

# Appendix A

## ABORTION FORMS

Shown below and 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.

### *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 4<sup>th</sup> 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 4<sup>th</sup> Street**  
**Pierre, South Dakota 57501-2536**

**PLACE OF OCCURRENCE**

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

**PATIENT INFORMATION**

Residence:	Residence Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No	Marital Status: Married? <input type="checkbox"/> Yes <input type="checkbox"/> No
State:                      County:                      City:		

Zip Code:	Of Hispanic Origin? (check the boxes that best describe that patient's Hispanic Origin):
Race: (check the boxes that best describe that patient's race):	<input type="checkbox"/> No, not Spanish/Hispanic/Latina
<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano
<input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino                      Specify Tribe _____	<input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban
<input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (specify) _____	<input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Columbian) (specify) _____
<input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan	
<input type="checkbox"/> Other Pacific Islander (specify) _____ <input type="checkbox"/> Other (specify) _____	

Education (check the box that best describes patient's education):	Age on Last Birthday:
<input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Associate degree (AA, AS, etc) <input type="checkbox"/> Teacher's Certificate	Age, if known, of unborn child's father (if patient was younger than 16 years of age at conception):
<input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> grade, no diploma <input type="checkbox"/> Bachelor's degree (BA, AB, BS, etc) <input type="checkbox"/> Votech	
<input type="checkbox"/> High School Grad./GED <input type="checkbox"/> Master's degree (MA, MS, MBA, etc)	
<input type="checkbox"/> Some college, no degree <input type="checkbox"/> Doctorate (PhD, etc) or Professional degree (MD, DDS, etc)	

**PAYMENT INFORMATION**

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

**PREVIOUS PREGNANCIES (complete each section)**

Live Births		Other Terminations	
Now Living	Now Dead	Spontaneous	Previous Induced
<input type="checkbox"/> None      Number _____			

**MEDICAL INFORMATION**

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

Primary Procedure That Terminated Pregnancy (check only one)	Type of Termination Procedure	Any Additional Procedures Used (check all that apply)
<input type="checkbox"/>	Suction	<input type="checkbox"/>
<input type="checkbox"/>	Medical/Non-surgical	<input type="checkbox"/>
<input type="checkbox"/>	Dilation and Evacuation	<input type="checkbox"/>
<input type="checkbox"/>	Intra-Uterine Instillation	<input type="checkbox"/>
<input type="checkbox"/>	Sharp Curettage	<input type="checkbox"/>
<input type="checkbox"/>	Hysterotomy/Hysterectomy	<input type="checkbox"/>
<input type="checkbox"/>	Other (Specify) _____	<input type="checkbox"/>

Type of Anesthetic Used:	Complications from the abortion:
<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> General	1. _____
<input type="checkbox"/> Regional <input type="checkbox"/> Local	2. _____
<input type="checkbox"/> IV Conscious Sedation	3. _____

-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**  
**615 East 4<sup>th</sup> Street**  
**Pierre, South Dakota 57501-2536**

**REASON FOR INDUCED ABORTION**

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

**PHYSICIAN INFORMATION**

Name of Physician and License Number: _____  Physician's Specialty: _____	Physician Has Been Subject To: License Revocation <input type="checkbox"/> Yes <input type="checkbox"/> No License Suspension <input type="checkbox"/> Yes <input type="checkbox"/> No Other Professional Sanction <input type="checkbox"/> Yes <input type="checkbox"/> No
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**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 4<sup>th</sup> 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.