Wyoming Department of Health

Report of Induced Termination of Pregnancy (ITOP)

THIS REPORT IS REQUIRED BY WYOMING STATUTE 35-6-131.

DATE RECEIVED IN STATE OFFICE

1. AGE OF PATIENT	2. DATE OF TERMINATION *(Day, Month, Year)*
3. FACILITY TYPE *(Office, Hospital, or Clinic)*	4. RESIDENCE STATE/COUNTY
5. RACE (*American Indian, Black, White, etc.)*	6. OF HISPANIC ORIGIN? *(Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)* ☐ NO ☐ YES Specify_____

7. PREVIOUS PREGNANCIES *(Complete each section)*

LIVE BIRTHS		OTHER TERMINATIONS	
7a. Now Living	7b. Now Deceased	7c. Spontaneous	7d. Induced *(Do not include this termination)*
Number _____ None ☐	Number _____ None ☐	Number _____ None ☐	Number _____ None ☐

8. PROCEDURE THAT TERMINATED PREGNANCY *(Check only one)*	9. COMPLICATIONS OF PREGNANCY TERMINATION *(Check all that apply)*
☐ Suction Curettage	☐ None
☐ Medical (Nonsurgical) Specify Medication(s)_____	☐ Hemorrhage
☐ Dilation and Evacuation (D&E)	☐ Infection
☐ Intra-Uterine Instillation (Saline or Prostaglandin)	☐ Uterine Perforation
☐ Sharp Curettage (D&C)	☐ Cervical Laceration
☐ Hysterotomy / Hysterectomy	☐ Retained Products
☐ Other (Specify)_____	☐ Other (Specify) _____

10. WEIGHT OF FETUS IN GRAMS: _____ 10a. LENGTH OF FETUS IN CMs: _____	11. PHYSICIAN'S ESTIMATE OF GESTATION *(Weeks)*

Forms can be mailed to:
State of Wyoming Health Officer
Vital Statistics Services
2300 Capitol Ave
Cheyenne, WY 82002

Questions regarding this form, please contact (307) 777-7264