WEST VIRGINIA Department of Health & Human Resources

Patient's medical record # _____
Patient's name _____

FACILITY WORKSHEET FOR THE REPORT OF FETAL DEATH

Definition of Fetal Death:

Complete this worksheet for pregnancies resulting in fetal death. W. Va. State Code §16-5-1(7) states that: ""Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of the pregnancy and which is not an induced termination of pregnancy, such death being indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles." Although not part of the codified definition, National Model code also adds the following advisory statement, "Heart beats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps." The additional advisory language should be taken into consideration when making determination.

Threshold for the Reporting of Fetal Death:

Although the definition includes all fetal deaths irrespective of the duration of pregnancy, ONLY those that weigh 350 grams or more at the time of delivery are REPORTABLE under W.Va. Code §16-5-21. IF WEIGHT AT DELIVERY IS UNKNOWN, the threshold for reporting is 20 weeks or more gestational age calculated from the date of the last normal menstrual period to the date of delivery.
REMEMBER – Weight is the primary reporting threshold. When weight is unknown, only then is gestational age used.

	Weight at Delivery		
Gestational Age	**<350 grams**	**>= 350 grams**	**Weight Unknown**
<20 Weeks	Not Reportable	Reportable	Not Reportable
>= 20 Weeks	Not Reportable	Reportable	Reportable

For detailed definitions, instructions, information on sources, and common key words and abbreviations for many of the items included in the worksheet, please see "The Guide to Completing Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death (2003 Revision)." The Guide is available from the Vital Registration Office or is available online at: http://www.cdc.gov/nchs/nvss/vital_certificate_revisions.htm

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

2. Facility I.D.: (National Provider Identifier)**:** _____

3. City, town or location of delivery: _____ **Zip code:** _____

4. County of delivery: _____

5. Place of delivery:

☐ Hospital

☐ Freestanding birthing center (Freestanding birthing center is defined as one which has no direct physical connection with an operative delivery center.)

☐ Home delivery If so, Planned to deliver at home? ☐ Yes ☐ No

☐ Clinic/Doctor's Office

☐ Other (Specify, e.g., taxi cab, train, plane, etc.):_____

Prenatal Information

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

Information for the following items should come from the patient's prenatal care records and from other medical reports in the patient's chart. If the patient'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.

6. 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.)

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

☐ **No prenatal care** (The mother did not receive prenatal care at any time during the pregnancy.)

7. Date last normal menses began: __ __ __ __ __ __ __ __
M M D D Y Y Y Y

8. Number of previous live births now living: (For multiple deliveries, include live born infants born before this fetus in the multiple set.)

_____ Number ☐ None

9. Number of previous live births now dead: (For multiple deliveries, include live born infants born before this fetus in the multiple set who subsequently died.)

_____ Number ☐ None

10. Date of last live birth: __ __ __ __ __ __ __ __
M M D D Y Y Y Y

11. 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.)

Prenatal Information

11. Risk factors in this pregnancy, cont'd.

☐ **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.

☐ **Patient 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?

_____Number

☐ **None of the risk factors listed in Item 11.**

Labor and Delivery

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

12. Date of delivery: ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

13. Time of delivery: _____ 24 hour clock

14. Name and title of person completing report:
(May be, but need not be, the same as the attendant at delivery.)

Name: _____
Title: _____

15. Date report completed: ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

16. Attendant's name, title, and N.P.I.: (National Provider Identifier) (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 a fetus 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 N.P.I.

Attendant's title:

- ☐ MD
- ☐ DO
- ☐ CNM/CM - (Certified Nurse Midwife/Certified Midwife)
- ☐ Other Midwife - (Midwife other than CNM/CM)
- ☐ Other (specify):_____

17. Method of delivery: (The physical process by which the complete delivery was effected.)

(Complete A and B):

A. 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 presentation not listed above)

B. 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

Labor and Delivery, cont'd.

18. Maternal morbidity: (Serious complications experienced by the patient associated with labor and delivery.)

(Check all that apply):

☐ Ruptured uterus - (Tearing of the uterine wall.)

☐ Admission to intensive care unit - (Any admission of the mother to a facility/unit designated as providing intensive care.)

☐ None of the above

19. Weight of fetus: _____(grams) (Do not convert lb/oz to grams)

If weight in grams is not available, weight of fetus: _____(lb/oz)

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

21. Sex: (Male, Female, or Unknown): _____

22. 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.):_____

23. 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): _____

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

25. Method of Disposition:

☐ Burial

☐ Cremation

☐ Hospital Disposition

☐ Donation

☐ Removal from State

☐ Other (Specify)_____

Cause-of-Death Section

Causes/Conditions Contributing to Fetal Death

Previous questions collected details on 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.

26. 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.

REPORT ONE ITEM ONLY IN THIS BOX

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-of-Death Section, cont'd.

27. Other Significant Causes or Conditions:
Select or Specify All Other Conditions Contributing to Death in Item 27.
IF APPLICABLE, YOU MAY REPORT ONE OR MORE ITEMS IN THIS BOX

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. Was an autopsy performed? ☐ Yes ☐ No ☐ Planned

29. Was a histological placental examination performed? ☐ Yes ☐ No ☐ Planned

30. Was an autopsy or histological placental examination result used in determining the cause of fetal death?

☐ Yes ☐ No

31. 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

W.VA. STATE CODE
REGARDING THE FILING OF REPORTS OF FETAL DEATH

16-5-21. Reports of fetal death.

(a) Each fetal death of three hundred fifty grams or more, and if weight is unknown, of twenty completed weeks of gestation or more, calculated from the date the last normal menstrual period began to the date of delivery, which occurs in this state, shall be reported within five days after delivery to the section of vital statistics or as otherwise directed by the State Registrar.

(1) When a fetal death occurs, the person in charge of the institution or his or her designated representative shall prepare and file the report. In obtaining the information required by the report, all institutions shall use information gathering procedures, including worksheets, provided or approved by the State Registrar.

(2) When a fetal death occurs, the physician in attendance at or immediately after delivery shall prepare and file the report.

(3) When inquiry is required pursuant to article twelve, chapter sixty-one, or other applicable provisions of this code, the State Medical Examiner or designee or county medical examiner or county coroner shall investigate the cause of fetal death and shall prepare and file the report within five days. If after investigation, the State Medical Examiner or designee or county medical examiner or county coroner decline jurisdiction, the person declining jurisdiction may direct the local health officer to investigate the cause of fetal death and prepare and file the report.

(4) When a fetal death occurs in a moving conveyance and the fetus is first removed from the conveyance in this state, the place where the fetus was first removed from the conveyance will be considered the place of fetal death.

(b) When a fetus is found in this state and the place of death is unknown, the fetal death shall be recorded in this state, and the place where the fetus was found will be considered the place of fetal death.