**Instructions:**Theclinician reviews the clinical and laboratory findings and the progress ion of the illness to decide on the PRIMARY cause of mortality and the CONTRIBUTORY maternal and infant causes of mortality following the WHO guidance on certification of causes of mortality.. This form should be completed as soon as the infant dies.

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| --- | --- | --- | --- | --- | --- | --- |
| **1 Gestational age** | Weeks\_\_\_\_\_ days\_\_\_\_\_ | | | | | |
| **2** Postnatal age | Weeks\_\_\_\_\_ days\_\_\_\_\_ | | | | | |
| **3. If Infant died at or prior to day 28** | Date of Death: |\_\_|\_\_|-|\_\_|\_\_|-|\_\_|\_\_|\_\_|\_\_| (DD – MM – YYYY) | | | | | |
| 4. Was consent for autopsy contained? | 1Yes | 2No | 3Don’t know |  | | |
|  | **researcher observation based on clinic and other findings** | | | | | |
| 5. Primary cause of death  *→Select one:* | 1 Congenital malformation 2 Respiratory Distress Syndrome/Hyaline membrane disease 3Asphyxia 4Hemorrhagic Disease of NB/DIC 5Persistent Pulmonary Hypertension of the Newborn (PPHN) 6 Intraventricular Hemorrhage (IVH) 8Sepsis 9Pneumonia 10 Meningitis 11 NEC 12 Hypothermia 13 Apnea of prematurity 14Hyperbilirubinemia/Kernicterus 15 Anemia 16 Renal failure 17Tetanus 18Other, specify:\_\_\_\_\_\_\_\_\_\_ | | | | | |
| 6.Contributing cause of death  *→check all that apply:* | 1 Congenital malformation 2 Respiratory Distress Syndrome/Hyaline membrane disease 3Asphyxia 4Hemorrhagic Disease/DIC  5Persistent Pulmonary Hypertension of the Newborn (PPHN) 7IVH 8Sepsis 9Pneumonia 10 Meningitis 11 NEC 12 Hypothermia 13 Apnea of prematurity 14Hyperbilirubinemia/kernicterus 15 Anemia 16 Renal failure 17Tetanus 18Other, specify:\_\_\_\_\_\_\_\_\_\_ | | | | | |
| 7. If died, maternal risk factors *→check all that apply:* | 1Obstructed labor 2Cord prolapse/complication 3Signs of fetal distress 4Antenatal hemorrhage 5Preeclampsia/eclampsia 6Maternal signs of infection 7Chorioamnionitis 8Other, specify:\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| **8. Death summary information necessary for the pathologist.**  ­­­­­­­­­­­­­ | | | | | | |
| **FORM COMPLETION** |  |  |  |  |  |  |
| 9. Form completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_|\_\_|\_\_| 10. Date of Completion: |\_\_|\_\_|-|\_\_|\_\_|-|\_\_|\_\_|\_\_|\_\_| (DD – MM – YYYY) | | | | | | |