

FETAL DEATH REPORT
FACILITY WORKSHEET

Only use this form to report a Fetal Death

Do **NOT** file a fetal death report if the delivery resulted in a live birth, regardless of duration. A fetal death is indicated by the fact that after delivery, the fetus does not breathe or show any other evidence of life. If after delivery the fetus showed any evidence of life, you are required to complete **BOTH** a certificate of live birth and death. A fetal disposition permit can only be used for a fetal death. A planned induced termination of pregnancy is **NOT** a fetal death.

FETUS					
Fetus Name First _____ Middle _____ Last _____ Suffix _____			Date of Delivery MM / DD / YYYY	Time of Delivery AM <input type="checkbox"/> PM <input type="checkbox"/> Military <input type="checkbox"/>	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined
METHOD OF DISPOSITION (Select one)					
Facility releasing fetus for Final Disposition; hospital must provide a disposition permit to any party transporting remains: <input type="checkbox"/> Hospital released fetus to parents <input type="checkbox"/> Hospital released fetus to funeral home (name) _____					
MOTHER'S HEALTH			PRENATAL		
Did she get WIC food for herself during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No			Date of Last Menses MM / DD / YYYY		
Height ft. _____ in. _____	Cigarettes Smoked Per Day		No Prenatal Care <input type="checkbox"/> OR Date of 1st Visit MM / DD / YYYY		
Weight (Pre-pregnancy) lbs. _____	3 months before pregnancy # _____ Cigarettes	1 st 3 months of pregnancy # _____ Cigarettes	Previous Live Births (Does not include this fetus)		Date Last Live Birth MM / YYYY
	2 nd 3 months of pregnancy # _____ Cigarettes	3 rd 3 months of pregnancy # _____ Cigarettes	# now living _____	# now deceased _____	
PREGNANCY FACTORS					
Risk Factors					
<input type="checkbox"/> Diabetes-Pre-pregnancy		<input type="checkbox"/> Previous Preterm Births (<37 Completed Weeks Gestation)			
<input type="checkbox"/> Diabetes-Gestational (Diagnosis In This Pregnancy)		<input type="checkbox"/> Infertility Treatment-Fertility-enhancing drugs			
<input type="checkbox"/> Hypertension-Pre-pregnancy (Chronic)		<input type="checkbox"/> Infertility Treatment-Assisted Reproductive Technology			
<input type="checkbox"/> Hypertension-Gestational (PIH, Pre-eclampsia)		<input type="checkbox"/> Mother Had A Previous Cesarean Delivery: How Many? _____			
<input type="checkbox"/> Hypertension-Eclampsia		<input type="checkbox"/> None Of The Above			
DELIVERY					
Method of Delivery			If Cesarean, was a Trial of Labor Attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No		Maternal Morbidity (check all that apply)
Fetal Presentation at Delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other					<input type="checkbox"/> Ruptured uterus
Final Route and Method of Delivery <input type="checkbox"/> Vaginal/Spontaneous					<input type="checkbox"/> Admission to intensive care unit
<input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean					<input type="checkbox"/> None of the above
Mother Transferred for maternal or fetal indication prior to delivery <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility _____					
FETAL ATTRIBUTES					
Weight of Fetus _____ <input type="checkbox"/> lb/oz <input type="checkbox"/> grams		Obstetric Estimate of Gestation (weeks) _____		Plurality (Single, Twin, Triplet, etc.) _____	
				Delivery Order (1 st , 2 nd , 3 rd , 4 th , etc.) _____	
CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH					
Initiating Cause/Conditioning (enter <u>one</u> condition or cause only)			Other Significant Cause/Condition (enter other conditions or causes)		
Maternal Conditions/Disease (specify) _____			Maternal Conditions/Disease (specify) _____		
Complications of placenta, cord or membranes:			Complications of placenta, cord or membranes:		
<input type="checkbox"/> Rupture of membranes		<input type="checkbox"/> Prolapsed cord		<input type="checkbox"/> Rupture of membranes	
<input type="checkbox"/> Abruptio placenta		<input type="checkbox"/> Chorioamnionitis		<input type="checkbox"/> Abruptio placenta	
<input type="checkbox"/> Placental insufficiency		<input type="checkbox"/> Other		<input type="checkbox"/> Placental insufficiency	
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) _____		
<input type="checkbox"/> Unknown			<input type="checkbox"/> Unknown		
Estimated time of fetal death <input type="checkbox"/> Dead at first assessment, no labor ongoing <input type="checkbox"/> Dead at first assessment, labor ongoing					
<input type="checkbox"/> Died during labor, after first assessment <input type="checkbox"/> Unknown time of fetal death					
Autopsy performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned Histological Placental Examination Performed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Planned					
Autopsy or Histological Placental Examination used in Determining Cause of Fetal Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable					
Attendant at delivery		First	Middle	Last	Title
Facility to obtain ID tag number from funeral home where remains released to:			ID TAG NUMBER _____		