



**CERTIFICATION OF PROVISION OF PERINATAL HOSPICE INFORMATION
(TIME OF DIAGNOSIS OF A LETHAL FETAL ANOMALY)**

State Form 56113 (R / 8-24)
INDIANA DEPARTMENT OF HEALTH – IC 16-25-4.5-6

PROVIDER RESPONSIBLE FOR COMPLETION OF FORM: A provider who diagnoses a pregnant woman's unborn child with a lethal fetal anomaly is responsible for providing this form to the patient and securing the patient's certification.

PURPOSE OF FORM: This form is required if your unborn child is diagnosed with a lethal fetal anomaly. It documents that, at the time of your unborn child's diagnosis, the provider has given you a printed copy of the ISDH Perinatal Hospice Brochure and a printed list of perinatal providers and programs in Indiana, as required under IC 16-25-4.5-4 and IC 16-25-4.5-5.

The completed form is kept by the provider as part of your medical record. You will be provided with a copy of the completed form.

Patient Certification

I certify that:

1. I have been provided with the following information: *(Please initial.)*

_____ A copy of the ISDH Perinatal Hospice Brochure

_____ A list of perinatal hospice providers and programs in Indiana
2. The above information was provided at the time of receiving a diagnosis that my unborn child has a lethal fetal anomaly.

I certify the following: *(Select appropriate item.)*

- _____ I am eighteen (18) years of age or older. *(Attach documentation of age.)*
- _____ I am under eighteen (18) years of age but have been emancipated by a court order or issued a waiver of parental consent by a juvenile court. *(Attach copy of court order or waiver.)*
- _____ I am under eighteen (18) years of age. *(Parent or guardian consent required; see following section.)*

Printed Name of Patient

Patient's Medical Record Number

Signature of Patient

Date (month, day, year)

Time

Parent / Guardian Certification (if required)

The certification of a parent or guardian is required if a woman having the abortion is under the age of eighteen (18) unless the woman has been emancipated by a court order or issued a waiver of parental consent by a juvenile court.

I certify that:

1. I am the parent or legal guardian of the patient identified above. (*Attach documentation of parental or guardian status.*)
2. My child or ward has been provided with a printed copy of the ISDH Perinatal Hospice Brochure and a printed list of perinatal providers and programs in Indiana.
3. The information described above was provided to my child or ward at the time she received a diagnosis that her unborn child has a lethal fetal anomaly.

Printed Name of Parent / Guardian Relationship to Patient

Signature of Parent / Guardian Date (month, day, year) Time

Provider Certification

I certify that:

1. The unborn child of the patient named above has been diagnosed with a lethal fetal anomaly.
2. At the time of diagnosis of the lethal fetal anomaly, the patient was provided all the required information described above.
3. I have had the patient and, if applicable, the patient's parent or guardian complete this form.
4. A completed copy of this form has been provided to the patient and, if applicable, the patient's parent or guardian.

Printed Name of Provider Professional Credentials License Number

Signature of Provider Date (month, day, year)