APPENDIX D: SAMPLE FORMS

Appendix D: Sample forms

Oregon Report of Fetal Death – 2017 Data Fields

Filed electronically with the Oregon Vital Events Registration System
(Multiple choice options listed in italics)

Fetus

Fetus Name: First, Middle, Other Middle, Last, Suffix

Date of Delivery

Time of Delivery

Sex *(Male, Female, Undetermined)*

Method of disposition *(Burial, Cremation, Hospital Disposition, Removal From State)*

Funeral Home: Facility Name; Street Number; Pre Directional; Street Name or PO Box, Rural Route, etc.; Street Designator; Post Directional; Apartment Number; City or Town; State; Country; Zip Code

ID Tag Number

Mother

Mother's Current Legal Name: First, Middle, Last, Suffix

Mother's Name Prior to First Marriage: First, Middle, Last, Suffix

Date of Birth

Age

Mother Birthplace: Birthplace State, Birthplace Country

Mother Address

Residence Address: Street Number; Pre Directional; Street Name, Rural Route, etc.; Street Designator; Post Directional; Apt #, Suite #, etc.; City or Town; County; State; Country; Zip Code

Inside City Limits *(Yes, No, Unknown)*

Mother Attributes

Education *(8th grade or less, 9th-12th grade (no diploma), High school graduate/GED, Some college (no degree), Associate degree, Bachelor's degree, Master's degree, Doctorate or professional degree, Unknown)*

Hispanic Origin (Check all that apply): No, not Hispanic; Yes, Mexican; Yes, Puerto Rican; Yes, Cuban; Yes, Other Hispanic Origin (specify); Unknown

Which one or more of the following is your race? (Check all that apply): White, Black or African American, American Indian or Alaska Native (specify tribe), Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian (specify), Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander (specify), Other (Specify)

Mother Health

Did Mother get WIC food for herself during this pregnancy? *(Yes, No, Unknown)*

Height (feet/inches)

Mother Pre-pregnancy Weight (pounds)

Mother Weight at Delivery (pounds)

Cigarette smoking per day before and/or during pregnancy: Three months before pregnancy, First three months of pregnancy, Second three months of pregnancy, Last Trimester of Pregnancy

Did mother go into labor intending to deliver at home or freestanding birthing center? *(No, Unknown, Yes)*

What was the primary attendant type at onset of labor?

Marital Status

Was Mother Married at Conception, at Delivery or within 300 days of Delivery? *(No, Oregon Registered Domestic Partnership, Unknown, Yes)*

Will Father information be collected on this Report? *(Yes, No)*

Father

Father's Name: First, Middle, Last, Suffix

Date of Birth

Age

Father's Birthplace: Birthplace State, Birthplace Country

Father Attributes

Education *(8th grade or less, 9th-12th grade (no diploma), High school graduate/GED, Some college (no degree), Associate degree, Bachelor's degree, Master's degree, Doctorate or professional degree, Unknown)*

Hispanic Origin (Check all that apply): No, not Hispanic; Yes, Mexican; Yes, Puerto Rican; Yes, Cuban; Yes, Other Hispanic Origin (specify); Unknown

Which one or more of the following is your race? (Check all that apply): White, Black or African American, American Indian or Alaska Native (specify tribe), Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Other Asian (specify), Native Hawaiian, Guamanian or Chamorro, Samoan, Other Pacific Islander (specify), Other (Specify)

Place of Delivery

Type of Place of Delivery *(Hospital, Freestanding Birthing Center, Clinic/Doctor's Office, Home Delivery Planned, Home Delivery Unplanned, Home Delivery Unknown if Planned, Other (specify))*

Facility Name

Facility NPI

Address: Street Number; Pre Directional; Street Name, Rural Route, etc.; Street Designator; Post Directional; Apt #, Suite #, etc.; City or Town; County; State; Country; Zip Code

Reporter

Name and Title of Person Completing Report: First, Middle, Last, Suffix

Title *(Birth Certifier, DO, MD, Nurse Practitioner, Other (Specify), Other Licensed Medical (Specify), RN)*

Date Report Completed

Prenatal

Mother Medical Record #

Date of Last Menses

Prenatal Care: No Prenatal Care, Date of First Visit, Total Number of Prenatal Visits

Previous Live Births: Number Now Living, Number Now Dead, Date of Last Live Birth

Other Pregnancy Outcomes (Spontaneous or Induced Terminations or Ectopic Pregnancies): Number of Other Pregnancy Outcomes, Date of Last Other Pregnancy Outcome

Pregnancy Factors

Risk Factors for this Pregnancy (Check all that apply): 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); Pregnancy Resulted From Infertility Treatment-Fertility-enhancing drugs; Pregnancy Resulted From Infertility Treatment-Assisted Reproductive Technology; Mother Had A Previous Cesarean Delivery; None Of The Above

Infections Present and / or Treated During this Pregnancy (Check all that apply): Gonorrhea, Syphilis, Chlamydia, Listeria, Group B streptococcus, Cytomegalovirus, Parvovirus, Toxoplasmosis, None Of The Above, Other (specify)

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): Maternal transfusion, Third or fourth degree perineal laceration, Ruptured uterus, Unplanned hysterectomy, Admission to intensive care unit, Unplanned operating room procedure following delivery, None Of The Above

Mother Transferred for maternal medical or fetal indication prior to delivery *(Yes, No)*

Fetal Attributes

Weight of Fetus: Pounds / Ounces, Grams

Obstetric Estimate of Gestation (weeks)

Plurality *(Single, Twin, Triplet, Quadruplet, Quintuplet, Sextuplet, Septuplet, Conjoined twins, Not Stated)*

Delivery Order *(First, Second, Third, Fourth, Fifth, Sixth, Seventh, Eighth or more, Not Stated)*

Congenital Anomalies (Check all that apply): Anencephaly, Meningomyelocele/spina bifida, Cyanotic congenital heart disease, Congenital diaphragmatic hernia, Omphalocele, Gastroschisis, Limb reduction defect (excluding congenital amputation and dwarfing syndromes), Cleft lip with or without cleft palate, Cleft palate alone, Down Syndrome Karyotype Confirmed, Down Syndrome Karyotype Pending, Suspected chromosomal disorder karyotype confirmed, Suspected chromosomal disorder karyotype pending, Hypospadias, None of the anomalies listed above

Cause/Conditions Contributing to fetal death

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.

Maternal Conditions/Disease (Specify)
Complications of placenta, cord or Membranes: Rupture of membranes, Abruptio placenta, Placental insufficiency, Prolapsed cord, Chorioamnionitis, Other (specify)
Other Obstetrical or Pregnancy Complications (Specify)
Fetal Anomaly (Specify)
Fetal Injury (Specify)
Fetal Infection (Specify)
Other Fetal Conditions/Disorders (Specify)
Unknown

Other Significant Causes or Conditions: Select or Specify all other conditions contributing to death.

Maternal Conditions/Disease (Specify)
Complications of placenta, cord or Membranes: Rupture of membranes, Abruptio placenta, Placental insufficiency, Prolapsed cord, Chorioamnionitis, Other (specify)
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 *(No, Not Applicable, Yes)*

Attendant/Certifier

Attendant's Name: First, Middle, Last, Suffix

Attendant's Title *(Doctor of Medicine, Doctor of Osteopathy, Other (Specify), Licensed Direct Entry Midwife, Midwife, Nurse Practitioner, Other Licensed Medical (Specify), RN)*

Attendant NPI

Address: Street Number; Pre Directional; Street Name or PO Box, Rural Route, etc.; Street Designator; Post Directional; Apt #, Suite #, etc; City or Town; State; Country; Zip Code

Certifier's Name: First, Middle, Last, Suffix

Certifier's Title *(Birth Certifier, DO, MD, Nurse Practitioner, Other (Specify), Other Licensed Medical (Specify), RN)*

Certifier NPI

Date Certified

TYPE OR PRINT IN PERMANENT BLACK INK.

Oregon Health Authority

CENTER FOR HEALTH STATISTICS

REPORT OF DEATH

I.D. TAG NO. 136- STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY

1. Legal name: First Middle Last Suffix (Include AKAs, if any) | **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, full name given at birth.):

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/Parent B's full name given at birth: | **24.** Mother/Parent A's full name given at birth:

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→	**IMMEDIATE CAUSE** ↓: a.	
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).	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:

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