Surveillance Fetal Death Evaluation Form

(Stamper Plate/ID label)

Hospital Name _____

Individual Completing Form _____

If you would like a follow-up call re: the surveillance activities of this case, please indicate ☐ and provide contact information _____

Mother's Name: _____MR#: _____

County of Residence: _____

Age: _____ Race: _____ Ethnicity: _____

Father's Name: _____ Race: _____

Ethnicity: _____ County of Residence: _____

Date of Stillbirth Diagnosis: _____ EDC: _____

Ultrasound findings at time of stillbirth diagnosis:

_____
_____
_____
_____
_____

Probable factors contributing to fetal death:

_____
_____

OBSTETRICAL HISTORY

G _____ P _____ AB _____T _____PT _____ L _____

Prior obstetrical complications:

_____
_____
_____
_____
_____
_____
_____
_____

LMP: _____/_____/_____

Maternal Medical History:

_____
_____
_____
_____
_____

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

_____
_____
_____

Allergies: _____

Smoking: _____ Alcohol Use: _____

Illicit Drug Use: _____

Maternal/Family Interview

Summary of discussion with mother and other involved family members - include baby's activity patterns (hiccups, kicks, big turns, patterns of movement etc.), when first noticed baby wasn't moving, any discomforts during day or night, and any other events deemed relevant by mother or family. Consider asking - Did you experience reduced fetal movements in the days before the stillbirth? If so how many days before? Did you experience sudden increase in fetal movements in the days before the stillbirth? If so how many days before? Did you see your care provider in the days before the stillbirth? Was this a routine visit? If it was not routine what was the reason for your visit? When do you think your baby died?:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Did the parents receive any education regarding tracking the movements of the baby, such as kick counting?

☐ Yes ☐ No

If yes, from whom? -

_____

Which sleeping position does the mother report using the majority of the time while pregnant?

☐ Left Side

☐ Right Side ☐ Check if mother used a pillow to "prop" herself in her sleeping position

☐ Back

☐ Modified stomach

Assessment Form

ANTEPARTUM FINDINGS

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

ABO/Rh: _____ Antibody: _____ VDRL: _____ HbsAg: _____

Diabetes Testing: 1 hr Glucola: _____ 3 hr GTT-FBS: _____ 1 hr: _____ 2 hr. _____3 hr. _____

Maternal Serum Screening (i.e., Integrated Screen, Expanded AFP/QUAD Screen, Triple Test, or MSAFP):

Y/N Results: _____

Amniocentesis:

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:

_____

_____

Maternal Drug Screen:

Source: _____ Results: _____

Blood Pressure:

☐ Low diastolic BP consistently 60 or less

☐ Borderline Low diastolic BP consistently between 60-75

☐ Normal diastolic BP consistently between 75-90

☐ High diastolic BP consistently higher than 90

Blood Pressure range of mother prior to stillbirth: _____

HEALTH AT TIME OF DIAGNOSIS

Fever/Rash: Y/N Explain: _____

Bleeding: Y/N Pain: Y/N Explain: _____

Exposure History:

Illnesses Y/N Explain: _____

Teratogens: Y/N Explain: _____

Recent Trauma: Y/N Explain: _____

Comments:
_____
_____
_____
_____

TESTS AT DIAGNOSIS

(At order of attending physician)

☐ Fetal Hemoglobin in the Maternal Circulation: Kleihauer-Betke or flow cytometry: _____

☐ Lupus Anticoagulant: _____

☐ Anticardiolipin antibodies: _____

☐ (If extensive placental infarction, Factor V Leiden _____; Prothrombin gene mutation: _____)

☐ Urine Drug Screen: _____

☐ Chromosomal analysis (amniocentesis): _____

☐ Hemoglobin A1c (HbgA1c)

☐ TSH

☐ CBC

☐ STORCH Titers: IgG and IgM for syphilis, toxoplasmosis, cytomegalovirus, herpes virus, and rubella

☐ PCR (Polymerase Chain Reaction) for STORCH

☐ Parvovirus IgG and IgM

FINDINGS AT DELIVERY

Comments:

_____

_____

GROSS FETAL EXAM

Fetus weight: _____

	Normal	Abnormal (describe)		
1. General Appearance	☐	☐ trauma evidence	☐ macerated +, ++, +++ ☐ edema	
2. Skin	☐	☐ mec.stained ☐ jaundice	☐ bruising ☐ petechiae	
3. Head	☐	☐ hydrocephalic ☐ neural tube defect	☐ collapsed ☐ anencephalic	
4. Scalp	☐	☐ defects	☐ masses	
5. Eyes	☐	Spacing: ☐ narrow ☐ wide Slanting: ☐ up ☐ down	☐ cataracts ☐ sunken ☐ eyelids closed	☐ opaque ☐ 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 ☐ barrelled
13. Abdomen	☐	☐ flattened	☐ distended	☐ wall defect
14. Back	☐	☐ sacral dimple ☐ scoliosis	☐ neural tube defect ☐ kyphosis	
15. Arms	☐	☐ short ☐ abnormal muscle dev't	☐ long ☐ absent	☐ abnormal positioning
16. Hands	☐	☐ creases abnormal ☐ extra digits	☐ webbing fingers ☐ absent digits	☐ abnormal positioning ☐ abnormal nails
17. Legs	☐	☐ short ☐ abnormal muscle dev't	☐ long ☐ absent	☐ abnormal positioning
18. Feet	☐	☐ club foot ☐ extra toes	☐ webbing toes ☐ absent toes	☐ abnormal positioning ☐ abnormal nails
19. Genital-Rectal	Gender ☐M☐F	☐ hypospadias ☐ ambiguous	☐ undescended testes ☐ imperforate anus	

OTHER TESTS/EXAM

☐ Iowa Newborn Screen Blood Spots obtained and sent to lab.

☐ Whole Body X-Ray (limbs extended): _____

☐ Autopsy (consent obtained):

_____

_____

_____

_____

☐ Chromosomal analysis: Cell source: amniotic fluid, amnion, placenta, fetal collagen_____

DO NOT PLACE SAMPLE IN FORMALIN. PLACE IN STERILE CONTAINER

Results:

_____

_____

☐ Photographs: Whole Body _____ Face _____

Anomalies: _____

Gross Description of Postpartum Placenta

1. Complete	☐ yes	☐ no If incomplete, amount apparently missing ___%
2. Intact	☐ Yes	☐ No ☐Placenta accreta ☐Placenta increta ☐Placenta percreta
3. Diameter	Approximately _____cms	
4.Thickness	Approximately _____cms	
5. Shape	☐ discoid ☐ oval	☐ bilobed ☐ succenturiate lobe present ☐ other anomaly present _____
6. Consistency	☐ normal	☐ soft ☐firm ☐gritty
7. Hemorrhage	☐ no	☐yes ☐approximate size of hemorrhage _____cms Consistency of hemorrhage _____ Adherence of clot ☐yes ☐no
8. Other abnormalities	☐ Amniotic nodules ☐ Malodor	☐ Staining of amniotic surface ☐ Amniotic bands

Gross Description of Umbilical Cord

1. Insertion	☐ Central	☐ Eccentric ☐Velamentous	☐ Marginal
2. Length	Approximately _____cms		
3. Diameter	Approximately _____cms		
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 Describe _____ _____	

Return form to:

State Genetic Coordinator

Iowa Department of Public Health

321 E. 12th Street

Des Moines, IA 50319-0075

Or fax to 515-725-1760

Call 1-800-383-3826 for questions.