Primary Reg. Dist. No.

Registrar's No.

State File No.

Ohio Department of Health
Office of Vital Statistics
Report of Fetal Death

VOID

MOTHER

1. NAME OF FETUS (optional-at the discretion of the parents)
2. TIME OF DELIVERY (24hr)
3. SEX (M/F/Unk)
4. DATE OF DELIVERY (Mo/Day/Yr)
5a. CITY, TOWN, OR LOCATION OF DELIVERY
5b. ZIP CODE OF DELIVERY
6. COUNTY OF DELIVERY
7. PLACE WHERE DELIVERY OCCURRED (Check one) ☐ Hospital ☐ Freestanding birthing center ☐ Home Delivery Planned to deliver at home? ☐ Yes ☐ No ☐ Clinic/Doctor's office ☐ Other (Specify)
8. FACILITY NAME (if not institution, give street and number)
9. FACILITY ID. (NPI)
10a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)
10d. BIRTHPLACE (State, Territory, or Foreign Country)
11a. RESIDENCE OF MOTHER-STATE
11b. COUNTY
11c. CITY, TOWN, OR LOCATION
11d. STREET AND NUMBER
11e. APT. NO.
11f. ZIP CODE
11g. INSIDE CITY LIMITS? ☐ Yes ☐ No

FATHER

12a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
12b. DATE OF BIRTH (Mo/Day/Yr)
12c. BIRTHPLACE (State, Territory, or Foreign Country)

DISPOSITION

13. METHOD OF DISPOSITION ☐ Burial ☐ Cremation ☐ Hospital Disposition ☐ Donation ☐ Removal from State ☐ Other (Specify)
DATE PERMIT ISSUED mm /dd /yyyy

ATTENDANT AND REGISTRATION INFORMATION

14. ATTENDANT
NPI
TITLE ☐ MD ☐ DO ☐ CNM/CM ☐ Other Midwife ☐ Other (Specify)
15. PERSON COMPLETING REPORT
TITLE
16. DATE REPORT COMPLETED mm /dd /yyyy
17. DATE RECEIVED BY REGISTRAR mm /dd /yyyy

CAUSE OF FETAL DEATH

18. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

18a. 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)

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

18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS
(select or specify all other conditions contributing to death in item 18b)

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

18c. WEIGHT OF FETUS (grams preferred, specify unit) ☐ grams ☐ lb/oz

18d. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY (completed weeks)

18e. 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

18f. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No ☐ Planned

18g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? ☐ Yes ☐ No ☐ Planned

18h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ☐ Yes ☐ No

OAC 3701-5-02
Appendix C

MOTHER

19. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
☐ 8th grade or less ☐ High school graduate or GED completed ☐ Associate degree (e.g., AA, AS) ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
☐ 9th–12th grade, no diploma ☐ Some college credit but no degree ☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

20. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)
☐ Not Spanish/Hispanic/Latina ☐ Mexican, Mexican American, Chicana ☐ Puerto Rican ☐ Cuban ☐ Other Spanish/Hispanic/Latina (Specify)_____

21. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
☐ White ☐ Black or African American ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ ☐ Asian Indian
☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian (Specify)_____
☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander (Specify)_____ ☐ Other (Specify)_____

22. MOTHER MARRIED? (At delivery, conception, or anytime between)	23a. DATE OF FIRST PRENATAL CARE VISIT	23b. DATE OF LAST PRENATAL CARE VISIT	24. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
☐ Yes ☐ No	mm /dd /yyyy ☐ No Prenatal Care	mm /dd /yyyy	_____ (If none, enter "0".)
25. MOTHER'S HEIGHT	26. MOTHER'S PREPREGNANCY WEIGHT	27. MOTHER'S WEIGHT AT DELIVERY	28. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY
_____ (feet/inches)	_____ (pounds)	_____ (pounds)	☐ Yes ☐ No

29. NUMBER OF PREVIOUS LIVE BIRTHS
29a. Now Living Number: _____ Number ☐ None
29b. Now Dead: _____ Number ☐ None
29c. DATE OF LAST LIVE BIRTH: mm /yyyy

30. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)
30a. OTHER OUTCOMES: _____ Number (Do not include this fetus) ☐ None
30b. DATE OF LAST OTHER PREGNANCY OUTCOME: mm / yyyy

31. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day.

Three Months Before Pregnancy	_____	☐ # of cigarettes	☐ # of packs
First Three Months of Pregnancy	_____	☐ # of cigarettes	☐ # of packs
Second Three Months of Pregnancy	_____	☐ # of cigarettes	☐ # of packs
Third Trimester of Pregnancy	_____	☐ # of cigarettes	☐ # of packs

32. DATE LAST NORMAL MENSES BEGAN: mm /dd /yyyy

33. PLURALITY Single, Twin, Triplet, etc. (Specify) _____

34. IF NOT SINGLE BIRTH Born First, Second, Third, etc. (Specify) _____

35. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No If yes, enter name of facility mother transferred from _____

MEDICAL AND HEALTH INFORMATION

36. RISK FACTORS IN THIS PREGNANCY (Check all that apply)
Diabetes
☐ Prepregnancy (Diagnosis prior to this pregnancy)
☐ Gestational (Diagnosis in this pregnancy)
Hypertension
☐ Prepregnancy (Chronic)
☐ Gestational (PIH, preeclampsia)
☐ Eclampsia
☐ Previous preterm birth
☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
☐ Pregnancy resulted from infertility treatment
If yes, check all that apply:
☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
☐ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
☐ Mother had a previous cesarean delivery
If yes, how many _____
☐ None of the above

37. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
☐ Listeria ☐ Group B Streptococcus ☐ Cytomegalovirus ☐ Parvovirus ☐ Toxoplasmosis ☐ Gonorrhea ☐ Syphilis ☐ Chlamydia ☐ None of the above ☐ Other (Specify) _____

38. METHOD OF DELIVERY
A. Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No
C. Fetal presentation at delivery ☐ Cephalic ☐ Breech ☐ Other
D. Final route and method of delivery (Check one) ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean
If cesarean, was a trial of labor attempted? ☐ Yes ☐ No
E. Hysterotomy/Hysterectomy ☐ Yes ☐ No

39. MATERNAL MORBIDITY (Complications associated with labor and delivery) (Check all that apply)
☐ Ruptured uterus ☐ Unplanned hysterectomy ☐ Admission to intensive care unit ☐ Maternal transfusion ☐ Unplanned operating room procedure following delivery ☐ Third or fourth degree perineal laceration ☐ None of the above

40. CONGENITAL ANOMALIES OF THE FETUS (Check all that apply)
☐ Anencephaly
☐ Meningomyelocele/Spina bifida
☐ Cyanotic congenital heart disease
☐ Congenital diaphragmatic hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
☐ Cleft Lip with or without Cleft Palate
☐ Cleft Palate alone
☐ Hypospadias
☐ None of the anomalies listed above
☐ Down Syndrome
☐ Karyotype confirmed
☐ Karyotype pending
☐ Suspected chromosomal disorder
☐ Karyotype confirmed
☐ Karyotype pending

NOTE: This recommended standard fetal death report is the result of an extensive evaluation process.
Information on the process and resulting recommendations as well as plans for future activities is available on the Internet at: http://www.cdc.gov/nchs/vital_certs_rev.htm.