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

FORM I

RMP Opinion Form

(For gestation age upto 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 (a) to (e) write the one which is appropriate:

a. in order to save the life of the pregnant women,
b. in order to prevent grave injury to the physical and mental health of the pregnant woman,
c. 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,
d. as the pregnancy is alleged by pregnant woman to have been caused by rape,
e. 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

FORM E

Opinion Form of Registered Medical Practitioners

(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 hear by 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: Signature of the Registered Medical Practitioner

Date:

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.

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: .....

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) Upto 9 weeks (Medical Methods of Abortion Only):
(b) Upto 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 Contraceptive:
(d) Others:

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

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:

B. Between 20-24 weeks of gestation

(a) Survivors of Sexual Assault/Rape/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 disasters or emergency situations as declared by Government:

C. Beyond 24 weeks of gestation

(a) 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:

Signature of the Officer In-charge with Date

FORM III

[Refer Regulation 5]

Admission Register

(To be destroyed on the expiry of five years from the date of the last entry in the 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 the names 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

Mandatory Documentation

To fill and record information in following forms:

Before any technique (MMA or surgical / any trimester.

1. Consent Form - Form C
2. RMP Opinion Form
    - MTP < 20 wks POG – FORM I
    - MTP 20 – 24 wks POG – FORM E
    - MTP > 24 wks POG - Medical board approval in FORM D
3. Form II – Monthly Reporting Form (to be sent to the district authorities every month)
4. Form III – Admission Register or case record register. *This register has entire details of the patient and a serial number is assigned to every patient, hereafter patients's name should not be written in any document but the serial no. should be used,so as to maintain the confidentiality*

THANKS & REGARDS

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FOGSI – MTP Committee Chairperson . 2021-2024