WISCONSIN STILLBIRTH SERVICE PROGRAM

SUMMARY SHEET -- TO BE SENT TO US WITH INITIAL MATERIALS

Date_____

Baby's Name_____ Birthdate____ ____ ____

Mother's Name_____ Hospital_____

INDICATE WHAT INFORMATION WE CAN EXPECT TO RECEIVE:

MATERNAL PRENATAL & PERINATAL RECORDS	**Y**	**N**
CLINICAL EXAMINATION	**Y**	**N**
PHOTOGRAPHS	**Y**	**N**
X-RAYS	**Y**	**N**
KLEIHAUER-BETKE TESTING	**Y**	**N**
PLACENTAL PATHOLOGY REPORT	**Y**	**N**
POSTMORTEM (where?_____)	**Y**	**N**
CHROMOSOMES (what tissues?_____)	**Y**	**N**

INDICATE TO WHOM COPIES OF OUR SUMMARY SHOULD BE SENT:

ATTENDING PHYSICIAN **Y N**
name_____
address_____
_____
_____

THE CONTACT PERSON IN YOUR HOSPITAL **Y N**

PATHOLOGIST **Y N**
name_____
address_____
_____
_____

OTHERS
name_____
address_____
_____
_____

WERE THE PARENTS GIVEN 'PARENT LETTER' FROM THIS PROTOCOL? Y N

SHOULD WE CONTACT THE PARENTS DIRECTLY CONCERNING THE RESULTS OF THIS EVALUATION? Y N

parents' names_____
address_____
_____
_____