STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH

121-________________
STATE FILE NUMBER

REPORT OF FETAL DEATH

(TYPE OR PRINT IN INK)

CHILD

1. CHILD'S NAME (If parents 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 complete address)
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, Suffix)

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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 city name, or township)
- ☐ 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 - IF NOT USA, NAME COUNTRY
18b. MOTHER'S DATE OF BIRTH (Month, Day, Year)
18c. CURRENT MARITAL STATUS (Never married, married, divorced, separated, etc.)
19a. FATHER'S STATE OF BIRTH - IF NOT USA, NAME COUNTRY
19b. FATHER'S DATE OF BIRTH (Month, Day, Year)

	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	20d. EDUCATION
MOTHER			☐ YES ☐ NO	☐
FATHER			☐ YES ☐ NO	☐

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 - 12 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

MOTHER

21. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ YES ☐ NO
22. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
23a. DATE OF FIRST PRENATAL CARE VISIT (Month, Day, Year)
23b. DATE OF LAST PRENATAL CARE VISIT (Month, 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 ☐ NO ☐ UNKNOWN

64a. For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked.

Average number of cigarettes or packs of cigarettes smoked per day

	# of cigarettes		# of packs
Three months before pregnancy	____	OR	____
First three months of pregnancy	____	OR	____
Second three months of pregnancy	____	OR	____
Last three months of pregnancy	____	OR	____

65. DID MOTHER QUIT SMOKING? ☐ YES ☐ NO ☐ UNKNOWN
66. DATE MOTHER QUIT SMOKING
25c. DO OTHERS IN HOUSEHOLD SMOKE? ☐ YES ☐ NO ☐ UNKNOWN

MEDICAL AND HEALTH INFORMATION

26. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS

26a. NOW LIVING
Number ____
None ☐

26b. NOW DEAD
Number ____
None ☐

26c. DATE OF LAST LIVE BIRTH (Month, Day, Year)

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

26e. DATE OF LAST OTHER PREGNANCY OUTCOME (Month, Day, Year)

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

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 (Specfy) ________________

30. MOTHER'S HEIGHT (Feet/Inches)
31a. MOTHER'S PREPREGNANCY WEIGHT (Pounds)
31b. MOTHER'S WEIGHT AT DELIVERY (Pounds)

DCH-0615 (11/13)

Please return to: Michigan Department of Community Health
Vital Records & Health Statistics Section
P.O. Box 30691, Lansing, Michigan 48909

Mother's Name ________________ Mother's Medical Record No. ________________

32. RISK FACTORS IN THIS PREGNANCY
(Check all that apply or check "None")

Diabetes
- ☐ 01 Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ 02 Gestational (Diagnosis in this pregnancy)

Hypertension
- ☐ 03 Prepregnancy (Chronic)
- ☐ 04 Gestational (PIH, preeclampsia)
- ☐ 05 Eclampsia

- ☐ 06 Previous preterm birth
- ☐ 07 Other previous poor pregnancy outcome (includes perinatal death, small-for gestational age/ intrauterine growth restricted birth)
- ☐ 08 Vaginal bleeding during this pregnancy prior to the onset of labor
- ☐ 09 Pregnancy resulted from infertility treatment -- If yes, check all that apply:
  - ☐ 10 Fertility-enhancing drugs, artificial insemination or intrauterine insemination
  - ☐ 11 Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
- ☐ 12 Mother had a previous cesarean delivery If yes, how many? ________
- ☐ 13 Alcohol use during pregnancy
- ☐ 00 None of the above
- ☐ 99 Unknown

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

- 1 ☐ Gonorrhea
- 2 ☐ Syphillis
- 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 MORIDITY
(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

Down Syndrome
- 11 ☐ Karyotype confirmed
- 12 ☐ Karyotype pending

Suspected chromosomal disorder
- 13 ☐ Karyotype confirmed
- 14 ☐ Karyotype pending

- 15 ☐ Hypospadias
- 16 ☐ 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 AND TITLE OF PERSON COMPLETING THE REPORT (Type or Print)

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

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