

ABORTION NOTIFICATION

ABORTION ACT 1967 – FORM OF NOTIFICATION FOR PREGNANCIES TERMINATED IN ENGLAND AND WALES

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

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

OR

The Chief Medical Officer
National Assembly for Wales
Cathays Park
CARDIFF CF10 3NQ
for pregnancies terminated in Wales

PLEASE USE BLOCK CAPITALS AND NUMERALS FOR DATES THROUGHOUT, KEEPING WITHIN THE BOXES
DO NOT CROSS THROUGH ANY BOXES THAT DO NOT NEED TO BE COMPLETED

1 PRACTITIONER TERMINATING THE PREGNANCY

FULL NAME

I

PERMANENT
ADDRESS

of

GMC registration number

hereby give notice that I terminated the pregnancy of the woman identified 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 HSA1 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 HSA1.

a. To be completed in all cases.

b. Do not complete if the operating practitioner joined in giving Certificate HSA1.

FULL NAME(S)

PERMANENT
ADDRESS

Did the practitioner named at a. certify that s/he saw/and examined the pregnant woman before giving the certificate?

☐ YES ☐ NO

Did the practitioner named at b. certify that s/he saw/and examined the pregnant woman before giving the certificate?

☐ YES ☐ NO

* delete as appropriate



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3 PATIENT'S DETAILS

a) PATIENT'S REFERENCE

Patient's hospital/clinic number or NHS number:

If not available enter full name below

b) DATE OF BIRTH

In all cases enter date of birth

d	d	m	m	y	y	y	y

c) POSTCODE

For UK residents, state full postcode

If full postcode is not available,
enter complete address below

For non-UK residents, state country of residence

☐ Republic of Ireland

Other – state

d) ETHNICITY

Please state the patient's self-reported ethnicity, where known:

White:

- ☐ British
☐ Irish
☐ Any other white background

Mixed:

- ☐ White and Black Caribbean
☐ White and Black African
☐ White and Asian
☐ Any other mixed background

Asian or Asian British:

- ☐ Indian
☐ Pakistani
☐ Bangladeshi
☐ Any other Asian background

Black or Black British:

- ☐ Caribbean
☐ African
☐ Any other Black background

Chinese or other ethnic group:

- ☐ Chinese
☐ Any other

Not known:

- ☐ Not Known

e) MARITAL STATUS (tick appropriate box)

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Single (no partner) | <input type="checkbox"/> Married | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Single (with partner) | <input type="checkbox"/> Widowed | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Single (partner status not known) | <input type="checkbox"/> Civil Partnership | <input type="checkbox"/> Not known |

f) PARITY

Number of previous pregnancies resulting in:

Livebirths and stillbirths over 24 weeks Spontaneous miscarriages and ectopic pregnancies Legal terminations

P + + (enter number – if nil enter 0)



4 TREATMENT DETAILS

a) NAME AND ADDRESS OF PLACE OF TERMINATION INCLUDING PLACE OF TREATMENT WITH ANTIPROGESTERONE

Hospital/clinic code

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Please specify whether this was an NHS funded or privately funded abortion

☐ NHS funded abortion ☐ Privately funded abortion

b) FETICIDE

Where feticide used complete this section. Otherwise go to 4c or 4d as appropriate

(i) Date of feticide

				2	0		
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(ii) Method of feticide

Please now complete 4c or 4d according to the method used to evacuate the uterus.

c) SURGICAL TERMINATIONS

TERMINATION Date of termination

				2	0		
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If date of admission or discharge are different from date of termination, please enter dates below:

ADMISSION Date of admission to place of termination

				2	0		
--	--	--	--	---	---	--	--

DISCHARGE Date of discharge from place of termination

				2	0		
--	--	--	--	---	---	--	--

d d m m y y y y

State method used:

Vacuum aspiration/Suction ☐

Other surgical – specify:

Dilatation and Evacuation ☐

An evacuation of retained products of conception is not a termination and should not be entered.

Please now go to Section 5

d) MEDICAL TERMINATIONS

(i) Date of treatment with Antiprogesterone

				2	0		
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(ii) Date of treatment with Prostaglandin

				2	0		
--	--	--	--	---	---	--	--

(iii) Date termination confirmed

				2	0		
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d d m m y y y y

Name and address of place of treatment with Prostaglandin (if different from address at Section 4a)

Hospital/clinic code

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Medical Terminations – continued overleaf



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d) MEDICAL TERMINATIONS – continued

If other medical agents were used, specify:

(i) Date of treatment (ii) Medical agent used

(i)

				2	0		
d	d	m	m	y	y	y	y

If an overnight stay was required please also complete date of discharge in Section 4(c) on page 3

(ii)

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5 GESTATION

Specify number of completed weeks

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6 GROUNDS

The certified ground(s) for terminating the pregnancy stated on HSA1 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.

B ☐

that the termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman.

A or 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 (this includes pregnancies up to 24 weeks and 0 days).

Was there a risk to the woman's mental health?

☒ YES

☐ NO

If not, please state the main medical condition(s)

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 (this includes pregnancies up to 24 weeks and 0 days).

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 the abnormality or other reason for termination

For ground E cases only, state method(s) of diagnosis (tick appropriate box(es))

Amniocentesis ☐ Ultrasound ☐ Chorionic villus sampling ☐ Other – specify

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6 GROUND – continued

EMERGENCY ONLY Termination was immediately necessary, as stated on HSA2:

F ☐ to save the life of the pregnant woman OR

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

F or G State main medical condition(s):

7 SELECTIVE TERMINATION

If this was a selective termination, state:

(i) original number of fetuses: ☐ (ii) number of fetuses reduced to: ☐

All other relevant sections of the form should also be completed

8 CHLAMYDIA SCREENING

Was screening for chlamydia offered?

☐ YES ☐ NO

9 COMPLICATIONS – up until the time of discharge (tick appropriate box(es))

None ☐ Haemorrhage ☐ Uterine Perforation ☐ Sepsis ☐

Other – specify:

An evacuation of retained products of conception is not a complication

10 DEATH OF WOMAN

In the case of death, specify:

DATE

				2	0		
d	d	m	m	y	y	y	y

State cause of death

Please now send the form in a sealed envelope (HSA4ENV)
to the address shown on page 1



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A guidance note to aid completion of this form may be found at
www.dh.gov.uk or requested from hsa4@dh.gsi.gov.uk

Supplies of forms HSA1, HSA2, HSA4 (27259) and HSA4ENV are available from:

Department of Health
PO Box 777
London
SE1 6XH

Fax: 01623 724 524

Or you can call the NHS Responseline on 08701 555 455

Sample

