LOCAL FILE NO.

US STANDARD REPORT OF FETAL DEATH

STATE FILE NUMBER:

MOTHER

1. NAME OF FETUS (optional-at the discretion of the parents)

2. TIME OF DELIVERY (24hr)

3. SEX (M/F/Unk)

4. DATE OF DELIV ERY (Mo/Day/Yr)

5a. CITY, TOWN, OR LOCATION OF DELIVERY

5b. ZIP CODE OF DELIVERY

6. COUNTY OF DELIVERY

7. PLACE WHERE DELIVERY OCCURRED (Check one)

- □ Hospital
- □ Freestanding birthing center
- □ Home Delivery: Planned to deliver at home? □ Yes □ No
- □ Clinic/Doctor's office
- □ Other (Specify)________________________________

8. FACILITY NAME (If not institution, give street and number)

9. FACILITY ID. (NPI)

10a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)

10b. DATE OF BIRTH (Mo/Day/Yr)

10c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)

10d. BIRTHPLACE (State, Territory, or Foreign Country)

11a. RESIDENCE OF MOTHER-STATE

11b. COUNTY

11c. CITY, TOWN, OR LOCATION

11d. STREET AND NUMBER

11e. APT. NO.

11f. ZIP CODE

11g. INSIDE CITY LIMITS? □ Yes □ No

FATHER

12a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)

12b. DATE OF BIRTH (Mo/Day/Yr)

12c. BIRTHPLACE (State, Territory, or Foreign Country)

DISPOSITION

13. METHOD OF DISPOSITION:

□ Burial □ Cremation □ Hospital Disposition □ Donation □ Removal from State □ Other (Specify)____________________________________

ATTENDANT AND REGISTRATION INFORMATION

14. ATTENDANT'S NAME, TITLE, AND NPI

NAME: ___________________________________

NPI:_______________

TITLE: □ MD □ DO □ CNM/CM □ OTHER MIDWIFE

□ OTHER (Specify)______________________

15. NAME AND TITLE OF PERSON COMPLETING REPORT

Name ___________________________

Title ____________________________

16. DATE REPORT COMPLETED

______/ ______ / ________
MM DD YYYY

17. DATE RECEIVED BY REGISTRAR

______/ ______ / ________
MM DD YYYY

CAUSE OF FETAL DEATH

18. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

18a. 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/Diseases (Specify) ___________________________________

Complications of Placenta, Cord, or Membranes

- □ Rupture of membranes prior to onset of labor
- □ 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

18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS

(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 18b)

Maternal Conditions/Diseases (Specify) ___________________________________

Complications of Placenta, Cord, or Membranes

- □ Rupture of membranes prior to onset of labor
- □ 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

18c. WEIGHT OF FETUS (grams preferred, specify unit)

____
□ grams □ lb/oz

18d. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY

_________________________ (completed weeks)

18e. ESTIMATED TIME OF FETAL DEATH

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

18f. WAS AN AUTOPSY PERFORMED? □ Yes □ No □ Planned

18g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? □ Yes □ No □ Planned

18h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? □ Yes □ No

Mother's Name ____________

Mother's Medical Record No. ____________

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MOTHER

19. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- ◻ 8th grade or less
- ◻ 9th - 12th grade, no diploma
- ◻ High school graduate or GED completed
- ◻ Some college credit but no degree
- ◻ Associate degree (e.g., AA, AS)
- ◻ Bachelor's degree (e.g., BA, AB, BS)
- ◻ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ◻ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

20. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)

- ◻ No, not Spanish/Hispanic/Latina
- ◻ Yes, Mexican, Mexican American, Chicana
- ◻ Yes, Puerto Rican
- ◻ Yes, Cuban
- ◻ Yes, other Spanish/Hispanic/Latina

(Specify)_____________________________

21. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

- ◻ White
- ◻ Black or African American
- ◻ American Indian or Alaska Native (Name of the enrolled or principal tribe)________________
- ◻ Asian Indian
- ◻ Chinese
- ◻ Filipino
- ◻ Japanese
- ◻ Korean
- ◻ Vietnamese
- ◻ Other Asian (Specify)______________________________
- ◻ Native Hawaiian
- ◻ Guamanian or Chamorro
- ◻ Samoan
- ◻ Other Pacific Islander (Specify)______________________
- ◻ Other (Specify)____________________________________

22. MOTHER MARRIED? (At delivery, conception, or anytime between) ◻ Yes ◻ No

23a. DATE OF FIRST PRENATAL CARE VISIT
______ /________/ __________ ◻ No Prenatal Care
M M D D YYYY

23b. DATE OF LAST PRENATAL CARE VISIT
_______/________/ __________
M M D D YYYY

24. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
_________ (If none, enter "0".)

25. MOTHER'S HEIGHT
_______ (feet/inches)

26. MOTHER'S PREPREGNANCY WEIGHT
_________ (pounds)

27. MOTHER'S WEIGHT AT DELIVERY
_________ (pounds)

28. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ◻ Yes ◻ No

29. NUMBER OF PREVIOUS LIVE BIRTHS

29a. Now Living
Number _____
◻ None

29b. Now Dead
Number _____
◻ None

30. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

30a. Other Outcomes
Number (Do not include this fetus) ____
◻ None

31. 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 Three Months of Pregnancy	_________	OR	________
Second Three Months of Pregnancy	_________	OR	________
Third Trimester of Pregnancy	_________	OR	________

29c. DATE OF LAST LIVE BIRTH
_______/________
MM Y Y Y Y

30b. DATE OF LAST OTHER PREGNANCY OUTCOME
_______/________
MM Y Y Y Y

32. DATE LAST NORMAL MENSES BEGAN
____ /_____/ __________
MM D D Y Y Y Y

33. PLURALITY - Single, Twin, Triplet, etc.
(Specify)________________

34. IF NOT SINGLE BIRTH- Born First, Second, Third, etc.
(Specify)________________

35. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ◻ Yes ◻ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: ____

MEDICAL AND HEALTH INFORMATION

36. RISK FACTORS IN THIS PREGNANCY (Check all that apply):

Diabetes
- ◻ Prepregnancy (Diagnosis prior to this pregnancy)
- ◻ Gestational (Diagnosis in this pregnancy)

Hypertension
- ◻ Prepregnancy (Chronic)
- ◻ Gestational (PIH, preeclampsia)
- ◻ Eclampsia

- ◻ Previous preterm birth
- ◻ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ◻ Pregnancy resulted from infertility treatment-If yes, check all that apply:
  - ◻ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
  - ◻ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
- ◻ Mother had a previous cesarean delivery
  If yes, how many __________
- ◻ None of the above

37. 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)_____________________________

38. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?
◻ Yes ◻ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
◻ Yes ◻ No

C. Fetal presentation at delivery
- ◻ Cephalic
- ◻ Breech
- ◻ Other

D. Final route and method of delivery (Check one)
- ◻ Vaginal/Spontaneous
- ◻ Vaginal/Forceps
- ◻ Vaginal/Vacuum
- ◻ Cesarean
  If cesarean, was a trial of labor attempted?
  - ◻ Yes
  - ◻ No

E. Hysterotomy/Hysterectomy
◻ Yes ◻ No

39. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)

- ◻ 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

40. CONGENITAL ANOMALIES OF THE FETUS (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
  - ◻ Karyotype pending
- ◻ Suspected chromosomal disorder
  - ◻ Karyotype confirmed
  - ◻ Karyotype pending
- ◻ Hypospadias
- ◻ None of the anomalies listed above

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NOTE: This recommended standard fetal death report is the result of an extensive evaluation process.
Information on the process and resulting recommendations as well as plans for future activities is available on the Internet at: http://www.cdc.gov/nchs/vital_certs_rev.htm.