NAMING YOUR BABY AND INFORMATION ABOUT THE CERTIFICATE OF BIRTH RESULTING IN STILLBIRTH

The information provided on this worksheet will be used to create a record of this pregnancy.
Please complete this information carefully and completely.

MOTHER'S INFORMATION		
CURRENT FIRST NAME	CURRENT MIDDLE NAME	CURRENT LAST NAME
NAME BEFORE FIRST MARRIAGE (FIRST)	NAME BEFORE FIRST MARRIAGE (MIDDLE)	NAME BEFORE FIRST MARRIAGE (LAST)
BIRTHPLACE – STATE OR FOREIGN COUNTRY	BIRTHPLACE - CITY	DATE OF BIRTH / /
RESIDENCE ADDRESS		
COUNTY OF RESIDENCE	IF NOT WITHIN CITY LIMITS, NAME OF TOWNSHIP	SOCIAL SECURITY NUMBER - -
MAILING ADDRESS		☐ SAME AS RESIDENCE ADDRESS
Are you legally married now, or were you divorced or widowed during this pregnancy?		☐ Yes ☐ No

BABY'S INFORMATION			
You can give your baby any name you choose. Legally, it is permissible to give your child the last name of the mother or father, or any name of your choosing. Names print on certificates in all capital letters. Apostrophes and hyphens can be placed between two letters, but not at the beginning or end of a name. No other special characters are permitted.			
BABY'S FIRST NAME	BABY'S MIDDLE NAME		BABY'S LAST NAME
DATE OF BIRTH / /	SEX	☐ SINGLE ☐TWIN ☐TRIPLET ______________	IF NOT A SINGLE, BIRTH ORDER
PLACE OF THIS BIRTH AND BIRTH ATTENDANT			☐ Hospital ☐ Residence ☐ Other (specify)

FATHER'S INFORMATION		
FIRST NAME	MIDDLE NAME	LAST NAME SUFFIX
DATE OF BIRTH / /	BIRTHPLACE – STATE OR FOREIGN COUNTRY	BIRTHPLACE - CITY
SOCIAL SECURITY NUMBER - -	MAILING ADDRESS	☐ SAME AS MOTHER'S ADDRESS

ADDITIONAL INFORMATION

For birth record research. This information does not print on the certificate.

DID YOU PARTICIPATE IN WIC NUTRITIONAL PROGRAM DURING THIS PREGNANCY? ☐ **Yes** ☐ **No** If *yes*, what month of pregnancy did WIC begin? (1st, 2nd, 3rd, etc.)	SMOKING – Did you smoke cigarettes 3 months before or during this pregnancy? ☐ **Yes** ☐ **No** If yes, indicate number of ☐ cigarettes or ☐ packs per day _____ 3 months before _____ First trimester _____ Second trimester _____ Third trimester

BOTH PARENTS' DEMOGRAPHICS – EDUCATION

Check the box that best describes your highest level of school completed at the time of this baby's birth

MOTHER	FATHER	
☐	☐	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, MEng, MEd, MSW, MBA)
☐	☐	Doctorate's degree (e.g. ,PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)

BOTH PARENTS' DEMOGRAPHICS – HISPANIC ORIGIN

Check all that apply

MOTHER	FATHER	
☐	☐	No, not Spanish/Hispanic /Latina/Latino
☐	☐	Yes, Mexican, Mexican American
☐	☐	Yes, Puerto Rican
☐	☐	Yes, Cuban
☐	☐	Yes, Other Hispanic (e.g., Salvadoran, Dominican, Colombian) (specify) ________________________________

BOTH PARENTS' DEMOGRAPHICS – RACE/ETHNICITY

Check all that apply

MOTHER	FATHER	
☐	☐	**White**
☐	☐	**Black or African American**
☐	☐	Somali
☐	☐	Liberian
☐	☐	Kenyan
☐	☐	Nigerian
☐	☐	Ethiopian
☐	☐	Sudanese
☐	☐	Ghanaian
☐	☐	Other African (specify) ______________________________
☐	☐	**American Indian or Alaska Native** (specify name of enrolled or principal tribe) ____________________
☐	☐	**Asian**
☐	☐	Asian Indian
☐	☐	Chinese
☐	☐	Filipino
☐	☐	Japanese
☐	☐	Korean
☐	☐	Cambodian
☐	☐	Hmong
☐	☐	Laotian
☐	☐	Vietnamese
☐	☐	Other Asian (specify) ______________________________
☐	☐	**Pacific Islander**
☐	☐	Native Hawaiian
☐	☐	Guamanian or Chamorro
☐	☐	Samoan
☐	☐	Other Pacific Islander (specify) ______________________________
☐	☐	**Other Race** (specify) ______________________________

MEDICAL PORTION – FETAL DEATH/STILLBIRTH INFORMATION

Use this form only for babies 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 newborn examination.

Fetus' Delivery Information

DATE OF DELIVERY	TIME ☐am ☐pm ☐ 24hr	MOTHER'S NAME OR MEDICAL RECORD NUMBER		PERSON COMPLETING FETAL DEATH REPORT
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 SIGNFICANT CAUSES OR CONDITIONS

- ☐ 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'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
- ☐ Self pay
- ☐ Champus/Tricare
- ☐ Other _______________________---
- ☐ Medicaid
- ☐ Indian health service
- ☐ Other government

Mother's Medical 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/vacuum
- ☐ Cesarean Was trial of labor attempted? ☐ Yes ☐ No
- ☐ Hysterotomy/Hysterectomy ☐ Yes ☐ No
- ☐ Vaginal / forceps
- ☐ VBAC

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