



STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES
COMPLICATION REPORT FOR POST-ABORTION CARE

PATIENT	1A. PATIENT NUMBER	1B. DATE OF BIRTH (MO/DAY/YR)	1C. RESIDENCE-STATE	1D. COUNTY	1E. CITY, TOWN OR LOCATION	2. DATE OF ABORTION (MO/DAY/YR)
FACILITY WHERE ABORTION WAS PERFORMED	3A. FACILITY NAME	3B. STREET ADDRESS		3C. CITY, TOWN OR LOCATION	3D. STATE	3E. TYPE OF ABORTION PERFORMED ☐ Surgical ☐ Medical (Non-surgical)
FACILITY REPORTING COMPLICATION	4A. FACILITY NAME	4B. STREET ADDRESS		4C. CITY, TOWN OR LOCATION		4D. STATE
	5A. WAS PATIENT PREVIOUSLY SEEN AT ANOTHER FACILITY FOR POST-ABORTION CARE? ☐ YES ☐ NO	5B. IF YES, NAME OF FACILITY	5C. STREET ADDRESS	5D. CITY, TOWN OR LOCATION	5E. STATE	
6. COMPLICATIONS (PLEASE CHECK ALL THAT APPLY)				7. RESULT OF COMPLICATION (PLEASE CHECK ALL THAT APPLY)		
☐ Incomplete Abortion ☐ Hemorrhage ☐ Endometritis ☐ Parametritis ☐ Pyrexia ☐ Abscess, Pelvic ☐ Uterine Perforation ☐ Failed Medical Abortion ☐ Failed Surgical Abortion, Immediately recognized ☐ Failed Surgical Abortion, with delayed recognition ☐ Retained Products ☐ Cervical Lacerations ☐ Diagnosable Psychiatric Condition ☐ Other (Describe): _____				☐ Hysterectomy ☐ Death of Woman ☐ Transfusion ☐ Other (Describe): _____		
				8. WAS PATIENT HOSPITALIZED? ☐ YES ☐ NO		
				IF YES, NAME OF HOSPITAL		
				HOSPITAL - STREET ADDRESS		
				HOSPITAL - CITY, TOWN, LOCATION		
PHYSICIAN PROVIDING CARE						
9A. NAME OF PHYSICIAN (TYPE OR PRINT)			9B. SIGNATURE OF PHYSICIAN		10. DATE OF THIS POST-ABORTION CARE (MO/DAY/YR)	
Within 45 days from the date of post-abortion care for complication, submit this form to: Department of Health and Senior Services Attention: Bureau of Vital Records P.O. Box 570 Jefferson City, MO 65012						