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

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)*_____

45-3 (06/03)