

**TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Abortion Complications Reporting**

Where and when the abortion was performed:

Facility Name _____ Date: _____

Facility Type: _____ License #: _____ Telephone: _____

Address: _____ Contact person(s): _____

Type of abortion that caused or may have caused the complication(s): _____

The number of weeks of gestation at which the abortion was performed: _____

Number of patient's previous induced abortions: _____ Number of patient's previous live births: _____

Type of anesthesia used during the procedure: intravenous sedation general anesthesia

Where and when the complication was diagnosed and treated if different than the above information:

Facility Name and Type: _____ Date: _____

Complications Information (check all that apply):

- Incomplete Abortion
- Post-procedure infection
- Hemorrhage
- Damage to the uterus
- Death
- Other

Summary of abortion complication(s) :

Within **30 calendar days of the discovery of the complication:**
Return this form **via certified mail** and **marked confidential** to:

Texas Department of State Health Services
Vital Statistics Unit
Post Office Box 4124
Austin, Texas 78765-4124