Technical Notes

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TECHNICAL NOTES

SOURCES OF DATA

BIRTHS, DEATHS AND FETAL DEATHS: Birth, death and fetal death certificates were the source documents for data on vital events to Delaware residents. A copy of each certificate is included as Appendices F, G and H.

The cut-off date for data in this report was October 31 after the close of the calendar year. Any data pertaining to an event for which a certificate was filed after this date, are not included in this report. It is possible that data obtained directly from the Delaware Health Statistics Center (DHSC) may differ slightly from that which appear in this report. If this should occur, it is the result of an update that was made after the cut-off date for this report.

Births and deaths to Delaware residents which took place in other states are included in this report. The inclusion of these data is made possible by an agreement among all registration areas in the United States for the exchange of copies of resident certificates.

MARRIAGES AND DIVORCES: Each of Delaware's three counties has a state office for the collection of marriage certificates. All of these certificates are processed and maintained by the Office of Vital Statistics in the Division of Public Health's central office in Dover. Copies of divorce certificates are forwarded to the Office of Vital Statistics from the Delaware Family Court system so that certain selected data items can be processed for statistical purposes. A copy of each of these certificates is included as Appendices I and J.

INDUCED TERMINATIONS OF PREGNANCY: Beginning on January 1, 1997, all induced terminations of pregnancy (ITOP) were required to be reported to the Department. Reports of induced termination of pregnancy are filed directly with the DHSC. The reports are filed for statistical purposes only and are shredded and discarded when all reports for the data year have been coded. ITOP records are currently not being exchanged among the states, so events to Delaware residents occurring out-of-state are not included in this report. A copy of the reporting form is included as Appendix K.

REPORTED PREGNANCIES: Reported pregnancies refer to live births, fetal deaths, and ITOP. When used in combination, these three events can yield a great deal of information regarding pregnancy and pregnancy outcomes that is not possible by looking at each individual event separately. For example, live birth rates can be calculated using live births in conjunction with population data. However, differences observed between live birth rates in two or more geographic areas or within the same area at different points in time may be due to differences in the rate of pregnancy, differences in pregnancy outcomes (i.e., live birth, fetal death, or ITOP), or a combination of these factors. Only pregnancy rates allow such questions to be thoroughly examined. It should be kept in mind that both births and fetal deaths of Delaware residents are reported regardless of state of occurrence, while induced terminations are reported for only those that occur in Delaware.

POPULATION PROJECTIONS: The state, county and city population figures used in this report are estimates and projections produced by the Delaware Population Consortium (DPC). The DHSC is a member of the DPC and supplies birth and death data used in making the projections. Copies of the most recent projections for Delaware's population by age, race, sex, and geographic location are available at http://stateplanning.delaware.gov/information/dpc_projections.shtml.

DATA QUALITY

QUERY AND FIELD PROGRAMS: The quality of vital statistics data presented in this report is directly related to the completeness and accuracy of the information contained on the certificates and forms. The DHSC works with the Office of Vital Statistics to ensure that the information received is as complete and accurate as possible. The Office of Vital Statistics operates two programs related to improving the quality of information received on vital records--the query and field programs.

The query program is a system used to follow-back to hospital and clinic personnel, funeral directors and/or physicians concerning data quality problems. The follow-back contact is usually via mail and/or telephone. The field program attempts to improve vital statistics data quality by educating the participants in the vital registration system (i.e., hospital personnel, funeral directors, physicians, etc.) of the uses and importance of vital statistics data.

The field program completes this mission by conducting seminars with various associations representing the individuals listed above.

The National Center for Health Statistics (NCHS) monitors Delaware's coding of statistical data on death certificates. A 20 percent sample of death records coded and submitted monthly by the state are used as a quality control mechanism by NCHS. NCHS codes these sample records independently and then conducts an item-by-item computer match of codes entered by the state and NCHS. NCHS has established an upper limit of two percent for coding differences involving any one data item of these sample records, with the exception of cause of death. NCHS independently codes cause of death information.

COMPUTER EDITS AND DATA PROCESSING: Another dimension of data quality is related to the procedures and methodologies used in preparing the data for presentation. Beginning with the 1991 Annual Vital Statistics Report, methodologies for editing and processing vital data were standardized to match the procedures used by NCHS in tabulating national vital statistics data. These procedures include checking for valid codes, computation of data items (e.g., age, live-birth order, weeks of gestation, duration of marriage, interval between divorce and remarriage), consistency checks between data items (e.g., age and education), and imputation of missing values.

FETAL DEATHS: In terms of the completeness of the data, the reporting of deaths and live births is considered to be virtually complete. However, in Delaware, a spontaneous termination of pregnancy is not required to be reported when the fetus weighs less than 350 grams or, when weight is unattainable, if the duration of pregnancy is less than 20 weeks. National estimates (Ventura, Taffel and Mosher, 1985) indicate that over 90 percent of all spontaneous terminations of pregnancy may occur before this 20-week period and thus go unreported. In addition, the exchange agreement among states for resident fetal death records is problematic due to different reporting requirements; it is unknown whether complete exchange is taking place. The result is that a large number of spontaneous terminations may not be reported.

GEOGRAPHY ALLOCATION

In Delaware's registration program, as in other states, vital events are classified geographically in two ways. The first way is by place of occurrence (i.e., the actual state and county in which the birth or death took place). The second and more customary way is by place of residence (i.e., the state, county, and census tract) stated to be the usual residence of the decedent in the case of death, or of the mother in the case of a newborn.

While occurrence statistics are accurate and have both administrative value and some statistical importance, residence statistics are by far the more useful tool in developing health indices for planning and evaluation purposes. The natality and mortality statistics provided in this report are based upon Delaware residence data. However, the marriage and divorce statistics are occurrence data. This is primarily due to the fact that two separate residences are usually involved in a marriage or a divorce, and there are no accepted standard procedures for classification of residence in these events.

Allocation of vital events by place of residence is sometimes difficult because classification depends entirely on a statement of the usual place of residence furnished by the informant at the time the original certificate is completed. For various reasons, this statement may be incorrect or incomplete. However, in recent years, the DHSC has invested a great deal of effort into editing of address information leading to a significant improvement in data quality.

In any case, geographical allocation is generally a problem only at the level of census tract. Resident counts at the State level are, for all practical purposes, complete. County resident figures are substantially correct and can be used with a high degree of confidence.

Most of the data provided in this report are available at the census tract level. This information can be obtained by contacting the DHSC.

BIRTH WEIGHT

This report presents birth weight in grams in order to provide data comparable to that published for the United States and other countries. For those live birth certificates where birth weight is reported in pounds and ounces, DHSC converts the birth weight into grams.

The equivalents of the gram intervals in pounds and ounces are as follows:

499 grams or less = 1 lb. 1 oz. or less
500 - 999 grams = 1 lb. 2 ozs. - 2 lbs. 3ozs.
1,000 - 1,499 grams = 2 lbs. 4 ozs. - 3 lbs. 4ozs.
1,500 - 1,999 grams = 3 lbs. 5 ozs. - 4 lbs. 6ozs.
2,000 - 2,499 grams = 4 lbs. 7 ozs. - 5 lbs. 8ozs.
2,500 - 2,999 grams = 5 lbs. 9 ozs. - 6 lbs. 9ozs.
3,000 - 3,499 grams = 6 lbs. 10 ozs. - 7 lbs. 11ozs.
3,500 - 3,999 grams = 7 lbs. 12 ozs. - 8 lbs. 12ozs.
4,000 - 4,499 grams = 8 lbs. 13 ozs. - 9 lbs. 14ozs.
4,500 - 4,999 grams = 9 lbs. 15 ozs. - 11 lbs. 0ozs.
5,000 grams or more = 11 lbs. 1 oz. or more

RATES

Absolute counts of births and deaths do not readily lend themselves to analysis and comparison between years and various geographic areas because of differences in population characteristics (e.g., age, sex, and race). In order to account for such differences, the absolute number of events is converted to a relative number such as a percentage, rate, ratio, or index. These conversions are made by relating the number of events to the population at risk in a particular area at a specified time.

Precautions should always be taken when comparing any rates based on vital events. Both the number of events and the characteristics of the population are important to take into account when interpreting a rate.

All statistics are subject to random variation.[1] Rates based on a relatively small number of events tend to be subject to more random variation than rates based on a large number of events.

In addition to the problem of small numbers, demographic characteristics of populations (i.e., age, race and sex) can affect the comparability of rates. Since mortality rates vary substantially by age, race and sex, comparisons between rates from populations that differ in these characteristics could be misleading. However, there are two methods that can be used separately or in combination to improve the comparability of mortality rates. The first method involves comparing rates for specific age, race, and/or sex groups in the populations of interest. With this method, the rates are easily calculated and very specific groups may be compared. However, when very specific groups are compared the numbers are often small, and relationships between the overall populations are difficult to determine.

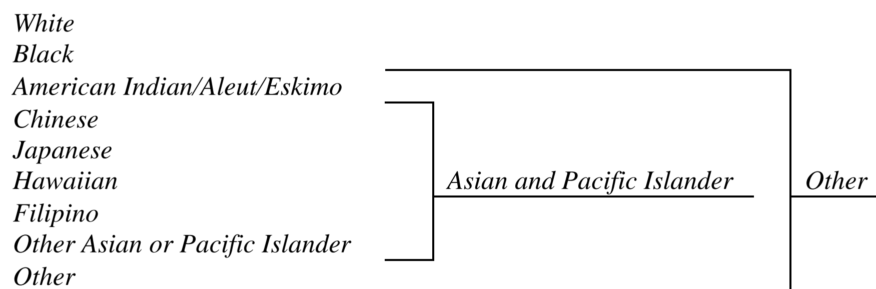
The second method is a more sophisticated technique that statistically "adjusts" for demographic differences between populations and allows direct comparisons between overall population rates. The major

[1]See Appendix A for more details.

disadvantages of adjusted rates are that they can be cumbersome to calculate without the aid of a computer and they only have meaning when compared to other rates adjusted in the same manner.

RACE

All Delaware vital records contain an item(s) regarding race. Race is self-reported in all records except on death certificates where it is provided by an informant. Although the question allows for a free form response, all race data are grouped for purposes of data analysis into the following categories established by NCHS:



The categories *Chinese*, *Japanese*, *Hawaiian*, *Filipino*, and *Other Asian or Pacific Islander* can be combined to form the category *Asian or Pacific Islander*. For purposes of this report, *American Indian/Aleut/Eskimo*, *Chinese*, *Japanese*, *Hawaiian*, *Filipino*, *Other Asian or Pacific Islander*, and *Other* have been combined to form the category *Other*.

In the case of death, race of decedent from the death certificate is reported in all tables except in the birth cohort (see next paragraph). However, in the case of birth and fetal death, race is indicated on the birth and fetal death certificates for the mother and father only (i.e., race of the newborn is not given). Consequently, birth and fetal death data are reported by race of the mother in most tables throughout this report. However, some tables containing historical birth data prior to 1989 are reported by race of child. For these tables, race of child was imputed using criteria established by NCHS.

In the birth cohort section of this report, birth certificate data for infants dying in the first year of life are combined with information from their death certificates. Therefore, data are available for race of the mother and race of the deceased infant for each case. In the vast majority of these cases, the race listed for the mother and infant

are the same. However, in a small number of cases the race of the mother and infant differ. To maintain consistency with data in the natality section, race of the mother is used for all tables in the birth cohort section.

HISPANIC ORIGIN

Beginning in 1989, a specific question regarding Hispanic origin was added to the birth and death certificates. This question is considered to be separate from the Race question. Therefore, a person may report Hispanic origin in combination with any race category. The Hispanic question has two parts. The first simply asks whether the person is of Hispanic origin (Yes or No). The second part is a free-form item that asks for the specific origin (e.g., *Cuban*, *Mexican*, *Puerto Rican*, etc.).

MISSING INFORMATION REGARDING FATHERS

The Delaware vital statistics law specifies that information regarding the father should not be entered on the birth certificate if the mother is single. As such, there is no information regarding the father for the vast majority of births to single mothers. However, in a few cases, information about the father was entered on the certificate when the mother was single. Some tables in the natality section (e.g., births to parents of Hispanic origin) may contain information regarding the father that includes such cases.

Beginning on January 1, 1995, a new program was instituted to allow fathers to acknowledge paternity through completion of a simple form in cases where the mother and father are not married. This form can be completed at any time up to the child’s eighteenth birthday. When such acknowledgments are completed at the hospital at the time of birth, the DHSC is able to add father information to its electronic data base.

SOURCE OF PAYMENT FOR DELIVERY

Beginning with the 1991 data year, the Center began obtaining information regarding the source of payment for delivery on birth certificates (private insurance, Medicaid, and self pay). However, this information was not available for all Delaware resident mothers giving birth in other states (approximately 5 percent of all resident births). For purposes of this report, all such mothers were assigned to the private insurance category. This assignment was based on detailed analyses of the characteristics of these mothers. These analyses indicated that the

demographic characteristics of these mothers very closely matched the characteristics of Delaware resident mothers who gave birth within the State and had private insurance listed as their source of payment. Furthermore, an examination of Medicaid data indicated that it is extremely rare for Medicaid mothers to give birth out-of-state.

2000 POPULATION STANDARD

Beginning with the 1999 report, all mortality rates were age-adjusted using the projected 2000 U.S. population standard. All previous versions of the vital statistics report used the 1940 U.S. population standard from the census of the same year. All historical mortality data have been adjusted to the new standard to allow comparisons over time. Comparisons between rates using the old standard and the new standard are not valid and should not be made.

A more detailed explanation of the rationale for updating the population standard can be found in a special report from NCHS (Anderson and Rosenberg, 1998).

Appendices

Back of Appendices Title Page
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APPENDIX A

RANDOM VARIATION

In this report, the number of vital events represent complete counts for the U.S., Delaware, and county populations. Therefore, they are not subject to sampling error, although they are subject to certain errors in the registration process such as age misreporting. However, the number of events and the corresponding rates are subject to random variation. That is, the rates that actually occurred may be considered as one of a large number of possible outcomes that could have arisen under the same circumstances (National Office of Vital Statistics, 1961). As a result, rates in a given population may tend to fluctuate from year to year even when the health of the population is unchanged. Random variation in rates based on a relatively small number of events, tends to be larger than for rates based upon events that occur more frequently. Delaware rates for some events (e.g., infant deaths) are particularly subject to such variations due to the small number of events that occur by definition in a relatively small population. Therefore, caution should be exercised when drawing conclusions about rates based on small numbers.

The issue of random variation was handled in two ways in this report. First, multi-year average rates were reported instead of annual rates. This tended to reduce the effects of random variation since the number of events in a five-year period was much larger. Second, tests of statistical significance were used to make comparisons between rates when appropriate. These statistical tests were used to determine the chance that the observed differences would occur in populations with equal rates by random variation alone. The methods used to calculate infant mortality rates are described in Appendix B.

APPENDIX B

METHODS FOR CALCULATION AND STATISTICAL ANALYSIS OF FIVE-YEAR AVERAGE INFANT MORTALITY RATES

Due to the small number of infant deaths in Delaware, slight year-to-year changes in the number of deaths can lead to substantial fluctuations in annual rates. In many cases, this problem makes interpretation of annual rates extremely difficult, if not impossible. Since there is far less random fluctuation in five-year average (FYA) rates, they are much better for assessing the health status of infants in Delaware.[2] When rolling FYA rates (e.g., rates for 1980-1984, 1981-1985, and 1982-1986) are used, the patterns of changes in infant mortality over a number of years can be determined.

A description of the methods used to calculate the running FYA rates and the statistical methodology used to compare infant mortality rates are described below.

FIVE-YEAR AVERAGE INFANT MORTALITY RATES: Running FYA infant, neonatal, and postneonatal mortality rates (see Definitions) were calculated by race for the U.S., Delaware, and Delaware's three counties. The rates (i.e., infant, neonatal, or postneonatal) were computed by dividing the total number of deaths over each five-year period by the total number of live births over the same five-year period and multiplying the result by 1,000.

STATISTICAL TESTS:

Confidence intervals for rates based on fewer than 100 deaths:

$$LCL = R_1 * L(.95, D_{adj})$$
$$UCL = R_1 * U(.95, D_{adj})$$
$$where\ D_{adj} = \frac{D * B}{D + B}$$

L and U are upper and lower confidence factors based on a gamma distribution with parameter D_{adj}.

[2]See Appendix A for a description of random variation and rationale for use of five-year average rates.

Confidence intervals for rates based 100 or more deaths:

$$R_1 \pm 1.96 * SE$$
$$where\ SE(R_1) = R_1 * \frac{RSE(R_1)}{100}$$
$$and\ RSE(R_1) = 100 * \sqrt{\left(\frac{1}{D} + \frac{1}{B}\right)}$$

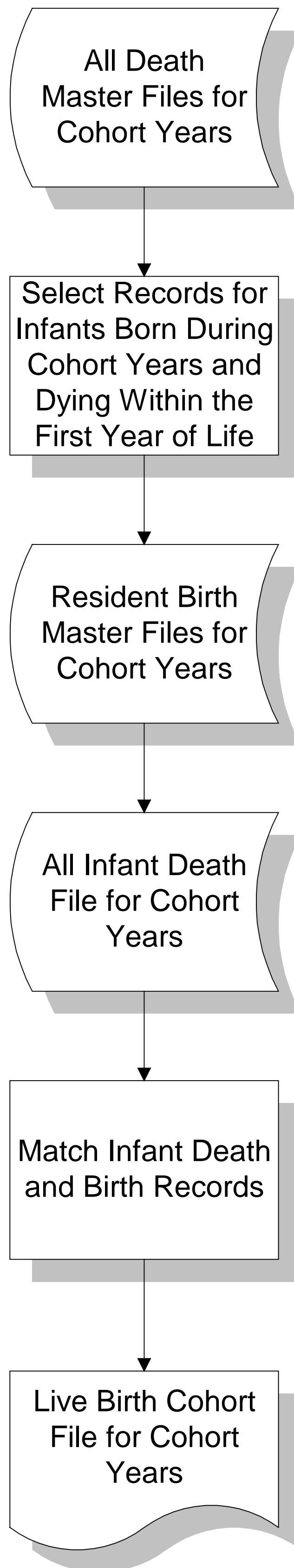
Comparison of two infant mortality rates - When the number of events for one or both of the rates was less than 100, comparisons between rates were based on the confidence intervals for each. If they overlapped, the difference was not significant. When the number of events for both rates was 100 or more, the following z-test was used to define a significant test statistic:

$$z = \frac{R_1 - R_2}{\sqrt{R_1{}^2\left(\frac{RSE(R_1)}{100}\right)^2 + R_2{}^2\left(\frac{RSE(R_2)}{100}\right)^2}}$$

If $|z| \geq 1.96$ then the difference between the rates was statistically significant at the 0.05-level.

APPENDIX C

CREATION OF A LIVE BIRTH COHORT FILE



APPENDIX D

COMPARABLE CATEGORY CODES FOR SELECTED CAUSES OF INFANT DEATH

Cause of death	Category codes according to	
	ICD-10[1]	ICD-9[2]
Diarrhea and gastroenteritis of infectious origin	A09	009
Tuberculosis	A16–A19	010-018
Tetanus	A33,A35	037,771.3
Diptheria	A36	032
Whooping cough	A37	033
Meningococcal infection	A39	036
Septicemia	A40-A41	038
Congenital syphilis	A50	090
Gonococcal infection	A54	098
Acute poliomyelitis	A80	045
Varicella (chickenpox)	B01	052
Measles	B05	055
Human immunodeficiency virus (HIV)	B20-B24	042-044
Mumps	B26	072
Candidiasis	B37	112
Malaria	B50–B54	084
Pneumocystosis	B59	136.3
Malignant Neoplasms	C00-C97	140-208
In situ, benign, and neoplasms of uncertain or unk behavior	D00-D48	210-239
Diseases of blood and blood-forming organs and certain disorders involving the immune mechanism	D50-D89	135,279-289
Short stature, not elsewhere classified	E34.3	259.4
Nutritional deficiencies	E40-E64	260-269
Cystic fibrosis	E84	277.0
Volume depletion, disorders of fluid, electrolyte and acid-base balance	E86-E87	276
Meningitis	G00,G03	320-322
Infantile spinal muscular atrophy, type I	G12.0	335.0
Infantile cerebral palsy	G80	343
Anoxic brain damage, not elsewhere classified	G93.1	348.1
Diseases of the ear and mastoid process	H60-H93	380-389
Diseases of the circulatory system	I00-I99	390-434,436-459
Acute upper respiratory infections	J00-J06	034.0,460-465
Influenza and pneumonia	J10-J18	480-487
Acute bronchitis and bronchiolitis	J20-J21	466
Bronchitis, chronic and unspecified	J40-J42	490-491
Asthma	J45-J46	493
Pneumonitis due to solids and liquids	J69	507
Gastritis, duodenitis, and noninfective enteritis and colitis	K29,K50-K55	535,555-558
Hernia of abdominal cavity and intestinal obstruction without hernia	K40-K46,K56	550-553,560
Renal failure and other disorders of kidney	N17-N19,N25,N27	584-589
Newborn affected by maternal hypertensive disorders	P00.0	760.0
Newborn affected by other maternal conditions which may be unrelated to present pregnancy	P00.1-P00.9	760.1-760.6,760.8-760.9
Newborn affected by maternal complications of pregnancy	P01	761
Newborn affected by complications of placenta, cord, and membranes	P02	762

APPENDIX D (cont.)

COMPARABLE CATEGORY CODES FOR SELECTED CAUSES OF INFANT DEATH

Cause of death	Category codes according to	
	ICD-10[1]	ICD-9[2]
Newborn affected by other complications of labor and delivery	P03	763.0-763.4,763.6-763.9
Newborn affected by noxious influences transmitted via placenta or breast milk	P04	760.7,763.5
Slow fetal growth and fetal malnutrition	P05	764
Disorders related to short gestation and low birth weight, not elsewhere classified	P07	765
Disorders related to long gestation and high birth weight	P08	766
Birth trauma	P10-P15	767
Intrauterine hypoxia and birth asphyxia	P20-P21	768
Respiratory distress of newborn	P22	769
Congenital pneumonia	P23	770.0
Neonatal aspiration syndrome	P24	770.1
Interstitial emphysema and related conditions originating in the perinatal period	P25	770.2
Pulmonary hemorrhage originating in the perinatal period	P26	770.3
Chronic respiratory disease originating in the perinatal period	P27	770.7
Atelectasis	P280.-P28.1	770.4-770.5
Bacterial sepsis of newborn	P36	771.8
Omphalitis of newborn with or without mild hemorrhage	P38	771.4
Neonatal hemorrhage	P50-P52,P54	772
Hemorrhagic disease of newborn	P53	776.0
Hemolytic disease of newborn due to isoimmunization and other perinatal jaundice	P55-P59	773-774
Hematological disorders	P60-P61	776.1-776.9
Syndrome of infant of a diabetic mother and neonatal diabetes mellitus	P70.0-P70.2	775.0-775.1
Necrotizing enterocolitis of newborn	P77	777.5
Hydrops fetalis not due to hemolytic disease	P83.2	778.0
Congenital malformations, deformations, and chromosomal abnormalities	Q00-Q99	740-759
Sudden infant death syndrome	R95	798.0
Accidents	V01-X59	800-869,880-929
Homicide	X85-Y09	960-968
Complications of medical and surgical care	Y40-Y84,Y88	E870-E879,E930-E949

1. International Classification of Diseases, Tenth Revision.
2. International Classification of Diseases, Ninth Revision.

APPENDIX E

COMPARABLE CATEGORY CODES FOR SELECTED CAUSES OF DEATH

Cause of death	Category codes according to	
	ICD-10[1]	ICD-9[2]
Salmonella infections	A01-A02	002-003
Shigellosis and amebiasis	A03,A06	004,006
Tuberculosis	A16–A19	010-018
Whooping cough	A37	033
Scarlet fever and erysipelas	A38,A46	034.1-035
Meningococcal infection	A39	036
Septicemia	A40-A41	038
Syphilis	A50–A53	090-097
Acute poliomyelitis	A80	045
Arthropod-borne viral encephalitis	A83-A84,A85.2	062-064
Measles	B05	055
Viral hepatitis	B15–B19	070
Human immunodeficiency virus (HIV)	B20-B24	042-044
Malaria	B50–B54	084
Malignant Neoplasms	C00-C97	140-208
In situ, benign, and neoplasms of uncertain or unk behavior	D00-D48	210-239
Anemias	D50-D64	280-285
Diabetes mellitus	E10-E14	250
Nutritional deficiencies	E40-E64	260-269
Meningitis	G00,G03	320-322
Parkinson's disease	G20-G21	332
Alzheimer's Disease	G30	331.0
Diseases of the Heart	I00-I09, I11, I13, I20-I51	390-398, 402, 404, 410-429
Essential (primary) hypertension and hypertensive renal disease	I10, I12	401, 403
Cerebrovascular Diseases	I60-I69	430-434, 436-438
Atherosclerosis	I70	440
Aortic aneurysm and dissection	I71	441
Influenza and pneumonia	J10-J18	480-487
Acute bronchitis and bronchiolitis	J20-J21	466
Chronic Lower Respiratory Diseases	J40-J47	490-494, 496
Pneumoconioses and chemical effects	J60-J66,J68	500-506
Pneumonitis due to solids and liquids	J69	507
Peptic ulcer	K25-K28	531-534
Disease of the appendix	K35-K38	540-543
Hernia	K40-K46	550-553
Chronic liver disease and cirrhosis	K70, K73-K74	571
Cholelithiasis and other disorders of gallbladder	K80-K82	574-575
Nephritis, nephrotic syndrome, and nephrosis	N00-N07, N17-N19, N25-N27	580-589
Infections of kidney	N10-N12,N13.6,N15.1	590
Hyperplasia of prostate	N40	600
Inflammatory disease of female pelvic organs	N70-N76	614-616
Pregnancy, childbirth and the puerperium	O00-O99	630-676
Certain conditions originating in the perinatal period	P00-P96	760-771.2, 771.4-779

APPENDIX E (cont.)

COMPARABLE CATEGORY CODES FOR SELECTED CAUSES OF DEATH

Cause of death	Category codes according to	
	ICD-10[1]	ICD-9[2]
Congenital malformations, deformations and chromosomal abnormalities	Q00-Q99	740-759
Accidents (unintentional injuries)	V01-X59,Y85-Y86	E800-E869, E880-E929
Intentional self-harm (suicide)	*U03, X60-X84,Y87.0	E950-E959
Assault (Homicide)	*U01-*U02, X85-Y09, Y87.1	E960-E969
Legal intervention	Y35,Y89.0	E970-E978
Operations of war and their sequelae	Y36,Y89.1	E990-E999
Complications of medical and surgical care	Y40-Y84,Y88	E870-E879,E930-E949

1. International Classification of Diseases, Tenth Revision.
2. International Classification of Diseases, Ninth Revision.

APPENDIX F

STATE OF DELAWARE CERTIFICATE OF LIVE BIRTH

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES (107)
CERTIFICATE OF LIVE BIRTH
STATE FILE #

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)
2. TIME OF BIRTH (24HR)
3. SEX
4. DATE OF BIRTH (Mo/Day/Yr)
5. FACILITY NAME (If not institution, give street and number)
6. CITY, TOWN, OR LOCATION OF BIRTH
7. COUNTY OF BIRTH

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
8b. MOTHER'S DATE OF BIRTH (Mo/Day/Yr)
8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)
8d. BIRTHPLACE (State, Territory, or Foreign Country)
9a. RESIDENCE OF MOTHER-STATE
9b. COUNTY
9c. CITY, TOWN, OR LOCATION
9d. STREET AND NUMBER
9e. APT. NO.
9f. ZIP CODE
9g. INSIDE CITY LIMITS? ☐ YES ☐ NO

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. BIRTHPLACE (State, Territory, or Foreign Country)

CERTIFIER

11. CERTIFIER'S NAME ____
TITLE: ☐ MD ☐ DO ☐ HOSPITAL ADMIN. ☐ CNM/CM ☐ OTHER MIDWIFE
☐ OTHER (SPECIFY) ____
12. DATE CERTIFIED __/__/__ MM DD YYYY
13. DATE FILED BY REGISTRAR __/__/__ MM DD YYYY

INFORMATION FOR ADMINISTRATIVE USE

MOTHER

14. MOTHER'S MAILING ADDRESS: ☐ Same as residence, or: STATE: CITY, TOWN, OR LOCATION
STREET & NUMBER: APARTMENT NO. ZIP CODE:
15. MOTHER MARRIED? (At birth, conception, or any time between) ☐ Yes ☐ No
IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED IN THE HOSPITAL? ☐ Yes ☐ No
16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ☐ Yes ☐ No
17. FACILITY ID. (NPI)
18. MOTHER'S SOCIAL SECURITY NUMBER:
19. FATHER'S SOCIAL SECURITY NUMBER:

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER

MOTHER'S MEDICAL RECORD NO. ____

20. 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, MEngMEd, MSW, MBA)
☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

21. MOTHER OF 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) ____

22. 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 the 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) ____
Predominant Race ____

FATHER

23. 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, M.Ed., MSW, MBA)
☐ Doctorate (e.g., Ph.D., EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

24. FATHER OF 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) ____

25. 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 the 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) ____
Predominant Race ____

STATE OFFICE USE ONLY

26. PLACE WHERE BIRTH OCCURRED (Check one)
☐ Hospital
☐ Freestanding birthing center
☐ Home Birth: Planned to deliver at home? ☐ Yes ☐ No
☐ Clinic/Doctor's office
☐ Other (Specify)

27. ATTENDANT'S NAME, TITLE, AND NPI
NAME: ____
NPI ____
TITLE: ☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE
☐ OTHER (Specify) ____

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:
____

DPH REV 4/2005

SAMPLE

APPENDIX F (cont.)

STATE OF DELAWARE CERTIFICATE OF LIVE BIRTH
STATISTICAL SECTION

MOTHER

29a. DATE OF FIRST PRENATAL CARE VISIT ___/___/___ MM DD YYYY ☐ No Prenatal Care

29b. DATE OF LAST PRENATAL CARE VISIT ___/___/___ MM DD YYYY

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

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

35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)
- 35a. Now Living Number ______ ☐ None
- 35b. Now Dead Number ______ ☐ None
- 35c. DATE OF LAST LIVE BIRTH ___/___ MM YYYY

36. NUMBER OF OTHER PREGNANCY OUTCOMES (Spontaneous or induced losses or ectopic pregnancies)
- 36a. OTHER OUTCOMES NUMBER ______ ☐ None
- 36b. DATE OF LAST OTHER PREGNANCY OUTCOME ___/___ MM YYYY

37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter the number of cigarettes smoked IF NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day

	# of Cigarettes		# or packs
Three Months Before Pregnancy	______	OR	______
First Three Months of Pregnancy	______	OR	______
Second Three Months of Pregnancy	______	OR	______
Last Trimester of Pregnancy	______	OR	______

38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
- ☐ Private Insurance
- ☐ Medicaid
- ☐ Self pay
- ☐ Other (Specify) ______

39. DATE LAST NORMAL MENSES BEGAN ___/___/___ MM DD YYYY

40. MOTHER'S MEDICAL RECORD NUMBER

MEDICAL AND HEALTH INFORMATIION

41. RISK FACTORS IN THIS PREGNANCY (check all that apply)

Diabetes
- ☐ Pre-Pregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

Hypertension
- ☐ Pre-Pregnancy (Chronic)
- ☐ Gestational
- ☐ 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

44. ONSET OF LABOR (CHECK ALL THAT APPLY)
- ☐ Premature Rupture of Membranes (prolonged, >= 12 hrs.)
- ☐ Precipitous Labor (< 3 hrs.)
- ☐ Prolonged Labor (>= 20 hrs.)
- ☐ None of the Above

46. 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

42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ None of the above

43. OBSTETRIC PROCEDURES (Check all that apply)
- ☐ Cervical cerclage
- ☐ Tocolysis

External cephalic version:
- ☐ Successful
- ☐ Failed
- ☐ None of the above

45. CHARACTERISTICS OF LABOR AND DELIVERY
- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ Antibiotics received by the mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38°$ C (100.4° F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

47. 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

NEWBORN INFORMATION

NEWBORN

48. NEWBORN MEDICAL RECORD NUMBER

49. BIRTHWEIGHT (grams preferred, specify unit) ______ ☐ grams ☐ lb/oz

50. OBSTETRIC ESTIMATE OF GESTATION ______(completed weeks)

51. APGAR SCORE

Score at 5 minutes ______

If 5 minute score is less than 6,

Score at 10 minutes ______

52. PLURALITY – Single, Twin, Triplet, etc. (Specify) ______

53. IF NOT SINGLE BIRTH – Born first, second, third, etc. (Specify) ______

54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
- ☐ Assisted ventilation required immediately following delivery
- ☐ Assisted ventilation required for more than six Hours
- ☐ NICU admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Antibiotics received by the newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
- ☐ None of the above

55. CONGENITAL ANOMALIES OF THE NEWBORN (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 above

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: ______

57. IS INFANT LIVING AT TIME OF REPORT? ☐ Yes ☐ No ☐ Infant transferred, status unknown

58. IS INFANT BEING BREASTFED AT DISCHARGE? ☐ Yes ☐ No

SAMPLE

APPENDIX G

STATE OF DELAWARE CERTIFICATE OF DEATH

OFFICE OF VITAL STATISTICS

CERTIFICATE OF DEATH
State of Delaware
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

(107)

State File Number

Sample

To Be Completed/ Verified By: FUNERAL DIRECTOR

1. DECEDENT'S LEGAL NAME (Include AKA's if any) (First, Middle, Last)
2. SEX
3. SOCIAL SECURITY NUMBER

4a. AGE-Last Birthday (Years)
4b. UNDER 1 YEAR: Months | Days
4c. UNDER 1 DAY: Hours | Minutes
5. DATE OF BIRTH (Mo/Day/Yr)
6. BIRTHPLACE (City and State or Foreign Country)

7a. RESIDENCE-STATE
7b. COUNTY
7c. CITY OR TOWN

7d. STREET AND NUMBER
7e. APT. NO.
7f. ZIP CODE
7g. INSIDE CITY LIMITS? ☐ Yes ☐ No

8. EVER IN US ARMED FORCES? ☐ Yes ☐ No
9. MARITAL STATUS AT TIME OF DEATH ☐ Married ☐ Widowed ☐ Divorced ☐ Never Married ☐ Unknown
10. SURVIVING SPOUSE'S NAME (If wife, give name prior to first marriage)

11. FATHER'S NAME (First, Middle, Last)
12. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last)

13a. INFORMANT'S NAME
13b. RELATIONSHIP TO DECEDENT
13c. MAILING ADDRESS (Street and Number, City, State, Zip Code)

14. PLACE OF DEATH (Check only one; see instructions)

IF DEATH OCCURRED IN A HOSPITAL:
☐ Inpatient ☐ Emergency Room/Outpatient ☐ Dead on Arrival

IF DEATH OCCURRED SOMEWHERE OTHER THAN A HOSPITAL:
☐ Hospice facility ☐ Nursing home/Long term care facility ☐ Decedent's home ☐ Other (Specify):

15. FACILITY NAME (If not institution, give street & number)
16. CITY OR TOWN , STATE, AND ZIP CODE
17. COUNTY OF DEATH

18. METHOD OF DISPOSITION: ☐ Burial ☐ Cremation ☐ Donation ☐ Entombment ☐ Removal from State ☐ Other (Specify):
19. PLACE OF DISPOSITION (Name of cemetery, crematory, other place)

20. LOCATION-CITY, TOWN, AND STATE
21. NAME AND COMPLETE ADDRESS OF FUNERAL FACILITY

22. SIGNATURE OF FUNERAL SERVICE LICENSEE OR OTHER AGENT
23. LICENSE NUMBER (Of Licensee)

To Be Completed By: MEDICAL CERTIFIER

ITEMS 24-28 MUST BE COMPLETED BY PERSON WHO PRONOUNCES OR CERTIFIES DEATH
24. DATE PRONOUNCED DEAD (Mo/Day/Yr)
25. TIME PRONOUNCED DEAD

26. SIGNATURE OF PERSON PRONOUNCING DEATH (Only when applicable)
27. LICENSE NUMBER
28. DATE SIGNED (Mo/Day/Yr)

29. ACTUAL OR PRESUMED DATE OF DEATH (Mo/Day/Yr) (Spell Month)
30. ACTUAL OR PRESUMED TIME OF DEATH
31. WAS MEDICAL EXAMINER CONTACTED?

CAUSE OF DEATH (See instructions and examples)

32. **PART I.** Enter the chain of events--diseases, injuries, or complications--that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. Enter only one cause on a line. Add additional lines if necessary.

Approximate interval: Onset to death

IMMEDIATE CAUSE (Final disease or condition ---------> resulting in death)
a.______________________________ ____________
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **UNDERLYING CAUSE** (disease or injury that initiated the events resulting in death) **LAST**
b.______________________________ ____________
Due to (or as a consequence of):

c.______________________________ ____________
Due to (or as a consequence of):

d.______________________________ ____________

PART II. Enter other significant conditions contributing to death but not resulting in the underlying cause given in PART I

33. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No ☐ Unknown

34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? ☐ Yes ☐ No ☐ Unknown

APPENDIX G (cont.)

STATE OF DELAWARE CERTIFICATE OF DEATH

35. DID TOBACCO USE CONTRIBUTE TO DEATH?
☐ Yes ☐ Probably
☐ No ☐ Unknown

36. IF FEMALE:
☐ Not pregnant within past year
☐ Pregnant at time of death
☐ Not pregnant, but pregnant within 42 days of death
☐ Not pregnant, but pregnant 43 days to 1 year before death
☐ Unknown if pregnant within the past year

37. MANNER OF DEATH
☐ Natural ☐ Homicide
☐ Accident ☐ Pending Investigation
☐ Suicide ☐ Could not be determined

38. DATE OF INJURY (Mo/Day/Yr) (Spell Month)

39. TIME OF INJURY

40. PLACE OF INJURY (e.g., Decedent's home; construction site; restaurant; wooded area)

41. INJURY AT WORK? ☐ Yes ☐ No

42. LOCATION OF INJURY: State: City or Town:
Street & Number: Apartment No.: Zip Code:

43. DESCRIBE HOW INJURY OCCURRED:

44. IF TRANSPORTATION INJURY, SPECIFY:
☐ Driver/Operator
☐ Passenger
☐ Pedestrian
☐ Other (Specify)

45. CERTIFIER (Check only one):
☐ Certifying physician-To the best of my knowledge, death occurred due to the cause(s) and manner stated.
☐ Pronouncing & Certifying physician-To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner stated.
☐ Medical Examiner-On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner stated.

Signature of certifier:____________________

46. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH (Item 32)

47. TITLE OF CERTIFIER

48. LICENSE NUMBER

49. DATE CERTIFIED (Mo/Day/Yr)

50. **FOR REGISTRAR ONLY** -DATE FILED (Mo/Day/Yr)

Amendment Code: ____

Amendment Number: ____

Date: ____

User ID: ____

DE Birth SFN: ____

To Be Completed By: FUNERAL DIRECTOR

51. DECEDENT'S EDUCATION-Check the box that best describes the highest degree or level of school completed at the time of death.
☐ 8th grade or less
☐ 9th - 12th grade; no diploma
☐ High school graduate or GED completed
☐ Professional Trade School
☐ 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)
☐ Unknown

52. DECEDENT OF HISPANIC ORIGIN? Check the box that best describes whether the decedent is Spanish/Hispanic/Latino. Check the "No" box if decedent 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) _
☐ Unknown

53. DECEDENT'S RACE (Check one or more races to indicate what the decedent considered himself or herself to be)
☐ White
☐ Black or African American
☐ American Indian or Alaska Native (Name of the 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) :____
☐ Unknown

54. DECEDENT'S USUAL OCCUPATION (Indicate type of work done during most of working life. DO NOT USE RETIRED.)

55. KIND OF BUSINESS/INDUSTRY

Sample

APPENDIX H

STATE OF DELAWARE CERTIFICATE OF FETAL DEATH

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
REPORT OF FETAL DEATH

(107)
STATE FILE #

FETUS

1. NAME OF FETUS (optional-at the discretion of the parents)
2. TIME OF DELIVERY (24hr)
3. SEX (M/F/Unk)
4. DATE OF DELIVERY (Mo/Day/Yr)

5a. CITY, TOWN, OR LOCATION OF DELIVERY
5b. ZIP CODE OF DELIVERY
6. COUNTY OF DELIVERY

7. PLACE WHERE DELIVERY OCCURRED (Check one)
- ☐ Hospital
- ☐ Freestanding birthing center
- ☐ Home Delivery: Planned to deliver at home? ☐ Yes ☐ No
- ☐ Clinic/Doctor's office
- ☐ Other (Specify)__________

8. FACILITY NAME (If not institution, give street and number)
9. FACILITY ID. (NPI)

MOTHER

10a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)
10d. BIRTHPLACE (State, Territory, or Foreign Country)
11a. RESIDENCE OF MOTHER-STATE
11b. COUNTY
11c. CITY, TOWN, OR LOCATION
11d. STREET AND NUMBER
11e. APT. NO.
11f. ZIP CODE
11g. INSIDE CITY LIMITS? ☐ Yes ☐ No

FATHER

12a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
12b. DATE OF BIRTH (Mo/Day/Yr)
12c. BIRTHPLACE (State, Territory, or Foreign Country)

CAUSE OF FETAL DEATH

13. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

13a. 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

13b. OTHER SIGNIFICANT CAUSES OR CONDITIONS

(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 13b)

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

13c. WEIGHT OF FETUS (grams preferred, specify unit)
__________ ☐ grams ☐ lb/oz

13d. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY
__________ (completed weeks)

13e. 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

13f. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No ☐ Planned

13g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? ☐ Yes ☐ No ☐ Planned

13h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ☐ Yes ☐ No

DISPOSITION

14. METHOD OF DISPOSITION:
☐ Burial ☐ Cremation ☐ Hospital Disposition ☐ Donation ☐ Removal from State ☐ Other (Specify)__________

CERTIFIER AND REGISTRATION INFORMATION

15a. ATTENDANT'S NAME
15b. ATTENDANT'S NPI
15c. ATTENDANT'S TITLE
☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE
☐ OTHER(Specify)__________

16a. I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE SHOWN AND THAT THE FETUS WAS BORN DEAD
SIGNATURE ➤
16b. DATE SIGNED
16c. MAILING ADDRESS

MOTHER'S MEDICAL RECORD NO

17a. NAME OF CEMETARY OR CREMATORY
17b. LOCATION (CITY, TOWN, COUNTY) (STATE)

18a. DATE RECEIVED BY REGISTRAR
18b. REGISTRAR'S SIGNATURE ➤
19. FUNERAL DIRECTOR'S SIGNATURE ➤
ADDRESS

Sample

APPENDIX H (cont.)

STATE OF DELAWARE CERTIFICATE OF FETAL DEATH

MOTHER

20. 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)

21. MOTHER OF 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)________________________

22. 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 the 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)________________

Predominant Race________________

23. MOTHER MARRIED? (At delivery, conception, or anytime between) ☐ Yes ☐ No

24a. DATE OF FIRST PRENATAL CARE VISIT ____/____/________ (MM DD YYYY) ☐ No Prenatal Care

24b. DATE OF LAST PRENATAL CARE VISIT ____/____/________ (MM DD YYYY)

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

26. MOTHER'S HEIGHT ______ (feet/inches)

27. MOTHER'S PRE-PREGNANCY WEIGHT ________ (pounds)

28. MOTHER'S WEIGHT AT DELIVERY ________ (pounds)

29. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No

30. NUMBER OF PREVIOUS LIVE BIRTHS

30a. Now Living — Number _____ ☐ None

30b. Now Dead — Number _____ ☐ None

30c. DATE OF LAST LIVE BIRTH ____/______ (MM YYYY)

31. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced Losses or ectopic pregnancies)

31a. Other Outcomes — Number (Do not include this fetus) _____ ☐ None

31b. DATE OF LAST OTHER PREGNANCY OUTCOME ____/______ (MM YYYY)

32. 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".

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	______

33. DATE LAST NORMAL MENSES BEGAN ____/____/______ (MM DD YYYY)

34. PLURALITY - Single, Twin, Triplet, etc. (Specify)________

35. IF NOT SINGLE BIRTH- Born First, Second, Third, etc. (Specify)________

36. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: ________________________

MEDICAL AND HEALTH INFORMATION

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

Diabetes
- ☐ Pre-pregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

Hypertension
- ☐ Pre-pregnancy (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

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. 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 delivery
- ☐ 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

E. Hysterotomy/Hysterectomy
☐ Yes ☐ No

40. 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

41. 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

sample

STATE OF DELAWARE CERTIFICATE OF FETAL DEATH

OFFICE OF VITAL STATISTICS

STATE OF DELAWARE
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
REPORT OF FETAL DEATH

(107)
STATE FILE #

FETUS

1. NAME OF FETUS (optional-at the discretion of the parents)
2. TIME OF DELIVERY (24hr)
3. SEX (M/F/Unk)
4. DATE OF DELIVERY (Mo/Day/Yr)

5a. CITY, TOWN, OR LOCATION OF DELIVERY
5b. ZIP CODE OF DELIVERY
6. COUNTY OF DELIVERY

7. PLACE WHERE DELIVERY OCCURRED (Check one)
- ☐ Hospital
- ☐ Freestanding birthing center
- ☐ Home Delivery: Planned to deliver at home? ☐ Yes ☐ No
- ☐ Clinic/Doctor's office
- ☐ Other (Specify)______

8. FACILITY NAME (If not institution, give street and number)
9. FACILITY ID. (NPI)

MOTHER

10a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)
10d. BIRTHPLACE (State, Territory, or Foreign Country)
11a. RESIDENCE OF MOTHER-STATE
11b. COUNTY
11c. CITY, TOWN, OR LOCATION
11d. STREET AND NUMBER
11e. APT. NO.
11f. ZIP CODE
11g. INSIDE CITY LIMITS? ☐ Yes ☐ No

FATHER

12a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
12b. DATE OF BIRTH (Mo/Day/Yr)
12c. BIRTHPLACE (State, Territory, or Foreign Country)

CAUSE OF FETAL DEATH

13. CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

13a. 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

13b. OTHER SIGNIFICANT CAUSES OR CONDITIONS

(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 13b)

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

13c. WEIGHT OF FETUS (grams preferred, specify unit)
☐ grams ☐ lb/oz

13d. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY
______ (completed weeks)

13e. 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

13f. WAS AN AUTOPSY PERFORMED? ☐ Yes ☐ No ☐ Planned

13g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED? ☐ Yes ☐ No ☐ Planned

13h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH? ☐ Yes ☐ No

DISPOSITION

14. METHOD OF DISPOSITION
☐ Burial ☐ Cremation ☐ Hospital Disposition ☐ Donation ☐ Removal from State ☐ Other (Specify)______

CERTIFIER AND REGISTRATION INFORMATION

15a. ATTENDANT'S NAME
15b. ATTENDANT'S NPI
15c. ATTENDANT'S TITLE
☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE
☐ OTHER(Specify)______

16a. I CERTIFY THAT THIS DELIVERY OCCURRED ON THE DATE SHOWN AND THAT THE FETUS WAS BORN DEAD
SIGNATURE ➢
16b. DATE SIGNED
16c. MAILING ADDRESS

MOTHER'S MEDICAL RECORD NO. ______

17a. NAME OF CEMETARY OR CREMATORY
17b. LOCATION (CITY, TOWN, COUNTY) (STATE)
18a. DATE RECEIVED BY REGISTRAR
18b. REGISTRAR'S SIGNATURE ➢
19. FUNERAL DIRECTOR'S SIGNATURE ➢
ADDRESS

Sample

APPENDIX H (cont.)

STATE OF DELAWARE CERTIFICATE OF FETAL DEATH

AUTHORITY FOR BURIAL, TRANSPORTATION AND REMOVAL

This Burial-Transit Permit when completely filled in and bearing items 16a and 19, the signatures of the attending physician and the Funeral Director, becomes authority for Burial, Transportation and Removal of the above named Decedent.

This permit is not authority for cremation; separate authorization must be obtained.

CEMETERY OR CREMATORY SHALL FILL OUT SECTION BELOW

The Decedent named above was buried ☐ cremated ☐ in the cemetery or crematory in item 17a.

BURIAL WAS IN
Section_______ Lot_______ Grave_______. The appropriate entry in the ☐ Cemetery ☐ Crematory registry has been made.

Signature ______________________________ ______________________
Sexton or other person in charge — Date Signed

This Burial-Transit Permit must be signed above by the Cemetery or Crematory Authority. If no full time person is in charge of the cemetery, the Funeral Director may sign as Sexton. This Burial-Transit Permit is to be retained by the Manager, Superintendent, Caretaker, Sexton or other person in charge of Burial, Entombment or Cremation, or if none, then the Funeral Director.

REV: 04/2005

Sample

APPENDIX I

STATE OF DELAWARE CERTIFICATE OF MARRIAGE

1

TO OFFICIANT - PLEASE COMPLETE LOWER PART OF FORM AND MAIL WITHIN 4 DAYS, COPIES 1, 3, AND 4
TO: OFFICE OF VITAL STATISTICS, P.O. Box 637, Dover, DE 19903.

OFFICE OF VITAL STATISTICS

CERTIFICATE OF MARRIAGE
State of Delaware
DIVISION OF PUBLIC HEALTH

STATE FILE NUMBER

LOCAL REGISTRAR'S NO. | LICENSE NO. 58801 | NO. LICENSE APPLICATION | PLACE LICENSE ISSUED

GROOM				BRIDE		
NAME FIRST	MIDDLE	LAST		FIRST	MIDDLE	LAST
RESIDENCE STREET OR NUMBER, CITY				RESIDENCE STREET OR NUMBER, CITY		
STATE	ZIP	COUNTY		STATE	ZIP	COUNTY
DATE OF BIRTH	AGE			DATE OF BIRTH	AGE	
BIRTHPLACE (STATE OR FOREIGN COUNTRY)				BIRTHPLACE (STATE OR FOREIGN COUNTRY)		

WE HEREBY CERTIFY THAT THE INFORMATION PROVIDED IS CORRECT TO THE BEST OF OUR KNOWLEDGE AND BELIEF AND THAT WE ARE FREE TO MARRY UNDER THE LAWS OF THIS STATE

SIGNATURE OF GROOM X | SIGNATURE OF BRIDE X

FATHER	NAME FIRST	MIDDLE	LAST	FATHER	NAME FIRST	MIDDLE	LAST
	BIRTHPLACE (STATE OR FOREIGN COUNTRY)				BIRTHPLACE (STATE OR FOREIGN COUNTRY)		
MOTHER	MAIDEN NAME FIRST	MIDDLE	LAST	MOTHER	MAIDEN NAME FIRST	MIDDLE	LAST
	BIRTHPLACE (STATE OR FOREIGN COUNTRY)				BIRTHPLACE (STATE OR FOREIGN COUNTRY)		

DRAFT

I hereby certify that on the ________ day of ____________ 19___, _____ M. HOUR

the aforementioned persons were by me united in marriage at ____________ (CITY, TOWN, OR LOCATION)

County of ____________, in accordance with the Laws of the State of Delaware.

Signature of Clergy or Other Official ▶ ____________ TITLE ____________

RESIDENCE-STATE ____________ COUNTY ____________

Witnesses (two are required.)
1. NAME ▶ ____________ RESIDENCE ____________
2. NAME ▶ ____________ RESIDENCE ____________
3. NAME ▶ ____________ RESIDENCE ____________

REGISTRAR'S SIGNATURE ▶ | DATE RECEIVED BY LOCAL REGISTRAR

VALID ONLY IN THE STATE OF DELAWARE

STATE FILE COPY

	Number of this Marriage - 1st, 2nd, etc. (Specify below)	If Previously Married: Date of First Marriage (Mth./Day/Year)	Last Marriage Ended by Death Divorce or Annul. (Specify below)	Last Marriage Ended on: Mth./Day/Year	Race/American Indian, Black, White, etc. (Specify below)	Education (Specify highest grade completed): Elementary/ Secondary (0-12)	College (1-4 or 5+)
GROOM							
BRIDE							

APPENDIX J

STATE OF DELAWARE CERTIFICATE OF DIVORCE OR ANNULMENT

TYPE/PRINT IN PERMANENT BLACK INK

CERTIFICATE OF DIVORCE OR ANNULMENT

State of Delaware

OFFICE OF VITAL STATISTICS

DIVISION OF PUBLIC HEALTH

State File No.

HUSBAND

1. HUSBAND'S NAME *(First, Middle, Last)*

2a. RESIDENCE - STREET OR NUMBER, CITY | 2b. COUNTY

2c. STATE | ZIP | 3. BIRTHPLACE *(State or Foreign Country)* | 4. DATE OF BIRTH *(Month, Day, Year)*

WIFE

5a. WIFE'S NAME *(First, Middle, Last)* | 5b. MAIDEN SURNAME

6a. RESIDENCE - STREET OR NUMBER, CITY | 6b. COUNTY

6c. STATE | ZIP | 7. BIRTHPLACE *(State or Foreign Country)* | 8. DATE OF BIRTH *(Month, Day, Year)*

MARRIAGE

9a. PLACE OF THIS MARRIAGE - CITY, TOWN, OR LOCATION | 9b. COUNTY | 9c. STATE OR FOREIGN COUNTRY | 10. DATE OF THIS MARRIAGE *(Month, Day, Year)*

11. DATE COUPLE LAST RESIDED IN SAME HOUSEHOLD | 12. NUMBER OF CHILDREN UNDER 18 IN THIS HOUSEHOLD AS OF THE DATE IN ITEM 11 — Number ______ ( ) None | 13. PETITIONER ( ) Husband ( ) Wife ( ) Both ( ) Other *(Specify)*

DRAFT

ATTORNEY

14a. NAME OF PETITIONER'S ATTORNEY *(Type/Print)* | 14b. ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

DECREE

15. I CERTIFY THAT THE MARRIAGE OF THE NAMED PERSONS WAS DISSOLVED *(Month, Day, Year)* | 16. TYPE OF DECREE - Divorce or Annulment *(Specify)* | 17. DATE RECORDED *(Month, Day, Year)*

18. NUMBER OF CHILDREN UNDER 18 WHOSE PHYSICAL CUSTODY WAS AWARDED TO:

Husband ______ Wife ______

Joint *(Husband/Wife)* ______ Other ______

( ) No Children

CONTESTED ☐ YES ☐ NO

19. COUNTY OF DECREE | 20. TITLE OF COURT

21. SIGNATURE OF CERTIFYING OFFICIAL | 22. TITLE OF CERTIFYING OFFICIAL | 23. DATE SIGNED *(Month, Day, Year)*

STATE FILE COPY

ATTORNEY - Complete items 1-14b and 24-27 when filing petition and leave with Clerk of the Court.
CLERK OF THE COURT - After final decree complete item 15-23 and forward to:
Office of Vital Statistics, P.O. Box 637, DOVER, DELAWARE 19903

	24. Number of this Marriage - 1st, 2nd, etc. (Specify below)	25. If Previously Married			26. Race/American Indian, Black, White, etc. (Specify below)	27. Education (Specify highest grade completed)	
		Date of First Marriage (Mth./Day/Year)	Last Marriage Ended by Death, Divorce or Annulment (Specify below)	Last Marriage Ended on: (Mth./Day/Year)		Elementary/ Secondary (0-12)	College (1-4 or 5+)
HUSBAND	24a.	25a.	25b.	25c.	26a.	27a.	
WIFE	24b.	25d.	25e.	25f.	26b.	27b.	

APPENDIX K

STATE OF DELAWARE REPORT OF INDUCED TERMINATION OF PREGNANCY

DELAWARE HEALTH AND SOCIAL SERVICES

REPORT OF INDUCED TERMINATION OF PREGNANCY

1. FACILITY NAME *(if not clinic or hospital, give address)*	2. CITY, TOWN, OR LOCATION OF PREGNANCY TERMINATION	3. COUNTY OF PREGNANCY TERMINATION

4. FORM NUMBER	5. AGE LAST BIRTHDAY	6. MARRIED? ☐Yes ☐No	7. DATE OF PREGNANCY TERMINATION *(Month, Day, Year)*

8a. RESIDENCE - STATE	8b. COUNTY	8c. CITY, TOWN, OR LOCATION	8d. ZIP CODE

9. OF HISPANIC ORIGIN?	10. RACE	11. EDUCATION *(Specify only highest grade completed)*	
(Specify No or Yes - If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐No ☐Yes Specify:	☐ White ☐ Black ☐ Other *(Specify)* ____________	Elementary/Secondary (0-12)	College (1-4 or 5+)

12. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*	13. CLINICAL ESTIMATE OF GESTATION *(Weeks)*	14. PREVIOUS PREGNANCIES *(Complete each section)*			
		LIVE BIRTHS		OTHER TERMINATIONS	
		14a. Now Living	14b. Not Living	14c. Spontaneous	14d. Induced *(Do not include this termination)*
		Number ____ ☐ None	Number ____ ☐ None	Number ____ ☐ None	Number ____ ☐ None

15. TYPE OF TERMINATION PROCEDURE
(Check only one)

- ☐ Suction Curettage
- ☐ Medical (Nonsurgical), Specify Medication(s)____________________
- ☐ Dilation and Evacuation (D&E)
- ☐ Intra-Uterine Instillation (Saline or Prostoglandin)
- ☐ Sharp Curettage (D&C)
- ☐ Hysterotomy/Hysterectomy
- ☐ Other (Specify)__________________________

Draft

(Instructions on back)

Mail completed forms to:
Delaware Health Statistics Center
417 Federal Street
Dover, DE 19903
(302) 744-4541

Doc. No. 35-01-20-96-12-01

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