Agency Logo

Infant Death Notification Form

Infant Death	Fetal Death

Baby's Name: _____

Baby's Record #: _____

Mother's Name: _____

Mother's Record #: _____

Date of Death: _____ Time of Death: _____ : _____ AM/PM

Date of Birth: _____ Time of Birth: _____ : _____ AM/PM

Birth weight: _____ grams Gestational Age: _____ weeks

Age of Mother: _____ years

Entrance to Care: _____ months

No. of Prenatal Visits: _____

	White	Black	Latino	Native Am.	Asian	Other
Race of Mother						

Location of Death: _____

Cause of Death: _____

Underlying Causes: _____

Who completed this form:

Name: _____

Phone: _____

Email: _____

If paper copy, fax to:
FIMR Coordinator:
FAX Number_____
If electronic file, email to:
e-mail address_____

CONFIDENTIAL