Rhode Island Department of Health

Instructions to Complete a Fetal Death Certificate

For Funeral Directors & Physicians

Presented by:

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Table of Contents

Facility Information

Type or Print in Permanent Black Ink.

Rhode Island Department of Health
Certificate of Fetal Death

Mother's Name:_____
Mother's Medical Record Number:_____
For Use by PHYSICIAN or Institution Only

Facility

1. Fetus' Name (Optional)	2. Date of Delivery _____/_____/_____	3. Time of Delivery _____:_____ AM/PM	4. Plurality	5. Birth Order
6. Number of Fetal Deaths (This Birth)	7. Ob. Est. of Gestational Age (Weeks)	8. Fetus' Sex	9. Fetus' Weight (Grams / Lbs)	10. Facility Name
11. Address of Delivery (If not in Hospital)	12. City / Town of Delivery		13. Residence Address (Street Address, City / Town, State, Zip Code)	

14. Place of Delivery

❑ Hospital ❑ Home Delivery - Intended ❑ Home Delivery - Not Intended
❑ Freestanding Birth Center ❑ Clinic / Doctor's Office ❑ Other (Specify)_____

Mother / Parent

15. Legal Name (First, Middle, Last)	16. Last Name at Birth (Maiden Name)	17. Date of Birth _____/_____/_____	18. Birthplace (State, Territory, or Country)

Father / Parent

19. Legal Name (First, Middle, Last)	20. Last Name at Birth (Maiden Name)	21. Date of Birth _____/_____/_____	22. Birthplace (State, Territory, or Country)

Attendant / Certifier

23. Attendant's Name	24. Attendant's Title ❑ MD ❑ DO ❑ RPN ❑ CNM ❑ Other(Specify)_____	
25. Attendant's Address, City / Town, State, Zip Code	26. Certifier's Name (If Different From Attendant)	
27. I certify that the pregnancy loss occurred on the date specified above	28. Date Signed _____/_____/_____	29. License No.

30. Autopsy Performed? ❑ Yes ❑ No ❑ Planned	31. Histological Exam Performed? ❑ Yes ❑ No ❑ Planned	32. Autopsy or Hist Exam Results Used? ❑ Yes ❑ No

Facility Information (cont…)

Facility	1. Fetus' Name (Optional)		2. Date of Delivery _____/_____/_____	3. Time of Delivery _____:_____ AM/PM	4. Plurality	5. Birth Order
	6. Number of Fetal Deaths (This Birth)	7. Ob. Est. of Gestational Age (Weeks)	8. Fetus' Sex	9. Fetus' Weight (Grams / Lbs)	10. Facility Name	

1. **Fetus' Name** – This field should be left blank if the mother/parents are not naming the fetus.

2. **Date of Delivery** – Enter the date the fetal death occurred. This should be the date the fetus was removed from the mother either by expulsion or extraction.

3. **Time of Delivery** – Enter the time the fetal death occurred. This should be the time the fetus was removed from the mother either by expulsion or extraction. If unknown, enter unknown.

4. **Plurality** – Enter the plurality of the birth. (Single, Twin, Triplet, etc…) If unknown, enter unknown.

5. **Birth Order** – If not a singleton, specify delivered 1st, 2nd, etc. For multiple deliveries, the order this infant was delivered in the set. Include all live births and fetal losses. If unknown, enter unknown.

6. **Number of Fetal Deaths** – If not a singleton, specify the number of fetal deaths in this delivery. For multiple deliveries, the number of fetal deaths delivered at any point in the pregnancy. If unknown, enter unknown.

Facility Information (cont…)

6. Number of Fetal Deaths (This Birth)	7. Ob. Est. of Gestational Age (Weeks)	8. Fetus' Sex	9. Fetus' Weight (Grams / Lbs)	10. Facility Name
11. Address of Delivery (If not in Hospital)	12. City / Town of Delivery		13. Residence Address (Street Address, City / Town, State, Zip Code)	
14. Place of Delivery ❑ Hospital ❑ Freestanding Birth Center	❑ Home Delivery - Intended ❑ Clinic / Doctor's Office		❑ Home Delivery - Not Intended ❑ Other (Specify)_____	

7. **Ob. Est. of Gestational Age** – Enter the estimated gestational age of the fetus. If unknown but within a specific range, enter the range. If unknown, enter unknown.

8. **Fetus' Sex** – Enter whether the fetus is male, female or if the sex of the fetus is not yet determined. If unknown, enter unknown.

9. **Fetus' Weight** – Enter the weight of the fetus in either grams or lbs./ounces. If unknown, enter unknown.

10. **Facility Name** – If fetal death occurred in a facility, enter the facility name here. If the fetal death occurred at home, leave this blank.

11. **Address of Delivery** – If fetal death did not occur in a facility, enter the address where the fetal death occurred, including street number and street.

12. **City/Town of Delivery** – Enter one of the 39 cities/towns. Do not enter a village. See Appendix A

13. **Residence Address** – Enter the address where the mother currently resides. PO boxes may not be entered. Do not enter villages. If mother resides outside the US, enter the country in place of state.

14. **Place of Delivery** – Select the location where the fetus was removed from the mother either by expulsion or extraction.

Mother/Father/Parent's Information

Mother / Parent	15. Legal Name (First, Middle, Last)	16. Last Name at Birth (Maiden Name)	17. Date of Birth _____/_____/_____	18. Birthplace (State, Territory, or Country)
Father / Parent	19. Legal Name (First, Middle, Last)	20. Last Name at Birth (Maiden Name)	21. Date of Birth _____/_____/_____	22. Birthplace (State, Territory, or Country)

- **Field #'s 15-22** should be filled out by the funeral home if a funeral home is handling the disposition.
- If a facility is handling the disposition, the fields should be completed by the facility.

Parent's Information

Mother / Parent	15. Legal Name (First, Middle, Last)	16. Last Name at Birth (Maiden Name)	17. Date of Birth _____/_____/_____	18. Birthplace (State, Territory, or Country)
Father / Parent	19. Legal Name (First, Middle, Last)	20. Last Name at Birth (Maiden Name)	21. Date of Birth _____/_____/_____	22. Birthplace (State, Territory, or Country)

15. **Legal Name** – Enter the mother/parent's full legal name (first, middle, and last) at the time of the fetal death.

16. **Last Name at Birth** – Enter the mother/parent's last name at birth (maiden name). If legal name is same as last name at birth, still enter last name at birth.

17. **Date of Birth** – Enter the mother/parent's date of birth.

18. **Birthplace** – Enter the place the mother/parent was born. If born within the US, enter the state. If born outside the US, enter the country.

19. **Legal Name** - Enter the father/parent's full legal name (first, middle, and last) at the time of the fetal death. A Father's name may only be added if couple was married at time of Fetal Death. If an unmarried couple still wishes to add a father's name, they must both sign a Paternity Affidavit.

20. **Last Name at Birth** – Enter the father/parent's last name at birth (maiden name). If legal name is same as last name at birth, still enter last name at birth.

21. **Date of Birth** - Enter the father/parent's date of birth.

22. **Birthplace** – Enter the place the father/parent was born. If born within the US, enter the state. If born outside the US, enter the country.

Certifier/Attendant Information

Attendant / Certifier									
	23. Attendant's Name			24. Attendant's Title	❑ MD	❑ DO	❑ RPN	❑ CNM	❑ Other(Specify)_____
	25. Attendant's Address, City / Town, State, Zip Code			26. Certifier's Name (If Different From Attendant)					
	27. I certify that the pregnancy loss occurred on the date specified above			28. Date Signed _____/_____/_____			29. License No.		
	30. Autopsy Performed? ❑ Yes ❑ No ❑ Planned			31. Histological Exam Performed? ❑ Yes ❑ No ❑ Planned			32. Autopsy or Hist Exam Results Used? ❑ Yes ❑ No		
	33. Medical Examiner Notified?			❑ Yes ❑ No					
	34. Manner of Death	❑ Natural	❑ Accident	❑ Homicide	❑ Pending Investigation	❑ Couldn't Be Determined			

Field #'s 23-34 should be completed by the certifying or attending physician who is completing the Fetal Death Certificate**.**

Certifier/Attendant's Information

Attendant / Certifier			
	23. Attendant's Name	24. Attendant's Title ❑ MD ❑ DO ❑ RPN ❑ CNM ❑ Other(Specify)_____	
	25. Attendant's Address, City / Town, State, Zip Code	26. Certifier's Name (If Different From Attendant)	
	27. I certify that the pregnancy loss occurred on the date specified above	28. Date Signed _____/_____/_____	29. License No.
	30. Autopsy Performed? ❑ Yes ❑ No ❑ Planned	31. Histological Exam Performed? ❑ Yes ❑ No ❑ Planned	32. Autopsy or Hist Exam Results Used? ❑ Yes ❑ No

23. **Attendant's Name** – Enter the name of the attendant.

24. **Attendant's Title** – Select the title of the attendant. If none of the selections fit, select other and specify the title of the attendant.

25. **Attendant's Address, City/Town, State, Zip Code** – Enter the address of the attendant including street number and street, city/town, state, and zip code of the attendant.

26. **Certifier's Name** – If certifying physician is different than attendant, enter the certifier's name.

27. **I certify that the pregnancy loss occurred on the date specified above** – The certifying physician should review the certificate to make sure all information completed is correct. After review, the certificate must be signed.

28. **Date Signed** – The certifying physician is required to enter the date that the certificate is signed.

29. **License No** – Enter the license number of the certifier.

30. **Autopsy Performed** – Select whether an autopsy was performed or is planned on being performed.

Certifier/Attendant's Information (cont…)

30. Autopsy Performed?			31. Histological Exam Performed?			32. Autopsy or Hist Exam Results Used?	
❑ Yes	❑ No	❑ Planned	❑ Yes	❑ No	❑ Planned	❑ Yes	❑ No
33. Medical Examiner Notified?			❑ Yes	❑ No			
34. Manner of Death	❑ Natural		❑ Accident	❑ Homicide	❑ Pending Investigation	❑ Couldn't Be Determined	

31. **Histological Placental Examination Performed** – Select whether a histological placental examination was performed or is planned on being performed.

32. **Autopsy or Histological Exam Results Used** – Select whether the results from the autopsy or histological exam were used in completing the cause of death. If neither were performed, leave this box blank.

33. **Medical Examiner Notified** – Select whether the Medical Examiner was notified of the fetal death. Rhode Island law and "Regulations Governing the Medical Examiner System" require the following events to be reported to the Office of State Medical Examiners [R23-4-ME]:
    - All fetal deaths occurring without medical attendance or after delivery of a live born fetus following therapeutic abortion, or when inquiry is required in accordance with section 23-3-17 € of the General Laws of Rhode Island, as amended.
    - Deaths of newborns and stillbirths delivered or occurring outside of a hospital or when the mother is involved in a recent or past traumatic event (motor vehicle crash, suicide attempt, etc.) that may have precipitate the delivery and may have a causal relationship to the newborn death, and all infant deaths occurring within 24 hours of deliver without known reasonable cause of death, or if the cause is suspected to be traumatic before, during or after said delivery.

34. **Manner of Death** – Select the manner of death. If the fetal death is due to or suspected of being either an accident or homicide, it is required to be referred to the Medical Examiner's Office. (§ 802.1.15)

Cause of Death

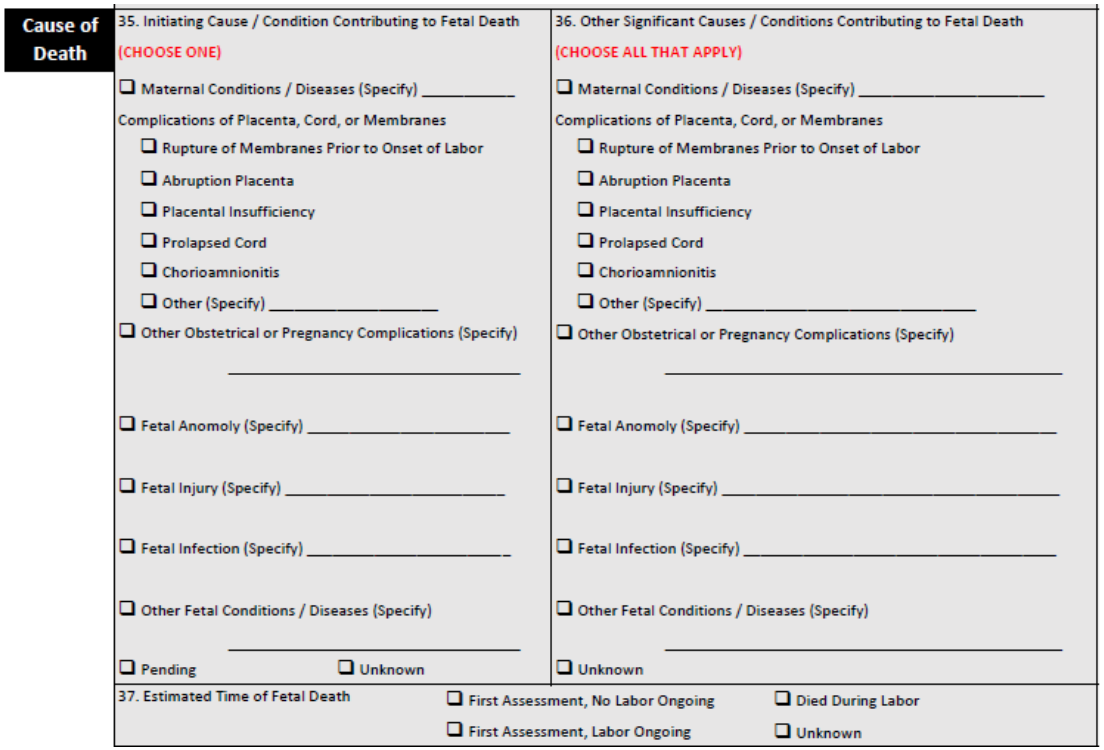
Cause of Death

35. Initiating Cause / Condition Contributing to Fetal Death (CHOOSE ONE)	36. Other Significant Causes / Conditions Contributing to Fetal Death (CHOOSE ALL THAT APPLY)
❑ Maternal Conditions / Diseases (Specify) _____	❑ Maternal Conditions / Diseases (Specify) _____
Complications of Placenta, Cord, or Membranes	Complications of Placenta, Cord, or Membranes
❑ Rupture of Membranes Prior to Onset of Labor	❑ Rupture of Membranes Prior to Onset of Labor
❑ Abruption Placenta	❑ Abruption Placenta
❑ Placental Insufficiency	❑ Placental Insufficiency
❑ Prolapsed Cord	❑ Prolapsed Cord
❑ Chorioamnionitis	❑ Chorioamnionitis
❑ Other (Specify) _____	❑ Other (Specify) _____
❑ Other Obstetrical or Pregnancy Complications (Specify) _____	❑ Other Obstetrical or Pregnancy Complications (Specify) _____
❑ Fetal Anomoly (Specify) _____	❑ Fetal Anomoly (Specify) _____
❑ Fetal Injury (Specify) _____	❑ Fetal Injury (Specify) _____
❑ Fetal Infection (Specify) _____	❑ Fetal Infection (Specify) _____
❑ Other Fetal Conditions / Diseases (Specify) _____	❑ Other Fetal Conditions / Diseases (Specify) _____
❑ Pending ❑ Unknown	❑ Unknown

37. Estimated Time of Fetal Death		
	❑ First Assessment, No Labor Ongoing	❑ Died During Labor
	❑ First Assessment, Labor Ongoing	❑ Unknown

Field #'s 35-37 should be completed by the certifying or attending physician who is completing the Fetal Death Certificate.

Cause of Death (cont…)



Cause of Death	35. Initiating Cause / Condition Contributing to Fetal Death (CHOOSE ONE)	36. Other Significant Causes / Conditions Contributing to Fetal Death (CHOOSE ALL THAT APPLY)
	❑ Maternal Conditions / Diseases (Specify) _____	❑ Maternal Conditions / Diseases (Specify) _____
	Complications of Placenta, Cord, or Membranes	Complications of Placenta, Cord, or Membranes
	❑ Rupture of Membranes Prior to Onset of Labor	❑ Rupture of Membranes Prior to Onset of Labor
	❑ Abruption Placenta	❑ Abruption Placenta
	❑ Placental Insufficiency	❑ Placental Insufficiency
	❑ Prolapsed Cord	❑ Prolapsed Cord
	❑ Chorioamnionitis	❑ Chorioamnionitis
	❑ Other (Specify) _____	❑ Other (Specify) _____
	❑ Other Obstetrical or Pregnancy Complications (Specify) _____	❑ Other Obstetrical or Pregnancy Complications (Specify) _____
	❑ Fetal Anomoly (Specify) _____	❑ Fetal Anomoly (Specify) _____
	❑ Fetal Injury (Specify) _____	❑ Fetal Injury (Specify) _____
	❑ Fetal Infection (Specify) _____	❑ Fetal Infection (Specify) _____
	❑ Other Fetal Conditions / Diseases (Specify) _____	❑ Other Fetal Conditions / Diseases (Specify) _____
	❑ Pending ❑ Unknown	❑ Unknown
	37. Estimated Time of Fetal Death	❑ First Assessment, No Labor Ongoing ❑ Died During Labor ❑ First Assessment, Labor Ongoing ❑ Unknown

35. **<u>Initiating Cause/Condition Contributing to Fetal Death</u>** – Select only **ONE** cause or condition which most likely began the sequence of events resulting in the fetal death.

36. **<u>Other Significant Causes/Conditions Contributing to Fetal Death</u>** – Select all other causes or conditions which contributed to the fetal death. Check all that apply.

37. **<u>Estimated Time of Fetal Death</u>** – Select the time of assessment when the fetal death was determined. If unknown, select unknown.

Funeral Home Information

	38. Method of Disposition	❑ Hospital Disposition	❑ Burial	❑ Cremation	❑ Donation	❑ Removal from State
		❑ Other (Specify) _____				
Funeral Home / Agent	39. Place of Disposition (Name of Cemetery, Crematory, or other)			40. Funeral Home/Agent's Name		
	41. Funeral Director/Agent's Signature		42. Funeral Home License No.		43. Funeral Home/Agent's Address	

Field # 38 should be filled out by the funeral home if a funeral home is handling the disposition. If a facility is handling the disposition, the field should be completed by the facility.

Field #'s: 39-43 are to be completed by the funeral home only if a funeral home handled the disposition of the fetus. If the disposition was handled by a facility, these fields are to be left blank.

Funeral Home Information (cont…)

	38. Method of Disposition	❑ Hospital Disposition	❑ Burial	❑ Cremation	❑ Donation	❑ Removal from State
		❑ Other (Specify) _____				
Funeral Home / Agent	39. Place of Disposition (Name of Cemetery, Crematory, or other)			40. Funeral Home/Agent's Name		
	41. Funeral Director/Agent's Signature		42. Funeral Home License No.		43. Funeral Home/Agent's Address	

38. **Method of Disposition** – Select the method of disposition for the fetus. If none of the selections fit, select other and specify the method of disposition.

39. **Place of Disposition** – Enter the place where the final disposition of the fetus occurred. If cremated, this should be the crematory which handled the cremation. If buried, this should be the cemetery where the fetus was buried. If other, specify the place of disposition.

40. **Funeral Home/Agent's Name** – Enter the name of the funeral home or agent that handled the disposition.

41. **Funeral Director/Agent's Signature** – The funeral director/agent should review the certificate and make sure all information is complete before signing the fetal death certificate.

42. **Funeral Home License No.** – Enter the license number of the funeral home which handled the disposition of the fetus.

43. **Funeral Home/Agent's Address** – Enter the address of the funeral home/agent which handled the disposition of the fetal death, including the street number, street, city/town, state, and zip code.

Registrar

VR-FDC REV 11/16	Registrar	44. State Registrar - Signature	45. File Date - Date Received by State Registrar

Field #'s 44-45 will be completed by the Center for Vital Records at the time of filing.

44. **State Registrar's Signature** – The State Registrar shall sign the Fetal Death Certificate upon arrival.

45. **File Date- Date Received by State Registrar.** – The Center for Vital Records date stamps the Fetal Death Certificate upon arrival.

Burial-Transit Permit

Mother's Name: _____

Burial-Transit Permit	Rhode Island Department of Health		Permit Number
Name of Parent of Fetus	Date of Delivery _____/_____/_____		City / Town of Delivery
Burial, Cremation, Donation, Other (Specify)	Place of Disposition (Name of Cemetery, Crematory, or other)		City / Town, State
Funeral Director/Agent's Signature	Funeral Home/Agent's Name & Address		Funeral Home License No.
Certification - I hereby certify that the above listed fetus was delivered without signs of life and hereby grant authority to dispose of this fetus **Signature of Physician or Medical Examiner**	**Title**	**Date Signed**	**License Number**
Authorized Disposition As Stated Above Occurred on (Date) _____/_____/_____	Tomb	Lot	Signature of Sexton or Person in Charge of Cemetery

VR-FDC

REV 06/17

THIS PERMIT VALID ONLY IF SIGNED BY BOTH THE PHYSICIAN OR MEDICAL EXAMINER AND BY THE FUNERAL DIRECTOR/AGENT

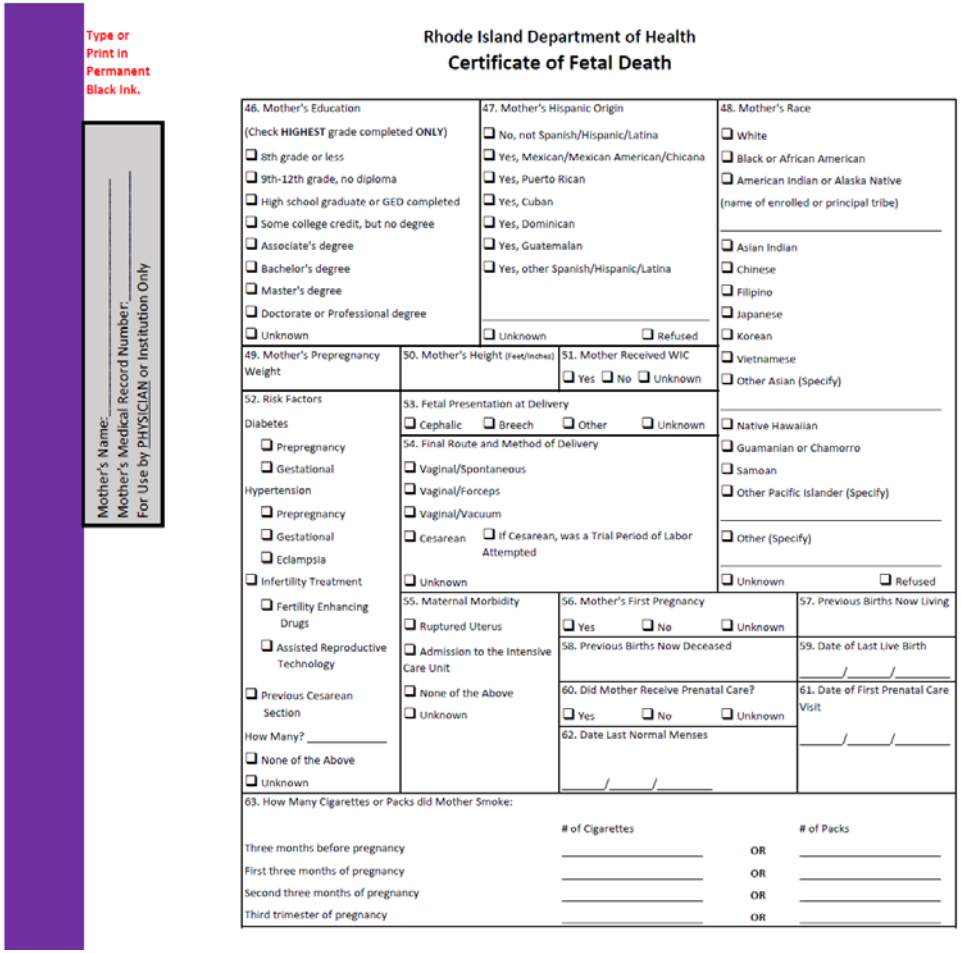
INSTRUCTIONS FOR BURIAL-TRANSIT PERMIT

Funeral Home/Agent - The Burial-Transit Permit is required for any manner of disposition of a dead body, including interment, storage, cremation and transportation. If the body will be cremated, a Certificate of Cremation must be obtained from the R.I. Medical Examiner's Office.

Transportation - When transporting by common carrier, this Burial-Transit Permit or a duplicate thereof should be enclosed in a strong envelope attached to the shipping case. No separate transit permit is required. Before shipment by train or express, the body must be embalmed or, if embalming is not practicable, must be enclosed in a tightly sealed outer case.

Sexton - It is unlawful for any sexton, or other person in charge of a burial place, to permit burial or other disposition of a dead body before a burial-transit permit has been received. In Rhode Island, all burial-transit permits must be preserved and forwarded to the city or town clerk where the burial takes place by the 5th of the month following burial.

Demographic and Medical Statistical Information



Type or Print in Permanent Black Ink.

Mother's Name: _____
Mother's Medical Record Number: _____
For Use by PHYSICIAN or Institution Only

Rhode Island Department of Health
Certificate of Fetal Death

46. Mother's Education (Check **HIGHEST** grade completed **ONLY**)	47. Mother's Hispanic Origin	48. Mother's Race
❑ 8th grade or less ❑ 9th-12th grade, no diploma ❑ High school graduate or GED completed ❑ Some college credit, but no degree ❑ Associate's degree ❑ Bachelor's degree ❑ Master's degree ❑ Doctorate or Professional degree ❑ Unknown	❑ No, not Spanish/Hispanic/Latina ❑ Yes, Mexican/Mexican American/Chicana ❑ Yes, Puerto Rican ❑ Yes, Cuban ❑ Yes, Dominican ❑ Yes, Guatemalan ❑ Yes, other Spanish/Hispanic/Latina ❑ Unknown ❑ Refused	❑ White ❑ Black or African American ❑ American Indian or Alaska Native (name of enrolled or principal tribe) _____ ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Other Asian (Specify) _____ ❑ Native Hawaiian ❑ Guamanian or Chamorro ❑ Samoan ❑ Other Pacific Islander (Specify) _____ ❑ Other (Specify) _____ ❑ Unknown ❑ Refused

49. Mother's Prepregnancy Weight	50. Mother's Height (Feet/Inches)	51. Mother Received WIC ❑ Yes ❑ No ❑ Unknown

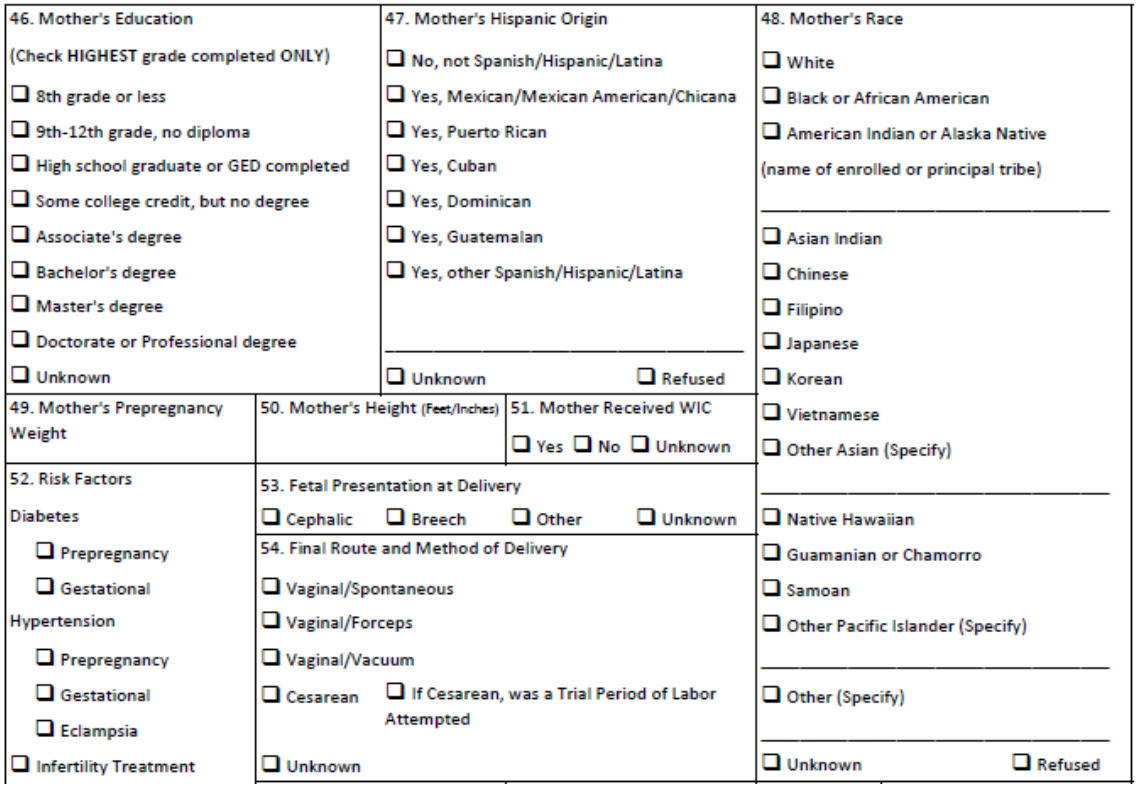
52. Risk Factors	53. Fetal Presentation at Delivery	54. Final Route and Method of Delivery	55. Maternal Morbidity	56. Mother's First Pregnancy	57. Previous Births Now Living
Diabetes ❑ Prepregnancy ❑ Gestational Hypertension ❑ Prepregnancy ❑ Gestational ❑ Eclampsia ❑ Infertility Treatment ❑ Fertility Enhancing Drugs ❑ Assisted Reproductive Technology ❑ Previous Cesarean Section How Many? _____ ❑ None of the Above ❑ Unknown	❑ Cephalic ❑ Breech ❑ Other ❑ Unknown	❑ Vaginal/Spontaneous ❑ Vaginal/Forceps ❑ Vaginal/Vacuum ❑ Cesarean ❑ If Cesarean, was a Trial Period of Labor Attempted ❑ Unknown	❑ Ruptured Uterus ❑ Admission to the Intensive Care Unit ❑ None of the Above ❑ Unknown	❑ Yes ❑ No ❑ Unknown 58. Previous Births Now Deceased 60. Did Mother Receive Prenatal Care? ❑ Yes ❑ No ❑ Unknown 62. Date Last Normal Menses _____/_____/_____	59. Date of Last Live Birth _____/_____/_____ 61. Date of First Prenatal Care Visit _____/_____/_____

63. How Many Cigarettes or Packs did Mother Smoke:

	# 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	_____

Field #'s 46-63 are to be completed by the facility.

Demographic and Medical Statistical Information



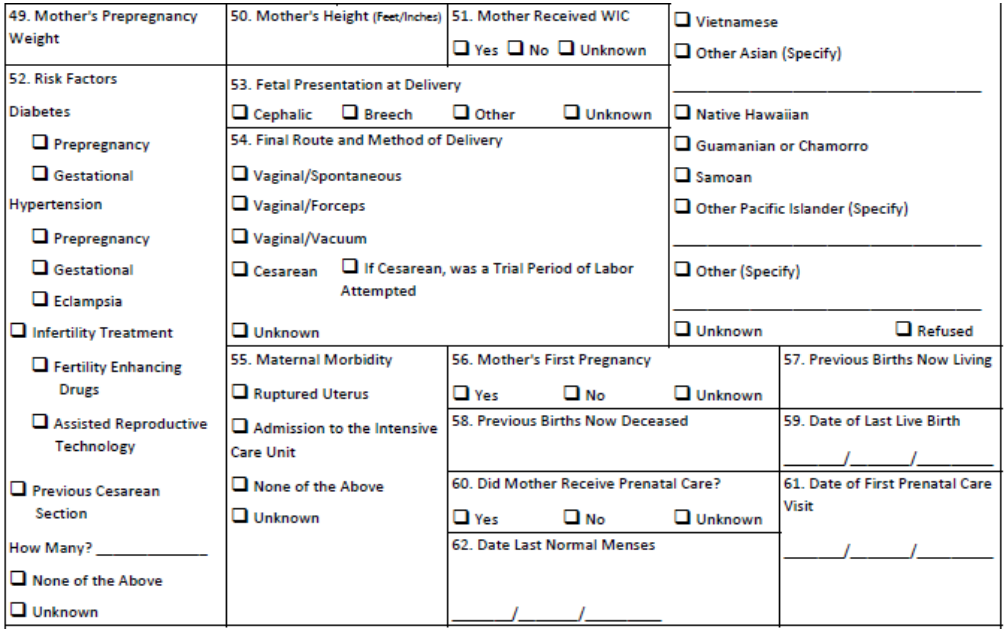
46. Mother's Education (Check HIGHEST grade completed ONLY) ❑ 8th grade or less ❑ 9th-12th grade, no diploma ❑ High school graduate or GED completed ❑ Some college credit, but no degree ❑ Associate's degree ❑ Bachelor's degree ❑ Master's degree ❑ Doctorate or Professional degree ❑ Unknown	47. Mother's Hispanic Origin ❑ No, not Spanish/Hispanic/Latina ❑ Yes, Mexican/Mexican American/Chicana ❑ Yes, Puerto Rican ❑ Yes, Cuban ❑ Yes, Dominican ❑ Yes, Guatemalan ❑ Yes, other Spanish/Hispanic/Latina _____ ❑ Unknown ❑ Refused	48. Mother's Race ❑ White ❑ Black or African American ❑ American Indian or Alaska Native (name of enrolled or principal tribe) _____ ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean ❑ Vietnamese ❑ Other Asian (Specify) _____ ❑ Native Hawaiian ❑ Guamanian or Chamorro ❑ Samoan ❑ Other Pacific Islander (Specify) _____ ❑ Other (Specify) _____ ❑ Unknown ❑ Refused
49. Mother's Prepregnancy Weight	50. Mother's Height (Feet/Inches)	51. Mother Received WIC ❑ Yes ❑ No ❑ Unknown
52. Risk Factors Diabetes ❑ Prepregnancy ❑ Gestational Hypertension ❑ Prepregnancy ❑ Gestational ❑ Eclampsia ❑ Infertility Treatment	53. Fetal Presentation at Delivery ❑ Cephalic ❑ Breech ❑ Other ❑ Unknown 54. Final Route and Method of Delivery ❑ Vaginal/Spontaneous ❑ Vaginal/Forceps ❑ Vaginal/Vacuum ❑ Cesarean ❑ If Cesarean, was a Trial Period of Labor Attempted ❑ Unknown	

46. **Mother's Education** – Select the highest level of education completed by the mother. If unknown, select unknown.

47. **Mother's Hispanic Origin** – Select the Hispanic origin of the mother. If not Hispanic, select no. If unknown, select unknown.

48. **Mother's Race** – Select the race of the mother which best describes what she considers herself to be. If the mother is of mixed race, enter all that apply. If unknown, select unknown.

Demographic and Medical Statistical Information (cont…)



49. Mother's Prepregnancy Weight	50. Mother's Height (Feet/Inches)	51. Mother Received WIC ❑ Yes ❑ No ❑ Unknown	❑ Vietnamese ❑ Other Asian (Specify) _____
52. Risk Factors Diabetes ❑ Prepregnancy ❑ Gestational Hypertension ❑ Prepregnancy ❑ Gestational ❑ Eclampsia ❑ Infertility Treatment ❑ Fertility Enhancing Drugs ❑ Assisted Reproductive Technology ❑ Previous Cesarean Section How Many? _____ ❑ None of the Above ❑ Unknown	53. Fetal Presentation at Delivery ❑ Cephalic ❑ Breech ❑ Other ❑ Unknown 54. Final Route and Method of Delivery ❑ Vaginal/Spontaneous ❑ Vaginal/Forceps ❑ Vaginal/Vacuum ❑ Cesarean ❑ If Cesarean, was a Trial Period of Labor Attempted ❑ Unknown		❑ Native Hawaiian ❑ Guamanian or Chamorro ❑ Samoan ❑ Other Pacific Islander (Specify) _____ ❑ Other (Specify) _____ ❑ Unknown ❑ Refused
	55. Maternal Morbidity ❑ Ruptured Uterus ❑ Admission to the Intensive Care Unit ❑ None of the Above ❑ Unknown	56. Mother's First Pregnancy ❑ Yes ❑ No ❑ Unknown 58. Previous Births Now Deceased 60. Did Mother Receive Prenatal Care? ❑ Yes ❑ No ❑ Unknown 62. Date Last Normal Menses _____/_____/_____	57. Previous Births Now Living 59. Date of Last Live Birth _____/_____/_____ 61. Date of First Prenatal Care Visit _____/_____/_____

49. **Mother's Pre-pregnancy Weight** – Enter the weight of the mother directly before the pregnancy. If unknown, enter unknown.

50. **Mother's Height** – Enter the height of the mother. If this is unknown, enter unknown.

51. **Mother Received WIC** – Select whether the mother received WIC during her pregnancy. If unknown, select unknown.

52. **Risk Factors** – Select any risk factors which occurred during this pregnancy. If the patient had more than one risk factor, check all that apply. If none, select none of the above. If unknown, select unknown.

Demographic and Medical Statistical Information (cont…)

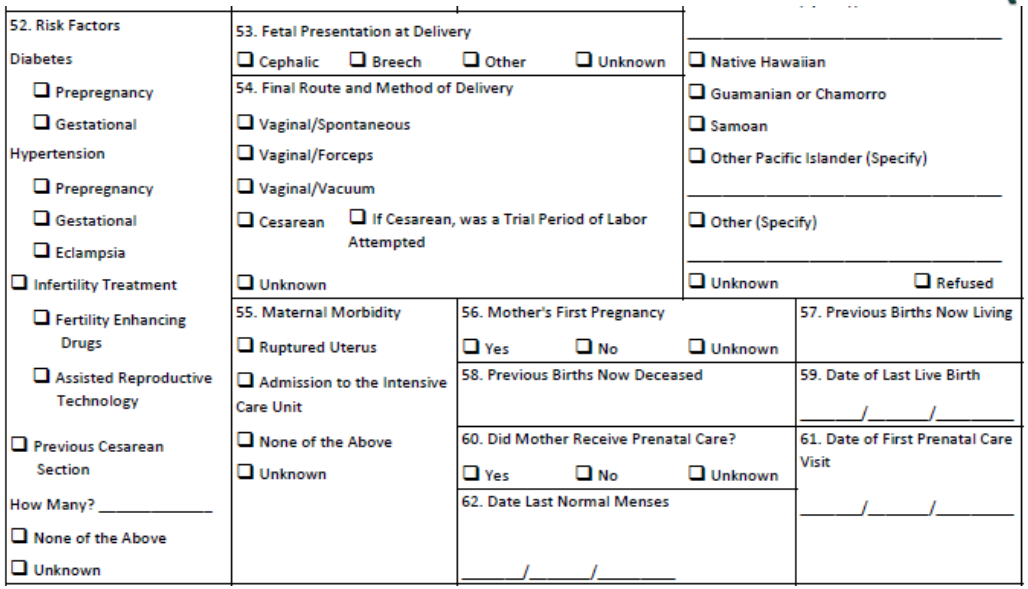
52. Risk Factors	53. Fetal Presentation at Delivery		
Diabetes ❑ Prepregnancy ❑ Gestational Hypertension ❑ Prepregnancy ❑ Gestational ❑ Eclampsia ❑ Infertility Treatment ❑ Fertility Enhancing Drugs ❑ Assisted Reproductive Technology ❑ Previous Cesarean Section How Many? _____ ❑ None of the Above ❑ Unknown	❑ Cephalic ❑ Breech ❑ Other ❑ Unknown 54. Final Route and Method of Delivery ❑ Vaginal/Spontaneous ❑ Vaginal/Forceps ❑ Vaginal/Vacuum ❑ Cesarean ❑ If Cesarean, was a Trial Period of Labor Attempted ❑ Unknown	_____ ❑ Native Hawaiian ❑ Guamanian or Chamorro ❑ Samoan ❑ Other Pacific Islander (Specify) _____ ❑ Other (Specify) _____ ❑ Unknown ❑ Refused	
55. Maternal Morbidity ❑ Ruptured Uterus ❑ Admission to the Intensive Care Unit ❑ None of the Above ❑ Unknown	56. Mother's First Pregnancy ❑ Yes ❑ No ❑ Unknown 58. Previous Births Now Deceased 60. Did Mother Receive Prenatal Care? ❑ Yes ❑ No ❑ Unknown 62. Date Last Normal Menses _____/_____/_____	57. Previous Births Now Living 59. Date of Last Live Birth _____/_____/_____ 61. Date of First Prenatal Care Visit _____/_____/_____	

53. **Fetal Presentation at Delivery** – Select the presentation of the fetus at delivery. If this is unknown or could not be determined, select unknown.

54. **Final Route and Method of Delivery** – Select the method of delivery of the fetus. If this is unknown or could not be determined, select unknown.

55. **Maternal Morbidity** – Select any complications experienced by the mother associated with labor and delivery. If the patient had more than one complication, check all that apply. If none, select none of the above. If unknown, select unknown.

Demographic and Medical Statistical Information (cont…)



56. **Mother's First Pregnancy** –Select whether this is the mother's first pregnancy. If yes, skip field #'s 57-59. If no, answer field #'s 57-59. In the case of a plural pregnancy as the mother's first pregnancy, only the first birth outcome should be considered first pregnancy.

57. **Previous Births Now Living** – If field #56 is no, enter the number of previous live births which are still living. If none, enter 0.

58. **Previous Births Now Deceased** – If field #56 is no, enter the number of previous live births which are now deceased. If none, enter 0.

59. **Date of Last Live Birth** – Enter the date of the last live birth, regardless if that birth is still living or deceased. If unknown, enter unknown.

Demographic and Medical Statistical Information (cont…)

❑ Previous Cesarean Section How Many? _____ ❑ None of the Above ❑ Unknown	❑ None of the Above ❑ Unknown	60. Did Mother Receive Prenatal Care? ❑ Yes ❑ No ❑ Unknown 62. Date Last Normal Menses _____/_____/_____	61. Date of First Prenatal Care Visit _____/_____/_____

63. How Many Cigarettes or Packs did Mother Smoke:

	# 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	_____

60. **Did Mother Receive Prenatal Care** – Select whether the mother received prenatal care during this pregnancy. If unknown, select unknown.

61. **Date of First Prenatal Care Visit** – If field #60 is yes, enter the date of the first prenatal care visit, otherwise, leave blank. If exact day is unknown, enter month and year.

62. **Date Last Normal Menses** – Enter the date of the mother's last normal menses. If exact day is unknown, enter month and year.

63. **How Many Cigarettes or Packs did Mother Smoke** – Enter the number of cigarettes or packs the mother smoked during each trimester of her pregnancy, including the three month before the pregnancy. If none, enter 0. If the fetal death occurred prior to 2nd or 3rd trimester, leave those selections blank. If unknown, enter unknown.

APPENDIX A: 39 City & Towns

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

TITLE 23
Health and Safety

CHAPTER 23-3
Vital Records

SECTION 23-3-17

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

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

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

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

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

Fetal Death Registration (Cont…)

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

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

Supplemental Cause of Death Form

Rhode Island Department of Health, Center for Vital Records, Three Capitol Hill, Providence. RI 02908

Supplemental Report for Fetal Cause of Death

_____
Date

_____
Patient's Name

_____
City/Town of Delivery

_____
Date of Delivery

Dear Registrar:
To complete the previously submitted fetal death certificate on the above patient, I am submitting the following arrangement of the cause(s) of fetal death based on additional information, autopsy, or other findings.

Manner of Death	**Estimated Time of Fetal Death**
❑ Natural ❑ Accident ❑ Homicide ❑ Pending Investigation ❑ Couldn't Be Determined	❑First Assessment, No Labor Ongoing ❑Died During Labor ❑ First Assessment, Labor Ongoing ❑ Unknown
Initiating Cause / Condition Contributing to Fetal Death (Choose One) ❑ Maternal Conditions / Diseases (Specify) _____ Complications of Placenta, Cord or Membranes ❑ Rupture of Membranes Prior to Onset of Labor ❑ Abruption 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 / Diseases (Specify) _____ ❑ Pending ❑ Unknown	**Other Significant Causes / Conditions Contributing to Fetal Death (Choose All That Apply)** ❑ Maternal Conditions / Diseases (Specify) _____ Complications of Placenta, Cord or Membranes ❑ Rupture of Membranes Prior to Onset of Labor ❑ Abruption 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 / Diseases (Specify) _____ ❑ Unknown

Autopsy Performed?	**Histological Exam Performed?**	**Autopsy or Hist Exam Results Used?**
❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑No

_____ _____ _____
Signature Printed Name of Physician Date Signed

VS-219 Supplemental Report for Fetal Cause of Death Rev. 11/03/2016

Supplemental Cause of Death Form Additional Information

Rhode Island Department of Health, Center for Vital Records
Three Capitol Hill, Providence, RI 02908

Supplemental Report For Fetal Death Additional Information

Today's Date: _____

Dear Registrar,

To complete the previously submitted fetal death certificate or form on patient below, I am submitting the following information for correction(s). This additional information is based on our patient record(s):

Date of Delivery: _____

Mother's Legal Last Name: _____

Mother's Legal First Name: _____

Mother's Date of Birth: _____

Field Omitted or in Error	As Item Now Appears	As Item Should Appear

Sincerely,

_____
Signature

_____
Print/Typed Name

_____
Title/Position

_____
Date Signed

Note: To be used only for fields that are not in the Supplemental Report for Fetal Cause of Death

VS-220 Fetal Death Additional Information - Revised 11/3/2016

Contact Information

- Ana Tack – Fetal Death Registration Manager
- (401) 222-5165
- Ana.Tack@health.ri.gov

- Richard Missaghian – Death & Fetal Death Training Manager
- (401) 222-8051
- Richard.Missaghian@health.ri.gov