

For hospital use only:

Mother's Medical Record # \_\_\_\_\_

Mother's Name \_\_\_\_\_

Newborn's Date of Birth \_\_\_\_\_

Newborn's Medical Record # \_\_\_\_\_

## Mother's Worksheet for Child's Birth

The information you provide below will be used to create your child's birth certificate as well as other public health purposes. The birth certificate is a document that will be used for important purposes including proving your child's age, citizenship and parentage. The birth certificate will be used by your child throughout his/her life.

It is very important that you provide complete and accurate information to all of the questions. In addition, this information is used by health and medical researchers to study and improve the health of mothers and newborn infants. Items such as education, race, and smoking will be used for studies but will not appear on copies of your child's birth certificate (unless requested by a person listed in the certificate). State of Ohio law provides protection against the unauthorized release of health and medical information, but mandates the release of identifying information from the birth certificate under public record law.

### Please print clearly.

Newborn's Sex  Male  Female  Undetermined

Newborn's Date of Birth \_\_\_\_\_

Was this delivery a:  single birth  multiple birth (twins, triplets, etc.)

If multiple, this worksheet is for baby:  A (first born)  B (second born)  C (third born)  D (fourth born)

1. What will be your baby's legal name (as it should appear on the birth certificate)? Special accents, excluding numbers, are allowed on your child's name. Please note that other government agencies (such as social security); will not be able to accommodate these special characters when reprinting your child's name.

\_\_\_\_\_ First

\_\_\_\_\_ Middle

\_\_\_\_\_ Last

\_\_\_\_\_ Suffix

Name not yet chosen

2. What is your current legal name?

\_\_\_\_\_ First

\_\_\_\_\_ Middle

\_\_\_\_\_ Last

\_\_\_\_\_ Suffix

3. What was your last name prior to your first marriage (maiden name, surname, family name, or your name as it appears on your birth certificate)?

\_\_\_\_\_ Maiden Name/Surname

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

United States or Canada  Outside of the United States\*

\*If NOT United States or Canada, country: \_\_\_\_\_ [Please go to Question #6]

If United States or Canada, please list your state, Province, or U.S. territory: \_\_\_\_\_

County (if applicable): \_\_\_\_\_

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

Street address: \_\_\_\_\_

Apartment Number: \_\_\_\_\_

Zip Code/Postal Code: \_\_\_\_\_

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

Yes     No     Don't know

6. What is your mailing address? This is the address where your child's Social Security card will be sent if requested.

Same as residence [Go to Question #7]

Complete number and street: \_\_\_\_\_

Apartment Number: \_\_\_\_\_ P. O. Box. \_\_\_\_\_

City, Town, or Location: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code or Postal Code: \_\_\_\_\_

(or U.S. Territory, Canadian Province)

If not in the United States, *country* \_\_\_\_\_

7. What is the telephone number that someone can contact you at?

Primary Phone Number: \_\_\_\_\_  
Area Code    Phone Number

Secondary Phone Number: \_\_\_\_\_  
Area Code    Phone Number

work phone number  
 cell phone number  
 relative

I have no phone number where I can be contacted.

8. What is your date of birth? (Example: 03 - 24 - 1977 for March 24, 1977)

\_\_\_\_\_  
Month            Day            Year

Unknown

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

If born in the United States or US Territory (i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern or the Marianas), please list the state or U.S. Territory: \_\_\_\_\_

or,

If born outside of the United States, please list the foreign country \_\_\_\_\_

Unknown

10. What is the highest level of schooling that you will have completed at the time of delivery?

- |                                                                                  |                                                                                             |
|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| 1. <input type="checkbox"/> 8 <sup>th</sup> grade or less                        | 5. <input type="checkbox"/> Associate's degree (e.g. AA, AS)                                |
| 2. <input type="checkbox"/> No diploma, 9 <sup>th</sup> – 12 <sup>th</sup> grade | 6. <input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS)                             |
| 3. <input type="checkbox"/> High school graduate or GED completed                | 7. <input type="checkbox"/> Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)              |
| 4. <input type="checkbox"/> Some college credit, but no degree                   | 8. <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS) |
|                                                                                  | 9. <input type="checkbox"/> Unknown                                                         |

11. Are you Spanish/Hispanic/Latina? If not Spanish/Hispanic/Latina, check the "No" box. If Spanish/Hispanic/Latina, check the appropriate box or boxes.

- 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, Colombian) (specify) \_\_\_\_\_
- Unknown

12. What is your race? (Please check one or more races to indicate what you consider yourself to be.)

- White
- Black or African American
- American Indian or Alaska Native (name of enrolled or principal tribe) \_\_\_\_\_
- Asian Indian (e.g. Cambodian, Vietnamese, Laotian)
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian (specify) \_\_\_\_\_
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander (specify) \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- Unknown

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

- No       Yes       Unknown

14. What is your height?

\_\_\_\_\_ feet \_\_\_\_\_ inches       Unknown



**21. In what State, U.S. territory, or foreign country was the father born? Please specify one of the following:**

If born in the United States or US Territory (i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern or the Marianas), please list the state or U.S. Territory: \_\_\_\_\_

or,  
If born outside of the United States, please list the foreign country \_\_\_\_\_

Unknown

**22. What is the highest level of schooling that the father will have completed at the time of delivery?**

- |                                                                                  |                                                                                             |
|----------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| 1. <input type="checkbox"/> 8 <sup>th</sup> grade or less                        | 5. <input type="checkbox"/> Associate's degree (e.g. AA, AS)                                |
| 2. <input type="checkbox"/> No diploma, 9 <sup>th</sup> – 12 <sup>th</sup> grade | 6. <input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS)                             |
| 3. <input type="checkbox"/> High school graduate or GED completed                | 7. <input type="checkbox"/> Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)              |
| 4. <input type="checkbox"/> Some college credit, but no degree                   | 8. <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS) |
|                                                                                  | 9. <input type="checkbox"/> Unknown                                                         |

**23. Is the father Spanish/Hispanic/Latino? If not Spanish/Hispanic/Latino, check the "No" box. If Spanish/Hispanic/Latino, check the appropriate box or boxes.**

- 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, Colombian) (specify) \_\_\_\_\_
- Unknown

**24. 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 (e.g. Cambodian, Vietnamese, Laotian)
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian (specify) \_\_\_\_\_
- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander (specify) \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- Unknown

25. Furnishing parent(s) Social Security Number(s) (SSNs) is required by Federal Law, 42 USC 405(c)(section 205(c) of the Social Security Act). The number(s) will be made available to the (State Social Services Agency) to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance. The SSN is also collected as authorized by Ohio law to be use for public health purposes.

25a. What is your Social Security Number? IF you do not have a Social Security Number, please mark "None".

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None

25b. What is the father's Social Security Number? If you are not married AND an Acknowledgement of Paternity has not been completed, please leave this item blank. If the father does not have a Social Security Number, please mark "None".

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None

26a. Do you want a Social Security Number issued for your child?

- Yes [Please sign request below]
- No [Go to Question #27]

26b. 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.

*I understand that if I was married at any time during the 300 days prior to the birth of my child, and I refuse to list my husband as the father, and do not have legal documentation (court order, separation agreement, journal entry, divorce decree) stating that my husband is not to be listed as the father of my child, my child's birth information will not be electronically transmitted to receive a Social Security number.*

Signature of mother \_\_\_\_\_ Date \_\_\_\_\_

27. What is the name and relationship of the person providing information for this worksheet?

- Mother of the child     Father of the child
- Other, please specify \_\_\_\_\_

28. What is your primary language – that is – what language do you feel the most comfortable speaking?

- English     - Spanish     - Somali
- Other, please specify \_\_\_\_\_

**Please return your completed birth certificate worksheet to:**

XXXXXXXXXXXXXXXXXXXXXXXXXXXX

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: \_\_\_\_\_

**1. Place of birth:**

- Hospital/Birthing Center (Please go to Question #3)
- En Route (Please go to Question #3)
- Home birth\*
  - Planned to deliver at home  Yes  No
- Other \* (specify, e.g., taxi cab, car, plane, etc.) \_\_\_\_\_

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

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

State: \_\_\_\_\_  
 County: \_\_\_\_\_  
 City, Town, or Township: \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 Apartment Number: \_\_\_\_\_ Zip Code/Postal Code: \_\_\_\_\_

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

- a.  Health insurance through Private insurance current or former employer or union.
- b.  Medicare
- c.  Medicaid – (e.g. Healthy Start, Medicaid waiver programs, disability assistance, Healthy Families)
- d.  Purchased directly
- e.  Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal, state, local)) \_\_\_\_\_
- f.  Uninsured
- g.  Unknown

## 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.

- 4. 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):

                             Unknown portions of the date should be entered as "99"  
 No prenatal care (Please go to Question #6)  
 Unknown

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

                             Unknown portions of the date should be entered as "99"  
 Unknown

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

Unknown

- 7. Date last normal menses began:**

                             Unknown portions of the date should be entered as "99"  
 Unknown

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

\_\_\_\_\_ Number  
 Unknown

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

\_\_\_\_\_ Number  
 Unknown

- 10. Date of last live birth:**

                             Unknown portions of the date should be entered as "99"  
 Unknown

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

\_\_\_\_ Number  
 Unknown

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

                             Unknown portions of the date should be entered as "99"  
 Unknown

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

- a.  None
- b.  Prepregnancy diabetes
- c.  Gestational diabetes
- d.  Prepregnancy hypertension (chronic)
- e.  Gestational hypertension w/o eclampsia
- f.  Eclampsia
- g.  Previous preterm births – (a live birth of less than 37 weeks of gestation)
- h.  Other previous poor pregnancy outcome (Please see desk reference for conditions covered)
- i.  Pregnancy resulted from fertility-enhancing drugs, artificial insemination or intrauterine insemination
- j.  Pregnancy resulted from assisted reproductive technology
- k.  Mother had a previous cesarean delivery  
If Yes, how many \_\_\_\_\_
- l.  Anemia (Hct,30/Hgb. < 10)
- m.  Cardiac Disease
- n.  Acute or Chronic Lung Disease
- o.  Hydramnios/Oligohydramnios
- p.  Hemoglobinopathy
- q.  Unknown

**14. Infections present and/or treated during this pregnancy** – (Check all that apply):

- a.  None
- b.  Bacterial Vaginosis
- c.  Chlamydia
- d.  CMV
- e.  Gonorrhea
- f.  Hepatitis B
- g.  Hepatitis C
- h.  Herpes Simplex Virus
- i.  In Utero Infection (TORCHS)
- j.  Maternal Group B Strep Colonization
- k.  Measles
- l.  Mumps
- m.  PID
- n.  Rubella
- o.  Syphilis
- p.  Trichinosis
- q.  Toxoplasmosis
- r.  Varicella
- s.  Unknown

**15. Obstetric procedures** – (Check all that apply):

- a.  None
- b.  External cephalic version - Successful
- c.  External cephalic version - Failed
- d.  Cervical cerclage
- e.  Tocolysis
- f.  Unknown

## Labor and Delivery

Sources: Labor and delivery records, mother's medical records

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

Yes\*  No  Unknown

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

\_\_\_\_\_

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

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

- a.  None
- b.  Premature Rupture of the Membranes (prolonged  $\geq 12$  hours)
- c.  Precipitous labor ( $< 3$  hours)
- d.  Prolonged labor ( $\geq 20$  hours)
- e.  Unknown

18. Date of birth:

                         
M M D D Y Y Y Y

19. Time of birth: \_\_\_\_\_ 24 hour clock

Unknown

20. 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:

- a.  M.D.
- b.  D.O.
- c.  CNM/CM -(Certified Nurse Midwife/Certified Midwife)
- d.  Other Midwife - (Midwife other than CNM/CM)
- e.  Other specify): \_\_\_\_\_

21. Mother's weight at delivery (pounds): \_\_\_\_\_

Unknown

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

- a.  None
- b.  Induction of labor
- c.  Augmentation of labor
- d.  Non-vertex presentation
- e.  Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- f.  Antibiotics received by the mother during labor
- g.  Clinical chorioamnionitis diagnosed during labor or maternal temperature  $\geq 38^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ )
- h.  Moderate/heavy meconium staining of the amniotic fluid
- i.  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
- j.  Epidural or spinal anesthesia during labor
- k.  Abruptio Placenta
- l.  Placenta Previa
- m.  Cephalopelvic disproportion
- n.  Other excessive bleeding
- o.  Cord prolapse
- p.  Anesthetic complications
- q.  Unknown

**23. Method of delivery:**

- A. Was delivery with forceps attempted but unsuccessful?  
 Yes  No  Unknown
- B. Was delivery with vacuum extraction attempted but unsuccessful?  
 Yes  No  Unknown
- C. Fetal presentation at birth (Check one):  
 Cephalic  Breech  Other  Unknown
- D. Final route and method of delivery (Check one):
  - a.  Vaginal/Spontaneous
  - b.  Vaginal/Forceps
  - c.  Vaginal/Vacuum
  - d.  Cesarean – (no labor attempted)
  - e.  Cesarean – (labor attempted)
  - f.  Unknown

**24. Maternal morbidity (Check all that apply):**

- a.  None
- b.  Maternal transfusion
- c.  Third or fourth degree perineal laceration
- d.  Ruptured uterus
- e.  Unplanned hysterectomy
- f.  Admission to intensive care unit
- g.  Unplanned operating room procedure following delivery
- h.  Unknown

## Newborn

Sources: Labor and delivery records, Newborn's medical records, mother's medical records

25. Infant's medical record number: \_\_\_\_\_
26. Birth weight: \_\_\_\_\_ (grams) (Do not convert lb/oz to grams)  
If weight in grams is not available, birth weight: \_\_\_\_\_ (lb/oz)
27. Obstetric estimate of gestation at delivery (completed weeks): \_\_\_\_\_  Unknown
28. Sex:  Male  Female  Undetermined
29. Apgar score  
Score at 5 minutes \_\_\_\_\_  Unknown  
If 5 minute score is less than 6:  
Score at 10 minutes \_\_\_\_\_  Unknown
30. 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.): \_\_\_\_\_
31. Order of Delivery (Order delivered in the pregnancy, specify 1<sup>st</sup>, 2<sup>nd</sup>, 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup>, 7<sup>th</sup>, etc.) (Note: Delivery includes all live births and fetal losses resulting from this pregnancy): \_\_\_\_\_
32. If not single birth, for this delivery specify:  
Number born alive: \_\_\_\_\_  
Number of fetal deaths: \_\_\_\_\_
33. Metabolic Kit Number: \_\_\_\_\_
34. Name of Prophylactic Used in Eyes of Child (Check one):
- |                                                                |                                                   |
|----------------------------------------------------------------|---------------------------------------------------|
| a. <input type="checkbox"/> Ilotycin Ophthalmic                | i. <input type="checkbox"/> EES                   |
| b. <input type="checkbox"/> Ilotycin Ointment                  | j. <input type="checkbox"/> Cholostrum            |
| c. <input type="checkbox"/> Ilotycin                           | k. <input type="checkbox"/> Boric Acid            |
| d. <input type="checkbox"/> Erythromycin Ophthalmic            | l. <input type="checkbox"/> Breast Milk           |
| e. <input type="checkbox"/> Erythromycin Ointment              | m. <input type="checkbox"/> Unknown               |
| f. <input type="checkbox"/> Erythromycin                       | n. <input type="checkbox"/> None                  |
| g. <input type="checkbox"/> AGNO <sub>3</sub> (Silver Nitrate) | o. <input type="checkbox"/> Other (Specify) _____ |
| h. <input type="checkbox"/> Neosporin                          |                                                   |

**35. Abnormal conditions of the newborn** (Check all that apply):

- a.  None
- b.  • ssisted ventilation required immediately following delivery
- c.  Assisted ventilation required for more than six hours
- d.  NICU admission
- e.  Newborn given surfactant replacement therapy
- f.  Antibiotics received by the newborn for suspected neonatal sepsis
- g.  Seizure or serious neurologic dysfunction
- h.  Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
- i.  Unknown

**36. Congenital anomalies of the newborn** (Check all that apply):

- a.  None
- b.  Anencephaly
- c.  Craniofacial Anomalies
- d.  Meningocele/Spina bifida
- e.  Hydrocephalus w/o Spina bifida
- f.  Encephalocele
- g.  Microcephalus
- h.  Cyanotic congenital heart disease
- i.  Tetralogy of Fallot
- j.  Congenital diaphragmatic hernia
- k.  Omphalocele
- l.  Gastroschisis
- m.  Bladder exstrophy
- n.  Rectal/large intestinal atresia/stenosis
- o.  Hirshsprung's disease
- p.  Congenital hip dislocation
- q.  Amniotic bands
- r.  Limb reduction defect
- s.  Congenital cataract
- t.  Cleft Lip with/without Cleft Palate
- u.  Cleft Palate alone
- v.  Down Syndrome – Karyotype pending
- w.  Down Syndrome –Karyotype confirmed
- x.  Suspected chromosomal disorder – Karyotype confirmed
- y.  Suspected chromosomal disorder - Karyotype pending
- z.  Hypospadias
- aa.  Unknown

**37. Was infant transferred within 24 hours of delivery?**

- Yes\*  No  Unknown

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

\_\_\_\_\_

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

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

- Yes  No  Infant transferred, status unknown

If No, complete a death record.

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

- Yes  No  Unknown