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

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 cemetery, crematory, other place)
20c. LOCATION - City or Town, State
21a. SIGNATURE OF OREGON FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH
22. NAME, ADDRESS AND ZIP OF FACILITY.
23. DATE FILED (Month, Day, Year)
24. REGISTRAR'S SIGNATURE

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

RESERVED FOR REGISTRAR'S USE

TO BE COMPLETED BY CERTIFYING PHYSICIAN

27. TIME OF DEATH
28. WAS MEDICAL EXAMINER NOTIFIED? ☐ Yes ☐ No
29. To the best of my knowledge, death occurred at the time, date, place and ☐ Yes ☐ No
(Signature)
30. DATE SIGNED (Month, Day, Year)
31a. TIME OF DEATH
31b. DATE PRONOUNCED DEAD (Month, Day, Year, Hour)
32. On the basis of examination and/or investigation, in my opinion death occurred
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)

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

CAUSE OF DEATH

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) DUE TO, OR AS A CONSEQUENCE OF: — Interval between onset and death
(b) DUE TO, OR AS A CONSEQUENCE OF: — Interval between onset and death
(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 ☐ Pending Investigation ☐ Undetermined Manner ☐ Legal Intervention ☐ Other
41a. DATE OF INJURY (Month, Day, Year)
41b. TIME OF INJURY
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)

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

RESERVED FOR REGISTRAR'S USE

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

SAMPLE

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).)* — Specify Fetal or Maternal

(a)

Fetal and/or maternal conditions, if any, giving rise to the immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF: — Specify Fetal or Maternal

(b)

DUE TO, OR AS A CONSEQUENCE OF: — Specify Fetal or Maternal

(c)

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)* 12. TITLE

NAME OF PERSON COMPLETING REPORT 13. TITLE

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	17. EDUCATION (Highest grade completed) Elementary or 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			18a.	18b.
FATHER	15b. [ ] No [ ] Yes Specify		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)

Oregon Department of Human Services – Health Division

Adolescent Suicide Attempt Report

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 overdoses, and other potentially toxic substances
    Specify substance(s): _____
    Hanging or suffocation – Specify method: _____
    Firearms and explosives – Specify type (Handgun, rifle, etc.) *and* body site: _____
    Cutting or piercing – Specify instrument(s): _____
    Other means such as motor vehicle, jumping, drowning, fire, etc. – Specify: _____
12. **History of mental health issues:**
    ☐ Acute depression ☐ Chronic depression ☐ Bipolar disorder ☐ Adjustment disorder
    ☐ Conduct disorder ☐ Other _____ ☐ Unknown ☐ None
13. **Number of previous suicide 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:_____

MAIL THIS FORM TO THE ADDRESS LISTED BELOW NO LATER THAN THE 15TH OF THE MONTH FOLLOWING 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)