

## FETAL DEATH REPORT FACILITY WORKSHEET

Use this worksheet to collect fetal death information for entry into the Oregon Vital Events Registration System (OVERS). All fetal deaths that occur in a hospital facility and meet the mandatory reporting requirements should be reported using OVERS. This worksheet may be accompanied by the parent worksheet. Some of the information requested on this form is also requested on the parent worksheet and need not be collected twice.

**Fetal death reports must be completed within 5 days of delivery of the fetus. Retain worksheets in your files for at least 1 and no more than 2 years.**

### **When is a death a fetal death?**

Only complete the report of fetal death for pregnancy outcomes that **do not result in a live birth**.

Oregon law (ORS 432.005 Definition (14)) defines fetal death as death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, that 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 the voluntary muscles. If you have questions as to whether the fetus was dead at the time of delivery you can review the pregnancy outcome flow chart at

<http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Pages/InstructionsFetalDeath.aspx> or call 971-673-1180. **If a child is born living and then dies shortly after birth, do not file the fetal death report.**

### **Mandatory reporting requirements**

You are only required to report fetal deaths if the birth weight of the fetus is **350 grams or more**. If the delivery weight is unknown, the report must be filed if the gestational age is **20 weeks or more**. For mandatory reports, the information we are requesting has several purposes including: collecting information required by federal law; and gathering medical information that is used for public health. You can access detailed instructions for completing the fetal death report at

<http://public.health.oregon.gov/BirthDeathCertificates/RegisterVitalRecords/Pages/InstructionsFetalDeath.aspx>

### **Non-mandatory reporting requirements**

Although it is not mandatory to report a fetal demise in instances where the birth weight is less than 350 grams or (if the weight is unknown) the gestation period is less than 20 weeks, you may file a report if a family requests it so that they may later purchase a commemorative Certificate of Stillbirth.

If you complete a non-mandatory report of fetal demise for a fetus that is less than the minimum weight and gestational age for mandatory reporting, you only need to include the:

- Parents' names,
- Delivery weight,
- Place of delivery, and;
- Date of delivery.

### **Completing the legal portion of the report**

It is very important that the names, date of delivery, and place of delivery are correct. Please use full names for the parents. Parents may choose to leave the first and middle names blank for the fetus but the last name must be entered.

### **Burial and other disposition information**

You must provide the funeral director with a disposition permit when they pick up the fetal remains, but you should not provide them with a copy of the fetal death report. The disposition permit includes everything on the report except for the causes/conditions of death. The disposition permit can be downloaded from OVERS under the fetal death registration menu>print forms.

**Please answer every question** to the best of your knowledge. Each question has a purpose.

**Thank You for Your Help.**

**FETAL DEATH REPORT  
FACILITY WORKSHEET**

<b>FETUS</b>				<b>(Page 1 of 2)</b>			
Fetus Name First		Middle	Last	Suffix	Date of Delivery MM / DD / YYYY	Time of Delivery	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined

**METHOD OF DISPOSITION (Select one)**

Facility Coordinating Final Disposition (hospital must provide a disposition permit to any party transporting remains)

Hospital transfer to funeral home      Name of Funeral facility: \_\_\_\_\_

Hospital disposition

Hospital transfer to parents

**MOTHER'S HEALTH**

Did she get WIC food for herself during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>Cigarette Smoking</b> <small>Number cigarettes(per day)</small>	
Height ft. _____ in. _____		3 months <u>before</u> pregnancy # _____ Cigarettes	
Weight (Pre-pregnancy) lbs. _____		1 <sup>st</sup> 3 months of pregnancy # _____ Cigarettes	
Weight (at delivery) lbs. _____		2 <sup>nd</sup> 3 months of pregnancy # _____ Cigarettes	
		3 <sup>rd</sup> 3 months of pregnancy # _____ Cigarettes	

**PRENATAL**

Date of Last Menses MM / DD / YYYY	Prenatal Care No prenatal care <input type="checkbox"/> Date of 1 <sup>st</sup> visit MM / DD / YYYY Total # of visits _____	Previous Live Births # now living _____ # now deceased _____ Date of last live birth MM / YYYY	Other Pregnancy Outcomes <small>(Spontaneous or induced terminations or ectopic pregnancy)</small> # of other outcomes _____ <small>(combined #)</small> Date of last other outcome MM / YYYY
---------------------------------------	---	---	---

**PREGNANCY FACTORS**

Risk Factors

<input type="checkbox"/> Diabetes-Pre-pregnancy	<input type="checkbox"/> Previous Preterm Births (<37 Completed Weeks Gestation)
<input type="checkbox"/> Diabetes-Gestational (Diagnosis In This Pregnancy)	<input type="checkbox"/> Infertility Treatment-Fertility-enhancing drugs
<input type="checkbox"/> Hypertension-Pre-pregnancy (Chronic)	<input type="checkbox"/> Infertility Treatment-Assisted Reproductive Technology
<input type="checkbox"/> Hypertension-Gestational (PIH, Pre-eclampsia)	<input type="checkbox"/> Mother Had A Previous Cesarean Delivery: How Many? _____
<input type="checkbox"/> Hypertension-Eclampsia	<input type="checkbox"/> None Of The Above

Infections Present and / or Treated During this Pregnancy (Check all that apply)

<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Group B Streptococcus	<input type="checkbox"/> Parvovirus	<input type="checkbox"/> None of the above
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Listeria	<input type="checkbox"/> Cytomegalovirus	<input type="checkbox"/> Toxoplasmosis	<input type="checkbox"/> Other (Specify) _____

**DELIVERY**

Method of Delivery

Fetal Presentation at Delivery  Cephalic  Breech  Other

Final Route and Method of Delivery  Vaginal/Spontaneous  Vaginal/Forceps  Vaginal/Vacuum  Cesarean

If Cesarean, was a Trial of Labor Attempted?  Yes  No

Maternal Morbidity (check all that apply)

<input type="checkbox"/> Maternal transfusion	<input type="checkbox"/> Unplanned hysterectomy	<input type="checkbox"/> Unplanned operating room procedure following delivery
<input type="checkbox"/> Third or fourth degree perineal laceration	<input type="checkbox"/> Admission to intensive care unit	<input type="checkbox"/> None of the above
<input type="checkbox"/> Ruptured uterus		

Mother Transferred for maternal or fetal indication prior to delivery  Yes  No If yes, name of facility \_\_\_\_\_

**FETAL ATTRIBUTES**

Weight of Fetus _____ <input type="checkbox"/> lb/oz <input type="checkbox"/> grams	Obstetric Estimate of Gestation(weeks) _____	Plurality (Single, Twin, Triplet, etc.) _____	Delivery Order (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> , 4 <sup>th</sup> , etc.) _____
--	--	---	--

Congenital Anomalies

<input type="checkbox"/> Anencephaly	<input type="checkbox"/> Limb reduction defect	<input type="checkbox"/> Suspected chromosomal disorder, karotype confirmed
<input type="checkbox"/> Meningomyelocele/Spina bifida	<input type="checkbox"/> Cleft Lip with or without Cleft Palate	<input type="checkbox"/> Suspected chromosomal disorder, karotype pending
<input type="checkbox"/> Cyanolic congenital heart disease	<input type="checkbox"/> Cleft Palate alone	<input type="checkbox"/> Hypospadias
<input type="checkbox"/> Congenital diaphragmatic hernia	<input type="checkbox"/> Down Syndrome, karotype confirmed	<input type="checkbox"/> None of the anomalies listed above
<input type="checkbox"/> Omphalocele	<input type="checkbox"/> Down Syndrome, karotype pending	
<input type="checkbox"/> Gastroschisis		

