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)

DUE TO, OR AS A CONSEQUENCE OF:

(b)

DUE TO, OR AS A CONSEQUENCE OF:

(c)

Specify Fetal or Maternal

PART II **OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER** 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)* 12.

TITLE

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

TITLE

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 (>100^0 F or 38^0 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)*_____

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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

If this fetus is going to be removed from the facility where delivery occurred, this permit must accompany the remains to the funeral home and/or the cemetery/crematorium. A burial/cremation tag is also required if the fetus is removed from the facility of delivery.

This form, when signed by the funeral service licensee or person acting as such, shall serve as a disposal-transit permit for these fetal remains.

INSTRUCTIONS: THE PERSON IN CHARGE OF THE PLACE OF FINAL DISPOSITION SHALL DATE AND SIGN THIS FORM BELOW AND RETURN IT TOTHE REGISTRAR OF THE COUNTY WHERE THE DELIVERY OCCURRED WITHIN 10 DAYS AFTER THE DATE OF FINAL DISPOSITION.

DATE OF DISPOSITION _____

SEXTON'S SIGNATURE _____