

U.S. STANDARD REPORT OF FETAL DEATH

LOCAL FILE NO.

STATE FILE NUMBER:

MOTHER	1. NAME OF FETUS (optional-at the discretion of the parents)		2. TIME OF DELIVERY (24hr)	3. SEX (M/F/Unk)	4. DATE OF DELIVERY (Mo/Day/Yr)	
	5a. CITY, TOWN, OR LOCATION OF DELIVERY	7. PLACE WHERE DELIVERY OCCURRED (Check one)		8. FACILITY NAME (If not institution, give street and number)		
	5b. ZIP CODE OF DELIVERY	<input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home Delivery: Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	6. COUNTY OF DELIVERY	<input type="checkbox"/> Clinic/Doctor's office <input type="checkbox"/> Other (Specify)		9. FACILITY ID. (NPI)		
	10a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			10b. DATE OF BIRTH (Mo/Day/Yr)		
	10c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)			10d. BIRTHPLACE (State, Territory, or Foreign Country)		
11a. RESIDENCE OF MOTHER-STATE		11b. COUNTY		11c. CITY, TOWN, OR LOCATION		
11d. STREET AND NUMBER			11e. APT. NO.	11f. ZIP CODE	11g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	

FATHER	12a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		12b. DATE OF BIRTH (Mo/Day/Yr)	12c. BIRTHPLACE (State, Territory, or Foreign Country)
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DISPOSITION	13. METHOD OF DISPOSITION: <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Hospital Disposition <input type="checkbox"/> Donation <input type="checkbox"/> Removal from State <input type="checkbox"/> Other (Specify) _____			
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ATTENDANT AND REGISTRATION INFORMATION	14. ATTENDANT'S NAME, TITLE, AND NPI		15. NAME AND TITLE OF PERSON COMPLETING REPORT	16. DATE REPORT COMPLETED	17. DATE RECEIVED BY REGISTRAR
	NAME: _____		Name _____	MM / DD / YYYY	MM / DD / YYYY
	NPI: _____		Title _____		
TITLE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify) _____					

18. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

CAUSE OF FETAL DEATH	18a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE SELECT THE <u>ONE</u> WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)		18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 18b)	
	Maternal Conditions/Diseases (Specify) _____ Complications of Placenta, Cord, or Membranes <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Prolapsed cord <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) _____ Other Obstetrical or Pregnancy Complications (Specify) _____ Fetal Anomaly (Specify) _____ Fetal Injury (Specify) _____ Fetal Infection (Specify) _____ Other Fetal Conditions/Disorders (Specify) _____ <input type="checkbox"/> Unknown		Maternal Conditions/Diseases (Specify) _____ Complications of Placenta, Cord, or Membranes <input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Prolapsed cord <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify) _____ Other Obstetrical or Pregnancy Complications (Specify) _____ Fetal Anomaly (Specify) _____ Fetal Injury (Specify) _____ Fetal Infection (Specify) _____ Other Fetal Conditions/Disorders (Specify) _____ <input type="checkbox"/> Unknown	

Mother's Name

Mother's Medical Record No.

18c. WEIGHT OF FETUS (grams preferred, specify unit) _____	18e. ESTIMATED TIME OF FETAL DEATH <input type="checkbox"/> Dead at time of first assessment, no labor ongoing <input type="checkbox"/> Dead at time of first assessment, labor ongoing <input type="checkbox"/> Died during labor, after first assessment <input type="checkbox"/> Unknown time of fetal death	18f. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned
18d. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY _____ (completed weeks)		18g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned
		18h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No

MOTHER

19. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)		20. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)		21. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)			
<input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		<input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____		<input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____			
22. MOTHER MARRIED? (At delivery, conception, or anytime between)		23a. DATE OF FIRST PRENATAL CARE VISIT		23b. DATE OF LAST PRENATAL CARE VISIT		24. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY	
<input type="checkbox"/> Yes <input type="checkbox"/> No		____/____/____ <input type="checkbox"/> No Prenatal Care M M D D Y Y Y Y		____/____/____ M M D D Y Y Y Y		_____ (If none, enter "0".)	
25. MOTHER'S HEIGHT _____ (feet/inches)		26. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)		27. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)		28. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No	
29. NUMBER OF PREVIOUS LIVE BIRTHS		30. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)		31. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY			
29a. Now Living Number ____ <input type="checkbox"/> None		29b. Now Dead Number ____ <input type="checkbox"/> None		30a. Other Outcomes Number (Do not include this fetus) ____ <input type="checkbox"/> None		For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day.	
				# of cigarettes OR # of packs		Three Months Before Pregnancy _____ OR _____ First Three Months of Pregnancy _____ OR _____ Second Three Months of Pregnancy _____ OR _____ Third Trimester of Pregnancy _____ OR _____	
29c. DATE OF LAST LIVE BIRTH ____/____/____ M M Y Y Y Y		30b. DATE OF LAST OTHER PREGNANCY OUTCOME ____/____/____ M M Y Y Y Y		32. DATE LAST NORMAL MENSES BEGAN ____/____/____ M M D D Y Y Y Y		33. PLURALITY - Single, Twin, Triplet, etc. (Specify) _____	
						34. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) _____	
35. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: _____							

MEDICAL AND HEALTH INFORMATION

36. RISK FACTORS IN THIS PREGNANCY (Check all that apply):		37. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)	
Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) <input type="checkbox"/> Pregnancy resulted from infertility treatment-If yes, check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)) <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many _____ <input type="checkbox"/> None of the above		<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Listeria <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Cytomegalovirus <input type="checkbox"/> Parvovirus <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> None of the above <input type="checkbox"/> Other (Specify) _____	
38. METHOD OF DELIVERY		39. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)	
A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Fetal presentation at delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other D. Final route and method of delivery (Check one) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No E. Hysterotomy/Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operating room procedure following delivery <input type="checkbox"/> None of the above	
		40. CONGENITAL ANOMALIES OF THE FETUS (Check all that apply)	
		<input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the anomalies listed above	

Mother's Name _____
 Mother's Medical Record No. _____