FETAL DEATH REPORT
FACILITY WORKSHEET

Use this worksheet to collect fetal death information for entry into the Oregon Vital Events Registration System (OVERS). All fetal deaths that occur in a hospital facility and meet the mandatory reporting requirements should be reported using OVERS. This worksheet may be accompanied by the parent worksheet. Some of the information requested on this form is also requested on the parent worksheet and need not be collected twice. **Fetal death reports must be completed within 5 days of delivery of the fetus. Retain worksheets in your files for at least 1 and no more than 2 years.**

**When is a death a fetal death?**
Only complete the report of fetal death for pregnancy outcomes that do not result in a live birth. Oregon law (ORS 432.005 Definition (14)) defines fetal death as death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, that is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of the voluntary muscles. If you have questions as to whether the fetus was dead at the time of delivery you can review the pregnancy outcome flow chart at http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Pages/InstructionsFetalDeath.aspx or call 971-673-1180. **If a child is born living and then dies shortly after birth, do not file the fetal death report.**

**Mandatory reporting requirements**
You are only required to report fetal deaths if the birth weight of the fetus is 350 grams or more. If the delivery weight is unknown, the report must be filed if the gestational age is 20 weeks or more. For mandatory reports, the information we are requesting has several purposes including: collecting information required by federal law; and gathering medical information that is used for public health. You can access detailed instructions for completing the fetal death report at http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Pages/InstructionsFetalDeath.aspx

**Non-mandatory reporting requirements**
Although it is not mandatory to report a fetal demise in instances where the birth weight is less than 350 grams or (if the weight is unknown) the gestation period is less than 20 weeks, you may file a report if a family requests it so that they may later purchase a commemorative Certificate of Stillbirth.

If you complete a non-mandatory report of fetal demise for a fetus that is less than the minimum weight and gestational age for mandatory reporting, you only need to include the:

- Parents’ names,
- Delivery weight,
- Place of delivery, and;
- Date of delivery.

**Completing the legal portion of the report**
It is very important that the names, date of delivery, and place of delivery are correct. Please use full names for the parents. Parents may choose to leave the first and middle names blank for the fetus but the last name must be entered.

**Burial and other disposition information**
You must provide the funeral director with a disposition permit when they pick up the fetal remains, but you should not provide them with a copy of the fetal death report. The disposition permit includes everything on the report except for the causes/conditions of death. The disposition permit can be downloaded from OVERS under the fetal death registration menu>print forms.

Please answer every question to the best of your knowledge. Each question has a purpose.

Thank You for Your Help.
<table>
<thead>
<tr>
<th>FETUS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Fetus Name</td>
<td>First</td>
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</tbody>
</table>

**METHOD OF DISPOSITION (Select one)**
- Hospital Coordinating Final Disposition (hospital must provide a disposition permit to any party transporting remains)
  - Name of Funeral facility: __________
- Hospital disposition
- Hospital transfer to parents

**MOTHER’S HEALTH**
- Did she get WIC food for herself during pregnancy? Yes ☐ No ☐
- Cigarette Smoking
  - Number cigarettes (per day)
  - 3 months before pregnancy # ______ Cigarettes
  - 1st 3 months of pregnancy # ______ Cigarettes
  - 2nd 3 months of pregnancy # ______ Cigarettes
  - 3rd 3 months of pregnancy # ______ Cigarettes

**HEIGHT**
- Height ft. in.
- Weight (Pre-pregnancy) lbs.
- Weight (at delivery) lbs.

**PREGNATAL**
- Date of Last Menses / / MM DD YYYY
- Prenatal Care
  - No prenatal care ☐
- Date of 1st visit / / MM DD YYYY
- Total # of visits
- Previous Live Births
  - # now living ______
  - # now deceased ______
- Date of last live birth / / MM DD YYYY
- Other Pregnancy Outcomes
  - (Spontaneous or induced terminations or ectopic pregnancy)
  - # of other outcomes (combined #) ______
  - Date of last other outcome / / MM YYYY

**PREGNANCY FACTORS**
- Risk Factors
  - Diabetes-Pre-pregnancy ☐
  - Diabetes-Gestational (Diagnosis In This Pregnancy) ☐
  - Hypertension-Pre-pregnancy (Chronic) ☐
  - Hypertension-Gestational (PIH, Pre-eclampsia) ☐
  - Hypertension-Eclampsia ☐
  - Previous Preterm Births (<37 Completed Weeks Gestation) ☐
  - Infertility Treatment-Fertility-enhancing drugs ☐
  - Infertility Treatment-Assisted Reproductive Technology ☐
  - Mother Had A Previous Cesarean Delivery: How Many? ______
  - None Of The Above ☐

- Infections Present and / or Treated During this Pregnancy (Check all that apply)
  - Gonorrhea ☐
  - Chlamydia ☐
  - Group B Streptococcus ☐
  - Parvovirus ☐
  - None of the above ☐
  - Syphilis ☐
  - Listeria ☐
  - Cytomegalovirus ☐
  - Toxoplasmosis ☐
  - Other (Specify) ☐

**DELIVERY**
- Method of Delivery
  - Fetal Presentation at Delivery Cephalic ☐ Breech ☐ Other ☐
  - Final Route and Method of Delivery Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐
  - If Cesarean, was a Trial of Labor Attempted? Yes ☐ No ☐

- Maternal Morbidity (check all that apply)
  - Maternal transfusion ☐
  - Unplanned hysterectomy ☐
  - Third or fourth degree perineal laceration ☐
  - Admission to intensive care unit following delivery ☐
  - Ruptured uterus ☐
  - None of the above ☐

- Mother Transferred for maternal or fetal indication prior to delivery Yes ☐ No ☐

**FETAL ATTRIBUTES**
- Weight of Fetus lb/oz grams
- Obstetric Estimate of Gestation (weeks)
- Plurality (Single, Twin, Triplet, etc.)
- Delivery Order (1st, 2nd, 3rd, 4th, etc.)

- Congenital Anomalies
  - Anencephaly ☐
  - Meningomyelocele/Spina bifida ☐
  - Cleft Lip with or without Cleft Palate ☐
  - Cleft Palate alone ☐
  - Down Syndrome, karotype confirmed ☐
  - Suspected chromosomal disorder, karotype confirmed ☐
  - Suspected chromosomal disorder, karotype pending ☐
  - Hypospadias ☐
  - None of the anomalies listed above ☐

<p>| Last revised: Dec. 2014 |</p>
<table>
<thead>
<tr>
<th>CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH</th>
<th>(Page 2 of 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiating Cause/Conditioning</strong></td>
<td><strong>Other Significant Causes or Conditions</strong></td>
</tr>
<tr>
<td>(enter one condition or cause only)</td>
<td>(enter all other conditions or causes)</td>
</tr>
<tr>
<td>Maternal Conditions/Disease (specify)</td>
<td>Maternal Conditions/Disease (specify)</td>
</tr>
<tr>
<td>Complications of placenta, cord or membranes:</td>
<td>Complications of placenta, cord or membranes:</td>
</tr>
<tr>
<td>☐ Rupture of membranes ☐ Prolapsed cord</td>
<td>☐ Rupture of membranes ☐ Prolapsed cord</td>
</tr>
<tr>
<td>☐ Abruptio placenta ☐ Chorioamnionitis</td>
<td>☐ Abruptio placenta ☐ Chorioamnionitis</td>
</tr>
<tr>
<td>☐ Placental insufficiency ☐ Other</td>
<td>☐ Placental insufficiency ☐ Other</td>
</tr>
<tr>
<td>Other obstetrical or pregnancy complications(specify)</td>
<td>Other obstetrical or pregnancy complications(specify)</td>
</tr>
<tr>
<td>Fetal Anomaly(specify)</td>
<td>Fetal Anomaly(specify)</td>
</tr>
<tr>
<td>Fetal Injury(specify)</td>
<td>Fetal Injury(specify)</td>
</tr>
<tr>
<td>Fetal Infection (specify)</td>
<td>Fetal Infection (specify)</td>
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<tr>
<td>Other fetal conditions/disorders (specify)</td>
<td>Other fetal conditions/disorders (specify)</td>
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<tr>
<td>☐ Unknown</td>
<td>☐ Unknown</td>
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<tr>
<td>Estimated time of fetal death</td>
<td>Estimated time of fetal death</td>
</tr>
<tr>
<td>☐ Dead at first assessment, no labor ongoing</td>
<td>☐ Dead at first assessment, labor ongoing</td>
</tr>
<tr>
<td>☐ Died during labor, after first assessment</td>
<td>☐ Unknown time of fetal death</td>
</tr>
<tr>
<td>Autopsy performed ☐ Yes ☐ No ☐ Planned</td>
<td>Autopsy performed ☐ Yes ☐ No ☐ Planned</td>
</tr>
<tr>
<td>Histological Placental Examination Performed ☐ Yes ☐ No ☐ Planned</td>
<td>Histological Placental Examination Performed ☐ Yes ☐ No ☐ Planned</td>
</tr>
<tr>
<td>Autopsy or Histological Placental Examination used in Determining Cause of Fetal Death ☐ Yes ☐ No ☐ Not applicable</td>
<td>Autopsy or Histological Placental Examination used in Determining Cause of Fetal Death ☐ Yes ☐ No ☐ Not applicable</td>
</tr>
<tr>
<td>Attendant at delivery First</td>
<td>Attendant at delivery Middle</td>
</tr>
</tbody>
</table>

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