Report 59

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 4 (Month) 25 (Day) 13 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood Southwest Ohio Region

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cincinnati, OH 45219

4. Date post RU-486 complication began:
5/11/13

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours _____ Days monitored for ~3wks.

7. Remarks: pt. monitored over few weeks since bleeding not heavy and D+C done ~ oral meds not effective.

8. a. Name of physician who provided RU-486 Sharon Liner

8. b. Physician's signature _____ MD/DO

Date 10/9/13

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

Prescribed: 5/--/2011, Rev. 12/13/12

Report 58

MEDICAL BOARD
OCT 15 2013

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 (Month) 4 (Day) 13 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood Southwest Ohio Region

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave, Cincinnati, OH 45219

4. Date post RU-486 complication began: 6/20/13

5. Event(s) (Please check all that apply):

___ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ✓ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: 2 Hours _____ Days

7. Remarks: pt had D+C at Follow up due to drop in Hb and still moderate amount of blood in uterus.

8. a. Name of physician who provided RU-486 Sharon Liviz

8. b. Physician's signature _____ MD/DO

Date 10/9/13

Send completed forms to: State Medical Board of Ohio
Legal Department
30 E. Broad St., 3rd Floor
Columbus, OH 43215-6127

Prescribed: S/--/2011, Rev. 12/13/12

Report 57

MEDICAL BOARD
OCT 15 2013

State Medical Board of Ohio
Report of RU-486 Event

(Required pursuant to R.C. 2919.123)

To be completed by the physician who provided RU-486

1. Date RU-486 was provided: 6 (Month) 4 (Day) 13 (Year)

2. Name of medical practice or facility at which RU-486 was provided:
Planned Parenthood Southwest Ohio Region

3. Address of medical practice or facility at which RU-486 was provided:
2314 Auburn Ave. Cincinnati, OH 45219

4. Date post RU-486 complication began: 6/18/13

5. Event(s) (Please check all that apply):

✓ Incomplete abortion ___ Adverse reaction to RU-486 ___ Patient hospitalized

___ Patient received a transfusion ___ Severe bleeding

___ Other serious event (specify) _____

6. Duration of event: _____ Hours 10 Days

7. Remarks:
pt. had non-viable sac at 7w, attempted additional dose of cytotec x1 and then D&C for retained sac.

8. a. Name of physician who provided RU-486 Sharon Liner

8. b. Physician's signature _____ MD/DO

Date 10/9/13

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