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Arizona Department of Health Services

Abortion Procedure Report

NOTICE: This is a MONTHLY report that must be filed within 15 days after the last day of the reporting month.

Facility Information

Facility Name

Facility Type

County of Pregnancy Termination

Address of Facility

City

State

Zip

Provider First Name *

Provider Last Name *

Provider Type *

License Number *

Additional Provider Clear Fields

Patient Information

Age *

Education * Help

Residence State *

- Non USA Resident
- Residence Unknown

Residence County *

Hispanic Origin? *

Yes No Unknown

Race, check all that apply *

- White
- American Indian
- Black or African American
- Asian
- Native Hawaiian or Other Pacific Islander
- Other

Married *

Prior Pregnancy *

Prior Birth *

Prior Abortion *

Prior Spontaneous Terminations *

Clear Fields

Medical Information

Estimate of Gestational Age *

Date of Termination *

Reason for Termination (* **Please hold control key to select multiple options)**

----Please Select----

Diagnosis Code *

Surgical Procedure Performed *

Intrauterine instillation Performed *

Non-Surgical/Medication-Induced Procedure Performed *

Medical Complication *

Preexisting medical conditions that would complicate pregnancy * (4000 characters left)

The basis for any medical judgment that a medical emergency existed that excused the physician from compliance with the requirements of this chapter.

Please Explain * (4000 characters left)

Physician's statement if required pursuant to Arizona Revised Statutes
Title 36 Public Health and Safety - Section 36-2301.01

Fetus Weight In Grams if Physician's Statement Required *

Physician's Statement * (4000 characters left)

Clear Fields

Disposition of Fetal Tissue

Final Disposition *

If custody of fetal tissue was transferred to a person(s) or establishment, identify the person(s) or establishment

Person First Name

Person Last Name

Person Address

Person City | Person State | Person Zip

Additional Person

Amount of Monetary Compensation if any

$

☐ Check if patient gave informed consent for the transfer

Clear Fields

Affidavits

Was the fetus delivered alive? *

Clear Fields

Submit Form

Name of Person Preparing Report * | Report Date *

☐ I declare that the information in this report provided to the Arizona Department of Health Services is correct to the best of my knowledge.

You are submitting a report for Facility:

Submit

After you press the submit button, if you do not receive a confirmation message with a report number your report was not received by ADHS.

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