

Report of Fetal Death Worksheet

We are truly sorry about the loss you have experienced. We understand that this is a difficult time for you and your loved ones. We need to ask you a few questions to assist in the completion of the official report of fetal death. State laws provide protection against the unauthorized release of identifying information from the report of fetal death to ensure confidentiality of the parents. This information may also help researchers understand some of the factors that are related to miscarriage and stillbirth. Your assistance in providing complete and accurate information is very important. We appreciate your help, especially during this very difficult time.

PLEASE PRINT CLEARLY

Please note: If delivery occurred in a hospital, nursing care institution, or hospice inpatient facility, the Human Remains Release Form (HRRF) must be completed (reference A.R.S. §36-326 and A.A.C. R9-19-301.)

Funeral Home/County Information Available for Disposition: Yes No

Fetus Information

Name of Fetus-- This is optional. Fetus Not Named

1A. FETUS FIRST NAME	1B. MIDDLE NAME	1C. LAST NAME	1D. SUFFIX (Jr, II, etc)
2. DATE OF DELIVERY (mm/dd/yyyy)	3. TIME OF DELIVERY <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Military <input type="checkbox"/> Unknown	4. FETUS SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	5. HRRF (Human Remains Release Form) <input type="checkbox"/> Yes <input type="checkbox"/> No _____ (mm/dd/yyyy)

Mother's Information

6A. MOTHER'S <u>CURRENT LEGAL</u> NAME – FIRST NAME	6B. MIDDLE NAME	6C. LAST NAME	6D. SUFFIX (Jr, II, etc)
7A. MOTHER'S NAME PRIOR TO FIRST MARRIAGE – FIRST NAME	7B. MIDDLE NAME	7C. LAST NAME	7D. SUFFIX (Jr, II, etc)
8A. MOTHER'S DATE OF BIRTH (mm/dd/yyyy)	8B. MOTHER'S STATE OF BIRTH	8C. MOTHER'S COUNTRY OF BIRTH	

Mother's Residence Address

9A. MOTHER'S ADDRESS			9B. Apt. # /Suite
9C. ZIP CODE	9D. CITY OR TOWN	9E. COUNTY	9F. STATE
9G. COUNTRY	9H. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
9I. Is Mother's Residence in an Arizona Tribal Community? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, identify the name of the tribal community _____ (For a list of Native American tribes specific to Arizona, reference the *Arizona Tribal Addendum at the end of the worksheet)			

Mother's Attributes

10. MOTHER'S EDUCATION

Select the Item that Best Describes the Highest Degree or Level of School Completed at the Time of Delivery

- 8th grade or less; none
 9th – 12th grade; no diploma
 High school graduate or GED completed
 Some college credit, but not a degree
 Associate degree (e.g. AA, AS)
 Bachelor's degree (e.g. BA, AB, BS)
 Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
 Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
 Unknown
 Unknown due to mother has left the facility

11. MOTHER'S HISPANIC ORIGIN

Select the Item that Best Describes whether the Mother is Spanish/Hispanic/Latina; Select "No" if the Mother is not Spanish/Hispanic/Latina.

- No, Not Spanish/Hispanic/Latina
 Yes, Mexican, Mexican-American, Chicana
 Yes, Puerto Rican
 Yes, Cuban
 Unknown, if Spanish/Hispanic/Latina
 Yes, Other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Columbian) Specify _____

12. MOTHER'S RACE (Check all that apply)

*(For a list of Native American tribes specific to Arizona, reference the *Arizona Tribal Addendum at the end of the worksheet)*

- White
 Asian Indian
 Other Asian (Specify) _____
 Other Pacific Islander (Specify) _____
 Unknown
 Black or African American
 Chinese _____
 American Indian or Alaska Native (name of enrolled/principal tribe) _____
 Filipino _____
 Japanese
 Native Hawaiian
 Other (Specify) _____
 Korean
 Guamanian or Chamorro _____
 Vietnamese
 Samoan _____

Marital Status

13. MARITAL INFORMATION

- Was Mother Ever Married? Yes No Unknown
 Was Mother Married At: Delivery, Conception, or anytime in between? Yes No Unknown
 Will Father's information be collected on the Report? Yes No

Father's Information

14A. FATHER'S <u>CURRENT LEGAL</u> NAME – FIRST NAME	14B. MIDDLE NAME	14C. LAST NAME	14D. SUFFIX (Jr, II, etc)
15A. FATHER'S DATE OF BIRTH (mm/dd/yyyy)	15B. FATHER'S STATE OF BIRTH	15C. FATHER'S COUNTRY OF BIRTH	

Father's Attributes

16. FATHER'S EDUCATION

Select the Item that Best Describes the Highest Degree or Level of School Completed at the Time of Delivery

- 8th grade or less; none
 9th – 12th grade; no diploma
 High school graduate or GED completed
 Some college credit, but not a degree
 Associate degree (e.g. AA, AS)
 Bachelor's degree (e.g. BA, AB, BS)
 Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
 Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
 Unknown

17. FATHER'S HISPANIC ORIGIN

Select the Item that Best Describes whether the Father is Spanish/Hispanic/Latino; Select "No" if the Father is not Spanish/Hispanic/Latino.

- No, Not Spanish/Hispanic/Latino
 Yes, Mexican, Mexican American, Chicano
 Yes, Puerto Rican
 Yes, Cuban
 Unknown
 Yes, Other Spanish/Hispanic/Latino (e.g. Spaniard, Salvadoran, Columbian) Specify _____

18. FATHER'S RACE (Check all that apply)

*(For a list of Native American tribes specific to Arizona, reference the *Arizona Tribal Addendum at the end of the worksheet)*

- White
 Asian Indian
 Other Asian (Specify) _____
 Other Pacific Islander (Specify) _____
 Unknown
 Black or African American
 Chinese _____
 American Indian or Alaska Native (name of enrolled/principal tribe) _____
 Filipino _____
 Japanese
 Native Hawaiian
 Other (Specify) _____
 Korean
 Guamanian or Chamorro _____
 Vietnamese
 Samoan _____

<p>31. Date of First Prenatal Care Visit _____ (mm/dd/yyyy) <input type="checkbox"/> No Prenatal Care</p> <p>Date of Last Prenatal Care Visit _____ (mm/dd/yyyy)</p> <p>Total Number of Prenatal Visits for this Pregnancy; If None, Enter "0" _____</p>	<p>32. Number of Now Living _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p>Number Now Dead _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p>Date of Last Live Birth _____ (mm/dd/yyyy)</p>	<p>33. Number of Other Pregnancy Outcomes (Spontaneous, Induced Losses or Ectopic Pregnancies) (Do Not Include This Fetus.) If none, enter "0" or check the None box _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p>Date of Last Other Pregnancy Outcome (mm/yyyy) _____</p> <p>Was the Prenatal Record Available for Completion of the Fetal Death Report? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
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Pregnancy Factors

<p>34. Medical Risk Factors in This Pregnancy (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes - Pre-pregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Diabetes - Gestational (Diagnosis in this pregnancy) <input type="checkbox"/> Hypertension - Pre-pregnancy (Chronic) <input type="checkbox"/> Hypertension - Gestational (PIH, pre-eclampsia) <input type="checkbox"/> Hypertension – Eclampsia <input type="checkbox"/> Previous Preterm Birth <input type="checkbox"/> Other Previous Poor Pregnancy Outcome (Includes Perinatal Death, Small for Gestational Age/Intrauterine Growth Restricted Birth) <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor <input type="checkbox"/> Pregnancy Resulted from Infertility Treatment – Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Pregnancy Resulted from Infertility Treatment – Assisted Reproductive Technology (e.g., in vitro fertilization (IVF), gamete, Intrafallopian transfer (GIFT)) <input type="checkbox"/> Mother had a Previous Cesarean Delivery – If Yes, how many? _____ <input type="checkbox"/> Autoimmune Disorder <input type="checkbox"/> Hemoglobinopathy <input type="checkbox"/> Uterine Anomaly <input type="checkbox"/> Blood Antigen Isoimmunization <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other Traumatic Injury <input type="checkbox"/> Acute Drug Effect/Toxicity/Reaction <input type="checkbox"/> Prior Incision of the Uterine Wall <input type="checkbox"/> Fetal Death Prior to 20 Weeks <input type="checkbox"/> Fetal Death at 20 Weeks or More <input type="checkbox"/> Fetus/Infant with Congenital Anomaly <input type="checkbox"/> Neonatal Death <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Unknown _____ <input type="checkbox"/> None of the Above 	<p>35. Infections Present and/or Treated During This Pregnancy (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Listeria <input type="checkbox"/> Group B Streptococcus <input type="checkbox"/> Cytomegalovirus <input type="checkbox"/> Parvovirus <input type="checkbox"/> Toxoplasmosis <input type="checkbox"/> Unknown <input type="checkbox"/> None of the Above <input type="checkbox"/> Other (Specify)
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Delivery

<p>36. Method of Delivery</p> <p>Was Delivery With Forceps Attempted, But Unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Was Delivery with Vacuum Extraction Attempted, But Unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Fetal Presentation at Delivery <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other <input type="checkbox"/> Unknown</p>	<p>37. Final Route and Method of Delivery – (Check One)</p> <p><input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown</p> <p>If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable</p> <p>Hysterotomy or Hysterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
<p>38. Maternal Morbidity (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Maternal Transfusion <input type="checkbox"/> Third or Fourth Degree Perineal Laceration <input type="checkbox"/> Ruptured Uterus <input type="checkbox"/> Unplanned Hysterectomy <input type="checkbox"/> Admission to Intensive Care Unit <input type="checkbox"/> Unplanned Operating Room Procedure Following Delivery <input type="checkbox"/> None of the Above <input type="checkbox"/> Unknown 	<p>39. Characteristics of Labor and Delivery (Check all that apply)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Induction of Labor <input type="checkbox"/> Augmentation of Labor <input type="checkbox"/> Non-Vertex Presentation <input type="checkbox"/> Antibiotics Received by Mother During Labor <input type="checkbox"/> Moderate/Heavy Meconium Staining of the Amniotic Fluid <input type="checkbox"/> Epidural or Spinal Anesthesia During Labor <input type="checkbox"/> Steroids (glucocorticoids) for Fetal Lung Maturation Received by the Mother Prior to Delivery <input type="checkbox"/> Unknown

<p>40. Was Mother Transferred for Maternal Medical or Fetal Indications Prior to Delivery?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, Name of Facility Mother Transferred From _____</p> <p>Enter Facility Address _____</p>	<p>41. Obstetric Procedures (Check all that apply)</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> <td style="text-align: center;">Unknown</td> <td></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Cervical Cerclage</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Tocolysis</td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td><input type="checkbox"/> Successful External Cephalic Version</td> </tr> <tr> <td colspan="3"></td> <td><input type="checkbox"/> None of the Above</td> </tr> </table>	Yes	No	Unknown		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cervical Cerclage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tocolysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Successful External Cephalic Version				<input type="checkbox"/> None of the Above
Yes	No	Unknown																			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Cervical Cerclage																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Tocolysis																		
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Successful External Cephalic Version																		
			<input type="checkbox"/> None of the Above																		

Fetal Attributes

<p>42. WEIGHT OF FETUS</p> <p>_____ Gram</p>	<p>43. OBSTETRIC ESTIMATE OF GESTATION</p> <p>_____ Weeks</p>	<p>44A. PLURALITY (Specify Single, Twins, Triplets, etc.)</p>	<p>44B. IF NOT SINGLE BIRTH, SPECIFY BIRTH ORDER (First, Second, Third, etc.)</p>
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45. Congenital Anomalies of Child (Check all that apply)

<input type="checkbox"/> Unknown	<input type="checkbox"/> Cyanotic Congenital Heart Disease	<input type="checkbox"/> Hypospadias
<input type="checkbox"/> Anencephaly	<input type="checkbox"/> Gastroschisis	<input type="checkbox"/> Congenital Heart Disease/Defect
<input type="checkbox"/> Congenital Diaphragmatic Hernia	<input type="checkbox"/> Limb Reduction Defect (Excluding Congenital Amputation and Dwarfing Syndromes)	<input type="checkbox"/> Anterior Abdominal Wall Defect
<input type="checkbox"/> Meningomyelocele/Spina Bifida	<input type="checkbox"/> Cleft Lip with or without Cleft Palate	<input type="checkbox"/> Down Syndrome
<input type="checkbox"/> Omphalocele	<input type="checkbox"/> Cleft Palate Alone	<input type="checkbox"/> None of the Anomalies Listed Above

Cause/Conditions Contributing to Fetal Death

46. Initiating Cause or Conditions (Check all that apply) *Among the choices below, please select the one which most likely began the sequence of events resulting in the death of the Fetus.*

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 True Knot in Cord

Other (Specify) _____

Other Obstetrical or Pregnancy Complications (Specify) _____

Fetal Anomaly (Specify) _____

Fetal Injury (Specify) _____

Fetal Infection (Specify) _____

Other Fetal Conditions/Disorders (Specify) _____

Elective Abortion

Unknown

47. Other Significant Causes or Conditions (Check all that apply) *Select or Specify all other conditions contributing to death.*

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 True Knot in Cord

Other (Specify) _____

Other Obstetrical or Pregnancy Complications (Specify) _____

Fetal Anomaly (Specify) _____

Fetal Injury (Specify) _____

Fetal Infection (Specify) _____

Other Fetal Conditions/Disorders (Specify) _____

Elective Abortion

Unknown

48. Estimated Time of Fetal Death (Check one)

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

Autopsy Performed? Yes No Planned

Histological Placental Examination Performed? Yes No Planned

Autopsy or Histological Placental Examination Results used in Determining Cause of Fetal Death?

Yes No Not Applicable

Was Medical Examiner Contacted? Yes No

ME Case #: _____

49. Placenta Appearance (Check One) <input type="checkbox"/> Normal Placenta Appearance <input type="checkbox"/> Unknown Placenta Appearance <input type="checkbox"/> Abnormal Placenta Appearance (Specify) _____	50. Fetal Appearance (Check One) <input type="checkbox"/> Fetus Structure and Appearance Normal <input type="checkbox"/> Obvious Dysmorphic Value <input type="checkbox"/> Unknown Fetal Appearance at Delivery <input type="checkbox"/> Minimal to Mild Desquamation/Maceration <input type="checkbox"/> Moderate to Severe Desquamation/Maceration <input type="checkbox"/> Hydrops Fetalis <input type="checkbox"/> Mummification <input type="checkbox"/> Other; Specify _____
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Name of Person Completing Report

51A. FIRST NAME	51B. MIDDLE NAME	51C. LAST NAME	51D. SUFFIX (Jr, II, etc)
51E. TITLE/OFFICE LOCATION (<i>NOT FOR HOSPITAL USE</i>)		52. DATE WORKSHEET COMPLETED (mm/dd/yyyy)	53. PHONE NUMBER

Attendant Information

54A. ATTENDANT'S NAME		54B. ATTENDANT NPI <input type="checkbox"/> None <input type="checkbox"/> Unknown	
54C. ATTENDANT'S TITLE			
<input type="checkbox"/> M.D.	<input type="checkbox"/> Registered Nurse (RN)	<input type="checkbox"/> D.O.	<input type="checkbox"/> C.N.M./C.M
<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Other Midwife	<input type="checkbox"/> Student Nurse Midwife (SNM)	<input type="checkbox"/> Physician's Assistant (PA)
			<input type="checkbox"/> Neonatal Nurse Practitioner (NNP) <input type="checkbox"/> Midwife
54D. ATTENDANT'S ADDRESS			44E. ATTENDANT'S ZIP CODE
54F. ATTENDANT'S CITY, TOWN OR LOCATION		54G. ATTENDANT'S STATE	54H. ATTENDANT'S COUNTRY

Certifier Information

55A. CERTIFIER'S NAME		55B. DATE CERTIFIED
55C. CERTIFIER'S TITLE		
<input type="checkbox"/> M.D.	<input type="checkbox"/> Registered Nurse (RN)	<input type="checkbox"/> D.O.
<input type="checkbox"/> Nurse Midwife	<input type="checkbox"/> Other Midwife	<input type="checkbox"/> Student Nurse Midwife (SNM)
		<input type="checkbox"/> Physician's Assistant (PA)
		<input type="checkbox"/> Neonatal Nurse Practitioner (NNP) <input type="checkbox"/> Midwife
<input type="checkbox"/> Other (Specify) _____		

Informant

56A. FIRST NAME	56B. MIDDLE NAME	56C. LAST NAME	56D. SUFFIX (Jr, II, etc)
56E. PHONE NUMBER	56F. EMAIL ADDRESS		

56G. I attest the information provided on this form is accurate, true and valid to the best of my knowledge.	56H. DATE
SIGNATURE	

Certification Review (For The Office of Medical Examiner Use Only)

57A. NAME OF MEDICAL EXAMINER	57B. LICENSE NUMBER	57C. DATE APPROVED	57D. ME CASE NUMBER
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***Arizona Tribal Addendum**

Ak-Chin Indian Community
Cocopah Indian Reservation
Colorado River Indian Reservation
Fort McDowell Mohave-Apache Community
Fort McDowell Yavapai Nation
Fort Mohave Reservation
Fort Yuma – Quechan Reservation
Gila River Indian Community
Havasupai Reservation
Hopi Reservation
Hualapai Reservation
Kaibab-Paiute Reservation

Navajo Nation
Pascua Yaqui Reservation
Pueblo of Zuni
Salt River Pima-Maricopa Indian Community
San Carlos Apache Nation
San Juan Southern Paiute
Tohono O’Odham Nation
Tonto Apache Nation
White Mountain Apache Nation
Yavapai-Apache Nation
Yavapai-Prescott Reservation

Thank you for completing this worksheet at this very difficult time. The information you have provided is very important; it will be used by researchers to better understand factors related to miscarriage and stillbirth and lead to improved prevention strategies for the future.