Appendix B

IN PERMANENT INK

File Date
(State Use Only)

ARKANSAS DEPARTMENT OF HEALTH
VITAL RECORDS BRANCH
CHEMICAL INDUCED TERMINATION OF PREGANANCY REPORT
(COMPLETE ON EACH CHEMICAL INDUCED TERMINATION)

1. FACILITY NAME (if not clinic or hospital give address)	2. CITY, TOWN OR LOCATION OF PREGNANCY TERMINATION	3. COUNTY OF PREGNANCY TERMINATION

4. DATE OF PREGNANCY TERMINATION (Month, Day, Year)	5. PATIENTS NAME (Last, First, Middle)	6. MARRIED? ☐ YES ☐ NO	7. AGE LAST BIRTHDAY

8a. RESIDENCE - STATE	8b. COUNTY	8c. CITY, TOWN, OR LOCATION	8d. INSIDE CITY LIMITS? ☐YES ☐NO	8e. ZIP CODE

9. HISPANIC ORIGIN? (Specify No or Yes - if Yes, specify Cuban Mexican, Puerto Rican, etc.) ☐NO ☐YES - Specify:	10. RACE ☐ AMERICAN INDIAN ☐ BLACK ☐ WHITE ☐ OTHER - SPECIFY:	11. EDUCATION (Specify only highest grade completed)		12. DATE OF LAST NORMAL MENSES BEGAN *(Month, Day, Year)*
		Elementary/Secondary 0-12	College 1-4 or 5+	

13. PREVIOUS PREGNANCIES (Complete each section)				14. RECEIVED VERBAL OR WRITTEN COUNSELING RELATED TO POTENTIAL RISKS OR COMPLICATIONS AND ALTERNATIVES TO CHEMICAL ABORTION
LIVE BIRTHS		TERMINATIONS		
13a. Now Living Number: ☐None	13b. Now Dead Number: ☐None	13c. Spontaneous Number: ☐None	13b. Now Dead Number: ☐None	☐YES ☐NO

15. CONSENT (Answer each section)			16. PAYMENT TYPE
15a. Was Parental Consent Required? ☐ NO ☐ YES	15b. Was Parental Consent Obtained? ☐ NO ☐ YES	15c. Was Judicial Waiver Obtained? ☐ NO ☐ YES	☐ Private Health Coverage ☐ Public Assistance Health Coverage ☐ Self-Pay ☐ Other (Specify):

17. PROBABLE POST-FERTILIZATION GESTATIONAL AGE (PPF)				18.SPECIFIC CHEMICAL REGIME USED
17a. PPF Age (Weeks) ☐Undetermined (Complete 17c.)	17b. Method of Determining PPF ☐ Ultrasound ☐ Physical Examination ☐ LMP ☐ Other (Specify):	17c. If PPF Age was undetermined, basis a medical emergency existed:	17d. If PPF Ages is 20 weeks or more, basis for immediate abortion of pregnancy:	☐ Mifepristone ☐ Misoprostol ☐ Metotrexate ☐ Other (Specify):

19. SPECIFIC REASON FOR THE ABORTION

- ☐ Rape or Incest
- ☐ Economic Reasons
- ☐ Does not want pregnancy at this time
- ☐ Save the life of the mother
- ☐ Physical health is endangered (Specify):
- ☐ Mental health is endangered (Specify):
- ☐ Impairment of major bodily function (Specify):
- ☐ Genetic anomaly (Specify):
- ☐ Other reason (Specify):
- ☐ Refused to answer

20. IF PPF AGE IS 20 WEEKS OR MORE, DID THE METHOD USED PROVIDE THE BEST OPPORTUNITY FOR THE UNBORN CHILD TO SURVIVE? ☐YES ☐NO (SPECIFY):	21. DID THE ABORTION RESULT IN A LIVE BIRTH? ☐NO ☐YES

22. ANY COMPLICATIONS FROM THE CHEMICAL ABORTION? NO YES (SPECIFY):

23. NAME OF STAFF PERSON COMPLETING REPORT (TYPE OR PRINT):

24. NAME OF ATTENDING PHYSICIAN (TYPE OR PRINT):

25. SIGNATURE OF ATTENDING PHYSICIAN:

INSTRUCTIONS FOR COMPLETING
CHEMICAL INDUCED TERMINATION OF PREGNANCY REPORT

A report must be completed on each chemical induced termination of pregnancy performed. This report is considered an official document and maybe released upon a court order.

ITEM	INSTRUCTION
1. Facility Name	Enter name of facility or give address if not a clinic or hospital.
2. City, Town, or Location	Enter name of city, town, or location of pregnancy termination.
3. County	Enter name of county where pregnancy termination occurred.
4. Date	Enter Month-Day-Year of pregnancy termination (e.g., 10-23-2001).
5. Married	Check "Yes" if the patient was legally married at any time between conception and termination. Otherwise check "No."
6. Age	Enter age in years of patient at her last birthday.
7. Residence	
a. State	Enter name of state in which patient lives.
b. County	Enter name of county in which patient lives.
c. City	Enter name of city in which patient lives.
d. Inside City	Enter Yes or No
e. ZIP Code	Enter ZIP code of patient's residence.
8. Hispanic Origin	Check No or Yes; if Yes Specify Mexican, Cuban, Puerto Rican, etc.
9. Race	Check White, Black, American Indian, or Other. If Other, specify.
10. Education	Fill in number for highest grade of school completed. If more than 5 years of college, enter 5+.
11. Date of Last Menses	Enter date that last menses began (e.g., 5-14-2001).
12. Previous Pregnancies	
a. Now Living	Enter the number of live births that are still living.
b. Now Dead	Enter the number of live births that have died.
c. Spontaneous	Enter the number of spontaneous abortions (miscarriages) that have occurred.
d. Induced	Enter the number of Previous induced abortions that have occurred.
No. 13 Reference(s): Act 560 of 2021 (§20-16-2404)	
13. Received Counseling	Check Yes or No, if received written or verbal counseling related to potential risks or complications and alternatives to chemical abortions.
No. 14 Reference(s): Act 934 of 2015 (§20-16-801)	
14. Parental Consent	Check Yes or No on each item
a. Consent Required	
b. Consent Obtained	
c. Judicial Waiver Obtained	
No. 15 Reference(s): Act 560 of 2021 (§20-16-2404)	
15. Payment Type	Check payment type. If other, specify.
No. 16 Reference(s): Act 171 of 2013 (§20-16-1406)	
16. Probable Post-Fertilization (PPF)	
a. PPF age	Enter estimate of probable post-fertilization age. Do not do ranges.
b. Method	Check method for determining PPF age
c. PPF Age Undetermined	List the basis of the determination that a medical emergency existed.
d. PPF 20 weeks or more	List the basis of the determination that the pregnant woman had a condition which so complicated her medical condition as to necessitate the immediate abortion of her pregnancy to avert her death or to avert serious risk of substantial and irreversible physical impairment of major bodily function of the pregnant women, not including psychological or emotional condition.
No. 17 & 18 Reference(s): Act 560 of 2021 (§20-16-2404) & Act 787 of 2021 (§20-16-608, §20-16-705(c))	
17. Specific Regimen	Check the chemical regimen used to terminate this pregnancy. If other, specify.
18. Specific Reason	Check the reason for the abortion. Specify if required.
No. 19 Reference(s): Act 171 of 2013 (§20-16-1406)	
19. Best Opportunity for Survival	Check Yes or No. If No, specify reason for choice of method.
No. 20 References(s): Act 801 of 2019 (§20-16-604)	
20. Did Abortion Result In a Live Birth	Check Yes or No
No. 21 Reference(s): Act 560 of 2021 (§20-16-2404)	
21. Complications	Check no or yes if there were complications from the chemical abortion. If yes, specify.
22. Staff Person Name	Enter name of staff person completing this report.
23. Name of Physician	Enter name of attending physician
No.24 Reference(s): Act 560 of 2021 (§20-16-2404)	
24. Signature	Attending physician signature.

This report must be submitted 15 days after each month end. Mail to the Arkansas Department of Health, Health Statistics Branch, 4815 West Markham Street, Slot #19, Little Rock, AR 72205 or Fax: (501) 661-2544.