Oregon Health Authority
Center for Health Statistics

Birth Record
FACILITY WORKSHEET

CHILD

Name First Middle Last Suffix

Date of Birth ___/___/___ MM DD YYYY

Time of Birth

Sex ☐ Male ☐ Female ☐ Undetermined

MOTHER HEALTH

Did she get WIC food for herself during pregnancy? ☐ Yes ☐ No ☐ Unknown

Height ___ft ___in.

Weight (Pre-pregnancy) ___lbs

Weight (At delivery) ___lbs

Cigarette Smoking ☐ Check if none

	Number per day
3 months before pregnancy	#_____Cigarettes
1st 3 months of pregnancy	#_____Cigarettes
2nd 3 months of pregnancy	#_____Cigarettes
3rd 3 months of pregnancy	#_____Cigarettes

Alcohol use during this pregnancy? ☐ Yes ☐ No If yes, average number of drinks per week?

PLACE OF BIRTH

☐ At this facility ☐ Home delivery Was home delivery planned? ☐ Yes ☐ No ☐ Unknown

☐ Other location (specify):__________

Specify address if not this facility:__________

No. & Street Apt/Unit/Space City County State ZIP

PRENATAL

Mother's Medical Record # (optional):__________

Mother's Medicaid #:__________

Date of Last Menses___/___/___ MM DD YYYY

Principal Method of Payment

☐ Medicaid/Oregon Health Plan
☐ Private insurance
☐ Self-pay
☐ Indian Health Services
☐ Champus/Tricare
☐ Other government
☐ Other: __________
☐ Unknown

Prenatal Care ☐ Check if none

Date of 1st visit ___/___/___ MM DD YYYY Total # of visits ______

Previous Live Births

now living______ # now dead ______ Date of last live birth___/___ MM YYYY

Other Pregnancy Outcomes (Spontaneous, induced terminations or ectopic pregnancy)

Combined # of other outcomes ______ Date of last other outcome ___/___ MM YYYY

Mother tested for HIV? ☐ Yes ☐ No ☐ Unknown

PREGNANCY FACTORS

Risk Factors

☐ Diabetes – Gestational
☐ Diabetes – Pre-pregnancy
☐ Hypertension – Pre-pregnancy (Chronic)
☐ Hypertension – Gestational
☐ Hypertension – Eclampsia
☐ Previous Preterm Births (<37 Completed Wks. Gestation)
☐ Pregnancy Resulted From Infertility Treatment – Fertility-enhancing drugs
☐ Pregnancy Resulted From Infertility Treatment – Assisted Reproductive Technology
☐ Mother Had A Previous Cesarean Delivery How Many? ____
☐ None Of The Above

Mother tested for:

☐ Syphilis
☐ Group B Strep

Infections Present and / or Treated

☐ Gonorrhea
☐ Syphilis
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ None of the above

Obstetric Procedures

☐ Cervical cerclage
☐ Tocolysis

External cephalic version: ☐ Successful ☐ Failed

☐ None of the above

LABOR

Onset of Labor ☐ Premature rupture ≥ 12 hours ☐ Precipitous labor < 3 hours ☐ Prolonged labor ≥ 20 hours ☐ None of the above

Characteristics of Labor and Delivery

☐ Induction of labor
☐ Augmentation of labor
☐ Steroids for fetal lung maturation prior to delivery
☐ Antibiotics during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temp. >=38C
☐ Epidural or spinal anesthesia during labor
☐ Unknown
☐ None of the above

DELIVERY

Method of Delivery

Fetal Presentation at Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown

Final Route and Method of Delivery: ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown

If Cesarean, was a Trial of Labor Attempted? ☐ Yes ☐ No

Maternal Morbidity (check all that apply)

☐ Maternal transfusion
☐ Third or fourth degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the above
☐ Unknown at this time

Mother transferred to this facility prior to delivery? ☐ Yes ☐ No If yes, name of facility__________

Infant transferred from this facility after delivery? ☐ Yes ☐ No If yes, name of facility __________

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Hospital Staff

No individual or agency other than the Center for Health Statistics should be provided with a copy of this worksheet.

NEWBORN

Medical Rec # (optional):____________________ Birth Weight:___________ ☐ lb/oz ☐ g APGAR _______5min _______10min

Obstetric Estimate of Gestation: (weeks) _______ Plurality: (Single, Twin, Triplet, etc.) _______ Birth Order (1st,2nd,3rd, 4th, etc.)_______

Number born alive this delivery: _______ Infant alive at time of report ☐ Yes ☐ No Infant breastfed at discharge ☐ Yes ☐ No

NEWBORN FACTORS

Abnormal Conditions of the Newborn

- ☐ Assisted ventilation required immediately
- ☐ Assisted ventilation for more than 6 hours
- ☐ NICU admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Antibiotics received by newborn for suspected neonatal sepsis
- ☐ Seizure/serious neurologic dysfunction
- ☐ Other significant birth injury
- ☐ None of the above

Congenital Anomalies

- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Cleft lip with or without cleft palate
- ☐ Cleft palate alone
- ☐ Down Syndrome, karyotype confirmed
- ☐ Down Syndrome, karyotype pending
- ☐ Down Syndrome, karyotype unknown
- ☐ Suspected chromosomal disorder, karyotype confirmed
- ☐ Suspected chromosomal disorder, karyotype pending
- ☐ Suspected chromosomal disorder, karyotype unknown
- ☐ Hypospadias
- ☐ None of the anomalies listed above

ATTENDANT

Attendant at delivery First Middle Last Title

Below items should be reported as soon as information is available.
These items are not required to certify the birth and can be added after the birth report is certified.

HEARING SCREENING

Was hearing test performed?
☐ Inpatient ☐ Outpatient ☐ Refused ☐ Transfer ☐ Missed

Test date:___/___/____
MM DD YYYY

Test Results
Left Ear: ☐ Pass ☐ Refer ☐ Equip. failure ☐ Physical condition Equipment type used: ☐ A-ABR ☐ OAE

Right Ear: ☐ Pass ☐ Refer ☐ Equip. failure ☐ Physical condition Equipment type used: ☐ A-ABR ☐ OAE

IMMUNIZATION

Did Infant receive Hepatitis B Vaccine?
☐ Yes ☐ No ☐ Refused Date administered:____/____/_____
MM DD YYYY

Manufacturer ☐ Glaxo ☐ Merck ☐ Other:____________________

Lot number:____________________

Mother HBsAg+
☐ Positive ☐ Negative ☐ Unknown ☐ Not screened

Did Infant receive Hepatitis B Immune Globulin (HBIG) 7?
☐ Yes ☐ No ☐ Refused Date administered:____/____/_____
MM DD YYYY

Manufacturer ☐ Glaxo ☐ Merck ☐ Other:____________________
Lot number:____________________

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