Mother's Worksheet for Child's Birth Certificate

FOR HOSPITAL USE ONLY:

MOTHER MR# _____ **NEWBORN MR#** _____

MEDICAID # _____ **DELIVERING DR** _____ **RM #** _____

The information you provide on this worksheet is used to create your child's birth certificate. The birth certificate is a legal document used to prove your child's age, citizenship and parentage. Your child will use the birth certificate throughout his/her life. The State of Texas safeguards against the unauthorized release of identifying information from birth certificates to protect the confidentiality of parents and their child.

Please PRINT your responses carefully and accurately as errors are difficult and expensive to correct.

CHILD'S PLACE OF BIRTH

Name of Hospital or Location	Address	State
MEMORIAL HERMANN SUGAR LAND	17500 WEST GRAND PARKWAY SOUTH	TEXAS

County	City	Zip Code
FORT BEND	SUGAR LAND	77479

CHILD'S INFORMATION

Time of Birth		Date of Birth	Plurality **(please circle one)**
	Am / Pm		Single / Twin / Triplets / Quadruplets / Quintuplets

Birth Order **(please circle one)**	Number of Infants Born Alive at this Birth? **(please circle one)**
First / Second / Third / Fourth / Fifth	One / Two / Three / Four / Five

MOTHER'S CURRENT LEGAL NAME

First Name	Middle Name	Last Name	Suffix

CHILD'S LEGAL NAME

First Name	Middle Name	Last Name	Suffix

MOTHER'S RESIDENCE ADDRESS

Residence Address	Apartment Number	State/Foreign Country	County

City/Town/Location	Zip Code / Extension	Inside City Limits?
		☐ **Yes** ☐ **No**

MOTHER'S MAILING ADDRESS (If same as residence address, LEAVE THIS SECTION BLANK)

Mailing Address	Apartment Number	State/Foreign Country

City/Town/Location	Zip Code / Extension	Inside City Limits?
		☐ **Yes** ☐ **No**

MOTHER'S INFORMATION

Date of Birth	Place of Birth (State/Foreign Country/Territory)	Social Security

Apply for Baby's Social Security?	Did Mother Give up Rights to the Child?	Date Rights Given Up?
☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	

Occupation	Type of Business

Mother's Education

- ☐ 8th grade or less
- ☐ 9th – 12th grade, no diploma
- ☐ High School graduate or GED completed
- ☐ Some College credit, but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

Is Mother of Hispanic Origin?

- ☐ No, not Spanish / Hispanic / Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish / Hispanic / Latina
  Specify_____

What is Mother's Race?

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native
  (Name of the enrolled or principal tribe)
  _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian_____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
  Specify _____
- ☐ Other _____
- ☐ Unknown

MOTHER'S HEALTH INFORMATION

Did you receive WIC for this Birth?	Height	Weight Before Pregnancy	Weight At Delivery
☐ **Yes** ☐ **No**			

How many cigarettes did you smoke before and during pregnancy?

Three Months Before Cigs/Day: ____ Packs/Day: ___ **First Three Months** Cigs/Day: ____ Packs/Day: ___

Second Three Months Cigs/Day: ____ Packs/Day: ___ **Third Trimester** Cigs/Day: ____ Packs/Day: ___

MOTHER'S MARITAL STATUS (Please read carefully)

- If you are married, your husband may be listed as the father on the birth certificate, or the information may be left blank.
- If you are not married, the father's name may be listed on the birth certificate only if both parents complete an Acknowledgment of Paternity.
- If you are or have been married to someone other than the biological father of this child, or have been married to someone other than the biological father within 300 days before this child's birth, the Acknowledgment of Paternity must also include a Denial of Paternity from your husband or former husband to allow the biological father's information to be listed on the birth certificate.

☐ **Yes,** Currently Married	☐ **Yes,** Never Married	☐ **Yes,** Divorced	☐ **Yes,** Widowed

☐ **Yes,** Married – (no paternity information on birth certificate)

Have you been married to someone other than the biological father in the 300 days before the child's birth? ☐ **Yes** ☐ **No**

Do you want to complete an Acknowledgement of Paternity? ☐ **Yes** ☐ **No**

MOTHER'S NAME PRIOR TO HER FIRST MARRIAGE

First Name	Middle Name	Last Name	Suffix

FATHER'S INFORMATION (Biological father)

Legal First Name	Middle Name	Last Name	Suffix

Date of Birth	Place of Birth (State/Foreign Country/Territory)	Social Security

Occupation	Type of Business

Father's Education

- ☐ 8th grade or less
- ☐ 9th – 12th grade, no diploma
- ☐ High School graduate or GED completed
- ☐ Some College credit, but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

Is Father of Hispanic Origin?

- ☐ No, not Spanish / Hispanic / Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish / Hispanic / Latino
  Specify_____

What is Father's Race?

- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander
  Specify _____
- ☐ Other _____
- ☐ Unknown

Has Paternity – Genetic Testing Been Done?	Mailing Address	Apartment Number
☐ **Yes** ☐ **No**		

State/Foreign Country/Territory	City/Town/Location	Zip Code / Extension

PRESUMED FATHER'S INFORMATION (Complete ONLY if applicable)

Date of Birth	Social Security

First Name	Middle Name	Last Name	Suffix

Mailing Address	Apartment Number	State/Foreign Country/Territory

City/Town/Location	Zip Code Extension

MOTHER'S MEDICAID INFORMATION (Complete ONLY if applicable)

Mother's Medicaid Name	Mother's Medicaid Number

IMMTRAC REGISTRY

Do you consent for your baby's immunization information to be included in the statewide Immunization Registry and to share the immunization information with registered providers? ☐ **Yes** ☐ **No**

Congratulations on the birth of your new Little Texan!

Texas Vital Statistics would like to take this opportunity to answer some most commonly asked questions about birth certificates in Texas. . .

"How do I get a copy of my baby's birth certificate?"
You can request and purchase a certified copy of your child's birth certificate from the local registrar's office located in the city or county where the birth occurred, or from the Texas Vital Statistic office located in Austin, Texas.

A *Certified Birth Certificate* is a permanent legal document filed in the State of Texas that establishes your child's identity and is used to apply for medical or government services, passports, school admission, etc.

"When will I receive my baby's social security card?"
If you answered "Yes" to the question, "Apply for baby's social security number?", the birth information will be forwarded to the Social Security Administration as soon as the Texas Vital Statistic office receives the data from the hospital. The Social Security Administration then requires 2-3 weeks to process the information. A social security card will be mailed to the mother's mailing address as provided in this worksheet. The entire process usually takes **4-6 weeks** to complete.

"When will I receive my baby's Medicaid number?"
If you provided an answer for the questions "Mother's Medicaid Name?" and "Mother's Medicaid Number?", the birth information will be forwarded to the Medicaid office as soon as the Texas Vital Statistic office receives the data from the hospital. Medicaid then requires 2-3 weeks to process the information. An Infant Medicaid card will be mailed to the mother's mailing address as provided in this worksheet. The entire process usually takes **4-6 weeks** to complete.

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

HIV test done at Delivery ☐ 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