COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

FETAL DEATH REPORT – MEDICAL CERTIFICATE FORM (MCF) WORKSHEET

MOTHER'S HOSP NUMBER: _____

MCF PART 1 — **FETUS, MOTHER, AND DELIVERY ATTENDANT INFORMATION**

F E T U S

1. DATE OF DELIVERY (Mo/Day/Year) _____/ _____/ _____

2. TIME OF DELIVERY : _____ : _____ [ ] AM [ ] PM

3. SEX : [ ] Male or [ ] Female

4. PLACE WHERE DELIVERY OCCURRED:

[ ] HOSPITAL : [ ] CHC [ ] RHC [ ] THC

[ ] FREESTANDING BIRTHING CENTER

[ ] HOME BIRTH: PLANNED? [ ] Yes [ ] No

[ ] CLINIC/DOCTOR'S OFFICE

[ ] OTHER *(specify)* _____

5. CITY, TOWN, OR LOCATION OF DELIVERY

[ ] GARAPAN
[ ] SONGSONG VILLAGE
[ ] SAN JOSE VILLAGE
[ ] OTHER (specify):

_____

6. COUNTY OF DELIVERY

[ ] SAIPAN
[ ] TINIAN
[ ] ROTA
[ ] NORTHERN ISLANDS (specify)

_____

M O T H E R

7. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)

8. DATE OF BIRTH (Mo/Day/Yr)

A T T E N D A N T

9a. ATTENDANT'S NAME, TITLE AND NPI :

NAME: _____

TITLE: □ MD □ DO □ CNM/CM □ OTHER MIDWIFE

□ OTHER (Specify) _____

CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

C A U S E O F F E T A L D E A T H

10a. INITIATING CAUSE/CONDITION

(AMONG THE CHOICES BELOW, PLEASE 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
□ Abruptio 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/Disorders (Specify) _____

_____

□ UNKNOWN

10b. OTHER SIGNIFICANT CAUSES OR CONDITIONS

(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 18b)

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 (Specify) _____

Fetal Infection (Specify) _____

Other Fetal Conditions/Disorders (Specify) _____

_____

□ UNKNOWN

10c. WEIGHT OF FETUS (grams preferred, specify unit)

_____

□ grams □ lb/oz

10d. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY

_____ (completed weeks)

10e. 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

10f. WAS AN AUTOPSY PERFORMED?

□ Yes □ No □ Planned

10g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?

□ Yes □ No □ Planned

10h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?

□ Yes □ No

Name of Nurse Completing MCF PART 1: _____ **Date** _____

CLINICIAN REVIEWING AND COMPLETING REPORT

As the reviewing clinician, I hereby certify that the medical information provided on the Fetal Death Report are true and correct.

Name of the Reviewing Clinician : _____ Title: _____

Signature & Date : _____ Date signed: _____

HVSO-FORM-MCF001_20230921

Pursuant to 1CMC § 26015, Reports of Fetal Death Statute, the physician or other person in attendance shall provide the medical information required by the certificate within 5 days after the delivery.

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

CERTIFICATE OF LIVE BIRTH – MEDICAL CERTIFICATE FORM (MCF) WORKSHEET

MCF PART 2 — MATERNAL PRENATAL CARE INFORMATION

11. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? □ Yes □ No

IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: _____

12. □ No Prenatal Care

12a. DATE OF FIRST PRENATAL CARE VISIT _____ /_____/ _____ (MM DD YYYY)

12b. DATE OF LAST PRENATAL CARE VISIT _____ /_____/ _____ (M M D D YYYY)

13.. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY _____ (If none, enter "0".)

14. MOTHER'S HEIGHT _____ (feet/inches)

15. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)

16.. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)

17. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? □ Yes □ No

18. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child) : #_____

18a. Now Living Number _____ □ None

18b. Now Dead Number _____ □ None

19. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

19a. Other Outcomes Number _____ □ None

20a. 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".
(SEE SUPPLEMENTAL SUBSTANCE USE FORM 37b-37e)
Average number of cigarettes or packs of cigarettes 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	_____

21. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
□ Private Insurance
□ Medicaid
□ Self-pay
□ Other (Specify) _____

18c. DATE OF LAST LIVE BIRTH _____/_____ (MM YYYY)

19b. DATE OF LAST OTHER PREGNANCY OUTCOME _____/_____ (MM YYYY)

22. DATE LAST NORMAL MENSES BEGAN: _____ /_____/ _____ (M M D D YYYY)

23. PLURALITY – Single, Twin, Triplet, etc. (Specify) _____

24. IF NOT SINGLE – Born First, Second, Third, etc. (Specify) _____

MOTHER'S SUBSTANCE USE DURING PREGNANCY

20b. MOTHER BETEL NUT CHEWING DURING PREGNANCY □ Yes □ No - . IF YES, BETEL NUT CHEWING WITH TOBACCO? □ Yes □ No

20c. MOTHER USE OF ILLICIT DRUGS DURING PREGNANCY: □ Yes □ No - IF YES, SPECIFY: (Check one or more) □ CANNABIS □ CRYSTAL METHAMPHETAMINE □ OPIOID □ OTHER (Specify):_____

20d. MOTHER CONSUMED ALCOHOL DURING PREGNANCY □ Yes □ No

20e. MOTHER E-CIGARETTE (VAPING) USE DURING PRENANCY: □ Yes □ No - IF YES, SPECIFY: (Check frequency of use □ THREE MONTHS BEFORE PREGNANCY □ FIRST THREE MONTHS DURING PREGNANCY □ SECOND THREE MONTHS DURING PREGNANCY □ THIRD TRIMESTER OF PREGNANCY

Name of Nurse Completing MCF PART 2: _____ **Date** _____

MCF PART 3 — MATERNAL RISK FACTORS INFORMATION

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

Diabetes
- □ Prepregnancy (Diagnosis prior to this pregnancy)
- □ Gestational (Diagnosis in this pregnancy)

Hypertension
- □ Prepregnancy (Chronic)
- □ Gestational (PIH, preeclampsia)
- □ Eclampsia

□ Previous preterm birth

□ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

□ Pregnancy resulted from infertility treatment-If yes, check all that apply:
- □ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
- □ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))

□ Mother had a previous cesarean delivery
If yes, how many _____

□ None of the above

26. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

□ Gonorrhea
□ Syphilis
□ Chlamydia
□ Listeria
□ Group B Streptococcus
□ Cytomegalovirus
□ Parvovirus
□ Toxoplasmosis
□ NONE OF THE ABOVE
□ Other (Specify) _____

29. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?
□ Yes □ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
□ Yes □ No

C. Fetal presentation at birth
- □ Cephalic
- □ Breech
- □ Other

D. 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

30. 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

□ NONE OF THE ABOVE

55. 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
- □ None of the anomalies listed above

Name of Nurse Completing MCF PART 3: _____ **Date** _____