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 Services, 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):**

   ____ ___ _____
   MM DD YYYY 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):**

   ____ ___ _____
   MM DD YYYY 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 of last normal menses began:

____ ___ _____
MM DD YYYY 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 1st 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 1st born in the set if completing this worksheet for that child):
_____ Number
☐Unknown

10. Date of last live birth:

____ ___ _____
MM DD YYYY 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):

____ ___ _____
MM DD YYYY Unknown portions of the date should be entered as "99"
☐Unknown

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

a. ☐None
b. ☐Pre-pregnancy diabetes
c. ☐Gestational diabetes
d. ☐Pre-pregnancy 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. ☐ Trichimoniasis
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 >12 hours)
c. ☐ Precipitous labor (<3 hours)
d. ☐ Prolonged labor (>20 hours)
e. ☐ Unknown

18. Date of Birth

____ ____ _____
MM DD YYYY

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 interior 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 during labor
f. ☐Antibiotics received by the mother during labor
g. ☐Clinical chorioamnionitis diagnosed during labor or maternal temp≥38°C (100.4° F)
☐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 desproportion
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. ☐Admisson to intensive care unit
g. ☐Unplanned operating room procedure following delivery

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 lbs./oz. to grams)
If weight in grams is not available, birth weight: _____ (lbs. /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 (twins), 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 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, 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. ☐ Ilotycin Opthalmic
b. ☐ Ilotycin Ointment
c. ☐ Ilotycin
d. ☐ Erythromycin Opthalmic
e. ☐ Erythromycin Ointment
f. ☐ Erythromycin
g. ☐ AGNO3 (Silver Nitrate)
h. ☐ Neosporin
i. ☐ EES
j. ☐ Cholostrum
k. ☐ Boric Acid
l. ☐ Breast Milk
m. ☐ Unknown
n. ☐ None
o. ☐ Other (Specify)

35. Abnormal conditions of the newborn (Check all that apply):
a. ☐ None
b. ☐ Assisted ventilation required immediately Following delivery
c. ☐ Assisted ventilation required for more than 6 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. ☐ Meningomyelocele /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