SFN:002915

TERMINATED PREGNANCY REPORT

INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

** If the patient is less than sixteen (16) years of age the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov.
Further, this **report shall also be submitted** to the Indiana State Department of Health within three (3) days of the termination. (See IC 16-34-2-5)

Reports for all other patients shall be submitted to the Indiana State Department of Health **no later than 30 days after each termination is performed.** Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Facility Name and Address	City or town, of pregnancy termination	County of pregnancy termination
THE WOMEN'S MED CENTER OF INDIANAPOLIS - 1201 N ARLINGTON AVE, INDIANAPOLIS, IN, 46219	INDIANAPOLIS	MARION

Patient's age**	Married	Date of pregnancy termination	Education
12	☐ Yes ☒ No	05/11/2018	8th Grade or Less

Race
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☒ White ☐ Other ☐ Unknown

Ethnicity
☐ Hispanic or Latino ☒ Not Hispanic or Latino ☐ Unknown

Live Births:	Number now living: 0	Number now deceased: 0
Other Terminations:	Number of spontaneous terminations: 0	Number of induced terminations: 0

Dates of terminations *(Do not include this termination. If more than six (6), those most recent.)*
1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive?	If yes, length of time fetus survived:	Complication(s) of Pregnancy Termination
☐ Yes ☒ No		☒ None ☐ Uterine Perforation
Fetus viable? ☐ Yes ☒ No	If viable, medical reason for termination:	☐ Hemorrhage ☐ Cervical Laceration
		☐ Infection ☐ Retained Products
		☐ Other *(Specify)*
Pathological examination performed? ☒ Yes ☐ No	If yes, results: CHORIONIC VILLAE, GESTATIONAL SAC	Did this termination of pregnancy result in a maternal death? ☐ Yes ☒ No

Type of Termination Procedures

Procedure that Terminated Pregnancy	Additional Procedure that Terminated Pregnancy
☐ Medical (Nonsurgical) Mifepristone ☐ Medical (Nonsurgical) Misoprostol ☐ Medical (Nonsurgical) Other *(Specify)*	☐ Medical (Nonsurgical) Mifepristone ☐ Medical (Nonsurgical) Misoprostol ☐ Medical (Nonsurgical) Other *(Specify)*
☒ Medical (Surgical) Suction Curettage ☐ Medical (Surgical) Menstrual Aspiration ☐ Medical (Surgical) Other *(Specify)*	☐ Medical (Surgical) Suction Curettage ☐ Medical (Surgical) Menstrual Aspiration ☐ Medical (Surgical) Other *(Specify)*
For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? ☐ Yes ☒ No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? ☐ Yes ☐ No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	For Medical (Surgical) procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? ☐ Yes ☐ No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? ☐ Yes ☐ No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?

Date last normal menses began	Physician estimate of gestation *(in weeks)*	Post fertilization age of the fetus *(in weeks)*
03/01/2018	8	6

How were the gestational age and post fertilization age determined?
ULTRASOUND EXAMINATION, PELVIC EXAMINATION

Full name of physician performing termination
DR. JEFFREY D. GLAZER

Address of physician performing termination *(number and street, city, state, and zip code)*
1201 N ARLINGTON AVE, INDIANAPOLIS, IN 46219

[redacted]

**Date Reported to DCS, if Patient under 16 *(month, day, year)*: _____

DATE RECEIVED BY ISDH *(month, day, year)*: 05/11/2018