TENNESSEE DEPARTMENT OF HEALTH

Office of Vital Records

REPORT OF INDUCED TERMINATION OF PREGNANCY

TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

ALL ITEMS 1-18 MUST BE COMPLETED

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

4. PATIENT IDENTIFICATION NUMBER	5. AGE LAST BIRTHDAY	6. MARRIED?	7. DATE OF PREGNANCY TERMINATION *(Month, Day, Year)*
		1 YES 2 NO	

8a. RESIDENCE-STATE	8b. COUNTY	8c. CITY, TOWN OR LOCATION	8d. INSIDE CITY LIMITS? 1 YES 2 NO	8e. ZIP CODE

9. OF HISPANIC ORIGIN? *(Specify Yes or No – If yes, specify Cuban, Mexican, Puerto Rican, etc)*	10. RACE	11. EDUCATION *(Specify only highest grade completed)*	
YES NO Specify, if yes_____	1. White 2. Black 3. American Indian Other (Specify)____	*Elementary/Secondary (0-12)*	*College (1-4 or 5+)*

12. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	13. CLINICAL ESTIMATE OF GESTATION (Weeks)	14. PREVIOUS PREGNANCIES *(Complete each section)*			
		LIVE BIRTHS		OTHER TERMINATIONS	
		14a. Now Living Number_____ None	14b. Now Dead Number_____ None	14c. Spontaneous Number_____ None	14d. Induced *(Do not include this termination)* Number_____ None

PERSON IN CHARGE OF INSTITUTION OR ATTENDING PHYSICIAN MUST FILE REPORT WITHIN 10 DAYS AFTER PROCEDURE WAS PERFORMED.

SEND TO:
VS UNIT
TN OFFICE OF VITAL RECORDS
Andrew Johnson Tower, 1st Floor
710 James Robertson Parkway
NASHVILLE, TN 37243

15. TERMINATION PROCEDURES

15a. PROCEDURE THAT TERMINATED PREGNANCY	TYPE OF TERMINATION PROCEDURE	15b. ADDITIONAL PROCEDURES USED FOR THIS TERMINATION, IF ANY
(Circle only one)		*(Circle all that apply)*
1	Suction Curettage	*1*
2	Sharp Curettage	2
3	Dilation and Evacuation (D&E)	3
4	Intra-Uterine Saline Instillation	4
5	Intra-Uterine Prostaglandin Instillation	5
6	Hysterotomy	6
7	Hysterectomy	7
8	Medical Termination (mifepristone/misoprostol)	8
0	Other (Specify)	0

16. DISPOSITION

16a. Method of Disposition (Check all that apply)	16b. Remains Released to (Name of individual or facility)	16c. Location of Disposition (Name, Address, Telephone No.)
☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Sterilization ☐ On-site Disposal ☐ Off-site (Specify Location) _____ ☐ Other (Specify)_____	☐ Patient _____ ☐ Parent _____ ☐ Family Member_____ ☐ Crematory _____ ☐ Funeral Home _____ ☐ Facility _____ ☐ Other _____	

17. NAME OF ATTENDING PHYSICIAN (Type/Print)	18. NAME OF PERSON COMPLETING REPORT (Type/Print)