

TYPE ALL ENTRIES,
USE BLACK INK
FOR SIGNATURES
SEE HANDBOOK FOR
INSTRUCTIONS

REPORT OF FETAL DEATH

STATE OF HAWAII
DEPARTMENT OF HEALTH
OFFICE OF HEALTH STATUS MONITORING

STATE
FILE NO. **151**

1 FETUS - FIRST NAME		MIDDLE NAME		LAST NAME		2a DATE OF DELIVERY (MONTH DAY YEAR)		2b HOUR	
3 SEX		4a THIS DELIVERY - SINGLE, TWIN, TRIPLET, ETC (SPECIFY)		4b IF NOT SINGLE DELIVERY - BORN FIRST SECOND THIRD ETC (SPECIFY)		5a COUNTY OF DELIVERY		M.	
5b CITY, TOWN, OR LOCATION OF DELIVERY		5c INSIDE CITY LIMITS (SPECIFY YES OR NO)		5d HOSPITAL - NAME		6b AGE (AT TIME OF THIS DELIVERY)		6c STATE OF BIRTH (IF NOT IN U.S.A. NAME COUNTRY)	
6a MOTHER - FIRST NAME		MIDDLE NAME		MAIDEN NAME		7a RESIDENCE - STATE		7b COUNTY	
7a RESIDENCE - STATE		7b COUNTY		7c CITY, TOWN, LOCATION		7d INSIDE CITY LIMITS (SPECIFY YES OR NO)		7e STREET AND NUMBER	
8a FATHER - FIRST NAME		MIDDLE NAME		LAST NAME		8b AGE (AT TIME OF THIS DELIVERY)		8c STATE OF BIRTH (IF NOT IN U.S.A. NAME COUNTRY)	
8b FATHER - FIRST NAME		MIDDLE NAME		LAST NAME		8d ACTIVE MEMBER OF U.S. ARMED FORCES? (SPECIFY YES OR NO)		SPECIFY FETAL OR MATERNAL	
9 PART I FETAL DEATH WAS CAUSED BY									
FETAL OR MATERNAL CONDITION DIRECTLY CAUSING FETAL DEATH <input type="checkbox"/> (a) IMMEDIATE CAUSE <input type="checkbox"/> (b) DUE TO, OR AS A CONSEQUENCE OF FETAL AND/OR MATERNAL CONDITIONS, IF ANY, GIVING RISE TO THE IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST <input type="checkbox"/> (c) DUE TO, OR AS A CONSEQUENCE OF PART II OTHER SIGNIFICANT CONDITIONS OF FETUS OR MOTHER (CONDITIONS CONTRIBUTING TO FETAL DEATH BUT NOT RELATED TO CAUSE GIVEN IN PART I (a))									
10 FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY. UNKNOWN (SPECIFY)									
11a AUTOPSY (SPECIFY YES OR NO)									
11b IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSE OF DEATH (SPECIFY YES OR NO)									
12a Specify that this delivery occurred on the date stated above and the fetus was born dead <input type="checkbox"/> PHYSICIAN'S RECORD <input type="checkbox"/> HOSPITAL RECORD <input type="checkbox"/> OTHER (SPECIFY) SIGNATURE OF CERTIFIER 12b DATE SIGNED (MONTH, DAY YEAR) 12c ATTENDANT'S TITLE (M.D., D.O., MIDWIFE, OTHER (SPECIFY)) 13 AUTHORIZED OFFICIAL (IF DELIVERY NOT ATTENDED BY PHYSICIAN) SIGNATURE 14a BIRTH, CREMATION, OR REMOVAL (SPECIFY) 14b CEMETERY OR CREMATORY - NAME 14c LOCATION (CITY OR TOWN, STATE) 14d DATE (MONTH, DAY, YEAR) 15a FUNERAL HOME - NAME 15b FUNERAL DIRECTOR SIGNATURE 16a LOCAL REGISTRAR SIGNATURE 16b DATE RECEIVED BY LOCAL REGISTRAR 16c DATE FILED BY STATE REGISTRAR									

CONFIDENTIAL INFORMATION FOR MEDICAL AND HEALTH USE ONLY

17a RACE - (Caucasian, Japanese, etc.) (SPECIFY)		IS PERSON OF SPANISH ORIGIN?		EDUCATION (Specify only highest grade completed)		LIVE BIRTHS		OTHER TERMINATIONS (Spontaneous and Induced)	
17b <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> MEXICAN YES <input type="checkbox"/> CUBAN <input type="checkbox"/> CENTRAL AMERICAN <input type="checkbox"/> OTHER & UNKNOWN SPANISH ORIGIN		NO <input type="checkbox"/> YES <input type="checkbox"/> OTHER & UNKNOWN SPANISH ORIGIN		18 Elem or Secondary (0-12) College (1-4 or 5+)		21a NOW LIVING 21b NOW DEAD		21d BEFORE 20 WEEKS 21e AFTER 20 WEEKS	
19a 19b <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> MEXICAN YES <input type="checkbox"/> CUBAN <input type="checkbox"/> CENTRAL AMERICAN <input type="checkbox"/> OTHER & UNKNOWN SPANISH ORIGIN		NO <input type="checkbox"/> YES <input type="checkbox"/> OTHER & UNKNOWN SPANISH ORIGIN		20 Elem Or Secondary (0-12) College (1-4 or 5+)		NONE <input type="checkbox"/> NONE <input type="checkbox"/>		NONE <input type="checkbox"/> NONE <input type="checkbox"/>	
22 IS MOTHER MARRIED (SPECIFY YES OR NO)		23 BIRTH WEIGHT GRAMS		24a MONTH PRENATAL CARE BEGAN (1 ST , 2 ND , ETC - SPECIFY)		21c DATE OF LAST LIVE BIRTH (MONTH YEAR)		21f DATE OF LAST OTHER TERMINATION (MONTH YEAR) (AS INDICATED IN d OR e ABOVE)	
24b PRENATAL VISITS TOTAL NO (IF NONE, SO STATE)		25 DATE LAST NORMAL MENSES BEGAN (MO, DAY, YR)		26 PHYSICIAN'S ESTIMATE OF GESTATION WEEKS		27 COMPLICATIONS OF PREGNANCY (DESCRIBE OR WRITE "NONE")		28 COMPLICATIONS OF LABOR AND/OR DELIVERY (DESCRIBE OR WRITE "NONE")	
29 CONCURRENT ILLNESS OR CONDITIONS AFFECTING THE PREGNANCY (DESCRIBE OR WRITE "NONE")		30 CONGENITAL MALFORMATIONS OR ANOMALIES OF FETUS (DESCRIBE OR WRITE "NONE")		31 CONGENITAL MALFORMATIONS OR ANOMALIES OF FETUS (DESCRIBE OR WRITE "NONE")		32 CONGENITAL MALFORMATIONS OR ANOMALIES OF FETUS (DESCRIBE OR WRITE "NONE")		33 CONGENITAL MALFORMATIONS OR ANOMALIES OF FETUS (DESCRIBE OR WRITE "NONE")	

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INTENTIONAL FALSIFICATION IS A CRIME

NO DISPOSAL PERMIT IS REQUIRED FOR A FETUS OF LESS THAN 24 WEEKS GESTATION.