



ABORTION COMPLICATION REPORT

State Form 56522 (R2 / 1-22)
INDIANA STATE DEPARTMENT OF HEALTH – VITAL RECORDS
per IC 16-34-2

PLEASE CHECK IF AN AMENDED FORM:

E-mail completed form to: TPComplications@health.in.gov

*Abortion Complication Reports for all patients shall be mailed to the Indiana State Department of Health at the above address.
Each failure to file this report on time, as required, is a Class B misdemeanor per IC 16-34-2-4.7(j)*

Facility name		City or town of abortion complication		County of abortion complication	
If facility is not a hospital or clinic, please enter address (number and street, city, state, and ZIP code)					
Patient's age		Date of pregnancy termination (month, day, year)		Date of abortion complication (month, day, year)	
Race (Select one or more.) <input type="checkbox"/> Black or African American		<input type="checkbox"/> American Indian, Alaska Native, or Asian	<input type="checkbox"/> Declined to state	<input type="checkbox"/> White	Ethnicity
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		<input type="checkbox"/> Multiracial	<input type="checkbox"/> Other	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Not Hispanic or Latino
Patient's county of residence			Patient's state of residence		
Method of termination obtained by patient			If medication was used to terminate the pregnancy, was medication obtained by a mail order or internet source? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Disclosed		
Name of facility where the termination was performed			If medication was obtained by mail order or internet source, please list the source.		
Name of medication(s) used for termination, if any					
Did you perform the termination for the named patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			Was this complication previously managed by the abortion provider or abortion provider's backup physician? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Please list each diagnosed abortion complication and, for each, provide the treatment provided.				Was this an initial visit by this patient or a follow up visit?	
				Initial visit: <input type="checkbox"/> Yes <input type="checkbox"/> No	
				Follow up visit: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date(s) (month, day, year) of each follow up visit, if any:					

Signature of physician		Full name of physician	
Address of physician (number and street, city, state, and ZIP code)			

DATE RECEIVED BY ISDH (month, day, year): _____

General Instructions for the Use and Completion of the Abortion Complication Report (State Form 56522 (R2 / 1-22))

Providers must utilize State Form 56522 (R2 / 1-22), entitled Abortion Complication Report, in recording and transmitting the information required under Indiana Code section 16-34-2-4.7.

Please follow these instructions for completing the Abortion Complication Report:

- The form should be submitted within 30 days of the onset of treatment of the abortion complication.
- Physicians should use their reasonable medical judgment in determining whether a diagnosed condition is a reportable as an abortion complication.
- A report should be submitted for the patient's initial visit for a complication is treated and for any follow-up visits where a new complication is diagnosed and treated.
- The completed form must include a list of each abortion complication diagnosed and describe in detail the medical treatment provided for each complication.
- Either the treating physician **or** the facility needs to submit the form, **not both**. Physicians and facilities should have a documented policy about submission to avoid confusion.
- The abortion complications reporting form is a separate form in addition to the terminated pregnancy report that must be filed for each abortion. **Do not** reference the abortion complication in any terminated pregnancy report.
- Providers should ensure that no identifying information of the patient is included in the abortion complication report.
- Providers must file an abortion complication report if the physician determines that any of the following physical or psychological conditions arose from the induction or performance of an abortion:

- (1) Uterine perforation.
- (2) Cervical laceration.
- (3) Infection.
- (4) Vaginal bleeding that qualifies as a Grade 2 or higher adverse event according to the Common Terminology Criteria for Adverse Events (CTCAE).
- (5) Pulmonary embolism.
- (6) Deep vein thrombosis.
- (7) Failure to terminate the pregnancy.
- (8) Incomplete abortion (retained tissue).
- (9) Pelvic inflammatory disease.
- (10) Missed ectopic pregnancy.
- (11) Cardiac arrest.
- (12) Respiratory arrest.
- (13) Renal failure.
- (14) Shock.
- (15) Amniotic fluid embolism.
- (16) Coma.
- (17) Placenta previa in subsequent pregnancies.
- (18) Pre-term delivery in subsequent pregnancies.
- (19) Free fluid in the abdomen.
- (20) Hemolytic reaction due to the administration of ABO-incompatible blood or blood products.
- (21) Hypoglycemia occurring while the patient is being treated at the abortion facility.
- (22) Allergic reaction to anesthesia or abortion-inducing drugs.
- (23) Psychological complications, including depression, suicidal ideation, anxiety, and sleeping disorders.
- (24) Death.
- (25) Any other adverse event as defined by criteria provided in the Food and Drug Administration Safety Information and Adverse Event Reporting Program.