Mother's Name:	Mother's Med. Rec. Number:

New York State Birth Certificate Work Booklet

A child's birth certificate is a very important document. It is the official record of the child's full name, date of birth and place of birth. Throughout the child's lifetime, it provides proof of identity and age. As a child grows from childhood to adulthood information in the birth certificate will be needed for many important events such as: entrance to school, obtaining a work permit, driver's license or marriage license, entrance in the Armed Forces, employment, collection of Social Security and retirement benefits, and for a passport to travel in foreign lands.

Because the birth certificate is such an important document, great care must be taken to make certain that it is correct in every detail. By completing this work booklet carefully, you can help assure the accuracy of the child's birth certificate. The information collected in this work booklet will be used to complete the Statewide Perinatal Data System (SPDS). The SPDS combines the New York State Certificate of Live Birth and a number of Quality Improvement (QI) questions. The QI questions strive to improve services provided to pregnant woman and their babies through the analysis of this information. The information that is collected is held in the strictest confidence. Data are analyzed in groups only, and individuals are not identified.

PARENTS, please complete the <u>unshaded</u> portions of this work booklet, see pages 2, 3, 7-8 & 11 (the shaded portions will be completed by hospital staff).

Information in the work booklet will be used to prepare the official birth certificate, which is filed with the local Registrar of Vital Statistics in your area within five (5) business days after the birth and with the New York State Department of Health. When the filing process is completed, the mother will receive a Certified copy of the birth certificate. This is an official form that may be used as proof of age, parentage and identity. Receiving it confirms that the child's birth certificate is officially registered in the State of New York. Additional copies of the baby's birth certificate may be obtained from the local registrar or the New York State Department of Health, P.O. Box 2602, Albany, New York 12220-2602. For further information about obtaining copies, please call (518) 474-3077 or visit the DOH website at *http://www.health.state.ny.us/nysdoh/consumer/vr.htm*.

All information (including personal information) is shared with the County Health Departments or other Local Health Units where the child was born and where the mother resides, if different. County Health Departments and Local Health Units may use this data for Public Health Programs. The Social Security Administration and Immunization Registry programs receive a minimal set of data ONLY when the parents have indicated, in this work booklet, that they wish to participate in these programs.

While individual information is important, public health workers will use medical and demographic data (without personal identifying information) in their efforts to identify, monitor and reduce maternal and newborn risk factors. This information (without personal identifying information) also provides physicians and medical scientists with the basis to develop new maternal and childcare programs for New York State residents.

ATTENTION HOSPITAL STAFF:

This work booklet has been designed to obtain information relating to the pregnancy, birth and the 72-hour period immediately following the birth of a live born child in New York State. Hospital staff, please complete the shaded portions of the work booklet.

New York State Public Health Law provides the basis for the collection of the birth certificate data. For pertinent information about the New York State Public Health Laws refer to sections 206(1)(e), 4102, 4130.5, 4132 and 4135. These laws are also described in the New York State Birth Certificate Guidelines. The Guidelines are available to SPDS users on the Vital Records Home Page *https://commerce.health.state.ny.us/dyn3/cgi-bin/applinks/spds/home.htm* under Vital Records Resources.

New York State Birth Certificate Work Booklet

New Birth Registration

Mother

Mother's Name: *First* *Middle* *Maiden Last Name* *Current Last Name*

Social Security Number: – –

Mother's Date of Birth: *(MM/DD/YYYY)* / /

Infant

Infant's Name: *First* *Middle* *Last* *Suffix*

Sex: ☐ Male ☐ Female ☐ Undetermined

Plurality:

Birth Order:

Medical Record No.:

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

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

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

If New York State Birthing Center, enter its name:

In what county was the child born?

Birthplace

Institution

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

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:

Zip / Postal Code:

Attendant

Attendant's Information:

License Number:

Name: *First* *Middle* *Last*

Title: *(Select one)*

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

Certifier

Certifier's Information:

☐ 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

Payor

Primary Payor for this Delivery:

Select one:

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

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

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

Release Form

Mother's Name: *First*	*Middle*	*Last*	Mother's Med. Rec. Number:
Father's Name: *First*	*Middle*	*Last*	*Suffix*
Infant's Name: *First*	*Middle*	*Last* *Suffix*	Date of Birth

To the hospital:

1. Obtain the parent(s) signature(s).
2. File the original Release Form in the mother's hospital record.
   Note: It is not necessary to file the remainder of the Work Booklet.
3. Provide a copy to the parent(s).
4. Do **not** send copies to the New York State Department of Health or to any Social Security office, unless specifically requested by such agency.

To the parent(s):

1. Please read the following notice about the collection and use of Social Security Numbers on your child's birth certificate.
2. Please check "Yes" or "No" to indicate if you wish to participate in any of the listed programs.

NOTICE REGARDING COLLECTION OF PARENTS' SOCIAL SECURITY NUMBERS: The collection of parents' Social Security Numbers on the New York State Certificate of Live Birth is mandatory. They are required by Public Health Law Section 4132(1) and may be used for child support enforcement, public health related purposes, when requested by State, federal and municipal governments for official purposes, when required by Public Health Law Section 4173 or 4174 and when otherwise required or authorized by law.

Yes ☐ **No** ☐

Social Security Release

The Social Security Administration offers the parents of newborns an opportunity to apply for a Social Security Number for their child through the birth certificate registration process. This is referred to by the Social Security Administration as Enumeration at Birth (EAB). If you participate in the EAB, the New York State Department of Health will forward to the Social Security Administration information from your child's birth certificate. Please note that the Social Security Administration will not process your EAB request unless, the birth certificate includes your child's full name. If you participate in the EAB, disclosure of parents' Social Security Numbers is mandated by 42 U.S.C. 405(c)(2). The Social Security Number(s) will be used by the Internal Revenue Service (IRS) solely for the purpose of determining Earned Income Tax Credit compliance. Do you want to participate in the Social Security Administration EAB program?

Yes ☐ **No** ☐

Immunization Registry

I consent to my child's immunization information, and my child's and my own identifying demographic information contained on the Birth Certificate, being placed in the New York State Immunization Registry to assist in my child's medical care and treatment. I understand that my child will be enrolled in the Immunization Registry and all of his/her immunizations will be entered in the registry. The immunization information will be released on request to: me or the child's legal guardian, my child when he/she reaches 18 years of age, the child's insurance company, his/her school or licensed day care, the local and state health department, or to a medical provider authorized to provide medical care for my child.
I understand that I can withdraw from the registry at any time with written notification to my child's medical care provider.

Mother's Signature ▶ _____ **Date** _____

Father's Signature ▶ _____ **Date** _____

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

Hospital Name:	
Signature of Hospital Representative: ▶	Date:

Mother's Name:	Mother's Med. Rec. Number:

Infant

Infant

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

Birth Weight:
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

QI

Select all that apply:

☐ Rapid / Advanced Labor ☐ Bleeding ☐ Fetus at Risk ☐ Severe pre-eclampsia
☐ Woman Refused Transfer ☐ Other *(specify)*

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

NYS Hospital Infant Transferred To:

State/Terr./Province:

Birth Information

Apgar Scores
1 minute: 5 minutes: 10 minutes:

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

Clinical Estimate of Gestation: *(Weeks)*

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

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

Hepatitis B

Hepatitis B Inoculation

Immunization Administered:
☐ Yes ☐ No
Date: *(MM/DD/YYYY)* / /

Immunoglobulin Administered:
☐ Yes ☐ No
Date: *(MM/DD/YYYY)* / /

Abnormal Conditions of the Newborn

Abnormal Conditions of the Newborn:

☐ None ☐ Unknown at this time

Select all that apply

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

Congenital Anomalies

Congenital Anomalies

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

Diagnosed Prenatally?

If Yes, please indicate all methods used:

QI

Yes ☐ No ☐	Anencephaly	Yes ☐ No ☐	☐ Level II Ultrasound ☐ MSAFP / Triple Screen ☐ Amniocentesis ☐ Other ☐ Unknown	
Yes ☐ No ☐	Meningomyelocele/Spina Bifida	Yes ☐ No ☐	☐ Level II Ultrasound ☐ MSAFP / Triple Screen ☐ Amniocentesis ☐ Other ☐ Unknown	
Yes ☐ No ☐	Cyanotic Congenital Heart Disease	Yes ☐ No ☐	☐ Level II Ultrasound ☐ Other ☐ Unknown	
Yes ☐ No ☐	Congenital Diaphragmatic Hernia	Yes ☐ No ☐	☐ Level II Ultrasound ☐ Other ☐ Unknown	
Yes ☐ No ☐	Omphalocele	Yes ☐ No ☐	☐ Level II Ultrasound ☐ Other ☐ Unknown	

Mother's Name:	Mother's Med. Rec. Number:

Congenital Anomalies

Congenital Anomalies

Select all that apply		Diagnosed Prenatally?	If Yes, please indicate all methods used: QI
Yes No ☐ ☐	Gastroschisis	Yes No ☐ ☐	☐ Level II Ultrasound ☐ Other ☐ Unknown
Yes No ☐ ☐	Limb Reduction Defect	Yes No ☐ ☐	☐ Level II Ultrasound ☐ Other ☐ Unknown
Yes No ☐ ☐	Cleft lip with or without Cleft Palate	Yes No ☐ ☐	☐ Level II Ultrasound ☐ Other ☐ Unknown
Yes No ☐ ☐	Cleft Palate Alone	Yes No ☐ ☐	☐ Level II Ultrasound ☐ Other ☐ Unknown
Yes No ☐ ☐	Down Syndrome ☐ Karyotype confirmed ☐ Karyotype pending	Yes No ☐ ☐	☐ Level II Ultrasound ☐ MSAFP / Triple Screen ☐ CVS ☐ Amniocentesis ☐ Other ☐ Unknown
Yes No ☐ ☐	Other Chromosomal Disorder ☐ Karyotype confirmed ☐ Karyotype pending	Yes No ☐ ☐	☐ Level II Ultrasound ☐ MSAFP / Triple Screen ☐ CVS ☐ Amniocentesis ☐ Other ☐ Unknown
Yes No ☐ ☐	Hypospadias	Yes No ☐ ☐	☐ Level II Ultrasound ☐ Other ☐ Unknown

Labor & Delivery

Labor & Delivery

Mother Transferred in Antepartum: ☐ Yes ☐ No	NYS Facility Mother Transferred From:	State/Terr./Province:
Mother's Weight at Delivery: *lbs.*		

Method of Delivery

Fetal Presentation: *(select one)*
☐ Cephalic ☐ Breech ☐ Other

Route & Method: *(select one)*
☐ Spontaneous ☐ Forceps – Mid ☐ Forceps – Low / Outlet ☐ Vacuum ☐ Cesarean ☐ Unknown

Attempted Procedures:
Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No
Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No

Trial Labor:
If Cesarean section, was trial labor attempted? ☐ Yes ☐ No

Indications for C-Section: QI
☐ Unknown

Select all that apply

☐ Failure to progress	☐ Malpresentation	☐ Previous C-Section
☐ Fetus at Risk / NFS	☐ Maternal Condition – Not Pregnancy Related	☐ Maternal Condition – Pregnancy Related
☐ Refused VBAC	☐ Elective	☐ Other

Mother's Name:	Mother's Med. Rec. Number:

Labor & Delivery

Method of Delivery

Indications for Vacuum:

☐ Unknown

QI

Select all that apply

☐ Failure to progress ☐ Fetus at Risk

☐ Other

Indications for Forceps:

☐ Unknown

QI

Select all that apply

☐ Failure to progress ☐ Fetus at Risk

☐ Other

Labor

Onset of Labor

☐ None ☐ Unknown at this time

Select all that apply

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

☐ Prolonged Labor (20 or more hours)

Characteristics

Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Induction of Labor – AROM ☐ Induction of Labor – Medicinal ☐ Augmentation of Labor

☐ Steroids ☐ Antibiotics ☐ Chorioamnionitis

☐ Meconium Staining ☐ Fetal Intolerance ☐ External Electronic Fetal Monitoring

☐ Internal Electronic Fetal Monitoring

Maternal Morbidity

Maternal Morbidity

☐ None ☐ Unknown at this time

Select all that apply

☐ Maternal Transfusion ☐ Perineal Laceration (3rd / 4th Degree) ☐ Ruptured Uterus

☐ Unplanned Hysterectomy ☐ Admit to ICU ☐ Unplanned Operating Room Procedure Following Delivery

☐ Postpartum transfer to a higher level of care

QI

Anesthesia / Analgesia

Anesthesia / Analgesia

☐ None ☐ Unknown at this time

Select all that apply

☐ Epidural (Caudal) ☐ Local ☐ Spinal

☐ General Inhalation ☐ Paracervical ☐ General Intravenous

☐ Pudendal

Was an analgesic administered?

☐ Yes ☐ No

Procedures

Other Procedures Performed at Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Episiotomy and Repair ☐ Sterilization

Mother's Name:	Mother's Med. Rec. Number:

Mother

Medical Record Number:

Mother's Demographics

Mother's Education: *(select one)*

- ☐ 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:	Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Other Spanish/Hispanic/Latina
  Specify:
- ☐ Yes, Puerto Rican

Mother's Demographics

Race:

Select all that apply

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Korean
- ☐ Gaumanian or Chamorro
- ☐ American Indian or Alaska Native **Tribe:**
- ☐ Other Asian **Specify:**
- ☐ Other Pacific Islander **Specify:**
- ☐ Other **Specify:**
- ☐ Black or African American
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian

Mother's Residence

Residence Address

Street Address:

County: *(if NYS)*	City, Town or Village:	State/Terr./Province:

Zip/Postal Code:	U.S./Canadian Phone Number: ( ) –	Mother's Country of Residence, if not USA:

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)*

Mailing Address:

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

Employment

Employment History

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

Name of Company or Firm:	Address:

City:	State/Terr./Province:	Zip / Postal Code:

Mother's Name:	Mother's Med. Rec. Number:

Father

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

Father's Demographics

Father's Name: *First* *Middle* *Last* *Suffix*

Social Security Number: – –

Demographics

Father's Date of Birth: *(MM/DD/YYYY)* / /

Education: *(select one)*

- ☐ 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: | Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Other Spanish/Hispanic/Latino — **Specify:**
- ☐ Yes, Puerto Rican

Race:

Select all that apply

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Korean
- ☐ Gaumanian or Chamorro
- ☐ American Indian or Alaska Native **Tribe:**
- ☐ Other Asian **Specify:**
- ☐ Other Pacific Islander **Specify:**
- ☐ Other **Specify:**
- ☐ Black or African American
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian

Father's Residence

Residence Address

☐ Check here if the father's residence address is the same as the mother's address *(otherwise enter information below)*

Street Address:

County: *(if NYS)* | City, Town or Village: | State/Terr./Province:

Zip/Postal Code: | U.S./Canadian Phone Number: ( ) – | Father's Country of Residence, if not USA:

Employment

Employment History

Current / Most Recent Occupation: | Kind of Business / Industry:

Name of Company or Firm: | Address:

City: | State/Terr./Province: | Zip / Postal Code:

Mother's Name:	Mother's Med. Rec. Number:

Prenatal History

Prenatal History

Did mother receive prenatal care?	Primary Prenatal Care Provider Type:	Did mother participate in WIC?
☐ Yes ☐ No	☐ MD / DO / C(N)M / HMO ☐ No Information ☐ Clinic ☐ No Provider ☐ Other	☐ Yes ☐ No

Key Pregnancy Dates *(MM/DD/YYYY)*

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
/ /	/ /	/ /	/ /

Prenatal Visits

Total Number of Prenatal Visits:	

Pregnancy History

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number ☐	**Now Dead** None or Number ☐	**Less than 20 Weeks** None or Number ☐	**20 Weeks or More** None or Number ☐	None or Number ☐	None or Number ☐

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
/	/	/	*lbs.*	*ft.* *in.*

Prenatal Care

Risk Factors

Risk Factors in this Pregnancy

☐ None ☐ Unknown at this time

Select all that apply

☐ Prepregnancy Diabetes	☐ Gestational Diabetes	☐ Prepregnancy Hypertension	☐ Gestational hypertension
☐ Other Serious Chronic Illnesses	☐ Previous Preterm Births	☐ Abruptio Placenta	☐ Other Vaginal Bleeding
☐ Other Poor Pregnancy Outcomes	☐ Infertility Treatment, **Number of Embryos Implanted:** (if applicable)		☐ Previous Cesarean Section, **Number:**
☐ Prelabor Referred for High Risk Care			

Infections

Infections Present and/or Treated During Pregnancy

☐ None ☐ Unknown at this time

Select all that apply

☐ Gonorrhea	☐ Syphilis	☐ Herpes Simplex Virus (HSV)	☐ Chlamydia
☐ Hepatitis B	☐ Hepatitis C	☐ Tuberculosis	☐ Rubella
☐ Bacterial Vaginosis			

Other Risk Factors

Other Risk Factors

Smoking Before or During Pregnancy?	List Number of Packs OR Cigarettes Smoked Per DAY			
	3 Months Prior to Pregnancy	First Three Months of Pregnancy	Second Three Months of Pregnancy	Last Trimester of Pregnancy
☐ Yes ☐ No	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes

Mother's Name:	Mother's Med. Rec. Number:

Prenatal Care

Other Risk

Other Risk Factors

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

Obstetric Procedures

Obstetric Procedures

☐ None ☐ Unknown at this time

Select all that apply

☐ Cervical Cerclage ☐ Tocolysis ☐ External Cephalic Version — ☐ Successful ☐ Failed

☐ Fetal Genetic Testing QI

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

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

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

Mother's Name:	Mother's Med. Rec. Number:

Interview/Records

Survey of Mother (in hospital)

Survey of Mother (in hospital)

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

1. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?

	Yes	No
a. How smoking during pregnancy could affect your baby?	☐	☐
b. How drinking alcohol during your pregnancy could affect your baby?	☐	☐
c. How using illegal drugs could affect your baby?	☐	☐
d. How long to wait before having another baby?	☐	☐
e. Birth control methods to use after your pregnancy?	☐	☐
f. What to do if your labor starts early?	☐	☐
g. How to keep from getting HIV (the virus that causes AIDS)?	☐	☐
h. Physical abuse to women by their husbands or partners?	☐	☐

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

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

4. During your pregnancy, would you say that you were: *(select one)*
   - ☐ 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?
   - ☐ 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?
- ☐ Yes, Full Record
- ☐ Yes, Prenatal Summary Only
- ☐ No

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

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

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

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

Admission & Discharge

Admission and Discharge Information

Mother

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

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

Infant

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

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