MN 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. This information is required by law and will be confidentially used by public health. 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		
Est. gestation	Plurality	Birth order	# Fetal deaths (this delivery)	Disposition information ☐ Burial ☐ Cremation ☐ Hospital disposition ☐ Donation ☐ Removal from state ☐ Other

Congenital anomalies

- ☐ Anencephaly
- ☐ Meningomyelocele /Spina bifida
- ☐ Hypospadias
- ☐ Other urogenital anomalies __________ ______________________________________
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Polydactyly /syndactyly /adactyly
- ☐ Club foot
- ☐ Other musculoskeletal/integumental anomalies ______________________
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Down syndrome – confirmed? ______
- ☐ Other chromosomal – conf? ________
- ☐ Other anomalies _________________
- ☐ None

Funeral home name

Funeral home city

Fetus' cause of death

1. Initiating cause/condition

- ☐ 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

- ☐ 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 autopsy performed? ☐ Yes ☐ No ☐ Planned

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

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

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 care began	Mother's height

Risk factors this pregnancy

- ☐ Diabetes – pre pregnancy
- ☐ Diabetes – gestational
- ☐ Hypertension – pre pregnancy
- ☐ 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______________________________
- ☐ None

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

Prev live births living	Prev live births dead	Other outcomes

Date of last live birth / /	Date of last other 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/ MN care /Medicaid
- ☐ Self pay / uninsured
- ☐ Other (Tricare, Indian Health, Other government

Mother or gestational carrier's medical information II - Delivery

Infections present/treated

- ☐ Chlamydia
- ☐ Cytomegalovirus
- ☐ Genital herpes
- ☐ Gonorrhea
- ☐ GBS
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV positive
- ☐ Listeria
- ☐ Parvovirus
- ☐ Syphilis
- ☐ Toxoplasmosis
- ☐ Other (specify)____________ ______________________
- ☐ None of the above

Method of delivery

- ☐ Forceps attempted ☐ Successful ☐ No
- ☐ Vacuum attempted ☐ Successful ☐ No

Fetal presentation ☐ Cephalic ☐ Breech ☐ Other___________

- ☐ Vaginal/spontaneous ☐ Vaginal / forceps
- ☐ Vaginal/vacuum ☐ VBAC
- ☐ Cesarean Was trial of labor attempted? ☐ Yes ☐ No
- ☐ Hysterotomy/Hysterectomy ☐ Yes ☐ No

Mother transferred prior to delivery? ☐ Yes ☐ No

Facility she was transferred from:

Maternal morbidity

- ☐ Maternal transfusion
- ☐ 3rd or 4th deg. 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 ____
- ☐ None