

TYPE  
OR  
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PERMANENT  
INK

**KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT**  
Office of Health Care Information  
Curtis State Office Building, Suite 130  
1000 SW Jackson  
Topeka, Kansas 66612-1354  
785-296-8627

**Report of Induced Termination of Pregnancy**

State File Number

INSTRUCTIONS SEE HANDBOOK

1. Provider Identification Number		00000																											
2. Patient ID Number		3. Age on Last Birthday		4. Married <input type="checkbox"/> Yes <input type="checkbox"/> No																									
				5. Date of Pregnancy Termination <table style="width:100%; text-align:center;"> <tr> <td style="border:1px solid black; width:20px; height:20px;"></td> <td style="border:1px solid black; width:20px; height:20px;"></td> <td style="border:1px solid black; width:20px; height:20px;"></td> <td style="border:1px solid black; width:20px; height:20px;"></td> <td style="border:1px solid black; width:20px; height:20px;"></td> <td style="border:1px solid black; width:20px; height:20px;"></td> </tr> <tr> <td>Month</td> <td>Day</td> <td colspan="4">Year</td> </tr> </table>								Month	Day	Year															
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6a. Residence <i>US State or Country</i>		6b. County		6c. City or Town																									
				6d. Inside City Limits <input type="checkbox"/> Yes <input type="checkbox"/> No																									
7a. Hispanic Origin <i>(Check the box or boxes that best describes whether the individual is Spanish, Hispanic, or Latina, or not Spanish, Hispanic, or Latina)</i>		7b. Ancestry <i>(Enter the name of the country that best describes the heritage or origin of the individual)</i>		8. Race <i>(Check one or more races to indicate what the individual considers herself to be)</i>																									
<input type="checkbox"/> Not Spanish, Hispanic, or Latina <input type="checkbox"/> Mexican, Mexican American, or Chicana <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Central American <input type="checkbox"/> South American <input type="checkbox"/> Other Spanish, Hispanic, or Latina (specify) _____  <input type="checkbox"/> Unknown				<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native Principal Tribe(s) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (specify) _____ <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown																									
9. Education <i>(specify only highest grade completed)</i>																													
<input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th-12th grade no diploma <input type="checkbox"/> High school graduate/GED <input type="checkbox"/> Some College - no degree <input type="checkbox"/> Associate degree <input type="checkbox"/> Bachelor's degree <input type="checkbox"/> Master's degree <input type="checkbox"/> Unknown																													
10. Date Last Normal Menses Began		11. Clinical Estimate of Gestation <i>(Weeks) (1)</i>		12. Previous Pregnancies <i>(Enter number or zero in every section)</i>																									
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SAMPLE																													
13 TERMINATION PROCEDURES																													
13a Procedure that terminated pregnancy  <i>(Check only one)</i>			13b Additional procedures used for this termination, if any  <i>(Check all that apply)</i>																										
<input type="checkbox"/> Suction Curettage <input type="checkbox"/> Sharp Curettage <input type="checkbox"/> Dilation & Evacuation <input type="checkbox"/> Medical Procedure I (Mifepristone) <input type="checkbox"/> Medical Procedure II (Methotrexate) <input type="checkbox"/> Intra-Uterine Prostaglandin Instillation <input type="checkbox"/> Hysterotomy <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Digoxin/Induction <input type="checkbox"/> Partial Birth (2) <input type="checkbox"/> Other (Specify) _____			<input type="checkbox"/> Suction Curettage <input type="checkbox"/> Sharp Curettage <input type="checkbox"/> Dilation & Evacuation <input type="checkbox"/> Medical Procedure I (Mifepristone) <input type="checkbox"/> Medical Procedure II (Methotrexate) <input type="checkbox"/> Intra-Uterine Prostaglandin Instillation <input type="checkbox"/> Hysterotomy <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Digoxin/Induction <input type="checkbox"/> Partial Birth (2) <input type="checkbox"/> Other (Specify) _____																										

1 If clinical estimate of gestational age is 22 weeks or more, complete reverse side of form  
 2 If Partial Birth Procedure as defined by KSA 65-6721 is used, complete reverse side of form

**Complete the following items only if the clinical estimate of gestational age is 22 weeks or more**

14. Reasons for determining gestational age 22 weeks or more

15a Was fetus viable?  
 YES       NO

15b Reasons for the determination

Complete 16a-c only if 15a is yes

16a Was this abortion necessary to  
(Check all that apply)

Prevent patient's death  
 Prevent substantial and irreversible impairment of a major bodily function

16b Reasons for determination

16c Basis for determination

**SAMPLE**

**Complete the following items only if a partial birth procedure was performed**

17a Was fetus viable?  
 YES       NO

17b Reasons for determination

Complete 18a-b only if 17a is yes

18a Was this abortion necessary to  
(Check all that apply)

Prevent patient's death  
 Prevent substantial and irreversible impairment of a major bodily function  
    If so, was the impairment

Physical  
 Mental

18b Reasons for determination