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| <p style="text-align: center;">INSTRUCTIONS FOR:</p> <p>Completion of the 2003 Version<br/>of the Fetal Death Report</p> | <p style="text-align: center;">EFFECTIVE DATE:</p> <p style="text-align: center;">June 1, 2003</p> | <p style="text-align: center;">INSTRUCTION LETTER<br/>NUMBER:</p> <p style="text-align: center;">_____ 15 _____</p> <p style="text-align: center;">Page <u>  1  </u> of <u>  25  </u></p> |
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These instructions provide information on the proper completion of the fetal death report as revised for use in the reporting of fetal deaths that occur on or after June 1, 2003. The revisions to the form are in response to the requirements of Act 562 of 2002 which changed the Michigan law on reporting fetal death and which takes effect on June 1, 2003. The revisions also adopt changes to reporting based upon a revised national standard form for reporting fetal death.

There are two versions of this form available for reporting a fetal death. Form DCH-0615 is a 2 sided 8 ½ by 11 inch form, while DCH-0615L is the same form but in a one sided 8 ½ by 14 inch format. Both forms carry the revision date of 6/2003 in the lower left hand corner of the form blank.

**Forward completed forms to the Department of Community Health. These reports are not to be filed with the local vital records registrar.**

Fetal death report forms dated earlier than 6/2003 should be retained for use in reporting fetal deaths occurring earlier than June, 2003, until all are reported. The supplies of pre 6/2003 forms will then become obsolete and must be destroyed. As the fetal death reports for deliveries through May 2003 are cleared up it is important to properly match the form used with the event being recorded.

From 1978 until June, 2003, the fetal death reports were reports used only for medical and health purposes and were not retained nor made available as official records of these events. Fetal death certificates that were registered prior to 1978 and after June 1, 2003 are permanent records of the events and are available to family members as certified copies.

Note that certified copies of a Certificate of Stillbirth for still births reported on and after June 1, 2003, can be obtained by the parents directly from the Department of Community Health. Certified copies are generally available within 60 days of filing the Report of Fetal Death with the Department.

#### Responsibility for the Report

When it is determined that a fetal death has occurred, it is the responsibility of the facility where the delivery occurred to report the event to the Michigan Department of Community Health within 5 days. The facility also has the responsibility to report a fetal death should the delivery occur en route to the facility and be attended to shortly thereafter.

If a fetal death occurs outside a facility and is not attended to shortly after birth within a facility, the physician in attendance at the delivery is responsible for reporting the event.

In instances where the attendant is not a physician, arrangements for the reporting of the fetal death must be made directly with the medical examiner of the county where the delivery occurred. Fetal deaths that occur without medical attendance must be reported to the medical examiner. Section 333.2834(5) requires that if a fetal death occurs without medical attendance at or after the delivery, the attendant, the mother or other person having knowledge of the fetal death shall notify the medical examiner of the county where the delivery occurred.

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### Definition of a Reportable Fetal Death

Michigan law defines when the delivery of a still birth delivered dead is reportable. The definition of a fetal death contained in section 333.2803 of the Michigan Compiled Laws is:

The death of a fetus which has completed at least 20 weeks of gestation or weighs at least 400 grams.

The fetus must be separated from the mother, i.e., delivered, to be reportable. A fetus that dies in utero prior to the end of the 20 weeks gestation and before reaching 400 grams need not be reported.

Note that this definition does not apply to the proper disposition of a stillborn fetus. It is important to distinguish that this section relates to the reporting of a fetal death only. A permit for the disposition of a dead fetus is required regardless of the gestational age or the weight of the fetus. For more information refer to Instruction Letter Number 1, Issuance of Burial Transit Permits for Disposition of Dead Fetuses.

While the development of the fetus is important to determining when to report a fetal death, it is first essential to determine that the fetus was delivered dead. What constitutes evidence of life is for the physician or other attendant to determine. To aid the attendant in determining the presence of life, the current definition of a live birth as defined in section 333.1071 of the Michigan Compiled Laws is:

The complete expulsion or extraction of a product of conception from its mother, regardless of the duration of the pregnancy, that after expulsion or extraction, whether or not the umbilical cord has been cut or the placenta is attached, shows any evidence of life, including, but not limited to, one or more of the following: breath, a heartbeat, umbilical cord pulsation or definite movement of voluntary muscles.

**Note:** A birth certificate, rather than a fetal death report, must be filed if the attendant determines that a live birth occurred. In addition, if the infant subsequently dies, a death certificate must be filed for the child, irrespective of the duration of life or the viability of the live born.

### Completion of the Report of Fetal Death

Under the provisions of new fetal death reporting law, which was amended by Act 562 of 2002, information within a report of fetal death that is completed and filed pursuant to the law is retained in the state vital records repository as a permanent legal record of the event. This law is effective for fetal death reports filed on and after June 1, 2003. The information will be available for the issuance of certified copies to permit establishing the facts of a fetal death. Great care should be taken in the preparation of these documents to insure each is complete, accurate and legible.

The reports may be typed or hand written. If completed by hand, please print legibly. Hand written entries must be in ink. Unlike a live birth certificate or a death certificate, however,

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corrections and amendments can be made to these reports by erasing or crossing out incorrect entries. Please be sure any corrections are legible and understandable.

The names of the individuals recorded on the document, including the child and the parents must be written in English alphabetic characters, except that surname suffixes may be entered as Roman or Arabic numerals.

These reports also serve to provide valuable information essential to the measurement of perinatal health, the development and evaluation of programs to improve pregnancy outcomes and other important uses. The usefulness of these reports in accomplishing these purposes relates directly to the completeness in reporting these significant events and to the care taken in collecting and reporting on each fetal death that occurs. It is important to complete all items. Each item should be completed as specified in the instruction for that item.

It is important to avoid abbreviations except as recommended for specific items.

Entries of "-" or "x" should not be used except for check box items.

Upon completion, fetal death reports are to be shipped directly to:

Registration Unit  
Vital Records and Health Data Development Section  
Michigan Department of Community Health  
P.O. Box 30691  
Lansing, Michigan 48909

Do not send these to a local registrar's office.

Forwarding reports on at least a weekly basis is recommended.

Upon filing the report, it will be reviewed for completeness, legibility, accuracy and conformity to these instructions. If the record is not acceptable for filing, it will be returned to you. You will be responsible for preparing an acceptable record and for filing the replacement record within 5 days of the returned record.

**SPECIFIC INSTRUCTIONS FOR COMPLETING EACH ITEM**

*The line in the legend of the form is for the state file number and should be left blank. This is for Michigan Department of Community Health use only.*

**Item 1      Child - Name**

If the parent or parents have chosen to name the child, enter the name given to the child by the parent(s) of the child. Enter the name in the order of first, middle and last name. Junior (Jr.) or II, III, etc. or similar designations may be entered following the last name.

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Verify the spelling of the child's name with the parent(s).

If the parent or parents have chosen not to name the child, enter the last name only. Leave the spaces for the first and middle name blank. DO NOT ENTER THE WORDS BABY GIRL, BABY BOY, TWIN A OR TWIN B, etc.

The surname (last name) may be any name designated by the child's parent(s).

Item 2     Sex of Child

Record the sex of the fetus by indicating male, female or indeterminable.

Item 3     Name And Title Of Attendant

Enter the name and title of the individual who attended the delivery.

Item 4     Birthweight of Fetus

Enter weight of the fetus as it is recorded in the hospital records. Entries should be made in either grams or pounds and ounces depending on the scales used. Do not convert from one measure to the other. Specify the type of measure used (grams or pounds and ounces). Weight in grams is preferred.

Item 5     Obstetric Estimate of Gestation

Enter gestation in weeks as best determined by a physician or a qualified nurse in the absence of a physician.

Item 6     Date of Delivery

Enter the exact month, day and year of the delivery. Enter the full or standard abbreviated name of the month. Example: Sept. or September.

Do not use a number for a month or use numbers such as 6/12/75 for the date. This date should be written as June 12, 1975.

Deliveries occurring at midnight are considered as having occurred at the end of one day rather than the beginning of the next day.

Item 7     Time of Delivery

Enter the exact time (hour and minute) that the fetus was delivered. Enter 12 noon as "12 noon" and 12 midnight as "12 MID." One minute after noon is entered as 12:01 P.M. and one minute after midnight is entered as 12:01 A.M.

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Note: When a plural delivery occurs the exact time of each delivery should be recorded.

Item 8a Facility Name

If the delivery occurred in a hospital, enter the full name of the hospital. If the delivery occurred en route to the hospital enter the name of the hospital and add the words en route.

If the delivery occurred at a place other than a hospital, enter the street address or a description of the place where the delivery occurred.

If the delivery occurred at home or at some other place outside a hospital and the mother and child were subsequently taken to a hospital, enter the address and zip code of the actual place of occurrence (for example, the home address) as the place of delivery. If a child is born at home, items 8a and 15 must agree while 27 may differ.

Item 8b City, Village, or Township of Delivery

Enter the name of the city, village or township in which the delivery occurred. The name of the city should be entered only if the delivery occurred within the corporate city limits. If the delivery occurred outside the city limits, the village or township of occurrence should be entered.

Item 8c County of Delivery

Enter the county where the delivery occurred. This may differ from the county of residence of the parent(s). (Note: Care should be taken not to enter Michigan in this item.)

Item 9 Mother's Current Legal Name

Enter the current legal name of the mother. Verify the spelling of the name with the mother.

Item 10 Father's Current Legal Name

Enter the current legal name of the father as instructed below.

Note: A woman may name the father of a fetal death regardless of whether the child was conceived in wedlock. Note that an acknowledgment of

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paternity can be filed for a still birth but is not required prior to listing a father on a Report of Fetal Death.

Item 11     Mother's Full Name Before First Married If Different From Current Name

Enter the surname before first married of the woman who delivered the fetus. If the woman is married, widowed, or divorced, be sure to enter her surname before first being married, not a last name acquired by marriage. Verify the spelling of the name with the mother.

Item 12     Medical Record Number Of Mother

Enter the facility's medical record number used for the mother.

If the delivery was not in a facility nor attended in a facility following delivery, leave this item blank.

Item 13     Expected Source of Payment for Medical Services

Enter the expected source of payment for the medical expenses associated with attending the delivery and/or any subsequent medical care associated with the delivery. (Self-pay, private insurance, HMO, Medicaid, etc.)

Note that if the mother's expenses are covered by Medicaid through a managed care plan, enter Medicaid.

Item 14     Residence of Mother

This section is designed to give the geographic location of the mother's usual residence.

The mother's residence is the place where she has set up housekeeping and usually sleeps. This is not necessarily the same as her home state, voting residence or legal residence.

Never enter a temporary residence such as one used during a visit, business trip or a vacation. Residence for a short time at the home of a relative, friend or home for unwed mothers for the purpose of awaiting delivery is considered to be temporary and should not be entered here. However, place of residence during a tour of military duty or during attendance at college is not considered as temporary and may be used.

THE ACTUAL PLACE OF RESIDENCE MAY DIFFER FROM THE MOTHER'S MAILING ADDRESS.

ENTER THE ACTUAL PLACE OF RESIDENCE ONLY IN THIS ITEM.

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Item 14a Residence of Mother - State

Enter the state where the mother resides.

Item 14b County of Residence

Enter the name of the county in which the mother resides.

Item 14c Residence - Place

Check the appropriate box of "inside city or village of", "inside township of" or "unincorporated place of" to describe the locality where the mother resides as appropriate. In areas close to urban centers, there is a tendency for a person to identify with the city. Care must be taken to determine whether the "usual residence" is located within the corporate limits of any city or village. If the "usual residence" is not located within the corporate limits of any city or village, the box indicating "unincorporated place of" should be checked.

Enter the name of the locality pertaining to the box checked.

Item 15 Residence Street Address

Enter the complete residence address of the mother.

Item 16 Zip Code

Enter the residence zip code of the mother.

Item 17 Mother's Mailing Address if Different From Residence

Enter the complete mailing address of the mother, if different from the mother's residence address.

Item 18a Mother's State of Birth

If the mother was born in the United States, enter the name of the state. If the mother was not born in the United States, enter the name of the country. If the mother was born in the United States, but the state is unknown, enter U.S. - unknown.

If the mother was born in a foreign country but the country is unknown, enter foreign - unknown.

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Item 18b Mother's Date of Birth

Enter the exact month, day and year that the mother was born.

Enter the full or abbreviated name of the month (Jan., Feb., March, etc.). Do not use a number for a month. A birth date of June 12, 1965 should be written June 12, 1965 instead of 6/12/65.

Item 18c Was Mother Married at Delivery or Conception?

If mother was married at time of conception and/or at the time of birth, enter yes. If mother was not married at time of conception nor at the time of birth, enter no.

Item 19a Father's State of Birth

If the father was born in the United States, enter the name of the state. If the father was not born in the United States, enter the name of the country.

If the father was born in the United States, but the state is unknown, enter U.S. - unknown.

If the father was born in a foreign country but the country is unknown, enter foreign - unknown.

If no father is named in item 10, this item and all other items on the father may be left blank.

Item 19b Father's Date of Birth

Enter the exact month, day and year that the father was born.

Enter the full or abbreviated name of the month (Jan., Feb., March, etc.). Do not use a number for a month. A birth date of June 12, 1965 should be written June 12, 1965 instead of 6/12/65.

If no father is named in item 10, this item and all other items on the father may be left blank.

Item 20a Race

Enter the race of the mother and of the father as obtained from the parent(s) or other informant. This item should be completed for the mother on all reports and



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for the father in all cases where the name of the father is shown on the report. The entry in this item should reflect the response of the informant.

For Asians and Pacific Islanders, enter the national origin of the mother and father, such as Chinese, Japanese, Korean, Filipino or Hawaiian.

If the informant indicates that the mother and/or father is of more than one race, enter all races or ancestries.

Race of the Mother

Enter the race of the mother as explained above.

Race of the Father

Enter the race of the father as explained above.

Item 20b Ancestry

Enter the ancestry as obtained from the parent(s) or other informant. This item should be completed for the mother on all reports and for the father if known. **Do not leave this item blank.** The entry in this item should reflect the response of the informant. (If ancestry information is not available, enter unknown.)

For the purpose of this item, ancestry refers to the nationality, lineage or country in which the person or his or her ancestors were born before their arrival in the United States. Alaska Native ancestry should be entered as such.

For **American Indian**, enter the **principle tribe** in the ancestry item.

There is no set rule as to how many generations are to be taken into account in determining ancestry. A person may report ancestry based on the country of origin of a parent, grandparent or some far-removed ancestor. The response should reflect what the person considers himself or herself to be and is not based on percentages of ancestry.

Some persons may not identify with the foreign birthplace of their ancestors or with a nationality and may report "American." If, after clarification of the intent of this item, the person still feels that he or she is an American, enter "American" on the record.

If a person indicates that he or she is of multiple ancestry, enter the ancestry as reported (for example, English-Scottish-Irish, Mexican-American).

If a respondent gives a religious group - such as, Jewish, Moslem, or Protestant - ask for the country of origin or nationality.

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This item is not a part of the Race item. Both questions, Race and Ancestry, should be asked independently. This means that for certain groups - such as Japanese, Chinese or Hawaiian, the entry will be the same in both items. The entry should be made in both items even if it is the same. However, an entry of "Black" or "White" should never be recorded in the ancestry item.

Mother - Ancestry

Enter the specific ancestry of the mother as indicated above.

Father - Ancestry

Enter the specific ancestry of the father as indicated above.

Item 20c Hispanic Origin

Indicate whether the mother and/or the father are of Hispanic origin. Enter yes or no.

Examples of Hispanic origins include: Mexican, Cuban, Salvadoran, Colombian, etc.

Item 20d Education

Indicate the category that best describes the highest degree or level of school completed by the mother and the father. Report only those years of school that were completed. A person who enrolls in college but does not complete one full year should not be identified with any college education in this item.

Count formal schooling. Do not include beauty, barber, trade, business, technical or other special schools when determining the highest grade completed.

Education of the Mother

Enter the education of the mother as explained above.

Education of the Father

Enter the education of the father as explained above.

Item 21 Did Mother Get WIC Food For Herself During This Pregnancy?

This item is to be completed based on information obtained from the mother. Either the "yes" or "no" box must be checked.

If the information is unknown, enter "unknown".

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Item 22     Date Last Normal Menses Began

Enter the month, day and year of the mother's last normal menses.

If an exact date is unknown, enter an approximate date.

If unknown, enter unknown.

Item 23     Prenatal Care

Information that summarizes the prenatal care of the mother is necessary to complete items 23a, 23b and 23c.

Item 23a    Date of First Prenatal Care Visit

Enter the date the first prenatal care visit occurred. Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman.

If no prenatal care was received, enter none. If Item 23c is reported "None," this item should also be completed as "None."

**Do not leave this item blank.**

Item 23b    Date of Last Prenatal Care Visit

Enter the date the last prenatal care visit occurred.

If no prenatal care was received, enter none. If Item 23c is reported "None," this item should also be completed as "None."

**Do not leave this item blank.**

Item 23c    Prenatal Visits - Total Number

Enter the number of visits made for medical supervision of the pregnancy by a physician or other health care provider during the prenatal period.

If no prenatal care was received, enter "None". If Items 23a and 23b are reported as "None," this item should also be completed as "None."

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If "None," is entered in Item 23a and 23b and a number is reported in Item 23c, check to determine if a mistake has been made.

**Do not leave this item blank.**

Item 24 Plurality - Single, Twin, Triplet, etc.

When a plural delivery occurs, prepare and file a separate certificate of live birth or report of fetal death for each child or fetus depending upon the status of each child in the set. File certificates and reports relating to the same plural delivery at the same time. However, if holding the completed certificates or reports while waiting for incomplete ones would result in late filing, the completed certificate should be filed first.

Item 24a Plurality of This Pregnancy

Specify the birth as single, twin, triplet, quadruplet, etc.

Item 24b If Not Single Birth

For multiple births, specify the order in which the fetus being reported was delivered - first, second, third, etc.

If this is a single delivery, leave the item blank.

Item 25a Did Mother Smoke Before or During Pregnancy?

Indicate whether mother smoked before or during pregnancy by entering "Yes", "No" or "Unknown".

Item 25b If Mother Quit Smoking, How Long Ago?

If mother quit smoking, enter how long ago she quit. Enter the number of weeks, months or years since she quit. Be sure to indicate the number and whether weeks, months, or years, i.e., "5 years".

If unknown, enter unknown.

If the mother never smoked or never quit, leave this item blank.

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Item 25c Do Others in the Household Smoke?

Indicate whether others in the household smoke by entering "Yes", "No" or "Unknown".

Enter "Yes" if the mother was living with others who were smokers during any part of her pregnancy.

Item 26 Pregnancy History (Complete Each Section)

When certificates or reports are prepared for a plural delivery, items 26a through 26e on the certificate or report of the first-delivered should not include any of the other deliveries. On the certificate or report of the second delivery, these items should include information about the first delivery of the plural delivery. Similarly, for the third delivery, these items should include information about the first and second deliveries, and so on.

Item 26a Live Births Now Living

Enter the number of children born alive to this mother who are still living at the time of this delivery. Do not include children by adoption.

Check the box marked none if this is the first delivery to this mother or if all previous children are dead.

If this information is unavailable, enter unknown.

Item 26b Live Births Now Dead

Enter the number of prior children born alive to this mother who are no longer living at the time of this delivery. Do not include children by adoption.

Check the box marked none if this is the first delivery for this mother or if all previous children are still living.

If no information is available, enter unknown.

Item 26c Date of Last Live Birth

Enter the date (month, day and year) of birth of the last live-born child of the mother.

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If this report is for the second delivery of a twin set, enter the date of birth for the first baby of the set, if it was born alive. Similarly, for triplets or other multiple deliveries, enter the date of birth of the previous live birth of the set. If all previously born members of a multiple set were born dead, enter the date of the mother's last delivery that resulted in a live birth.

Enter the full name or abbreviation of the month - Jan., Feb., March, etc. Do not use a number to designate the month.

If only a partial date is known, i.e., month and year or year only, enter the partial date.

Enter "Not applicable," or "None," if the mother has not had a previous live birth.

If no information is available, enter unknown.

**Do not leave this item blank.**

Item 26d Other Pregnancy Outcomes

Enter the number of fetuses that were delivered dead regardless of the length of gestation. Include each recognized loss of a product of conception, such as ectopic pregnancy, miscarriage, fetal death and spontaneous or induced abortion. Do not include this fetus.

Check "None" if this is the first delivery for this mother or if all previous deliveries resulted in live-born infants.

Item 26e Date of Last Other Pregnancy Outcome

Enter the date (month, day and year) of the last termination of pregnancy that was not a live birth regardless of the length of gestation.

Enter the full or abbreviated name of the month (Jan., Feb., March, etc.). Do not use a number for the month.

If only a partial date is known, i.e., month and year or year only, enter the partial date

If the mother has never had such a termination, enter "Not applicable" or "None."  
**Do not leave this item blank.**

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If this report is for the second delivery of a twin set and the first was born dead, enter the date of delivery of that fetus. Similarly, for other multiple births, if any previous member of the set was born dead, enter the date of delivery of that fetus. If all previously born members of a multiple set were born alive, enter the date of the mother's last delivery that resulted in a fetal death.

Item 27 Mother Transferred for Maternal Medical or Fetal Indications for Delivery?

Check "No" if this is the first facility the mother was admitted to for delivery. Check "Yes" if the mother was transferred from one facility to another facility before the fetus was delivered.

If the mother was transferred before delivery, enter the name of the facility that transferred her. If the mother was transferred more than once, enter the name of the last facility from which she was transferred.

Item 28 Attendant at Delivery

Indicate the title of the attendant at delivery by checking M.D., D.O., nurse, etc. If the title of attendant is not listed on the report, check other and enter a description of the attendant on the line provided.

Item 29 Place Where Delivery Occurred

Report a categorical description for the place of delivery in this item. Check the box that best describes the place of delivery where the birth occurred. A birthing center located in and operated by a hospital is considered part of the hospital and should be reported as occurring in the hospital. Freestanding birthing centers include those facilities that are operated independently from hospitals (autonomously). The "clinic/doctor's office" category includes other non-hospital outpatient facilities where births occasionally occur.

If a home delivery, indicate whether home delivery was planned or unplanned, by checking the appropriate box.

If the place of delivery is other than the options listed, check other and enter the type of place.

Item 30 Mother's Height

Enter the mother's height in feet and inches. If the record indicates height in fractions such as 5 feet 6 ½ inches, truncate and enter 5 feet, 6 inches.

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If the mother's height is unknown, print or type "unknown" in the space.

Item 31a Mother's Pre-Pregnancy Weight

Record weight in whole pounds only; do not include fractions.

If the mother's pre-pregnancy weight is unknown, print or type "unknown" in the item's space.

Item 31b Mother's Weight at Delivery

Record weight in whole pounds only; do not include fractions.

If the mother's delivery weight is unknown, print or type "unknown" in the item's space.

Check Box Items 32-36

The following medical and health items are formatted into check boxes for ease of manual completion. It has been demonstrated that this format generally produces higher quality and more complete information than open-ended items. Please review each check box listed and carefully check the appropriate box(es). Clearly mark an "X" or check the box. The mark should not overlap more than one box.

Item 32 Risk Factors in This Pregnancy

Report each of the risk factors that the mother experienced during this pregnancy. The mother may have more than one risk factor; check all that apply. Complications should be entered even if they are a part of the cause of fetal death in Item 37. Risk factors should be identified from the hospital or physician record.

**Do not leave this item blank.**

Indicate all risk factors by checking all appropriate box(es) or by writing the number(s) associated with the risk factor, overwriting across the printed text within this item.

If there were no risk factors, check "None of the above" or write "None".

If unknown enter "Unknown."

An explanation for each reportable risk factor is provided below:

1. DIABETES (PRE-PREGNANCY): Glucose intolerance requiring treatment diagnosed prior to this pregnancy.



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2. DIABETES (GESTATIONAL): Glucose intolerance requiring treatment diagnosed during this pregnancy.
3. HYPERTENSION (PRE-PREGNANCY): (Chronic) Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy.
4. HYPERTENSION (GESTATIONAL): (PIH, Preeclampsia, eclampsia) Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy.
5. PREVIOUS PRE-TERM BIRTHS: History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.
6. OTHER PREVIOUS POOR PREGNANCY OUTCOME: (Includes perinatal death, small for gestational age/intrauterine growth restricted birth) History of pregnancies continuing into the 20<sup>th</sup> week of gestation (post menstrual age) and resulting in any of the listed outcomes. Perinatal death includes fetal and neonatal deaths.
7. VAGINAL BLEEDING DURING THIS PREGNANCY PRIOR TO THE ONSET OF LABOR: Any reported or observed bleeding per vaginum at any time in the pregnancy presenting prior to the onset of labor.
8. PREGNANCY RESULTED FROM INFERTILITY TREATMENT: Any assisted reproduction technique whether artificial insemination, drugs (e.g., Clomid, Pergonal) or any technical procedures (e.g., in-vitro fertilization) used to initiate the pregnancy.
9. PREVIOUS CESAREAN DELIVERY: Previous operative delivery in which the fetus is extracted through an incision in the maternal abdominal and uterine walls.
10. ALCOHOL USE DURING PREGNANCY: The use of alcohol by the mother during this pregnancy constituted a potential or perceived risk to the pregnancy.

Item 33     Infections Present and/or Treated During This Pregnancy

Infections present at the time of pregnancy diagnosis or confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment is adequate if a definitive diagnosis is not present in the available record.

**Do not leave this item blank.**

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Indicate all infections by checking all appropriate box(es) or by writing the number(s) associated with each diagnosis, overwriting across the printed text within this item.

If there were no infections to report, check "None of the above" or write "None".

If the prenatal care record is not available and the information is not available from other medical records, write "unknown" in the space.

If some other infection not listed was diagnosed that affected the pregnancy, check "Other" and specify the diagnosis.

More than one infection may be checked.

1. GONORRHEA – a positive test for *Neisseria gonorrhoeae*.
2. SYPHILIS also called lues - a positive test for *Treponema pallidum*.
3. GENITAL HERPES – a positive test for genital herpes.
4. CHLAMYDIA - a positive test for *Chlamydia trachomatis*.
5. LISTERIA (LM) – a diagnosis of or positive test for *Listeria monocytogenes*.
6. GROUP B STREPTOCOCCUS (GBS) – a diagnosis of or positive test for *Streptococcus agalactiae* or group B streptococcus.
7. CYTOMEGALOVIRUS (CMV) – a diagnosis of or positive test for Cytomeglovirus.
8. PARVO VIRUS (B19) – a diagnosis of or positive test for Parvo virus B19.
9. TOXOPLASMOSIS (Toxo) – a diagnosis of or positive test for *Toxoplasmosis gondii*.

Item 34     Method of Delivery

A response to each of the 5 sections within this item is required.

If any of the information for an individual section is not known, print or type unknown in the space for the particular section.

The following definitions pertain to the method of delivery items:

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**ATTEMPTED FORCEPS OR VACUUM:** Obstetric forceps, ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt to effect delivery of the head through the vagina.

**CEPHALIC PRESENTATION:** Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP).

**BREECH PRESENTATION:** Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech.

**OTHER PRESENTATION:** Any other presentation or presenting part not listed above.

**SPONTANEOUS DELIVERY:** Delivery of the entire fetus through the vagina by the natural forces of labor with or without manual assistance from the delivery attendant.

**FORCEPS DELIVERY:** Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.

**VACUUM DELIVERY:** Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.

**CESAREAN DELIVERY:** Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.

**HYSTEROTOMY/HYSTERECTOMY:** Hysterotomy – the incision into the uterus extending into the uterine cavity. May be performed vaginally or transabdominally. Hysterectomy – the surgical removal of the uterus. May be performed abdominally or vaginally.

**SECTION A: DELIVERY ATTEMPTED WITH FORCEPS**

Either the “yes” or “no” box for the item “Attempted forceps” must be checked.

**SECTION B: DELIVERY ATTEMPTED WITH VACUUM**

Either the “yes” or “no” box for the item “Attempted vacuum” must be checked

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SECTION C: FETAL PRESENTATION AT DELIVERY

Choose one box only.

SECTION D: FINAL ROUTE AND METHOD OF DELIVERY

Choose one box only.

If "Cesarean" is checked, a response to the question on the attempted trial of labor is required.

If the final route and method chosen is "forceps," the variable for "Attempted forceps" must be assigned the "no" code.

If the final route and method chosen is "vacuum," the variable "Attempted vacuum" must be assigned the "no" code.

SECTION E. HYSTEROTOMY/HYSTERECTOMY

Either the "yes" or "no" box for the section if either procedure was used for this delivery.

Item 35 Maternal Morbidity

Check all boxes that apply. If none are indicated, check "None of the above." If the data are not available, indicate "Unknown". **DO NOT LEAVE THIS ITEM BLANK.**

The following definitions pertain to the maternal morbidity section:

**MATERNAL TRANSFUSION:** Includes infusion of whole blood or packed red blood cells within the period specified.

**THIRD OR FOURTH DEGREE PERINEAL LACERATION:** 3<sup>rd</sup> degree laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4<sup>th</sup> degree laceration is all of the above with extension through the rectal mucosa.

**RUPTURED UTERUS:** Tearing of the uterine wall.

**UNPLANNED HYSTERECTOMY:** Surgical removal of the uterus that was not planned prior to admission for delivery. Includes an anticipated or possible but not definitively planned procedure.

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ADMISSION TO INTENSIVE CARE UNIT: Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care.

UNPLANNED OPERATING ROOM PROCEDURE FOLLOWING DELIVERY: Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.

Item 36 Congenital Anomalies of the Fetus

Indicate all malformations of the fetus diagnosed prenatally or after delivery.

Report all that apply.

**Do not leave this item blank.**

Indicate all appropriate condition by checking all appropriate box(es) or by writing the number(s) associated with the diagnosis, overwriting across the printed text within this item.

If there were no anomalies to report, check "None of the above" or write "None".

If the prenatal care record is not available and the information is not available from other medical records, write "unknown" in the space.

If some other anomaly not listed was diagnosed that was medically significant, check "Other" and specify the diagnosis on the line provided.

More than one anomaly may be checked.

The following definitions pertain to the congenital anomalies section:

**ANENCEPHALY:** Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Fetus' with craniorachischisis (anencephaly with contiguous spine defect) should also be included in this category.

**MENINGOMYELOCELE / SPINA BIFIDA:** Spina bifida refers to herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele refers to herniation of meninges and spinal cord tissue. A fetus with meningocele (herniation of meninges without spinal cord tissue) should also be included in the category. Both open and closed (covered with skin) lesions should be included. Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges) should not be included in this category.

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**CONGENITAL HEART DISEASE:** Any congenital heart condition prenatally or postnatally diagnosed.

**CYANOTIC CONGENITAL HEART DISEASE:** Congenital heart defects which cause cyanosis. Includes but is not limited to transposition of the great arteries (vessels), teratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.

**CONGENITAL DIAPHRAGMATIC HERNIA:** Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.

**OMPHALOCELE:** A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane, (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Umbilical hernia (completely covered by skin) should not be included in this category.

**GASTROSCHISIS:** An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.

**LIMB REDUCTION DEFECT:** (excluding congenital amputation and dwarfing syndromes) Complete or partial absence of a portion of an extremity secondary to failure to develop.

**CLEFT LIP WITH OR WITHOUT CLEFT PALATE:** Cleft lip with or without cleft palate refers to incomplete closure of the lip. Cleft lip may be unilateral, bilateral or median; all should be included in this category.

**CLEFT PALATE ALONE:** Cleft palate refers to incomplete fusion of the palatal shelves. This may be limited to the soft palate or may also extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without cleft Palate" category, rather than here.

**DOWN SYNDROME:** Trisomy 21

**SUSPECTED CHROMOSOMAL DISORDER:** Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure. Examples include Turner's

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syndrome, Trisomy 13 or Patau's syndrome, Trisomy 18 or Edward's syndrome and autosomal deletion syndromes.

Note: The selection of Karyotype pending or confirmed for the Down Syndrome and suspected chromosomal disorder anomalies should only be checked if the corresponding box for Down Syndrome and/or Suspected chromosomal disorder boxes are checked. This information serves to establish the certainty of the diagnosis.

HYPOSPADIAS: Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree – on the glans ventral to the tip, second degree – in the coronal sulcus, and third degree – on the penile shaft.

Items 37a  
and 37b

Cause/Conditions Contributing to Fetal Death - Overview

A fetal death report provides important information used for medical and epidemiological research on disease etiology and evaluating the effectiveness of diagnostic and therapeutic techniques. It is a measure of health status at local, state, national, and international levels.

The cause-of-death section consists of two parts. The initiating cause/condition (37a) is for reporting a single condition that most likely began the sequence of events resulting in the death of the fetus. Other significant causes or conditions (37b) include all other conditions contributing to death. These conditions may be conditions that are triggered by the initiating cause (37a) or causes that are not among the sequence of events triggered by the initiating cause (37a).

Cause of fetal death should include information provided by the pathologist if tissue analysis, autopsy, or another type of postmortem exam was done. If microscopic exams for a fetal death are still pending at the time the report is filed, the additional information should be reported to the registrar as soon as it is available.

Physician's responsibility

The physician's primary responsibility in completing the cause-of-death section is to report to the best of his or her knowledge, based upon available information, the initiating condition that most likely began the sequence of events resulting in the death of the fetus and other contributing causes or conditions.

Medical examiner's responsibility

When a death occurs without medical attendance at or immediately after the delivery, or when further investigation is otherwise indicated, a medical examiner shall investigate the fetal death. An unattended fetal death must be reported to the medical examiner as required by State law. The medical examiner must investigate

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the cause of death and prepare and file the report {MCL 333.2834(4)}.

General instructions for completing cause of fetal death

Abbreviations and parentheses should be avoided in reporting causes of death.

The original fetal death report should be amended if additional medical information or autopsy or histological placental findings become available that would change the cause of death originally reported.

Unattended fetal deaths, without medical attendance at or immediately after the delivery, must be reported to the medical examiner in accordance with MCL 333.2834(4) with the fetal death reported by the medical examiner.

It is important to report the underlying cause of the death. The terminal event which led to death should not be used. The initiating cause of the terminal event should be reported in 37a. The cause of death to report in item 37a should be:

*The disease or injury that is responsible for initiating the lethal chain of events which led to death.*

Do not report the mode of death in item 37a such as respiratory failure or terms such as intrauterine fetal demise. If an organ system failure is listed as a cause of death, its etiology should be reported.

If an external cause of death, the fatal injury (e.g., stab wound of mother's abdomen), the trauma, and impairment of function should always be reported.

All diseases or conditions contributing to death that were not reported in 37a and that did not result in the initiating cause of death should be reported in 37b.

If two or more possible sequences resulted in death, or if two conditions seem to have added together, the one that most directly caused death should be reported in 37a. Report in 37b all other conditions or diseases that contributed to the death.

Item 38     Estimated Time of Fetal Death

Item to indicate when the fetus died with respect to labor and assessment. The most appropriate box should be checked to indicate the time of fetal death.

Item 39a    Was An Autopsy Performed?

Item to indicate whether an autopsy was performed. If a partial or complete autopsy was performed, 'Yes' should be selected.

If an autopsy has been ordered but not yet performed, check "Planned".



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Item 39b Was A Histological Placental Examination Performed?

Item to indicate whether a histological placental examination was performed. If any histological placental examination was performed, 'Yes' should be selected.

If a placental examination has been ordered but not yet performed, check "Planned".

Item 39c Were Autopsy or Histological Placental Examination Results Used in Determining the Cause of Fetal Death?

If yes is checked for either 39a or 39b, complete item 39c. Otherwise, leave this item blank.

Item 40a Name of Person Completing Report

Enter the name of the person completing the report. This is the person who completed the form and may not necessarily be the physician or medical examiner who determined the cause of death. If more than one person completed various parts of the form enter the name of the primary contact for questions on the report.

Item 40b Date Report Completed

Enter the date (month, day and year) the report was completed. Write out the month or use standard abbreviations. Do not use numbers such as 6/1/03 in writing the date. This date should be written as June 1, 2003.

Send the completed report within 5 days after the delivery to:

Registration Unit  
Vital Records and Health Data Development Section  
Michigan Department of Community Health  
P.O. Box 30691  
Lansing, MI 48909

Questions regarding the completion of the fetal death reports may be addressed to the Registration Unit at (517) 335-8685.