Reset Form

TERMINATED PREGNANCY REPORT

State Form 36526 (R5 / 10-23)
INDIANA DEPARTMENT OF HEALTH – VITAL RECORDS
Per IC 16-34-2

**** If the patient is less than sixteen (16) years of age** the physician performing the termination shall transmit this report to the Department of Child Services within **three (3) days after** the termination is performed via email at dcshotlinereports@dcs.in.gov.
Further, this **report shall also be submitted** to the Indiana Department of Health within three (3) days of the termination. (See IC 16-34-2-5 (b))

Reports for all other patients shall be submitted to the Indiana Department of Health **no later than 30 days after each termination is performed.**
Each failure to file this report on time as required is a Class B misdemeanor per IC 16-34-2-5(d).

Termination Location *(Facility name and Address, City, State, Zip Code)*	City or town, of pregnancy termination	County of pregnancy termination

Patient's age**	Married	Date of pregnancy termination	Education

Sex of fetus if detectable	Multifetal Pregnancies
☐ Male ☐ Female ☐ Unknown	☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other

Race	Ethnicity

Reason for Abortion

If applicable, Diagnosis Code(s)

Previous Pregnancies

Live Births	Number now living	Number now deceased
Other Terminations	Number of spontaneous terminations	Number of induced terminations

Years of termination *(Do not include this termination. If more than six (6), those most recent.)*

1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Fetus delivered alive?	If yes, length of time fetus survived:	List any preexisting medical conditions of the patient that may complicate the abortion.
☐ Yes ☐ No		

Pathological examination performed?	If yes, results if available:	Did this termination of pregnancy result in a maternal death?
☐ Yes ☐ No		☐ Yes ☐ No

Type of Termination Procedures

Procedure that Terminated Pregnancy	For Surgical procedures, answer the following question
For Nonsurgical procedures, answer the following question Check the box indicating the following items were completed ☐ The manufacturer's instructions provided to the patient ☐ Not applicable ☐ The patient signed the patient agreement ☐ Not applicable	Did the fetus have a post fertilization age at least 20 weeks? ☐ Yes ☐ No ☐ Not applicable If the previous question was answered yes, complete the following question. Was the fetus given the best opportunity to survive? ☐ Yes ☐ No ☐ Not applicable

If performed after viability or 20 weeks, list the name of the second doctor present.

Date last normal menses began	Physician estimate of gestation *(in weeks)*	Postfertilization age of the fetus *(in weeks)*

How were the gestational age and post fertilization age determined?

Was a waiver of parental consent obtained pursuant (IC 16-34-2-4)?	Was a waiver of parental notification obtained (IC 16-34-2-4)?
☐ Yes ☐ No	☐ Yes ☐ No

Diagnostic
Did patient have a prenatal diagnostic procedure that revealed lethal fetal anomaly? ☐ Yes ☐ No ☐ Unknown Was the fetus diagnosed with or has a potential diagnosis of having Down Syndrome or any other disability? ☐ Yes ☐ No Was diagnosis confirmed after termination by autopsy or other pathological examination? ☐ Yes ☐ No ☐ Unknown
Is the patient seeking an abortion as a result of abuse, coercion, harassment, or trafficking?

Full name of physician performing termination
Address of physician performing termination *(number and street, city, state, and zip code)*

Patient Identification Number	State of Residence	County of Residence
Age of father	If age not known, approximate age	

Date Reported to DCS, if Patient under 16 (month, day, year) _____

Date Received by IDOH (month, day, year) _____