









Abortion case record extraction form

 **Note to provider:** This form should be completed for each case that presents to the facility seeking abortion care (request to terminate pregnancy or postabortion care) during regular working hours as well as off working hours. All items in the form are very essential and should be filled accordingly. Make sure this form is available to all providers in your facility.

A. Socio-demographics of client:






	<i>Item</i>	<i>Response</i>
Q1	Age of client (in completed years)	_____ (years old)
Q2	Where does the client come from?  Note to provider: tick only one response	1. This city/town <input type="checkbox"/> 2. Country side/ rural area <input type="checkbox"/> 3. Another city/town <input type="checkbox"/> 4. Other (specify) _____
Q3	Current marital status of client  Note to provider: tick only one response	1. Single, never married <input type="checkbox"/> 2. Married <input type="checkbox"/> 3. Living together (co-habitation) <input type="checkbox"/> 4. Separated/divorced/widowed <input type="checkbox"/>
Q4	Level of education attained by client  Note to provider: tick only one response	1. Did not attend formal education <input type="checkbox"/> 2. Grade 1 to 6 <input type="checkbox"/> 3. Grade 7 to 8 <input type="checkbox"/> 4. Grade 9 to 10 <input type="checkbox"/> 5. Grade 10 plus 1 or 2 or 3 <input type="checkbox"/> 6. Preparatory <input type="checkbox"/> 7. Post-secondary <input type="checkbox"/>

B. Reproductive history of client:

Q5	Total number of all pregnancies  Note to provider: Please ask the client for all pregnancies she has including the one she is seeking care for.	_____ (number)
Q6	Total number of live deliveries  Note to provider: Please ask the client for all live deliveries she has experienced.	_____ (number)
Q7	Total number of currently live children  Note to provider: Please ask the client for all live children she has.	_____ (number)
Q8	Total number of previous miscarriages Note to provider: Please ask the client for how many miscarriages/spontaneous abortions she had before excluding the one she is seeking care now. 	_____ (number)

✂ To be torn off by supervisor

Facility chart No: _____


	<i>Item</i>	<i>Response</i>
Q9	Total number of previous induced abortions  Note to provider: Please <i>ask</i> the client for how many induced abortions she had before excluding the one she is seeking care now.	_____ (number)
Q10	Was client using modern contraception to prevent the current pregnancy that she is seeking care for?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
C. Clinical history and vital signs findings on arrival to the facility for the current care:		
Q11	Date of visit to the facility for seeking care	____/____/____ (E.C.) (day/month/year)
Q12	Main reason for seeking care  Note to provider: tick only <i>one</i> response	1. Request for termination <input type="checkbox"/> 2. Postabortion care <input type="checkbox"/>
Q13	Gestational age from last menstrual period (LMP) in weeks	1. <input type="text"/> <input type="text"/> weeks 2. Unknown LMP <input type="checkbox"/>
Q14	Best clinical estimate of gestation by trimester  Note to provider: Base your answer to this question on <i>history</i> and <i>clinical exam</i> finding including <i>uterine size</i> determination	1. ≤ 12 weeks <input type="checkbox"/> 2. > 12 weeks <input type="checkbox"/>
Q15	Did the woman provide a history of interference with the pregnancy?  Note to provider: Please <i>ask</i> the client if she has attempted to induce the pregnancy elsewhere	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
Q16	<u>Vital Signs:</u>  Note to provider: Please record the following vital signs of the client on her <i>arrival</i> for seeking care. A. Body temperature (rounded to the tenth decimal point) B. Pulse rate C. Respiratory rate D. Systolic blood pressure E. Diastolic blood pressure	 _____ °C _____ per minute _____ per minute _____ mmHg _____ mmHg


D. Vaginal examination findings on arrival to the facility for the current care:





 **Note to provider:** To answer the following questions (Q17, Q18, Q19) you have to perform vaginal examination using speculum and note your findings accordingly.





	<i>Item</i>	<i>Response</i>
Q17	<p>A. Evidence of foreign body in vagina</p> <p>B. Evidence of foreign body in cervix</p> <p>.....</p> <p>C. Evidence of foreign body in uterus</p> <p>.....</p> <p>D. Evidence of foreign body in other parts of the genitalia</p> <p>.....</p>	<p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p> <p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p>
Q18	<p>On examination, which of the following mechanical injuries did you detect?</p>	<p>1. Cervical laceration <input type="checkbox"/></p> <p>2. Cervical tears <input type="checkbox"/></p> <p>3. Tenaculum bites of the cervix <input type="checkbox"/></p> <p>4. Mechanical injury of uterus <input type="checkbox"/></p> <p>5. Intra-abdominal injury <input type="checkbox"/></p> <p>6. No sign of mechanical injury <input type="checkbox"/></p>
Q19	<p>On vaginal examination, did you note offensive or foul smelling products of conceptus?</p>	<p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p>

E. Physical examination findings on arrival to the facility for the current care:

 **Note to provider:** To answer the following questions (Q20, Q21) you have to perform thorough physical examination and tick *All that you have found*.

Q20	<p>Which of the following signs did you find on examination?</p> <p> Note to provider: tick All that apply</p>	<p>1. Endometritis <input type="checkbox"/></p> <p>2. Pelvic abscess <input type="checkbox"/></p> <p>3. Pelvic peritonitis <input type="checkbox"/></p> <p>4. Generalized peritonitis <input type="checkbox"/></p> <p>5. Uterine perforation <input type="checkbox"/></p> <p>6. Gangrenous uterus <input type="checkbox"/></p> <p>7. Gangrenous bowel <input type="checkbox"/></p> <p>8. Sepsis <input type="checkbox"/></p> <p>9. Shock <input type="checkbox"/></p> <p>10. Tetanus <input type="checkbox"/></p> <p>11. Other (<i>specify</i>) _____</p> <p>12. No sign of infection was found <input type="checkbox"/></p>
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	<i>Item</i>	<i>Response</i>
Q21	<p>Which of the following signs of organ/system failure did you find on examination?</p>  Note to provider: tick All that apply	<p>1. Respiratory distress syndrome <input type="checkbox"/></p> <p>2. Renal failure <input type="checkbox"/></p> <p>3. Liver failure <input type="checkbox"/></p> <p>4. Cardiac failure <input type="checkbox"/></p> <p>5. Coma <input type="checkbox"/></p> <p>6. Coagulation defect (DIC) <input type="checkbox"/></p> <p>7. Others (<i>specify</i>) _____</p> <p>8. No organ/system failure noted <input type="checkbox"/></p>
F. Diagnosis on arrival to the facility for the current care:		
 Note to provider: Answer the following question (Q22, Q23, Q24) based on your evaluation of the clinical history, physical and vaginal examination findings.		
Q22	<p>Clinical stage of abortion (the diagnosis) is:</p>  Note to provider: tick only one response	<p>1. Threatened abortion <input type="checkbox"/></p> <p>2. Inevitable abortion <input type="checkbox"/></p> <p>3. Incomplete abortion <input type="checkbox"/></p> <p>4. Missed abortion <input type="checkbox"/></p> <p>5. Complete abortion <input type="checkbox"/></p> <p>6. Intact pregnancy/request for termination/ <input type="checkbox"/></p> <p>7. Others (<i>specify</i>) _____</p>
Q23	<p>Is the clinical stage of abortion (the diagnosis) also septic?</p>	<p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p>
Q24	<p>Based on your overall assessment of the client, is the abortion induced?</p>	<p>1. Yes <input type="checkbox"/></p> <p>2. No <input type="checkbox"/></p> <p>3. Don't know <input type="checkbox"/></p>
G. Laboratory investigations conducted for the current care:		
Q25	<p>Which of the following investigations were carried out?</p>  Note to provider: tick All that apply	<p>1. Hemoglobin/Hematocrit <input type="checkbox"/></p> <p>2. WBC <input type="checkbox"/></p> <p>3. ESR <input type="checkbox"/></p> <p>4. Blood grouping <input type="checkbox"/></p> <p>5. Blood culture <input type="checkbox"/></p> <p>6. VDRL <input type="checkbox"/></p> <p>7. HIV/VCT <input type="checkbox"/></p> <p>8. None <input type="checkbox"/></p> <p>9. Others (<i>specify</i>) _____</p>

H. Clinical management:		
	<i>Item</i>	<i>Response</i>
Q26	<p>Was any uterine evacuation procedure performed to treat the client for her presenting problem?</p> <p>.....</p> <p>a. If yes, describe the procedure</p> <p> Note to provider: tick only one response</p> <p>.....</p> <p>b. If yes, the evacuation procedure was performed primarily by:</p> <p> Note to provider: tick only one response</p> <p>.....</p> <p>c. If yes, where was the evacuation procedure performed?</p>	<p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p> <p>.....</p> <p>1. Evacuation and curettage (E&C) <input type="checkbox"/></p> <p>2. Dilation and curettage (D&C) <input type="checkbox"/></p> <p>3. Manual vacuum aspiration (MVA) <input type="checkbox"/></p> <p>4. Electrical vacuum aspiration (EVA) <input type="checkbox"/></p> <p>5. Medical methods <input type="checkbox"/></p> <p>6. Others (<i>specify</i>) _____</p> <p>.....</p> <p>1. Ob/Gyn <input type="checkbox"/></p> <p>2. GP <input type="checkbox"/></p> <p>3. Health Officer <input type="checkbox"/></p> <p>4. Resident <input type="checkbox"/></p> <p>5. Intern <input type="checkbox"/></p> <p>6. Midwife/nurse <input type="checkbox"/></p> <p>7. Other (<i>specify</i>) _____</p> <p>.....</p> <p>1. Operating theatre <input type="checkbox"/></p> <p>2. OPD or PAC room <input type="checkbox"/></p> <p>3. Other (<i>specify</i>) _____</p>
Q27	<p>Was the client provided any pain medication during the evacuation procedure?</p> <p>.....</p> <p>a. If yes, what did the client receive?</p> <p> Note to provider: tick all that apply</p>	<p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p> <p>.....</p> <p>1. General anesthesia <input type="checkbox"/></p> <p>2. Para cervical <input type="checkbox"/></p> <p>3. Valium/pethidine <input type="checkbox"/></p> <p>4. Analgesics <input type="checkbox"/></p> <p>5. Others (<i>specify</i>) _____</p> <p>.....</p>
Q28	<p>After the evacuation procedure, which of the following surgical procedures were carried out?</p> <p>a.  Note to provider: tick all that apply</p>	<p>1. Hysterectomy <input type="checkbox"/></p> <p>2. Salpingectomy <input type="checkbox"/></p> <p>3. Abscess drainage <input type="checkbox"/></p> <p>4. Repair of cervical tear <input type="checkbox"/></p> <p>5. Repair of perforation <input type="checkbox"/></p> <p>6. Laparotomy <input type="checkbox"/></p> <p>7. Other (<i>specify</i>) _____</p>

	<i>Item</i>	<i>Response</i>
		8. None <input type="checkbox"/>
Q29	<p>Was the client given antibiotics during her current visit at this facility?</p> <p>.....</p> <p>a. If yes, type of antibiotics given:</p>	<p>1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/></p> <p>.....</p> <p>1. Oral only <input type="checkbox"/></p> <p>2. Parental only <input type="checkbox"/></p> <p>3. Combined (oral + parental) <input type="checkbox"/></p>
Q30	Was the client given intravenous fluids during her current visit at this facility?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
Q31	Was the client given blood or blood products during her current visit at this facility?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
Q32	Was the client given oxytocics (oxytocin or ergometrine) after the uterine evacuation procedure?	1. Yes <input type="checkbox"/> 2. No <input type="checkbox"/>
Q33	How long did the client stay in the facility for care?	1. Less the 24 hours <input type="checkbox"/> 2. More than 24 hours <input type="checkbox"/>
I. Outcome of clinical management of current care:		
Q34	The outcome of current care was	<p>Client was:</p> <p>1. Discharged well <input type="checkbox"/></p> <p>2. Died <input type="checkbox"/></p> <p>3. Left against medical advice <input type="checkbox"/></p> <p>Please specify condition :</p> <p>_____</p> <p>4. Referred to other facility <input type="checkbox"/></p> <p>Please specify condition :</p> <p>_____</p>
Q35	If client was admitted, Date of admission	____/____/____ (E.C.) Day/month/year
Q36	Date of discharge/death/abscondment/referral of client	____/____/____ (E.C.) Day/month/year

Validated by: _____ Date of validation: ____/____/____