

May 22nd and 26th 2017

Birth Reporting Webinar Conference Call

Fetal Death Reporting

Public Health Division
Center for Public Health Practice
Center for Health Statistics



Today's Presenters

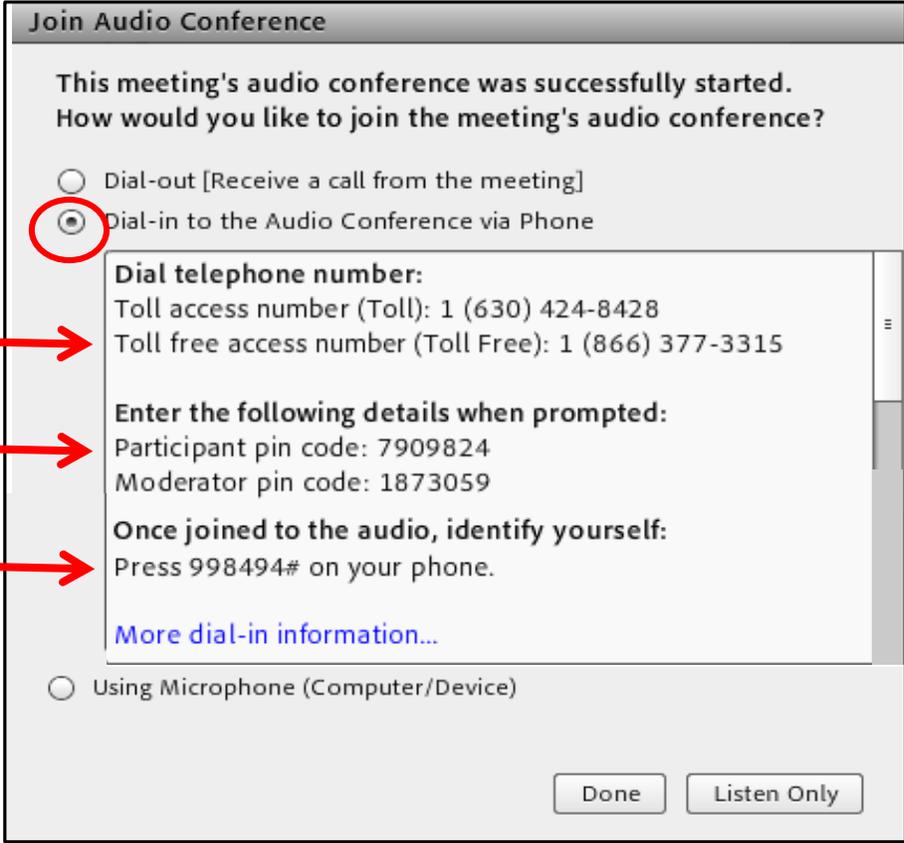
JoAnn Jackson
State Registration Manager

Krystalyn Salyer
OVERS Training Coordinator



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Enter the following details when prompted:
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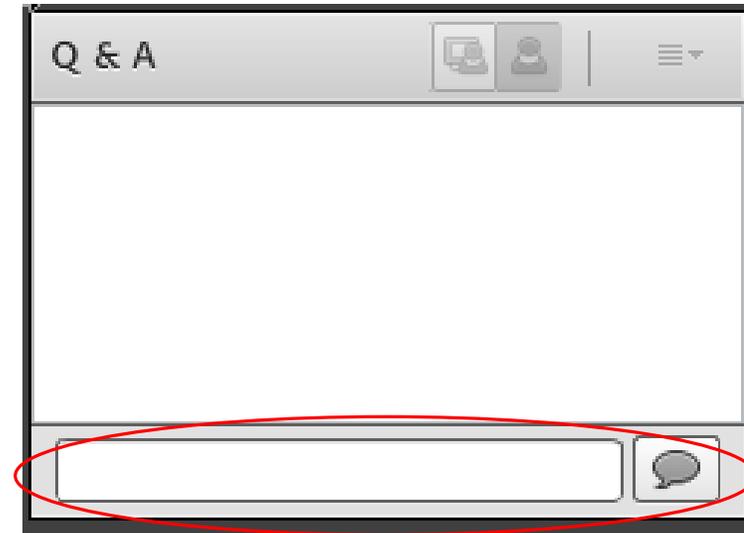
Using Microphone (Computer/Device)

Buttons: Done, Listen Only

Red annotations: A red circle highlights the 'Dial-in to the Audio Conference via Phone' radio button. Three red arrows point to the 'Dial telephone number' section, the 'Enter the following details when prompted' section, and the 'Once joined to the audio, identify yourself' section.

How we will communicate

- Phones will be muted when the speaker is presenting; no hold music
- We will unmute the phones and pause for a question and answer session in between sections
- Feel free to type any questions in the Q & A chat box; we will respond to questions to the whole group during open discussion



Today's Agenda: Fetal Death Reporting

- 1. Definition of a Fetal Death**
- 2. Requirements to report (who, what, when)**
- 3. Collecting information using the Fetal Death Parent and Facility Worksheets**
- 4. Transporting Fetal Remains – Disposition Permits**

Fetal Death

What is a fetal death?

Definition:

(ORS 432.005 (14))

“Fetal death” means 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.

Facility vs. Vital Record's terms

- Facilities may use terms such as: perinatal, neonatal, post neonatal or infant death
- Vital statistics use only the following terms: Fetal Death and Live Birth

How is fetal death determined?

- Whether a delivery is a fetal death or is a live birth, a medical determination must be made.
- Defined by law
 - Signs of life, even if alive for only seconds and very early gestation = LIVE BIRTH requiring a birth record and a death record
 - No signs of life after extraction or expulsion = FETAL DEATH requiring a fetal death report only if the delivery weight is 350 grams or more, or 20 weeks gestation if delivery weight is unknown

Key indicators of fetal death

- When a pregnancy ends unintentionally
- Fetus is delivered without a heart beat, breath, umbilical cord pulsation or movement
- Birth attendant requests the event be reported using a fetal death report

Oregon Health Authority Center for Health Statistics				FETAL DEATH REPORT FACILITY WORKSHEET			
(Page 1 of 2)							
FETUS				Date of Delivery		Time of Delivery	Sex
Fetus Name First Middle Last Suffix				MM / DD / YYYY			<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined
METHOD OF DISPOSITION (Select one)							
Facility Coordinating Final Disposition (hospital must provide a disposition permit to any party transporting remains)							
<input type="checkbox"/> Hospital transfer to funeral home Name of Funeral facility: _____							
<input type="checkbox"/> Hospital disposition							
<input type="checkbox"/> Hospital transfer to parents							
MOTHER'S HEALTH							
Did she get WIC food for herself during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No						Cigarette Smoking Number cigarettes (per day)	
Height ft. _____ in. _____		Weight (Pre-pregnancy) lbs. _____		Weight (at delivery) lbs. _____		3 months before pregnancy # _____ Cigarettes	
						1 st 3 months of pregnancy # _____ Cigarettes	
						2 nd 3 months of pregnancy # _____ Cigarettes	
						3 rd 3 months of pregnancy # _____ Cigarettes	
PRENATAL							
Date of Last Menses MM / DD / YYYY		Prenatal Care No prenatal care <input type="checkbox"/> Date of 1 st visit MM / DD / YYYY		Previous Live Births # now living _____ # now deceased _____ Date of last live birth MM / 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							
<input type="checkbox"/> Diabetes-Pre-pregnancy				<input type="checkbox"/> Previous Preterm Births (<37 Completed Weeks Gestation)			
<input type="checkbox"/> Diabetes-Gestational (Diagnosis In This Pregnancy)				<input type="checkbox"/> Infertility Treatment-Fertility-enhancing drugs			
<input type="checkbox"/> Hypertension-Pre-pregnancy (Chronic)				<input type="checkbox"/> Infertility Treatment-Assisted Reproductive Technology			
<input type="checkbox"/> Hypertension-Gestational (PIH, Pre-eclampsia)				<input type="checkbox"/> Mother Had A Previous Cesarean Delivery: How Many? _____			
<input type="checkbox"/> Hypertension-Eclampsia				<input type="checkbox"/> None Of The Above			
Infections Present and / or Treated During this Pregnancy (Check all that apply)							
<input type="checkbox"/> Gonorrhea		<input type="checkbox"/> Chlamydia		<input type="checkbox"/> Group B Streptococcus		<input type="checkbox"/> Parvovirus	
<input type="checkbox"/> Syphilis		<input type="checkbox"/> Listeria		<input type="checkbox"/> Cytomegalovirus		<input type="checkbox"/> Toxoplasmosis	
						<input type="checkbox"/> None of the above	
						<input type="checkbox"/> Other (Specify) _____	
DELIVERY							
Method of Delivery							
Fetal Presentation at Delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other							
Final Route and Method of Delivery <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							
Maternal Morbidity (check all that apply)							
<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	
Mother Transferred for maternal or fetal indication prior to delivery <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility _____							
FETAL ATTRIBUTES							
Weight of Fetus _____ lb/oz <input type="checkbox"/> _____ grams		Obstetric Estimate of Gestation(weeks) _____		Plurality (Single, Twin, Triplet, etc.) _____		Delivery Order (1 st , 2 nd , 3 rd , 4 th , etc.) _____	
Congenital Anomalies							
<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		<input type="checkbox"/> Cleft Lip with or without Cleft Palate	
						<input type="checkbox"/> Cleft Palate alone	
						<input type="checkbox"/> Down Syndrome, karotype confirmed	
						<input type="checkbox"/> Down Syndrome, karotype pending	
						<input type="checkbox"/> Suspected chromosomal disorder, karotype confirmed	
						<input type="checkbox"/> Suspected chromosomal disorder, karotype pending	
						<input type="checkbox"/> Hypospadias	
						<input type="checkbox"/> None of the anomalies listed above	

What is *not* a fetal death?

- If an infant is born showing signs of life but dies shortly after
 - Signs of life include
 - Heartbeat
 - Breath
 - Movement
- An Induced Termination of Pregnancy (ITOP) is NOT a fetal death
 - ITOP is the purposeful interruption of pregnancy and fetal death is an unintentional occurrence
 - ITOP is reported through a different module in OVERS or by paper form

Important:

If after delivery the fetus showed any evidence of life, BOTH a certificate of life birth and certificate of death are required.

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Birth Record FACILITY WORKSHEET

CHILD
Name _____

MOTHER
Did she get _____

Alcohol use _____

PLACE OF BIRTH
 At this facility
 Other location
Specify address _____

PRENATAL
Mother's M _____
Mother's M _____
Date of Lab _____
Prenatal C _____
Date of 1st visit _____

Other Pre _____
Combined # _____

PREGNANCY
Risk Factors
 Diabetes
 Diabetes
 Hypertension
 Hypertension
Mother tests
 Syphilis
 Group B

LABOR
Onset of L _____
Characteristics
 Induction
 Augmentation
 Steroids
DELIVERY
Method of Delivery _____
Fetal Present _____
Final Route of Delivery _____
If Cesarean, _____
Maternal M _____
 Maternal M _____
 Third or fourth _____
 Ruptured _____
Mother transferred _____
Infant transferred _____

No individual _____

OREGON DEATH CERTIFICATE WORKSHEET FOR FUNERAL HOMES

Instructions: This worksheet is designed to be used as a supplemental tool when obtaining information from an informant or family member about the decedent. We recommend that both the informant and funeral director review the worksheet for completeness and sign and date it. If a typographical error occurs in marital status or name of spouse, having a signed worksheet can be used as evidence to support the correction of the record by the funeral director.

1. Decedent's full legal name – Legal name, not nicknames

Prefix _____ First _____ Middle _____ Other Middle _____
Last name prior to first marriage _____ Last _____ Suffix _____

AKA (full name) _____ (Only include if substantially different than legal name)

2 a-b. Date of death _____ (mo dd yyyy)
 Actual date of death Approximate date of death Court determined date of death
 Presumed date of death Found date of death

3 a-b. Time of death _____ AM PM Military
 Actual time of death Approximate time of death Court determined time of death
 Presumed time of death Unknown time of death Found time of death

4. County of death _____

5. Sex M F Undetermined Unknown **6. SSN** _____ None Unknown

7. Date of birth _____ (mo dd yyyy) **8 a-b. Age** _____ years months days hours minutes

9. Birth place _____
City or Town _____ State _____ Country _____

10. a-c. Served in U.S. Armed Forces? No Yes Unknown
If cannot determine if the decedent served in the Armed Forces, select unknown. DO NOT leave this blank.

If the decedent served in the U.S. Armed Forces, did the decedent serve in a **Combat Zone**? No Yes.
If "Yes", add the **Location of Combat Zone**: _____

The informant may select the **Combat Zone Location(s)** that apply from the list at the end of this document or they may provide other locations(s). We will accept any location(s) provided.

If this is an electronic death record, you must use a semi-colon in the electronic system (";") between locations, if more than one location is listed.

See attached list at the end of this worksheet for a list of **Combat Zone Locations**

11. Decedent's resident address

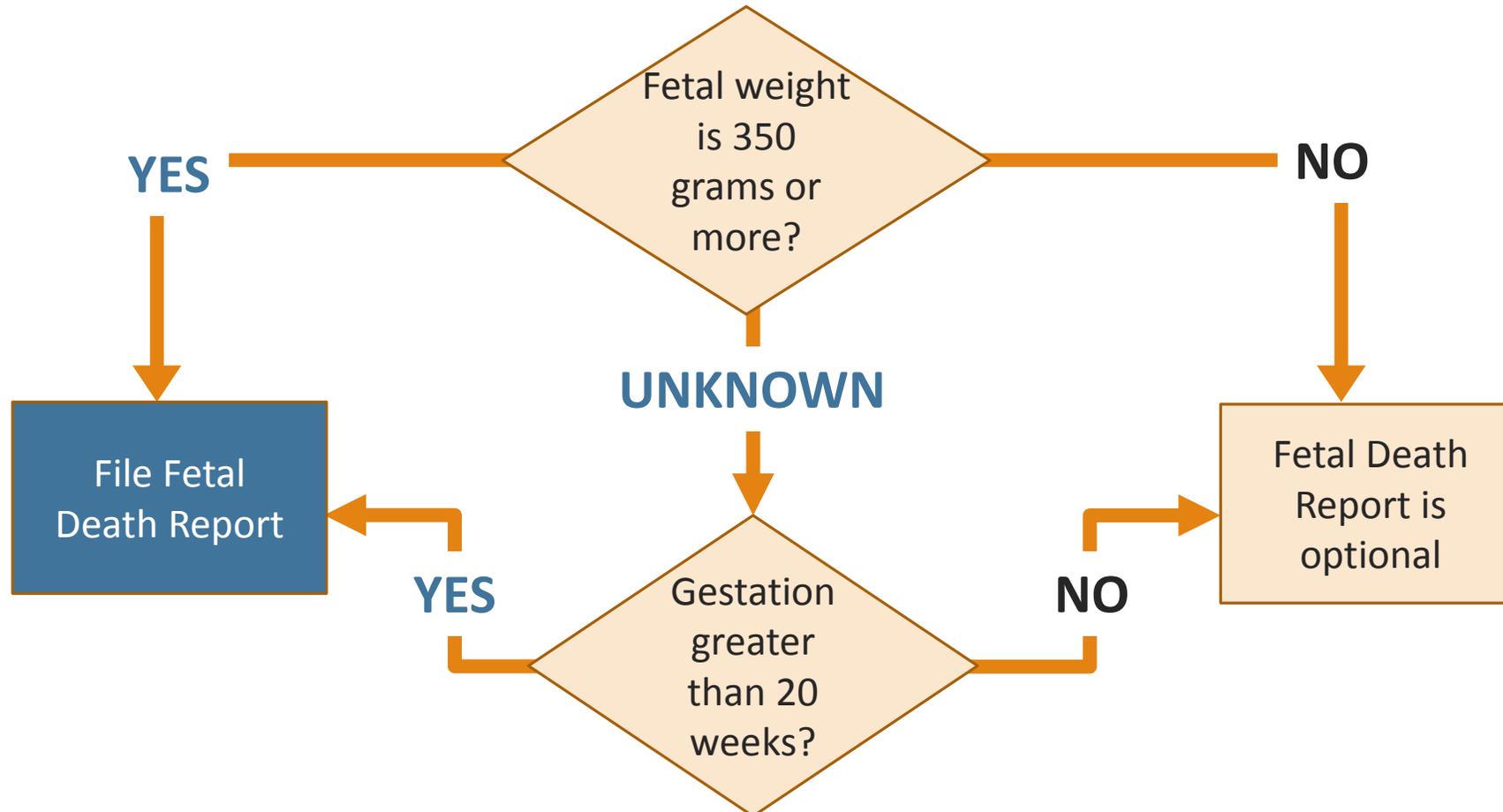
_____ City or Town _____
Street Number, Name, Apt # _____
County _____ State _____ Country _____ Zip Code + 4 _____

1 04/2017

Reporting Requirements

Who, What, When

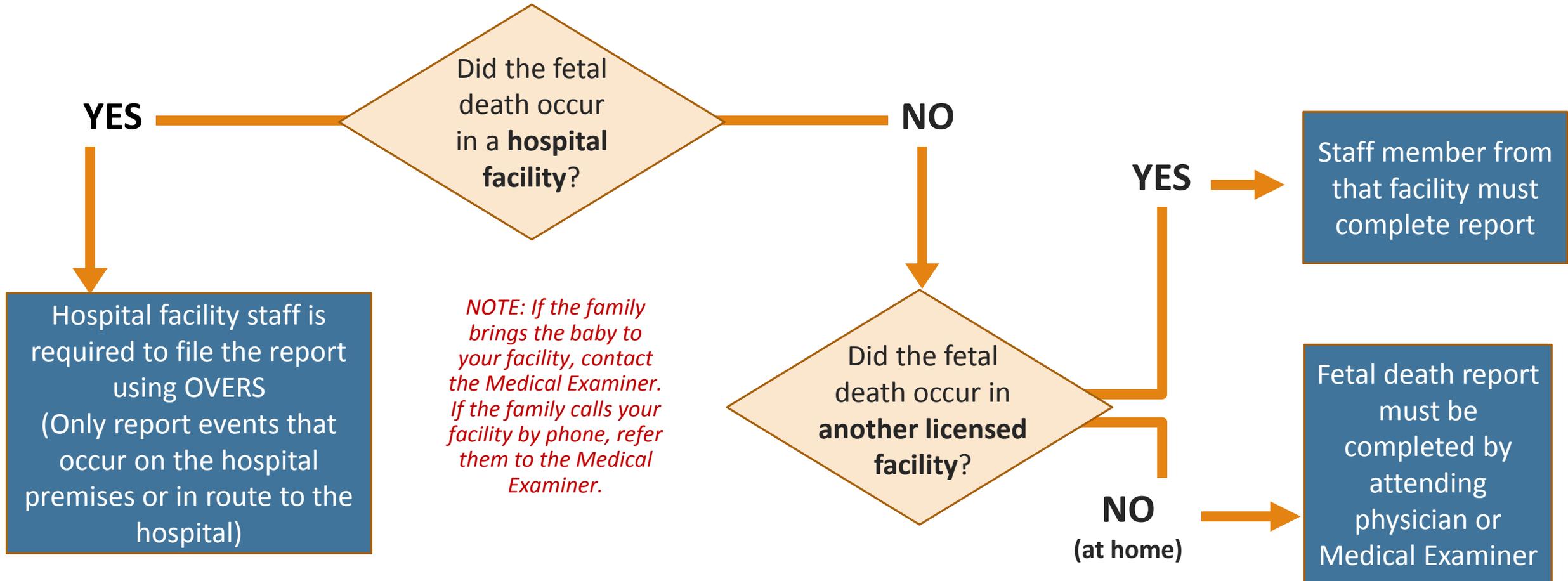
What is mandatory to report?



When is a fetal death report required to be filed?

Mandatory reports of fetal deaths must be filed at the Center for Health Statistics within 5 days of the event

Who is responsible for reporting?



Collecting report details

Using the Fetal Death Parent/Facility Worksheets



Parent and Facility Worksheets

- Parent Worksheet: Mother's prenatal care

- Facility Worksheet: Medical and health information

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Do NOT file a fetal death report after delivery, the fetus of you are required to complete. A fetal disposition permit can

FETUS
Fetus Name
First _____ Middle _____ Other Middle _____ Last _____ Suffix _____

METHOD OF DISPOSITION
Facility Coordinating Final Disposition a disposition permit to any person

MOTHER'S HEALTH
Did she get WIC food for herself during pregnancy?
Height _____ Weight (Pre-pregnancy) _____
ft. _____ in. _____ lbs. _____

PREGNANCY FACTORS
Risk Factors
 Diabetes-Pre-pregnancy
 Diabetes-Gestational (Diabetes)
 Hypertension-Pre-pregnancy
 Hypertension-Gestational
 Hypertension-Eclampsia

DELIVERY
Method of Delivery
Fetal Presentation at Delivery
Final Route and Method of Delivery
 Vaginal/Forceps Vaginal/Cesarean, was a Trial of Labor
Mother Transferred for maternal health reasons

FETAL ATTRIBUTES
Weight of Fetus _____ lb/oz _____

CAUSES/CONDITIONS OF FETAL DEATH
Initiating Cause/Conditioning Cause
Maternal Conditions/Disease
Complications of placenta, cord, or membranes
 Rupture of membranes
 Abruptio placentae
 Placental insufficiency
Other obstetrical or pregnancy related conditions

Fetal Anomaly (specify) _____
Fetal Injury (specify) _____
Fetal Infection (specify) _____
Other fetal conditions/disorders
 Unknown

Estimated time of fetal death _____

Autopsy performed Yes No
Autopsy or Histological Place _____
Attendant at delivery _____

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FETAL DEATH REPORT PARENT WORKSHEET (Page 1 of 2)

Please print neatly

FETUS
Fetus Name
First _____ Middle _____ Other Middle _____ Last _____ Suffix _____

METHOD OF DISPOSITION – Parents' selection
Disposition method: Burial Cremation Hospital disposition Donation Removal from state
 Other _____
Facility Coordinating Final Disposition
 Hospital to release fetus to funeral home Name of Funeral facility: _____
 Hospital to release fetus to parents (must provide parents with a disposition permit for transporting remains)

MOTHER
Mother's Current Legal Name
First _____ Middle _____ Last _____ Suffix _____
Mother's Legal Name prior to first marriage/as it appears on your birth certificate Check if same as current Legal Name
First _____ Middle _____ Last _____ Suffix _____
Mother's Date of Birth _____ Birthplace _____ State or Canadian Province _____ COUNTRY _____
MM / DD / YYYY

MOTHER'S ADDRESS
Mother's Resident Address No. & Street _____ City _____ County _____ State _____ ZIP _____ Inside City Limits? Yes No

MOTHER'S ATTRIBUTES
Education: What is the highest level of education you have completed?
 8th grade or less Some college credit but no degree Master's degree
 9th – 12th grade; no diploma Associate's degree Doctorate or Professional degree
 High school diploma or GED Bachelor's degree

Hispanic Origin (Check all that apply. Do not leave blank.)
 No, not Spanish/Hispanic/Latina Yes, Puerto Rican Yes, other Hispanic Origin (specify): _____
 Yes, Mexican, Mexican-American, Chicana Yes, Cuban Unknown

Race: Which one or more of the following is your race? (Check all that apply. Do not leave blank.)
 White Filipino Guamanian or Chamorro
 Black or African American Japanese Samoan
 American Indian or Alaska Native Korean Other Pacific Islander (specify) _____
 Vietnamese Other Asian (specify) _____
 Asian Indian (specify) _____ Unknown
 Chinese Native Hawaiian

MOTHER'S HEALTH
Did you get WIC food for yourself during pregnancy?
 Yes No
Cigarettes Smoked Per Day Check if none
3 months before pregnancy # _____ Cigarettes
1st 3 months of pregnancy # _____ Cigarettes
2nd 3 months of pregnancy # _____ Cigarettes
3rd 3 months of pregnancy # _____ Cigarettes
Height ft. _____ in. _____ Weight (Pre-pregnancy) lbs. _____

Did you go into labor planning to deliver at home or at freestanding birthing center (excludes hospital birthing center)?
 Yes No
If yes, the planned primary attendant type at onset of labor was:
 Traditional Midwife Certified Nurse Midwife
 Naturopathic Doctor Medical Doctor
 Licensed Direct Entry Midwife

LEGAL RELATIONSHIP OF PARENTS
Did you have a legal spouse or Oregon Registered Domestic (same sex) Partner at conception, at delivery, or within 300 days prior to delivery? Yes NO
If so, were you married? Yes NO
If not married, were you in an Oregon Registered Domestic (same sex) Partnership? Yes NO
Will father/second parent information be provided? Yes NO

Last revised May 2017

Website for forms

- Birth Parent & Facility Worksheets

<http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Pages/InstructionsBirth.aspx>

- Fetal Death Parent & Facility Worksheets

<http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Pages/InstructionsFetalDeath.aspx>

Transporting Fetal Remains

Disposition Permits



What is needed?

- Before the fetal remains can be removed for disposition from the facility where the delivery occurred, the facility must complete a disposition permit and give it to the funeral director or parents when they take the remains.
- The disposition permit gives permission to transport remains to the location of burial or cremation.
- The permit requires ID Tag Number and some burial or cremation details.

Choosing the right disposition permit

Authorization for Fetal Disposition 45-3D

- Used for a fetal death
- Hospital can dispose of fetal remains
- Disposition permit can be completed by birth information specialist

Authorization for Disposition 45-9

- Used when delivery was a live birth with a subsequent death
- Baby always leaves the hospital
- Authorization for Disposition must have doctor approval

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I.D. Tag Number **REPORT OF FETAL DEATH** State File Number

1. Name of Fetus — Optional (First, Middle, Last, Suffix)		2. Time of Delivery	3. Sex	4. Date of Delivery
5a. Place of Delivery		5b. City, Town, or Location	5c. Zip Code	5d. County of Delivery
6a. Current Legal Name (First, Middle, Last, Suffix)			6b. Date of Birth	
6c. Name Prior to First Marriage (First, Middle, Last, Suffix)			6d. Birthplace	
6e. Residence — State		6f. County	6g. City, Town	
6h. Street and Number			6i. Zip Code	6j. Inside City Limits
7a. Current Legal Name (First, Middle, Last, Suffix)		7b. Date of Birth	7c. Birthplace	
8a. Date Report Completed	8b. Name and Title of Person Completing Report			
9. Name and Title of Attendant				
10. If Services: Funeral Home Name and Address				
11a. Date Filed by Registrar		11b. Registrar — Signature		
12. Amendment				

Mother

Father

45-3D (03/08)

Was fetal death report filed by hospital? No Yes

If this fetus is going to be removed from the facility where delivery occurred, this permit must accompany the remains to the funeral home and/or the cemetery/crematorium. A burial/cremation tag is also required if the fetus is removed from the facility of delivery.

This form, when signed by the funeral service licensee or person acting as such, shall serve as a disposal-transit permit for these fetal remains.

INSTRUCTIONS: THE PERSON IN CHARGE OF THE PLACE OF FINAL DISPOSITION SHALL DATE AND SIGN BOTH COPIES OF THIS FINAL DISPOSITION AUTHORIZATION. FORWARD THE FIRST COPY TO THE REGISTRAR OF THE COUNTY WHERE THE DEATH OCCURRED WITHIN 10 DAYS OF FINAL DISPOSITION. THE SECOND COPY WILL BE RETAINED BY THE CEMETERY OR CREMATORY.

DATE OF DISPOSITION: _____

SEXTON'S SIGNATURE: _____

PLACE OF DISPOSITION: _____

Authorization for Fetal Disposition (45-3D)

Live Birth vs. Fetal Death Reporting Summary

	Live Birth with subsequent death	Fetal Death
Records required	<ol style="list-style-type: none">1) Certificate of Live Birth in every case, regardless of birth weight, gestation, or length of life2) Death record in every case	<ol style="list-style-type: none">1) Report of Fetal Death only if delivery weight is 350 grams or more, or if weight is unknown 20 weeks gestation2) Optional Commemorative Certificate if family wants one; a fetal death report is required.
Disposition	<ol style="list-style-type: none">1) Authorization for Disposition must have a doctor's approval2) Baby always leaves the hospital	<ol style="list-style-type: none">1) Authorization for Fetal Disposition completed by birth information specialist2) Disposal of fetal remains by hospital possible

Questions?

Contact Information of Presenters

JoAnn Jackson,
State Registration Manager
JoAnn.Jackson@state.or.us
971-673-1160

Krystalyn Salyer,
OVERS Training Coordinator
Krystalyn.Salyer@state.or.us
971-673-1197



Thank you!