## PREGNANCY Verification for Out-of-Institution Births

I, _____, verify that _____
(PRINT: Health Care Provider's Name) (PRINT: Woman's Name)

(born _____), whom I saw on _____ is pregnant.
(Woman's Date of Birth) (PRINT: Visit Date)

_____ _____
Health Care Provider's Signature Date

_____
Health Care Provider's License Number

## INFANT Verification for Out-of-Institution Births

I, _____, verify that _____
(PRINT: Health Care Provider's Name) (PRINT: Infant's Name)

was born alive on _____ to _____.
(Infant's Date of Birth) (PRINT: Mother's Name)

_____ _____
Health Care Provider's Signature Date

_____
Health Care Provider's License Number

# Checklist for Registration of an Out of Institution Birth

Please utilize the following checklist to document evidence for all births occurring outside of an institution. Evidence from each section must be presented to completely fulfill the requirements of Rule 3701-5-16. * All evidence should be submitted via fax to 614-564-2514 for approval BEFORE a birth record shall be created for filing. A copy of all documentation should be clipped to the final birth record when submitted to ODH/VS for filing.

*** Note: If an out of institution birth is filed eleven (11) days or more after the birth, but within one year, an affidavit is required to affirm that the birth occurred at the time and place indicated on the certificate. See pages 8-9 for the "delayed birth registration" affidavit and a sample.**

### Section 1: Evidence of Pregnancy

Please select one (1) that applies and attach supporting documentation to this list:

☐ A prenatal record or postnatal medical record consistent with the date of delivery, **OR**

☐ A statement from a physician or other health care provider (e.g., a registered nurse, nurse practitioner, public health nurse, licensed midwife, or EMS employee) qualified to determine pregnancy. Statement shall include mother's name, mother's date of birth, date of health exam, provider's signature, provider's printed name, signature date, and license number, **OR**

☐ A home visit exam by a public health nurse or other health care provider, **OR**

☐ _____other evidence as accepted by the State Registrar (Please see listing on page 4) *

### Section 2: Evidence that the infant was born alive.

Please select one (1) that applies and attach supporting documentation to this list:

☐ A statement from the physician or other health care provider who saw or examined the infant, **OR**

☐ An observation of the infant during a home visit by a public health nurse or health care provider, **OR**

☐ _____other evidence as accepted by the State Registrar (Please see listing on page 4) *

### Section 3: Evidence of the mother's presence in Ohio and proof of residence.

If the birth occurred outside of the mother's place of residence, please skip Section 3 and provide documentation for Section 4. Please select one (1) that applies and attach supporting documentation to this list:

☐ A valid driver's license, or a state issued identification card, which includes the mother's current residence on the face of the license or card, **OR**

☐ A recent rent receipt of any type of utility, telephone or other bill that includes the mother's name and address, **OR**

☐ A social service record at the time of the child's birth if the mother was receiving public assistance (e.g. WIC, food stamps, child support record), **OR**

☐ A recent bank statement that includes the mother's name and address, **OR**

☐ _____other evidence as accepted by the State Registrar (Please see listing on page 4) *

# EXAMPLES OF ACCEPTABLE DOCUMENTATION

**The following list is provided as examples only and does not constitute a comprehensive list of all acceptable or non-acceptable forms of documentation. As Vital Statistics identifies more illustrative examples, we will update this list. Please black out any sensitive information (e.g. SSN, account number, etc.) before faxing the information to VS.**

## Section One – Proof of Pregnancy:

Acceptable:

- Statement by a physician, licensed nurse, chiropractor, dentist or other licensed health care professional who has firsthand knowledge of this pregnancy and is willing to attest to that fact even if did not provide direct treatment and who is not an immediate family member.
- Statement by a Certified Professional Midwife (CPM) who submits a copy of current and valid certificate from the North American Registry of Midwives (NARM) that establishes their credentials as a CPM. Please make sure to check 'Other' (last option) in the checklist.
- Statement by a midwife who submits a copy of their "Certificate of Authorization" with the signature of the State Registrar. (see page 7 for "pregnancy verification" form)

Non-acceptable:

- Statement by the husband or the mother even if licensed health care professional.
- Statement from any other person that does not fall within the licensed health care professional category, the CPM, or the authorized midwife.

## Section Two – Proof of Live Birth

Acceptable:

- Statement by a physician, licensed nurse, chiropractor, dentist or other licensed health care professional who has firsthand knowledge of the live birth and is willing to attest to that fact even if did not provide direct treatment and who is not an immediate family member.
- Statement by a Certified Professional Midwife (CPM) who submits a copy of current and valid certificate from the North American Registry of Midwives (NARM) that establishes their credentials as a CPM. Please make sure to check 'Other' (last option) in the checklist.
- Statement by a midwife who submits a copy of their "Certificate of Authorization" with the signature of the State Registrar. (see page 7 for "infant verification" form)
- PKU test results

Non-acceptable:

- Statement by the husband or the mother even if licensed health care professional.
- Statement from any other person that does not fall within the licensed health care professional category, the CPM, or the authorized midwife.

## Sections Three and Four – Proof of residence

Acceptable

- Recent tax return
- Deed
- Current proof of insurance
- Motor vehicle registration
- W-2
- Pay stub
- State issued ID
- Photo-less ID from BMV
- Bishops letter from community
- Hunting license with signature and date
- SSN card of the child, if includes stub with current address

Non-acceptable:

- Paternity affidavit
- Voided check

Ohio
Department of Health

| For Hospital Use Only: |
|---|
| Mother's Medical Record # _____ |
| Mother's Name _____ |
| Newborn's Date of Birth _____ |
| Newborn's Medical Record # _____ |

# Birth Parent's Worksheet

## Ohio Department of Health Bureau of Vital Statistics

The information you provide below will be used to create your child's birth certificate and will be used for other public health purposes. The birth certificate is a document that will be used for important purposes including proving your child's age, citizenship and parentage. The birth certificate will be used by your child throughout his/her life.

It is very important that you provide complete and accurate information to all of the questions. In addition, this information is used by health and medical researchers to study and improve the health of mothers and newborn infants. Items such as education, race, and smoking will be used for studies but will not appear on copies of your child's birth certificate (unless requested by a person listed on the certificate). State of Ohio law provides protection against the unauthorized release of health and medical information, but mandates the release of identifying information from the birth certificate under public record law.

**Please print clearly in black or dark blue ink. If needed, please ask hospital staff for help.**

### BABY'S INFORMATION

**1. Baby's Legal Name As It Should Appear On The Birth Certificate**

**Notice:** You may name your baby whatever you want; however, it will take a legal change of name court order to change it after registration. Only hyphens (-) and apostrophes (') will be printed as part of the birth record.

| First | Middle, if any | Last | Generational suffix (if any) |
|---|---|---|---|
| | | | |

| Newborn's Sex | Date of Birth | Was this delivery a: |
|---|---|---|
| ☐ Male ☐ Female | / / | ☐ Single birth ☐ Multiple birth |

If multiple, this worksheet is for baby: ☐ (First born) ☐ (Second born) ☐ (Third born) ☐ (Fourth born)

### BIRTH PARENT INFORMATION

| PREFERRED PARENTAGE TITLE (Check one) | GENDER (Check one) |
|---|---|
| ☐ Mother ☐ Father ☐ Parent | ☐ Female ☐ Male |

**2. Birth Parent Current Legal Name**

| First | Middle, if any | Last |
|---|---|---|
| | | |

What was your last name prior to your first marriage or your last name as it appears on your birth record if you were never married.

**3. Birth Parent Current Residence (Actual physical location of where you live)**

| Street Address (Street Name and Number) | Address Line 2/Apt. Number |
|---|---|
| Country (United States or Name of Foreign Country) | State, U.S. Territory, or Canadian Province |

| County | City | Zip Code |
|---|---|---|
| | | |

Is your current residence located within the city limits? (Check one) ☐ Yes ☐ No ☐ I don't know

4. Birth Parent Mailing Address Same as resident ☐ (Check if the mailing and residence addresses are the same, then go to Item #5)

Complete below only if the birth parent mailing address is different from the residence address

| Street Name and Number and /or P.O. Box Number | | Address Line 2/Apt. Number |
|---|---|---|
| Country (United States or Name of Foreign Country) | | State, U.S. Territory, or Canadian Province |
| County | City | Zip Code |

5. Birth Parent Phone Information

| Primary ( ) | Secondary ( ) | Type of Contact ☐ Cell ☐ Other ☐ Relative ☐ Work |
|---|---|---|
| ☐ I do not have a phone number where I can be contacted | | |

6. Birth Parent Date of Birth

| Month | Day | Year | Current Age |
|---|---|---|---|
| | | | |

7. Birth Parent Place of Birth (Please check only one and write in the state, province or foreign country).

☐ U.S. State or Territory _____

☐ Canada/Province _____ ☐ Other Foreign Country _____

8. What is the highest level of schooling that you have completed? (Check one)

☐ Grade 8 or Less
☐ Grade 9-12 With No Diploma
☐ High School Graduate or GED Completed
☐ College Credit, But No Degree
☐ Associates Degree (e.g., AA, AS)
☐ Bachelor's Degree (e.g., BA, AB, BS)
☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
☐ Doctorate Degree (e.g., PhD, EdD) or Professional Degree (e.g., MD, DO, DDS, LLP, DVM, JD)

9. Are you of Spanish/Hispanic/Latina Origin? (Check all that apply)

☐ No, not Spanish/Hispanic/Latina
☐ Yes (Check one) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other _____
☐ Unknown

10. What is your race? (Check all that apply)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native (specify) _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify) _____
☐ Native Hawaiian Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify)
☐ Other (Specify) _____

11. Did you receive WIC (Women's Infant & Children) assistance during this pregnancy? ☐ Yes ☐ No

12. What is your current height?

Feet _____ Inches _____

13. What was your weight before pregnancy? _____

14. How many cigarettes or packs of cigarettes did you smoke on an average day for each of the time periods? If you never smoked enter zero (0) for # of cigarettes for each time period.

| | | | |
|---|---|---|---|
| Three months before pregnancy # of cigarettes | _____ | OR # of packs of cigarettes | _____ |
| First three months of pregnancy # of cigarettes | _____ | OR # of packs of cigarettes | _____ |
| Second three months of pregnancy # of cigarettes | _____ | OR # of packs of cigarettes | _____ |
| Last three months of pregnancy # of cigarettes | _____ | OR # of packs of cigarettes | _____ |

15. How many alcoholic beverages did you consume on an average day during the following time periods? If you never drank, enter zero (0) for # of drinks for each time period.

Number Of Drinks

| | | | |
|---|---|---|---|
| Three months before pregnancy | _____ | First three months of pregnancy | _____ |
| Second three months of pregnancy | _____ | Last three months of pregnancy | _____ |

16. Birth Parent's Marital Status – Required to Register Birth Record and to Establish Parentage

Were you married at the time you conceived this child, at the time of birth, or within 300 days prior to the birth of your child?

16a. ☐ Yes

16b. ☐ Yes, but I can provide legal documentation (court order, separation agreement, journal entry, divorce decree) stating my husband is not to be listed as the father of my child. [Please go to Question #17]. This documentation is subject to approval by the Ohio Department of Health, Bureau of Vital Statistics.

16c. ☐ Yes, but I refuse to provide my husband's name as the father of my child. [Please go to Question #24]. *Please note that under State of Ohio law, by refusing to complete your husband's information, your child's birth certificate will not be registered as a legal document and your child's birth information will not be electronically transmitted for a Social Security number to be issued.

16d. ☐ No, [Please go to Question #17]

17. Has a paternity acknowledgment been completed? (That is, have you and the other parent signed an Affidavit of Paternity form in which the father accepted legal responsibility for the child?)

☐ Yes [Please go to Question #18]

☐ No [Please go to Question #24.] If you were not married, or if an Affidavit of Paternity form has not been completed, information about the father cannot be included on the birth certificate.

## SECOND PARENT INFORMATION

PREFERRED PARENTAGE TITLE (Check one)

☐ Mother ☐ Father ☐ Parent

GENDER (Check one)

☐ Female ☐ Male

18. Second Birth Parent Current Legal Name

| First | Middle, if any | Last | Generational suffix (if any) |
|---|---|---|---|
| | | | |

What was your last name prior to your first marriage or your last name as it appears on your birth record if you were never married.

19. Second Parent Date of Birth

| Month | Day | Year | Current Age |
|---|---|---|---|
| | | | |

20. Second Parent Place of Birth (Please check only one and write in the state, province or foreign country).

☐ U.S. State or Territory _____

☐ Canada/Province _____ ☐ Other Foreign Country _____

21. What is the highest level of schooling of the second parent? (Check one)

☐ Grade 8 or Less
☐ Grade 9- 12 With No Diploma
☐ High School Graduate or GED Completed
☐ College Credit, But No Degree
☐ Associates Degree (e.g., AA, AS)
☐ Bachelor's Degree (e.g., BA, AB, BS)
☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
☐ Doctorate Degree (e.g., PhD, EdD) or Professional Degree (e.g., MD, DO, DDS, LLP, DVM, JD)

22. Is the second parent of Spanish/Hispanic/Latino origin? (Check all that apply)

☐ No, not Spanish/Hispanic/Latino
☐ Yes (Check one) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other _____
☐ Unknown

23. What is your race? (Check all that apply)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native (specify) _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify) _____
☐ Native Hawaiian Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify)
☐ Other (Specify) _____

Furnishing parent(s) Social Security Number(s) (SSNs) is required by Federal Law, 42 USC 405c section 205c of the Social Security Act. The number(s) will be made available to the State Social Services Agency to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance. The SSN is also collected as authorized by Ohio law to be used for public health purposes.

24. What is your Social Security Number? If you do not have a Social Security Number, please mark "None".

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

None ☐

25. If a second parent was listed on the form, what is the Second Parent's Social Security Number? If the second parent does not have a Social Security Number, please mark "None".

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |

None ☐

26. Do you want a Social Security Number issued for your child?

☐ Yes (Please sign request below)*

☐ No (Go to Question #27)

I request that the Social Security Administration assign a Social Security Number to the child named on this form and authorize the State to provide the Social Security Administration with the information from this form which is needed to assign a number.

I understand that if I was married at any time during the 300 days prior to the birth or my child; and I refuse to list my husband as the father; and do not have legal documentation (court order, separation agreement, journal entry, divorce decree) stating that my husband is not to be listed as the father of my child, my child's birth information will not be electronically transmitted to receive a Social Security number.

| *Signature of Birth Parent | Date |
|---|---|
| | |

27. What is the relationship of the person providing information for this worksheet?

☐ Birth Parent ☐ Second Parent

☐ Other, Please Specify _____

28. What is the birth parent's primary language (that is, what language do you feel the most comfortable speaking)?

☐ English ☐ Spanish ☐ Somali

☐ Other, please specify _____

Please return your completed Birth Parent's Worksheet to:

**Mother's Medical Record #** _____
**Mother's Name** _____
**Child's Date of Birth** _____
**Child's Medical Record #** _____

# FACILITY WORKSHEET FOR THE CERTIFICATE OF LIVE BIRTH

**Child's Last Name:** _____ **Plurality:** _____ **Birth Order:** _____

## Facility

1. **Facility Name:** _____
2. **Facility ID: National Provider Identifier:** _____

3. **Address of birth (if Home Birth or Other in #4 is marked):**

   State: _____

   County: _____

   City, Town, or Township: _____

   Street Address: _____

   Apartment Number: _____ Zip Code/Postal Code: _____

4. **Place of birth:**
   - ☐ Hospital/Birthing Center
   - ☐ Clinic/Doctor's Office
   - ☐ En Route (specify. e.g., taxi, ambulance, car, cab, plane etc.)
   - ☐ Freestanding Birth Center
   - ☐ Home Birth (Intended)
   - ☐ Home Birth (Not Intended)
   - ☐ Other * (specify, e.g., taxi, ambulance, cab, car, plane, etc.)_____

5. **Principal source of payment for this delivery** (At time of delivery):
   a. Health insurance through private insurance
   b. Medicaid – (Please refer to the Medicaid Card Example Tip Sheet)
   c. Medicare
   d. Self Pay (no third party involved)
   e. Uninsured
   f. Unknown
   g. Champus/Tricare
   h. Other (specify, e.g., Indian Health Service, other government [federal, state, local])_____

# Prenatal

**Sources: Prenatal care records, mother's medical records, labor and delivery records**

**Information for the following items should come from the mother's prenatal care records and from other medical reports in the mother's chart, as well as the infant's medical record. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record, or a copy of the prenatal care information. Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.**

6. **Date of first prenatal care visit** (Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy):

| ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
|---|---|---|---|---|---|---|---|
| M | M | D | D | Y | Y | Y | Y |

Unknown portions of the date should be entered as "99"
☐ No prenatal care
☐ Unknown

7. **Date of last prenatal care visit** (Enter the date of the last visit as recorded in the mother's prenatal records):

| ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
|---|---|---|---|---|---|---|---|
| M | M | D | D | Y | Y | Y | Y |

Unknown portions of the date should be entered as "99"
☐ Unknown

8. **Total number of prenatal care visits for this pregnancy** (Count only those visits recorded in the record. If none enter "0"): _____
☐ Unknown

9. **Date last normal menses began:**

| ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
|---|---|---|---|---|---|---|---|
| M | M | D | D | Y | Y | Y | Y |

Unknown portions of the date should be entered as "99"
☐ Unknown

10. **Pregnancy / Ultrasound Dating**
    1. ☐ Ultrasound BEFORE or = 20 weeks gestation
    2. ☐ Ultrasound AFTER 20 weeks gestation
    3. ☐ NO ultrasound performed

**11. Number of previous live births now living** (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):

____ Number
☐ Unknown

**12. Number of previous live births now deceased** (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):

____ Number
☐ Unknown

**13. Date of last live birth:**

| M | M | D | D | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Unknown portions of the date should be entered as "99"
☐ Unknown

**14. Total number of other pregnancy outcomes** (Include fetal losses of any gestational age)

_____ Number
☐ Unknown

**15. Date of last other pregnancy outcome** (Date when last pregnancy which did not result in a live birth ended):

| M | M | D | D | Y | Y | Y | Y |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

Unknown portions of the date should be entered as "99"
☐ Unknown

## Pregnancy

**Sources: Prenatal care records, mother's medical records, labor and delivery records**

**16. Risk factors in this pregnancy** (Check all that apply):

**a.** ☐ None
**b.** ☐ Pre-pregnancy diabetes
**c.** ☐ Gestational diabetes
**d.** ☐ Pre-pregnancy hypertension (chronic)
**e.** ☐ Gestational hypertension w/o eclampsia
**f.** ☐ Eclampsia
**g.** ☐ Previous preterm births – (a live birth of less than 37 weeks of gestation)
**h.** ☐ Other previous poor pregnancy outcome (Please see desk reference for conditions covered)
**i.** ☐ Infertility Treatment
  a. Fertility enhancing drugs, artificial insemination (AI) or intrauterine insemination
  b. Assisted reproductive technology

☐ Pregnancy resulted from assisted reproductive technology

**j.** ☐ Mother had a previous cesarean delivery

If Yes, how many____

Which of the following has the mother ever had? Check all that apply

☐ Prior Low Transverse or LTCS
☐ Prior Classical or Vertical CS
☐ Prior Uterine Rupture
☐ Prior Uterine Window
☐ None of the Above

**k.** ☐ Anemia (Hct,30/Hgb. < 10)
**l.** ☐ Cardiac Disease
**m.** ☐ Acute or Chronic Lung Disease
**n.** ☐ Polyhydramnios (excessive amniotic fluid) / Oligohydramnios (reduced amniotic fluid)
**o.** ☐ Hemoglobinopathy
**p.** ☐ IUGR (Suspected prenatally)
**q.** ☐ Renal (Kidney) disease
**r.** ☐ Cholestasis
**s.** ☐Blood group Allo-immunization
**t.** ☐Prior non-pregnant uterine surgery

**17. Infections present and/or treated during this pregnancy** – (Check all that apply):

**a.** ☐ None
**b.** ☐ Bacterial Vaginosis
**c.** ☐ Chlamydia
**d.** ☐ CMV
**e.** ☐ Gonorrhea
**f.** ☐ Hepatitis B
**g.** ☐ Hepatitis C
**h.** ☐ Herpes Simplex Virus
**i.** ☐ In Utero Infection (TORCHS)
**j.** ☐ Maternal Group B Strep Colonization
**k.** ☐ Measles
**l.** ☐ Mumps
**m.** ☐ PID
**n.** ☐ Rubella
**o.** ☐ Syphilis
**p.** ☐ Trichimoniasis
**q.** ☐ Toxoplasmosis
**r.** ☐ Varicella
**s.** ☐ HIV

**18. Obstetric procedures** – (Check all that apply):

**a.** ☐ None
**b.** ☐ External cephalic version - Successful
**c.** ☐ External cephalic version – Failed
**d.** ☐ Cervical cerclage
**e.** ☐ Tocolysis

**19. Progesterone – Did Mother receive Progesterone in any form *after the first trimester* to prevent prematurity?**

☐ Yes ☐ No

## Labor and Delivery

**Sources: Labor and delivery records, mother's medical records**

**20. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?**

☐ Yes* ☐ No

*If Yes, enter the name of the facility mother transferred from:

_____

Other (specify): _____

**21. Onset of Labor** (Check all that apply):

**a.** ☐ None
**b.** ☐ Premature Rupture of the Membranes
**c.** ☐ Precipitous labor (<3 hours)
**d.** ☐ Prolonged labor (>=20 hours)

**22. Date of birth:**

| ___ | ___ | ___ | ___ | ___ | ___ | ___ | ___ |
|---|---|---|---|---|---|---|---|
| M | M | D | D | Y | Y | Y | Y |

**23. Time of birth:** _____ 24-hour military format

**24. Attendant's name, title, and N.P.I.** (National Provider Identifier) (The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant):

_____ _____

Attendant's name N.P.I.

**Attendant's title:**

☐ CNM/CM - (Certified Nurse Midwife/Certified Midwife)
☐ D.O.
☐ EMT
☐ M.D.
☐ NURSE (RN, LPN)
☐ NURSE PRACTITIONER
☐ OTHER (specify) _____
☐ OTHER MIDWIFE: (Midwife other than CNM/CM)
☐ PHYSICIAN'S ASSISTANT
☐ UNKNOWN

**25. Certifier's name and Title and Date Certified**

| Certifier's Name | Certifier's Title | Date Certified |
|---|---|---|

**26. Mother's weight at delivery** (pounds only, do not round up): _____

**27. Characteristics of labor and delivery** (Check all that apply):

**a.** ☐ None
**b.** ☐ Induction of labor
**c.** ☐ Augmentation of labor
**d.** ☐ Non-vertex presentation
**e.** ☐ Steroids (glucocorticoids, ANCS) for fetal lung maturation received by the mother prior to delivery
**f.** ☐ Antibiotics received by the mother between the onset of labor and the actual delivery
**g.** ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F)
**h.** ☐ Moderate/heavy meconium staining of the amniotic fluid
**i.** ☐ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
**j.** ☐ Epidural or spinal anesthesia during labor
**k.** ☐ Abruptio Placenta
**l.** ☐ Placenta Previa
**m.** ☐ Cephalopelvic disproportion
**n.** ☐ Other excessive bleeding
**o.** ☐ Cord prolapse
**p.** ☐ Anesthetic complications

**28. Method of delivery:** **Note:** If foundling, mark "Unknown" to all items

**a.** Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No ☐ Unknown

**b.** Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No ☐ Unknown

**c.** Fetal presentation at birth (Check one):
☐ Breech ☐ Cephalic ☐ Other ☐ Unknown

**d.** Final route and method of delivery (Check one):
☐ Vaginal/Spontaneous
☐ Vaginal/Forceps
☐ Vaginal/Vacuum
☐ Cesarean – (no labor attempted)
☐ Cesarean – (labor attempted)
☐ Unknown

29. **Maternal morbidity** (Check all that apply):
    - **a.** ☐ None
    - **b.** ☐ Maternal transfusion
    - **c.** ☐ Third or fourth degree perineal laceration
    - **d.** ☐ Ruptured uterus
    - **e.** ☐ Unplanned Hysterectomy
    - **f.** ☐ Admission to intensive care unit
    - **g.** ☐ Unplanned OR following delivery

## Newborn

**Sources: Labor and delivery records, Newborn's medical records, mother's medical records**

30. **Infant's medical record number:** _____

31. **Birth weight**: _____ (grams) (Do not convert lb/oz to grams)

    If weight in grams is not available, birth weight: _____ (lb/oz)

32. **Obstetric estimate of gestation at delivery:** Completed Weeks: _____ Days _____

33. **Sex of child:** ☐ Male ☐ Female ☐ Unknown or Undetermined

34. **Apgar score**

    Score at **5** minutes _____ ☐ Unknown

    If 5 minute score **is less than 6:**

    Score at **10** minutes _____ ☐ Unknown

35. **Plurality** (Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.) (Include all live births and fetal losses resulting from this pregnancy.):

    _____

36. **Order of Delivery** (Order delivered in this pregnancy; specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Note: Delivery includes all live births and fetal losses resulting from this pregnancy):

    _____

37. **If not single birth, for this delivery specify: (Do Not include this birth)**

    Number born alive: _____

    Number of fetal deaths: _____

38. **Metabolic Kit Number:** _____

**39. Name of Prophylactic Used in Eyes of Child** (Check one):

- **a.** ☐ Ilotycin Ophthalmic
- **b.** ☐ Ilotycin Ointment
- **c.** ☐ Ilotycin
- **d.** ☐ Erythromycin Ophthalmic
- **e.** ☐ Erythromycin Ointment
- **f.** ☐ Erythromycin
- **g.** ☐ AGNO3 (Silver Nitrate)
- **h.** ☐ Neosporin
- **i.** ☐ EES
- **j.** ☐ Colostrum
- **k.** ☐ Boric Acid
- **l.** ☐ Breast Milk
- **m.** ☐ Unknown
- **n.** ☐ None

☐ Other (Specify) _____

**40. Abnormal conditions of the newborn** (Check all that apply):

- **a.** ☐ None
- **b.** ☐ Assisted ventilation required immediately following delivery
- **c.** ☐ Assisted ventilation required for more than six hours
- **d.** ☐ NICU admission
- **e.** ☐ Newborn given surfactant replacement therapy
- **f.** ☐ Antibiotics received by the newborn for suspected neonatal sepsis
- **g.** ☐ Seizure or serious neurologic dysfunction
- **h.** ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)

**41. Congenital anomalies of the newborn** (Check all that apply):

- **a.** ☐ None
- **b.** ☐ Anencephaly
- **c.** ☐ Craniofacial Anomalies
- **d.** ☐ Meningomyelocele / Spina bifida
- **e.** ☐ Hydrocephalus w/o Spina bifida
- **f.** ☐ Encephalocele
- **g.** ☐ Microcephalus
- **h.** ☐ Cyanotic congenital heart disease
- **i.** ☐ Tetralogy of Fallot
- **j.** ☐ Congenital diaphragmatic hernia
- **k.** ☐ Omphalocele
- **l.** ☐ Gastroschisis
- **m.** ☐ Bladder exstrophy
- **n.** ☐ Rectal/large intestinal atresia/stenosis
- **o.** ☐ Hirshsprung's disease
- **p.** ☐ Congenital hip dislocation
- **q.** ☐ Amniotic bands
- **r.** ☐ Limb reduction defect
- **s.** ☐ Congenital cataract
- **t.** ☐ Cleft Lip with/without Cleft Palate
- **u.** ☐ Cleft Palate alone
- **v.** ☐ Down Syndrome – Karyotype pending
- **w.** ☐ Down Syndrome –Karyotype confirmed
- **x.** ☐ Suspected chromosomal disorder – Karyotype confirmed
- **y.** ☐ Suspected chromosomal disorder Karyotype pending
- **z.** ☐ Hypospadias

**42. Was infant transferred within 24 hours of delivery?**

☐ Yes* ☐ No

*If Yes, enter the name of the facility infant was transferred to:

_____

Other (specify): _____

**43. Is infant living at time of report?**

☐ Yes ☐ No ☐ Infant transferred, status unknown

If No, complete a death record.

**44. Is infant being breastfed at discharge?**

☐ Yes ☐ No

**45. Exclusive breast milk feeding through entire stay?**

☐ Yes ☐ No

UNIVERSAL NEWBORN HEARING SCREENING

**Childs name:** _____ **DOB** _____

**Parents sig.** _____ **Date** _____

**Rec'd Pamphlet Yes / No**

UNIVERSAL NEWBORN HEARING SCREENING

**Childs name:** _____ **DOB** _____

**Parents sig.** _____ **Date** _____

**Rec'd Pamphlet Yes / No**