



## Hospital Fetal Death Case Abstraction Format

Name of Hospital:		Ward / Unit:	
<b>A Summary Sheet</b>			
A	Clinical Record / BHT No:		
B	Name of Mother		
C	Ethnicity of mother	<input type="checkbox"/> Sinhalese <input type="checkbox"/> Tamil <input type="checkbox"/> Muslim <input type="checkbox"/> Other: _____	
D	Residential Address		
E	MOH Area	F. District / RDHS	
G	Age of mother	____ Years	H. NIC No:
I	Type of Foetal Death	<input type="checkbox"/> < 28 Weeks <input type="checkbox"/> > 28 Weeks	
H	Gravida	I. Parity: P____   C____	
J	Type of Pregnancy	<input type="checkbox"/> Singleton <input type="checkbox"/> Twin <input type="checkbox"/> Higher____	
L	Date of Delivery of dead foetus	DD / MM / YYYY	
M	Type of Delivery	<input type="checkbox"/> Normal Vaginal <input type="checkbox"/> Breech <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Elective CS <input type="checkbox"/> Emergency CS <input type="checkbox"/> Hysterotomy <input type="checkbox"/> Laparotomy for rupture uterus <input type="checkbox"/> Other: _____	
O	POG at birth	____ Weeks ____ days	P. Method of assessment: <input type="checkbox"/> LMP <input type="checkbox"/> USS <input type="checkbox"/> other
Q	Birth Weight	____ grams	R. Sex : <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous
S	Date of death	DD / MM / YYYY	
U	Timing of death	<input type="checkbox"/> Antepartum <input type="checkbox"/> Intrapartum <input type="checkbox"/> Unable to classify timing	
<b>Cause/s of Death</b>			
V1	ICD-PM Group <i>The group of main disease or condition that lead to death in fetus or infant</i>	<b>Antepartum</b> A1_Congenital_malformations_and_chromosomal_abnormalities A2_Infection A3_Antepartum_hypoxia A4_Other_specified_antepartum_disorder A5_Disorders_related_to_fetal_growth A6_Fetal_death_of_unspecified_cause Unable_to_classify	<b>Intrapartum</b> I1_Congenital_malformations_and_chromosomal_abnormalities I2_Birth_Trauma I3_Acute_intrapartum_event I4_Infection I5_Other_specified_intrapartum_disorder I6_Disorders_related_to_fetal_growth I7_Intrapartum_death_of_unspecified_cause Unable_to_classify
V2	Broad ICD-PM Cause	The <u>broad</u> cause of death selected from Broad ICD codes. (Please refer to guidelines & codes)	
V3	ICD specific category	Specific cause/s of death	
<b>Maternal conditions contributing to death</b>			
W1	ICD -PM Group (Main maternal disease or condition affecting fetus or infant)	M1_Complications_of_placenta_cord_and_membranes M2_Maternal_complications_of_pregnancy M3_Other_complications_of_labour_and_delivery M4_Maternal_medical_and_surgical_conditions M5_No_maternal_condition	
W2	ICD -PM specific group (Specific maternal condition/s affecting fetus or infant)		
<b>Post-mortem Details</b>			
X	Pathological / Forensic Record No: _____	Done <input type="checkbox"/> Not done <input type="checkbox"/> <u>Details:</u>	
Y	Stillbirth Registration Information	Foetal Deaths >28 wks: Certificate of Still Birth (B22) filled ? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of posting a copy to Registrar General's Department: DD / MM / YYYY	

<b>B Additional Details</b>					
<b>a Maternal History</b>					
1	Marital Status	<input type="checkbox"/> Unmarried <input type="checkbox"/> Married <input type="checkbox"/> Living together <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
2	Maternal Risk Factors	<input type="checkbox"/> Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Betel Leave Chewing <input type="checkbox"/> Consanguinity <input type="checkbox"/> Other_____			
3	POG at booking	___ Wks	4	BMI at booking	___ Kg/M <sup>3</sup>
<b>b Hospital Inward Management</b>					
1	Date Admitted	DD / MM / YYYY   Time: HH:MM	2.	FHS on admission to hospital	<input type="checkbox"/> Present (Rate:___) <input type="checkbox"/> Not present
3	Reason for admission / Presenting complaints / conditions:				
4	Details of Prenatal Screening :		5	Antenatal Investigations:	
6	Antepartum complications:				
<b>c Intrapartum care / Labour Room Care</b>					
1	FHS on admission to labour room		<input type="checkbox"/> Present <input type="checkbox"/> Not present		2. Rate (if present):
3	Type of labor	<input type="checkbox"/> Spontaneous <input type="checkbox"/> Induced	4	Partograph used	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5	Indication/s for IOL		6	Fetal Monitoring intrapartum	
7	Method of induction of labor		<input type="checkbox"/> Oxytocin <input type="checkbox"/> Misoprostol <input type="checkbox"/> Prostaglandins <input type="checkbox"/> Foley's catheter <input type="checkbox"/> ARM		
9	Intrapartum complications: <input type="checkbox"/> Non progress of labor <input type="checkbox"/> Prolonged second stage <input type="checkbox"/> Fetal distress <input type="checkbox"/> Obstructed labor <input type="checkbox"/> Cord complications <input type="checkbox"/> Fever <input type="checkbox"/> Rupture uterus <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Abruptio <input type="checkbox"/> Eclampsia <input type="checkbox"/> Other_____				
10	Type of Delivery	<input type="checkbox"/> Normal Vaginal <input type="checkbox"/> Breech <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum <input type="checkbox"/> Elective CS <input type="checkbox"/> Emergency CS			
11	Indications for cesarean / instrumental delivery:				
12	Decision to delivery interval	___ Min.	13	Duration of stages	1 <sup>st</sup> : __Hrs 2 <sup>nd</sup> : __ Min 3 <sup>rd</sup> : __ Min
14	Duration of rupture membranes	___ Hrs	15	Delivery conducted by	<input type="checkbox"/> Midwife <input type="checkbox"/> Nurse <input type="checkbox"/> HO <input type="checkbox"/> SHO <input type="checkbox"/> Registrar <input type="checkbox"/> SR <input type="checkbox"/> VOG
16	Maternal outcome	<input type="checkbox"/> Alive and well <input type="checkbox"/> Alive but with serious morbidity <input type="checkbox"/> Death			
<b>d Placental Examination</b>					
1	Weight	___ (gm)	3 Details & Histopathology findings:		
2	Morphology	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal			
<b>e Baby details</b>					
1	Delivery outcome		<input type="checkbox"/> Fresh stillbirth <input type="checkbox"/> Macerated stillbirth		
2	Birth Weight	___ grams	3	OFC:	___ cm
4	Maturity at Birth	___ wks	5	Length:	___ cm
6	Congenital Abnormalities present ?		<input type="checkbox"/> Yes <input type="checkbox"/> No Describe:		
7	Issues identified in provision of care				
Date Foetal Death notification sent			DD / MM / YYYY		
Date Foetal Death Data entered in Web System			DD / MM / YYYY		
Date of hospital Perinatal Mortality Review conducted			DD / MM / YYYY		

Name of Obstetrician: Dr.

Signature :

Date:

Hospital Head:

Signature :

Date:

Data in this format should be entered to National Hospital Fetal Death Register: <https://erhmis.fhb.health.gov.lk/mmsbds/dhis-web-commons/security/login.action>