## Medical Data Worksheet for Child's Birth Certificate

This form to be completed by hospital staff. This data will be used to populate the medical data portion of the birth certificate for the newborn. The medical data is required to be reported within five days of the birth. **[HSC §192.003]** 

PATIENT REFERRENCE:		
MOTHER MR#	NEWBORN MR#	
MOTHER'S NAME	NEWBORN NAME	
MEDICAID#	DOB	
DELIVERING DR	_ DATE AOP SENT	
MOTHER TRANSFERRED		
☐ Born at Facility		
Prenatal Care  Yes  No  Unknown	Source of Prenatal Care (check all that apply)	
Date of First Visit//	□ None □ Midwife	
Date of Last Visit//	Hospital Clinic     Other, Specify	
Total Number of Prenatal Visits for this Pregnancy:	Public Health Clinic     Unknown	
Date Last Normal Menses Began//	Private Physician	
	Risk Factors in this Pregnancy (check all that apply)	
Pregnancy History	Diabetes	
Live births now living (Do not include this birth. For multiple	Prepregnancy (diagnosis prior to this pregnancy)	
deliveries, do not include the 1 <sup>st</sup> born in the set if completing this worksheet for that child. If <b>none</b> enter " <b>0</b> ".):	□ Gestational (diagnosis in this pregnancy)	
Live births now dead (Do not include this birth. For multiple	Hypertension	
deliveries, do not include the 1 <sup>st</sup> born in the set if completing this worksheet for that child. If <b>none</b> enter <b>"0</b> ".):	Prepregnancy (chronic)	
	Gestational (PIH, preeclampsia)	
Date of last live birth:/	Eclampsia	
<b>Number of other pregnancy outcomes</b> (Include fetal losses of any gestational age. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy.	Previous preterm birth	
	□ Other previous poor pregnancy outcome (includes perinatal death, small-for-	
If <u>none</u> enter " <b>0</b> ".):	gestational age/intrauterine growth restricted birth)	
Date of last other pregnancy outcome:/	<ul> <li>Pregnancy resulted from infertility treatment</li> <li>Fertility-enhancing drugs, artificial</li> </ul>	
MM YYYY	insemination or intrauterine insemination	
Infections Present and/or Treated During	□ Assisted reproductive technology	
Pregnancy (check all that apply)	□ Mother had a previous cesarean delivery	
Gonorrhea Hepatitis B	If yes, how many?	
Syphilis Hepatitis C	□ Antiretrovirals administered during pregnancy or at delivery	
Chlamydia None of the above	□ None of the above	
HIV Test		
HIV test done Prenatally	HIV test done at Delivery	
(check all that apply)		
First Trimester     Third Trimester     Second Trimester     Unknown     None	Infant tested for HIV at birth  Yes  No  Unknown	

Obstetric Procedures (check all that apply)	Onset of Labor (check all that apply)
Cervical cerclage	□ Premature Rupture of the Membranes [prolonged > =12 hours]
	Precipitous Labor [< 3 hours]
External cephalic version	Prolonged Labor [> = 20 hours]
Successful Failed	□ None of the above
□ None of the above	
	Method of Delivery
Characteristics of Labor & Delivery (check all that apply)	Was delivery with forceps attempted but unsuccessful?
□ Induction of labor	Was delivery with vacuum extraction attempted but unsuccessful?
□ Augmentation of labor	Fotal proceptation at hirth
□ Non-vertex presentation	Fetal presentation at birth         Cephalic       Breech         Other,
Steroids (glucocorticoids) for fetal lung maturation received by mother prior to delivery	Final route and method of delivery Vagina/Spontaneous Vagina/Forceps Vagina/Vacuum
□ Antibiotics received by mother during labor	
Chorioamnionitis or maternal temperature > = 38 degrees C or 100.4 degrees F	If cesarean, was a trial of labor attempted?  Cesarean Yes No Unknown
□ Moderate/heavy meconium staining of the amniotic fluid	Child's Health Information
□ Fetal intolerance of labor was such that one or more of the	Birth Weight Grams, orLBOZ.
following actions was taken: in-utero resuscitative measures, further assessments, or operative delivery	Obstetric Estimate of Gestation (completed weeks):
Epidural or spinal anesthesia during labor	Child's Sex:  Male  Female  Not yet determined
□ None of the above	
	Apgar Score: at 5 min:; (if less than 6) at 10 min:
Maternal Morbidity – Complications associated	Abnormal Conditions of the Newborn (check all that apply)
with Labor & Delivery (check all that apply)	
Maternal transfusion	Assisted ventilation required immediately following delivery
□ Third or forth degree perineal laceration	<ul> <li>Assisted ventilation required for more than six hours</li> <li>NICU admission</li> </ul>
Ruptured uterus	Newborn given surfactant replacement therapy
Unplanned hysterectomy	□ Antibiotics received by the newborn for suspected neonatal sepsis
Admission to intensive care unit	Seizure or serious neurologic dysfunction
Unplanned operating room procedure following delivery	□ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or
□ None of the above	soft tissue/solid organ hemorrhage which requires intervention)
	None of the above
	Congenital Anomalies of the Newborn (check all that apply)
Was Infant Transferred within 24 hours of Delivery?	Anencephaly     Cleft palate alone
□ No □ Yes, Specify Facility	□ Meningomyelocele/Spina bifida □ Down syndrome
Is Infant Living at Time of Report?	□ Cyanotic congenital heart disease □ Karyotype confirmed
	Congenital diaphragmatic hernia     Karyotype pending
	Omphalocele     Suspected chromosomal disorder     Suspected chromosomal disorder
Is Infant Being Breastfed at Discharge?	Gastroschisis  Gastroschisis  Karyotype confirmed  Karyotype confirmed
	Limb reduction defect     (excluding congenital amputation
Hepatitis B Immunization given?	and dwarfing syndromes)
🗆 Yes 🔲 No	□ Cleft lip with or without Cleft palate □ None of the above