CONFIDENTIAL INDUCED ABORTION CASE REPORT

(Please submit **only one** report per case)

For internal DHHS use only

Facility Code: _____

Date of Today's Pregnancy Termination

_____ / _____ / _____ *(MM/DD/CCYY)*

1. **Date of Today's Pregnancy Termination (MM/DD/CCYY) _____ /_____ /_____**
2. **Name of Facility: _____**
3. **Name of physician who provided the abortion medication or performed the surgical abortion:**

   _____
4. **Name of referring physician, agency, or service *(if applicable)*: _____**
5. **Name of physician who diagnosed the life-limiting anomaly *(if applicable):* _____**
6. **Residence of Patient** Country: _____ State: _____ County: _____
7. **Age of Patient** (in years): _____
8. **a. Race of patient**

   ☐ 1 = White
   ☐ 2 = Black/African American
   ☐ 3 = American Indian/ Alaskan Native
   ☐ 4 = Asian
   ☐ 5 = Native Hawaiian/ Other Pacific Islander
   ☐ 6 = Multi-racial

   b. Hispanic Origin

   ☐ 1 = Yes
   ☐ 2 = No
9. **Patient's past pregnancy information:**
   a. Number of previous pregnancies: _____
   b. Number of live births: _____
   c. Number of previous miscarriages/spontaneous abortions: _____
   d. Number of previous induced abortions/terminations: _____
10. **Date Last Normal Period Began** (MM/DD/CCYY) **_____ /_____ /_____**
11. **Date of Ultrasound** (MM/DD/CCYY) **_____ /_____ /_____**
12. **Estimated Gestational Age, in Completed Weeks** *(if a fraction of a week, round down to the whole week; e.g. record 6 2/7 weeks as 6 weeks, record 7 6/7 weeks as 7 weeks):*

    _____
13. **For abortions > 12 weeks, a copy of an ultrasound image that depicts measurement(s) to assign dating is included. Name and other identifying patient information is removed**. ☐ Yes ☐ Not applicable
14. **Pre-existing Medical Condition which could complicate pregnancy** ☐ Yes ☐ No

    If yes, list conditions: _____
15. **Method of termination** (check only the method that terminated the pregnancy)

    Surgical (Check the type of surgical procedure)

    ☐ 1 = D&C (Dilation and Curettage)*
    ☐ 2 = D&E (Dilation and Evacuation)
    ☐ 3 = Hysterotomy/Hysterectomy
    ☐ 4 = Other surgical (Specify)

Medical/Non-surgical (Check the principle medication or medications)

- ☐ 5 = Mifepristone (RU-486 or Mifeprex®)
- ☐ 6 = Misoprostol (Cytotec®) or another prostaglandin**
- ☐ 7 = Other medication (Specify): _____
- ☐ 8 = Intrauterine Instillation (intra-amniotic injection, typically with saline, prostaglandin or urea)
- ☐ 9 = Other: _____
- ☐ 10 = Unknown

* Additional terms that may be used include: aspiration curettage, suction curettage, manual vacuum aspiration, menstrual extraction, and sharp curettage.

** Some commonly used prostaglandins include misoprostol (Cytotec®) and dinoprostone (also known as Cervidil®, prepidil, prostin E2, or dinoprostol).

16. **At the time of this report, has the patient experienced a complication?** ☐ Yes ☐ No
(If yes, or patient subsequently develops a complication, you are required to complete form 1891a found here: http://www.ncdhhs.gov/ncdhhs-abortion-complications-reporting-supplement-1891a-english/download?attachment)

17. **Did patient return for follow-up visit for a medical abortion?** ☐ Yes ☐ No ☐ N/A

18. **If NO, what efforts were made to encourage patient to return for follow-up visit?**

☐ Phone call/ voice message ☐ Text message ☐ Email ☐ Patient Portal message

☐ Other: _____

19. **Date of follow-up visit, if applicable** (MM/DD/CCYY): _____ /_____ /_____

20. **Was the abortion complete at that time?** ☐ Yes ☐ No ☐ N/A

_____ _____

SIGNATURE OF PHYSICIAN WHO ADMINISTERED ABORTION MEDICATION OR PERFORMED THE SURGICAL ABORTION DATE

Purpose: To comply with North Carolina Session Law 2023-14, which requires the North Carolina Department of Health and Human Services to collect statistical summary reports concerning the medical and demographic characteristics of abortions. The reports will be for statistical purposes only and the confidentiality of the patient relationship shall be protected. Per law, a report completed under this section shall not contain the woman's name, any common identifiers of the woman, or any other information that would make it possible to identify the woman.

Distribution: It is the responsibility of the facility to ensure that case report forms are submitted for all abortions performed, consistent with figures reported to the North Carolina Department of Health and Human Services, Division of Health Service Regulation (DHSR) for licensure renewal. Required information should be transmitted via a means that will allow the facility to track the packages to ensure receipt by DHHS. Completed report information should be submitted within 15 days after either the (i) date of the follow-up appointment following a medical abortion, (ii) date of the last patient encounter for treatment directly related to a surgical abortion, or (iii) end of the month in which the last scheduled appointment occurred, whichever is later. A report completed for a minor shall be sent to the Department and the Division of Social Services within 30 days of the surgical or medical abortion. Send information to:

State Center for Health Statistics
1908 Mail Service Center
Raleigh, NC 27699-1900

If your facility is interested in setting up secure file transfer for reporting, please reach out to: SCHS.reporting@dhhs.nc.gov

In the case of a minor, a copy of this information should be sent to the Division of Social Services at NCDSS_abortionreport@dhhs.nc.gov

Additional Supplies: Available at www.ncdhhs.gov/reprohealth

Or Order forms from:

State Center for Health Statistics
1908 Mail Service Center
Raleigh, NC 27699-1900
Phone: (919) 733-4728