Government of South Australia | Commission on Excellence and Innovation in Health

Termination of Pregnancy Notification Form

This form must be forwarded via **secure file transfer** or posted to:
SOUTH AUSTRALIAN PREGNANCY OUTCOME UNIT
PO BOX 287, Rundle Mall, ADELAIDE SA, 5001

PLEASE DO NOT EMAIL THIS FORM

Termination of pregnancy service providers located within South Australia are required to comply with information provision under the *Termination of Pregnancy Act 2021* regardless of the usual place of residence of the person having the termination of pregnancy.

DEMOGRAPHICS

Surname _____
Given Names _____
Date of Birth _____/_____/_____
Patient Suburb _____
Patient Postcode _____

Hospital/Clinic Name _____
Hospital/Clinic Suburb _____
Hospital/Clinic Postcode _____
Medical Record Number (MRN) _____
(MRN - Hospitals Only)

TERMINATION INFORMATION

Termination of Pregnancy Date
_____/_____/_____
(Or Date EMA Administered)

Gestation at Time of Termination
_____weeks +
_____days

Counselling Information Provided to Patient?
- ☐ Yes
- ☐ No
- ☐ N/A Emergency Termination

Was the Termination Administered via Telemedicine?
- ☐ Yes
- ☐ No

Registered Medical Practitioner Category (select one)
- ☐ General Practitioner
- ☐ Medical Practitioner Family Advisory Clinic
- ☐ Trainee Obstetrician/Gynaecologist
- ☐ Obstetrician/Gynaecologist
- ☐ Other (specify)

_____

Date of Admission to Place of Termination
_____/_____/_____
Date of Discharge from Place of Termination
_____/_____/_____

Method of Termination (select all that apply)
- ☐ Dilation & Curettage
- ☐ Hysterotomy – Abdominal
- ☐ Hysterotomy – Vaginal
- ☐ Hysterectomy
- ☐ Vacuum Aspiration
- ☐ Intra-Uterine Injection
- ☐ Intravenous Infusion
- ☐ Dilation & Evacuation
- ☐ Mifepristone
- ☐ Misoprostol
- ☐ Vaginal or Cervical Prostaglandins

Complication(s), if known, at Time of Termination
- ☐ None
- ☐ Retained Products of Conception
- ☐ Uterine Perforation
- ☐ Anaesthesia Complications
- ☐ Haemorrhage
- ☐ Damage to Cervix
- ☐ Uterine Infection
- ☐ Death
- ☐ Other (specify) _____

Genetic Testing Performed?
- ☐ Yes
- ☐ No

Genetic Testing Positive for Congenital Anomaly?
- ☐ Yes
- ☐ No

Structural Anomaly Identified via U/S?
- ☐ Yes
- ☐ No
- ☐ Unknown

Congenital Anomaly (please specify)
_____
_____
_____

Early Medical Abortion Successful
- ☐ Yes
- ☐ No
- ☐ N/A

TERMINATION OF PREGNANCY AFTER 22 WEEKS + 6 DAYS GESTATION

This Section is mandatory only for termination of pregnancy after 22 weeks + 6 days gestation

Reason for Termination of Pregnancy after 22 Weeks Plus 6 days Gestation
- ☐ Termination is necessary to save the life of the pregnant person or save another foetus
- ☐ Continuance of the pregnancy would involve significant risk of injury to the physical or mental health of the pregnant person
- ☐ There is a case, or significant risk, of serious foetal anomalies associated with the pregnancy

Was the Termination Performed in a Prescribed Facility?
- ☐ Yes
- ☐ No, Emergency Termination of Pregnancy

If no, name the emergency facility
_____

READMISSION TO THE TERMINATION HOSPITAL/CLINIC

This Section is for reporting readmissions and complications that occurred post-termination at the Hospital/Clinic performing the termination of pregnancy only

Readmission Required?
- ☐ Yes
- ☐ No

Readmission Date
_____/_____/_____

Readmission Discharge Date
_____/_____/_____

Complication(s) Requiring Readmission
- ☐ Retained Products of Conception
- ☐ Haemorrhage
- ☐ Perforation or Trauma to Uterus
- ☐ Uterine Infection
- ☐ Septicaemia
- ☐ Anaesthesia Complications
- ☐ Failed Procedure
- ☐ Death
- ☐ Other (specify)

_____

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