Appendix A

ABORTION FORMS

Shown 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.

In 2016 there were two different *Report of Induced Abortion* forms used due to changes in state law. The first form was used from January 1-June 30, 2016. The second form was used July 1-December 31, 2016.

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
615 East 4th Street
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:_____

The patient is (check one box): SDCL 34-23A-7

☐ Emancipated minor (if checked, please skip to letter C)
☐ Unemancipated minor, with parental notice required
☐ Unemancipated minor, with guardian notice required due to court-ordered guardianship or conservatorship
☐ Incompetent minor or adult, with guardian notice required due to court-ordered guardianship or conservatorship

Complete questions A or B and question C.

A. **Notice was provided**, per SDCL §§ 34-23A-39(1) and 34-23A-7, to patient's: ☐ Parent or ☐Guardian/Conservator (if checked, please skip to letter C).

OR

B. **Notice was not provided**, per SDCL 34-23A-7, to patient's: ☐ Parent or ☐ Guardian/Conservator **because one of the following three notice exceptions applies** (check applicable exception):

1. ☐ A **medical emergency** existed with insufficient time to provide the required notice. SDCL 34-23A-7(1).

☐ Verbal notice was provided to parent/guardian within 24 hours after the abortion. SDCL §§ 34-23A-39(2), 34-23A-39(4), and 34-23A-7(1).

☐ Mandatory written notice was provided to parent/guardian after the abortion. SDCL §§ 34-23A-39(2), 34-23A-39(4), 34-23A-7(1).

OR

☐ Judge of circuit court authorizes waiver of required notice, per SDCL §§ 34-23A-39(2), 34-23A-39(3), 34-23A-39(4), and 34-23A-7(1), because:

☐ Judge determined patient is mature and capable of giving informed consent. SDCL §§ 34-23A-39(2), 34-23A-39(3), 34-23A-39(4), and 34-23A-7(1).

OR

☐ Judge determined patient is not mature, or patient does not claim to be mature, and Judge determines performance of abortion without notification of parent would be in patient's best interests. SDCL §§ 34-23A-39(2), 34-23A-39(3), 34-23A-39(4), and 34-23A-7(1).

2. ☐ The **parent or guardian entitled to notice certifies in writing that s/he was notified**, with the parent or guardian's signature notarized. SDCL §§ 34-23A-39(1) and 34-23A-7(2).

3. ☐ Any **judge of a circuit court** , after an appropriate hearing, **authorizes a physician to perform the induced abortion without prior notice**. SDCL §§ 34-23A-39(3) and 34-23A-7(3).

C. Patient obtained induced abortion: ☐Yes ☐ No ☐ Unknown SDCL §§ 34-23A-39(1), 34-23A-39(2), 34-23A-39(3), and 34-23A-39(4).

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
615 East 4th Street
Pierre, South Dakota 57501-2536

PLACE OF OCCURRENCE

Name of Hospital, Clinic or Physician's Office:
State: County: City:

Date of Report (Month/Day/Year)
_____/_____/____

Patient ID Number:

PATIENT INFORMATION

Residence:
State: County: City:

Residence Inside City Limits? ☐Yes ☐No

Marital Status: Married? ☐Yes ☐No

Zip Code:

Race: (**check the boxes** that best describe that patient's race):
☐ White ☐Black or African American ☐American Indian or Alaska Native
☐ Asian Indian ☐Chinese ☐ Filipino Specify Tribe_____
☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (specify)_____
☐ Native Hawaiian ☐ Guamanian or Chamarro ☐ Samoan
☐ Other Pacific Islander (specify)_____ ☐ Other (specify)_____

Of Hispanic Origin? (**check the boxes** that best describe that patient's Hispanic Origin):
☐ No, not Spanish/Hispanic/Latina
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican ☐Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latina
(e.g. Spaniard, Salvadoran, Dominican, Columbian)
(specify)_____

Education (**check the box** that best describes patient's education):
☐ 8th grade or less ☐ Associate degree (AA, AS, etc) ☐ Teacher's Certificate
☐ 9th-12th grade, no diploma ☐ Bachelor's degree (BA, AB, BS, etc) ☐ Votech
☐ High School Grad./GED ☐ Master's degree (MA, MS, MBA, etc)
☐ Some college, no degree ☐ Doctorate (PhD, etc) or Professional degree (MD, DDS, etc)

Age on Last Birthday:

Age, if known, of unborn child's father (if patient was younger than 16 years of age at conception):

PAYMENT INFORMATION

Payment for this Procedure:
☐ Private Insurance
☐ Public Health Plan
☐ Other (Specify):_____

Insurance Coverage Type:
☐ Fee-for-service Insurance Co.
☐ Managed Care Company
☐ Other (Specify): _____

Fee Collected for Performing or Treating the Induced Abortion:
$ _____

PREVIOUS PREGNANCIES (complete each section)

Live Births		Other Terminations	
Now Living	Now Dead	Spontaneous	Previous Induced
☐None Number _____	☐None Number_____	☐None Number_____	☐None Number_____

MEDICAL INFORMATION

Date of Induced Abortion (Month/Day/Year)
_____/_____/_____

Date Last Normal Menses Began (Month/Day/Year)
_____/_____/_____

Patient Received Required Counseling?
☐ Yes ☐ No

Presence of Fetal Abnormality?
☐Yes ☐No ☐Unknown

Approximate Gestational Age
_____ weeks

Measurement of Fetus
_____
☐Unknown (refer to instructions)

Method of Disposal:
☐ Burial ☐ Cremation
☐ Incineration ☐ 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 (*check only one*)	Type of Termination Procedure	Any Additional Procedures Used (*check all that apply*)
☐	Suction	☐
☐	Medical/Non-surgical	☐
☐	Dilation and Evacuation	☐
☐	Intra-Uterine Instillation	☐
☐	Sharp Curettage	☐
☐	Hysterotomy/Hysterectomy	☐
☐	Other (Specify)_____	☐

Type of Anesthetic Used:
☐None
☐General
☐Regional ☐Local
☐IV Conscious Sedation

Complications from the abortion:
☐ None
1._____
2. _____
3. _____

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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
615 East 4th Street
Pierre, South Dakota 57501-2536

REASON FOR INDUCED ABORTION	
Check the boxes that best describe patient's reason:	
☐ The mother would suffer substantial and irreversible impairment of a major bodily function if the pregnancy continued	
☐ The pregnancy was a result of rape	☐ The pregnancy was a result of incest
☐ The mother could not afford the child	☐ The mother did not desire to have the child
☐ The mother's emotional health was at risk	☐ Other, which shall be specified: _____

PHYSICIAN INFORMATION	
Name of Physician and License Number: Physician's Specialty: _____	Physician Has Been Subject To: License Revocation ☐ Yes ☐ No License Suspension ☐ Yes ☐ No Other Professional Sanction ☐ Yes ☐ No

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
615 East 4th Street
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 information described in SDCL 34-23A-10.1(1), information described in SDCL 34-23A-10.1(2), printed educational materials described in SDCL 34-23A-10.3, and opportunity to view sonogram in SDCL 34-23A-37(3A).

☐ Patient was timely provided the information as described in **SDCL 34-23A-10.1(1).**
Information was provided:
☐ in person (face-to-face) ☐ during telephone conversation

Information was provided by:
☐ referring physician ☐ physician performing induced abortion

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

Information was provided by:
☐ referring physician ☐ physician performing induced abortion
☐ agent of referring physician ☐ agent of physician performing induced abortion

☐ Patient was offered the printed materials as described in **SDCL §§ 34-23A-10.3**.

☐ Patient accepted the printed materials on public and private assistance agencies.
☐ Patient did not accept the printed materials on public and private assistance agencies.
AND
☐ Patient accepted the Fetal Growth and Development booklet.
☐ Patient did not accept the Fetal Growth and Development booklet.

☐ Patient was offered the DOH website address for "Information on Fetal Development, Birth, Abortion and Adoption."

☐ Patient accepted the DOH website address.
☐ Patient did not accept the DOH website address.

☐ Patient was offered the opportunity to view a **sonogram** of her unborn child prior to the procedure as described in **SDCL 34-23A-37(3A)** and **34-23A-52.**

☐ Patient accepted the opportunity to view a sonogram of her unborn child.
OR
☐ Patient did not accept the opportunity to view a sonogram of her unborn child.

Patient obtained induced abortion: ☐ ***Yes*** ☐ ***No*** ☐ ***Unknown*** *SDCL 34-23A-37(3), 34-23A-37(3A), and 34-23A-52.*

☐ Patient obtained induced abortion. **Patient was not provided the 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 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 DOH-PO66 must be submitted to Department of Health.

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
Office of Health Statistics
615 East 4th Street
Pierre, South Dakota 57501-2536

PLACE OF OCCURRENCE

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

PATIENT INFORMATION

Residence: State:_____County:_____ City:_____	Residence Inside City Limits? ☐ Yes ☐ No	Marital Status: Married? ☐ Yes ☐ No

Zip Code:

Race: (**check the boxes that best describe the patient's race**):
□ White □ Black or African American □ American Indian or Alaska Native
□ Asian Indian □ Chinese □ Filipino Specify Tribe:_____
□ Japanese □ Korean □ Vietnamese □ Other Asian: (specify)_____
□ Native Hawaiian □ Guamanian or Chamarro □ Samoan
□ Other Pacific Islander (specify)_____ □ Other (specify):_____

Of Hispanic Origin? (**check the boxes** that best describe the patient's Hispanic Origin):
□ No, not Spanish/Hispanic/Latina
□ Yes, Mexican, Mexican American, Chicano
□ Yes, Puerto Rican □ Yes, Cuban
□ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Columbian)
(Specify:_____)

Education: (**check the box that best describe the patient's education level. If patient is currently enrolled, check the box that indicates the previous grade or highest degree recieved**):
□ 8th grade or less □ Associate degree (AA, AS, etc.) □ Teacher's Certificate
□ 9-12th grade, no diploma □ Bachelor's degree (BA, AB, BS, etc.) □ VoTech
□ High School Grad./GED □ Master's degree (MA, MS, MBA, etc.)
□ Some college, no degree □ Doctorate (PhD, etc.) or Professional degree (MD, DDS, etc.)

Age on Last Birthday:_____

Age, if known, of unborn child's father (if patient was younger than 16 years of age at conception) :

PAYMENT INFORMATION

Payment for this Procedure: □ Private Insurance □ Public Health Plan □ Other (Specify):_____	Insurance Coverage Type: □ Fee-for-service Insurance Co. □ Managed Care Company □ Other (Specify):_____	Fee Collected for Performing or Treating the Induced Abortion: $_____

PREVIOUS PREGNANCIES (complete each section)

Live Births		Other Terminations	
Now Living □ None Number_____	Now Dead □ None Number_____	Spontaneous □ None Number_____	Previous Induced □ None Number_____

MEDICAL INFORMATION

Date of Induced Abortion (Month/Day/Year) _____/_____/_____	Date Last Normal Menses Began (Month/Day/Year) _____/_____/_____	Patient Received Required Counseling? ☐ Yes ☐ No	Presence of Fetal Abnormality? ☐ Yes ☐ No ☐ Unknown

Approximate Gestational Age _____weeks	Measurement/Weight of Fetus _____ ☐ Unknown (refer to instructions)	Method of Disposal: ☐ Burial ☐ Cremation ☐ Incineration ☐ 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

Sex of the unborn child: ☐ Male ☐ Female ☐ Unknown
If sex is known: Did mother use a sex-determining test? ☐ Yes ☐ No
If Yes, what type of sex-determining test was used? _____
Approximate gestational age of unborn child, in weeks, when the test was taken:_____

Post-fertilization age: _____ weeks

How was the post-fertilization age determined?:_____

If post-fertilization age was not determined, what was the basis of the determination that an exception existed?_____
_____

Was an intra-fetal injection used in an attempt to induce fetal demise? □ Yes □ No
If the unborn child was deemed capable of experiencing pain, what was the basis of the determination that it was a medical emergency?_____
_____

-OVER-

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
Office of Health Statistics
615 East 4th Street
Pierre, South Dakota 57501-2536

If the unborn child was deemed capable of experiencing pain, did the method of abortion provide the best opportunity for the unborn child to survive? □ Yes □ No

If such a method was not used, what was the basis of the determination that termination in that manner would pose a greater risk either of the death of the pregnant woman or of the substantial and irreversible physical impairment of a major bodily function, not including a psychological or emotional condition, of the woman than other available methods?_____

_____

MEDICAL PROCEDURES

Primary Procedure That Terminated Pregnancy *(check only one)*	Type of Termination Procedure	Any Additional Procedures Used *(check all that apply)*
□	Suction	□
□	Medical/Non-surgical	□
□	Dilation and Evacuation	□
□	Intra-uterine Instillation	□
□	Sharp Curettage	□
□	Hysterotomy/Hysterectomy	□
□	Other (Specify)_____	□

Type of Anesthetic Used:	Maternal Complications from the Abortion:
□ None	□ None
□ General	1._____
□ Regional □ Local	2._____
□ IV Conscious Sedation	3._____

REASON FOR INDUCED ABORTION

Check the boxes that best describe the patient's reason:
□ The mother would suffer substantial and irreversible impairment of a major bodily function if the pregnancy continued
□ The pregnancy was the result of rape
□ The mother could not afford the child
□ The mother's emotional health was at risk
□ The pregnancy was a result of incest
□ The mother did not desire to have the child
□ Other, which shall be specified:_____

PHYSICIAN INFORMATION

Name of Physician and License Number:	Physician Has Been Subject To:
	License Revocation ☐ Yes ☐ No
	License Suspension ☐ Yes ☐ No
Physician's Specialty:_____	Other Professional Sanction ☐ Yes ☐ No