TENNESSEE DEPARTMENT OF HEALTH

Report of Induced Termination of Pregnancy

Type/Print in Permanent Black Ink All Items 1-16c Must Be Completed

Person In Charge of Institution Attending Physician Must File Report Within 10 Days After Procedure Was Performed

Do Not Report Patient's Name

Send To:
Division of Vital Records and Statistics
ATTN: Office of Vital Statistics
Andrew Johnson Tower, 2nd Floor
710 James Robertson Parkway
Nashville, TN 37243

FACILITY

1. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION

2. COUNTY OF PREGNANCY TERMINATION

PATIENT

3. PATIENT IDENTIFICATION NUMBER

4. PATIENT AGE

5. PATIENT MARRIED?
◯ YES ◯ NO ◯ UNK

6. DATE OF TERMINATION
_____/_____/_____
MM DD YYYY

7a. RESIDENCE – STATE

7b. RESIDENCE – COUNTY

7c. RESIDENCE – CITY OR TOWN

8. PATIENT OF HISPANIC ORIGIN?
(Check the box that best describes whether the patient is Spanish/Hispanic/Latina. Check the "No" box if patient is not Spanish/Hispanic/Latina)

◯ No, not Spanish/Hispanic/Latina
◯ Yes, Mexican, Mexican American, Chicana
◯ Yes, Puerto Rican
◯ Yes, Cuban
◯ Yes, other Spanish/Hispanic Latina
Specify: _____
◯ Unknown

9. PATIENT'S RACE
(Check one or more races to indicate what the patient considers herself to be)

☐ White
☐ Black or African American
☐ American Indian or Alaskan Native
Name of enrolled or principal tribe: _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian, Specify: _____
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander, Specify: _____
☐ Other, Specify: _____
☐ Unknown

10. PATIENT'S EDUCATION
(Check the box that best describes the highest degree or level of school completed at the time of termination)

◯ 8th grade or less
◯ 9th – 12th grade, no diploma
◯ High school graduate or GED completed
◯ Some college credit but no degree
◯ Associate degree (e.g., AA, AS)
◯ Bachelor's degree (e.g., BA, BS, AB)
◯ Master's degree (e.g., MA, MS, MEd, MSW, MBA)
◯ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
◯ Unknown

11. DATE LAST NORMAL MENSES BEGAN
_____/_____/_____
MM DD YYYY

12. CLINICAL ESTIMATE OF GESTATION
_____ weeks

13. PREVIOUS PREGNANCIES

NUMBER OF PREVIOUS LIVE BIRTHS		OTHER TERMINATIONS	
13a. NOW LIVING	**13b. NOW DEAD**	**13c. SPONTANEOUS**	**13d. INDUCED** (Do not include this termination)
Number _____ ◯ None	Number _____ ◯ None	Number _____ ◯ None	Number _____ ◯ None

TERMINATION PROCEDURES

14. WAS AN ULTRASOUND CONDUCTED?
◯ YES ◯ NO

IF YES, WAS A HEARTBEAT DETECTED?
◯ YES ◯ NO

15. TERMINATION PROCEDURES

	15a. PROCEDURE THAT TERMINATED THIS PREGNACY (Select only one)	15b. ADDITIONAL PROCEDURES, IF ANY (Select all that apply)
Surgical:		
Suction Curettage	◯	☐
Dilation & Curettage (D&C)	◯	☐
Dilation & Evacuation (D&E)	◯	☐
Intra-Uterine Instillation (Surgical Saline, Prostaglandin)	◯	☐
Hysterotomy/Hysterectomy	◯	☐
Medical:		
Mifepristone (RU486, Mifeprex)	◯	☐
Misoprostol (Cytotec), Other Prostaglandin	◯	☐
Methotrexate (Amethopterin, MTX)	◯	☐
Other Medical (Specify)	_____	_____
Other Procedure (Specify)	_____	_____

DISPOSITION

16a. METHOD OF DISPOSITION
(Select one)

◯ Burial
◯ Cremation
◯ N/A, Specify: _____

16b. REMAINS RELEASED TO
(Indicate name of facility)

◯ Patient
◯ Parent
◯ Family Member
◯ Crematory _____
◯ Funeral Home _____
◯ Facility _____
◯ Other _____
◯ N/A _____

16c. LOCATION OF DISPOSITION
(Do not provide names of patient or patient's family)

Location Name: _____

Address: _____

Telephone: (____) _____

DATE OF DISPOSITION
_____/_____/_____
MM DD YYYY

◯ N/A, Specify: _____