TENNESSEE DEPARTMENT OF HEALTH

Report of Induced Termination of Pregnancy

Type/Print in Permanent Black Ink

All Items 1-19 Must Be Completed

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

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. FACILITY NAME (If not clinic or hospital, give address)

2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION

3. COUNTY OF PREGNANCY TERMINATION

PATIENT

4. PATIENT IDENTIFICATION NUMBER

5. AGE LAST BIRTHDAY

6. PATIENT MARRIED? ☐ YES ☐ NO

7. DATE OF TERMINATION ____/____/_____ MM DD YYYY

8a. RESIDENCE – STATE

8b. RESIDENCE – COUNTY

8c. RESIDENCE – CITY OR TOWN

8d. RESIDENCE – INSIDE CITY LIMITS? ☐ YES ☐ NO

8e. RESIDENCE – ZIP CODE

9. 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: _____

10. 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: _____

11. 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)

12. DATE LAST NORMAL MENSES BEGAN ____/____/_____ MM DD YYYY

13. CLINICAL ESTIMATE OF GESTATION _____ weeks

14. PREVIOUS PREGNANCIES

NUMBER OF PREVIOUS LIVE BIRTHS		OTHER TERMINATIONS	
14a. NOW LIVING	**14b. NOW DEAD**	**14c. SPONTANEOUS**	**14d. INDUCED** (Do not include this termination)
Number _____ ☐ None	Number _____ ☐ None	Number _____ ☐ None	Number _____ ☐ None

TERMINATION PROCEDURES

15. WAS AN ULTRASOUND CONDUCTED? ☐ YES ☐ NO

IF YES, WAS A HEARTBEAT DETECTED? ☐ YES ☐ NO ☐ N/A

16. TERMINATION PROCEDURES

16a. PROCEDURE THAT TERMINATED THIS PREGNACY (Select only one)		16b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY (Select all that apply)
☐	Suction Curettage	☐
☐	Sharp Curettage	☐
☐	Dilation & Evacuation (D&E)	☐
☐	Intra-Uterine Saline Instillation	☐
☐	Intra-Uterine Prostaglandin Instillation	☐
☐	Hysterotomy	☐
☐	Hysterectomy	☐
☐	Medical Termination (Mifepristone/Misoprostol)	☐
_____	Other (Specify)	_____

DISPOSITION

17a. METHOD OF DISPOSITION
(Check all that apply)

- ☐ Burial
- ☐ Cremation
- ☐ Donation
- ☐ Entombment
- ☐ Removal from State
- ☐ Sterilization
- ☐ On-site Disposal
- ☐ Off-site Disposal
  Specify Location: _____
- ☐ N/A, Specify: _____

17b. REMAINS RELEASED TO
(Indicate name of individual or facility)

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

17c. LOCATION OF DISPOSITION

Name: _____

Address: _____

Telephone: _____

DATE OF DISPOSITION

____/____/_____ MM DD YYYY

☐ N/A, Specify: _____

ATTENDANT

18. NAME OF ATTENDING PHYSICIAN (Type/Print)

19. NAME OF PERSON COMPLETING REPORT (Type/Print)

20. DATE REPORT COMPLETED ____/____/_____ MM DD YYYY