Reset Form

DISPOSITION OF ABORTED FETUS CERTIFICATION

State Form 56114 (R4 / 12-21)
INDIANA DEPARTMENT OF HEALTH – IC 16-34-2-1.1(a)(2), IC 16-34-3-2(b)

PURPOSE OF FORM: This form documents your decision concerning the final disposition of the aborted fetus. 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.

If you decide for the provider to be responsible for disposition, the provider may dispose of the aborted fetus by burial or cremation at a funeral home or crematorium. Ask the provider if you want to know the specific method or location for disposition. If you wish to choose a different method or location for disposition of the aborted fetus, you have the right to choose that option and will be responsible for the costs of the burial or cremation, if any. You also have the right to change your mind before the final disposition is completed.

If you have a medication abortion, it is possible you will expel an aborted fetus and tissue associated with the pregnancy. You may or may not see tissue that looks like an embryo or fetus. If you expel the fetus somewhere other than the provider's facility, you have the right if you wish to return the fetus to the provider for disposition by burial or cremation at a funeral home or crematorium. Ask the provider if you want to know the specific method or location for disposition.

Patient Certification

I certify that:

1. At least eighteen (18) hours before the abortion, the provider has informed me orally and in writing that I have a right to determine the final disposition of the aborted fetus; provided me with information concerning the available options for disposition of the aborted fetus; and, if applicable, told me the specific method for disposition of the aborted fetus in this case.

2. I have decided to dispose of the aborted fetus by:

   ☐ Abortion clinic / health care facility will arrange for burial / cremation of the aborted fetus with a crematorium or funeral home.

   ☐ I am choosing a method or location for burial / cremation of the aborted fetus that is different than the abortion clinic / health care facility arrangements and will be responsible for the costs of the burial or cremation, if any.

   ☐ *(For medication abortions only)* I am planning to return the aborted fetus to the abortion clinic / health care facility, which will arrange for burial / cremation of the aborted fetus with a crematorium or funeral home.

I further 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

Patient MRN: _____

Parent / Guardian Certification and Notarization ***(if required)***
IC 16-18-2-267

The consent 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. At least eighteen (18) hours before the abortion, my child or ward has been provided the information described above.
3. My child or ward has determined the disposition of the aborted fetus as selected above.
4. I consent in my child or ward's disposition of the aborted fetus as selected above.

_____ _____
Printed Name of Parent / Guardian Relationship to Patient

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

State of Indiana
County of: _____

Having personally appeared and upon positive identification; signed and

affirmed under oath before me on _____, 20___ by_____.

_____
Notary Public Signature
Commissioned in _____ County.

Notary Public Seal

Patient MRN: _____

Provider Certification

I certify that:

1. At least eighteen (18) hours before the abortion, the patient named above has been informed orally and in writing that she has a right to determine the final disposition of the aborted fetus; provided with information concerning the available options for disposition of the aborted fetus; and, if applicable, told which specific method and location of disposition will be used in this case.

2. The patient has determined the disposition of the aborted fetus as selected above.

3. If applicable, the patient's parent or guardian has consented in the patient's determination of disposition of the aborted fetus as selected above.

4. A completed copy of this form has been provided to the patient and, if applicable, to the patient's parent or guardian, and this form will be filed in the patient record.

Printed Name of Physician or Other Provider	Professional Credentials	License Number

Signature of Physician or Other Provider	Date *(month, day, year)*

Patient MRN: _____