

**REPORTING OF FETAL/NEONATAL/INFANT OR MATERNAL DEATH**  
**[O.A.C. 3701-7-15(E)]**

HOSPITAL NAME: \_\_\_\_\_ MATERNITY LICENSE #: \_\_\_\_\_

☐ **FETAL/NEONATAL/INFANT DEATH** (Report the death of all fetuses of twenty weeks gestation or greater that showed evidence of life at any point from the mother's admission through delivery; all liveborn neonates before twenty-eight days of age, from delivery or admission through transfer or discharge; or all liveborn infants twenty-eight days of age through one year of age, from delivery or admission through transfer or discharge. The maternity rules do not require that this form be used for reporting of induced termination of the pregnancy. (However, other abortion-related laws may require a report on an induced termination.)

☐ **MATERNAL DEATH** (This includes reporting any maternal death that occurs from any cause related to or aggravated by pregnancy or its management from the woman's admission and care at delivering hospital through transfer or discharge.)

1. Name of mother: \_\_\_\_\_ 2. Date/Time of admission (Mother): \_\_\_\_\_

3. Age: \_\_\_\_\_ Gravida: \_\_\_\_\_ Para: \_\_\_\_\_ Race: \_\_\_\_\_ Gestational age at the time of delivery \_\_\_\_\_ weeks

4. Risk factors (Circle all that apply): Obesity (BMI > 30); Diabetes Mellitus: Gestational, Type I, Type II;  
Hypertension: Chronic, Gestational, Pre-Eclampsia, Eclampsia;  
Substance Abuse: Alcohol, Opiates, Cocaine, Methamphetamines, Tobacco, Marijuana, Other \_\_\_\_\_;  
Mental Health Issues: Depression, Bipolar Disorder, Schizophrenia, Other \_\_\_\_\_; Domestic Violence

5. Other medical diagnoses: \_\_\_\_\_

6. Initiation of prenatal care at \_\_\_\_\_ weeks gestation/number of visits if known \_\_\_\_\_ 7. Source of Prenatal Care \_\_\_\_\_

8. Date/Time of delivery: \_\_\_\_\_ Method: ☐ Induction ☐ Vaginal ☐ Primary C/S ☐ Repeat C/S ☐ Emergency C/S  
☐ Trial of Labor After Cesarean (TOLAC) Successful (Circle) Yes/No

9. Type of anesthesia: \_\_\_\_\_

10. Date/Time of death: \_\_\_\_\_ 11. Autopsy performed (Circle) Yes/No 12. Coroner's Case (Circle) Yes/No

13. Cause of death, if known: \_\_\_\_\_ 14. Source (Circle) Autopsy/Medical Record

15. Site of delivery/birth, if different from where death occurred: \_\_\_\_\_

16. Clinical course (include labor and delivery): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

17. Newborn: APGAR scores at 1 minute/5 minutes: \_\_\_\_\_ Weight: \_\_\_\_\_

18. If Maternal Death, outcome of fetus/newborn (circle or indicate all that apply):

A. Live birth/fetus stillborn/undelivered: \_\_\_\_\_

B. Admitted to Level I/Level II/Level III (Name the hospital): \_\_\_\_\_

C. Discharged live/Remains in hospital/Expired: \_\_\_\_\_

Name and Title of Person Completing This Form: \_\_\_\_\_ Date: \_\_\_\_\_

Contact

Number: \_\_\_\_\_

07/09/2018

**INSTRUCTIONS FOR COMPLETION OF FETAL/NEONATAL/INFANT DEATH/MATERNAL DEATH  
MATERNITY LICENSURE**

**General Instructions:**

1. Complete each applicable section of the form by printing or typing. Please use black ink.
2. If there is insufficient space to complete an answer, continue the answer on an additional separate page.
3. Call the Ohio Department of Health (ODH), Office of Health Assurance and Licensing (information provided below) if you have any questions.
4. Please submit this report **within 24 hours** of infant death or maternal death to:

Ohio Department of Health  
Office of Health Assurance and Licensing  
Maternity/Newborn  
246 North High Street  
Columbus, Ohio 43215  
(614) 387-0801

Or fax the form along with any supporting documentation to: 614-564-2475

Or you can print this form at link: <http://www.odh.ohio.gov/odhprograms/chcf/comhfs/munit/mu1.aspx>, complete it and attach it in an e-mail to [community@odh.ohio.gov](mailto:community@odh.ohio.gov)

**Line-by-Line Instructions:**

Please place the appropriate checkmark in box identifying whether fetal/neonatal/infant or maternal death.

Lines 1-6: Self explanatory

Line 7: Indicate where mother received her prenatal care

Line 8: Indicate date, time and type of delivery

Line 9: Indicate type of anesthesia used (e.g., general, epidural, spinal, pudendal, local, or combination)

Line 10-12: indicate the date of death; whether an autopsy was performed; and whether a coroner's case

Line 13-14: Indicate preliminary cause of death where determinable and source where cause of death was found

Line 15: If death occurred after transfer of either mother or infant from another hospital, list that hospital if known

Line 16: Please describe the clinical course that led up to the death of the fetus/neonate/infant or mother (include labor and delivery)

Line 17: Please complete for either neonate/infant or maternal death if neonate/infant was delivered

Line 18: Please complete status of fetus/neonate/infant for all maternal deaths