Rhode Island Department of Health

Instructions to Complete a Fetal Death Form for Under 20 Weeks Gestational Age

Presented by:
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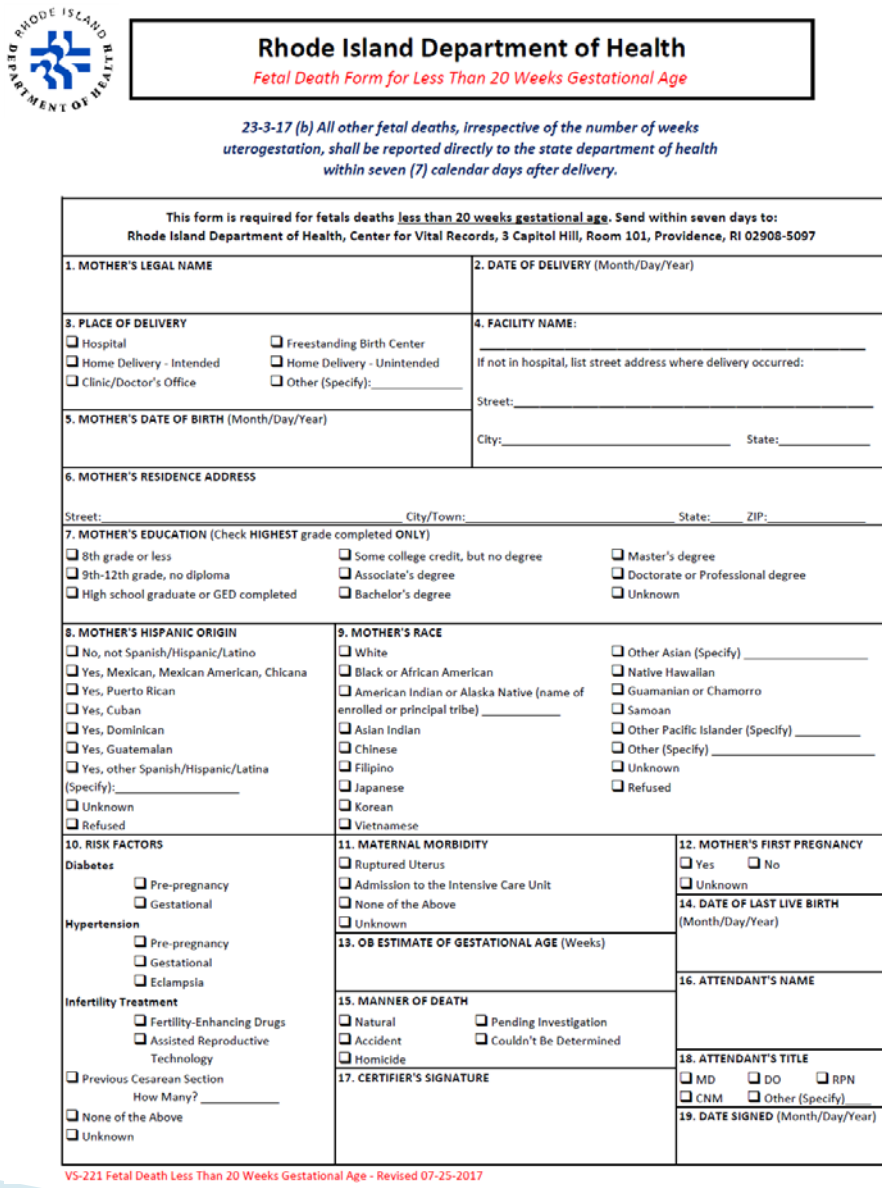
Fetal Death Form for Under 20 Weeks Gestational Age



Rhode Island Department of Health

Fetal Death Form for Less Than 20 Weeks Gestational Age

23-3-17 (b) All other fetal deaths, irrespective of the number of weeks uterogestation, shall be reported directly to the state department of health within seven (7) calendar days after delivery.

This form is required for fetals deaths less than 20 weeks gestational age. Send within seven days to:
Rhode Island Department of Health, Center for Vital Records, 3 Capitol Hill, Room 101, Providence, RI 02908-5097

1. MOTHER'S LEGAL NAME

2. DATE OF DELIVERY (Month/Day/Year)

3. PLACE OF DELIVERY
- ❑ Hospital
- ❑ Freestanding Birth Center
- ❑ Home Delivery - Intended
- ❑ Home Delivery - Unintended
- ❑ Clinic/Doctor's Office
- ❑ Other (Specify):_____

4. FACILITY NAME:
_____
If not in hospital, list street address where delivery occurred:
Street:_____
City:_____ State:_____

5. MOTHER'S DATE OF BIRTH (Month/Day/Year)

6. MOTHER'S RESIDENCE ADDRESS
Street:_____ City/Town:_____ State:_____ ZIP:_____

7. MOTHER'S EDUCATION (Check **HIGHEST** grade completed **ONLY**)
- ❑ 8th grade or less
- ❑ 9th-12th grade, no diploma
- ❑ High school graduate or GED completed
- ❑ Some college credit, but no degree
- ❑ Associate's degree
- ❑ Bachelor's degree
- ❑ Master's degree
- ❑ Doctorate or Professional degree
- ❑ Unknown

8. MOTHER'S HISPANIC ORIGIN
- ❑ No, not Spanish/Hispanic/Latino
- ❑ Yes, Mexican, Mexican American, Chicana
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Dominican
- ❑ Yes, Guatemalan
- ❑ Yes, other Spanish/Hispanic/Latina (Specify):_____
- ❑ Unknown
- ❑ Refused

9. MOTHER'S RACE
- ❑ 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) _____
- ❑ Unknown
- ❑ Refused

10. RISK FACTORS

Diabetes
- ❑ Pre-pregnancy
- ❑ Gestational

Hypertension
- ❑ Pre-pregnancy
- ❑ Gestational
- ❑ Eclampsia

Infertility Treatment
- ❑ Fertility-Enhancing Drugs
- ❑ Assisted Reproductive Technology

- ❑ Previous Cesarean Section
  How Many? _____
- ❑ None of the Above
- ❑ Unknown

11. MATERNAL MORBIDITY
- ❑ Ruptured Uterus
- ❑ Admission to the Intensive Care Unit
- ❑ None of the Above
- ❑ Unknown

13. OB ESTIMATE OF GESTATIONAL AGE (Weeks)

15. MANNER OF DEATH
- ❑ Natural
- ❑ Pending Investigation
- ❑ Accident
- ❑ Couldn't Be Determined
- ❑ Homicide

17. CERTIFIER'S SIGNATURE

12. MOTHER'S FIRST PREGNANCY
- ❑ Yes ❑ No
- ❑ Unknown

14. DATE OF LAST LIVE BIRTH (Month/Day/Year)

16. ATTENDANT'S NAME

18. ATTENDANT'S TITLE
- ❑ MD ❑ DO ❑ RPN
- ❑ CNM ❑ Other (Specify)____

19. DATE SIGNED (Month/Day/Year)

VS-221 Fetal Death Less Than 20 Weeks Gestational Age - Revised 07-25-2017

Fetal Death Form for Under 20 Weeks Gestational Age

1. MOTHER'S LEGAL NAME	**2. DATE OF DELIVERY** (Month/Day/Year)
3. PLACE OF DELIVERY ❑ Hospital ❑ FreeStanding Birth Center ❑ Home Delivery - Intended ❑ Home Delivery - Unintended ❑ Clinic/Doctor's Office ❑ Other (Specify):_____	**4. FACILITY NAME:** _____ If not in hospital, list street address where delivery occurred: Street:_____
5. MOTHER'S DATE OF BIRTH (Month/Day/Year)	City:_____ State:_____

1. **MOTHER'S LEGAL NAME:** Enter the mother's full first, middle, and last current legal name.

2. **DATE OF DELIVERY:** Enter the date the fetal death occurred. This should be the date the fetus was removed from the mother either by expulsion or extraction.

3. **PLACE OF DELIVERY:** Select the location where the fetus was removed from the mother either by expulsion or extraction.

4. **FACILITY NAME**: Enter the name of the facility/hospital where the fetal death occurred. If fetal death did not occur in a facility, enter the address where the fetal death occurred. Do not enter villages.

5. **MOTHER'S DATE OF BIRTH:** Enter the mother's date of birth.

Fetal Death Form for Under 20 Weeks Gestational Age

6. MOTHER'S RESIDENCE ADDRESS

Street:_____ City/Town:_____ State:____ Zip:_____

7. MOTHER'S EDUCATION (Check **HIGHEST** grade completed **ONLY**)

❑ 8th grade or less	❑ Some college credit, but no degree	❑ Master's degree
❑ 9th-12th grade, no diploma	❑ Associate's degree	❑ Doctorate or Professional degree
❑ High school graduate or GED completed	❑ Bachelor's degree	❑ Unknown

8. MOTHER'S HISPANIC ORIGIN

- ❑ No, not Spanish/Hispanic/Latino
- ❑ Yes, Mexican, Mexican American, Chicana
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, Dominican
- ❑ Yes, Guatemalan
- ❑ Yes, other Spanish/Hispanic/Latina (Specify):_____
- ❑ Unknown
- ❑ Refused

9. MOTHER'S RACE

❑ White	❑ Other Asian (Specify) _____
❑ Black or African American	❑ Native Hawaiian
❑ American Indian or Alaska Native (name of enrolled or principal tribe) _____	❑ Guamanian or Chamorro
	❑ Samoan
❑ Asian Indian	❑ Other Pacific Islander (Specify) _____
❑ Chinese	❑ Other (Specify) _____
❑ Filipino	❑ Unknown
❑ Japanese	❑ Refused
❑ Korean	
❑ Vietnamese	

6. **MOTHER'S RESIDENCE ADDRESS**: Enter the address where the mother currently resides. PO boxes may not be entered. Do not enter villages. If mother resides outside the US, enter the country in place of state.

7. **MOTHER'S EDUCATION:** Select the highest level of education completed by the mother at the time of the fetal demise. If unknown, select unknown.

8. **MOTHER'S HISPANIC ORIGIN:** Select the Hispanic origin of the mother. If not Hispanic, select No, not Spanish/Hispanic/Latino**.** If unknown, select unknown.

9. **MOTHER'S RACE:** Select the Race(s) of the mother which best describes what she considers herself to be. If the mother is of mixed race, enter all that apply. If unknown, select unknown.

Fetal Death Form for Under 20 Weeks Gestational Age

10. RISK FACTORS

Diabetes

- ❑ Pre-pregnancy
- ❑ Gestational

Hypertension

- ❑ Pre-pregnancy
- ❑ Gestational
- ❑ Eclampsia

Infertility Treatment

- ❑ Fertility-Enhancing Drugs
- ❑ Assisted Reproductive Technology

❑ Previous Cesarean Section
How Many? _____

❑ None of the Above

❑ Unknown

11. MATERNAL MORBIDITY

- ❑ Ruptured Uterus
- ❑ Admission to the Intensive Care Unit
- ❑ None of the Above
- ❑ Unknown

13. OB ESTIMATE OF GESTATIONAL AGE (Weeks)

15. MANNER OF DEATH

- ❑ Natural
- ❑ Accident
- ❑ Homicide
- ❑ Pending Investigation
- ❑ Couldn't Be Determined

17. CERTIFIER'S SIGNATURE

12. MOTHER'S FIRST PREGNANCY

❑ Yes ❑ No
❑ Unknown

14. DATE OF LAST LIVE BIRTH
(Month/Day/Year)

16. ATTENDANT'S NAME

18. ATTENDANT'S TITLE

❑ MD ❑ DO ❑ RPN
❑ CNM ❑ Other (Specify)____

19. DATE SIGNED (Month/Day/Year)

VS-221 Fetal Death Less Than 20 Weeks Gestational Age - Revised 07-25-2017

10. <u>RISK FACTORS</u>: Select any risk factors which occurred during this pregnancy. If the patient had more than one risk factor, check all that apply. If none, select none of the above. If unknown, select unknown.

11. <u>MATERNAL MORBIDITY</u>: Select any complications experienced by the mother associated with labor and delivery. If the patient had more than one complication, check all that apply. If none, select none of the above. If unknown, select unknown.

12. <u>MOTHER'S FIRST PREGNANCY</u>: Select Yes, No, or Unknown.

Fetal Death Form for Under 20 Weeks Gestational Age

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- ❑ Gestational

Hypertension

- ❑ Pre-pregnancy
- ❑ Gestational
- ❑ Eclampsia

Infertility Treatment

- ❑ Fertility-Enhancing Drugs
- ❑ Assisted Reproductive Technology

❑ Previous Cesarean Section
How Many? _____

❑ None of the Above

❑ Unknown

11. MATERNAL MORBIDITY

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- ❑ Accident
- ❑ Homicide
- ❑ Pending Investigation
- ❑ Couldn't Be Determined

17. CERTIFIER'S SIGNATURE

12. MOTHER'S FIRST PREGNANCY

❑ Yes ❑ No
❑ Unknown

14. DATE OF LAST LIVE BIRTH
(Month/Day/Year)

16. ATTENDANT'S NAME

18. ATTENDANT'S TITLE

❑ MD ❑ DO ❑ RPN
❑ CNM ❑ Other (Specify)____

19. DATE SIGNED (Month/Day/Year)

VS-221 Fetal Death Less Than 20 Weeks Gestational Age - Revised 07-25-2017

13. <u>OB EST OF GESTATIONAL AGE</u>: Enter the best estimate of the gestational age of the fetus. If unknown but within a specific range, enter the range. If unknown, enter unknown.

14. <u>DATE OF LAST LIVE BIRTH</u>: Enter the date of the last live birth, regardless if that birth is still living or deceased.

Fetal Death Form for Under 20 Weeks Gestational Age

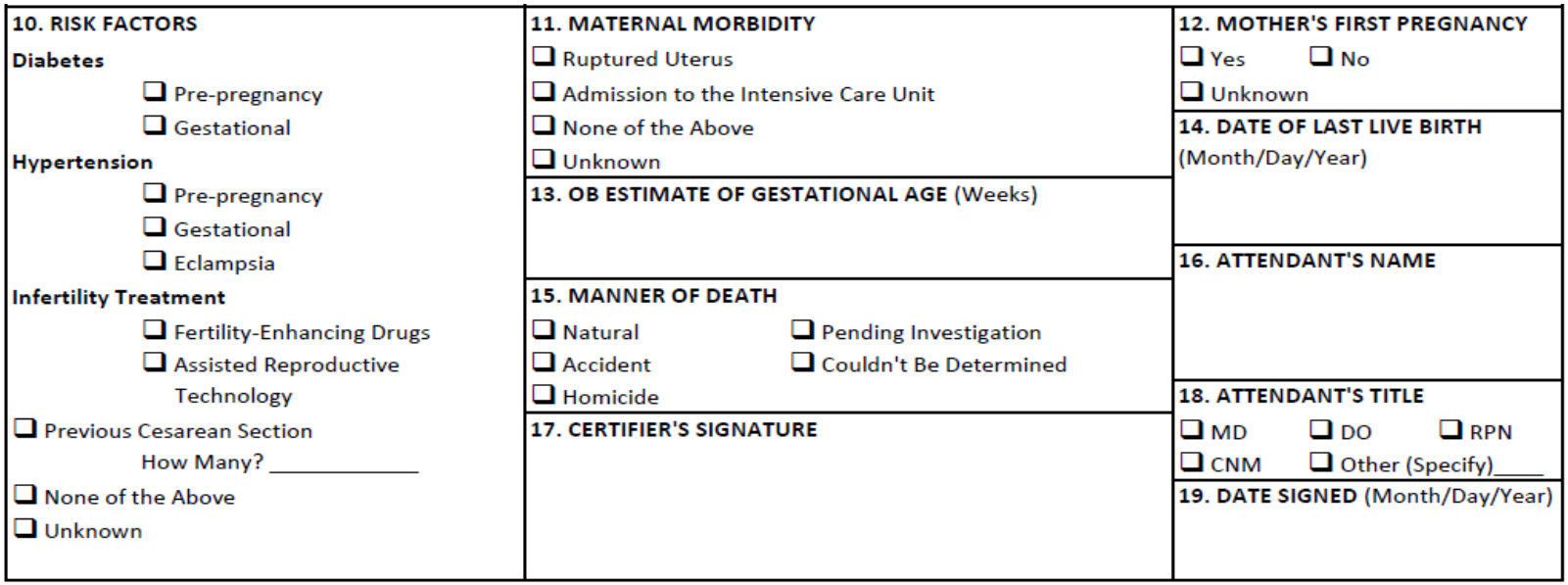
10. RISK FACTORS	11. MATERNAL MORBIDITY	12. MOTHER'S FIRST PREGNANCY
Diabetes ❑ Pre-pregnancy ❑ Gestational **Hypertension** ❑ Pre-pregnancy ❑ Gestational ❑ Eclampsia **Infertility Treatment** ❑ Fertility-Enhancing Drugs ❑ Assisted Reproductive Technology ❑ Previous Cesarean Section How Many? _____ ❑ None of the Above ❑ Unknown	❑ Ruptured Uterus ❑ Admission to the Intensive Care Unit ❑ None of the Above ❑ Unknown **13. OB ESTIMATE OF GESTATIONAL AGE** (Weeks) **15. MANNER OF DEATH** ❑ Natural ❑ Pending Investigation ❑ Accident ❑ Couldn't Be Determined ❑ Homicide **17. CERTIFIER'S SIGNATURE**	❑ Yes ❑ No ❑ Unknown **14. DATE OF LAST LIVE BIRTH** (Month/Day/Year) **16. ATTENDANT'S NAME** **18. ATTENDANT'S TITLE** ❑ MD ❑ DO ❑ RPN ❑ CNM ❑ Other (Specify)____ **19. DATE SIGNED** (Month/Day/Year)

VS-221 Fetal Death Less Than 20 Weeks Gestational Age - Revised 07-25-2017

15. <u>MANNER OF DEATH</u>: Select the Manner of Death. If the fetal death is due to or suspected of being either an Accident or Homicide, it is required to be referred to the Medical Examiner's Office. Rhode Island law and "Regulations Governing the Medical Examiner System" require the following events to be reported to the Office of State Medical Examiners [R23-4-ME]:

- Fetal deaths or pregnancy losses where a toxic drug or poison (cocaine, heroin, amphetamine, or any other illicit or prescribed medication) has been abused by the mother; where there is a past history of drug addiction, and/or where laboratory findings indicate the presence of such substances.
- Stillbirths occurring outside a hospital or when the mother was involved in a recent or past traumatic event (motor vehicle crash, suicide attempt, etc.) that may have precipitated the delivery.

Fetal Death Form for Under 20 Weeks Gestational Age



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Hypertension
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- ❑ Eclampsia

Infertility Treatment
- ❑ Fertility-Enhancing Drugs
- ❑ Assisted Reproductive Technology

❑ Previous Cesarean Section
How Many? _____

❑ None of the Above

❑ Unknown

11. MATERNAL MORBIDITY
- ❑ Ruptured Uterus
- ❑ Admission to the Intensive Care Unit
- ❑ None of the Above
- ❑ Unknown

13. OB ESTIMATE OF GESTATIONAL AGE (Weeks)

15. MANNER OF DEATH
- ❑ Natural
- ❑ Accident
- ❑ Homicide
- ❑ Pending Investigation
- ❑ Couldn't Be Determined

17. CERTIFIER'S SIGNATURE

12. MOTHER'S FIRST PREGNANCY
- ❑ Yes ❑ No
- ❑ Unknown

14. DATE OF LAST LIVE BIRTH (Month/Day/Year)

16. ATTENDANT'S NAME

18. ATTENDANT'S TITLE
- ❑ MD ❑ DO ❑ RPN
- ❑ CNM ❑ Other (Specify)____

19. DATE SIGNED (Month/Day/Year)

VS-221 Fetal Death Less Than 20 Weeks Gestational Age - Revised 07-25-2017

16. <u>NAME OF ATTENDING PHYSICIAN</u>: Enter the full name of the attending physician.

17. <u>CERTIFIER'S SIGNATURE:</u> The certifier needs to sign the form, certifying that the event took place on the date stated.

18. <u>TITLE OF ATTENDING PHYSICIAN</u>: Enter the title of the attending physician: MD, DO, RPN, CNM or Other (Specify). If Other, please Specify

19. <u>DATE SIGNED:</u> Enter the date the certifier signed the form.

APPENDIX A: 39 City & Towns

- Barrington
- Bristol
- Burrillville
- Central Falls
- Charlestown
- Coventry
- Cranston
- Cumberland
- East Greenwich
- East Providence
- Exeter
- Foster
- Glocester
- Hopkinton
- Jamestown
- Johnston
- Lincoln
- Little Compton
- Middletown
- Narragansett
- Newport
- New Shoreham
- North Kingstown
- North Providence
- North Smithfield
- Pawtucket
- Portsmouth
- Providence
- Richmond
- Scituate
- Smithfield
- South Kingstown
- Tiverton
- Warren
- Warwick
- Westerly
- West Greenwich
- West Warwick
- Woonsocket

TITLE 23
Health and Safety

CHAPTER 23-3
Vital Records

SECTION 23-3-17

§ 23-3-17 Fetal death registration. – (a) A fetal death certificate for each fetal death which occurs in this state after a gestation period of twenty (20) completed weeks or more shall be filed with the state registrar of vital records or as otherwise directed by the state registrar within seven (7) calendar days after the delivery and prior to removal of the fetus from the state, and shall be registered if it has been completed and filed in accordance with this section; provided:

(1) That if the place of fetal death is unknown, a fetal death certificate shall be filed with the state registrar of vital records or as otherwise directed by the state registrar within seven (7) calendar days after the occurrence; and

(2) That if a fetal death occurs on a moving conveyance, a fetal death certificate shall be filed with the state registrar of vital records or as otherwise directed by the state registrar.

(b) All other fetal deaths, irrespective of the number of weeks uterogestation, shall be reported directly to the state department of health within seven (7) calendar days after delivery.

(c) The funeral director, his or her duly authorized agent, or another person acting as agent, who first assumes custody of a fetus, shall file the fetal death certificate. In the absence of a funeral director or agent, the physician or another person in attendance at or after delivery shall file the certificate of fetal death. He or she shall obtain the personal data from the next of kin or the best qualified person or source available. He or she shall obtain the medical certification of cause of death from the person responsible for the certification.

Fetal Death Registration (Cont…)

d) The medical certification shall be completed and signed within forty-eight (48) hours after delivery by the physician in attendance at or after delivery except when inquiry is required by chapter 4 of this title.
(e) When a fetal death occurs without medical attendance upon the mother at or after the delivery or when inquiry is required by chapter 4 of this title, the medical examiner shall investigate the cause of fetal death and shall complete and sign the medical certification within forty-eight (48) hours after taking charge of the case.
(f) Each funeral director shall, on or before the tenth (10th) day of the following month, file a report with the state registrar of vital records listing funerals and/or decedents serviced following deaths or fetal deaths within the month. Failure to file these reports or any of the certificates required under § 23-3-16 and this section within the prescribed time limits shall be grounds for disciplinary action, including revocation of license by the state board of examiners in embalming.

History of Section.
(P.L. 1961, ch. 87, § 1; P.L. 1976, ch. 293, § 1; P.L. 1977, ch. 110, § 1; P.L. 2000, ch. 164, § 1.)

Contact Information

- Ana Tack – Fetal Death Registration Manager
- (401) 222-5165
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- Richard Missaghian – Training and Development Manager
- (401) 222-8051
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