STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

MISSOURI FETAL DEATH FACILITY WORKSHEET

MOTHER'S MEDICAL RECORD #	MOTHER'S NAME	
DATE OF DELIVERY	PLURALITY	BIRTH ORDER

Definition of Spontaneous Fetal Death: Death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy and which is not an induced termination of pregnancy. An infant that has no heartbeat, respiration, voluntary movement of muscles or any evidence of life. Reporting Requirement: Each spontaneous fetal death of 20 completed weeks gestation or more, calculated from the date the last normal menstrual period began to the date of delivery, or a weight of 350 grams or more, which occurs in this state shall be reported within seven (7) days after delivery per state law.

PRENATAL

1. Place of delivery:
- ☐ Hospital
- ☐ Freestanding birthing center
- ☐ Home birth
  Planned to deliver at home? ☐ Yes ☐ No
- ☐ Clinic/Doctor's Office
- ☐ En route
- ☐ Other (specify) _____

2(a). Date of first prenatal care visit

_____
MM/DD/YYYY
☐ No prenatal care

2(b). Date of last prenatal care visit

_____
MM/DD/YYYY

3. Total number of prenatal care visits for this pregnancy
_____ Number ☐ No visits

4. Date last normal menses began

_____
MM/DD/YYYY

5. Number of previous live births now living
_____ Number ☐ None

6. Number of previous live births now dead
_____ Number ☐ None

7. Date of last live birth

_____
MM/DD/YYYY

8. Total number of other pregnancy outcomes
_____ Number ☐ None

9. Date of last other pregnancy outcome

_____
MM/DD/YYYY

10. Risk factors in this pregnancy (*check ALL that apply)*

Diabetes: (specify)
- ☐ Prepregnancy
- ☐ Gestational
- ☐ Insulin Dependent

Hypertension: (specify)
- ☐ Prepregnancy
- ☐ Gestational
- ☐ Eclampsia

- ☐ Previous preterm births
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pregnancy resulted from infertility treatment; if YES, check all that apply:
  - ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
  - ☐ Assisted reproductive technology
- ☐ Mother had a previous cesarean delivery; if YES, how many? _____
- ☐ None of the above

11. Infections present and/or treated during this pregnancy– *check ALL that apply*
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ HIV
- ☐ Hepatitis C
- ☐ Hepatitis B
- ☐ Listeria (LM)
- ☐ Group B Steptococcus (GBS)
- ☐ Cytomegalovirus (CMV)
- ☐ Parvovirus (B19)
- ☐ Toxoplasmosis (TOXO)
- ☐ Zika Virus
- ☐ None of the above
- ☐ Other (specify) _____

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LABOR AND DELIVERY

12. Mother's weight at delivery
_____ pounds

13. Characteristics of labor and delivery - *check ALL that apply*
☐ Induction of labor

14. Method of delivery
A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No
C. Fetal presentation at birth - *check ONE:*
☐ Cephalic ☐ Breech ☐ Other
D. Final route and method of delivery - *check ONE:*
☐ Vaginal / Spontaneous
☐ Vaginal / Forceps
☐ Vaginal / Vacuum
☐ Cesarean: if yes, was a trial of labor attempted?
☐ Yes ☐ No
E. Hysterotomy/Hysterectomy? ☐ Yes ☐ No

15. Maternal morbidity - ***check ALL that apply***
☐ 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

16. Attendant (individual physically present at the delivery who is responsible for the delivery):

Name: _____

NPI: _____

Title: ☐ MD ☐ DO ☐ CNM/CM ☐ CPM ☐ Other midwife
☐ Other (specify) _____

17. Was the mother transferred to this facility for maternal medical or fetal indications for delivery? ☐ Yes ☐ No
If yes, enter the name of the facility mother transferred from:

_____

18. Principal source of payment for this delivery (at time of delivery):
☐ Private insurance
☐ Medicaid
☐ Self-pay
☐ Other (specify) _____

FETUS

19. Date of delivery:

_____
MM/DD/YYYY

20. Time of delivery: _____ ☐ a.m. ☐ p.m.

21. Weight of fetus: _____ **grams** or _____ **lb/oz**

22. Obstetric est. of gestation at delivery (comp wks): _____

23. Sex: ☐ Male ☐ Female ☐ Undetermined

24. Plurality (single, twin, triplet, etc.): _____

25. If not single birth, order delivered in the pregnancy: _____ **and number of fetal deaths in this delivery** _____

26. Congenital anomalies of the newborn - *check ALL that apply*
☐ Anencephaly
☐ Microcephaly
☐ Meningomyelocele/Spina bifida
☐ Cyanotic congenital heart disease
☐ Congenital diaphragmatic hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb reduction defect
☐ Cleft lip with or without cleft palate
☐ Cleft palate alone
☐ Down Syndrome:
☐ Karyotype confirmed ☐ Karyotype pending
☐ Other chromosomal disorder:
☐ Karyotype confirmed ☐ Karyotype pending
☐ Hypospadias
☐ None
☐ Other (specify) _____

27. Method of disposition
☐ Burial
☐ Cremation
☐ Hospital Disposition
☐ Donation
☐ Removal from State
☐ Other (specify) _____

28. Cemetery

Name: _____

Location: _____
City or Town

_____
State

29. Date of disposition

_____
MM/DD/YYYY

30. Disposition facility:
Name: _____
Number & Street: _____
City or Town: _____
State: _____ Zip: _____

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MISSOURI FETAL DEATH FACILITY WORKSHEET

CAUSE OF DEATH

Causes/Conditions Contributing to Fetal Death:
Previous questions collected details on anomalies, 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.

31. 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.

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

32. Other Significant Causes or Conditions: Select or specify all other conditions contributing to death in Item 31.

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

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

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

35. Were autopsy or histological placental examination results used in determining the cause of fetal death?
☐ Yes ☐ No

36. 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