Commonwealth of Massachusetts
Registry of Vital Records and Statistics

REPORT OF FETAL DEATH

Form R304W-102014

HOSPITAL WORKSHEET FOR REPORT OF FETAL DEATH

INSTRUCTIONS: Use this worksheet to assist you in the completion of the Report of Fetal Death. Fetal deaths are reportable when twenty weeks or more gestation OR of a weight of 350 grams or more. On the actual Report of Fetal Death, use only durable black ink. Strikeovers, erasures, liquid erasure, use of correction tape on correcting typewriters are not permitted. Complete front and reverse sides of form, and send original copy to:

Registry of Vital Records and Statistics/ Natality Data Unit—FD, 150 Mt. Vernon Street, 1st Floor, Dorchester, MA 02125.

When forwarding for disposition permit: Do not send the original report to the local Board of Health. Photocopy and forward only Page 1 of 4 AND Page 2 of 4 (Cause of Death/Certifier Info) of the Form R304-102014. The original report must be sent to the Department of Public Health at the address listed above.

Please direct any questions to (617) 740-2681, or refer to the "Manual for Completing the Massachusetts Report of Fetal Death."

	Mother's Medical Record Number	**Place Where Delivery Occurred** *(Check one)*
		☐ Hospital ☐ Clinic/Doctor's office ☐ Freestanding birthing center ☐ Unknown ☐ Other *(specify)*_____ ☐ Home Delivery Planned to deliver at home? ☐ Yes ☐ No

Fetus

Name of Fetus (optional-at the discretion of the parents) *First Name*	**Time of Delivery** *(24 hr)*	**Sex** ☐ Male ☐ Female ☐ Unknown	**Weight of Fetus** *(grams)*	**Obstetric Estimate of Gestation at Delivery** *(completed weeks)*
Middle Name	**Date of Delivery** *(Month, Day, Year)*			
Last Name	**Plurality** (*specify*) ☐ Single ☐ Other_____ ☐ Twin	**Birth Order** (*specify if plural birth*) ☐ 1st ☐ 3rd ☐ 2nd ☐ Other _____		**Clinical Estimate of Gestation** *(in weeks)*

Mother/Parent

Mother's Name *First Name*	*Middle Name*
Last Name	*Surname at Birth or Adoption (Maiden Name)*
Date of Birth *(Month, Day, Year)*	**Birthplace** *(City/Town, State, Country)*

Residence of Mother- *Please give the actual address where the mother lives now, including the name, number and proper city/town name. Do NOT give the mailing address. Do not use neighborhood designations or locality names: e.g. write "BOSTON" not "DORCHESTER".*

Apt #	**City/Town**	**County**	**State**	**Zip Code**	**Inside City Limits?** *(if not MA resident)* ☐ Yes ☐ No

Marital Status

Mother's Marital Status	
☐ Married ☐ Never Married	☐ Widowed ☐ Divorced

Father/Parent

Father's Name *First Name*	*Middle Name*
Last Name	*Surname at Birth or Adoption*
Date of Birth *(Month, Day, Year)*	**Birthplace** *(City/Town, State, Country)*

Method of Disposition	**Place of Disposition**
☐ Burial ☐ Cremation ☐ Entombment ☐ Removal from state ☐ Donation ☐ Medical waste ☐ Other (specify):_____	Name _____ City/Town, State:_____ *(i.e., cemetery, crematory, hospital, etc.)* Funeral Service Licensee *(if any)*: _____ License# _____ Name of Facility (*if any*): _____ Date of Disposition: _____ *(Month, Day, Year)*

CONFIDENTIAL PUBLIC HEALTH INFORMATION: **The information below is transmitted directly to the state Department of Public Health for the purposes of statistical data use and to meet certain federal requirements. This information provides important background information for the state's perinatal database, providing valuable comparison with identical items on the birth certificate database. Information relating to parent demographics may be obtained from the pre-registration birth certificate worksheet when available, if your facility uses this method of data collection. Prenatal information may be obtained from a hospital or prenatal provider worksheet for birth certificates, when available.**

Cause of Fetal Death

Cause/Conditions Contributing to Fetal Death

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)*	**Other Significant Causes or Conditions** *(Select or specify all other conditions contributing to death in Other Significant Causes or Conditions)*
Maternal Conditions/Diseases (*specify*) _____	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)* _____	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)* _____	Other Obstetrical or Pregnancy Complications *(specify)* _____
Fetal Anomaly *(specify)* _____	Fetal Anomaly *(specify)* _____
Fetal Injury *(specify)* _____	Fetal Injury *(specify)* _____
Fetal Infection *(specify)* _____	Fetal Infection *(specify)* _____
Other Fetal Conditions/Disorders *(specify)* _____	Other Fetal Conditions/Disorders *(specify)* _____
☐ Unknown	☐ Unknown

Estimated Time of Fetal Death	**Was the case referred to a Medical Examiner?**	**Was a histological placental examination performed?**	**Were autopsy or histological placental examination results used in determining the cause 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	☐ Yes ☐ No **Was an autopsy performed?** ☐ Yes ☐ No ☐ Planned	☐ Yes ☐ No ☐ Planned	☐ Yes ☐ No ☐ Not Applicable

Certifier

Is Certifier a Medical Examiner?
☐Yes ☐No

_____ Title ☐ MD ☐ DO ☐ NP
Type or Print-Name of Certifier or Medical Examiner

License#:_____

_____
_____
Certifier Street # and Address

_____
City/Town State Zip Code

Attendant *(if different)*

_____
Type or Print-Name of Attendant

Title ☐ MD ☐ DO ☐ CNM/CM ☐ Other Midwife ☐ Other *(Specify)* _____ License #_____

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PRENATAL CARE INFORMATION

Date of First Prenatal Care Visit	**Date of Last Prenatal Care Visit**	**Total # of prenatal care visits for this pregnancy** *(If none, enter "0")*	**Did mother get WIC food for herself during this pregnancy?**	**Insurance** (*Prenatal Care Source of Payment*)	
_____/_____/_____ MM / DD / YYYY ☐ No Prenatal Care	_____/_____/_____ MM / DD / YYYY		☐ Yes ☐ No ☐ Refused ☐ Unknown	☐ Medicaid ☐ Private Insurance ☐ Self-pay ☐ Indian Health Service	☐ CHAMPUS/TRICARE ☐ Other Government (Fed, State, Local) ☐ Other _____ ☐ Unknown

PREGNANCY HISTORY

Number of Previous Live Births: Now Living	**Number of Previous Live Births: Now Dead**	**Date of Last Live Birth**	**Number of Other Pregnancy Outcomes** *(do not include this fetus):*	**Date of Last Other Pregnancy Outcome**
#_____ ☐ None	#_____ ☐ None	_____/_____ MM / YYYY	# _____ ☐ None	_____/_____ MM / YYYY

Date Last Normal Menses Began	**Mother's Weight at Delivery**	**Mother's Prepregnancy Weight**	**Mother's Height**
_____/_____/_____ MM / DD / YYYY	_____ (pounds)	_____ (pounds)	_____ (feet) _____ (inches)

DELIVERY INFORMATION

Fetal presentation at delivery *(Check one)*	**Final route and method of delivery** *(Check one)*	**Hysterotomy/Hysterectomy**	**Was mother transferred for maternal medical or fetal indications for delivery?** ☐ Yes ☐ No **If yes, enter name of facility mother transferred from:**
☐ Cephalic ☐ Breech ☐ Other	☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean If cesarean, was a trial of labor attempted? ☐ Yes ☐ No	☐ Yes ☐ No	_____

MEDICAL INFORMATION

RISK FACTORS IN THIS PREGNANCY *(Check all that apply)*	**INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY** *(Check all that apply)*	**CONGENITAL ANOMALIES OF THE FETUS** *(Check all that apply)*
☐ Diabetes – Prepregnancy (Diagnosis prior to this pregnancy) ☐ Diabetes – Gestational (Diagnosis in this pregnancy) ☐ Hypertension – Prepregnancy (Chronic) ☐ Hypertension – Gestational (PIH, preeclampsia) ☐ Hypertension – 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 checked, please see ***Birth Trends and Technologies*** section) ☐ Mother had a previous cesarean delivery If yes, how many _____ ☐ None of the above	☐ Chlamydia ☐ Cytomegalovirus ☐ Gonorrhea ☐ Group B Streptococcus ☐ Listeria ☐ Syphilis ☐ Parvovirus ☐ Toxoplasmosis ☐ Other (*Specify*) _____ ☐ None of the above	☐ Anencephaly ☐ Cleft Lip with or without Cleft Palate ☐ Cleft Palate alone ☐ Congenital diaphragmatic hernia ☐ Cyanotic congenital heart disease ☐ Down Syndrome ☐ Karyotype confirmed ☐ Karyotype pending ☐ Gastroschisis ☐ Hypospadias ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) ☐ Meningomyelocele/Spina bifida ☐ Omphalocele ☐ Suspected chromosomal disorder ☐ Karyotype confirmed ☐ Karyotype pending ☐ None of the above

MATERNAL MORBIDITY *(Check all that apply)* Complications associated with labor and delivery

☐ Admission to intensive care unit ☐ Maternal transfusion ☐ Ruptured uterus ☐ Third or fourth degree perineal laceration	☐ Unplanned hysterectomy ☐ Unplanned operating room procedure following delivery ☐ None of the above

BIRTH TRENDS AND TECHNOLOGIES: If Mother/Parent took any fertility drugs or received any medical procedures from a doctor, nurse, or other health care worker to help get pregnant with this current pregnancy (this may include infertility treatments such as fertility-enhancing drugs or assisted reproductive technology), check all that apply:

☐ Fertility-enhancing drugs ☐ Artificial insemination ☐ Intrauterine insemination	☐ Assisted reproductive technology ☐ Other medical treatment Other (*Specify*) _____	☐ Anonymous egg donor ☐ Anonymous sperm donor	☐ Surrogacy ☐ None of these apply

REPORTED ALCOHOL AND TOBACCO USE

CIGARETTE SMOKING BEFORE AND DURING PREGNANCY *(For each time period, enter either the average number of cigarettes or the average number of packs of cigarettes smoked per day. If none, enter "0".)*

3 months before pregnancy	***Second 3 months of pregnancy***
#_____ ☐ Cigarettes ☐ Packs	#_____ ☐ Cigarettes ☐ Packs
First 3 months of pregnancy	***Third Trimester of pregnancy***
#_____ ☐ Cigarettes ☐ Packs	#_____ ☐ Cigarettes ☐ Packs

ALCOHOL USE BEFORE AND DURING PREGNANCY *(For each time period, enter the number of drinks mother had in an average week. If none, enter "0".)*

3 months before pregnancy	***Second 3 months of pregnancy***
#_____	#_____
First 3 months of pregnancy	***Third Trimester of pregnancy***
#_____	#_____

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DEMOGRAPHIC INFORMATION

MOTHER/PARENT RACE *(Check one or more boxes that best describes the mother/parent's race)*

- ☐ American Indian/Alaska Native/Native American
- ☐ Asian
- ☐ Black
- ☐ Guamanian or Chamorro
- ☐ Hispanic/Latina/Black
- ☐ Hispanic/Latina/White
- ☐ Hispanic/Latina/Other

…Specify (Other Hispanic Latina)

_____

- ☐ Native Hawaiian
- ☐ Samoan
- ☐ White
- ☐ Other Pacific Islander
- ☐ Other

…Specify (Other)

_____

- ☐ Refused
- ☐ Unknown

MOTHER/PARENT ETHNICITY *(Check one or more boxes that best describes the mother/parent's ethnicity)*

- ☐ African

….Specify (African)

_____

- ☐ African American
- ☐ American
- ☐ Asian Indian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander

…Specify (Caribbean Islander)

_____

- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European

…Specify (European)

_____

- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican American, Chicana
- ☐ Middle Eastern

…Specify (Middle Eastern)

_____

- ☐ Native American/American Indian/Alaskan Native

...Specify (Tribe)

_____

- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other Asian

…Specify (Other Asian)

_____

- ☐ Other Central American

….Specify (Other Central American)

_____

- ☐ Other Pacific Islander

...Specify (Other Pacific Islander)

_____

- ☐ Other Portuguese

…Specify (Other Portuguese)

_____

- ☐ Other South American

…Specify (Other South American)

_____

- ☐ Other

…Specify (Other)

_____

- ☐ Unknown
- ☐ Refused

MOTHER/PARENT EDUCATION *(Check the box that best describes the highest degree or level of school that the mother/parent completed at the time of delivery)*

- ☐ 8th grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High School graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Certificate
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate or Professional Degree
- ☐ Unknown
- ☐ Refused

MOTHER/PARENT OCCUPATION *(Please list the mother/parent's occupation over the past year)*	MOTHER/PARENT INDUSTRY *(Please list the mother/parent's industry over the past year)*

FATHER/PARENT RACE *(Check one or more boxes that best describes the father/parent's race)*

- ☐ American Indian/Alaska Native/Native American
- ☐ Asian
- ☐ Black
- ☐ Guamanian or Chamorro
- ☐ Hispanic/Latino/Black
- ☐ Hispanic/Latino/White
- ☐ Hispanic/Latino/Other

…Specify (Other Hispanic Latino)

_____

- ☐ Native Hawaiian
- ☐ Samoan
- ☐ White
- ☐ Other Pacific Islander
- ☐ Other

…Specify (Other)

_____

- ☐ Refused
- ☐ Unknown

FATHER/PARENT ETHNICITY *(Check one or more boxes that best describes the father/parent's ethnicity)*

- ☐ African

….Specify (African)

_____

- ☐ African American
- ☐ American
- ☐ Asian Indian
- ☐ Brazilian
- ☐ Cambodian
- ☐ Cape Verdean
- ☐ Caribbean Islander

…Specify (Caribbean Islander)

_____

- ☐ Chinese
- ☐ Colombian
- ☐ Cuban
- ☐ Dominican
- ☐ European

…Specify (European)

_____

- ☐ Filipino
- ☐ Guatemalan
- ☐ Haitian
- ☐ Honduran
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mexican, Mexican American, Chicano
- ☐ Middle Eastern

…Specify (Middle Eastern)

_____

- ☐ Native American/American Indian/Alaskan Native

...Specify (Tribe)

_____

- ☐ Portuguese
- ☐ Puerto Rican
- ☐ Russian
- ☐ Salvadoran
- ☐ Vietnamese
- ☐ Other Asian

…Specify (Other Asian)

_____

- ☐ Other Central American

….Specify (Other Central American)

_____

- ☐ Other Pacific Islander

...Specify (Other Pacific Islander)

_____

- ☐ Other Portuguese

…Specify (Other Portuguese)

_____

- ☐ Other South American

…Specify (Other South American)

_____

- ☐ Other

…Specify (Other)

_____

- ☐ Unknown
- ☐ Refused

FATHER/PARENT EDUCATION *(Check the box that best describes the highest degree or level of school that the father/parent completed at the time of delivery)*

- ☐ 8th grade or less
- ☐ 9th-12th grade, no diploma
- ☐ High School graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Certificate
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate or Professional Degree
- ☐ Unknown
- ☐ Refused

FATHER/PARENT OCCUPATION *(Please list the father/parent's occupation over the past year)*	FATHER/PARENT INDUSTRY *(Please list the father/parent's industry over the past year)*

NAME OF PERSON COMPLETING REPORT	TITLE	DATE COMPLETED (MM/DD/YYYY)