Appendix D: Sample forms

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)	Specify Fetal or Maternal
DUE TO, OR AS A CONSEQUENCE OF: (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, OR UNKNOWN** *(Specify)* 10.	**AUTOPSY** 11. ☐ Yes ☐ No

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

SAMPLE

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° 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)*____

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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