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 purposes, other information from the birth certificate is used by health and medical researchers to study and improve the health of mothers 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.

TYPE OF BIRTH - PICK ONE:

☐ Born at Facility ☐ Born En-Route to Facility ☐ Born at Non Participating Facility
☐ Born En-Route to Non Participating Facility ☐ Home Birth ☐ Foundling

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

2. City, Town or Location of birth: _____

3. County of birth: _____

4. Place of birth:

☐ **Hospital** ☐ **Freestanding birthing center (freestanding birthing center is one that has no direct physical connection to a hospital)**
☐ **Home birth** **Planned to deliver at home?** ☐ **Yes** ☐ **No**
☐ **Clinic/Doctor's Office** ☐ **Other (specify, e.g., taxi cab, train, plane** _____
*Facilities may wish to have pre-set responses (hard-copy and/or electronic) to questions 1-5 for births which occur at their institutions.

5. Time of birth: _____

☐ **AM** ☐ **PM** ☐ **NOON** ☐ **MIDNIGHT**

6. Date of birth: ___ ___/___ ___/___ ___ ___ ___ M M D D Y Y Y Y

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

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

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

10. Sex (Male, Female, or Not yet determined): _____

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

_____

First Middle Last Suffix (Jr., III, etc.)

12. MOTHER: What is your current legal name?

_____ _____ _____ _____

First **Middle** **Last** **Suffix (Jr., III, etc.)**

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

Building number: _____ Pre-directional _____
Name of street _____
Street Designator, eg Street, Avenue, etc. _____
Post Directional _____ Apartment Number _____
State: _____(or U.S. Territory, Canadian Province)
If not United States, *Country* _____
City, Town, or Location:_____ County: _____ Zip: _____

14. Is this household inside city limits (inside the incorporated limits of the city, town or location where you live)? ☐ Yes ☐ No ☐ Don't know

15. MOTHER: What is your mailing address? ☐ Same as residence [Go to next question]

Building number: _____ Pre-directional _____
Name of street _____
Street Designator, eg Street, Avenue, etc. _____
Post Directional _____ Apartment Number _____
State: _____(or U.S. Territory, Canadian Province)
If not United States, *Country* _____
City, Town, or Location:_____ County: _____ Zip: _____

16. MOTHER: What is your date of birth? (Example: 03-04-1977)

___ ___/___ ___/___ ___ ___ ___ M M D D Y Y Y Y **AGE:** _____

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

State _____County _____ City _____
OR U.S. territory, i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas
_____ OR Foreign country _____
☐ **UNKNOWN**

18. MOTHER: What is your Social Security Number?

_____ _____ _____--_____ _____--_____ _____ _____ _____

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

☐ **Yes (Please sign request below)** ☐ **No (Continue)**

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 father_____
Date: ___ ___/___ ___/___ ___ ___ ___ M M D D Y Y Y Y

20. Will infant be placed for Adoption?

☐ Yes ☐ No

21. MOTHER: 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)

22. MOTHER: 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.

Usual Occupation: _____

Usual Industry: _____

☐ Unemployed ☐ Unknown

23. MOTHER: Are you Spanish/Hispanic/Latina? If not Spanish/Hispanic/Latina, check the "No" box. If Spanish/Hispanic/Latina, check the appropriate box.

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

24. MOTHER: What is your race? (Please check all that apply).

- ☐ White ☐ Black or Af rican 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) _____

MOTHER: Additional Information To Be Filled In If A PATERNITY AFFIDAVIT IS TO BE FILED FOR THIS BIRTH If Not Filing Paternity Affidavit skip to question 30.

25. What is Your Phone Number? Required _____

26. What is the name of your Employer (Company name)? Optional

_____

27. What is your Employer's address? Optional

_____

28. What is the name of your Medical Insurance Company? Optional

_____

29. What is your Medical Insurance Policy number? Optional

_____

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

☐ Yes ☐ No ☐ Unknown

31. MOTHER: What is your height? _____feet _____ inches

32. MOTHER: What was your pre-pregnancy weight, that is, your weight immediately before you became pregnant with this child? _____lbs.

33. Mother's weight at delivery _____lbs.

34. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY: 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 _____

35. CURRENT MARITAL STATUS

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

36. Mother's name prior to her first marriage, (Maiden Name)

_____

First Middle Last Suffix

37. MOTHER'S Marital Status, ARE YOU MARRIED TO THE FATHER OF YOUR CHILD?

☐ Yes [Please go to question 39

☐ No [Please go to question 38

38. If not married, has a Paternity Affidavit been completed for this child?

☐ Yes, a paternity affidavit has been completed
If Yes Date Affidavit was signed: ___ ___/___ ___/___ ___ ___ ___

☐ No, a paternity affidavit has not been completed
If No please go to question 53

39. FATHER'S CURRENT LEGAL NAME

_____ _____ _____ _____

First Middle Last Suffix(Jr., III, etc.)

40. FATHER: What is the father's date of birth? (Example: 03-04-1977)

___ ___/___ ___/___ ___ ___ ___M M D D Y Y Y Y **AGE:** _____

41. FATHER: In what State, U.S. territory, or foreign country was he born? Please specify one of the following:

State _____ County _____ City _____
OR U.S. territory, i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas
_____ OR Foreign country _____

☐ UNKNOWN

42. What is the father's Social Security Number? If you are not married, or if a paternity acknowledgment has not been completed, leave this item blank.

_____ _____ _____—_____ _____---_____ _____ _____ _____

43. What is the highest level of schooling that the FATHER will have completed at the time of delivery? (Check the box that best describes his education. If he is 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)

44. What is the father's usual occupation or industry. Please fill in below. For example his occupation is Photographer, Farmer, Nurse, etc., and the industry in which he works is Factory, Skating Rink, Army, etc.

Usual Occupation: _____

Usual Industry: _____

☐ Unemployed ☐ Unknown

45. Is the father Spanish/Hispanic/Latino? If not Spanish/Hispanic/Latino, check the "No" box. If Spanish/Hispanic/Latino, check all that apply.

☐ 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)_____

46. What is the father's race? Please check one or more races to indicate what he considers himself to be.

☐ 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) _____

FATHER Additional Information To Be Filled In If A PATERNITY AFFIDAVIT IS TO BE FILED FOR THIS BIRTH If Not Filing Paternity Affidavit skip to question 53

47. What is Your Phone Numbert? Information is required _____

48. What is Your Current AddressNumber, Street, City, State and Zip Information is required

_____

49. What is the name of your Employer (Company name)? Information is optional

_____

50. What is your Employer's address? Information is optional

_____

51. What is the name of your Medical Insurance Company? Information is optional

_____

52. FATHER What is your Medical Insurance Policy Number Information is optional

_____

53. DID MOTHER RECEIVE PRENATAL CARE?

☐ YES ☐ NO ☐ UNKNOWN

54. 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

55. 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

56. Source of pre-natal care?

☐ MD ☐ DO ☐ Clinic ☐ Other, Specify: _____

57. Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record. If none enter "0"): _____

58. Date last normal menses began: ___ ___ ___ ___ ___ ___ ___ ___ M M D D Y Y Y Y

59. 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.

_____

60. 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. _____

61. Date of last live birth _____ _____/_____ _____ _____ _____ M M Y Y Y Y

62. Total number of other pregnancy outcomes (Include fetal losses of any gestational age-spontaneous losses, induced losses, 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.: _____

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

____ ____/____ ____ ____ ____ MMYYYY

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

☐ None

Diabetes - (Glucose intolerance requiring treatment)

☐ Prepregnancy - (Diagnosis prior to this pregnancy)

☐ Gestational - (Diagnosis in this pregnancy)

Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition.)

☐ Prepregnancy - (Chronic) (Elevation of blood pressure above normal for age, gender, and physiological condition) (Diagnosed prior to the onset of this pregnancy)

☐ 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 contuining 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 – Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs(e.g. Clomid, Pergonal) artifical insemination, or intrauterine insemation and assisted reproduction technology (ART) procedures(e.g. IVF, GIFT and ZIFT)

☐ Fertility enhancing drugs, artificial insemination, intrauterine insemination (Any fertility-enhancing drugs(e.g. Clomid, Pergonal) artifical insemination, or intrauterine insemation used to initate the pregnancy.

☐ Assisted reproductive technology – Any assisted reproduction technology (ART) technical procedures(e.g. in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT) used to initate 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____

☐ Antiretrovirals administered during pregnancy or at delivery

☐ Group B Strep

65. 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
☐ 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)

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

☐ **YES** **If Yes give the date the specimen was taken: _____(MMDDYYYY)**

If Yes when was the test performed? ☐ **During pregnancy** ☐ **Time of Delivery**

☐ **NO** **If No give 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.)**

67. 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
☐ 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)
☐ 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

68. Were precautions taken against ophthalmia neonatorum? ☐ **Yes** ☐ **No**

If Yes, then specify the Medication Used: _____

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

☐ **YES If Yes give the date the specimen was taken:**_____**(MMDDYYYY)**

If Yes when was the test performed? ☐ **During pregnancy** ☐ **Time of Delivery**

☐ **NO If No give reason (check one below)**

☐ **Mother's Refusal** ☐ **Syphilis Status Known**

☐ **Other (specify):**_____

☐ **Unknown (Reason why there was no test is unknown)**

Unknown (Unknown whether or not the test was performed)

70. 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

71. 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 accerlate 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 chroniamninitis 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 C (100.4 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 Resucative 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 anesthic 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

72. 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

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

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 - (Any other presentation not listed above)

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? (Labor was allowed, augmented or induced with plans for a vaginal delivery)

  ☐ Yes ☐ No

73. 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.)

74. Birthweight:

GRAMS: _____ or **POUNDS/OUNCES:** _____

75. 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)

76. 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

If 5 minute score **is less than 6**:

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

77. 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 six hours (Infant given mechanical ventilation (breathing assistance) by any method for > 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. pencillin, ampicillin, gentamicin, cefotoxine 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, stipor or coma , i.e. hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the bascence of other neurologic findings. Exclude systems associated with CNS congential 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 sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and\or extremity echymosis 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)

78. 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 abscent 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) tetratology of Fallott , 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 hernation of abdominal organs into the thoracic cavity)

- ☐ Omphalocele (A defect in the anterior abdominal wall, accompanied by hernation of some abdominal organs through a widened umbilibal 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)

☐ Gastroschisis (An abnormalitiy of the anterior abdominal wall, lateral to the umbilicus, resulting in hernation 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
- ☐ Unknown

☐ Suspected 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

☐ 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 thried degree- on the penile shaft)

☐ Microcephaly

79. 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, name of facility infant transferred to:_____

80. 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 ☐ Infant transferred, status unknown

81. Is infant being breastfed at discharge?

☐ Yes ☐ No ☐ Unknown

82. Hepatitis B Immunization given?

☐ Yes ☐ No ☐ Unknown

If Yes, Date given: _____ _____/_____ _____/_____ _____ _____ _____

83. Attendant's name, title, and N.P.I

_____

Attendant's name

Attendant's title:

☐ M.D. ☐ D.O. ☐ CNM/CM - (Certified Nurse Midwife/Certified Midwife)

☐ Other Midwife - (Midwife other than CNM/CM)

☐ Other specify):_____

84. Is the Certifier the same as the Attendant

☐ Yes ☐ No ☐ Unknown

If NO answer Certifier question

85. 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.)

☐ M.D. ☐ D.O. ☐ Hospital administrator or designee

☐ CNM/CM (Certified Nurse Midwife / Certified Midwife)

☐ Other Midwife (Midwife other than CNM/CM)

☐ Other (Specify)_____

86. Date certified: _ _ _ _ _ _ _ _ M M D D Y Y Y Y

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

☐ Private Insurance

☐ Medicaid (Comparable State program)

☐ Self-pay (No third party identified)

☐ Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal,state, local))

_____

88. Infant's medical record number: _____

89. Newborn Screening Number: _____

If Unknown check reason why ☐ **Religious Waiver**

90. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?

(Transfers include hospital to hospital, birth facility to hospital, etc.)

☐ Yes ☐ No

If Yes, enter the name of the facility mother transferred from:

_____