



# TERMINATED PREGNANCY REPORT

State Form 36526 (R6 / 4-26)  
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](mailto: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 ( <i>Facility name and Address, City, State, Zip Code</i> )	City or town, of pregnancy termination	County of pregnancy termination
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Patient's age**	Married	Date of pregnancy termination	Education
Sex of fetus if detectable <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Multifetal Pregnancies <input type="checkbox"/> N/A <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other		

Race	Ethnicity
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Reason for Abortion <i>If applicable, Diagnosis Code(s)</i>
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Previous Pregnancies		
Live Births	Number now living	Number now deceased
Other Terminations	Number of spontaneous terminations	Number of induced terminations

Years of termination ( <i>Do not include this termination. If more than six (6), those most recent.</i> )					
1. _____	2. _____	3. _____	4. _____	5. _____	6. _____

Fetus delivered alive? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, length of time fetus survived:	List any preexisting medical conditions of the patient that may complicate the abortion.
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Pathological examination performed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, results if available:	Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Type of Termination Procedures	
Procedure that Terminated Pregnancy For Nonsurgical procedures, answer the following question Check the box indicating the following items were completed <input type="checkbox"/> The manufacturer's instructions provided to the patient <input type="checkbox"/> Not applicable <input type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> Not applicable	For Surgical procedures, answer the following question Did the fetus have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable If the previous question was answered yes, complete the following question. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable Was the medication used to induce labor? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 ( <i>in weeks</i> )	Postfertilization age of the fetus ( <i>in weeks</i> )
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How were the gestational age and post fertilization age determined?
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Was a waiver of parental consent obtained pursuant (IC 16-34-2-4)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was a waiver of parental notification obtained (IC 16-34-2-4)? <input type="checkbox"/> Yes <input type="checkbox"/> No
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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) \_\_\_\_\_