

Appendix D: Sample forms

OREGON HEALTH AUTHORITY CENTER FOR HEALTH STATISTICS

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Type or print in
permanent black ink.
See handbook for
instructions.

I.D. Tag Number		REPORT OF FETAL DEATH		State File Number	
1. NAME OF FETUS — Optional (First, Middle, Last, Suffix)		2. TIME OF DELIVERY (24 hr)	3. SEX	4. DATE OF DELIVERY (Month, Day, Year)	
5a. FACILITY — NAME (If not an institution, give street and number)		5b. CITY, TOWN, OR LOCATION OF DELIVERY	5c. ZIP CODE	5d. COUNTY OF DELIVERY	
6a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			6b. DATE OF BIRTH (Month, Day, Year)		
6c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)			6d. BIRTHPLACE (State, Territory, or Foreign Country)		
6e. RESIDENCE OF MOTHER — STATE		6f. COUNTY	6g. CITY, TOWN, OR LOCATION		
6h. STREET AND NUMBER			6i. ZIP CODE	6j. INSIDE CITY <input type="checkbox"/> No <input type="checkbox"/> Yes	
7a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		7b. DATE OF BIRTH (Month, Day, Year)	7c. BIRTHPLACE (State, Territory, or Foreign Country)		
8a. DATE REPORT COMPLETED (Month, Day, Year)		8b. NAME AND TITLE OF PERSON COMPLETING REPORT (Type or print)			
9. NAME AND TITLE OF ATTENDANT (Type or print)					
10. IF SERVICES: FUNERAL HOME NAME AND ADDRESS					
11a. DATE FILED BY REGISTRAR			11b. REGISTRAR — SIGNATURE		

<p>12a. INITIATING CAUSE/CONDITION (AMONG THE CHOICES BELOW, PLEASE SELECT THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS.)</p> <p>Maternal Conditions/Diseases (Specify): _____</p> <p>Complications of Placenta, Cord, or Membranes</p> <p><input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Protruded cord <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify): _____</p> <p>Other Obstetrical or Pregnancy Complications (Specify): _____</p> <p>Fetal Anomaly (Specify): _____</p> <p>Fetal Injury (Specify): _____</p> <p>Fetal Infection (Specify): _____</p> <p>Other Fetal Conditions/Disorders (Specify): _____</p> <p><input type="checkbox"/> Unknown</p>	<p>12b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH)</p> <p>Maternal Conditions/Diseases (Specify): _____</p> <p>Complications of Placenta, Cord, or Membranes</p> <p><input type="checkbox"/> Rupture of membranes prior to onset of labor <input type="checkbox"/> Abruptio placenta <input type="checkbox"/> Placental insufficiency <input type="checkbox"/> Protruded cord <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Other (Specify): _____</p> <p>Other Obstetrical or Pregnancy Complications (Specify): _____</p> <p>Fetal Anomaly (Specify): _____</p> <p>Fetal Injury (Specify): _____</p> <p>Fetal Infection (Specify): _____</p> <p>Other Fetal Conditions/Disorders (Specify): _____</p> <p><input type="checkbox"/> Unknown</p>
<p>13a. ESTIMATED TIME OF FETAL DEATH</p> <p><input type="checkbox"/> Dead at time of first assessment, no labor ongoing <input type="checkbox"/> Dead at time of first assessment, labor ongoing <input type="checkbox"/> Died during labor, after first assessment <input type="checkbox"/> Unknown time of fetal death</p>	<p>13b. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned</p> <p>13c. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned</p> <p>13d. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
14. AMENDMENT	

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

MOTHER

FATHER

MOTHER

14. MOTHER MARRIED (at delivery, conception, or any time between?) <input type="checkbox"/> Yes <input type="checkbox"/> No		15. FACILITY'S NPI		16. MOTHER'S MEDICAL RECORD NUMBER	
17. OF HISPANIC ORIGIN? (Check "Yes" or "No") (If "yes," specify all that apply; e.g., Cuban, Mexican, Puerto Rican, etc.)		18. RACE (e.g., White, Black, American Indian, etc.) (Specify all that apply below.)		19. EDUCATION (Highest grade completed)	
17a. <input type="checkbox"/> Yes <input type="checkbox"/> No Specify		18a.		19a.	
17b. <input type="checkbox"/> Yes <input type="checkbox"/> No Specify		18b.		19b.	
20a. DATE OF FIRST PRENATAL CARE VISIT? (Month, Day, Year) <input type="checkbox"/> No Prenatal Care		20b. DATE OF LAST PRENATAL CARE VISIT? (Month, Day, Year)		20c. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY? (If none, enter "0")	
21. MOTHER'S HEIGHT? (feet/inches)		22. MOTHER'S PRE-PREGNANCY WEIGHT? (pounds)		23. MOTHER'S WEIGHT AT DELIVERY? (pounds)	
24. DID MOTHER GET WIC FOOD FOR HERSELF? <input type="checkbox"/> Yes <input type="checkbox"/> NO		25. NUMBER OF LIVE BIRTHS (Do not include this fetus.)		26. NUMBER OF OTHER PREGNANCY OUTCOMES (Spontaneous or induced losses or ectopic pregnancies)	
25a. Number Now Living: _____ <input type="checkbox"/> None		25b. Number Now Dead: _____ <input type="checkbox"/> None		27. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day: # of cigarettes # of packs Three months before Pregnancy _____ OR _____ First Trimester of Pregnancy _____ OR _____ Second Trimester of Pregnancy _____ OR _____ Third Trimester of Pregnancy _____ OR _____	
28a. DATE OF LAST LIVE BIRTH (Month, Year)		28b. DATE OF LAST OTHER PREGNANCY OUTCOME (Month, Year)		28c. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)	
29. PLACE WHERE THIS DELIVERY OCCURRED (Check one.) <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home Birth Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clinic / Doctor's Office <input type="checkbox"/> Other (Specify) _____		30. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, ENTER NAME OF FACILITY FROM WHICH MOTHER WAS TRANSFERRED: _____		31. ATTENDANT'S NPI	
32. RISK FACTORS IN THIS PREGNANCY (Check all that apply.) <input type="checkbox"/> Diabetes <input type="checkbox"/> Pre-Pregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) <input type="checkbox"/> Hypertension <input type="checkbox"/> Pre-Pregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, pre-eclampsia) <input type="checkbox"/> Eclampsia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) <input type="checkbox"/> Pre-Pregnancy resulted from infertility treatment - If yes, check all that apply: <input type="checkbox"/> Fertility enhancing drugs, artificial insemination or intrauterine insemination. <input type="checkbox"/> Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)) <input type="checkbox"/> Mother had a previous Cesarean delivery If yes, how many? _____ <input type="checkbox"/> Alcohol use during pregnancy If yes, average number of drinks per week? _____ <input type="checkbox"/> None of the above		33. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply.) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Listeria <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Cytomegalovirus <input type="checkbox"/> Parvovirus <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> None of the above <input type="checkbox"/> Other (Specify): _____		34. METHOD OF DELIVERY A Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other B Fetal route and method of delivery (Check all that apply.) <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 C Was delivery with forceps attempted, but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No D Was delivery with vacuum extraction attempted, but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No	
35. MATERNAL MORBIDITY (Check all that apply.) (Complications associated with labor and delivery) <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		36. METHOD OF DISPOSITION: <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"/> Other (Specify) _____		37. WEIGHT OF FETUS (grams preferred; specify unit) _____ <input type="checkbox"/> grams <input type="checkbox"/> lb/oz	
38. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY _____ (completed weeks)		39. PLURALITY - Single, Twins, Triplets, etc. (Specify) _____		40. IF NOT SINGLE BIRTHS - Delivered First, Second, Third, etc. (Specify) _____	
41. CONGENITAL ANOMALIES OF THE FETUS (Check all that apply.) <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 (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone		42. Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the anomalies listed above		STATE USE ONLY a. _____ b. _____ c. _____ d. _____	