**Mother’s medical record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mother’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Child’s medical record # \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FACILITY WORKSHEET FOR THE LIVE BIRTH CERTIFICATE**

**Child’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Plurality: \_\_\_\_ Birth Order: \_\_\_\_**

**Facility**

1. **Place of birth:**

🞎 Hospital/Birthing Center (Please go to Question #3)

🞎 Clinic/Doctor’s Office

🞎 En Route (Please go to Question #3)

🞎 Freestanding Birth Center

🞎 Home Birth (Intended)

🞎 Home Birth (Not Intended)

🞎 Other \* (specify, e.g., taxi cab, car, plane, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*(If Home birth or Other, please complete Question #2)

1. **Address of birth (if Home Birth or Other is marked):**

State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, Town, or Township: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Apartment Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code/Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Principal source of payment for this delivery** (At time of delivery):
2. 🞎 Health insurance through Private insurance current or former employer or union.
3. 🞎 Other Government
4. 🞎 Medicaid – (Please refer to the Medicaid Card Example Tip Sheet)
5. 🞎 Purchased directly
6. 🞎 Uninsured
7. 🞎 Unknown
8. 🞎 Champus/Tricare

🞎 Other (Specify, e.g., Indian Health Service) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Prenatal**

**Sources: Prenatal care records, mother’s medical records, labor and delivery records**

**Information for the following items should come from the mother’s prenatal care records and from other medical reports in the mother’s chart, as well as the infant’s medical record. If the mother’s prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record, or a copy of the prenatal care information. Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.**

1. **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

Unknown portions of the date should be entered as “99”

🞎 No prenatal care(Please go to Question #6)

🞎 Unknown

1. **Date of last prenatal care visit** (Enter the date of the last visit as recorded in the mother’s prenatal records):

\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

M M D D Y Y Y Y

Unknown portions of the date should be entered as “99”

🞎 Unknown

1. **Total number of prenatal care visits for this pregnancy** (Count only those visits recorded in the record. If none enter “0”): \_\_\_\_\_\_\_\_\_\_\_\_

🞎 Unknown

1. **Date last normal menses began:**

\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

M M D D Y Y Y Y

Unknown portions of the date should be entered as “99”

🞎 Unknown

1. **Pregnancy / Ultrasound Dating**
2. 🞎 Ultrasound BEFORE or = 20 weeks gestation
3. 🞎 Ultrasound AFTER 20 weeks gestation
4. 🞎 NO ultrasound performed
5. **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):

\_\_\_\_ Number

🞎 Unknown

1. **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):

\_\_\_\_ Number

🞎 Unknown

1. **Date of last live birth:**

\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

M M D D Y Y Y Y

Unknown portions of the date should be entered as “99”

🞎 Unknown

1. **Total number of other pregnancy outcomes** (Include fetal losses of any gestational age)

\_\_\_\_ Number

🞎 Unknown

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

\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

M M D D Y Y Y Y

Unknown portions of the date should be entered as “99”

🞎 Unknown

**Pregnancy**

**Sources: Prenatal care records, mother’s medical records, labor and delivery records**

1. **Risk factors in this pregnancy** (Check all that apply):
2. 🞎 None
3. 🞎 Pre-pregnancy diabetes
4. 🞎 Gestational diabetes
5. 🞎 Pre-pregnancy hypertension (chronic)
6. 🞎 Gestational hypertension w/o eclampsia
7. 🞎 Eclampsia
8. 🞎 Previous preterm births – (a live birth of less than 37 weeks of gestation)
9. 🞎 Other previous poor pregnancy outcome (Please see desk reference for conditions covered)
10. 🞎 Infertility Treatment

🞎 Fertility enhancing drugs. Al or intrauterine insemination

🞎 Assisted reproductive technology

🞎 Pregnancy resulted from assisted reproductive technology

1. 🞎 Mother had a previous cesarean delivery

If Yes, how many\_\_\_\_

Which of the following has the mother ever had? Check all that apply

🞎 Prior Low Transverse or LTCS

🞎 Prior Classical or Vertical CS

🞎 Prior Uterine Rupture

🞎 Prior Uterine Window

🞎 None of the Above

1. 🞎 Anemia (Hct,30/Hgb. < 10)
2. 🞎 Cardiac Disease
3. 🞎 Acute or Chronic Lung Disease
4. 🞎 Polyhydramnios (excessive amniotic fluid) / Oligohydramnios (reduced amniotic fluid)
5. 🞎 Hemoglobinopathy
6. 🞎 IUGR (Suspected prenatally)
7. 🞎 Renal (Kidney) disease
8. 🞎 Cholestasis
9. 🞎Blood group Allo-immunization
10. 🞎Prior non-pregnant uterine surgery
11. **Infections present and/or treated during this pregnancy** – (Check all that apply):
    1. 🞎 None
    2. 🞎 Bacterial Vaginosis
    3. 🞎 Chlamydia
    4. 🞎 CMV
    5. 🞎 Gonorrhea
    6. 🞎 Hepatitis B
    7. 🞎 Hepatitis C
    8. 🞎 Herpes Simplex Virus
    9. 🞎 In Utero Infection (TORCHS)
    10. 🞎 Maternal Group B Strep Colonization
    11. 🞎 Measles
    12. 🞎 Mumps
    13. 🞎 PID
    14. 🞎 Rubella
    15. 🞎 Syphilis
    16. 🞎 Trichimoniasis
    17. 🞎 Toxoplasmosis
    18. 🞎 Varicella
    19. 🞎 HIV
12. **Obstetric procedures** – (Check all that apply):
    1. 🞎 None
    2. 🞎 External cephalic version - Successful
    3. 🞎 External cephalic version – Failed
    4. 🞎 Cervical cerclage
    5. 🞎 Tocolysis
13. **Progesterone – Did Mother receive Progesterone in any form to prevent prematurity?**

🞎 Yes 🞎 No

**Labor and Delivery**

**Sources: Labor and delivery records, mother’s medical records**

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

🞎 Yes\* 🞎 No

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Onset of Labor** (Check all that apply):
   1. 🞎 None
   2. 🞎 Premature Rupture of the Membranes (prolonged >=12 hours)
   3. 🞎 Precipitous labor (<3 hours)
   4. 🞎 Prolonged labor (>=20 hours)
2. **Date of birth:**

\_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_ \_\_

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1. **Time of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** 24 hour military format
2. **Attendant’s name, title, and N.P.I.** (National Provider Identifier) (The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attendant’s name N.P.I.

**Attendant’s title:**

🞎 CNM/CM - (Certified Nurse Midwife/Certified Midwife)

🞎 D.O.

🞎 EMT

🞎 M.D.

🞎 NURSE (RN, LPN, NC)

🞎 NURSE PRACTITIONER

🞎 Other specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

🞎 PHYSICIAN’S ASSISTANT

🞎 UNKNOWN

1. **Mother’s weight at delivery** (pounds):\_\_\_\_\_\_\_\_\_\_\_\_
2. **Characteristics of labor and delivery** (Check all that apply):
   1. 🞎 None
   2. 🞎 Induction of labor
   3. 🞎 Augmentation of labor
   4. 🞎 Non-vertex presentation
   5. 🞎 Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
   6. 🞎 Antibiotics received by the mother during labor
   7. 🞎 Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F)
   8. 🞎 Moderate/heavy meconium staining of the amniotic fluid
   9. 🞎 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
   10. 🞎 Epidural or spinal anesthesia during labor
   11. 🞎 Abruptio Placenta
   12. 🞎 Placenta Previa
   13. 🞎 Cephalopelvic disproportion
   14. 🞎 Other excessive bleeding
   15. 🞎 Cord prolapse
   16. 🞎 Anesthetic complications
3. **Method of delivery:**
4. Was delivery with forceps attempted but unsuccessful?

🞎 Yes 🞎 No 🞎 Unknown

1. Was delivery with vacuum extraction attempted but unsuccessful?

🞎 Yes 🞎 No 🞎 Unknown

1. Fetal presentation at birth (Check one):

🞎 Breech 🞎 Cephalic 🞎 Other

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

🞎 Cesarean – (no labor attempted)

🞎 Cesarean – (labor attempted)

🞎 Vaginal/Forceps

🞎 Vaginal/Spontaneous

🞎 Vaginal/Vacuum

1. **Maternal morbidity** (Check all that apply):
   1. 🞎 None
   2. 🞎 Maternal transfusion
   3. 🞎 Third or fourth degree perineal laceration
   4. 🞎 Ruptured uterus
   5. 🞎 Unplanned hysterectomy
   6. 🞎 Admission to intensive care unit
   7. 🞎 Unplanned operating room procedure following delivery

**Newborn**

**Sources: Labor and delivery records, Newborn’s medical records, mother’s medical records**

1. **Infant’s medical record number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Birth weight**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (grams) (Do not convert lb/oz to grams)

If weight in grams is not available, birth weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (lb/oz)

1. **Obstetric estimate of gestation at delivery:** Completed Weeks: \_\_\_\_\_\_\_\_ Days \_\_\_\_\_\_\_\_\_
2. **Sex:** 🞎 Male 🞎 Female 🞎 Undetermined
3. **Apgar score**

Score at **5** minutes \_\_\_\_\_\_\_ 🞎 Unknown

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

Score at **10** minutes \_\_\_\_\_\_\_ 🞎 Unknown

1. **Plurality** (Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.) (Include all live births and fetal losses resulting from this pregnancy.):

\_\_\_\_\_\_\_\_

1. **Order of Delivery** (Order delivered in this pregnancy; specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Note: Delivery includes all live births and fetal losses resulting from this pregnancy):

\_\_\_\_\_\_\_\_\_

1. **If not single birth, for this delivery specify:**

Number born alive: \_\_\_\_\_\_\_

Number of fetal deaths: \_\_\_\_\_\_\_

1. **Metabolic Kit Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Name of Prophylactic Used in Eyes of Child (**Check one):
   1. 🞎 Ilotycin Ophthalmic
   2. 🞎 Ilotycin Ointment
   3. 🞎 Ilotycin
   4. 🞎 Erythromycin Ophthalmic
   5. 🞎 Erythromycin Ointment
   6. 🞎 Erythromycin
   7. 🞎 AGNO3 (Silver Nitrate)
   8. 🞎 Neosporin
   9. 🞎 EES
   10. 🞎 Colostrum
   11. 🞎 Boric Acid
   12. 🞎 Breast Milk
   13. 🞎 Unknown
   14. 🞎 None

🞎 Other (Specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Abnormal conditions of the newborn** (Check all that apply):
   1. 🞎 None
   2. 🞎 Assisted ventilation required immediately following delivery
   3. 🞎 Assisted ventilation required for more than six hours
   4. 🞎 NICU admission
   5. 🞎 Newborn given surfactant replacement therapy
   6. 🞎 Antibiotics received by the newborn for suspected neonatal sepsis
   7. 🞎 Seizure or serious neurologic dysfunction
   8. 🞎 Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
2. **Congenital anomalies of the newborn** (Check all that apply):
   1. 🞎 None
   2. 🞎 Anencephaly
   3. 🞎 Craniofacial Anomalies
   4. 🞎 Meningomyelocele / Spina bifida
   5. 🞎 Hydrocephalus w/o Spina bifida
   6. 🞎 Encephalocele
   7. 🞎 Microcephalus
   8. 🞎 Cyanotic congenital heart disease
   9. 🞎 Tetralogy of Fallot
   10. 🞎 Congenital diaphragmatic hernia
   11. 🞎 Omphalocele
   12. 🞎 Gastroschisis
   13. 🞎 Bladder exstrophy
   14. 🞎 Rectal/large intestinal atresia/stenosis
   15. 🞎 Hirshsprung’s disease
   16. 🞎 Congenital hip dislocation
   17. 🞎 Amniotic bands
   18. 🞎 Limb reduction defect
   19. 🞎 Congenital cataract
   20. 🞎 Cleft Lip with/without Cleft Palate
   21. 🞎 Cleft Palate alone
   22. 🞎 Down Syndrome – Karyotype pending
   23. 🞎 Down Syndrome –Karyotype confirmed
   24. 🞎 Suspected chromosomal disorder – Karyotype confirmed
   25. 🞎 Suspected chromosomal disorder Karyotype pending
   26. 🞎 Hypospadias
3. **Was infant transferred within 24 hours of delivery?**

🞎 Yes\* 🞎 No

\*If Yes, enter the name of the facility infant was transferred to:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Is infant living at time of report?**

🞎 Yes 🞎 No 🞎 Infant transferred, status unknown

If No, complete a death record.

1. **Is infant being breastfed at discharge?**

🞎 Yes 🞎 No 🞎 Unknown

1. **Exclusive breast milk feeding through entire stay?**

🞎 Yes 🞎 No