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):

- **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.** ☐ Infertility Treatment
  - a. Fertility enhancing drugs, artificial insemination (AI) or intrauterine insemination
  - b. Assisted reproductive technology

  ☐ Pregnancy resulted from assisted reproductive technology
- **j.** ☐ Mother had a previous cesarean delivery

If Yes, how many____

Which of the following has the mother ever had? Check all that apply

- ☐ Prior Low Transverse or LTCS
- ☐ Prior Classical or Vertical CS
- ☐ Prior Uterine Rupture
- ☐ Prior Uterine Window
- ☐ None of the Above

- **k.** ☐ Anemia (Hct,30/Hgb. < 10)
- **l.** ☐ Cardiac Disease
- **m.** ☐ Acute or Chronic Lung Disease
- **n.** ☐ Polyhydramnios (excessive amniotic fluid) / Oligohydramnios (reduced amniotic fluid)
- **o.** ☐ Hemoglobinopathy
- **p.** ☐ IUGR (Suspected prenatally)
- **q.** ☐ Renal (Kidney) disease
- **r.** ☐ Cholestasis
- **s.** ☐Blood group Allo-immunization
- **t.** ☐Prior non-pregnant uterine surgery

17. 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.** ☐ HIV

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

- **a.** ☐ None
- **b.** ☐ External cephalic version - Successful
- **c.** ☐ External cephalic version – Failed
- **d.** ☐ Cervical cerclage
- **e.** ☐ 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):

- **a.** ☐ None
- **b.** ☐ Induction of labor
- **c.** ☐ Augmentation of labor
- **d.** ☐ Non-vertex presentation
- **e.** ☐ Steroids (glucocorticoids, ANCS) for fetal lung maturation received by the mother prior to delivery
- **f.** ☐ Antibiotics received by the mother between the onset of labor and the actual delivery
- **g.** ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° 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

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.** ☐ Ilotycin Ophthalmic
- **b.** ☐ Ilotycin Ointment
- **c.** ☐ Ilotycin
- **d.** ☐ Erythromycin Ophthalmic
- **e.** ☐ Erythromycin Ointment
- **f.** ☐ Erythromycin
- **g.** ☐ AGNO3 (Silver Nitrate)
- **h.** ☐ Neosporin
- **i.** ☐ EES
- **j.** ☐ Colostrum
- **k.** ☐ Boric Acid
- **l.** ☐ Breast Milk
- **m.** ☐ Unknown
- **n.** ☐ None
- ☐ Other (Specify) _______________

40. 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 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)

41. 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

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