FACILITY WORKSHEET FOR THE
LIVE BIRTH CERTIFICATE

Child’s Last Name: ______________________  Plurality: ____  Birth Order: ____

1. Place of birth:
   □ Hospital/Birthing Center (Please go to Question #3)
   □ En Route (Please go to Question #3)
   □ Home birth*  Planned to deliver at home  □ Yes  □ No
   □ Other * (specify, e.g., taxi cab, car, plane, etc.)_________________________
   *(If Home birth or Other, please complete Question #2)

2. Address of birth (if Home Birth or Other is marked):
   State: ___________________
   County: ___________________
   City, Town, or Township: ____________________________
   Street Address: __________________________________
   Apartment Number: ________________Zip Code/Postal Code: _____________

3. Principal source of payment for this delivery (At time of delivery):
   a. □ Health insurance through Private insurance current or former employer or union.
   b. □ Medicare
   c. □ Medicaid - (e.g. Healthy Start, Medicaid waiver programs, disability assistance, Healthy Families)
   d. □ Purchased directly
   e. □ Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal, state, local)) ________________
   f. □ Uninsured
   g. □ Unknown

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.

4. 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 (Please go to Question #6)  □ Unknown

5. 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

6. Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record. If none enter “0”):
   ____________  □ Unknown

7. Date last normal menses began:
   _ _ _ _ _ _ _ _  M M D D Y Y Y Y
   Unknown portions of the date should be entered as “99”  □ Unknown

8. 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

9. 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):
   ___ Number  □ Unknown

10. Date of last live birth:
   _ _ _ _ _ _ _ _  M M D D Y Y Y Y
   Unknown portions of the date should be entered as “99”
11. Total number of other pregnancy outcomes (Include fetal losses of any gestational age)
   ____ Number
   □ Unknown

12. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended):
   __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ (__
21. Mother’s weight at delivery (pounds):________ □ Unknown

22. 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) for fetal lung maturation received by the mother prior to delivery 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
   f. □ Antibiotics received by the mother during labor
   g. □ Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38°$ C (100.4° F)
   h. □ Moderate/heavy meconium staining of the amniotic fluid
   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
   q. □ Unknown

23. Method of delivery:
   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):
      □ Cephalic □ Breech □ Other □ Unknown
   D. Final route and method of delivery (Check one):
      a. □ Vaginal/Spontaneous          c. □ Vaginal/Vacuum          e. □ Cesarean - (labor attempted)
      b. □ Vaginal/Forceps            d. □ Cesarean - (no labor attempted)          f. □ Unknown

24. 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 operating room procedure following delivery
   h. □ Unknown

Newborn
   Sources: Labor and delivery records, Newborn’s medical records, mother’s medical records

25. Infant’s medical record number: ________________________________

26. Birth weight: ________________ (grams) (Do not convert lb/oz to grams)
   If weight in grams is not available, birth weight: _________________ (lb/oz)

27. Obstetric estimate of gestation at delivery (completed weeks): ________ □ Unknown

28. Sex: □ Male □ Female □ Undetermined

29. Apgar score
   Score at 5 minutes _______ □ Unknown
   If 5 minute score is less than 6:
   Score at 10 minutes _______ □ Unknown

30. 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.):________

31. Order of Delivery (Order delivered in the pregnancy, specify 1$^{st}$, 2$^{nd}$, 3$^{rd}$, 4$^{th}$, 5$^{th}$, 6$^{th}$, 7$^{th}$, etc.) (Note: Delivery includes all live births and fetal losses resulting from this pregnancy):________

32. If not single birth, for this delivery specify: Number born alive: ________
   Number of fetal deaths: ________

33. Metabolic Kit Number: __________________________

34. 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
   o. □ Other (Specify)__________________
35. 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)
   i. □ Unknown

36. 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 extrophy
   n. □ Rectal/large intestinal atresia/stenosis
   o. □ Hirschprung’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
   aa. □ Unknown

37. Was infant transferred within 24 hours of delivery?
   □ Yes*  □ No  □ Unknown
   *If Yes, enter the name of the facility infant was transferred to: __________________________________________
   Other (specify): ________________________________________

38. Is infant living at time of report?
   □ Yes  □ No  □ Infant transferred, status unknown
   If No, complete a death record.

39. Is infant being breastfed at discharge?
   □ Yes  □ No  □ Unknown