IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH
Bureau of Vital Records and Health Statistics

ABORTION COMPLICATIONS REPORTING FORM INSTRUCTIONS

Idaho Code Title 39 Chapter 95, The Abortion Complications Reporting Act (the Act), requires every hospital, licensed health care facility, or individual medical practitioner to file a written report with the Bureau of Vital Records and Health Statistics (Bureau) if any woman comes under their care and receives treatment for any item listed below that constitutes an abnormal or a deviant process or event arising from the performance or completion of an abortion (IC 39-9504(1)). If a women receives treatment for any item listed below and, based upon your reasonable medical judgment, it is an abnormal or a deviant process or event arising from the performance or completion of an abortion, you must report it to the Bureau if you are one of the entities or medical practitioners subject to reporting under the Act:

- A fever of 100.4 degrees or higher for more than 24 hours
- Adverse or allergic reaction to anesthesia or other drugs
- Any psychological or emotional condition reported by the patient, such as depression, suicidal ideation, anxiety or a sleeping disorder
- Blood clots
- Blood transfusion
- Cardiac Arrest
- Cervical perforation or injury to the cervix
- Coma
- Death
- Embolism
- Endometritis
- Failure to actually terminate the pregnancy
- Free fluid in the abdomen
- Heavy or excessive bleeding
- Hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- Hemorrhage
- Hypoglycemia where onset occurs while the patient is being cared for in the abortion facility
- Incomplete abortion or retained tissue
- Infection
- Injury or damage to any organ
- Metabolic disorder
- Missed ectopic pregnancy
- Pain or cramps that do not improve with medication
- Pelvic inflammatory disease
- Placenta previa or preterm delivery in subsequent pregnancies
- Renal failure
- Respiratory arrest
- Shock
- Subsequent development of breast cancer
- Uterine perforation or injury to the uterus
- Weakness, nausea, vomiting or diarrhea that last for more than 24 hours
- Any other adverse event as defined by the federal Food and Drug Administration criteria provided in the MedWatch reporting system

The report must be completed by the hospital, health care facility or attending medical practitioner who treated the woman, signed by the attending medical practitioner and transmitted to the department within 90 days from the last date of treatment or other care or consultation for the complication. The data gathered from the reports will be prepared by the department in a comprehensive annual statistical report for the legislature. The information will be kept confidential and will not disclose the identity of any medical practitioner, or any person filing a report, nor of a woman about whom a report is filed. Failure to submit a report will result in grounds for professional discipline up to and including licensure suspension or revocation in accordance with Idaho Code 39-9506.

Please mail this report to: IDAHO VITAL RECORDS
PO BOX 83720
BOISE, IDAHO
83720-0036

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Please attempt to ascertain answers for all fields in this form and complete all fields. If unknown or not applicable, please indicate. Select all complications that apply.

PATIENT INFORMATION [if unknown(UNK) or not applicable(NA), please indicate]

Age	County of Residence	State of Residence

Number of Previous Pregnancies	Number of Previous Live Births	Number of Previous Abortions

Race

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander (specify) _____
- ☐ Other (specify) _____
- ☐ Unknown
- ☐ Not Applicable

Hispanic Origin?

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Not Applicable

ABORTION PROCEDURE INFORMATION [for the abortion that led to the complication] [if unknown(UNK) or not applicable(NA), please indicate]

Date Abortion Was Performed

Date Abortion Was Completed

Gestational Age of Fetus (as defined in Idaho Code § 18-604), including weeks gestation

- ☐ 1st Trimester, _____weeks
- ☐ 2nd Trimester, _____weeks
- ☐ 3rd Trimester, _____weeks
- ☐ Unknown
- ☐ Not Applicable

Physician Who Performed the Abortion

Facility Where the Abortion Was Performed

Referring Medical Practitioner, Agency, or Service (If Any)

Methods Used

- ☐ Suction Curettage
- ☐ Medical (Non-Surgical) (specify medications) _____
- ☐ Dilation and Evacuation (D&E)
- ☐ Intra-Uterine Instillation (Saline or Prostaglandin)
- ☐ Sharp Curettage (D&C)
- ☐ Hysterotomy/ Hysterectomy
- ☐ Other (specify) _____
- ☐ Unknown
- ☐ Not Applicable

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Was a post-abortion follow-up visit scheduled or required by the abortion provider?

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Not Applicable

If Yes, did the patient attend the follow-up visit?

- ☐ Yes
- ☐ No, refused
- ☐ No, failed to attend
- ☐ Unknown
- ☐ Not Applicable

Was there any follow-up care, surgery, or aspiration procedure performed because of incomplete abortion or retained tissue?

- ☐ Yes. If yes, describe: _____
- ☐ No
- ☐ Unknown
- ☐ Not Applicable

COMPLICATIONS INFORMATION (select all that apply)

- ☐ A fever of 100.4 degrees or higher for more than 24 hours
- ☐ Adverse or allergic reaction to anesthesia or other drugs
- ☐ Any psychological or emotional condition reported by the patient, such as depression, suicidal ideation, anxiety or a sleeping disorder
- ☐ Blood clots
- ☐ Blood transfusion
- ☐ Cardiac Arrest
- ☐ Cervical perforation or injury to the cervix
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- ☐ Renal failure
- ☐ Respiratory arrest
- ☐ Shock
- ☐ Subsequent development of breast cancer
- ☐ Uterine perforation or injury to the uterus
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Physical Location of the Complication	**Date Complication Occurred**

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Please Note Any Pre-Existing Conditions That Would Potentially Have Complicated the Pregnancy or Abortion

COMPLICATION REFERRAL AND TREATMENT INFORMATION [if unknown(UNK) or not applicable(NA), please indicate]

Was the patient referred to a hospital, emergency department, or urgent care clinic or department for treatment for any complication listed above?

- ☐ Yes
- ☐ No
- ☐ Unknown
- ☐ Not Applicable

Did the woman receive treatment from any other medical practitioner for the specific complication?	If yes, what date did such previous treatment occur?
☐ Yes ➡ ☐ No ☐ Unknown ☐ Not Applicable	

If yes, please provide the names of practitioner(s) who provided the treatment:

Name(s)

REPORTING PROVIDER INFORMATION

Title	First	Middle	Last	License #

Facility Name			

Facility Address - Street/ PO Box	City	State	Zip Code

Email Address	Phone

Signature	Date of Treatment	Date of Report