DEPARTMENT OF HEALTH

Cause of fetal death and medical information for fetus and mother

Complete this form only for fetuses delivered without signs of life. Minnesota law requires the reporting of fetal deaths with gestational ages of 20 or more weeks. The preferred source of this data is the medical professional in attendance at the time of delivery and/or post-delivery examination.

Fetus' delivery information

Date of delivery	Time ☐am ☐pm ☐24hr	Mother's name or medical record number	Person providing fetal death information
Weight of fetus ☐ lb/oz ☐grams		Birth attendant name	

Obstetric estimate of gestation at delivery (in completed weeks)	Plurality	Birth order	# Fetal deaths (this delivery)

Congenital anomalies

- ☐ Anencephaly
- ☐ Meningomyelocele /Spina bifida
- ☐ Hypospadias
- ☐ Other urogenital anomalies - specify _____
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Polydactyly /syndactyly /adactyly
- ☐ Club foot
- ☐ Other musculoskeletal/integumental anomalies - specify_____
- ☐ Cleft lip (w/ or w/o cleft palate)
- ☐ Cleft palate
- ☐ Down syndrome – confirmed? _____
- ☐ Other chromosomal – conf? _____
- ☐ Other anomalies - specify_____
- ☐ None of the above

Disposition information

- ☐ Burial
- ☐ Cremation
- ☐ Hospital disposition
- ☐ Donation
- ☐ Removal from state
- ☐ Other

Funeral home name

Funeral home city

Fetus' cause of death

1. Initiating cause/condition

In this section, describe the conditions that, in your opinion, contributed to the fetal death. Please report any condition judged to be a cause of death *even if it has been reported elsewhere on this worksheet.*

- ☐ 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 cause/condition

2. Other significant cause or condition

In this section, include all other conditions contributing to death.

- ☐ 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 cause/condition

Estimated time of fetal death

- ☐ Dead at time of first assessment, no labor ongoing
- ☐ Dead at time of first assessment, labor ongoing
- ☐ Died during labor, after first assessment
- ☐ Unknown time of fetal death

Was an autopsy performed? * ☐ Yes ☐ No ☐ Planned

Was a histological placental exam performed? ☐ Yes ☐ No ☐ Planned

Were autopsy and/or histology results used in determining the cause of fetal death? ** ☐Yes ☐No ☐Not applicable

Please complete both sides of this form

Mother or gestational carrier's medical information I - Prenatal

Date of delivery	Mother's name or medical record number

Prenatal care? ☐ Yes ☐ No	First prenatal visit / /	Date of last prenatal visit / /	Total prenatal visits	Month prenatal care began	Mother's height (ft/in)

Risk factors this pregnancy

- ☐ Diabetes – prepregnancy
- ☐ Diabetes – gestational
- ☐ Hypertension – prepregnancy (chronic)
- ☐ Hypertension – gestational (PIH, preeclampsia)
- ☐ Eclampsia
- ☐ Pregnancy resulted from infertility treatments
  - ☐ Fertility enhancing drugs
  - ☐ Assisted reproductive technology (IVF, GIFT)
- ☐ Anemia
- ☐ Previous preterm birth
- ☐ Other previous poor outcome (perinatal death, SGA, IUGR)
- ☐ Previous cesarean birth
- ☐ Other risk factors - specify_____
- ☐ None of the above

Pre-preg. weight (lbs)	Weight at delivery (lbs)	Last menstrual period / /

# prev live births now living	# prev live births now dead	# other outcomes (spontaneous or induced losses or ectopic pregnancies)

Date of last live birth before this birth / /	Date of last other preg. outcome / /

Toxicology * – were toxicology tests administered to mother and/ or the fetus? ☐No ☐Yes
Results:

Principal source of payment for this delivery

- ☐ Private insurance
- ☐ Medical Assistance/ MinnesotaCare /Medicaid
- ☐ Self pay / uninsured
- ☐ Other (Tricare, Indian Health, Other government)

Mother or gestational carrier's medical information II - Delivery

Infections present/treated this pregnancy

- ☐ Chlamydia
- ☐ Cytomegalovirus
- ☐ Genital herpes
- ☐ Gonorrhea
- ☐ Group B Strep
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV positive
- ☐ Listeria
- ☐ Parvovirus
- ☐ Syphilis
- ☐ Toxoplasmosis
- ☐ Other - specify _____ _____
- ☐ None of the above

Method of Delivery
Was delivery with forceps attempted but unsuccessful? Yes ☐ No ☐
Was delivery with vacuum extraction attempted but unsuccessful? Yes ☐ No ☐

Fetal presentation at delivery
☐ Cephalic ☐ Breech ☐ Other

Final route and method of birth (Check one)

- ☐ Vaginal/spontaneous
- ☐ Vaginal/forceps
- ☐ Vaginal/vacuum
- ☐ Vaginal Birth After Cesarean
- ☐ Cesarean - Was a trial of labor attempted? ☐ Yes ☐ No

Hysterotomy / Hysterectomy Yes ☐ No ☐

Mother transferred (for maternal medical or fetal indications for birth) **prior to delivery?** ☐ Yes ☐ No

Facility she was **transferred from**:

Maternal morbidity (check all that apply)

- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Cord prolapse
- ☐ Seizure during labor
- ☐ Placental abruption
- ☐ Placenta previa
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to ICU
- ☐ Unplanned operating room procedure following delivery
- ☐ Other - specify_____
- ☐ None

***Results of an autopsy, placental histological exam, or toxicology tests may not be available when filing the fetal death record. Please update the fetal death record when the results become available.**
****If the autopsy or histology results influence the cause of death, please update the cause of death.**

Please complete both sides of this form