

## APPENDIX III

**Fetal Examination:** To be completed by delivering physician, genetics, or pathologist

	Yes	No		Yes	No
Foul Smelling	<input type="checkbox"/>	<input type="checkbox"/>	Encephalocele	<input type="checkbox"/>	<input type="checkbox"/>
Meconium	<input type="checkbox"/>	<input type="checkbox"/>	Nuchal Cystic Hygroma	<input type="checkbox"/>	<input type="checkbox"/>
Maceration	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Wall Defect	<input type="checkbox"/>	<input type="checkbox"/>
Skull Collapse	<input type="checkbox"/>	<input type="checkbox"/>	Chest Deformity/Asymmetry	<input type="checkbox"/>	<input type="checkbox"/>
Wasting Fat/Muscles	<input type="checkbox"/>	<input type="checkbox"/>	Skeletal Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Plethoric	<input type="checkbox"/>	<input type="checkbox"/>	Limb Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Hydropic	<input type="checkbox"/>	<input type="checkbox"/>	Number of Digits: Hands _____	<input type="checkbox"/>	<input type="checkbox"/>
Bruising/Forceps Marks	<input type="checkbox"/>	<input type="checkbox"/>	Feet _____		
Micro/Macrocephalic	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>
Low Set Ears	<input type="checkbox"/>	<input type="checkbox"/>	Imperforate Anus	<input type="checkbox"/>	<input type="checkbox"/>
Ear Tags/Pits	<input type="checkbox"/>	<input type="checkbox"/>	Genital Abnormality	<input type="checkbox"/>	<input type="checkbox"/>
Wide/Narrow Spaced Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Placenta Abruption	<input type="checkbox"/>	<input type="checkbox"/>
Up/Down Slanting Palpebral Fissures	<input type="checkbox"/>	<input type="checkbox"/>	Tight Nuchal Cord	<input type="checkbox"/>	<input type="checkbox"/>
Cleft Lip/Palate	<input type="checkbox"/>	<input type="checkbox"/>	Knot or Stricture in Cord	<input type="checkbox"/>	<input type="checkbox"/>
Other Facial Defects	<input type="checkbox"/>	<input type="checkbox"/>	Number of Vessels in Cord	<input type="checkbox"/>	<input type="checkbox"/>
Micrognathia	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Weight: \_\_\_\_\_  Crown-rump Length or  Crown-heel Length: \_\_\_\_\_

Head Circumference: \_\_\_\_\_ Genitalia:  Male  Female  Ambiguous

Delivery Complications: \_\_\_\_\_

\_\_\_\_\_

Description of Abnormal Findings: \_\_\_\_\_

\_\_\_\_\_

Suspected Diagnoses: \_\_\_\_\_

\_\_\_\_\_

Special Instructions for Pathologists: \_\_\_\_\_

\_\_\_\_\_

Completed By: \_\_\_\_\_

Date: \_\_\_\_\_

**References:**

1. ACOG Committee Opinion, No.383, October 2007. Evaluation of Stillbirths and Neonatal Deaths.
2. Silver, Robert. Fetal Death. Obstet Gynecol 2007; 109: 153-167.

ADM  
ATN

RTS Physician's/Genetics  
Check List  
Rev. 4-08 Form 0185

