

COMMONWEALTH OF KENTUCKY
STATE REGISTRAR OF VITAL STATISTICS
REPORT OF ABORTION

TYPE OR PRINT IN PERMANENT BLACK INK



Facility Information			
<i>The full name and address of the referring physician, agency, or service, if any.</i>			
1a. Facility Name:			
1b. Physician performing procedure:		1c. Referring Physician:	
1d. Address:			
1e. City:		1f. State:	1g. Zip Code:
Patient Information			
<i>The pregnant patient's city or town, county, state, country of residence, and zip code.</i>			
2a. City or Town:		2b. County:	
2c. State:		2d. Country:	2e. Zip Code:
2f. Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race (<i>Specify</i>): _____			
2g. Age:	2h. Is Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No		2i. Age of Father (<i>If known</i>):
Medical History			
<i>List the total number and year for each previous pregnancies, live births, and abortions of the pregnant patient.</i>			
3a. Total number of previous pregnancies:			
Live Births			
3b. Previous Live Births: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, add year(s) for each live birth below			
Other Abortions			
3c. Previous Abortions: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, add year(s) for each abortion below			
Pre-Existing Medical Conditions			
A list of pre-existing medical conditions of the pregnant patient that may complicate the pregnancy is required, including hemorrhage, infection, uterine perforation, cervical laceration, retained products, or any other condition.			
4. Were there pre-existing medical conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list medical conditions below)			
5. Patient tested for STDs 24 hours before procedure or at time of procedure: <input type="checkbox"/> Yes <input type="checkbox"/> No		6. If positive, treated for or referred for treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Rh Status			
7. If negative, patient was provided with a Rh negative information fact sheet and treated with the prevailing medical standard of care to prevent harmful fetal or child outcomes or Rh incompatibility in future pregnancies: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Consent			
8a. Patient a minor: <input type="checkbox"/> Yes <input type="checkbox"/> No		8b. Consent in accordance with KRS 311.732(2)(a): <input type="checkbox"/> Yes <input type="checkbox"/> No	
8c. If medical emergency for minor, parent notification in accordance with KRS 311.732(9)(c): <input type="checkbox"/> Yes <input type="checkbox"/> No			
8d. Patient is an emancipated minor in accordance with KRS 311.732(2)(b): <input type="checkbox"/> Yes <input type="checkbox"/> No			
8e. Minor patient has received court approval in accordance with KRS 311.732(4)(a): <input type="checkbox"/> Yes <input type="checkbox"/> No			
Medical Judgment			
9a. Heartbeat Detected: <input type="checkbox"/> Yes <input type="checkbox"/> No	9b. Date (MM/DD/YYYY)	9c. Time	9d. Method used to detect heartbeat
10a. In the attending physician's reasonable medical judgment, the abortion was necessary to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list medical condition:			
10b. Emergency prevented parental notification: <input type="checkbox"/> Yes <input type="checkbox"/> No		10c. Emergency prevented spousal notification: <input type="checkbox"/> Yes <input type="checkbox"/> No	
11. If the probable gestational age of the fetus is <u>more than 15 weeks</u> , in the attending physician's reasonable medical judgment, the Abortion was necessary to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman: <input type="checkbox"/> Yes <input type="checkbox"/> No			
12a. If the probable gestational age of the fetus is <u>more than 15 weeks</u> , a different physician, not professionally related to the attending physician, made the reasonable medical judgment the abortion was necessary to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman: <input type="checkbox"/> Yes <input type="checkbox"/> No			

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12b. Name of Physician providing judgment in 12a:	
12c. Date medical judgment received from physician listed in 12b (MM/DD/YYYY):	
Reason for Abortion	
13. Reason for Abortion (If known): <input type="checkbox"/> Sex of the unborn child <input type="checkbox"/> The race, color, or national origin of the unborn child <input type="checkbox"/> The diagnosis, or potential diagnosis, of Down syndrome or any other disability <input type="checkbox"/> Abuse	<input type="checkbox"/> Coercion <input type="checkbox"/> Harassment <input type="checkbox"/> Trafficking <input type="checkbox"/> Reason unknown <input type="checkbox"/> Other (if known) _____
Probable Gestational Age of the Unborn Child	
14a. Method to confirm Gestational Age:	
14b. Clinical Estimate of Gestation (Weeks):	14c. Date of Gestational Age Confirmation (MM/DD/YYYY):
Probable Post-Fertilization Age of the Unborn Child	
15a. Method to confirm Post-Fertilization Age:	
15b. Clinical Estimate of Post-Fertilization Age (Weeks):	15c. Date of Post-Fertilization (MM/DD/YYYY):
16a. Date of Abortion (MM/DD/YYYY):	16. Date of consent (MM/DD/YYYY):
16c. Abortion Certificate Requested: <input type="checkbox"/> Yes <input type="checkbox"/> No If requested by the patient to whom an abortion is provided, the person in charge of the institution or the person's designated representative, shall complete the Abortion Form Certificate, and file the certificate with the state registrar within five (5) working days from Date of Abortion .	
Abortion Method	
17. Abortion Procedures That Aborted Pregnancy (Check only one) <input type="checkbox"/> Suction Curettage <input type="checkbox"/> Drug-induced (must complete 17b) <input type="checkbox"/> Dilation and Evacuation (D&E) <input type="checkbox"/> Intra-Uterine Instillation (Saline or Prostaglandin)	
<input type="checkbox"/> Sharp Curettage (D&C) <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Other _____	
17b. List medication(s) used to induce abortion:	
Must complete VS-913P	
18. If the post-fertilization age of the fetus is <u>more than 15 weeks</u> , certify the attending physician's written certification for the method and reasons for choosing the method that aborted the pregnancy. (Specify):	
19. Was a pathological examination of the fetus performed: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Complications as a Result of the Abortion	
20a. Were there any abortion complications or adverse events known to the provider as a result of the abortion? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, check all that apply)	
<input type="checkbox"/> Allergic reaction to anesthesia or abortion-inducing drugs <input type="checkbox"/> Amniotic fluid embolism <input type="checkbox"/> Cardiac arrest <input type="checkbox"/> Cervical laceration <input type="checkbox"/> Coma <input type="checkbox"/> Death <input type="checkbox"/> Deep vein thrombosis <input type="checkbox"/> Failure to terminate the pregnancy <input type="checkbox"/> Free fluid in the abdomen <input type="checkbox"/> Heavy bleeding that causes symptoms of hypovolemia or the need for a blood transfusion <input type="checkbox"/> Hemolytic reaction due to the administration of ABO-incompatible blood or blood products <input type="checkbox"/> Hypoglycemia occurring while the patient is being treated at the abortion facility <input type="checkbox"/> Any other adverse event as defined by criteria provided in the Food and Drug Administration Safety Information and Adverse Event Reporting Program.	<input type="checkbox"/> Incomplete abortion or retained tissue <input type="checkbox"/> Infection <input type="checkbox"/> Missed ectopic pregnancy <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/> Placenta Previa in subsequent pregnancies <input type="checkbox"/> Pre-term delivery in subsequent pregnancies <input type="checkbox"/> Psychological complications including depression, suicidal ideation, anxiety, and sleeping disorders <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Renal failure <input type="checkbox"/> Respiratory arrest <input type="checkbox"/> Shock <input type="checkbox"/> Uterine laceration <input type="checkbox"/> Other (Specify) _____

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20b. Follow up treatments provided: <input type="checkbox"/> Yes <input type="checkbox"/> No	20c. Were additional drugs provided to complete the drug-induced abortion: <input type="checkbox"/> Yes <input type="checkbox"/> No
20d. Was the fetus delivered alive: <input type="checkbox"/> Yes <input type="checkbox"/> No	20e. If fetus was born alive, provide length of time fetus survived:
20f. Was the fetus viable: <input type="checkbox"/> Yes <input type="checkbox"/> No	20g. If fetus was viable, provide the medical reason for termination:

Treatments Provided For Complications or Adverse Events

(If complications or adverse event occurs during the procedure or while patient is still in the facility)

21a. Treatments and Medical Interventions Provided *(including)*:

<input type="checkbox"/> Emergency Medical Services	<input type="checkbox"/> Urgent Care Follow-Up
<input type="checkbox"/> Stabilization on Site	<input type="checkbox"/> Primary Care Provider
<input type="checkbox"/> Transport to Another Medical Facility (Provide name of facility):	

21b. Was the complication or adverse event previously managed by the qualified physician who provided the abortion inducing drug or a back up qualified physician: Yes No

21c. Date the pregnant patient presented for diagnosis or treatment for the complication or adverse event:

Billing For Specific Complications or Adverse Events

The amount billed to cover the treatment for specific complications or adverse events, including whether the treatment was billed to Medicaid, private insurance, private pay, or other method. This should include ICD-10 codes reported and charges for any physician, hospital, emergency room, 1 prescription or other drugs, laboratory tests, and any other costs for 2 treatment rendered.

22a. The amount billed to cover the treatment for specific complications, including whether the treatment was billed to Medicaid, private insurance, private pay, or other method; including:

22b. Charges for any physician, hospital, emergency room, prescription or other drugs, laboratory tests, and any other costs for treatment rendered:

23. List the ICD-10 codes if treatment was provided:

Appointment

24a. Follow-up appointment kept: Yes No Date (MM/DD/YYYY)

24b. Results of follow-up appointment:

24c. If appointment was not kept were reasonable efforts made to reschedule the follow-up appointment: Yes No

24d. If yes, describe what reasonable efforts were made:

25. Name of person completing report *(Type or print)* _____

This form shall be sent to the State Registrar of Vital Statistics within 3 days after the end of the month in which the abortion occurred.

(Each abortion as defined in KRS 311.720 that occurs in the commonwealth, regardless of the length of gestation, shall be reported to the Vital Statistics Branch by the person in charge of the institution or attending physician within three (3) days after the end of the month in which the abortion occurred.)

**Office of Vital Statistics
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