

Surveillance Fetal Death Evaluation Form

(Stamper Plate/ID label)

Hospital Name _____

If you would like a follow-up call re: the surveillance activities of this case, please indicate and provide contact information _____

Mother's Name: _____ MR#: _____

County of Residence: _____

Age: _____ Race: _____ Ethnicity: _____

Father's Name: _____ Race: _____

Ethnicity: _____ County of Residence: _____

Date of Stillbirth Diagnosis: _____ EDC: _____

Ultrasound findings at time of stillbirth diagnosis:

Probable factors contributing to fetal death:

Blood Pressure range of mother prior to stillbirth: _____

OBSTETRICAL HISTORY

G _____ P _____ AB _____ T _____ PT _____ L _____

Prior obstetrical complications:

LMP: _____/_____/_____

Maternal Medical History:

Medications (Include over-the-counter medications and herbs):

Allergies: _____

Smoking: _____ Alcohol Use: _____

Illicit Drug Use: _____

Assessment Form

ANTEPARTUM FINDINGS

Date of first prenatal visit: ____/____/____ Number of antepartum visits: ____

ABO/Rh: ____ Antibody: ____ VDRL: ____ HbsAg: _____

Diabetes Testing: 1 hr Glucola: _____ 3 hr GTT-FBS: _____ 1 hr: _____ 2 hr: _____
3 hr: _____

Maternal Serum Screening (i.e., Integrated Screen, Expanded AFP/QUAD Screen, Triple Test, or MSAFP):

Y/N Results:

Amniocentesis:

Y/N Results:

Ultrasounds (List from most recent to initial exam):

Date: _____ Gestational Age: _____

Findings:

Date: _____ Gestational Age: _____

Findings:

Date: _____ Gestational Age: _____

Findings:

Date: _____ Gestational Age: _____

Findings:

Maternal Drug Screen:

Source: _____ Results:

Blood Pressure at last two visits: _____/_____/_____ and _____/_____/_____

History of low blood pressure: Y/N

History of high blood pressure: Y/N

HEALTH AT TIME OF DIAGNOSIS

Fever/Rash: Y/N Explain: _____

Bleeding: Y/N Pain: Y/N Explain:

Exposure History:

Illnesses Y/N Explain:

Teratogens: Y/N Explain:

Recent Trauma: Y/N Explain:

Comments:

TESTS AT DIAGNOSIS

Fetal Hemoglobin in the Maternal Circulation: Kleihauer-Betke or flow cytometry:

Lupus Anticoagulant: _____

Anticardiolipin antibodies: _____

(If extensive placental infarction, Factor V Leiden _____; Prothrombin gene mutation: _____)

Urine Drug Screen:

Chromosomal analysis (amniocentesis):

Hemoglobin A1c (HbgA1c)

STORCH Titers: IgG and IgM for syphilis, toxoplasmosis, cytomegalovirus, herpes virus, and rubella

TSH
STORCH

PCR (Polymerase Chain Reaction) for

CBC

Parvovirus IgG and IgM

FINDINGS AT DELIVERY

GROSS FETAL EXAM

Fetus weight: _____ Length: Crown Rump _____ Crown Heel _____

	Normal	Abnormal (describe)		
1. General Appearance	<input type="checkbox"/>	<input type="checkbox"/> trauma evidence	<input type="checkbox"/> macerated +, ++, +++ <input type="checkbox"/> edema	
2. Skin	<input type="checkbox"/>	<input type="checkbox"/> mec.stained <input type="checkbox"/> jaundice	<input type="checkbox"/> bruising <input type="checkbox"/> petechiae	
3. Head	<input type="checkbox"/>	<input type="checkbox"/> hydrocephalic <input type="checkbox"/> neural tube defect	<input type="checkbox"/> collapsed <input type="checkbox"/> anencephalic	
4. Scalp	<input type="checkbox"/>	<input type="checkbox"/> defects	<input type="checkbox"/> masses	
5. Eyes	<input type="checkbox"/>	Spacing: <input type="checkbox"/> narrow <input type="checkbox"/> wide Slanting: <input type="checkbox"/> up <input type="checkbox"/> down	<input type="checkbox"/> cataracts <input type="checkbox"/> sunken <input type="checkbox"/> eyelids closed	<input type="checkbox"/> opaque <input type="checkbox"/> prominent <input type="checkbox"/> eyelids fused
6. Nose	<input type="checkbox"/>	<input type="checkbox"/> flat bridge	<input type="checkbox"/> asymmetric	
7. Nostrils	<input type="checkbox"/>	<input type="checkbox"/> obstructed	<input type="checkbox"/> single nostril	
8. Ears	<input type="checkbox"/>	<input type="checkbox"/> abnormal position <input type="checkbox"/> abnormal form	<input type="checkbox"/> periauricular tags/pits	
9. Mouth	<input type="checkbox"/>	<input type="checkbox"/> small <input type="checkbox"/> large	<input type="checkbox"/> cleft lip <input type="checkbox"/> cleft palate	
10. Mandible	<input type="checkbox"/>	<input type="checkbox"/> micrognathia	<input type="checkbox"/> asymmetric	
11. Neck	<input type="checkbox"/>	<input type="checkbox"/> short	<input type="checkbox"/> excess skin <input type="checkbox"/> cystic mass	
12. Chest	<input type="checkbox"/>	<input type="checkbox"/> asymmetric <input type="checkbox"/> small	<input type="checkbox"/> nipples wide spaced <input type="checkbox"/> constricted	<input type="checkbox"/> sternal defects <input type="checkbox"/> barrelled
13. Abdomen	<input type="checkbox"/>	<input type="checkbox"/> flattened	<input type="checkbox"/> distended	<input type="checkbox"/> wall defect
14. Back	<input type="checkbox"/>	<input type="checkbox"/> sacral dimple <input type="checkbox"/> scoliosis	<input type="checkbox"/> neural tube defect <input type="checkbox"/> kyphosis	
15. Arms	<input type="checkbox"/>	<input type="checkbox"/> short <input type="checkbox"/> abnormal muscle dev't	<input type="checkbox"/> long <input type="checkbox"/> absent	<input type="checkbox"/> abnormal positioning
16. Hands	<input type="checkbox"/>	<input type="checkbox"/> creases abnormal <input type="checkbox"/> extra digits	<input type="checkbox"/> webbing fingers <input type="checkbox"/> absent digits	<input type="checkbox"/> abnormal positioning <input type="checkbox"/> abnormal nails
17. Legs	<input type="checkbox"/>	<input type="checkbox"/> short <input type="checkbox"/> abnormal muscle dev't	<input type="checkbox"/> long <input type="checkbox"/> absent	<input type="checkbox"/> abnormal positioning
18. Feet	<input type="checkbox"/>	<input type="checkbox"/> club foot <input type="checkbox"/> extra toes	<input type="checkbox"/> webbing toes <input type="checkbox"/> absent toes	<input type="checkbox"/> abnormal positioning <input type="checkbox"/> abnormal nails
19. Genital-Rectal	Gender <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> hypospadias <input type="checkbox"/> ambiguous	<input type="checkbox"/> undescended testes <input type="checkbox"/> imperforate anus	

OTHER TESTS/EXAM

Iowa Neonatal Metabolic Screen Blood Spots obtained and sent to lab.

Whole Body X-Ray (limbs extended):

Autopsy (consent obtained):

Chromosomal analysis: Cell source: amniotic fluid, amnion, placenta, fetal collagen _____ **DO NOT PLACE SAMPLE IN FORMALIN. PLACE IN STERILE CONTAINER**

Results:

Photographs: Whole Body _____ Face

Anomalies:

Gross Description of Postpartum Placenta

1. Complete	<input type="checkbox"/> yes	<input type="checkbox"/> no If incomplete, amount apparently missing ____%
2. Intact	<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Placenta accreta <input type="checkbox"/> Placenta increta <input type="checkbox"/> Placenta percreta
3. Diameter	Approximately ____cms	
4. Thickness	Approximately ____cms	
5. Shape	<input type="checkbox"/> discoid <input type="checkbox"/> oval	<input type="checkbox"/> bilobed <input type="checkbox"/> succenturiate lobe present <input type="checkbox"/> other anomaly present _____
6. Consistency	<input type="checkbox"/> normal	<input type="checkbox"/> soft <input type="checkbox"/> firm
7. Hemorrhage	<input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> approximate size of hemorrhage ____cms Consistency of hemorrhage _____ Adherence of clot <input type="checkbox"/> yes <input type="checkbox"/> no
8. Other abnormalities	<input type="checkbox"/> Amniotic nodules <input type="checkbox"/> Malodor	<input type="checkbox"/> Staining of amniotic surface <input type="checkbox"/> Amniotic bands

Gross Description of Umbilical Cord

1. Insertion	<input type="checkbox"/> Central	<input type="checkbox"/> Eccentric <input type="checkbox"/> Velamentous	<input type="checkbox"/> Marginal
2. Length	Approximately _____cms		
3. Diameter	Approximately _____cms		
4. Knots	<input type="checkbox"/> No	<input type="checkbox"/> Yes Describe _____ _____	
5. Cord around body	<input type="checkbox"/> No	<input type="checkbox"/> Nuchal x _____ <input type="checkbox"/> tight <input type="checkbox"/> loose	<input type="checkbox"/> Around torso or shoulder x _____
6. Number of vessels	_____	<input type="checkbox"/> Single artery	
7. Thromboses	<input type="checkbox"/> No	<input type="checkbox"/> Yes Describe _____ - _____	
8. Wharton's Jelly	<input type="checkbox"/> Present	<input type="checkbox"/> Absent	
9. Torsion	<input type="checkbox"/> No	<input type="checkbox"/> Yes Describe _____ _____	

Return form to:

State Genetic Coordinator

321 E. 12th Street

Des Moines, IA 50319-0075

Or fax to 515-242-6013

Call 1-800-383-3826 for questions.