

CONFIDENTIAL

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Medical Emergency Abortion
Incident Report Form**

Name of Facility: _____
Address: _____
Contact person: _____
Telephone: _____ Email: _____
Facility License #: _____

Reporting Information – (incidents must be reported within 30 days):

Pursuant to Family Code, Chapter 33, Section 33.002; and Health and Safety Code, Chapter 171, Section 171.0124 and Chapter 285, Section 285.202, a physician may perform an abortion without obtaining informed consent (and notice for minors) in a medical emergency. A physician who performs an abortion in a medical emergency shall:

- (1) include in the patient’s medical records a statement signed by the physician certifying the nature of the medical emergency; and**
- (2) not later than the 30th day after the date the abortion is performed, certify to the Department of State Health Services the specific medical condition/indications that constituted the emergency.**

For purposes of this physician reporting requirement, a medical emergency abortion shall be considered an incident.

- 1. Date of this report: _____

- 2. Date of incident (Medical Emergency Abortion): _____

- 3. Please describe or explain the specific medical condition that constituted the emergency (*attach a separate sheet if necessary*):

I, (*printed name*) _____, hereby certify that the specific medical condition described in this incident report constituted a medical emergency.

Signature: _____ Date: _____

**Return this form
within 30 days of the incident to:**

Texas Department of State Health Services
DATA MANAGEMENT GROUP
PO Box 4124
Austin, TX 78765-4124