NORTH DAKOTA CERTIFIER'S WORKSHEET FOR FETAL DEATH

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
SFN 58707 (1-2015)

This worksheet is to be completed by the facility using the prenatal record, mother's medical records and the labor and delivery records. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record or a copy of the prenatal care information. Please do not provide information from sources other than those listed.

This worksheet should not be completed by the parents except in the case of a home birth. In the case of a home birth, this worksheet should be completed by the certifier (person delivering the child) or the mother.

CERTIFIER/ATTENDANT INFORMATION

Certifier's Name	Certifier's Title
(The individual, who certifies to the fact that the birth occurred. May be, but need not be the same as the attendant) ☐ Physician - M.D. ☐ D.O. ☐ CNM ☐ Other Midwife ☐ Other (includes the father, etc.)	
Attendant's Name	Attendant's Title
(The individual physically present at the delivery, who is responsible for the delivery. If an intern or nurse midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant) ☐ Same as Certifier ☐ Physician - M.D. ☐ D.O. ☐ Nurse Practitioner ☐ Other Midwife ☐ Other (includes the father, etc.)	
Signature	Date

DELIVERY INFORMATION

Date of Delivery (MM/DD/YYYY)	Time of Delivery (Use Military Time)	Gender ☐ Male ☐ Female ☐ Not yet determined
Fetus Weight **(only complete one)** Grams **OR** Pounds/Ounces		Obstetric Estimation of Gestation (Number of Completed Whole Weeks) **(Not Computed on LMP)**
Facility Name (If home birth - address, if enroute list hospital name where first removed from the vehicle.)		
County of Delivery	ZIP Code	City, Town, or Location of Delivery / Inside City Limits? ☐ Yes ☐ No

Type of Place of Delivery

☐ Clinic/Doctor's Office
☐ Freestanding Birthing Center
☐ Hospital
☐ Other (Named place - describe, e.g. McDonalds) _____
☐ Planned to Deliver at Home? ☐ Yes ☐ No
☐ Unknown

Plurality? (Include all live births and fetal losses resulting from this pregnancy - 1, 2, 3, 4, 5, 6, 7, etc.)

If not a single delivery, delivery order? (Include all live births and fetal losses resulting from this pregnancy)
(1st, 2nd, 3rd, 4th, 5th, 6th,7th, etc)

If not single delivery, specify number of infants born alive

Was the delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No

Was the delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No

Fetal Presentation at Birth (check one) ☐ Cephalic ☐ Breech ☐ Other ☐ Refused/Unknown

What was the final route and method of delivery?

☐ Vaginal/Forceps
☐ Vaginal/Spontaneous
☐ Vaginal/Vacuum
☐ Cesarean - Was a trial of labor attempted? ☐ Yes ☐ No

Hysterectomy/Hysterotomy ☐ Yes ☐ No

Abnormal Conditions of the Newborn (Check all that apply)

☐ Assisted ventilation required immediately following delivery
☐ Assisted ventilation required for more than six hours
☐ NICU Admission
☐ Newborn given surfactant replacement therapy
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ Significant birth injury
☐ Fetal Alcohol Syndrome
☐ None of the abnormal conditions listed

Congenital Anamolies of Newborn (Check all that apply)

- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Acyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalacele
- ☐ Down Syndrome
  - ☐ Karotype Confirmed
  - ☐ Karotype Pending
- ☐ Suspected chromosomal disorder
  - ☐ Karotype Confirmed
  - ☐ Karotype Pending
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Cleft lip with or without a cleft palate
- ☐ Cleft palate alone
- ☐ Hypospadias
- ☐ None of Above

CAUSE OF DEATH SECTION

Causes/Conditions Contributing to Fetal Death

The purpose of this section is to get a description of those 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 the worksheet.

Initiating Cause/Condition. Among the choices below, please select ONE which most likely began the sequence of events resulting in the death of the fetus. If it is not clear to you where to report a condition, write it on the "(Specify)" line that seems most appropriate.

- ☐ Maternal Conditions/Diseases
  Specify: _____
- ☐ Complications of Placenta, Cord or Membranes (check all that apply)
  - ☐ 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

Other Significant Causes or Conditions. Select or specify all other conditions contributing to death.

- ☐ Maternal Conditions/Diseases
  Specify: _____
- ☐ Complications of Placenta, Cord or Membranes (check all that apply)
  - ☐ 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

Was an autopsy performed?	Was a histological placental examination performed?	Was autopsy or histological placental examination results used in determining the cause of fetal death?
☐ Yes ☐ No ☐ Planned	☐ Yes ☐ No ☐ Planned	☐ Yes ☐ No

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

Funeral Home Assigned

MOTHER PRENATAL

Mother's Medical Record Number	Mother's Current Legal Name (First, Middle, Last, Suffix (Jr. III, etc.))	
Number of Prenatal Visits	If no prenatal care was provided, enter all 9's for both dates and 0 for the number of visits.	First Visit (MM/DD/YYYY)
Was the mother transferred to this facility for maternal medical or fetal indications for delivery? ☐ Yes ☐ No		If yes, enter the name of the facility mother transferred from
Mother's Height Feet Inches	Mother's Pre-Pregnancy Weight Pounds	Mother's Weight at Delivery Pounds
Number of previous live births now living (Do not include this child. For multiple deliveries, do not include any of the children born during this event)		Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include any of the children born during this event)
Date of Last Live Birth	Total number of other pregnancy outcomes (Include fetal losses of any gestational age – spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy):	
Date of last other pregnancy outcome (Date when last pregnancy ended, which did not result in a live birth) (MM/YYYY)		
Date the last normal menses began? Enter 9's for unknown portions of the date)		

MOTHER LABOR AND DELIVERY

Medical Risk Factors for this Pregnancy (Check all the apply)

- ☐ Diabetes
  - ☐ Type I
  - ☐ Type II
  - ☐ Gestational
- ☐ Previous pre-term births
- ☐ Pregnancy resulted from infertility treatment (Check all that apply)
  - ☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination
  - ☐ Assisted reproductive technology
- ☐ Mother had a previous cesarean delivery
  - If Yes, how many?_____
- ☐ Hypertension
  - ☐ Pre-pregnancy
  - ☐ Gestational
  - ☐ Eclampsia
- ☐ Exposure to illegal drugs
  - ☐ Methamphetamines
  - ☐ Marijuana
  - ☐ Cocaine
  - ☐ Other
- ☐ Exposure to alcohol
- ☐ None of these risk factors

Infections present and/or treated during this pregnancy (Check all that apply)

☐ Chlamydia	☐ Group B Strep	☐ Hepatitis C	☐ Rubella	☐ None of these infections
☐ Cytomeglovirus	☐ HIV/AIDS	☐ Listeria	☐ Syphilis	☐ Other
☐ Gonorrhea	☐ Hepatitis B	☐ Parvo virus	☐ Toxoplasmosis	

Obstetric procedures performed during the pregnancy? (Check all that apply)

- ☐ Cervical Cerclage
- ☐ Tocolysis
- ☐ External cephalic version
  - ☐ Successful
  - ☐ Failed
- ☐ None of the Above

Onset of Labor (Check all that apply)

- ☐ Premature Rupture of the membranes
- ☐ Precipitous Labor
- ☐ Prolonged Labor
- ☐ None of the Above

Characteristics of labor and delivery (Check all that apply)

- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ Antibiotics received by the mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor maternal temperature >= 38 C (100.4 F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal Intolerance of labor requiring In-utero resuscitative measures, Further fetal assessment or Operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of these characteristics

Maternal Morbidity - Complications of the mother experienced during labor and delivery (Check all that apply)

- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to the intensive care unit
- ☐ Unplanned operating procedure following delivery
- ☐ None of these complications

Completed By