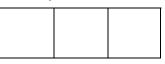
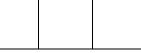
		Today'	s Date		
d	d	m	m	У	ſ

Participant ID										

Facility ID



Provider Initials



Instructions: (PROVIDER) Use this form to assess the woman's eligibility for medication abortion. For open responses, write the response in space provided. For Yes/No questions, tick the appropriate box.

I. MEDICATION ABORTION ELIGIBILITY AND PROCEDURE CHOICE

Question	Res	ponse
1. Positive urine pregnancy test or other confirmation of pregnancy?	□ Yes (1)	□ No (0)
a. Gestational age ≤ 84 days (12 weeks)?	□ Yes (1)	□ No (0)
b. Gestational age ≤ 63 days (9 weeks)?	□ Yes (1)	□ No (0)
c. If yes, was this based on (tick all that apply)	□ Yes (1)	□ No (0)
i. LMP? Date of LMP:	COMPLETE DATE	
ddmmyy		
ii. Provider's clinical assessment?	□ Yes (1)	□ No (0)
iii. Provider's ultrasound assessment?	□ Yes (1)	□ No (0)
	COMPLETE	
	MM.	
3. Final gestational age assessment:		
	wks	dys
IF NOT PREGNANT OR ABOVE 63 DAYS OF GESTATIONAL AGE, STOR LESS, PROCEED.	TOP HERE. IF	63 DAYS
Does she live or work within 1 hour of an emergency medical facility?	□ Yes (1)	□ No (0)
5. Is she willing to come for at least one follow-up visit?	□ Yes (1)	□ No (0)
6. a. Are there any contraindications to medication abortion?	□ Yes (1)	□ No (0)
b. IF YES, please specify:		
If all of the answers to Questions 1 to 6 appear in shaded sections, the		
woman is eligible for medication abortion. Continue to complete this form.7. Is the patient eligible for medication abortion?	□ Yes (1)	□ No (0)

Medication Abortion Screening Checklist (MASP)

	Today's Date						Par	ticipan	t ID	
d	d	m	m	У	r					

8. Indicate her choice of procedures: TOP (1) TOP (2)		If 7 is YES, provide information on medication abortion and ask the woman to choose either medication or surgical abortion.8. Indicate her choice of procedures:	□ Medical TOP (1)	□ Surgical TOP (2)
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II. BRIEF MEDICAL HISTORY

9. a. Does she take medication(s) on a daily basis?	□ Yes (1)	□ No (0) SKIP B.
 b. If yes, please note what medication(s) she takes (name of drug, dosage and frequency). 		
10. a. Other comments/concerns (other medical conditions or history)	□ Yes (1)	□ No (0)
b. If yes, describe		

Medication Abortion Screening Checklist (MASP)

	Today's Date						Par	ticipan	t ID	
d	d	m	m	У	ľ					

III. COMPLETE THIS SECTION FOR MEDICAL ABORTION CLIENTS ONLY

If the woman has chosen medication abortion, administer mifepristone, and complete the following:

11. Time mifepristone taken by woman:	
	h (24 hr clock)
12. Date mifepristone taken by woman:	
	day/ month/ year
13. Number of mifepristone tablets given:	
15. Lot number:	

Then provide her with 4 misoprostol tablets (200 μ g each).

16. Number of misoprostol tablets given:	
17. Lot number(s):	

Provide the woman with analgesics and advise her to take for pain management (per guidelines established in training).

18. Pain medication given:	А. Туре:
	B. Dosage per tablet:
	C. Number of tablets:

Then give her the Patient Information Sheet and explain to her that...

- She needs to take the misoprostol at home approximately 48 hours after taking mifepristone.
- She may be nauseated, vomit or have diarrhea after taking misoprostol.

Today's Date							Par	ticipan	t ID	
d	d	m	m	У	r					

- She will probably also have abdominal pain or cramping stronger than menses.
- She will also have bleeding which may be heavier than she usually experiences with her menses and that all of these side effects are temporary.
- If she forgets to take misoprostol in 48 hours she should take it as soon as she remembers.
- Explain that she has been given a telephone number (in the consent form) to call in case of a medical emergency or if she has any questions or concerns during the study.

IV. COMPLETE THISE SECTION FOR SURGICAL CLIENTS ONLY

19. Date booked for TOP						
	D	D	М	М	Y	Y