

**We would like to learn about your experiences to help improve care for women who experience stillbirths. The questions on this survey are about your pregnancy when your baby died, except when noted. We understand that some questions may be sensitive, but we appreciate any information you are able to share.**

**Please check the box next to your answer or follow the directions included with the question. You may be asked to skip some questions that do not apply to you.**

**BEFORE PREGNANCY**

The first questions are about you.

**1. How tall are you without shoes?**

\_\_\_\_ Feet    \_\_\_\_ Inches  
**OR**    \_\_\_\_ Centimeters

**2. Just before you got pregnant, how much did you weigh?**

\_\_\_\_ Pounds    **OR**    \_\_\_\_ Kilos

**3. What is your date of birth?**

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Month            Day            Year

**The next questions are about the time *before* you got pregnant.**

**4. During the 3 months before you got pregnant, did you have any of the following health conditions?** For each one, check **No** if you did not have the condition or **Yes** if you did.

- |  | <b>No</b>                | <b>Yes</b>               |
|--|--------------------------|--------------------------|
| a. Type 1 or Type 2 diabetes ( <b>not</b> gestational diabetes or diabetes that starts during pregnancy) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure or hypertension .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Asthma .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Thyroid problems .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. PCOS (polycystic ovarian syndrome) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Anxiety .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**5. During the month before you got pregnant, how many times a week did you take a multivitamin, a prenatal vitamin, or a folic acid vitamin?**

- I didn't take a multivitamin, prenatal vitamin, or folic acid vitamin in the *month before* I got pregnant
- 1 to 3 times a week
- 4 to 6 times a week
- Every day of the week

**We would like to find out about your pregnancy history.**

**6. How many times have you been pregnant?** Please include this pregnancy and ALL pregnancies you have had (both losses and live births).

- 1 time
- 2 to 4 times
- 5 to 7 times
- 8 or more times

**Go to Page 2, Question 12**

**Go to Page 2, Question 7**

7. **Before this pregnancy, did you have any babies who were born alive?**

- No —————> **Go to Question 10**  
 Yes

8. **Did your last baby who was born alive weigh 5 pounds, 8 ounces (2.5 kilos) or less at birth?**

- No  
 Yes

9. **Was your last baby who was born alive born earlier than 3 weeks before his or her due date?**

- No  
 Yes

10. **Before this pregnancy, did you have any pregnancies that ended in a loss?**

- No —————> **Go to Question 12**  
 Yes

11. **Please indicate the number of previous losses you had that ended in each of the following time periods (not including this baby):**

Number of pregnancies that ended before  
 \_\_\_\_\_ 12 weeks

Number of pregnancies that ended  
 \_\_\_\_\_ between 12 and 27 weeks

Number of pregnancies that ended at 28  
 \_\_\_\_\_ weeks or later

12. **When you got pregnant with this baby, were you trying to get pregnant?**

- No  
 Yes

**The next questions are about your health insurance coverage before, during, and after your pregnancy.**

13. **During the *month before* you got pregnant, what kind of health insurance did you have?**

**Check ALL that apply**

- Private health insurance from my job or the job of my husband or partner  
 Private health insurance from my parents  
 Private health insurance from the Health Insurance Marketplace or HealthCare.gov  
 Medicaid  
 TRICARE or other military health care  
 Indian Health Service (IHS) or tribal  
 Other health insurance —————> Please tell us:  
 \_\_\_\_\_  
 I did not have any health insurance during the *month before* I got pregnant

14. **During your *pregnancy*, what kind of health insurance did you have for your *prenatal care*?**

**Check ALL that apply**

- I did not go for prenatal care —————> **Go to Question 15**  
 Private health insurance from my job or the job of my husband or partner  
 Private health insurance from my parents  
 Private health insurance from the Health Insurance Marketplace or HealthCare.gov  
 Medicaid  
 TRICARE or other military health care  
 Indian Health Service (IHS) or tribal  
 Other health insurance —————> Please tell us:  
 \_\_\_\_\_  
 I did not have any health insurance for my *prenatal care*

15. What kind of health insurance do you have now?

Check ALL that apply

- Private health insurance from my job or the job of my husband or partner
- Private health insurance from my parents
- Private health insurance from the Health Insurance Marketplace or HealthCare.gov
- Medicaid
- TRICARE or other military health care
- Indian Health Service (IHS) or tribal
- Other health insurance → Please tell us:

\_\_\_\_\_

- I do not have health insurance *now*

### DURING PREGNANCY

The next questions are about the prenatal care you received during your pregnancy. Prenatal care includes visits to a doctor, nurse, or other health care worker during your pregnancy to get checkups and advice about pregnancy. (It may help to look at the calendar when you answer these questions.)

16. How many weeks or months pregnant were you when you had your first visit for prenatal care?

{ \_\_\_\_\_ Weeks OR \_\_\_\_\_ Months

- I didn't go for prenatal care →

Go to Question 18

Go to Question 17

17. During any of your prenatal care visits, did a doctor, nurse, or other health care worker ask you any of the things listed below? For each item, check **No** if they did not ask you about it or **Yes** if they did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. If I knew how much weight I should gain during pregnancy.....         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If I was taking any prescription medication.....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| c. If I was smoking cigarettes.....                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If I was drinking alcohol .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| e. If someone was hurting me emotionally or physically.....              | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If I was feeling down or depressed.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was using drugs such as marijuana, cocaine, crack, or meth ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I wanted to be tested for HIV (the virus that causes AIDS) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I planned to breastfeed my new baby..                              | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If I planned to use birth control after my baby was born .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| k. If I knew how to track my baby's movements.....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| l. If I knew about recommended sleeping positions during pregnancy.....  | <input type="checkbox"/> | <input type="checkbox"/> |

18. During this pregnancy, were you on WIC (the Special Supplemental Nutrition Program for Women, Infants, and Children)?

- No
- Yes

19. During the 12 months before your baby was delivered, did you get a flu shot?

Check ONE answer

- No
- Yes, before my pregnancy
- Yes, during my pregnancy

**20. During your pregnancy, did you have any of the following health conditions?** For each one, check **No** if you did not have the condition or **Yes** if you did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Gestational diabetes (diabetes that <b>started</b> during <i>this</i> pregnancy) .....                  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. High blood pressure (that <b>started</b> during <i>this</i> pregnancy), pre-eclampsia or eclampsia..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Depression .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Anxiety .....   | <input type="checkbox"/> | <input type="checkbox"/> |

**21. Did you have any of the following problems during your pregnancy?** For each item, check **No** if you did not have the problem or **Yes** if you did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Vaginal bleeding .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Kidney or bladder (urinary tract) infection (UTI).....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. <b>Severe</b> nausea, vomiting, or dehydration that sent me to the doctor or hospital .....                 | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Cervix had to be sewn shut (cerclage for incompetent cervix) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Complications with the placenta (such as abruptio placentae or placenta previa) .....                       | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Labor pains more than 3 weeks before my baby was due (preterm or early labor) .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Water broke more than 3 weeks before my baby was due (preterm premature rupture of membranes [PPROM]) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I had to have a blood transfusion.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I was hurt in a car accident.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Decreased fetal movement or a change in fetal movement.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Fever of 101° or higher.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. A gut feeling that something was wrong.....   | <input type="checkbox"/> | <input type="checkbox"/> |

**22. During your pregnancy, did a doctor, nurse, or other health care worker tell you that you had any of the following infections?** For each item, check **No** if you were not told that you had the infection or **Yes** if you were.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Yeast infections.....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Urinary tract infection (UTI) .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Cytomegalovirus (CMV) .....             | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Genital warts (HPV).....                | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Herpes.....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Chlamydia.....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Gonorrhea .....                         | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Pelvic inflammatory disease (PID) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Syphilis.....                           | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Group B Strep (Beta Strep) .....        | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Bacterial vaginosis.....                | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Trichomoniasis (Trich).....             | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Listeria .....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Toxoplasmosis .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| o. Other .....                             | <input type="checkbox"/> | <input type="checkbox"/> |

Please tell us:

**The next questions are about smoking and alcohol use around the time of pregnancy (before, during, and after). We are not asking these questions because we think you did anything to affect your baby. We ask similar questions of other women on a different survey.**

**23. Have you smoked any cigarettes in the past 2 years?**

- No → **Go to Question 27**
- Yes

**Go to Question 24**

**24. In the 3 months *before* you got pregnant, how many cigarettes did you smoke on an average day?** A pack has 20 cigarettes.

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I didn't smoke then

**25. In the *last 3 months* of your pregnancy, how many cigarettes did you smoke on an average day?** A pack has 20 cigarettes.

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I didn't smoke then

**26. How many cigarettes do you smoke on an average day *now*?** A pack has 20 cigarettes.

- 41 cigarettes or more
- 21 to 40 cigarettes
- 11 to 20 cigarettes
- 6 to 10 cigarettes
- 1 to 5 cigarettes
- Less than 1 cigarette
- I don't smoke now

**The next questions are about using other tobacco products around the time of pregnancy.**

**E-cigarettes (electronic cigarettes) and other electronic nicotine products** (such as vape pens, e-hookahs, hookah pens, e-cigars, e-pipes) are battery-powered devices that use nicotine liquid rather than tobacco leaves, and produce vapor instead of smoke.

A **hookah** is a water pipe used to smoke tobacco. It is not the same as an e-hookah or hookah pen.

**27. Have you used any of the following products in the *past 2 years*?** For each item, check **No** if you did not use it or **Yes** if you did.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. E-cigarettes or other electronic nicotine products..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Hookah .....  | <input type="checkbox"/> | <input type="checkbox"/> |

**If you used e-cigarettes or other electronic nicotine products in the *past 2 years*, go to Question 28. Otherwise, go to Page 6, Question 30.**

**28. During the 3 months *before* you got pregnant, on average, how often did you use e-cigarettes or other electronic nicotine products?**

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

29. During the *last 3 months* of your pregnancy, on average, how often did you use e-cigarettes or other electronic nicotine products?

- More than once a day
- Once a day
- 2-6 days a week
- 1 day a week or less
- I did not use e-cigarettes or other electronic nicotine products then

30. Have you had any alcoholic drinks in the *past 2 years*? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

- No → **Go to Question 33**
- Yes

31. During the *3 months before* you got pregnant, how many alcoholic drinks did you have in an average week?

- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

32. During the *last 3 months* of your pregnancy, how many alcoholic drinks did you have in an average week?

- 14 drinks or more a week
- 8 to 13 drinks a week
- 4 to 7 drinks a week
- 1 to 3 drinks a week
- Less than 1 drink a week
- I didn't drink then

Pregnancy can be a difficult time. The next questions are about things that may have happened *before* and *during* your pregnancy.

33. Did you have depression during your pregnancy?

- No → **Go to Question 37**
- Yes

34. During your pregnancy, did you *ask for help* for depression from a doctor, nurse, or other health care worker?

- No
- Yes

35. During your pregnancy, did you *get* counseling for depression?

- No
- Yes

36. At any time during your pregnancy, did you take prescription medicine for your depression?

- No
- Yes

**37. This question is about things that may have happened during the 12 months before your baby was delivered.** For each item, check **No** if it did not happen to you or **Yes** if it did. (It may help to look at the calendar when you answer these questions.)

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. A close family member was very sick and had to go into the hospital.....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I got separated or divorced from my husband or partner.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I moved to a new address.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was homeless or had to sleep outside, in a car, or in a shelter.....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My husband or partner lost their job .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I lost my job even though I wanted to go on working.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| g. My husband, partner, or I had a cut in work hours or pay.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I was apart from my husband or partner due to military deployment or extended work-related travel..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I argued with my husband or partner more than usual.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| j. My husband or partner said they didn't want me to be pregnant.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I had problems paying the rent, mortgage, or other bills.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. My husband, partner, or I went to jail .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Someone very close to me had a problem with drinking or drugs.....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| n. Someone very close to me died.....   | <input type="checkbox"/> | <input type="checkbox"/> |

**38. In the 12 months before you got pregnant, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way?** For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

- |                                      | No                       | Yes                      |
|--------------------------------------|--------------------------|--------------------------|
| a. My husband or partner .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-husband or ex-partner ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Someone else .....                | <input type="checkbox"/> | <input type="checkbox"/> |

**39. During your pregnancy, did any of the following people push, hit, slap, kick, choke, or physically hurt you in any other way?** For each person, check **No** if they did not hurt you during this time or **Yes** if they did.

- |                                      | No                       | Yes                      |
|--------------------------------------|--------------------------|--------------------------|
| a. My husband or partner .....       | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My ex-husband or ex-partner ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Someone else .....                | <input type="checkbox"/> | <input type="checkbox"/> |

## AFTER PREGNANCY

**The next questions are about your baby and your experiences around the time of delivery. We understand that some of these options may not apply to you.**

**40. When was your baby due?**

	/		/	20	
Month		Day		Year	

**41. When was your baby delivered?**

	/		/	20	
Month		Day		Year	

**42. What date do you think your baby died?**

	/		/	20	
Month		Day		Year	

I don't know

#### 43. What date did you find out that your baby died?

	/		/	20
--	---	--	---	----

Month                      Day                      Year

I don't know

#### 44. When did your baby die?

- Before delivery  
 During delivery  
 I don't know

#### 45. How was your baby delivered?

- Vaginally → Go to Question 47  
 Cesarean delivery (c-section)

#### 46. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)?

Check ONE answer

- My health care provider scheduled my cesarean delivery **before** my baby died  
 My health care provider recommended a cesarean delivery **before** I went into labor  
 My health care provider recommended a cesarean delivery while I was in labor  
 I asked for the cesarean delivery

#### 47. When were you discharged from the hospital after your baby was delivered?

}		/		/	20
---	--	---	--	---	----

Month                      Day                      Year

- I didn't have my baby in a hospital →

Go to Page 10,  
Question 52

Go to Question 48

#### 48. Were you offered any of the following things during your hospital stay? For each item, check **No** if it was not offered or **Yes** if it was.

- |  | No                       | Yes                      |
|--|--------------------------|--------------------------|
| a. Photographs of my baby .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Photographs of my baby with family .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Hand and/or foot prints/impressions .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Holding my baby .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Bathing my baby .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Dressing my baby .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Baptism or blessing of my baby .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Mementos (ex. hat, clothes) .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Funeral/memorial service resources .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Support groups/peer volunteer resources .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Visit with a religious leader (bishop, chaplain, pastor, priest, rabbi, imam, etc.) ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Visit with a hospital social worker .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| m. To have my baby stay in my room .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| n. A cooling bed .....   | <input type="checkbox"/> | <input type="checkbox"/> |



**49. Which of the following things did you receive during your hospital stay?** For those items that were received, please indicate if you felt it was helpful or not.

	<b>Received</b>		<b>Helpful</b>	
	<b>No</b>	<b>Yes</b>	<b>No</b>	<b>Yes</b>
a. Photographs of my baby .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Photographs of my baby with family.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Hand and/or foot prints/impressions.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Holding my baby .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Bathing my baby.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Dressing my baby .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Baptism or blessing of my baby.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Mementos (ex. hat, clothes)..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Funeral/memorial service resources.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Support groups/peer volunteer resources .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Visit with a religious leader (bishop, chaplain, pastor, priest, rabbi, imam, etc.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Visit with a hospital social worker.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. To have my baby stay in my room .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. A cooling bed.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**50. Did any of the following things happen to you before you left the hospital?** For each item, check **No** if it did not happen or **Yes** if it did.

	<b>No</b>	<b>Yes</b>
a. I felt adequately supported by my doctor or midwife in my grieving process.....	<input type="checkbox"/>	<input type="checkbox"/>
b. I felt adequately supported by the hospital nursing staff in my grieving process.....	<input type="checkbox"/>	<input type="checkbox"/>
c. I felt adequately supported by the grief counseling staff in my grieving process.....	<input type="checkbox"/>	<input type="checkbox"/>
d. I was given information about my breast milk coming in .....	<input type="checkbox"/>	<input type="checkbox"/>
e. I was given information about what to do when my breast milk came in.....	<input type="checkbox"/>	<input type="checkbox"/>
f. I was given a bereavement packet with information on where to seek support....	<input type="checkbox"/>	<input type="checkbox"/>
g. The hospital staff gave me the opportunity to ask questions.....	<input type="checkbox"/>	<input type="checkbox"/>
h. My healthcare provider discussed with me what might have happened to my baby.....	<input type="checkbox"/>	<input type="checkbox"/>

**The next questions are about autopsy and other exams that may have been done to learn about what caused your baby's death. We are trying to learn more about tests offered in hospitals. We understand that some of the options may not apply to you.**

**51. Were any of the following tests offered to you during your hospital stay?** For each test, check **No** if it was not offered or **Yes** if it was.

	<b>No</b>	<b>Yes</b>
a. Blood tests (mother).....	<input type="checkbox"/>	<input type="checkbox"/>
b. Detailed exam of placenta .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Autopsy (full or partial).....	<input type="checkbox"/>	<input type="checkbox"/>
d. Genetic testing of the baby .....	<input type="checkbox"/>	<input type="checkbox"/>

**52. Were any of the following tests performed on you and/or your baby?** For each test, check **No** if it was not performed or **Yes** if it was.

- |                                      | No                       | Yes                      |
|--------------------------------------|--------------------------|--------------------------|
| a. Blood tests (mother).....         | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Detailed exam of placenta .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Placenta went to pathology .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Genetic testing of the baby ..... | <input type="checkbox"/> | <input type="checkbox"/> |

**53. Did your baby have a full or partial autopsy?**

- No  
 Yes

→ **Go to Question 55**

**54. What were the reasons that the autopsy was not done?**

**Check ALL that apply**

- An autopsy was too expensive  
 I was told it would not be covered by insurance  
 I declined for personal or religious reasons  
 I did not have enough information about the procedure  
 The doctors were able to determine the cause(s) of death without an autopsy  
 I was told that an autopsy would not provide any answers  
 An autopsy was not offered to me  
 Other → Please tell us:

**55. Did you learn what may have caused your baby's death?**

- No  
 Yes

→ **Go to Question 57**

**Go to Question 56**

**56. Which of the following things may have caused your baby's death?**

**Check ALL that apply**

- Complications with the cervix  
 Complications with the umbilical cord/cord accident  
 Placental abruption (separation of the placenta from the uterus)  
 Infection  
 Other complications with the placenta  
 Hypertension  
 Preterm (premature) labor  
 Diabetes  
 Membranes ruptured  
 Congenital defect(s) / birth defect(s)/ chromosomal abnormalities  
 Other → Please tell us:

**The next questions are about your health since your baby was delivered.**

**57. Since your baby was delivered, have you had a postpartum checkup for yourself?** A postpartum checkup is the regular checkup a woman has about 4-6 weeks after she gives birth.

- No  
 Yes

→ **Go to Question 59**

**58. During your postpartum checkup, did a doctor, nurse, or other health care worker do any of the following things?** For each item, check **No** if they did not do it or **Yes** if they did.

- |   | No                       | Yes                      |
|---|--------------------------|--------------------------|
| a. Talk to me about how long to wait before getting pregnant again .....    | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about birth control methods I can use after giving birth..... | <input type="checkbox"/> | <input type="checkbox"/> |

59. *Since your baby was delivered, have you received support or counseling for feelings of grief?*

- No  
 Yes

Go to Question 61

60. *Did any of the following things keep you from receiving support or counseling?*

Check ALL that apply

- I felt fine and do not think I needed support or counseling  
 I didn't know where to go for counseling  
 I didn't have insurance to cover the cost of counseling  
 I was not aware of support groups in my area  
 Other → Please tell us:

\_\_\_\_\_

61. *Are you pregnant now?*

- No  
 Yes

Go to Question 63

62. *What was the first day of your last period?*

\_\_\_\_ / \_\_\_\_ / 20\_\_\_\_

Month Day Year

- I did not have a period before I became pregnant again

The last questions are about the time during the 12 months before your baby was delivered.

63. *During the 12 months before your baby was delivered, what was your yearly total household income before taxes? Include your income, your husband's or partner's income, and any other income you may have received. All information will be kept private and will not affect any services you are now getting.*

- \$0 to \$16,000  
 \$16,001 to \$20,000  
 \$20,001 to \$24,000  
 \$24,001 to \$28,000  
 \$28,001 to \$32,000  
 \$32,001 to \$40,000  
 \$40,001 to \$48,000  
 \$48,001 to \$57,000  
 \$57,001 to \$60,000  
 \$60,001 to \$73,000  
 \$73,001 to \$85,000  
 \$85,001 or more

64. *During the 12 months before your baby was delivered, how many people, including yourself, depended on this income?*

\_\_\_\_ People

65. *What is today's date?*

\_\_\_\_ / \_\_\_\_ / 20\_\_\_\_

Month Day Year

**Please use this space for any additional comments you would like to share about your pregnancy and baby.**

***Thank you for answering these questions. By answering these questions, you are helping us find out why stillbirths happen and how we can improve the care received by families. Again, please accept our deepest sympathies to you and your family on the loss of your baby.***

