

# GUIDELINES

FOR  
THE NEW YORK STATE  
CERTIFICATE OF LIVE BIRTH  
& QUALITY IMPROVEMENT  
2010

Bureau of Productions Systems Management  
(Vital Records)  
Bureau of Women's Health

New York State Department of Health

November 2010

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## **INTRODUCTION AND EXPLANATORY INFORMATION**

The birth certificate is the official record of an infant's full name, date of birth and place of birth. The birth registration process has been incorporated into the context of the Statewide Perinatal Data System (SPDS).

The following instructions are given to guide the entry of the information from hospital and physician records and notes into the New York State Certificate of Live Birth. The instructions refer to the web based Birth Certificate. The guidelines follow the order of the SPDS screens and work booklet.

The data will be entered into the SPDS application and ONLY the legal portion of the record will be printed. The legal and medical/confidential information will be electronically transported to the New York State Department of Health over the Health Provider Network (HPN). If a hospital wishes to retain a copy of the information from the SPDS, a facsimile record can be printed from the application, which contains most of the legal and Medical/Confidential information.

A work booklet is available in English and Spanish to assist hospital staff in gathering the information to prepare for entry into the SPDS. It is highly recommended that this be used.

An index at the end identifies the pages on which specific guidelines occur. The information contained herein will help to ensure that data gathered from different hospitals throughout the state will be consistent and will provide comparable statistics among various hospital settings.

The next 2 pages contain sections of the New York State Public Health Law that governs the collection and distribution of birth certificate information.

## **NEW YORK STATE PUBLIC HEALTH LAW PERTAINING TO LIVE BIRTHS**

New York State Public Health Law, Section 206(1)(e), states the Commissioner of Health shall obtain, collect and preserve such information relating to marriage, birth, mortality, disease and health as may be useful in the discharge of his/her duties or may contribute to the promotion of health or the security of life in the state; establish rules and regulations for the determination of asymptomatic conditions including, but not limited to Rh sensitivity, anemia, sickle cell anemia, Cooley's anemia and venereal disease.

New York State Public Health Law, Section 4102, states any person shall be deemed guilty of a misdemeanor, and upon conviction shall be fined or be imprisoned or be both fined and imprisoned in the discretion of the court, who for himself or as an officer, agent, or employee of any other person, or of any corporation or partnership, shall:

- § refuse or fail to furnish correctly any information in his possession, or shall furnish false information affecting any certificate or record, required by this article; or
- § willfully alter, otherwise than is provided by this article, or shall falsify any certificate of birth or death, or any record established by this article; or
- § being a registrar, deputy registrar or subregistrar, shall fail, neglect or refuse to perform his duty as required by this article and by the instructions and directions of the commissioner thereunder.

It further states whenever any physician, licensed midwife, or other person shall fail or neglect properly to record and file a certificate of birth as required by this article such person shall be liable to a fine, such person shall be guilty of a misdemeanor, punishable by a fine, or by imprisonment, or both.

New York State Public Health Law, Section 4130.5, states when a birth occurs in a hospital, the person in charge of such hospital or his designated representative shall obtain the personal data, prepare the certificate, secure the signatures required by the certificate and file it with the registrar. The physician in attendance or a physician acting in his behalf shall certify to the facts of birth and provide the medical information required by the certificate within five days after birth.

New York State Public Health Law, Section 4131.1, states that the report of the finding of a child whose parents are unknown, filed by the commissioner of social services or by the city social services officer in accordance with the provisions of subdivision two of section three hundred ninety-eight of the social services law, shall constitute the birth record of such child.

New York State Public Health Law, Section 4131.2, states the district wherein such child was found shall be considered as the place of birth, and the date of birth shall be that determined by the commissioner of social services or by the city social services officer as the approximate date of birth.

New York State Public Health Law, Section 4131.3, states if, however, such child be subsequently identified, and it should appear that a certificate of birth for this child has either before or following identification been filed, as otherwise provided in this article, the report of the commissioner of social services or of the city social services officer shall be placed under seal by the state commissioner of health, such seal not to be broken except upon order of a court of competent jurisdiction.

New York State Public Health Law, Section 4132, states the certificate of birth shall contain such information, including the social security numbers of the parents, and be in such form as the commissioner may prescribe. The personal particulars called for shall be obtained from a competent person acquainted with the facts. The certificate shall be signed by the attending physician or licensed midwife, with date of signature and his or her address.

It further states if there was no physician or licensed midwife, in attendance then the certificate of birth shall be signed by the father or mother of the child, householder, owner of the premises, director or other person in charge of the public or private institution where the birth occurred, or by any other competent person whose duty it is to notify the local registrar of such birth. The registrar shall enter the exact date of filing of the certificate of birth in his office attested by his official signature and registered number of birth.

New York State Public Health Law, Section 4135, states there shall be no specific statement on the birth certificate as to whether the child is born in wedlock or out of wedlock or as to the marital name or status of the mother. The phrase “child born out of wedlock” when used in this article, refers to a child whose father is not its mother’s husband.

The name of the putative father of a child born out of wedlock shall not be entered on the certificate of birth prior to filing without the consent in writing of both the mother and putative father, witnessed by two persons not related to either of them and filed with the record of birth, except that with respect to a child born out of wedlock to a married woman, a determination of parentage made by a court of competent jurisdiction shall be required before the putative father’s name may be entered on the birth certificate.

Orders relating to parentage shall be held confidential by the commissioner and shall not be released or otherwise divulged except by order of a court of competent jurisdiction.

New York State Public Health Law, Section 4172, states when the commissioner shall have so ordered, each registrar shall transmit, at such times as the commissioner shall direct, to the county health commissioner, public health director, director of patient services of a county, or to the state district health officer of the respective county or state health district in which such registrar’s primary district is included, copies of original birth, fetal death and death certificates which have been registered in such primary registration district.

Each county health commissioner, public health director or director of patient services of a county and each state district health officer receiving copies of original certificates shall retain such copies thereof pursuant to subdivision one of this section as confidential records subject to such further regulation to assure such confidentiality as may be prescribed by the commissioner.

## **NEW BIRTH REGISTRATION SCREEN**

### **MOTHER'S NAME**

Enter the mother's first, middle and maiden names and her current last name. Maiden name is her last name at her birth, not a last name acquired by marriage.

### **MOTHER'S SOCIAL SECURITY NUMBER**

Enter the parent's Social Security number. If the parent does not have a Social Security number, enter all zeros. If the Social Security number is unknown, enter all nines.

### **MOTHER'S DATE OF BIRTH**

Enter the exact month, day and year (including the century) the parent was born. Use numbers for months and days such as 06 04 1977 for June 4, 1977.

### **INFANT'S NAME**

If the parents have not selected given names for the child, enter the last name only. Do not enter Baby girl, Child, Infant boy, Newborn, Female, Male, etc. The child must have a first and last name in order to receive a social security card and number through the Enumeration at Birth program.

§ FIRST – Capitalize the first letter of the entire name.

§ MIDDLE – Capitalize the first letter of the entire name.

§ LAST – Enter the last name of the child according to the following instructions:

**Married Couple:** A married couple may select any surname for their child. They may choose the traditional paternal surname, the maternal surname, the maternal maiden name, a combination of paternal and maternal surnames (hyphenated or otherwise), a name derived from ethnic custom, a name unrelated to the parents, etc

If there is a disagreement between the parents that cannot be resolved within the 5-day filing requirement, we recommend that you enter the husband's surname as the surname of the child. Advise the parents that they may change the child's name by court order.

If non-marital birth is alleged, the mother may select the child's surname unless the husband objects. If the husband objects, enter his surname. The final choice of surname will be determined after the court rules on the child's paternity.

**Unmarried Mother:** The mother may select any surname that she wants for the child. She may even choose the name of the putative father regardless of whether or not he has signed an Acknowledgment of Paternity. Without an Acknowledgment of Paternity, surname, in and of itself, does not prove parentage.

**Widowed or Divorced:** Selection of surname will depend on when the child was conceived. If conception occurred before the husband's death or the divorce was finalized, handle in the same manner as for a married couple. If conception occurred after the husband's death or the divorce was finalized, handle in the same manner as for an unmarried mother.

§ SUFFIX Select an acceptable entry from the list provided in SPDS (Jr., 1<sup>st</sup> –10<sup>th</sup>, or Roman numerals I – X).

**INFANT'S SEX**

Record the child's sex by selecting male, female or undetermined.

**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. If not a single birth, specify the type of delivery as single, twin, triplet, etc by using 1, 2, 3 etc.

**BIRTH ORDER**

If the birth results in one child, this field will be automatically filled with a '0'. If the birth results in more than 1 child, specify the order in which this child was born, i.e., first, second, etc. Be sure to count each member of this delivery, even if born dead. A separate birth certificate or fetal death certificate, as the case may be, is required for each member of a multiple birth.

**INFANT'S MEDICAL RECORD NUMBER**

Enter the medical record number from the infant's chart.

**INFANT'S DATE OF BIRTH**

Enter the exact month, day and year (including the century) the child was born. When entering the date enter the numbered abbreviation for the date in the correct fields (e.g., 06 04 2001). Midnight or 2400 hours in military time belongs to the day that is ending. A new day begins at 12:01 a.m. or 0001 in military time.

**INFANT'S TIME OF BIRTH**

Enter the correct local time. Use standard or military time. Valid entries for military time are 0001-2400. Midnight or 2400 hours in military time belongs to the day that is ending. A new day begins at 12:01 a.m. or 0001 in military time.

**WAS CHILD BORN IN THIS FACILITY?****IF OTHER NYS FACILITY, SELECT ITS NAME****TYPE OF PLACE OF BIRTH**

Select the place of birth where the child was born:

- § Hospital
- § Home (intended)
- § Home (unintended)
- § Home (unknown intent)
- § Clinic/Doctor's Office (not regulated by DOH)
- § Freestanding birthing center (regulated by DOH)
- § Out of state hospital (DOH users only)
- § Other
- § Unknown

**IN WHICH COUNTY WAS THE CHILD BORN?**

## **INSTITUTION SCREEN**

### **BIRTHPLACE**

### **FACILITY OF BIRTH**

The hospital of birth should be displayed.

### **TYPE OF PLACE OF BIRTH**

### **SITE OF BIRTH IF OTHER TYPE OF PLACE**

If the infant was not born at the hospital but arrived at the hospital from a conveyance (e.g. ambulance, private car, taxi, bus public vehicle), indicate the name of hospital and the word 'enroute'. For the above conveyances, include the word "enroute" in parentheses.

### **STREET ADDRESS, IF PLACE OTHER THAN HOSPITAL, BIRTHING CENTER, ENROUTE**

### **OTHER THAN HOSPITAL/BIRTH CENTER, LOCALITY**

Enter the City, Town or Village by choosing from the list in the SPDS.

### **IF OTHER THAN HOSPITAL/BIRTH CENTER, ZIP CODE**

NBS

### **INFANT'S PEDIATRICIAN/FAMILY PRACTITIONER**

Enter the name (and location, if known) of the doctor or other health care professional 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.

NBS

### **ATTENDANT AT BIRTH - LICENSE**

Enter the attendant's license number. If the attendant is a physician or a doctor of osteopathy, they should have a six-digit license number. If you do not have a six-digit number for them call them (or the State Education Department) and ask for it. Call the Board of Medicine at 518-474-3841 for MD's and DO's license numbers. Call the Midwifery Board at 518-474-3848 for midwife's six digit state number. This is not the ACNM number that had been previously used. License numbers for physicians and midwives may be obtained from the New York State Education Department web site at [www.nysed.gov](http://www.nysed.gov). If the attendant is an intern or other person without a license number, the license number of the supervising doctor should be used. There will be some births where the attendant may not have a license number (e.g. mom, dad, taxi driver).

### **ATTENDANT AT BIRTH - NAME**

The attendant is the person who delivered the infant. If nobody was present for the birth the mom would be the attendant. Enter the name of the attendant.

The name, title, mailing address and license number of each person eligible to attend births in this institution may be stored in the SPDS. Enter the license number of the attendant. If the attendant's information is stored in the SPDS it will populate the remaining attendant fields. If the attendant's data is not stored in the SPDS, key in the attendant information.

### **ATTENDANT AT BIRTH - TITLE**

Enter the title of the attendant. If the attendant is not one of the ones listed choose 'other'. The 'other' category would be used when the mother, father, taxi driver etc. was the attendant.

## **CERTIFIER OF BIRTH**

- § **BIRTHING HOSPITAL BIRTHS** When a birth occurs in a birthing hospital, the physician, licensed midwife or other person in attendance is required to certify to the facts of birth by signing and dating the birth certificate. In the absence of the person who attended the birth, the hospital administrator is required to designate a physician to certify the facts of birth. The paper portion of the birth certificate will not be accepted without the signature of the certifier and the date. This means a licensed midwife may only sign for themselves and not for a physician or another licensed midwife. If you know who the certifier will be as you are filling in the birth certificate enter his/her license number, name and title.
- § **CLINICS AND NON-BIRTHING HOSPITAL BIRTHS** These births must be filed on long forms.
- § **EXTRAMURAL BIRTHS** If you are preparing a certificate as a courtesy for a birth that occurred outside of a hospital or clinical setting the mother or other person (EMT, ambulance attendant, etc.) who delivered the baby should be listed as attendant. The attendant must certify the birth certificate and you should make a reasonable attempt (telephone call, letter) to obtain the certifier's signature on the birth certificate. If the attendant is not available to certify the birth certificate, the birth certificate should be sent without the certifier's signature to the local registrar of the municipality where the child was born. Please advise the local registrar that the birth certificate is incomplete. The local registrar will then be responsible for obtaining the signature of the mother or other person who attended the birth. The certifier must sign before the birth certificate can be filed or copies issued.

## **PRIMARY PAYOR FOR THIS DELIVERY**

- § **Medicaid** – select this choice if the mother's care was paid for by Medicaid, PCAP, MOMS, Child Health Plus A, Medicaid Managed Care, or Family Health Plus
- § **Private Insurance** – select this item if the mother's care was paid for by private insurance, including indemnity insurance and/or managed care insurance
- § **Self-pay** – select this item if the mother had no health insurance
- § **Indian Health Service**
- § **CHAMPUS/TRICARE** (Military and dependents)
- § **Other government** (e.g. Child Health Plus B, Veteran's Administration)
- § **Other**
- § **Unknown**

## **MEDICAID CLIENT IDENTIFICATION NUMBER (CIN)**

The CIN (Client Identification Number) is a unique identifying number that is assigned to individuals who are in receipt of Medicaid or Family Health Plus. The "number" sequence always consists of two letters, followed by five numbers, followed by another letter. Medicaid enrollees should have an identification card with the CIN. Family Health Plus enrollees will NOT have a "Medicaid" or "Family Health Plus" card, but will have a Managed Care card which should have a number with the CIN sequence; this suggests that a person who presents with a managed care card with what appears to be a CIN may be enrolled in Family Health Plus. If a hospital has reason to believe that a mother is in receipt of Medicaid/Family Health Plus but they do not have a number, there is a provider line that a hospital or doctor's office can call to obtain the number (518 473-4620); the client's name, date of birth, and social security number will be needed. If a hospital has reason to believe that a mother is in receipt of Medicaid/Family Health Plus but they do not have a number and are unable to obtain one, they should report the payor as Medicaid on SPDS (either primary or secondary), and the system will attempt to find the mother's case based on demographic information (such as name, Social Security Number and

date of birth).

**SECONDARY MEDICAID PAYOR?**

Select 'yes' if the mother's primary payor is NOT Medicaid, but she had Medicaid coverage.



**HMO ENROLLMENT?**

Select 'yes' if the mother's primary insurer is either Medicaid, private, Indian Health Service, CHAMPUS/TRICARE, or other government and she was enrolled in a managed care plan/organization. Synonyms for managed care plan include health maintenance organization (HMO) and preferred provider organization (PPO).

**RELEASE OF INFORMATION ATTESTATION**

§ **SOCIAL SECURITY** This release form indicates whether NYSDOH has parental permission to furnish the Social Security Administration with information from this form, so that they may issue a Social Security number in the child's name. This is known as the Enumeration At Birth (EAB) program. A 'Yes' should only be indicated if a parent has signed the release and the release is kept on file in the hospital.

If the parents do not have an SSN themselves, hospitals should encourage the parents to apply for the child's SSN through the EAB process. The EAB program requires that the child have a first and last name and be alive at the time of the application. If the parents have not selected a first name for the child, they may not participate in the EAB process. If the parents have not selected a first name for the child, enter the last name only and make the parents aware that they may apply for a social security number at their local Social Security office once they have chosen a first name. Do not enter Baby girl, Child, Infant boy, etc.

**INFANT SCREEN**

**INFANT'S NAME**

If the parents have not selected given names for the child, enter the last name only. Do not enter Baby girl, Child, Infant boy, Newborn, Female, Male, etc. The child must have a first and last name in order to receive a social security card and number through the Enumeration at Birth program.

§ **FIRST** – Capitalize the first letter of the entire name.

§ **MIDDLE** – Capitalize the first letter of the entire name.

§ **LAST** – Enter the last name of the child according to the following instructions:

Married Couple: A married couple may select any surname for their child. They may choose the traditional paternal surname, the maternal surname, the maternal maiden name, a combination of paternal and maternal surnames (hyphenated or otherwise), a name derived from ethnic custom, a name unrelated to the parents, etc

If there is a disagreement between the parents that cannot be resolved within the 5-day filing requirement, we recommend that you enter the husband's surname as the surname of the child. Advise the parents that they may change the child's name by court order.

If non-marital birth is alleged, the mother may select the child's surname unless the husband objects. If the husband objects, enter his surname. The final choice of surname will be determined after the court rules on the child's paternity.

Unmarried Mother: The mother may select any surname that she wants for the child. She may even choose the name of the putative father regardless of whether or not he has signed an Acknowledgment of Paternity. Without an Acknowledgment of Paternity, surname, in and of itself, does not prove parentage.

Widowed or Divorced: Selection of surname will depend on when the child was conceived. If conception occurred before the husband's death or the divorce was finalized, handle in the same manner as for a married couple. If conception occurred after the husband's death or the divorce was finalized, handle in the same manner as for an unmarried mother.

§ SUFFIX Select an acceptable entry from the list provided in SPDS (Jr., 1st –10th, or Roman numerals I – X).

### **INFANT'S SEX**

Record the child's sex by checking the appropriate box. In the event that the sex is indeterminate, be sure that the appropriate congenital malformation is recorded in the medical portion of the certificate.

### **PLURALITY**

Specify the type of delivery as single, twin, triplet, etc by using 1, 2, 3 etc.

### **BIRTH ORDER**

If the birth results in one child, this field will be automatically filled with a '0'. If the birth results in more than 1 child, specify the order in which this child was born, i.e., first, second, etc. Be sure to count each member of this delivery, even if born dead. A separate birth certificate or fetal death certificate, as the case may be, is required for each member of a multiple birth.

### **INFANT'S MEDICAL RECORD NUMBER**

Enter the medical record number from the infant's chart.

### **NUMBER OF LIVE BIRTHS (If Multiple Births)**

This is used to check the values entered in plurality and birth order fields.

### **NUMBER OF FETAL DEATHS (If Multiple Births)**

This is used to check the values entered in plurality and birth order fields.

### **INFANT'S DATE OF BIRTH**

Enter the exact month, day and year (including the century) the child was born. When entering the date enter the numbered abbreviation for the date in the correct fields (e.g., 06 04 2001). Midnight or 2400 hours in military time belongs to the day that is ending. A new day begins at 12:01 a.m. or 0001 in military time.

### **INFANT'S TIME OF BIRTH**

Enter the correct local time. Use standard or military time. Valid entries for military time are 0001-2400. Midnight or 2400 hours in military time belongs to the day that is ending. A new day begins at 12:01 a.m. or 0001 in military time.

### **BIRTHWEIGHT**

Enter the birthweight of the infant as it is recorded on the hospital record. Enter the birthweight in either grams **OR** pounds and ounces, depending on the scales used. Do not convert from one

measure to the other. The SPDS will display the weight in both grams and pounds and ounces.

**IF BIRTHWEIGHT < 1250 GRAMS (or 2 lbs 12 oz.), REASON FOR DELIVERY AT A LESS THAN LEVEL III HOSPITAL**

Please indicate reasons for delivery at birth hospital if it is not a Level III or IV facility and the infant's birthweight is less than 1250 grams, or 2lbs. 12oz..

- § Rapid/advanced labor 4 or more centimeters dilated
- § Bleeding more than 100 ml/hr
- § Fetus at risk/NFS
  - Evidence from a biophysical profile of a disturbance in utero
  - Positive contraction stress test, the presence of late decelerations, during oxytocin stimulation with half or more of the contractions
  - Breech or a malpresentation such as transverse lie, shoulder presentation
  - Frank prolapse of the cord
  - Fetal structural anomaly, such as fetal hydrocephalus
  - Persistent late decelerations during most contractions
  - Persistent variable decelerations during most contractions, often 60 to 80 bpm
  - Prolonged bradycardia below 120 to 100 bpm 10 minutes or longer
  - Prolonged tachycardia above 160 to 180 bpm persisting longer than 10 minutes
  - Fetal scalp pH of less than 7.2. Include acidosis.
- § Severe preeclampsia/eclampsia Select this if one or more of the following criteria is present:
  - Blood pressure of 160 mm Hg systolic or higher or 110 mm Hg diastolic or higher on two occasions at least 6 hours apart while the patient is on bed rest.
  - Proteinuria of 5 g or higher in a 24-hour urine specimen or 3+ or greater on two random urine samples collected at least 4 hours apart.
  - Oliguria of less than 500 mL in 24 hours
  - Cerebral or visual disturbances
  - Pulmonary edema or cyanosis
  - Epigastric or right upper-quadrant pain
  - Impaired liver function
  - Thrombocytopenia
  - Fetal growth restriction
  - seizures/convulsions
- § Woman refused transfer
- § Other (specify)
- § None
- § Unknown at this time

**INFANT TRANSFERRED**

Indicate whether the infant was transferred to another facility within 24 hours or after 24 hours.

**HOSPITAL INFANT TRANSFERRED TO**

If the infant was transferred to another facility within NYS choose from the list in the SPDS. If the infant was transferred to a hospital that is not in New York State choose the state the infant was transferred to from the list in the SPDS.

**APGAR SCORE AT 1, 5, AND 10 MINUTES**

Enter 1-minute and 5-minute scores for all newborns. Enter a 10-minute score if the 5-minute score is less than 6.

**IS THE INFANT ALIVE?**

Indicate the infant's vital status, alive or dead, at the time the birth certificate was filed by selecting Yes, No, or Transferred/Status Unknown. Remember the birth certificate is intended to report the facts of birth and the 72 hours immediately following the birth.

**CLINICAL ESTIMATE OF GESTATION**

The obstetric estimate of the infant’s gestation in completed weeks based on the birth attendant’s final estimate of gestation which should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam.

**NEWBORN TREATMENT GIVEN?**

Indicate if vitamin K was given. Also, indicate if there was preventative treatment for conjunctivitis administered.

**INFANT FEEDING**

During the period between birth and the fifth day of life (or discharge from the hospital if the infant is discharged before the fifth day of life), indicate whether the infant has been fed breast milk exclusively, infant formula only, a combination of both breast milk and formula, or other.

- § **Breast Milk Only:** (Exclusive breast milk feeding) Infant has been fed ONLY breast milk and no other liquids or solids except for drops or syrups consisting of vitamins, minerals, or medicines. Breast milk feeding includes expressed mother’s milk as well as donor human milk, both of which may be fed to the infant by means other than suckling at the breast.
- § **Formula Only:** Infant has been fed formula (any amount). Has NOT been fed any breast milk. May or may not have been fed other liquids, such as water or glucose water.
- § **Both Breast Milk and Formula:** Infant has been fed BOTH breast milk (any amount) AND formula, water, glucose water and/or other liquids (any amount).
- § **Other:** Infant has NOT been fed any breast milk or formula. This response is rare; it will include infants in the intensive care unit who require intravenous feeding.

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**NEWBORN SCREENING**

- § **Screen Lab ID Number:** Enter the nine-digit Lab ID number that appears on the upper left corner of the Newborn Screening Blood Collection Form. It may be necessary to contact the Newborn Screening Coordinator for this information.
- § **Reason if Lab ID not submitted** Select the appropriate check box. The “ID unknown/illegible” item should be chosen when the Brood Collection Form was completed and the
  - Lab ID number cannot be read; or the
  - Lab ID number does not pass the validation algorithm. An error message will occur if an invalid number is entered.

**HEPATITIS B INOCULATION**

**Immunization Administered** Select “Yes” for this item if the infant received a dose of Hepatitis B vaccine. Synonyms: HB vaccine, Recombivax HB and Engerix-B.

IMM  
IMM

- § **Date Immunization Administered** No partial dates are allowed.
- § **Manufacturer:** Choose the manufacturer from the drop down list. If you have a manufacturer that does not appear on the drop down list contact NYSIIS staff at (518) 473-2839 so that it may be added to the list.
- § **Lot:** Enter lot number from the vaccine packaging, vial or pre-filled syringe.

**Immunoglobulin Administered** Select “Yes” for this item if the infant received a dose of Hepatitis B immunoglobulin. Synonyms: HBIG, H-BIG, HyperHep, Hep-B-Gammagee.

- § **Date Immunoglobulin Administered** No partial dates are allowed.

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§ **Manufacturer** Choose the manufacturer from the drop down list. If you have a manufacturer that does not appear on the drop down list contact NYSIIS staff at (518) 473-2839 so that it may be added to the list.

IMM

§ **Lot:** Enter lot number from the vaccine packaging, vial or pre-filled syringe.

#### **ABNORMAL CONDITIONS OF THE NEWBORN**

- § **Assisted ventilation required immediately after delivery:** Infant given manual breaths with bag and mask or bag and endotracheal tube within the first several minutes from birth for any duration. Excludes oxygen only and laryngoscopy for aspiration of meconium.
- § **Assisted ventilation required for more than 6 hours:** Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours. Includes conventional, high frequency and/or continuous positive airway pressure (CPAP).
- § **Neonatal Intensive Care Unit (NICU):** Admission into a unit staffed and equipped to provide continuous mechanical ventilatory support for the newborn. This includes special nurseries and newborns transferred to a hospital with a NICU for the purpose of providing that infant with intensive care (e.g. surgery or ventilatory support). Temporary stays in the NICU would not be reported as a NICU admission. Only if the infant is actually admitted to the NICU should it be reported as such.
- § **Newborn given surfactant replacement therapy:** Endotracheal instillation of a surface-active suspension for the treatment of surfactant deficiency due to either preterm birth or pulmonary injury resulting in decreased lung compliance (respiratory distress). Includes both artificial and extracted natural surfactant.
- § **Antibiotics received by the newborn for suspected neonatal sepsis:** Any antibacterial drug given systemically (intravenous or intramuscular.) (e.g. penicillin, ampicillin, gentamicin, cefotaxime, etc.) to treat neonatal sepsis, a blood-borne bacterial infection of the newborn.
- § **Seizure or serious neurologic dysfunction:** Seizure defined as any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction defined as severe alteration of alertness such as obtundation, stupor, or coma, i.e. hypoxicischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with Central Nervous System (CNS) congenital anomalies.
- § **Significant birth injury:** (e.g., skeletal fracture(s), peripheral nerve injury and/or soft tissue/solid organ hemorrhage that requires intervention) Defined as present immediately following delivery or manifesting following delivery. Includes any bony fracture or weakness, but excludes fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and /or extremity ecchymosis accompanied by evidence of anemia and/or hypovolemia and/or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma. All require confirmation by diagnostic imaging or exploratory laparotomy. Note: DO NOT include Intraventricular hemorrhage (IVH) in this item. See below for listing of significant birth injuries:
  - Adrenal hemorrhage/hematoma
  - Brachial plexus injury (Also reported as Erb's Palsy, Dujenne-Erb Paralysis, Klumpke's Palsy, Klumpke-Déjérine Syndrome)
  - Cranial fracture (exclude cephalohematoma, hemorrhagic caput succedaneum)
  - Facial palsy – non transient
  - Femur fracture
  - Humerus fracture
  - Intracranial hemorrhage, including subdural or subarachnoid hemorrhage, but excluding intraventricular hemorrhage (IVH)

- Peripheral nerve injury
- Phrenic nerve injury
- Recurrent laryngeal nerve injury
- Ruptured liver and/or spleen
- Skeletal fractures – Exclude clavicle fractures.
- Skull/cranial fracture also reported by skull bone: parietal, frontal or occipital fracture
- Soft tissue or solid organ hemorrhage
- Subgaleal hemorrhage
- Subcapsular hemorrhage of liver
- None: Select this item if none of the items listed are selected, even if other abnormal conditions of the newborn exist.
- Unknown: Select this item if it is not currently known if any of the listed conditions of the newborn exist.

## **CONGENITAL ANOMALIES SCREEN**

### **CONGENITAL ANOMALIES OF THE CHILD**

Indicate any of the specific conditions listed below. Information about other congenital anomalies is no longer being collected on the birth certificate. All congenital anomalies, both those listed below and any other significant anomaly, must be reported to the New York State Congenital Malformations Registry. Call (518) 402-7990 for further information about reporting.

- § **ANENCEPHALY** Select this item if diagnosed by a physician. Synonyms include absent brain, acrania, anencephalic, anencephalus, amyelencephalus, craniorachischisis, hemianencephaly, or hemicephaly.
- § **MENINGOMYELOCELE / SPINA BIFIDA** Select this item if diagnosed by a physician. Synonyms include meningocele, myelocele, myelomeningocele, myelocystocele, syringomyelocele, hydromeningocele, rachischisis. Do NOT include spina bifida occulta detected on radiographs.
- § **CYANOTIC CONGENITAL HEART DISEASE** Select this item if any of the following conditions has been diagnosed by a physician: transposition of the great arteries (vessels), teratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total or partial anomalous pulmonary venous return with or without obstruction.
- § **CONGENITAL DIAPHRAGMATIC HERNIA** Select this item if diagnosed by a physician.
- § **OMPHALOCELE** Select this item if diagnosed by a physician. Synonyms include exomphalos. Do NOT include umbilical hernia (completely covered by skin) in this category.
- § **GASTROSCHISIS** Select this item if diagnosed by a physician. Synonyms include limb-body wall complex.
- § **LIMB REDUCTION DEFECT** Select this item if diagnosed by a physician. This includes a missing hand, arm, foot, or leg, or any portion of it, excluding congenital amputation and dwarfing syndromes.
- § **CLEFT LIP WITH OR WITHOUT CLEFT PALATE** Select this item if diagnosed by a physician. Synonyms for cleft lip include harelip, cheiloschisis, and labium leporinum. Synonyms for cleft palate include cleft uvula, palate fissure, and palatoschisis.
- § **CLEFT PALATE ALONE** Select this item if diagnosed by a physician. Synonyms include cleft uvula, palate fissure, palatoschisis. If cleft lip also present, record only under item above.

- § **DOWN SYNDROME** Select this item if diagnosed by a physician. Synonyms include Trisomy 21. Indicate "Karyotype Confirmed" if chromosomal studies have been completed. Indicate "Karyotype Pending" if chromosomal studies have been initiated, but final results are not in.
- § **OTHER CHROMOSOMAL DISORDER** Select this item if diagnosed by a physician. Examples include Trisomy 13, Trisomy 18, Klinefelter syndrome, Edwards syndrome, Patau syndrome. Indicate "Karyotype Confirmed" if chromosomal studies have been completed. Indicate "Karyotype Pending" if chromosomal studies have been initiated, but final results are not in.
- § **HYPOSPADIAS** Select this item if diagnosed by a physician.
- § **NONE** Select this item if the infant had none of the anomalies listed, even if he/she had other congenital anomalies. All significant congenital anomalies must be reported to the New York State Congenital Malformations Registry.
- § **UNKNOWN AT THIS TIME**

## **LABOR AND DELIVERY SCREEN**

### **MOTHER TRANSFERRED FROM ANOTHER FACILITY IN ANTEPARTUM?**

Indicate Yes or No. Indicate 'yes' only if the mother was transferred from another hospital prior to delivery because the delivery was believed to be high risk.

### **NYS FACILITY MOTHER WAS TRANSFERRED FROM**

If the mother was transferred from a hospital within New York State, choose from the list in the SPDS. If the mother was transferred from a hospital that is not in New York State, enter the US state/territory or Canadian province of the transferring hospital.

### **MOTHER'S WEIGHT AT DELIVERY**

#### **METHOD OF DELIVERY**

##### § **FETAL PRESENTATION**

- **Cephalic** – Synonyms include vertex. Presenting part of the fetus listed as 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 or presenting part not listed above.
- **Unknown**

##### § **ROUTE & METHOD**

Indicate how delivery was finally accomplished, regardless of whether other procedures were attempted prior to successful delivery.

##### § **CESAREAN SECTION HISTORY**

- **Previous C-section** Select 'Yes' if mom has had a previous operative delivery in which the fetus was extracted through an incision in the maternal abdominal and uterine walls.
- **Number** Indicate the number of previous c-section deliveries.

##### § **ATTEMPTED PROCEDURES**

- **Forceps** Select 'yes' if forceps delivery was attempted unsuccessfully.
- **Vacuum** Select 'yes' if vacuum delivery was attempted unsuccessfully.

##### § **TRIAL OF LABOR**

If infant was delivered by cesarean, indicate whether mother had a trial of labor before the cesarean.

## INDICATIONS FOR C-SECTION

- § **Failure to progress** Select this item if a cesarean was performed because labor progressed more slowly than normal or because labor stopped before full dilation of the cervix; synonym: dystocia and arrest of descent
- § **Fetus at Risk/NFS** Select this item if a cesarean was performed because of concerns about the fetus's wellbeing and ability to tolerate labor.
  - Evidence from a biophysical profile of a disturbance in utero
  - Positive contraction stress test, the presence of late decelerations, during oxytocin stimulation with half or more of the contractions
  - Breech or a malpresentation such as transverse lie, shoulder presentation
  - Frank prolapse of the cord
  - Fetal structural anomaly, such as fetal hydrocephalus
  - Persistent late decelerations during most contractions
  - Persistent variable decelerations during most contractions, often 60 to 80 bpm
  - Prolonged bradycardia below 120 to 100 bpm 10 minutes or longer
  - Prolonged tachycardia above 160 to 180 bpm persisting longer than 10 minutes
  - Fetal scalp pH of less than 7.2. Include acidosis.
- § **Malpresentation** Select this item if the presenting part of the fetal body within the birth canal, or nearest to it was NOT the vertex or the occipital fontanel. Synonyms include face presentation, brow presentation, frank breech, complete breech, footling breech, transverse lie, shoulder presentation and oblique lie.
- § **Maternal Condition – Pregnancy Related** Select this item if the mother had an obstetric condition that led to cesarean delivery, e.g. abruptio placenta, placenta previa.
- § **Maternal Condition – Not Pregnancy Related** Select this item if the mother had a non-obstetric medical condition that led to cesarean delivery, e.g. active genital herpes, HIV infection.
- § **Elective** Select this item if the cesarean delivery was planned and scheduled prior to the onset of labor. In addition to selecting "Elective", you must also select a specific indication for the cesarean, unless it was done for a non-medical indication.
- § **Other** Select this item if the indication for cesarean does not fall into any of the other categories.
- § **Refused VBAC** Select this item if the mother was eligible for a trial of labor, but refused, opting for repeat cesarean delivery instead. Synonym: refused voluntary trial of labor.
- § **Previous C-Section** Select this item if the mother had a previous cesarean delivery and was not eligible for trial of labor, e.g. due to classical uterine scar.
- § **Unknown**

## INDICATIONS FOR VACUUM

- § **Failure to progress** Select this item if a vacuum extractor was used because delivery (second stage of labor) was progressing more slowly than normal; other related terms: dystocia, maternal exhaustion.
- § **Fetus at Risk / NFS** Select this item if a vacuum extractor was used because of concerns about the fetus's wellbeing.
  - Evidence from a biophysical profile of a disturbance in utero
  - Positive contraction stress test, the presence of late decelerations, during oxytocin stimulation with half or more of the contractions
  - Breech or a malpresentation such as transverse lie, shoulder presentation
  - Frank prolapse of the cord
  - Fetal structural anomaly, such as fetal hydrocephalus
  - Persistent late decelerations during most contractions
  - Persistent variable decelerations during most contractions, often 60 to 80 bpm

- Prolonged bradycardia below 120 to 100 bpm 10 minutes or longer
- Prolonged tachycardia above 160 to 180 bpm persisting longer than 10 minutes
- Fetal scalp pH of less than 7.2. Include acidosis.

§ **Other** Select this item if an indication other than those listed above was given for the use of vacuum extraction.

§ **Unknown**

#### INDICATIONS FOR FORCEPS

§ **Failure to progress** Select this item if forceps were used because delivery (second stage of labor) was progressing more slowly than normal; other related terms: dystocia, maternal exhaustion.

§ **Fetus at Risk / NFS** Select this item if forceps were used because of concerns about the fetus's wellbeing.

- Evidence from a biophysical profile of a disturbance in utero
- Positive contraction stress test, the presence of late decelerations, during oxytocin stimulation with half or more of the contractions
- Breech or a malpresentation such as transverse lie, shoulder presentation
- Frank prolapse of the cord
- Fetal structural anomaly, such as fetal hydrocephalus
- Persistent late decelerations during most contractions
- Persistent variable decelerations during most contractions, often 60 to 80 bpm
- Prolonged bradycardia below 120 to 100 bpm 10 minutes or longer
- Prolonged tachycardia above 160 to 180 bpm persisting longer than 10 minutes
- Fetal scalp pH of less than 7.2. Include acidosis.

§ **Other** Select this item if an indication other than those listed above was given for the use of forceps.

§ **Unknown**

#### ONSET OF LABOR

§ **Precipitous Labor** Select this if the total time between onset of labor and delivery was fewer than 3 hours. Precipitous labor and prolonged labor are mutually exclusive and therefore both may not be chosen for the same delivery.

§ **Premature Rupture of Membranes** Select this item if there was spontaneous tearing of the amniotic sac (natural breaking of the 'bag of waters') before labor begins.

§ **Prolonged Labor** Select this item if the total time between onset of labor and delivery was 20 hours or longer, regardless of mother's parity. Precipitous labor and prolonged labor are mutually exclusive and therefore both may not be chosen for the same delivery.

§ **Prolonged Rupture of Membranes** Select this item if the mother's membranes ruptured 12 hours or more before delivery, regardless of whether the mother was in labor or not.

§ **None** Select this item if none of the items listed are selected.

§ **Unknown at this time**

#### CHARACTERISTICS OF LABOR AND DELIVERY

§ **Induction of Labor – AROM** Initiation of uterine contractions by surgical means for the purpose of promoting delivery before spontaneous onset of labor. Synonyms include: artificial rupture of membranes, amniotomy. If AROM was done to augment labor that should be reported under Augmentation of Labor.

§ **Induction of Labor – Medical** Initiation of uterine contractions by administration of medications (e.g. pitocin, prostaglandin) for the purpose of promoting delivery before spontaneous onset of labor.

- § **Augmentation of Labor** – Simulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery.
- § **Steroids** – (glucosteroids) Steroids given any time prior to delivery for fetal lung maturation received by the mother prior to delivery. Includes betamethasone, dexamethasone or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to mother as an anti-inflammatory treatment.
- § **Antibiotics** - This includes antibiotics given to the mother during labor. It 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, Cefataxime, Ceftriaxone, etc.).
- § **Chorioamnionitis** A clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever (> 100.4 F or 38 C), uterine tenderness and/or irritability, leukocytosis, and fetal tachycardia. Any recorded maternal temperature at or above the febrile threshold as stated should be reported. However, do not report a single temperature elevation with a good alternative explanation.
- § **Meconium staining** Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or delivery which is more than enough to cause a greenish color change of an otherwise thin fluid, regardless of the characteristics of the meconium.
- § **Fetal intolerance** of labor such that one or more of the following actions was taken : in-utero resuscitation measures, further fetal assessment or operative delivery; *In utero resuscitative measure-s* such as any of the following: maternal position change, oxygen administration to the mother, intravenous fluid administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents. *Further fetal assessment* includes any of the following: scalp pH, scalp stimulation, acoustic stimulation. *Operative delivery*-operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery. The symptoms described and the measures used to treat them may be seen with administration of regional analgesia. However, if any of the measures listed in the Guide are documented in the chart, the response should be ‘YES’. An isolated episode with a good alternative explanation that resolves readily should not be reported.
- § **External Electronic Fetal Monitoring** Use of a non-invasive fetal monitoring device to track fetal heart rate during labor and/or delivery.
- § **Internal Electronic Fetal Monitoring** Use of an internal fetal monitoring device (synonym: scalp electrode) to track fetal heart rate during labor and/or delivery.
- § **None** Select this item if none of the items listed are selected, even if other characteristics of pregnancy exist.
- § **Unknown at this time**

## MATERNAL MORBIDITY

Admission to ICU Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care.

- § **Maternal transfusion** Includes infusion of whole blood or packed red blood cells associated with labor and delivery.
- § **Perineal laceration (3rd or 4th degree)** 3<sup>rd</sup> degree laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4<sup>th</sup> degree laceration is all of the above with extension through the rectal mucosa.
- § **Ruptured uterus** Tearing of the uterine wall.
- § **Unplanned Hysterectomy** Surgical removal of the uterus that was not planned prior to admission for delivery. Includes an anticipated or possible but not definitively planned



procedure.

- § **Admit to ICU** Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care.
- § **Unplanned operating room procedure following delivery** Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.
- § **Postpartum transfer to a higher level of care**
  - For maternity hospital deliveries: select this item if the mother was transferred to another hospital following delivery in order to provide her with more specialized or intensive care than available on the maternity service where she delivered.
  - For planned out-of-hospital deliveries (e.g. birthing center, planned home birth): select this item if mother required admission to a hospital following delivery.
  - For unplanned out-of-hospital or non-maternity hospital deliveries: Do not select this item if the mother was admitted to a maternity hospital after giving birth precipitously at home, en route to the hospital, or at a non-maternity hospital.
- § **None** Select this item if none of the items listed are selected, even if other maternal morbidity conditions exist.
- § **Unknown at this time**

#### **ANALGESIA**

Select “yes” for analgesia if during labor and/or delivery the mother received an analgesic medication, that is, one that decreases the sensation of pain (relief of pain). It may include any narcotic or non-narcotic painkiller. A sedative, that is, a substance that calms activity or excitement, does not qualify as analgesia when administered alone. Intrathecal (spinal) analgesia (narcotic +/- a small amount of local anesthetic), also called “intrathecal Duramorph,” should be reported here AND as “Anesthesia, Spinal,” since it carries risks and side effects of both. Exclude analgesics administered during other procedures performed after delivery such as episiotomy or laceration repair.

#### **ANESTHESIA USED FOR DELIVERY**

Indicate all types of anesthesia used during this labor and/or delivery. Anesthesia is a medication or other agent used to cause a loss of feeling (loss of sensation of pain). Report only the type of anesthesia used during labor and delivery, not the anesthetic agent.

- § **Epidural:** Select this item if the denervation of the vaginal region and lower abdomen was obtained by the introduction of an anesthetic agent into the epidural or peridural space.
- § **Local:** Select this item if the denervation of the vaginal area was obtained by the introduction of an anesthetic agent into the perineum for the provision of an episiotomy or repair of a laceration or episiotomy wound.
- § **Spinal:** Select this item if the denervation of the vaginal region was obtained by the introduction of an anesthetic agent into the subarachnoid space. Synonyms include saddle block. Intrathecal (spinal) analgesia (narcotic +/- a small amount of local anesthetic), also called “intrathecal Duramorph,” should be reported here AND as “Analgesia,” since it carries risks and side effects of both.
- § **General Inhalation:** Select this item if there was the reduction of pain over the entire body induced by respiration of a gaseous anesthetic agent.
- § **Paracervical:** Select this item if the denervation of the vaginal region was obtained by the introduction of an anesthetic agent to the tissues surrounding the cervix of the uterus.
- § **General Intravenous:** Select this item if there was the reduction of pain over the entire body induced by the introduction of an anesthetic agent into a vein.
- § **Pudendal:** Select this item if the denervation of the pudendal nerve was obtained by an injection of an anesthetic agent.

§ **None** Select this item if none of the items listed are selected.

§ **Unknown at this time**

### **OTHER PROCEDURES PERFORMED AT DELIVERY**

Record the procedures performed at the time of delivery or during the birth hospitalization.

§ **Episiotomy & Repair** Select this procedure if an incision was made to enlarge the vaginal opening and then repaired.

§ **Sterilization** Select this procedure if at any time during the birth hospitalization the mother received any procedure that permanently prevented future pregnancies. Synonyms include bilateral tubal ligation (BTL), hysterectomy, laparoscopic tubal ligation, oophorectomy, pomeroy, salpingectomy, tubal ligation.

§ **None** Select this item if none of the items listed are selected.

§ **Unknown at this time**

### **MOTHER'S SCREEN**

#### **MOTHER'S NAME**

Enter the mother's first, middle and maiden names and her current last name. Maiden name is her last name at her birth, not a last name acquired by marriage.

#### **MOTHER'S SOCIAL SECURITY NUMBER**

Enter the parent's Social Security number. If the parent does not have a Social Security number, enter all zeros. If the Social Security number is unknown, enter all nines.

#### **MOTHER'S MEDICAL RECORD NUMBER**

Enter the medical record number from the mother's chart.

#### **MOTHER'S DATE OF BIRTH**

Enter the exact month, day and year (including the century) the parent was born. Use numbers for months and days such as 06 04 1977 for June 4, 1977.

#### **MOTHER'S EDUCATIONAL LEVEL**

Enter the highest degree or level of schooling completed by each parent. Enter the highest level completed only.

§ Elementary school includes grades 01 through 08;

§ Secondary school includes grades 09 through 12, without receipt of diploma or GED;

§ High school graduate or GED recipient;

§ Some college credit, but no degree should be selected if the parent received some post-secondary or college education, but no degree;

§ Associate, Bachelor's, Master's, or Doctorate/Professional degree should be selected only if the degree was completed; select only the highest degree received;

§ Unknown

§ Do not enter any other kind of schooling or training. While beauty, barber, business, trade schools, etc., are important, they should not be considered for the purpose of this item.

#### **MOTHER'S BIRTHPLACE**

Select a country from the list of countries presented in the SPDS. If "USA" or "Canada" is selected, select the correct state or province from the list presented in the SPDS and then type the city of birth. Include both the city and state of the parent's birth. If "USA" is not selected, enter

only the country the parent was born in.

### **MOTHER'S HISPANIC ORIGIN**

Choose from the listing of Hispanic subgroups within the SPDS. If more than one was indicated by a parent, select as many as mentioned. There is no set rule as to how many generations are to be taken into account in determining ancestry or ethnic origin. The response is to reflect what the person considers himself or herself to be, and is not based on percentages of ancestry.

### **MOTHER'S RACE**

Choose from the races listed in the SPDS. Race is self-reported, meaning the parent is considered to be whatever race they say they are, regardless of appearance. If the "Other", "American Indian", "Alaskan Native", "Other Asian" or "Other Pacific Islander" category is selected, enter up to 2 specific nationalities or tribes.

### **MOTHER'S RESIDENCE ADDRESS**

A person's residence is not necessarily the same as the mailing address, legal address or voting address. Individual entry of residence items is the same as mailing address (above).

- § The residence entry on the certificate should be the place the mother lives, not where she receives her mail.
- § Do not enter a temporary residence such as an address used during a vacation, business trip or a visit to the home of a friend or relative or a home for unwed mothers.
- § Do not use a post office box as a residence address.
- § The place of residence during military duty or while attending college is considered a permanent residence and should be entered when applicable.
- § For those whose permanent address is a prison or psychiatric facility they should list the street address of the facility. However, there should be no mention of the facility name.

### **MOTHER'S STATE OF RESIDENCE**

Select the mother's state of residence from the list in the SPDS if the mother resides in the USA. If the mother does not reside in the USA, choose a country from the list in the SPDS and do not select a state.

### **MOTHER'S PHONE NUMBER**

Enter the mother's area code and phone number of her residence.

### **MOTHER'S MAILING ADDRESS**

This is where the parent receives their mail, not necessarily, where they live. Enter either the Post Office box number, city, state and zip code or the house number, street name, apartment number, city, state and zip code where the parent receives their mail. Each of the address segments are entered into separate fields: house number, street direction (e.g., N, SW), street name, street type (e.g., Dr, Ave, Pl), and apartment number.

- § HOUSE NUMBER Enter the house number.
- § STREET DIRECTION Enter the street direction such as North, South, East, West, Northwest, Southeast etc.
- § STREET NAME Enter the street name
- § STREET TYPE Choose from the drop down list in the SPDS.
- § CITY/TOWN/VILLAGE
- § STATE CODE Choose from the drop down list in the SPDS.
- § ZIP CODE 5 + 4 EXTENSION Enter either the 5 or 9-digit zip code.

**EMPLOYED WHILE PREGNANT?**

Select Yes or No, which ever is appropriate.

**MOTHER’S CURRENT OR MOST RECENT OCCUPATION**

Enter the mother’s usual or most recent occupation. Enter homemaker only if she was NEVER employed outside the home. Enter student only if she was a FULL time student during this pregnancy and had never held a full time job at any previous time.

**MOTHER’S KIND OF BUSINESS OR INDUSTRY**

Enter the kind of business or industry related to the occupation. Examples of businesses or industries are government, retail store, farming, manufacturing, construction, insurance, chemical, etc.

**MOTHER’S INDUSTRY NAME/ADDRESS**

Enter the name and locality of the firm or company corresponding to the entry made in the kind of business or industry item. For example, "State Health Department - Albany, NY."

**SECOND PARENT SCREEN (formerly FATHER’S SCREEN)**

**WHAT TYPE OF CERTIFICATE IS REQUIRED?**

In most cases the answer to this question will be “Mother/Father.” When the certificate is printed the titles “MOTHER” and “FATHER” will appear on certificate.

§ **MOTHER/FATHER** certificate is used for:

- Single mothers – in this case the father’s section of the birth certificate will be left blank.
- Heterosexual couples, whether married or executing an Acknowledgment of Paternity.

§ **MOTHER/MOTHER** certificate is used for:

- Married female couples who are legally married in another jurisdiction.
- NOT used for those couples who are “domestic partners.”

**WILL THE MOTHER AND FATHER BE EXECUTING AN ACKNOWLEDGMENT OF PATERNITY – *An Acknowledgment of Paternity may only be used for Mother/Father birth certificates.***

§ **“Yes”** means that the couple is not married but they wish to add the father to the birth certificate using form LDSS-4418. This form must be signed and witnessed BEFORE the birth certificate is filed with the local registrar.

§ **“No”** means that this is for a single mother and only the mother’s name will appear on the birth certificate.

§ **“Not Required”** means that the couple is married. The couple may be heterosexual or same sex females.

**SECOND PARENT’S CURRENT LAST NAME – FATHER**

This is the last name the parent currently uses – Enter the name of the father in accordance with the following instructions:

In New York State, there is a legal presumption that a child is the legitimate offspring of the mother and the mother’s husband. The husband’s name should be entered as the father of the child on the birth certificate if at any time during the pregnancy the mother is:

§ Married or separated;

- § Divorced, if the divorce was granted after conception;
- § Widowed, if widowed after conception.

New York State Public Health Law, Section 4135.2 requires a determination of parentage by a court of competent jurisdiction to name someone other than the mother's husband as the father of the child on the birth certificate. If a court determination cannot be obtained until after the birth certificate is filed, enter the husband's name or leave the father's name blank. Advise the mother that the State Health Department will enter the father's name upon receipt of a determination of parentage from the court.

If the mother has never been married, an Acknowledgment of Paternity (Form LDSS-4418) signed by both the mother and the putative father is required to enter the putative father's name as father on the birth certificate.

A properly completed Acknowledgment of Paternity is also required if, at the time of birth, the mother is unmarried and was divorced or widowed before conception. Hospitals should maintain a supply of Acknowledgement of Paternity forms. Form LDSS-4418 is available from your local registrar or the Office of Temporary and Disability Assistance.

Advise the mother that if an Acknowledgement of Paternity cannot be completed before the birth certificate is filed; the certificate must be filed with the father's name left blank. The father's name may be added later by filing an Acknowledgement of Paternity with the State Health Department.

#### **SECOND PARENT'S CURRENT LAST NAME – MOTHER**

This is the last name the parent currently uses. A female may be listed as the second parent *only* if she is legally married to the birth mother. Domestic partnerships are not marriages. Therefore, a woman in a domestic partnership with the birth mother may not be entered on the birth certificate as the second parent.

#### **SECOND PARENT'S LAST NAME ON BIRTH CERTIFICATE**

- § For males this is usually the same as their current last name. In the event that a male changes his last name at the time of marriage, the name on his birth certificate would be listed here. *This may or may not be the same as his current name depending on whether his name was changed by marriage only or changed through a court proceeding resulting in an amendment to his birth certificate.*
- § For females this is commonly referred to as maiden name.
- § If the second parent was adopted it would be the last name on his or her birth certificate *after* adoption.

#### **SECOND PARENT'S SOCIAL SECURITY NUMBER**

Enter the parent's Social Security number. If the parent does not have a Social Security number, enter all zeros. If the Social Security number is unknown, enter all nines.

#### **SECOND PARENT'S DATE OF BIRTH**

Enter the exact month, day and year (including the century) the parent was born. Use numbers for months and days such as 06 04 1977 for June 4, 1977.

#### **SECOND PARENT'S EDUCATIONAL LEVEL**

Enter the highest degree or level of schooling completed by each parent. Enter the highest level completed only.

- § Elementary school includes grades 01 through 08;
- § Secondary school includes grades 09 through 12, without receipt of diploma or GED;
- § High school graduate or GED recipient;
- § Some college credit, but no degree should be selected if the parent received some post-secondary or college education, but no degree;
- § Associate, Bachelor's, Master's, or Doctorate/Professional degree should be selected only if the degree was completed; select only the highest degree received;
- § Unknown
- § Do not enter any other kind of schooling or training. While beauty, barber, business, trade schools, etc., are important, they should not be considered for the purpose of this item.

### **SECOND PARENT'S BIRTHPLACE**

Select a country from the list of countries presented in the SPDS. If "USA" or "Canada" is selected, select the correct state or province from the list presented in the SPDS and then key enter the city of birth. Include both the city and state of the parent's birth. If "USA" is not selected, enter only the country the parent was born in.

### **SECOND PARENT'S HISPANIC ORIGIN**

Choose from the listing of Hispanic subgroups within the SPDS. If more than one was indicated by a parent, select as many as mentioned. There is no set rule as to how many generations are to be taken into account in determining ancestry or ethnic origin. The response is to reflect what the person considers himself or herself to be, and is not based on percentages of ancestry.

### **SECOND PARENT'S RACE**

Choose from the races listed in the SPDS. Race is self-reported, meaning the parent is considered to be whatever race they say they are, regardless of appearance. If the "Other", "American Indian", "Alaskan Native", "Other Asian" or "Other Pacific Islander" category is selected, enter up to 2 specific nationalities or tribes.

### **SECOND PARENT'S RESIDENCE ADDRESS**

A person's residence is not necessarily the same as the mailing address, legal address or voting address. Individual entry of residence items is the same as mailing address (above).

- § The residence entry on the certificate should be the place the parent lives, not where he or she receives his or her mail.
- § Do not enter a temporary residence such as an address used during a vacation, business trip or a visit to the home of a friend or relative.
- § Do not use a post office box as a residence address.
- § The place of residence during military duty or while attending college is considered a permanent residence and should be entered when applicable.
- § For those whose permanent address is a prison or psychiatric facility they should list the street address of the facility. However, there should be no mention of the facility name.

### **SECOND PARENT'S STATE OF RESIDENCE**

Select the father's state of residence from the list in the SPDS if the father resides in the USA. If the father does not reside in the USA, choose a country from the list in the SPDS and do not select a state.

### **SECOND PARENT'S CURRENT OR MOST RECENT OCCUPATION**

Enter the father's usual or most recent occupation. Enter homemaker only if he was never employed outside the home. Enter student only if he was a FULL time student during this pregnancy and had never held a full time job at any previous time.

**SECOND PARENT'S KIND OF BUSINESS OR INDUSTRY**

Enter the kind of business or industry related to the occupation. Examples of businesses or industries are government, retail store, farming, manufacturing, construction, insurance, chemical, etc.

**SECOND PARENT'S INDUSTRY NAME/ADDRESS**

Enter the name and locality of the firm or company corresponding to the entry made in the kind of business or industry item. For example, "Crowley Dairy – Binghamton, NY."

**PRENATAL HISTORY SCREEN****DID MOTHER RECEIVE PRENATAL CARE?****PRIMARY PRENATAL CARE PROVIDER**

Select the primary setting in which prenatal care was given:

- § private office (MD, DO, midwife, managed care plan health center)
- § clinic
- § other
- § no information - select if mother received prenatal care but provider type unknown
- § no provider - select if mother received no prenatal care

**PARTICIPATION IN WIC DURING PREGNANCY**

Select yes if the mother received food support through the Special Supplemental Food Program for Women, Infants and Children (WIC).

**DATE LAST NORMAL MENSES BEGAN**

Enter the month, day and year on which the mother's last normal menses began for this pregnancy. If the exact day is unknown, but the month and year are known, obtain an estimate of the day from the mother or her physician. Entries such as "BEG" for beginning, "MID" for middle and "END" for the end of the month should be converted to '07', '15' and '24'.

**ESTIMATED DUE DATE**

Enter the month day and year on which the mother is expected to deliver her child(ren).

**DATE OF FIRST PRENATAL CARE VISIT**

Enter the date upon which the mother first presented for prenatal care. Include only the visit to a private physician or to a clinic or outpatient department of a hospital in which the mother's health history was taken and an initial physical examination for this pregnancy was performed. Do not include a visit in which only the fact of pregnancy was confirmed. The preferred source of this information is the prenatal care medical record. If an exact date is not available, try to get an estimate such as beginning, middle or end of the month. These estimates should be converted to '07', '15' and '24', respectively. If no prenatal care was received, leave the date blank.

**DATE OF LAST PRENATAL CARE VISIT**

Enter the date upon which the mother's last prenatal care visit. Include only a visit to a private provider or to a clinic or outpatient department of a hospital in which the mother received prenatal care. Do not include healthcare visits unrelated to pregnancy care, e.g. emergency room care for an injury. If an exact date is not available, try to get an estimate such as beginning,

middle or end of the month. These estimates should be converted to '07', '15' and '24', respectively. If no prenatal care was received, leave the date blank.

#### **NUMBER OF PRENATAL VISITS**

Enter the total number of prenatal visits made by the mother to a physician or prenatal clinic for the purpose of prenatal care. A prenatal visit includes all regular visits to a doctor or clinic and any other visits to a doctor, clinic or emergency room for treatment of a pregnancy related problem. If an exact date is not known estimate the number of visits.

#### **PREVIOUS LIVE BIRTHS, NOW LIVING**

- § Enter the number of previous children born alive to this mother who are still alive at the time of this birth.
- § Do not include the child for whom this certificate is being completed.
- § If this is a multiple delivery, include any of the set previously born alive and are still living when the child named on this certificate was delivered.
- § Indicate "None" if this is the first live birth to this mother or if all previous children are dead.

#### **PREVIOUS LIVE BIRTHS, NOW DEAD**

- § Enter the number of previous children born alive to this mother who are now dead.
- § If this is a multiple delivery, include in your count any of the set previously born alive who died before the delivery of the child named on this certificate.
- § If none, indicate None.

#### **PREVIOUS SPONTANEOUS TERMINATIONS - GESTATIONS OF 20 WEEKS OR MORE AND PREVIOUS SPONTANEOUS TERMINATIONS - LESS THAN 20 WEEKS GESTATION**

- § Enter only previous spontaneous fetal deaths.
- § Enter the number of spontaneous fetal deaths in the space that corresponds to the gestation of the fetus at death. For example, fetal deaths of less than 20 weeks gestation (under 5 months) should be entered in the space labeled Less than 20 Weeks.
- § If this is the mother's first pregnancy or if all previous pregnancies resulted only in live born infants or induced terminations, indicate None.
- § If this is a multiple delivery, include in your count all fetuses in the set which were born dead prior to the infant that is named on this certificate.

#### **PREVIOUS INDUCED TERMINATIONS OF PREGNANCY**

- § Enter the total number of fetal deaths resulting from an induced termination of pregnancy prior to the birth of the infant named on this certificate.
- § If this is the mother's first pregnancy or if all previous pregnancies resulted in live born infants or spontaneous fetal deaths, indicate none.

#### **TOTAL PRIOR PREGNANCIES**

- § Enter the total number of times that the mother was pregnant prior to this pregnancy.
- § Count every previous pregnancy regardless of whether it resulted in live birth or fetal death.
- § A previous pregnancy that resulted in a multiple delivery counts only as one pregnancy. If this is the mother's first pregnancy, enter "00".

#### **DATE OF FIRST LIVE BIRTH**

- § Enter the month and year of the first live birth born to this mother.
- § Do not enter the date of this live birth if it is a single birth.
- § If this is the first pregnancy for this woman AND it is her second, third, etc. member of a set,

enter the date of birth of the first live born child.

#### **DATE OF LAST LIVE BIRTH**

- § Enter the month and year of the last live birth born to this mother.
- § Do not enter the date of this live birth if it is a single birth.
- § If this is the mother's first live birth, leave this item blank.
- § If this is her second live birth, repeat the date entered in first live birth.
- § For a multiple delivery, if this certificate is for the second, third, etc. member of the set, then the required date is the month and year of the last set member born alive prior to the child named on this certificate. Usually this date will be the same as for the child named on this certificate. If all previous set members were born dead or if this certificate is for the first set member, enter the month and year of the last delivery involving a live birth.

#### **DATE OF LAST OTHER PREGNANCY OUTCOME**

- § Enter the month and year of the mother's last spontaneous or induced termination.
- § If this is the mother's first delivery or if all previous deliveries resulted in only live born infants, leave this item blank.
- § For a multiple delivery, if this certificate is for the second, third, etc. member of the set and previously delivered set members were born dead, enter the month and year of the last set member born dead. Usually this will be the same date as the birth date of the child named on this certificate.
- § If all previously delivered set members were born alive, or if this certificate is for the first set member, enter the month and year of the last delivery involving a fetal death.

#### **PREPREGNANCY WEIGHT**

Enter the mother's weight prior to this pregnancy.

#### **MATERNAL HEIGHT**

Enter the mother's height in feet and inches.

### **PRENATAL CARE SCREEN**

#### **RISK FACTORS IN THIS PREGNANCY**

Select the items below if diagnosed by a physician.

- § **Prepregnancy Diabetes** Glucose intolerance requiring treatment diagnosed prior to this pregnancy.
- § **Gestational Diabetes** Glucose intolerance requiring treatment, diagnosed during to this pregnancy.
- § **Prepregnancy Hypertension (Chronic)** Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy.
- § **Gestational Hypertension (PIH, Preeclampsia)** Elevation of blood pressure above normal for age, gender, and physiological condition, diagnosed during this pregnancy
- § **Other Serious Chronic Illnesses** Select this item if the mother has a chronic illness that requires ongoing medical care and carries a significant risk of premature death or disability (e.g. ulcerative colitis, multiple sclerosis; NOT eczema, allergic rhinitis).
- § **Previous Preterm Births** History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.
- § **Abruptio Placenta** Synonyms include placental abruption, premature detachment of the placenta.

- § **Eclampsia** is diagnosed when convulsions, not caused by any coincidental neurological disease such as epilepsy, develop in a woman who also has clinical criteria for preeclampsia.
- § **Other Poor Pregnancy Outcomes** (Includes perinatal death, small for gestational age/intrauterine growth restricted birth.) History of pregnancies continuing into the 20<sup>th</sup> week of gestation (post menstrual age) and resulting in any of the listed outcomes. Perinatal death includes fetal and neonatal deaths.
- § **Prelabor Referral For High Risk** Select this item if the patient was identified as needing a higher level of care for maternal medical or fetal was then referred from the lower level of care to a higher level. This includes being referred for testing/consultation, or for transfer of care to a high risk provider. It's not so much a measure of the patient's risk status per se, as a measure of the responsiveness of the system to changes in status.
- § **Other Vaginal Bleeding** during this pregnancy prior to onset of labor: Any reported or observed bleeding per vaginum at any time in the pregnancy presenting prior to the onset of labor. Include placenta previa here.
- § **Previous Low Birthweight Infant** A previous live birth where the infant's birthweight was less than 2,500 grams.
- § **Pregnancy Resulted from Infertility Treatment** Any assisted reproduction technique used to initiate the pregnancy. Infertility Treatment is any assisted reproduction technique used to initiate the pregnancy. Check this item if any of the following apply:
- Fertility-enhancing drugs, artificial insemination or intrauterine insemination. Ovulation induction/stimulation (Clomid, Pergonal) should be included here.
  - Assisted reproductive technology, e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT). Intracytoplasmic sperm injection, zona drilling ISCI, SUZI and ZIFT should be included here.
  - Enter the number of embryos implanted, if applicable. The number of embryos implanted is a QI item.
- § **None** of the above. Select this item if none of the items above are selected, even if other medical/obstetric risk factors exist.
- § **Unknown**

## INFECTIONS

- § **Gonorrhea** Select this item if the mother had a diagnosis of or received treatment for gonorrhea during this pregnancy. Synonyms include *Neisseria gonorrhoeae*.
- § **Syphilis** Select this item if the mother had a diagnosis of or received treatment for syphilis during this pregnancy. Synonyms include *Treponema palidum*
- § **Herpes simplex virus (HSV)** Select this item if the mother had a diagnosis of or received treatment for herpes simplex virus during this pregnancy. Synonyms include HSV.
- § **Chlamydia** Select this item if the mother had a diagnosis of or received treatment for a positive test for *Chlamydia trachomatis*
- § **Hepatitis B** (HBV, serum hepatitis) Select this item if the mother had a positive test for the hepatitis B virus. Exclude administration of Hepatitis B vaccine.
- § **Hepatitis C** (non-A non-B hepatitis, HCV) Select this item if the mother had a positive test for hepatitis C virus.
- § **Tuberculosis** Select this item if the mother had a diagnosis of or received treatment for active tuberculosis during this pregnancy. Exclude positive skin test for tuberculosis without mention of treatment and/or diagnosis of active tuberculosis. Synonyms include TB
- § **Rubella** Select this item if the mother had a diagnosis of infection with rubella or "German measles" during this pregnancy. Exclude positive rubella antibody test without mention of active infection.

- § **Bacterial vaginosis** Select this item if the mother had a diagnosis of or received treatment for bacterial vaginosis during this pregnancy. Synonyms include BV.
- § **None** Select this item if none of the items above are selected, even if other infections exist.
- § **Unknown**

#### OTHER RISK FACTORS

- § **Daily tobacco use** Select yes if the mother smoked cigarettes during each trimester of this pregnancy or during the three months prior to conception. Indicate the average number of cigarettes or packs of cigarettes she smoked per day in each of the time periods indicated. It is recommended that this information come from the mother and NOT from the medical records.
- § **Alcohol use** Select yes if the mother used alcohol during this pregnancy. Indicate the average number of drinks per week that the mother consumed. Any mention of alcohol use should be considered a positive response (yes). If the mother has indicated that she may have had a few drinks from the time of conception to a positive pregnancy test consider that a positive response (yes). Fetal alcohol syndrome studies will not be done based on this question. A ‘yes’ response will show that the woman did not receive adequate pre-conception care.
- § **Used illegal drugs** Select yes if the mother used any illegal or recreational drugs during pregnancy, for example cocaine/crack, heroin, marijuana, amphetamines, ecstasy. Any mention of illegal drug use should be considered a positive (yes) response. A ‘yes’ response will show that the woman did not receive adequate pre-conception care.

#### OBSTETRIC PROCEDURES

- § **Cervical cerclage** Circumferential banding or suture of the cervix to prevent or treat passive dilation. Includes MacDonald’s suture, Shirodkar procedure, abdominal cerclage via laparotomy.
- § **Tocolysis** Administration of any agent with the intent to inhibit pre-term uterine contractions to extend the length of the pregnancy.
- § **External cephalic version** Select this item if an attempt was made to convert the infant’s position from a breech presentation to a vertex position by external manipulation. Indicate whether the attempt was successful or failed.
- § **Fetal genetic testing** Fetal genetic testing includes genetic amniocentesis and CVS (chorionic villus sampling).
- § **None**
- § **Unknown at this time**

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#### IF WOMAN WAS 35 OR OLDER, WAS FETAL GENETIC TESTING OFFERED?

Fetal genetic testing includes genetic amniocentesis and CVS (chorionic villus sampling).

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#### SEROLOGICAL TESTING

- § **Serological test for Syphilis** Select ‘yes’ if the mother was tested for syphilis during this pregnancy. Synonyms include *Treponema palidum*
- § **Date of Test** If the exact date of the test is not known estimate the date.
- § **Reason if No Test**

## **INTERVIEW/RECORDS SCREEN**

### **DID YOU RECEIVE PRENATAL CARE?**

Prenatal care includes visits to a doctor, nurse or other health care worker before your baby was born to get checkups and advice about pregnancy. Answer 'yes' if you made such visits for the pregnancy prior to admission for delivery.

### **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?**

Please count only discussions, not reading materials or videos. For each item, answer Yes if someone talked with you about it or answer No if no one talked with you about it.

### **HOW MANY TIMES PER WEEK DURING YOUR CURRENT PREGNANCY DID YOU EXERCISE FOR 30 MINUTES OR MORE, ABOVE YOUR USUAL ACTIVITIES?**

Please enter the number of times that you exercise, not counting routine daily activities such as walking to the store, lifting boxes at your place of employment, etc.

### **DID YOU HAVE ANY PROBLEMS WITH YOUR GUMS AT ANY TIME DURING PREGNANCY, FOR EXAMPLE, SWOLLEN OR BLEEDING GUMS?**

### **DURING YOUR PREGNANCY, WOULD YOU SAY YOU WERE DEPRESSED**

### **THINKING BACK TO JUST BEFORE YOU WERE PREGNANT, HOW DID YOU FEEL ABOUT BECOMING PREGNANT?**

### **CHART REVIEW**

Please review the woman's medical records (prenatal and delivery) for the following information.

#### **§ Copy of prenatal record in chart?**

§ **Was formal risk assessment in prenatal chart?** Social Assessment refers to psychosocial, socioeconomic and other social issues that may affect a pregnancy. Examples include: on or need Medicaid and/or public assistance; unwed or baby's father is not actively involved; under emotional or physical stress; recently felt depressed or hopeless; mother and/or her children in foster care, past or pregnant; thinking about adoption; want to see a social worker or public health nurse; housing, legal, transportation, safety or child care problems.

§ **Was MSAFP / triple screen test offered?** If the mother was offered a triple screen / MSAFP test, please select 'Yes'. If the test was not offered, please select 'No'. If it was too late in the pregnancy for the test to be offered/done, please select "No, Too Late".

§ **Was MSAFP / triple screen test done?** If triple screen / MSAFP test was done, please select 'Yes'. If the test was not done, please select 'No'.

§ **How many times was the mother hospitalized during this pregnancy, NOT including hospitalization for this delivery?** Enter the number of times the mother was hospitalized during this pregnancy for at least 24 hours or more, excluding the hospitalization for this delivery.

### **ADMISSION AND DISCHARGE INFORMATION**

§ **Mother** Enter the date the mother was admitted and discharged for this delivery.

§ **Infant** Enter the discharge date for the Infant.

○ **Discharged Home**



- **Infant Died at Birth Hospital**
- **Infant Still in Hospital** Select only if the infant is still in your facility. Do not enter a discharge date if the infant is still in-house.
- **Infant Discharged to Foster Care/Adoption**
- **Infant Transferred Out** Select if infant was transferred out to a NICU or Special Care Nursery, including those within your own facility, or to another facility. Enter the date the infant was transferred out.
- **Unknown** Select only if the disposition of the infant is not documented in the infant or woman's medical records.

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