Medication Abortion Screening Checklist (MASP)

Today's Date					
d	d	m	m	y	r

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	Response	
1. Positive urine pregnancy test or other confirmation of pregnancy?	☐ Yes (1)	☐ No (0)
2. 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) i. LMP? *Date of LMP:* _____dd_____mm_____yy	☐ Yes (1) COMPLETE DATE	☐ No (0)
ii. Provider's clinical assessment?	☐ Yes (1)	☐ No (0)
iii. Provider's ultrasound assessment? *BPD:* ☐☐☐ mm *CRL:* ☐☐☐ mm	☐ Yes (1) COMPLETE MM.	☐ No (0)
3. Final gestational age assessment:	_____wks _____dys	
IF NOT PREGNANT OR ABOVE 63 DAYS OF GESTATIONAL AGE, STOP HERE. IF 63 DAYS OR LESS, PROCEED.		
4. 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? b. IF YES, please specify:	☐ Yes (1)	☐ No (0)
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)

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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)

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) b. If yes, describe	☐ Yes (1)	☐ No (0)

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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 μg 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:	A. Type: 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.***

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- ***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***	***M***	***M***	***Y***	***Y***	