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? ☐ Yes ☐ No If so, WHERE?		BABY'S MEDICAL RECORD NUMBER
BIRTH WEIGHT ☐ lb./oz. ☐ grams	ESTIMATED GESTATION In completed weeks	APGAR Scores
PLURALITY / # live born in this birth / birth order of this baby		1 min____________/ 5 min /10 min (if applicable) *The one minute score is not recorded in the birth record.*
MOTHER'S HEP B STATUS ☐ Negative ☐ Positive ☐ Unknown	Did baby get Hep B vaccine? ☐ No ☐ Refused If Yes - when?	HBIG given to baby? ☐ No ☐ Refused If Yes - when?

Abnormal conditions of the newborn	**Congenital anomalies**
☐ Assisted ventilation immediately after birth	☐ Anencephaly
☐ Assisted ventilation > 6 hours	☐ Meningomyelocele /Spina bifida
☐ NICU admission	☐ Hypospadias
☐ Newborn surfactant therapy	☐ Other urogenital anomalies
☐ Antibiotics for suspected sepsis	☐ Cyanotic congenital heart disease
☐ Confirmed bacterial infection	☐ Congenital diaphragmatic hernia
☐ Seizure or neurologic dysfunction	☐ Omphalocele
☐ Birth injury	☐ Gastroschisis
☐ Anemia	☐ Limb reduction defect
☐ Other ___________________________	☐ Polydactyly /syndactyly /adactyly
☐ None of the above	☐ Club foot
	☐ Other musculoskeletal/integumental
	☐ Cleft lip
	☐ Cleft palate
	☐ Down syndrome – confirmed? _____
	☐ Other chromosomal – conf? _______
	☐ Other anomalies ________________
	☐ None of the above

WAS BABY BREASTFED or fed breast milk ☐ No ☐ During stay ☐ At discharge	INFANT ALIVE AT TIME OF FILING? ☐ Yes ☐ No	TIME OF BIRTH ☐ 24 hr. ☐ AM ☐ PM

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.

Mother's Medical Information I - Prenatal

MOTHER'S NAME OR MED RECORD NUMBER	Did mother receive prenatal care? ☐ Yes ☐ No

Date of first prenatal visit / /	Date of last prenatal visit / /	Total prenatal visits	Month of pregnancy care began (1st, 2nd, 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

- ☐ Diabetes – pre pregnancy
- ☐ Diabetes – gestational
- ☐ Hypertension – pre pregnancy
- ☐ Hypertension – gestational (PIH, preeclampsia)
- ☐ Eclampsia
- ☐ Pregnancy resulted from infertility treatments
  - ☐ Fertility drugs, artificial insem, intrauterine insemination
  - ☐ Assisted reproductive technology (IVF, GIFT)
- ☐ Anemia
- ☐ Previous preterm birth
- ☐ Other previous poor outcome (perinatal death, SGA, IUGR)
- ☐ Previous cesarean birth How many? ___________________
- ☐ Other____
- ☐ None of the above

TOXICOLOGY– were toxicology tests administered to mother and/or the newborn?
☐ No ☐ Yes If yes, Results:

PRINICPAL SOURCE OF PAYMENT for this delivery
- ☐ Private insurance
- ☐ Self pay (uninsured)
- ☐ Other (Tricare/Indian Health/Other government)
- ☐ Medical Assistance/MN Care/Medicaid

Mother's Medical II - Delivery

Infections present / treated

- ☐ Chlamydia
- ☐ Genital herpes
- ☐ Gonorrhea
- ☐ GBS
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV positive
- ☐ Syphilis
- ☐ Other ___________________
- ☐ None of the above

Prenatal OB procedures

- ☐ Cerclage
- ☐ Tocolysis
- ☐ Version
- ☐ None of the above

Mother transferred prior to delivery? ☐ Yes ☐ No
Facility she was transferred from

Onset of labor

- ☐ PROM (> 12 hours)
- ☐ Prolonged labor (>20 hours)
- ☐ Precipitous labor (< 3 hours)
- ☐ None of the above

Characteristics of labor

- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids for fetal lung maturation prior to birth
- ☐ Antibiotics received during labor
- ☐ Chorioamnionitis diagnosed during labor
- ☐ Maternal temp >38 C
- ☐ Meconium staining (moderate - heavy)
- ☐ Fetal intolerance of labor requiring corrective action: In-utero resuscitative measures, further fetal assessment, or operative birth
- ☐ Epidural or spinal anesthesia
- ☐ Water birth *(enter in MR&C as OTHER)*
- ☐ Other: ____
- ☐ None of the above

Date of delivery	**TIME of birth** ☐ 24 hr. ☐ AM ☐ PM

Method of birth

- ☐ Forceps attempted ☐ Successful ☐ No
- ☐ Vacuum attempted ☐ Successful ☐ No

Fetal presentation ☐ Cephalic ☐ Breech ☐ Other___________

- ☐ Vaginal/spontaneous
- ☐ Vaginal / forceps
- ☐ Vaginal/vacuum
- ☐ VBAC
- ☐ Cesarean Was trial of labor attempted? ☐ Yes ☐ No

Maternal morbidity

- ☐ Maternal transfusion
- ☐ 3rd or 4th deg. perineal laceration
- ☐ Cord prolapse
- ☐ Seizure during labor
- ☐ Placental abruption
- ☐ Placenta previa
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to ICU
- ☐ Unplanned operating room procedure
- ☐ None of the above
- ☐ Other ___________________________

Scheduled deliveries

For scheduled deliveries (inductions or cesareans without trial of labor) at less than 39 complete weeks of gestation:
Was a "hard stop" process used to schedule this delivery based on the medical record? ☐ Yes ☐ No