, Columbus, Ohio 43213			
4. Date post RU-486 complication began: <u>11/23/2021</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>intrauterine clots</u>			
6. Duration of event: <u>1</u> Hours <u>0</u> Days			
7. Remarks: <u>patient called on-call RN reported bleeding and clotting for several weeks post MAB. US on 11/23/21 showed intrauterine clots.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. Sincay</u>			
8. b. Physician's signature <u>[Signature]</u> <u>M.D./D.O.</u> Date <u>12-2-2021</u>			

Send completed forms to:

State Medical Board of Ohio

Legal Department

30 E. Broad St., 3rd Floor

Columbus, OH 43215-6127

JAN 19 2022

STATE MEDICAL BOARD OF OHIO

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(Required pursuant to R.C. 2919.123)

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1. Date RU-486 was provided:	<div style="border: 1px solid black; padding: 2px; margin: 0 auto; width: 100px;"> <div style="display: flex; justify-content: space-between;"> Month Day </div> <div style="display: flex; justify-content: space-between;"> 7 27 </div> </div>	<div style="border: 1px solid black; padding: 2px; margin: 0 auto; width: 100px;"> <div style="display: flex; justify-content: space-between;"> Year </div> <div style="display: flex; justify-content: space-between;"> 21 </div> </div>
2. Name of medical practice or facility at which RU-486 was provided:	<div style="border: 1px solid black; padding: 5px; margin: 0 auto; width: 80%;"> Planned Parenthood of Greater Ohio </div>	
3. Address of medical practice or facility at which RU-486 was provided:	<div style="border: 1px solid black; padding: 5px; margin: 0 auto; width: 80%;"> 3255 E. Main St. Columbus, Oh 43213 </div>	
4. Date post RU-486 complication began:	<div style="border: 1px solid black; padding: 2px; margin: 0 auto; width: 100px;"> 7/30/21 </div>	
5. Event(s) (Please check all that apply):	<div style="border: 1px solid black; padding: 5px; margin: 0 auto; width: 80%;"> <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) _____ </div>	
6. Duration of event:	<div style="border: 1px solid black; padding: 2px; margin: 0 auto; width: 100px;"> 1 Hours Days </div>	
7. Remarks:	<div style="border: 1px solid black; padding: 5px; margin: 0 auto; width: 80%;"> MAB procedure was initiated per FDA regimen on 7/27/21. Pt. called on 7/30/21 to report little to no bleeding. US on 8/3/21 revealed continuing pregnancy. Surgical aspiration was performed 8/3/21; pt. did well post op. </div>	
8. a. Name of physician who provided RU-486	<div style="border: 1px solid black; padding: 2px; margin: 0 auto; width: 100px;"> Dr Rivlin </div>	
8. b. Physician's signature	<div style="border: 1px solid black; padding: 2px; margin: 0 auto; width: 100px;"> <div style="display: flex; justify-content: space-between;"> M.D./D.O. </div> </div>	
	<div style="border: 1px solid black; padding: 2px; margin: 0 auto; width: 100px;"> Date 8/27/21 </div>	

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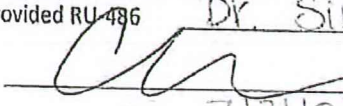
Legal Department
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MEDICAL BOARD

OCT 14 2021

State Medical Board of Ohio
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1. Date RU-486 was provided:	7	8	2021
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood Of Greater Ohio			
3. Address of medical practice or facility at which RU-486 was provided: 3255 E Main St, Columbus, Ohio 43213			
4. Date post RU-486 complication began: 7/19/21			
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: 1 Hours _____ Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 7/2/21. F/U call revealed continued pregnancy S/S. Surgical aspiration performed 7/12/21			
8. a. Name of physician who provided RU-486 Dr. Sina			
8. b. Physician's signature  M.D./D.O. Date 7/21/21			

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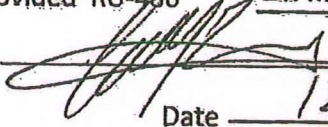
MEDICAL BOARD

OCT 14 2021

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>6</u>	<u>28</u>	<u>21</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: Planned Parenthood of Greater Ohio			
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: 8/6/21			
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>1</u> Hours <u> </u> Days			
7. Remarks: MAB procedure was initiated per FDA regimen on 6/28/21. Pt. called on 8/5/21 with + HSPT and bleeding/cramping. Pt. went to ER on 8/5/21 and had suction procedure after ultrasound revealed incomplete AB. Pt. did well post op and will follow up with her Ob/Gyn			
8. a. Name of physician who provided RU-486 <u>Dr. McCluney</u>			
8. b. Physician's signature  <u>MD/DO</u> Date <u>12/6/2021</u>			

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To be completed by the physician who provided RU-486

1. Date RU-486 was provided:	<u>4</u>	<u>21</u>	<u>21</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</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>4.29.21</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>1</u> Hours <u> </u> Days			
7. Remarks: <u>Mab procedure initiated per FDA regimen on 4.21.21. Phone call on 4.29.21 Pt states she went to ER. US on 4.29.21 revealed continuing pregnancy. Surgical aspiration was performed 5.3.21; Pt. did well post-op.</u>			
8. a. Name of physician who provided RU-486: <u>Dr. Lowther</u>			
8. b. Physician's signature: <u>[Signature]</u> (M.D./D.O.)			
Date: <u>6/23/21</u>			

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MEDICAL BOARD

AUG 17 2021

State Medical Board of Ohio Report of RU-486 Event

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1. Date RU-486 was provided:	<u>3</u>	<u>1</u>	<u>21</u>
	Month	Day	Year
2. Name of medical practice or facility at which RU-486 was provided: <u>Planned Parenthood of Greater Ohio</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>3.29.21</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>1</u> Hours _____ Days			
7. Remarks: <u>Mab was initiated per FDA regimen on 3.1.21. US on 3.29.21 revealed intrauterine debris. Aspiration was performed 4.2.21; Pt did well post-op.</u>			
8. a. Name of physician who provided RU-486 <u>Dr. McCluney</u>			
8. b. Physician's signature <u>[Signature]</u> <u>MD DO</u>			
Date <u>6/21/2021</u>			

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MEDICAL BOARD

AUG 17 2021