*Commonwealth of Massachusetts*
*Registry of Vital Records and Statistics*

# REPORT OF FETAL DEATH



**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 the FRONT 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)* | 5 **Zip Code of Delivery** | 6 **County of Delivery** |
|---|---|---|
| ☐ Hospital<br>☐ Clinic/Doctor's office<br>☐ Freestanding birthing center<br>☐ Home Delivery: Planned to deliver at home? ☐ Yes ☐ No<br>☐ Unknown<br>☐ Other *(specify)* ________________ | | |

## Fetus

| **Name of Fetus** (optional-at the discretion of the parents)<br>7a *First Name* | 8 **Time of Delivery** *(24 hr)* | 9 **Sex**<br>☐ Male<br>☐ Female<br>☐ Unknown | 10 **Weight of Fetus** *(grams)* | 11 **Obstetric Estimate of Gestation at Delivery** *(completed weeks)* |
|---|---|---|---|---|
| 7b *Middle Name* | 12 **Date of Delivery** *(Month, Day, Year)* | | | |
| 7c *Last Name* | 13 **Plurality** *(specify)*<br>☐ Single ☐ Other_______<br>☐ Twin | 14 **Birth Order** *(specify if plural birth)*<br>☐ 1st ☐ 3rd<br>☐ 2nd ☐ Other _____ | 15 **Clinical Estimate of Gestation** *(in weeks)* | |

## Mother/Parent

| **Mother's Name**<br>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)*<br>☐ Yes ☐ No |
|---|---|---|---|---|---|

## Marital Status

20 **Mother's Marital Status**

| ☐ Married<br>☐ Never Married | ☐ Widowed<br>☐ Divorced |
|---|---|

## Father/Parent

| **Father's Name**<br>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:** ______________________________________

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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)*

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

**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

**28 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

**29 Was the case referred to a Medical Examiner?**
☐ Yes ☐ No

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

**31 Was a histological placental examination performed?**
- ☐ Yes
- ☐ No
- ☐ Planned

**32 Were autopsy or histological placental examination results used in determining the cause of fetal death?**
- ☐ 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

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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<br>☐ No Prenatal Care | ____/____/____ MM / DD / YYYY | | ☐ Yes<br>☐ No<br>☐ Refused<br>☐ Unknown | ☐ Medicaid<br>☐ Private Insurance<br>☐ Self-pay<br>☐ Indian Health Service | ☐ CHAMPUS/TRICARE<br>☐ Other Government (Fed, State, Local)<br>☐ Other ________<br>☐ 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 |
|---|---|---|---|
| ☐ Cephalic<br>☐ Breech<br>☐ Other | ☐ Vaginal/Spontaneous<br>☐ Vaginal/Forceps<br>☐ Vaginal/Vacuum<br>☐ Cesarean<br>If cesarean, was a trial of labor attempted? ☐ Yes ☐ No | ☐ Yes<br>☐ No | 50b **If yes, enter name of facility mother transferred from:**<br>________________ |

## Medical Information

**51 Risk Factors in this pregnancy** *(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

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

- ☐ Chlamydia
- ☐ Cytomegalovirus
- ☐ Gonorrhea
- ☐ Group B Streptococcus
- ☐ Listeria
- ☐ Syphilis
- ☐ Parvovirus
- ☐ Toxoplasmosis
- ☐ Other (*Specify*)
  ________________
- ☐ None of the above

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

- ☐ 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*** |
| #______ | #______ |

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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 |
|---|---|
| | |