

Patient's medical record # _____ Patient's name _____
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FACILITY WORKSHEET FOR THE REPORT OF FETAL DEATH

Complete this worksheet for pregnancies resulting in fetal death. The Model State Vital Statistics Act and Regulations recommend the following definition of fetal death. "Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of the pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heart beats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps. For detailed definitions, instructions, information on sources, and common key words and abbreviations for many of the items included in the worksheet please see "The Guide to Completing Facility Worksheets for the Certificate of Live Birth."

1. Facility name:* _____
(If not institution, give street and number)

2. Facility I.D. (National Provider Identifier): _____

3. City, Town or Location of delivery: _____ **Zip code:** _____

4. County of delivery: _____

5. Place of delivery:

- Hospital
- Freestanding birthing center (Freestanding birthing center is defined as one which has no direct physical connection with an operative delivery center.)
- Home delivery
Planned to deliver at home Yes No
- Clinic/Doctor's Office
- Other (Specify, e.g., taxi cab, train, plane, etc.) _____

*Facilities may wish to have pre-set responses (hard-copy and/or electronic) to questions 1-5 for deaths which occur at their institutions.

Prenatal

Sources: Prenatal care records, patient's medical records, labor and delivery records

Information for the following items should come from the patient's prenatal care records and from other medical reports in the patient's chart. If the patient's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record, or a copy of the prenatal care information. Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.

6(a). Date of first prenatal care visit (Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy):

M M D D Y Y Y Y

No prenatal care (The mother did not receive prenatal care at any time during the pregnancy. If this box is checked skip 6(b))

6(b). Date of last prenatal care visit (Enter the date of the last visit recorded in the mother's prenatal records):

M M D D Y Y Y Y

7. Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record.

If none enter "0"): _____

8. Date last normal menses began:

M M D D Y Y Y Y

9. Number of previous live births now living (For multiple deliveries, includes live born infants born before this fetus in the multiple set.):

_____ Number None

10. Number of previous live births now dead (For multiple deliveries, includes live born infants born before this fetus in the multiple set who subsequently died):

_____ Number None

11. Date of last live birth:

M M D D Y Y Y Y

12. Total number of other pregnancy outcomes (Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this fetus in the pregnancy):

_____ Number None

13. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended):

M M Y Y Y Y

14. Risk factors in this pregnancy (Check all that apply):

Diabetes - (Glucose intolerance requiring treatment)

Prepregnancy - (Diagnosis prior to this pregnancy)

Gestational - (Diagnosis in this pregnancy)

Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition.)

Prepregnancy - (Chronic) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy)

Gestational - (PIH, preeclampsia) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face).)

Eclampsia - (Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema)

Previous preterm births - (History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation)

Other previous poor pregnancy outcome - (Includes perinatal death, small for gestational age/intrauterine growth restricted birth) - (History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes. Perinatal death includes fetal and neonatal deaths.)

- Pregnancy resulted from infertility treatment** - Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g., IVF, GIFT and ZIFT).

If Yes, check all that apply:

- Fertility-enhancing drugs, artificial insemination or intrauterine insemination** - Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.
- Assisted reproductive technology** - Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT) used to initiate the pregnancy.

- Patient had a previous cesarean delivery** - (Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.)

If Yes, how many _____

- None of the above

15. Infections present and/or treated during this pregnancy - (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.) (Check all that apply):

- Gonorrhea - (a diagnosis of or positive test for *Neisseria gonorrhoeae*)
- Syphilis - (also called lues - a diagnosis of or positive test for *Treponema pallidum*)
- Chlamydia - (a diagnosis of or positive test for *Chlamydia trachomatis*)
- Listeria (LM) - (a diagnosis of or positive test for *Listeria monocytogenes*)
- Group B Streptococcus (GBS) - (a diagnosis of or positive test for *Streptococcus agalactiae* or group B streptococcus)
- Cytomegalovirus (CMV) - (a diagnosis of or positive test for the *cytomegalovirus*)
- Parvovirus (B19) - (a diagnosis of or positive test for parvovirus B19)
- Toxoplasmosis (Toxo) - (a diagnosis of or positive test for *Toxoplasma gondii*)
- None of the above
- Other (specify) _____

Labor and Delivery
Sources: Labor and delivery records, patient's medical records

16. Date of delivery:
 M M D D Y Y Y Y

17. Time of delivery: _____ 24 hour clock

18. Name and title of person completing report:
(May be, but need not be, the same as the attendant at delivery.)

Name: _____
Title: _____

19. Date report completed:
 M M D D Y Y Y Y

20. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?
(Transfers include hospital to hospital, birth facility to hospital, etc.)

- Yes No

If Yes, enter the name of the facility mother transferred from:

21. Attendant's name, title, and N.P.I. (National Provider Identifier) (The attendant at delivery is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers a fetus under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant):

Attendant's name

N.P.I.

Attendant's title:

- M.D.
 D.O.
 CNM/CM - (Certified Nurse Midwife/Certified Midwife)
 Other Midwife - (Midwife other than CNM/CM)
 Other (specify): _____

22. Mother's weight at delivery (pounds): _____

23. Method of delivery (The physical process by which the complete delivery was effected)
(Complete A, B, C, D, and E):

A. Was delivery with forceps attempted but unsuccessful? – (Obstetric forceps was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)
 Yes No

B. Was delivery with vacuum extraction attempted but unsuccessful? – (Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)
 Yes No

C. Fetal presentation at delivery (Check one):

- Cephalic – (Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP))
- Breech – (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech)
- Other – (Any presentation not listed above)

D. Final route and method of delivery (Check one):

- Vaginal/Spontaneous – (Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.)
- Vaginal/Forceps - (Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.)
- Vaginal/Vacuum - (Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.)
- Cesarean - (Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls)
If cesarean, was a trial of labor attempted? - (Labor was allowed, augmented or induced with plans for a vaginal delivery.)
 - Yes
 - No

E. Hysterotomy/Hysterectomy

- Yes
- No

24. Maternal morbidity (Serious complications experienced by the patient associated with labor and delivery)

(Check all that apply):

- Maternal transfusion - (Includes infusion of whole blood or packed red blood cells associated with labor and delivery.)
- Third or fourth degree perineal laceration - (3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- Ruptured uterus - (Tearing of the uterine wall.)
- Unplanned hysterectomy - (Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.)
- Admission to intensive care unit - (Any admission of the mother to a facility/unit designated as providing intensive care.)
- Unplanned operating room procedure following delivery - (Any transfer of the patient back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.)
- None of the above

25. Weight of fetus: _____ (grams) (Do not convert lb/oz to grams)

If weight in grams is not available, weight of fetus: _____ (lb/oz)

26. Obstetric estimate of gestation at delivery (completed weeks): _____

(The delivery attendant's final estimate of gestation based on all perinatal factors and assessments. Do not compute based on date of the last menstrual period and the date of delivery.)

27. Sex (Male, Female, or Unknown): _____

28. Plurality (Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.)

(Include all live births and fetal losses resulting from this pregnancy.): _____

29. If not single delivery (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Include all live births and fetal losses resulting from this pregnancy): _____

30. If not single delivery, specify number of infants in this delivery born alive: _____

31. Congenital anomalies of the fetus (Malformations of the fetus diagnosed prenatally or after delivery.)

(Check all that apply):

- Anencephaly** - (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes fetuses with craniorachischisis (anencephaly with a contiguous spine defect).)
- Meningomyelocele/Spina bifida** - (Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).)
- Cyanotic congenital heart disease** - (Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetralogy of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.)
- Congenital diaphragmatic hernia** - (Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.)
- Omphalocele** - (A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.)
- Gastroschisis** - (An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.)
- Limb reduction defect** (excluding congenital amputation and dwarfing syndromes) - (Complete or partial absence of a portion of an extremity associated with failure to develop.)
- Cleft Lip with or without Cleft Palate** - (Incomplete closure of the lip. May be unilateral, bilateral or median.)
- Cleft Palate alone** - (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without Cleft Palate" category above.)
- Down Syndrome** - (Trisomy 21)
 - Karyotype confirmed
 - Karyotype pending
- Suspected chromosomal disorder** - (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.)
 - Karyotype confirmed
 - Karyotype pending
- Hypospadias** - (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.)
- None of the anomalies listed above**

32. Method of Disposition

- Burial
- Cremation
- Hospital Disposition
- Donation
- Removal from State
- Other (Specify)_____

Cause-of-Death Section

Causes/Conditions Contributing to Fetal Death

Previous questions collected details on anomalies, morbidities, and risk factors known to be present for this patient and the fetus. The purpose of the next section is to get a description of those conditions that, in your opinion, contributed to the fetal death. Please report any condition judged to be a cause of death even if it has been reported elsewhere on the worksheet.

33. Initiating Cause/Condition

Among the choices below, please select the ONE which most likely began the sequence of events resulting in the death of the fetus. If it is not clear to you where to report a condition, write it on the “(Specify)” line that seems most appropriate.

<p>Maternal Conditions/Diseases (Specify) _____</p>
<p>Complications of Placenta, Cord or Membranes</p> <ul style="list-style-type: none"><input type="checkbox"/> Rupture of membranes prior to onset of labor<input type="checkbox"/> Abruptio placenta<input type="checkbox"/> Placental insufficiency<input type="checkbox"/> Prolapsed cord<input type="checkbox"/> Chorioamnionitis<input type="checkbox"/> Other (Specify) _____
<p>Other Obstetrical or Pregnancy Complications (Specify) _____</p>
<p>Fetal Anomaly (Specify) _____</p>
<p>Fetal Injury (Specify) _____</p>
<p>Fetal Infection (Specify) _____</p>
<p>Other Fetal Conditions/Disorders (Specify) _____</p>
<p><input type="checkbox"/> Unknown</p>

34. Other Significant Causes or Conditions

Select or Specify All Other Conditions Contributing to Death in Item 34.

Maternal Conditions/Diseases

(Specify) _____

Complications of Placenta, Cord or Membranes

- Rupture of membranes prior to onset of labor
- Abruptio placenta
- Placental insufficiency
- Prolapsed cord
- Chorioamnionitis
- Other (Specify) _____

Other Obstetrical or Pregnancy Complications (Specify) _____

Fetal Anomaly (Specify) _____

Fetal Injury (Specify) _____

Fetal Infection (Specify) _____

Other Fetal Conditions/Disorders

(Specify) _____

Unknown

35. Was an autopsy performed?

- Yes No Planned

36. Was a histological placental examination performed?

- Yes No Planned

37. Were autopsy or histological placental examination results used in determining the cause of fetal death?

- Yes No

38. Estimated time of fetal death

- 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