Oregon Health Authority
Center for Health Statistics

Please print neatly

FETAL DEATH REPORT

FACILITY WORKSHEET

Only use this form to report a Fetal Death

*Do **NOT** file a fetal death report if the delivery resulted in a live birth, regardless of duration. A fetal death is indicated by the fact that after delivery, the fetus does not breathe or show any other evidence of life. If after delivery the fetus showed any evidence of life, you are required to complete **BOTH** a certificate of live birth and death. A fetal disposition permit can only be used for a fetal death. A planned induced termination of pregnancy is **NOT** a fetal death.*

FETUS

Fetus Name First	Middle	Last	Suffix	Date of Delivery MM / DD / YYYY	Time of Delivery AM ☐ PM ☐ Military ☐	Sex ☐ Male ☐ Female ☐ Undetermined
				/ /		

METHOD OF DISPOSITION (Select one)

Facility releasing fetus for Final Disposition; hospital must provide a disposition permit to any party transporting remains:

☐ Hospital released fetus to parents ☐ Hospital released fetus to funeral home (name) _____

MOTHER'S HEALTH

Did she get WIC food for herself during pregnancy? ☐ Yes ☐ No

Height ft.____in.____

Weight (Pre-pregnancy) lbs. _____

Cigarettes Smoked 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

PRENATAL

Date of Last Menses ____/____/____ MM DD YYYY

Previous Live Births Date of last live birth ____/____ (Does not include this fetus) MM YYYY

now living _____ # now deceased_____

No Prenatal Care ☐ ***OR*** Date of 1st visit ____/____/____ MM DD 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

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)
☐ Ruptured uterus
☐ Admission to intensive care unit
☐ None of the above

Mother Transferred for maternal or fetal indication prior to delivery ☐ Yes ☐ No If yes, name of facility_____

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.)_____

CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH

Initiating Cause/Conditioning (enter one condition or cause only)

Maternal Conditions/Disease (specify)_____

Complications of placenta, cord or membranes:

☐ Rupture of membranes ☐ Prolapsed cord
☐ Abruptio placenta ☐ Chorioamnionitis
☐ Placental insufficiency ☐ Other

Other obstetrical or pregnancy complications(specify) _____

Fetal Anomaly (specify) _____

Fetal Injury(specify) _____

Fetal Infection (specify) _____

Other fetal conditions/disorders (specify) _____

☐ Unknown

Other Significant Cause/Condition (enter other conditions or causes)

Maternal Conditions/Disease (specify)_____

Complications of placenta, cord or membranes:

☐ Rupture of membranes ☐ Prolapsed cord
☐ Abruptio placenta ☐ Chorioamnionitis
☐ Placental insufficiency ☐ Other

Other obstetrical or pregnancy complications(specify)_____

Fetal Anomaly(specify) _____

Fetal Injury(specify) _____

Fetal Infection (specify) _____

Other fetal conditions/disorders (specify)_____

☐ Unknown

Estimated time of fetal death ☐ Dead at first assessment, no labor ongoing ☐ Dead at first assessment, labor ongoing ☐ Died during labor, after first assessment ☐ Unknown time of fetal death

Autopsy performed ☐ Yes ☐ No ☐ Planned Histological Placental Examination Performed ☐ Yes ☐ No ☐ Planned

Autopsy or Histological Placental Examination used in Determining Cause of Fetal Death ☐ Yes ☐ No ☐ Not applicable

Attendant at delivery First Middle Last Title

Facility to obtain ID tag number from funeral home where remains released to: **ID TAG NUMBER**_____

Last revised December 2018