|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| REG-26 JUL 18 | | **New Jersey Department of Health** CERTIFICATE OF FETAL DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | **STATE FILE NO.** | | | | | | |
| 1. NAME OF FETUS *(First, Middle, Last) (OPTIONAL)* | | | | | | | | | | | | | | | | | | | | | | | | | 2a. DATE OF DELIVERY *(Mo/Day/Yr)* | | | | | | | | | | | | | 2b. TIME *(24 Hour)* | | |
| 3. SEX  MALE  FEMALE  UNKNOWN/UNDETERMINED | | | | | | | | | 4a. THIS DELIVERY  SINGLE  TWIN  OTHER **\_\_\_\_\_\_\_\_**  *(Specify)* | | | | | | | | | | | | | | | | | | | 4b. IF NOT SINGLE DELIVERY, THIS FETUS DELIVERED  1st  2nd  OTHER **\_\_\_\_\_\_\_\_**  *(Specify)* | | | | | | | | | | | | |
| 5a. PLACE OF DELIVERY  1  HOSPITAL 3  CLINIC/DOCTOR’S OFFICE 5  OTHER *(Specify)*:  2  FREESTANDING BIRTHING CENTER 4  HOME DELIVERY-Planned to deliver at home?  Yes  No | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5b. NAME OF FACILITY *(If not institution, give street address)* | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 5c. FACILITY ID (NPI) | | | | | | |
| 5d. CITY, TOWN OR LOCATION OF DELIVERY | | | | | | | | | | | | | | | | | | | 5e. COUNTY OF DELIVERY | | | | | | | | | | | | | | | | | 5f. ZIP CODE OF DELIVERY | | | | |
| 6a. MOTHER’S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)* | | | | | | | | | | | | | | | | | | | | | | | | | | | 6b. DATE OF BIRTH *(Mo/Day/Yr)* | | | | | | | | | | | | | |
| 6c. MOTHER’S NAME PRIOR TO FIRST MARRIAGE *(List name given at birth or on birth certificate/Maiden name)(First, Middle, Last, Suffix)* | | | | | | | | | | | | | | | | | | | | | | | | | | | 6d. BIRTHPLACE *(State, Territory or Foreign Country)* | | | | | | | | | | | | | |
| 7a. RESIDENCE OF MOTHER - STATE | | | | | | | | | | 7b. COUNTY | | | | | | | | | | | | 7c. CITY OR TOWN | | | | | | | | | | | | | | | | | | |
| 7d. STREET AND NUMBER | | | | | | | | | | | | 7e. APT NO. | | 7f. ZIP CODE *(or Mother’s Mailing Address, if different from 7d)* | | | | | | | | | | | | | | | | | | | | | | | 7g. INSIDE CITY LIMITS  YES  NO | | | |
| 8a. FATHER’S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)* | | | | | | | | | | | | | | | | | 8b. DATE OF BIRTH *(Mo/Day/Yr)* | | | | | | | | | | | | | | 8c. BIRTHPLACE *(State, Territory or Foreign Country)* | | | | | | | | | |
| 9a. NAME OF INFORMANT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | 9b. RELATIONSHIP TO FETUS | | | | | | | |
| **10. CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. 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) | | | | | | | | | | | | | | | | | | 10b. OTHER SIGNIFICANT CAUSES OR CONDITIONS  (Select or specify all other conditions contributing to death in item 10b) | | | | | | | | | | | | | | | | | | | | | | |
|  | MATERNAL CONDITIONS/DISEASES *(Specify)*: | | | | | | | | | | | | | | |  | |  | | 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 | | | | | | | | | | | | | | |  | |  | | COMPLICATIONS OF PLACENTA, CORD OR MEMBRANES:  RUPTURE OF MEMBRANES PRIOR TO ONSET OF LABOR  ABRUPTIO PLACENTA  PLACENTAL INSUFFICIENCY  PROLAPSED CORD  CHORIOAMNIONITIS | | | | | | | | | | | | | | | | | | | |  |
|  | OTHER *(Specify)*: | | | |  | | | | | | | | | | |  | |  | | OTHER *(Specify)*: | | | | | | | | |  | | | | | | | | | | |  |
|  | OTHER OBSTETRICAL OR PREGNANCY COMPLICATIONS *(Specify)*: | | | | | | | | | | | | | | |  | |  | | OTHER OBSTETRICAL OR PREGNANCY COMPLICATIONS *(Specify)*: | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | |  | |  | |  | | | | | | | | | | | | | | | | | | | |  |
|  | FETAL ANOMALY *(Specify)*: | | | | |  | | | | | | | | | |  | |  | | FETAL ANOMALY *(Specify)*: | | | | | | | | | | | |  | | | | | | | |  |
|  |  | | | | | | | | | | | | | | |  | |  | |  | | | | | | | | | | | | | | | | | | | |  |
|  | FETAL INJURY *(Specify)*: | | | | |  | | | | | | | | | |  | |  | | FETAL INJURY *(Specify)*: | | | | | | | | | | | |  | | | | | | | |  |
|  | FETAL INFECTION *(Specify)*: | | | | |  | | | | | | | | | |  | |  | | FETAL INFECTION *(Specify)*: | | | | | | | | | | | |  | | | | | | | |  |
|  | OTHER FETAL CONDITIONS/DISORDERS *(Specify)*: | | | | | | | | | | | | | | |  | |  | | OTHER FETAL CONDITIONS/DISORDERS *(Specify)*: | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | |  | |  | |  | | | | | | | | | | | | | | | | | | | |  |
|  | UNKNOWN | | | | | | | | | | | | | | |  | |  | | UNKNOWN | | | | | | | | | | | | | | | | | | | |  |
|  |  | | | | | | | | | | | | | | |  | |  | |  | | | | | | | | | | | | | | | | | | | |  |
| 10c. WEIGHT OF FETUS  (grams preferred, specify unit)/oz | | | | | | | grams  lb/oz | | | | | | | | | | | 10d. OBSTRETRIC 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 | |
| 11a. NAME OF CERTIFIER/ATTENDANT | | | | | | | | | | | | | | | | | | | | | | | | 11b. NPI | | | | | | | | | | 11c. TITLE  ATTENDING  MD /  DO  MEDICAL EXAMINER  CERTIFYING  MD /  DO | | | | | | |
| 11d. ADDRESS OF CERTIFIER/ATTENDANT | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11e. SIGNATURE OF CERTIFIER/ATTENDANT | | | | | | | | | | | | | | | | | | | | | 11f. DATE | | | | | | | | | | | | |
| 12a. NAME OF PERSON COMPLETING REPORT | | | | | | | | | | | 12b. TITLE | | | | | | | | | | | | | | | | | | | 12c. DATE REPORT COMPLETED *(MM/DD/YYYY)* | | | | | | | | | | |
| 13. DISPOSITION  BURIAL  CREMATION  HOSPITAL DISPOSITION  DONATION  REMOVAL FROM STATE  OTHER *(Specify)*: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | | | | | 15a. CITY/TOWN | | | | | | | | | | | | | | | | | | | | | | | 15b. STATE | | | |
| 16. NAME AND ADDRESS OF FUNERAL HOME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 17a. NAME OF FUNERAL DIRECTOR *(Print or Type)* | | | | | | | | | | | | | 17b. SIGNATURE OF FUNERAL DIRECTOR | | | | | | | | | | | | | | | | | | | | | | 17c. NJ LICENSE NO. | | | | | |
| 18a. NAME OF REGISTRAR *(Print or Type)* | | | | | | | | | | | 18b. SIGNATURE OF REGISTRAR | | | | | | | | | | | | | | | | | | | 18c. DATE RECEIVED BY REGISTRAR *(MM/DD/YYYY* | | | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| New Jersey Department of HealthCERTIFICATE OF FETAL DEATH | | | | | | | | | | | | | | | | **STATE FILE NO.** | | |
| THE FOLLOWING CONFIDENTIAL INFORMATION MAY BE USED IN CONNECTION WITH RESEARCH STUDIES APPROVED BY THE PUBLIC HEALTH COUNCIL AS AUTHORIZED BY CHAPTER 68, P.L. 1963. SUCH INFORMATION WILL NOT APPEAR ON ANY CERTIFIED COPY OF THIS RECORD. | | | | | | | | | | | | | | | | | | |
| 19a. 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 or GED completed  Some college credit but no degree  Associate degree (e.g., AA, AS)  Bachelor’s degree (e.g., BA, AB, BS)  Master’s degree (e.g., MA, MS, MEng, MEd, MSW, MBA)  Doctorate (e.g., PhD, EdD) or Professional degree (e.g. MD. DDS, DVM, LLB, JD) | | | | 20a. MOTHER’S HISPANIC ORIGIN (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the “No” box if mother is not Spanish/Hispanic/Latina.)  No, not Spanish/Hispanic/Latina  Yes, Mexican, Mexican American, Chicana  Yes, Puerto Rican  Yes, Cuban  Yes, other Spanish/Hispanic/Latina *(Specify)*:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | 21a. 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  Filipina  Japanese  Korean  Vietnamese  Other Asian *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_**  Native Hawaiian  Guamanian or Chamorro  Samoan  Other Pacific Islander *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_**  Other *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| 19b. FATHER’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 or GED completed  Some college credit but no degree  Associate degree (e.g., AA, AS)  Bachelor’s degree (e.g., BA, AB, BS)  Master’s degree (e.g., MA, MS, MEng, MEd, MSW, MBA)  Doctorate (e.g., PhD, EdD) or Professional degree (e.g. MD. DDS, DVM, LLB, JD) | | | | 20b. FATHER’S HISPANIC ORIGIN (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the “No” box if father is not Spanish/Hispanic/Latino.)  No, not Spanish/Hispanic/Latino  Yes, Mexican, Mexican American, Chicano  Yes, Puerto Rican  Yes, Cuban  Yes, other Spanish/Hispanic/Latino *(Specify)*:  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | 21b. FATHER’S RACE (Check one or more races to indicate what the father considers himself 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)*: **\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | |
| 22. OCCUPATION DURING THE PAST YEAR | | | | | | | | | 23. BUSINESS/INDUSTRY WORKED AT DURING THE PAST YEAR | | | | | | | | | |
| a. Mother: |  | | | | | | |  | a. Mother: | | | |  | | | | |  |
| b. Father: |  | | | | | | |  | b. Father: | | | |  | | | | |  |
|  | | | | | | | | |  | | | | | | | | | |
| 24. MOTHER MARRIED? *(At delivery,* *conception, or any time between)*  Yes  No | | | 25. DATE LAST NORMAL MENSES BEGAN *(MM/DD/YYYY)*  **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  Month / Day / Year | | | 26. DATE OF FIRST PRENATAL CARE VISIT *(MM/DD/YYYY)*  **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  Month / Day / Year  No Prenatal Care | | | | | 27. DATE OF LAST PRENATAL CARE VISIT *(MM/DD/YYYY)*  **\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**  Month / Day / Year | | | | | | 28. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY  *(If “None”, enter “0”)* | |
| 29a. NUMBER OF PREVIOUS LIVE BIRTHS, NOW LIVING  Number: **\_\_\_\_\_\_\_\_**  None | | | 29a. NUMBER OF PREVIOUS LIVE BIRTHS, NOW DEAD  Number: **\_\_\_\_\_**  None | | | 29c. DATE OF LAST LIVE BIRTH *(MM/YYYY)*  **\_\_\_\_\_/\_\_\_\_\_**  Month / Year | | | | | 30a. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies) (Do not include this fetus)  Number: **\_\_\_\_\_\_\_\_**  None | | | | | | 30b. DATE OF LAST OTHER PREGNANCY OUTCOME *(MM/YYYY)*  **\_\_\_\_\_/\_\_\_\_\_**  Month / Year | |
| 31. MOTHER’S HEIGHT *(feet/inches)*  **\_\_\_\_\_\_\_\_** | | 32. MOTHER’S PRE-PREGNANCY WEIGHT *(pounds)*  **\_\_\_\_\_\_\_\_** | | | | | 33. MOTHER’S WEIGHT AT DELIVERY *(pounds)*  **\_\_\_\_\_\_\_\_** | | | | | 34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?  Yes  No | | | | | | |
| 35a. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY (FOR EACH TIME PERIOD, ENTER EITHER THE AVERAGE NUMBER OF CIGARETTES OR THE AVERAGE NUMBER OF PACKS OF CIGARETTES SMOKED PER DAY.) IF NONE, ENTER “0”.  Three Months Before Pregnancy: **\_\_\_\_\_\_\_\_** number of cigarettes **OR** **\_\_\_\_\_\_\_\_** number of packs  First Three Months of Pregnancy: **\_\_\_\_\_\_\_\_** number of cigarettes **OR** **\_\_\_\_\_\_\_\_** number of packs  Second Three Months of Pregnancy: **\_\_\_\_\_\_\_\_** number of cigarettes **OR** **\_\_\_\_\_\_\_\_** number of packs  Third Trimester of Pregnancy: **\_\_\_\_\_\_\_\_** number of cigarettes **OR** **\_\_\_\_\_\_\_\_** number of packs | | | | | | | | | | | | | | | | | | |
| 35b. OTHER RISK FACTORS FOR THIS PREGNANCY *(Complete all items)*  Alcohol Use during pregnancy?  Yes  No Average number of drinks per week: **\_\_\_\_\_\_\_\_**  Homelessness?  Yes  No  Domestic Violence?  Yes  No  Use of cocaine, heroin, marijuana, or methamphetamines during pregnancy?  Yes  No | | | | | | | | | | | | | | | | | | |
| **NAME OF FETUS *(First, Middle, Last)*** | | | | | | | | | | | | | | | | | | |
| REG-26  JUL 18 Page 2 of 3 Pages. | | | | | | | | | | | | | | | | | | |
| **New Jersey Department of Health** CERTIFICATE OF FETAL DEATH | | | | | | | | | | | | | | | | **STATE FILE NO.** | | |
| 36a. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY?  No  Yes IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: | | | | | | | | | | | | | | | | | | |
| 36b. MUNICIPALITY NAME | | | | | | | | | | | | | | 36c. COUNTY NAME | | | | |
| MEDICAL AND HEALTH INFORMATION | | | | | | | | | | | | | | | | | | |
| 37. MEDICAL RISK FACTORS FOR THIS PREGNANCY *(Check all that apply)*  Anemia (Hct. <30 / Hgb. <10)  Cardiac disease  Acute or chronic lung disease  Diabetes, Prepregnancy (diagnosis prior to this pregnancy)  Diabetes, Gestational (diagnosis in this pregnancy)  Genital herpes  Hydramnios/Oligohydramnios  Hemoglobinopathy  Hypertension, Prepregnancy (Chronic)  Hypertension, Gestational (PIH, preeclampsia)  Hypertension, Eclampsia  Incompetent cervix  Previous infant 4000+ grams  Previous preterm birth  Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth-restricted birth)  Renal Disease  Rh sensitization  Uterine bleeding  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? **\_\_\_\_\_\_\_\_**  Other *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_**  None of the above | | | | | 40. MATERNAL MORBIDITY (COMPLICATIONS OF LABOR AND/OR DELIVERY)  *(Check all that apply)*  Febrile (>100° F. or 38° C.)  Meconium, moderate/heavy  Premature rupture of membrane (>12 hours)  Abruptio placenta  Placenta previa  Other excessive bleeding  Seizures during labor  Precipitous labor (<3 hours)  Prolonged labor (>20 hours)  Dysfunctional labor  Breech/Malpresentation  Cephalopelvic disproportion  Cord prolapse  Anesthetic complications  Fetal distress  Maternal transfusion  Third or fourth degree perineal laceration  Ruptured uterus  Unplanned hysterectomy  Admission to intensive care unit  Unplanned operating room procedure following delivery  Other *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  None of the above | | | | | | | | | | 42. CONGENITAL ANOMALIES OF FETUS (PRESENT OR KNOWN TO EXIST) (*Check all that apply)*  Anencephaly  Meningomyelocele/Spina bifida  Hydrocephalus  Microcephalus  Other CNS anomalies  *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Heart malformations  Cyanotic congenital heart disease  Congenital diaphragmatic hernia  Other circulatory/respiratories anomalies  *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Omphalocele  Gastroschisis  Rectal atresia / stenosis  Tracheo-esophageal fistula / Esophageal atresia  Other gastrointestinal anomalies  *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Malformed genitalia  Renal agenesis  Other urogenital anomalies  *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Polydactyly / Syndactyly / Adactyly  Club foot  Limb reduction defect (excluding congenital amputation and dwarfing syndromes)  Other musculoskeletal / integumental anomalies  *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Cleft Lip with or without Cleft Palate  Cleft Palate alone  Down Syndrome  Karyotype confirmed  Karyotype pending  Suspected chromosomal disorder  Karyotype confirmed  Karyotype pending  Other chromosomal anomalies  *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Hypospadias  Other  *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  None of the anomalies listed above | | | |
| 41. METHOD OF DELIVERY *(Check all that apply)*  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 delivery:  Cephalic  Breech  Other  D. Final route and method of delivery *(Check one)*  D&E  Vaginal/Spontaneous  Vaginal/Forceps  Vaginal/Va­cuum  If vaginal, was vaginal birth after previous Cesarean section?  Yes  No  Cesarean, Primary  Cesarean, Repeat  If cesarean, was a trial of labor attempted?  Yes  No  E. Hysterotomy/Hysterectomy  Yes  No | | | | | | | | | |
| 38. 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)*: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| 39. OBSTETRIC PROCEDURES  *(Check all that apply)*  None  Amniocentesis  Electronic fetal monitoring  Induction of labor  Stimulation of labor  Tocolysis  Ultrasound  Other *(Specify)*: **\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **NAME OF FETUS *(First, Middle, Last)*** | | | | | | | | | | | | | | | | | | |
| REG-26  JUL 18 Page 3 of 3 Pages. | | | | | | | | | | | | | | | | | | |