

FETAL DEATH REPORT

PARENT WORKSHEET

We recognize that this is a difficult time for you and your family. This sheet provides important information about reporting requirements and services available to you. Please complete the parent worksheet and return it to the hospital staff before you leave the hospital. **Please answer every question to the best of your knowledge.**

Requirements to report

Oregon law requires that every fetal death be reported to the Center for Health Statistics (Oregon's vital records office) if the delivery weight is 350 grams or more. If the delivery weight is not known, the hospital will report the fetal death if gestation was 20 weeks or longer. Since there are fewer than 300 fetal deaths reported each year, information from every mother is important. Each report helps us understand why fetal deaths occur and what services or programs may help prevent fetal deaths in the future.

Commemorative Certificate of Stillbirth

While the fetal death report is available to order by the parents that are listed on the report, some parents prefer the Commemorative Certificate of Stillbirth. Both documents are available only if the hospital files a fetal death report. **If you think you might want a certificate at any time in the future, you can ask the hospital to file the report even if the delivery weight is under 350 grams.**

Completing the report

Most of the information you report will not appear on the fetal death vital record or the commemorative certificate. Your information is used in combination with other fetal death reports to tell us what problems women are having during pregnancy and which health services were used. We ask about education, race, ethnicity, and place of birth of the parents because this information helps identify health disparities and determine what services are needed.

Personal and medical information gathered through fetal death reports is highly confidential. The fetal death vital record can be ordered by immediate family and their representatives only. Public health researchers might receive a data file rather than individual reports. These researchers have strict requirements for confidentiality and cannot release the information to any other person or group.

This is very important information and each question has a purpose. Please answer every question to the best of your knowledge.

Thank you for your help.

FETAL DEATH REPORT PARENT WORKSHEET

Please print neatly

FETUS					(Page 1 of 2)
Fetus Name					
<small>First</small>	<small>Middle</small>	<small>Other Middle</small>	<small>Last</small>	<small>Suffix</small>	
METHOD OF DISPOSITION – Parents' selection					
Disposition method: <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"/> Hospital to release fetus to funeral home Name of Funeral facility: _____					
<input type="checkbox"/> Hospital to release fetus to parents					
If the facility is releasing the fetus for Final Disposition, facility must provide a disposition permit for transporting remains.					
MOTHER (PERSON WHO DELIVERED)					
Mother's Current Legal Name					
<small>First</small>	<small>Middle</small>	<small>Last</small>			<small>Suffix</small>
Mother's Legal Name prior to first marriage/as it appears on your birth certificate <input type="checkbox"/> Check if same as current Legal Name					
<small>First</small>	<small>Middle</small>	<small>Last</small>			<small>Suffix</small>
Mother's Date of Birth		Birthplace		State or Canadian Province COUNTRY	
____ / ____ / ____ <small>MM DD YYYY</small>					
MOTHER'S ADDRESS					
Mother's Resident Address No. & Street City County State ZIP					Inside City Limits?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
MOTHER'S ATTRIBUTES					
Education: What is the highest level of education you have completed?					
<input type="checkbox"/> 8 th grade or less		<input type="checkbox"/> Some college credit but no degree		<input type="checkbox"/> Master's degree	
<input type="checkbox"/> 9 th – 12 th grade; no diploma		<input type="checkbox"/> Associate's degree		<input type="checkbox"/> Doctorate or Professional degree	
<input type="checkbox"/> High school diploma or GED		<input type="checkbox"/> Bachelor's degree			
Hispanic Origin (Check all that apply. Do not leave blank.)					
<input type="checkbox"/> No, not Spanish/Hispanic/Latina		<input type="checkbox"/> Yes, Puerto Rican		<input type="checkbox"/> Yes, other Hispanic Origin (specify): _____	
<input type="checkbox"/> Yes, Mexican, Mexican-American, Chicana		<input type="checkbox"/> Yes, Cuban		<input type="checkbox"/> Unknown	
Race: Which one or more of the following is your race? (Check all that apply. Do not leave blank.)					
<input type="checkbox"/> White		<input type="checkbox"/> Filipino		<input type="checkbox"/> Guamanian or Chamorro	
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Japanese		<input type="checkbox"/> Samoan	
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Korean		<input type="checkbox"/> Other Pacific Islander	
(specify tribe(s)) _____		<input type="checkbox"/> Vietnamese		(specify) _____	
<input type="checkbox"/> Asian Indian		<input type="checkbox"/> Other Asian		<input type="checkbox"/> Other (specify) _____	
<input type="checkbox"/> Chinese		<input type="checkbox"/> Native Hawaiian			
MOTHER'S HEALTH					
Did you get WIC food for yourself during pregnancy?			Cigarettes Smoked Per Day <input type="checkbox"/> Check if none		
<input type="checkbox"/> Yes <input type="checkbox"/> No			3 months <u>before</u> pregnancy # _____ Cigarettes		
Height ft. ____ in. ____ Weight (Pre-pregnancy) lbs. _____			1 st 3 months of pregnancy # _____ Cigarettes		
			2 nd 3 months of pregnancy # _____ Cigarettes		
			3 rd 3 months of pregnancy # _____ Cigarettes		
Did you go into labor planning to deliver at home or at freestanding birthing center (excludes hospital birthing center)?					
<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, the planned primary attendant type at onset to labor was:		<input type="checkbox"/> Traditional Midwife		<input type="checkbox"/> Certified Nurse Midwife	
		<input type="checkbox"/> Naturopathic Doctor		<input type="checkbox"/> Medical Doctor	
		<input type="checkbox"/> Licensed Direct Entry Midwife			

LEGAL RELATIONSHIP OF PARENTS**(Page 2 of 2)**

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**

FATHER/SECOND PARENT

Father/Second Parent's Name

First

Middle

Last

Suffix

Date of Birth

Birthplace

State or Canadian Province

COUNTRY

____/____/____
MM DD YYYY

FATHER/SECOND PARENT'S ATTRIBUTES

Education: What is the highest level of education you have completed?

☐ 8th grade or less☐ Associate's degree☐ 9th – 12th grade; no diploma☐ Bachelor's degree☐ High school diploma or GED☐ Master's degree☐ Some college credit but no degree☐ Doctorate or Professional degree

Hispanic Origin (Check all that apply. Do not leave blank.)

☐ No, not Spanish/Hispanic/Latino☐ Yes, Puerto Rican☐ Yes, other Hispanic Origin☐ Yes, Mexican, Mexican-American,
Chicano☐ Yes, Cuban

(specify) _____

☐ Unknown

Race: Which one or more of the following is your race? (Check all that apply. Do not leave blank.)

☐ White☐ Filipino☐ Native Hawaiian☐ Black or African American☐ Japanese☐ Guamanian or Chamorro☐ American Indian or Alaska Native☐ Korean☐ Samoan

(specify tribe(s)) _____

☐ Vietnamese☐ Other Pacific Islander☐ Asian Indian☐ Other Asian (specify) _____

(specify) _____

☐ Chinese☐ Other (specify) _____**PRENATAL**

Date of last menses (Date of last period)

____/____/____
MM DD YYYY

Previous live births

now living _____

now deceased _____

Date of last live birth ____/____/____
MM YYYY

I certify that the information provided on this form for the purpose of registering the fetal death is correct to the best of my knowledge.

X _____ Date signed: _____
Informant's signature