(REV. 02/11)

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE (Each question MUST be answered)

CONFIDENTIAL MEDICAL REPORT OF SPONTANEOUS TERMINATION OF PREGNANCY

WORKSHEET (2 of 3)

Mother/Parent Medical Record No. _____

22. Date Last Normal Menses Began: ____/____/_____ (mm dd yyyy)

23. PARENT'S EDUCATION

(Check the box that best describes the highest degree or level of school completed at time of delivery)

a. Mother/Parent		b. Father/Parent
☐	8th grade or less; none	☐
☐	9th-12th grade, no diploma	☐
☐	High school graduate or GED	☐
☐	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)	☐
☐	Unknown	☐

24. PARENT'S OCCUPATION

a. Was mother/parent employed during pregnancy? Yes ☐ No ☐

	1. Current/most recent occupation	2. Kind of business or industry
b. Mother/Parent		
c. Father/Parent		

25. PARENT'S ANCESTRY

(Check **one** box and specify what the parent considers her/himself to be)

a. Mother/Parent **b. Father/Parent**

☐ Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.) ☐

Specify

_____ (Mother/Parent) _____ (Father/Parent)

☐ NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukranian, Nigerian, Taiwanese, etc.) ☐

Specify

_____ (Mother/Parent) _____ (Father/Parent)

☐ Unknown ☐

26. PARENT'S RACE

Race as defined by the U.S. Census
(Check **one or more** to indicate what the parent considers her/himself to be)

a. Mother/Parent **b. Father/Parent**

☐ White ☐

☐ Black or African American ☐

☐ American Indian or Alaska Native ☐

Name of enrolled or principal tribe

_____ (Mother/Parent) _____ (Father/Parent)

☐ Asian Indian ☐

☐ Chinese ☐

☐ Filipino ☐

☐ Japanese ☐

☐ Korean ☐

☐ Vietnamese ☐

☐ Other Asian ☐

Specify

_____ (Mother/Parent) _____ (Father/Parent)

☐ Native Hawaiian ☐

☐ Guamanian or Chamorro ☐

☐ Samoan ☐

☐ Other Pacific Islander ☐

Specify

_____ (Mother/Parent) _____ (Father/Parent)

☐ Other ☐

Specify

_____ (Mother/Parent) _____ (Father/Parent)

☐ Unknown ☐

27. PARENT'S LENGTH OF TIME IN U.S.

a. Mother/Parent **b. Father/Parent**

☐ Never lived in United States ☐

If born outside of the United States, how long lived in U.S.?

years

_____ (Mother/Parent) _____ (Father/Parent)

or if <1 yr, months

_____ (Mother/Parent) _____ (Father/Parent)

28. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

a. Initiating Cause/Condition

(Among the choices below, please select the **one** that most likely began the sequence of events resulting in the death of the fetus).

☐ Maternal Conditions/Diseases (Specify) _____

☐ Complications of Placenta, Cord, or Membranes
- ☐ Rupture of membranes prior to onset of labor
- ☐ Abruptio placenta
- ☐ Placental insufficiency
- ☐ Prolapsed cord
- ☐ Chorioamnionitis
- ☐ Other (Specify) _____

☐ Other Obstetrical or Pregnancy Complications (Specify) _____

☐ Fetal Anomaly (Specify) _____

☐ Fetal Injury (Please consult with OCME) _____

☐ Fetal Infection (Specify) _____

☐ Other Fetal Conditions/Disorders (Specify) _____

☐ Unknown

b. Other Significant Causes or Conditions

(Select or specify **all** other conditions contributing to death).

☐ 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 (Please consult with OCME) _____

☐ Fetal Infection (Specify) _____

☐ Other Fetal Conditions/Disorders (Specify) _____

☐ Unknown

c. Was this case referred to OCME? ☐ Yes ☐ No ☐ Unknown If yes, ME Case Number: _____

FOR GESTATION OF 20 WEEKS OR MORE: ALL ITEMS BELOW MUST BE COMPLETED (except OCME cases).

29. PRENATAL

a. Primary Payor (Check **one**)

☐ Medicaid ☐ Self-pay
☐ Other govt. insurance ☐ None
☐ Private insurance ☐ Unknown

b. Total Number of Prenatal Visits for this Pregnancy

☐ None _____

c. Date of First Prenatal Care Visit

(mm/dd/yyyy) ____/____/_____

d. Date of Last Prenatal Care Visit

(mm/dd/yyyy) ____/____/_____

e. Previous Live Births

1. Total Number of Previous Live Births _____ ☐ None
2. Number Born Alive and Now Living _____ ☐ None
3. Number Born Alive and Now Dead _____ ☐ None

f. Date of First Live Birth (mm/yyyy) ____/_____

g. Date of Last Live Birth (mm/yyyy) ____/_____

h. Total Number of Other Pregnancy Outcomes _____ ☐ None
(Spontaneous or Induced losses or ectopic pregnancies)
Do not include this fetus

i. Date of Last Other Pregnancy Outcome
(mm/yyyy) ____/_____

30. MOTHER/PARENT HEALTH

a. Height _____ feet _____ inches

b. Pre-Pregnancy Weight _____ pounds

c. Weight Immediately Prior to Event _____ pounds

d. Cigarette Smoking

1. Cigarette smoking in the 3 months before or during pregnancy?
☐ Yes ☐ No ☐ Unknown

If yes, average number of cigarettes or packs/day (enter 0 if None)

	Cigarettes	or	Packs/Day
2. 3 mo. before pregnancy	_____	or	_____
3. First 3 mo. of pregnancy	_____	or	_____
4. Second 3 mo. of pregnancy	_____	or	_____
5. Third trimester of pregnancy	_____	or	_____

e. Alcohol use during this pregnancy?
☐ Yes ☐ No ☐ Unknown

f. Illicit and other drugs used during this pregnancy?
☐ Yes ☐ No ☐ Unknown

If yes, check **all** that apply

☐ Heroin ☐ Sedatives
☐ Cocaine ☐ Tranquilizers
☐ Methadone ☐ Anticonvulsants
☐ Methamphetamine ☐ Other
☐ Marijuana ☐ Unknown

31. PREGNANCY FACTORS

a. Risk Factors in this Pregnancy
(Check **all** that apply)

☐ Diabetes – Prepregnancy
☐ Diabetes – Gestational
☐ Hypertension – Pre-pregnancy
☐ Hypertension – Gestational
☐ Hypertension – Eclampsia
☐ Previous Preterm Birth
☐ Other previous poor pregnancy outcome
☐ Infertility Treatment – Fertility-enhancing drugs, Artificial/Intrauterine insemination
☐ Infertility Treatment – Assisted Reproductive Technology
☐ Mother had a Previous Cesarean Delivery

If yes, how many? _____

☐ Other
☐ None
☐ Unknown

(REV. 02/11)

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE (Each question MUST be answered)

CONFIDENTIAL MEDICAL REPORT OF SPONTANEOUS TERMINATION OF PREGNANCY

WORKSHEET (3 of 3)

Mother/Parent Medical Record No. _____

FOR GESTATION OF 20 WEEKS OR MORE: ALL ITEMS BELOW MUST BE COMPLETED (except OCME cases).

31. PREGNANCY FACTORS (cont.)

b. Infection Present and/or Treated During Pregnancy
(Check **all** that apply)

- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Herpes Simplex (HSV)
- ☐ Chlamydia
- ☐ Bacterial Vaginosis
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Listeria
- ☐ Group B Strep
- ☐ Tuberculosis
- ☐ Rubella
- ☐ Cytomegalovirus
- ☐ Parvovirus
- ☐ Toxoplasmosis
- ☐ Other
- ☐ None
- ☐ Unknown

32. DELIVERY

a. Method of Delivery

1. Was delivery with forceps attempted but unsuccessful?
- ☐ Attempted and successful ☐ Attempted and unsuccessful
- ☐ Forceps were not used ☐ Unknown

2. Was delivery with vacuum extraction attempted but unsuccessful?
- ☐ Attempted and successful ☐ Attempted and unsuccessful
- ☐ Vacuum extraction was not used ☐ Unknown

3. Fetal presentation at delivery
- ☐ Cephalic
- ☐ Breech
- ☐ Other
- ☐ Unknown

4. Final route and method of delivery
(Check **one**)
- ☐ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum
  Vaginal delivery after a previous C-section?
  ☐ Yes ☐ No ☐ Unknown
- ☐ Primary Cesarean
- ☐ Repeat Cesarean
  If cesarean, was a trial of labor attempted?
  ☐ Yes ☐ No ☐ Unknown

5. Hysterotomy/Hysterectomy
☐ Yes ☐ No ☐ Unknown

b. Maternal Morbidity (Check **all** that apply)
(Complications associated with labor and delivery)

- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following delivery
- ☐ Hemorrhage
- ☐ Postpartum transfer to a higher level of care
- ☐ Other
- ☐ None
- ☐ Unknown

c. Was mother transferred for maternal medical or fetal indication prior to delivery?
☐ Yes ☐ No ☐ Unknown
If yes, name of facility transferred from:
_____

33. FETAL ATTRIBUTES

a. Weight of Fetus (grams preferred, specify unit)
_____ ☐ lb/oz _____ ☐ grams

b. Estimated Time of Fetal Death
- ☐ Death at time of first assessment, no labor ongoing
- ☐ Death at time of first assessment, labor ongoing
- ☐ Died during labor, after first assessment
- ☐ Unknown time of fetal death

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

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

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

f. Congenital Anomalies of the Fetus
(Check **all** that apply)
- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ☐ Cleft lip with or without cleft palate
- ☐ Cleft palate alone
- ☐ Down syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☐ Other
- ☐ None
- ☐ Unknown

THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF SPONTANEOUS TERMINATION OF PREGNANCY

WORKSHEET (1 of 3)

(REV. 02/11)

Did heart beat after delivery? _____
Was there movement of voluntary muscle? _____

If answer to either is yes, do not use this form. Case must be reported by filing a certificate of birth and a certificate of death.

FETUS

1. NAME *(Optional):* (First, Middle, Last, Suffix)

2a. DATE OF DELIVERY *(Month) (Day) (Year-yyyy)*

2b. TIME _____ ☐ AM ☐ PM ☐ Unknown

3. SEX ☐ Male ☐ Female ☐ Unknown

4. OBSTETRIC ESTIMATE OF GESTATION _____ # of weeks

5a. NUMBER DELIVERED THIS PREGNANCY _____

IF MORE THAN ONE
5b. Number in order of delivery _____
5c. Number born alive _____

FETUS Place of Delivery

6a. TYPE OF PLACE
- ☐ Hospital – ER/ED
- ☐ Hospital – Amb. Surg.
- ☐ Hospital – Labor/Labor and Delivery
- ☐ Hospital – Other
- ☐ Freestanding Birthing Center
- ☐ Home
- ☐ Clinic/Doctor's Office
- ☐ Other, Specify _____
- ☐ Unknown

6b. FACILITY NAME/ADDRESS

*If not in facility, street address: (*Street Number and Name, City or Town, County, State, Country, Zip Code)

MOTHER/PARENT

7. CURRENT LEGAL NAME: (First, Middle, Last, Suffix)

8. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

9. DATE OF BIRTH *(Month) (Day) (Year-yyyy)*

10. AGE

11. SEX ☐ Male ☐ Female

12. BIRTHPLACE City _____ State _____ Country

13. RESIDENCE ADDRESS: (Street Number and Name, Apt. No., City or Town, County, State, Country, Zip Code)

14. INSIDE CITY LIMITS? ☐ Yes ☐ No ☐ Unknown

FATHER/PARENT

15. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

16. DATE OF BIRTH *(Month) (Day) (Year-yyyy)*

17. AGE

18. SEX ☐ Male ☐ Female

19. BIRTHPLACE City _____ State _____ Country

ATTENDANT/CERTIFIER

20. ATTENDANT NAME AT DELIVERY: ☐ MD ☐ DO ☐ LIC. Midwife ☐ RPA ☐ Other, *(specify)* _____

(First, Middle, Last, Suffix)

21. CERTIFIER: I HEREBY CERTIFY THAT THIS EVENT OCCURRED AT THE TIME AND ON THE DATE INDICATED AND THAT ALL FACTS STATED IN THIS CERTIFICATE ARE TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF. ☐ MD ☐ DO

Signature of Physician Certifier

Name of Physician Certifier

Address

License No. _____ *Date* ____/____/____

FUNERAL DIRECTOR'S CERTIFICATE

FUNERAL DIRECTOR'S CERTIFICATE

I hereby certify that I have been employed as Funeral Director by _____ *(Name of person in control of disposition)*

of _____ *(Address)*. This statement is made to obtain a disposition permit for this fetus _____

(Signature of Funeral Director) *(License No.)*

Funeral Establishment _____ Business Registration No. _____

Address _____

NAME OF CEMETERY OR CREMATORY (OR DESTINATION)	CITY OR COUNTY AND STATE	DATE OF DISPOSITION *(Month) (Day) (Year-yyyy)*