

# CERTIFICATE OF LIVE BIRTH WORKSHEET

PLEASE COMPLETE THIS INFORMATION TO PREPARE  
YOUR CHILD'S BIRTH CERTIFICATE

**FOR HOSPITAL USE ONLY:**

ROOM: \_\_\_\_\_ MR: \_\_\_\_\_

DELIVERY DR: \_\_\_\_\_

CLERK INITIAL: \_\_\_\_\_

DATE GIVEN TO PARENT(S): \_\_\_\_\_

DATE COMPLETED: \_\_\_\_\_

**NAME OF CHILD:**

FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

LAST: \_\_\_\_\_

SEX: MALE \_\_\_ FEMALE \_\_\_ UNK \_\_\_ WAS THIS BIRTH: SINGLE \_\_\_ TWIN \_\_\_ TRIPLET \_\_\_ QUAD \_\_\_ OTHER \_\_\_

IF MULTIPLE, THIS CHILD: 1<sup>ST</sup> \_\_\_ 2<sup>ND</sup> \_\_\_ 3<sup>RD</sup> \_\_\_ 4<sup>TH</sup> \_\_\_ OTHER \_\_\_ (CHECK APPROPRIATE ENTRY)

CHILD'S DATE OF BIRTH: \_\_\_\_\_ TIME OF BIRTH: \_\_\_\_\_

ARE THE PARENTS MARRIED AND/OR IN A STATE REGISTERED PARTNERSHIP (SRDP)? YES \_\_\_ NO \_\_\_

IF THE PARENTS ARE NOT MARRIED OR IN A SRDP, THEN THE BIOLOGICAL PARENTS MUST SIGN PATERNITY PAPERS TO ADD THE PARENT'S NAME TO THE CHILD'S BIRTH CERTIFICATE. REFERENCE HEALTH AND SAFETY CODE SECTION 102425(a)(4).

**BIRTH NAME OF PARENT NOT GIVING BIRTH (FIELDS 6A, 6B, 6C, ON CHILD'S BIRTH CERTIFICATE):**

FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

LAST: \_\_\_\_\_ SSN: \_\_\_\_\_

RELATIONSHIP TO CHILD: MOTHER  FATHER  PARENT  NOT SPECIFIED

BIRTHPLACE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
(U.S. STATE OR FOREIGN COUNTRY)

**BIRTH NAME OF PARENT GIVING BIRTH (FIELDS 9A, 9B, 9C, ON CHILD'S BIRTH CERTIFICATE), UNLESS COURT ORDER IS PRESENTED:**

FIRST: \_\_\_\_\_ MIDDLE: \_\_\_\_\_

LAST: \_\_\_\_\_ SSN: \_\_\_\_\_

RELATIONSHIP TO CHILD: MOTHER  FATHER  PARENT  NOT SPECIFIED

BIRTHPLACE: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
(U.S. STATE OR FOREIGN COUNTRY)

**GENETIC FATHER INFORMATION (MALE GENETIC CONTRIBUTOR FOR THE CREATION OF THE BABY THROUGH SPERM DONATION OR SEXUAL INTERCOURSE):**

IF HISPANIC, SPECIFY ORIGIN: \_\_\_\_\_

RACE: \_\_\_\_\_ (ENTER UP TO THREE RACES)

CIRCLE HIGHEST DEGREE/LEVEL OF EDUCATION: ENTER HIGHEST YEAR COMPLETED \_\_\_ (0-11<sup>TH</sup> GRADE); 12<sup>TH</sup> GRADE (NO DIPLOMA); HS DIPLOMA; GED; SOME COLLEGE (NO DEGREE); ASSOCIATE DEGREE; BACHELORS DEGREE; MASTERS DEGREE; DOCTORATE

DATE LAST WORKED (MONTH AND YEAR): \_\_\_\_\_

USUAL OCCUPATION: \_\_\_\_\_  
(WORK DONE FOR THE LONGEST PERIOD OF TIME)

KIND OF BUSINESS/INDUSTRY: \_\_\_\_\_

**GENETIC MOTHER INFORMATION (PERSON THAT SUPPLIED EGG RESULTING IN AN EMBRYO):**

IF HISPANIC, SPECIFY ORIGIN: \_\_\_\_\_

RACE: \_\_\_\_\_ (ENTER UP TO THREE RACES)

CIRCLE HIGHEST DEGREE/LEVEL OF EDUCATION: ENTER HIGHEST YEAR COMPLETED \_\_\_\_ (0-11<sup>TH</sup> GRADE);  
12<sup>TH</sup> GRADE (NO DIPLOMA); HS DIPLOMA; GED; SOME COLLEGE (NO DEGREE); ASSOCIATE DEGREE; BACHELORS  
DEGREE; MASTERS DEGREE; DOCTORATE

DATE LAST WORKED (MONTH AND YEAR): \_\_\_\_\_

USUAL OCCUPATION: \_\_\_\_\_  
(WORK DONE FOR THE LONGEST PERIOD OF TIME)

KIND OF BUSINESS/INDUSTRY: \_\_\_\_\_

**BIRTH PARENT'S RESIDENCE ADDRESS (REQUIRED):** \_\_\_\_\_

(ADDRESS, COUNTY, CITY, STATE, ZIP CODE. P.O. BOXES ARE **NOT** ACCEPTABLE.)

**MAILING ADDRESS (IF DIFFERENT):** \_\_\_\_\_

(ADDRESS, COUNTY, CITY, STATE, ZIP CODE. P.O. BOXES ARE ACCEPTABLE.)

**DID BIRTH PARENT RECEIVE WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM FOOD DURING PREGNANCY?**

YES  NO  UNKNOWN

**DID THE BIRTH PARENT SMOKE BEFORE OR DURING THE PREGNANCY? ENTER NUMBER OF CIGARETTES  
SMOKED PER DAY AS FOLLOWS:**

DURING THE THREE MONTHS PRIOR TO BECOMING PREGNANT: \_\_\_\_\_  
DURING THE FIRST THREE MONTHS OF PREGNANCY: \_\_\_\_\_  
DURING THE SECOND THREE MONTHS OF PREGNANCY: \_\_\_\_\_  
DURING THE LAST THREE MONTHS OF PREGNANCY: \_\_\_\_\_

**BIRTH PARENT'S:** PRE PREGNANCY WEIGHT: \_\_\_\_\_ WEIGHT AT DELIVERY: \_\_\_\_\_ HEIGHT: \_\_\_\_\_

**APGAR (1):** \_\_\_\_\_ **APGAR (5):** \_\_\_\_\_ **APGAR (10):** \_\_\_\_\_

**DATE OF LAST NORMAL MENSES:** \_\_\_\_\_ **ESTIMATED CONFINEMENT DATE:** \_\_\_\_\_  
(ESTIMATED DUE DATE AS PROVIDED BY DR)

**DATE OF FIRST PRENATAL CARE VISIT:** \_\_\_\_\_

**PREGNANCY MONTH PRENATAL CARE BEGAN:** \_\_\_\_\_ **DATE OF LAST PRENATAL CARE VISIT:** \_\_\_\_\_  
(e.g., 1<sup>ST</sup>, 2<sup>ND</sup>, 3<sup>RD</sup>, etc.) (DO NOT ENTER DELIVERY DATE)

**NUMBER OF PRENATAL VISITS:** \_\_\_\_\_ (IF UNSURE, ESTIMATE. DO NOT INCLUDE NON-PREGNANCY RELATED VISITS TO ER; VISIT  
TO CONFIRM PREGNANCY; NUTRITIONIST; DIETITIAN; HEALTH EDUCATOR, ETC. NORMAL PRENATAL VISITS ARE APPROXIMATELY 16.)

**SOURCE OF PAYMENT FOR PRENATAL CARE:** \_\_\_\_\_ **EXPECTED SOURCE OF PAYMENT FOR DELIVERY:** \_\_\_\_\_

**BIRTHWEIGHT IN GRAMS:** \_\_\_\_\_ **OBSTETRIC ESTIMATE OF GESTATION:** \_\_\_\_\_ (COMPLETED WEEKS)

**HEARING RESULTS:**  
PASS BOTH: \_\_\_\_\_ REFER ONE: \_\_\_\_\_ REFER BOTH: \_\_\_\_\_ RESULTS PENDING: \_\_\_\_\_

**NUMBER OF PREVIOUS LIVE BIRTHS:** \_\_\_\_\_ **NUMBER OF LIVE BIRTHS NOW DEAD:** \_\_\_\_\_

**DATE OF LAST LIVE BIRTH:** \_\_\_\_\_ (DO NOT COUNT THIS CHILD)

**NUMBER OF MISCARRIAGES BEFORE 20 WEEKS:** \_\_\_\_\_ **AFTER 20 WEEKS:** \_\_\_\_\_ (DO NOT COUNT ABORTIONS)

**DATE OF LAST MISCARRIAGE:** \_\_\_\_\_ **METHOD OF DELIVERY:** \_\_\_\_\_

## REQUESTING THE CHILD'S SOCIAL SECURITY NUMBER THROUGH THE BIRTH CERTIFICATE PROCESS

NOTICE TO PARENTS: Completion of this form in the hospital will enable you to receive a valuable service from the federal government. Federal law requires that a Social Security Number be provided for all dependents listed on federal tax forms. A Social Security Number is also necessary when applying for welfare or other public assistance benefits for your child. By completing this form and requesting a Social Security Number for your new baby, the California Department of Public Health will transmit your request to the Social Security Administration, and a card will be mailed to you usually within six weeks, eliminating the need for you to personally visit a Social Security office with evidence of your child's identity, birth date, and citizenship.

If you choose to participate in this program, and the parent(s) Social Security Number(s) are provided on the birth certificate, the parent(s) Social Security Number(s) will be disclosed to the Internal Revenue Service. The Social Security Number(s) will be used by the Internal Revenue Service solely for the purpose of tax benefits based on support or residence of a child, pursuant to 42 USC 405 (c)(2) as amended by Section 1090(b) of Public Law 105-34. For further information about this program, please contact the Social Security Administration at (800) 772-1213.

For certified copies of your child's birth certificate, contact the health department or the recorder's office of the county where the birth occurred. You may also obtain an application for a certified copy through the California Department of Public Health by calling (916) 445-2684 or by visiting the web site at [www.cdph.ca.gov](http://www.cdph.ca.gov).

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### NEWBORN AUTOMATIC NUMBER ASSIGNMENT (NANA)

Baby's Name as Reported on Birth Certificate:

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(A SOCIAL SECURITY NUMBER CANNOT BE ISSUED FOR A CHILD THAT HAS NOT BEEN NAMED.)

1. Do you want a Social Security number for your new baby?  
 Yes     No
2. May the Social Security Administration share it with the California Department of Public Health?  
 Yes     No

I acknowledge that I am responsible for reviewing my child's birth certificate for accuracy and that the birth certificate worksheet is only retained for a limited time period. Beyond that, it will not be the responsibility of the hospital to amend the birth certificate for anything other than an incorrect date of birth, time of birth, or sex of infant. All other amendments to the birth certificate are the responsibility of the parent.

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Parent's Signature

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Date

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Parent's Name (Please print)

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Medical Record Number

This form should be completed and signed by the child's parent(s). After coding Box F on the birth certificate, retain this form with the birth parent's medical records.

**HOSPITAL USE ONLY**

**CERTIFICATES OF LIVE BIRTH AND FETAL DEATH  
MEDICAL DATA SUPPLEMENTAL WORKSHEET  
VS 10A (Rev. 1/ 2006)**

**Use the codes on this Worksheet to report the appropriate entry in items numbered 25D and 28A through 31 on the "Certificate of Live Birth" and for items 29D and 32B through 35 on the "Certificate of Fetal Death."**

**Item 25D. (Birth) PRINCIPAL SOURCE OF PAYMENT FOR PRENATAL CARE**

**Item 29D. (Fetal Death)** (Enter only 1 code)

02 Medi-Cal, without CPSP Support Services	07 Private Insurance Company	99 Unknown
13 Medi-Cal, with CPSP Support Services	09 Self Pay	00 No Prenatal Care
05 Other Government Programs (Federal, State, Local)	14 Other	

**Item 28A. (Birth) METHOD OF DELIVERY**

**Item 32A (Fetal Death)** (Enter only 1 code/number under each section, separated by commas: A,B,C,D,E,F)

**A. Final delivery route**

- 01 Cesarean—primary
- 11 Cesarean—primary, with trial of labor attempted
- 21 Cesarean—primary, with vacuum
- 31 Cesarean—primary, with vacuum & trial of labor attempted
- 02 Cesarean—repeat
- 12 Cesarean—repeat, with trial of labor attempted
- 22 Cesarean—repeat, with vacuum
- 32 Cesarean—repeat, with vacuum & trial of labor attempted
- 03 Vaginal—spontaneous
- 04 Vaginal—spontaneous, after previous Cesarean
- 05 Vaginal—forceps
- 15 Vaginal—forceps, after previous Cesarean
- 06 Vaginal—vacuum
- 16 Vaginal—vacuum, after previous Cesarean
- 88 Not Delivered (Fetal Death Only)

**B. If mother had a previous Cesarean—How many? \_\_\_\_\_**

(Enter 0 – 9, or U if Unknown)

**C. Fetal presentation at birth**

- 20 Cephalic fetal presentation at delivery
- 30 Breech fetal presentation at delivery
- 40 Other fetal presentation at delivery
- 90 Unknown

**D. Was vaginal delivery with forceps attempted, but unsuccessful?**

- 50 Yes
- 58 No
- 59 Unknown

**E. Was vaginal delivery with vacuum attempted, but unsuccessful?**

- 60 Yes
- 68 No
- 69 Unknown

**F. Hysterotomy/ Hysterectomy (Fetal Death Only)**

- 70 Yes
- 78 No

**Item 28B. (Birth) EXPECTED PRINCIPAL SOURCE OF PAYMENT FOR DELIVERY**

**Item 32B (Fetal Death)** (Enter only 1 code)

02 Medi-Cal	05 Other Government Programs (Federal, State, Local)	14 Other
15 Indian Health Service	07 Private Insurance	99 Unknown
16 CHAMPUS/TRICARE	09 Self Pay	00 Medically Unattended Birth

**Item 29. (Birth)**

**Item 33. (Fetal Death)**

**COMPLICATIONS AND PROCEDURES OF PREGNANCY AND CONCURRENT ILLNESSES**

(Enter up to 16 codes, separated by commas, for the most important complications/procedures.)

**DIABETES**

- 09 Prepregnancy (Diagnosis prior to this pregnancy)
- 31 Gestational (Diagnosis in this pregnancy)

**HYPERTENSION**

- 03 Prepregnancy (Chronic)
- 01 Gestational (PIH, Preeclampsia)
- 02 Eclampsia

**OTHER COMPLICATIONS/ PREGNANCIES**

- 32 Large fibroids
- 33 Asthma
- 34 Multiple pregnancy (more than 1 fetus this pregnancy)
- 35 Intrauterine growth restricted birth this pregnancy
- 23 Previous preterm birth (<37 weeks gestation)
- 36 Other previous poor pregnancy outcomes (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth, large for gestational age, etc.)

**OBSTETRIC PROCEDURES**

- 24 Cervical cerclage
- 28 Tocolysis
- 37 External cephalic version—Successful
- 38 External cephalic version—Failed
- 39 Consultation with specialist for high risk obstetric services

**PREGNANCY RESULTED FROM INFERTILITY TREATMENT**

- 40 Fertility-enhancing drugs, artificial insemination or intrauterine insemination
- 41 Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))

**INFECTIONS PRESENT AND/ OR TREATED DURING THIS PREGNANCY**

- 42 Chlamydia
- 43 Gonorrhea
- 44 Group B streptococcus
- 18 Hepatitis B (acute infection or carrier)
- 45 Hepatitis C
- 16 Herpes simplex virus (HSV)
- 46 Syphilis
- 47 Cytomegalovirus (Fetal Death Only)
- 48 Listeria (Fetal Death Only)
- 49 Parvovirus (Fetal Death Only)
- 50 Toxoplasmosis (Fetal Death Only)

**PRENATAL SCREENING DONE FOR INFECTIOUS DISEASES**

- 51 Chlamydia
- 52 Gonorrhea
- 53 Group B streptococcal infection
- 54 Hepatitis B
- 55 Human immunodeficiency virus (offered)
- 56 Syphilis

**NONE OR OTHER COMPLICATIONS/ PROCEDURES NOT LISTED**

- 00 None
- 30 Other Pregnancy Complications/Procedures not Listed

**See reverse side for codes to Birth Items 30 and 31 and Fetal Death Items 34 and 35.**

**Do not enter any identification by patient name or number on this worksheet. Discard after use.  
Do not retain the worksheet in the medical records or submit with the "Certificates of Live Birth or Fetal Death."**

**CERTIFICATE OF LIVE BIRTH AND FETAL DEATH—MEDICAL DATA SUPPLEMENTAL WORKSHEET (Continued)**

**Item 30 (Birth)**

**COMPLICATIONS AND PROCEDURES OF LABOR AND DELIVERY**

**Item 34 (Fetal Death)**

*(Enter up to 9 codes, separated by commas, for the most important complications/procedures.)*

**ONSET OF LABOR**

- 10 Premature rupture of membranes (< 12 hours)
- 07 Precipitous labor (< 3 hours)
- 08 Prolonged labor (> 20 hours)

**CHARACTERISTICS OF LABOR AND DELIVERY**

- 11 Induction of labor
- 12 Augmentation of labor
- 32 Non-vertex presentation
- 33 Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- 34 Antibiotics received by the mother during labor
- 35 Clinical chorioamnionitis diagnosed during labor or maternal temperature > 38°C / > 100.4°F
- 19 Moderate/heavy meconium staining of the amniotic fluid
- 36 Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- 37 Epidural or spinal anesthesia during labor
- 25 Mother transferred for delivery from another facility for maternal medical or fetal indications

**COMPLICATIONS OF PLACENTA, CORD, AND MEMBRANES**

- 38 Rupture of membranes prior to onset of labor
- 13 Abruptio placenta
- 39 Placental insufficiency
- 20 Prolapsed cord
- 17 Chorioamnionitis

**MATERNAL MORBIDITY**

- 24 Maternal blood transfusion
- 40 Third or fourth degree perineal laceration
- 41 Ruptured uterus
- 42 Unplanned hysterectomy
- 43 Admission to ICU
- 44 Unplanned operating room procedure following delivery

**NONE OR OTHER COMPLICATIONS/ PROCEDURES NOT LISTED**

- 00 None
- 31 Other Labor/Delivery Complications/Procedures not Listed

**Item 31 (Birth)**

**ABNORMAL CONDITIONS AND CLINICAL PROCEDURES RELATING TO THE NEWBORN**

**Item 35 (Fetal Death)**

**ABNORMAL CONDITIONS AND CLINICAL PROCEDURES RELATING TO THE FETUS**

*(Enter up to 10 codes, separated by commas, for the most important conditions/procedures.)*

**CONGENITAL ANOMALIES (NEWBORN OR FETUS)**

- 01 Anencephaly
- 02 Meningocele/Spina bifida
- 76 Cyanotic congenital heart disease
- 77 Congenital diaphragmatic hernia
- 78 Omphalocele
- 79 Gastroschisis
- 80 Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- 28 Cleft palate alone
- 29 Cleft lip alone
- 30 Cleft palate with cleft lip
- 57 Down's Syndrome—Karyotype confirmed
- 81 Down's Syndrome—Karyotype pending
- 82 Suspected chromosomal disorder—Karyotype confirmed
- 83 Suspected chromosomal disorder—Karyotype pending
- 35 Hypospadias
- 88 Aortic stenosis
- 89 Pulmonary stenosis
- 90 Atresia
- 62 Additional and unspecified congenital anomalies not listed above

**ABNORMAL CONDITIONS (NEWBORN OR FETUS)**

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

**ADDITIONAL ABNORMAL CONDITIONS/ PROCEDURES (NEWBORN ONLY)**

- 71 Assisted ventilation required immediately following delivery
- 85 Assisted ventilation required for more than 6 hours
- 73 NICU admission
- 86 Newborn given surfactant replacement therapy
- 87 Antibiotics received by the newborn for suspected neonatal sepsis
- 70 Seizure or serious neurological dysfunction
- 74 Newborn transferred to another facility within 24 hours of delivery

**NONE OR OTHER ABNORMAL CONDITIONS/ PROCEDURES NOT LISTED**

- 00 None (Newborn or Fetus)
- 75 Other Conditions/Procedures not Listed (Newborn Only)
- 67 Other Conditions/Procedures not Listed (Fetal Death Only)