



## 2026 REPORT OF INDUCED ABORTION FORM INSTRUCTIONS

### PLACE OF OCCURRENCE

**Name of Hospital, Clinic, or Physician's Office:** Enter the full name of the hospital or clinic where the induced abortion occurred. SDCL §§ 34-23A-34(18).

**State of Occurrence:** Enter South Dakota. SDCL §§ 34-23A-34(20)(a).

**County of Occurrence:** Enter the name of the county where the induced abortion occurred. SDC §§ 34-23A-34(20)(a).

**City of Occurrence:** Enter the name of the city or town where the induced abortion occurred. SDCL §§ 34-23A-34(20)(a).

**Date of Report:** Enter exact month, day, and year this form was completed. SDCL §§ 34-23A-43 (verification purposes).

**Patient ID Number:** Use a unique number to link this report to medical record for inspection, clarification and correction purposes. Please select a Patient ID number that cannot, of itself, reasonably lead to the identification of any person obtaining an abortion. SDCL §§ 34-23A-34(19), 34-23A-19, 34-23A-26, 34-23A-36, and 34-23A-44.

### PATIENT INFORMATION

**State of Residence:** Enter the name of the State where the patient lives. This may differ from the state in her mailing address. If the patient is not a resident of the United States, enter the name of the country. SDCL §§ 34-23A-34(20)(b); also see 45 C.F.R. § 164.514(e)(2)(ii).

**County of Residence:** Enter the name of the county where the patient lives. SDCL §§ 34-23A-34(20)(b); also see 45 C.F.R. § 164.514(e)(2)(ii).

**City of Residence:** Enter the name of the city, town or location where the patient lives. This may differ from her mailing address. SDCL §§ 34-23A-34(20)(b); also see 45 C.F.R. § 164.514(e)(2)(ii).

**Residence Inside City Limits?:** Enter "Yes" if the city, town or location where the patient resides is incorporated and the patient's residence is inside its boundaries. See 45 C.F.R. § 164.514(e)(2)(ii) (also consistent with other South Dakota vital records and used for public health geocoding purposes).

**Marital Status:** Married? Check "Yes" if the patient was legally married (including separated) at the time of conception, at the time of the induced abortion, or at any time between conception and the induced abortion. SDCL §§ 34-23A-34(20)(c); 45 C.F.R. §



164.512(b)(1)(i) (allows complete reporting to the Centers for Disease Control (CDC) of the public health services in the United States Department of Health and Human Services); also see 45 C.F.R. § 164.514(e)(3)(i).

**Zip Code:** Enter the ZIP code of the place where the patient lives. See 45 C.F.R. § 164.514(e)(2)(ii).

**Race:** Check the boxes that describe the race of the patient. The entry should reflect the patient's response. SDCL §§ 34-23A-34(20)(e); 45 C.F.R. § 164.512(b)(1)(i) (allows complete reporting to CDC); also see 45 C.F.R. § 164.514(e)(3)(i).

**Of Hispanic Origin?:** Hispanic refers to people whose origins are from Spain, Mexico, Puerto Rico, Cuba or the Spanish-speaking countries of Central or South America. This item is not a part of the Race item. A person of Hispanic origin may be of any race. SDCL §§ 34-23A-34(20)(e); 45 C.F.R. § 164.512(b)(1)(i) (allows complete reporting to CDC); also see 45 C.F.R. § 164.514(e)(3)(i).

**Education (Specify the highest level of schooling that the patient has completed at the time of the induced abortion):** Check the box that best describes the patient's education. If currently enrolled, check the box that indicates the previous grade or highest degree received. SDCL §§ 34-23A-34(20)(d); (also consistent with other South Dakota vital records and used for public health geocoding purposes).

**Age on Last Birthday:** Enter the age of the patient in years at her last birthday. SDCL §§ 34-23A-34(4). If patient is under the age of 18, also complete Parental Notice Form DOH-AO15. SDCL §§ 34-23A-39, and 34-23A-7.

**Age, if known, of Unborn Child's Father (if patient was younger than 16 years of age at conception):** Enter "N/A" for not applicable if patient was 16 years of age or older at conception; enter the age, if known, of the unborn child's father if patient was younger than 16 years of age at conception. SDCL §§ 34-23A-34(4).

## **PAYMENT INFORMATION**

**Payment Source:** Check the box that best describes the source for payment of this procedure. SDCL §§ 34-23A-34(6). If "Other" is checked please specify source.

**Coverage Type:** Check the box that best describes the type of coverage for this patient. SDCL §§ 34-23A-34(7). If "Other" is checked please specify source.

**Fee Collected for Performing or Treating the Induced Abortion:** Report total dollar amount collected for this induced abortion. This amount must include the costs for all services related in any manner to the induced abortion. SDCL §§ 34-23A-34(9).

## **PREVIOUS PREGNANCIES**

**Live Births, Now Living:** Enter the number of children born alive to this patient who are still



living at the time of this induced abortion. Do not include children by adoption. Check “none” if all previous children are dead. SDCL §§ 34-23A-34(15); 45n.C.F.R. § 164.512(b)(1)(i) (allows complete reporting to CDC); also see 45 C.F.R. § 164.514(e)(3)(i).

**Live Births, Now Dead:** Enter the number of children born alive to this patient who are no longer living at the time of this induced abortion. Do not include children by adoption. Check “None” if all previous children are still living. SDCL §§ 34-23A-34(15); 45 C.F.R. § 164.512(b)(1)(i) (allows complete reporting to CDC); also see 45 C.F.R. § 164.514(e)(3)(i).

**Other Terminations, Spontaneous:** Enter the number of previous pregnancies that ended spontaneously and did not result in a live born infant. SDCL §§ 34-23A-34(14). This should not include the current induced termination or any previous induced termination. Check “None” if the patient has had no previous pregnancies or if all previous pregnancies ended in live born infants.

**Other Terminations, Previous Induced:** Enter the number of previous induced abortions for the patient. SDCL §§ 34-23A-34(14); 45 C.F.R. § 164.512(b)(1)(i) (allows complete reporting to CDC); also see 45 C.F.R. § 164.514(e)(3)(i). Do not include the current induced termination. Check “None” if the patient has had no previous induced termination(s).

## MEDICAL INFORMATION

**Date of Induced Abortion:** Enter the exact month, day, and year of the induced abortion. SDCL §§ 34-23A-34(1), 34-23A-34(3), and 34-23A-19(3); 45 C.F.R. § 164.512(b)(1)(i) (allows complete reporting to CDC); also see 45 C.F.R. § 164.514(e)(3)(i).

**Date Last Normal Menses Began:** Enter the exact date of the first day of the patient's last normal menstrual period, as obtained from the hospital, clinic record or the patient herself. If the exact day is unknown but the month and year are known, obtain an estimate of the day from the patient, her physician or the medical record. If an estimate of the date cannot be obtained, enter the month and year only. Enter “unknown” if the date cannot be determined. SDCL §§ 34-23A-34(16); 45 C.F.R. § 164.512(b)(1)(i) (allows complete reporting to CDC); also see 45 C.F.R. § 164.514(e)(3)(i).

**Patient Received Required Counseling:** Check appropriate box. This refers to counseling as required by SDCL §§ 34-23A-10.1. Refer to Voluntary and Informed Consent Form DOH-AO14 for more information.

**Presence of Fetal Abnormality:** Check appropriate box. SDCL §§ 34-23A-19(3).

**Approximate Gestational Age:** Enter the length of gestation as estimated by the attending physician in weeks. SDCL §§ 34-23A-19(3), 34-23A-34(3).

**Measurement/Weight of Fetus:** Enter the measurement/weight of the fetus from the



pathology report, or, if the facility is not equipped to complete this information, then check the “Unknown” box. The preferred method of measurement is the weight of the fetus in grams. SDCL §§ 34-23A-19(3).

**Method of Disposal:** Check appropriate box. SDCL §§ 34-23A-34(11), 34-25-32.3 to 34-25-32.7.

**Rhesus factor (Rh) information:** Whether the patient received the Rh test check “Yes” or “No”; if no check “patient provided info from elsewhere” or “info is in patient’s chart”. Answer whether patient is “Positive”, “Negative” or “Unknown” for Rh factor. And answer whether patient received Rho injection by checking “Yes” or “No”. SDCL §§ 34-23A-34(21)(a), 34-23A-34(21)(b), and 34-23A-34(21)(c).

**Sex of the Unborn Child:** Check appropriate box: Male, Female, or Unknown. SDCL §§ 34-23A-34(22)

**Sex-determining test:** If the sex of the unborn child is known, answer “Did mother use a sex-determining test: Yes or No”. SDCL §§ 34-23A-34(22) (a). If the answer is ‘Yes’, write in what type of sex-determining test was used in the space provided. SDCL §§ 34-23A-34(22) (b).

**Approximate Gestational Age of Unborn Child:** Write in the approximate gestational age of the unborn child, in weeks, when the test was taken. SDCL §§ 34-23A-34(22) (c).

**Post-Fertilization age \_\_\_ weeks:** Write in the post-fertilization age of the unborn child, in weeks. §§34-23A-34(23)(a)

**How was the post-fertilization age determined?:** Specify on the line provided how post-fertilization age was determined.  
§§34-23A-34(23)(a)

**If post-fertilization age was not determined, what was the basis of the determination that an exception existed?:** Specify on line(s) provided §§34-23A-34(23)(a)

**Was an intra-fetal injection used in an attempt to induce fetal demise?:** Check appropriate box: Yes or No. §§34-23A-34(23)(b)

**If the unborn child was deemed capable of experiencing pain, what was the basis of the determination that it was a medical emergency?:** Specify on line(s) provided §§34-23A-34(23)(c)

**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?:** Check appropriate box: Yes or No §§34-23A-34(23)(d)



**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?:** Specify on line(s) provided §§34-23A-34(23)(d)

**Was the infant born alive?** Check appropriate box: Yes or No §§ 34-23A-16.1

**If yes, what medical action was taken to preserve the life of the infant?** Specify on line provided §§ 34-23A-19

**Did the infant survive?** Check appropriate box: Yes or No §§ 34-23A-19

**If no, what was the Location of death?** Specify on line provided §§ 34-23A-19

### MEDICAL PROCEDURES

**Primary Procedure That Terminated Pregnancy:** Check the box that describes the primary procedure terminating this pregnancy. SDCL §§ 34-23A-19(2), 34-23A-34(2). Check only one box. If more than one procedure was used, identify the additional procedures(s) in the “Any Additional Procedures Used” section. If a procedure not listed was used, check “Other” and specify on the line provided. 45 C.F.R. §§ 164.512(b)(1)(i) and 164.514(e)(3)(i) (allows complete reporting to CDC).

**Any Additional Procedures Used:** Check the box(es) describing the additional procedure(s) used. SDCL §§ 34-23A-19(2), 34-23A-34(2). If no additional procedures were used, leave all boxes blank. If a procedure used is not listed, check “Other” and specify on the line provided.

**Type of Anesthetic Used:** Check appropriate box for the type of anesthetic used. SDCL §§ 34-23A-34(10).

**Maternal Complications:** List the maternal complications resulting from the induced abortion. SDCL §§ 34-23A-34(8), 34-23A-19(4), 34-23A-19(5). Maternal complications occurring after the original report is filed with the Department of Health require the filing of an amended report. SDCL §§ 34-23A-36.

### REASON FOR INDUCED ABORTION

**Check the box(es) that describe the reason(s) for this induced abortion.** SDCL §§ 34-23A-34(5). If a reason for the induced abortion was reported other than those listed, check “other” and specify on the line provided.

### PHYSICIAN INFORMATION

**Name of Physician and License Number:** Enter the full name and license number of the physician. SDCL §§ 34-23A-34(17).

**Physician’s Specialty:** List the physician’s specialty. SDCL §§ 34-23A-34(12).



**Physician Subject to License Revocation, License Suspension or Other Professional Sanction:** Check the appropriate box(es). SDCL §§ 34-23A-34(13).

Return completed report to:  
South Dakota Department of Health  
Office of Health Statistics  
615 East 4th Street  
Pierre, South Dakota 57501-2536



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**

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

**PATIENT INFORMATION**

<b>Residence State:</b>
<b>Residence County:</b>
<b>Residence City:</b>
<b>Residence Inside City Limits?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Marital Status:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Zip Code:</b>
<b>Race: (Check the boxes that best describe the patient's race):</b> <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Japanese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander (specify): _____ <input type="checkbox"/> Black or African American <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> American Indian or Alaska Native (specify): _____ <input type="checkbox"/> Other Asian (specify): _____ <input type="checkbox"/> Samoan <input type="checkbox"/> Other (specify): _____
<b>Of Hispanic Origin? (check the boxes that best describe the patient's Hispanic Origin):</b> <input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (e.g., Spaniard, Salvadoran, Dominican, Colombian): (specify): _____
<b>Education: (check the box that best describes the patient's education level. If the patient is currently enrolled, check the box that indicates the previous grade or highest degree received):</b> <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9-12th grade, no diploma <input type="checkbox"/> High School Grad./GED <input type="checkbox"/> Some college, no degree



<input type="checkbox"/> Associate degree (AA, AS, etc.) <input type="checkbox"/> Bachelor's degree (BA, AB, BS, etc.) <input type="checkbox"/> Master's degree (MA, MS, MBA, etc.) <input type="checkbox"/> Doctorate (PhD, etc.) or Professional degree (MD, DDS, etc.) <input type="checkbox"/> Teacher's Certificate <input type="checkbox"/> VoTech
<b>Age on Last Birthday:</b> _____
<b>Age, if known, of unborn child's father (if patient was younger than 16 years of age at conception):</b> _____

### PAYMENT INFORMATION

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

### PREVIOUS PREGNANCIES (COMPLETE EACH SECTION)

<b>Fee Collected for Performing or Treating the Induced Abortion:</b> \$ _____
<b>Live Births:</b> Now Living - <input type="checkbox"/> None   Number: _____ Now Dead - <input type="checkbox"/> None   Number: _____
<b>Other Terminations:</b> Spontaneous - <input type="checkbox"/> None   Number: _____ Previous Induced - <input type="checkbox"/> None   Number: _____

### MEDICAL INFORMATION

<b>Date of Induced Abortion (Month/Day/Year):</b>
<b>Date Last Normal Menses Began (Month/Day/Year):</b>
<b>Patient Received Required Counseling?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Presence of Fetal Abnormality?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Approximate Gestational Age in weeks:</b>
<b>Measurement/Weight of Fetus:</b> _____ <input type="checkbox"/> Unknown (refer to instructions)
<b>Method of Disposal:</b> <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Incineration <input type="checkbox"/> Unknown/Medical
<b>Rhesus factor (Rh) Information</b>
<b>Patient received Rh test:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If no, why?</b> <input type="checkbox"/> Patient provided information from elsewhere <input type="checkbox"/> Information is in patient's chart
<b>Patient is positive or negative for Rh factor:</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
<b>Patient received Rho (D) immune globulin injection:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No



<p><b>Sex of the unborn child:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown</p> <p><b>If sex is known: Did mother use a sex-determining test?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If yes, what type of sex-determining test was used?</b> _____</p> <p><b>Approximate gestational age of unborn child, in weeks, when the test was taken:</b> _____</p>
<p><b>Post-fertilization age in weeks:</b> _____</p> <p><b>How was the post-fertilization age determined?</b> _____</p> <p><b>If post-fertilization age was not determined, what was the basis of the determination that an exception existed?</b> _____</p>
<p><b>Was an intra-fetal injection used in an attempt to induce fetal demise?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If the unborn child was deemed capable of experiencing pain, what was the basis of the determination that it was a medical emergency?</b> _____</p>
<p><b>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?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>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?</b> _____</p>
<p><b>Was the infant born alive?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>If Yes, what medical action was taken to preserve the life of the infant?</b> _____</p>
<p><b>Did the infant survive?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Location of death:</b> _____</p>

### MEDICAL PROCEDURES

<p><b>Primary Procedure That Terminated Pregnancy (<i>check only one</i>):</b></p> <p><input type="checkbox"/> Suction <input type="checkbox"/> Medical/Non-Surgical <input type="checkbox"/> Dilation and Evacuation <input type="checkbox"/> Intra-Uterine Instillation</p> <p><input type="checkbox"/> Sharp Curettage <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Other (specify): _____</p>
<p><b>Any Additional Procedures Used (<i>check all that apply</i>):</b></p> <p><input type="checkbox"/> Suction <input type="checkbox"/> Medical/Non-Surgical <input type="checkbox"/> Dilation and Evacuation <input type="checkbox"/> Intra-Uterine Instillation</p> <p><input type="checkbox"/> Sharp Curettage <input type="checkbox"/> Hysterotomy/Hysterectomy <input type="checkbox"/> Other (specify): _____</p>
<p><b>Type of Anesthetic Used:</b></p> <p><input type="checkbox"/> None <input type="checkbox"/> General <input type="checkbox"/> Regional <input type="checkbox"/> Local <input type="checkbox"/> IV Conscious Sedation</p>

**Maternal Complications from the Abortion:** None

1. \_\_\_\_\_

2. \_\_\_\_\_

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  NoLicense Suspension:  Yes  NoOther Professional Sanction:  Yes  No