IOWA Health and Human Services

Stillbirth Surveillance Evaluation Form

*If this is a multifetal pregnancy, please complete a separate form for each fetus.

(Stamper Plate/ID label)

Hospital Name: _____

Individual Completing the Form: _____

Mother's Name: _____

County of Residence: _____ Age: _____

Race: _____ Ethnicity: _____

Father's Name: _____ Age: _____

Race: _____ Ethnicity: _____

Date of Stillbirth Diagnosis: _____ Gestational Age at Diagnosis: _____

Ultrasound findings at time of stillbirth diagnosis:

_____

_____

_____

Maternal History

G _____ P _____ T _____ P _____ AB _____L _____

LMP: _____/_____/_____ EDC: _____/_____/_____

Maternal Medical History (e.g., diabetes mellitus, chronic hypertension, antiphospholipid syndrome, heart disease):

_____

_____

_____

Obstetric history (e.g., previous fetal demise, previous child with anomaly or hereditary condition, previous gestational hypertension or preeclampsia):

_____

_____

_____

Current Pregnancy (e.g., multifetal gestation, cholestasis, preterm labor or rupture of membranes, ultrasound abnormalities):

_____

_____

_____

Social Determinants of Health (SDOH) (e.g., economic stability, education access and quality, health care access and quality, neighborhood and environment, social and community support):

_____

_____

Medications (Including over-the-counter medications and herbs):

_____

_____

Tobacco or nicotine use (e.g., cigarettes, cigars, e-cigarettes/vapes, smokeless tobacco):

☐ No ☐ Yes- specify_____ Frequency: _____

☐ Former user- quit date: _____

Alcohol use: ☐ No ☐ Yes- Frequency: _____

☐ Former use- quit date: _____

Illicit Drug Use: ☐ No ☐ Yes- Frequency: _____

☐ Former use- quit date: _____

Maternal/Family Interview

Summary of discussion with the mother and other involved family members - include baby's activity patterns, when they first noticed baby wasn't moving, any discomforts during the day or night, and any other events deemed relevant by the mother or family. Consider asking- Was there any point where you felt like something wasn't right with your baby? If so, when did you start to feel that way? What did you notice? Looking back on the experience after the fact, some parents may recall things like decreased movement, or a sudden increase in movement, did you experience anything like that? Did you contact your OB provider or Triage? If so, what were you advised to do (lay down, eat something, come right to hospital, etc.)? Did you see your care provider in the days prior to the death of your baby? Was this visit routine or did you request a visit with them? What made you reach out? Were you able to see your physician or midwife for your prenatal visits? Were you instructed on what to do if you had a concern? (This provides an opportunity to express grief, ask questions, feel heard and build trust.)

_____

_____

_____

_____

_____

_____

_____

_____

Did the parents receive any education regarding tracking the movements of the baby, such as kick counting? ☐ Yes ☐ No

If yes, from whom: _____

Assessment Form

Antepartum Findings

Date of first prenatal visit: _____/_____/_____ Number of prenatal visits: _____

BMI: Pre-pregnancy: _____ Current: _____

Prenatal Labs: ABO/RH: _____ Antibody: _____ Rubella: _____ Hep B: _____

Hep C: _____ HIV: _____ Syphilis: _____ Gonorrhea: _____ Chlamydia: _____

GBS: _____ CMV: _____ Covid 19: _____

Diabetes Testing: 1 hr GTT: Pass / Fail. 3 hr GTT: Pass / Fail.

Maternal Serum Screening (e.g., first trimester screening, quad screen, integrated screen, cell-free DNA testing): Y / N Results:_____

Amniocentesis / chorionic villus sampling: Y / N Results: _____

Ultrasounds (list from most recent to initial exam):

Date: ___/___/_____ Gestational Age: _____

Findings:

_____

Date: ___/___/_____ Gestational Age: _____

Findings:

_____

Date: ___/___/_____ Gestational Age: _____

Findings:

_____

Date: ___/___/_____ Gestational Age: _____

Findings:

_____

Blood Pressure:

- ☐ Low BP (below 90/60)
- ☐ Normal BP (120/80)
- ☐ Elevated BP (above 120/80)
- ☐ Chronic Hypertension
- ☐ Gestational Hypertension (current pregnancy)
- ☐ Preeclampsia (current pregnancy)

Health At Time of Diagnosis

Fever/Rash: Y / N Explain: _____

Bleeding: Y / N Explain: _____

Pain: Y / N Explain: _____

Exposure History

Illnesses: Y / N Explain: _____

Teratogens: Y / N Explain: _____

Recent Trauma: Y / N Explain: _____

Comments: _____

Tests At Diagnosis (as ordered by attending provider)

- ☐ Kleihauer-Betke / Fetal Blood screen
- ☐ Lupus Anticoagulant
- ☐ Anticardiolipin antibodies
- ☐ Factor V Leiden
- ☐ Prothrombin gene mutation
- ☐ CBC
- ☐ TSH
- ☐ Hemoglobin A1c
- ☐ Bile acids
- ☐ Parvovirus IgG and IgM
- ☐ STORCH Titers: IgG and IgM for syphilis, toxoplasmosis, cytomegalovirus, herpes virus, and rubella
- ☐ PCR (Polymerase Chain Reaction) for STORCH
- ☐ Genetic Testing (amniocentesis): _____
- ☐ Maternal drug screen: _____

Findings At Delivery

_____

_____

_____

Gross Fetal Exam

Weight (grams): _____ Length (inches): _____ Head circumference (inches): _____

	Normal	Abnormal (describe)		
1. General Appearance	☐	☐ trauma evidence	☐ macerated +, ++, +++ ☐ edema	
2. Skin	☐	☐ meconium stained ☐ jaundice	☐ bruising ☐ petechiae	
3. Head	☐	☐ hydrocephalic ☐ collapsed ☐ neural tube defect ☐ anencephalic		
4. Scalp	☐	☐ defects ☐ masses		
5. Eyes	☐	Spacing: ☐ narrow ☐ wide Slanting: ☐ up ☐ down	☐ cataracts ☐ opaque ☐ sunken ☐ prominent ☐ eyelids fused	
6. Nose	☐	☐ flat bridge	☐ asymmetric	
7. Nostrils	☐	☐ obstructed	☐ single nostril	
8. Ears	☐	☐ abnormal position ☐ abnormal form	☐ periauricular tags/pits	
9. Mouth	☐	☐ small ☐ large	☐ cleft lip ☐ cleft palate	
10. Mandible	☐	☐ micrognathia	☐ asymmetric	
11. Neck	☐	☐ short	☐ excess skin	☐ cystic mass
12. Chest	☐	☐ asymmetric ☐ small	☐ nipples wide spaced ☐ constricted	☐ sternal defects ☐ barreled
13. Abdomen	☐	☐ flattened	☐ distended	☐ wall defect
14. Back	☐	☐ sacral dimple ☐ scoliosis	☐ Neural tube defect ☐ kyphosis	
15. Arms	☐	☐ short ☐ abnormal muscle development	☐ long ☐ absent	☐ abnormal positioning
16. Hands	☐	☐ creases abnormal ☐ extra digits	☐ webbing fingers ☐ absent digits	☐ abnormal positioning ☐ abnormal nails
17. Legs	☐	☐ short ☐ abnormal muscle development	☐ long ☐ absent	☐ abnormal positioning
18. Feet (length: _____ in)	☐	☐ club foot ☐ extra toes	☐ webbing toes ☐ absent toes	☐ abnormal positioning ☐ abnormal nails
19. Genital-Rectal	Sex ☐M☐F	☐ hypospadias ☐ ambiguous	☐ undescended testes ☐ imperforate anus	

Other Tests/Exams After Delivery (as ordered by attending provider)

- ☐ Iowa newborn blood spot screen obtained and sent to lab
- ☐ Whole body x-ray (limbs extended)
- ☐ Autopsy (consent obtained)
- ☐ Photographs (body, face, extremities, palms)
- ☐ Chromosomal analysis: Cell source (circle one)- amniotic fluid (obtained via amniocentesis at time of prenatal diagnosis of demise is preferred), placental block (1x1 cm, taken from below cord insertion site of unfixed placenta), umbilical cord segment (1.5 cm), internal fetal tissue specimen (such as costochondral junction or patella- skin is not recommended). DO NOT PLACE SAMPLE IN FORMALIN.
- ☐ Placenta to pathology

Gross Placental Exam

Weight: _____

1. Complete	☐ yes	☐ no If incomplete, amount apparently missing- ____%
2. Maternal surface	☐ normal	☐ abnormal: ☐ ragged, ☐ adherent tissue
3. Diameter	Approximately ___cm	
4.Thickness	Approximately ___cm	
5. Shape	☐ discoid ☐ oval	☐ bi-lobed ☐ succenturiate lobe present ☐ other anomaly present _____
6. Consistency	☐ normal	☐ soft ☐firm ☐gritty
7. Hemorrhage	☐ no	☐yes Approximate size of hemorrhage: ____ cm. Consistency of hemorrhage: _____ Adherence of clot ☐yes ☐no
8. Other abnormalities	☐ Amniotic nodules ☐ Malodor	☐ Staining of amniotic surface ☐ Amniotic bands ☐ Other: _____

Gross Umbilical Cord Exam

1. Insertion	☐ Central	☐ Eccentric ☐Velamentous	☐ Marginal
2. Length	Approximately _____cm		
3. Diameter	Approximately _____cm		
4. Knots	☐ No	☐ Yes Describe: _____	
5. Cord around body	☐ No	☐ Nuchal x ___ ☐tight ☐loose	☐ Around torso or shoulder x ___
6. Number of vessels	_____	☐ Single artery	
7. Thromboses	☐ No	☐ Yes Describe_____	
8. Wharton's Jelly	☐ Present	☐ Absent	
9. Torsion	☐ No	☐ Yes	

Return form to:
Director, Center for Congenital and Inherited Disorders
Iowa Department of Health and Human Services
321 E. 12th Street
Des Moines, IA 50319-0075
OR fax to 515-242-6013
Call 1-833-496-8040 for questions.