STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH

REPORT OF FETAL DEATH

121 - _____
STATE FILE NUMBER

(TYPE OR PRINT IN INK)

CHILD

1. CHILD'S NAME *(If parent's choose to provide a name)* (FIRST) (MIDDLE) (LAST) (SUFFIX) | 2. SEX OF CHILD

3. NAME AND TITLE OF ATTENDANT | 4. BIRTHWEIGHT *(Specify unit)* | 5. OBSTETRIC ESTIMATE OF GESTATION (completed weeks) | 6. DATE OF DELIVERY *(Month, Day, Year)* | 7. TIME OF DELIVERY M

PLACE OF DELIVERY

8a. FACILITY NAME (If not institution, give street, number, and zip code) | 8b. CITY, VILLAGE, OR TOWNSHIP OF DELIVERY | 8c. COUNTY OF DELIVERY

PARENT(S)

9. MOTHER'S CURRENT LEGAL NAME *(First, Middle, Last)* | 10. FATHER'S CURRENT LEGAL NAME *(First Middle Last)*

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MOTHER

11. MOTHER'S FULL NAME BEFORE FIRST MARRIED IF DIFFERENT FROM CURRENT NAME | 12. MEDICAL RECORD NUMBER OF MOTHER | 13. EXPECTED SOURCE OF PAYMENT FOR MEDICAL SERVICES (Private Insurance, Medicaid, etc.)

14a. RESIDENCE OF MOTHER - STATE | 14b. COUNTY OF RESIDENCE | 14c. RESIDENCE - PLACE *(Check one box and specify)*
☐ INSIDE CITY OR VILLAGE OF
☐ INSIDE TOWNSHIP OF
☐ UNINCORPORATED PLACE OF

15. RESIDENCE STREET ADDRESS | 16. ZIP CODE | 17. MOTHER'S MAILING ADDRESS IF DIFFERENT FROM RESIDENCE (Street Number, City or Village, State, Zip)

PARENT(S)

18a. MOTHER'S STATE OF BIRTH - NAME COUNTRY IF NOT USA | 18b. MOTHER'S DATE OF BIRTH *(Mo, Day, Yr)* | 18c. WAS MOTHER MARRIED AT DELIVERY **OR** CONCEPTION? *(Yes or No)* | 19a. FATHER'S STATE OF BIRTH - NAME COUNTRY IF NOT USA | 19b. FATHER'S DATE OF BIRTH *(Mo, Day, Yr)*

MOTHER

20a. RACE - American Indian, Black, White, etc. *(If Asian give nationality, i.e. Chinese, Filipino, etc.)(Enter all that apply)* | 20b. ANCESTRY - Mexican, Cuban, Arab, English, French, Dutch, etc. If American Indian, enter principal tribe. *(Enter all that apply)* | 20c. HISPANIC ORIGIN *(Yes or No)*

FATHER

20d. EDUCATION - Indicate the category that best describes the highest degree or level of school completed by the Mother and the Father

☐ 1 8th grade or less
2 9th - 12th grade; no diploma
3 High school graduate or GED
4 Some college but no degree
☐ 5 Associate degree (AA, AS)
6 Bachelor's degree (BA, AB, BS)
7 Master's degree (MA, MS, MEng, MEd, MSW, MBA)
8 Doctorate or Professional degree (PhD, EdD, MD, DO, DDS, DVM, LLB, JD)
9 Unknown

21. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No | 22. DATE LAST NORMAL MENSES BEGAN *(Mo, Day, Year)* | 23a. DATE OF FIRST PRENATAL CARE VISIT *(Mo., Day, Year)* | 23b. DATE OF LAST PRENATAL CARE VISIT *(Mo., Day, Year)* | 23c. TOTAL PRENATAL CARE VISITS

24a. PLURALITY OF THIS PREGNANCY Single, Twin, Triplet, etc. *(Specify)* | 24b. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. *(Specify)* | 25a. MOTHER SMOKED BEFORE OR DURING PREGNANCY? *(Yes or No)* | 25b. IF MOTHER QUIT SMOKING, HOW LONG AGO? *(weeks, months, years)* | 25c. DO OTHERS IN HOUSEHOLD SMOKE? *(Yes or No)*

MEDICAL AND HEALTH INFORMATION

26. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS
26a. NOW LIVING Number _____ None ☐
26b. NOW DEAD Number _____ None ☐

26d. OTHER PREGNANCY OUTCOMES (Spontaneous and induced losses or ectopic pregnancies)
Number _____ (Do not include this stillbirth)
None ☐

27. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? 1 ☐ YES 2 ☐ NO
If yes enter name of facility transferred from:

28. ATTENDANT AT DELIVERY
1 ☐ MD
2 ☐ DO
3 ☐ NURSE
4 ☐ CERTIFIED NURSE MIDWIFE
5 ☐ CERTIFIED MIDWIFE
6 ☐ OTHER MIDWIFE
7 ☐ OTHER

29. PLACE WHERE DELIVERY OCCURRED
1 ☐ HOSPITAL
2 ☐ FREESTANDING BIRTHING CENTER
3 ☐ HOME - PLANNED
4 ☐ HOME - UNPLANNED
6 ☐ CLINIC/DOCTORS OFFICE
7 ☐ OTHER *(Specify)* _____

26c. DATE OF LAST LIVE BIRTH *(Mo., Day, Year)* | 26e. DATE OF LAST OTHER PREGNANCY OUTCOME *(Mo., Day, Year)* | 30. MOTHER'S HEIGHT (feet/inches) | 31a. MOTHER'S PREPREGNANCY WEIGHT (pounds) | 31b. MOTHER'S WEIGHT AT DELIVERY (pounds)

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Vital Records & Health Data Development Section
P.O. Box 30691, Lansing, MI 48909

Mother's Name _____

Mother's Medical Record No. _____

32. RISK FACTORS IN THIS PREGNANCY (Check all that apply or check none):

Diabetes

1 ☐ Prepregnancy (Diagnosis prior to this pregnancy)
2 ☐ Gestational (Diagnosis in this pregnancy)

Hypertension

3 ☐ Prepregnancy (Chronic)
4 ☐ Gestational (PH, preeclampsia, eclampsia)

5 ☐ Previous preterm birth
6 ☐ Other previous poor pregnancy outcome (includes perinatal death, small-growth restricted birth)
7 ☐ Vaginal bleeding during this pregnancy prior to the onset of labor
8 ☐ Pregnancy resulted from infertility treatment
9 ☐ Mother had a previous cesarean delivery
If yes, how many _____
10 ☐ Alcohol use during pregnancy

0 ☐ None of the above

33. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

1 ☐ Gonorrhea
2 ☐ Syphilis
3 ☐ Genital Herpes
4 ☐ Chlamydia
5 ☐ Listeria
6 ☐ Group B Streptococcus
7 ☐ Cytomegalovirus
8 ☐ Parvo virus
9 ☐ Toxoplasmosis
10 ☐ Other (Specify) _____
0 ☐ None of the above

34. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?
1 ☐ Yes 2 ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
1 ☐ Yes 2 ☐ No

C. Fetal presentation at delivery?
1 ☐ Cephalic
2 ☐ Breech
3 ☐ Other

D. Final route and method of delivery (check one)
1 ☐ Vaginal/Spontaneous
2 ☐ Vaginal/Forceps
3 ☐ Vaginal/Vacuum
4 ☐ Cesarean
If Cesarean, was a trial of labor attempted?
1 ☐ Yes 2 ☐ No

E. Hysterotomy/Hysterectomy
1 ☐ Yes 2 ☐ No

35. MATERNAL MORBIDITY (Complications associated with labor and delivery) (Check all that apply or check none)

1 ☐ Maternal transfusion
2 ☐ Third or fourth degree perineal laceration
3 ☐ Ruptured uterus
4 ☐ Unplanned hysterectomy
5 ☐ Admission to intensive care unit
6 ☐ Unplanned operating room procedure following delivery
0 ☐ None of the above

36. CONGENITAL ANOMALIES OF THE FETUS (Check all that apply or check none)

1 ☐ Anencephalus
2 ☐ Meningomyelocele/Spina Bifida
3 ☐ Congenital heart disease
4 ☐ Cyanotic congenital heart disease
5 ☐ Congenital diaphragmatic hernia
6 ☐ Omphalocele
7 ☐ Gastroschisis
8 ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
9 ☐ Cleft Lip with or without Cleft Palate
10 ☐ Cleft Palate alone
11 ☐ Down Syndrome
12 ☐ Karyotype confimed
13 ☐ Karyotype pending
14 ☐ Suspected chromosomal disorder
15 ☐ Karyotype confirmed
16 ☐ Karyotype pending
17 ☐ Hypospadias
18 ☐ Other (specify)_____
00 ☐ None of the anomalies listed above

CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

37a. 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 OR CHECK UNKNOWN)

Maternal Conditions/Diseases (Specify) _____

_____

Complications of Placenta, Cord, or Membranes

1 ☐ Rupture of membranes prior to onset of labor
2 ☐ Abruptio placenta
3 ☐ Placental insufficiency
4 ☐ Prolapsed cord
5 ☐ Chorioamnionitis
6 ☐ Other (Specify)
_____

Other Obstetrical or Pregnancy Complications (Specify) _____

_____

Fetal Anomaly (Specify) _____

_____

Fetal Injury (Specify) _____

_____

Fetal Infection (Specify) _____

_____

Other Fetal Conditions/Disorders (Specify) _____

_____

9 ☐ Unknown

37b. OTHER SIGNIFICANT CAUSES OR CONDITIONS
(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 37a OR CHECK UNKNOWN)

Maternal Conditions/Diseases (Specify) _____

_____

Complications of Placenta, Cord, or Membranes

1 ☐ Rupture of membranes prior to onset of labor
2 ☐ Abruptio placenta
3 ☐ Placental insufficiency
4 ☐ Prolapsed cord
5 ☐ Chorioamnionitis
6 ☐ Other (Specify)
_____

Other Obstetrical or Pregnancy Complications (Specify) _____

_____

Fetal Anomaly (Specify) _____

_____

Fetal Injury (Specify) _____

_____

Fetal Infection (Specify) _____

_____

Other Fetal Conditions/Disorders (Specify) _____

_____

9 ☐ Unknown

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

39a. WAS AN AUTOPSY PERFORMED?

1 ☐ Yes 2 ☐ No 3 ☐ Planned

39b. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?

1 ☐ Yes 2 ☐ No 3 ☐ Planned

39c. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?

1 ☐ Yes 2 ☐ No

40a. NAME OF PERSON COMPLETING REPORT *(TYPE OR PRINT)*

40b. DATE REPORT COMPLETED *(Month, Day, Year)*

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