

**COMMONWEALTH OF KENTUCKY
STATE REGISTRAR OF VITAL STATISTICS**



Abortion Prescription Reporting Form

Physician Reporting **Pharmacy Reporting**

For Physician Reporting: Each prescription issued for which the primary indication is the induction of abortion as defined in KRS 311.720 shall be reported to the Office of Vital Statistics within three (3) days after the prescription was issued as required by KRS 311.774. The report shall not include information that will identify the woman involved or anyone who may be picking up the prescription on behalf of the woman.

For Pharmacy Reporting: Each prescription dispensed for which the primary indication is the induction of abortion as defined in KRS 213.101 shall be reported to the Office of Vital Statistics within three (3) days after the end of the month in which the prescription was dispensed as required by KRS 213.172. The report shall not include information that will identify the woman involved or anyone who may be picking up the prescription on behalf of the woman.

Physician Information		
<i>The full name and address of the referring physician, agency, or service, if any.</i>		
1a. Facility Name:	1b. Referring Physician:	
1c. Address:		
1d. City:	1e. State:	1f. Zip Code:
1g. Medications Prescribed and Dispensed by Physician: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, Pharmacy information in sections 3a through 3f not required to be completed by Physician)</i>		
Medications Prescribed		
2a. Select the medication provided:	2b. Date Prescribed:	
<input type="checkbox"/> RU-486		
<input type="checkbox"/> Cytotec		
<input type="checkbox"/> Pitocin		
<input type="checkbox"/> Mifeprex		
<input type="checkbox"/> Misoprostol		
<input type="checkbox"/> Other (specify)		
Pharmacy Information		
<i>The full name of the pharmacist, name, and address of the pharmacy dispensing medication.</i>		
3a. Pharmacy Name:	3b. Pharmacist Name:	
3c. Address:		
3d. City:	3e. State:	3f. Zip Code:
Patient Information		
<i>The pregnant patient's city or town, county, state, country of residence, and zip code.</i>		
4a. City or Town:	4b. County:	
4c. State:	4d. Country:	4e. Zip Code:
4f. 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>): _____		
4g. Age:	4h. Is Hispanic: <input type="checkbox"/> Yes <input type="checkbox"/> No	4i. Age of Father (<i>If known</i>):
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.		
5. Were there pre-existing medical conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, list medical conditions below)		
Rh Status		
6. 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		

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Reason for Abortion					
7. 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"/> Other (if known) _____		
Medications Dispensed					
8a. Select the medication dispensed:	8b. Date Dispensed	8c. Serial No.	8d. National Drug Code	8e. Lot No.	8f. Expiration Date
<input type="checkbox"/> RU-486					
<input type="checkbox"/> Cytotec					
<input type="checkbox"/> Pitocin					
<input type="checkbox"/> Mifeprex					
<input type="checkbox"/> Misoprostol					
<input type="checkbox"/> Other (specify)					
Method for Obtaining the Abortion-inducing Drug					
9a. Prescription ordered directly with pharmacy <input type="checkbox"/> Name of pharmacy:					
9b. Mail order <input type="checkbox"/> Name of pharmacy:					
9c. Internet order <input type="checkbox"/> Website address:					
9d. Telehealth provider <input type="checkbox"/>					

Office of Vital Statistics Address:

**Office of Vital Statistics
275 East Main Street, 1E-A
Frankfort, KY 40621
Fax: 502-564-9398**

Failure to submit a report by the end of thirty (30) days following the due date shall be subject to a late fee of five hundred dollars (\$500) for each additional thirty (30) day period or portion of a thirty (30) day period the report is overdue.

Failure by any pharmacist or pharmacy to comply with these reporting requirements, other than filing a late report, or to submit a complete report in accordance with a court order shall subject the pharmacist or pharmacy to KRS 315.121.

Signature of person completing the form

Date