The Certificate of Fetal Death is made up of two parts:

Part 1. ORIGINAL CERTIFICATE. After completion, detach and send to Town Clerk.

Part 2. CONFIDENTIAL INFORMATION and Carbon Copy of Certificate. The law now requires that the Confidential Information section be completed. Upon completion, part 2 must be sent directly to the Department of Public Health.

STATE OF CONNECTICUT

CERTIFICATE OF FETAL DEATH

VS-5 REV. 1/18

DEPARTMENT OF PUBLIC HEALTH

THIS FETUS

1a. NAME *First*	*1b. Middle*	*1c. Last*	2. DATE OF DELIVERY

3. TIME OF DELIVERY ☐ AM ☐ MIL ☐ PM	4. SEX *(M/F/Unk)*	5. FACILITY NAME *(If not facility, give street address)*	6. TOWN	7. ZIP CODE	8. FACILITY ID (NPI)

MOTHER

9. MOTHER'S CURRENT LEGAL NAME *(First/ Middle/ Last/ Gen. ID, e.g. Jr., III)*	10. MOTHER'S LAST NAME PRIOR TO 1ST MARRIAGE

11. DATE OF BIRTH *(MM/DD/YYYY)*	12. BIRTHPLACE *(State OR Foreign Country)*	13. RESIDENCE *(No. and Street/Town/State/Zip Code)*

FATHER

14. FATHER'S CURRENT LEGAL NAME *(First/ Middle/ Last/ Gen ID)*	15. DATE OF BIRTH *(MM/DD/YYYY)*	16. BIRTHPLACE *(State OR Foreign Country)*

CAUSE(S) OF DEATH

17. **INITIATING CAUSE/ CONDITION** *(Among the choices below, select the **ONE** which 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 ☐ Prolapsed cord
☐ Abruptio placenta ☐ Chorioamnionitis
☐ Placental insufficiency ☐ Other *(Specify)* _____

Other Obstetrical or Pregnancy Complications *(Specify)* _____

Fetal Anomaly *(Specify)* _____

Fetal Injury *(Specify)* _____

Fetal Infection *(Specify)* _____

Other Fetal Conditions/Disorders *(Specify)* _____

Unknown ☐

18. **OTHER SIGNIFICANT CAUSES OR CONDITIONS**

*(Select or specify **ALL** other conditions contributing to the death of the fetus)*

Maternal Conditions/ Diseases *(Specify)*_____

Complications of Placenta, Cord or Membranes:

☐ Rupture of membranes prior to onset of labor ☐ Prolapsed cord
☐ Abruptio placenta ☐ Chorioamnionitis
☐ Placental insufficiency ☐ Other *(Specify)* _____

Other Obstetrical or Pregnancy Complications *(Specify)* _____

Fetal Anomaly *(Specify)* _____

Fetal Injury *(Specify)* _____

Fetal Infection *(Specify)* _____

Other Fetal Conditions/Disorders *(Specify)* _____

Unknown ☐

I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED AND THAT THE FETUS WAS DELIVERED DEAD.

CERTIFIER

19. CERTIFIER'S NAME *(First, M.I., Last)*	20. TITLE ☐ MD ☐ DO ☐ CNM ☐ Other *(Specify)* _____

21. CERTIFIER'S SIGNATURE	22. NPI	23. DATE SIGNED

BURIAL

24. DISPOSITION ☐ Burial ☐ Cremation ☐ Hospital Disposition ☐ Donation ☐ Removal from State	25. CEMETERY OR CREMATORY NAME AND LOCATION *(Town/State)*

26. FUNERAL HOME NAME AND ADDRESS *(Street/City/State/Zip Code)*	27. FUNERAL DIRECTOR LIC. #

28. FUNERAL DIRECTOR'S NAME	29. FUNERAL DIRECTOR'S SIGNATURE	30. DATE SIGNED

REGISTRAR

31. TOWN REGISTRAR'S SIGNATURE	32. DATE REGISTERED

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STATE OF CONNECTICUT

CERTIFICATE OF FETAL DEATH

DEPARTMENT OF PUBLIC HEALTH

VS-5 REV. 1/18

THIS FETUS

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14. FATHER'S CURRENT LEGAL NAME *(First/ Middle/ Last/ Gen ID)*	15. DATE OF BIRTH *(MM/DD/YYYY)*	16. BIRTHPLACE *(State OR Foreign Country)*

CAUSE(S) OF DEATH

17. **INITIATING CAUSE/CONDITION** *(Among the choices below, select the **ONE** which most likely began the sequence of events resulting in the death of the fetus)*

Maternal Conditions/ Diseases *(Specify)*_____

_____

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☐ Placental insufficiency ☐ Other *(Specify)* _____

Other Obstetrical or Pregnancy Complications *(Specify)* _____

_____

Fetal Anomaly *(Specify)* _____

_____

Fetal Injury *(Specify)* _____

Fetal Infection *(Specify)* _____

Other Fetal Conditions/Disorders *(Specify)* _____

_____

Unknown ☐

18. **OTHER SIGNIFICANT CAUSES OR CONDITIONS**

*(Select or specify **ALL** other conditions contributing to the death of the fetus)*

Maternal Conditions/ Diseases *(Specify)*_____

_____

Complications of Placenta, Cord or Membranes:

☐ Rupture of membranes prior to onset of labor ☐ Prolapsed cord
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☐ Placental insufficiency ☐ Other *(Specify)* _____

Other Obstetrical or Pregnancy Complications *(Specify)* _____

_____

Fetal Anomaly *(Specify)* _____

_____

Fetal Injury *(Specify)* _____

Fetal Infection *(Specify)* _____

Other Fetal Conditions/Disorders *(Specify)* _____

_____

Unknown ☐

I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE STATED AND THAT THE FETUS WAS DELIVERED DEAD.

CERTIFIER

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REGISTRAR

31. TOWN REGISTRAR'S SIGNATURE	32. DATE REGISTERED

CERTIFIER MUST ENSURE COMPLETION OF ALL ITEMS. UPON COMPLETION, RETURN FORM TO CT DEPARTMENT OF PUBLIC HEALTH

CONFIDENTIAL MEDICAL AND HEALTH INFORMATION – COMPLETION OF THE FOLLOWING INFORMATION IS REQUIRED BY LAW

33. WEIGHT OF FETUS (*specify unit, grams preferred*)

_____

☐ grams
☐ lb./oz.

34. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY

_____

(completed weeks)

35. 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

36. WAS AN AUTOPSY PERFORMED?

☐ Yes ☐ No ☐ Planned

37. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?

☐ Yes ☐ No ☐ Planned

38. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAM RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ☐ Yes ☐ No

39. MOTHER OF HISPANIC ORIGIN?

☐ No, Not Spanish/Hispanic/Latina
☐ Yes, Mexican, Mexican American, Chicana
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, Other Spanish /Hispanic/ Latina

(Specify) _____

40. MOTHER'S RACE *(Check one or more races to indicate what the mother considers herself 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)*_____

41. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY

(For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. If NONE, enter "0".)

Average number of cigarettes or packs smoked per day

	# 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	_____

42. MOTHER'S EDUCATION *(Check the box that best describes the highest degree or level of school completed at the time of delivery)*

☐ 8th grade or less
☐ 9th-12th grade, no diploma
☐ High School Graduate/GED
☐ Some college, no degree
☐ Associate degree
☐ Bachelor degree
☐ Master's degree
☐ Doctorate or Professional degree

43. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No

44. DATE LAST NORMAL MENSES BEGAN

_____/ _____/ _____
MM DD YYYY

45. DATE OF FIRST PRENATAL CARE VISIT

_____/ _____/ _____ ☐ No Prenatal Care
MM DD YYYY

46. NUMBER OF PREVIOUS LIVE BIRTHS Now Living

_____ ☐ None

47. NUMBER OF PREVIOUS LIVE BIRTHS Now Dead

_____ ☐ None

48. DATE OF LAST LIVE BIRTH

____/ ____/_____
MM DD YYYY

49. MOTHER'S HEIGHT

_____ *(feet/inches)*

50. MOTHER'S PRE-PREGNANCY WEIGHT

_____ *(pounds)*

51. PLACE WHERE DELIVERY OCCURRED *(Check One)*

☐ Hospital
☐ Freestanding birthing center
☐ Clinic/Doctor's Office
☐ Born En route or on Arrival
☐ Home Delivery

If home delivery, was it planned? Yes ○ No ○

☐ Other *(Specify)* _____

52. BIRTH ATTENDANT TITLE

☐ MD
☐ DO
☐ CNM
☐ Other *(Specify)*

_____

53. PLURALITY – Single, twin, triplet, etc. *(Specify)*

54. TOTAL # OF FETAL LOSSES IN THIS PREGNANCY

55. IF NOT SINGLE DELIVERY - Specify delivered first, second, third, etc.

56. RISK FACTORS IN THIS PREGNANCY *(Check all that apply)*

Diabetes:

☐ Pre-pregnancy *(Diagnosis prior to this pregnancy)*
☐ Gestational *(Diagnosis during this pregnancy)*

Hypertension:

☐ Pre-pregnancy *(Chronic)*
☐ Gestational *(PIH, preeclampsia)*
☐ Eclampsia

☐ Pregnancy resulted from infertility treatment

If yes, check all that apply:

☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
☐ Assisted reproductive technology, Gamete intrafallopian transfer

☐ Mother had a previous cesarean delivery: *If yes, how many:* _____
☐ None of the above

57. METHOD OF DELIVERY

Fetal Presentation at delivery

☐ Cephalic
☐ Breech
☐ Other

Final route and method of delivery (Check one)

☐ Vaginal/ Spontaneous
☐ Vaginal/ Forceps
☐ Vaginal/ Vacuum
☐ Cesarean

If Cesarean, was a trial of labor attempted? Yes ○ No ○

58. CONGENITAL ANOMALIES

☐ Microcephaly
☐ Cytomegalovirus
☐ None of the above

59. MATERNAL MORBIDITY *(Check all that apply) (Complications associated with labor and delivery)*

☐ Ruptured uterus
☐ Admission to intensive care unit
☐ None of the above