Infant Medical record # _____

Mother's medical record # _____
Mother's name _____

FACILITY WORKSHEET FOR THE LIVE BIRTH CERTIFICATE

Labor & Delivery

1. Date of birth
___ ___ _____
MM DD YYYY

2. Time of birth
_____

3.Birthweight
_____ □ Grams □ lbs./oz.

4. Birthweight at Discharge
_____ Grams or lbs./oz. (Circle one)

5. Sex:
□ Male □ Female
□ Not yet determined

6. Attendant's name, title, and N.P.I
_____ _____
Attendant's name, Title N.P.I

Perinatal

7.a Date of first prenatal care visit
___ ___ _____
MM DD YYYY
□ **No prenatal care**

7b. Date of last prenatal care visit
___ ___ _____
MM DD YYYY

7c. Total number of prenatal care visits for this pregnancy
(If none enter "0"):
_____

8. First Date of last normal menses began:
___ ___ _____
MM DD YYYY

9. Number of previous live births now living
_____ Number
□ None

10. Number of previous live births now dead
____ Number
□ None

11. Date of last live birth
___ ___ _____
MM DD YYYY

12. Total number of other pregnancy outcomes
____ Number
□ None

13. Date of last other pregnancy outcome
___ ___ _____
MM DD YYYY

14. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?
□ Yes, Transferred from_____ □ No

15. Risk Factors in this Pregnancy:
□ Diabetes
□ Pre-pregnancy (Diagnosis prior to this pregnancy)
□ Gestational (Diagnosis in this pregnancy)

□ Hypertension
□ Pre-pregnancy (diagnosed prior to the onset of this pregnancy)
□ Gestational (diagnosed during this pregnancy)
□ 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-If yes, check all that apply:
□ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
□ Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intra fallopian transfer (GIFT)

□ Mother had a previous cesarean delivery
If yes, how many _____
□ Other_____
□ None of the above
□ Unknown

16. Onset of Labor (Check all that apply):
□ Premature Rupture of the Membranes (prolonged >=12 hours)
□ Precipitous labor (<3 hours) (Labor that progresses rapidly and lasts for less than 3 hours.)
□ Prolonged labor (>=20 hours) (Labor that progresses slowly and lasts for 20 hours or more.)
□ Other_____
□ None of the above
□ Unknown

17. Characteristics of labor and delivery (Check all that apply):
□ Induction of labor
□ Augmentation of labor
□ Non-vertex presentation
□ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
□ Antibiotics received by the mother during labor - (Includes antibacterial medications given systemically
□ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F) -
□ Moderate/heavy meconium staining of the amniotic
□ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative
□ Epidural or spinal anesthesia during
□ Other_____
□ None of the above
□ Unknown

18. Infections present and/or treated during this pregnancy (Check all that apply):
□ Gonorrhea
□ Syphilis
□ Chlamydia
□ Hepatitis B
□ Hepatitis C
□ HIV
□ Other_____
□ None of the above
□ Unknown

19. Method of delivery
□ Yes □ No Was delivery with forceps attempted but unsuccessful?
□ Yes □ No Was delivery with vacuum extraction attempted but unsuccessful?

Fetal presentation at birth (Check one):
□ Cephalic
□ Breech
□ Other

Final route and method of delivery (Check one):
□ Vaginal/Spontaneous
□ Vaginal/Forceps
□ Vaginal/Vacuum
□ Cesarean

If cesarean, was a trial of labor attempted?
□ Yes □ No □ Unknown

20. Obstetric procedures (Check all that apply):
- ☐ Cervical cerclage
- ☐ Tocolysis

- ☐ External cephalic version
  - ☐ Successful
  - ☐ Failed
- ☐ Other_____
- ☐ None of the above
- ☐ Unknown

21. Maternal (Check all that apply):
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care
- ☐ Unplanned operating room procedure following delivery
- ☐ Other_____
- ☐ None of the above
- ☐ Unknown

22. Obstetric estimate of gestation at delivery

_____ (weeks)

23. Apgar score

Score at 5 minutes _____

If 5-minute score **is less than 6:**

Score at 10 minutes _____

24. Plurality

_____

25. Birth Order

(If not single birth)

_____

Newborn

26. 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
- ☐ Other_____
- ☐ None of the above
- ☐ Unknown

27. 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
- ☐ Other_____
- ☐ None of the above
- ☐ Unknown

28. Was infant transferred within 24 hours of delivery?

☐ Yes ☐ No

If yes, name of facility infant transferred to:

_____

29. Is infant living at time of report?
- ☐ Yes
- ☐ No _____ (Date Expired MM/DD/YYYY)
- ☐ Infant transferred, status unknown

30. Is infant being breastfed at discharge?
- ☐ Yes
- ☐ No
- ☐ Unknown

31. Was infant screened for hearing?
- ☐ Yes
- ☐ No
- ☐ Unknown

32. Hearing Screening Results
- ☐ Passed
- ☐ Failed:

  Follow-Up Scheduled:
  - ☐ Yes ☐ No
- ☐ Missed:
  - ☐ Transferred ☐ Deceased ☐ Prematurity ☐ Other: _____

Immunization

33. Did mother refuse vaccination?
- ☐ Yes (SKIP TO #43)
- ☐ No
- ☐ Unknown

34. Was vaccination given at Hospital?

☐ Yes ☐ No

If yes, name of Vaccinator

_____

35. HepB Date

___ ___ _____

MM DD YYYY

36. HepB Lot Number

_____

37. HepB Manufacturer

☐ Merck ☐ GlaxoSmithKline

☐ Other:_____

38. HepB Time Given

_____

39. HBIG Date

___ ___ _____

MM DD YYYY

40. HBIG Lot Number

_____

41. HBIG Manufacturer

☐ Talecris Biotherapeutics
☐ Nabi Biopharmaceuticals
☐ Other:_____

42. HBIG Time Given

_____

HIV/AIDS

43. Prenatal HIV Testing
(check all that apply)
- ☐ Pre-natal 1st trimester or 2nd trimester
- ☐ Pre-natal 3rd trimester
- ☐ Labor and Delivery
- ☐ Post-natal
- ☐ Not tested
  - ☐ Known HIV-positive prior to pregnancy care
  - ☐ Refused
- ☐ Unknown

44. Mother's HIV Status
- ☐ Positive
- ☐ Documented Negative
- ☐ Unknown

45. Antiretroviral (ARV) Administration
(check all that apply)
- ☐ ARVs to mother during pregnancy
- ☐ ARVs to mother during delivery
- ☐ ARVs to baby