



# ABORTION COMPLICATION REPORT

State Form 56522 (R5 / 4-24)  
INDIANA DEPARTMENT OF HEALTH – VITAL RECORDS  
per IC 16-34-2

<b>Date Received by IDOH (month, day, year)</b>

Abortion Complication Reports for all patients shall be emailed to the Indiana Department of Health at [TPComplications@health.in.gov](mailto:TPComplications@health.in.gov). Additionally, all corrections to the submitted form shall be directed to this address. Each failure to file this report on time, as required, is a Class B misdemeanor per IC 16-34-2-4.7(j). This form shall be typed except for the physician or facility signature.

Name of facility where abortion complication was treated		City or town where abortion complication was treated		County where abortion complication was treated	
Address of facility where abortion complication was treated (number and street, city, state, and ZIP code)					
Patient's age		Date of abortion (month, day, year)		Date of abortion complication (month, day, year)	
Which one or more of the following is your race? (Select one or more.) <input type="checkbox"/> American Indian or Alaska Native				Hispanic Origin (Check all that apply)	
<input type="checkbox"/> Asian Indian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander				<input type="checkbox"/> No, not Spanish, Hispanic or Latino	
<input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian				<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano	
<input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)				<input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban	
<input type="checkbox"/> Yes, other Spanish, Hispanic, Latino				<input type="checkbox"/> Unknown	
Patient's county of residence			Patient's state of residence		
Name of facility where the abortion was performed			If medication was used to abort 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		
Method of abortion obtained by patient <input type="checkbox"/> Surgical <input type="checkbox"/> Non-surgical <input type="checkbox"/> Other <input type="checkbox"/> Unknown			If medication was obtained by mail order or internet source, please list the source.		
Name of medication(s) used for abortion, if any					
Did you perform the abortion 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		
Select each diagnosed abortion complication.				Was this an initial visit by this patient at the time of the of the abortion or a follow-up visit after the initial abortion?	
<input type="checkbox"/> Uterine perforation				Initial visit: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Cervical laceration				Follow-up visit: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Infection				Date(s) (month, day, year) of each follow-up visit, if any:	
<input type="checkbox"/> Vaginal bleeding that qualifies as a Grade 2 or higher adverse event according to the Common Terminology Criteria for Adverse Events (CTCAE)				Select each treatment for the diagnosed abortion complication	
<input type="checkbox"/> Pulmonary embolism				<input type="checkbox"/> Admission to the hospital	
<input type="checkbox"/> Deep vein thrombosis				<input type="checkbox"/> Surgical intervention	
<input type="checkbox"/> Failure to terminate pregnancy				<input type="checkbox"/> Blood transfusion	
<input type="checkbox"/> Incomplete abortion (retained tissue)				<input type="checkbox"/> Medication treatment	
<input type="checkbox"/> Pelvic inflammatory disease				<input type="checkbox"/> Other (Specify)	
<input type="checkbox"/> Missed ectopic pregnancy				Signature of physician or facility staff member	
<input type="checkbox"/> Cardiac arrest				Full name of treating physician	
<input type="checkbox"/> Respiratory arrest				Address of physician office (number and street, city, state, and ZIP code)	
<input type="checkbox"/> Renal failure				Full name of staff member completing form	
<input type="checkbox"/> Shock					
<input type="checkbox"/> Amniotic fluid embolism					
<input type="checkbox"/> Coma					
<input type="checkbox"/> Placenta previa in subsequent pregnancies					
<input type="checkbox"/> Pre-term delivery in subsequent pregnancies					
<input type="checkbox"/> Free fluid in the abdomen					
<input type="checkbox"/> Hemolytic reaction due to the administration of ABO-incompatible blood or blood products					
<input type="checkbox"/> Hypoglycemia occurring while the patient is being treated at the abortion facility					
<input type="checkbox"/> Allergic reaction to anesthesia or abortion-inducing drugs					
<input type="checkbox"/> Psychological complications, including depression, suicidal ideation, anxiety, and sleep disorders					
<input type="checkbox"/> Death					
<input type="checkbox"/> Any other adverse event as defined by criteria provided in the Food and Drug Safety Information and Adverse Event Reporting Program					
<input type="checkbox"/> Other (Specify)					

## General Instructions for the Use and Completion of the Abortion Complication Report (State Form 56522 (R4 / 10-23))

Providers must utilize State Form 56522 (R4 / 10-23), 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 reportable as an abortion complication.
- The form must be typed, except for physician signature.
- A report should be submitted for the patient's initial visit for a complication that is treated and for any follow-up visits where a new complication is diagnosed and treated.
- The completed form must select each abortion complication diagnosed and the medical treatment provided for each complication. Physicians may fill in the "other" box when the complication or treatment is not included as an option.
- 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 sleep 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