VS-913 Rev. 12/2022

RESET

COMMONWEALTH OF KENTUCKY
STATE REGISTRAR OF VITAL STATISTICS
REPORT OF ABORTION
TYPE OR PRINT IN PERMANENT BLACK INK

Kentucky Public Health
Prevent. Promote. Protect.

Facility Information

The full name and address of the referring physician, agency, or service, if any.

1a. Facility Name:

1b. Physician performing procedure: | 1c. Referring Physician:

1d. Address:

1e. City: | 1f. State: | 1g. Zip Code:

Patient Information

The pregnant patient's city or town, county, state, country of residence, and zip code.

2a. City or Town: | 2b. County:

2c. State: | 2d. Country: | 2e. Zip Code:

2f. Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Unknown
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other Race (*Specify*): _____

2g. Age: | 2h. Is Hispanic: ☐ **Yes** ☐ **No** | 2i. Age of Father (*If known*):

Medical History

List the total number and year for each previous pregnancies, live births, and abortions of the pregnant patient.

3a. Total number of previous pregnancies:

Live Births

3b. Previous Live Births: ☐ **Yes** ☐ **No** If yes, *add year(s) for each live birth below*

Other Abortions

3c. Previous Abortions: ☐ **Yes** ☐ **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: ☐ **Yes** ☐ **No** (If yes, *list medical conditions below)*

5. Patient tested for STDs 24 hours before procedure or at time of procedure: ☐ **Yes** ☐ **No**

6. If positive, treated for or referred for treatment: ☐ **Yes** ☐ **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: ☐ **Yes** ☐ **No**

Consent

8a. Patient a minor: ☐ **Yes** ☐ **No**

8b. Consent in accordance with KRS 311.732(2)(a): ☐ **Yes** ☐ **No**

8c. If medical emergency for minor, parent notification in accordance with KRS 311.732(9)(c): ☐ **Yes** ☐ **No**

8d. Patient is an emancipated minor in accordance with KRS 311.732(2)(b): ☐ **Yes** ☐ **No**

8e. Minor patient has received court approval in accordance with KRS 311.732(4)(a): ☐ **Yes** ☐ **No**

Medical Judgment

9a. Heartbeat Detected: ☐ **Yes** ☐ **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: ☐ **Yes** ☐ **No** If yes, list medical condition:

10b. Emergency prevented parental notification: ☐ **Yes** ☐ **No**

10c. Emergency prevented spousal notification: ☐ **Yes** ☐ **No**

11. If the probable gestational age of the fetus is more than 15 weeks, 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: ☐ **Yes** ☐ **No**

12a. If the probable gestational age of the fetus is more than 15 weeks, 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: ☐ **Yes** ☐ **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*):
- ☐ Sex of the unborn child
- ☐ The race, color, or national origin of the unborn child
- ☐ The diagnosis, or potential diagnosis, of Down syndrome or any other disability
- ☐ Abuse
- ☐ Coercion
- ☐ Harassment
- ☐ Trafficking
- ☐ Reason unknown
- ☐ 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**: ☐ **Yes** ☐ **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*)
- ☐ Suction Curettage
- ☐ Drug-induced (must complete 17b)
- ☐ Dilation and Evacuation (D&E)
- ☐ Intra-Uterine Instillation (Saline or Prostaglandin)
- ☐ Sharp Curettage (D&C
- ☐ Hysterotomy/Hysterectomy
- ☐ Other _____

17b. List medication(s) used to induce abortion:

****Must complete VS-913P****

18. If the post-fertilization age of the fetus is more than 15 weeks, 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: ☐ **Yes** ☐ **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? ☐ **Yes** ☐ **No**

(If yes, check all that apply)
- ☐ Allergic reaction to anesthesia or abortion-inducing drugs
- ☐ Amniotic fluid embolism
- ☐ Cardiac arrest
- ☐ Cervical laceration
- ☐ Coma
- ☐ Death
- ☐ Deep vein thrombosis
- ☐ Failure to terminate the pregnancy
- ☐ Free fluid in the abdomen
- ☐ Heavy bleeding that causes symptoms of hypovolemia or the need for a blood transfusion
- ☐ Hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- ☐ Hypoglycemia occurring while the patient is being treated at the abortion facility
- ☐ Any other adverse event as defined by criteria provided in the Food and Drug Administration Safety Information and Adverse Event Reporting Program.
- ☐ Incomplete abortion or retained tissue
- ☐ Infection
- ☐ Missed ectopic pregnancy
- ☐ Pelvic inflammatory disease
- ☐ Placenta Previa in subsequent pregnancies
- ☐ Pre-term delivery in subsequent pregnancies
- ☐ Psychological complications including depression, suicidal ideation, anxiety, and sleeping disorders
- ☐ Pulmonary embolism
- ☐ Renal failure
- ☐ Respiratory arrest
- ☐ Shock
- ☐ Uterine laceration
- ☐ Other (Specify) _____

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20b. Follow up treatments provided: ☐ **Yes** ☐ **No**	20c. Were additional drugs provided to complete the drug-induced abortion: ☐ **Yes** ☐ **No**
20d. Was the fetus delivered alive: ☐ **Yes** ☐ **No**	20e. If fetus was born alive, provide length of time fetus survived:
20f. Was the fetus viable: ☐ **Yes** ☐ **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*):

☐ Emergency Medical Services
☐ Stabilization on Site
☐ Transport to Another Medical Facility (Provide name of facility)
☐ Urgent Care Follow-Up
☐ Primary Care Provider

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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