New Birth Registration

Parents — Mother

Mother's First Name: mom_first_name

Mother's Middle Name: mom_mid_name

Mother's Current Last Name : mom_last_maiden

Last Name on Mother's Birth Certificate: mom_ last_current

Social Security Number: mom_medrec

Mother's Date of Birth: *(MM/DD/YYYY)* mom_dob [mom_age]calculated

Infant

Infant's First Name: inf_first_name

Infant's Middle Name: inf_mid_name

Infant's Last Name: inf_last_name

Infant's Name Suffix inf_suffix
(e.g. Jr., 2nd, III):

Sex: ☐ Male ☐ Female sex_of_inf ☐ Undetermined

Plurality: plurality

Birth Order: birth_orde

Medical Record No.: inf_medrec

Date of Birth: *(MM/DD/YYYY)* inf_dob

Time of Birth: *(HH:MM)* inf_tob ☐ am ☐ pm ☐ military (24-hour time)

Parents — Infant

Was child born in this facility? ☐ Yes ☐ No If child was **not** born in this facility, please answer the following questions:

In what type of place was the infant born?

☐ Freestanding Birth Center (regulated by DOH)
☐ Home (intended)
☐ Home (unintended)
☐ Home (unknown intent)
☐ Clinic / Doctor's Office (not regulated by DOH)
☐ Other inst_type

If New York State Birthing Center, enter its name: hospcode

In what county was the child born?

Parents — Birthplace

Institution inst_code

Site of Birth, If **Other** Type of Place: site_of _birth

Street Address – if other than Hospital / Birthing Center:

If place of infant's birth was other than Hospital or Birthing Center:

City, town or village where birth occurred: dis_code

Zip / Postal Code: zip_postal

Infant's Pediatrician/Family Practitioner: NBS

Attendant

Attendant's Information:

License Number: attn_lic

Name: *First* *Middle* *Last*

Title: *(Select one)* att_type

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Licensed Midwife (CNM) ☐ Licensed Midwife (CM) ☐ Other

Certifier

Certifier's Information: cert_num

☐ Check here if the Certifier is the same as the Attendant *(otherwise enter information below)*

License Number:

Name: *First* *Middle* *Last*

Title: *(Select one)*

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Licensed Midwife (CNM) ☐ Licensed Midwife (CM) ☐ Other

Parents — Payor

Primary Payor for this Delivery:

Select one: primary_pa

☐ Medicaid / Family Health Plus
☐ CHAMPUS / TRICARE
☐ Self-pay
☐ Private Insurance
☐ Other Government / Child Health Plus B
☐ Indian Health Service
☐ Other

If Medicaid is not the primary payor, is it a secondary payor for this delivery? med_pay ☐ Yes ☐ No

Is the mother enrolled in an HMO or other managed care plan? medicaid_m ☐ Yes ☐ No QI

Infant

Infant

If Multiple Births:
Number of Live Births: mu_lb
Number of Fetal Deaths: mu_fd

Birth Weight: birth_wgt
grams | *lbs.* *oz.*

If birth weight < 1250 grams (2 lbs. 12 oz.), reason(s) for delivery at a less than level III hospital: *(Only if applicable)*

☐ None ☐ Unknown at this time lev3_none lev3_unk

Select all that apply:

☐ Rapid / Advanced Labor lev3_rapid ☐ Bleeding lev3_bleed ☐ Fetus at Risk lev3_risk ☐ Severe pre-eclampsia lev3_eclamp
☐ Woman Refused Transfer lev3_ref ☐ Other *(specify)* lev3_oth lev3_lit

QI

Infant Transferred:
☐ Within 24 hrs ☐ After 24 hrs. ☐ Not transferred transfer_i

NYS Hospital Infant Transferred To: hosp_trsfr

State/Terr./Province:

Birth Information

Apgar Scores
1 minute: apgar_1_mi
5 minutes: apgar_5_mi
10 minutes: apgar_10_mi

Is the Infant Alive?
☐ Yes ☐ No
☐ Infant Transferred / Status Unknown
Inf_status

Clinical Estimate of Gestation: *(Weeks)*
est_gest

Newborn Treatment Given:
☐ Conjunctivitis only
☐ Vitamin K only
☐ Both
☐ Neither

How is infant being fed at discharge? *(Select one)*
☐ Breast Milk Only ☐ Formula Only ☐ Both Breast Milk and Formula
☐ Other ☐ Do Not Know infant_fee

Newborn Screening

Newborn Blood-Spot Screening
Screening Lab ID Number: *(9-digits)*

___ ___ ___ ___ ___ ___ ___ ___ ___

Reason if Lab ID is not submitted:

☐ No NBS Lab ID because infant died prior to test
☐ No NBS Lab ID because infant transferred prior to test
☐ Lab ID is unknown / illegible
☐ Refused NBS

NBS

Hepatitis B

Hepatitis B Inoculation

Immunization Administered: ☐ Yes ☐ No hepb_uniz
Date: *(MM/DD/YYYY)* ____/____/____
Mfr: _____
Lot: _____

Immunoglobulin Administered: ☐ Yes ☐ No
hepb_glob
Date: *(MM/DD/YYYY)* ____/____/____
Mfr: _____
Lot: _____

Abnormal Conditions of the Newborn

Abnormal Conditions of the Newborn:

☐ None ☐ Unknown at this time noinfo_abn abn_unk

Select all that apply

☐ Assisted ventilation required immediately following delivery o5min_av_a
☐ NICU Admission nicu_infan
☐ Antibiotics received by the newborn for suspected neonatal sepsis abn_sep
☐ Significant birth injury (skeletal fx, peripheral nerve injury, soft tissue/solid organ hemorrhage which requires intervention) abn_injury
☐ Assisted ventilation required for more than six hours o30min_avx
☐ Newborn given surfactant replacement therapy surfact_ab
☐ Seizures or serious neurologic dysfunction abn_seiz

Congenital Anomalies

Congenital Anomalies

☐ None of the listed ☐ Unknown at this time
none_congm unk_at
Select all that apply

		Diagnosed Prenatally?	If Yes, please indicate all methods used:
Yes No ☐ ☐	Anencephaly anenceph_c	Yes No ☐ ☐ anen_prenat	☐ Level II Ultrasound anen_lev2 ☐ MSAFP / Triple Screen anen_screen ☐ Amniocentesis anen_amnio ☐ Other anen_oth ☐ Unknown anen_unk
Yes No ☐ ☐	Meningomyelocele/Spina Bifida m_spina	Yes No ☐ ☐ menin_prenat	☐ Level II Ultrasound menin_lev2 ☐ MSAFP / Triple Screen menin_screen ☐ Amniocentesis menin_amnio ☐ Other menin_oth ☐ Unknown menin_unk
Yes No ☐ ☐	Cyanotic Congenital Heart Disease c_heart	Yes No ☐ ☐ cyan_prenat	☐ Level II Ultrasound cyan_lev2 ☐ Other cyan_oth ☐ Unknown cyan_unk
Yes No ☐ ☐	Congenital Diaphragmatic Hernia diaphragm_h	Yes No ☐ ☐ congen_prenat	☐ Level II Ultrasound congen_lev2 ☐ Other congen_oth ☐ Unknown congen_unk
Yes No ☐ ☐	Omphalocele omphalo	Yes No ☐ ☐ omph_prenat	☐ Level II Ultrasound omph_lev2 ☐ Other omph_oth ☐ Unknown omph_unk
Yes No ☐ ☐	Gastroschisis gastros	Yes No ☐ ☐ gastro_prenat	☐ Level II Ultrasound gastro_lev2 ☐ Other gastro_oth ☐ Unknown gastro_unk
Yes No ☐ ☐	Limb Reduction Defect limb_reduc	Yes No ☐ ☐ limb_prenat	☐ Level II Ultrasound limb_lev2 ☐ Other limb_oth ☐ Unknown limb_unk
Yes No ☐ ☐	Cleft lip with or without Cleft Palate cleft_lipx	Yes No ☐ ☐ lip_prenat	☐ Level II Ultrasound lip_lev2 ☐ Other lip_oth ☐ Unknown lip_unk
Yes No ☐ ☐	Cleft Palate Alone cleft	Yes No ☐ ☐ pala_prenat	☐ Level II Ultrasound pala_lev2 ☐ Other pala_oth ☐ Unknown pala_unk
Yes No ☐ ☐	Down Syndrome down_sy ☐ Karyotype confirmed down_ka down_kp ☐ Karyotype pending	Yes No ☐ ☐ down_prenat	☐ Level II Ultrasound down_lev2 ☐ MSAFP / Triple Screen down_screen ☐ CVS down_cvs ☐ Amniocentesis down_amnio ☐ Other down_oth ☐ Unknown down_unk
Yes No ☐ ☐	Other Chromosomal Disorder chrom_di ☐ Karyotype confirmed chro_kc chro_kp ☐ Karyotype pending	Yes No ☐ ☐ chrom_prenat	☐ Level II Ultrasound chrom_lev2 ☐ MSAFP / Triple Screen chrom_screen ☐ CVS chrom_cvs ☐ Amniocentesis chrom_amnio ☐ Other chrom_oth ☐ Unknown chrom_unk
Yes No ☐ ☐	Hypospadias hypospadias	Yes No ☐ ☐ hypos_prenat	☐ Level II Ultrasound hypos_lev2 ☐ Other hypos_oth ☐ Unknown hypos_unk

Labor & Delivery

Labor & Delivery

Mother Transferred in Antepartum: ☐ Yes ☐ No mom_trsfr

NYS Facility Mother Transferred From: hosp_mom_t

State/Terr./Province: trans_state

Mother's Weight at Delivery: delv_wt *lbs.*

Method of Delivery

Fetal Presentation: *(select one)*

☐ Cephalic ☐ Breech ☐ Other pres_del

Route & Method: *(select one)*

☐ Spontaneous ☐ Forceps – Mid ☐ Forceps – Low / Outlet ☐ Vacuum ☐ Cesarean ☐ Unknown route_main

Cesarean Section History:

☐ Previous C-Section prev_cs ☐ Number num_cs

Attempted Procedures:

Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No forceps

Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No vacuum_met

Method of Delivery

Trial Labor:

If Cesarean section, was trial labor attempted? ☐ Yes ☐ No trial_lab

Indications for C-Section:

☐ Unknown c_sec_unk

Select all that apply

☐ Failure to progress c_sec_progress
☐ Fetus at Risk / NFS fetus_at_r
☐ Refused VBAC ref_vbac
☐ Malpresentation c_sec_malp
☐ Maternal Condition – Not Pregnancy Related mat_cond_n
☐ Elective c-sec_elec
☐ Previous C-Section c_sec_previous
☐ Maternal Condition – Pregnancy Related mat_cond_p
☐ Other other_csin

Indications for Vacuum:

☐ Unknown vac_unk

Select all that apply

☐ Failure to progress vac_progress
☐ Other vac_oth
☐ Fetus at Risk vac_risk

Indications for Forceps:

☐ Unknown forceps_unk

Select all that apply

☐ Failure to progress forceps_fail
☐ Other forceps_oth
☐ Fetus at Risk forceps_risk

Labor

Onset of Labor

☐ None ☐ Unknown at this time
labor_none labor_unk

Select all that apply

☐ Prolonged Rupture of Membranes -- (12 or more hours) room_12
☐ Prolonged Labor (20 or more hours) labor_pro
☐ Premature Rupture of Membranes -- (prior to labor) prom
☐ Precipitous Labor -- (less than 3 hours) labor_precip

Characteristics

Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time
char_none char_unk

Select all that apply

☐ Induction of Labor – AROM ind_arom
☐ Steroids ad_steroids
☐ Meconium Staining mecon
☐ Internal Electronic Fetal Monitoring ifm
☐ Induction of Labor – Medicinal ind_med
☐ Antibiotics ip_abx
☐ Fetal Intolerance nrfs
☐ Augmentation of Labor augment
☐ Chorioamnionitis chorio
☐ External Electronic Fetal Monitoring efm

Labor & Delivery

Maternal Morbidity

Maternal Morbidity

☐ None ☐ Unknown at this time

morbi_none morbi_unk

Select all that apply

☐ Maternal Transfusion mat_tx

☐ Unplanned Hysterectomy morbi_hyst

☐ Postpartum transfer to a higher level of care mat_pp_trans

☐ Perineal Laceration (3rd / 4th Degree) peri_lac

☐ Admit to ICU morbi_icu

☐ Ruptured Uterus ut_rupt

☐ Unplanned Operating Room Procedure Following Delivery morbi_oper

QI

Anesthesia / Analgesia

Anesthesia / Analgesia

☐ None ☐ Unknown at this time

none_anes unk_anes

Select all that apply

☐ Epidural (Caudal) epidural_a

☐ General Inhalation gen_inhalx

☐ Pudendal pudendal_a

☐ Local local_anes

☐ Paracervical paracerv_a

☐ Spinal spinal_ane

☐ General Intravenous gen_intrax

Was an analgesic administered?

☐ Yes ☐ No analgesia

Procedures

Other Procedures Performed at Delivery

☐ None ☐ Unknown at this time

othproc_no othproc_unk

Select all that apply

☐ Episiotomy and Repair epis_othpr ☐ Sterilization steril_oth

Mother

Medical Record Number: mom_medrec

Parents

Mother's Demographics

Mother's Education: *(select one)* mom_educ

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate; or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree

City of Birth:	State/Terr./Province of Birth: mom_statex	Country of Birth, if not USA: mom_countr

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latina mhis_no
- ☐ Yes, Cuban mhis_cu
- ☐ Yes, Mexican, Mexican American, Chicana mhis_me
- ☐ Yes, Other Spanish/Hispanic/Latina mhis_ot
  Specify:
- ☐ Yes, Puerto Rican mhis_pr

Mother's Demographics

Race:

Select all that apply

- ☐ White/Caucasian mom_whi
- ☐ Chinese mom_chi
- ☐ Korean mom_kor
- ☐ Guamanian or Chamorro mom_gua
- ☐ American Indian or Alaska Native Tribe: mom_aina
- ☐ Other Asian mom_oas
- ☐ Other Pacific Islander mom_opi Specify:
- ☐ Other mom_oth Specify:
- ☐ Black or African American mom_bla
- ☐ Filipino mom_fil
- ☐ Vietnamese mom_vie
- ☐ Samoan mom_sam
- ☐ Asian Indian mom_si
- ☐ Japanese mom_jap
- ☐ Native Hawaiian mom_nha

Mother's Residence

Residence Address

Street Address: mom_res_add_house mom_res_add_dir mom_res_add_name mom_res_add_st mom_res_add_post_dir mom_res_add_apt

State/Terr./Province: mom_state	County: res_county	City, Town or Village: mom_add_lit

Zip/Postal Code: reszip5 reszip5ext	Mother's Country of Residence, if not USA: res_mom_countr	U.S./Canadian Phone Number: mom_phone

Mother's Mailing Address

Mailing Address – Most Recent

☐ Check here if the mailing address is the same as the residence address *(otherwise enter information below)* mail_add_other

Mailing Address: res_mailing_house res_mailing_dir res_mailing_name res_mailing_st res_mailing_post_dir res_mailing apt

City, Town or Village: mom_add_lit	State/Terr./Province mail_state:	Country, if not USA: mail_countr	Zip/Postal Code: res_mailing_zip

Employment

Employment History

Employed while Pregnant: ☐ Yes ☐ No mom_employ	Current / Most Recent Occupation: mom_occup	Kind of Business / Industry: mom_industry

Name of Company or Firm:	Address:

City:	State/Territory/Province:	Zip / Postal Code:

Father or Second Parent

Will the mother and father be executing an Acknowledgement of Paternity? ☐ Yes ☐ No ☐ Not required
pat_aff paternity_ind

What type of certificate is required? ☐ Mother / Father ☐ Mother / Mother

Parents

Father's or Second Parent's Demographics

Parent's First Name: dad_first_name

Parent's Middle Name: dad_mid_name

Parent's Current Last Name: dad_last_name

Last Name on Parent's Birth Certificate:

Parent's Name Suffix dad_suffix
(e.g. Jr., 2nd, III):

Social Security Number:
– –

Demographics

Parent's Date of Birth:
dad_dob [dad_age] calculated
(MM/DD/YYYY)
/ /

Education: *(select one)*
dad_educ
☐ 8th grade or less
☐ 9th – 12th grade; no diploma
☐ High school graduate; or GED
☐ Some college credit, but no degree
☐ Associate's degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate degree

City of Birth:

State/Terr./Province of Birth:
dad_bp_sta

Country of Birth, if not USA:
dad_bp_cou

Hispanic Origin:
Select all that apply
☐ No, not Spanish/Hispanic/Latino dhis_no
☐ Yes, Cuban dhis_cu
☐ Yes, Mexican, Mexican American, Chicano dhis_me
☐ Yes, Puerto Rican dhis_pr
☐ Yes, Other Spanish/Hispanic/Latino dhis_ot
Specify:

Race:
Select all that apply
☐ White/Caucasian dad_whi
☐ Chinese dad_chi
☐ Korean dad_kor
☐ Guamanian or Chamorro dad_gua
☐ American Indian or Alaska Native Tribe:
dad_aina
☐ Other Asian dad_oas Specify:
☐ Other Pacific Islander dad_opi Specify:
☐ Other dad_oth Specify:
☐ Black or African American dad_bla
☐ Filipino dad_fil
☐ Vietnamese dad_vie
☐ Samoan dad_sam
☐ Asian Indian dad_si
☐ Japanese dad_jap
☐ Native Hawaiian dad_nha

Parent's Residence

Residence Address
☐ Check here if the parent's residence address is the same as the mother's address
(otherwise enter information below)

Street Address: dad_res_add_house dad_res_add_dir
dad_res_add_name dad_res_add_st dad_res_add_post_dir dad_res_add_apt

City, Town or Village:
dad_add_lit

State / Territory / Province:
dad_mom_statex

Parent's Country of Residence, if not USA:
dad_countr

Zip / Postal Code:
dad_reszip5

Employment

Employment History

Current / Most Recent Occupation:
dad_occup

Kind of Business / Industry:
dad_industry

Name of Company or Firm:

Address:

City:

State / Territory / Province:

Zip / Postal Code:

Prenatal History

Parents

Prenatal History

Did mother receive prenatal care? ☐ Yes ☐ No pre_yes

Primary Prenatal Care Provider Type: primary_pr
☐ MD / DO / C(N)M / HMO ☐ No Information
☐ Clinic ☐ No Provider
☐ Other

Did mother participate in WIC? wic_mompar ☐ Yes ☐ No

Key Pregnancy Dates *(MM/DD/YYYY)* [gestdays] calculated

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
lmp_date		first_visit_date	last_visit_date

Prenatal Visits care_days est_pnc_mo calc_trimester

Total Number of Prenatal Visits: num_visits

Pregnancy History

Pregnancy History [calc_birth_his calc_birth_all] calculated

Previous Live Births: tot_preg		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number ☐ live_livex	Now Dead None or Number ☐ live_deadx	Less than 20 Weeks None or Number ☐ u20_spon_p	20 Weeks or More None or Number ☐ o20_spon_p	None or Number ☐ Induced_pr	None or Number ☐ tot_preg

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
first_livex	last_livex	last_oth	pre_preg-_wt *lbs.*	mom_ht *ft.* *in.*

Prenatal Care

Risk Factors

Risk Factors in this Pregnancy

☐ None ☐ Unknown at this time
none_medri unk_risk

Select all that apply

☐ Prepregnancy Diabetes diabetes_m
☐ Other Serious Chronic Illnesses othe_ill
☐ Other Poor Pregnancy Outcomes poor_preg
☐ Gestational Diabetes diabetes_g
☐ Previous Preterm Births pre_term_m
☐ Prelabor Referred for High Risk Care prelab_ref
☐ Prepregnancy Hypertension hyper_chro
☐ Abruptio Placenta abrupt
☐ Other Vaginal Bleeding vag_
☐ Gestational hypertension hyper_preg
☐ Eclampsia eclampsiax
☐ Previous Low Birthweight Infant

☐ Pregnancy resulted from infertility treatment (if yes, check all that apply) inferti
☐ Fertility-enhancing drugs, artificial or intrauterine insemination infert_med
☐ Assisted reproductive technology (e.g. IVF, GIFT) **Number of Embryos Implanted:** (if applicable)
Infert_art embroyos

QI QI

Infections

Infections Present and/or Treated During Pregnancy

☐ None ☐ Unknown at this time
none unk_inf

Select all that apply

☐ Gonorrhea infec_gc
☐ Hepatitis B hepb
☐ Bacterial Vaginosis bac_vag
☐ Syphilis syph_medri
☐ Hepatitis C hepc
☐ Herpes Simplex Virus (HSV) infec_hsv
☐ Tuberculosis tb_medrisk
☐ Chlamydia chlamyd
☐ Rubella rubella_me

Parents

Other Risk Factors

Other Risk Factors

Smoking Before or During Pregnancy? tobacco_yn ☐ Yes ☐ No

List Number of Packs OR Cigarettes Smoked Per DAY

3 Months Prior to Pregnancy		First Three Months of Pregnancy		Second Three Months of Pregnancy		Third Trimester of Pregnancy	
Packs	OR Cigarettes	Packs	OR Cigarettes	Packs	OR Cigarettes	Packs	OR Cigarettes
smo_pri		smo_1st		smo_2nd		smo_3rd	

Prenatal Care

Other Risk

Other Risk Factors

Alcohol Consumed During This Pregnancy? alcohol_ot	Number of Drinks per Week: num_drink	Illegal Drugs Used During This Pregnancy? idrug_y	
☐ Yes ☐ No		☐ Yes ☐ No	

Obstetric Procedures

Obstetric Procedures

☐ None ☐ Unknown at this time

none_obpro proc_tocol

Select all that apply

☐ Tocolysis proc_obpro ☐ External Cephalic Version — ☐ Successful ☐ Failed proc_ecv

☐ Cervical Cerclage

proc_cer

☐ Fetal Genetic Testing genetic_test

If woman was 35 or over, was fetal genetic testing offered?

☐ Yes ☐ No, Too Late ☐ No, Other Reason amnio_offe

Serological Test for Syphilis?	Date of Test: *(MM/DD/YYYY)*	Reason, if No Test:
☐ Yes ☐ No sero_test		☐ Mother refused ☐ Religious reasons ☐ No prenatal care ☐ Other ☐ No time before delivery

Interview/Records QI

laborParents

Survey of Mother (in hospital)

Survey of Mother (in hospital) pre_yes

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?	☐	☐	hc_smoking
b. How drinking alcohol during your pregnancy could affect your baby?	☐	☐	hc_drinking
c. How using illegal drugs could affect your baby?	☐	☐	hc_drugs
d. How long to wait before having another baby?	☐	☐	wait_baby
e. Birth control methods to use after your pregnancy?	☐	☐	birth_control
f. What to do if your labor starts early?	☐	☐	early_labor
g. How to keep from getting HIV (the virus that causes AIDS)?	☐	☐	hiv
h. Physical abuse to women by their husbands or partners?	☐	☐	abuse

2. How many times per week during your current pregnancy did you exercise for 30 minutes or more, above your usual activities? num_exer_q — Times per week:

3. Did you have any problems with your gums at any time during pregnancy, for example, swollen or bleeding gums? gums — ☐ Yes ☐ No

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

☐ Not depressed at all ☐ A little depressed
☐ Moderately depressed ☐ Very depressed
☐ Very depressed and had to get help

5. Thinking back to just before you were pregnant, how did you feel about becoming pregnant? preg_planx

☐ You wanted to be pregnant sooner ☐ You wanted to be pregnant later
☐ You wanted to be pregnant then ☐ You didn't want to be pregnant then or at any time in the future

Chart Review (Prenatal and Medical)

Chart Review (Prenatal and Medical)

1a. Copy of prenatal record in chart? prenatal_rec
☐ Yes, Full Record ☐ Yes, Prenatal Summary Only
☐ No

1b. Was formal risk assessment in prenatal chart? formal_risk
☐ Yes, with Social Assessment ☐ Yes, without Social Assessment
☐ No

1c. Was MSAFP / triple screen test offered? msafp_offe
☐ Yes ☐ No
☐ No, Too Late

1d. Was MSAFP / triple screen test done? msafp_done
☐ Yes ☐ No

2. How many times was the mother hospitalized during this pregnancy, not including hospitalization for delivery? mom_hospitalized

Admission & Discharge

Admission and Discharge Information

Mother

Admission Date for Delivery *(MM/DD/YYYY)* mom_adm

Discharge Date *(MM/DD/YYYY)* mom_dischg

Infant

Discharge Date *(MM/DD/YYYY)* inf_dischg

status_inf
☐ Discharged Home ☐ Infant Died at Birth Hospital
☐ Infant Still in Hospital ☐ Infant Discharged to Foster Care/Adoption
☐ Infant Transferred Out ☐ Unknown