HOSPITAL MANUAL FOR COMPLETING THE MASSACHUSETTS REPORT OF FETAL DEATH

(FORM R304-102014)

Registry of Vital Records and Statistics
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INTRODUCTION

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This manual is intended to reference cases of fetal death that occur in or are transferred into a general hospital or birthing center. This manual does not cover unique and individual cases where the Medical Examiner assumes jurisdiction. For cases that do not appear to be covered by the manual, call the Registry of Vital Records and Statistics for advice before proceeding with the completion of the Report of Fetal Death.

THE 2014 CHANGES

The 2014 revision of the Report of Fetal Death (form R304-102014) contains a number of changes. Most changes are in order to make Massachusetts compliant with the federally, and state-mandated, required minimum data set for fetal deaths. The national standard, developed by the National Center for Health Statistics (NCHS), closely resembles the birth certificate and death certificate, containing the relevant items of the two.

Although the Department recognizes that in some cases, the availability of certain data may be less accessible than for birth certificate reporting, in general those items appearing on the legal portion of the birth certificate and on the death certificate are to be considered ***required***. All other items are required as ***available*** from hospital and prenatal sources.

FETAL DEATH REPORTING

Massachusetts General Law oversees most of the vital events registration process. *Chapter 111, Section 202* governs the reporting of fetal death information. The Report of the Fetal Death should be received by the Registry of Vital Records within 10 days of the fetal death. Although we recognize that in a limited number of cases, problems may develop which will not allow the facility to report the fetal death within 10 days; no report should be held by the facility for more than 30 days. Incomplete records should **never** be retained by the facility for more than 30 days.

REPORTABLE FETAL DEATHS

If a stillbirth is delivered at 20 weeks gestation or more and/or weighs 350 grams or more, a report of fetal death must be completed. In order for it to be a reportable fetal death, the fetus may either be delivered at 20 weeks gestation or more OR weighs 350 grams or more. The fetus does not have to meet both the gestational age requirement and the weight requirement for it to be a reportable fetal death.

Massachusetts General Law (MGL Chapter 111, Section 202) is very specific in that the death is determined at the time of complete "expulsion or extraction" of the fetus. Gestational Age at delivery is determined by length of time in utero, i.e., weeks between last menstrual period and date of delivery. This may differ from the clinical estimate of gestation at time of death, which is not a determinant of reportability. "Fetal death" does not include an abortion as defined in MGL Chapter 112, Section 12 K.

NON-REPORTABLE FETAL DEATHS

If a stillbirth is delivered, extracted or expulsed, before 20 weeks gestation AND weighs less than 350 grams, it is a non-reportable fetal death. No Report of Fetal Death should be completed. In cases where a private disposition is arranged, it will be necessary for the hospital to provide a hospital letter of notification for the funeral director or the family to obtain a permit rather than a Report of Fetal Death. The Standard Certificate of Death and the Standard Certificate of Live Birth should also NEVER be used with a fetal death of any gestation.

CONFIDENTIALITY

Reports of Fetal Death are not public records, differing in this way from birth and death certificates. The fetal death reports shall be confidential and shall be released by the Department only upon written request of the parent, his or her guardian, executor, attorney or any other person designated by the parent in writing. Such reports may also be released to the National Center for Health Statistics, and to persons authorized by the Commissioner of Public Health under section twenty-four A of this chapter to conduct research studies. The department may release copies of such reports or information contained therein, to other persons only in a manner in which does not allow identification of the parents. *See Appendix on MGL Chapter 111, Section 202.*

The information collected from the confidential items is used for aggregate data only. That is, no names or other identifying information is ever made available to others outside of rigorously reviewed approved public health research activities.

The finalized fetal death data files at the State Registry have a multitude of uses, not least of which is a tool for health professionals in implementing programs to improve maternal and child health. Good data quality is vital in assessing where health problems exist, and this depends on fully completed fetal death reports.

WORKSHEETS

An accompanying Worksheet for Completing the Report of Fetal Death is a recommended tool for the completion of fetal death reports. However, there is NO Parent Worksheet as there is for birth certificates.

The method that the facility uses to complete the fetal death report is left to the discretion of the facility. Use of the hospital worksheet provided by the Registry is strongly recommended. A facility may develop its own worksheet(s), but in doing so, it is important to remember that all items assigned to categories on the Registry worksheet must remain the same and must be continually updated to conform to Registry changes**. It is recommended that any worksheet used by the facility be sent to the Registry to insure that the required information is being collected**. In this way, many potential problems may be avoided. It is also recommended that worksheets be retained for at least a year, in case problems develop with the fetal death report.

Because the elements of the Report of Fetal Death are exactly the same as the birth certificate for most items, if the hospital has received a completed or partially completed birth certificate worksheet (i.e. Parent Worksheet for Birth Certificates, Preregistration Worksheet for Birth Certificates, Hospital Worksheet or Prenatal Provider Worksheet), they can be used to complete the Report of Fetal Death when it becomes necessary.

Although the Report of Fetal Death contains elements found on the Parent Worksheet for Birth Certificates, the Registry **STRONGLY DISCOURAGES** hospitals from giving parents a Parent Worksheet after a fetal demise. Except for those elements found on the front side of the Report of Fetal Death, parents should not be asked to complete any of the statistical items such as race, education, smoking status, etc. The hospital should complete these elements to the best of its ability, by making use of previously completed Preregistration Worksheets or from hospital medical records. The Registry recognizes that in some cases, the parent demographic statistical information may not be available.

INFORMATION COLLECTION

Assignment of the unit responsible for fetal death report data collection is left to the discretion of the facility. Varying among facilities, it may be the medical records departments, OB/GYN units, or admitting departments having responsibility for the fetal death report. It is important to note that even if

the mother is not admitted to the hospital, e.g., and emergency room delivery, or ambulance delivery en-route to the hospital, the hospital is still required to complete the Report of Fetal Death.

CERTIFICATION

All items on the Report of Fetal Death must be completed in full. The report must be signed by medical doctor, medical examiner, or nurse practitioner. The original Report of Fetal Death must be sent to the Registry of Vital Records and Statistics. A copy of the report must be kept at the hospital. If the fetus is to be buried or cremated, the funeral director (or the family) will need a copy of the report in order to obtain the burial permit.

For non-reportable fetal deaths, for which the parent(s) wish for private disposition, a letter should be provided on hospital letterhead stationery and it must contain the following information: date of delivery, parent(s) name, gestational age and weight. The letter must be signed by a medical doctor, nurse practitioner or a hospital administrator. A Report of Fetal Death should never be completed for a non-reportable fetal death.

DISPOSITION

If the fetal disposition takes place in a hospital facility, the hospital is responsible for providing the information in sections labeled "Method of Disposition" and "Place of Disposition". Otherwise, the Board of Health is responsible for completing the information after receipt of the photocopy from the funeral director or the family. It is important to note, that in the case of fetal death, *whether or not the fetal death is reportable*, that the parents may elect to have private disposition. Under Massachusetts General Law, Chapter 111, Section 202, "…Before disposition, the physician or person in charge of the hospital shall ensure that the parent is informed of his right to direct either burial, entombment or cremation of the fetal remains, or disposal of the remains by the hospital or physician. Before disposition, the parent shall be informed in writing of the hospital policy relating to disposal of fetal remains, and shall be informed of the availability of a chaplain if any for counsel."

LIVE BIRTH

If a live birth occurs, regardless of weight or gestational age, a Standard Certificate of Live Birth must be completed even if the gestational age and/or birthweight do not meet the requirements for a Report of Fetal Death.

QUESTIONS

Hospitals should call the Registry with any questions prior to submitting a Report of Fetal Death. Because copies of the Report may be issued to the parents by the Registry of Vital Records and Statistics, it is important that the Report of Fetal Death be as neat and legible as possible. A carelessly completed report, or one that contains errors, may be distressing to the parents.

Questions about the Report of Fetal Death should be directed to (617) 740-2681.

FOR STATE USE ONLY

State File #:

The Registry assigns a consecutive six-digit number to all Report of Fetal Death records as they are processed.
Please leave blank. The Registry will complete State File #.

Date Received by Registrar:

The date Report of Fetal Death record is received by the Registry as they are processed.
Please leave blank. The Registry will complete Date Received by Registrar.

FACILITY

Items 1-6 identify the place of delivery, which is used to study relationships of hospital and nonhospital pregnancy terminations. It is also used by many States to produce statistical data by specific facility. Information on place of delivery, together with residence information, provides data to evaluate the utilization and distribution of health services.

Item 1: Facility ID (Number)

The Facility ID is the unique four-digit identifier of the facility completing the report of fetal death. It is used for simplifying fetal death processing.

Please leave blank. The Registry will complete Item 1: Facility ID (Number) upon receipt of completed Report of Fetal Death.

Item 2: Facility Name

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.

Determine the Place of Death*:*

If the fetal death occurred in a:

GENERAL HOSPITAL OR BIRTHING CENTER:
The place of delivery is the facility. Provide the full name of the facility. DO NOT provide facility name if facility is other than a general hospital or birthing center.

MOVING CONVEYANCE EN ROUTE OR UPON ARRIVAL TO HOSPITAL:
The place of delivery is the hospital. Enter the full name of the facility followed by the notation "EN ROUTE" (e.g. YOUR HOSPITAL NAME: EN ROUTE").

MOVING CONVEYANCE NOT EN ROUTE TO GENERAL HOSPITAL OR BIRTHING FACILITY
The place of delivery is the exact site where the fetus was first removed from the conveyance. Enter the street number AND street name where fetus was first removed from the conveyance (e.g. address, not name, of the airport if the fetus was delivered in flight, or home address if mother delivered in a car en route to her home). DO NOT use a mailing address (e.g. a post office box).

OTHER SITE, NOT A MOVING CONVEYANCE, INCLUDING HOME:
The place of delivery is the actual site of fetal death occurrence. Enter the street number and street name where the fetal death occurred. If the fetal death occurred in a school or institution other than a hospital or birthing center (e.g. in a correctional or mental health facility), DO NOT name the institution. Enter the address only. Facility name should be completed only for a general hospital or birthing center. In all cases, do not use a mailing address.

Item 3: City, Town, or Location of Delivery

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.
Recommended Sources of Information: Hospital Worksheet, Medical Records

Enter the name of the city or town in which the fetal death delivery occurred. The city or town should be one of the 351 communities in Massachusetts. For example, if a fetal death occurs in Dorchester, the city should read "BOSTON". *See Appendix for a list of Massachusetts cities, towns, and corresponding counties.*

Item 4: Place Where Delivery Occurred (*Check one*):

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.
Recommended Sources of Information: Hospital Worksheet, Medical Record

Check the box that best describes the type of place where the fetal death delivery occurred. If the type of place is not known, check the "Unknown" box.

- Hospital
- Clinic/Doctor's Office
- Freestanding birthing center
- Home Delivery
    - Planned to deliver at home? □ Yes □ No
- Unknown
- Other (specify) _____

Item 5: Zip Code of Delivery

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.

Enter the zip code of the city or town in which the fetal death delivery occurred.

Item 6: County of Delivery

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.
Recommended Sources of Information: Hospital Worksheet, Medical Record

Enter the name of the county in which the fetal death delivery occurred. Whenever possible, check to make sure that the county coincides with the city/town of delivery. *See Appendix for a list of Massachusetts cities, towns and corresponding counties.*

FETUS

Name of Fetus ***(optional-at the discretion of the parents)***
The fetus name is optional. If the parents do not wish to name the fetus, leave Items 7a to 7c blank.

If the parents wish to name the fetus, enter the first, middle, last name as requested by the mother. DO NOT enter "Baby Smith" or any other designation that is not specifically requested by the mother.

Hospitals can make the mother aware, if they feel that this would be appropriate or helpful, that a name can be given to the fetus for the purposes of completing the Report of Fetal Death.

If a name is not given at the time of the Report, the parent s may later request a Certificate of Birth Resulting in Stillbirth. The parents will have the option to name the fetus by completing the Request Form for a Certificate of Birth Resulting in Stillbirth.

Item 7a: First Name
Enter the first name of fetus.

Item 7b: Middle Name
Enter the middle name of fetus.

Item 7c: Last Name
Enter the last name of fetus.

Item 8: Time of Delivery ***(24 hr)***
THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.
Recommended Sources of Information: Hospital Worksheet, Medical Record, or Labor & Delivery Log
This item documents the exact time of delivery for various legal uses, such as the order of delivery in plural deliveries. When the delivery occurs around midnight, the exact hour and minute may affect the date of death. For deliveries occurring at the end of the year, the hour and minute affect not only the day but also the year of death.

Enter the time of delivery the fetus was extracted or expulsed based on a 24-hour clock (military time). Based on the recommendation the National Center for Health Statistics received from the National Institute of Standards and Technology, it is strongly recommended that the 24-hour clock with the range of 00:00-23:59 be used. 00.00 is considered the start of the new day.

In cases of plural deliveries, the exact time that the fetus was delivered should be recorded as the hour and minute of delivery.

Item 9: Sex
THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.
Recommended Sources of Information: Hospital Worksheet, Medical Record, or Labor & Delivery Log
This information is used to measure fetal and perinatal mortality by sex. This information helps identify differences in the impact of environmental and biological factors between the sexes.

Check the appropriate box to indicate whether the fetus is male or female. If the sex cannot be determined after verification of medical records or other sources, check the "Unknown" box.

Item 10: Weight of Fetus *(grams)*

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.

Recommended Sources of Information: Hospital Worksheet, Medical Record, or Labor & Delivery Log

Weight of fetus is the single most important characteristic associated with the viability of the fetus. It is also related to prenatal care, socioeconomic status, marital status and other factors surrounding the delivery. It is useful in evaluating the effectiveness of health care.

Enter the weight (in grams) of the fetus as it is recorded in the hospital record.

Item 11: Obstetric Estimate of Gestation at Delivery *(completed weeks)*

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.

Recommended Sources of Information: Hospital Worksheet, Medical Record, or Labor & Delivery Log

This item is intended to provide an alternate estimate of gestational age when the date last normal menses began is missing or apparently incompatible with the weight of the fetus. This item is required as a primary determinant of fetal death reportability. It is the weeks of gestation at time of extraction or expulsion, which may differ from Item 15: Clinical Estimate of Gestation that is reported on the report.

Enter the best obstetric estimate of the infant's gestation in completed weeks.

This item should reflect the number of weeks the fetus was carried in utero. If the fetus died at the 10th week, but was not delivered until the 37th week, the weeks gestation in this item should read "37 weeks".

If a fraction of a week is given (e.g. 32.2 weeks), round down to the next whole week (e.g. 32 weeks). DO NOT complete this item based solely on the date of delivery and the mother's date of last menses.

If the number of weeks is less than 20, but the weight of the fetus at delivery is 350 grams or more, the fetal death is REPORTABLE. **The fetal death is not reportable only when BOTH the weight is less than 350 grams and the number of weeks is also less than 20.**

Item 12: Date of Delivery *(Month, Day, Year)*

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.

Recommended Sources of Information: Hospital Worksheet, Medical Record, or Labor & Delivery Log

This item is used in conjunction with the date of last normal menses began to calculate the length of gestation, which is an essential element in the study of low birth weight deliveries.

Enter the exact month, day and year that the fetus was delivered.

MONTH: Use full or alphabetic abbreviated name of the month (e.g. JAN, FEB). DO NOT USE A NUMBER FOR THE MONTH. Numeric designations for months are susceptible to error or misinterpretation across cultures.

DAY: Enter the exact numeric day of the delivery.

YEAR: Use four-digit designation for the year of delivery. Vital records are permanent records and have been recorded over centuries. For this reason, it is important to distinguish records through the centuries.

Item 13: Plurality *(specify)*

THIS ITEM IS REQUIRED IF PLURAL BIRTH. DO NOT LEAVE THIS ITEM BLANK.

Recommended Sources of Information: Hospital Worksheet, Medical Record, or Labor & Delivery Log

If this is a singleton delivery, leave this item blank. For multiple deliveries, check the appropriate box to indicate the order that this fetus was delivered in the set, e.g. first, second, third, other. Count all live births and fetal deaths delivered at any point during the pregnancy. "Reabsorbed" fetuses, those which are not "delivered"—expulsed or extracted from the mother—should not be counted.

NOTE: If a mother delivers a fetal death as part of a multiple birth, the hospital is responsible for completing a separate report for each fetus and/or birth in the delivery.

- A plural delivery occurs whenever there are two or more products of conception from one pregnancy. For example, if a woman has a fetal death at 19 weeks gestation which is later extracted at the time of birth of a second child at 36 weeks, the birth is considered a plural birth and the fetal death is reportable.

- However, if the first twin died at ten weeks, and was reabsorbed s so that the mother only delivered one product of the pregnancy, then record the live birth as a single birth and the fetal death is not reportable.

NOTE: A live birth less than 350 grams in weight or under 20 weeks gestation is to be considered a live birth and a birth certificate must be prepared. A fetus born dead under 350 grams and under 20 weeks at time of extraction or expulsion does not require a fetal death report.

Item 14: Birth Order *(specify if plural birth)*

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.

Recommended Sources of Information: Hospital Worksheet, Medical Record, or Labor & Delivery Log

Specify the order in which the fetus being reported was delivered, e.g., FIRST, SECOND, THIRD, etc. Count all live births and fetal deaths at any point in the pregnancy.

Item 15: Clinical Estimate of Gestation *(in weeks)*

This reflects the date of death that is prior to the expulsion or extraction of the fetus. Reportability is determined by Item 11: Obstetric Estimate of Gestation at Delivery.

Enter the clinical estimate of gestation, in weeks.

MOTHER/PARENT

Item 16a-16d: Mother's Name

THESE ITEMS ARE REQUIRED. DO NOT LEAVE THESE ITEMS BLANK.

Recommended Sources of Information: Mother's Preregistration Worksheet, Admission Records (with verification from mother)

Mother's name is needed for identification of the fetal death. The mother's surname at birth or adoption (maiden name) is an important part of an index to birth/death and fetal death files in that the last name of the child being registered and the mother's married name may change several times, but the maiden name will always stay the same.

Enter the mother's current legal name in Items 16a-16d.

Item 16a: First Name

Enter the mother's first name.

Item 16b: Middle Name

Enter the mother's middle name. If there is no middle name, leave this item blank. DO NOT enter NMI, NMN, etc.

Item 16c: Last Name

Enter the mother's current last name. This item will still need to be completed even if the name is the same as in Item 16d.

Item 16d: Surname at Birth or Adoption *(Maiden Name)*

Enter the mother's maiden surname. This would be the name that is listed on her birth certificate. This item will still need to be completed even if the name is the same as in Item 16c.

Item 17: Date of Birth *(Month, Day, Year)*

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.

Recommended Sources of Information: Preregistration Worksheet, Mother's Medical Record

This item is used to compute mother's age. Mother's age is one of the most important factors in studying childbearing and child health patterns. For example, there have been many studies which have shown relationships between the age of the mother at birth and the child's weight, illness patterns and other factors.

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

MONTH: Use alphabetic full or alphabetic abbreviated name of the month (e.g. JAN, FEB). DO NOT USE A NUMBER FOR THE MONTH.
DAY: Enter the exact numeric day of mother's birth.
YEAR: Use four-digit designation for year of mother's birth (e.g. 1975).

Item 18: Birthplace *(City/Town, State, Country)*

THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.

Recommended Sources of Information: Preregistration Worksheet, Patient Interview

The birthplace item may become an important identifier for legal purposes to link family relationships. As a statistical item, it is used together with census data to compare child bearing patterns of women who reside in the state where they were born with that of women who reside in a state other than their state of birth. Birthplace is also used for studying migration patterns of generations and tracing family histories.

CITY/TOWN

For mothers *born in the United States*, enter the proper name of the city or town of mother's birth.
For mothers *born outside of the United States*, enter the name of the city or town of mother's birth.

DO NOT use the name of a subsection of a municipality or a village (e.g. "BOSTON" not "DORCHSTER"). Use only proper city and town names whenever possible.

For mothers born outside of New England, the birthplace may be a jurisdiction other than a city or town name, e.g. a county.

If this information cannot be obtained from hospital sources, enter "---".

STATE/COUNTRY
For mothers *born in the United States*, enter the name of the state of the mother's birth.
For mothers born *outside of the United States*, enter the name of the country of the mother's birth.

e.g.	BOSTON, MA	NOT	DORCHESTER, MA
	CAMBODIA	NOT	UNKNOWN, CAMBODIA
			UNKNOWN

Item 19a-19g: Mother/Parent's Residence Information

THESE ITEMS ARE REQUIRED. DO NOT LEAVE THESE ITEMS BLANK.
Recommended Sources of Information: Hospital Admission Records, Mother's Preregistration Worksheet, or Patient Interview
Statistics on fetal deaths are tabulated by place of residence of the mother. This makes it possible to compute fetal and perinatal death rates based on the population residing in that area. These data are used in planning for and evaluating community services and facilities, including maternal and child health programs. "Inside City Limits" is used to properly assign residence to either the city or the remainder of the county.

These items refer to the mother's residence address, not her postal address. Do not include post office boxes or rural route numbers.

The mother's residence is the place where her household is located. This is not necessarily the same as her home state, voting residence, mailing address, or legal residence. The state, county, city and street address should be for the place where the mother actually lives. Never enter a temporary residence, such as one used during a visit, business trip or vacation. Residence for a short time at the home of a relative, friend, or home for unwed mothers for the purpose of awaiting the birth of the child is considered temporary and should not be entered here. However, place of residence during a tour of military duty or during attendance at a college is not considered temporary and should be entered on the certificate as the mother's place of residence.

Item 19a: Residence of Mother-*Number and Street Address*

Enter the actual address where the mother lives now, including the street name, number and proper city/town name. DO NOT use a post office box or other address used for mailing purposes only.

Item 19b: Apt

Enter the apartment, unit or room number of the mother's residence. Leave this blank if not applicable.

Item 19c: City/Town

If the mother is a US resident, enter the name of the city, town, or location in which the mother lives. DO NOT list a neighborhood, village or other subdivision name.

Item 19d: County

If the mother is a US resident, enter the county in which the mother lives. Leave this blank if the mother is not a US resident.

Item 19e: State

If the mother is a US resident, enter the US state or territory where the mother lives.
If the mother is a Canadian resident, enter the name of the province or territory followed by "Canada" (e.g. "British Columbia, Canada").
If the mother is not a resident of the US, enter the name of the county of residence.

Item 19f: Zip Code

Enter the zip code for the mother's residence. Leave this blank if not applicable.

Item 19g: Inside City Limits? *(if not MA resident)*

Check whether the mother's residence city town (Item 19c) is incorporated (if non-MA resident) and if the mother's residence is inside its boundaries; otherwise, mark "No".

If the mother is not a U.S. resident, leave this item blank.

Item 20: Mother's Marital Status

Marital status is used to monitor the special health problems and risk factors encountered among unmarried women and their children. It has been shown that unmarried women are more likely to have less prenatal care, and a higher incidence of lower birthweight babies and infant mortality. By including this information on the fetal death report, these factors can be considered in studies of fetal deaths.

Recommended Sources of Information: Mother's Preregistration Worksheet, Admission Records or Medical Records.

Check the appropriate box to indicate mother's marital status.

If the mother is separated from her husband, she is still considered to be legally married until the divorce has been finalized. Therefore answer "MARRIED" in this section.

The mother's marital status has no impact on her ability to name a father of her choice on the Report of Fetal Death. A mother may be unmarried or married to a person other than the biological father, but may list the biological father on the Report of Fetal Death without affidavits of paternity or denial.

FATHER/PARENT

Item 21a-d: Father's Name

Recommended Sources of Information: Mother's Preregistration Worksheet, Patient Interview
Father's information may be included regardless of mother's marital status. The Report of Fetal Death is not a legal record, but rather a legally mandated report. An unmarried mother may list father's information without providing paternity affidavits; and a married mother may list a father other than her spouse without providing denial of paternity affidavits. HOWEVER, listing a father on the Report of Fetal Death does not constitute proof of paternity.

If the parents are unmarried, father's information may be listed, without documentation of parentage. However, if the mother does not wish to name a father, insert dashes in all father information items on the front of the form, and in any reverse side of the form items as cannot be completed.

Item 21a: First Name

Enter the father's first name.

Item 21b: Middle Name

Enter the father's middle name. If there is no middle name leave this item blank. Do not enter NMI, NMN, etc.

Item 21c: Last Name

Enter the father's last name. Enter any suffixes following the last name.
Include Generational designations such as "JR" or "III" as a part of the father's last name.

Item 21d: Surname at Birth or Adoption

Enter the father's surname at birth or adoption. This would be the name that is listed on his birth certificate.

Item 22: Date of Birth *(Month, Day, Year)*

Recommended Sources of Information: Mother's Preregistration Worksheet, Patient Interview

Enter the exact month, day and year that the father was born. If no father is listed, enter dashes "---" in this item.

MONTH: Use alphabetic full or alphabetic abbreviated name of the month (e.g. JAN, FEB). DO NOT USE A NUMBER FOR THE MONTH.
DAY: Enter the exact numeric day of father's birth.
YEAR: Use four-digit designation for year of father's birth (e.g. 1975).

Item 23: Birthplace *(City/Town, State, Country)*

Recommended Source of Information: Mother's Preregistration Worksheet
The birthplace item may become an important identifier for legal purposes to link family relationships. Birthplace is also used for studying migration patterns of generations and tracing family histories.

CITY/TOWN
For fathers *born in the United States*, enter the proper name of the city or town of father's birth.
For fathers *born outside of the United States*, enter the name of the city or town of father's birth.

Do NOT use the name of a subsection of a municipality or a village (e.g. "BOSTON" not "DORCHSTER"). Use only proper city and town names.

For fathers born outside of New England, the birthplace may be a jurisdiction other than a city or town name, e.g. a county. When this occurs, you must contact the Registry before entering the information.

STATE/COUNTRY

For fathers ***born in the United States***, enter the name of the state of the father's birth.
For fathers born ***outside of the United States***, enter the name of the country of the father's birth.
Spell out or use appropriate postal abbreviations for US states.

e.g.	BOSTON, MA	NOT	DORCHESTER, MA
	CAMBODIA	NOT	UNKNOWN, CAMBODIA
			UNKNOWN

If the information is unknown, enter "---".

DISPOSITION

ITEM 24: METHOD OF DISPOSITION AND ITEM 25: PLACE OF DISPOSITION ARE REQUIRED. DO NOT LEAVE THESE ITEMS BLANK.
If the disposition is not known to the hospital, leave these items blank. They will be completed by the Board of Health.

Item 24: Method of Disposition
THIS ITEM IS REQUIRED. DO NOT LEAVE THIS ITEM BLANK.
This information indicates whether the fetus was disposed of as required by law. It also serves to help locate the fetus in case of exhumation, autopsy, or transfer is required later.
Check the box corresponding to the method of disposition of the fetus. Removal from state indicates the body was removed or shipped out of MA for burial or other disposition. Only one box should be marked.

If the fetus is to be used by a hospital, medical or mortuary school for scientific or educational purposes, check "Donation" and specify the name and location of the institution in Items 25a-25e. "Donation" refers only to the entire fetus, not to individual organs.

If the disposition is not known to the hospital, leave this item blank. It will be completed by the Board of Health.

- **Burial**: Check this box if the immediate method of disposition by the funeral director listed is burial. This means that the fetus is not being shipped out of state for subsequent burial, nor is the fetus being held for later burial after the ground thaws, nor is the body being cremated.

- **Cremation**: Check this box if the immediate disposition by the funeral director listed is cremation. Even if the remains will subsequently be buried in a family plot, the immediate disposition is cremation.

- **Entombment**: Check this box if the body is entombed as the immediate disposition. For example, a fetus dies in January, and the remains are being held in a tomb for subsequent burial in the spring. The immediate disposition is entombment.

- **Removal from state**: Check this box if the fetus is being transported out of state by the listed funeral director. If for example, a Massachusetts funeral director is shipping a body out of country for disposition this box would be marked.

- **Donation**: Check this box if the fetus is donated for medical research and education.

- **Medical Waste**: Check this box if hospital is handling fetal disposition as pathological waste.

- **Other (specify)**: Another common "other" might be "HOLDING" if the funeral director is holding the remains at his facility for later burial or transportation.

Item 25a-f: Place of Disposition
THESE ITEMS ARE REQUIRED. DO NOT LEAVE THEM BLANK.
Enter the disposition information of the fetal death in Items 25a-25f.
If the disposition is not known to the hospital, leave these items blank. They will be completed by the Board of Health.

Item 25a: Name *(i.e. cemetery, crematory, hospital, etc.)*
Enter the name of the cemetery, crematory, or other facility where the immediate fetal disposition occurred.

Item 25b: City/Town, State
Enter the name of the city or town and state where the immediate fetal disposition occurred.

Item 25c: Funeral Service Licensee *(if any)*
Enter the name of the funeral service licensee responsible for the immediate disposition listed on the Report of Fetal Death. If the disposition takes place in a hospital facility, and there is no funeral director involved, then write "NONE".

If the fetus is being shipped out-of-state for final disposition, list the funeral director that removes the fetus from the hospital.

Item 25d: License
Enter the personal state license number of the funeral service licensee, if any. If the license number is not from Massachusetts, enter the 2-character US Postal abbreviation prior to the license number.

Item 25e: Name of Facility *(if any)*
Enter the name of the facility handling the fetal remains prior to burial or other disposition. The funeral director listed must be associated with this facility.

Item 25f: Date of Disposition *(Month, Day, Year)*
Enter the exact month, day and year of disposition.

MONTH: Use full or alphabetic abbreviated name of the month of disposition (e.g. JAN, FEB). DO NOT USE A NUMBER FOR THE MONTH.

DAY: Enter the exact numeric day of disposition.

YEAR: Use four-digit designation for the year of disposition (e.g. 1979).
If "Removal from State" is stated, then the date of disposition should be the date the remains are shipped, not the date of ultimate disposition.

BOARD OF HEALTH INFO

Item 26a-b: Board of Health Info

The city/town Board of Health is the responsible agency to issue the disposition permit. The funeral home can provide the following to the city/town Board of Health:

- If a fetal death occurs that is reportable to the Registry of Vital Records and Statistic (20 weeks or more in gestational age or weight of 350 grams or more), a photocopy only Page 1 of 4 AND Page 2 of 4 (Cause of Death and Certifier Info) of the Report of Fetal Death is used to issue the permit. The Report of Fetal Death is a confidential report that is retained for 30 days only by the burial agent and is not forwarded to the city/town clerk.

- If an unreportable fetal death occurs (less than 20 weeks in gestational age or less than 350 grams in weight), a letter from the physician or hospital stating the facts of the case is used to obtain the burial permit. A Report of Fetal Death is not completed.

Item 26a: Date Report Was Received

Enter the date the Report of Fetal Death was received by the city/town Board of Health clerk.

Item 26b: City/Town of Board of Health

Enter the city/town of where the disposition permit is issued for fetal death**.**

CAUSE OF FETAL DEATH

For research and statistical purposes, it is important that the reported information on the fetal death report be as specified as precisely as possible.

Cause of death is one of the most important statistical and research items on the fetal death report. It provides medical information that serves as a basis for describing trends in human health and mortality and for analyzing the conditions leading to death. Mortality statistics provide a basis for epidemiological studies that focus on leading causes of death by age, race and sex. They also provide a basis for research in disease etiology and evaluation of diagnostic techniques, which in turn lead to improvements in patient care. Fetal death reports differ from death certificates, in that maternal conditions are sought more extensively in cause of death, and other statistical items that follow. Causes of fetal death are examined by both fetal and maternal conditions, and relationships between the two.

Items 27a: Initiating Cause/Condition and 27b: Other Significant Cause or Conditions:
THESE ITEMS ARE REQUIRED. DO NOT LEAVE THEM BLANK.

These items are to be completed by the person whose name appears in Item 33b to 33d.

The cause of death section consists of two parts. The initiating cause/condition (Item 27a) 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 (Item 27b) include all other conditions contributing to death. These conditions may be triggered by the initiating cause (Item 27a) or causes that are not among the sequence of events triggered by the initiating cause (Item 27a).

The cause-of-death information should be the certifier's best medical opinion. Report a specific condition in the space most appropriate to the given situation. A condition can be listed as "probable" even if it has not been definitively diagnosed. In reporting the causes of fetal death, conditions in the fetus or mother, or of the placenta, cord, or membranes, should be reported if they are believed to have adversely affected the fetus.

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 Registry as soon as it is available.

<u>Common problems in fetal death certification</u>
Uncertainty:
Often several acceptable ways of writing a cause-of-death statement exist. Optimally, a certifier will be able to provide a simple description of the initiating cause and other contributing causes that is etiologically clear and to be confident that this is correct. However, realistically, description of the process is sometimes difficult because the certifier is not certain.

In this case, the certifier should think through the causes about which he/she is confident and what possible etiologies could have resulted in these conditions. The certifier should select the causes that are suspected to have been involved and use words such as "probable" or "presumed" to indicate that the description provided is not completely certain. Causes of death on the fetal death report should not include terms such as "prematurity" without explaining the etiology because they have little value for public health or medical research.

Reporting a cause of fetal death as unknown should be a last resort.

When a number of conditions or multiple organ/system failure resulted in death, the physician, medical examiner, or nurse practitioner should choose a single condition which most likely began the sequence of events resulting in the fetal death and list the other conditions in *Item 27b: Other Significant Cause or Conditions*. "Multiple system failure" could be included as an "other significant cause or condition" but also specify the systems involved to ensure that the detailed information is captured. Maternal conditions may have initiated or affected the sequence

that resulted in a fetal death. These maternal conditions should be reported in the cause-of-death statement in addition to the fetal causes.

Avoid ambiguity:

Most certifiers will find themselves, at some point, in the circumstance in which they are unable to provide a simple description of the process of death. In this situation, the certifier should try to provide an initiating condition, qualify the causes about which he/she is uncertain, and be able to explain the certification chosen.

Item 27a: Initiating Cause/Condition

Among the choices below, select the **ONE** which most likely began the sequence of events resulting in the death of the fetus. If it is not clear where to report a condition, write it on the "(Specify)" line that seems most appropriate.

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)*

_____

Other Obstetrical or Pregnancy Complications *(specify)*

_____

Fetal Anomaly *(specify)*

_____

Fetal Injury *(specify)*

_____

Fetal Infection *(specify)*

_____

Other Fetal Conditions/Disorders *(specify)*

_____

☐ Unknown

Item 27b: Initiating Cause/Condition

Select or specify all other conditions contributing to death in Item 27b.

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)*

_____

Other Obstetrical or Pregnancy Complications *(specify)*

_____

Fetal Anomaly *(specify)*

_____

Fetal Injury *(specify)*

_____

Fetal Infection *(specify)*

_____

Other Fetal Conditions/Disorders *(specify)*

_____

☐ Unknown

Item 28: Estimated Time of Fetal Death

This item is used as a check to ensure that the delivery was properly reported as a fetal death and was not a live birth. It also gives information on care.

Indicate when the fetus died by specifying one choice.

- 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

Item 29: Was the case referred to a Medical Examiner?

Massachusetts General Law requires that ALL fetal deaths must be referred to a medical examiner. (See Appendix about MGL Chapter 38, Section 3)

Report "Yes" if the case was referred to the medical examiner, even if the medical examiner did not assume jurisdiction.

Item 30: Was an autopsy performed?

An autopsy is important in giving additional insight into the conditions that led to death. This additional information is particularly important when the cause is not immediately clear.

Check the "Yes" box if a partial or complete autopsy was performed or is being performed at the time of filing of the fetal death record.

Check "No" if no autopsy has been performed and no autopsy is planned.

Check "Planned" if an autopsy is not being performed at the time of the filing of the fetal death record but one is going to be performed.

Item 31: Was a histological placental examination performed?

A histological placental examination provides additional information about the conditions that led to death. This may provide insight into the appropriate causes of death to report.

Check the "Yes" box if any Histological Placental Examination was performed or is being performed at the time of filing.

Check the "Planned" box if a Histological Placental Examination is not being performed at the time of the filing of the fetal death record but one is going to be performed.

Check the "No" box if no Histological Placental Examination has been performed and no Histological Placental Examination is planned.

Item 32: Were autopsy or histological placental examination results used in determining the cause of fetal death?

This information assists in determining whether information was available to assist in ascertaining the cause of death. Knowing whether the exam results were available gives insight into the quality of the cause-of death data.

If "Yes" is checked for Item 30 OR Item 31, complete Item 32. If "No" is checked for both Item 30 AND Item 31, check "Not applicable" in Item 32.

CERTIFIER

Item 33a-i: Certifier
All certifier information must be provided. The certifier accepts the responsibility of certifying that "to the best of my knowledge, the fetus was delivered at the time, date, and place as shown and fetal death was due to the cause(s) as stated:" on the certificate. The certification must come from a physician, medical examiner or nurse practitioner in all cases of fetal death. Signatures must be written in permanent black ink.

A midwife or certified nurse-midwife may be listed as an attendant on the fetal death certificate; however they may not be listed as a certifier. Only a physician, medical examiner, or nurse practitioner may be listed as the certifier on the fetal death certificate.

Item 33a: Is Certifier a Medical Examiner?
Indicate whether the certifying physician is a medical examiner at the Massachusetts Office of the Chief Medical Examiner.

Item 33b: Signature of Certifying Physician, Medical Examiner, or Nurse Practitioner
The signature must be handwritten in permanent black ink.

Item 33c: Title
Check the appropriate box to indicate whether the certifier is a physician, medical examiner, or nurse practitioner.

Item 33d: Type or Print-Name of Certifying Physician or Medical Examiner
Enter the name of certifying physician, medical examiner, or nurse practitioner.

Item 33e: License
Enter the license number of the certifier.

Item 33f: Certifier Street # and Address
Enter the street # and work address of the certifier.

Item 33g: City/Town
Enter the city/town of the certifier's work address.

Item 33h: State
Enter the state of the certifier's work address.

Item 33i: Zip Code
Enter the zip code of the certifier's work address.

ATTENDANT

Item 34a-c: Attendant *(if different)*

The attendant at delivery is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers a fetus under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant.

Enter the name of the attendant (if different from the certifying physician, medical examiner, or nurse practitioner).

Item 34a: Type or Print-Name of Attendant

Enter the name of the person who attended the delivery.

Item 34b: Title

Check one box to specify the attendant's title. If the "Other (specify)" box is checked, enter the title of the attendant. Examples include: nurse, father, police office, EMS technician, etc.

Item 34c: License

Enter the license number of the attendant at birth. If certifier is the same as the Certifier, enter "---".

PRENATAL CARE INFORMATION

Item 35: Date of First Prenatal Care Visit

This item identifies when during the pregnancy the patient entered prenatal care and is needed as the basis for measures of how soon patients initiate prenatal care and for measures of the appropriate utilization of services. This information is also used to study the impact of prenatal care on pregnancy outcome.

Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy.

Recommended Sources of Information: Hospital Worksheet, Prenatal Care Records, Mother's Medical Record

Enter the month, day, and year of the first prenatal care visit in the following format: MM/DD/YYYY. Complete all parts of the date that are available; use 9s for unknowns. If it is not known whether the patient had prenatal care, enter "99/99/9999" for unknown. If month and day is unknown, enter "99/99/YYYY"; if day is unknown, MM/99/YYYY.

If the mother did not receive prenatal care at any time during the pregnancy, check the "No prenatal care" box and leave the date blank.

Item 36: Date of Last Prenatal Care Visit

Enter the date of the last visit recorded in the mother's prenatal records in the following format: MM/DD/YYYY. Complete all parts of the date that are available; use 9s for unknowns. Complete all parts of the date that are available; use 9s for unknowns. If it is not known whether the patient had prenatal care, enter "99/99/9999" for unknown. If month and day is unknown, enter "99/99/YYYY"; if day is unknown, MM/99/YYYY.

Item 37: Total # of prenatal care visits for this pregnancy

This item is needed as the basis for measures of utilization of prenatal care services. It is also used in conjunction with "Date of First Prenatal Care Visit" to assess the adequacy of prenatal care.
Enter the total number of prenatal care visits for this pregnancy in this space.

If the patient had no prenatal care, enter "0" in the space. NOTE: the "No prenatal care" box should also be checked in item 35.

If the patient had prenatal care but the number of visits is not known, enter "99" in the space.

Item 38: Did mother get WIC food for herself during this pregnancy?

WIC is the nutrition program for Women, Infants, and Children and gives pregnant women and/or their children food, checks, or vouchers for food. Public health program planners would like to know if women sign up for WIC because they become pregnant and if receiving WIC food during pregnancy helps mothers deliver healthier babies.
Check the appropriate box to indicate if mother received WIC food for herself because she was pregnant during this pregnancy.

Item 39: Insurance (Prenatal Care Source of Payment)

This item is an indicator of the patterns of change occurring in the delivery of prenatal care. In conjunction with other items relating to prenatal care, it is used to determine relationships between quality of prenatal care and birth outcomes.
Recommended Sources of Information: Hospital Worksheet, Clinician's Prenatal Worksheet, Mother's Medical Record, Prenatal Record

Check the appropriate box to indicate the source of payment for prenatal care during this pregnancy. If the "Other" box is marked, enter the other source of payment for prenatal care. If mother did not receive prenatal care, please leave blank.

- **Medicaid**: A public health insurance program for Massachusetts residents who meet general and financial eligibility requirements.

- **Private Insurance**: A health insurance program not provided by the government (e.g. Blue Cross/Blue Shield, Aetna, etc.).

- **Self-pay**: Prenatal care was paid for privately, without insurance, HMO or government payment sources. No third party identified.

- **Indian Health Service**: The Indian Health Service is an agency within the Department of Health and Human Services that is responsible for providing federal health services to American Indians and Alaska Natives.

- **CHAMPUS/TRICARE**: Military health insurance that pays for Active Duty, Retired, Reserve, Guard, Veteran, and family members.

- **Other Government (Fed, State, Local)**: Other health plans provided by the government (e.g. Medicare)

- **Other**: Specify prenatal care source of payment that do not belong to listed options.

- **Unknown**: Prenatal care source of payment is not known.

PREGNANCY HISTORY

The information in Items 40-44 is essential for determining live-birth and total-birth order, which are important in studying trends in childbearing and child spacing. The information is useful in studying health problems associated with birth order. The dates of last live birth and last other pregnancy outcome permit the calculation of intervals between live births and fetal deaths and between pregnancies. This information allows researchers to analyze the relationship of various maternal characteristics and pregnancy outcomes with birth and pregnancy intervals.
Recommended Sources of Information: Hospital Worksheet, Prenatal Care Records, Mother's Medical Record, Labor & Delivery Log

Item 40: Number of Previous Live Births: Now Living
Enter the number of children born alive to this mother previous to this birth, and who are still living. If the mother has not had any live births, or if all live-born children have died, mark "None". For multiple deliveries, include live born infants born before this fetus in the multiple set. If information cannot be obtained from medical records, enter "99" for unknown.

Item 41: Number of Previous Live Births: Now Dead
Enter the number of children born alive to this mother who are now dead. If the mother has not had any live births, or if all live-born children are currently living, mark "None". For multiple deliveries, include live born infants born before this multiple set who subsequently died. If information cannot be obtained from medical records, enter "99" for unknown.

Item 42: Date of Last Live Birth
Enter the date of the last live birth for this mother in the following month and year format: MM/YYYY. If the answers to both Items 40 and 41 are "None", leave Item 42 blank. Complete all parts of the date that are available; use 9s for unknowns. If it is not known whether the patient had a previous live birth, enter "99/9999" for unknown. If month is unknown, enter "99/YYYY".

If this certificate 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 births, 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 the live birth.

Item 43: Number of Other Pregnancy Outcomes *(do not include this fetus)*
Enter the number of previous pregnancy outcomes that did not result in a live birth, regardless of the length of gestation. Include fetal losses of any gestational age-spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this fetus in the pregnancy. If information cannot be obtained from medical records, enter "99" for unknown.

Item 44: Date of Last Other Pregnancy Outcome
Enter the date when last pregnancy which did not result in a live birth ended in the following month and year format: MM/YYYY. If the answer to Item 43 is "None", skip Item 44. If the answer to Item 43 is other than "None", enter the date if known. Complete all parts of the date that are available; use 9s for unknowns. If it is not known whether the patient had another pregnancy outcome, enter "99/9999" for unknown. If month is unknown, enter "99/YYYY".

Item 45: Date Last Normal Menses Began
This item provides information on the length of gestation, which can be associated with weight of fetus to determine the maturity of the fetus at delivery. It is also associated with infant morbidity and mortality, and is important in medical research.
Recommended Sources of Information: Hospital Worksheet, Prenatal Care Records, Clinician's Prenatal Worksheet, Mother's Medical Record

Enter the mother's date last normal menses began in the following format: MM/DD/YYYY. Complete all parts of the date that are available; use 9s for unknowns. If the date is unknown, enter "99/99/9999". If month is unknown, enter "99/DD/YYYY; if day is unknown, enter "MM/99/YYYY".

Item 46: Mother's Weight at Delivery and Item 47: Mother's Prepregnancy Weight

In combination with known statistics about weight gain during pregnancy, public health researchers want to study pre-pregnancy weights to see if some weight ranges result in healthier mothers and babies.

Recommended Sources of Information: Hospital Worksheet, Clinician's Prenatal Worksheet, Mother's Medical Record

Item 46: Mother's Weight at Delivery

Enter the mother's weight at the time of admission for delivery in pounds. If the mother's delivery weight is not known, enter "999" in the item's space. Record weight in whole pounds only. Do not include fractions.

____ (pounds)

Item 47: Mother's Prepregnancy Weight

Enter the mother's weight in pounds before delivery. If the mother's delivery weight is not known, enter "999" in the item's space. Record weight in whole pounds only. Do not include fractions.

____ (pounds)

Item 48: Mother's Height

Enter the mother's height in feet and inches. If the record indicates height in fractions such as 5 feet and 6 and one-half inches, truncate and enter 5 feet, 6 inches. If the patient's height is unknown, enter "99" for feet and "99" for inches.

____ (feet) _____ (inches)

DELIVERY INFORMATION

The delivery information in items 49a-50b provide information on current obstetric practices and outcomes. The final route and method of delivery portion will allow for a more complete report of the obstetric intervention used to effect delivery. Cesarean data are needed to evaluate the impact of the current emphasis on vaginal delivery in pregnancies subsequent to a cesarean delivery.
Recommended Sources of Information: Hospital Worksheet, Mother's Medical Record, Labor and Delivery Log

Item 49a: Fetal presentation at delivery
Check ONE of the three boxes.
- **Cephalic:** Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP)
- **Breech**: Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech
- **Other**: Any other presentation not listed above

Item 49b: Final route and method of delivery
Check ONE of the boxes.
- **Vaginal/Spontaneous**: Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant
- **Vaginal/Forceps**: Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head
- **Vaginal/Vacuum**: Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head
- **Cesarean:** Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls
    - If cesarean, was a trial of labor attempted?
      Labor was allowed, augmented or induced with plans for a vaginal delivery.
      Check Yes or No.

Item 49c: Hysterotomy/Hysterectomy
Check the appropriate box to indicate if mother had either procedure.
A hysterotomy is an incision into the uterus extending into the uterine cavity. It may be performed vaginally or transabdominally.

A hysterotomy is applicable to fetal deaths only.
A hysterectomy is the surgical removal of the uterus, which may be performed abdominally or vaginally.

Item 50a-b: Mother's Transfer
Transfer information is important in identifying high-risk deliveries and follow up on maternal and infant deaths. Transfers include hospital to hospital, birth facility to hospital, etc.

Item 50a: Was mother transferred for maternal medical or fetal indications for delivery?
Check the "No" box if this is the first facility the mother was admitted to for delivery.

Check the "Yes" box if the mother was transferred from one facility to another facility before the fetus was delivered and enter the name of facility from which the mother was transferred (Item 50b).
Transfers include hospital to hospital, birth facility to hospital, etc. DOES NOT INCLUDE home to hospital.

Item 50b: If yes, enter name of facility mother transferred from _____
If the name of the facility is not known, enter "Unknown."

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

MEDICAL INFORMATION

Item 51: Risk Factors in this pregnancy *(Check all that apply)*

Recommended Sources of Information: Hospital Worksheet, Mother's Medical Record, Labor and Delivery Log

The mother may have more than one risk factor, check all boxes that apply. If the mother had none of the risk factors, check the "None of the above".

- **Diabetes – Prepregnancy**: Glucose intolerance requiring treatment-Diagnosis before this pregnancy (If diabetes is present, check either prepregnancy or gestational diabetes. DO NOT check both.)

- **Diabetes – Gestational**: Glucose intolerance requiring treatment-Diagnosis during this pregnancy (If diabetes is present, check either prepregnancy or gestational diabetes. DO NOT check both.)

- **Hypertension – Prepregnancy (Chronic)**: Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy

- **Hypertension – Gestational (PIH, preeclampsia)**: Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy (may include proteinuria (protein in the urine), without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face)).

- **Hypertension – Eclampsia**: Pregnancy induced hypertension with proteinuria with generalized seizures or coma (may include pathologic edema).

- **Previous preterm birth**: History of pregnancy (ies) terminating in a live birth of less than 37 completed weeks of gestation

- **Other previous poor pregnancy**: History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes: perinatal death (including fetal and neonatal deaths), small-for-gestational age/intrauterine growth restricted birth.

- **Pregnancy resulted from infertility treatment**: Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs ***(***e.g. Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g. IVF, GIFT, and ZIFT). If checked, please see Birth Trends and Technologies section.

- **Mother had a previous cesarean delivery**: Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls. If yes, how many___

- **None of the above**

Item 52: Infections Present and/or Treated During This Pregnancy *(Check all that apply)*

All of the listed infections are known to cause concomitant fetal and/or subsequent neonatal infection and thus have significant public health implications. In addition, there is no current national reporting system for these infections that focuses on the prevalence of perinatal transmission.

Below are infections present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.

If the prenatal record is not available and the information is not available from other medical records, enter "Unknown"

- **Chlamydia**: A diagnosis of or positive test for *Chlamydia trachomatis*.
- **Cytomegalovirus (CMV)**: A diagnosis of or positive test for the cytomegalovirus.
- **Gonorrhea**: A diagnosis of or positive test for *Neisseria gonorrhoeae*.

- **Group B Streptococcus (GBS)**: A diagnosis of or positive test for Streptococcus agalactiae or group B streptococcus.
- **Listeria (LM)**: A diagnosis of or positive test for Listeria monocytogenes.
- **Syphilis (also called lues)**: A diagnosis of or positive test for *Treponema pallidum*.
- **Parvovirus (B19)**: A diagnosis of or positive test for Parvovirus B19.
- **Toxoplasmosis (Toxo)**: A diagnosis of or positive test for Toxoplasma gondii
- **Other (specify) _____**
- **None of the above**

Item 53: Congenital Anomalies of the Fetus *(Check all that apply)*

Malformations of the fetus diagnosed prenatally or after delivery regardless of whether they contributed to fetal death. The items selected for this section will provide more specific information regarding fetal death events. Identifying the conditions and contributing causes of fetal death is necessary to understanding why they occur and may lead to possible prevention of fetal loss in the future. For "Downs Syndrome" and "Suspected Chromosomal Disorder", if karyotype status is unknown leave both the "Karyotype confirmed" and "Karyotype pending" boxes blank.

Recommended Sources of Information: Hospital Worksheet, Medical Record, Labor and Delivery Log

- **Anencephaly**: *Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes fetuses with craniorachischisis (anencephaly with a contiguous spine defect).*

- **Cleft Lip with or without Cleft Palate**: *Incomplete closure of the lip. May be unilateral, bilateral, or median.*

- **Cleft Palate alone**: *Incomplete fusion of the palatial shelves. May be limited to the soft palate or may 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 above.*

- **Congenital diaphragmatic hernia**: *Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.*

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

- **Down Syndrome**: *Trisomy 21*
  Check if a diagnosis of Down syndrome, Trisomy 21, is confirmed or pending
  - *Karyotype confirmed*
  - *Karyotype pending*

- **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 the absence of a protective membrane.*

- **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).*

- **Limb reduction defect**: *(excluding congenital amputation and dwarfing syndromes) - Complete or partial absence of a portion of an extremity associated with failure to develop.*

- **Meningomyelocele/Spina bifida**: *Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both*

open and closed (covered with skin) lesions should be included. DO NOT include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).

- **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 above]), although this sac may rupture. Also called exomphalos. DO NOT* include *umbilical hernia (completely covered by skin) in this category.*

- **Suspected chromosomal disorder**: *Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure*.
  Check if a diagnosis of a suspected chromosomal disorder is confirmed or pending (May include Trisomy 21)
  - *Karyotype confirmed*
  - *Karyotype pending*

- **None of the anomalies listed above**

Item 54: Maternal Morbidity *(Check all that apply)*

Serious complications experienced by the mother associated with labor and delivery.

- **Admission to intensive care unit**: *Any admission, planned or unplanned, of the mother to a facility or unit designated as providing intensive care.*

- **Maternal transfusion**: *Includes infusion of whole blood or packed red blood cells associated with labor and delivery.*

- **Ruptured uterus**: *Tearing of the uterine wall.*

- **Third or fourth degree perineal laceration**: *3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.*

- **Unplanned hysterectomy**: *Surgical removal of the uterus that was not planned before the admission. Includes an anticipated, but not definitively planned hysterectomy.*

- **Unplanned operating room procedure following delivery**: *Any transfer of the mother back to the surgical area for an operative procedure that was not planned before the admission for delivery. Excludes postpartum tubal ligations.*

- **None of the above**

Item 55: Birth Trends and Technologies *(Check all that apply)*

Better information about use of fertility drugs and assisted reproductive technologies will allow researchers to determine trends in the use of new types of treatments. This data will also help obstetricians and their patients know more about what risks and benefits there may be to mothers and newborns, depending on mother's age, genetic relationship to the child, and other characteristics.

- **Fertility-enhancing drugs**: *Progesterone, Gonadotrophins (e.g. Clomid®, Serophene), Gonadotrophin-releasing Hormone Agonists (GnRH Agonists) (e.g. Synarel, Zolodex), Gonadotrophin-releasing Hormone Antagonists (GnRH Antagonists) (e.g. Cetrotide)*

- **Artificial insemination**: *Fertility treatment in which sperm were collected and placed in the female reproductive tract. Do not include intrauterine insemination.*

- **Intrauterine insemination**: *Fertility treatment in which sperm were collected and placed in the woman's uterus.*

- **Assisted reproductive technology**: *Include in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI], frozen embryo transfer, or donor embryo transfer.*

- **Other medical treatment, Other (Specify)**: _____

- **Anonymous egg donor**

- **Anonymous sperm donor**

- **Surrogacy**

- **None of these apply**

REPORTED ALCOHOL AND TOBACCO USE

Item 56: Cigarette Smoking Before and During Pregnancy

Recommended Sources of Information: Mother's Preregistration Worksheet, Medical and Prenatal Record

Information about tobacco use by mothers before and during pregnancy helps doctors provide better information to pregnant women on the effects of smoking on birth weight and other birth outcomes. This question will help to find out whether reducing or increasing smoking at different stages during the pregnancy has different results.

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".

This item is to be completed by the facility based on information obtained from the patient. If the delivery did not occur in a facility, it is to be completed by the attendant or certifier based on information obtained from the patient.

If the patient's worksheet indicates "Unknown" or "Refused", enter "Unknown". Enter either the average number of cigarettes or the average number of packs of cigarettes smoked for each time period. If none, enter "0".

This item provides information on changes in tobacco use before and during pregnancy, which has an important impact on pregnancy outcome.

Item 57: Alcohol Use Before and During Pregnancy

Recommended Sources of Information: Mother's Preregistration Worksheet, Medical and Prenatal Record

This question will help to find out which amounts of alcohol have an effect on birth weight and other birth outcomes and if drinking at different times during pregnancy has different results. With real data about alcohol use during pregnancy, doctors can give better advice to pregnant mothers.

For each time period, enter the number of drinks (beer, wine or cocktails) mother had in an average week. If none, enter "0"

DEMOGRAPHIIC INFORMATION

Item 58: Mother/Parent Race

Recommended Sources of Information: Mother's Preregistration Worksheet, Admission Systems

Information about race of parents help researchers understand more about birth rates, health conditions and other factors relating to race that may affect birth outcomes and health service needs in Massachusetts communities.

Check one or more boxes that best describe the race of the mother/parent.

Item 59: Mother/Parent Ethnicity

Recommended Sources of Information: Mother's Preregistration Worksheet, Admission Systems

Information about ethnicities of parents help researchers understand more about genetic conditions, cultures, and geographic locations of existing and new ethnic communities that may affect the availability of quality prenatal care services, outcomes of pregnancies, and future health needs of young children and their families.

Check one or more boxes that best describe the ethnicity of the mother/parent.

Item 60: Mother/Parent Education

Recommended Sources of Information: Mother's Preregistration Worksheet, Admission Forms and Systems

Information about education of parents helps researchers understand more about trends in age and education levels of Massachusetts parents, choices in delivery methods and assisted reproductive technologies, reading levels required for health education materials, health information needs in schools by district, and other factors that may affect birth outcomes and maternal and child health.

Check the box that best describes the highest degree or level of schooling completed at the time of delivery. If no box is checked, check "Unknown".

Item 61: Mother/Parent Occupation and Item 62: Mother/Parent Industry

Mother's occupation is useful in studying occupationally related infant mortality, birth defects, and other complications. These items are used to determine potential health-hazards of different work environments on the fetus and in identifying specific job-related risk areas. Mother's occupation and industry can also be used as a socio-economic indicator that may be related to the mother's access to prenatal care.

Recommended Sources of Information: Mother's Preregistration Worksheet, Admitting Forms/Systems

Item 61: Mother/Parent Occupation

Examples: computer programmer, cashier, homemaker, unemployed

Enter the specific occupation of the mother/parent most recently held during the past 12 months.

Item 62: Mother/Parent Industry

Examples: software company, Smith's Supermarket, own home

Enter the kind of business or industry to which the occupation listed previously is related.

Company names are acceptable responses for an industry, when a category description cannot be determined.

Item 63 Father/Parent Race:

Recommended Source of Information: Mother's Preregistration Worksheet

Information about race of parents help researchers understand more about birth rates, health conditions and other factors relating to race that may affect birth outcomes and health service needs in Massachusetts communities.

Check one or more boxes that best describe the race of the father/parent.

Item 64: Father/Parent Ethnicity

Information about ethnicities of parents help researchers understand more about genetic conditions, cultures, and geographic locations of existing and new ethnic communities that may affect the availability of quality prenatal care services, outcomes of pregnancies, and future health needs of young children and their families.

Check one or more boxes that best describe the ethnicity of the father/parent.

Item 65: Father/Parent Education

Recommended Sources of Information: Mother's Preregistration Worksheet, Admission Forms and Systems

Information about education of parents helps researchers understand more about trends in age and education levels of Massachusetts parents, choices in delivery methods and assisted reproductive technologies, reading levels required for health education materials, health information needs in schools by district, and other factors that may affect birth outcomes and maternal and child health.
Check the box that best describes the highest degree or level of schooling completed at the time of delivery. If no box is checked, check "Unknown".

Item 66: Father/Parent Occupation and Item 67: Father/Parent Industry

Recommended Sources of Information: Mother's Preregistration Worksheet, Admitting Forms/Systems
Father's occupation and industry are important statistical items used with mother's information to establish birthrates in populations of different occupations and socioeconomic status. It is used also to establish any correlations between father's occupation and adverse birth outcomes. Father's occupation and industry can also be used as a socio-economic indicator that may be related to the mother's access to prenatal care.

Item 66: Father/Parent Occupation

Recommended Sources of Information: Mother's Preregistration Worksheet, Admitting Forms/Systems
Examples: computer programmer, cashier, homemaker, unemployed
Enter the specific occupation of the father/parent most recently held during the past 12 months.

Item 67: Father/Parent Industry

Examples: software company, Smith's Supermarket, own home
Enter the kind of business or industry to which the occupation above is related.
Company names are acceptable responses for an industry, when a category description cannot be determined.

APPENDIX

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
001	ABINGTON	12	PLYMOUTH
002	ACTON	09	MIDDLESEX
003	ACUSHNET	03	BRISTOL
004	ADAMS	02	BERKSHIRE
005	AGAWAM	07	HAMPDEN
006	ALFORD	02	BERKSHIRE
007	AMESBURY	05	ESSEX
008	AMHERST	08	HAMPSHIRE
009	ANDOVER	05	ESSEX
010	ARLINGTON	09	MIDDLESEX
011	ASHBURNHAM	14	WORCESTER
012	ASHBY	09	MIDDLESEX
013	ASHFIELD	06	FRANKLIN
014	ASHLAND	09	MIDDLESEX
015	ATHOL	14	WORCESTER
016	ATTLEBORO	03	BRISTOL
017	AUBURN	14	WORCESTER
018	AVON	11	NORFOLK
019	AYER	09	MIDDLESEX
020	BARNSTABLE	01	BARNSTABLE
021	BARRE	14	WORCESTER
022	BECKET	02	BERKSHIRE
023	BEDFORD	09	MIDDLESEX
024	BELCHERTOWN	08	HAMPSHIRE
025	BELLINGHAM	11	NORFOLK
026	BELMONT	09	MIDDLESEX
027	BERKLEY	03	BRISTOL
028	BERLIN	14	WORCESTER
029	BERNARDSTON	06	FRANKLIN
030	BEVERLY	05	ESSEX
031	BILLERICA	09	MIDDLESEX
032	BLACKSTONE	14	WORCESTER
033	BLANDFORD	07	HAMPDEN
034	BOLTON	14	WORCESTER
035	BOSTON	13	SUFFOLK
036	BOURNE	01	BARNSTABLE
037	BOXBOROUGH	09	MIDDLESEX

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
038	BOXFORD	05	ESSEX
039	BOYLSTON	14	WORCESTER
040	BRAINTREE	11	NORFOLK
041	BREWSTER	01	BARNSTABLE
042	BRIDGEWATER	12	PLYMOUTH
043	BRIMFIELD	07	HAMPDEN
044	BROCKTON	12	PLYMOUTH
045	BROOKFIELD	14	WORCESTER
046	BROOKLINE	11	NORFOLK
047	BUCKLAND	06	FRANKLIN
048	BURLINGTON	09	MIDDLESEX
049	CAMBRIDGE	09	MIDDLESEX
050	CANTON	11	NORFOLK
051	CARLISLE	09	MIDDLESEX
052	CARVER	12	PLYMOUTH
053	CHARLEMONT	06	FRANKLIN
054	CHARLTON	14	WORCESTER
055	CHATHAM	01	BARNSTABLE
056	CHELMSFORD	09	MIDDLESEX
057	CHELSEA	13	SUFFOLK
058	CHESHIRE	02	BERKSHIRE
059	CHESTER	07	HAMPDEN
060	CHESTERFIELD	08	HAMPSHIRE
061	CHICOPEE	07	HAMPDEN
062	CHILMARK	04	DUKES
063	CLARKSBURG	02	BERKSHIRE
064	CLINTON	14	WORCESTER
065	COHASSET	11	NORFOLK
066	COLRAIN	06	FRANKLIN
067	CONCORD	09	MIDDLESEX
068	CONWAY	06	FRANKLIN
069	CUMMINGTON	08	HAMPSHIRE
070	DALTON	02	BERKSHIRE
071	DANVERS	05	ESSEX
072	DARTMOUTH	03	BRISTOL

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
073	DEDHAM	11	NORFOLK
074	DEERFIELD	06	FRANKLIN
075	DENNIS	01	BARNSTABLE
076	DIGHTON	03	BRISTOL
077	DOUGLAS	14	WORCESTER
078	DOVER	11	NORFOLK
079	DRACUT	09	MIDDLESEX
080	DUDLEY	14	WORCESTER
081	DUNSTABLE	09	MIDDLESEX
082	DUXBURY	12	PLYMOUTH
083	EAST BRIDGEWATER	12	PLYMOUTH
084	EAST BROOKFIELD	14	WORCESTER
085	EAST LONGMEADOW	07	HAMPDEN
086	EASTHAM	01	BARNSTABLE
087	EASTHAMPTON	08	HAMPSHIRE
088	EASTON	03	BRISTOL
089	EDGARTOWN	04	DUKES
090	EGREMONT	02	BERKSHIRE
091	ERVING	06	FRANKLIN
092	ESSEX	05	ESSEX
093	EVERETT	09	MIDDLESEX
094	FAIRHAVEN	03	BRISTOL
095	FALL RIVER	03	BRISTOL
096	FALMOUTH	01	BARNSTABLE
097	FITCHBURG	14	WORCESTER
098	FLORIDA	02	BERKSHIRE
099	FOXBOROUGH	11	NORFOLK
100	FRAMINGHAM	09	MIDDLESEX
101	FRANKLIN	11	NORFOLK
102	FREETOWN	03	BRISTOL
103	GARDNER	14	WORCESTER
104	GAY HEAD	04	DUKES
105	GEORGETOWN	05	ESSEX
106	GILL	06	FRANKLIN

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
107	GLOUCESTER	05	ESSEX
108	GOSHEN	08	HAMPSHIRE
109	GOSNOLD	04	DUKES
110	GRAFTON	14	WORCESTER
111	GRANVILLE	07	HAMPDEN
113	GREAT BARRINGTON	02	BERKSHIRE
114	GREENFIELD	06	FRANKLIN
115	GROTON	09	MIDDLESEX
116	GROVELAND	05	ESSEX
117	HADLEY	08	HAMPSHIRE
118	HALIFAX	12	PLYMOUTH
119	HAMILTON	05	ESSEX
120	HAMPDEN	07	HAMPDEN
121	HANCOCK	02	BERKSHIRE
122	HANOVER	12	PLYMOUTH
123	HANSON	12	PLYMOUTH
124	HARDWICK	14	WORCESTER
125	HARVARD	14	WORCESTER
126	HARWICH	01	BARNSTABLE
127	HATFIELD	08	HAMPSHIRE
128	HAVERHILL	05	ESSEX
129	HAWLEY	06	FRANKLIN
130	HEATH	06	FRANKLIN
131	HINGHAM	12	PLYMOUTH
132	HINSDALE	02	BERKSHIRE
133	HOLBROOK	11	NORFOLK
134	HOLDEN	14	WORCESTER
135	HOLLAND	07	HAMPDEN
136	HOLLISTON	09	MIDDLESEX
137	HOLYOKE	07	HAMPDEN
138	HOPEDALE	14	WORCESTER
139	HOPKINTON	09	MIDDLESEX
140	HUBBARDSTON	14	WORCESTER
141	HUDSON	09	MIDDLESEX
142	HULL	12	PLYMOUTH

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
143	HUNTINGTON	08	HAMPSHIRE
144	IPSWICH	05	ESSEX
145	KINGSTON	12	PLYMOUTH
146	LAKEVILLE	12	PLYMOUTH
147	LANCASTER	14	WORCESTER
148	LANESBOROUGH	02	BERKSHIRE
149	LAWRENCE	05	ESSEX
150	LEE	02	BERKSHIRE
151	LEICESTER	14	WORCESTER
152	LENOX	02	BERKSHIRE
153	LEOMINSTER	14	WORCESTER
154	LEVERETT	06	FRANKLIN
155	LEXINGTON	09	MIDDLESEX
156	LEYDEN	06	FRANKLIN
157	LINCOLN	09	MIDDLESEX
158	LITTLETON	09	MIDDLESEX
159	LONGMEADOW	07	HAMPDEN
160	LOWELL	09	MIDDLESEX
161	LUDLOW	07	HAMPDEN
162	LUNENBURG	14	WORCESTER
163	LYNN	05	ESSEX
164	LYNNFIELD	05	ESSEX
165	MALDEN	09	MIDDLESEX
166	MANCHESTER BY THE SEA	05	ESSEX
167	MANSFIELD	03	BRISTOL
168	MARBLEHEAD	05	ESSEX
169	MARION	12	PLYMOUTH
170	MARLBOROUGH	09	MIDDLESEX
171	MARSHFIELD	12	PLYMOUTH
172	MASHPEE	01	BARNSTABLE
173	MATTAPOISETT	12	PLYMOUTH
174	MAYNARD	09	MIDDLESEX
175	MEDFIELD	11	NORFOLK
176	MEDFORD	09	MIDDLESEX

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
177	MEDWAY	11	NORFOLK
178	MELROSE	09	MIDDLESEX
179	MENDON	14	WORCESTER
180	MERRIMAC	05	ESSEX
181	METHUEN	05	ESSEX
182	MIDDLEBOROUGH	12	PLYMOUTH
183	MIDDLEFIELD	08	HAMPSHIRE
184	MIDDLETON	05	ESSEX
185	MILFORD	14	WORCESTER
186	MILLBURY	14	WORCESTER
187	MILLIS	11	NORFOLK
188	MILLVILLE	14	WORCESTER
189	MILTON	11	NORFOLK
190	MONROE	06	FRANKLIN
191	MONSON	07	HAMPDEN
192	MONTAGUE	06	FRANKLIN
193	MONTEREY	02	BERKSHIRE
194	MONTGOMERY	07	HAMPDEN
195	MOUNT WASHINGTON	02	BERKSHIRE
196	NAHANT	05	ESSEX
197	NANTUCKET	10	NANTUCKET
198	NATICK	09	MIDDLESEX
199	NEEDHAM	11	NORFOLK
200	NEW ASHFORD	02	BERKSHIRE
201	NEW BEDFORD	03	BRISTOL
202	NEW BRAINTREE	14	WORCESTER
203	NEW MARLBOROUGH	02	BERKSHIRE
204	NEW SALEM	06	FRANKLIN
205	NEWBURY	05	ESSEX
206	NEWBURYPORT	05	ESSEX
207	NEWTON	09	MIDDLESEX
208	NORFOLK	11	NORFOLK
209	NORTH ADAMS	02	BERKSHIRE
210	NORTH ANDOVER	05	ESSEX

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
211	NORTH ATTLEBOROUGH	03	BRISTOL
212	NORTH BROOKFIELD	14	WORCESTER
213	NORTH READING	09	MIDDLESEX
214	NORTHAMPTON	08	HAMPSHIRE
215	NORTHBOROUGH	14	WORCESTER
216	NORTHBRIDGE	14	WORCESTER
217	NORTHFIELD	06	FRANKLIN
218	NORTON	03	BRISTOL
219	NORWELL	12	PLYMOUTH
220	NORWOOD	11	NORFOLK
221	OAK BLUFFS	04	DUKES
222	OAKHAM	14	WORCESTER
223	ORANGE	06	FRANKLIN
224	ORLEANS	01	BARNSTABLE
225	OTIS	02	BERKSHIRE
226	OXFORD	14	WORCESTER
227	PALMER	07	HAMPDEN
228	PAXTON	14	WORCESTER
229	PEABODY	05	ESSEX
230	PELHAM	08	HAMPSHIRE
231	PEMBROKE	12	PLYMOUTH
232	PEPPERELL	09	MIDDLESEX
233	PERU	02	BERKSHIRE
234	PETERSHAM	14	WORCESTER
235	PHILLIPSTON	14	WORCESTER
236	PITTSFIELD	02	BERKSHIRE
237	PLAINFIELD	08	HAMPSHIRE
238	PLAINVILLE	11	NORFOLK
239	PLYMOUTH	12	PLYMOUTH
240	PLYMPTON	12	PLYMOUTH
241	PRINCETON	14	WORCESTER
242	PROVINCETOWN	01	BARNSTABLE
243	QUINCY	11	NORFOLK

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
244	RANDOLPH	11	NORFOLK
245	RAYNHAM	03	BRISTOL
246	READING	09	MIDDLESEX
247	REHOBOTH	03	BRISTOL
248	REVERE	13	SUFFOLK
249	RICHMOND	02	BERKSHIRE
250	ROCHESTER	12	PLYMOUTH
251	ROCKLAND	12	PLYMOUTH
252	ROCKPORT	05	ESSEX
253	ROWE	06	FRANKLIN
254	ROWLEY	05	ESSEX
255	ROYALSTON	14	WORCESTER
256	RUSSELL	07	HAMPDEN
257	RUTLAND	14	WORCESTER
258	SALEM	05	ESSEX
259	SALISBURY	05	ESSEX
260	SANDISFIELD	02	BERKSHIRE
261	SANDWICH	01	BARNSTABLE
262	SAUGUS	05	ESSEX
263	SAVOY	02	BERKSHIRE
264	SCITUATE	12	PLYMOUTH
265	SEEKONK	03	BRISTOL
266	SHARON	11	NORFOLK
267	SHEFFIELD	02	BERKSHIRE
268	SHELBURNE	06	FRANKLIN
269	SHERBORN	09	MIDDLESEX
270	SHIRLEY	09	MIDDLESEX
271	SHREWSBURY	14	WORCESTER
272	SHUTESBURY	06	FRANKLIN
273	SOMERSET	03	BRISTOL
274	SOMERVILLE	09	MIDDLESEX
275	SOUTH HADLEY	08	HAMPSHIRE
276	SOUTHAMPTON	08	HAMPSHIRE
277	SOUTHBOROUGH	14	WORCESTER
278	SOUTHBRIDGE	14	WORCESTER

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
279	SOUTHWICK	07	HAMPDEN
280	SPENCER	14	WORCESTER
281	SPRINGFIELD	07	HAMPDEN
282	STERLING	14	WORCESTER
283	STOCKBRIDGE	02	BERKSHIRE
284	STONEHAM	09	MIDDLESEX
285	STOUGHTON	11	NORFOLK
286	STOW	09	MIDDLESEX
287	STURBRIDGE	14	WORCESTER
288	SUDBURY	09	MIDDLESEX
289	SUNDERLAND	06	FRANKLIN
290	SUTTON	14	WORCESTER
291	SWAMPSCOTT	05	ESSEX
292	SWANSEA	03	BRISTOL
293	TAUNTON	03	BRISTOL
294	TEMPLETON	14	WORCESTER
295	TEWKSBURY	09	MIDDLESEX
296	TISBURY	04	DUKES
297	TOLLAND	07	HAMPDEN
298	TOPSFIELD	05	ESSEX
299	TOWNSEND	09	MIDDLESEX
300	TRURO	01	BARNSTABLE
301	TYNGSBOROUGH	09	MIDDLESEX
302	TYRINGHAM	02	BERKSHIRE
303	UPTON	14	WORCESTER
304	UXBRIDGE	14	WORCESTER
305	WAKEFIELD	09	MIDDLESEX
306	WALES	07	HAMPDEN
307	WALPOLE	11	NORFOLK
308	WALTHAM	09	MIDDLESEX
309	WARE	08	HAMPSHIRE
310	WAREHAM	12	PLYMOUTH
311	WARREN	14	WORCESTER
312	WARWICK	06	FRANKLIN
313	WASHINGTON	02	BERKSHIRE

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
314	WATERTOWN	09	MIDDLESEX
315	WAYLAND	09	MIDDLESEX
316	WEBSTER	14	WORCESTER
317	WELLESLEY	11	NORFOLK
318	WELLFLEET	01	BARNSTABLE
319	WENDELL	06	FRANKLIN
320	WENHAM	05	ESSEX
321	WEST BOYLSTON	14	WORCESTER
322	WEST BRIDGEWATER	12	PLYMOUTH
323	WEST BROOKFIELD	14	WORCESTER
324	WEST NEWBURY	05	ESSEX
325	WEST SPRINGFIELD	07	HAMPDEN
326	WEST STOCKBRIDGE	02	BERKSHIRE
327	WEST TISBURY	04	DUKES
328	WESTBOROUGH	14	WORCESTER
329	WESTFIELD	07	HAMPDEN
330	WESTFORD	09	MIDDLESEX
331	WESTHAMPTON	08	HAMPSHIRE
332	WESTMINSTER	14	WORCESTER
333	WESTON	09	MIDDLESEX
334	WESTPORT	03	BRISTOL
335	WESTWOOD	11	NORFOLK
336	WEYMOUTH	11	NORFOLK
337	WHATELY	06	FRANKLIN
338	WHITMAN	12	PLYMOUTH
339	WILBRAHAM	07	HAMPDEN
340	WILLIAMSBURG	08	HAMPSHIRE
341	WILLIAMSTOWN	02	BERKSHIRE
342	WILMINGTON	09	MIDDLESEX
343	WINCHENDON	14	WORCESTER
344	WINCHESTER	09	MIDDLESEX
345	WINDSOR	02	BERKSHIRE

MASSACHUSETTS CITIES AND TOWNS

CITY CODE	COMMUNITY	COUNTY CODE	COUNTY
346	WINTHROP	13	SUFFOLK
347	WOBURN	09	MIDDLESEX
348	WORCESTER	14	WORCESTER
349	WORTHINGTON	08	HAMPSHIRE
350	WRENTHAM	11	NORFOLK
351	YARMOUTH	01	BARNSTABLE

Massachusetts General Laws, Chapter 38, Section 3: Duty to report deaths; failure to report
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleVI/Chapter38/Section3

Section 3. It shall be the duty of any person having knowledge of a death which occurs under the circumstances enumerated in this paragraph immediately to notify the office of the chief medical examiner, or the medical examiner designated to the location where the death has occurred, of the known facts concerning the time, place, manner, circumstances and cause of such death:
(1) death where criminal violence appears to have taken place, regardless of the time interval between the incident and death, and regardless of whether such violence appears to have been the immediate cause of death, or a contributory factor thereto;
(2) death by accident or unintentional injury, regardless of time interval between the incident and death, and regardless of whether such injury appears to have been the immediate cause of death, or a contributory factor thereto;
(3) suicide, regardless of the time interval between the incident and death;
(4) death under suspicious or unusual circumstances;
(5) death following an unlawful abortion;
(6) death related to occupational illness or injury;
(7) death in custody, in any jail or correctional facility, or in any mental health or mental retardation institution;
(8) death where suspicion of abuse of a child, family or household member, elder person or disabled person exists;
(9) death due to poison or acute or chronic use of drugs or alcohol;
(10) skeletal remains;
(11) death associated with diagnostic or therapeutic procedures;
(12) sudden death when the decedent was in apparent good health;
(13) death within twenty-four hours of admission to a hospital or nursing home;
(14) death in any public or private conveyance;
(15) fetal death, as defined by section two hundred and two of chapter one hundred and eleven, where the period of gestation has been twenty weeks or more, or where fetal weight is three hundred and fifty grams or more;
(16) death of children under the age of 18 years from any cause;
(17) any person found dead;
(18) death in any emergency treatment facility, medical walk-in center, child care center, or under foster care; or
(19) deaths occurring under such other circumstances as the chief medical examiner shall prescribe in regulations promulgated pursuant to the provisions of chapter thirty A.

A physician, police officer, hospital administrator, licensed nurse, department of children and families social worker, or licensed funeral director, within the commonwealth, who, having knowledge of such an unreported death, fails to notify the office of the chief medical examiner of such death shall be punished by a fine of not more than five hundred dollars. Such failure shall also be reported to the appropriate board of registration, where applicable.

Massachusetts General Laws, Chapter 211, Section 202: Fetal deaths; reports; confidentiality; disposition of remains; violations; forms
https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/Chapter111/Section202

Section 202. As used in this section, "fetal death" means death prior to the complete expulsion or extraction from its mother of a fetus, irrespective of the duration of pregnancy, as 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 voluntary muscles. "Fetal death" does not include an abortion as defined in section twelve K of chapter one hundred and twelve.

When a fetal death occurs in a hospital, if a fetus is of twenty weeks gestation or more, or a weight of three hundred and fifty grams or more, the physician in attendance shall prepare and transmit a report of such death to the person in charge of the hospital or his designated representative, who shall file such report with the commissioner within ten days after such death.

When a fetal death occurs outside a hospital, if a fetus is of twenty weeks gestation or more, or a weight of three hundred and fifty grams or more, the physician in attendance at or immediately after delivery shall prepare and file a report of such death with said commissioner within ten days after such death.

When a fetal death occurs without medical attendance at or immediately after delivery or when the fetal death may have occurred from violence or unnatural causes, if a fetus is of twenty weeks gestation or more, or a weight of three hundred and fifty grams or more, the medical examiner shall investigate the cause and shall prepare and file a report of such death with said commissioner within ten days after such death.

Said commissioner may compile an annual statistical report of fetal deaths, and may make such further use of such records as he deems useful for administrative and research purposes connected with health programs and population studies.

Fetal death reports shall be confidential and shall be released by the department only upon written request of the parent, his or her guardian, executor, attorney, or any other person designated by the parent in writing. Such reports may also be released to the National Center for Health Statistics in the Department of Health, Education and Welfare, and to persons authorized by said commissioner under section twenty-four A of this chapter to conduct research studies. The department may release copies of such reports, or information contained therein, to other persons only in a manner which does not allow identification of the parents.

Disposition of fetal remains shall be made at the direction of the parent in either manner as hereinafter provided: the remains may be buried, entombed or cremated in accordance with chapter one hundred and fourteen and a copy of a report required by this section shall constitute the certificate required by section forty-five of said chapter one hundred and fourteen. Said copy shall, within thirty days after the issuance of a burial permit, be destroyed by the local board of health; or in all other circumstances, the fetal remains shall be disposed of by the hospital or as directed by the attending physician or medical examiner in a manner which does not create a hazard to the public health. Such disposition shall not be subject to the provisions of said chapter one hundred and fourteen. Before disposition, the physician or person in charge of the hospital shall ensure that the parent is informed of his right to direct either burial, entombment or cremation of the fetal remains, or disposal of the remains by the hospital or physician. Before disposition, the parent shall be informed in writing of the hospital policy relating to disposal of fetal remains, and shall be informed of the availability of a chaplain if any for counsel.

The provisions of chapter forty-six regarding the reporting of deaths shall not apply to fetal deaths.

A physician or medical examiner neglecting or refusing to file a report required by this section, or who makes a false statement therein, shall be subject to a fine of not more than fifty dollars.

The commissioner shall prescribe the form for the making of reports under this section, which shall be consistent with the United States standard report of fetal death.

Report of Fetal Death

Commonwealth of Massachusetts
Registry of Vital Records and Statistics
REPORT OF FETAL DEATH

Form R304-102014 Page 1 of 4
FOR STATE USE ONLY
State File #
Date Received by Registrar

INSTRUCTIONS: Complete a Report of Fetal Death only for fetal deaths of 20 weeks or more gestation OR of a weight of 350 grams or more. A fetal death occurs when the fetus shows no signs of life at the time of expulsion or extraction. Complete front and reverse sides of form within 10 days and send original copy to the 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 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 this form. The original report must be sent to the Registry of Vital Records and Statistics, an agency within the Massachusetts Department of Public Health.

Facility

1 Facility ID	2 Facility Name	3 City, Town, or Location of Delivery

4 Place Where Delivery Occurred *(Check one)*

☐ Hospital
☐ Clinic/Doctor's office
☐ Freestanding birthing center
☐ Home Delivery: Planned to deliver at home? ☐ Yes ☐ No
☐ Unknown
☐ Other *(specify)* _____

5 Zip Code of Delivery

6 County of Delivery

Fetus

Name of Fetus (optional-at the discretion of the parents)
7a *First Name*

7b *Middle Name*

7c *Last Name*

8 Time of Delivery *(24 hr)*

9 Sex
☐ Male
☐ Female
☐ Unknown

10 Weight of Fetus *(grams)*

11 Obstetric Estimate of Gestation at Delivery *(completed weeks)*

12 Date of Delivery *(Month, Day, Year)*

13 Plurality *(specify)*
☐ Single ☐ Other_____
☐ Twin

14 Birth Order *(specify if plural birth)*
☐ 1st ☐ 3rd
☐ 2nd ☐ Other _____

15 Clinical Estimate of Gestation *(in weeks)*

Mother/Parent

Mother's Name
16a *First Name*

16b *Middle Name*

16c *Last Name*

16d *Surname at Birth or Adoption (Maiden Name)*

17 Date of Birth *(Month, Day, Year)*

18 Birthplace *(City/Town, State, Country)*

19a Residence of Mother- *Number and Street Address*

19b Apt #	19c City/Town	19d County	19e State	19f Zip Code	19g Inside City Limits? *(if not MA resident)* ☐ Yes ☐ No

Marital Status

20 Mother's Marital Status

☐ Married
☐ Never Married
☐ Widowed
☐ Divorced

Father/Parent

Father's Name
21a *First Name*

21b *Middle Name*

21c *Last Name*

21d *Surname at Birth or Adoption*

22 Date of Birth *(Month, Day, Year)*

23 Birthplace *(City/Town, State, Country)*

24 Method of Disposition

☐ Burial
☐ Cremation
☐ Entombment
☐ Removal from state
☐ Donation
☐ Medical waste
☐ Other
(*specify*):_____

25 Place of Disposition

25a Name _____ 25b City/Town, State: _____
(i.e., cemetery, crematory, hospital, etc.)

25c Funeral Service Licensee *(if any)*: _____ 25d License# _____

25e Name of Facility (*if any*): _____

25f Date of Disposition: _____
(Month, Day, Year)

26 Board of Health Info (NOTE: This Report MUST be destroyed within 30 days after city/town issuance of a burial permit. DO NOT return to RVRS.)

26a **Date Report Was Received:** _____ 26b **City/Town of Board of Health:** _____

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

REPORT OF FETAL DEATH

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Cause of Fetal Death

Cause/Conditions Contributing to Fetal Death

27a **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)*	27b **Other Significant Causes or Conditions** *(Select or specify all other conditions contributing to death in Item 27b)*
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

28 **Estimated Time of Fetal Death**	29 **Was the case referred to a Medical Examiner?**	31 **Was a histological placental examination performed?**	32 **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 **30 Was an autopsy performed?** ☐ Yes ☐ No ☐ Planned	☐ Yes ☐ No ☐ Planned	☐ Yes ☐ No ☐ Not Applicable

Certifier

***I HEREBY CERTIFY** that this delivery occurred on the date stated and the product of conception was not a live birth.*

Is Certifier a Medical Examiner? ☐Yes ☐No (33a)

_____
Signature of Certifier or Medical Examiner (33b)

Title ☐ MD ☐ DO ☐ NP (33c)

_____
Type or Print-Name of Certifier or Medical Examiner (33d)

License#:_____ (33e)

_____
Certifier Street # and Address (33f)

_____
City/Town (33g) State (33h) Zip Code (33i)

Attendant (If different)

_____
Type or Print-Name of Attendant (34a)

Title ☐ MD ☐ DO ☐ CNM/CM ☐ Other Midwife ☐ Other *(Specify)* _____ (34b)

License #_____ (34c)

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

REPORT OF FETAL DEATH

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Prenatal Care Information

35 Date of First Prenatal Care Visit	36 Date of Last Prenatal Care Visit	37 Total # of prenatal care visits for this pregnancy *(If none, enter "0")*	38 Did mother get WIC food for herself during this pregnancy?	39 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

40 Number of Previous Live Births: Now Living	41 Number of Previous Live Births: Now Dead	42 Date of Last Live Birth	43 Number of Other Pregnancy Outcomes *(do not include this fetus):*	44 Date of Last Other Pregnancy Outcome
#_____ ☐ None	#_____ ☐ None	____/____ MM / YYYY	#_____ ☐ None	____/____ MM / YYYY

45 Date Last Normal Menses Began	46 Mother's Weight at Delivery	47 Mother's Prepregnancy Weight	48 Mother's Height
____/____/____ MM / DD / YYYY	_____ (pounds)	_____ (pounds)	_____ (feet) _____ (inches)

Delivery Information

49a Fetal presentation at delivery *(Check one)*	49b Final route and method of delivery *(Check one)*	49c Hysterotomy/Hysterectomy	50a Was mother transferred for maternal medical or fetal indications for delivery? ☐ Yes ☐ No 50b 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

51 Risk Factors in this pregnancy *(Check all that apply)*	52 Infections Present and/or Treated During This Pregnancy *(Check all that apply)*	53 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

54 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

55 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

56 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

57 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*
#_____	#_____

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

REPORT OF FETAL DEATH

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Demographic Information

58 Mother/Parent Race *(May check more than one 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

59 Mother/Parent Ethnicity *(May check more than one 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

60 Mother/Parent Education *(Check the box that best describes the highest degree or level of school 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

61 Mother/Parent Occupation

62 Mother/Parent Industry

63 Father/Parent Race *(May check more than one 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

64 Father/Parent Ethnicity *(May check more than one 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

65 Father/Parent Education *(Check the box that best describes the highest degree or level of school 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

66 Father/Parent Occupation

67 Father/Parent Industry

Hospital Worksheet

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)*

HOSPITAL WORKSHEET *FOR REPORT OF FETAL DEATH* Page 1 of 4

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 #_____

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.

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

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.

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)

HOSPITAL WORKSHEET *FOR REPORT OF FETAL DEATH* Page 4 of 4

Instructions

Commonwealth of Massachusetts
Registry of Vital Records and Statistics

INSTRUCTIONS FOR COMPLETING THE REPORT OF FETAL DEATH

(Form R304-102014)

General Instructions

- Criteria for Reportability
  - Fetus was extracted or expulsed **on or after 20 weeks** of pregnancy and/or weighed **350 grams or more.**
  - The fetus was stillborn and there were no signs of life at time of extraction or expulsion.

- If non-reportable, then
  - **If any signs of life were present**, even of a very small gestational age or weight, then a birth certificate and a death certificate must be completed, regardless of gestational age. Hospital disposition is not allowed for a baby born alive.
  - **If a private disposition is being arranged** for a non-reportable fetal death, then the hospital will provide a statement on hospital or physician letterhead stating the facts of the case, including gestational weeks and weight of fetus at time of extraction or expulsion, to be given to the funeral director or the family.

- Complete only one original Report of Fetal Death and send the original to the Registry of Vital Records and Statistics (within 10 days of fetal delivery) at 150 Mt. Vernon Street, 1st Floor, Dorchester, MA 02125, Attn: Natality Data Unit-FD

- Use the current ***Report of Fetal Death*** form (Form R304-102014) designated by the Registry of Vital Records and Statistics. An accompanying ***Hospital Worksheet for Report of Fetal Death*** (Form R304W-102014) is a recommended tool for the completion of fetal death reports.

- All information except signatures and checkboxes should be typed. Manually printed Report of Fetal Death forms are discouraged, but if it is not possible to type the information, print legibly using permanent black ink. Complete each item, following the specific instructions for that item. Do not use correction fluid or make alterations, erasures or strike-overs.

- Certifier must be a physician, medical examiner, or nurse practitioner.

- Photocopy and forward only **Page 1 of 4 AND Page 2 of 4 (Cause of Death and Certifier Info)** of this form to the funeral director or the family for the purposes of filing with the local Board of Health and obtaining a burial permit.

Hospital

Complete the following sections of the Report of Fetal Death
If disposition of fetal remains is taking place in a hospital facility, complete all sections of the form.
If disposition of fetal remains is not taking place in a hospital facility, complete all sections except ***Item 24****: Method of Disposition*; ***Item 25****: Place of Disposition*; *and* ***Item 26****: Board of Health Info.*

Board of Health

Complete the following sections of the photocopied Report of Fetal Death for disposition permit purposes at the Board of Health:

- Item 24: Method of Disposition
- Item 25: Place of Disposition
- Item 26: Board of Health Info

This completed photocopied Report of Fetal Death **MUST** be destroyed within 30 days after city/town issuance of burial permit. **DO NOT** return to the Registry of Vital Records and Statistics.

Questions

Contact the Registry at (617) 740-2681.

ITEM-BY-ITEM INSTRUCTIONS

FACILITY

Item 1: Facility ID

The Facility ID is the unique four-digit identifier of the facility completing the report of fetal death. It is used for simplifying fetal death processing. ***Please leave blank. The Registry will complete Item 1: Facility ID (Number) upon receipt of completed Report of Fetal Death.***

Item 2: Facility Name

Enter the name of the facility where the fetal death delivery occurred. If this fetal death delivery did not occur in a hospital or freestanding birthing center, enter the street and number of the place where the fetal death delivery occurred. If the fetal death delivery occurred en route (that is, in a moving conveyance), enter the city, town, village, or location where the fetus was first removed from the conveyance.

Item 3: City, Town, or Location of Delivery

Enter the name of the city or town in which the fetal death delivery occurred. The city or town should be one of the 351 communities in Massachusetts. For example, if a fetal death occurs in Dorchester, the city should read "BOSTON". *Please see listing in Manual for Report of Fetal Death 09192014.*

Item 4: Place Where Delivery Occurred

Check ONE box that best describes the type of place where the fetal death delivery occurred. If the type of place is not known, check the "Unknown" box.

Item 5: Zip Code of Delivery

Enter the zip code of the city or town in which the fetal death delivery occurred.

Item 6: County of Delivery

Enter the name of the county in which the fetal death delivery occurred, if known. If not known, please leave blank.

FETUS

Items 7a-7c: Name of Fetus *(optional-at the discretion of the parents)*

The fetus name is optional. If the parents do not wish to name the fetus, leave Items 7a to 7c blank.
If the parents wish to name the fetus, enter the first, middle, last name as requested by the mother. DO NOT enter "Baby Smith" or any other designation that is not specifically requested by the mother.

Item 7a: First Name

Enter the first name of fetus.

Item 7b: Middle Name

Enter the middle name of fetus.

Item 7c: Last Name

Enter the last name of fetus.

Item 8: Time of Delivery *(24 hr)*

Enter the time of delivery the fetus was extracted or expulsed based on a *24-hour* clock (military time). Use the 24-hour clock with the range of 00:00-23:59. 00.00 is considered the start of the new day.

Item 9: Sex

Check ONE box to indicate whether the fetus is male or female. If the sex cannot be determined after verification of medical record or other sources, check the "Unknown" box.

Item 10: Weight of Fetus *(grams)*

Enter the weight (in grams) of the fetus as it is recorded in the hospital record.

Item 11: Obstetric Estimate of Gestation at Delivery ***(completed weeks)***
Enter the length of pregnancy in weeks, at the time of expulsion or extraction. This number is generally obtained from the date last normal menses began to date of delivery.

This item should reflect the number of weeks the fetus was carried in utero. If the fetus died at the 10th week, but was not delivered until the 37th week, the weeks gestation in this item should read "37 weeks".

Item 12: Date of Delivery ***(Month, Day, Year)***
Enter the exact month, day and year that the fetus was delivered. **Month**: Use full or alphabetic abbreviated name of the month (e.g. JAN, FEB). DO NOT USE A NUMBER FOR THE MONTH. **Day**: Enter the exact numeric day of the delivery. **Year**: Use four-digit designation for the year of delivery.

Item 13: Plurality ***(specify)***
Check ONE box to indicate the number delivered in this pregnancy. Specify the delivery as single, twin, triplet, etc. Include all products of the pregnancy, that is, all live births and fetal deaths delivered at any point during the pregnancy. "Reabsorbed" fetuses, those which are not "delivered"—expulsed or extracted from the mother—should not be counted.

Item 14: Birth Order ***(specify if plural birth)***
Specify the order in which the fetus being reported was delivered, e.g., first, second, third, etc. Count all live births and fetal deaths at any point in the pregnancy.

Item 15: Clinical Estimate of Gestation ***(in weeks)***
Enter the clinical estimate of gestation, in weeks. This reflects the date of death that is prior to the expulsion or extraction of the fetus

MOTHER/PARENT
Item 16a-16d: Mother's Name
Enter the mother's current legal name in Items 16a-16d.

Item 16a: First Name
Enter the mother's first name.

Item 16b: Middle Name
Enter the mother's middle name. If there is no middle name, leave this item blank. Do not enter NMI, NMN, etc.

Item 16c: Last Name
Enter the mother's current last name. This item will still need to be completed even if the name is the same as in Item 16d.

Item 16d: Surname at Birth or Adoption ***(Maiden Name)***
Enter the mother's maiden surname. This would be the name that is listed on her birth certificate. This item will still need to be completed even if the name is the same as in Item 16c.

Item 17: Date of Birth ***(Month, Day, Year)***
Enter the exact month, day and year that mother was born. **Month**: Use full or alphabetic abbreviated name of the month (e.g. JAN, FEB). DO NOT USE A NUMBER FOR THE MONTH. **Day**: Enter the exact numeric day of birth. **Year**: Use four-digit designation for the year of birth.

Item 18: Birthplace ***(City/Town, State, Country)***
Enter the proper name of the city/town of mother's birth. Enter the name of the state of mother's birth if she was born in the US. If she was born outside the United States, enter the name of the country in which she was born. United States territories are Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, and Northern Marianas.

Item 19a-19g: Mother/Parent's Residence Information

These items refer to the mother's residence address, not her postal address. Do not include post office boxes or rural route numbers. The mother's residence is the place where her household is located. This is not necessarily the same as her home state, voting residence, mailing address, or legal residence. The state, county, city and street address should be for the place where the mother actually lives. Never enter a temporary residence, such as one used during a visit, business trip or vacation. Residence for a short time at the home of a relative, friend, or home for unwed mothers for the purpose of awaiting the birth of the child is considered temporary and should not be entered here. However, place of residence during a tour of military duty or during attendance at a college is not considered temporary and should be entered on the certificate as the mother's place of residence.

Item 19a: Residence of Mother-*Number and Street Address*

Enter the actual address where the mother lives now, including the street name, number and proper city/town name. DO NOT use a post office box or other address used for mailing purposes only.

Item 19b: Apt

Enter the apartment, unit or room number of the mother's residence. Leave this blank if not applicable.

Item 19c: City/Town

If the mother is a US resident, enter the name of the city, town, or location in which the mother lives. DO NOT list a neighborhood, village or other subdivision name.

Item 19d: County

If the mother is a US resident, enter the county in which the mother lives. Leave this blank if the mother is not a US resident.

Item 19e: State

If the mother is a US resident, enter the US state or territory where the mother lives.
If the mother is a Canadian resident, enter the name of the province or territory followed by "Canada" (e.g. "British Columbia, Canada").
If the mother is not a resident of the US, enter the name of the county of residence.

Item 19f: Zip Code

Enter the zip code for the mother's residence. Leave this blank if not applicable.

Item 19g: Inside City Limits? *(if not MA resident)*

If mother is not a MA resident, check whether the mother's residence city town (Item 19c) is incorporated and if the mother's residence is inside its boundaries; otherwise, mark "No".
If the mother is not a U.S. resident, leave this item blank.

MARITAL STATUS

Item 20: Mother's Marital Status

Check ONE box to indicate mother's marital status.

FATHER/PARENT

Item 21a-d: Father's Name

Father's information may be included regardless of mother's marital status. The Report of Fetal Death is not a legal record, but rather a legally mandated report. An unmarried mother may list father's information without providing paternity affidavits; and a married mother may list a father other than her spouse without providing denial of paternity affidavits. HOWEVER, listing a father on the Report of Fetal Death does not constitute proof of paternity.

Item 21a: First Name

Enter the father's first name.

Item 21b: Middle Name

Enter the father's middle name. If there is no middle name leave this item blank. Do not enter NMI, NMN, etc.

Item 21c: Last Name
Enter the father's last name. Enter any suffixes following the last name.

Item 21d: Surname at Birth or Adoption
Enter the father's surname at birth or adoption. This would be the name that is listed on his birth certificate.

Item 22: Date of Birth ***(Month, Day, Year)***
Enter the exact month, day and year that father was born. **Month**: Use full or alphabetic abbreviated name of the month (e.g. JAN, FEB). DO NOT USE A NUMBER FOR THE MONTH. **Day**: Enter the exact numeric day of birth. **Year**: Use four-digit designation for the year of birth.

Item 23: Birthplace ***(City/Town, State, Country)***
Enter the proper name of the city/town of father's birth. Enter the name of the state of father's birth if he was born in the US. If he was born outside the United States, enter the name of the country in which he was born. United States territories are Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, and Northern Marianas.

Item 24: Method of Disposition
Check ONE box to indicate the method of disposition of the fetus. Removal from state indicates the body was removed or shipped out of MA for burial or other disposition.
If the fetus is to be used by a hospital, medical or mortuary school for scientific or educational purposes, check "Donation" and specify the name and location of the institution in Items 25a-25e. "Donation" refers only to the entire fetus, not to individual organs.
If the disposition is not known to the hospital, leave this item blank. It will be completed by the Board of Health.

Item 25a-f: Place of Disposition
Enter the disposition information of the fetal death in Items 25a-25f.
If the disposition is not known to the hospital, leave these items blank. They will be completed by the Board of Health.

Item 25a: Name ***(i.e. cemetery, crematory, hospital, etc.)***
Enter the name of the cemetery, crematory, or other facility where the immediate fetal disposition occurred.

Item 25b: City/Town, State
Enter the name of the city or town and state where the immediate fetal disposition occurred.

Item 25c: Funeral Service Licensee ***(if any)***
Enter the name of the funeral service licensee responsible for the immediate disposition listed on the Report of Fetal Death. If the disposition takes place in a hospital facility, and there is no funeral director involved, then write "NONE".
If the fetus is being shipped out-of-state for final disposition, list the funeral director that removes the fetus from the hospital.
If the disposition is not known to the hospital, leave these items blank. They will be completed by the Board of Health.

Item 25d: License #
Enter the personal state license number of the funeral service licensee, if any. If the license number is not from Massachusetts, enter the 2-character US Postal abbreviation prior to the license number.

Item 25e: Name of Facility ***(if any)***
Enter the name of the facility handling the fetal remains prior to burial or other disposition. The funeral director listed must be associated with this facility.

Item 25f: Date of Disposition ***(Month, Day, Year)***
Enter the exact month, day and year of disposition. **Month**: Use full or alphabetic abbreviated name of the month (e.g. JAN, FEB). DO NOT USE A NUMBER FOR THE MONTH. **Day**: Enter the exact numeric day of birth. **Year**: Use four-digit designation for the year of birth.
If "Removal from State" is stated, then the date of disposition should be the date the remains are shipped, not the date of ultimate disposition.

Item 26a: Date Report Was Received
Enter the date the Report of Fetal Death was received by the city/town Board of Health clerk. *(To be filled in by Board of Health)*

Item 26b: City/Town of Board of Health
Enter the city/town of where the disposition permit is issued for fetal death. *(To be filled in by Board of Health)*

CAUSE OF FETAL DEATH
Items 27a-27b: Cause/Conditions Contributing to Fetal Death
These items are to be completed by the person whose name appears in Item 33b to 33d.

The cause of death section consists of two parts. The initiating cause/condition (Item 27a) 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 (Item 27b) include all other conditions contributing to death. These conditions may be triggered by the initiating cause (Item 27a) or causes that are not among the sequence of events triggered by the initiating cause (Item 27a).

The cause-of-death information should be the certifier's best medical opinion. Report a specific condition in the space most appropriate to the given situation. A condition can be listed as "probable" even if it has not been definitively diagnosed. In reporting the causes of fetal death, conditions in the fetus or mother, or of the placenta, cord, or membranes, should be reported if they are believed to have adversely affected the fetus.

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 Registry as soon as it is available.

Item 27a: Initiating Cause/Condition
Among the choices below, select the **ONE** which most likely began the sequence of events resulting in the death of the fetus. If it is not clear where to report a condition, write it on the "(Specify)" line that seems most appropriate.

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)*

_____

Other Obstetrical or Pregnancy Complications *(specify)*

_____

Fetal Anomaly *(specify)*

_____

Fetal Injury *(specify)*

_____

Fetal Infection *(specify)*

_____

Other Fetal Conditions/Disorders *(specify)*

_____

☐ Unknown

Item 27b: Other Significant Causes or Conditions

Select or specify all other conditions contributing to death in Item 27b.

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)*

_____

Other Obstetrical or Pregnancy Complications *(specify)*

_____

Fetal Anomaly *(specify)*

_____

Fetal Injury *(specify)*

_____

Fetal Infection *(specify)*

_____

Other Fetal Conditions/Disorders *(specify)*

_____

☐ Unknown

Item 28: Estimated Time of Fetal Death

Indicate when the fetus died by specifying ONE choice.

Item 29: Was the case referred to a Medical Examiner?

Massachusetts General Law Chapter 38, Section 3 requires that ALL fetal deaths must be referred to a medical examiner.
Report "Yes" if the case was referred to the medical examiner, even if the medical examiner did not assume jurisdiction.

Item 30: Was an autopsy performed?

Check the "Yes" box if a partial or complete autopsy was performed or is being performed at the time of filing of the fetal death record.
Check "No" if no autopsy has been performed and no autopsy is planned.
Check "Planned" if an autopsy is not being performed at the time of the filing of the fetal death record but one is going to be performed.

Item 31: Was a histological placental examination performed?

Check the "Yes" box if any Histological Placental Examination was performed or is being performed at the time of filing.
Check the "Planned" box if a Histological Placental Examination is not being performed at the time of the filing of the fetal death record but one is going to be performed.
Check the "No" box if no Histological Placental Examination has been performed and no Histological Placental Examination is planned.

Item 32: Were autopsy or histological placental examination results used in determining the cause of fetal death?

If "Yes" is checked for Item 30 OR Item 31, complete Item 32. If "No" is checked for both Item 30 AND Item 31, check "Not applicable" in Item 32.

Item 33a-i: Certifier
All certifier information must be provided. The certifier accepts the responsibility of certifying that "to the best of my knowledge, the fetus was delivered at the time, date, and place as shown and fetal death was due to the cause(s) as stated:" on the certificate. The certification must come from a physician, medical examiner or nurse practitioner in all cases of fetal death. Signatures must be written in permanent black ink.

A midwife or certified nurse-midwife may be listed as an attendant on the fetal death certificate; however they may not be listed as a certifier. Only a physician, medical examiner, or nurse practitioner may be listed as the certifier on the fetal death certificate.

Item 33a: Is Certifier a Medical Examiner?
Indicate whether the certifying physician is a medical examiner at the Massachusetts Office of the Chief Medical Examiner.

Item 33b: Signature of Certifying Physician, Medical Examiner, or Nurse Practitioner
The signature must be handwritten in permanent black ink.

Item 33c: Title
Check ONE box to indicate whether the certifier is a physician or nurse practitioner.

Item 33d: Type or Print-Name of Certifying Physician or Medical Examiner
Enter the name of certifying physician, medical examiner, or nurse practitioner.

Item 33e: License #
Enter the license number of the certifier.

Item 33f: Certifier Street # and Address
Enter the street # and work address of the certifier.

Item 33g: City/Town
Enter the city/town of the certifier's work address.

Item 33h: State
Enter the state of the certifier's work address.

Item 33i: Zip Code
Enter the zip code of the certifier's work address.

Item 34a-c: Attendant ***(if different)***
Enter the name of the attendant (if different from the certifying physician, medical examiner, or nurse practitioner).

Item 34a: Type or Print-Name of Attendant
Enter the name of the person who attended the delivery.

Item 34b: Title
Check ONE box to specify the attendant's title. If the "Other (specify)" box is checked, please enter the title of the attendant. Examples include: nurse, father, police office, EMS technician, etc.

Item 34c: License #
Enter the license number of the attendant at birth. If certifier is the same as the Certifier, enter "---".

PRENATAL CARE INFORMATION

Sources of Information: Prenatal Care Records, Mother's Medical Records, Labor and Delivery Records

Item 35: Date of First Prenatal Care Visit *(Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for this pregnancy)*

Enter the month, day, and year of the first prenatal care visit in the following format: MM/DD/YYYY. Complete all parts of the date that are available; use 9s for unknowns. If it is not known whether the patient had prenatal care, enter "99/99/9999" for unknown. If month and day is unknown, enter "99/99/YYYY"; if day is unknown, MM/99/YYYY.

If the mother did not receive prenatal care at any time during the pregnancy, check the "No prenatal care" box and Skip Item 36.

Item 36: Date of Last Prenatal Care Visit

Enter the date of the last visit recorded in the mother's prenatal records in the following format: MM/DD/YYYY. Complete all parts of the date that are available; use 9s for unknowns. Complete all parts of the date that are available; use 9s for unknowns. If it is not known whether the patient had prenatal care, enter "99/99/9999" for unknown. If month and day is unknown, enter "99/99/YYYY"; if day is unknown, MM/99/YYYY.

Item 37: Total # of prenatal care visits for this pregnancy

(Count only those visits recorded in the record)

Enter the total number of prenatal care visits for this pregnancy in this space.
If the patient had no prenatal care, enter "0" in the space. NOTE: the "No prenatal care" box should also be checked in Item 35.
If the patient had prenatal care but the number of visits is not known, enter "99" in the space.

Item 38: Did mother get WIC food for herself during this pregnancy?

Check the appropriate box to indicate if mother received WIC food for herself because she was pregnant during this pregnancy.

Item 39: Insurance (Prenatal Care Source of Payment)

Check the appropriate box to indicate the source of payment for prenatal care during this pregnancy. If the "Other" box is marked, enter the other source of payment for prenatal care.

PREGNANCY HISTORY

Sources of Information: Prenatal Care Records, Mother's Medical Records, Labor and Delivery Records

Item 40: Number of Previous Live Births: Now Living

Enter the number of children born alive to this mother previous to this birth, and who are still living. If the mother has not had any live births, or if all live-born children have died, mark "None". For multiple deliveries, include live born infants born before this fetus in the multiple set. If information cannot be obtained from medical records, enter "99" for unknown.

Item 41: Number of Previous Live Births: Now Dead

Enter the number of children born alive to this mother who are now dead. If the mother has not had any live births, or if all live-born children are currently living, mark "None". For multiple deliveries, include live born infants born before this multiple set who subsequently died. If information cannot be obtained from medical records, enter "99" for unknown.

Item 42: Date of Last Live Birth

Enter the date of the last live birth for this mother in the following month and year format: MM/YYYY. If the answers to both Items 40 and 41 are "None", leave Item 42 blank. Complete all parts of the date that are available; use 9s for unknowns. If it is not known whether the patient had a previous live birth, enter "99/9999" for unknown. If month is unknown, enter "99/YYYY".

If this certificate 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 births, 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 the live birth

Item 43: Number of Other Pregnancy Outcomes

Enter the number of previous pregnancy outcomes that did not result in a live birth, regardless of the length of gestation. Include fetal losses of any gestational age-spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this fetus in the pregnancy. If information cannot be obtained from medical records, enter "99" for unknown.

Item 44: Date of Last Other Pregnancy Outcome

Enter the date when last pregnancy which did not result in a live birth ended in the following month and year format: MM/YYYY. If the answer to Item 43 is "None", skip Item 44. If the answer to Item 43 is other than "None", enter the date if known. Complete all parts of the date that are available; use 9s for unknowns. If it is not known whether the patient had another pregnancy outcome, enter "99/9999" for unknown. If month is unknown, enter "99/YYYY".

Item 45: Date Last Normal Menses Began

Enter the mother's date last normal menses began in the following format: MM/DD/YYYY. Complete all parts of the date that are available; use 9s for unknowns. If the date is unknown, enter "99/99/9999". If month is unknown, enter "99/DD/YYYY; if day is unknown, enter "MM/99/YYYY".

Item 46: Mother's Weight at Delivery

Enter the mother's weight at the time of admission for delivery in pounds. If the mother's delivery weight is not known, enter "999" in the space. Enter weight in whole pounds only. Do not include fractions.

Item 47: Mother's Prepregnancy Weight

Enter the mother's weight in pounds before delivery. If the mother's delivery weight is not known, enter "999" in the space. Enter weight in whole pounds only. Do not include fractions.

Item 48: Mother's Height

Enter the mother's height in feet and inches. If the record indicates height in fractions such as 5 feet and 6 and one-half inches, truncate and enter 5 feet, 6 inches. If the patient's height is unknown, enter "99" for feet and "99" for inches.

DELIVERY INFORMATION

Sources of Information: Labor and Delivery Records, Mother's Medical Records

Item 49a: Fetal presentation at delivery

Check only ONE box that best describes the fetal presentation at delivery.

- **Cephalic**: Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP)
- **Breech**: Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech
- **Other**: Any other presentation or presenting part not listed above

Item 49b: Final route and method of delivery

Check only ONE box that best describes the final route and method of delivery.

- **Vaginal/Spontaneous**: Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant
- **Vaginal/Forceps**: Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head
- **Vaginal/Vacuum**: Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head
- **Cesarean:** Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls
    - If cesarean, was a trial of labor attempted?

  (Labor was allowed, augmented or induced with plans for a vaginal delivery)
  Check Yes or No.

Item 49c: Hysterotomy/Hysterectomy

Check the appropriate box to indicate if mother had either procedure.
A hysterotomy is an incision into the uterus extending into the uterine cavity. It may be performed vaginally or transabdominally.

A hysterotomy is applicable to fetal deaths only.
A hysterectomy is the surgical removal of the uterus, which may be performed abdominally or vaginally.

Item 50a: Was mother transferred for maternal medical or fetal indications for delivery?

Check the "No" box if this is the first facility the mother was admitted to for delivery.
Check the "Yes" box if the mother was transferred from one facility to another facility before the fetus was delivered. Enter the name of facility from which the mother was transferred in Item 50b.

Item 50b: If yes, enter name of facility mother transferred from _____

If the name of the facility is not known, enter "Unknown."
If the mother was transferred more than once, enter the name of the last facility from which she was transferred.

MEDICAL INFORMATION

Sources of Information: Prenatal Care Records, Mother's Medical Records, Labor and Delivery Records

Item 51: Risk Factors in this pregnancy

Check all that apply.
The mother may have more than one risk factor. If the mother had none of the risk factors, check the "None of the above" box.

- **Diabetes Prepregnancy**: Glucose intolerance requiring treatment-Diagnosis *before* this pregnancy
- **Diabetes – Gestational**: Glucose intolerance requiring treatment-Diagnosis *during* this pregnancy
- **Hypertension – Prepregnancy (Chronic)**: Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy
- **Hypertension – Gestational (PIH, preeclampsia)**: Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy (may include proteinuria (protein in the urine), without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face)).
- **Hypertension – Eclampsia**: Pregnancy induced hypertension with proteinuria with generalized seizures or coma (may include pathologic edema).
- **Previous preterm birth**: History of pregnancy (ies) terminating in a live birth of less than 37 completed weeks of gestation
- **Other previous poor pregnancy outcome**: History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes: perinatal death (including fetal and neonatal deaths), small-for-gestational age/intrauterine growth restricted birth.
- **Pregnancy resulted from infertility treatment**: Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g. Clomid, Pergonal), artificial insemination, or intrauterine insemination and

assisted reproduction technology (ART) procedures (e.g. IVF, GIFT, and ZIFT). If checked, please see Birth Trends and Technologies section.

- **Mother had a previous cesarean delivery**: Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.
    - If yes, please note number of previous deliveries: _____
- **None of the above**

Item 52: Infections Present and/or Treated During This Pregnancy

Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment

Check all that apply.

- **Chlamydia**: A diagnosis of or positive test for *Chlamydia trachomatis*.
- **Cytomegalovirus (CMV)**: A diagnosis of or positive test for the cytomegalovirus.
- **Gonorrhea**: A diagnosis of or positive test for *Neisseria gonorrhoeae*.
- **Group B Streptococcus (GBS)**: A diagnosis of or positive test for Streptococcus agalactiae or group B streptococcus.
- **Listeria (LM)**: A diagnosis of or positive test for Listeria monocytogenes.
- **Syphilis (also called lues)**: A diagnosis of or positive test for *Treponema pallidum*.
- **Parvovirus (B19)**: A diagnosis of or positive test for Parvovirus B19.
- **Toxoplasmosis (Toxo)**: A diagnosis of or positive test for Toxoplasma gondii.
- **Other (specify) _____**
- **None of the above**

Item 53: Congenital Anomalies of the Fetus

Malformations of the fetus diagnosed prenatally or after delivery regardless of whether they contributed to fetal death.

Check all that apply.

- **Anencephaly**: Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes fetuses with craniorachischisis (anencephaly with a contiguous spine defect).
- **Cleft Lip with or without Cleft Palate**: Incomplete closure of the lip. May be unilateral, bilateral, or median.
- **Cleft Palate alone**: Incomplete fusion of the palatial shelves. May be limited to the soft palate or may 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 above.
- **Congenital diaphragmatic hernia**: Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.
- **Cyanotic congenital heart disease**: Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.
- **Down Syndrome**: Trisomy 21
    Check if a diagnosis of Down Syndrome, Trisomy 21, is confirmed or pending
    - Karyotype confirmed
    - Karyotype pending
- **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 the absence of a protective membrane.
- **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).
- **Limb reduction defect**: *(excluding congenital amputation and dwarfing syndromes)* Complete or partial absence of a portion of an extremity secondary to failure to develop.
- **Meningomyelocele/Spina bifida**: Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. DO NOT include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).
- **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

above), although this sac may rupture. Also called exomphalos. DO NOT include umbilical hernia (completely covered by skin) in this category.

- **Suspected chromosomal disorder**: Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.
  Check if a diagnosis of a suspected chromosomal disorder is confirmed or pending (May include Trisomy 21)
  - Karyotype confirmed
  - Karyotype pending
- **None of the anomalies listed above**

Item 54: Maternal Morbidity

Serious complications experienced by the mother associated with labor and delivery.
Check all that apply.

- **Admission to intensive care unit**: Any admission, planned or unplanned, of the mother to a facility or unit designated as providing intensive care.
- **Maternal transfusion**: Includes infusion of whole blood or packed red blood cells associated with labor and delivery.
- **Ruptured uterus**: Tearing of the uterine wall.
- **Third or fourth degree perinatal laceration**: 3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.
- **Unplanned hysterectomy**: Surgical removal of the uterus that was not planned before the admission. Includes an anticipated, but not definitively planned hysterectomy.
- **Unplanned operating room procedure following delivery**: Any transfer of the mother back to the surgical area for an operative procedure that was not planned before the admission for delivery. Excludes postpartum tubal ligations.
- **None of the above**

Item 55: Birth Trends and Technologies

Check all that apply.

- **Fertility-enhancing drugs**: Progesterone, Gonadotrophins (e.g. Clomid®, Serophene), Gonadotrophin-releasing Hormone Agonists (GnRH Agonists) (e.g. Synarel, Zolodex), Gonadotrophin-releasing Hormone Antagonists (GnRH Antagonists) (e.g. Cetrotide)
- **Artificial insemination**: Fertility treatment in which sperm were collected and placed in the female reproductive tract. Do not include intrauterine insemination.
- **Intrauterine insemination**: Fertility treatment in which sperm were collected and placed in the woman's uterus.
- **Assisted reproductive technology**: Include in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI], frozen embryo transfer, or donor embryo transfer.
- **Other medical treatment**
  Other (Specify): _____
- **Anonymous egg donor**
- **Anonymous sperm donor**
- **Surrogacy**
- **None of these apply**

REPORTED ALCOHOL AND TOBACCO USE

Sources of Information: Prenatal Care Records, Mother's Medical Records, Labor and Delivery Records

Item 56: 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".

Item 57: Alcohol Use Before and During Pregnancy

For each time period, enter the number of drinks (beer, wine or cocktails) mother had in an average week. If none, enter "0"

DEMOGRAPHIC INFORMATION

Item 58: Mother/Parent Race

Check one or more boxes that best describe the race of the mother/parent.

Item 59: Mother/Parent Ethnicity
Check one or more boxes that best describe the ethnicity of the mother/parent.

Item 60: Mother/Parent Education
Check the box that best describes the highest degree or level of schooling completed at the time of delivery. If no box is checked, check "Unknown".

Item 61: Mother/Parent Occupation
Examples: computer programmer, cashier, homemaker, unemployed
Enter the specific occupation of the mother/parent most recently held during the past 12 months.

Item 62: Mother/Parent Industry
Examples: software company, Smith's Supermarket, own home
Enter the kind of business or industry to which the occupation listed previously is related.

Item 63 Father/Parent Race:
Check one or more boxes that best describe the race of the father/parent.

Item 64: Father/Parent Ethnicity
Check one or more boxes that best describe the ethnicity of the father/parent.

Item 65: Father/Parent Education
Check the box that best describes the highest degree or level of schooling completed at the time of delivery. If no box is checked, check "Unknown".

Item 66: Father/Parent Occupation
Examples: computer programmer, cashier, homemaker, unemployed
Enter the specific occupation of the father/parent most recently held during the past 12 months.

Item 67: Father/Parent Industry
Examples: software company, Smith's Supermarket, own home
Enter the kind of business or industry to which the occupation above is related.