## Post Abortion Care Report For Complications Ohio Department of Heath

(Required Pursuant to O.A.C. 3701-47-03 To be completed by the physician providing post-abortion care

					State Use Only
1. Facility where post-abortion care v	was provided:				
2. Street or Post Number		City		State	Zip
3. Date of Abortion: Month Day	Voar	4. Weeks of Gestation:			
3. Date of Abortion. World Day					
5A. Facility where Abortion was perf	formed:			****	
5B. Address of Facility:	Street or Post Number	City		State	Zip
6. Date Post Abortion Care Begin: Month Day Year 7. Patient Number					
		//	'	//	_//
8. Complication (s) (Please check all	that apply):				
Hemorrhage	Anesthetic _	Hematometra	Perforation	of Uterus	
Failure of Amniotic Fluid Ex	RH Incompatibility _	Cervical Laceration Failed Abortion			
Infection	Incomplete Abortion	Death	Other (Spec	cify)	
9. Duration of treatment: (Indicate n	umber of hours or days)				
	Hours	Days			
10. Remarks					
			P-10		
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			V1/07-		1,4900
	T WAR THE TOTAL		-9.54	700.0	
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11A. Physician's Name providing care (Type or print)		11.B Phys	icians Signature:	M.D. D.O.	Date:
(1) pe of printy				D.O.	

Send Completed Forms to: Ohio Department of Health

Confidential Reports A PO Box 118 Columbus, Ohio 43216