

Mother's Name:	Mother's Med. Rec. Number:
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**New York State Birth Certificate and Statewide Perinatal Data System 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.

**New York State Birth Certificate:**

**PARENTS, for the birth certificate, you must complete the unshaded portions of this work booklet, see pages 3 - 5, 10 - 12 & 14 (the shaded portions will be completed by hospital staff).**

Information that is not labeled "QI", "IMM" or "NBS" in the work booklet will be used to prepare the official birth certificate. The completed birth certificate is filed with the Local Registrar of Vital Statistics of the municipality where the child was born 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 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 New York State Department of Health web site at: [http://www.nyhealth.gov/vital\\_records/](http://www.nyhealth.gov/vital_records/).

All information (including personal/identifying 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 receives a minimal set of data ONLY when the parents have indicated, in this work booklet, that they wish to participate in the Social Security Administration's Enumeration at Birth program.

While individual information is important, public health workers will use medical and demographic data in their efforts to identify, monitor, and reduce maternal and newborn risk factors. This information also provides physicians and medical scientists with the basis to develop new maternal and childcare programs for New York State residents.

**Statewide Perinatal Data System (SPDS) – Quality Improvement (QI), Immunization Registry (IMM) and Newborn Screening Program (NBS) Information:**

The information labeled "QI" collected in this work booklet will be used by medical providers and scientists to perform data analyses aimed at improving services provided to pregnant women and their babies. Information labeled "IMM" will be used by New York State's Immunization Information System (NYSIIS). A birthing hospital's obligation to report immunizations for newborns can be met by recording all the information in SPDS. This includes the manufacturer and lot number as required by law. Information labeled "NBS" will result in significant improvements in the Newborn Screening Program such as better identification and earlier treatment of infants at risk for a variety of disorders.

**ATTENTION HOSPITAL STAFF:**

This work booklet has been designed to obtain information relating to the pregnancy and birth during 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 **Help** tab of the SPDS Core Module.

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## **Help for Parents Completing This Work Booklet**

**Page 4: Last Name on Mother’s Birth Certificate**

This is commonly referred to as “maiden name.” If the mother was adopted, it would be the last name on her birth certificate *after* the adoption.

**Page 4: Infant’s Pediatrician/Family Practitioner**

Enter the name of the doctor who will care for the infant after he/she is released from the hospital. This may or may not be the same as the doctor who cared for the infant while in the hospital.

**Page 11: Last Name on Father’s / Second Parent’s Birth Certificate**

- **Father:** This is usually the same as his current last name. In the event that a man has changed his last name through marriage, the name on his birth certificate should be entered here. This may or may not be the same as his current last name depending on whether his name was changed by marriage only or changed through a court proceeding which resulted in an amendment to his birth certificate.
- **Mother (Second Parent):** This is commonly referred to as maiden name and is the name on her birth certificate.
- **In either case:** If the parent was adopted it would be the last name on his or her birth certificate *after* the adoption.

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**New Birth Registration**

<b>Parents</b>	<b>Mother</b>	Mother's First Name:		Mother's Middle Name:		
		Mother's Current Last Name :		Last Name on Mother's Birth Certificate:		
		Social Security Number: - -	Mother's Date of Birth: (MM/DD/YYYY) / /			
	Infant's First Name:			Infant's Middle Name:		
	Infant's Last Name:				Infant's Name Suffix (e.g. Jr., 2 <sup>nd</sup> , III):	
<b>Infant</b>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined		Plurality:	Birth Order:	Medical Record No.:	
	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)	

<b>Parents</b>	<b>Infant</b>	Was child born in this facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If child was <b>not</b> 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"/> Clinic / Doctor's Office (not regulated by DOH) <input type="checkbox"/> Home (intended) <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?	
	<b>Birthplace</b>	<b>Institution</b>			
Site of Birth, If <b>Other</b> Type of Place:		Street Address – if other than Hospital / Birthing Center:			
<b>If place of infant's birth was other than Hospital or Birthing Center:</b>					
City, town or village where birth occurred:				Zip / Postal Code:	

**Infant's Pediatrician/Family Practitioner:** **NBS**

<b>Attendant</b>	<b>Attendant's Information:</b>			
	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				
<b>Certifier</b>	<b>Certifier's Information:</b>			
	<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				

<b>Parents</b>	<b>Payor</b>	<b>Primary Payor for this Delivery:</b>			
		<b>Select one:</b> <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			

Mother's Name: <i>First</i>	<i>Middle</i>	<i>Last</i>	Mother's Med. Rec. Number:
Father / Second Parent Name: <i>First</i>	<i>Middle</i>	<i>Last</i>	<i>Suffix</i>
Infant's Name: <i>First</i>	<i>Middle</i>	<i>Last</i>	<i>Suffix</i> 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 the Social Security Administration's Enumeration at Birth program.

**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.

**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. If you wish to participate in the Social Security Administration EAB program check "Yes" below.

**May the Social Security Administration be furnished with information from this form to issue your child a social security number?**

Yes

No

**Mother's Signature** ▶ \_\_\_\_\_ **Date** \_\_\_\_\_

**Father's or Second Parent's Signature** ▶ \_\_\_\_\_ **Date** \_\_\_\_\_

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

Hospital Name:	
Signature of Hospital Representative:	Date:

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**Infant**

<b>Infant</b>	<b>If Multiple Births:</b> Number of Live Births: _____ Number of Fetal Deaths: _____	<b>Birth Weight:</b> _____ 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	
	<b>Select all that apply:</b> <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 <i>(specify)</i>	
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: _____

<b>Birth Information</b>	Apgar Scores 1 minute: _____ 5 minutes: _____ 10 minutes: _____	Is the Infant Alive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant Transferred / Status Unknown	Clinical Estimate of Gestation: <i>(Weeks)</i> _____	Newborn Treatment Given: <input type="checkbox"/> Conjunctivitis only <input type="checkbox"/> Vitamin K only <input type="checkbox"/> Both <input type="checkbox"/> Neither
	How is infant being fed at discharge? <i>(Select one)</i> <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			

<b>Newborn Screening</b>	<b>Newborn Blood-Spot Screening</b> Screening Lab ID Number: <i>(9-digits)</i> _____	<b>Reason if Lab ID is not submitted:</b> <input type="checkbox"/> No NBS Lab ID because infant died prior to test <input type="checkbox"/> No NBS Lab ID because infant transferred prior to test <input type="checkbox"/> Lab ID is unknown / illegible <input type="checkbox"/> Refused NBS
	<b>NBS</b>	

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

<b>Abnormal Conditions of the Newborn</b>	Abnormal Conditions of the Newborn: <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time
	<b>Select all that apply</b> <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)

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<b>Congenital Anomalies</b>				
<b>Congenital Anomalies</b>	<input type="checkbox"/> None of the listed <input type="checkbox"/> Unknown at this time <b>Select all that apply</b>	<b>Diagnosed Prenatally?</b>	<b>If Yes, please indicate all methods used:</b>	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Anencephaly	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Meningomyelocele/Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> MSAFP / Triple Screen <input type="checkbox"/> Amniocentesis <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Cyanotic Congenital Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Congenital Diaphragmatic Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Omphalocele	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Gastroschisis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Limb Reduction Defect	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Cleft lip with or without Cleft Palate	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Cleft Palate Alone	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending	<input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Other Chromosomal Disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending	<input type="checkbox"/> Yes <input type="checkbox"/> 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
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	Hypospadias	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Level II Ultrasound <input type="checkbox"/> Other <input type="checkbox"/> Unknown

<b>Labor &amp; Delivery</b>		
<b>Labor &amp; Delivery</b>	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>	
<b>Method of Delivery</b>	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	
	Cesarean Section History: <input type="checkbox"/> Previous C-Section   Number <input style="width: 40px; border: 1px solid black;" type="text"/>	
	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	

Mother's Name:	Mother's Med. Rec. Number:
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<b>Labor &amp; Delivery</b>		
<b>Method of Delivery</b>	<b>Trial Labor:</b> If Cesarean section, was trial labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	<b>Indications for C-Section:</b> <span style="font-size: 2em; font-weight: bold; color: gray;">QI</span> <input type="checkbox"/> Unknown <b>Select all that apply</b> <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	
	<table style="width:100%; border: none;"> <tr> <td style="width: 50%; padding: 5px; vertical-align: top;"> <b>Indications for Vacuum:</b> <span style="font-size: 2em; font-weight: bold; color: gray;">QI</span>  <input type="checkbox"/> Unknown  <b>Select all that apply</b>  <input type="checkbox"/> Failure to progress      <input type="checkbox"/> Fetus at Risk  <input type="checkbox"/> Other                         </td> <td style="width: 50%; padding: 5px; vertical-align: top;"> <b>Indications for Forceps:</b> <span style="font-size: 2em; font-weight: bold; color: gray;">QI</span>  <input type="checkbox"/> Unknown  <b>Select all that apply</b>  <input type="checkbox"/> Failure to progress      <input type="checkbox"/> Fetus at Risk  <input type="checkbox"/> Other                         </td> </tr> </table>	<b>Indications for Vacuum:</b> <span style="font-size: 2em; font-weight: bold; color: gray;">QI</span> <input type="checkbox"/> Unknown <b>Select all that apply</b> <input type="checkbox"/> Failure to progress <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Other
<b>Indications for Vacuum:</b> <span style="font-size: 2em; font-weight: bold; color: gray;">QI</span> <input type="checkbox"/> Unknown <b>Select all that apply</b> <input type="checkbox"/> Failure to progress <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Other	<b>Indications for Forceps:</b> <span style="font-size: 2em; font-weight: bold; color: gray;">QI</span> <input type="checkbox"/> Unknown <b>Select all that apply</b> <input type="checkbox"/> Failure to progress <input type="checkbox"/> Fetus at Risk <input type="checkbox"/> Other	
<b>Labor</b> <b>Onset of Labor</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <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) <input type="checkbox"/> Prolonged Labor (20 or more hours)		
<b>Characteristics</b> <b>Characteristics of Labor &amp; Delivery</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <input type="checkbox"/> Induction of Labor – AROM <input type="checkbox"/> Induction of Labor – Medicinal <input type="checkbox"/> Augmentation of Labor <input type="checkbox"/> Steroids <input type="checkbox"/> Antibiotics <input type="checkbox"/> Chorioamnionitis <input type="checkbox"/> Meconium Staining <input type="checkbox"/> Fetal Intolerance <input type="checkbox"/> External Electronic Fetal Monitoring <input type="checkbox"/> Internal Electronic Fetal Monitoring		
<b>Maternal Morbidity</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <input type="checkbox"/> Maternal Transfusion <input type="checkbox"/> Perineal Laceration (3 <sup>rd</sup> / 4 <sup>th</sup> Degree) <input type="checkbox"/> Ruptured Uterus <input type="checkbox"/> Unplanned Hysterectomy <input type="checkbox"/> Admit to ICU <input type="checkbox"/> Unplanned Operating Room Procedure Following Delivery <input type="checkbox"/> Postpartum transfer to a higher level of care <span style="font-size: 2em; font-weight: bold; color: gray;">QI</span>		
<b>Anesthesia / Analgesia</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <input type="checkbox"/> Epidural (Caudal) <input type="checkbox"/> Local <input type="checkbox"/> Spinal <input type="checkbox"/> General Inhalation <input type="checkbox"/> Paracervical <input type="checkbox"/> General Intravenous <input type="checkbox"/> Pudendal <b>Was an analgesic administered?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Procedures</b> <b>Other Procedures Performed at Delivery</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <input type="checkbox"/> Episiotomy and Repair <input type="checkbox"/> Sterilization		

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**Mother**

<b>Mother</b>										
	Medical Record Number:									
Parents	<b>Mother's Education: (select one)</b> <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Master's degree <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> 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									
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">City of Birth:</td> <td style="width: 33%;">State/Terr./Province of Birth:</td> <td style="width: 33%;">Country of Birth, if not USA:</td> </tr> </table>	City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:						
	City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:							
	<b>Hispanic Origin:</b> <b>Select all that apply</b> <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 <b>Specify:</b> <input style="width: 100%;" type="text"/>									
<b>Race:</b> <b>Select all that apply</b> <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"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> American Indian or Alaska Native <b>Tribe:</b> <input style="width: 100%;" type="text"/> <input type="checkbox"/> Other Asian <b>Specify:</b> <input style="width: 100%;" type="text"/> <input type="checkbox"/> Other Pacific Islander <b>Specify:</b> <input style="width: 100%;" type="text"/> <input type="checkbox"/> Other <b>Specify:</b> <input style="width: 100%;" type="text"/>										
Mother's Residence	<b>Residence Address</b>									
	Street Address:									
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">State/Terr./Province:</td> <td style="width: 33%;">County:</td> <td style="width: 33%;">City, Town or Village:</td> </tr> <tr> <td>Zip/Postal Code:</td> <td>Mother's Country of Residence, if not USA:</td> <td>U.S./Canadian Phone Number: (     )     -</td> </tr> </table>	State/Terr./Province:	County:	City, Town or Village:	Zip/Postal Code:	Mother's Country of Residence, if not USA:	U.S./Canadian Phone Number: (     )     -			
State/Terr./Province:	County:	City, Town or Village:								
Zip/Postal Code:	Mother's Country of Residence, if not USA:	U.S./Canadian Phone Number: (     )     -								
Mother's Mailing Address	<b>Mailing Address – Most Recent</b>									
	<input type="checkbox"/> Check here if the mailing address is the same as the residence address (otherwise enter information below)									
	Mailing Address:									
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">City, Town or Village:</td> <td style="width: 33%;">State/Terr./Province:</td> <td style="width: 33%;">Country, if not USA:</td> <td style="width: 15%;">Zip/Postal Code:</td> </tr> </table>	City, Town or Village:	State/Terr./Province:	Country, if not USA:	Zip/Postal Code:						
City, Town or Village:	State/Terr./Province:	Country, if not USA:	Zip/Postal Code:							
Employment	<b>Employment History</b>									
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">Employed while Pregnant: <input type="checkbox"/> Yes   <input type="checkbox"/> No</td> <td style="width: 33%;">Current / Most Recent Occupation:</td> <td style="width: 33%;">Kind of Business / Industry:</td> </tr> <tr> <td>Name of Company or Firm:</td> <td colspan="2">Address:</td> </tr> <tr> <td>City:</td> <td>State/Territory/Province:</td> <td>Zip / Postal Code:</td> </tr> </table>	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/Territory/Province:	Zip / Postal Code:
	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/Territory/Province:	Zip / Postal Code:								

Mother's Name:	Mother's Med. Rec. Number:
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**Father or Second Parent**

Will the mother and father be executing an Acknowledgement of Paternity? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not required	What type of certificate is required? <input type="checkbox"/> Mother / Father <input type="checkbox"/> Mother / Mother
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Parent's First Name:	Parent's Middle Name:
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Parent's Current Last Name:	Last Name on Parent's Birth Certificate:
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Parent's Name Suffix <i>(e.g. Jr., 2<sup>nd</sup>, III):</i>	Social Security Number: - -	
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**Demographics**

Parent's Date of Birth: <i>(MM/DD/YYYY)</i>  / /	Education: <i>(select one)</i> <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Master's degree <input type="checkbox"/> 9 <sup>th</sup> – 12 <sup>th</sup> 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
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City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:
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Hispanic Origin: <b>Select all that apply</b>		
<input type="checkbox"/> No, not Spanish/Hispanic/Latino	<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano	<input type="checkbox"/> Yes, Puerto Rican
<input type="checkbox"/> Yes, Cuban	<input type="checkbox"/> Yes, Other Spanish/Hispanic/Latino	
<b>Specify:</b> _____		

Race: <b>Select all that apply</b>		
<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"/> Guamanian or Chamorro	<input type="checkbox"/> Samoan	
<input type="checkbox"/> American Indian or Alaska Native Tribe:	_____	_____
<input type="checkbox"/> Other Asian <b>Specify:</b>	_____	_____
<input type="checkbox"/> Other Pacific Islander <b>Specify:</b>	_____	_____
<input type="checkbox"/> Other <b>Specify:</b>	_____	_____

<b>Residence Address</b>	<input type="checkbox"/> Check here if the parent's residence address is the same as the mother's address <i>(otherwise enter information below)</i>
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Street Address:	_____
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City, Town or Village:	State / Territory / Province:
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Parent's Country of Residence, if not USA:	Zip / Postal Code:
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**Employment History**

Current / Most Recent Occupation:	Kind of Business / Industry:
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Name of Company or Firm:	Address:
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City:	State / Territory / Province:	Zip / Postal Code:
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Parents  
Father's or Second Parent's Demographics

Mother's Name:	Mother's Med. Rec. Number:
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**Prenatal History**

<b>Parents</b>	<b>Prenatal History</b>	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				
		<b>Key Pregnancy Dates</b> (MM/DD/YYYY)							
		Date of Last Menses: / /		Estimated Due Date: / /		Date of First Prenatal Visit: / /		Date of Last Prenatal Visit: / /	
<b>Prenatal Visits</b>		Total Number of Prenatal Visits: _____							
<b>Parents</b>	<b>Pregnancy History</b>	<b>Pregnancy History</b>							
		Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:		Total Prior Pregnancies:	
		Now Living None or Number <input type="checkbox"/>	Now Dead None or Number <input type="checkbox"/>	Less than 20 Weeks None or Number <input type="checkbox"/>	20 Weeks or More None or Number <input type="checkbox"/>	None or Number <input type="checkbox"/>	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**

<b>Parents</b>	<b>Risk Factors</b>	<b>Risk Factors in this Pregnancy</b>							
		<input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <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"/> Abruption Placenta <input type="checkbox"/> Eclampsia <input type="checkbox"/> Other Poor Pregnancy Outcomes <input type="checkbox"/> Prelabor Referred for High Risk Care <input type="checkbox"/> Other Vaginal Bleeding <input type="checkbox"/> Previous Low Birthweight Infant <b>QI</b> <input type="checkbox"/> Pregnancy resulted from infertility treatment (if yes, check all that apply) <input type="checkbox"/> Fertility-enhancing drugs, artificial or intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g. IVF, GIFT) <b>Number of Embryos Implanted:</b> (if applicable) <input type="text"/> <b>QI</b>							
<b>Parents</b>	<b>Other Risk Factors</b>	<b>Infections Present and/or Treated During Pregnancy</b>							
		<input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <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							
<b>Smoking Before or During Pregnancy?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>List Number of Packs OR Cigarettes Smoked Per DAY</b>							
		3 Months Prior to Pregnancy		First Three Months of Pregnancy		Second Three Months of Pregnancy		Third Trimester of Pregnancy	
		Packs	OR	Cigarettes	Packs	OR	Cigarettes	Packs	OR

Mother's Name:	Mother's Med. Rec. Number:
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<b>Prenatal Care</b>			
	<b>Other Risk Factors</b>		
<b>Other Risk</b>	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
	<b>Obstetric Procedures</b>		
<b>Obstetric Procedures</b>	<input type="checkbox"/> None <input type="checkbox"/> Unknown at this time <b>Select all that apply</b> <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 <b>QI</b>		
	If woman was 35 or over, was fetal genetic testing offered? <b>QI</b>		
	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

Mother's Name:	Mother's Med. Rec. Number:
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**Interview/Records**

**Survey of Mother (in hospital)**

Did you receive prenatal care?  Yes  No (If 'Yes' please answer question 1. Otherwise skip to question 2.)

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?  Yes  
 No

4. During your pregnancy, would you say that you were: (select one)

- |   |   |
|---|---|
| <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)**

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?

Chart Review (Prenatal and Medical)

**Admission and Discharge Information**

Mother

Admission Date for Delivery (MM/DD/YYYY) / /	Discharge Date (MM/DD/YYYY) / /
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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

Admission & Discharge