LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS
Public Health

Mother's Name: _____

Mother's Medical Record # _____
FOR HOSPITAL USE ONLY

FACILITY WORKSHEET FOR THE FETAL DEATH CERTIFICATE

1. Sex (Male, Female, or Not yet determined): _____

2. Time of death: _____ AM / PM

3. Date of death: __ __ (M M) __ __ (D D) __ __ __ __ (Y Y Y Y)

4. Mother's medical record number: _____

5. Facility name*: _____
   (If not institution, give street and number)

6. Facility I.D. (National Provider Identifier): _____

7. City, Town or Location of delivery: _____

8. Parish of death: _____

9. Zip Code: _____

10. Place of death:

- ☐ Hospital
- ☐ Freestanding birthing center
  (Freestanding birthing center is defined as one which has no direct physical connection with an operative delivery center)
- ☐ Home
  Planned to deliver at home ☐ Yes ☐ No
- ☐ Clinic / Doctor's Office
- ☐ Other (specify, e.g., taxi cab, train, plane, etc.) _____

* *Facilities may wish to have pre-set responses (hard-copy and/or electronic) to questions 1-5 for deliveries which occur at their institutions.*

Rev. 1/2013

FETUS

Sources: Labor and delivery records, mother's medical records

11. Weight: _____ (grams) Note: Do not convert lb / oz to grams
    If weight in grams is not available, weight: _____ (lb / oz)

12. Obstetric estimate of gestation at delivery (completed weeks): _____
    (The attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam. Do not compute based on date of the last menstrual period and the date of delivery.)

13. Plurality (Specify 1 [single], 2 [twin], 3 [triplet], 4 [quadruplet], 5 [quintuplet], 6 [sextuplet], 7 [septuplet], etc.)
    (Include all live births and fetal losses resulting from this pregnancy.):_____

14. If not single delivery (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Include all live births and fetal losses resulting from this pregnancy): _____

15. If not single delivery, specify number of infants in this delivery born alive:_____

16. Congenital anomalies of the fetus (Malformations of the fetus diagnosed prenatally or after delivery.)
    (Check all that apply):

    □ Anencephaly - (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).)

    □ Meningomyelocele/Spina bifida - (Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).)

    □ Cyanotic congenital heart disease - (Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.)

    □ Congenital diaphragmatic hernia - (Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.)

    □ Omphalocele - (A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.)

    □ Gastroschisis - (An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.)

    □ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) - (Complete or partial absence of a portion of an extremity associated with failure to develop.)

    □ Cleft Lip with or without Cleft Palate - (Incomplete closure of the lip. May be unilateral, bilateral or median.)

    □ Cleft Palate alone - (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without Cleft Palate" category above.)

- □ Down Syndrome - (Trisomy 21)
  - □ Karyotype confirmed
  - □ Karyotype pending
- □ Suspected chromosomal disorder - (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.)
  - □ Karyotype confirmed
  - □ Karyotype pending
- □ Hypospadias - (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.)
- □ None of the anomalies listed above

Information for the following items should come from the mother's prenatal care records and from other medical reports in the mother's chart. 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. Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.

MEDICAL / HEALTH INFO

Sources: Prenatal care records, mother's medical records, labor and delivery records

17. Risk factors in this pregnancy (Check all that apply):

- □ Diabetes (Glucose intolerance requiring treatment)
  - □ Prepregnancy - (Diagnosis prior to this pregnancy)
  - □ Gestational - (Diagnosis in this pregnancy)
- □ Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition.)
  - □ Prepregnancy - (Chronic) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy)
  - □ Gestational - (PIH, preeclampsia) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, Including swelling of the hands, legs and face)
  - □ Eclampsia - (Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema)
- □ Previous preterm births - (History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation)
- □ Other previous poor pregnancy outcome - (Includes perinatal death, small for gestational age/intrauterine growth restricted birth) - (History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes. Perinatal death includes fetal and neonatal deaths.)
- □ Pregnancy resulted from infertility treatment - Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g., IVF, GIFT and ZIFT).

If Yes, check all that apply:

- □ Fertility-enhancing drugs, artificial insemination or intrauterine insemination - Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.
- □ Assisted reproductive technology - Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT) used to initiate the pregnancy.

□ Mother had a previous cesarean delivery - (Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls)

If Yes, how many_____

□ None of the above

18. Infections present and/or treated during this pregnancy - (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.) (Check all that apply)

□ Gonorrhea - (a diagnosis of or positive test for Neisseria gonorrhoeae)
□ Syphilis - (also called lues - a diagnosis of or positive test for Treponema pallidum)
□ Chlamydia - (a diagnosis of or positive test for Chlamydia trachomatis)
□ Hepatitis B - (HBV, serum hepatitis - a diagnosis of or positive test for the hepatitis B virus)
□ Hepatitis C - (non A, non B hepatitis, HCV - a diagnosis of or positive test for the hepatitis C virus)
□ CMV
□ Herpes Simplex Virus
□ Rubella
□ Toxoplasmosis
□ None of the above

19. Obstetric procedures - (Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically in the treatment of the pregnancy, management of labor and/or delivery) (Check all that apply)

□ Cervical cerclage - (Circumferential banding or suture of the cervix to prevent or treat passive dilatation. Includes MacDonald's suture, Shirodkar procedure, abdominal cerclage via laparotomy)
□ Tocolysis - (Administration of any agent with the intent to inhibit preterm uterine contractions to extend length of the pregnancy)
□ External cephalic version - (Attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation)
  □ Successful □ Failed
□ None of the above

20. Onset of Labor (Check all that apply):

□ Premature Rupture of the Membranes (prolonged >=12 hours)
(Spontaneous tearing of the amniotic sac, (natural breaking of the bag of waters), 12 hours or more before labor begins)
□ Precipitous labor (<3 hours) (Labor that progresses rapidly and lasts for less than 3 hours)
□ Prolonged labor (≥20 hours) (Labor that progresses slowly and lasts for 20 hours or more)
□ None of the above

21. Characteristics of labor and delivery (Check all that apply):

- ☐ Induction of labor - (Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor.)
- ☐ Augmentation of labor - (Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery.)
- ☐ Non-vertex presentation - (Includes any non-vertex fetal presentation, e.g., breech, shoulder, brow, face presentations, and transverse lie in the active phase of labor or at delivery other than vertex.)
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery - (Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to the mother as an anti-inflammatory treatment.)
- ☐ Antibiotics received by the mother during labor - (Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.)
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F) - (Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis and fetal tachycardia. Any maternal temperature at or above 38°C (100.4°F).
- ☐ Moderate/heavy meconium staining of the amniotic fluid - (Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery which is more than enough to cause a greenish color change of an otherwise clear fluid.)
- ☐ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery - (*In Utero Resuscitative measures* such as any of the following - maternal position change, oxygen administration to the mother, intravenous fluids administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents. *Further fetal assessment* includes any of the following - scalp pH, scalp stimulation, acoustic stimulation. *Operative delivery* – operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery.)
- ☐ Epidural or spinal anesthesia during labor - (Administration to the mother of a regional anesthetic for control of the pain of labor, i.e., delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.)
- ☐ None of the above

22. Method of delivery (The physical process by which the complete delivery of the infant was effected) (Complete A, B, C, and D):

A. Was delivery with forceps attempted but unsuccessful? - (Obstetric forceps was applied to the fetal head in an unsuccessful attempt at vaginal delivery)

☐ Yes ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful? - (Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)

☐ Yes ☐ No

C. Fetal presentation at delivery (Check one):

- ☐ Cephalic - (Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP)
- ☐ Breech - (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech)
- ☐ Other - (Any other presentation not listed above)

D. Final route and method of delivery (Check one):

- □ Vaginal/Spontaneous - (Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.)
- □ Vaginal/Forceps - (Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.)
- □ Vaginal/Vacuum - (Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.)
- □ Cesarean - (Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.)

If cesarean, was a trial of labor attempted? - (Labor was allowed, augmented or induced with plans for a vaginal delivery.)

□ Yes □ No

23. Maternal morbidity (Serious complications experienced by the mother associated with labor and delivery) (Check all that apply):

- □ Maternal transfusion - (Includes infusion of whole blood or packed red blood cells associated with labor and delivery.)
- □ Third or fourth degree perineal laceration - (3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- □ Ruptured uterus - (Tearing of the uterine wall.)
- □ Unplanned hysterectomy - (Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.)
- □ Admission to intensive care unit - (Any admission of the mother to a facility/unit designated as providing intensive care.)
- □ Unplanned operating room procedure following delivery - (Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.)
- □ None of the above

MOTHER'S MEDICAL

Sources: Labor and delivery records, mother's medical records

24. Prenatal Care
(a) Did mother receive Prenatal Care?

- □ Yes [Go to Question 25]
- □ No [The mother did not receive prenatal care at any time during the pregnancy. If this box is checked please go to Question 26]

25. (a) Date of first prenatal care visit (Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy):

__ __ __ __ __ __ __ __ □ Date Unknown _____
M M D D Y Y Y Y

(b) Date of last prenatal care visit (Enter the date of the last visit recorded in the mother's prenatal records):

__ __ __ __ __ __ __ __ □ Date Unknown _____
M M D D Y Y Y Y

(c) Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record - If none enter "0":_____

26. Mother's weight at delivery (pounds):_____

27. Number of previous live births now living (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):

_____ Number □ None

28. Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):

_____ Number □ None

29. Date of last live birth:

__ __ __ __ __ __
M M Y Y Y Y

30. 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):

_____ Number □ None

31. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended):

__ __ __ __ __ __
M M Y Y Y Y

32. Date last normal menses began

__ __ __ __ __ __ __ __
M M D D Y Y Y Y

33. Was the mother transferred to this facility for maternal medical or fetal indications for delivery? (Transfers include hospital to hospital, birth facility to hospital, etc.)

□ Yes □ No

If Yes, enter the name of the facility mother transferred from: _____

34. Principal source of payment for this delivery (At time of delivery):

□ Private Insurance
□ Medicaid (Comparable State program)
□ Self-pay (No third party identified)
□ Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal, state, local))

Cause-of-Death Section

Causes/Conditions Contributing to Fetal Death

Previous questions collected details on anomalies, morbidities, and risk factors known to be present for this patient and the fetus. The purpose of the next 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.

35. 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. 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

☐ 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

36. Other Significant Causes or Conditions

Select or Specify All Other Conditions Contributing to Death in Item 34.

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

37. Was an autopsy performed?

☐ Yes ☐ No ☐ Planned

38. Was a histological placental examination performed?

☐ Yes ☐ No ☐ Planned

39. Were autopsy or histological placental examination results used in determining the cause of fetal death?

☐ Yes ☐ No

40. 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

ATTENDANT

41. Attendant's name, title, and N.P.I. (National Provider Indentifier) (The attendant at delivery is the individual physically present at the delivery who is responsible for the delivery. For example, 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):

_____ _____

Attendant's Name NPI

Attendant's title:

□ M.D.
□ D.O.
□ CNM/CM - (Certified Nurse Midwife/Certified Midwife)
□ Other Midwife - (Midwife other than CNM/CM)
□ Other (specify):_____

42. Is the certifier same as attendant? (If certifier is the same as the attendant then please go to Question 44)

□ Yes □ No

43. Certifier's name and title: _____
(The individual who certifies to the fact that the fetal death occurred. May be, but need not be, the same as the attendant at delivery.)

□ M.D.
□ D.O.
□ Hospital administrator or designee
□ CNM/CM (Certified Nurse Midwife / Certified Midwife)
□ Other Midwife (Midwife other than CNM/CM)
□ Other (Specify)_____

44. Date certified

__ __ __ __ __ __ __ __

M M D D Y Y Y Y