SCHEDULE 2 Regulation 4

IN CONFIDENCE **ABORTION NOTIFICATION**

Please leave blank

ABORTION ACT 1967
FORM OF NOTIFICATION (England and Wales)

This form is to be COMPLETED BY THE PRACTITIONER TERMINATING THE PREGNANCY and sent in a sealed envelope within SEVEN DAYS of the termination to:-

The Chief Medical Officer
Department of Health
Richmond House
79 Whitehall
LONDON
SW1A 2NS

OR

The Chief Medical Officer
Welsh Office
Cathays Park
CARDIFF
CF1 3NQ

in respect of the termination of the pregnancy in Wales

PLEASE USE BLOCK CAPITALS AND NUMERALS FOR DATES THROUGHOUT

1. PRACTITIONER TERMINATING THE PREGNANCY

NAME **I,** .....

PERMANENT ADDRESS **of** .....

.....

hereby give notice that I terminated the pregnancy of the woman named overleaf, and to the best of my knowledge the particulars on this form are correct. **I further certify that I joined/did not join† in giving Certificate A having seen/not seen† and examined/not examined† her before doing so.**

Signature ..... **Date** .....

2. CERTIFICATION In all non-emergency cases state particulars of practitioners who joined in giving Certificate A.

	1. To be completed in **all** cases.	2. Do **not** complete if the operating practitioner joined in giving Certificate A.
NAME	.....	.....
PERMANENT ADDRESS	.....	.....
	.....	.....

(tick appropriate box)

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**

DO NOT COMPLETE IF SECTION 20 BELOW APPLIES

Please leave these boxes blank

3. NAME AND ADDRESS OF PLACE OF TERMINATION .....
.....

☐☐☐☐☐

Was the patient a NHS case terminated in an approved place under an agency agreement? **(tick appropriate box)** ☐ **YES** ☐ **NO** ☐

†delete as appropriate

Form HSA4 (Revised 1991)

4.	**WOMAN'S FULL NAME AND PERMANENT ADDRESS (INCLUDING COUNTRY IF RESIDENT OUTSIDE ENGLAND AND WALES)**	**Surname** **Forename(s)** **Address** ..... **Postcode**	**Please leave these boxes blank**
	PRESENT ADDRESS IN ENGLAND AND WALES	.... **Postcode**	
5.	**DATE OF BIRTH**	.....DAY .....MONTH .....YEAR	
6.	**MARITAL STATUS**	**(tick appropriate box)** 1 ☐ Single 3 ☐ Widowed 5 ☐ Separated 2 ☐ Married 4 ☐ Divorced NK ☐ Not Known	
7.	**PARITY**	Number of woman's previous:- a. (i) Livebirths ..... (Enter number - If NIL enter 0) (ii) Stillbirths ..... (iii) Spontaneous miscarriages ..... b. Legal terminations	
8*.	**ADMISSION**	Date of admission to place of termination .....DAY .....MONTH .....YEAR	
9*.	**TERMINATION**	Date of termination .....DAY .....MONTH .....YEAR	
10*.	**DISCHARGE**	Date of discharge from place of termination .....DAY .....MONTH .....YEAR	
11*.	**DAY CASE**	**(tick appropriate box)** Was this a planned day case? ☐ **YES** ☐ **NO**	

*** If the method of treatment used to terminate the pregnancy was Antiprogesterone with Prostaglandin without any supplementary surgical termination do not complete sections 8-11 but INSTEAD complete section 20**

Please leave these boxes blank

12. GESTATION 1. Specify number of weeks by completing a or b as appropriate

a. Pregnancy has NOT exceeded its 24th week

Gestation estimated at.....weeks

b. Pregnancy HAS exceeded its 24th week (ensure that section 14 is also completed)

Gestation estimated at .....weeks

2. Methods of estimation **(tick appropriate box(es))**

☐ LMP ☐ Ultrasound ☐ Other - specify:- .....

13. GROUNDS The certified ground(s) for terminating the pregnancy stated on CERTIFICATE A were:-

(tick appropriate box(es))

☐ **A** that the continuance of the pregnancy would involve risk to the life of the pregnant woman greater than if the pregnancy were terminated. — **A** State main medical condition(s):-

☐ **B** that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman. — **B** State main medical condition(s):-

☐ **C** that 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. — **C** State main medical condition(s):-

☐ **D** that 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 any existing child(ren) of the family of the pregnant woman. — **D** State number of children:-

☐ **E** that 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:- STATE

EITHER (i) (a) Diagnosis.....

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

☐ Amniocentesis ☐ Ultrasound ☐ Chorionic Villus Sampling ☐ Other - specify .....

OR (ii) Condition in pregnant woman causing suspected condition in fetus. Complete 1 and 2

1. Condition in woman - specify:-.....

.....

2. Suspected condition in fetus - specify:-.....

.....

EMERGENCY ONLY Termination was immediately necessary, as stated on CERTIFICATE B:-

☐ **F** to save the life of the pregnant woman — **F or G** - state main medical condition(s):-

OR

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

14. OVER 24 WEEKS GESTATION If the pregnancy was terminated after it had exceeded its 24th week please give below a full statement of the medical condition of the pregnant woman/fetus.

15. SELECTIVE TERMINATION Was this a selective termination? **(tick appropriate box)** ☐ **YES** ☐ **NO**

State:- (i) original number of fetuses .....

(ii) number of fetuses reduced to .....

All other relevant sections of the form should also be completed

Please leave these boxes blank

16. METHOD

(tick appropriate boxes)

Cervical preparation? ☐ **YES** ☐ **NO**

.....

Surgical termination:-

☐ Vacuum aspiration

☐ Dilatation and Evacuation

☐ Hysterotomy

☐ Hysterectomy

☐ Other surgical - specify:-

.....

*Medical termination:-

☐ Prostaglandin only

☐ Prostaglandins with:- **(tick appropriate boxes)**

☐ Oxytocin

☐ Antiprogesterone (if used see also section 20 below)

☐ Other medical agents-specify:-

.....

* Do not enter an evacuation of retained products of conception as a further method of termination.

17. COMPLICATIONS*

(tick appropriate box(es))

☐ None ☐ Haemorrhage ☐ Uterine Perforation ☐ Sepsis

☐ Other - specify:- .....

*Do not enter an evacuation of retained products of conception as a complication.

18. STERILISATION

(tick appropriate box)

Was a sterilisation operation performed? ☐ **YES** ☐ **NO**

19. DEATH OF WOMAN

In the case of death, specify:-

(i) Date .....DAY .....MONTH .....YEAR

(ii) Cause .....

20. ANTIPROGESTERONE WITH PROSTAGLANDIN

Do not complete this section unless the method used was Antiprogesterone with Prostaglandin

(i) Date of treatment with Antiprogesterone .....DAY .....MONTH .....YEAR

Name .....

Address of place of treatment .....

(ii) Date of treatment with Prostaglandin .....DAY .....MONTH .....YEAR

Name .....

Address of place of treatment .....

(iii) Date termination confirmed .....DAY .....MONTH .....YEAR

(iv) Was the patient a NHS case treated under an agency agreement? **(tick appropriate box)** ☐ **YES** ☐ **NO**