



# INSTRUCTIONS FOR COMPLETING THE REPORT OF FETAL DEATH

(Form R304-102014)

## General Instructions

- Criteria for Reportability
  - Fetus was extracted or expelled **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, 1<sup>st</sup> 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 102014.*

#### **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 expelled 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 10<sup>th</sup> week, but was not delivered until the 37<sup>th</sup> 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 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.

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)*

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Complications of Placenta, Cord, or Membranes

- Rupture of membranes prior to onset of labor
  - Abruptio placenta
  - Placental insufficiency
  - Prolapsed cord
  - Chorioamnionitis
  - Other *(specify)*
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Other Obstetrical or Pregnancy Complications *(specify)*

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Fetal Anomaly *(specify)*

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Fetal Injury *(specify)*

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Fetal Infection *(specify)*

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Other Fetal Conditions/Disorders *(specify)*

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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 officer, 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 20<sup>th</sup> 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 palatal 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), tetralogy 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 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.

- **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.