STATE OF IOWA
IOWA DEPARTMENT OF PUBLIC HEALTH

CERTIFICATE OF FETAL DEATH

1. NAME OF FETUS FIRST *(Optional)*	MIDDLE *(Optional)*	LAST *(Required)*	SUFFIX, *if any*

DELIVERY

2. SEX OF FETUS *(Spell out)*	3. DATE OF DELIVERY *(Month/Day/Year)*	4. TIME OF DELIVERY MILITARY	5. ATTENDANT TITLE ☐ M.D. ☐ D.O. ☐ CNM/ARNP ☐ Other Midwife ☐ Other *(Specify)* _____

6. PLACE OF DELIVERY *(Check only one)* ☐ Hospital or En route to hospital ☐ Residence: Was this a planned "home" delivery? ☐ Yes ☐ No ☐ Unknown ☐ Freestanding Birthing Center ☐ Clinic/Doctor's office ☐ Other *(Specify)* _____

7a. FACILITY NAME *(If not institution, give street and number)*	7b. CITY, TOWN, OR LOCATION

PARENT 1: MOTHER / PARENT *(CIRCLE ONE)*

8a. PARENT 1 – CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*	8b. PARENT 1 – DATE OF BIRTH *(Month/Day/Year)*
8c. PARENT 1 – NAME PRIOR TO ANY MARRIAGE *(First, Middle, Last, Suffix)*	**8d. PARENT 1 – BIRTHPLACE** *(U.S. State or Territory, Canada/Province, or Foreign Country)*

9a. RESIDENCE-STATE	9b. RESIDENCE-COUNTY	9c. RESIDENCE-CITY OR TOWN	9d. RESIDENCE-STREET ADDRESS & ZIP CODE	9e. INSIDE CITY LIMITS? ☐ Yes ☐ No

PARENT 2: FATHER / MOTHER / PARENT *(CIRCLE ONE)*

10a. PARENT 2 – CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*	10b. PARENT 2 – DATE OF BIRTH *(Month/Day/Year)*
10c. PARENT 2 – NAME PRIOR TO ANY MARRIAGE *(First, Middle, Last, Suffix)*	**10d. PARENT 2 – BIRTHPLACE** *(U.S. State or Territory, Canada/Province, or Foreign Country)*

DISPOSITION

11. METHOD OF DISPOSITION
(Check all that apply) ☐ Burial ☐ Cremation ☐ Donation ☐ Removal from State ☐ Hospital Disposition ☐ Other *(Specify)* _____

12a. PLACE OF DISPOSITION *(Name of Cemetery, Crematory, or other place)*	12b. LOCATION OF DISPOSITION *(City or Town & State)*

13a. PERSON RESPONSIBLE FOR DISPOSITION *(PRINT)*	13b. FULL ADDRESS

13c. SIGNATURE OF FUNERAL DIRECTOR OR PERSON RESPONSIBLE FOR DISPOSITION	13d. IF FUNERAL DIRECTOR/IOWA LICENSE NUMBER

CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

14a. INITIATING CAUSE OR CONDITION
*(Select the **ONE** that most likely began the sequence of events resulting in the death of the fetus.)*

☐ Maternal Conditions/Diseases *(Specify)* _____

☐ Complications of Placenta, Cord, or Membrane:
- ☐ 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

14b. OTHER SIGNIFICANT CAUSES OR CONDITIONS
(Select or specify all other conditions contributing to the death of the fetus.)

☐ Maternal Conditions/Diseases *(Specify)* _____

☐ Complications of Placenta, Cord, or Membrane:
- ☐ 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

14c. WEIGHT OF FETUS *(Prefer grams) – Specify unit*
☐ Grams ☐ Lb/Oz _____

14d. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY
_____ *(Completed weeks)*

14e. 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

14f. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No ☐ Planned

14g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? ☐ Yes ☐ No ☐ Planned

14h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ☐ Yes ☐ No

CERTIFIER

15a. MEDICAL CERTIFIER NAME *(Type or print legibly)*	15b. TITLE ☐ MD ☐ DO ☐ PA ☐ ARNP ☐ Medical Examiner

15c.COMPLETE MAILING ADDRESS	15d. LICENSE NUMBER

15e. SIGNATURE OF MEDICAL CERTIFIER	15f. DATE CERTIFIED *(Month/Day/Year)*

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17. MOTHER'S EDUCATION. Check the box that best describes the highest degree or level of school completed at the time of delivery.

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate or GED completed
- ☐ College, 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 (e.g., PhD, EdD) or Professional degree (e.g., MD, DO, DDS, DVM, LLB, JD)
- ☐ Technical/Instruction School
- ☐ Unobtainable

18. MOTHER OF HISPANIC ORIGIN? Check the box that best describes whether the mother is Spanish/Hispanic/ Latina. Check the "No" box if mother is not Spanish / Hispanic / Latina.

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina *(Specify)* _____
- ☐ Unobtainable

19. MOTHER'S RACE. Check one or more races to indicate what the mother considers herself to be.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native *(Specify name of the enrolled or principal tribe)* _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian *(Specify)* _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander *(Specify)* _____
- ☐ Other *(Specify)* _____
- ☐ Unobtainable

20a. MOTHER EVER MARRIED? ☐ Yes ☐ No ☐ Unknown

20b. MOTHER MARRIED AT DELIVERY, CONCEPTION OR ANY TIME BETWEEN? ☐ Yes ☐ No

21a. DATE OF FIRST PRENATAL CARE VISIT *(Month/Day/Year)* ☐ No Prenatal Care

21b. DATE OF LAST PRENATAL CARE VISIT *(Month/Day/Year)*

22. NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY _____ *(If none, enter "0")*

23. MOTHER'S HEIGHT ____ *Feet* ____ *Inches*

24. MOTHER'S PREPREGNANCY WEIGHT _____ *(pounds)*

25. MOTHER'S WEIGHT AT DELIVERY _____ *(pounds)*

26. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No ☐ Don't Know

27. NUMBER OF PREVIOUS LIVE BIRTHS

☐ No Previous Live Births

27a. Number Now Living _____

27b. Number Now Dead _____

27c. Date of last live birth *(Month/Year)*

_____

28. NUMBER OF OTHER PREGNANCY OUTCOMES NOT RESULTING IN A LIVE BIRTH (Spontaneous or induced losses or ectopic pregnancies.) Do NOT include this fetus.

☐ No Other Outcomes

28a. Number of Other Outcomes _____

28b. Date of last other outcome *(Month/Year)*

_____

29. NUMBER OF CIGARETTES MOTHER SMOKED ON AN AVERAGE DAY BEFORE AND DURING THIS PREGNANCY *If none for a time period, enter "0". (1 pack = 20 cigarettes)*

Three months before pregnancy _____
First three months of pregnancy _____
Second three months of pregnancy _____
Last three months of pregnancy _____

30. DATE LAST NORMAL MENSES BEGAN *(Month/Day/Year)*

_____

31. PLURALITY *(Single, Twin, Triplet, etc.)*

(Specify) _____

32. IF NOT SINGLE BIRTH *(Born first, second, third, etc.)*

(Specify) _____

33. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No

IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM *(Include city & state)*: _____

34. RISK FACTORS IN THIS PREGNANCY *(Check all that apply)*

- ☐ Diabetes *(If yes, check one)*
  - ☐ Pre-pregnancy *(diagnosis prior to this pregnancy)*
  - ☐ Gestational *(diagnosis in this pregnancy)*
- ☐ Hypertension *(If yes, check one)*
  - ☐ Pre-pregnancy *(Chronic)*
  - ☐ Gestational *(PIH, pre-eclampsia)*
  - ☐ Eclampsia
- ☐ Previous preterm births
- ☐ Other previous poor pregnancy outcome *(perinatal death, small for gestational age/interuterine growth restriction)*
- ☐ Pregnancy resulted from infertility treatment *(If yes, check as applies)*
  - ☐ Fertility-enhancing drugs, artificial insemination, or intrauterine insemination
  - ☐ Assisted reproductive technology *(e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))*
- ☐ Mother had a previous cesarean delivery **If yes, how many** _____
- ☐ None of the above

35. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY *(Check all that apply)*

- ☐ Gonorrhea – *a positive test for Neisseria gonorrhoeae*
- ☐ Syphilis *(a.k.a. lues)* – *a positive test for Treponema pallidum*
- ☐ Chlamydia – *a positive test for Chlamydia trachomatis*
- ☐ Listeria (LM) – *a diagnosis of or positive test for Listeria monocytogenes*
- ☐ Group B Streptococcus (GBS) – *a diagnosis of or positive test for Streptococcus agalactiae or Group B streptococcus*
- ☐ Cytomegalovirus (CMV) – *a diagnosis of or positive test for Cytomegalovirus*
- ☐ Parvovirus (B19) – *a diagnosis of or positive test for Parvovirus B19*
- ☐ Toxoplasmosis (Toxo) – *a diagnosis of or positive test for Toxoplasmosis gondii*
- ☐ None of the above
- ☐ Other *(Specify)* _____

36.METHOD OF DELIVERY

36a. Fetal presentation at delivery *(Check one)*

☐ Cephalic ☐ Breech ☐ Other

36b. Final route and method of delivery *(Check Vaginal or Cesarean)*

☐ Vaginal *(Check only the final one)*
☐ Spontaneous ☐ Forceps ☐ Vacuum

☐ Cesarean **If yes**, did mother experience labor?
☐ Yes ☐ No

36c. Hysterotomy or Hysterectomy?

☐ Yes
☐ No

37. MATERNAL MORBIDITY *(Check all that apply)*
(Complications associated with labor & delivery)

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

38. CONGENITAL ANOMALIES OF THE FETUS *(Check all that apply)*

- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect *(excludes congenital amputation & dwarfing syndromes)*
- ☐ Cleft lip with or without cleft palate
- ☐ Cleft palate alone
- ☐ Down syndrome *(Trisomy 21)* *(Check known status of Karyotype)*
  - ☐ Karyotype confirmed ☐ Karyotype pending
- ☐ Suspected chromosomal disorder *(Check known status of Karyotype)*
  - ☐ Karyotype confirmed ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None of the above

Version based on national standard revised 11/2003, National Center for Health Statistics
Implemented by Iowa Department of Public Health effective with fetal deaths occurring in Iowa 07/01/2017, and later.
Version 1.5 (updated for IVES)