

Mother's Name:

Mother's Med. Rec. Number:

New York State Birth Certificate Work Booklet

A child's birth certificate is a very important document. It is the official record of the child's full name, date of birth and place of birth. Throughout the child's lifetime, it provides proof of identity and age. As a child grows from childhood to adulthood information in the birth certificate will be needed for many important events such as: entrance to school, obtaining a work permit, driver's license or marriage license, entrance in the Armed Forces, employment, collection of Social Security and retirement benefits, and for a passport to travel in foreign lands.

Because the birth certificate is such an important document, great care must be taken to make certain that it is correct in every detail. By completing this work booklet carefully, you can help assure the accuracy of the child's birth certificate. The information collected in this work booklet will be used to complete the Statewide Perinatal Data System (SPDS). The SPDS combines the New York State Certificate of Live Birth and a number of Quality Improvement (QI) questions. The QI questions strive to improve services provided to pregnant woman and their babies through the analysis of this information. The information that is collected is held in the strictest confidence. Data are analyzed in groups only, and individuals are not identified.

PARENTS, please complete the unshaded portions of this work booklet, see pages 2, 3, 7-8 & 11 (the shaded portions will be completed by hospital staff).

Information in the work booklet will be used to prepare the official birth certificate, which is filed with the local Registrar of Vital Statistics in your area within five (5) business days after the birth and with the New York State Department of Health. When the filing process is completed, the mother will receive a Certified copy of the birth certificate. This is an official form that may be used as proof of age, parentage and identity. Receiving it confirms that the child's birth certificate is officially registered in the State of New York. Additional copies of the baby's birth certificate may be obtained from the local registrar or the New York State Department of Health, P.O. Box 2602, Albany, New York 12220-2602. For further information about obtaining copies, please call (518) 474-3077 or visit the DOH website at <http://www.health.state.ny.us/nysdoh/consumer/vr.htm>.

All information (including personal information) is shared with the County Health Departments or other Local Health Units where the child was born and where the mother resides, if different. County Health Departments and Local Health Units may use this data for Public Health Programs. The Social Security Administration and Immunization Registry programs receive a minimal set of data ONLY when the parents have indicated, in this work booklet, that they wish to participate in these programs.

While individual information is important, public health workers will use medical and demographic data (without personal identifying information) in their efforts to identify, monitor and reduce maternal and newborn risk factors. This information (without personal identifying information) also provides physicians and medical scientists with the basis to develop new maternal and childcare programs for New York State residents.

ATTENTION HOSPITAL STAFF:

This work booklet has been designed to obtain information relating to the pregnancy, birth and the 72-hour period immediately following the birth of a live born child in New York State. Hospital staff, please complete the shaded portions of the work booklet.

New York State Public Health Law provides the basis for the collection of the birth certificate data. For pertinent information about the New York State Public Health Laws refer to sections 206(1)(e), 4102, 4130.5, 4132 and 4135. These laws are also described in the New York State Birth Certificate Guidelines. The Guidelines are available to SPDS users on the Vital Records Home Page <https://commerce.health.state.ny.us/dyn3/cgi-bin/applinks/spds/home.htm> under Vital Records Resources.

New York State Birth Certificate Work Booklet

New Birth Registration			
Mother	Mother's Name: <i>First</i> <i>Middle</i> <i>Maiden Last Name</i> <i>Current Last Name</i>		
	Social Security Number: - -	Mother's Date of Birth: (MM/DD/YYYY) / /	
Infant	Infant's Name: <i>First</i> <i>Middle</i> <i>Last</i> <i>Suffix</i>		
	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined	Plurality:	Birth Order:
	Date of Birth: (MM/DD/YYYY) / /		Time of Birth: (HH:MM) : <input type="checkbox"/> am <input type="checkbox"/> pm <input type="checkbox"/> military (24-hour time)

Infant	Was child born in this facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If child was not born in this facility, please answer the following questions:	
	In what type of place was the infant born? <input type="checkbox"/> Freestanding Birth Center (regulated by DOH) <input type="checkbox"/> Home (unknown intent) <input type="checkbox"/> Home (intended) <input type="checkbox"/> Clinic / Doctor's Office (not regulated by DOH) <input type="checkbox"/> Home (unintended) <input type="checkbox"/> Other	If New York State Birthing Center, enter its name: In what county was the child born?
	Institution	
Birthplace	Site of Birth, If Other Type of Place:	Street Address – if other than Hospital / Birthing Center:
	If place of infant's birth was other than Hospital or Birthing Center: City, town or village where birth occurred: Zip / Postal Code:	

Attendant	Attendant's Information:		
	License Number:	Name: <i>First</i> <i>Middle</i> <i>Last</i>	
	Title: (Select one) <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Doctor of Osteopathy <input type="checkbox"/> Licensed Midwife (CNM) <input type="checkbox"/> Licensed Midwife (CM) <input type="checkbox"/> Other		
Certifier	Certifier's Information:		
	<input type="checkbox"/> Check here if the Certifier is the same as the Attendant (otherwise enter information below)		
	License Number:	Name: <i>First</i> <i>Middle</i> <i>Last</i>	
	Title: (Select one) <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Doctor of Osteopathy <input type="checkbox"/> Licensed Midwife (CNM) <input type="checkbox"/> Licensed Midwife (CM) <input type="checkbox"/> Other		

Payor	Primary Payor for this Delivery:	
	Select one: <input type="checkbox"/> Medicaid / Family Health Plus <input type="checkbox"/> Private Insurance <input type="checkbox"/> Indian Health Service <input type="checkbox"/> CHAMPUS / TRICARE <input type="checkbox"/> Other Government / Child Health Plus B <input type="checkbox"/> Other <input type="checkbox"/> Self-pay	
	If Medicaid is not the primary payor, is it a secondary payor for this delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the mother enrolled in an HMO or other managed care plan? <input type="checkbox"/> Yes <input type="checkbox"/> No

Release Form

Mother's Name: <i>First</i>	Middle	Last	Mother's Med. Rec. Number:
Father's Name: <i>First</i>	Middle	Last	Suffix
Infant's Name: <i>First</i>	Middle	Last	Suffix
			Date of Birth

To the hospital:

1. Obtain the parent(s) signature(s).
2. File the original Release Form in the mother's hospital record.
Note: It is not necessary to file the remainder of the Work Booklet.
3. Provide a copy to the parent(s).
4. Do **not** send copies to the New York State Department of Health or to any Social Security office, unless specifically requested by such agency.

To the parent(s):

1. Please read the following notice about the collection and use of Social Security Numbers on your child's birth certificate.
2. Please check "Yes" or "No" to indicate if you wish to participate in any of the listed programs.

NOTICE REGARDING COLLECTION OF PARENTS' SOCIAL SECURITY NUMBERS: The collection of parents' Social Security Numbers on the New York State Certificate of Live Birth is mandatory. They are required by Public Health Law Section 4132(1) and may be used for child support enforcement, public health related purposes, when requested by State, federal and municipal governments for official purposes, when required by Public Health Law Section 4173 or 4174 and when otherwise required or authorized by law.

Yes No

Social Security Release

The Social Security Administration offers the parents of newborns an opportunity to apply for a Social Security Number for their child through the birth certificate registration process. This is referred to by the Social Security Administration as Enumeration at Birth (EAB). If you participate in the EAB, the New York State Department of Health will forward to the Social Security Administration information from your child's birth certificate. Please note that the Social Security Administration will not process your EAB request unless, the birth certificate includes your child's full name. If you participate in the EAB, disclosure of parents' Social Security Numbers is mandated by 42 U.S.C. 405(c)(2). The Social Security Number(s) will be used by the Internal Revenue Service (IRS) solely for the purpose of determining Earned Income Tax Credit compliance. Do you want to participate in the Social Security Administration EAB program?

Yes No

Immunization Registry

I consent to my child's immunization information, and my child's and my own identifying demographic information contained on the Birth Certificate, being placed in the New York State Immunization Registry to assist in my child's medical care and treatment. I understand that my child will be enrolled in the Immunization Registry and all of his/her immunizations will be entered in the registry. The immunization information will be released on request to: me or the child's legal guardian, my child when he/she reaches 18 years of age, the child's insurance company, his/her school or licensed day care, the local and state health department, or to a medical provider authorized to provide medical care for my child. I understand that I can withdraw from the registry at any time with written notification to my child's medical care provider.

Mother's Signature ▶ _____ **Date** _____

Father's Signature ▶ _____ **Date** _____

Either parent's signature applies to all of the above releases.
If neither box is checked for a release, a 'No' response will be assumed.

Hospital Name:	
Signature of Hospital Representative: ▶	Date:

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Infant

Infant	If Multiple Births:		Birth Weight:	
	Number of Live Births:	Number of Fetal Deaths:	grams	lbs. oz.
	If birth weight < 1250 grams (2 lbs. 12 oz.), reason(s) for delivery at a less than level III hospital: <i>(Only if applicable)</i>			
<input type="checkbox"/> None <input type="checkbox"/> Unknown at this time				
Select all that apply:				
<input type="checkbox"/> Rapid / Advanced Labor <input type="checkbox"/> Bleeding <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Severe pre-eclampsia <input type="checkbox"/> Woman Refused Transfer <input type="checkbox"/> Other (specify)				
Infant Transferred: <input type="checkbox"/> Within 24 hrs <input type="checkbox"/> After 24 hrs. <input type="checkbox"/> Not transferred			NYS Hospital Infant Transferred To:	
State/Terr./Province:				

Birth Information	Apgar Scores			Is the Infant Alive?	Clinical Estimate of Gestation: (Weeks)	Newborn Treatment Given:
	1 minute:	5 minutes:	10 minutes:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant Transferred / Status Unknown		<input type="checkbox"/> Conjunctivitis only <input type="checkbox"/> Vitamin K only <input type="checkbox"/> Both <input type="checkbox"/> Neither
How is infant being fed? (Select one) <input type="checkbox"/> Breast Milk Only <input type="checkbox"/> Formula Only <input type="checkbox"/> Both Breast Milk and Formula <input type="checkbox"/> Other <input type="checkbox"/> Do Not Know						

Hepatitis B	Hepatitis B Inoculation			Immunoglobulin		
	Immunization Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: (MM/DD/YYYY) / /	Immunoglobulin Administered: <input type="checkbox"/> Yes <input type="checkbox"/> No	Date: (MM/DD/YYYY) / /		

Abnormal Conditions of the Newborn	Abnormal Conditions of the Newborn:					
	<input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU Admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizures or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fx, peripheral nerve injury, soft tissue/solid organ hemorrhage which requires intervention)					

Congenital Anomalies

Congenital Anomalies	<input type="checkbox"/> None of the listed <input type="checkbox"/> Unknown at this time Select all that apply		Diagnosed Prenatally?	If Yes, please indicate all methods used:
	Yes No	Anencephaly	Yes No	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No	Meningomyelocele/Spina Bifida	Yes No	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No	Cyanotic Congenital Heart Disease	Yes No	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No	Congenital Diaphragmatic Hernia	Yes No	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No	Omphalocele	Yes No	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown

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Congenital Anomalies				
Congenital Anomalies	Select all that apply	Diagnosed Prenatally?	If Yes, please indicate all methods used: QI	
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Gastroschisis	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Limb Reduction Defect	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Cleft lip with or without Cleft Palate	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Cleft Palate Alone	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> CVS <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Other Chromosomal Disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> CVS <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	Yes No <input type="checkbox"/> <input type="checkbox"/>	Hypospadias	Yes No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown

Labor & Delivery		
Labor & Delivery	Mother Transferred in Antepartum: <input type="checkbox"/> Yes <input type="checkbox"/> No	NYS Facility Mother Transferred From: State/Terr./Province:
	Mother's Weight at Delivery: <i>lbs.</i>	
Method of Delivery	Fetal Presentation: <i>(select one)</i> <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other	
	Route & Method: <i>(select one)</i> <input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps – Mid <input type="checkbox"/> Forceps – Low / Outlet <input type="checkbox"/> Vacuum <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown	
	Attempted Procedures: Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Trial Labor: If Cesarean section, was trial labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Indications for C-Section: <input type="checkbox"/> Unknown Select all that apply <input type="checkbox"/> Failure to progress <input type="checkbox"/> Malpresentation <input type="checkbox"/> Previous C-Section <input type="checkbox"/> Fetus at Risk / NFS <input type="checkbox"/> Maternal Condition – Not Pregnancy Related <input type="checkbox"/> Maternal Condition – Pregnancy Related <input type="checkbox"/> Refused VBAC <input type="checkbox"/> Elective <input type="checkbox"/> Other	

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Labor & Delivery	
Method of Delivery	<p>Indications for Vacuum:</p> <p><input type="checkbox"/> Unknown QI</p> <p>Select all that apply</p> <p><input type="checkbox"/> Failure to progress <input type="checkbox"/> Fetus at Risk</p> <p><input type="checkbox"/> Other</p> <hr/> <p>Indications for Forceps:</p> <p><input type="checkbox"/> Unknown QI</p> <p>Select all that apply</p> <p><input type="checkbox"/> Failure to progress <input type="checkbox"/> Fetus at Risk</p> <p><input type="checkbox"/> Other</p>
Labor	<p>Onset of Labor</p> <p><input type="checkbox"/> None <input type="checkbox"/> Unknown at this time</p> <p>Select all that apply</p> <p><input type="checkbox"/> Prolonged Rupture of Membranes -- (12 or more hours) <input type="checkbox"/> Premature Rupture of Membranes -- (prior to labor) <input type="checkbox"/> Precipitous Labor -- (less than 3 hours)</p> <p><input type="checkbox"/> Prolonged Labor (20 or more hours)</p>
Characteristics	<p>Characteristics of Labor & Delivery</p> <p><input type="checkbox"/> None <input type="checkbox"/> Unknown at this time</p> <p>Select all that apply</p> <p><input type="checkbox"/> Induction of Labor – AROM <input type="checkbox"/> Induction of Labor – Medicinal <input type="checkbox"/> Augmentation of Labor</p> <p><input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Chorioamnionitis</p> <p><input type="checkbox"/> Meconium Staining <input type="checkbox"/> Fetal Intolerance <input type="checkbox"/> External Electronic Fetal Monitoring</p> <p><input type="checkbox"/> Internal Electronic Fetal Monitoring</p>
Maternal Morbidity	<p>Maternal Morbidity</p> <p><input type="checkbox"/> None <input type="checkbox"/> Unknown at this time</p> <p>Select all that apply</p> <p><input type="checkbox"/> Maternal Transfusion <input type="checkbox"/> Perineal Laceration (3rd / 4th Degree) <input type="checkbox"/> Ruptured Uterus</p> <p><input type="checkbox"/> Unplanned Hysterectomy <input type="checkbox"/> Admit to ICU <input type="checkbox"/> Unplanned Operating Room Procedure Following Delivery</p> <p><input type="checkbox"/> Postpartum transfer to a higher level of care QI</p>
Anesthesia / Analgesia	<p>Anesthesia / Analgesia</p> <p><input type="checkbox"/> None <input type="checkbox"/> Unknown at this time</p> <p>Select all that apply</p> <p><input type="checkbox"/> Epidural (Caudal) <input type="checkbox"/> Local <input type="checkbox"/> Spinal</p> <p><input type="checkbox"/> General Inhalation <input type="checkbox"/> Paracervical <input type="checkbox"/> General Intravenous</p> <p><input type="checkbox"/> Pudendal</p> <p>Was an analgesic administered?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Procedures	<p>Other Procedures Performed at Delivery</p> <p><input type="checkbox"/> None <input type="checkbox"/> Unknown at this time</p> <p>Select all that apply</p> <p><input type="checkbox"/> Episiotomy and Repair <input type="checkbox"/> Sterilization</p>

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Mother	
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	Medical Record Number:
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Mother's Demographics	Mother's Education: (select one) <input type="checkbox"/> 8 th grade or less <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Master's degree <input type="checkbox"/> 9 th – 12 th grade; no diploma <input type="checkbox"/> Associate's degree <input type="checkbox"/> Doctorate degree <input type="checkbox"/> High school graduate; or GED <input type="checkbox"/> Bachelor's degree		
	City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:
	Hispanic Origin: Select all that apply <input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, Other Spanish/Hispanic/Latina Specify: _____		

Mother's Demographics	Race: Select all that apply <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Gaumanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> American Indian or Alaska Native Tribe: _____ <input type="checkbox"/> Other Asian Specify: _____ <input type="checkbox"/> Other Pacific Islander Specify: _____ <input type="checkbox"/> Other Specify: _____		

Mother's Residence	Residence Address		
	Street Address:		
	County: (if NYS)	City, Town or Village:	State/Terr./Province:
	Zip/Postal Code:	U.S./Canadian Phone Number: () -	Mother's Country of Residence, if not USA:

Mother's Mailing Address	Mailing Address – Most Recent			
	<input type="checkbox"/> Check here if the mailing address is the same as the residence address (otherwise enter information below)			
	Mailing Address:			
City, Town or Village:		State/Terr./Province:	Country, if not USA:	Zip/Postal Code:

Employment	Employment History		
	Employed while Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No	Current / Most Recent Occupation:	Kind of Business / Industry:
	Name of Company or Firm:		Address:
City:		State/Terr./Province:	Zip / Postal Code:

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Prenatal History						
Prenatal History	Did mother receive prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Primary Prenatal Care Provider Type: <input type="checkbox"/> MD / DO / C(N)M / HMO <input type="checkbox"/> No Information <input type="checkbox"/> Clinic <input type="checkbox"/> No Provider <input type="checkbox"/> Other		Did mother participate in WIC? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Key Pregnancy Dates (MM/DD/YYYY)					
	Date of Last Menses: / /	Estimated Due Date: / /	Date of First Prenatal Visit: / /	Date of Last Prenatal Visit: / /		
Prenatal Visits	Total Number of Prenatal Visits: _____					
Pregnancy History	Pregnancy History					
	Previous Live Births: Now Living: None or Number <input type="checkbox"/> Now Dead: None or Number <input type="checkbox"/>		Previous Spontaneous Terminations: Less than 20 Weeks: None or Number <input type="checkbox"/> 20 Weeks or More: None or Number <input type="checkbox"/>		Previous Induced Terminations: None or Number <input type="checkbox"/>	Total Prior Pregnancies: None or Number <input type="checkbox"/>
	First Live Birth: (MM / YYYY) /	Last Live Birth: (MM / YYYY) /	Last Other Pregnancy Outcome: (MM / YYYY) /	Prepregnancy Weight: _____ lbs.	Height: _____ ft. _____ in.	

Prenatal Care							
Risk Factors	Risk Factors in this Pregnancy <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time						
	Select all that apply <input type="checkbox"/> Prepregnancy Diabetes <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Prepregnancy Hypertension <input type="checkbox"/> Gestational hypertension <input type="checkbox"/> Other Serious Chronic Illnesses <input type="checkbox"/> Previous Preterm Births <input type="checkbox"/> Abruptio Placenta <input type="checkbox"/> Other Vaginal Bleeding <input type="checkbox"/> Other Poor Pregnancy Outcomes <input type="checkbox"/> Infertility Treatment, Number of Embryos Implanted: <input type="text"/> <input type="checkbox"/> Previous Cesarean Section, Number: <input type="text"/> <input type="checkbox"/> Prelabor Referred for High Risk Care (if applicable)						
Infections	Infections Present and/or Treated During Pregnancy <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time						
	Select all that apply <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Herpes Simplex Virus (HSV) <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Rubella <input type="checkbox"/> Bacterial Vaginosis						
Other Risk Factors	Other Risk Factors						
	Smoking Before or During Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	List Number of Packs OR Cigarettes Smoked Per DAY					
	3 Months Prior to Pregnancy	First Three Months of Pregnancy		Second Three Months of Pregnancy		Last Trimester of Pregnancy	
	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes

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Prenatal Care			
Other Risk	Other Risk Factors		
	Alcohol Consumed During This Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of Drinks per Week:	Illegal Drugs Used During This Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No
Obstetric Procedures	Obstetric Procedures		
	<input type="checkbox"/> None <input type="checkbox"/> Unknown at this time Select all that apply <input type="checkbox"/> Cervical Cerclage <input type="checkbox"/> Tocolysis <input type="checkbox"/> External Cephalic Version — <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> Fetal Genetic Testing QI		
	If woman was 35 or over, was fetal genetic testing offered? QI <input type="checkbox"/> Yes <input type="checkbox"/> No, Too Late <input type="checkbox"/> No, Other Reason		
	Serological Test for Syphilis? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Test: (MM/DD/YYYY) / /	Reason, if No Test: <input type="checkbox"/> Mother refused <input type="checkbox"/> Religious reasons <input type="checkbox"/> No prenatal care <input type="checkbox"/> Other <input type="checkbox"/> No time before delivery

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Interview/Records 

Survey of Mother (in hospital)	Survey of Mother (in hospital)	
	Did you receive prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If 'Yes' please answer question 1. Otherwise skip to question 2.)</i>	
	1. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?	
		Yes No
	a. How smoking during pregnancy could affect your baby?	<input type="checkbox"/> <input type="checkbox"/>
	b. How drinking alcohol during your pregnancy could affect your baby?	<input type="checkbox"/> <input type="checkbox"/>
c. How using illegal drugs could affect your baby?	<input type="checkbox"/> <input type="checkbox"/>	
d. How long to wait before having another baby?	<input type="checkbox"/> <input type="checkbox"/>	
e. Birth control methods to use after your pregnancy?	<input type="checkbox"/> <input type="checkbox"/>	
f. What to do if your labor starts early?	<input type="checkbox"/> <input type="checkbox"/>	
g. How to keep from getting HIV (the virus that causes AIDS)?	<input type="checkbox"/> <input type="checkbox"/>	
h. Physical abuse to women by their husbands or partners?	<input type="checkbox"/> <input type="checkbox"/>	
	2. How many times per week during your current pregnancy did you exercise for 30 minutes or more, above your usual activities?	Times per week:
	3. Did you have any problems with your gums at any time during pregnancy, for example, swollen or bleeding gums?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	4. During your pregnancy, would you say that you were: <i>(select one)</i>	
	<input type="checkbox"/> Not depressed at all <input type="checkbox"/> A little depressed <input type="checkbox"/> Moderately depressed <input type="checkbox"/> Very depressed <input type="checkbox"/> Very depressed and had to get help	
	5. Thinking back to just before you were pregnant, how did you feel about becoming pregnant?	
	<input type="checkbox"/> You wanted to be pregnant sooner <input type="checkbox"/> You wanted to be pregnant later <input type="checkbox"/> You wanted to be pregnant then <input type="checkbox"/> You didn't want to be pregnant then or at any time in the future	
Chart Review (Prenatal and Medical)	Chart Review (Prenatal and Medical)	
	1a. Copy of prenatal record in chart?	
	<input type="checkbox"/> Yes, Full Record	<input type="checkbox"/> Yes, Prenatal Summary Only
	<input type="checkbox"/> No	
	1b. Was formal risk assessment in prenatal chart?	
	<input type="checkbox"/> Yes, with Social Assessment	<input type="checkbox"/> Yes, without Social Assessment
<input type="checkbox"/> No		
1c. Was MSAFP / triple screen test offered?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> No, Too Late		
1d. Was MSAFP / triple screen test done?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. How many times was the mother hospitalized during this pregnancy, not including hospitalization for delivery?		/ /
Admission & Discharge	Admission and Discharge Information	
	Mother	
	Admission Date for Delivery (MM/DD/YYYY) / /	Discharge Date (MM/DD/YYYY) / /
	Infant	
Discharge Date (MM/DD/YYYY) / /	<input type="checkbox"/> Discharged Home <input type="checkbox"/> Infant Died at Birth Hospital <input type="checkbox"/> Infant Still in Hospital <input type="checkbox"/> Infant Discharged to Foster Care/Adoption <input type="checkbox"/> Infant Transferred Out <input type="checkbox"/> Unknown	