Appendix D: Sample forms

TYPE OR PRINT IN **PERMANENT BLACK INK**

I.D. TAG NO.

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS

REPORT OF FETAL DEATH

136-

Local File Number | State File Number

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

CITY, TOWN OR LOCATION OF DELIVERY 1b.

COUNTY OF DELIVERY 1c.

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

HOUR 2b.

SEX OF FETUS 3.

MOTHER

MOTHER - NAME First Middle Last 4a.

MAIDEN SURNAME 4b.

DATE OF BIRTH 5.

RESIDENCE - STATE 6a.

COUNTY 6b.

CITY, TOWN, OR LOCATION 6c.

STREET AND NUMBER 6d.

INSIDE CITY LIMITS? 6e. ☐ Yes ☐ No

ZIP CODE 6f.

FATHER

FATHER -- NAME First Middle Last 7.

DATE OF BIRTH 8.

CAUSE OF FETAL DEATH

PART I Fetal or maternal condition directly causing fetal death. Fetal and/or maternal conditions, if any, giving rise to the immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE *(Enter only one cause per line for (a), (b), and (c).)* (a) — Specify Fetal or Maternal

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

DUE TO, OR AS A CONSEQUENCE OF: (c) — 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.

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

AUTOPSY 11. ☐ Yes ☐ No

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

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

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

OPTIONAL
Fetus - Name

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

	15. **OF HISPANIC ORIGIN?** *(Specify No or Yes)* If yes, specify origin(s) - *Cuban, Mexican, Puerto Rican, etc.)*	16. **RACE-** Specify all that apply below *(White, Black, American Indian, Asian Indian, Alaskan Native, Chinese, Filipino, Japanese, Korean, Vietnamese, Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander, Other Asian, Other - specify if tribe or Other reported.)*	17. **EDUCATION** (Specify only highest grade completed.) Elementary or Secondary (0-12) College (1-4 or 5+)
MOTHER	15a. ☐ Yes ☐ No Specify	16a.	17a.
FATHER	15b. ☐ Yes ☐ No Specify	16b.	17b.

18. **PREGNANCY HISTORY**	**LIVE BIRTHS** Now living Number_____ ☐ None	Now dead Number_____ ☐ None	**DATE OF LAST LIVE BIRTH** (Month/Year)	**OTHER TERMINATIONS** *(Spontaneous and induced)* 18a. Number_____ ☐ None	18b. **DATE OF LAST OTHER TERMINATION** *(Month/Year)*

19. **CLINICAL ESTIMATE OF GESTATION** *(Weeks)*	20. **WEIGHT OF FETUS** *(Specify units)*	21. **MOTHER MARRIED?** *(At birth, conception, or any time between)* ☐ Yes ☐ No	22. **DATE LAST NORMAL MENSES BEGAN** *(Month, Day, Year)*

23a. **PLURALITY** - Single, twin, triplet, etc. *(Specify)*	23b. **IF NOT SINGLE BIRTH** - Born first, second,third, etc. *(Specify)*	24. **MONTH OF PREGNANCY THAT PRENATAL CARE BEGAN** *(Specify first, second, etc.)*	25. **PRENATAL VISITS** Total number *(If none, so state)*

26. MEDICAL 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)*_____

27. 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)*_____

28. OTHER FACTORS FOR THIS PREGNANCY *(Complete all items)*

01. Tobacco use during pregnancy ☐ Yes ☐ No
02. Average number cigarettes per day _____
03. Alcohol use during pregnancy ☐ Yes ☐ No
04. Average number drinks per week _____
05. Weight gained during pregnancy _____ lbs.
06. History available ☐ Yes ☐ No
07. Other *(Specify)*_____

29. ANTENATAL PROCEDURES *(Check all that apply)*

01 ☐ Amniocentesis
02 ☐ Tocolysis
03 ☐ Ultrasound
04 ☐ No History available
00 ☐ None
05 ☐ Other *(Specify)*_____

30. INTRAPARTUM PROCEDURES *(Check all that apply)*

01 ☐ Electronic fetal monitoring
02 ☐ Induction of labor
03 ☐ Stimulation of labor
00 ☐ None
04 ☐ Other *(Specify)*_____

31. 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

32. 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 (06/03)

TYPE OR PRINT IN PERMANENT BLACK INK.

I.D. TAG NO.

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS

CERTIFICATE OF DEATH

136-

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY

1. Legal Name (Include AKAs, if any) First Middle Last Suffix | **2.** Death Date (MON DD YYYY)

3. Sex (M/F) | **4a.** Age – Last Birthday | **4b.** Under 1 Year Months Days | **4c.** Under 1 Day Hours Minutes | **5.** Social Security Number | **6.** County of Death

7. Birthdate (MON DD YYYY) | **8a.** Birthplace (City/Town, or County) | **8b.** (State or Foreign Country) | **9.** Decedent's Education

10. Was Decedent of Hispanic Origin? (Yes or No. If yes, specify.) | **11.** Decedent's Race(s) | **12.** Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☐ No

13. Residence: Number and Street (e.g., 624 SE 5th Street, Apt. No. 8) | **14.** City/Town

15. Residence County | **16.** State or Foreign Country | **17.** Zip Code + 4 | **18.** Inside City Limits? ☐ Yes ☐ No ☐ Unknown

19. Marital Status at Time of Death | **20.** Spouse's Name (If married or widowed, give name prior to first marriage.)

21. Usual Occupation (Indicate type of work done during most of working life. DO NOT USE "RETIRED.") | **22.** Kind of Business/Industry (DO NOT USE COMPANY NAME.)

23. Father's Name (First, Middle, Last, Suffix) | **24.** Mother's Name Prior to First Marriage (First, Middle, Last)

25. Informant's Name | **26.** Telephone Number | **27.** Relation to Decedent | **28.** Mailing Address (Number & Street, City/Town, State, Zip + 4)

29. Place of Death | **30.** Facility Name

31. Location of Death (Give address.) | **32.** City/Town or Location of Death | **33.** State | **34.** Zip Code + 4

35. Method of Disposition | **36.** Place of Disposition (Name of cemetery, crematory, or other place) | **37.** Location

38. Name and Complete Address of Funeral Facility (Number & Street, City/Town, State, Zip + 4)

39. Date of Disposition (MON DD YYYY) | **40. Funeral Director's Signature** ▶ | **41.** OR License Number

42. Registrar's Signature ▶ | **43. Date Received** (MON DD YYYY) | **44.** Local File Number

45. Record Amendment

TO BE COMPLETED BY MEDICAL CERTIFIER

46. Was case referred to Medical Examiner? ☐ Yes ☐ No | **47.** Autopsy? ☐ Yes ☐ No | **48.** Were autopsy findings available to complete the cause of death? ☐ Yes ☐ No | **49.** Time of Death

CAUSE OF DEATH (See instructions and examples.)

50. Enter the chain of events - diseases, injuries, or complications - that directly caused the death. DO NOT ENTER TERMINAL EVENTS such as cardiac arrest, respiratory arrest or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Approximate Interval: Onset to Death
Final disease or condition resulting in death→ Sequentially list conditions, if any, leading to the cause listed on line a. ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).	**IMMEDIATE CAUSE** ↓ a.	
	Due to (or as a consequence of) ↓ b.	
	Due to (or as a consequence of) ↓ c.	
	Due to (or as a consequence of) ↓ d.	

51. Other significant conditions contributing to death, but not resulting in the underlying cause given above:

52. Manner of Death ☐ Natural ☐ Homicide ☐ Accident ☐ Undetermined ☐ Suicide ☐ Pending | **53.** If Female ☐ Not pregnant within past year ☐ Not pregnant, but pregnant 43 days to 1 year before death ☐ Pregnant at time of death ☐ Unknown if pregnant within the past year ☐ Not pregnant, but pregnant within 42 days before death | **54.** Did tobacco use contribute to death? ☐ Yes ☐ Probably ☐ No ☐ Unknown

55. Date of Injury (MON DD YYYY) | **56.** Time of Injury | **57.** Place of Injury (e.g., Decedent's home, construction site, restaurant, wooded area) | **58.** Injury at Work? ☐ Yes ☐ No ☐ Unknown

59. Location of Injury (Number & Street, City/Town, State, Zip + 4)

60. Describe how injury occurred. | **61.** If transportation injury, specify. ☐ Driver/Operator ☐ Passenger ☐ Pedestrian ☐ Other (Specify) _____

62. Name and Address of Certifier (Number & Street, City/Town, State, Zip + 4)

63. Name and Title of Attending Physician if Other than Certifier

64. Title of Certifier | **65.** License Number | **66.** Date Signed (MON DD YYYY)

67. Medical Certifier – To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated. ▶

68. Medical Examiner – On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated. ▶

69. Record Amendment

ORIGINAL - VITAL RECORDS COPY

45-2 (06/06)