VIRGINIA DIVISION OF VITAL RECORDS & HEALTH STATISTICS FETAL DEATH TRAINING MANUAL

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Fetal Death Training Manual Table of Contents

Page 1. Virginia Code §32.1-249, Definitions, (including definition of a Fetal Death)
Page 2. Virginia Code §32.1-258.1, Certificate of Birth Resulting in Stillbirth, requirements
Page 3. Virginia Code §32.1-263, Filing Death Certificates
Page 4. Virginia Code §32.1-264, Reports of Fetal Deaths
Page 5. Virginia Code §32.1-274, Persons in Charge of Institutions & Funeral Directors
Page 6. Virginia Code §32.1-275.1, Matching of Birth & Death Certificates
Page 7. Virginia Administrative Code, (VAC) §12VAC5-550-110, Death Certificate Items
Page 8. VAC §12VAC5-550-120, Fetal Death or Induced Termination of Pregnancy, report items
Page 9. VAC §12VAC5-550-125, Certificate of Birth resulting in a Stillbirth
Page 10. VAC §12VAC5-550-150, Requirements for Completion
Page 11. VAC §12VAC5-550-180, Acceptance of Certificates
Page 12. VAC §VAC5-550-190, Local records
Page 13. VAC §VAC5-550-350, Proper & Complete Medical Certification of Cause of Death
Pages 14-15. VAC §VAC5-550-360, Responsibility of the Attending Physician
Page 16. VAC §VAC5-550-370, Responsibility of the Medical Examiner
Page 17. VAC §VAC5-550-380, Responsibility of the Hospital or Institution
Pages 18-19. VAC §VAC5-550-390, Responsibility of the Funeral Service Licensee
Page 20 VAC §VA54.1-2957.02 When nurse practitioner signature accepted

Additional Guides/Forms & Worksheets

Guide to Completing the Report of Spontaneous Fetal Death, (Form VS 5, pages 1-4)
Copy of the Report of Spontaneous Fetal Death, (Form VS 5)
Instructions for filling out the Vital Statistics Monthly Fetal Death Report Form (VS34)
Copy of Vital Statistics Monthly Fetal Death Report, (Form VS34, revised March 2007)
Completion of Fetal Death Worksheet & Labor & Delivery patient's Worksheet
Hospitals/Facility Fetal Death Worksheet
Mother's Information Worksheet
Patient's Worksheet for the Report of Fetal Death
National Center for Health Statistics Patient's Worksheet for the Report of Fetal Death, (Pages 1-5)
National Center for Health Statistics Facility Worksheet for the Report of Fetal Death, (Pages 1-9)
National Center for Health Statistics Spainish Patient's Worksheet for the Report of Fetal Deaths, (Pages 1-5)
Frequently asked Questions and Answers

§ 32.1-249. Definitions

As used in this chapter: 1. "Dead body" means a human body or such parts of such human body from the condition of which it reasonably may be concluded that death recently occurred. 2. "Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, regardless of the duration of pregnancy; death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. a. "Induced termination of pregnancy" means the intentional interruption of pregnancy with the intention to produce other than a live-born infant or to remove a dead fetus and which does not result in a live birth. b. "Spontaneous fetal death" means the expulsion or extraction of a product of human conception resulting in other than a live birth and which is not an induced termination of pregnancy. 3. "File" means the presentation of a vital record provided for in this chapter for registration by the Department. 4. "Final disposition" means the burial, interment, cremation, removal from the Commonwealth or other authorized disposition of a dead body or fetus. 5. "Institution" means any establishment, public or private, which provides inpatient medical, surgical, or diagnostic care or treatment, or nursing, custodial or domiciliary care, or to which persons are committed by law. 6. "Live birth" means the complete or substantial expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. "Substantial expulsion or extraction" means, in the case of a headfirst presentation, the infant's entire head is outside the body of the mother or, in the case of a breech delivery, when any part of the infant's trunk past the navel is outside the body of the mother. 7. "Physician" means a person authorized or licensed to practice medicine or osteopathy in this Commonwealth. 8. "Registration" means the acceptance by the Department and the incorporation of vital records as provided for in this chapter into its official records. 9. "System of vital records" means the registration, collection, preservation, amendment, and certification of vital records; the collection of other reports required by this chapter; and related activities. 10. "Vital records" means certificates or reports of births, deaths, fetal deaths, adoptions, marriages, divorces or annulments and amendment data related thereto.

(Code 1950, § 32-353.4; 1960, c. 451; 1975, c. 267; 1979, c. 711; 1983, c. 240; 2003, cc. 961, 963.)

§ 32.1-258.1. Certificate of Birth Resulting in Stillbirth; requirements

Upon the request of either individual listed as the mother or father on a report of fetal death in the Commonwealth as defined in § 32.1-264, the State Registrar shall issue a Certificate of Birth Resulting in Stillbirth for unintended, intrauterine fetal deaths occurring after a gestational period of 20 weeks or more. The requesting mother or father may, but shall not be required to, provide a name for the stillborn child on the Certificate of Birth Resulting in Stillbirth. The Board of Health shall prescribe a reasonable fee to cover the administrative cost and preparation of such certificate. This section shall apply retroactively to any circumstances that would have resulted in the issuance of a Certificate of Birth Resulting in Stillbirth, as prescribed by the Board.

(2003, cc. 537, 552.)

32.1-263. Filing death certificates; medical certification; investigation by medical examiner

A. A death certificate, including, if known, the social security number or control number issued by the Department of Motor Vehicles pursuant to § 46.2-342 of the deceased, shall be filed for each death which occurs in this Commonwealth with the registrar of the district in which the death occurred within three days after such death and prior to final disposition or removal of the body from the Commonwealth, and shall be registered by such registrar if it has been completed and filed in accordance with the following requirements: 1. If the place of death is unknown, but the dead body is found in this Commonwealth, a death certificate shall be filed in the registration district in which the dead body is found in accordance with this section. The place where the dead body is found shall be shown as the place of death. If the date of death is unknown, it shall be determined by approximation, taking into consideration all relevant information, including but not limited to, information provided by the immediate family regarding the date and time that the deceased was last seen alive, if the individual died in his home; and 2. When death occurs in a moving conveyance, in the United States of America and the body is first removed from the conveyance in this Commonwealth, the death shall be registered in this Commonwealth and the place where it is first removed shall be considered the place of death. When a death occurs on a moving conveyance while in international waters or air space or in a foreign country or its air space and the body is first removed from the conveyance in this Commonwealth, the death shall be registered in this Commonwealth but the certificate shall show the actual place of death insofar as can be determined. B. The licensed funeral director, funeral service licensee, office of the state anatomical program, or next of kin as defined in § 54.1-2800 who first assumes custody of a dead body shall file the certificate of death with the registrar. He shall obtain the personal data, including the social security number of the deceased or control number issued to the deceased by the Department of Motor Vehicles pursuant to § 46.2-342, from the next of kin or the best qualified person or source available and obtain the medical certification from the person responsible therefor. C. The medical certification shall be completed, signed and returned to the funeral director within 24 hours after death by the physician in charge of the patient's care for the illness or condition which resulted in death except when inquiry or investigation by a medical examiner is required by § 32.1-283 or § 32.1-285.1. In the absence of the physician or with his approval, the certificate may be completed and signed by an associate physician, the chief medical officer of the institution in which death occurred, or the physician who performed an autopsy upon the decedent, if such individual has access to the medical history of the case and death is due to natural causes. D. When inquiry or investigation by a medical examiner is required by § 32.1-283 or § 32.1-285.1, the medical examiner shall investigate the cause of death and shall complete and sign the medical certification portion of the death certificate within 24 hours after being notified of the death. If the medical examiner refuses jurisdiction, the physician last furnishing medical care to the deceased shall prepare and sign the medical certification portion of the death certificate. E. If the cause of death cannot be determined within 24 hours after death, the medical certification shall be completed as provided by regulations of the Board. The attending physician or medical examiner shall give the funeral director or person acting as such notice of the reason for the delay, and final disposition of the body shall not be made until authorized by the attending physician or medical examiner.

(Code 1950, § 32-353.20; 1960, c. 451; 1978, c. 308; 1979, c. 711; 1983, c. 240; 1993, c. 965; 1997, cc. 794, 898; 2003, c. 484; 2004, c. 124.)

§ 32.1-264. Reports of fetal deaths; medical certification; investigation by medical examiner; confidentiality of information concerning abortions.

A. A fetal death report for each fetal death which occurs in this Commonwealth shall be filed, on a form furnished by the State Registrar, with the registrar of the district in which the delivery occurred or the abortion was performed within three days after such delivery or abortion and shall be registered with such registrar if it has been completed and filed in accordance with this section; provided that: 1. If the place of fetal death is unknown, a fetal death report shall be filed in the registration district in which a dead fetus was found within three days after discovery of such fetus; and 2. If a fetal death occurs in a moving conveyance, a fetal death report shall be filed in the registration district in which the fetus was first removed from such conveyance. B. The funeral director or person who first assumes custody of a dead fetus or, in the absence of a funeral director or such person, the hospital representative who first assumes custody of a fetus shall file the fetal death report; in the absence of such a person, the physician or other person in attendance at or after the delivery or abortion shall file the report of fetal death. The person completing the forms shall obtain the personal data from the next of kin or the best qualified person or source available, and he shall obtain the medical certification of cause of death from the person responsible for preparing the same as provided in this section. In the case of induced abortion, such forms shall not identify the patient by name. C. The medical certification portion of the fetal death report shall be completed and signed within twenty-four hours after delivery or abortion by the physician in attendance at or after delivery or abortion except when inquiry or investigation by a medical examiner is required. D. When a fetal death occurs without medical attendance upon the mother at or after the delivery or abortion or when inquiry or investigation by a medical examiner is required, the medical examiner shall investigate the cause of fetal death and shall complete and sign the medical certification portion of the fetal death report within twenty-four hours after being notified of a fetal death. E. The reports required pursuant to this section are statistical reports to be used only for medical and health purposes and shall not be incorporated into the permanent official records of the system of vital records. A schedule for the disposition of these reports may be provided by regulation. F. The physician or facility attending an individual who has delivered a dead fetus shall maintain a copy of the fetal death report for one year and, upon written request by the individual and payment of an appropriate fee, shall furnish the individual a copy of such report.

(Code 1950, § 32-353.21; 1960, c. 451; 1975, c. 267; 1979, c. 711; 1983, c. 240; 1987, c. 405.)

§ 32.1-274. Persons in charge of institutions and funeral directors, etc., to keep records; lists sent to State Registrar.

A. Every person in charge of an institution shall keep a record of personal data concerning each person admitted or confined to such institution. This record shall include such information as required for the certificates of birth, death, and reports of spontaneous fetal death and induced termination of pregnancy required by this chapter. The record shall be made at the time of admission from information provided by the person being admitted or confined, but when it cannot be so obtained, the information shall be obtained from relatives or other persons acquainted with the facts. The name and address of the person providing the information shall be a part of the record. B. When a dead human body is released or disposed of by an institution, the person in charge of the institution shall keep a record showing the name of the deceased, date of death, the name and address of the person to whom the body is released and the date of removal from the institution, or, if final disposal is by the institution, the date, place, and manner of disposition. C. A funeral director, embalmer, or other person who removes from the place of death or transports or is in charge of final disposition of a dead body or fetus, in addition to filing any certificate, report or form required by this chapter, shall keep a record which shall identify the body, and such information pertaining to his receipt, removal, and delivery of such body as may be prescribed in regulations adopted by the Board. D. Not later than the tenth day of the month following the month of occurrence, the administrator of each institution shall cause to be sent to the State Registrar a list showing thereon all births, deaths, and fetal deaths occurring in such institution during the preceding month. Such lists shall be on forms provided by the State Registrar. E. Not later than the tenth day of the month following the month of occurrence, each funeral director shall send to the State Registrar a list showing thereon all caskets furnished, bodies prepared for disposition and transportation and funerals performed where no casket was furnished by the funeral director during the preceding month. Such lists shall be on forms provided by the State Registrar. F. Records maintained under this section shall be retained for a period of not less than ten years and shall be made available for inspection by the State Registrar or his representative upon demand.

(Code 1950, § 32-353.29; 1960, c. 451; 1979, c. 711; 1983, c. 240.)

§ 32.1-275.1. Matching of birth and death certificates; marking of certificates and copies.

To protect the integrity of vital records and prevent the fraudulent use of birth certificates of deceased persons, the State Registrar is hereby authorized to match birth and death certificates, in accordance with regulations promulgated by the Board, to prove beyond a reasonable doubt the fact of death, and to post the facts of death to the appropriate birth certificate. Copies issued from birth certificates marked deceased shall be similarly marked.

(1983, c. 240.)

12VAC5-550-110. Death certificate items.

The certificate of death to be used shall be the Certificate of Death, Commonwealth of Virginia, and shall contain the following items: full name of decedent; place of death; usual residence; date of death; sex; hispanic origin, if any, and race; education; date of birth; age; birthplace; citizenship; usual occupation and industry; veteran status; social security number or control number issued by the Department of Motor Vehicles; father's name; mother's maiden name; marital status and name of spouse, if married or widowed; informant's name and relationship to decedent; medical certification of cause of death; autopsy; if female, was there a pregnancy during past three months; and supplementary data concerning death due to external causes; certification of attending physician or medical examiner, including title, address, and date signed; disposition of the body; signature of funeral service licensee; name and address of funeral home; date received by registrar; registrar's signature; registration area and certificate numbers; and state file number.

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

Historical Notes

Derived from VR355-29-100 §3.2, eff. April 1, 1995; amended, Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

12VAC5-550-120. Fetal death or induced termination of pregnancy report items.

A. The Report of Fetal Death Commonwealth of Virginia, and shall contain the following items for spontaneous fetal deaths: place of occurrence; usual residence of patient (mother); full maiden name of patient; medical record number and social security number of patient; hispanic origin, if any, and race of patient; age of patient; education of patient; sex of fetus; patient married to father; previous deliveries to patient; single or plural delivery and order of plural delivery; date of delivery; date of last normal menses and physician's estimate of gestation; weight of fetus in grams; month of pregnancy care began; number of prenatal visits; when fetus died; congenital malformations, if any; events of labor and delivery; medical history for this pregnancy; other history for this pregnancy; obstetric procedures and method of delivery; autopsy; medical certification of cause of spontaneous fetal death; signature of attending physician or medical examiner including title, address and date signed; method of disposal of fetus; signature and address of funeral service licensee or hospital representative; date received by registrar; registrar's signature; registration area and report numbers.

B. The Report of Induced Termination of Pregnancy, Commonwealth of Virginia, and shall contain the following items for induced terminations of pregnancy: place of occurrence; usual residence of patient; patient identification number; age of patient; hispanic origin, if any, and race of patient; education of patient; patient married to father; date of pregnancy termination; pregnancy history of patient; date of last normal menses and physician's estimate of gestation; type of termination procedures; pregnancy terminated because of genetic defect; signature, title, and address of person completing this report; registration area and report numbers.

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

Historical Notes

Derived from VR355-29-100 §3.3, eff. April 1, 1995; amended, Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

12VAC5-550-125. Certificate of birth resulting in a stillbirth.

In accordance with §32.1-258.1 of the Code of Virginia, a certificate of birth resulting in a stillbirth shall be issued upon request from the parent for a fetal death of 20 weeks or more gestation and payment of the appropriate fee for a vital record. This certificate shall contain the following information; name (optional), mother's maiden name, father's name (if indicated), date of event, and hospital of occurrence. When no report of spontaneous fetal death is available to establish the event, documentation from the following sources is acceptable: physician or licensed nurse midwife who provided care to the mother, documentation from the medical record maintained at the hospital of occurrence, copy of the report of spontaneous fetal death or documentation from funeral service director (if such services were provided).

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

Historical Notes

Derived from Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

12VAC5-550-150. Requirements for completion.

All certificates and records provided for in the statutes governing vital event registration shall be prepared on a typewriter with a black ribbon whenever possible or shall be printed legibly in black ink or written legibly in black unfading ink or entered on electronic media approved by the State Registrar. All signatures required shall be entered in black ink. No certificate shall be considered as complete and correct and acceptable for filing that:

1. Does not supply all items of information called for thereon or satisfactorily account for their omission.

2. Contains alterations or erasures.

3. Does not contain original signatures.

4. Is marked "copy" or "duplicate."

5. Is a carbon copy or photocopy.

6. Is prepared on an improper form.

7. Contains obviously improper or inconsistent data.

8. Contains any data relative to the putative father of a child born out of wedlock without his written consent or unless determined by a court of competent jurisdiction as required by §32.1-257 of the Code of Virginia.

9. Contains an indefinite cause of death denoting only symptoms of disease or conditions resulting from disease.

10. Is not prepared in conformity with these regulations or instructions issued by the State Registrar.

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

Derived from VR355-29-100 §4.01, eff. April 1, 1995; amended, Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

12VAC5-550-180. Acceptance of certificates.

Each registrar shall examine certificates as they are submitted for registration to determine whether they have been prepared in accordance with the provisions of the statutes, regulations, and instructions. If unsatisfactory, it shall be the duty of the registrar to notify the person responsible for the registration of its defects and to secure a complete and correct registration. Each registrar or his deputy shall note over his signature the date each certificate of birth, death, or report of fetal death was filed with him and shall number consecutively the certificates of birth, death, and fetal death in three separate series beginning with number 1 for the first certificate in each respective series in each calendar year.

Statutory Authority

§32.1-273 of the Code of Virginia.

Historical Notes

Derived from VR355-29-100 §6.1, eff. April 1, 1995.

12VAC5-550-190. Local records.

On forms furnished by the State Registrar or on electronic media approved by the State Registrar, each registrar shall record the following information from the original records before forwarding such original records to the State Registrar:

1. For birth records: the full name of the child, sex and race of child, date of birth, place of birth, names of parents, residence of parents, date filed, and local certificate number.

2. For death records: the full name of the decedent, race and sex of decedent, date of death and place of death, date filed, and local certificate number.

3. For spontaneous fetal death records: surname of family, race and sex of fetus, date and place of delivery, date filed, and local report number.

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

Historical Notes

Derived from VR355-29-100 §6.2, eff. April 1, 1995; amended, Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

12VAC5-550-350. A proper and complete medical certification of cause of death defined.

A complete and properly executed medical certification of cause of death shall mean the entry by a physician or medical examiner of a definite medical diagnosis of the underlying cause of death and related conditions following the instructions indicated on the death certificate. This may be variously:

1. Supported by clinical findings of the physician who attended the deceased for the illness or condition that resulted in death;

2. Supported by tentative clinical findings that may or may not be supported by the gross findings of an autopsy; or

3. Supported by autopsy findings where necessary to establish a definite medical diagnosis of cause of death.

In cases where an autopsy is to be performed, the physician or medical examiner shall not defer the entry of the cause of death pending a full report of microscopic and toxicological studies. In any case where the autopsy findings significantly change the medical diagnosis of cause of death, a supplemental report of the cause of death shall be made by the physician or medical examiner to the registrar as soon as the findings are available. (As examples: If it is clear that a patient dies of "cancer of the stomach," report the cause while a determination of the histological type is being carried out. Similarly, if it is clear that a death is from "influenza," do not delay the medical certification while a laboratory test is being carried out to determine the strain).

Statutory Authority

§32.1-273 of the Code of Virginia.

Historical Notes

Derived from VR355-29-100 §10.1, eff. April 1, 1995.

12VAC5-550-360. Responsibility of the attending physician.

When a patient dies, the physician in charge of the patient's care for the illness or condition shall be responsible for executing and signing the medical certification of cause of death as follows:

1. The physician shall execute and sign the medical certification of cause of death on the death certificate form prescribed by the State Registrar.

2. In an case where an autopsy is scheduled and the physician wishes to await its gross finding to confirm a tentative clinical finding, he shall give the funeral service licensee notice that he attended the patient and when he expects to have the medical data necessary for the certification of cause of death. If the provisions of 12VAC5-550-350 cannot be adhered to, he shall indicate that the cause is pending and sign the certification. Immediately after the medical data necessary for determining the cause of death have been made known, the physician shall, over his signature, forward the cause of death to the registrar.

3. If the physician is unable to establish the cause of death or if a death is within the jurisdiction of the medical examiner, he shall immediately report the case to the local medical examiner and advise the funeral service licensee of this fact. If the medical examiner does not assume jurisdiction, the physician shall sign the medical certification noting special circumstances and exception.

4. An associate physician who relieves the attending physician while he is on vacation or otherwise temporarily unavailable may certify to the cause of death in any case where he has access to the medical history of the case, provided that he views the deceased at or after death occurs and that death is from natural causes. In all other cases in which a physician is unavailable, the funeral service licensee shall contact the medical examiner.

5. When the attending physician shall have given the person in charge of an institution authorization in writing, the person in charge of such institution, or his designated representative, may prepare the medical certification of cause of death in cases where all pertinent aspects of the medical history are a part of the official medical records and the death is due to natural causes. In such instances, the signature shall be that of a physician.

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

Historical Notes

Derived from VR355-29-100 §10.2, eff. April 1, 1995; amended, Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

12VAC5-550-370. Responsibility of the medical examiner.

When a medical examiner assumes jurisdiction in a death or when a medically unattended death occurs without medical attendance a known medical history or information, the medical examiner shall be responsible for executing and signing the medical certification of cause of death as follows:

1. The medical examiner shall, at the time of releasing a body to a funeral service licensee or person who first assumes custody of a dead body, or as soon as practicable thereafter, execute and sign the medical certification of cause of death on the death certificate form prescribed by the State Registrar.

2. In any case where an autopsy is scheduled and the medical examiner wishes to await its gross findings to confirm a tentative clinical finding, he shall give the funeral service licensee notice as to when he expects to have the medical data necessary for the certification of cause of death. If the provisions of 12VAC5-550-350 cannot be adhered to, he shall indicate that the cause is pending and sign the certification. Immediately after the medical data necessary for determining the cause of death have been made known, the medical examiner shall, over his signature, forward the cause of death to the registrar.

3. In any case where a death has been referred to the medical examiner because a physician in attendance is deceased or physically incapacitated and there was no associate physician, the medical examiner shall prepare and sign the medical certification of cause of death.

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

Historical Notes

Derived from VR355-29-100 §10.3, eff. April 1, 1995; amended, Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

12VAC5-550-380. Responsibility of the hospital or institution.

When a patient shall die in a hospital or institution, and the death is not under the jurisdiction of the medical examiner, the person in charge of such institution, or his designated representative, shall where feasible and where the cause of death is known, aid in the preparation of the death certificate as follows:

1. Place the full name of the deceased on the death certificate form and obtain from the attending physician the medical certification of cause of death.

2. If authorized in writing by the attending physician, the person in charge, or his designated representative, may prepare the medical certification of cause of death in cases where all pertinent aspects of the medical history are a part of the official hospital records and the death is due to natural causes. The signature shall be that of a physician.

3. Present the partially completed death certificate identified by the name and the complete medical certification to the funeral service licensee.

4. In a case of long-term residence by a patient in a state institution, a death certificate including personal particulars of the deceased may be prepared for presentation to the funeral service licensee.

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

Historical Notes

Derived from VR355-29-100 §10.4, eff. April 1, 1995; amended, Virginia Register Volume 19, Issue 26, eff. October 8, 2003.

12VAC5-550-390. Responsibility of the funeral service licensee.

Each funeral service licensee who has been authorized to take custody of a dead human body shall exercise the following responsibilities with respect to the preparation and filing of the death certificate:

1. When he arrives to take custody of the body, he shall first ascertain whether an attending physician or local medical examiner has established the cause of death as follows:

a. The funeral service licensee shall obtain the medical certification of cause of death from the physician if the death is from natural causes. An associate physician or person in charge of an institution may prepare the medical certification as outlined in 12VAC5-550-360.

b. If a physician attended the deceased but did not complete the medical certification of cause of death, the funeral service licensee shall immediately contact such physician in person or by telephone to be certain that he was the attending physician and to ascertain whether the physician is to assume responsibility for the medical certification or to refer the case to the medical examiner.

c. When a medical examiner assumes jurisdiction in a death, or when a physician in attendance is incapacitated, the funeral service licensee shall obtain the signed medical certification of cause of death from the medical examiner as required by subdivision 3 of 12VAC5-550-370.

2. The personal history of the deceased and the facts of the death shall be obtained from the best source possible. This source may be variously: a member of the immediate family of the deceased who possesses the necessary information; a hospital records custodian whose records contain the necessary information; or the local medical examiner having jurisdiction over a case.

The name of the informant, his address and relationship to the decedent shall be entered on the death certificate. The facts required as to the manner and place of disposal of the body or its removal from the Commonwealth shall be entered over the signature of the funeral service licensee. He shall personally sign the certificate and print or type the name of his firm.

3. Except as outlined in 12VAC5-550-410, a satisfactory death certificate shall be filed with the city, county, or special registrar in the city or county where death occurred, or a dead body is found, prior to final disposal of the body or its removal from the Commonwealth, and within three days. In cases where a completed medical certification is not available when the funeral service licensee takes possession of a body, he shall not move the body from the place of death until so authorized by the local medical examiner or until the attending physician has advised him that death is from natural causes and the physician is able to prepare the medical certification of cause of death. In every case, the removal of a dead human body from the city or county of death is unlawful unless notice is given to the city, county, or special registrar by telephone or in person. Such notice shall consist of the name of the deceased, date and place of death, and the name of the attending physician or of the medical examiner, as the case may be, and, if the body is to be removed, the destination within the Commonwealth. Such notification shall be made during the next available business hours of the registrar following the time of death. After business hours, in independent cities and in designated counties, such notification shall be made immediately on assumption of custody of the deceased to the registrar's representative.

Statutory Authority

§§32.1-12 and 32.1-250 of the Code of Virginia.

§ 54.1-2957.02. When nurse practitioner signature accepted.

Whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a nurse practitioner.

(2004, c. 855.)

Guide to Completing the Commonwealth of Virginia Report of Spontaneous Fetal Death (Form VS5)
Department of Health-Division of Vital Records & Health Statistics

Field Number	Definition of Field Number	Instructions for Filling Out the Field Number
Above Field 1	Name of Fetus, (optional at the discretion of the parents)	Enter the name, if the parents chose to name the fetus. If parents chose not to name the fetus, leave this line blank.
	FIELDS 1-4 PLACE OF THE FETAL DEATH	
Field 1	Name of Hospital or Facility of Occurrence	Enter the Hospital/Facility name. If this Fetal Death did not occur in a hospital/facility, enter the home, doctors office where the FD occurred. if this FD occurred en route, that in in a moving conveyance, enter the location where the child was first removed from the conveyance.
Field 2	County of Occurrence (If Independent City Leave Blank)	Enter the County of the Hospital/Facility/Place where the FD occurred. If an independent city leave this line blank.
Field 3	City or Town of Occurrence Inside City Limits?	Enter the city or town of the hospital/facility/ place where the FD occurred. If inside city limits check the Yes box, if not check the No box.
Field 4	Street address or RT. Number of Plaec of occurrence	Enter the address of the hospital/facility or the address of the place of occurrence of the FD.
	FIELDS 5-8 USUAL RESIDENCE OF PATIENT (MOTHER)	
Field 5	State (Or Foreign Country) of Residence	Enter the state the mother resides in. If in the military or college enter the state which they currently reside in, not their home state.
Field 6	County of Residence (if Independent City Leave Blank)	Enter the name of the County the mother resides in, if an Independent City, leave this line blank.
Field 7	City or Town of Residence Inside City Limits, (Yes or No)	Enter the city/county/town the mother resides in. if within city limits check the YES box, if not within city limits check the NO box.
Field 8	Street Address or RT Number of Residence and Zip Code	Enter the mother's street address or route number of her residence & enter the Zip Code.
	FIELDS 9-16 INFORMATION OF PATIENT (MOTHER)	
Field 9	Present Name, Last, First Middle	Enter the mother's present name, (This is the Name you will enter on Your Monthly Fetal Death Report Form VS34).
	Maiden Surname, (If Different)	Enter the mother's maiden surname if different from her present surname, (this names does not need to be entered on your Monthly Fetal Death Report Form VS34).
Field 10	Race	Enter the race of the mother, be as specific as possible

Field Number	Definition of Field Number	Instructions for Filling Out The Field Number
Field 11	Of Hispanic Origin? If yes, specify if Cuban, Mexican, Puerto Rican, etc.	You must check YES or NO box. If YES box is checked enter, Cuban, Mexican, Puerto Rico or any other Hispanic origin that the mother lists as her origin.
Field 12	Age	Enter the mother's age in years, 24, 28, 37 etc.
Field 13	Is Patient Married to Father?	Check either the YES or NO box.
Field 14	Education, (specify only highest grade completed) Elementaqry/Secondary 0-12 College (1-4 or 5+)	Enter the highest grade completed Enter highest grade completed for one of these two fields.
Field 15	Social Security Number	Enter the mother's Social Security Number. If mother doesn't have a SSN enter NONE.
Field 16	Medical Record Number	Enter the mother's Medical Record Number.

For Fetal Deaths 12 Weeks & Under Shaded Items Need Not Be Completed. The shaded items are lines 18, 19, 20, 21, 22, 23, 25, 28, 28, 30, 31, and 33.

FIELDS 17-33 INFORMATION ON PREGNANCY

Field 17	Date of Delivery **(Month, Day, Year)**	Enter the Month, Day & year of Delivery, 11/10/2007 or November 10, 2007.
Field 18	This Delivery, Single, Twin, Triplet	Check the appropriate box, Single, Twin or Triplet, if more then Triplet please enter Quadruplet or Quintuplet, etc.
Field 19	If Twin or Triplet, Born 1st, 2nd, 3rd	If a multiple birth, twin or triplet please check the correct box for the Birth number of this fetus 1st, 2nd, 3rd, 4th, 5th, etc.
Field 20	Sex of Fetus, Male, Female or Unknown	Please check the correct sex of the fetus, if unknown please check that box.
Field 21	Month in which Prenatal Care Began Choices/boxes are listed as None-9th	You MUST Check the correct month in which prenatal care started. If none, check the box Marked none otherwise check the correct box.
Field 22	Prenatal Visits Total Number, If None So State	Enter the total number of prenatla visits, if none enter none.
Field 23 (A & B)	A-Source Prenatal Care Check all that apply B-Main Payment sSource for Delivery, **(Check only one Box)**	A-Check all the boxes that were a source of prenatal care. B-Check Only the Main payment source box for question B, Remember on Question "B" check only ONE box.
Field 24	Weight of Fetus, **(Grams)**	Enter in GRAMS the weight of the fetus.
Field 25	Date last normal menses began **(Month, Day, Year)**	Enter the exact date of the mother's last menstrual period, may be obtained from the physician or hospital record or from the mother.
Field 26	Physician's Estimate of Gestation (Weeks) **This field must be filled in**	Enter the Physician's estimate of gestation in weeks. If there is doubt as to the accuracy of the gestation period you can report the time from the last menses to the date of delivery, in weeks only.

Field Number	Definition of Field Number	Instructions for Filling Out the Field Number
Field 27 (A & B)	Pregnancy History, Now Living Number, Now Dead Number, Date of Last Live Birth other terminations, number or box (None) & date of last other termination	Enter the number of live births that are still living in 27A, or check the box None, enter number now dead or check the None Box. Enter date of last live birth by entering the month & year. In Field 27B, enter the # of other terminations, include spontaneous & induced terminations or Check box none. (Remember Do Not include this Fetus).
Field 28	Medical History For This Pregnancy **(Check all boxes that apply)**	Check ANY & ALL Boxes that apply to this pregnancy, Boxes for this question range from 01-18 & include 00. **If 00 is selected no other Boxes should be selected.**
Field 29	Other History For This Pregnancy **(Complete ALL ITEMS)**	Check all Boxes/Items & if other street drugs were used specify the drug used & list the weight gained during pregnancy in pounds. If yes for Tobacco & alcohol use, be sure to list number of Cigarettes per day & number of drinks per week. If mother lost weight enter 0 for weight gained.
Field 30	Obsteric Procedures **(Check ALL That APPLY)**	Check boxes 1-7 for all procedures that apply to this pregnancy. If box 7 (Other) is checked specify what "Other" is on the blank space provided. If 00 is selected no toher box should be checked.
Field 31	Events of Labor And/Or Delivery **(Check all BOXES that APPLY)**	Check any & all boxes numbered 1-16 & 00 that apply to any events that occurred during this labor and/or delivery. If 00 is selected no other boxes should be checked.
Field 32	Method of Delivery **(Check ALL that APPLY)**	Check any & all boxes from 01-08 that apply to this pregnancy. If other specify what "Other" is On the blank space provided.
Field 33	Congenital Anomalies of Fetus **(Check ALL that APPLY)**	Check any & all boxes 01-22 that apply to this pregnancy. If 00 is selected no toher box should be checked. When "Other" is selected specify What other is on the blank space provided.
	FIELDS 34-36 To Physician or Medical Examiner/Cause of Death	
Field 34	Part 1, Fetal or Maternal Condition directly Casuing FD. Fetal and/or maternal conditions If any giving rise to the immediate casue. State the underlying cause last. Part II, other Significant condition of fetus, etc.	Part 1, enter the immediate Cause on Line A & check the box fetal or maternal to the far right, Fill out lines B & C if applicable & check the fetal or maternal boxes to the far right. Part II, list other significant conditions of the fetus or Mother contributing to the FD, etc.
Field 35	When Did The Fetus Die? **(Check Only ONE Box)**	Check the appropriate box for when the fetus died, either Before Labor, During Labor or Delivery or Unknown.

Field Number	Definition of Field Number	Instructions for Filling Out the Field Number
Field 36	I certify that this delivery occurred & the Fetus was born dead from the cause stated Above. Check the MD Attendant or MD Examiner Box, whichever one is correct	The Doctors Signatures (IN Black Ink), the address or county & date the doctor or ME signed the certificate.Some hospitals have designated several MD's who can sign the FD Certificate, in some hospitals the head of OBGYN/Labor & Delivery have been designated to sign the Fetal Death Certificates for their hospital/facility. In Emergency Rooms the head of the ER or other ER physicians have been designated to sign the Fetal Death Certificates, each hospital is different in how they handkle this requirement. Also Nurse Practitioners may also sign the Fetal Death Certificates.
	FIELDS 37-39, Disposal/Hospital or Funeral Director/Registrar	
Field 37	Three parts, part one Burial, Incineration, Other. Part two, Place of Burial, Incineration Etc. Part Three, Disposal was in Hospital At Home, In Cemetery & if Cemetery is Checked, Name of Cemetery must be entered.	Check the correct box, Burial, Incineration or Other. Enter the City and State where the Burial or Incineration took place. Part Three Check the correct box, Hospital, Home or Cemetery, if Cemetery is checked Enter the Name of the Cemetery.
Field 38	Signature of Funeral Director or Hospital Representative in that priority-if no Funeral Director and disposal was not in the hiospital Leave this field blank.	If Hospital Disposal the Hospital representative must sign here. If a Funeral Home is used then the Funeral Director will sign this field. If the Hospital/Facility has a contract with a funeral Home to pick up & dispose of the fetus & the Hospital list the fetal death as hospital disposal **Then the HOSPITAL is responsible for Filling the Fetal Death Certificate. When hospital Disposal is listed the funeral home is not Responsible for filling the FD certificate.**
Field 39	Registrar's Signature Date record Filed	The Hospital or Funeral Home who prepares the Fetal Death Certificate leaves this field blank. The local health department's registrar will fill In this field.

The Fetal Death Certificate by Virginia Law, (Code 32.1-264) is to be filed with the registrar of the local district health office in which the delivery occurred WITHIN THREE DAYS after such delivery.

VS 5 1/93

COMMONWEALTH OF VIRGINIA
REPORT OF SPONTANEOUS FETAL DEATH
DEPARTMENT OF HEALTH-DIVISION OF VITAL RECORDS
RICHMOND

REGISTRATION AREA NUMBER | REPORT NUMBER | STATE FILE NUMBER

PLACE OF FETAL DEATH

1. NAME OF HOSPITAL OR FACILITY OF OCCURRENCE
2. COUNTY OF OCCURRENCE *(if independent city, leave blank)*
3. CITY OR TOWN OF OCCURRENCE — Inside city limits? Yes ☐ No ☐
4. STREET ADDRESS OR RT. NO. OF PLACE OF OCCURRENCE

USUAL RESIDENCE OF PATIENT (MOTHER)

5. STATE (OR FOREIGN COUNTRY) OF RESIDENCE
6. COUNTY OF RESIDENCE *(if independent city, leave blank)*
7. CITY OR TOWN OF RESIDENCE — Inside city limits? Yes ☐ No ☐
8. STREET ADDRESS OR RT. NO. OF RESIDENCE — ZIP CODE

INFORMATION ON PATIENT (MOTHER)

9. PRESENT NAME *(last)* *(first)* *(middle)* — MAIDEN SURNAME *(if different)*
10. RACE
11. OF HISPANIC ORIGIN? If Yes, specify Cuban, Mexican, Puerto Rican, etc. ☐ No ☐ Yes
12. AGE years
13. IS PATIENT MARRIED TO FATHER? Yes ☐ No ☐
14. EDUCATION *(specify only highest grade completed)* Elementary/Secondary *(0-12)*____ College *(1-4 or 5+)*____
15. SOCIAL SECURITY NUMBER
16. MEDICAL RECORD NUMBER

INFORMATION ON PREGNANCY

17. DATE OF DELIVERY *(month, day, year)*
18. THIS DELIVERY single ☐ twin ☐ triplet ☐
19. IF TWIN OR TRIPLET, BORN 1st ☐ 2nd ☐ 3rd ☐
20. SEX OF FETUS male ☐ female ☐ unknown ☐
21. MONTH IN WHICH PRENATAL CARE BEGAN NONE ☐ 1ST ☐ 2ND ☐ 3RD ☐ 4TH ☐ 5TH ☐ 6TH ☐ 7TH ☐ 8TH ☐ 9TH ☐
22. PRENATAL VISITS Total number *(if none, so state)*
23. A. SOURCE PRENATAL CARE *(check all that apply)* ☐ Pvt Phys ☐ Hlth Dept ☐ Other
    B. MAIN PAYMENT SOURCE FOR DELIVERY *(check only one)* ☐ Medicaid ☐ Pvt Insurance ☐ Self-Pay
24. WEIGHT OF FETUS *(grams)*
25. DATE LAST NORMAL MENSES BEGAN *(month, day, year)*
26. PHYSICIAN'S ESTIMATE OF GESTATION *(weeks)*

FOR FETAL DEATHS 12 WEEKS AND UNDER SHADED ITEMS NEED NOT BE COMPLETED

27. PREGNANCY HISTORY *(complete each section)*
    a. LIVE BIRTHS — Now Living, Number____ ☐ None — Now Dead, Number____ ☐ None — DATE OF LAST LIVE BIRTH *(month, year)*____
    b. OTHER TERMINATIONS *(spontaneous and induced at any time after conception)* *(do not include this fetus)* — Number____ ☐ None — DATE OF LAST OTHER TERMINATION *(month, year)*____

28. MEDICAL HISTORY FOR THIS PREGNANCY *(check all that apply)*
    - Anemia (Hct. < 30/Hgb. < 10) 01 ☐
    - Cardiac disease 02 ☐
    - Acute or chronic lung disease 03 ☐
    - Diabetes 04 ☐
    - Genital herpes 05 ☐
    - Hydramnios/Oligohydramnios 06 ☐
    - Hemoglobinopathy 07 ☐
    - Hypertension, chronic 08 ☐
    - Hypertension, pregnancy-associated 09 ☐
    - Eclampsia 10 ☐
    - Incompetent cervix 11 ☐
    - Previous infant 4000 + grams 12 ☐
    - Previous preterm or small-for-gestational-age infant 13 ☐
    - Renal disease 14 ☐
    - Rh sensitization 15 ☐
    - Uterine bleeding 16 ☐
    - Maternal infections *(specify)*____ 17 ☐
    - None 00 ☐
    - Other *(specify)*____ 18 ☐
29. OTHER HISTORY FOR THIS PREGNANCY *(complete all items)*
    - Tobacco use during pregnancy Yes ☐ No ☐ — Average number cigarettes per day ____
    - Alcohol use during pregnancy Yes ☐ No ☐ — Average number drinks per week ____
    - Drug use during pregnancy:
      - Heroin Yes ☐ No ☐
      - Methadone Yes ☐ No ☐
      - Marijuana Yes ☐ No ☐
      - Cocaine or Crack Yes ☐ No ☐
      - Amphetamines Yes ☐ No ☐
      - Other street drugs Yes ☐ No ☐ *(specify)*____
    - Weight gained during pregnancy____ lbs.
30. OBSTETRIC PROCEDURES *(check all that apply)*
    - Amniocentesis 01 ☐
    - Electronic fetal monitoring 02 ☐
    - Induction of labor 03 ☐
    - Stimulation of labor 04 ☐
    - Tocolysis 05 ☐
    - Ultrasound 06 ☐
    - None 00 ☐
    - Other *(specify)*____ 07 ☐
31. EVENTS OF LABOR AND/OR DELIVERY *(check all that apply)*
    - Febrile (> 100° F. or 38° C.) 01 ☐
    - Meconium, moderate/heavy 02 ☐
    - Premature rupture of membrane (>12 hrs.) 03 ☐
    - Abruptio placenta 04 ☐
    - Placenta previa 05 ☐
    - Other excessive bleeding 06 ☐
    - Seizures during labor 07 ☐
    - Precipitous labor (< 3 hrs.) 08 ☐
    - Prolonged labor (> 20 hrs.) 09 ☐
    - Dysfunctional labor 10 ☐
    - Breech/Malpresentation 11 ☐
    - Cephalopelvic disproportion 12 ☐
    - Cord prolapse 13 ☐
    - Anesthetic complications 14 ☐
    - Fetal distress 15 ☐
    - None 00 ☐
    - Other *(specify)*____ 16 ☐
32. METHOD OF DELIVERY *(check all that apply)*
    - Vaginal 01 ☐
    - Vaginal birth after previous C-section 02 ☐
    - Primary C-section 03 ☐
    - Repeat C-section 04 ☐
    - Forceps 05 ☐
    - Vacuum 06 ☐
    - Hysterotomy/Hysterectomy 07 ☐
    - Other *(specify)*____ 08 ☐
33. CONGENITAL ANOMALIES OF FETUS *(check all that apply)*
    - Anencephalus 01 ☐
    - Spina bifida/Meningocele 02 ☐
    - Hydrocephalus 03 ☐
    - Microcephalus 04 ☐
    - Other central nervous system anomalies *(specify)*____ 05 ☐
    - Heart malformations 06 ☐
    - Other circulatory/respiratory anomalies *(specify)*____ 07 ☐
    - Rectal atresia/stenosis 08 ☐
    - Tracheo-esophageal fistula/Esophageal atresia 09 ☐
    - Omphalocele/Gastroschisis 10 ☐
    - Other gastrointestinal anomalies *(specify)*____ 11 ☐
    - Malformed genitalia 12 ☐
    - Renal agenesis 13 ☐
    - Other urogenital anomalies *(specify)*____ 14 ☐
    - Cleft lip/palate 15 ☐
    - Polydactyly/Syndactyly/Adactyly 16 ☐
    - Club foot 17 ☐
    - Diaphragmatic hernia 18 ☐
    - Other musculoskeletal/integumental anomalies *(specify)*____ 19 ☐
    - Down's syndrome 20 ☐
    - Other Chromosomal anomalies *(specify)*____ 21 ☐
    - None 00 ☐
    - Other *(specify)*____ 22 ☐

TO PHYSICIAN OR MED. EXAMINER
Complete and sign medical certification and give to hospital or to funeral director. NOTE: If home delivery and no funeral director, you are responsible for completing and filing a full report with registrar. Please complete as soon as possible after delivery or inquiry.

MEDICAL CERTIFICATION

34. CAUSE OF FETAL DEATH — Enter only one cause per line for a, b, and c.

PART I. Fetal or maternal condition directly causing fetal death.
IMMEDIATE CAUSE
a.____ Specify ☐ Fetal ☐ Maternal
DUE TO *(or as a consequence of)*:
Fetal and/or maternal conditions, if any, giving rise to the immediate cause. State the underlying cause last.
b.____ Specify ☐ Fetal ☐ Maternal
DUE TO *(or as a consequence of)*:
c.____ Specify ☐ Fetal ☐ Maternal

PART II. Other significant conditions of fetus or mother contributing to fetal death but not resulting in the underlying cause given in Part I.

35. WHEN DID FETUS DIE? before labor ☐ during labor or delivery ☐ unknown ☐

36. I CERTIFY THAT THIS DELIVERY OCCURRED AND THE **FETUS WAS BORN DEAD** FROM THE CAUSE STATED ABOVE.
ACTUAL SIGNATURE ☐ M. D. ATTENDANT ☐ M. D. MEDICAL EXAMINER — Address–*(city or county)* — *(date signed)*

DISPOSAL

37. BURIAL ☐ INCINERATION ☐ OTHER ☐ — PLACE OF BURIAL, INCINERATION, ETC. *(city)* *(state)* — DISPOSAL WAS IN HOSPITAL ☐ AT HOME ☐ IN CEMETERY ☐ — NAME OF CEMETERY

HOSPITAL OR FUNERAL DIRECTOR

38. Signature of funeral director or hospital representative in that priority–if no funeral director, and not in hospital, leave blank. — ADDRESS:

REGISTRAR

39. REGISTRAR'S SIGNATURE — DATE RECORD FILED:

Instructions for Filling out Form # VS 34, Vital Statistics Monthly Fetal Deaths Report

During The Month of:

Enter the month of the report you are filing, if it is April 6, 2007 you are most likely preparing the report for the month of **March.**

Year:

Enter the **year** 2007, 2008 etc.

AT:

Enter the **name of your Hospital/Institution/Clinic**. After entering the name, please enter your **complete mailing address**. (For most users this information will be recorded on your blank form that is contained on the enclosed disc. If any changes occur with your name or address you may simply **type over** the name and address information to make any necessary changes or corrections.

Date:

Enter the **date** of the fetal death, spontaneous abortion or ITOP.

Name of Mother

If a fetal death or spontaneous abortion enter the mothers name. If you are reporting an Induced Termination of Pregnancy, (ITOP) DO NOT LIST THE MOTHERS NAME or ANY IDENTIFYING INFORMATION**.**

Code Required Enter Either (FD), (SA) or (ITOP):

Enter the correct code, **FD for Fetal Death, SA for Spontaneous Abortion or ITOP for Induced Termination of Pregnancy**.

Name of Medical attendant – Has Yellow or Brown Bordered Form Been Filed Yes or NO.

Enter the name of the medical attendant/doctor and place a yes in the box next to the attendants name if the appropriate **brown bordered**, (Form VS-5A, Report of Induced Termination of Pregnancy) or **yellow bordered,** (VS 5, Report of Spontaneous Fetal Death) have been filed. Place a no next to the attendants name if the correct form has not been filed.

Name & Address of funeral home or institution disposing of the fetus, if ITOP list Mothers city/county & state of residence:

If the fetus if being disposed of by a funeral home, please list the complete name and address of the funeral home. If disposed of by the hospital, please record hospital disposal in this box. If you are reporting an Induced Termination of Pregnancy, (ITOP) then LIST THE MOTHERS CITY/COUNTY & STATE OF RESIDENCE, for example:

Woodbridge, VA	Chesterfield County, VA	Norfolk, VA
Johnson City, TN	Columbia, MD	Abingdon, VA
Rocky Mount, NC	South Hill, VA	Staunton, VA
Atlanta, GA	Sterling, VA	Roanoke, VA

Instructions for Filling Out Vital Statistics Monthly Fetal Deaths Report

Representative Filing this Report:

Please type or print the name of the person filing this report.

Representative's Phone Number:

List the phone number of the person filing this report, please remember to include extension if necessary, example 757-424-1000, ext 2578. This will be the number that the agency can contact you if they have any questions concerning the report you have filed.

SENDING THE REPORT TO DIVISION OF HEALTH STATISTICS

You may send this report to the Division of Health Statistics in any of the following manners:

Mail the report to the letterhead address located at the top right corner on the front side of the form.

Fax the report to attention Huston Kitts at 804-662-7261. Please include your phone number so that Health Statistics can call you to confirm that your fax was received and that the report was clear and readable.

IF YOU HAVE ANY QUESTIONS PLEASE CALL Mr. HUSTON KITTS at 804-662-6280.

VS 34 –- 03/07

This report must be filed with the State Registrar by the Tenth Day of the Following Month in accordance with State Codes 32.1-264 and 32.1-274.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF HEALTH

DIVISION OF HEALTH STATISTICS
P. O. BOX 1000, RICHMOND, VIRGINIA 23218-1000

VITAL STATISTICS MONTHLY FETAL DEATHS REPORT

THE FOLLOWING IS A LIST OF FETAL DEATHS, SPONTANEOUS ABORTIONS OR INDUCED TERMINATIONS OCCURRING

DURING THE MONTH OF**:** Year: **2007** AT:

_____

_____

(COMPLETE HOSPITAL OR INSTITUTION MAILING ADDRESS)

FETAL DEATHS (FD) SPONTANEOUS ABORTIONS (SA) INDUCED TERMINATIONS (ITOP)

DATE	*** NAME OF MOTHER ***	**CODE REQUIRED ENTER EITHER (FD), (SA), or (ITOP)**	**NAME OF MEDICAL ATTENDANT—HAS YELLOW OR BROWN BORDERED FORM BEEN FILED YES or NO**	**NAME & ADDRESS OF FUNERAL HOME OR INSTITUTION DISPOSING OF THE FETUS. IF ITOP LIST MOTHERS CITY/COUNTY & STATE OF RESIDENCE**

REPRESENTATIVE FILING THIS REPORT:

_____

(PLEASE TYPE OR PRINT NAME)

REPRESENTATIVE'S PHONE NUMBER:

_____

FETAL DEATH (FD) SPONTANEOUS ABORTIONS (SA) AND INDUCED TERMINATIONS (IT)

DATE	* NAME OF MOTHER *	CODE REQUIRED ENTER EITHER (FD), (SA) or (ITOP)	NAME OF MEDICAL ATTENDANT – HAS YELLOW OR BROWN BORDERED FORM BEEN FILED YES or NO	NAME & ADDRESS OF FUNERAL HOME OR INSTITUTION DISPOSING OF THE FETUS. IF ITOP LIST MOTHERS CITY/COUNTY & STATE OF RESIDENCE

"Fetal Death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, regardless of the duration of pregnancy; death is indicated by the fact that after such expulsion or extraction of the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

"Induced Termination of Pregnancy" means the intentional interruption of pregnancy with the intention to produce other than a live-born infant or to remove a dead fetus & which does not result in a live birth.

"**Spontaneous Fetal Death"** means the expulsion or extraction of a product of human conception resulting in other than a live birth & which is not an induced termination of pregnancy.

Physicians – 32.1-264 of the Code of Virginia paragraph "C" states that "The medical certification portion of the fetal death report shall be completed and signed within **twenty-four hours** after delivery or abortion by the physician in attendance at or after delivery or abortion except when inquiry or investigation by a medical examiner is required".

* **- DO NOT LIST the Mothers name for any INDUCED TERMINATIONS of PREGNANCY (ITOP).-***

Labor & Delivery Patient's Worksheet

PLEASE PRINT CLEARLY

Would you like to name the child, optional at the discretion of the parents?

_____ _____ _____ _____

First Middle Last Suffix

What is your present name?

_____ _____ _____ _____

First Middle Last Suffix

What is your Maiden Name, Surname, if different from your current last name?

_____

Maiden Surname

What is the Address that you currently live at?

Number & Street**:** _____

City/County: _____ Inside City Limits: _____

State/Zip Code: _____ Country: _____

What is your Race? _____

If of Hispanic Origin, please specify your origin: _____

Age: _____ Are you Married to the Father: circle **YES** or **NO**

Education please circle the highest grade/year completed:

Elementary/Secondary: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 5+

Social Security Number: _____

Date Last Menses, (Period) Began: _____

Total Number of previous live-born infants now living: _____

Date of Last Live Birth: _____

Number of other pregnancy outcomes that did not result in a live birth, (examples are spontaneous or induced losses ectopic pregnancy or previous fetal deaths): _____

Date of Last Termination: _____

Method of Disposition selected: Circle One

Burial Cremation Hospital Disposition Removal from State Other

Hospitals/Facility Worksheet

MOTHER'S INFORMATION

Full Name:

_____

First Middle Last

Maiden Surname (if different)

_____

Age: _____ Social Security Number: _____

Race: _____

If Hispanic Origin please specify origin: _____ Patient Married to father yes or no: _____

Current Street Address, City, State and Zip Code, **(Physical Address only, No P. O. Boxes)**

_____

_____

Is this address within city limits? _____ If not, what County?

_____

Highest Year of schooling completed **(circle only the highest year)**

Elementary/Secondary: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 5+

Medical Record Number**:** _____

Date of last normal period: _____

Date of this pregnancy termination: _____

Type of Termination: **(circle one)**

Miscarriage Missed Abortion Ectopic IUFD Stillbirth Other Specify:

_____

Physician's estimated gestation **(in weeks)** _____

When did the fetus die **(circle one)** Before Labor During Labor/Delivery Unknown

Method of Delivery **(circle one)** Vaginal C-Section Laparoscopy

Attending Physician: _____

Total # of previous Live Births: _____

Date of Last Live Birth: _____

Total number of children born living, but now deceased: _____

Total number of previous pregnancy terminations, miscarriages, stillbirths, ectopic pregnancies or abortions: _____

Date of last termination: _____

FOR FETAL DEATHS OVER 12 WEEKS GESTATION ONLY:

Month (of pregnancy) prenatal care began: (circle one) 1 2 3 4 5 6 7 8 9 NONE

Source of prenatal care (circle all that apply): Private Physician/MD Midwife

Health Dept. Other

Main payment source for delivery (circle only one): Medicaid Insurance Self Pay

Hospital Disposal or Burial:

_____

If Burial name of funeral home:

_____

Nurse/Hospital Staff Name _____

Floor/Department: _____

Forward Worksheet to: _____

MOTHER'S INFORMATION WORKSHEET

Mothers
Full Name:

_____
First Middle Last

Maiden Surname (if different):

_____

Age: _____ Social Security Number: _____ Race: _____

If Hispanic Origin please specify origin: _____

Patient Married to father yes or no: _____

Current Street Address, City, State and Zip Code, **(Physical Address only, No P. O. Boxes)**

_____

Is this address within city limits? Yes or NO: _____

If not, what County? _____

Highest Year of schooling completed **(circle only the highest year)**

Elementary/Secondary: 1 2 3 4 5 6 7 8 9 10 11 12 College 1 2 3 4 5+

Medical Record Number**:** _____

Date of last normal period: _____

Date of this pregnancy termination: _____

Type of Termination: **(circle one)**

Miscarriage Missed Abortion Ectopic IUFD Stillbirth Other Specify: _____

Physician's estimated gestation **(in weeks)** _____

When did the fetus die **(circle one)** Before Labor During Labor/Delivery Unknown

Method of Delivery **(circle one)** Vaginal C-Section Laparoscopy

Attending Physician: _____

Total # of previous Live Births: _____

Date of Last Live Birth: _____

Total number of children born living, but now deceased: _____

Total number of previous pregnancy terminations, miscarriages, stillbirths, ectopic pregnancies or abortions: _____

Date of last termination: _____

FOR FETAL DEATHS OVER 12 WEEKS GESTATION ONLY:

Month (of pregnancy) prenatal care began: (circle one) 1 2 3 4 5 6 7 8 9 NONE

Source of prenatal care (circle all that apply): Private Physician/MD Midwife Health Dept.

Other

Main payment source for delivery (circle only one): Medicaid Insurance Self Pay

Hospital Disposal or Burial:

_____

If Burial name of funeral home:

_____

Nurse/Hospital Staff Name _____

Floor/Department: _____

Forward Worksheet To/Department: _____

Patients Name: _____

Patient's Worksheet for the Reporting of a Fetal Death

We are truly sorry about the loss you have experienced. We understand that this is a difficult time for you & your loved ones. We need to ask you some questions to assist in the completion of the Official Report of a Fetal Death. Virginia State Laws provide protection against the unauthorized release of identifying information from the report of a 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 acurate information is very important. We appreciate your help, especially during this very difficult time and we want to thank you for your assistance in providing the requested information.

PLEASE PRINT CLEARLY

Would you like to name the child, optional at the discretion of the parents?

_____

First Middle Last Suffix

What is your Present Name?

_____

First Middle last Suffix

What is Your Maiden Surname, if different from your Present Name?

_____

Maiden Surname

What is the Address that you Currently Live at?

_____

Number & Street City/County Zipe Code Inside City Limits

What is Your Race? _____

If of Hispanic Origin, Please Specify Your Origin**: _____**

AGE: _____ Are you married to the father circle YES or NO

Education, Please circle the Highest Grade/year Completed:

Elem/Secondary: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 5+

Your Social Security Number: _____

Date of Last Menses, (Period) Began: _____

Total Number of children now living: _____

Date of Your Last Live Birth: _____

Number of Spontaneous or Induced Losses, Ectopic Pregnancy or previous fetal deaths: _____

Date of Your Last Termination: _____

Method of Disposal Selected: Circle One

Burial Cremation Hospital Disposal Removal From State Other

FINAL (2/5/04)

Patient's medical record # _____
Patient's name _____

FACILITY WORKSHEET FOR THE REPORT OF FETAL DEATH

Complete this worksheet for pregnancies resulting in fetal death. The Model State Vital Statistics Act and Regulations recommend the following definition of fetal death. "Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of the pregnancy and which is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heart beats are to be distinguished from transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps. For detailed definitions, instructions, information on sources, and common key words and abbreviations for many of the items included in the worksheet please see "The Guide to Completing Facility Worksheets for the Certificate of Live Birth."

1. Facility name:* _____
(If not institution, give street and number)

2. Facility I.D. (National Provider Identifier)**:** _____

3. City, Town or Location of delivery: _____ **Zip code:** _____

4. County of delivery: _____

5. Place of delivery:
- ❑ Hospital
- ❑ Freestanding birthing center (Freestanding birthing center is defined as one which has no direct physical connection with an operative delivery center.)
- ❑ Home delivery
  Planned to deliver at home ❑ Yes ❑ No
- ❑ Clinic/Doctor's Office
- ❑ Other (Specify, e.g., taxi cab, train, plane, etc.) _____

*Facilities may wish to have pre-set responses (hard-copy and/or electronic) to questions 1-5 for deaths which occur at their institutions.

Prenatal

Sources: Prenatal care records, patient's medical records, labor and delivery records

Information for the following items should come from the patient's prenatal care records and from other medical reports in the patient's chart. If the patient's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record, or a copy of the prenatal care information. Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.

6(a). Date of first prenatal care visit (Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy):

___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

❑ **No prenatal care** (The mother did not receive prenatal care at any time during the pregnancy. If this box is checked skip 6(b)

6(b). Date of last prenatal care visit (Enter the date of the last visit recorded in the mother's prenatal records):

___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

7. Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record. If none enter "0"): _____

8. Date last normal menses began: ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

9. Number of previous live births now living (For multiple deliveries, includes live born infants born before this fetus in the multiple set.):

_____ Number ☐ None

10. Number of previous live births now dead (For multiple deliveries, includes live born infants born before this fetus in the multiple set who subsequently died):

_____ Number ☐ None

11. Date of last live birth: ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

12. Total number of other pregnancy outcomes (Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this fetus in the pregnancy):

_____ Number ☐ None

13. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended):

___ ___ ___ ___ ___ ___
M M Y Y Y Y

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

Diabetes - (Glucose intolerance requiring treatment)

- ❑ **Prepregnancy -** (Diagnosis prior to this pregnancy)
- ❑ **Gestational -** (Diagnosis in this pregnancy)

Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition.)

- ❑ **Prepregnancy -** (Chronic) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy)
- ❑ **Gestational -** (PIH, preeclampsia) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face).)
- ❑ **Eclampsia** - (Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema)

❑ **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) - (History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes. Perinatal death includes fetal and neonatal deaths.)

- ❑ **Pregnancy resulted from infertility treatment -** Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) 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.

- ❑ **Patient had a previous cesarean delivery -** (Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.)

  If Yes, how many_____

- ❑ None of the above

15. Infections present and/or treated during this pregnancy - (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.) (Check all that apply):

- ❑ Gonorrhea - (a diagnosis of or positive test for *Neisseria gonorrhoeae)*
- ❑ Syphilis - (also called lues - a diagnosis of or positive test for *Treponema pallidum)*
- ❑ Chlamydia - (a diagnosis of or positive test for *Chlamydia trachomatis*)
- ❑ Listeria (LM) - (a diagnosis of or positive test for *Listeria monocytogenes*)
- ❑ Group B Streptococcus (GBS) - (a diagnosis of or positive test for *Streptococcus agalactiae* or group B streptococcus)
- ❑ Cytomegalovirus (CMV) - (a diagnosis of or positive test for the *cytomegalovirus*)
- ❑ Parvovirus (B19) - (a diagnosis of or positive test for parvovirus B19)
- ❑ Toxoplasmosis (Toxo) - (a diagnosis of or positive test for *Toxoplasma gondii*)
- ❑ None of the above
- ❑ Other (specify)_____

Labor and Delivery
Sources: Labor and delivery records, patient's medical records

16. Date of delivery: ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

17. Time of delivery: _____ 24 hour clock

18. Name and title of person completing report:
(May be, but need not be, the same as the attendant at delivery.)

Name: _____
Title: _____

19. Date report completed: ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

20. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?
(Transfers include hospital to hospital, birth facility to hospital, etc.)

❑ Yes ❑ No

If Yes, enter the name of the facility mother transferred from:

_____

21. Attendant's name, title, and N.P.I. (National Provider Indentifier) (The attendant at delivery is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers a fetus under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant):

_____ _____
Attendant's name N.P.I.

Attendant's title:

❑ M.D.
❑ D.O.
❑ CNM/CM - (Certified Nurse Midwife/Certified Midwife)
❑ Other Midwife - (Midwife other than CNM/CM)
❑ Other (specify):_____

22. Mother's weight at delivery (pounds):_____

23. Method of delivery (The physical process by which the complete delivery was effected)
(Complete A, B, C, D, and E):

A. Was delivery with forceps attempted but unsuccessful? – (Obstetric forceps was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)
❑ Yes ❑ No

B. Was delivery with vacuum extraction attempted but unsuccessful? – (Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery.
❑ Yes ❑ No

C. Fetal presentation at delivery (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 presentation not listed above)

D. 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

E. Hysterotomy/Hysterectomy

❑ Yes ❑ No

24. Maternal morbidity (Serious complications experienced by the patient 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 completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- ❑ Ruptured uterus - (Tearing of the uterine wall.)
- ❑ Unplanned hysterectomy - (Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.)
- ❑ Admission to intensive care unit - (Any admission of the mother to a facility/unit designated as providing intensive care.)
- ❑ Unplanned operating room procedure following delivery - (Any transfer of the patient back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.)
- ❑ None of the above

25. Weight of fetus: _____(grams) (Do not convert lb/oz to grams)
If weight in grams is not available, weight of fetus: _____(lb/oz)

26. Obstetric estimate of gestation at delivery (completed weeks):_____
(The delivery attendant's final estimate of gestation based on all perinatal factors and assessments. Do not compute based on date of the last menstrual period and the date of delivery.)

27. Sex (Male, Female, or Unknown): _____

28. Plurality (Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.)
(Include all live births and fetal losses resulting from this pregnancy.):_____

29. If not single delivery (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Include all live births and fetal losses resulting from this pregnancy): _____

30. If not single delivery, specify number of infants in this delivery born alive:_____

31. Congenital anomalies of the fetus (Malformations of the fetus 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 fetuses 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. Do not 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. Includes but is not limited to: transposition of the great arteries (vessels), tetratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.)

- ❑ 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, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not 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)
  - ❑ 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 anomalies listed above

32. Method of Disposition

- ❑ Burial
- ❑ Cremation
- ❑ Hospital Disposition
- ❑ Donation
- ❑ Removal from State
- ❑ Other (Specify)_____

Cause-of-Death Section

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.

33. 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

34. Other Significant Causes or Conditions

Select or Specify All Other Conditions Contributing to Death in Item 34.

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

35. Was an autopsy performed?
❑ Yes ❑ No ❑ Planned

36. Was a histological placental examination performed?
❑ Yes ❑ No ❑ Planned

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

38. 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

Patient's Medical Record #_____
FOR HOSPITAL USE ONLY

Final 1/28/04

Patient's Name_____

Patient's Worksheet for the Report of Fetal Death

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.

PLEASE PRINT CLEARLY

1. Would you like to name the child? This is entirely optional.

_____ _____ _____ _____
First Middle Last Suffix (Jr., III, etc.)

2. What is your current legal name?

_____ _____ _____ _____
First Middle Last Suffix (Jr., III, etc.)

3. Where do you usually live--that is--where is your household/residence located?

Complete number and street:_____ Apartment Number: _____
(Do not enter rural route numbers)
City, Town, or Location:_____
County: _____ State: _____
Zip Code:_____ (or U.S. Territory, Canadian Province)
If not United States, *country*_____

4. Is this household inside city limits (inside the incorporated limits of the city, town, or location where you live)?

- ❑ Yes
- ❑ No
- ❑ Don't know

Patient's Name_____

5. What is your mailing address?

❑ Same as residence [Go to next question]

Complete number and street: _____
Apartment Number: _____ P. O. Box._____
City, Town, or Location: _____
State: _____ Zip Code:_____
(or U.S. Territory, Canadian Province)

If not in the United States, *country*_____

6. What is your date of birth? (Example: 3 - 4 - 1977)

_____ _____ _____
Month Day Year

7. In what State, U.S. territory, or foreign country were you 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 _____

8. What is the highest level of schooling that you have completed at the time of delivery? (Check the box that best describes your education. If you are 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)

Patient's Name_____

9. Are you Spanish/Hispanic/Latina? If *not* Spanish/Hispanic/Latina, check the "*No*" box. If Spanish/Hispanic/Latina, check the appropriate box.

- ❑ 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, Columbian)(specify)_____

10. What is your race? (Please check *one or more races* to indicate what you consider yourself 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) _____

11. Have you ever been married?

- ❑ Yes [Please go to question 12]
- ❑ No [Please go to question 14]

12. What name did you use prior to your first marriage?

_____	_____	_____	_____
First	Middle	Last	Suffix(Jr., III, etc.)

Patient's Name_____

13. Were you married at the time you conceived this child, at the time of delivery, or at any time between conception and delivery?

- ❑ Yes
- ❑ No

14. What is the current legal name of your baby's father?

_____ _____ _____ _____
First Middle Last Suffix(Jr., III, etc.)

15. What is the father's date of birth? (Example: 3 - 4 - 1976)

_____ _____ _____
Month Day Year

- ❑ Don't know

16. 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_____

17. Did you receive WIC (Women, Infants & Children) food for yourself during this pregnancy?

- ❑ No
- ❑ Yes
- ❑ Don't know

Patient's Name_____

18. What is your height?

_____feet _____ inches

19. What was your prepregnancy weight, that is, your weight immediately before you became pregnant with this child?

_____lbs

20. How many cigarettes OR packs of cigarettes did you smoke on an average day during each of the following time periods? If you 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	_____

Thank you for completing this worksheet at this very difficult time. The information you have provided is very important; it will be used by researchers to better understand factors related to miscarriage and stillbirth and lead to improved prevention strategies for the future.

Patient's Medical Record #_____
FOR HOSPITAL USE ONLY

(1/6/04)

Nombre del paciente_____

Formulario para que el paciente reporte un nacimiento sin vida

[Patient's Worksheet for the Report of Fetal Death]

Sentimos mucho la pérdida que ha tenido. Sabemos que estos son momentos difíciles para usted y su familia. Necesitamos hacerle algunas preguntas para completar el informe oficial sobre el nacimiento sin vida. Para garantizar la privacidad de los padres, las leyes estatales protegen contra el uso no autorizado de información de este formulario que pueda servir de identificación. Esta información puede ayudarles a los investigadores de la salud a entender algunos de los factores que pueden haber estado relacionados con la pérdida del bebé. Es muy importante que usted nos brinde una información completa y precisa. Le agradecemos su ayuda, especialmente durante estos momentos difíciles.

POR FAVOR ESCRIBA CLARO Y EN LETRA DE MOLDE

1. ¿Quiere ponerle nombre al bebé? Esta pregunta es completamente opcional.
[Baby's name - optional]

_____	_____	_____	_____
Nombre [First]	Segundo nombre [Middle]	Apellido [Last]	Sufijo (Jr., III, etc.) [Suffix]

2. ¿Cuál es su nombre legal actual?
[Patient's legal name]

_____	_____	_____	_____
Nombre [First]	Segundo nombre [Middle]	Apellido [Last]	Sufijo (Jr., III, etc.) [Suffix]

3. ¿Dónde vive usualmente, es decir, cuál es su lugar de residencia?
[Usual place of residence]

Calle y Número de la casa completo:_____ Número del apartamento: _____ [Apt. Number]
[Number and street] (No escriba números de rutas rurales)
Ciudad, pueblo o lugar:_____ [City, town or location]
Condado: _____[County] Estado:_____ [State]
Código de área postal:_____ [Zip/Postal Code] (o territorio de Estados Unidos, Provincia Canadiense)

Si no vive en los Estados Unidos, escriba el *país*_____
[Country, if not U.S.]

4. ¿Está su residencia dentro de los límites de la ciudad (dentro de los límites incorporados de la ciudad, pueblo o lugar donde usted vive)?
[Household location inside incorporated area/city limits]

- ❑ Sí [Yes]
- ❑ No [No]
- ❑ No sabe [Don't know]

Nombre del paciente _____

5. ¿Cuál es su dirección postal?
[Mailing address]

❑ Igual a la dirección de mi residencia [Vaya a la siguiente pregunta]
[Same as residence]

Calle número de casa completo: _____ [Number and street]
Número del apartamento: _____ [Apt. Number] P. O. Box._____
Ciudad, pueblo o lugar:_____ [City, town or location]
Estado: _____ [State] Código de área postal:_____ [Zip/Postal Code]
(o territorio de los Estados Unidos, Provincia canadiense) [or U.S. Territory, Canadian Province]

Si no vive en los Estados Unidos, escriba el *país*_____ [Country, if not U.S.]

6. ¿Cuál es su fecha de nacimiento? (Ejemplo: 11 - 25 – 1977)
[Patient's date of birth]

_____ _____ _____
Mes Día Año
[Month] [Day] [Year]

7. ¿En qué estado, territorio de Estados Unidos o país extranjero nació usted? Por favor elija uno de los siguientes:
[Patient's birthplace]

Estado _____ [State]

o

territorio de los Estados Unidos, por ejemplo, Puerto Rico, Islas Vírgenes (EE.UU.), Guam, Samoa Americana o Islas Marianas del Norte _____ [Territory]

o

País extranjero _____ [Foreign country]

8. ¿Cuál es el nivel de educación más alto que tenía al momento del parto? Marque el cuadro que mejor describa su educación. (Si actualmente va a la escuela, marque el cuadro que indique el grado que tenía antes o el grado más alto que ha recibido).
[Highest level of schooling completed by patient]

❑ 8° grado o menos [8th grade or less]
❑ 9° - 12º grado, sin diploma [9-12th grade, no diploma]
❑ Graduado de la escuela secundaria (*high school*) o el equivalente (GED)[High school graduate or GED]
❑ Algunos créditos de universidad, pero sin título [Some college credit, no degree]
❑ Grado Asociado (p. ej. AA, AS) [Associate degree]
❑ Licenciatura (p. ej. BA, AB, BS) [Bachelor's degree]
❑ Maestría (p. ej. MA, MS, MEng, MEd, MSW, MBA) [Master's degree]
❑ Doctorado (p. ej. PhD, EdD) o grado profesional (p. ej. MD, DDS, DVM, LLB, JD)
[Doctorate or professional degree]

Nombre del paciente _____

9. ¿Es usted hispana/latina? Si no es hispana/latina, marque la caja que dice "*No*". Si es hispana/latina, marque la caja que corresponda a su caso.
[Patient's Spanish/Hispanic/Latina origin]

- ❑ No, no soy hispana/latina [No, not Hispanic/Latina]
- ❑ Sí, mexicana, mexico-americana, chicana [Yes, Mexican, Mexican American, Chicana]
- ❑ Sí, puertorriqueña [Yes, Puerto Rican]
- ❑ Sí, cubana [Yes, Cuban]
- ❑ Sí, otro país hispano/latino (p. ej. española, salvadoreña, dominicana, colombiana) (especifíque)_____ [Yes, other Hispanic]

10. ¿A qué raza pertenece usted? (Por favor marque la *raza o las razas* a las que usted considera que pertenece).
[Race]

- ❑ Blanca [White]
- ❑ Negra o afroamericana [Black or African American]
- ❑ India americana o nativa de Alaska (nombre de la tribu en la que está inscrita o nombre de la tribu principal)_____ [American Indian or Alaskan Native]
- ❑ India asiática [Asian Indian]
- ❑ China [Chinese]
- ❑ Filipina [Filipino]
- ❑ Japonesa [Japanese]
- ❑ Coreana [Korean]
- ❑ Vietnamita [Vietnamese]
- ❑ Otra asiática (especifique)_____ [Other Asian]
- ❑ Nativa de Hawai [Native Hawaiian]
- ❑ Guameña o Chamorro [Guamanian or Chamorro]
- ❑ Samoana [Samoan]
- ❑ Otra de las islas del Pacífico (especifique)_____ [Other Pacific Islander]
- ❑ Otra (especifique) _____ [Other]

11. ¿Ha estado casada alguna vez?
[Ever married?]

- ❑ Sí [Por favor vaya a la pregunta 12] [Yes]
- ❑ No [Por favor vaya a la pregunta 14] [No]

12. ¿Cuál era su nombre antes de su primer matrimonio?
[Name prior to first marriage]

_____	_____	_____	_____
Nombre [First]	Segundo nombre [Middle]	Apellido [Last]	Sufijo (Jr., III, etc.) [Suffix]

Nombre del paciente _____

13. ¿Estaba casada al momento de concebir este niño(a), al momento del parto o en cualquier momento entre la concepción y el parto?
[Married at time of conception, delivery, or in-between]

- ❑ Sí [Yes]
- ❑ No [No]

14. ¿Cuál es el nombre legal actual del padre del bebé?
[Current legal name of baby's father]

_____	_____	_____	_____
Nombre [First]	Segundo nombre [Middle]	Apellido [Last]	Sufijo (Jr., III, etc.) [Suffix]

15. ¿Cuál es la fecha de nacimiento del padre? (Ejemplo: 12 - 25 – 1976)
[Father's date of birth]

_____	_____	_____
Mes [Month]	Día [Day]	Año [Year]

- ❑ No sabe [Don't know]

16. ¿En qué estado, territorio de Estados Unidos o país extranjero nació el padre? Por favor elija uno de los siguientes:
[Father's birthplace]

Estado_____ [State]

o

territorio de los Estados Unidos, por ejemplo, Puerto Rico, Islas Vírgenes (EE.UU.), Guam, Samoa Americana o Islas Marianas del Norte _____ [U.S. Territory]

o

País extranjero_____ [Foreign country]

17. ¿Recibió alimentos del programa WIC (*Women, Infants & Children*) durante el embarazo?
[Received WIC food for self during this pregnancy]

- ❑ No [No]
- ❑ Sí [Yes]
- ❑ No sabe [Don't know]

Nombre del paciente_____

18. ¿Cuánto mide?
[Height]

_____ pies _____ pulgadas
[Feet] [Inches]

19. ¿Cuánto pesaba antes del embarazo, es decir, cuál era su peso inmediatamente antes de quedar embarazada?
[Prepregnancy weight]

_____ libras [Pounds]

20. ¿Cuántos cigarrillos O cajetillas de cigarrillos fumó (en promedio) por día durante cada uno de los siguientes períodos? Si NUNCA fumó, escriba "cero" para cada período.
[Average number of cigarettes or packs smoked during each time period]

	# de cigarrillos		# de cajetillas	
Tres meses antes del embarazo	_____	o	_____	[3 months before pregnancy]
Primeros tres meses del embarazo	_____	o	_____	[First 3 months of pregnancy]
Segundos tres meses del embarazo	_____	o	_____	[Second 3 months of pregnancy]
Últimos tres meses del embarazo	_____	o	_____	[Last 3 months of pregnancy]
	[# of cigarettes]		[# of packs]	

Gracias por haber llenado este formulario en este momento tan difícil. La información que nos dio es muy importante y será utilizada por investigadores de la salud para entender mejor los factores que provocaron la muerte del bebé y mejorar las estrategias de prevención en un futuro.

Fetal Deaths Frequently Asked Questions & Answers

Question: **What is the definition of a Fetal Death in Virginia?**

Answer: A Fetal Death is defined as "Death prior to the complete expulsion or extraction from its mother of a product of human conception, **regardless of the duration** of pregnancy; death is indicated by the fact that after the expulsion or extraction the fetus does not breathe or show any other evidence of life, such as beating of heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

Question: **Other then a doctor who can sign the Fetal Death Certificate Line 36?**

Answer: The Code of Virginia **§54.1-2957.02**, "Whenever any law or regulation requires a signature, certification, stamp, verification, affidavit or endorsement by a physician, it shall be deemed to include a signature, certification, stamp, verification, affidavit or endorsement by a **nurse practitioner.**

Question: **When do I file a Green Border Death certificate and not a Yellow Border Fetal Death Certificate?**

Answer: A Green Border Death Certificate is only filed if the baby was **born alive** and then died. As a rule of thumb if a Birth Certificate was filed for the infant and then the infant died later then a Green Border Death Certificate, (Form VS2) is filled out. A Fetal Death Certificate should never be filed if a Birth Certificate was filed.

Question: **The woman was only 3 weeks pregnant do I still need to report this as a fetal death?**

Answer: Yes. Virginia is one of only Five States (the other states are New York, Georgia, Pennsylvania, Rhode Island and Hawaii) that require you to report fetal deaths, "regardless of the duration of pregnancy.

Question: **We have a very difficult time getting the doctors to sign the Fetal Death Certificates, can someone else sign them.**

Answer: Yes. Any doctor in the hospital can sign the certificates. Many hospitals have designated one-three doctors who sign the certificates on a weekly basis. Also, the head or Director of the Labor & Delivery can sign the certificates. A Certified Nurse Practitioner can also sign the Fetal Death Certificate. If you are still having problems with doctors signing the FD certificate, give Huston Kitts a call at (804) 662-6280 and he will contact the doctor for you and inform him that Virginia Code requires signature of the certificate within 72 hours of the event.

Question: **Our ER treats a woman who had bleeding at home and who saw her OBGYN, the OBGYN then sends her to the ER for a DNC, who fills out the FD Certificate?**

Answer: If no products of conception are found then the hospital should not fill out a fetal death certificate. We will be sending out a letter to all OBGYN educating them on Fetal Deaths and the proper reporting procedures. Huston Kitts at (804) 662-6280

Question: **Can our Director of Medical Records or Risk Management sign the Fetal Death Certificate?**

Answer: NO, unless that Director is a Physician. Remember the signature on line 36 must be that of a physician or nurse practitioner.

Question: **Why is reporting Fetal Deaths so important?**

Answer: The easy answer is that it is the Law in Virginia that ALL Fetal Deaths are reported no matter what the gestation period was. More importantly fetal deaths affect the Pregnancy Rates both the Total and Teen Pregnancy rates, Community Assessments, and most importantly Allocations of Tax Dollars and Federal Grants. Other programs can also be affected such as WIC. Remember all the funding is based on our statistical reporting of the fetal deaths by heath district, county, city etc. So it is critical that reporting be as accurate as possible to make sure we are putting the appropriate amount of resources where they are needed.

Question: **Do I have to keep a copy of the Fetal Death Certificate and if so how long does the hospital/funeral director or facility have to keep a copy?**

Answer: Virginia Law, §32.1-264 states that the physician, hospital, facility or funeral home shall maintain a copy of the fetal death report for one year.

Question: **Do I have to file a report of Fetal Deaths with the Division of Vital Records & Health Statistics, and if yes what form do I use and where do I send it?**

Answer: Yes, you are required by Virginia Law to submit a monthly report. The State Registrar has designated that hospitals and facilities file a 'Vital Statistics Monthly Fetal Death Report, (Form VVS34 Revised March 2007). If you need copies of this form please call Huston Kitts at (804) 662-6280 and he can send you a supply of the forms and/or send you the form on a computer disc. This report is due to Vital Records by the tenth day of the following month, for example your October report is due on or before November 10th.

Question: **What do I do with the Fetal Death Certificate after I fill it out and it is signed by the physician? Do I send it to the state office?**

Answer: Once you have completed filling out the Fetal Death Certificate, you need to mail or delivery it to your local health department office as soon as possible. Do not mail the certificate to Vital Records. Some hospitals hold these certificates until the end of the month, remember the law states that the certificates are to be filed within 72 hours so please do not hold these certificates. Mail or deliver them to the local health department as soon as they are completed. Also remember to **make your copy before you send it to the local health department and that you are required to retain that copy for one year.**

Question: **When I have a question on anything relating to Fetal Deaths who can I call to get information and answers to Fetal Death related situations and/or questions.**

Answer: For Fetal Death, Induced Termination of Pregnancy and regular death certificate questions you can call Huston Kitts, (Senior Data Analyst for Health Statistics) at (804) 662-6280, or you can contact him by email at Huston.Kitts@vdh,virginia.gov, or you can fax him requests to his fax number (804) 662-7261.

Question: The doctor has not signed the Fetal Death Certificate and my report is due to your office on or around the 10th of the following month, do I hold the report until all the certificates are signed for that month and then send in the report or do I send the report even though I have unsigned certificates.

Answer: You can send the report in when it's due, the fact that a doctor has not signed a Fetal Death Certificate does not have any affect on filing the report. Just note on the report that you are waiting for a doctors signature in the fourth column, Name of Medical Attendant, and then once the doctor has signed the certificate you can call, email or fax me that it has been signed and submitted and I can update your report, so please do not hold a report until all the certificates have been signed.

Question: What Name should I list on my Vital Statistics Monthly Fetal Death Report, her married name or her maiden name or both?

Answer: Enter the name of the mother which is listed on Line 9, Present Name. You do not need to enter the Maiden Name on the Monthly Report, the system tracks the mothers maiden name.