Mother's Medical Record # _____ Mother's name _____

FOR HOSPITAL USE ONLY

FORM VS-2WA
(REV. 08/2020)

LIVE BIRTH WORKSHEET

The information you provide below will be used to create the child's birth certificate. The birth certificate is a document that will be used for legal purposes to prove child's age, citizenship and parentage. This document will be used by the child throughout his/her life. State laws provide protection against the unauthorized release of identifying information from the birth certificates to ensure the confidentiality of the parents and their child.

It is very important that you provide complete and accurate information to all of the questions. In addition to information used for legal purposes, other information from the birth certificate is used by health and medical researchers to study and improve the health of mothers and newborn infants. Items such as parent's education, race, and smoking habits will be used for statistical studies, but will not appear on copies of the birth certificate issued to you or the child.

All information pertaining to the mother should be for the woman who gave birth to the infant. In cases of surrogacy or gestational carrier, the information reported should be that for the surrogate or the gestational carrier; that is, the woman who gave birth to the infant.

MOTHER'S SECTION

PLEASE PRINT CLEARLY

Please fill out the complete form and leave no blanks unless otherwise instructed. Worksheet numbering matches the electronic system.

CHILD'S INFORMATION

1. Infant's medical record number: _____

2. What will be the baby's legal name (as it should appear on the birth certificate)?

First: _____

Middle: _____

Last: _____ Suffix (Jr., III, etc.): _____

❑ First and middle name not yet chosen

(Note: If the child is unnamed, enter "Unknown" for first name and mother's current legal surname for the child's surname.)

3. What is the baby's date of birth? _____ /_____ /_____
MM DD YYYY

4. What was the time of the baby's birth? (in 24-hour, i.e. 1:00 p.m. = 13:00) _____ : _____
Hour Minute

5. What is the sex of the baby? ❑ Male ❑ Female

6. What is the name of the birth facility where the baby was born? (If delivery occurred at home list as homebirth and use home address.)
Facility Name: _____

7. In what city, town, or location was the baby born? City, Town, or Location: _____

8. In what county was the baby born? County: _____

9. Plurality: _____
(The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age, or if the fetuses were delivered at different dates in the pregnancy. Include all live births and fetal losses resulting from this pregnancy. Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.)
(If more than one live birth, please fill out Multiple Live Birth Worksheet Form VS-2WB.)

10. If not single birth, order delivered in the pregnancy: _____
(Specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc. Include all live births and fetal losses resulting from this pregnancy.)

11. Mother's name prior to first marriage?

First: _____

Middle: _____

Last: _____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

12. Other than the mother, who is the contact person for the baby?

First: _____

Middle: _____

Last: _____ Suffix (Jr., III, etc.): _____

Contact Phone:

			-				-				

Contact Address:

Complete Number and Street: _____ Apt. Number: _____
(Do not enter rural route numbers)

City, Town, or Location: _____

County: _____State: _____ Zip Code: _____
(or U.S. Territory, Canadian Province)

Contact Relationship:

- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Stepmother
- ☐ Stepfather
- ☐ Other Relative
- ☐ Foster Parent
- ☐ Social Worker
- ☐ Neighbor
- ☐ Other

MOTHER'S INFORMATION

1. Mother's current legal name?

First: _____

Middle: _____

Last: _____

2. What is the mother's Social Security Number?

			-			-				

2a. What is the mother's Medicaid Number? (If none, write none or N/A.) _____

3. What is the mother's date of birth? _____ /_____ /_____
MM DD YYYY

5a. Where does the mother usually live--that is--where is the mother's household/residence located?

Complete Number and Street: _____ Apt. Number: _____
(Do not enter rural route numbers)

City, Town, or Location: _____

County: _____State: _____ Zip Code: _____
(or U.S. Territory, Canadian Province)

Inside City Limits: ❑ Yes ❑ No

If not United States, *country*_____

5b. What is the mother's mailing address?

❑ Same as Residence [Go to next question]

Complete Number and Street: _____

Apartment Number: _____P. O. Box: _____City, Town, or Location:_____

State: _____ Zip Code: _____
(or U.S. Territory, Canadian Province)

If not in the United States, *country*_____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

6. What is the mother's contact information?

Home Phone: | | | | - | | | | - | | | | |

Work Phone: | | | | - | | | | - | | | | |

Cell Phone: | | | | - | | | | - | | | | |

7. What is the mother's email address? _____

FATHER'S INFORMATION

(STOP! If mother is not married, and if a paternity acknowledgment has not been completed, leave these items blank and skip to item 8d.)

1. Father's current legal name?

First: _____

Middle: _____

Last: _____ Suffix (Jr., III, etc.): _____

2. What is the father's Social Security Number? | | | | - | | | - | | | | |

MOTHER'S INFORMATION (CONTINUED)

8d. In what State, U.S. territory, or foreign country was the mother born? Please specify one of the following: State _____ *or*

U.S. Territory _____(i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas)

Or Foreign Country _____

15. Was the mother married at the time the child was conceived, at the time of birth, or at any time between conception and giving birth?
❑ Yes [Please go to next question] ❑ No [Please see below]

If no, has a paternity acknowledgment been completed? (That is, have mother and the father signed a form [insert name of State paternity acknowledgment form] in which the father accepted legal responsibility for the child?) If not married, or if a paternity acknowledgment has not been completed, information about the father cannot be included on the birth certificate. Information about the procedures for adding the father's information to the Birth Certificate after it has been filed can be obtained from the State Vital Statistics Office.

❑ **Yes**, a paternity acknowledgment has been completed
❑ **No**, a paternity acknowledgment has not been completed

If yes, has the mother been separated from spouse for 10 months or more?
❑ Yes ❑ No

16. Do you want a Social Security Number issued for your baby? ❑ Yes ❑ No

Furnishing parent(s) Social Security Number(s) is required by Federal Law, 42 USC 405(c) of the Social Security Act. The number(s) will be made available to the State Social Services Agency to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance.

This worksheet serves as a disclosure agreement.

FATHER'S INFORMATION (CONTINUED)

10b. What is the father's date of birth? _____ /_____ /_____
MM DD YYYY

10c. In what State, U.S. territory, or foreign country was the father born? Please specify one of the following: State _____ *or*

U.S. Territory _____ (i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas)

Or Foreign Country _____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

MOTHER'S BACKGROUND

20. What is the highest level of schooling that the mother will have completed at the time of delivery? (Check the box that best describes her education. If she is currently enrolled, check the box that indicates the previous grade or highest degree received.)

- ☐ 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)

21. Is the mother of Hispanic origin? (Please check *one or more.)*

- ❑ No, not Spanish/Hispanic/Latina
- ❑ Yes, Mexican, Mexican American, Chicana
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Colombian)
  (specify)_____

22. What is the mother's race? (Please check *one or more races* to indicate what race mother considers herself to be.)

- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native
  (name of enrolled or principal tribe) _____
- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian (specify) _____
- ❑ Native Hawaiian
- ❑ Guamanian or Chamorro
- ❑ Samoan
- ❑ Other Pacific Islander (specify) _____
- ❑ Other (specify) _____

23. What was the mother's weight prior to pregnancy, that is, the weight immediately before the mother became pregnant with this child?
_____lbs.

24. What is the mother's height? _____feet _____ inches

25. Did the mother receive WIC (Women, Infants & Children) food because they were pregnant with this child? ❑ Yes ❑ No

26a. How many cigarettes OR packs of cigarettes did the mother smoke on an average day during each of the following time periods? If the mother NEVER smoked, enter zero for each time period.

	# of cigarettes*	OR	**# of packs**
Three months before pregnancy	_____	OR	_____
First three months of pregnancy	_____	OR	_____
Second three months of pregnancy	_____	OR	_____
Third trimester of pregnancy	_____	OR	_____

***refers to tobacco products only, NOT e-cigarettes.**

26b. Did the mother consume alcohol during the pregnancy? ❑ No ❑ Yes

Average number of drinks per week? _____

FATHER'S BACKGROUND

27. What is the highest level of schooling that the father will have completed at the time of delivery? (Check the box that best describes his education. If he is currently enrolled, check the box that indicates the previous grade or highest degree received.)

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

- ☐ 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)

28. Is the father of Hispanic origin? (Please check one or more.)

- ❑ No, not Spanish/Hispanic/Latina
- ❑ Yes, Mexican, Mexican American, Chicana
- ❑ Yes, Puerto Rican
- ❑ Yes, Cuban
- ❑ Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Colombian)
  (specify)_____

29. What is the father's race? (Please check *one or more races* to indicate what the father considers himself to be.)

- ❑ White
- ❑ Black or African American
- ❑ American Indian or Alaska Native
  (name of enrolled or principal tribe) _____
- ❑ Asian Indian
- ❑ Chinese
- ❑ Filipino
- ❑ Japanese
- ❑ Korean
- ❑ Vietnamese
- ❑ Other Asian (specify) _____
- ❑ Native Hawaiian
- ❑ Guamanian or Chamorro
- ❑ Samoan
- ❑ Other Pacific Islander (specify) _____
- ❑ Other (specify) _____

INFORMANT INFORMATION

If other than the mother, what is the name of the person providing information for this worksheet?

First: _____

Middle: _____

Last: _____ Suffix (Jr., III, etc.): _____

What is your relationship to the baby's birth mother?

- ☐ Father of baby
- ☐ Other relative
- ☐ Hospital employee
- ☐ Other, (specify) _____

*****MUST BE SIGNED BELOW*****

(Note: This portion of the worksheet must be signed by the mother and the father (if mother is married), as well as by the person who certified the birth of the child.)

Mother Signature: _____ ☐ I acknowledge this is my electronic signature.	**Date:** _____
Father Signature: _____ ☐ I acknowledge this is my electronic signature.	**Date:** _____
Certifier Signature: _____ ☐ I acknowledge this is my electronic signature.	**Date:** _____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

This Page Intentionally Left Blank

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

BIRTHING FACILITY SECTION

For pregnancies resulting in the births of two or more live-born infants, this worksheet should be completed for the 1st live born infant in the delivery. For each subsequent live-born infant, complete the Multiple Live Births Worksheet. FORM 2WB"

For detailed definitions, instructions, information on sources, and common key words and abbreviations, please see the CDC's "Guide to Completing Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death".

All birth certificate information reported for the mother should pertain to the woman who delivered the infant. In cases of surrogacy or gestational carrier, the information reported should be that for the surrogate or the gestational carrier, that is, the woman who delivered the infant.

PLEASE PRINT CLEARLY

Please fill out the complete form and leave no blanks unless otherwise instructed. Worksheet numbering matches electronic system.

FACILITY'S INFORMATION

11. Certifier's name and title: _____
(The individual who certifies to the fact that the birth occurred. May be, but need not be, the same as the attendant at birth.)

- ☐ M.D. - (Doctor of medicine)
- ☐ D.O. - (Doctor of osteopathy)
- ☐ Hospital administrator or designee
- ☐ CNM/CM (Certified Nurse Midwife or Certified Midwife)
- ☐ Other midwife (midwife other than CNM/CM)
- ☐ Other (specify) _____

12. Date certified: _____ /_____ /_____
MM DD YYYY

MOTHER'S INFORMATION

30. Place where birth occurred:

- ☐ Hospital
- ☐ Freestanding birthing center
  (Freestanding birthing center is defined as one which has no direct physical connection with an operative delivery center.)
- ☐ Home birth
  Planned to deliver at home ❑ Yes ❑ No ❑ Unknown
- ☐ Clinic/Doctor's Office
- ☐ Other (specify, e.g., taxicab, train, plane, etc.) _____

31. Attendant's name, title, license number and N.P.I. (National Provider Identifier)**:** (The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician should be reported as the attendant. If the obstetrician is not physically present, the intern or nurse midwife should be reported as the attendant.)

_____ _____
Attendant's Name N.P.I.

_____
Attendant's License Number (If applicable)

Attendant's title:

- ☐ M.D. - (Doctor of medicine)
- ☐ D.O. - (Doctor of osteopathy)
- ☐ CNM/CM - (Certified Nurse Midwife/Certified Midwife)
- ☐ Other Midwife - (midwife other than CNM/CM)
- ☐ Other (specify) _____

32. Mother's weight at delivery (pounds)**:** _____

33. Was the mother transferred from another facility for maternal medical or fetal indications for delivery? ❑ Yes ❑ No
(Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.)

If yes, enter the name of the facility mother transferred from:

_____

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

34. Number of previous live births

Number of previous live births now living: (Do not include this infant. For multiple deliveries, include all live-born infants delivered before this infant in the pregnancy who are still living.) ____ Number ❑ None

Number of previous live births now dead: (Do not include this infant. For multiple deliveries, include all live-born infants delivered before this infant in the pregnancy who are now dead.) ____ Number ❑ None

Date of last live birth: (Enter all known parts of the date of birth of the last live-born infant. Report "unknown" for any parts of the date that are missing.) _____ /_____ /_____
MM DD YYYY

35. Other pregnancy outcomes

Number of other pregnancy outcomes: (Total number of other pregnancy outcomes that did not result in a live birth. Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include any losses regardless of gestational age occurring before the delivery of this infant. This could include loss occurring in this pregnancy or in a previous pregnancy.)

____ Number ❑ None

Date of last other pregnancy outcome: (Enter all known parts of the date for the last pregnancy, which did not result in a live birth, ended. Include pregnancy losses at any gestational age – spontaneous losses, induced losses, and/or ectopic pregnancies. Enter "unknown" for any parts of the date that are missing.) _____ /_____ /_____
MM DD YYYY

36. Prenatal Care

Total number of prenatal care visits for this pregnancy: _____
(Count only those visits recorded in the most current records available. Do not include visits for laboratory and other testing in which a physician or health care professional did not examine or counsel the pregnant woman. Do not include classes, such as childbirth classes, where the physician or health care professional did not provide individual care to the pregnant woman. If none enter "0" and leave dates blank.)

Date of first prenatal care visit: (The date a physician or other health professional first examined and/or counseled the pregnant woman for the pregnancy. Complete all parts of the date that are available, leave the rest blank.) _____ /_____ /_____
MM DD YYYY

Date of last prenatal care visit: (The date a physician or other health professional last examined and/or counseled the pregnant woman for the pregnancy. Complete all parts of the date that are available, leave the rest blank.) _____ /_____ /_____
MM DD YYYY

37. Principal source of payment for this delivery: (The primary source of payment for the delivery at time of delivery)

- ☐ Private Insurance (Blue Cross/Blue Shield, Aetna, etc.)
- ☐ Medicaid (or a comparable State program)
- ☐ Self-pay (no third party identified)
- ☐ Other (specify, e.g., Indian Health Service, CHAMPUS/TRICARE, other federal, state, or local governmental charity)

_____

38. Date last normal menses began: (Enter all known parts of the date the mother's last normal menstrual period began. Report "unknown" for any parts of the date that are missing.) _____ /_____ /_____
MM DD YYYY

MEDICAL AND HEALTH INFORMATION

39. Mother's medical record number: _____

40. Risk factors in this pregnancy: (Check all that apply)

- ❑ Diabetes - (Glucose intolerance requiring treatment; if diabetes is present, check either prior to pregnancy or gestational, do not check both.)
  - ❑ Prior to pregnancy - (Diabetes diagnosed prior to this pregnancy)
  - ❑ Gestational - (Diabetes diagnosed in this pregnancy)
- ❑ Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition; if hypertension is present, check either prior to pregnancy or gestational, do not check both.)
  - ❑ Prior to pregnancy - (Chronic) (Hypertension diagnosed prior to the onset of this pregnancy)
  - ❑ Gestational - (PIH, preeclampsia) (Hypertension diagnosed during this pregnancy.)
  - ❑ Eclampsia - (Hypertension with proteinuria with generalized seizures or coma. May include pathologic edema. If eclampsia is present, either prior to pregnancy or gestational hypertension may be checked.)

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

- ❑ Previous preterm births - (History of pregnancies terminating in a live birth of less than 37 completed weeks of gestation)
- ❑ Other previous poor pregnancy outcomes (Includes perinatal death, small-for-gestational-age/intrauterine growth restricted birth.)
- ❑ Vaginal bleeding during this pregnancy prior to the onset of labor
- ❑ Pregnancy resulted from infertility treatment - (Any assisted reproduction treatment used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology procedures (e.g., IVF, GIFT and ZIFT).)
  If yes, check all that apply:
  - ❑ Fertility-enhancing drugs, artificial insemination or intrauterine insemination - (Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.)
  - ❑ Assisted reproductive technology - (Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT)) used to initiate the pregnancy.)
- ❑ Mother had a previous cesarean delivery - (Previous delivery by extracting the fetus, placenta and membranes through an incision in the mother's abdominal and uterine walls.)
  If Yes, how many? _____
- ❑ None of the above
- ❑ Unknown

41. Infections present and/or treated during this pregnancy: (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.)
(Check all that apply)

- ❑ Gonorrhea - (a positive test or culture for *Neisseria gonorrhoeae*)
- ❑ Syphilis - (also called lues - a positive test for *Treponema pallidum*)
- ❑ Herpes Simplex Virus (HSV)
- ❑ Chlamydia - (a positive test for Chlamydia *trachomatis*)
- ❑ Hepatitis B - (HBV, serum hepatitis - a positive test for the hepatitis B virus)
- ❑ Hepatitis C - (non A, non B hepatitis, HCV - a positive test for the hepatitis C virus)
- ❑ None of the above
- ❑ Unknown

42. Obstetric procedures: (Medical treatment or invasive or manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor or delivery.)

- ❑ Cervical Cerclage
- ❑ Tocolysis
- ❑ External Cephalic - Successful – (Fetus was converted to a vertex presentation.)
- ❑ External Cephalic - Failed - (Fetus was not converted to a vertex presentation.)
- ❑ None of the above
- ❑ Unknown

43. Onset of labor: (Check all that apply)

- ❑ Premature Rupture of the Membrane - (prolonged ≥ 12 hours)
- ❑ Prolonged Labor greater than 20 hours
- ❑ Precipitous Labor - (< 3 hours)
- ❑ None of the above
- ❑ Unknown

44. Characteristics of labor and delivery: (Information about the course of labor and delivery.)
(Check all that apply)

- ❑ Induction of labor - (Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor (i.e., before labor has begun). Does not include augmentation of labor.)
- ❑ Augmentation of labor - (Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery (i.e., after labor has begun). Do not include if induction of labor was performed.)
- ❑ Non-Vertex presentation
- ❑ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery - (Steroids received by the mother prior to delivery to accelerate fetal lung maturation. Typically administered in anticipation of preterm delivery. Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation. Excludes steroid medication given to the mother as an anti-inflammatory treatment before or after delivery.)
- ❑ Antibiotics received by the mother during labor - (Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefotaxime, Ceftriaxone, etc.)
- ❑ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F) - (Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis, fetal tachycardia, maternal tachycardia, or malodorous vaginal discharge. Any maternal temperature at or above 38°C (100.4°F).)
- ❑ Moderate/Heavy meconium staining of the amniotic fluid – (When there is a fair amount of amniotic fluid, but it is clearly stained with meconium.)
- ❑ Fetal intolerance of labor – (A complication that occurs during the birthing process when an unborn baby suffers from a lack of oxygen.)

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

- ❑ Epidural or spinal anesthesia during labor - (Administration to the mother of a regional anesthetic for control of the pain of labor, i.e., delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.)
- ❑ None of the above
- ❑ Unknown

45. Method of delivery: (The physical process by which the complete delivery of the infant was effected)

Was delivery with forceps attempted but unsuccessful? ❑ Yes ❑ No

Was delivery with vacuum extraction attempted but unsuccessful? ❑ Yes ❑ No

Fetal presentation at birth: (Check one)

- ❑ Cephalic - (Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP))
- ❑ Breech - (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech)
- ❑ Other - (Any other presentation not listed above, i.e., shoulder, funis, transverse lie, compound)
- ❑ Unknown

Final route and method of delivery: (Check one)

- ❑ Vaginal/Spontaneous - (Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.)
- ❑ Vaginal/Forceps - (Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.)
- ❑ Vaginal/Vacuum - (Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.)
- ❑ Cesarean - (Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls)

  If cesarean, was a trial of labor attempted? - (Labor was allowed, augmented or induced with plans for a vaginal delivery.)
  ❑ Yes ❑ No
- ❑ Unknown

46. Maternal morbidity: (Serious complications experienced by the mother associated with labor and delivery)
(Check all that apply)

- ❑ Maternal transfusion - (Includes infusion of whole blood or packed red blood cells associated with labor and delivery.)
- ❑ Third- or fourth-degree perineal laceration - (3° laceration extends through the perineal skin, vaginal mucosa, perineal body and partially or completely through the anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- ❑ Ruptured uterus - (Tearing of the uterine wall. A full-thickness disruption of the uterine wall that also involves the overlaying visceral peritoneum (uterine serosa). Does not include uterine dehiscence in which the fetus, placenta, and umbilical cord remain contained with the uterine cavity. Does not include a silent or incomplete rupture or an asymptomatic separation.)
- ❑ Unplanned hysterectomy - (Surgical removal of the uterus that was not planned prior to the admission. Includes an anticipated, but not definitively planned, hysterectomy.)
- ❑ Admission to intensive care unit - (Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care.)
- ❑ Unplanned operating room procedure following delivery
- ❑ None of the above
- ❑ Unknown

NEWBORN INFORMATION

48. Birthweight: _____ (grams) (Do not convert lb./oz. to grams)

If weight in grams is not available, birthweight: _____ (lb./oz.)

49. Obstetric estimate of gestation at delivery (completed weeks):_____
(The best obstetric estimate of the infant's gestational age in completed weeks based on the clinician's final estimate of gestation.)

50. Apgar score: (A systematic measure for evaluating the physical condition of the infant at specific intervals at birth)

Score at **5** minutes _____ If 5 minute score **is less than 6:** Score at **10** minutes _____

53. Abnormal conditions of the newborn: (Disorders or significant morbidity experienced by the newborn)
(Check all that apply)

- ❑ Assisted ventilation required immediately following delivery - (Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes free flow (blow-by) oxygen only, laryngoscopy for aspiration of meconium, nasal cannula, and bulb suction.)
- ❑ Assisted ventilation required for more than six hours - (Infant given mechanical ventilation (breathing assistance) by any method for more than six hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP). Excludes free flow oxygen

only, laryngoscopy for aspiration of meconium and nasal cannula.)

- ❑ NICU admission - (Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.)
- ❑ Newborn given surfactant replacement therapy - (Endotracheal instillation of a surface-active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.)
- ❑ Antibiotics received by the newborn for suspected neonatal sepsis - (Any antibacterial drug (e.g., penicillin, ampicillin, gentamicin, cefotoxine etc.) given systemically (intravenous or intramuscular). Does not include antibiotics given to infants who are NOT suspected of having neonatal sepsis.)
- ❑ Seizure or serious neurologic dysfunction - (Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.)
- ❑ Significant birth injury (Skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
- ❑ None of the above
- ❑ Unknown

54. Congenital anomalies of the newborn: (Malformations of the newborn diagnosed prenatally or after delivery.)
(Check all that apply)

- ❑ Anencephaly - (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).)
- ❑ Meningomyelocele/Spina bifida - (Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).)
- ❑ Congenital Heart Disease
  - ❑ Cyanotic congenital heart disease - (Congenital heart defects which cause cyanosis.)
  - ❑ Non-Cyanotic congenital heart disease - (Congenital heart defects which do not cause cyanosis.)
- ❑ Congenital diaphragmatic hernia - (Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.)
- ❑ Omphalocele - (A defect in the anterior abdominal wall in which the umbilical ring is widened, allowing herniation of abdominal organs into the umbilical cord. The herniating organs are covered by a nearly transparent membranous sac (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.)
- ❑ Gastroschisis - (An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.)
- ❑ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) - (Complete or partial absence of a portion of an extremity associated with failure to develop.)
- ❑ Cleft Lip with or without Cleft Palate - (Incomplete closure of the lip. May be unilateral, bilateral or median.)
- ❑ Cleft Palate alone - (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without Cleft Palate" category above.)
- ❑ Down Syndrome - (Trisomy 21 – A chromosomal abnormality caused by the presence of all or part of a third copy of chromosome 21.)
  - ❑ Karyotype confirmed
  - ❑ Karyotype pending
- ❑ Suspected chromosomal disorder - (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.)
  - ❑ Karyotype confirmed
  - ❑ Karyotype pending
- ❑ Hypospadias - (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.)
- ❑ None of the above
- ❑ Other (specify) _____
- ❑ Unknown

55. Was infant transferred within 24 hours of delivery? (Check "yes" if the infant was transferred from this facility to another within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.)

❑ Yes ❑ No If yes, name of facility infant transferred to: _____

56. Is infant living at time of report? (Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care. Answer "no" if it is known that the infant has died. If the infant was transferred and the status is known, indicate known status.) ❑ Yes ❑ No ❑ Unknown

Mother's Medical Record # _____ Mother's name _____
FOR HOSPITAL USE ONLY

57. Is infant being breastfed at discharge? (Check "yes" if the infant was receiving breastmilk or colostrum during the period between birth and discharge from the hospital. Include any attempt to establish breastmilk production during the period between birth and discharge from the hospital. Include if the infant received formula in addition to being breastfed. Does not include the intent to breastfeed.)

❑ Yes ❑ No ❑ Unknown

58. Vaccinations given?

Was infant given Hepatitis B vaccination? ❑ Yes ❑ No ❑ Unknown

Date Hepatitis B vaccination given: _____ /_____ /_____
MM DD YYYY

Was infant given Hepatitis B Immune Globulin (HBIG) vaccination? ❑ Yes ❑ No ❑ Unknown

Date Hepatitis B Immune Globulin (HBIG) vaccination given: _____ /_____ /_____
MM DD YYYY

*****MUST BE SIGNED BELOW*****
(Note: This portion of the worksheet must be signed by the person who attended the birth of the child.)

Attendant Signature: _____ ☐ I acknowledge this is my electronic signature.	**Date:** _____

All non-birthing facilities, midwives, and other attendants who cannot register this birth electronically through KY-CHILD must send this completed worksheet, with all required signatures, to:

Kentucky Office of Vital Statistics
275 East Main, 1E-A
Frankfort, KY 40621