

TERMINATED PREGNANCY REPORT
 INDIANA 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 deshotlinereports@dcs.in.gov. Further, this report shall also be submitted to the Indiana Department of Health within three (3) days of the termination. (See IC 16-34-2-5(b))

Reports for all other patients shall be submitted to the Indiana 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 PPIN-GEORGETOWN OR (PPGI) 8590 GEORG		City or Town, of pregnancy termination Indianapolis		County of pregnancy termination Marion	
Patient's age** 15		Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input checked="" type="checkbox"/> Not Married		Date of pregnancy termination 03/11/2022	
Sex of fetus if detectable <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Multifetal Pregnancies <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other			
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input checked="" type="checkbox"/> White <input type="checkbox"/> Korean <input type="checkbox"/> Black or African American <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Chinese <input type="checkbox"/> Other <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Japanese <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Yes, Mexican <input type="checkbox"/> Yes, Puerto Rican <input checked="" type="checkbox"/> No, not Hispanic <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Unknown if Hispanic <input type="checkbox"/> Yes, Other Hispanic Origin			
Previous Pregnancies					
Live Births:		Number now living None		Number now deceased None	
Other Terminations:		Number of spontaneous terminations None		Number of induced terminations None	
Years of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____					
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, length of time fetus survived:		List any preexisting medical conditions of the patient that may complicate the abortion None Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If viable, medical reason for termination:			
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		If yes, results:			
Type of Termination Procedures					
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> (Nonsurgical) Mifepristone <input type="checkbox"/> Intrauterine instillation (Saline or prostaglandin) <input checked="" type="checkbox"/> (Nonsurgical) Misoprostol <input type="checkbox"/> (Nonsurgical) Other (Specify)			Additional Procedure that Terminated Pregnancy <input type="checkbox"/> (Nonsurgical) Mifepristone <input type="checkbox"/> Intrauterine instillation (Saline or prostaglandin) <input type="checkbox"/> (Nonsurgical) Misoprostol <input type="checkbox"/> (Nonsurgical) Other (Specify)		
For (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement			For (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> The patient signed the patient agreement		
<input type="checkbox"/> (Surgical) Suction Curettage <input type="checkbox"/> Surgical Sharp Curettage (D & C) <input type="checkbox"/> (Surgical) Dilatation and Evacuation (D & E) <input type="checkbox"/> (Surgical) Other (Specify) <input type="checkbox"/> Hysterotomy/Hysterectomy			<input type="checkbox"/> (Surgical) Suction Curettage <input type="checkbox"/> Surgical Sharp Curettage (D & C) <input type="checkbox"/> (Surgical) Dilatation and Evacuation (D & E) <input type="checkbox"/> (Surgical) Other (Specify) <input type="checkbox"/> Hysterotomy/Hysterectomy		
For Surgical procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> 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 Surgical procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> 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?		
List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)					
Date last normal menses began 01/01/2022		Physician estimate of gestation (in weeks) 9		Post fertilization age of the fetus (in weeks) 7	
How were the gestational age and post fertilization age determined? Ultrasound					
Was a waiver of consent obtained pursuant to IC 16-34-2-4? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Was a waiver of notification obtained pursuant to IC 16-34-2-4? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					

Diagnostic

Did patient have a prenatal diagnostic procedure that revealed a fetal abnormality?

Observed or suspected anomaly(ies) - Check all that apply:

- Chromosomal Anomaly Heart Anomaly Down Syndrome
 Neural Tube Defect Ventral Wall Defect Other

Was diagnosis confirmed after termination by autopsy or other pathological examination?

Procedure(s) Used:

- Amniocentesis Chronic Villus Sampling Other
 Ultrasound Maternal Serum Alpha Fetoprotein Unknown
 Cordocentesis

Is the patient seeking an abortion as a result of being any of the following?

- Abused Coerced None
 Harassed Trafficked Unknown

Full name of physician performing termination

RHIANNON AMODEOBANKERT

Address of physician performing termination (number and street, city, state, and zip code)

5877 CREST INDIANPOLIS IN 46268

Age of father 17

If age not known, approximate age

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

Date Received by IDOH (month, day, year)

03/18/2022