

TERMINATED PREGNANCY REPORT
 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).

Facility Name and Address PLANNED PARENTHOOD (PPCSI) (MONROE CO.) 421 SOUTH		City or Town, of pregnancy termination Bloomington	County of pregnancy termination Monroe
Patient's age** 15	Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input checked="" type="checkbox"/> Not Married	Date of pregnancy termination 04/21/2022	Education 9th-12th grade, No Diploma
Sex of fetus if detectable <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Multifetal Pregnancies <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> Other	
Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input checked="" type="checkbox"/> White <input type="checkbox"/> Korean <input type="checkbox"/> Black or African American <input type="checkbox"/> Samoan <input type="checkbox"/> Other Asian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Chinese <input type="checkbox"/> Other <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Japanese <input type="checkbox"/> Unknown		Ethnicity <input type="checkbox"/> Yes, Mexican <input type="checkbox"/> Yes, Puerto Rican <input checked="" type="checkbox"/> No, not Hispanic <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Unknown if Hispanic <input type="checkbox"/> Yes, Other Hispanic Origin	
Previous Pregnancies			
Live Births:	Number now living None	Number now deceased None	
Other Terminations:	Number of spontaneous terminations None	Number of induced terminations None	
Years of terminations (Do not include this termination. If more than six (6), those most recent.) 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____			
Fetus delivered alive? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, length of time fetus survived:	List any preexisting medical conditions of the patient that may complicate the abortion None Did this termination of pregnancy result in a maternal death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Fetus viable? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If viable, medical reason for termination:		
Pathological examination performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, results:		
Type of Termination Procedures			
Procedure that Terminated Pregnancy <input checked="" type="checkbox"/> (Nonsurgical) Mifepristone <input type="checkbox"/> Intrauterine instillation (Saline or prostaglandin) <input checked="" type="checkbox"/> (Nonsurgical) Misoprostol <input type="checkbox"/> (Nonsurgical) Other (Specify) _____ For (Nonsurgical) procedures, answer the following question Check the box indicating the following items were completed <input checked="" type="checkbox"/> The manufacturer's instructions provided to the patient <input checked="" type="checkbox"/> The patient signed the patient agreement <input type="checkbox"/> (Surgical) Suction Curettage <input type="checkbox"/> Surgical Sharp Curettage (D & C) <input type="checkbox"/> (Surgical) Dilatation and Evacuation (D & E) <input type="checkbox"/> (Surgical) Other (Specify) _____ <input type="checkbox"/> Hysterotomy/Hysterectomy For Surgical procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman? List the name of the second doctor present, as required under IC 16-34-2-3(a)(3)		Additional Procedure that Terminated Pregnancy <input type="checkbox"/> (Nonsurgical) Mifepristone <input type="checkbox"/> Intrauterine instillation (Saline or prostaglandin) <input type="checkbox"/> (Nonsurgical) Misoprostol <input type="checkbox"/> (Nonsurgical) Other (Specify) _____ 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"/> The patient signed the patient agreement <input type="checkbox"/> (Surgical) Suction Curettage <input type="checkbox"/> Surgical Sharp Curettage (D & C) <input type="checkbox"/> (Surgical) Dilatation and Evacuation (D & E) <input type="checkbox"/> (Surgical) Other (Specify) _____ <input type="checkbox"/> Hysterotomy/Hysterectomy For Surgical procedures, answer the following question. Was the fetus viable or have a post fertilization age at least 20 weeks? <input type="checkbox"/> Yes <input type="checkbox"/> No If the previous question was answered yes, complete the following questions. Was the fetus given the best opportunity to survive? <input type="checkbox"/> Yes <input type="checkbox"/> No What was the basis for determination that the pregnant woman had a condition that required the procedure to avert death or serious impairment to the pregnant woman?	
Date last normal menses began 02/27/2022		Physician estimate of gestation (in weeks) 6	Post fertilization age of the fetus (in weeks) 4
How were the gestational age and post fertilization age determined? Ultrasound			
Was a waiver of consent obtained pursuant to IC 16-34-2-4? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Was a waiver of notification obtained pursuant to IC 16-34-2-4? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			

Diagnostic	
Did patient have a prenatal diagnostic procedure that revealed a fetal abnormality?	
Observed or suspected anomaly(ies) - Check all that apply:	
<input type="checkbox"/> Chromosomal Anomaly	<input type="checkbox"/> Heart Anomaly
<input type="checkbox"/> Neural Tube Defect	<input type="checkbox"/> Ventral Wall Defect
<input type="checkbox"/> Down Syndrome	
<input type="checkbox"/> Other	
Was diagnosis confirmed after termination by autopsy or other pathological examination?	
Procedure(s) Used:	
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Chronic Villus Sampling
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Maternal Serum Alpha Fetoprotein
<input type="checkbox"/> Cordocentesis	<input type="checkbox"/> Other
<input type="checkbox"/> Unknown	
Is the patient seeking an abortion as a result of being any of the following?	
<input type="checkbox"/> Abused	<input type="checkbox"/> Coerced
<input type="checkbox"/> Harassed	<input type="checkbox"/> Trafficked
<input type="checkbox"/> None	
<input type="checkbox"/> Unknown	
Full name of physician performing termination	
DEBORAH LYNN NUCATOLA	
Address of physician performing termination (number and street, city, state, and zip code)	
200 S. MER BOX 397 INDIANAPOLIS IN 462060397	
Age of father 15	If age not known, approximate age 15

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

Date Received by IDOH (month, day, year)

04/21/2022