FACILITY WORKSHEET FOR THE LIVE BIRTH CERTIFICATE

For pregnancies resulting in the births of two or more live-born infants, this worksheet should be completed for the 1st 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 State reporting requirements, complete the "Facility Worksheet for the Fetal Death Report."

Mother's name: _____

Mother's medical record # _____

Facility name: _____
(If not institution, give street and number**)**

County of birth: _____

City, Town or Location of birth: _____**Zip Code:** _____

Place of birth:
___Hospital
___Freestanding birthing center (Freestanding birthing center is defined as one which has no direct physical connection with an operative delivery center.)
___Home birth, Planned to deliver at home (Circle one) Yes No
___Clinic/Doctor's Office
___Other (specify, e.g., taxi cab, train, plane, etc.)_____

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.

Prenatal

(Sources: Prenatal care records, mother's medical records, labor and delivery records)

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):
Month __ __ Day__ __Year__ __ __ __

___No prenatal care (The mother did not receive prenatal care at any time during the pregnancy. If no prenatal care, skip the next question)

Date of last prenatal care visit (Enter the date of the last visit recorded in the mother's prenatal records):
Month__ __ Day__ __ Year__ __ __ __

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

Date last normal menses began: Month __ __ Day__ __Year__ __ __ __

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. If none enter "0"): _____

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. If none enter "0"): _____

Date of last live birth: Month __ __ Year__ __ __ __

Total number of other pregnancy outcomes (Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy. If none enter "0"): _____

Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended):
Month __ __ Year__ __ __ __

Risk factors in this pregnancy (Check all that apply):
Diabetes - (Glucose intolerance requiring treatment)
___*Prepregnancy* - (Diagnosis prior to this pregnancy)
___*Gestational* - (Diagnosis in this pregnancy)

Hypertension -
___*Prepregnancy* - (Chronic) Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy.
___*Gestational* - (PIH, preeclampsia) Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face).
___*Eclampsia* - Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema.

___*Previous preterm births* - (History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation)
___*Other previous poor pregnancy outcome* - (Includes perinatal death, small for gestational age/intrauterine growth restricted birth) - (History of pregnancies continuing into the 20th week of gestation and resulting in any of the listed outcomes. Perinatal death includes fetal and neonatal deaths.)
___*Vaginal bleeding during this pregnancy prior to the onset of labor.*

Infertility Treatment-
___*Pregnancy resulted from infertility treatment*. - Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g., IVF, GIFT and ZIFT).
___*Fertility-enhancing drugs* - Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.
___*Assisted reproductive technology* - Any assisted reproductive technology (ART)/ technical procedures (e.g., IVF, GIFT, ZIFT) used to initiate the pregnancy.

___*Mother had a previous cesarean deliver?* (Circle one) Yes No If Yes, how many? ____
___*None of the above*

Infections present and/or treated during this pregnancy -(Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.) (Check all that apply):
____*Gonorrhea* - (a diagnosis of or positive test for Neisseria gonorrhoeae)
____*Syphilis* - (also called lues - a diagnosis of or positive test for Treponema pallidum)
____*Chlamydia* - (a diagnosis of or positive test for Chlamydia trachomatis)
____*Herpes Simplex Virus* (HSV)
____*Hepatitis B* - (HBV, serum hepatitis - a diagnosis of or positive test for the hepatitis B virus)
____*Hepatitis C* - (non A, non B hepatitis, HCV - a diagnosis of or positive test for the hepatitis C virus)
____*None of the above*

Obstetric procedures -(Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically in the treatment of the pregnancy, management of labor and/or delivery.) (Check all that apply):
____*Cervical cerclage* - (Circumferential banding or suture of the cervix to prevent or treat passive dilatation. Includes MacDonald's suture, Shirodkar procedure, abdominal cerclage via laparotomy.)
____*Tocolysis* - (Administration of any agent with the intent to inhibit preterm uterine contractions to extend length of the pregnancy.)
External cephalic version -(Attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation.) ____Successful ____ Failed
____*None of the above*

Labor and Delivery

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

Onset of Labor (Check all that apply):
____*Premature Rupture of the Membranes* (prolonged >=12 hours) (Spontaneous tearing of the amniotic sac, (natural breaking of the bag of waters), 12 hours or more before labor begins.)
____*Precipitous labor (<3 hours)* (Labor that progresses rapidly and lasts for less than 3 hours.)
____*Prolonged labor (>=20 hours)* (Labor that progresses slowly and lasts for 20 hours or more.)
____*None of the above*

Date of birth: Month __ __ Day__ __Year__ __ __ __

Time of birth (12-hour clock)**:** _____Time (Circle one) a.m. p.m. noon midnight
Attendant/Certifier name and title: _____
(Either the individual physically present at the delivery who is responsible for the delivery or the individual who certifies to the fact that the birth occurred.)

____M.D.
____D.O.
____Hospital administrator or designee
____CNM/CM (Certified Nurse Midwife / Certified Midwife)
____Other (Specify)_____

Attendant/Certifier mailing address: Street and Number_____

City_____ State_____ Zip Code_____

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

____Private Insurance
____Medicaid
____Self-pay (No third party identified)
____Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal, state, local))
_____

Infant's medical record number: _____

Was the mother transferred to this facility for maternal medical or fetal indications for delivery?
(Transfers include hospital to hospital, birth facility to hospital, etc.): (Circle One) Yes No
If Yes, enter the name and location of the facility mother transferred from:
_____

Mother's weight at delivery (pounds): _____

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

____*Induction of labor* - (Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor.)
____*Augmentation of labor* - (Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery.)
____*Non-vertex presentation* - (Includes any non-vertex fetal presentation, e.g., breech, shoulder, brow, face presentations, and transverse lie in the active phase of labor or at delivery other than vertex.)
____*Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery* - (Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to the mother as an anti-inflammatory treatment.)
____*Antibiotics received by the mother during labor* - (Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.)

____*Clinical chorioamnionitis diagnosed during labor or maternal temperature >=38° C (100.4° F)* - (Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis and fetal tachycardia. Any maternal temperature at or above 38°C (100.4°F).

____*Moderate/heavy meconium staining of the amniotic fluid* - (Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery which is more than enough to cause a greenish color change of an otherwise clear fluid.)

____*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* - (In Utero Resuscitative measures such as any of the following - maternal position change, oxygen administration to the mother, intravenous fluids administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents. Further fetal assessment includes any of the following - scalp pH, scalp stimulation, acoustic stimulation. Operative delivery – operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery.)

____*Epidural or spinal anesthesia during labor* - (Administration to the mother of a regional anesthetic for control of the pain of labor, i.e., delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.)

____*None of the above*

Method of Delivery (The physical process by which the complete delivery of the infant was effected) (Complete A, B, C, and D):

A. *Was delivery with forceps attempted?* - (Obstetric forceps was applied to the fetal head in an attempt at vaginal delivery.) (Circle One) Yes No
If Yes, Was it successful? (Circle One) Yes No

B. *Was delivery with vacuum extraction attempted?* - (Ventouse or vacuum cup was applied to the fetal head in an attempt at vaginal delivery.) (Circle One) Yes No
If Yes, Was it successful? (Circle One) Yes No

C. *Fetal presentation at birth* (Check one):

____*Cephalic* - (Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP))

____*Breech* - (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech)

____*Other* - (Any other presentation not listed above)

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

____*Vaginal/Spontaneous* - (Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.)

____*Vaginal/Forceps* - (Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.)

____*Vaginal/Vacuum* - (Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.)

____*Cesarean* - (Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.) *If cesarean, was a trial of labor attempted?* - (Labor was allowed, augmented or induced with plans for a vaginal delivery.)
(Circle One) Yes No

Maternal morbidity (Serious complications experienced by the mother associated with labor and delivery) (Check all that apply):

____*Maternal transfusion* - (Includes infusion of whole blood or packed red blood cells associated with labor and delivery.)

____*Third or fourth degree perineal laceration* - (3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)

____*Ruptured uterus* - (Tearing of the uterine wall.)

____*Unplanned hysterectomy* - (Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.)

____*Admission to intensive care unit* - (Any admission of the mother to a facility/unit designated as providing intensive care.)

____*Unplanned operating room procedure following delivery* - (Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.)

____*None of the above*

Newborn

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

Birthweight (grams preferred): _____grams or _____pounds and _____ounces

Obstetric estimate of gestation at delivery (completed weeks):_____
(The birth attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam. Do not compute based on date of the last menstrual period and the date of birth.)

Sex (Circle One) Male Female Not yet determined

Apgar score (A systematic measure for evaluating the physical condition of the infant at specific intervals at birth):
Score at 5 minutes _____ Score at 10 minutes (If 5 minute score is less than 6)_____

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.):_____

If not single birth (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Include all live births and fetal losses resulting from this pregnancy):_____

Abnormal conditions of the newborn (Disorders or significant morbidity experienced by the newborn)
(Check all that apply):

_____*Assisted ventilation required immediately following delivery* - (Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes oxygen only and laryngoscopy for aspiration of meconium.)

_____*Assisted ventilation required for more than six hours* - (Infant given mechanical ventilation (breathing assistance) by any method for > 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).)

_____*NICU admission* - (Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.)

_____*Newborn given surfactant replacement therapy* - (Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.)

_____*Antibiotics received by the newborn for suspected neonatal sepsis* - (Any antibacterial drug (e.g., penicillin, ampicillin, gentamicin, cefotoxine, etc.) given systemically (intravenous or intramuscular).)

____ *Seizure or serious neurologic dysfunction* - (Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.)

_____ *Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)* - (Defined as present immediately following delivery or manifesting soon after delivery. Includes any bony fracture or weakness or loss of sensation, but excludes fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and/or extremity ecchymosis accompanied by evidence of anemia and/or hypovolemia and/or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma.)

_____*None of the above*

Congenital anomalies of the newborn (Malformations of the newborn diagnosed prenatally or after delivery.)
(Check all that apply):

_____*Anencephaly* - (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).

_____*Meningomyelocele/Spina bifida* - (Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).)

_____ *Cyanotic congenital heart disease* - (Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetratology of Fallot, pulmonary or pulmonic valvular

atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.)

_____ *Congenital diaphragmatic hernia* - (Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.)

_____ *Omphalocele* - (A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.)

_____ *Gastroschisis* - (An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.)

_____ *Limb reduction defect (excluding congenital amputation and dwarfing syndromes)* - (Complete or partial absence of a portion of an extremity associated with failure to develop.)

_____ *Cleft Lip with or without Cleft Palate* - (Incomplete closure of the lip. May be unilateral, bilateral or median.)

_____ *Cleft Palate alone* - (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without Cleft Palate" category above.)

_____ *Down Syndrome* - (Trisomy 21) (Circle One) Karyotype confirmed Karyotype pending

_____ *Suspected chromosomal disorder* - (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.) (Circle One) Karyotype confirmed Karyotype pending

_____*Hypospadias* - (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.)

_____*None of the above*

Was infant transferred within 24 hours of delivery? (Circle "yes" if the infant was transferred from this facility to another within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.) (Circle One) Yes No

If Yes, name and location of the facility infant transferred to:_____

Infant living at time of report? (Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care.)

_____Yes _____No _____Infant transferred, status unknown

Is infant being breast fed at discharge? (Circle One) Yes No

Is infant going to be adopted? (Circle One) Yes No Don't know

If the Acknowledgement of Paternity form has been signed, provide the date signed (if the date signed by the mother and father are different, provide the latest date signed): Month __ __ Day__ __Year__ __ __ __