

# 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.)*

## Child Information

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

CHILD'S FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX (Jr, II, etc)
CHILD'S SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	DATE OF DELIVERY (mm/dd/yyyy)  <input type="checkbox"/> Unknown	TIME OF DELIVERY <input type="checkbox"/> Unknown <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> MILITARY	PLURALITY (Specify Single, Twins, Triplets, etc.)
IF NOT SINGLE BIRTH, SPECIFY BIRTH ORDER (First, Second, Third, etc.) _____		HRRF (Human Remains Release Form) <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Place of Delivery

ZIP CODE OF DELIVERY	STATE OF DELIVERY	COUNTY OF DELIVERY	CITY, TOWN OR LOCATION OF DELIVERY
PLACE WHERE DELIVERY OCCURRED			
<input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home Delivery, Intended <input type="checkbox"/> Home Delivery, Unintended <input type="checkbox"/> Home Delivery, Unknown if Intended <input type="checkbox"/> Clinic/doctor's office <input type="checkbox"/> Enroute <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____			
NAME OF DELIVERY FACILITY OR SPECIFY LOCATION, STREET AND NUMBER			

## Attendant Information

FACILITY NPI	ATTENDANT NAME	ATTENDANT NPI <input type="checkbox"/> None <input type="checkbox"/> Unknown
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"/> Neonatal Nurse Practitioner (NNP) <input type="checkbox"/> Midwife <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"/> Other (Specify) _____		

## Name of Person Completing Report

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX (Jr, II, etc)
TITLE/OFFICE LOCATION ( <b>NOT FOR HOSPITAL USE</b> )		DATE WORKSHEET COMPLETED (mm/dd/yyyy)	PHONE NUMBER



**Father's Information**

FATHER'S <u>CURRENT LEGAL</u> NAME – FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX (Jr, II, etc)
FATHER'S DATE OF BIRTH (mm/dd/yyyy)	FATHER'S COUNTRY OF BIRTH	FATHER'S STATE OF BIRTH	
<b>FATHER'S EDUCATION</b> Select the Item that Best Describes the Highest Degree or Level of School Completed at the Time of Delivery <input type="checkbox"/> 8 <sup>th</sup> grade or less; or none <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but not a degree <input type="checkbox"/> Associate degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD) <input type="checkbox"/> Unknown			
Select the Item that Best Describes whether the Father is Spanish/Hispanic/Latino; Select "No" if the Father is not Spanish/Hispanic/Latino. <input type="checkbox"/> No, Not Spanish, Hispanic, or Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (e.g. Spaniard, Salvadoran, Columbian) Specify _____			
<b>FATHER'S RACE</b> (Check all that apply) <span style="float:right;"><i>(For a list of Native American tribes specific to Arizona, reference the*Arizona Tribal Addendum at the end of the worksheet)</i></span> <input type="checkbox"/> White <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Chinese <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese      Enrolled or Principal Tribe _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan      Additional Tribe _____ <input type="checkbox"/> Other Pacific Islander _____ <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Other Specify _____ (Specify) _____ (Specify) _____ (Specify) _____ <input type="checkbox"/> Unknown			

**Prenatal and Birthing Information**

Date Mother's Last Normal Menses Began (mm/dd/yyyy) \_\_\_\_\_  Unknown

Did Mother get WIC food for herself during this pregnancy?  Yes  No  Unknown

Date of First Prenatal Care Visit (mm/dd/yyyy) \_\_\_\_\_  No Prenatal Care  Unknown      Date of Last Prenatal Care Visit (mm/dd/yyyy) \_\_\_\_\_  Unknown

Total Number of Prenatal Visits for this Pregnancy; If None, Enter "0" \_\_\_\_\_

Was the Prenatal Record Available for Completion of the Fetal Death Report?  Yes  No

Weight of Child (in Grams) \_\_\_\_\_  Unknown      Obstetric Estimate of Gestation at Delivery (Completed Weeks) \_\_\_\_\_  Unknown

Mother's Height \_\_\_\_\_ (feet) \_\_\_\_\_ (inches)  Unknown

Mother's Pre-pregnancy Weight (Pounds) \_\_\_\_\_  Unknown      Mother's Weight at Delivery (Pounds) \_\_\_\_\_

Number of Previous Live Births \_\_\_\_ (If none, enter "0") Now Living \_\_\_\_  None      Now Dead \_\_\_\_  None      Date of Last Live Birth (mm/dd/yyyy) \_\_\_\_\_  Unknown

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) \_\_\_\_\_  None

Date of Last Other Pregnancy Outcome (mm/yyyy) \_\_\_\_\_  Unknown

**Cigarette Smoking Before and During Pregnancy**

Please answer for each time period the average number of cigarettes per day. (If none, enter "0." Note: 1 pack = 20 cigarettes)  
 Never smoked in lifetime

**Number of Cigarettes Per Day**

Three Months Before Pregnancy \_\_\_\_\_      First Three Months of Pregnancy \_\_\_\_\_  
 Second Three Months of Pregnancy \_\_\_\_\_      Last Trimester of Pregnancy \_\_\_\_\_

**Principal Source of Payment**

- Private Insurance
- Indian Health Services (IHS)
- AHCCCS
- Self-Pay
- Other (specify) \_\_\_\_\_
- Unknown



**Congenital Anomalies of Child (Check all that apply)**

**Yes**    **No**    **Unknown**

- Anencephaly
- Congenital Diaphragmatic Hernia
- Meningomyelocele/Spina Bifida
- Omphalocele
- Cyanotic Congenital Heart Disease
- Gastroschisis
- Limb Reduction Defect (Excluding Congenital Amputation and Dwarfing Syndromes)
- Cleft Lip with or without Cleft Palate
- Cleft Palate Alone

None of the Anomalies Listed Above

**Yes**    **No**    **Unknown**

- Hypospadias
- Congenital Heart Disease/Defect
- Anterior Abdominal Wall Defect
- Down Syndrome
- Karyotype Confirmed
- Karyotype Pending
- Suspected Chromosomal Disorder
- Karyotype Confirmed
- Karyotype Pending

Other (Specify) \_\_\_\_\_

**Obstetric Procedures (Check all that apply)**

**Yes**    **No**    **Unknown**

- Cervical Cerclage
  - Tocolysis
  - Successful External Cephalic Version
- None of the Above

**Method of Delivery**

Was Delivery With Forceps Attempted, But Unsuccessful?

Yes     No     Unknown

Fetal Presentation at Delivery

Cephalic     Breech     Other     Unknown

Was Delivery with Vacuum Extraction Attempted, But Unsuccessful?

Yes     No     Unknown

**Final Route and Method of Delivery – (Check One)**

Vaginal/Spontaneous     Vaginal/Forceps     Vaginal/Vacuum     Cesarean

Unknown

If cesarean, was a trial of labor attempted?     Yes     No     Unknown

Hysterotomy or Hysterectomy     Yes     No     Unknown

**Fetal and Placenta Appearance (Check One)**

**Placenta Appearance**

- Normal Placenta Appearance
- Abnormal Placenta Appearance (Specify)

Unknown Placenta Appearance

**Fetal Appearance at Delivery (Check One)**

- Fetus Structure and Appearance Normal     Obvious Dysmorphic Features
- Unknown Fetal Appearance

**(Check all that apply)**

**Yes**    **No**    **Unknown**

- Minimal to Mild Desquamation/Maceration
- Moderate to Severe Desquamation/Maceration
- Hydrops Fetalis
- Mummification

**Cause/Conditions Contributing to Fetal Death**

Initiating Cause or Conditions

Among the choices below, please select **the one** which most likely began the sequence of events resulting in the death of the fetus.

- Complications of Placenta, Cord, or Membrane: Rupture of Membranes Prior to Onset of Labor
- Complications of Placenta, Cord, or Membrane: Placental Insufficiency
- Complications of Placenta, Cord, or Membrane: Chorioamnionitis
- Complications of Placenta, Cord, or Membrane: Other (Specify) \_\_\_\_\_
- Maternal Conditions/Diseases (Specify) \_\_\_\_\_
- Other Obstetrical or Pregnancy Complications (Specify) \_\_\_\_\_
- Fetal Anomaly (Specify) \_\_\_\_\_
- Fetal Injury (Specify) \_\_\_\_\_
- Fetal Infection (Specify) \_\_\_\_\_
- Other Fetal Conditions/Disorders (Specify) \_\_\_\_\_
- Unknown
- Complications of Placenta, Cord, or Membrane: Abruption Placenta
- Complications of Placenta, Cord, or Membrane: Prolapsed Cord
- Complications of Placenta, Cord, or Membrane: True Knot in Cord
- Elective Abortion

**Other Significant Causes or Conditions (Check all that apply)**

Complications of Placenta, Cord, or Membrane

- Rupture of Membranes Prior to Onset of Labor
- Abruption Placenta
- Placental Insufficiency
- Prolapsed Cord
- Chorioamnionitis
- True Knot in Cord
- Other – Specify \_\_\_\_\_
- Maternal Conditions/Diseases (Specify) \_\_\_\_\_
- Other Obstetrical or Pregnancy Complications (Specify) \_\_\_\_\_
- Fetal Anomaly (Specify) \_\_\_\_\_
- Fetal Injury (Specify) \_\_\_\_\_
- Fetal Infection (Specify) \_\_\_\_\_
- Other Fetal Conditions/Disorders (Specify) \_\_\_\_\_
- Unknown
- Elective Abortion

**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
- Was Medical Examiner Contacted?  Yes  No
- Was an Autopsy Performed?  Yes  No  Planned
- Was a Histological Placental Examination Performed?  Yes  No  Planned
- Were Autopsy or Histological Placental Examination Results Used in Determining the Cause of Fetal Death?  Yes  No

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

NAME OF MEDICAL EXAMINER	LICENSE NUMBER	DATE APPROVED	ME CASE NUMBER
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**Disposition Information**

Method of Disposition

- Burial
- Unknown
- Is this a Family Disposition? \_\_\_\_\_
- Name of Disposition Facility #1: \_\_\_\_\_
- Complete Address #1: \_\_\_\_\_
- Donation
- Removal from State
- Cremation
- Removal from Country
- Entombment
- Other (Specify) \_\_\_\_\_
- Date of Disposition #1 \_\_\_\_\_
- Name of Disposition Facility #2: \_\_\_\_\_
- Complete Address #2: \_\_\_\_\_
- Held

**Funeral Facility**

FUNERAL FACILITY NAME	FUNERAL DIRECTOR
ADDRESS	LICENSE

**Name of the Informant**

FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX (Jr, II, etc)
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**Informant's Signature**

SIGNATURE	DATE
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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 Mojave 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  
Other

*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.*