



BIRTH CERTIFICATE INFORMATION – MEDICAL PORTION

This information is required by law and will be confidentially used by public health. The preferred source of this data is the medical professional in attendance at the time of delivery and/or newborn examination.

Child's Medical Information		
BIRTH ATTENDANT	MOTHER'S NAME OR MED RECORD NUMBER	DATE OF BIRTH
INFANT TRANSFERRED? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, WHERE?		BABY'S MEDICAL RECORD NUMBER
BIRTH WEIGHT <input type="checkbox"/> lb./oz. <input type="checkbox"/> grams	ESTIMATED GESTATION In completed weeks	APGAR Scores 1 min _____ / 5 min _____ / 10 min (if applicable) <i>The one minute score is not recorded in the birth record.</i>
PLURALITY / # live born in this birth / birth order of this baby		
MOTHER'S HEP B STATUS <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Unknown	Did baby get Hep B vaccine? <input type="checkbox"/> No <input type="checkbox"/> Refused If Yes - when?	HBIG given to baby? <input type="checkbox"/> No <input type="checkbox"/> Refused If Yes - when?
Abnormal conditions of the newborn <input type="checkbox"/> Assisted ventilation immediately after birth <input type="checkbox"/> Assisted ventilation > 6 hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn surfactant therapy <input type="checkbox"/> Antibiotics for suspected sepsis <input type="checkbox"/> Confirmed bacterial infection <input type="checkbox"/> Seizure or neurologic dysfunction <input type="checkbox"/> Birth injury <input type="checkbox"/> Anemia <input type="checkbox"/> Other _____ <input type="checkbox"/> None of the above		Congenital anomalies <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele / Spina bifida <input type="checkbox"/> Hypospadias <input type="checkbox"/> Other urogenital anomalies <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb reduction defect <input type="checkbox"/> Polydactyly / syndactyly / adactyly <input type="checkbox"/> Club foot <input type="checkbox"/> Other musculoskeletal/integumental <input type="checkbox"/> Cleft lip <input type="checkbox"/> Cleft palate <input type="checkbox"/> Down syndrome – confirmed? _____ <input type="checkbox"/> Other chromosomal – conf? _____ <input type="checkbox"/> Other anomalies _____ <input type="checkbox"/> None of the above
WAS BABY BREASTFED or fed breast milk <input type="checkbox"/> No <input type="checkbox"/> During stay <input type="checkbox"/> At discharge	INFANT ALIVE AT TIME OF FILING? <input type="checkbox"/> Yes <input type="checkbox"/> No	TIME OF BIRTH <input type="checkbox"/> 24 hr. <input type="checkbox"/> AM <input type="checkbox"/> PM



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Mother's Medical Information I - Prenatal				
MOTHER'S NAME OR MED RECORD NUMBER			Did mother receive prenatal care? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of first prenatal visit / /		Date of last prenatal visit / /		Total prenatal visits
Month of pregnancy care began (1 st , 2 nd , etc.)				
Mother's height		Pre-pregnancy weight		Weight at delivery
Last menstrual period / /				
Previous live births Still living	Previous live births Now dead	Mo/Yr of last live birth /	Number of terminations or other outcomes	Mo/Yr of last other outcome /
Risk factors this pregnancy				
<input type="checkbox"/> Diabetes – pre pregnancy <input type="checkbox"/> Diabetes – gestational <input type="checkbox"/> Hypertension – pre pregnancy <input type="checkbox"/> Hypertension – gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia <input type="checkbox"/> Pregnancy resulted from infertility treatments <input type="checkbox"/> Fertility drugs, artificial insemination, intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (IVF, GIFT)				
<input type="checkbox"/> Anemia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor outcome (perinatal death, SGA, IUGR) <input type="checkbox"/> Previous cesarean birth How many? _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> None of the above				
TOXICOLOGY– were toxicology tests administered to mother and/or the newborn? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, Results:			PRINCIPAL SOURCE OF PAYMENT for this delivery <input type="checkbox"/> Private insurance <input type="checkbox"/> Self pay (uninsured) <input type="checkbox"/> Other (Tricare/Indian Health/Other government) <input type="checkbox"/> Medical Assistance/MN Care/Medicaid	
Mother's Medical II - Delivery				
Infections present / treated			Prenatal OB procedures	
<input type="checkbox"/> Chlamydia <input type="checkbox"/> Genital herpes <input type="checkbox"/> Gonorrhea <input type="checkbox"/> GBS <input type="checkbox"/> Hepatitis B			<input type="checkbox"/> Cerclage <input type="checkbox"/> Tocolysis <input type="checkbox"/> Version <input type="checkbox"/> None of the above	
<input type="checkbox"/> Hepatitis C <input type="checkbox"/> HIV positive <input type="checkbox"/> Syphilis <input type="checkbox"/> Other _____ <input type="checkbox"/> None of the above				
Mother transferred prior to delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No Facility she was transferred from			Onset of labor <input type="checkbox"/> PROM (> 12 hours) <input type="checkbox"/> Prolonged labor (>20 hours) <input type="checkbox"/> Precipitous labor (< 3 hours) <input type="checkbox"/> None of the above	
Characteristics of labor				
<input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids for fetal lung maturation prior to birth <input type="checkbox"/> Antibiotics received during labor <input type="checkbox"/> Chorioamnionitis diagnosed during labor <input type="checkbox"/> Maternal temp >38 C <input type="checkbox"/> Meconium staining (moderate - heavy) <input type="checkbox"/> Fetal intolerance of labor requiring corrective action: In-utero resuscitative measures, further fetal assessment, or operative birth				
<input type="checkbox"/> Epidural or spinal anesthesia <input type="checkbox"/> Water birth (enter in MR&C as OTHER) <input type="checkbox"/> Other: _____ <input type="checkbox"/> None of the above				
Date of delivery			TIME of birth <input type="checkbox"/> 24 hr. <input type="checkbox"/> AM <input type="checkbox"/> PM	
Method of birth			Maternal morbidity	
<input type="checkbox"/> Forceps attempted <input type="checkbox"/> Successful <input type="checkbox"/> No <input type="checkbox"/> Vacuum attempted <input type="checkbox"/> Successful <input type="checkbox"/> No Fetal presentation <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other _____ <input type="checkbox"/> Vaginal/spontaneous <input type="checkbox"/> Vaginal / forceps <input type="checkbox"/> Vaginal/vacuum <input type="checkbox"/> VBAC <input type="checkbox"/> Cesarean Was trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Maternal transfusion <input type="checkbox"/> 3 rd or 4 th deg. perineal laceration <input type="checkbox"/> Cord prolapse <input type="checkbox"/> Seizure during labor <input type="checkbox"/> Placental abruption <input type="checkbox"/> Placenta previa <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to ICU <input type="checkbox"/> Unplanned operating room procedure <input type="checkbox"/> None of the above <input type="checkbox"/> Other _____	
Scheduled deliveries				
<i>For scheduled deliveries (inductions or cesareans without trial of labor) at less than 39 complete weeks of gestation:</i> Was a "hard stop" process used to schedule this delivery based on the medical record? <input type="checkbox"/> Yes <input type="checkbox"/> No				