Appendix D: Sample Forms

TYPE OR PRINT IN PERMANENT BLACK INK

I.D. TAG NO.

Local File Number

OREGON DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

136-

State File Number

DECEDENT

1. DECEDENT'S NAME *First* *Middle* *Last*
2. SEX
3. DATE OF DEATH *(Month, Day, Year)*
4. SOCIAL SECURITY NUMBER
5a. AGE-Last Birthday *(Years)*
5b. Under 1 Year — Mos. | Days
5c. Under 1 Day — Hours | Mins.
6. BIRTHPLACE *(City and State or Foreign Country)*
7. DATE OF BIRTH *(Month, Day, Year)*
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ Yes ☐ No
9a. PLACE OF DEATH *(Check only one)* HOSPITAL ☐ Inpatient ☐ ER/Outpatient ☐ DOA OTHER ☐ Nursing Home ☐ Decedent's Home ☐ Other *(Specify)*
9b. FACILITY NAME *(If not institution, give street and number)*
9c. CITY, TOWN, OR LOCATION OF DEATH
9d. COUNTY OF DEATH
10a. DECEDENT'S USUAL OCCUPATION *(Give kind of work done during most of working life. Do not use retired.)*
10b. KIND OF BUSINESS/INDUSTRY
11. MARITAL STATUS - *Married, Never Married, Widowed, Divorced (Specify)*
12. SPOUSE *(If Married, Widowed)*
13a. RESIDENCE - STATE
13b. COUNTY
13c. CITY, TOWN OR LOCATION
13d. STREET AND NUMBER
13e. INSIDE CITY LIMITS? ☐ Yes ☐ No
13f. ZIP CODE
14. WAS DECEDENT OF HISPANIC ORIGIN? *(Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)* ☐ No ☐ Yes *Specify:*
15. RACE American Indian, Black, White, etc *(Specify)*
16. DECEDENT'S EDUCATION *(Specify only highest grade completed)* Elementary/Secondary (0-12) | College (1-4 or 5 +)

PARENTS

17. FATHER - NAME first middle last
18. MOTHER - NAME first middle maiden
19. INFORMANT NAME and relationship to deceased

DISPOSITION

20a. METHOD OF DISPOSITION ☐ Mausoleum ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other *(Specify)*
20b. PLACE OF DISPOSITION *(Name of cemetery, crematory, or other place)*
20c. LOCATION - City or Town, State
21a. SIGNATURE OF OREGON FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
21b. OREGON LICENSE NO. *(Of Licensee)*
22. NAME, ADDRESS AND ZIP OF FACILITY

REGISTRAR

23. DATE FILED *(Month, Day, Year)*
24. REGISTRAR'S SIGNATURE

RESERVED FOR REGISTRAR'S USE

1___ 2___ 3___ 4___ 5___ 6___ 7___ 8___ 9___

CERTIFIER

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH
28. WAS MEDICAL EXAMINER NOTIFIED? ☐ Yes ☐ No
29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. *(Signature)*
30. DATE SIGNED *(Month, Day, Year)*
31a. TIME OF DEATH M
31b. DATE PRONOUNCED DEAD *(Month, Day, Year, Hour)* M
32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) and manner stated. *(Signature)*
33. DATE SIGNED *(Month, Day, Year)* COUNTY
34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER *(Type or Print)*
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER *(Type or Print)*

10___ 11___ 12___ 13___ 14___

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE *UNDERLYING CAUSE LAST*

36. IMMEDIATE CAUSE *(ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.* — Interval between onset and death

PART I
(a) — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(b) — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(c)

PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.

37. Did tobacco use contribute to the death? ☐ *Yes* ☐ *Probably* ☐ *No* ☐ *Unknown*
38. AUTOPSY ☐ *Yes* ☐ *No*
39. If YES were findings considered in determining cause of death? ☐ *Yes* ☐ *No* ☐ *N/A*
40. MANNER OF DEATH ☐ Natural ☐ Pending Investigation ☐ Accident ☐ Undetermined Manner ☐ Suicide ☐ Homicide ☐ Legal Intervention ☐ Other
41a. DATE OF INJURY *(Month, Day, Year)*
41b. TIME OF INJURY M
41c. INJURY AT WORK? ☐ Yes ☐ No
41d. DESCRIBE HOW INJURY OCCURRED
41e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. *(Specify)*
41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

15___ 16___ 17___

CAUSE OF DEATH INSTRUCTIONS ON REVERSE SIDE OF GREEN AND PINK COPY

RESERVED FOR REGISTRAR'S USE

SAMPLE

ORIGINAL-VITAL STATISTICS COPY

45-2-Rev (3/00)

TYPE OR PRINT IN PERMANENT BLACK INK

I D TAG NO

Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Center for Health Statistics

REPORT OF FETAL DEATH

136-

State File Number

1a. FACILITY NAME *(If not institution, give street and number)*

1b. CITY, TOWN, OR LOCATION OF DELIVERY

1c. COUNTY OF DELIVERY

2a. DATE OF DELIVERY *(Month, Day, Year)*

2b. HOUR

3. SEX OF FETUS

MOTHER

4a. MOTHER—NAME First Middle Last

4b. MAIDEN SURNAME

5. DATE OF BIRTH

6a. RESIDENCE—STATE

6b. COUNTY

6c. CITY, TOWN, OR LOCATION

6d. STREET AND NUMBER

6e. INSIDE CITY LIMITS? *(Yes or no)*

6f. ZIP CODE

FATHER

7. FATHER—NAME First Middle Last

8. DATE OF BIRTH

CAUSE OF FETAL DEATH

9\. PART I — Fetal or maternal condition directly causing fetal death

IMMEDIATE CAUSE *(Enter only one cause per line for (a), (b), and (c).)*

(a) — Specify Fetal or Maternal

Fetal and/or maternal conditions, if any, giving rise to the immediate cause (a), stating the underlying cause last

(b) DUE TO, OR AS A CONSEQUENCE OF: — Specify Fetal or Maternal

(c) DUE TO, OR AS A CONSEQUENCE OF: — Specify Fetal or Maternal

PART II — OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER: Conditions contributing to fetal death but not related to cause given in PART I.

10. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN *(Specify)*

11. AUTOPSY *(Specify yes or no)*

12. NAME OF PHYSICIAN OR ATTENDANT *(Type or print)* TITLE

13. NAME OF PERSON COMPLETING REPORT *(Type or print)* TITLE

14. IF SERVICES: FUNERAL DIRECTOR—FUNERAL HOME—Name and Address *(Street, city or town, state, zip)*

OPTIONAL

Fetus-Name

INFORMATION F[...] MEDICAL [...] HE[...] LY

	15. OF HISPANIC ORIGIN? *(Specify No or Yes) (If yes, specify Cuban, Mexican, Puerto Rican, etc.)*	16. RACE—*(e.g. White, Black, American Indian, etc.)* *(Specify below)*	17. EDU[...] *(Highe[...] de comple[...])* [...]dary / College (1-4 or 5+)	18. OCCUPATION AND BUSINESS/INDUSTRY *(Worked during last year)* Occupation	Business/Industry
MOTHER	15a [ ] No [ ] Yes Specify	16a.		18a.	18b.
FATHER	15b. [ ] No [ ] Yes Specify	16b.		18c.	18d

19. PREGNANCY HISTORY — 19a. Now [...] Number [...] None [ ] — [...] Now dead Number ____ None [ ]

19c. DATE OF LAST LIVE BIRTH *(Month, Year)*

OTHER TERMINATIONS *(Spontaneous and induced)* 19d. Number ____ None [ ]

19e. DATE OF LAST OTHER TERMINATION *(Month, Year)*

20. C[...]CAL ESTIMATE O[...] [...]TATION *(Weeks)*

21. WEIGHT OF FETUS *(Specify units)*

23. MOTHER MARRIED? *(At birth, conception, or any time between) (Yes or no)* [ ] No [ ] Yes

[...]AST NO[...] [...]NSES [...] *(Month, D[...] [...]ar)*

25a. PLURALITY—Single, twin, triplet, etc. *(Specify)*

25b. IF NOT SINGLE BIRTH—Born first, second, third, etc. *(Specify)*

26. MONTH OF PREGNANCY PRENATAL CARE BEGAN First, second, etc. *(Specify)*

27. PRENATAL VISITS Total number *(If none, so state)*

30 [M]EDICAL FACTORS FOR THIS PREGNANCY *(Check all that apply)*

01 [ ] Anemia (Hct · 30/Hgb · 10)
02 [ ] Cardiac disease
03 [ ] Acute or chronic lung disease
04 [ ] Diabetes (Chronic)
05 [ ] Diabetes (Gestational)
06 [ ] Genital herpes
07 [ ] Hydramnios/Oligohydramnios
08 [ ] Hemoglobinopathy
09 [ ] Hypertension, chronic
10 [ ] Hypertension, pregnancy associated
11 [ ] Eclampsia
12 [ ] Incompetent cervix
13 [ ] Previous infant 4000 + grams
14 [ ] Previous preterm or small for gestational age infant
15 [ ] Renal disease
16 [ ] Rh sensitization
17 [ ] Uterine bleeding
18 [ ] No history available
00 [ ] None
19 [ ] Other *(Specify)* ____

31 COMPLICATIONS OF LABOR AND/OR DELIVERY *(Check all that apply)*

01 [ ] Febrile (> 100°F. or 38°C)
02 [ ] Meconium, moderate/heavy
03 [ ] Premature rupture of membrane (> 12 hours)
04 [ ] Abruptio placenta
05 [ ] Placenta Previa
06 [ ] Other excessive bleeding
07 [ ] Seizures during labor
08 [ ] Precipitous labor (< 3 hours)
09 [ ] Prolonged labor (> 20 hours)
10 [ ] Dysfunctional labor
11 [ ] Breech/Malpresentation
12 [ ] Cephalopelvic disproportion
13 [ ] Cord prolapse
14 [ ] Anesthetic complications
15 [ ] Fetal distress
00 [ ] None
16 [ ] Other *(Specify)* ____

32 OTHER FACTORS FOR THIS PREGNANCY *(Complete all items)*

a. Tobacco use during pregnancy No [ ] Yes [ ]
b. Average number cigarettes per day ____
c. Alcohol use during pregnancy No [ ] Yes [ ]
d. Average number drinks per week ____
e. Weight gained during pregnancy ____ lbs
f. History available No [ ] Yes [ ]
g. Other *(Specify)* ____

33 ANTENATAL PROCEDURES *(Check all that apply)*

01 [ ] Amniocentesis
02 [ ] Tocolysis
03 [ ] Ultrasound
04 [ ] No History available
00 [ ] None
05 [ ] Other *(Specify)* ____

34 INTRAPARTUM PROCEDURES *(Check all that apply)*

01 [ ] Electronic fetal monitoring
02 [ ] Induction of labor
03 [ ] Stimulation of labor
00 [ ] None
04 [ ] Other *(Specify)* ____

35 METHOD OF DELIVERY *(Check all that apply)*

01 [ ] Vaginal
02 [ ] Vaginal birth after previous C-section
03 [ ] Primary C-section
04 [ ] Repeat C-section
05 [ ] Forceps
06 [ ] Vacuum

36 CONGENITAL ANOMALIES *(Check all that apply)*

01 [ ] Anencephalus
02 [ ] Spina bifida/Meningocele
03 [ ] Hydrocephalus
04 [ ] Microcephalus
05 [ ] Other central nervous system anomalies *(Specify)* ____
06 [ ] Heart malformations
07 [ ] Other circulatory/respiratory anomalies *(Specify)* ____
08 [ ] Rectal atresia/stenosis
09 [ ] Tracheo-esophageal fistula/Esophageal atresia
10 [ ] Omphalocele/Gastroschisis
11 [ ] Other gastrointestinal anomalies *(Specify)* ____
12 [ ] Malformed genitalia
13 [ ] Renal agenesis
14 [ ] Other urogenital anomalies *(Specify)* ____
15 [ ] Cleft lip/palate
16 [ ] Polydactyly/Syndactyly/Adactyly
17 [ ] Club foot
18 [ ] Diaphragmatic hernia
19 [ ] Other musculoskeletal/integumental anomalies *(Specify)* ____
20 [ ] Down Syndrome
21 [ ] Other chromosomal anomalies *(Specify)* ____
00 [ ] None apparent
22 [ ] Other *(Specify)* ____

45-3 (1-98)

SAMPLE

Oregon Department of Human Services – Health Division

Adolescent Suicide Attempt Report

1. **Name of hospital**:__________ **County**__________
2. **Date of attempt** (Month/Day/Year):____/____/____
3. **Admitted as an in-patient?** ☐ Yes ☐ No ☐ Transferred to another hospital (Specify)__________
4. **Patient or hospital chart number:**__________
5. **Date of birth** (Month/Day/Year):____/____/____
6. **Sex:** ☐ Male ☐ Female
7. **Race:** ☐ White ☐ Black ☐ Am. Indian ☐ Hispanic ☐ Other (Specify)__________
8. **Residence:** City__________ County__________
9. **Patient lives with:**
   ☐ Both parents ☐ Father only ☐ Mother only ☐ Foster parents ☐ Friends
   ☐ Parent and stepparent ☐ Unknown ☐ Other, homeless, etc. (Specify):__________
10. **Place of attempt:**
    ☐ Own home ☐ Another's home ☐ School ☐ Other (Specify):__________
11. **Method or methods used in attempt:**
    Poisoning by solid or liquid substance including drug or alcohol overdoses, and other potentially toxic substances
    Specify substance(s):__________
    Hanging or suffocation – Specify method:__________
    Firearms and explosives – Specify type (Hand gun, rifle, etc.) *and* bo[illegible]__________
    Cutting or piercing – Specify instrument *and* body site:__________
    Other means such as motor vehicle crash, drowning, fi[illegible] – Specify:__________
12. **History of mental health issues:**
    ☐ Acute depression ☐ Chronic depression ☐ Bipolar disorder ☐ Adjustment disorder
    ☐ Conduct disorder ☐ Other__________ ☐ Unknown ☐ None
13. **Number of previous suicide attempts made during lifetime:**
    ☐ 1 ☐ 2 ☐ 3 [illegible] ☐ [illegible] ☐ 6 ☐ 7+ ☐ Attempts made, but # unknown ☐ History unknown
14. **Precipitating events and risk factors:**
    ☐ Family discord ☐ Argument or breakup with boyfriend/girlfriend ☐ Peer pressure/argument
    ☐ School problems ☐ Suicide or attempt by friend/relative ☐ Pregnancy
    ☐ Death of friend/relative ☐ Move or new school ☐ None
    ☐ Physical abuse – Specify type and perpetrator, if known:__________
    ☐ Sexual abuse or rape – Specify type and perpetrator, if known:__________
    ☐ Alcohol and/or drug abuse – Specify substance(s):__________
    ☐ Prior arrests and/or convictions of a crime – Specify:__________
    ☐ Other – Specify:__________
15. **Did the youth tell others of his or her plan to attempt/commit suicide?** ☐ Yes ☐ No ☐ Unknown
    If yes, whom did the youth tell? ☐ Parent ☐ Friend ☐ Teacher ☐ Other__________
16. **Was the youth referred for intervention?** ☐ No ☐ Yes – Specify to whom:__________
17. **Name of person completing report** (*Print*):__________ Dept.__________

SAMPLE

ORS 441.750 states that
"Any hospital which treats as a patient a person *under 18* years of age because the person has attempted to commit suicide:
"Shall cause that person to be provided with information and referral to in-patient or out-patient community resources, crisis intervention or other appropriate intervention by the patient's attending physician, hospital social work staff or other appropriate staff." and
"Shall report statistical information to the Health Division of the Department of Human Services about the person. . ."

Mail this form no later than the 15th of the month following the month of the attempt to: **Center for Health Statistics**
P.O. Box 14050
Portland, Oregon 97293-0050

Telephone: 503-731-4354

OSHD Form 45-119 (Rev. 4-01)

Oregon Department of Human Resources
HEALTH DIVISION

ADOLESCENT SUICIDE ATTEMPT REPORT:
ZERO ATTEMPTS

1. Name of HOSPITAL______________________________ COUNTY________________________

2. During the month of ________________, there have been ZERO teen suicide attempts treated here.

3. Contact person at this facility:____

   Title/Dept:____ Phone:____________________

SAMPLE

MAIL THIS FORM TO THE ADDRESS LISTED BELOW NO LATER THAN THE 15TH OF THE MONTH FOLLOWING ANY MONTH IN WHICH THERE WERE NO TEEN SUICIDE ATTEMPTS TREATED AT YOUR HOSPITAL:

Adolescent Suicide Report Program
Center for Health Statistics
PO Box 14050
Portland, OR 97293-0050

Telephone (503) 731-4354

OSHD Form 45-120 (Rev 12-97)