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 ______________________ **SOURCE OF PAYMENT FOR DELIVERY** ______________________

☐ **Born at Facility** ☐ **Born En Route** ☐ **Foundling** ☐ **Home Birth**

Prenatal Care ☐ Yes ☐ No ☐ Unknown

Date of First Visit _____/_____/_______

Date of Last Visit _____/_____/_______

Total Number of Prenatal Visits for this Pregnancy: ________

Date Last Normal Menses Began ____/____/______

Pregnancy History

Live births now living (Do not include **this** birth. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child. If **none** enter "**0**".): ______

Live births now dead (Do not include **this** birth. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child. If **none** enter "**0**".): ______

Date of last live birth: _____/_______
MM YYYY

Number of other pregnancy outcomes (Include fetal losses of any gestational age. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy. If **none** enter "**0**".): ______

Date of last other pregnancy outcome: _____/_______
MM YYYY

Infections Present and/or Treated During Pregnancy (check all that apply)

☐ Gonorrhea ☐ Hepatitis B

☐ Syphilis ☐ Hepatitis C

☐ Chlamydia ☐ None of the above

Source of Prenatal Care (check all that apply)

☐ None ☐ Midwife

☐ Hospital Clinic ☐ Other, Specify ______________

☐ Public Health Clinic ☐ Unknown

☐ Private Physician

Risk Factors in this Pregnancy (check all that apply)

Diabetes

- ☐ Prepregnancy (diagnosis prior to this pregnancy)
- ☐ Gestational (diagnosis in this pregnancy)

Hypertension

- ☐ Prepregnancy (chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

☐ Previous preterm birth

☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Pregnancy resulted from infertility treatment

- ☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination
- ☐ Assisted reproductive technology

☐ Mother had a previous cesarean delivery
If yes, how many?______

☐ Antiretrovirals administered during pregnancy or at delivery

☐ None of the above

HIV Test

HIV test done Prenatally ☐ Yes ☐ No ☐ Unknown
(check all that apply)

☐ First Trimester ☐ Third Trimester

☐ Second Trimester ☐ Unknown ☐ None

HIV test done at Delivery ☐ Yes ☐ No ☐ Unknown

Infant tested for HIV at birth ☐ Yes ☐ No ☐ Unknown

Obstetric Procedures (check all that apply)

☐ Cervical cerclage

☐ Tocolysis

External cephalic version

☐ Successful ☐ Failed

☐ None of the above

Characteristics of Labor & Delivery
(check all that apply)

☐ Induction of labor

☐ Augmentation of labor

☐ Non-vertex presentation

☐ Steroids (glucocorticoids) for fetal lung maturation received by mother prior to delivery

☐ Antibiotics received by mother during labor

☐ Chorioamnionitis or maternal temperature > = 38 degrees C or 100.4 degrees F

☐ Moderate/heavy meconium staining of the amniotic fluid

☐ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further assessments, or operative delivery

☐ Epidural or spinal anesthesia during labor

☐ None of the above

Maternal Morbidity – Complications associated with Labor & Delivery (check all that apply)

☐ Maternal transfusion

☐ Third or forth degree perineal laceration

☐ Ruptured uterus

☐ Unplanned hysterectomy

☐ Admission to intensive care unit

☐ Unplanned operating room procedure following delivery

☐ None of the above

Was Infant Transferred within 24 hours of Delivery?

☐ No ☐ Yes, Specify Facility ____________________

Is Infant Living at Time of Report?

☐ Yes ☐ No

Is Infant Being Breastfed at Discharge?

☐ Yes ☐ No

Hepatitis B Immunization given?

☐ Yes ☐ No

Onset of Labor (check all that apply)

☐ Premature Rupture of the Membranes [prolonged > =12 hours]

☐ Precipitous Labor [< 3 hours]

☐ Prolonged Labor [> = 20 hours]

☐ None of the above

Method of Delivery

Was delivery with forceps attempted but unsuccessful?

☐ Yes ☐ No ☐ Unknown

Was delivery with vacuum extraction attempted but unsuccessful?

☐ Yes ☐ No ☐ Unknown

Fetal presentation at birth

☐ Cephalic ☐ Breech ☐ Other, ____________________

Final route and method of delivery

☐ Vagina/Spontaneous ☐ Vagina/Forceps ☐ Vagina/Vacuum

If cesarean, was a trial of labor attempted? ☐ Cesarean

☐ Yes ☐ No ☐ Unknown

Child's Health Information

Birth Weight ________ Grams, or ________LB. ________OZ.

Obstetric Estimate of Gestation (completed weeks): ________

Child's Sex: ☐ Male ☐ Female ☐ Not yet determined

Apgar Score: at 5 min:_______; (if less than 6) at 10 min:_______

Abnormal Conditions of the Newborn (check 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

☐ Seizure or serious neurologic dysfunction

☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)

☐ None of the above

Congenital Anomalies of the Newborn (check all that apply)

☐ Anencephaly

☐ Meningomyelocele/Spina bifida

☐ Cyanotic congenital heart disease

☐ Congenital diaphragmatic hernia

☐ Omphalocele

☐ Gastroschisis

☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)

☐ Cleft lip with or without Cleft palate

☐ Cleft palate alone

☐ Down syndrome
- ☐ Karyotype confirmed
- ☐ Karyotype pending

☐ Suspected chromosomal disorder
- ☐ Karyotype confirmed
- ☐ Karyotype pending

☐ Hypospadias

☐ None of the above