SCHEDULE 1 Regulation 3(1)

PART I

SCHEDULE 1 Regulation 3(1)

PART I

IN CONFIDENCE

Not to be destroyed within three years of the date of the operation

ABORTION ACT 1967
Certificate to be completed in relation to an abortion under Section 1(1) of the Act

I .....
(name and qualifications of practitioner : in Block Capitals)

of .....

.....
(full address of practitioner)

Have/have not* seen/examined* the pregnant woman to whom this certificate relates at

.....

.....
(Full address of place at which patient was seen or examined)

on .....

and I .....
(Name and qualifications of practitioner : in Block Capitals)

of .....

.....
(Full address of practitioner)

*(*delete as appropriate)* Have/have not* seen/and examined* the pregnant woman to whom this certificate relates at

.....

.....
(Full address of place at which patient was seen or examined)

on .....

We hereby certify that we are of the opinion, formed in good faith, that in the case of

.....
(Full name of pregnant woman : in Block Capitals)

of .....

.....
(Usual place of residence of pregnant woman : in Block Capitals)

Tick appropriate box

- ☐ A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.
- ☐ B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.
- ☐ C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.
- ☐ D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman.
- ☐ E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

This certificate of opinion is given before the commencement of treatment for the termination of pregnancy to which it refers.

Signed .....

Date .....

Signed .....

Date .....

PART II

IN CONFIDENCE

PART II

Certificate B

Not to be destroyed within three years of the date of the operation

ABORTION ACT 1967
Certificate to be completed in relation to an abortion performed in emergency under Section 1(4) of the Act

I, ...
(name and qualifications of practitioner : in Block Capitals)

of .....

.....
(full address of practitioner)

hereby certify that I *am/was of the opinion, formed in good faith, that it *is/was necessary immediately to terminate the pregnancy of

.....
(Full name of pregnant woman : in Block Capitals)

of .....

.....
(Usual place of residence of pregnant woman : in Block Capitals)

Tick appropriate box

☐ F to save the life of the pregnant woman; or

☐ G to prevent grave permanent injury to the physical or mental health of the pregnant woman.

This certificate of opinion is given:

Tick appropriate box

☐ 1 before the commencement of treatment for the termination of the pregnancy to which it relates; or, if that is not reasonably practicable, then

☐ 2 not later than 24 hours after such termination.

Signed .....

Date .....

*Delete as appropriate

SCHEDULE " Regulation 4

IN CONFIDENCE

SCHEDULE 2 Regulation 4

ABORTION ACT 1967
ABORTION (SCOTLAND) REGULATIONS 1991

NOTIFICATION OF AN ABORTION PERFORMED UNDER SECTION 1 OF THE ACT

(All questions to be answered to the best of the notifying practitioner's knowledge and belief)

BLOCK CAPITALS PLEASE

I.....
(name and qualifications of practitioner)

of.....
(full address of practitioner)

hereby give notice that I terminated the pregnancy of

.....
(full name of pregnant woman)

of.....
(usual place of residence)

..... Post Code .....

Date of birth ..... Hospital Case Reference Number .....

THE PREGNANCY WAS TERMINATED AT (to be completed for all terminations):-

Name of hospital/approved place/other place (address) .....

.....

on (date) .....

Consultant in nominal charge .....

Signature of practitioner who terminated pregnancy .....

In all non-emergency cases, particulars of the practitioner(s) who joined in giving the certificate required for the purpose of section 1 should be shown below in the appropriate space(s):

	1. To be completed in all cases	2. Do not complete if the operating practitioner joined in giving Certificate A
Name	.....	.....
Permanent address	.....	.....
	.....	.....
	.....	.....

Did the practitioner named at 1 certify that he saw/and examined* the pregnant woman before giving the certificate? ☐ YES ☐ NO

Did the practitioner named at 2 certify that he saw/and examined* the pregnant woman before giving the certificate? ☐ YES ☐ NO

*Delete as appropriate

NOTE

THIS FORM TO BE COMPLETED BY THE OPERATING PRACTITIONER AND SENT WITHIN SEVEN DAYS OF THE TERMINATION OF THE PREGNANCY IN A SEALED ENVELOPE MARKED "IN CONFIDENCE" TO THE CHIEF MEDICAL OFFICER, SCOTTISH OFFICE HOME AND HEALTH DEPARTMENT, ST ANDREW'S HOUSE, EDINBURGH EH1 3DE.

THE STATUTORY GROUNDS CERTIFIED for terminating the pregnancy were :

1. OTHERWISE THAN IN EMERGENCY

(Tick appropriate box(es))

Please specify as precisely as possible

☐ A the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated.

The main indication(s)

.....

.....

☐ B the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.

The main indication(s)

.....

.....

☐ C the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman.

The main indication(s)

.....

.....

.....

.....

☐ D the pregnancy has NOT exceeded its 24th week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman.

The main indication(s) and number of children in the family

.....

.....

.....

☐ E there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

For **Ground E** Complete the Appropriate Column below

EITHER

1 State diagnosis

.....

2 Method(s) of diagnosis (tick appropriate box(es))

☐ 1 Amniocentesis

☐ 2 Chorion Villus Sampling

☐ 3 Ultrasound

☐ 4 Other

Specify .....

OR

State condition in pregnant woman causing suspected condition in fetus (complete 1 and 2 below)

☐ 1 Condition in pregnant woman

Specify .....

☐ 2 Suspected condition in fetus

Specify .....

2. IN CASE OF EMERGENCY

☐ F it was necessary to save the life of the pregnant woman;

The main indication(s)

.....

.....

or

☐ G it was necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman

.....

.....

Was this a selective reduction? ☐ 1 YES ☐ 2 NO

Original number of fetuses .....

Reduced to .....

CURRENT PREGNANCY

Gestation in Weeks ..... based on ☐ 1 LMP ☐ 2 Ultrasound
(tick appropriate box(es))
☐ 3 Other Specify .....

Over 24 weeks.
If the pregnancy was terminated after it had exceeded its 24th week, please give below a full statement of the suspected medical condition of the pregnant woman and/or fetus.

ADDITIONAL PARTICULARS OF PATIENT

MARITAL STATUS *(tick appropriate box)*
☐ 1 Single ☐ 2 Married ☐ 3 Widowed
☐ 4 Divorced ☐ 5 Separated ☐ 6 Not known

PREVIOUS OBSTETRIC HISTORY *(Enter number)*

Total Pregnancies	Live Births	Still Births	Abortions	
			Spontaneous	Therapeutic

Date of Admission ..... Date of Discharge .....

Was this a *planned* Day Case ☐ 1 Yes ☐ 2 No
(tick appropriate box)

METHOD OF TERMINATION
(tick appropriate box(es))

Cervical preparation ☐ 1 Yes ☐ 2 No

Surgical

☐ 1 Vacuum Aspiration
☐ 2 Dilation and Evacuation/Curettage
☐ 3 Hysterotomy
☐ 4 Hysterectomy
☐ 5 Other Surgical

Specify .....

*Medical *(tick all appropriate boxes)*

☐ 6 Prostaglandins
☐ 7 Oxytocics
☐ 8 Antiprogesterones (see below)
☐ 9 Other medical agents

Specify .....

* DO NOT enter an Evacuation of retained products of conception as a further method of termination

If Antiprogesterone was used:-

Antiprogesterone

Date of administration .....
give name .....
and address
of place .....
of treatment
.....
Type of premises ..... ☐

Prostaglandin

Date of administration .....
give name .....
and address
of place .....
of treatment
.....
Type of premises ..... ☐

Date termination confirmed
.....

STERILISATION *(tick appropriate box)* ☐ 1 Yes ☐ 2 No

IN CASE OF DEATH Specify cause .....

SCHEDULE 3

Regulation 6

REVOCATIONS

Column 1 Regulations revoked	Column 2 References
The Abortion (Scotland) Regulations 1968	S.I.1968/505
The Abortion (Scotland) (Amendment) Regulations 1974	S.I. 1974/1309
The Abortion (Scotland) Amendment Regulations 1976	S.I. 1976/127
The Abortion (Scotland) Amendment Regulations 1980	S.I. 1980/1864