

Appendix A

ABORTION FORMS

Shown below and on the following pages
are the abortion forms physicians are

required to use under South Dakota Codified
Law 34-23A-34 to 34-23A-45.

***Physician's Induced Abortion Reporting Form
Parental Notice
South Dakota Codified Law § 34-23A-39 and 34-23A-7
(also 45 C.F.R. §§ 164.512(b)(1)(i) and 164.514(e)(3)(i))
South Dakota Department of Health
600 East Capitol Avenue
Pierre, South Dakota 57501-2536***

| | |
|--|-----------------------------------|
| SDCL 34-23A-43 (verification purposes) | |
| Name of Hospital, Clinic or Physician's Office: _____ | Date of Report ____ / ____ / ____ |
| Patient ID Number: _____ | |
| Person responsible for the patient who is a minor (check appropriate box): Parent <input type="checkbox"/> Guardian/conservator <input type="checkbox"/> | |
| SDCL §§ 34-23A-7 (introductory paragraph) and 34-23A-7(3) | |
| Complete questions A or B and question C. | |
| A. As outlined in SDCL 34-23A-7, notice was provided to: Parent <input type="checkbox"/> Guardian/conservator <input type="checkbox"/> | |
| B. Notice was not provided to parents or guardian/conservator of the minor as outlined in SDCL 34-23A-7 because: | |
| <input type="checkbox"/> A medical emergency existed complicating the medical condition of the pregnant female so as to necessitate the immediate abortion to avert her death or to avert the creation of a serious risk of substantial or irreversible impairment of a major bodily function. SDCL §§ 34-23A-7(1) and 34-23A-39(2). | |
| <input type="checkbox"/> The person who was entitled to notice certified in writing that he/she has been notified. SDCL §§ 34-23A-7(2) and 34-23A-39(2). | |
| <input type="checkbox"/> The patient was an emancipated minor as defined by SDCL 24-5-24. SDCL §§ 34-23A-7(2) and 34-23A-39(2). | |
| <input type="checkbox"/> The physician was authorized by the court under SDCL 34-23A-7(3) to perform the induced abortion without parental or guardian/conservator notice. SDCL 34-23A-39(2). | |
| C. Minor obtained induced abortion: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown SDCL §§ 34-23A-39(1), 34-23A-39(2), 34-23A-39(3), and 34-23A-39(4). | |

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REPORT OF INDUCED ABORTION
South Dakota Codified Law §§ 34-23A-35, 34-23A-34, 34-23A-19
(also 45 C.F.R. §§ 164.512(b)(1)(i) and 164.514(e)(3)(i))

South Dakota Department of Health
 600 East Capitol Avenue
 Pierre, South Dakota 57501-2536

PLACE OF OCCURRENCE

| | | | |
|---|---------|--|--------------------|
| Name of Hospital, Clinic or Physician's Office: | | Date of Report (Month/Day/Year) ____/____/____ | Patient ID Number: |
| State: | County: | City: | |

PATIENT INFORMATION

| | | | |
|------------|---|--|--|
| Residence: | | Residence Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No | Marital Status: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| State: | County: | City: | |
| Zip Code: | Race: <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Black <input type="checkbox"/> Other (specify): _____ | | Of Hispanic Origin? <input type="checkbox"/> Yes <input type="checkbox"/> No |

| | | |
|---|---|--|
| Education (check the box that best describes patient's education): | | Age on Last Birthday: |
| <input type="checkbox"/> 8 th grade or less | <input type="checkbox"/> Bachelor's degree (BA, AB, BS, etc) | Age, if known, of unborn child's father (if patient was younger than 16 years of age at conception): |
| <input type="checkbox"/> 9 th - 12 th grade, no diploma | <input type="checkbox"/> Master's degree (MA, MS, MBA, etc) | |
| <input type="checkbox"/> High School Grad. Or GED | <input type="checkbox"/> Doctorate (PhD, etc) or Professional degree (MD, DDS, etc) | |
| <input type="checkbox"/> Some college, no degree | <input type="checkbox"/> Teacher's Certificate | |
| <input type="checkbox"/> Associate degree (AA, AS, etc) | <input type="checkbox"/> Votech | |

PAYMENT INFORMATION

| | | |
|---|--|--|
| Payment for this Procedure: <input type="checkbox"/> Private Insurance <input type="checkbox"/> Public Health Plan <input type="checkbox"/> Other (Specify): _____ | Insurance Coverage Type: <input type="checkbox"/> Fee-for-service Insurance Co. <input type="checkbox"/> Managed Care Company <input type="checkbox"/> Other (Specify): _____ | Fee Collected for Performing or Treating the Induced Abortion: \$ _____ |
|---|--|--|

PREVIOUS PREGNANCIES (complete each section)

| Live Births | | Other Terminations | |
|---|---|--|---|
| Now Living <input type="checkbox"/> None Number _____ | Now Dead <input type="checkbox"/> None Number _____ | Spontaneous <input type="checkbox"/> None Number _____ | Previous Induced <input type="checkbox"/> None Number _____ |

MEDICAL INFORMATION

| | | | |
|--|---|---|---|
| Date of Induced Abortion (Month/Day/Year) ____/____/____ | Date Last Normal Menses Began (Month/Day/Year) ____/____/____ | Patient Received Required Counseling? <input type="checkbox"/> Yes <input type="checkbox"/> No | Presence of Fetal Abnormality? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
| Approximate Gestational Age _____ weeks | Measurement of Fetus _____ <input type="checkbox"/> Unknown (refer to instructions) | Method of Disposal: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Incineration <input type="checkbox"/> Unknown/Medical | |

Rhesus factor (Rh) information: Patient received Rh test: Yes No
 If no, why? Patient provided info from elsewhere Info is in patient's chart
 Patient is positive or negative for Rh factor: Positive Negative Unknown
 Patient received Rho (D) immune globulin injection: Yes No

MEDICAL PROCEDURES

| Primary Procedure That Terminated Pregnancy (<i>check only one</i>) | Type of Termination Procedure | Any Additional Procedures Used (<i>check all that apply</i>) |
|---|-------------------------------|--|
| <input type="checkbox"/> | Suction | <input type="checkbox"/> |
| <input type="checkbox"/> | Medical/Non-surgical | <input type="checkbox"/> |
| <input type="checkbox"/> | Dilation and Evacuation | <input type="checkbox"/> |
| <input type="checkbox"/> | Intra-Uterine Instillation | <input type="checkbox"/> |
| <input type="checkbox"/> | Sharp Curettage | <input type="checkbox"/> |
| <input type="checkbox"/> | Hysterotomy/Hysterectomy | <input type="checkbox"/> |
| <input type="checkbox"/> | Other (Specify) _____ | <input type="checkbox"/> |

| | |
|---|---|
| Type of Anesthetic Used: <input type="checkbox"/> None <input type="checkbox"/> General <input type="checkbox"/> Regional <input type="checkbox"/> Local <input type="checkbox"/> IV Conscious Sedation | Complications from the abortion: <input type="checkbox"/> None 1. _____ 2. _____ 3. _____ |
|---|---|

REASON FOR INDUCED ABORTION

Check all that apply.

| | |
|--|--|
| <input type="checkbox"/> The mother would suffer substantial and irreversible impairment of a major bodily function if the pregnancy continued | <input type="checkbox"/> The pregnancy was a result of incest |
| <input type="checkbox"/> The pregnancy was a result of rape | <input type="checkbox"/> The mother did not desire to have the child |
| <input type="checkbox"/> The mother could not afford the child | <input type="checkbox"/> Other, which shall be specified: _____ |
| <input type="checkbox"/> The mother's emotional health was at risk | |

PHYSICIAN INFORMATION

| | |
|---------------------------------------|--|
| Name of Physician and License Number: | Physician Has Been Subject To: License Revocation <input type="checkbox"/> Yes <input type="checkbox"/> No License Suspension <input type="checkbox"/> Yes <input type="checkbox"/> No Other Professional Sanction <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Physician's Specialty: _____ | |

Physician's Induced Abortion Reporting Form
Voluntary and Informed Consent
South Dakota Codified Law § 34-23A-37
(also 45 C.F.R. §§ 164.512(b)(1)(i) and 164.514(e)(3)(i))
 South Dakota Department of Health
 600 East Capitol Avenue
 Pierre, South Dakota 57501-2536

| | |
|--|-----------------------------------|
| Name of Hospital, Clinic or Physician's Office: _____ | Date of Report ____ / ____ / ____ |
| | Patient ID Number: _____ |
| SDCL 34-23A-43 (verification purposes) | |

Complete the appropriate categories regarding informed consent information supplied to female patients. This includes medical information described in SDCL 34-23A-10.1(1), resource information described in SDCL 34-23A-10.1(2), and printed fetal growth and development educational materials described in SDCL 34-23A-10.3.

Patient was timely provided the **medical** information as described in **SDCL §§ 34-23A-10.1(1) and 34-23A-10.1 (last paragraph)**.
 Medical information was provided:
 during telephone conversation in person (face-to-face)

Medical information was provided by:
 referring physician physician performing induced abortion

Patient was timely provided the **resource** information as described in **SDCL 34-23A-10.1(2)**.
 Resource information was provided:
 during telephone conversation in person (face-to-face)

Resource information was provided by:
 referring physician physician performing induced abortion
 agent of referring physician agent of physician performing induced abortion

Patient was timely offered the printed **fetal growth and development** information as described in **SDCL §§ 34-23A-10.3 and 34-23A-10.1(2)(c)** in both printed form and by website at www.state.sd.us/applications/ph17abortioninfo/inlet/fetal.pdf and www.state.sd.us/ph17abortioninfo.

Patient did not accept the printed fetal growth and development information described in SDCL §§ 34-23A-10.3 and 34-23A-10.1(2)(c).

Patient did not accept the website fetal growth and development information described in SDCL §§ 34-23A-10.4 and 34-23A-10.1(2)(c).

Patient obtained induced abortion: Yes No Unknown SDCL §§ 34-23A-10.1(1), 34-23A-10.1(2)(c), 34-23A-10.1(3), and 34-23A-10.1(4).

Patient obtained induced abortion. Patient was not provided the medical or resource information described in SDCL §§ 34-23A-10.1 (1) or 34-23A-10.1(2) because of a medical emergency which so complicated the medical condition of the pregnant female as to necessitate the immediate abortion of her pregnancy to avert her death, on the basis of the physician's good faith clinical judgment. SDCL §§ 34-23A-10.1 (introductory paragraph) and 34-23A-7(1). Report of Induced Abortion Form DOH-PO66 must be submitted to Department of Health.

Patient obtained induced abortion. Patient was not provided the medical or resource information described in SDCL §§ 34-23A-10.1 (1) or 34-23A-10.1(2) because a delay would have created a serious risk of substantial and irreversible impairment of a major bodily function, in the physician's good faith clinical judgment. SDCL §§ 34-23A-10.1 (introductory paragraph) and 34-23A-7(1). Report of Induced Abortion Form PO66 must be submitted to Department of Health.

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