Reset Form

State of Colorado
Certificate of Fetal Death

Local File No. _____ State File No. _____

Fetus

1. FETUS NAME (First, Middle, Last)

2. DATE OF DELIVERY (Month, Day, Year)

3. TIME OF DELIVERY

4. SEX (M/F/UNK)

5a. PLACE WHERE DELIVERY OCCURRED (check one)

❑ Hospital
❑ Clinic/Doctors office
❑ Freestanding birthing center
❑ Home delivery:
Planned to deliver at home? ❑ Yes ❑ No
❑ Other (Specify) _____

5b. FACILITY NAME (If not institution, give street and number)

5c. FACILITY ID. (NPI)

5d. CITY, TOWN, OR LOCATION OF DELIVERY

5e. ZIP CODE

5f. COUNTY OF DELIVERY

Parents

6a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last)

6b. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

6c. MOTHER'S DATE OF BIRTH

6d. MOTHER'S BIRTHPLACE (State, Territory, or Foreign Country)

7a. MOTHER'S RESIDENCE - STATE

7b. MOTHER'S RESIDENCE - COUNTY

7c. MOTHER'S RESIDENCE - CITY, TOWN, OR LOCATION

7d. MOTHER'S RESIDENCE STREET AND NUMBER

7e. MOTHER'S RESIDENCE - APT. NO.

7f. RESIDENCE - ZIP CODE

7g. INSIDE CITY LIMITS? ❑ Yes ❑ No

8a. FATHER'S/CO-PARENT CURRENT LEGAL NAME

8b. FATHER'S/CO-PARENT DATE OF BIRTH

8c. FATHER'S/CO-PARENT BIRTHPLACE (State, Territory, or Foreign Country)

Registration and Attendant

9a. *REGISTRAR'S SIGNATURE*

9b. *DATE FILED BY REGISTRAR (Month, Day, Year)*

10a. METHOD OF DISPOSITION

❑ Burial-Cemetery/Burial-Private Land/Entombment ❑ Hospital Disposition ❑ Cremation ❑ Removal From State ❑ Donation ❑ Other (Specify) _____

10b. NAME AND ADDRESS OF FUNERAL ESTABLISHMENT OR PERSON ACTING AS SUCH

10c. PLACE OF DISPOSITION (Name of cemetery, crematory, or other place)

11a. ATTENDANT'S NAME AND NPI

NAME: _____ NPI: _____

TITLE: ❑ MD ❑ DO ❑ CNM/CM ❑ OTHER MIDWIFE ❑ OTHER (Specify): _____

11b. ATTENDANT'S MAILING ADDRESS (Street or R.F.D. No. City, State, Zip)

12a. REPORT COMPLETED BY:

NAME: _____

TITLE: _____

12b. DATE REPORT COMPLETED

13a. WAS AN AUTOPSY PERFORMED?

❑ Yes ❑ No ❑ Planned

If yes, name of facility used for autopsy: _____

13b. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?

❑ Yes ❑ No ❑ Planned

13c. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?

❑ Yes ❑ No

14. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY

_____ Completed weeks

15. 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

CAUSE/CONDITION(S) CONTRIBUTING TO FETAL DEATH

Cause Contributing to Death

16a. 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)

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

16b. OTHER SIGNIFICANT CAUSES OR CONDITIONS (SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 16b)

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

❑ PARENT(S) IS (ARE) INTERESTED IN A STILLBIRTH CERTIFICATE.

17a. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at time time of delivery)

- ❑ 8th grade or less
- ❑ 9th-12th grade, no diploma
- ❑ High school graduate or GED completed
- ❑ Some college credit but no degree
- ❑ Associate degree (e.g., AA, AS)
- ❑ Bachelor's degree (e.g., BA, AB, BS)
- ❑ Master's degree (e.g.,MA, MS, MSW,MBA)
- ❑ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)
- ❑ Unknown

17b. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina.)

- ❑ No, not Spanish/Hispanic/Latina
- ❑ Yes, Mexican, Mexican American, Chicana
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latina (Specify) _____
- ❑ Unknown

17c. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian (Specify) _____
- ❑ Native Hawaiian
- ❑ Guamanian or Chamorro
- ❑ Samoan
- ❑ Other Pacific Islander (Specify) _____
- ❑ Other (Specify) _____
- ❑ Unknown

18. PREGNANCY HISTORY (Complete each section)

NUMBER OF PREVIOUS LIVE BIRTHS

18a. Now living: Number _____ ❑ NONE ❑ Unknown

18b. Now dead: Number _____ ❑ NONE ❑ Unknown

19. MOTHER MARRIED/UNION STATUS? (At time of delivery, conception, or any time in between)

❑ Yes ❑ No ❑ Civil Union ❑ Unknown

20. DATE OF FIRST PRENATAL CARE VISIT

❑ No care ❑ Unknown

21. MONTH OF PREGNANCY PRENATAL CARE BEGAN - First, Second, Third, etc. (Specify)

_____

❑ Unknown

22. DATE LAST NORMAL MENSES BEGAN

❑ Unknown

18c. DATE OF LAST LIVE BIRTH

23. PLURALITY - Single, Twin, Triplet, etc. (Specify)

24. IF NOT SINGLE DELIVERY - Delivered First, Second, Third, etc.

25. WEIGHT OF FETUS (Grams Preferred, Specify Unit)

❑ Grams _____ ❑ Lbs/Oz _____ ❑ Unknown

26. MOTHER'S HEIGHT

_____ (feet/inches) ❑ Unknown

27. MOTHER'S PREPREGNANCY WEIGHT

_____ (pounds) ❑ Unknown

28. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

❑ Yes ❑ No ❑ Unknown

29. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY. For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If none, enter "0".

Average number of cigarettes or packs of cigarettes smoked per day:	# of cigarettes		# of packs
Three months before pregnancy	_____	OR	_____
First three months of pregnancy	_____	OR	_____
Second three months of pregnancy	_____	OR	_____
Third trimester of pregnancy	_____	OR	_____

❑ Unknown

30. RISK FACTORS IN THIS PREGNANCY (Check all that apply):

DIABETES

- ❑ Prepregnancy (Diagnosis prior to this pregnancy)
- ❑ Gestational (Diagnosis in this pregnancy)

HYPERTENSION

- ❑ Prepregnancy (Chronic)
- ❑ Gestational (PIH, preeclampsia)
- ❑ Eclampsia

- ❑ Pregnancy resulted from infertility treatment - if yes, check all that apply:
  - ❑ Fertility-enhancing drugs, Artifical insemination or intrauterine insemination
  - ❑ Assisted reproductive technology (e.g., in vitro gamete intrafallopian transfer (GIFT)
- ❑ Mother had a previous cesarean delivery
  If yes, how many: _____
- ❑ Unknown
- ❑ None of the above

31. METHOD OF DELIVERY

A. Fetal presentation at delivery
- ❑ Cephalic
- ❑ Breech
- ❑ Other

B. Final route and method of delivery (Check one)
- ❑ Vaginal/Spontaneous
- ❑ Vaginal/Forceps
- ❑ Vaginal/Vacuum
- ❑ Cesarean

If cesarean, was a trial or labor attempted? ❑ Yes ❑ No

C. ❑ Unknown

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

- ❑ Ruptured uterus
- ❑ Admission to intensive care unit
- ❑ None of the above
- ❑ Unknown

FETUS NAME (First, Middle, Last)_____ DATE OF DELIVERY (Month, Day, Year)_____

COUNTY OF DELIVERY_____