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**ARKANSAS DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
REPORT OF INDUCED TERMINATION OF PREGNANCY
(For Statistical Use Only)**

File Date
(State Use Only)

| | | | | | |
|---|------------|---|--|---|---|
| 1. FACILITY NAME <i>(If not clinic or hospital, give address)</i> | | 2. CITY, TOWN OR LOCATION OF PREGNANCY TERMINATION | | 3. COUNTY OF PREGNANCY TERMINATION | |
| 4. AGE LAST BIRTHDAY | | 5. MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 6. DATE OF PREGNANCY TERMINATION <i>(Month, Day, Year)</i> | |
| 7a. RESIDENCE-STATE | 7b. COUNTY | 7c. CITY, TOWN, OR LOCATION | | 7d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | 7e. ZIP CODE |
| 8. OF HISPANIC ORIGIN? <i>(Specify No or Yes—If Yes, specify Cuba, Mexican, Puerto Rican, etc.)</i> <input type="checkbox"/> NO <input type="checkbox"/> YES Specify _____ | | 9. RACE <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> Other (Specify) _____ | | 10. EDUCATION <i>(Specify only highest grade completed)</i> Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 11. DATE LAST NORMAL MENSES BEGAN <i>(Month, Day, Year)</i> | | | | | |
| 12. PROBABLE POST-FERTILIZATION AGE (PPF) | | | | | |
| 12 (a). PPF AGE (WEEKS) <input type="checkbox"/> UNDETERMINED <i>(Complete 12c.)</i> | | 12 (b). METHOD OF DETERMINING PPF AGE <input type="checkbox"/> ULTRASOUND <input type="checkbox"/> PHYSICAL EXAMINATION <input type="checkbox"/> LMP <input type="checkbox"/> Other (Specify) _____ | | 12 (c). IF PPF AGE WAS UNDETERMINED, BASIS A MEDICAL EMERGENCY EXISTED | |
| 12 (d). IF PPF AGE IS 20 WEEKS OR MORE, BASIS FOR IMMEDIATE ABORTION OF PREGNANCY. | | | | | |
| 12 (e). IF PPF AGE IS 20 WEEKS OR MORE, DID METHOD USED PROVIDE THE BEST OPPORTUNITY FOR THE UNBORN CHILD TO SURVIVE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, Specify Basis _____ | | 13. PREVIOUS PREGNANCIES <i>(Complete each section)</i> | | | |
| | | LIVE BIRTHS | | OTHER TERMINATIONS | |
| | | 13a. Now Living | 13b. Now Dead | 13c. Spontaneous | 13d. Induced <i>(Do not include this termination)</i> |
| | | Number ----- <input type="checkbox"/> None | Number ----- <input type="checkbox"/> None | Number ----- <input type="checkbox"/> None | Number ----- <input type="checkbox"/> None |
| 14. TYPE OF TERMINATION PROCEDURE <i>(Check only one)</i> <input type="checkbox"/> Suction Curettage <input type="checkbox"/> Medical (Nonsurgical), Specify Medication(s) _____ <input type="checkbox"/> Dilation and Evacuation (D&E) <input type="checkbox"/> Intra-Uterine Instillation (Saline or Prostaglandin) <input type="checkbox"/> Sharp Curettage (D&C) <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Other (Specify) _____ | | | 15. CONSENT – answer all three parts | | |
| | | | a. Was Parental Consent Required? <input type="checkbox"/> Yes <input type="checkbox"/> No | b. Was Parental Consent Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No | c. Was Judicial Waiver Obtained? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. NAME OF ATTENDING PHYSICIAN <i>(Type/Print)</i> | | | 17. NAME OF PERSON COMPLETING REPORT <i>(Type/Print)</i> | | |

MAIL TO: ARKANSAS DEPARTMENT OF HEALTH
CENTER FOR HEALTH STATISTICS
4815 W. MARKHAM, SLOT # 19
LITTLE ROCK, AR 72205

INSTRUCTIONS FOR COMPLETING THE INDUCED TERMINATION OF PREGNANCY REPORT: VR-29

| ITEM | INSTRUCTION |
|----------------------------|--|
| 1. Facility Name | Enter name of facility or give address if not a clinical or hospital. |
| 2. City, Town, or Location | Enter name of city, town, or location of pregnancy termination. |
| 3. County | Enter name of county where pregnancy termination occurred. |
| 4. Age | Enter age in years of patient at her last birthday. |
| 5. Married | Check "Yes" if the patient was legally married at any time between conception and termination. Otherwise check "No." |
| 6. Date | Enter Month-Day-Year of pregnancy termination (e.g. 10-23-2001). |
| 7. Residence | |
| a. State | Enter name of state in which patient lives. |
| b. County | Enter name of county in which patient lives. |
| c. City | Enter name of city in which patient lives. |
| d. Inside City | Enter Yes, No, or Unknown. |
| e. ZIP Code | Enter ZIP code of patient's residence. |
| 8. Hispanic Origin | Check No or Yes; if Yes SPECIFY Mexican, Cuban, Puerto Rican, etc. |
| 9. Race | Check White, Black, American Indian, or Other. If Other, specify. |
| 10. Education | Fill in number for highest grade of school completed. If more than 5 years of college, enter 5+. |
| 11. Date of Last Menses | Enter date that last menses began (e.g. 5-14-2001). |

Question No. 12 has been added in accordance with Act 171 of 2013.

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| 12. . Probable Post-Fertilization (PPF) | |
| a. PPF age | Enter estimate of probable post-fertilization age. DO NOT USE RANGES. |
| b. Method | Check method for determining PPF age |
| c. PPF Age Undetermined | List the basis of the determination that a medical emergency existed. |
| d. PPF 20 weeks or more | List the basis of the determination that the pregnant woman had a condition which so complicated her medical condition as to necessitate the immediate abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of major bodily function of the pregnant women, not including psychological or emotional condition. |
| e. Best Opportunity for Survival | Check Yes or No. If No, specify reason for choice of method. |
| 13. Previous Pregnancies | |
| a. Now Living | Enter the number of live births that are still living. |
| b. Now Dead | Enter the number of live births that have died. |
| c. Spontaneous | Enter the number of spontaneous abortions (miscarriages) that have occurred. |
| d. Induced | Enter the number of PREVIOUS induced abortions that have occurred. |
| 14. Procedure | Check ONLY ONE type of procedure that terminated this pregnancy. |

Question No. 15 has been added in accordance with Act 934 of 2015.

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| 15. Parental Consent | Check Yes or No on each item |
| a. Consent Required | |
| b. Consent Obtained | |
| c. Judicial Waiver_Obtained | |
| 16. Name of Physician | Enter name of attending physician |
| 17. Staff Person Name | Enter name and telephone number of staff person completing this report. |