

Comprehensive Abortion Care (CAC)

DOCUMENTATION AND RECORDING
OF INDUCED ABORTION CASES



➤ As Per Medical
Termination of
Pregnancy Act



Contents

Form Name	Purpose	Page No.
Form C Consent Form	Consent of woman/guardian for MTP	1
Form I RMP Opinion Form	Opinion by one RMP for termination up to 20 weeks	2
Form E Opinion Form of RMPs	Opinion by two RMPs for termination between 20-24 weeks	3
Form D Report of the Medical Board	Opinion for termination beyond 24 weeks for foetal abnormalities	4
Form III Admission Register	Records of MTP cases	5
Form II Monthly Report	Monthly report of MTP cases	6
Form A Form of Application	Application form for the approval of a private place	7
Form B Certificate of Approval	Certificate of site approval issued by DLC	8

Form C

Consent Form



FORM C

(See rule 9)

I.....daughter/wife of.....

aged about.....years of.....

(here state the permanent address) at present residing at.....

do hereby give my consent to the termination of my pregnancy at.....

.....(state the name of place where the pregnancy is to be terminated)

Place:

Date:

Signature

(To be filled in by guardian where the woman is a mentally ill person or minor)

I.....son/daughter/wife of.....

aged about.....years of.....

(permanent address)

at present residing at.....do

hereby give my consent to the termination of the pregnancy of my ward.....

.....who is a minor/mentally ill person at.....

..... (place of termination of pregnancy)

Place:

Date:

Signature

> Purpose

Form for taking consent of a woman/guardian before the abortion procedure.

Form I

RMP Opinion Form

FORM I

(For gestation age up to twenty weeks)

[See Regulation 3]

I _____
(Name and qualifications of the Registered Medical Practitioner in block letters)

(Full address of the Registered Medical Practitioner)

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

(Full name of pregnant woman in block letters)

resident of _____

(Full address of pregnant woman in block letters)

for the reasons given below.*

I hereby give intimation that I terminated the pregnancy of the woman referred to above who bears the

Serial No. _____ in the Admission Register of the hospital/approved place.

Place:

Date: _____ Signature of the Registered Medical Practitioner

*of the reasons specified items(i) to (v) write the one which is appropriate:

- (i) in order to save the life of the pregnant woman,
- (ii) in order to prevent grave injury to the physical and mental health of the pregnant woman,
- (iii) in view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped,
- (iv) as the pregnancy is alleged by the pregnant woman to have been caused by rape,
- (v) as the pregnancy has occurred as a result of failure of any contraceptive device or methods used by a woman or her partner for the purpose of limiting the number of children or preventing pregnancy.

Note: Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

Place:

Date: _____ Signature of the Registered Medical Practitioner

> Purpose

Form for recording opinion of an RMP for pregnancy termination up to 20 weeks.

Form E

Opinion Form of Registered Medical Practitioners



FORM E

*(For gestation age beyond twenty weeks till twenty-four weeks)
[See sub-rule (2) of rule 4A]*

I.....
(Name and qualifications of the Registered Medical Practitioner in block letters)

.....
(Full address of the Registered Medical Practitioner)

I.....
(Name and qualifications of the Registered Medical Practitioner in block letters)

.....
(Full address of the Registered Medical Practitioner)

hereby certify that we are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of

.....
(Full name of pregnant woman in block letters)

resident of.....
(Full address of pregnant woman in block letters)

which is beyond twenty weeks but till twenty-four weeks under special circumstances as given below.*

*Specify the circumstance (s) from (a) to (g) appropriate for termination of pregnancy beyond twenty weeks till twenty-four weeks:

- (a) Survivors of sexual assault or rape or incest
- (b) Minors
- (c) Change of marital status during the ongoing pregnancy (widowhood and divorce)
- (d) Women with physical disabilities (major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 [49 of 2016])
- (e) Mentally ill women including mental retardation
- (f) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped
- (g) Women with pregnancy in humanitarian settings or disaster or emergency situations as declared by Government

We hereby give intimation that we terminated the pregnancy of the woman referred to above who bears the Serial No..... in the Admission Register of the hospital/approved place.

Signature of the Registered Medical Practitioner

Place:

Date:

Signature of the Registered Medical Practitioner

Note: Account may be taken of the pregnant woman's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

> Purpose

Form for recording opinion by two RMPs for pregnancy termination between 20-24 weeks for special categories of women.

Form D

Report by the Medical Board

FORM D

(See sub-clause [ii] of clause [b] of rule 3A)

Report of the Medical Board for Pregnancy Termination Beyond 24 Weeks

Details of the woman seeking termination of pregnancy:

1. Name of the woman:
2. Age:
3. Registration/Case Number:
4. Available reports and investigations:

S. No.	Report	Opinion on the findings

5. Additional investigations (if done):

S. No.	Investigations done	Key findings

6. Opinion by Medical Board for termination of pregnancy:

- a) Allowed
- b) Denied

Justification for the decision:

7. Physical fitness of the woman for the termination of pregnancy:

- a) Yes
- b) No

Members of the Medical Board who reviewed the case:

S. No.	Name	Signature

Date and Time:.....

> Purpose

Form for submitting the report by the Medical Board for pregnancy termination beyond 24 weeks in cases of substantial foetal abnormalities.

FORM III

(Refer Regulation 5)

[To be destroyed on the expiry of five years from the date of the last entry in the Register]

Form III

Admission Register



Name of Facility: _____ Month _____ Year _____

S. No.	Date of Admission	Name of the Patient	Wife/ Daughter of	Age	Religion	Address	Duration of Pregnancy	Reasons on which Pregnancy is terminated	Date of termination of Pregnancy	Date of discharge of Patient	Result & Remarks	Name of Registered Medical Practitioner(s) by whom the opinion is formed (For pregnancy beyond 24 weeks mention name of Medical Board members)	Name of Registered Medical Practitioner(s) by whom Pregnancy is terminated	Method of MTP (MVA/ EVA/ MMA/ D&C/ Others)	Post Abortion Contraception (Tubal Ligation [TL]/IUCD/ OCP/ Injectables/ Others/ None)
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16

Purpose

Format for recording details of all women undergoing induced abortion procedure.

Form II

Monthly Reporting Form

FORM II

[Refer Regulation 4 (5)]

Month & Year:.....

1. Name of the State:

2. Name of Hospital/approved place:

3. Duration of pregnancy *(Give total number only under each sub-head)*

- (a) Up to 9 weeks (Medical Methods of Abortion Only):
- (b) Up to 12 weeks (Surgical Methods of Abortion Only):
- (c) Between 12-20 weeks:
- (d) Between 20-24 weeks:
- (e) Beyond 24 weeks:

4. Religion of woman *(Give total number under each sub-head)*

- (a) Hindu:
- (b) Muslim:
- (c) Christian:
- (d) Others:

5. Termination with acceptance of contraception *(Give total number under each sub-head)*

- (a) Sterilization:
- (b) IUCD:
- (c) OCP/Injectable Contraceptives:
- (d) Others:

6. Reasons for termination *(Give total number under each sub-head)*

6 a. Up to 20 weeks of gestation

- (a) Danger to the life of the pregnant woman:
- (b) Grave injury to the physical and mental health of the pregnant woman:
- (c) Pregnancy caused by rape:
- (d) Substantial risk that if the child was born, it would suffer from such physical or mental abnormalities as to be seriously handicapped:
- (e) Failure of any contraceptive device or method:

6 b. Between 20-24 weeks of gestation

- (a) Survivors of sexual assault or rape or incest:
- (b) Minors:
- (c) Change of marital status during the ongoing pregnancy (widowhood and divorce):
- (d) Women with physical disabilities [major disability as per criteria laid down under the Rights of Persons with Disabilities Act, 2016 (49 of 2016)]:
- (e) Mentally ill women including mental retardation:
- (f) The foetal malformation that has substantial risk of being incompatible with life or if the child is born it may suffer from such physical or mental abnormalities to be seriously handicapped:
- (g) Women with pregnancy in humanitarian settings or disaster or emergency situations as declared by Government:

6 c. Beyond 24 weeks of gestation

- (a) The foetal malformation that has substantial risk of being incompatible with life or if the child was born it would suffer from such physical or mental abnormalities to be seriously handicapped:

Signature of the Officer-in-Charge with Date

> Purpose

Form for reporting monthly MTP cases by the head of the hospital or owner of the approved place to Chief Medical Officer of the district.

Form A

Application Form for Approval of Private Place



FORM A

[See sub-rule (2) of rule 5]

FORM OF APPLICATION FOR THE APPROVAL OF A PLACE UNDER CLAUSE (b) OF SECTION 4 OF THE ACT

Category of approved place:

(A) Pregnancy can be terminated up to twelve weeks

(B) Pregnancy can be terminated up to twenty-four weeks

(i) Name of the place (in capital letters):

(ii) Address in full:

(iii) Non-Government or Private or Nursing Home or Other Institutions:

(iv) State if the following facilities are available at the place:

CATEGORY A

(i) Gynaecological examination or labour table.

(ii) Resuscitation equipment.

(iii) Sterilisation equipment.

(iii) Facilities for treatment of shock, including emergency drugs.

(v) Facilities for transportations, if required.

CATEGORY B

(i) An operation table and instruments for performing abdominal or gynaecological surgery.

(ii) Drugs and parental fluid in sufficient supply for emergency cases.

(iii) Anesthetic equipment, resuscitation equipment and sterilisation equipment.

Place:

Date:

Signature of the owner for the place.

> Purpose

Form of application for the approval of a private place to provide safe abortion services. This form is submitted to the Chief Medical Officer of the district.

Form B

Certificate of Approval

FORM B

[See sub-rule (6) of rule 5]
CERTIFICATE OF APPROVAL

The place described below is hereby approved for the purpose of the Medical Termination of Pregnancy Act, 1971 (34 of 1971).

As read within up to.....weeks

Name of the place.....

Address and other descriptions.....

.....

Name of the owner.....

Place.....

Date.....

To the Government of the.....

➤ Purpose

Form for certificate of approval to be issued by DLC to any private place deemed fit to provide safe abortion services under the MTP Act.

