Post Abortion Care Report For Complications

Ohio Department of Heath

(Required Pursuant to O.A.C. 3701-47-03

To be completed by the physician providing post-abortion care

	State Use Only

1. Facility where post-abortion care was provided:			
2. Street or Post Number	City	State	Zip

3. Date of Abortion: Month Day Year _____/_____/_____/	4. Weeks of Gestation: _____
5A. Facility where Abortion was performed:	

5B. Address of Facility: Street or Post Number	City	State	Zip

6. Date Post Abortion Care Begin: Month Day Year _____/_____/_____/	7. Patient Number __/__/__/__/__/__/__/__/__/__/

8. Complication (s) (Please check all that apply):

____ Hemorrhage	____ Anesthetic	____ Hematometra	____ Perforation of Uterus
____ Failure of Amniotic Fluid Ex	____ RH Incompatibility	____ Cervical Laceration	____ Failed Abortion
____ Infection	____ Incomplete Abortion	____ Death	____ Other (Specify) _____

_____

9. Duration of treatment: (Indicate number of hours or days)

_____ Hours _____ Days

10. Remarks

_____

_____

_____

_____

_____

_____

11A. Physician's Name providing care (Type or print)	11.B Physicians Signature: M.D. D.O.	Date:

Send Completed Forms to: Ohio Department of Health
Confidential Reports A
PO Box 118
Columbus, Ohio 43216