Mother's Name_____

Mother's Medical Record #_____

CERTIFICATE OF LIVE BIRTH WORKSHEET

The information you provide below will be used to create your child's birth certificate. The birth certificate is a document that will be used for legal purposes to prove your child's age, citizenship and parentage. This document will be used by your child throughout his/her life. State laws provide protection against the unauthorized release of identifying information from the birth certificates to ensure the confidentiality of the parents and their child.

It is very important that you provide complete and accurate information to all of the questions. In addition to information used for legal `and newborn infants. Items such as parent's education, race, and smoking will be used for studies but will not appear on copies of the birth certificate issued to you or your child.

---

1. Facility name*: _____
(If not institution, or if a Homebirth, give street and number.)

2. City, Town, or Location of birth: _____

3. County of birth: _____

Child

4. What will be your BABY'S legal name (as it should appear on the birth certificate)?

_____ _____ _____
First Middle Other Middle

_____ _____
Last Suffix (Jr., III, etc.)

5. Date of birth:

__ __/__ __/__ __ __ __ M M D D Y Y Y Y

6. Time of birth:

_____ ☐ AM ☐ PM ☐ Military Time

7. Sex

_____ (Male, Female, or Not yet determined)

8. Do you want a Social Security Number issued for your baby?

☐ Yes (Please read request and sign below)
☐ No

I request that the Social Security Administration assign a Social Security number to the child named on this form and authorize the State to provide the Social Security Administration with the information from this form which is needed to assign a number. (Either parent, or the legal guardian, may sign.)

Signature of infant's mother or spouse_____

Date: __ __/__ __/__ __ __ __ M M D D Y Y Y Y

9. Safe Haven/Foundling Baby?

☐ Yes ☐ No

10.Is Adoption/Legal proceeding expected?

☐ Yes ☐ No

Mother/Parent

11. MOTHER/PARENT: What is your current legal name?

_____ _____ _____
First Middle Last

_____
Suffix (Jr., III, etc.)

12. Mother/Parent's name prior to her first marriage (Maiden Name)

_____ _____ _____
First Middle Last

_____
Suffix (Jr., III, etc.)

13. MOTHER/PARENT: What is your date of birth?

__ __/__ __/__ __ __ __ M M D D Y Y Y Y **Age: _____**

14. MOTHER/PARENT: What is your Social Security Number?

__ __ __--__ __--__ __ __ __ ☐ **None** ☐ **Unknown**

15. MOTHER/PARENT: In what State, U.S. territory, or foreign country were you born? Please specify one of the following:

City or Town _____ County _____

Birthplace State _____ Birthplace Country _____

Mother/Parent Address

16. MOTHER/PARENT: Where do you usually live--that is--where is your household/residence located?

Street number _____ Pre-directional _____ (E, N, NE, NW, S, SE, SW, W)

Street Name, Rural Route, etc. _____

Street Designator, e.g. Street, Avenue, etc. _____

Post Directional _____ (E, N, NE, NW, S, SE, SW, W)

Apartment#, Suite#, etc. _____

Zip Code _____ City or Town _____

County _____ State_____ (or U.S. Territory, Canadian Province)

If not United States, C*ountry* _____

17. Is this household inside city limits? (Inside the incorporated limits of the city, town or location where you live)

☐ Yes ☐ No ☐ Unknown

18. MOTHER/PARENT: What is your mailing address?

☐ Same as residence Address [Go to next question]

Street number _____ Pre-directional _____ (E, N, NE, NW, S, SE, SW, W)

Street Name, Rural Route, etc._____

Street Designator, e.g. Street, Avenue, etc. _____

Post Directional _____ (E, N, NE, NW, S, SE, SW, W)

Apartment#, Suite#, etc. _____

Zip Code_____ City or Town_____

County_____ State _____ (or U.S. Territory, Canadian Province)

If not United States, C*ountry* _____

19. Mother/Parent's Telephone Numbers?

Day (____) - ____ - _____

Evening (____) - ____ - _____

Mother/Parent Attributes

20. MOTHER/PARENT: What is your usual occupation or industry in which you work? Please fill in below. For example your occupation is Teacher, CPA, Waitress, Clerk, etc., and the industry in which you work is Department Store, Law Firm, Hospital, Factory, etc. Do not use retired.

Usual Occupation: _____

Kind of Business/Industry:_____

21. MOTHER/PARENT: What is the highest level of schooling that you will have completed at the time of delivery? (Check the box that best describes your education. If you are currently enrolled, check the box that indicates the previous grade or highest degree received).

- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Associate degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
- ☐ Unknown

22. MOTHER/PARENT: Are you Spanish/Hispanic/Latino? If not Spanish/Hispanic/Latino, check the "No" box. If Spanish/Hispanic/Latino, check the most appropriate box.

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (e.g. Spaniard, Salvadoran, Dominican, Columbian)

  (Specify)_____
- ☐ Unknown

23. MOTHER/PARENT: What is your race? (Please check all that apply).

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native

(name of enrolled or principal tribe(s)) _____

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian

(specify) _____

- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander

(specify) _____

- ☐ Other

(specify) _____

- ☐ Unknown

Mother/Parent Health

24. MOTHER/PARENT: Did you receive WIC (Women, Infants & Children) food for yourself because you were pregnant with this child?

- ☐ Yes
- ☐ No
- ☐ Unknown

25. MOTHER/PARENT: What is your height?

_____ Feet _____ inches

26. What was your pre-pregnancy weight? (Weight immediately before you became pregnant with this child)

_____lbs.

27. Mother/Parent's weight at delivery

_____lbs.

Tobacco/Nicotine use per day before and/or during pregnancy:

28. Tobacco use during this pregnancy

☐ Yes ☐ No ☐ Unknown

29. If you answered, "YES" to using tobacco, how many cigarettes OR packs of cigarettes did you smoke on an average day during each of the following time periods? If you NEVER smoked, enter zero for each time period.

	# of cigarettes		# of packs
Three months before pregnancy	_____	OR	_____
First three months of pregnancy	_____	OR	_____
Second three months of pregnancy	_____	OR	_____
Last three months of pregnancy	_____	OR	_____

30. If you answered "Yes" to using tobacco: On the days that you smoked cigarettes during any point of your pregnancy, how soon after you woke up did you usually have your first cigarette?

☐ Within 5 minutes
☐ From 6 to 30 minutes.
☐ From more than 30 to 1 hour
☐ After more than 1 hour
☐ Don't know/Not sure.

31. If you answered "Yes" to using tobacco: At any time during your pregnancy, did you stop smoking cigarettes for one day or longer because you were trying to quit smoking?

☐ Yes
☐ No
☐ Don't know/Not Sure

32. During any point during your pregnancy did you use:
E-cigarettes or Vapes (BLU, NJOY, JUUL, SUORIN DROP, PUFF BAR)

☐ Yes- less than 5 times
☐ Yes- more than 5 times
☐ No- I did not use this substance at all

33. Hookah, Shisha, or Water Pipe

☐ Yes- less than 5 times
☐ Yes- more than 5 times
☐ No- I did not use this substance at all

34. Cigarillos (BLACK & MILD, SWISHER SWEETS, PHILLIES BLUNTS) or Little Cigars (CHEYENNE, SENECA)

- ☐ Yes- less than 5 times
- ☐ Yes- more than 5 times
- ☐ No- I did not use this substance at all

35. Chewing Tobacco (GRIZZLY, SKOAL), Snus (CAMEL SNUS), or Nicotine Pouches (ZYN, VELO)

- ☐ Yes- less than 5 times
- ☐ Yes- more than 5 times
- ☐ No- I did not use this substance at all

36. During your pregnancy, did you stop using any other tobacco products, besides cigarettes, for one day or longer because you were trying to quit tobacco?

- ☐ Yes
- ☐ No
- ☐ Don't know/Not Sure

Marital Status

37. Current marital status

- ☐ Never Married
- ☐ Widowed
- ☐ Divorced
- ☐ Currently Married
- ☐ Married, but refusing husband's Information
- ☐ Unknown

38. Was mother married at Conception, at Birth, or within 300 days prior to birth?

- ☐ Yes, to biological father
- ☐ Yes, to same-sex spouse
- ☐ No, to biological father

39. Will acknowledgement of paternity need to be completed?

☐ Yes ☐ No

Father/Parent

40. Father/parent's name

_____ _____ _____
First Middle Last

_____
Suffix (Jr., III, etc.)

41. Father/parent's date of birth

__ __/__ __/__ __ __ __ M M D D Y Y Y Y **Age: _____**

42. Father/parent's Social Security Number

__ __ __--__ __--__ __ __ __

43. Residence Address

☐ Same As Mother's Address

Street Number_____ Pre Directional_____

Street name _____ Street Designator_____

Post Directional _____ Apt#, Suite#, etc:_____ Zip Code_____

City or Town_____ County_____ State_____ Country_____

44. Father/parent place of birth?

City or town_____ County_____ Birthplace State_____

Birthplace Country_____

45. What is the father/parent's usual occupation and kind of business/industry? Please fill in below. For example, their occupation is Photographer, Farmer, Nurse, etc., and the industry in which they work is Factory, Skating Rink, Army, etc.

Usual Occupation: _____

Usual Industry: _____

46. What is the highest level of schooling that the father/parent will have completed at the time of delivery? (Check the box that best describes their education. If they are currently enrolled, check the box that indicates the previous grade or highest degree received).

- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Associate degree (e.g. AA, AS)
- ☐ Bachelor's degree (e.g. BA, AB, BS)
- ☐ Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
- ☐ Unknown

47. Father/Parent Hispanic Origin If not Spanish/Hispanic/Latino, check the "No" box. If Spanish/Hispanic/Latino, check the most appropriate box.

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino (e.g. Spaniard, Salvadoran, Dominican, Columbian)

  (Please specify)_____
- ☐ Unknown

48. Father/Parent Which one or more of the following is your race? Please check all that apply.

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
  (name of enrolled or principal tribe)_____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian
  (specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
  (specify) _____
- ☐ Other
  (specify) _____
- ☐ Unknown

Informant

49. Relationship of Informant to Baby

- ☐ Mother
- ☐ Father
- ☐ Other Specify_____

50. Informant Name:

_____ _____ _____
First Middle Last

_____
Suffix (Jr., III, etc.)

Place of Birth:

51. Type of place of birth:

- ☐ Hospital
- ☐ Freestanding birthing center (freestanding birthing center is one that has no direct physical connection to a hospital)
- ☐ Home delivery planned
- ☐ Home delivery unplanned
- ☐ Home delivery unknown if planned
- ☐ Clinic/Doctor's Office
- ☐ Other (specify, e.g., taxi cab, train, plane) _____
- ☐ Unknown

52. Facility Name_____

Facility NPI_____

53. Facility Address

Street Number _____ Pre Directional_____ Street Name:_____

Street Designator (street avenue, blvd, etc.)_____ Post Directional _____

Apt#, Suite #, etc._____ Zip Code_____ City, Town, or Location _____

County _____State _____ Country _____

Prenatal

54. Mother Medical Record #:_____

55. Principal source of payment for this delivery (At time of delivery):

- ☐ Private Insurance
- ☐ Indian Health Service
- ☐ Medicaid (Comparable State program)
- ☐ CHAMPUS/TRICARE
- ☐ Self-pay (No third party identified)
- ☐ Unknown
- ☐ Other
  (Specify) _____
- ☐ Other Government
  (federal, state, local) _____

56. Date of Last Menses

__ __/__ __/__ __ __ __ M M D D Y Y Y Y

57. Did mother receive prenatal care?

- ☐ Yes
- ☐ No (skip to question 62)
- ☐ Unknown

58. Date of first prenatal care visit (prenatal care begins when a Physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy)

__ __/__ __/__ __ __ __ M M D D Y Y Y Y

59. Date of last prenatal care visit (Enter the date of the last visit recorded in the mother's prenatal records)

__ __/__ __/__ __ __ __ M M D D Y Y Y Y

60. Total number of prenatal care visits for this pregnancy (Count those visits recorded in the record, if available; otherwise refer to mother.):

_____ (visits)

61. Source of prenatal care?

- ☐ Hospital Clinic
- ☐ Public Health Clinic
- ☐ Private Physician
- ☐ Midwife
- ☐ Unknown
- ☐ Other, Specify: _____

62. Number of previous live births now living (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):

Enter number or 0 for none. _____

63. Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):

Enter number or 0 for none. _____

64. Date of last live birth

__ __/__ __ __ __ M M Y Y Y Y

65. Total number of other pregnancy outcomes (Include fetal losses of any gestational age-spontaneous terminations, induced terminations, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy).

Enter number or 0 for none. _____

66. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended)

__ __/__ __ __ __ M M Y Y Y Y

Pregnancy Factors

67. Risk factors in this pregnancy (Check all that apply):

- ☐ None
- ☐ Diabetes- Pre-pregnancy (Glucose intolerance requiring treatment, with diagnosis prior to this pregnancy)
- ☐ Diabetes- Gestational (Glucose intolerance requiring treatment, with diagnosis during this pregnancy)
- ☐ Hypertension- Pre-pregnancy (Chronic) (Elevation of blood pressure above normal for age, gender, and physiological condition. Diagnosed prior to the onset of this pregnancy.)
- ☐ Hypertension- Gestational (PIH, preeclampsia) (Elevation of blood pressure above normal for age, gender, and physiological condition. Diagnosed during this pregnancy.) May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (Generalized swelling, including swelling of the hands, legs and face)
- ☐ Eclampsia (Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema)
- ☐ Previous preterm births (History of pregnancy(ies) terminating in a live birth less than 37 completed weeks of gestation)
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small for gestational age/intrauterine growth restricted birth) (History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes. Perinatal death includes fetal and neonatal deaths.)
- ☐ Pregnancy resulted from infertility treatment- Fertility enhancing drugs, artificial insemination, intrauterine insemination (Any fertility-enhancing drugs (e.g. Clomid, Pergonal) artificial insemination, or intrauterine insemination used to initiate the pregnancy)
- ☐ Pregnancy resulted from infertility treatment- Assisted reproductive technology – Any assisted reproduction technology (ART) technical procedures (e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT) used to initiate the pregnancy.
- ☐ Mother had a previous cesarean delivery (Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls)

  If yes, how many_____

- ☐ Antiretroviral(s) administered during pregnancy or at delivery for treatment of HIV/AIDS
- ☐ Group B Strep
- ☐ Unknown

68. Was a Standard Licensed Diagnostic test for HIV performed for the Mother?

☐ Yes If yes, date the most recent specimen was taken: __ __/__ __/__ __ __ __ M M D D Y Y Y Y

If yes, when was the most recent test performed?

☐ During pregnancy ☐ Time of Delivery

☐ No If no, reason (check one below)

- ☐ Mother's Refusal
- ☐ HIV Status Known
- ☐ Insurance would not pay
- ☐ Other (specify): _____
- ☐ Unknown (Reason why there was no test is unknown)

☐ Unknown (Unknown whether or not the test was performed).

69. Was a Serological test for Syphilis performed for the Mother?

☐ Yes If yes, date the most recent specimen was taken: __ __/__ __/__ __ __ __ M M D D Y Y Y Y

If yes, when was the most recent test performed?

☐ During pregnancy ☐ Time of Delivery

☐ No If no, reason (check one below)

- ☐ Mother's Refusal
- ☐ Syphilis Status Known
- ☐ Insurance would not pay
- ☐ Other (specify): _____
- ☐ Unknown (Reason why there was no test is unknown)

☐ Unknown (Unknown whether or not the test was performed).

70. Mother Tested for Group B Strep?

- ☐ Yes
- ☐ No
- ☐ Unknown

71. Infections present and/or treated during this pregnancy - (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.) (Check all that apply):

- ☐ None
- ☐ Herpes Simplex Virus (HSV)
- ☐ Gonorrhea (a diagnosis of or positive test for *Neisseria gonorrhoeae)*
- ☐ Syphilis (also called lues - a diagnosis of or positive test for *Treponema pallidum)*
- ☐ Chlamydia (a diagnosis of or positive test for *Chlamydia trachomatis*)
- ☐ Hepatitis B (HBV, serum hepatitis - a diagnosis of or positive test for the hepatitis B virus)
- ☐ Hepatitis C (non A, non B hepatitis, HCV - a diagnosis of or positive test for the hepatitis C virus)
- ☐ Unknown

72. Obstetric procedures - (Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically in the treatment of the pregnancy, management of labor and/or delivery) (Check all that apply):

- ☐ None
- ☐ Amniocentesis
- ☐ Cervical cerclage (Circumferential banding or structure of the cervix to prevent or treat passive dilatation. Includes MacDonald's suture, Shirodkar procedure, abdominal cerclage via laparotomy)
- ☐ Electronic Fetal Monitoring
- ☐ Induction of Labor
- ☐ Tocolysis (Administration of any agent with the intent to inhibit preterm uterine contractions to extend length of pregnancy)
- ☐ External cephalic version (Attempted conversion of a fetus from a non-vertex presentation by external manipulation)
  - ☐ Successful ☐ Failed
- ☐ Stimulation of Labor
- ☐ Ultrasound
- ☐ Unknown
- ☐ Other (specify)

Labor

73. Onset of Labor (Check all that apply):

- ☐ None
- ☐ Premature Rupture of the Membranes (prolonged >=12 hours (Spontaneous tearing of the amniotic sac, (natural breaking of the bag of waters) 12 hours or more before labor begins))
- ☐ Precipitous labor (<3 hours) (Labor that progresses rapidly and last less than 3 hours)
- ☐ Prolonged labor (>=20 hours) (Labor that progresses slowly and last for 20 hours or more)
- ☐ Unknown

74. Characteristics of labor and delivery (Check all that apply):

- ☐ None
- ☐ Induction of labor (Initiation of uterine contractions by medical and\or surgical means for the purpose of delivery before the spontaneous onset of labor)
- ☐ Augmentation of labor (Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery)
- ☐ Non-vertex presentation (Includes any non-vertex fetal presentation, e.g. breech, shoulder, brow, face presentations, and transverse lie in the active phase of labor or at delivery other than vertex)
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery (Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to the mother as an anti-inflammatory treatment)
- ☐ Antibiotics received by the mother during labor (Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery)
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature > 38º C (100.4º F) (Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following; fever, uterine tenderness and/or irritability, leukocytosis and fetal tachycardia. Any maternal temperature at or above 38 º C (100.4 º F))
- ☐ Moderate/heavy meconium staining of the amniotic fluid (staining of the amniotic fluid caused by passage of fetal bowel contents during labor and\or at delivery which is more than enough to cause a greenish color change of an otherwise clear fluid)
- ☐ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery (In Utero Resuscitative measures such as any of the following: maternal position change, oxygen administration to the mother, intravenous fluids administered to the mother, amnioinfusion, support of maternal blood pressure and administration of uterine relaxing agents. Further fetal assessment includes any of the following: scalp pH, scalp stimulation, acoustic stimulation, Operative delivery- operative delivery intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery)
- ☐ Epidural or spinal anesthesia during labor (Administration to the mother of a regional anesthetic for control of the pain of labor i.e. delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body)
- ☐ Abruptio Placenta

Delivery

75. Method of delivery (The physical process by which the complete delivery of the infant was affected) (Complete A, B, C, and D):

A. Was delivery with forceps attempted but unsuccessful? (Obstetric forceps was applied to the fetal head in an unsuccessful attempt at vaginal delivery)

- ☐ Yes
- ☐ No
- ☐ Unknown

B. Was delivery with vacuum extraction attempted but unsuccessful? (Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery)

- ☐ Yes
- ☐ No
- ☐ Unknown

C. Fetal presentation at birth (Check one):

- ☐ Cephalic (Presenting part of the fetus listed as vertex, occipital anterior (OA), occipital posterior (OP))
- ☐ Breech (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech)
- ☐ Other (Specify) (Any other presentation not listed above) _____
- ☐ Unknown

D. Final route and method of delivery (Check one):

- ☐ Vaginal/Spontaneous (Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant)
- ☐ Vaginal/Forceps (Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head)
- ☐ Vaginal/Vacuum (Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head)
- ☐ Cesarean (Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls)

If cesarean, was a trial of labor attempted?

☐ Yes ☐ No

- ☐ Unknown

76. Maternal morbidity (Serious complications experienced by the mother associated with labor and delivery) (Check all that apply):

- ☐ None
- ☐ Maternal transfusion (Includes infusion of whole blood or packed red blood cells associated with labor and delivery).
- ☐ Third or fourth degree perineal laceration (3 laceration extends completely through the perinatal skin, vaginal mucosa, perineal body and anal sphincter. 4 laceration is all of the above with extension through the rectal mucosa)
- ☐ Ruptured uterus (Tearing of the uterine wall).
- ☐ Unplanned hysterectomy (Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy).
- ☐ Admission to intensive care unit (Any admission of the mother to a facility/unit designated as providing intensive care).
- ☐ Unplanned operating room procedure following delivery (Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations).
- ☐ Unknown at this time

77. Was the mother transferred to this facility for maternal medical or fetal indication prior to delivery? (Transfers include hospital to hospital, birth facility to hospital, etc.)

- ☐ Yes
- ☐ No
- ☐ Unknown

If "Yes," Transfer Facility: _____

78. Was infant transferred within 24 hours of delivery? (Check "yes" if the infant was transferred from this facility to another within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.)

- ☐ Yes
- ☐ No
- ☐ Unknown

If "Yes," Transfer Facility: _____

Newborn

79. Infant's medical record number: _____

80. Newborn Screening Requisition Number _____

81. Infant Birthweight

Pounds/Ounces: _____ OR Grams: _____

82. Apgar score (A systematic measure for evaluating the infant's physical condition at specific intervals at birth)

Score at **5** minutes _____ 0 through 10 ☐ Not Taken ☐ Unknown

Score at **10** minutes _____ 0 through 10 ☐ Not Taken ☐ Unknown

83. Obstetric estimate of gestation at delivery (completed weeks): (The birth attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam. Do not compute based on date of the last menstrual period and the date of birth).

_____ (weeks)

84. Plurality (Specify UNKOWN, SINGLE, TWIN, TRIPLET, QUADRUPLET, QUINTUPLET, SEXTUPLET, SEPTUPLET, or OCTUPLET for 8 or more. Include all live births and fetal losses resulting from this pregnancy):

_____

85. If not single birth (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc. and include all live births and fetal losses resulting from this pregnancy):

_____

86. If not single birth, specify number of infants in this delivery born alive:

_____

87. Type Prophylaxis used in eyes:

- ☐ AgNO3
- ☐ Erythromycin
- ☐ Ilotycin
- ☐ Penicillin
- ☐ Azithromycin
- ☐ Romycin
- ☐ None
- ☐ Not Reported
- ☐ Other Please Specify_____
- ☐ Yes, but not specified

88. Is infant living at time of report? (Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care.)

- ☐ Yes
- ☐ No
- ☐ Unknown

89. Is infant being breastfed at discharge?

- ☐ Yes
- ☐ No
- ☐ Unknown

Newborn Factors

90. **Abnormal conditions of the newborn** (Disorders or significant morbidity experienced by the newborn) (Check all that apply):

- ☐ None
- ☐ Assisted ventilation required immediately following delivery (Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes oxygen only and laryngoscopy for aspiration of meconium)
- ☐ Assisted ventilation required for more than 6 hours (Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours. Includes conventional, high frequency, and/or continuous positive pressure (CPAP)
- ☐ NICU admission (Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn)
- ☐ Newborn given surfactant replacement therapy (Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant)
- ☐ Antibiotics received by the newborn for suspected neonatal sepsis (Any antibacterial drug (e.g. penicillin, ampicillin, gentamicin, cefotaxime etc.) given systemically (intravenous or intramuscular)
- ☐ Seizure or serious neurological dysfunction (Seizure in any involuntary repetitive, convulsive movement of behavior. Serious neurologic dysfunction is severe alteration or alertness such as obtundation, stupor or coma, i.e. hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude systems associated with CNS congenital anomalies)
- ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) (Defined as present immediately following delivery or manifesting soon after delivery. Includes any bony fracture or weakness or loss of sensation, but excludes fractured clavicles and transient facial neve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes subgaleal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and\or extremity ecchymosis accompanied by evidence of anemia and/or hypovolemia and/or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma)

91. Congenital anomalies of the newborn (Malformations of the newborn diagnosed prenatal or after delivery) (Check all that apply):

- ☐ None of the anomalies listed
- ☐ Anencephaly (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect)
- ☐ Meningomyelocele/Spina bifida (Spina Bifida is herniation of the meninges and\or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do Not include Spina Bifida Occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges)
- ☐ Cyanotic congenital heart disease (Congenital heart defects which cause cyanosis. Includes but is limited to: transposition of the great arteries (vessels) tetralogy of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction)
- ☐ Congenital diaphragmatic hernia (Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity)
- ☐ Omphalocele (A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below) although this sac may rupture. Also called exomphalos. Do Not include umbilical hernia (completely covered by skin) in this category)

(List continues on next page)

- ☐ Gastroschisis (An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane)
- ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) (Complete or partial absence of a portion of an extremity associated with failure to develop)
- ☐ Cleft Lip with or without Cleft Palate (Incomplete closure of the lip. May be unilateral, bilateral or median)
- ☐ Cleft Palate alone (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of the cleft lip should be included in the "cleft lip with or without Cleft Palate" category above)
- ☐ Down Syndrome (Trisomy 21)

    - ☐ Karyotype Confirmed
    - ☐ Karyotype Pending
    - ☐ Karyotype Unknown

- ☐ Suspected other chromosomal disorder (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure)

    - ☐ Karyotype Confirmed
    - ☐ Karyotype Pending
    - ☐ Karyotype Unknown

- ☐ Hypospadias (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree- on the glans ventral to the tip, second degree- in the coronal sulcus, and third degree- on the penile shaft)
- ☐ Microcephalus
- ☐ Encephalocele
- ☐ Holoprosencephaly
- ☐ Anopthalmia/Micropthalmia
- ☐ Anotia/Microtia
- ☐ Choanal Atresia
- ☐ Trisomy 13 and 18
- ☐ Bladder Exstrophy
- ☐ Cloacal Exstrophy
- ☐ Congenital Posterior Urethral Valves
- ☐ Renal Agenesis/ Hypoplasia
- ☐ Esophageal Atresia/ Tracheoesophageal Fistula
- ☐ Intestinal Atresia/ Stenosis
- ☐ Unknown

Attendant/Certifier

92. Attendant's name

_____ _____ _____
First Middle Last

_____
Suffix (Jr., III, etc.)

93. Attendant's title:

- ☐ Physician
- ☐ Doctor of Osteopathy
- ☐ CNM/CM (Certified Nurse Midwife/Certified Midwife)
- ☐ Other Midwife (Midwife other than CNM/CM)
- ☐ Other (specify):_____

94. Attendant Address

Street Number_____ Pre Directional_____ ((E, N, NE, NW, S, SE, SW, W)

Street name _____ Street Designator_____

Post Directional _____ (E, N, NE, NW, S, SE, SW, W) Apt#, Suite#, etc:_____

Zip Code_____

City or Town_____ State_____ Country_____

95. Is the Certifier the same as the Attendant?

- ☐ Yes
- ☐ No (**If No, answer Certifier question)**

96. Certifier's name and title: (The individual who certifies to the fact that the birth occurred. May be, but need not be, the same as the attendant at birth)

_____ _____ _____
First Middle Last

_____
Suffix (Jr., III, etc.)

- ☐ Doctor of Medicine.
- ☐ Doctor of Osteopathy
- ☐ Hospital administrator or designee
- ☐ CNM/CM (Certified Nurse Midwife/Certified Midwife)
- ☐ Other Midwife (Midwife other than CNM/CM)
- ☐ Other (Specify) _____

97. Date certified: __ __/__ __/__ __ __ __ M M D D Y Y Y Y