

Mother's Medical Record #	_____
Mother's Name	_____
Child's Date of Birth	_____
Child's Medical Record #	_____

FACILITY WORKSHEET FOR THE CERTIFICATE OF LIVE BIRTH

Child's Last Name: _____ Plurality: _____ Birth Order: _____

Facility

1. Facility Name: _____
 2. Facility ID: National Provider Identifier: _____

3. Address of birth (if Home Birth or Other in #4 is marked):

State: _____

County: _____

City, Town, or Township: _____

Street Address: _____

Apartment Number: _____ Zip Code/Postal Code: _____

4. Place of birth:

- Hospital/Birthing Center
- Clinic/Doctor's Office
- En Route (specify, e.g., taxi, ambulance, car, cab, plane etc.)
- Freestanding Birth Center
- Home Birth (Intended)
- Home Birth (Not Intended)
- Other * (specify, e.g., taxi, ambulance, cab, car, plane, etc.) _____

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

- a. Health insurance through private insurance
- b. Medicaid – (Please refer to the Medicaid Card Example Tip Sheet)
- c. Medicare
- d. Self Pay (no third party involved)
- e. Uninsured
- f. Unknown
- g. Champus/Tricare
- h. Other (specify, e.g., Indian Health Service, other government [federal, state, local]) _____

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.

6. **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
 Unknown

7. **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

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

- Unknown

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

 M M D D Y Y Y Y

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

- Unknown

10. **Pregnancy / Ultrasound Dating**

1. Ultrasound BEFORE or = 20 weeks gestation
2. Ultrasound AFTER 20 weeks gestation
3. NO ultrasound performed

11. 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

12. Number of previous live births now deceased (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

13. Date of last live birth:

____ ____ ____ ____ ____ ____ ____ ____
 M M D D Y Y Y Y

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

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

____ Number
 Unknown

15. 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

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

- | | |
|--|---|
| <ul style="list-style-type: none"> a. <input type="checkbox"/> None b. <input type="checkbox"/> Pre-pregnancy diabetes c. <input type="checkbox"/> Gestational diabetes d. <input type="checkbox"/> Pre-pregnancy hypertension (chronic) e. <input type="checkbox"/> Gestational hypertension w/o eclampsia f. <input type="checkbox"/> Eclampsia g. <input type="checkbox"/> Previous preterm births – (a live birth of less than 37 weeks of gestation) h. <input type="checkbox"/> Other previous poor pregnancy outcome (Please see desk reference for conditions covered) i. <input type="checkbox"/> Infertility Treatment <ul style="list-style-type: none"> a. Fertility enhancing drugs, artificial insemination (AI) or intrauterine insemination b. Assisted reproductive technology <input type="checkbox"/> Pregnancy resulted from assisted reproductive technology | <ul style="list-style-type: none"> j. <input type="checkbox"/> Mother had a previous cesarean delivery <p>If Yes, how many_____</p> <p>Which of the following has the mother ever had? Check all that apply</p> <ul style="list-style-type: none"> <input type="checkbox"/> Prior Low Transverse or LTCS <input type="checkbox"/> Prior Classical or Vertical CS <input type="checkbox"/> Prior Uterine Rupture <input type="checkbox"/> Prior Uterine Window <input type="checkbox"/> None of the Above k. <input type="checkbox"/> Anemia (Hct,30/Hgb. < 10) l. <input type="checkbox"/> Cardiac Disease m. <input type="checkbox"/> Acute or Chronic Lung Disease n. <input type="checkbox"/> Polyhydramnios (excessive amniotic fluid) / Oligohydramnios (reduced amniotic fluid) o. <input type="checkbox"/> Hemoglobinopathy p. <input type="checkbox"/> IUGR (Suspected prenatally) q. <input type="checkbox"/> Renal (Kidney) disease r. <input type="checkbox"/> Cholestasis s. <input type="checkbox"/> Blood group Allo-immunization t. <input type="checkbox"/> Prior non-pregnant uterine surgery |
|--|---|

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

- | | |
|---|--|
| <ul style="list-style-type: none"> a. <input type="checkbox"/> None b. <input type="checkbox"/> Bacterial Vaginosis c. <input type="checkbox"/> Chlamydia d. <input type="checkbox"/> CMV e. <input type="checkbox"/> Gonorrhea f. <input type="checkbox"/> Hepatitis B g. <input type="checkbox"/> Hepatitis C h. <input type="checkbox"/> Herpes Simplex Virus i. <input type="checkbox"/> In Utero Infection (TORCHS) | <ul style="list-style-type: none"> j. <input type="checkbox"/> Maternal Group B Strep Colonization k. <input type="checkbox"/> Measles l. <input type="checkbox"/> Mumps m. <input type="checkbox"/> PID n. <input type="checkbox"/> Rubella o. <input type="checkbox"/> Syphilis p. <input type="checkbox"/> Trichomoniasis q. <input type="checkbox"/> Toxoplasmosis r. <input type="checkbox"/> Varicella s. <input type="checkbox"/> HIV |
|---|--|

18. Obstetric procedures – (Check all that apply):

- | | |
|--|--|
| <ul style="list-style-type: none"> a. <input type="checkbox"/> None b. <input type="checkbox"/> External cephalic version - Successful c. <input type="checkbox"/> External cephalic version – Failed | <ul style="list-style-type: none"> d. <input type="checkbox"/> Cervical cerclage e. <input type="checkbox"/> Tocolysis |
|--|--|

19. Progesterone – Did Mother receive Progesterone in any form *after the first trimester* to prevent prematurity?

Yes No

Labor and Delivery

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

20. 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): _____

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

- a. None
- b. Premature Rupture of the Membranes
- c. Precipitous labor (<3 hours)
- d. Prolonged labor (>=20 hours)

22. Date of birth:

____/____/____
M M D D Y Y Y Y

23. Time of birth: _____ 24-hour military format

24. 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)
- NURSE PRACTITIONER
- OTHER (specify) _____
- OTHER MIDWIFE: (Midwife other than CNM/CM)
- PHYSICIAN'S ASSISTANT
- UNKNOWN

25. Certifier's name and Title and Date Certified

 Certifier's Name

 Certifier's Title

 Date Certified

26. Mother's weight at delivery (pounds only, do not round up): _____

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

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

28. Method of delivery: Note: If foundling, mark "Unknown" to all items

- 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):
 Breech Cephalic Other Unknown
- d. Final route and method of delivery (Check one):
 Vaginal/Spontaneous
 Vaginal/Forceps
 Vaginal/Vacuum
 Cesarean – (no labor attempted)
 Cesarean – (labor attempted)
 Unknown

29. 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 OR following delivery

Newborn**Sources: Labor and delivery records, Newborn's medical records, mother's medical records****30. Infant's medical record number:** _____**31. Birth weight:** _____ (grams) (Do not convert lb/oz to grams)

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

32. Obstetric estimate of gestation at delivery: Completed Weeks: _____ Days _____**33. Sex of child:** Male Female Unknown or Undetermined**34. Apgar score**Score at 5 minutes _____ Unknown

If 5 minute score is less than 6:

Score at 10 minutes _____ Unknown**35. 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.):

36. 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):

37. If not single birth, for this delivery specify: (Do Not include this birth)

Number born alive: _____

Number of fetal deaths: _____

38. Metabolic Kit Number: _____

39. 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"/> Colostrum |
| 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 ₃ (Silver Nitrate) | <input type="checkbox"/> Other (Specify) _____ |
| h. <input type="checkbox"/> Neosporin | |

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

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

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

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

42. Was infant transferred within 24 hours of delivery? Yes* No

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

Other (specify): _____

43. Is infant living at time of report? Yes No Infant transferred, status unknown

If No, complete a death record.

44. Is infant being breastfed at discharge? Yes No**45. Exclusive breast milk feeding through entire stay?** Yes No