



Ohio
SOARS
Study of Associated Risks of Stillbirth

*With your help,
we hope to learn why stillbirths happen
and how to improve care.*

Ohio SOARS
Ohio Department of Health
246 N. High Street
Columbus, OH 43215

Funding for Ohio SOARS is provided by
the Ohio Department of Health and the
Ohio Department of Medicaid

For more information, please call
614-644-0190 or 877-212-7216

We would like to learn why stillbirths happen and 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 otherwise noted. We understand that some questions may be sensitive and we appreciate any information you are able to share. Your help is voluntary and all responses will be kept confidential. Please know that regardless of how you answer these questions, the purpose of these questions is for us to learn how our health care system could better serve moms and babies. If you are under 18 years of age, please consult with your parent or guardian before completing the survey.

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 question is about *you*.

1. What is your date of birth?

		/			/					Month / Day / Year
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The next questions are about the time *before* you got pregnant.

2. 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.

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

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79. If you would like to receive a copy of the summary of the study results when completed (this may take 12–18 months), please provide your email or mailing address.

Please provide your email address:

OR provide your mailing address:

Full Name: _____

Street 1: _____

Street 2: _____

City: _____

State: _____

Zip Code: _____

I do not want a copy of the study results

Thank you for answering these questions. Your answers will help us to learn more about stillbirth 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.

Please mail your completed survey in the enclosed envelope.

Your help is voluntary and your answers are completely confidential.

Questions? Contact the Ohio SOARS Manager at 877-212-7216

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

75. 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.*

- | | |
|---|---|
| <input type="checkbox"/> \$0 to \$16,000 | <input type="checkbox"/> \$40,001 to \$48,000 |
| <input type="checkbox"/> \$16,001 to \$20,000 | <input type="checkbox"/> \$48,001 to \$57,000 |
| <input type="checkbox"/> \$20,001 to \$24,000 | <input type="checkbox"/> \$57,001 to \$60,000 |
| <input type="checkbox"/> \$24,001 to \$28,000 | <input type="checkbox"/> \$60,001 to \$73,000 |
| <input type="checkbox"/> \$28,001 to \$32,000 | <input type="checkbox"/> \$73,001 to \$85,000 |
| <input type="checkbox"/> \$32,001 to \$40,000 | <input type="checkbox"/> \$85,001 or more |

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

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 People

77. What is today's date?

		/			/	2	0		
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 Month / Day / Year

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

3. 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.

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

- 1 time → [Go to Page 3, Question 10](#)
- 2 to 4 times
- 5 to 7 times
- 8 or more times

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

- No → [Go to Question 8](#)
- Yes

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

- No
- Yes

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

- No
- Yes

8. Before this pregnancy, did you have any pregnancies that ended in a loss (such as a miscarriage or stillbirth)?

- No → [Go to Page 3, Question 10](#)
- Yes

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

- a. Number of pregnancies that ended before 12 weeks.....

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- b. Number of pregnancies that ended between 12 and 27 weeks

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- c. Number of pregnancies that ended at 28 weeks or later.....

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10. Thinking back to just before you got pregnant, how did you feel about becoming pregnant? Check ONE answer

- I wanted to be pregnant later
- I wanted to be pregnant sooner
- I wanted to be pregnant then
- I didn't want to be pregnant then or at any time in the future
- I wasn't sure what I wanted

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

11. 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 Ohio Health Insurance Marketplace or HealthCare.gov
- Ohio Medicaid or an Ohio Medicaid Managed Care Plan
- TRICARE or other military health care
- Other health insurance → Please tell us: _____
- I did not have any health insurance during the month before I got pregnant

72. While you were pregnant during the COVID-19 pandemic, did you have any of the following experiences? For each item, check No if you did not, or Yes if you did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I had responsibilities or a job that prevented me from staying home..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Someone in my household had a job that required close contact with other people..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. When I went out, I found that other people around me did not practice social distancing | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I had trouble getting or making masks or cloth face coverings | <input type="checkbox"/> | <input type="checkbox"/> |
| e. It was hard for me to wear a mask or cloth face covering (trouble breathing, claustrophobia)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I was told by a health care provider that I had COVID-19..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Someone in my household was told by a health care provider that they had COVID-19 | <input type="checkbox"/> | <input type="checkbox"/> |

73. Are you pregnant now?

- No → Go to Page 25, Question 75
- Yes

74. What was the first day of your last period?

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 /

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 /

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 Month / Day / Year

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

The next questions are about Coronavirus disease 2019 or COVID-19. COVID-19 caused a worldwide disease outbreak or pandemic that reached Ohio in March 2020.

70. Whether or not you got sick with COVID-19, the pandemic may have affected your life. During your most recent pregnancy, to what extent were the following statements true for you? For each item, check ONE answer

	Very true	Somewhat true	Not at all true
a. Due to the COVID-19 pandemic, my household had more difficulty than usual paying for bills and expenses	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Due to the COVID-19 pandemic, I had more difficulty than usual obtaining health care for myself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Due to the COVID-19 pandemic, I delayed getting medical care for myself.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. I experienced more anxiety or depression than usual due to the COVID-19 pandemic.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

71. During the COVID-19 pandemic, which types of prenatal care appointments did you attend? Check ONE answer

- In-person appointments only
- Virtual appointments (video or telephone) only
- Both, in person and virtual appointments
- I did not have prenatal care

12. During your pregnancy, what kind of health insurance did you have to pay for your prenatal care? Check ALL that apply

- I did not go for prenatal care → **Go to Question 13**
- 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 Ohio Health Insurance Marketplace or HealthCare.gov
- Ohio Medicaid or an Ohio Medicaid Managed Care Plan
- TRICARE or other military health care
- Other health insurance → Please tell us: _____
- I did not have any health insurance to pay for my prenatal care

13. 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 Ohio Health Insurance Marketplace or HealthCare.gov
- Ohio Medicaid or an Ohio Medicaid Managed Care Plan → Please tell us for how many months or years you have been covered by Ohio Medicaid:

Months
 OR

 Years

- TRICARE or other military health care
- Other health insurance → Please tell us: _____
- I do not have health insurance now

DURING PREGNANCY

The next questions ask 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 a calendar when you answer these questions.)

14. 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 16**

15. Did you get prenatal care as early in your pregnancy as you wanted?

No
 Yes → **Go to Page 6, Question 17**

16. Did any of these things keep you from getting prenatal care when you wanted it?
 For each item, check **No** if it did not keep you from getting prenatal care or **Yes** if it did.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. I couldn't get an appointment when I wanted one | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't have enough money or insurance to pay for my visits..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have any transportation to get to the clinic or doctor's office. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. The doctor or my health plan would not start care as early as I wanted | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I had too many other things going on..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I couldn't take time off from work or school | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I didn't have my Medicaid card..... | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I didn't have anyone to take care of my children | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I didn't know that I was pregnant | <input type="checkbox"/> | <input type="checkbox"/> |
| j. I didn't want anyone else to know I was pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| k. I didn't want prenatal care..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not receive support or counseling for feelings of grief, go to Question 67. Otherwise go to Question 68.

67. Did any of the following things keep you from receiving support or counseling?
Check ALL that apply

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I felt fine and did not think I needed support or counseling..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I didn't know where to go for counseling..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I didn't have insurance to cover the cost of counseling..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I was not aware of support groups in my area..... | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Other → Please tell us: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

The next questions are about your employment status.

68. At any time during your pregnancy, did you work at a job for pay?

No → **Go to Page 23, Question 70**
 Yes

69. Have you returned to the job you had during your pregnancy? Check ONE answer

- No, and I do not plan to return
 No, but I will be returning
 Yes

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

64. 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 → **Go to Question 66**
 Yes

65. 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. Ask me if I want to be pregnant in the future..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Talk to me about how long to wait before getting pregnant again | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Talk to me about birth control methods I can use after giving birth ... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Ask me whether I was feeling down or depressed | <input type="checkbox"/> | <input type="checkbox"/> |

66. The following questions ask about your emotional well-being since your baby was delivered. For each item, check **No** if it did not happen to you, or **Yes** if it did.

- | | No | Yes |
|--|--------------------------|--------------------------|
| a. I answered written questions asking me to rate my mood..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. A doctor, nurse, or other health care worker told me I had depression | <input type="checkbox"/> | <input type="checkbox"/> |
| c. A doctor, nurse, or other health care worker told me I had anxiety .. | <input type="checkbox"/> | <input type="checkbox"/> |
| d. A doctor, nurse, or other health care worker recommended that I take a prescription medication for depression | <input type="checkbox"/> | <input type="checkbox"/> |
| e. I took medication for depression | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I took medication for anxiety | <input type="checkbox"/> | <input type="checkbox"/> |
| g. A doctor, nurse, or other health care worker recommended that I get counseling for depression | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I received counseling for depression or anxiety..... | <input type="checkbox"/> | <input type="checkbox"/> |
| i. I received support or counseling for feelings of grief..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you did not get prenatal care, go to Question 18.

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 over the counter medications or home remedies .. | <input type="checkbox"/> | <input type="checkbox"/> |
| c. If I was taking any prescription medication | <input type="checkbox"/> | <input type="checkbox"/> |
| d. If I was smoking cigarettes | <input type="checkbox"/> | <input type="checkbox"/> |
| e. If I was drinking alcohol..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. If someone was hurting me emotionally or physically | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If I was feeling down or depressed | <input type="checkbox"/> | <input type="checkbox"/> |
| h. If I was using drugs such as marijuana, cocaine, crack, or meth | <input type="checkbox"/> | <input type="checkbox"/> |
| i. If I wanted to be tested for HIV (the virus that causes AIDS) | <input type="checkbox"/> | <input type="checkbox"/> |
| j. If I planned to breastfeed my new baby | <input type="checkbox"/> | <input type="checkbox"/> |
| k. If I planned to use birth control after my baby was born | <input type="checkbox"/> | <input type="checkbox"/> |
| l. If I knew about recommended sleeping positions during pregnancy... | <input type="checkbox"/> | <input type="checkbox"/> |
| m. If I was aware of the risk of stillbirth during pregnancy | <input type="checkbox"/> | <input type="checkbox"/> |
| n. If I knew how to track my baby's movements | <input type="checkbox"/> | <input type="checkbox"/> |

18. During your pregnancy, did you keep track of your baby's movements?

- No
 Yes

19. Who was the main health care provider for your pregnancy?

- OB/GYN Physician
 Family Physician
 Midwife
 Maternal-Fetal Medicine Physician/Perinatologist
 Other → Please tell us: _____
 I did not have one

Please rate the degree to which you agree or disagree with the following statements.

20. Overall, while making decisions during my pregnancy, I felt:

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. Comfortable asking questions	<input type="checkbox"/>				
b. Comfortable declining care that was offered.....	<input type="checkbox"/>				
c. Comfortable accepting the options for care that my doctor/midwife recommended	<input type="checkbox"/>				
d. Pushed into accepting the options my doctor/midwife suggested.....	<input type="checkbox"/>				
e. I chose the care options that I received.....	<input type="checkbox"/>				
f. My personal preferences were respected	<input type="checkbox"/>				
g. My cultural preferences were respected	<input type="checkbox"/>				

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

- No
- Yes

22. 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 <u>started</u> during <i>this</i> pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>
b. High blood pressure (that <u>started</u> 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"/>

61. 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: _____

62. Did you learn about what may have caused your baby's death?

- No → **Go to Page 21, Question 64**
- Yes

63. 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 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.

58. 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.

	No	Yes	Don't Know
a. Blood tests (mother)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Detailed exam of placenta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Autopsy (full or partial)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Genetic testing of the baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

59. 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	Don't Know
a. Blood tests (mother)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Detailed exam of placenta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Placenta went to pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Genetic testing of the baby	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

60. Did your baby have a full or partial autopsy?

- No
 Yes → Go to Page 20, Question 62

23. 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. Decreased or increased fetal movement.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
c. Kidney or bladder (urinary tract) infection (UTI)	<input type="checkbox"/>	<input type="checkbox"/>
d. Severe nausea, vomiting, or dehydration that sent me to the doctor or hospital	<input type="checkbox"/>	<input type="checkbox"/>
e. Cervix had to be sewn shut (needing a stitch in my cervix).....	<input type="checkbox"/>	<input type="checkbox"/>
f. Complications with the placenta (such as placenta abruption or placenta previa)	<input type="checkbox"/>	<input type="checkbox"/>
g. Labor pains more than 3 weeks before my baby was due (preterm or early labor) <u>and</u> my doctor said that my cervix was dilated.....	<input type="checkbox"/>	<input type="checkbox"/>
h. Water broke more than 3 weeks before my baby was due (preterm premature rupture of membranes [PPROM]).....	<input type="checkbox"/>	<input type="checkbox"/>
i. Baby was small for gestational age	<input type="checkbox"/>	<input type="checkbox"/>
j. I had to have a blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
k. I was hurt in a car accident	<input type="checkbox"/>	<input type="checkbox"/>
l. Fever of 101° or higher	<input type="checkbox"/>	<input type="checkbox"/>
m. A gut feeling that something was wrong → Please tell us: _____	<input type="checkbox"/>	<input type="checkbox"/>

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

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

25. Were you considered 'high risk' for *this* pregnancy? **Check ALL that apply**

- No
- Yes, due to a medical condition diagnosed *before* pregnancy
- Yes, due to a medical condition diagnosed *during* pregnancy
- Yes, due to a pregnancy complication
- Yes, due to a previous pregnancy loss
- Yes, due to another reason → Please tell us: _____
- I don't know

56. 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.

	No	Yes
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"/>

57. Please tell us if there is anything else that you would like to share about your experience in the hospital:

55. Which of the following things were you offered during your hospital stay? Whether or not it was offered, please indicate if you felt it would be helpful.

	Was it offered?		Was/Would it have been helpful?	
	No	Yes	No	Yes
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"/>

26. Did you have a detailed ultrasound at about 20 weeks (sometimes called an anatomic scan)?

- No
- Yes

27. During an ultrasound, were any abnormalities or concerns identified?

- No
- Yes → Please tell us: _____

28. Did any of the tests you had during your pregnancy include Cardiotocography (CTG) also called a Non-Stress Test (NST)?

- No
- Yes

29. How much weight did you gain during your pregnancy? Check ONE answer and fill in the blank if needed.

I gained Pounds OR Kilos

- I didn't gain any weight during my pregnancy
- I don't know

The next questions are about smoking and alcohol use around the time of pregnancy (before and during). We understand these questions may be sensitive. Please know, we ask similar questions of other women on a different survey.

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

- No → Go to Page 11, Question 32
- Yes

31. During any of the following time periods, did you smoke cigarettes?

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. During the 3 months before I got pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |

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.

32. Have you used e-cigarettes or other electronic nicotine products in the *past 2 years*?

- No → **Go to Question 34**
 Yes

33. During any of the following time periods, did you use e-cigarettes or other electronic nicotine products?

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. During the 3 months before I got pregnant..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During my pregnancy..... | <input type="checkbox"/> | <input type="checkbox"/> |

34. During your pregnancy, how many alcoholic drinks did you have in an average week? A drink is 1 glass of wine, wine cooler, can or bottle of beer, shot of liquor, or mixed drink.

- 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 during my pregnancy

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

35. Did you have depression during your pregnancy?

- No → **Go to Page 12, Question 39**
 Yes

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

/ / Month / Day / Year

I don't know

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

/ / Month / Day / Year

I don't know

51. When did your baby die?

- Before delivery
 During delivery
 I don't know

52. How was your baby delivered?

- Vaginally → **Go to Question 54**
 Cesarean delivery (c-section)

53. Which statement best describes whose idea it was for you to have a cesarean delivery (c-section)? **Check ALL that apply**

- 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

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

/ / Month / Day / Year

I didn't have my baby in a hospital → **Go to Page 19, Question 58**

45. 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"/> |

If you need assistance relating to Questions 44 or 45, please call 1-800-799-SAFE (7233).
If you need immediate help, please call 911.

46. Are there any other details that you would like to share that may have impacted your pregnancy?

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.

47. When was your baby due?

		/			/	2	0			Month / Day / Year
--	--	---	--	--	---	---	---	--	--	--------------------

48. When was your baby delivered?

		/			/	2	0			Month / Day / Year
--	--	---	--	--	---	---	---	--	--	--------------------

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

- No
- Yes

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

- No
- Yes

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

- No
- Yes

39. During your pregnancy, which of the following statements about basic needs applied to you? For each item, check **No** if it was not true, or **Yes** if it was.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. I had affordable, reliable transportation | <input type="checkbox"/> | <input type="checkbox"/> |
| b. I skipped meals or ate less because there wasn't enough money to buy food..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. I had safe housing | <input type="checkbox"/> | <input type="checkbox"/> |
| d. I had consistent and stable housing | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My house or apartment was too crowded | <input type="checkbox"/> | <input type="checkbox"/> |
| f. I could keep basic utility services on (heat, water, lights)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g. I had access to a telephone when needed | <input type="checkbox"/> | <input type="checkbox"/> |
| h. I had other basic needs that were not met → Please tell us:
_____ | <input type="checkbox"/> | <input type="checkbox"/> |

40. 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 a 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"/> |

41. During the 12 months before you were pregnant, how often did you experience discrimination, or harassment, or were made to feel inferior because of your race, ethnicity, or culture?

- Always
- Often
- Sometimes
- Rarely
- Never

42. Did you experience discrimination by health care providers during your prenatal care, labor, or delivery because of the things listed below? For each item, check **No** if you did not experience discrimination, or **Yes** if you experienced discrimination.

- | | No | Yes |
|---|--------------------------|--------------------------|
| a. My race, ethnicity, or culture..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. My insurance or Medicaid status..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. My weight | <input type="checkbox"/> | <input type="checkbox"/> |
| d. My marital status | <input type="checkbox"/> | <input type="checkbox"/> |
| e. My sexual orientation | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Other → Please tell us: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

43. Please tell us about any experiences of discrimination, harassment, or being made to feel inferior because of your race, ethnicity, or culture.

44. 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"/> |