Appendix D: Sample forms

OREGON HEALTH AUTHORITY
CENTER FOR HEALTH STATISTICS

Type or print in permanent black ink. See handbook for instructions.

136-

I.D. Tag Number

REPORT OF FETAL DEATH

State File Number

1. NAME OF FETUS — Optional *(First, Middle, Last, Suffix)*	2. TIME OF DELIVERY *(24 hr)*	3. SEX	4. DATE OF DELIVERY *(Month, Day, Year)*
5a. FACILITY — NAME *(If not an institution, give street and number)*	5b. CITY, TOWN, OR LOCATION OF DELIVERY	5c. ZIP CODE	5d. COUNTY OF DELIVERY

6a. MOTHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*	6b. DATE OF BIRTH *(Month, Day, Year)*
6c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE *(First, Middle, Last, Suffix)*	6d. BIRTHPLACE *(State, Territory, or Foreign Country)*

OTHER

6e. RESIDENCE OF MOTHER — STATE	6f. COUNTY	6g. CITY, TOWN, OR LOCATION
6h. STREET AND NUMBER	6i. ZIP CODE	6j. INSIDE CITY LIMITS ☐ No ☐ Yes

ATHER

7a. FATHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*	7b. DATE OF BIRTH *(Month, Day, Year)*	7c. BIRTHPLACE *(State, Territory, or Foreign Country)*

8a. DATE REPORT COMPLETED *(Month, Day, Year)*	8b. NAME AND TITLE OF PERSON COMPLETING REPORT *(Type or print.)*

9. NAME AND TITLE OF ATTENDANT *(Type or print.)*

10. IF SERVICES: FUNERAL HOME NAME AND ADDRESS

11a. DATE FILED BY REGISTRAR	11b. REGISTRAR — SIGNATURE

12a. INITIATING CAUSE/CONDITION	12b. OTHER SIGNIFICANT CAUSES OR CONDITIONS
(AMONG THE CHOICES BELOW, PLEASE SELECT THE ONE WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS.)	(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH.)
Maternal Conditions/Diseases (Specify):	Maternal Conditions/Diseases (Specify):
Complications of Placenta, Cord, or Membranes	Complications of Placenta, Cord, or Membranes
☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis ☐ Other (Specify):	☐ Rupture of membranes prior to onset of labor ☐ Abruptio placenta ☐ Placental insufficiency ☐ Prolapsed cord ☐ Chorioamnionitis ☐ Other (Specify):
Other Obstetrical or Pregnancy Complications (Specify):	Other Obstetrical or Pregnancy Complications (Specify):
Fetal Anomaly (Specify):	Fetal Anomaly (Specify):
Fetal Injury (Specify):	Fetal Injury (Specify):
Fetal Infection (Specify):	Fetal Infection (Specify):
Other Fetal Conditions/Disorders (Specify):	Other Fetal Conditions/Disorders (Specify):
☐ Unknown	☐ Unknown

13a. ESTIMATED TIME OF FETAL DEATH	13b. WAS AN AUTOPSY PERFORMED?
☐ 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	☐ Yes ☐ No ☐ Planned
	13c. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? ☐ Yes ☐ No ☐ Planned
	13d. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ☐ Yes ☐ No

14. AMENDMENT

ORIGINAL - VITAL RECORD COPY

45-3 (01/11)

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

14. MOTHER MARRIED (at delivery, conception, or any time between)? ☐ Yes ☐ No

15. FACILITY'S NPI

16. MOTHER'S MEDICAL RECORD NUMBER

MOTHER

17. OF HISPANIC ORIGIN? *(Check "Yes" or "No")* *(If "yes," specify all that apply; e.g., Cuban, Mexican, Puerto Rican, etc.)*

18. RACE *(e.g., White, Black, American Indian, etc.)* *(Specify all that apply below.)*

19. EDUCATION *(Highest grade completed)*

FATHER

17a. ☐ Yes ☐ No *Specify*

18a.

19a.

17b. ☐ Yes ☐ No *Specify*

18b.

19b.

MOTHER

20a. DATE OF FIRST PRENATAL CARE VISIT? *(Month, Day, Year)* ☐ *No Prenatal Care*

20b. DATE OF LAST PRENATAL CARE VISIT? *(Month, Day, Year)*

20c. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY? _____ *(If none, enter "0".)*

21. MOTHER'S HEIGHT? *(feet/inches)*

22. MOTHER'S PRE-PREGNANCY WEIGHT? *(pounds)*

23. MOTHER'S WEIGHT AT DELIVERY? *(pounds)*

24. DID MOTHER GET WIC FOOD FOR HERSELF? ☐ Yes ☐ NO

25. NUMBER OF LIVE BIRTHS *(Do not include this fetus.)*

25a. Number Now Living: _____ ☐ None

25b. Number Now Dead: _____ ☐ None

26. NUMBER OF OTHER PREGNANCY OUTCOMES *(Spontaneous or induced losses or ectopic pregnancies)*

Number of Other Outcomes: _____ ☐ None

27. 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 Trimester of Pregnancy	_____	OR	_____
Second Trimester of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

28a. DATE OF LAST LIVE BIRTH *(Month, Year)*

28b. DATE OF LAST OTHER PREGNANCY OUTCOME *(Month, Year)*

28c. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*

29. PLACE WHERE THIS DELIVERY OCCURRED *(Check one.)*
- ☐ Hospital
- ☐ Freestanding birthing center
- ☐ Home Birth
  Planned to deliver at home? ☐ Yes ☐ No
- ☐ Clinic / Doctor's Office
- ☐ Other *(Specify)* _____

30. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No

IF YES, ENTER NAME OF FACILITY FROM WHICH MOTHER WAS TRANSFERRED: _____

31. ATTENDANT'S NPI

32. RISK FACTORS IN THIS PREGNANCY (Check all that apply.)
- ☐ Diabetes
  - ☐ Pre-Pregnancy *(Diagnosis prior to this pregnancy)*
  - ☐ Gestational *(Diagnosis in this pregnancy)*
- ☐ Hypertension
  - ☐ Pre-Pregnancy *(Chronic)*
  - ☐ Gestational *(PIH, pre-eclampsia)*
  - ☐ Eclampsia
- ☐ Previous preterm birth
- ☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pre-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? _____
- ☐ Alcohol use during pregnancy
  If yes, average number of drinks per week? _____
- ☐ None of the above

33. 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): _____

34. METHOD OF DELIVERY

A Fetal presentation at birth
- ☐ Cephalic
- ☐ Breech
- ☐ Other

B 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

C Was delivery with forceps attempted, but unsuccessful? ☐ Yes ☐ No

D Was delivery with vacuum extraction attempted, but unsuccessful? ☐ Yes ☐ No

35. 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

36. METHOD OF DISPOSITION:
- ☐ Burial
- ☐ Cremation
- ☐ Hospital Disposition
- ☐ Donation
- ☐ Removal from State
- ☐ Other (Specify) _____

37. WEIGHT OF FETUS *(grams preferred; specify unit)* _____ ☐ grams ☐ lb/oz

38. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY _____ *(completed weeks)*

39. PLURALITY - *Single, Twins, Triplets, etc.* *(Specify)* _____

40. IF NOT SINGLE BIRTH - Delivered First, Second, Third, etc. *(Specify)* _____

41. 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

STATE USE ONLY a. _____ b. _____ c. _____ d. _____

TYPE OR PRINT IN PERMANENT BLACK INK.

I.D. TAG NO.

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

136-

STATE FILE NUMBER

TO BE COMPLETED BY FUNERAL FACILITY

1. Legal Name (Include AKAs, if any) First / Middle / Last / Suffix					**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, give name prior to first marriage.)				
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's Name (First, Middle, Last, Suffix)				**24.** Mother's Name Prior to First Marriage (First, Middle, Last)	
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.	Due to (or as a consequence of) ↓ b.			
ENTER THE UNDERLYING CAUSE LAST (disease or injury that initiated the events resulting in death).	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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