STUDY NUMBER:_______

COST OF UNSAFE ABORTION

PROVIDER CASE INTERVIEW QUESTIONNAIRE

INTERVIEWER:
* ADMINISTER THIS QUESTIONNAIRE TO A PROVIDER ABOUT EACH FEMALE PATIENT BEING TREATED FOR POST-ABORTION COMPLICATIONS WHO:

1) HAS COMPLETED AN INTERVIEW AND

2) GAVE PERMISSION TO OBTAIN HER MEDICAL RECORD INFORMATION (answered “yes” to question 701 in the woman’s questionnaire).

* BE SURE TO WRITE IN THE PATIENT IDENTIFICATION NUMBER, PATIENT’S FIRST NAME AND ATTENDING HEALTH PROVIDER’S NAME (QUESTIONS 101-103) BELOW THAT CORRESPOND TO THE SAME QUESTIONS IN THE WOMAN’S QUESTIONNAIRE TO ENSURE A CORRECT MATCH TO THE MEDICAL INFORMATION.

1. IDENTIFICATION
101. Patient identification
   a. Identification number _______________________________
   b. File number______________________________________
   c. Date of admission__________
   d. Date of discharge__________

102. Patient’s first name________________________________________________

103. Attending health provider’s name_____________________________________

104. Name of health facility________________________________________________

105. Type of health facility [country-specific categories]________________________

106. Geographic area located [country-specific categories] ______________________

107. Date of Interview_____________________________________________________

108. Time of Interview_____________________________________________________

109. Interviewer’s Name____________________________________________________

110. Language of Interview________________________________________________

111. Field Reviewed/Edited by________________ Date:____________________

112. Office Reviewed/Edited by________________ Date:____________________

113. Data Entry by________________ Date:____________________
2. MEDICAL CARE

201. Presenting complaints (CHECK ALL THAT APPLY)

- □ Bleeding, blood loss
- □ Passage of tissue or products of conception
- □ Fever
- □ Pain
- □ Others (specify): __________________________________________________

202. Estimated gestational age:

______ weeks from last menstrual period

203. History at admission (CHECK ONE)

- □ Patient had symptoms/signs indicating induced abortion
- □ Patient had no symptoms/signs indicating induced abortion

204. Type of uterine evacuation (CHECK ONE)

- □ Manual vacuum aspiration (MVA)
- □ Electric vacuum aspiration (EVA)
- □ Medical abortion (misoprostol alone)
- □ Evacuation and curettage (E&C)
- □ Dilation and curettage (D&C)
- □ Dilation and evacuation (D&E)
- □ Evacuation using oxytocic/uterotonic agents
- □ No uterine evacuation
205. Other procedures (CHECK ALL THAT APPLY)

- Abdominal surgery
- Laparoscopy
- Repeat uterine evacuation:
  - Manual vacuum aspiration (MVA)
  - Electric vacuum aspiration (EVA)
  - Medical abortion (misoprostol alone)
  - Evacuation and curettage (E&C)
  - Dilation and curettage (D&C)
  - Dilation and evacuation (D&E)
  - Evacuation using oxytocic/uterotonic agents
- Other procedures (specify): ________________________________

206. Other treatments (CHECK ALL THAT APPLY)

- Blood transfusion
- Oral antibiotics
- IV antibiotics
- IV fluids
- Uterotonics
- Analgesics/painkillers
- Other medications (specify): ________________________________

207. Final diagnosis (complications) (CHECK ALL THAT APPLY)

- Sepsis/septicemia
- Pelvic infection
- Retained products of conception
- Hemorrhage
- Shock
- Fever
- Instrumental injury of cervix or vagina
- Instrumental injury of uterus
- Other (specify): _______________________________________________
208. Final diagnosis (type of abortion) (CHECK ONE)

☐ Induced abortion, uncomplicated
☐ Induced abortion with complications, suspected
☐ Induced abortion with complications, confirmed

☐ Spontaneous abortion with complications, suspected
☐ Spontaneous abortion with complications, confirmed

209. Condition at discharge (check one):

☐ Death
☐ Transferred to another facility (specify type): ___________________________
☐ Improved, returning home
☐ Other (specify): ___________________________________________________

210. Date of admission: ________________

211. Date of discharge: ________________

Additional remarks by the reporting provider:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signed: _______________________________________

(Interviewer)