Appendix D: Sample Forms

TYPE OR PRINT IN PERMANENT BLACK INK

I.D. TAG NO.

Local File Number

OREGON DEPARTMENT OF HUMAN SERVICES
HEALTH DIVISION
CENTER FOR HEALTH STATISTICS
CERTIFICATE OF DEATH

136-

State File Number

SAMPLE

DECEDENT

1. DECEDENT'S NAME — *First* — *Middle* — *Last*
2. SEX
3. DATE OF DEATH *(Month, Day, Year)*
4. SOCIAL SECURITY NUMBER
5a. AGE-Last Birthday *(Years)*
5b. Under 1 Year — Mos. — Days
5c. Under 1 Day — Hours — Mins.
6. BIRTHPLACE *(City and State or Foreign Country)*
7. DATE OF BIRTH *(Month, Day, Year)*
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ *Yes* ☐ *No*
9a. PLACE OF DEATH *(Check only one)* — HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA — OTHER: ☐ Nursing Home ☐ Decedent's Home ☐ Other *(Specify)* ______
9b. FACILITY NAME *(If not institution, give street and number)*
9c. CITY, TOWN, OR LOCATION OF DEATH
9d. COUNTY OF DEATH
10a. DECEDENT'S USUAL OCCUPATION *(Give kind of work done during most of working life. Do not use retired.)*
10b. KIND OF BUSINESS/INDUSTRY
11. MARITAL STATUS - *Married, Never Married, Widowed, Divorced (Specify)*
12. SPOUSE *(If Married, Widowed)*
13a. RESIDENCE - STATE
13b. COUNTY
13c. CITY, TOWN OR LOCATION
13d. STREET AND NUMBER
13e. INSIDE CITY LIMITS? ☐ *Yes* ☐ *No*
13f. ZIP CODE
14. WAS DECEDENT OF HISPANIC ORIGIN? *(Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.)* ☐ No ☐ Yes *Specify:*
15. RACE American Indian, Black, White, etc. *(Specify)*
16. DECEDENT'S EDUCATION *(Specify only highest grade completed)* — Elementary/Secondary (0-12) — College (1-4 or 5 +)

PARENTS

17. FATHER - NAME — first — middle — last
18. MOTHER - NAME — first — middle — maiden
19. INFORMANT - NAME and relationship to deceased

DISPOSITION

20a. METHOD OF DISPOSITION ☐ Mausoleum ☐ Burial ☐ Cremation ☐ Removal from State ☐ Donation ☐ Other *(Specify)* ______
20b. PLACE OF DISPOSITION *(Name of ce[metery], crematory, or other place)*
20c. LOCATION - City or Town, State
21a. SIGNATURE OF OREGON FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
21b. [LICENSE] NO.
22. NAME, ADDRESS AND ZIP OF FACILITY

REGISTRAR

23. DATE FILED *(Month, Day, Year)*
24. REGISTRAR'S SIGNATURE

RESERVED FOR REGISTRAR'S USE

CERTIFIER

TO BE COMP[LETED B]Y CERTIFYING PHYSICIAN

27. TIME OF DEATH — M
28. [W]AS MEDICAL EXAMINER NOTIFIED? ☐ *Yes* ☐ *No*
29. To the best of my knowledge, death occurred at the time, date, place and due to the cause(s) and manner stated. *(Signature)*
30. DATE SIGNED *(Month, Day, Year)*
31a. TIME OF DEATH — M
31b. DATE PRONOUNCED DEAD *(Month, Day, Year, Hour)* — M
32. On the basis of examination and/or investigation, in my opinion death occurred at the time, date, place and due to the cause(s) and manner stated. *(Signature)*
33. DATE SIGNED *(Month, Day, Year)* — COUNTY
34. NAME, TITLE, ADDRESS AND ZIP OF CERTIFIER/MEDICAL EXAMINER *(Type or Print)*
35. NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER *(Type or Print)*

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE *UNDERLYING CAUSE LAST*

36. IMMEDIATE CAUSE *(ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).) Do not enter mode of dying, e.g. Cardiac or Respiratory Arrest.* — Interval between onset and death

PART I
(a) ______ — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(b) ______ — Interval between onset and death
DUE TO, OR AS A CONSEQUENCE OF:
(c) ______

PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not resulting in the underlying cause given in PART I.

37. Did tobacco use contribute to the death? ☐ *Yes* ☐ *Probably* ☐ *No* ☐ *Unknown*
38. AUTOPSY ☐ *Yes* ☐ *No*
39. If YES were findings considered in determining cause of death? ☐ *Yes* ☐ *No* ☐ *N/A*
40. MANNER OF DEATH ☐ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Other ☐ Pending Investigation ☐ Undetermined Manner ☐ Legal Intervention
41a. DATE OF INJURY *(Month, Day, Year)*
41b. TIME OF INJURY — M
41c. INJURY AT WORK? ☐ *Yes* ☐ *No*
41d. DESCRIBE HOW INJURY OCCURRED
41e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. *(Specify)*
41f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

RESERVED FOR REGISTRAR'S USE

CAUSE OF DEATH INSTRUCTIONS ON REVERSE SIDE OF GREEN AND PINK COPY

1 __ 2 __ 3 __ 4 __ 5 __ 6 __ 7 __ 8 __ 9 __ 10 __ 11 __ 12 __ 13 __ 14 __ 15 __ 16 __ 17 __

ORIGINAL-VITAL STATISTICS COPY

45-2-Rev (3/00)

TYPE OR PRINT IN PERMANENT BLACK INK

I D TAG NO

Local File Number

OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Center for Health Statistics

REPORT OF FETAL DEATH

136-

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? (Yes or no) 6e.
ZIP CODE 6f.

FATHER

FATHER—NAME First Middle Last 7.
DATE OF BIRTH 8.

CAUSE OF FETAL DEATH

9. PART I — Fetal or maternal condition directly causing fetal death
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:
Fetal and/or maternal conditions, if any, giving rise to the immediate cause (a), stating the underlying cause last
(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, UNKNOWN (Specify) 10.
AUTOPSY (Specify yes or no) 11.

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

... HEALTH USE ONLY

15. OF HISPANIC ORIGIN? (Specify No or Yes) (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
16. RACE—(e.g. White, Black, American Indian, etc.) (Specify below)
17. EDUCATION ... (Specify only highest grade completed) ... Elementary/Secondary (0-12) College (1-4 or 5+)
18. OCCUPATION AND BUSINESS/INDUSTRY (Worked during last year) Occupation / Business/Industry

MOTHER: 15a. [ ] No [ ] Yes Specify — 16a. — 17a. — 18a. — 18b.
FATHER: 15b. [ ] No [ ] Yes Specify — 16b. — 17b. — 18c. — 18d.

19. PREGNANCY HISTORY
LIVE BIRTHS: 19a. Now living Number ___ None [ ] — 19b. Now dead Number ___ None [ ]
19c. DATE OF LAST LIVE BIRTH (Month, Year)
OTHER TERMINATIONS (Spontaneous and induced) 19d. Number ___ None [ ]
19e. DATE OF LAST OTHER TERMINATION (Month, Year)

20. CLINICAL ESTIMATE OF GESTATION (Weeks)
21. WEIGHT OF FETUS (Specify units)
23. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no) [ ] No [ ] Yes
24. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
25a. PLURALITY—Single, twin, triplet, etc. (Specify)
25b. IF NOT SINGLE BIRTH—Born first, second, third, etc. (Specify)
26. MONTH OF PREGNANCY PRENATAL CARE BEGAN First, second, etc. (Specify)
27. PRENATAL VISITS Total number (If none, so state)

30. 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) ___

31. 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) ___

32. OTHER FACTORS FOR THIS PREGNANCY (Complete all items)
a. Tobacco use during pregnancy No [ ] Yes [ ]
b. Average number cigarettes per day ___
c. Alcohol use during pregnancy No [ ] Yes [ ]
d. Average number drinks per week ___
e. Weight gained during pregnancy ___ lbs
f. History available No [ ] Yes [ ]
g. Other (Specify) ___

33. ANTENATAL PROCEDURES (Check all that apply)
01 [ ] Amniocentesis
02 [ ] Tocolysis
03 [ ] Ultrasound
04 [ ] No History available
00 [ ] None
05 [ ] Other (Specify) ___

34. INTRAPARTUM PROCEDURES (Check all that apply)
01 [ ] Electronic fetal monitoring
02 [ ] Induction of labor
03 [ ] Stimulation of labor
00 [ ] None
04 [ ] Other (Specify) ___

35. 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

36. 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 (1-98)

SAMPLE

Oregon Department of Human Services – Health Division

Adolescent Suicide Attempt Report

SAMPLE

1. **Name of hospital:** ______________________ **County** ______________
2. **Date of attempt** (Month/Day/Year): ______/______/______
3. **Admitted as an in-patient?** ☐ Yes ☐ No ☐ Transferred to another hospital (Specify) ______________
4. **Patient or hospital chart number:** ______________
5. **Date of birth** (Month/Day/Year): ______/______/______
6. **Sex:** ☐ Male ☐ Female
7. **Race:** ☐ White ☐ Black ☐ Am. Indian ☐ Hispanic ☐ Other (Specify) ______________
8. **Residence:** City ______________ County ______________
9. **Patient lives with:**
   ☐ Both parents ☐ Father only ☐ Mother only ☐ Foster parents ☐ Friends
   ☐ Parent and stepparent ☐ Unknown ☐ Other, homeless, etc. (Specify): ______________
10. **Place of attempt:**
    ☐ Own home ☐ Another's home ☐ School ☐ Other (Specify): ______________
11. **Method or methods used in attempt:**
    Poisoning by solid or liquid substance including drug or alcohol [illegible]doses, and other potentially toxic substances
    Specify substance(s): ______________
    Hanging or suffocation – Specify method: ______________
    Firearms and explosives – Specify type (Hand[illegible]etc.) [illegible] body site: ______________
    Cutting or piercing – Specify instrument a[illegible]: ______________
    Other means such as motor vehic[illegible]g, fire, etc. – Specify: ______________
12. **History of mental health iss[illegible]**
    ☐ Acute depressi[illegible] ☐ [illegible]pression ☐ Bipolar disorder ☐ Adjustment disorder
    ☐ Conduct di[illegible] [illegible]r ______________ ☐ Unknown ☐ None
13. **Number of previous [illegible]e attempts made during lifetime:**
    ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7+ ☐ Attempts made, but # unknown ☐ History unknown
14. **Precipitating events and risk factors:**
    ☐ Family discord ☐ Argument or breakup with boyfriend/girlfriend ☐ Peer pressure/argument
    ☐ School problems ☐ Suicide or attempt by friend/relative ☐ Pregnancy
    ☐ Death of friend/relative ☐ Move or new school ☐ None
    ☐ Physical abuse – Specify type and perpetrator, if known: ______________
    ☐ Sexual abuse or rape – Specify type and perpetrator, if known: ______________
    ☐ Alcohol and/or drug abuse – Specify substance(s): ______________
    ☐ Prior arrests and/or convictions of a crime – Specify: ______________
    ☐ Other – Specify: ______________
15. **Did the youth tell others of his or her plan to attempt/commit suicide?** ☐ Yes ☐ No ☐ Unknown
    If yes, whom did the youth tell? ☐ Parent ☐ Friend ☐ Teacher ☐ Other ______________
16. **Was the youth referred for intervention?** ☐ No ☐ Yes – Specify to whom: ______________
17. **Name of person completing report** (*Print*): ______________ Dept. ______________

ORS 441.750 states that

"Any hospital which treats as a patient a person *under 18* years of age because the person has attempted to commit suicide:

"Shall cause that person to be provided with information and referral to in-patient or out-patient community resources, crisis intervention or other appropriate intervention by the patient's attending physician, hospital social work staff or other appropriate staff." and

"Shall report statistical information to the Health Division of the Department of Human Services about the person. . ."

Mail this form no later than the 15th of the month following the month of the attempt to: **Center for Health Statistics**
P.O. Box 14050
Portland, Oregon 97293-0050

Telephone: 503-731-4354

OSHD Form 45-119 (Rev. 4-01)

Oregon Department of Human Resources
HEALTH DIVISION

ADOLESCENT SUICIDE ATTEMPT REPORT:
ZERO ATTEMPTS

1. Name of HOSPITAL________________________ COUNTY________________
2. During the month of ______________, there have been ZERO teen suicide attempts treated here.
3. Contact person at this facility:____

   Title/Dept:________________________________ [illegible]________________

SAMPLE

MAIL THIS F[illegible] THE ADDRESS LISTED BELOW NO LATER THAN THE 15TH OF THE MONT[illegible]OLLOWING ANY MONTH IN WHICH THERE WERE NO TEEN SUICIDE ATTEMPTS TREATED AT YOUR HOSPITAL:

Adolescent Suicide Report Program
Center for Health Statistics
PO Box 14050
Portland, OR 97293-0050

Telephone (503) 731-4354

OSHD Form 45-120 (Rev 12-97)