STATE OF IOWA
IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES

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 Health and Human Services effective with fetal deaths occurring in Iowa 07/01/2017, and later.
Version 1.5 (updated for IVES)