Mother's Name _____
Mother's Medical Record # _____
Child's Medical Record # _____

FACILITY WORKSHEET FOR THE CERTIFICATE OF LIVE BIRTH

- For pregnancies resulting in the births of two or more live-born infants, this worksheet should be completed for the first live-born infant in the delivery. For each subsequent live-born infant, complete the "Attachment for Multiple Births."
- For any fetal loss in the pregnancy reportable under Ohio requirements, complete the "Fetal Death Worksheet."
- For detailed definitions, instructions, information on sources, and common key words and abbreviations please visit the Centers for Disease Control & Prevention website (cdc.gov) and review: "Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death"

CHILD

Child's Legal Name as it should appear on the birth certificate:
First Middle Last Suffix

Date of Birth:	**Time of Birth:**	**Sex:**
	_____: _____ (24 hour) Hour Minute	☐ Male ☐ Female ☐ Not yet determined

PLACE OF BIRTH

Place where delivery occurred:

☐ Hospital
☐ Freestanding Birth Center
☐ Clinic/Doctor's Office*
☐ Other (Specify)*
☐ Home* (Intended)
☐ Home* (Not Intended)
☐ Home* (Unknown if Intended)

** If baby was delivered outside a facility, refer mother to local health department for creation of record)*

Facility Name

Street Number and Name

Zip Code	**City or Town**	**County**
State	**Country**	

PRENATAL

Information for the following items should come from the mother's prenatal care records, labor and delivery record, and 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.

Mother's medical record number:

Mother's Medicaid number:

Principal source of payment for this delivery (at time of delivery)

☐ Medicaid
☐ CHAMPUS/TRICARE
☐ Private Insurance
☐ Other Government
☐ Self-Pay
☐ Unknown
☐ Other (Specify): _____

Date last normal menses began:
Enter all known parts of the date, or "99" if unknown.
Month: Day: Year:

☐ Check if no prenatal care was given.

Date of first prenatal care visit:
Enter all known parts of the date, or "99" if unknown.
Month: Day: Year:

Total number of prenatal visits for this pregnancy:

For the questions in the following section, do not include this infant. Include all live-born infants previous to this birth. For multiples include all live-born infants before this infant in the pregnancy. If completing worksheet for the first born of a set, do not include this infant.

Number of previous live births now living:

Number of previous live births now deceased:

Date of last live birth:
Enter all known parts of the date, or "99" if unknown.
Month: Day: Year:

Number of other pregnancy outcomes:

Date of last other pregnancy outcome:
Enter all known parts of the date, or "99" if unknown.
Month: Day: Year:

PREGNANCY FACTORS

Risk factors in this pregnancy (check all that apply):

Diabetes

☐ Pre-pregnancy
☐ Gestational

Hypertension

☐ Pre-pregnancy (chronic)
☐ Gestational (PIH, Pre-eclampsia)
☐ Eclampsia

Pregnancy Resulted from Infertility Treatment

☐ Fertility enhancing drugs, Artificial insemination or Intrauterine insemination
☐ Assisted reproductive technology (e.g. in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT))

☐ Previous Cesarean delivery
How many? _____

☐ Previous preterm births
☐ Previous poor pregnancy outcome
☐ None of the above

Infections present and/or treated during this pregnancy (check all that apply):

☐ Gonorrhea
☐ Syphilis
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ None of the above

Obstetric procedures:

☐ Successful external cephalic version ☐ Failed external cephalic version ☐ None of the above

LABOR

Information for the following items should come from the labor and delivery record, and other records in the mother's chart.

Onset of labor (check all that apply):

☐ Premature rupture of the membrane (prolonged, >=12 hours)
☐ Precipitous labor (< 3 hours)
☐ Prolonged labor (>=20 hours)
☐ None of the above

Characteristics of labor and delivery (check all that apply):

☐ Induction of labor
☐ Augmentation of labor
☐ Antibiotics received by mother during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38^{0}C (100.4^{0}F)
☐ Steroids (Glucosteroids) for fetal lung maturation received by mother prior to delivery
☐ Epidural or spinal anesthesia during labor
☐ None of the above

Mother's Weight at Delivery (pounds)

DELIVERY

Information for the following items should come from the labor and delivery record, and other records in the mother's chart. If infant is a foundling, select "Unknown" for all items in this section.

Fetal presentation at birth:

☐ Cephalic ☐ Breech ☐ Other ☐ Unknown

Final route and method of delivery:

☐ Spontaneous
☐ Forceps
☐ Vacuum
☐ Cesarean - labor attempted
☐ Cesarean - no labor attempted
☐ Unknown

Maternal morbidity (check all that apply):

☐ Maternal transfusion
☐ Third- or fourth-degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ None of the above

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

☐ Yes ☐ No ☐ Unknown If Yes, please enter the name of the facility mother transferred from:

Was the infant transferred within 24 hours of delivery?

☐ Yes ☐ No ☐ Unknown If Yes, please enter the name of the facility infant transferred to:

NEWBORN

Information for the following items should come from the labor and delivery record, other reports in the mother's chart, and the infant's medical record.

Infant medical record number:

Infant birthweight:

_____ _____ **OR** _____
Pounds Ounces Grams

APGAR score:

5 minutes: 10 minutes:

Obstetric estimation of gestation at delivery:

Completed weeks:

Plurality (number of live births and fetal losses delivered in this pregnancy)**:**

Birth order (order of delivery for all births and fetal losses in this pregnancy)**:**

Number of infants in this delivery born alive:

Name of prophylaxis used in child's eyes:

☐ Erythromycin / EES
☐ Ilotycin
☐ Breastmilk/ colostrum
☐ Other: _____
☐ Unknown
☐ None/Refused

Infant living at time of report?

☐ Yes ☐ No ☐ Unknown

Is infant being breastfed at discharge?

☐ Yes ☐ No ☐ Unknown

Was infant breastfed exclusively through entire stay?

☐ Yes ☐ No ☐ Unknown

NEWBORN FACTORS

Abnormal conditions of the newborn (check all that apply):

☐ Assisted ventilation required immediately after delivery
☐ Assisted ventilation required for more than 6 hours
☐ NICU admission
☐ Newborn given surfactant replacement therapy
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ None of the above

Congenital anomalies of the newborn (check all that apply):

☐ Anencephaly
☐ Cleft Lip with or without cleft palate
☐ Cleft palate alone
☐ Congenital diaphragmatic hernia
☐ Cyanotic congenital heart disease
☐ Gastroschisis
☐ Hypospadias
☐ Limb reduction defect
☐ Meningomyelocele / Spina Bifida
☐ Microcephalus
☐ Omphalocele
☐ Down syndrome karyotype pending
☐ Down syndrome karyotype confirmed
☐ Suspected chromosomal disorder karyotype pending
☐ Suspected chromosomal disorder karyotype confirmed
☐ None of the above

ATTENDANT

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:

Attendant's title:

☐ MD
☐ DO
☐ CNP
☐ CNM / CM
☐ Other midwife
☐ Other (specify):

Attendant NPI: