Mother's Medical Record # ____________________ Mother's name ____________________________________
FOR HOSPITAL USE ONLY

FORM VS-3WA
(REV. 08/2020)

# STILLBIRTH WORKSHEET

**We are truly sorry about the loss you have experienced. We understand that this is a difficult time for you and your loved ones. We need to ask you a few questions to assist in the completion of the official report of fetal death. State laws provide protection against the unauthorized release of identifying information from the report of fetal death to ensure confidentiality of the parents. This information may also help researchers understand some of the factors that are related to miscarriage and stillbirth. Your assistance in providing complete and accurate information is very important. We appreciate your help, especially during this very difficult time.**

## MOTHER'S SECTION

**PLEASE PRINT CLEARLY**

**Please fill out the complete form and leave no blanks unless otherwise instructed. Worksheet numbering matches electronic system.**

### CHILD'S INFORMATION

**1. What will be the child's legal name (as it should appear on the stillbirth certificate)?**

First: ________________________________________

Middle: ______________________________________

Last: ________________________________________ Suffix (Jr., III, etc.): _______________

❑ First and middle name not yet chosen

(Note: If the child is unnamed, enter "Unknown" for first name and mother's current legal surname for the child's surname.)

**2. What was the time of the mother's delivery? (in 24-hour, i.e. 1:00 p.m. = 13:00)**

________ : ________
Hour Minute

**3. What is the child's sex?**

❑ Male ❑ Female

**4. What is the mother's delivery date?**

_______ /_______ /________
MM DD YYYY

### MOTHER'S INFORMATION

**10a. Mother's current legal name?**

First: ________________________________________

Middle: ______________________________________

Last: ________________________________________

**10b. What is the mother's date of birth?**

_______ /_______ /________
MM DD YYYY

**10c. Mother's name prior to first marriage?**

First: ________________________________________

Middle: ______________________________________

Last: ________________________________________

Mother's Medical Record # ____________________ Mother's name ______________________________
FOR HOSPITAL USE ONLY

**10d. In what State, U.S. territory, or foreign country was the mother born? Please specify one of the following:**

State __________

*or*

U.S. Territory ________________________
(i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas)

*or*

Foreign Country ____________________

**11. Where does the mother usually live--that is--where is the mother's household/residence located?**

Complete Number and Street: ____________________________________ Apt. Number: _____
(Do not enter rural route numbers)

City, Town, or Location: ______________________________________________

County: ____________________ State: __________ Zip Code: ________
(or U.S. Territory, Canadian Province)

Inside City Limits: ❑ Yes ❑ No

If not United States, *country*______________________________________

## FATHER'S INFORMATION

**(STOP! If mother is not married, and if a paternity acknowledgment has not been completed, leave these items blank and skip to item 19.)**

**12a. Father's current legal name?**

First: ________________________________________

Middle: _______________________________________

Last: ________________________________________ Suffix (Jr., III, etc.): ______________

**12b. What is the father's date of birth?**

_______ /_______ /________
MM DD YYYY

**12c. In what State, U.S. territory, or foreign country was the father born? Please specify one of the following:**

State __________

*or*

U.S. Territory ________________________
(i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas)

*or*

Foreign Country ____________________

## MOTHER'S BACKGROUND

**19. What is the highest level of schooling that the mother will have completed at the time of delivery?** (Check the box that best describes her education. If she is currently enrolled, check the box that indicates the previous grade or highest degree received.)

❑ 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)

**20. Is the mother of Hispanic origin? (Please check one or more)**

❑ No, not Spanish/Hispanic/Latina
❑ Yes, Mexican, Mexican American, Chicana
❑ Yes, Puerto Rican

- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Colombian)
  (Specify)_____________________________________________

**21. What is the mother's race?** (Please check *one or more races* to indicate what race mother considers herself 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. Was the mother married at the time the child was conceived, at the time of birth, or at any time between conception and giving birth?**

❑ Yes ❑ No

**23. Total number of prenatal care visits for this pregnancy? (Estimate if necessary, if none enter zero)**

__________

**24a. What is the date of the first prenatal care visit?**

_______ /_______ /________
MM DD YYYY

**24b. What is the date of the last prenatal care visit?**

_______ /_______ /________
MM DD YYYY

**25. What is the mother's height?**

________ feet _______ inches

**26. What was the mother's weight prior to pregnancy, that is, your weight immediately before the mother became pregnant with this child?**

__________ lbs.

**27. What was the mother's weight at delivery?**

__________ lbs.

**28. Did the mother receive WIC (Women, Infants & Children) food because she was pregnant with this child?**

❑ Yes ❑ No

**29a.-b. What was the number of previous live births? (If none, enter zero.)**

a. Now Living __________
b. Now Dead __________

**29c. What was the date of the last live birth?**

_______ /_______ /________
MM DD YYYY

Mother's Medical Record # ____________________ Mother's name ____________________________________
FOR HOSPITAL USE ONLY

**30a. What was the number of other pregnancy outcomes?**
(Include fetal losses of any gestational age-spontaneous losses, induced losses, and/or ectopic pregnancies.)

Other Outcomes __________

**30b. What was the date of the last other pregnancy outcome?**

_______ /_______ /________
MM DD YYYY

**31. How many cigarettes OR packs of cigarettes did the mother smoke on an average day during each of the following time periods? If the mother NEVER smoked, enter zero for each time period.**

| | **# of cigarettes*** | | **# of packs** |
|---|---|---|---|
| Three months before pregnancy | ____________ | OR | ____________ |
| First three months of pregnancy | ____________ | OR | ____________ |
| Second three months of pregnancy | ____________ | OR | ____________ |
| Third trimester of pregnancy | ____________ | OR | ____________ |

***refers to tobacco products only, NOT e-cigarettes.**

**32. What was the date last normal menses began?**

_______ /_______ /________
MM DD YYYY

**33. Was this birth a plurality?** (If so, specify twin, triplet, etc. and birth order.)

- ❑ No
- ❑ Yes
  - (Specify) ________________________________________
  - Birth order (First, second, third, etc.) ____________________

**35. Was the mother transferred for maternal medical or fetal indications for delivery?**

- ❑ No
- ❑ Yes
  - Facility mother transferred from __________________________________

## INFORMANT INFORMATION

**If other than the mother, what is the name of the person providing information for this worksheet?**

First: ___________________________________________

Middle: _________________________________________

Last: ___________________________________________ Suffix (Jr., III, etc.): _______________

**What is your relationship to the baby's mother?**

- ❑ Father of baby
- ❑ Hospital employee
- ❑ Other relative
- ❑ Other (Specify) ______________________________________

*****MUST BE SIGNED BELOW*****

**(Note: This portion of the worksheet must be signed by the mother and the father (if mother is married), as well as by the person who certified the birth of the child.)**

| | |
|---|---|
| **Mother Signature:** ____________________________________________________ | **Date:** ____________ |
| **Father Signature:** ____________________________________________________ | **Date:** ____________ |
| **Certifier Signature:** __________________________________________________ | **Date:** ____________ |

Mother's Medical Record # ____________________ Mother's name ____________________________________
FOR HOSPITAL USE ONLY

# BIRTHING FACILITY SECTION

**For detailed definitions, instructions, information on sources, and common key words and abbreviations please see the CDC's "Guide to Completing Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death".**

**All birth certificate information reported for the mother should be for the woman who delivered the infant. In cases of surrogacy or gestational carrier, the information reported should be that for the surrogate or the gestational carrier, that is, the woman who delivered the infant.**

**PLEASE PRINT CLEARLY**

**Please fill out the complete form and leave no blanks unless otherwise instructed. Worksheet numbering matches electronic system.**

## FACILITY INFORMATION

**5. What is the name of the birth facility where the delivery took place? (If delivery occurred at home, list home address.)**

Facility Name: ___________________________________________

**6. In what city, town, or location did the delivery take place?**

City, Town, or Location: ________________________

**7. What is the zip code of the delivery location?**

Zip Code: ________________________

**8. In what county did the delivery take place?**

County: ________________________

**9. Place where the delivery occurred?** (Check one)

- ❑ Hospital
- ❑ Freestanding Birthing Center
- ❑ Home Delivery
  - Planned to deliver at home?
    - ❑ Yes
    - ❑ No
- ❑ Clinic/Doctor's Office
- ❑ Other (specify) ________________________________________

## DISPOSITION INFORMATION

**13a. What is the method of disposition?**

- ❑ Burial
- ❑ Cremation
- ❑ Hospital Disposition
- ❑ Donation
- ❑ Removal from State
- ❑ Other, (specify) ____________________________________

**13b. What is the place of disposition?** (Name of cemetery, crematory, etc.)

Name: ____________________________________

**13c. What is the location of disposition?**

City/Town and State: ________________________

Mother's Medical Record # ____________________ Mother's name ____________________________________
FOR HOSPITAL USE ONLY

## ATTENDANT AND REGISTRATION INFORMATION

**14. What is Attendant's name, title, license number and N.P.I.** (National Provider Identifier)**?** (The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician should be reported as the attendant. If the obstetrician is not physically present, the intern or nurse midwife should be reported as the attendant.)

__________________________________ ______________________
Attendant's name N.P.I.

__________________________________
Attendant's License Number (If applicable)

**Attendant's title:**

- ❑ M.D. - (Doctor of medicine)
- ❑ D.O. - (Doctor of osteopathy)
- ❑ Hospital administrator or designee
- ❑ CNM/CM (Certified Nurse Midwife or Certified Midwife)
- ❑ Other midwife (midwife other than CNM/CM)
- ❑ Other (specify) ____________________

**15. What is the Certifier's name and title?**
(The individual who certifies to the fact that the birth occurred. May be, but need not be, the same as the attendant at birth.)

Certifier Name: _____________________________________

- ❑ M.D. - (Doctor of medicine)
- ❑ D.O. - (Doctor of osteopathy)
- ❑ Hospital administrator or designee
- ❑ CNM/CM (Certified Nurse Midwife or Certified Midwife)
- ❑ Other midwife (midwife other than CNM/CM)
- ❑ Other (specify) ____________________

**16. Date certified:** _______ /_______ /________
MM DD YYYY

## CAUSE OF FETAL DEATH INFORMATION

**18a. What was the initiating cause/condition?**

- ❑ Maternal Conditions/Diseases
- ❑ Rupture of Membranes Prior to Onset of Labor
- ❑ Abruptio Placenta
- ❑ Placental Insufficiency
- ❑ Prolapsed Cord
- ❑ Chorioamnionitis
- ❑ Other Complications of Placenta, Cord, or Membranes
- ❑ Other Obstetrical or Pregnancy Complications
- ❑ Fetal Anomaly
- ❑ Fetal Injury
- ❑ Fetal Infection
- ❑ Other Fetal Conditions/Disorders
- ❑ Unknown

**18b. Are there any other significant causes/conditions?** (Check all that apply)

- ❑ Maternal Conditions/Diseases
- ❑ Rupture of Membranes Prior to Onset of Labor
- ❑ Abruptio Placenta
- ❑ Placental Insufficiency
- ❑ Prolapsed Cord
- ❑ Chorioamnionitis
- ❑ Other Complications of Placenta, Cord, or Membranes
- ❑ Other Obstetrical or Pregnancy Complications
- ❑ Fetal Anomaly
- ❑ Fetal Injury
- ❑ Fetal Infection
- ❑ Other Fetal Conditions/Disorders
- ❑ Unknown

**18c. What is the weight of the fetus?** (Grams preferred) __________________________

Mother's Medical Record # ____________________ Mother's name ____________________________________
FOR HOSPITAL USE ONLY

**18d. What was the obstetric estimate of gestation at delivery?** (Completed weeks) ___________

**18e. What was the estimated time of stillbirth?**

- ❑ 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

**18f. Was an autopsy performed?**

❑ Yes ❑ No

**18g. Was a histological placental examination performed?**

❑ Yes ❑ No

## MEDICAL AND HEALTH INFORMATION

**36. Risk factors in this pregnancy:** (Check all that apply)

- ❑ Diabetes - (Glucose intolerance requiring treatment; if diabetes is present, check either prior to pregnancy or gestational, do not check both.)
  - ❑ Prior to pregnancy - (Diabetes diagnosed prior to this pregnancy)
  - ❑ Gestational - (Diabetes diagnosed in this pregnancy)
- ❑ Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition; if hypertension is present, check either prior to pregnancy or gestational, do not check both.)
  - ❑ Prior to pregnancy - (Chronic) (Hypertension diagnosed prior to the onset of this pregnancy)
  - ❑ Gestational - (PIH, preeclampsia) (Hypertension diagnosed during this pregnancy)
  - ❑ Eclampsia - (Hypertension with proteinuria with generalized seizures or coma. May include pathologic edema. If eclampsia is present, either prior to pregnancy or gestational hypertension may be checked.)
- ❑ Previous preterm births - (History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation)
- ❑ Other previous poor pregnancy outcome (Includes Perinatal Death, Small-for-Gestational Age/Intrauterine Growth Restricted Birth)
- ❑ Pregnancy resulted from infertility treatment - (Any assisted reproduction treatment used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology procedures (e.g., IVF, GIFT and ZIFT).)
  If yes, check all that apply:
  - ❑ Fertility-enhancing drugs, artificial insemination or intrauterine insemination - (Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.)
  - ❑ Assisted reproductive technology - (Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT)) used to initiate the pregnancy.)
- ❑ Mother had a previous cesarean delivery - (Previous delivery by extracting the fetus, placenta and membranes through an incision in the mother's abdominal and uterine walls.)
  If Yes, how many? ________
- ❑ None of the above
- ❑ Unknown

**37. Infections present and/or treated during this pregnancy**: (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.)
(Check all that apply)

- ❑ Gonorrhea - (a positive test or culture for *Neisseria gonorrhoeae*)
- ❑ Syphilis - (also called lues - a positive test for *Treponema pallidum*)
- ❑ Chlamydia - (a positive test for Chlamydia *trachomatis*)
- ❑ Listeria
- ❑ Group B Streptococcus
- ❑ Cytomegalovirus
- ❑ Parvovirus
- ❑ Toxoplasmosis
- ❑ None of the above
- ❑ Other (specify) ______________________________________
- ❑ Unknown

**38. Method of delivery:** (The physical process by which the complete delivery of the infant was effected.)

Was delivery with forceps attempted but unsuccessful?

❑ Yes ❑ No

Was delivery with vacuum extraction attempted but unsuccessful?

- ❑ Yes ❑ No

Fetal presentation at birth: (Check one)

- ❑ Cephalic - (Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP).)
- ❑ Breech - (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech.)
- ❑ Other - (Any other presentation not listed above, i.e., shoulder, funis, transverse lie, compound.)
- ❑ Unknown

Final route and method of delivery: (Check one)

- ❑ Vaginal/Spontaneous - (Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.)
- ❑ Vaginal/Forceps - (Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.)
- ❑ Vaginal/Vacuum - (Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.)
- ❑ Cesarean - (Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.)

  If cesarean, was a trial of labor attempted? - (Labor was allowed, augmented or induced with plans for a vaginal delivery.)

  - ❑ Yes ❑ No
- ❑ Unknown

**39. Maternal morbidity:** (Serious complications experienced by the mother associated with labor and delivery) (Check all that apply)

- ❑ Maternal transfusion - (Includes infusion of whole blood or packed red blood cells associated with labor and delivery.)
- ❑ Third- or fourth-degree perineal laceration - (3° laceration extends through the perineal skin, vaginal mucosa, perineal body and partially or completely through the anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- ❑ Ruptured uterus - (Tearing of the uterine wall. A full-thickness disruption of the uterine wall that also involves the overlaying visceral peritoneum (uterine serosa). Does not include uterine dehiscence in which the fetus, placenta, and umbilical cord remain contained with the uterine cavity. Does not include a silent or incomplete rupture or an asymptomatic separation.)
- ❑ Unplanned hysterectomy - (Surgical removal of the uterus that was not planned prior to the admission. Includes an anticipated, but not definitively planned, hysterectomy.)
- ❑ Admission to intensive care unit - (Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care.)
- ❑ Unplanned operating room procedure following delivery
- ❑ None of the above
- ❑ Unknown

**40. Congenital anomalies of the newborn:** (Malformations of the newborn diagnosed prenatally or after delivery.) (Check all that apply)

- ❑ Anencephaly - (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).)
- ❑ Meningomyelocele/Spina bifida - (Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. <u>Do not</u> include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).)
- ❑ Cyanotic congenital heart disease - (Congenital heart defects which cause cyanosis.)
- ❑ Congenital diaphragmatic hernia - (Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.)
- ❑ Omphalocele - (A defect in the anterior abdominal wall in which the umbilical ring is widened, allowing herniation of abdominal organs into the umbilical cord. The herniating organs are covered by a nearly transparent membranous sac (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. <u>Do not</u> include umbilical hernia (completely covered by skin) in this category.)
- ❑ Gastroschisis - (An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.)
- ❑ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) - (Complete or partial absence of a portion of an extremity associated with failure to develop.)
- ❑ Cleft Lip with or without Cleft Palate - (Incomplete closure of the lip. May be unilateral, bilateral or median.)
- ❑ Cleft Palate alone - (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without Cleft Palate" category above.)
- ❑ Down Syndrome - (Trisomy 21 – A chromosomal abnormality caused by the presence of all or part of a third copy of chromosome 21.)

Mother's Medical Record # ____________________ Mother's name ____________________________________
FOR HOSPITAL USE ONLY

- ❑ Karyotype confirmed
- ❑ Karyotype pending

❑ Suspected chromosomal disorder - (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.)
- ❑ Karyotype confirmed
- ❑ Karyotype pending

❑ Hypospadias - (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.)

❑ None of the above

❑ Other (specify) ____________________________________

❑ Unknown

*****MUST BE SIGNED BELOW*****

**(Note: This portion of the worksheet must be signed by the person who attended the birth of the child.)**

| **Attendant Signature:** ______________________________________________ | **Date:** ____________ |
|---|---|

**All non-birthing facilities, midwives, and coroners who cannot register this stillbirth electronically through KY-CHILD must send this completed worksheet, with all required signatures, to:**

**Kentucky Office of Vital Statistics**
**275 East Main, 1E-A**
**Frankfort, KY 40621**