REG-26
JUL 18

New Jersey Department of Health

CERTIFICATE OF FETAL DEATH

STATE FILE NO.

1. NAME OF FETUS *(First, Middle, Last) (OPTIONAL)* | 2a. DATE OF DELIVERY *(Mo/Day/Yr)* | 2b. TIME *(24 Hour)*

3. SEX
☐ MALE ☐ FEMALE
☐ UNKNOWN/UNDETERMINED

4a. THIS DELIVERY
☐ SINGLE ☐ TWIN ☐ OTHER _____ *(Specify)*

4b. IF NOT SINGLE DELIVERY, THIS FETUS DELIVERED
☐ 1st ☐ 2nd ☐ OTHER _____ *(Specify)*

5a. PLACE OF DELIVERY
1 ☐ HOSPITAL
2 ☐ FREESTANDING BIRTHING CENTER
3 ☐ CLINIC/DOCTOR'S OFFICE
4 ☐ HOME DELIVERY-Planned to deliver at home? ☐ Yes ☐ No
5 ☐ OTHER *(Specify)*:

5b. NAME OF FACILITY *(If not institution, give street address)* | 5c. FACILITY ID (NPI)

5d. CITY, TOWN OR LOCATION OF DELIVERY | 5e. COUNTY OF DELIVERY | 5f. ZIP CODE OF DELIVERY

6a. MOTHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)* | 6b. DATE OF BIRTH *(Mo/Day/Yr)*

6c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE *(List name given at birth or on birth certificate/Maiden name)(First, Middle, Last, Suffix)* | 6d. BIRTHPLACE *(State, Territory or Foreign Country)*

7a. RESIDENCE OF MOTHER - STATE | 7b. COUNTY | 7c. CITY OR TOWN

7d. STREET AND NUMBER | 7e. APT NO. | 7f. ZIP CODE *(or Mother's Mailing Address, if different from 7d)* | 7g. INSIDE CITY LIMITS ☐ YES ☐ NO

8a. FATHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)* | 8b. DATE OF BIRTH *(Mo/Day/Yr)* | 8c. BIRTHPLACE *(State, Territory or Foreign Country)*

9a. NAME OF INFORMANT | 9b. RELATIONSHIP TO FETUS

10. CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH

10a. INITIATING CAUSE/CONDITION (Among the choices below, select the ONE which most likely began the sequence of events resulting in the death of the fetus)

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

10b. OTHER SIGNIFICANT CAUSES OR CONDITIONS
(Select or specify all other conditions contributing to death in item 10b)

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

10c. WEIGHT OF FETUS (grams preferred, specify unit)/oz _____ ☐ grams ☐ lb/oz

10d. OBSTRETRIC ESTIMATE OF GESTATION AT DELIVERY _____ (completed weeks)

10e. 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

10f. WAS AN AUTOPSY PERFORMED? ☐ YES ☐ NO ☐ PLANNED

10g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? ☐ YES ☐ NO ☐ PLANNED

10h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ☐ YES ☐ NO

11a. NAME OF CERTIFIER/ATTENDANT | 11b. NPI | 11c. TITLE
☐ ATTENDING ☐ MD / ☐ DO
☐ MEDICAL EXAMINER
☐ CERTIFYING ☐ MD / ☐ DO

11d. ADDRESS OF CERTIFIER/ATTENDANT

11e. SIGNATURE OF CERTIFIER/ATTENDANT | 11f. DATE

12a. NAME OF PERSON COMPLETING REPORT | 12b. TITLE | 12c. DATE REPORT COMPLETED *(MM/DD/YYYY)*

13. DISPOSITION
☐ BURIAL ☐ CREMATION ☐ HOSPITAL DISPOSITION ☐ DONATION ☐ REMOVAL FROM STATE ☐ OTHER *(Specify)*:

14. NAME OF CEMETERY OR CREMATORY | 15a. CITY/TOWN | 15b. STATE

16. NAME AND ADDRESS OF FUNERAL HOME

17a. NAME OF FUNERAL DIRECTOR *(Print or Type)* | 17b. SIGNATURE OF FUNERAL DIRECTOR | 17c. NJ LICENSE NO.

18a. NAME OF REGISTRAR *(Print or Type)* | 18b. SIGNATURE OF REGISTRAR | 18c. DATE RECEIVED BY REGISTRAR *(MM/DD/YYYY*

New Jersey Department of Health

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THE FOLLOWING CONFIDENTIAL INFORMATION MAY BE USED IN CONNECTION WITH RESEARCH STUDIES APPROVED BY THE PUBLIC HEALTH COUNCIL AS AUTHORIZED BY CHAPTER 68, P.L. 1963. SUCH INFORMATION WILL NOT APPEAR ON ANY CERTIFIED COPY OF THIS RECORD.

19a. 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
- ☐ Some college credit 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. DDS, DVM, LLB, JD)

20a. MOTHER'S 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)*: _____

21a. 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
  (Name of enrolled or principal tribe): _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipina
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian *(Specify)*: _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander *(Specify)*: _____
- ☐ Other *(Specify)*: _____

19b. FATHER'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
- ☐ Some college credit 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. DDS, DVM, LLB, JD)

20b. FATHER'S HISPANIC ORIGIN (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino.)

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino *(Specify)*: _____

21b. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be.)

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
  (Name of 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)*: _____

22. OCCUPATION DURING THE PAST YEAR

a. Mother: _____

b. Father: _____

23. BUSINESS/INDUSTRY WORKED AT DURING THE PAST YEAR

a. Mother: _____

b. Father: _____

24. MOTHER MARRIED? *(At delivery, conception, or any time between)*

☐ Yes ☐ No

25. DATE LAST NORMAL MENSES BEGAN *(MM/DD/YYYY)*

____/____/____
Month / Day / Year

26. DATE OF FIRST PRENATAL CARE VISIT *(MM/DD/YYYY)*

____/____/____
Month / Day / Year

☐ No Prenatal Care

27. DATE OF LAST PRENATAL CARE VISIT *(MM/DD/YYYY)*

____/____/____
Month / Day / Year

28. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY *(If "None", enter "0")*

_____

29a. NUMBER OF PREVIOUS LIVE BIRTHS, NOW LIVING

Number: _____

☐ None

29a. NUMBER OF PREVIOUS LIVE BIRTHS, NOW DEAD

Number: _____

☐ None

29c. DATE OF LAST LIVE BIRTH *(MM/YYYY)*

____/____
Month / Year

30a. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies) (Do not include this fetus)

Number: _____ ☐ None

30b. DATE OF LAST OTHER PREGNANCY OUTCOME *(MM/YYYY)*

____/____
Month / Year

31. MOTHER'S HEIGHT *(feet/inches)*

_____

32. MOTHER'S PRE-PREGNANCY WEIGHT *(pounds)*

_____

33. MOTHER'S WEIGHT AT DELIVERY *(pounds)*

_____

34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

☐ Yes ☐ No

35a. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY (FOR EACH TIME PERIOD, ENTER EITHER THE AVERAGE NUMBER OF CIGARETTES OR THE AVERAGE NUMBER OF PACKS OF CIGARETTES SMOKED PER DAY.) IF NONE, ENTER "0".

Three Months Before Pregnancy:	_____ number of cigarettes	**OR**	_____ number of packs
First Three Months of Pregnancy:	_____ number of cigarettes	**OR**	_____ number of packs
Second Three Months of Pregnancy:	_____ number of cigarettes	**OR**	_____ number of packs
Third Trimester of Pregnancy:	_____ number of cigarettes	**OR**	_____ number of packs

35b. OTHER RISK FACTORS FOR THIS PREGNANCY *(Complete all items)*

Alcohol Use during pregnancy? ☐ Yes ☐ No Average number of drinks per week: _____

Homelessness? ☐ Yes ☐ No

Domestic Violence? ☐ Yes ☐ No

Use of cocaine, heroin, marijuana, or methamphetamines during pregnancy? ☐ Yes ☐ No

NAME OF FETUS ***(First, Middle, Last)***

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36a. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY?

☐ No ☐ Yes IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:

36b. MUNICIPALITY NAME

36c. COUNTY NAME

MEDICAL AND HEALTH INFORMATION

37. MEDICAL RISK FACTORS FOR THIS PREGNANCY *(Check all that apply)*

- ☐ Anemia (Hct. <30 / Hgb. <10)
- ☐ Cardiac disease
- ☐ Acute or chronic lung disease
- ☐ Diabetes, Prepregnancy (diagnosis prior to this pregnancy)
- ☐ Diabetes, Gestational (diagnosis in this pregnancy)
- ☐ Genital herpes
- ☐ Hydramnios/Oligohydramnios
- ☐ Hemoglobinopathy
- ☐ Hypertension, Prepregnancy (Chronic)
- ☐ Hypertension, Gestational (PIH, preeclampsia)
- ☐ Hypertension, Eclampsia
- ☐ Incompetent cervix
- ☐ Previous infant 4000+ grams
- ☐ Previous preterm birth
- ☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth-restricted birth)
- ☐ Renal Disease
- ☐ Rh sensitization
- ☐ Uterine bleeding
- ☐ Pregnancy resulted from infertility treatment; if Yes, check all that apply:
  - ☐ 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? _____
- ☐ Other *(Specify)*: _____
- ☐ None of the above

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

- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Listeria
- ☐ Group B Streptococcus
- ☐ Cytomegalovirus
- ☐ Parvovirus
- ☐ Toxoplasmosis
- ☐ None of the above
- ☐ Other *(Specify)*: _____

39. OBSTETRIC PROCEDURES *(Check all that apply)*

- ☐ None
- ☐ Amniocentesis
- ☐ Electronic fetal monitoring
- ☐ Induction of labor
- ☐ Stimulation of labor
- ☐ Tocolysis
- ☐ Ultrasound
- ☐ Other *(Specify)*: _____

40. MATERNAL MORBIDITY (COMPLICATIONS OF LABOR AND/OR DELIVERY) *(Check all that apply)*

- ☐ Febrile (>100° F. or 38° C.)
- ☐ Meconium, moderate/heavy
- ☐ Premature rupture of membrane (>12 hours)
- ☐ Abruptio placenta
- ☐ Placenta previa
- ☐ Other excessive bleeding
- ☐ Seizures during labor
- ☐ Precipitous labor (<3 hours)
- ☐ Prolonged labor (>20 hours)
- ☐ Dysfunctional labor
- ☐ Breech/Malpresentation
- ☐ Cephalopelvic disproportion
- ☐ Cord prolapse
- ☐ Anesthetic complications
- ☐ Fetal distress
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following delivery
- ☐ Other *(Specify)*: _____
- ☐ None of the above

41. METHOD OF DELIVERY *(Check all that apply)*

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 delivery:
- ☐ Cephalic
- ☐ Breech
- ☐ Other

D. Final route and method of delivery *(Check one)*
- ☐ D&E
- ☐ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum

If vaginal, was vaginal birth after previous Cesarean section?
☐ Yes ☐ No

- ☐ Cesarean, Primary
- ☐ Cesarean, Repeat

If cesarean, was a trial of labor attempted?
☐ Yes ☐ No

E. Hysterotomy/Hysterectomy
☐ Yes ☐ No

42. CONGENITAL ANOMALIES OF FETUS (PRESENT OR KNOWN TO EXIST) (*Check all that apply)*

- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Hydrocephalus
- ☐ Microcephalus
- ☐ Other CNS anomalies *(Specify)*: _____
- ☐ Heart malformations
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Other circulatory/respiratories anomalies *(Specify)*: _____
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Rectal atresia / stenosis
- ☐ Tracheo-esophageal fistula / Esophageal atresia
- ☐ Other gastrointestinal anomalies *(Specify)*: _____
- ☐ Malformed genitalia
- ☐ Renal agenesis
- ☐ Other urogenital anomalies *(Specify)*: _____
- ☐ Polydactyly / Syndactyly / Adactyly
- ☐ Club foot
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ☐ Other musculoskeletal / integumental anomalies *(Specify)*: _____
- ☐ Cleft Lip with or without Cleft Palate
- ☐ Cleft Palate alone
- ☐ Down Syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Other chromosomal anomalies *(Specify)*: _____
- ☐ Hypospadias
- ☐ Other *(Specify)*: _____
- ☐ None of the anomalies listed above

NAME OF FETUS *(First, Middle, Last)*