

**CLINICAL INFORMATION FOR
MISCARRIAGES, FETAL DEATH
OR STILLBIRTH
(Regardless of Gestational Age)**

Hospital of Origin: _____

UMRN: _____

Surname: _____

Given Name: _____

DOB: _____

AFFIX HOSPITAL LABEL

CLINICAL INFORMATION TO BE COMPLETED BY CLINICAL STAFF

Present Pregnancy: FDIU TOP Labour: Spontaneous Induced

Estimated Gestation: _____ (weeks) Gravida: _____ Parity: _____

Date of Birth: ____/____/____

Antenatal history (including PROM, bleeding, hypertension, chorioamnionitis and a brief description of presentation etc):

Previous obstetric history:

Maternal medical history:

Known fetal abnormalities:

Maternal investigation results (including NIPT, diagnostic genomics, imaging etc): *This should include information or copies of radiology and genetic reports where applicable.*

What specific questions would you, the requesting clinician, or next of kin like answered from this examination?