Mother's medical record # _____
Mother's name_____

FINAL (12/16)

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."

*For detailed definitions, instructions, information on sources, and common key words and abbreviations please see "**The Guide to Completing Facility Worksheets for the Certificate of Live Birth**."*

*All birth certificate information reported for the mother should be for **the woman who delivered the infant**. In cases of surrogacy or gestational carrier, the information reported should be that for the surrogate or the gestational carrier, that is, **the woman who delivered the infant**.*

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

2. Facility I.D. (National Provider Identifier)**:** _____

3. City, Town or Location of birth: _____

4. County of birth: _____

5. Place where birth occurred:

- ❑ 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 □ Yes □ No □ Unknown
- ❑ Clinic/Doctor's Office
- ❑ Other (specify, e.g., taxi cab, train, plane, etc.) _____

*Facilities may wish to have pre-set responses (hard-copy and/or electronic) to questions 1-5 for births which occur at their institutions.

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 (The date a physician or other health professional first examined and/or counseled the pregnant woman for the pregnancy. Complete all parts of the date that are available, leave the rest blank.)**:**

__ __ __ __ __ __ __ __
M M D D Y Y Y Y

❑ **No prenatal care** (The mother did not receive prenatal care at any time during the pregnancy. If this box is checked, enter "0" for the "Total number of prenatal care visits for this pregnancy" (#7).)

7. Total number of prenatal care visits for this pregnancy: _____
(Count only those visits recorded in the most current records available**.** Do not include visits for laboratory and other testing in which a physician or health care professional did not examine or counsel the pregnant woman. Do not include classes, such as childbirth classes, where the physician or health care professional did not provide individual care to the pregnant woman. If none enter "0" and check the "No prenatal care" box for "Date of first prenatal care visit.")

8. Date last normal menses began (Enter all known parts of the date the mother's last normal menstrual period began. Report "unknown" for any parts of the date that are missing.)**:**

__ __ __ __ __ __ __ __
M M D D Y Y Y Y

9. Number of previous live births now living (Do not include this infant. For multiple deliveries, include all live-born infants delivered before this infant in the pregnancy who are still living.):

____ Number ❑ None

10. Number of previous live births now dead (Do not include this infant. For multiple deliveries, include all live-born infants delivered before this infant in the pregnancy who are now dead.):

____ Number ❑ None

11. Date of last live birth (Enter all known parts of the date of birth of the last live-born infant. Report "unknown" for any parts of the date that are missing.)**:**

__ __ __ __ __ __
M M Y Y Y Y

12. Number of other pregnancy outcomes (Total number of other pregnancy outcomes that did not result in a live birth. Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include any losses regardless of gestational age occurring before the delivery of this infant. This could include loss occurring in this pregnancy or in a previous pregnancy.):

____ Number ❑ None

13. Date of last other pregnancy outcome (Enter all known parts of the date for the last pregnancy, which did not result in a live birth, ended. Include pregnancy losses at any gestational age – spontaneous losses, induced losses, and/or ectopic pregnancies. Enter "unknown" for any parts of the date that are missing.):

___ ___ ___ ___ ___ ___
M M Y Y Y Y

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

Diabetes - (Glucose intolerance requiring treatment; if diabetes is present, check either prepregnancy or gestational, do not check both.)

- ❑ Prepregnancy - (Diabetes diagnosed prior to this pregnancy)
- ❑ Gestational - (Diabetes diagnosed in this pregnancy)

Hypertension - (Elevation of blood pressure above normal for age, sex, and physiological condition; if hypertension is present, check either prepregnancy or gestational, do not check both.)

- ❑ Prepregnancy - (Chronic) (Hypertension diagnosed prior to the onset of this pregnancy)
- ❑ Gestational - (PIH, preeclampsia) (Hypertension diagnosed during this pregnancy.)

❑ Eclampsia - (Hypertension with proteinuria with generalized seizures or coma. May include pathologic edema. If eclampsia is present, either prepregnancy or gestational hypertension may be checked.)

❑ Previous preterm births - (History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation)

❑ Pregnancy resulted from infertility treatment - (Any assisted reproduction treatment used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology procedures (e.g., IVF, GIFT and ZIFT).)

If Yes, check all that apply:

- ❑ Fertility-enhancing drugs, artificial insemination or intrauterine insemination - (Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.)
- ❑ Assisted reproductive technology - (Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT)) used to initiate the pregnancy.)

❑ Mother had a previous cesarean delivery - (Previous delivery by extracting the fetus, placenta and membranes through an incision in the mother's abdominal and uterine walls.)

If Yes, how many? _____

❑ None of the above

15. Infections present and/or treated during this pregnancy - (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.)
(Check all that apply):

- ❑ Gonorrhea - (a positive test or culture for *Neisseria gonorrhoeae*)
- ❑ Syphilis - (also called lues - a positive test for *Treponema pallidum*)
- ❑ Chlamydia - (a positive test for Chlamydia *trachomatis*)
- ❑ Hepatitis B - (HBV, serum hepatitis - a positive test for the hepatitis B virus)
- ❑ Hepatitis C - (non A, non B hepatitis, HCV - a positive test for the hepatitis C virus)
- ❑ None of the above

16. Obstetric procedures - (Medical treatment or invasive or manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor or delivery.):

- ❑ External cephalic version - (Attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation.)
  - ❑ Successful - (Fetus was converted to a vertex presentation.)
  - ❑ Failed - (Fetus was not converted to a vertex presentation.)
- ❑ None of the above

Labor and Delivery

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

17. Date of birth: __ __ __ __ __ __ __ __
M M D D Y Y Y Y

18. Time of birth: _____
(Enter time based on a 24-hour clock. If time of birth is unknown (foundling), enter "unknown".)

19. Certifier's name and title: _____
(The individual who certifies to the fact that the birth occurred. May be, but need not be, the same as the attendant at birth.)

- ❑ M.D. - (Doctor of medicine)
- ❑ D.O. - (Doctor of osteopathy)
- ❑ Hospital administrator or designee
- ❑ CNM/CM (Certified Nurse Midwife or Certified Midwife)
- ❑ Other midwife (midwife other than CNM/CM)
- ❑ Other (Specify) _____

20. Date certified: __ __ __ __ __ __ __ __
M M D D Y Y Y Y

21. Principal source of payment for this delivery (The primary source of payment for the delivery at time of delivery):

- ❑ Private Insurance (Blue Cross/Blue Shield, Aetna, etc.)
- ❑ Medicaid (or a comparable State program)
- ❑ Self-pay (no third party identified)
- ❑ Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal, state, local), charity)

_____

22. Infant's medical record number: _____

23. 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. Does not include home to hospital.)

❑ Yes ❑ No

If Yes, enter the name of the facility mother transferred from:

_____

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 should be reported as the attendant. If the obstetrician is not physically present, the intern or nurse midwife should be reported as the attendant.):

_____ _____

Attendant's name N.P.I.

Attendant's title:

- ❑ M.D. - (Doctor of medicine)
- ❑ D.O. - (Doctor of osteopathy)
- ❑ CNM/CM - (Certified Nurse Midwife/Certified Midwife)
- ❑ Other Midwife - (midwife other than CNM/CM)
- ❑ Other (specify) _____

25. Mother's weight at delivery (pounds):_____

26. Characteristics of labor and delivery (Information about the course 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 (i.e., before labor has begun). Does not include augmentation of labor.)
- ❑ Augmentation of labor - (Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery (i.e., after labor has begun). Do not include if induction of labor was performed.)
- ❑ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery - (Steroids received by the mother prior to delivery to accelerate fetal lung maturation. Typically administered in anticipation of preterm delivery. Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation. Excludes steroid medication given to the mother as an anti-inflammatory treatment before or after delivery.)
- ❑ 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, Cefotaxime, 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, fetal tachycardia, maternal tachycardia, or malodorous vaginal discharge. Any maternal temperature at or above 38°C (100.4°F).)
- ❑ 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

27. Method of delivery (The physical process by which the complete delivery of the infant was effected)
(Complete C and D):

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, i.e., shoulder, funis, transverse lie, compound)

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.)

❑ Yes ❑ No

28. 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 through the perineal skin, vaginal mucosa, perineal body and partially or completely through the anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- ❑ Ruptured uterus - (Tearing of the uterine wall. A full-thickness disruption of the uterine wall that also involves the overlaying visceral peritoneum (uterine serosa). Does not include uterine dehiscence in which the fetus, placenta, and umbilical cord remain contained with the uterine cavity. Does not include a silent or incomplete rupture or an asymptomatic separation.)
- ❑ Unplanned hysterectomy - (Surgical removal of the uterus that was not planned prior to the admission. Includes an anticipated, but not definitively planned, hysterectomy.)
- ❑ Admission to intensive care unit - (Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care.)
- ❑ None of the above

Newborn

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

29. Birthweight: _____ (grams) (Do not convert lb/oz to grams)

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

30. Obstetric estimate of gestation at delivery (completed weeks):_____
(The best obstetric estimate of the infant's gestational age in completed weeks based on the clinician's final estimate of gestation.)

31. Sex: _____ (Male, Female, or Not yet determined)

32. Apgar score (A systematic measure for evaluating the physical condition of the infant at specific intervals at birth):

Score at **5** minutes _____

If 5 minute score **is less than 6:** Score at **10** minutes _____

33. Plurality: _____
(The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age, or if the fetuses were delivered at different dates in the pregnancy. Include all live births and fetal losses resulting from this pregnancy. Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.)

34. 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)

35. If not single birth, specify number of infants in this delivery born alive: _____

36. 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 free flow (blow-by) oxygen only, laryngoscopy for aspiration of meconium, nasal cannula, and bulb suction.)
- ❑ Assisted ventilation required for more than six hours - (Infant given mechanical ventilation (breathing assistance) by any method for more than six hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP). Excludes free flow oxygen only, laryngoscopy for aspiration of meconium and nasal cannula.)
- ❑ 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). Does not include antibiotics given to infants who are NOT suspected of having neonatal sepsis.)
- ❑ Seizure or serious neurologic dysfunction - (Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.)
- ❑ None of the above

37. 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.)
- ❑ 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 in which the umbilical ring is widened, allowing herniation of abdominal organs into the umbilical cord. The herniating organs are covered by a nearly transparent membranous sac (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 – A chromosomal abnormality caused by the presence of all or part of a third copy of chromosome 21.)

  - ❑ 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.)

  - ❑ 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

38. Was infant transferred within 24 hours of delivery? (Check "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.)

❑ Yes ❑ No

If yes, name of facility infant transferred to: _____

39. Is 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. Answer "no" if it is known that the infant has died. If the infant was transferred and the status is known, indicate known status.)

❑ Yes ❑ No ❑ Infant transferred, status unknown

40. Is infant being breastfed at discharge? (Check "yes" if the infant was receiving breastmilk or colostrum during the period between birth and discharge from the hospital. Include any attempt to establish breastmilk production during the period between birth and discharge from the hospital. Include if the infant received formula in addition to being breastfed. Does not include the intent to breastfeed.)

❑ Yes ❑ No