Reset Form

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

State Form 56113 (8-16)
Indiana State 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)*