

CHILD'S INFORMATION

First Name	Middle Name	Last Name	Suffix

Date of Birth	Time of Birth	Sex/Gender
	AM <input type="checkbox"/> PM <input type="checkbox"/>	Male <input type="checkbox"/> Female <input type="checkbox"/>

Request Social Security Number?	Safe Surrender?
Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

MOTHER'S INFORMATION

Mother's Current Legal Name:

First Name	Middle Name	Last Name

Mother's Name Prior to First Marriage:

First Name	Middle Name	Last Name

Date of Birth	Age	Social Security Number

Birthplace State	Birthplace Country

Residence Address	Mailing Address
Street Address:	Street Address:
City/State/Zip: _____	City/State/Zip: _____
County:	County:
Country:	Country:
Inside City Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>	Inside City Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>
Telephone Number:	Telephone Number:

Highest Level of Education
<input type="checkbox"/> Eighth grade or less
<input type="checkbox"/> 9 th -12 th Grade – No Diploma
<input type="checkbox"/> High School Graduate or GED
<input type="checkbox"/> Some College, no Degree
<input type="checkbox"/> Associates Degree
<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Master's Degree
<input type="checkbox"/> Doctorate
<input type="checkbox"/> Unknown

Is mother of Hispanic Origin?
<input type="checkbox"/> No, Spanish/ Hispanic/Latina
<input type="checkbox"/> Yes, Mexican/Mexican-American-Chicano
<input type="checkbox"/> Yes, Puerto Rican
<input type="checkbox"/> Yes, Cuban
<input type="checkbox"/> Yes, Other Spanish/Hispanic/Latina (Specify)
<input type="checkbox"/> Unknown

Mother's Race?	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> American Indian or Alaska Native (Specify)	<input type="checkbox"/> White
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian (Specify)
<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan
<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Island (Specify)
<input type="checkbox"/> Korean	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Unknown

WIC			
Did the mother receive WIC food for herself?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Unknown <input type="checkbox"/>

Mother's Health Information			
Mother's Height	Feet:	Inches:	

Mother's Weight	
Mother's prepregnancy weight in lbs.:	
Mother's weight at the time of delivery in lbs.:	

Cigarettes Smoking Before and During Pregnancy		
Did Mother use Tobacco use during this pregnancy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Three months before pregnancy Cigarettes per day:		
First trimester (first three months of pregnancy) Cigarettes per day:		
Second trimester (second three months of pregnancy) Cigarettes per day:		
Third trimester (third three months of pregnancy) Cigarettes per day:		

Marital Information	
<input type="checkbox"/> Currently Married	<input type="checkbox"/> Preemptive Court Order
<input type="checkbox"/> Never Married	<input type="checkbox"/> Married but refusing husbands information
<input type="checkbox"/> Divorced	<input type="checkbox"/> Widow
<input type="checkbox"/> Separated	

Was mother married at conception, birth or anytime between conception or birth?
<input type="checkbox"/> Yes, Spouse is legal parent
<input type="checkbox"/> No
<input type="checkbox"/> Yes, but Spouse is not Legal Parent
<input type="checkbox"/> Mother Refusing Father Information

Paternity Information				
Did a court rule the husband is NOT the father?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not Applicable <input type="checkbox"/>
Date of Divorce				
Do you plan to file an Affidavit of Parentage?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Unknown <input type="checkbox"/>	Not Applicable <input type="checkbox"/>

FATHER/PARENT'S INFORMATION

Father/Parent's Name:

First Name	Middle Name	Last Name	Suffix

Date of Birth	Age	Social Security Number

Birthplace State	Birthplace Country

Residence Address	Mailing Address
Street Address:	Street Address:
City/State/Zip: _____	City/State/Zip:
County:	County:
Country:	Country:
Inside City Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>	Inside City Limits: Yes <input type="checkbox"/> No <input type="checkbox"/>
Telephone Number:	Telephone Number:

Highest Level of Education
<input type="checkbox"/> Eight grade or less
<input type="checkbox"/> 9 th -12 – No Diploma
<input type="checkbox"/> High School Diploma or GED
<input type="checkbox"/> Some College
<input type="checkbox"/> Associates Degree
<input type="checkbox"/> Bachelor's Degree
<input type="checkbox"/> Master's Degree

Is Father/Parent of Hispanic Origin?
<input type="checkbox"/> No, Spanish/ Hispanic/Latina
<input type="checkbox"/> Yes, Mexican/Mexican-American-Chicano
<input type="checkbox"/> Yes, Puerto Rican
<input type="checkbox"/> Yes, Cuban
<input type="checkbox"/> Yes, Other Spanish/Hispanic/Latina (Specify)
<input type="checkbox"/> Unknown

Father/Parent's Race?	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Guamanian or Chamorro
<input type="checkbox"/> American Indian or Alaska Native (Specify)	<input type="checkbox"/> White
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Chinese	<input type="checkbox"/> Other Asian (Specify)
<input type="checkbox"/> Filipino	<input type="checkbox"/> Samoan
<input type="checkbox"/> Japanese	<input type="checkbox"/> Other Pacific Island (Specify)
<input type="checkbox"/> Korean	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Unknown

Informant Information

Informant Relation to Child
<input type="checkbox"/> Mother
<input type="checkbox"/> Father
<input type="checkbox"/> Other (Specify):

Informant Name

First Name	Middle Name	Last Name

Place of Birth

Type of Place:	
<input type="checkbox"/> Hospital	<input type="checkbox"/> Home Delivery Unknown if Planned
<input type="checkbox"/> Freestanding Birth Center	<input type="checkbox"/> Clinic/Doctor's Office
<input type="checkbox"/> Home – Planned	<input type="checkbox"/> Other (Specify)
<input type="checkbox"/> Home – Unplanned	<input type="checkbox"/> Unknown

Place of Birth Address
Facility Name:
Street Address:
City/State/Zip:
County: - -
Country: United States

PRENATAL:

Principal source of payment for this delivery:
<input type="checkbox"/> Medicaid
<input type="checkbox"/> Private Insurance
<input type="checkbox"/> Self Pay
<input type="checkbox"/> Other
<input type="checkbox"/> Unknown

Mother's Date last normal menses began

Mother's Transfer Status

Was mother transferred into this facility for maternal medical or fetal indications for delivery?	If "YES", which facility?
Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	

Prenatal Care Information

Did mother receive prenatal care? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>
First visit date:
Last visit date:
Total number of prenatal visits for this pregnancy:

Pregnancy History

Total Number of Live Births Now Living:
Total Number of Live Births Now Dead:
Date of last live birth:
Number of other pregnancy outcomes:
Date of last other pregnancy outcome:

Risk Factors

Risk Factor in this pregnancy (check all that apply):
<input type="checkbox"/> Diabetes - Gestational (diagnosis in this pregnancy)
<input type="checkbox"/> Diabetes - Prepregnancy (diagnosis prior to this pregnancy)
<input type="checkbox"/> Hypertension - Prepregnancy (chronic)
<input type="checkbox"/> Hypertension - Gestational (PIH, Preclampsia)
<input type="checkbox"/> Hypertension – Eclampsia
<input type="checkbox"/> Previous preterm birth
<input type="checkbox"/> Other Previous poor pregnancy outcome (Includes perinatal death, SGA, IUGR birth)
<input type="checkbox"/> Pregnancy Resulted from Infertility Treatment - Fertility-enhancing drugs, artificial insemination or intrauterine insemination
<input type="checkbox"/> Pregnancy Resulted from Infertility Treatment – Assisted reproductive technology (e.g. In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT))
<input type="checkbox"/> Mother had a previous cesarean delivery
<input type="checkbox"/> None of the above:
<input type="checkbox"/> Unknown

Was Mother Tested for HBsAG?	Date Tested	Test Results
Yes <input type="checkbox"/> No <input type="checkbox"/>		Positive <input type="checkbox"/> Negative <input type="checkbox"/>

Infections Present and/or treated during this pregnancy (check all that apply)
<input type="checkbox"/> Gonorrhea
<input type="checkbox"/> Syphilis
<input type="checkbox"/> Chlamydia
<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> Hepatitis C
<input type="checkbox"/> None of the above

Obstetric Procedures (check all that apply):
<input type="checkbox"/> Cervical cerclage
<input type="checkbox"/> Tocolysis
<input type="checkbox"/> External cephalic version - Successful
<input type="checkbox"/> External cephalic version – Failed
<input type="checkbox"/> None of the above

Onset of Labor (check all that apply):
<input type="checkbox"/> Premature rupture of the membranes (prolonged greater than or equal to 12 hours)
<input type="checkbox"/> Precipitous Labor (less than 3 hours)
<input type="checkbox"/> Prolonged Labor (greater than or equal to 20 hours)
<input type="checkbox"/> None of the above:
<input type="checkbox"/> Unknown

Characteristics of Labor & Delivery (check all that apply):
<input type="checkbox"/> Induction of labor
<input type="checkbox"/> Augmentation of labor
<input type="checkbox"/> Non-vertex presentation
<input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
<input type="checkbox"/> Antibiotics received by mother during labor
<input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature is greater than or equal to 38° C (100.4°F)
<input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid
<input type="checkbox"/> Fetal intolerance of labor such that one or more of the following actions was taken: In-utero resuscitative measures, further fetal assessment or operative delivery
<input type="checkbox"/> Epidural or spinal anesthesia during labor
<input type="checkbox"/> None of the above
<input type="checkbox"/> Unknown

Method of Delivery

Was Delivery with Forceps attempted but unsuccessful?	Was Delivery with Vacuum Extraction Attempted by unsuccessful?
Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>

Fetal Presentation at Birth
<input type="checkbox"/> Cephalic
<input type="checkbox"/> Breech
<input type="checkbox"/> Other
<input type="checkbox"/> Unknown

Final route and method of Delivery?
<input type="checkbox"/> Vaginal/Spontaneous
<input type="checkbox"/> Vaginal/Forceps
<input type="checkbox"/> Vaginal/Vacuum
<input type="checkbox"/> Cesarean
<input type="checkbox"/> Unknown

If Cesarean, was a trial of labor attempted?
Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable <input type="checkbox"/>

Maternal Morbidity (check all that apply):
<input type="checkbox"/> Maternal transfusion
<input type="checkbox"/> Third or fourth degree perineal laceration
<input type="checkbox"/> Ruptured uterus
<input type="checkbox"/> Unplanned hysterectomy
<input type="checkbox"/> Admission to intensive care unit
<input type="checkbox"/> Unplanned operating room procedure following delivery
<input type="checkbox"/> None of the above
<input type="checkbox"/> Unknown

Mother Transferred for maternal medical or fetal indication prior to delivery	Infant Transferred within 24 hours of delivery?
Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>

NEWBORN

Birth Weight
Pounds: Ounces:

APGAR Score
Score at 5 minutes:
If the 5 minute score is less than 6, score at 10 minutes:

Obstetric Estimate of Gestation
Obstetric Estimate of gestation (completed weeks):

Plurality	Birth Order	Number Born Alive

Is infant living at the time of report?	Is infant being breastfed at discharge?
Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>

Infant's Vaccination

Did infant receive Hepatitis B vaccine?	Date Hepatitis vaccine administered
Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Refused <input type="checkbox"/>	

Was infant immunized with Nirsevimab (RSV)?	Nirsevimab (RSV) dosage amount?	Nirsevimab (RSV) date administered
Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>	<input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg <input type="checkbox"/> Unknown	

Abnormal Conditions (check all that apply):
<input type="checkbox"/> Assisted ventilation required immediately following delivery
<input type="checkbox"/> Assisted ventilation required for more than six (6) hours
<input type="checkbox"/> NICU admission
<input type="checkbox"/> Newborn given surfactant replacement therapy
<input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis
<input type="checkbox"/> Seizure or serious neurologic dysfunction
<input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
<input type="checkbox"/> None of the above
<input type="checkbox"/> Unknown

Congenital Anomalies (check all that apply):

<input type="checkbox"/> Anencephaly
<input type="checkbox"/> Meningomyelocele/Spina bifida
<input type="checkbox"/> Cyanotic congenital heart disease
<input type="checkbox"/> Congenital diaphragmatic hernia
<input type="checkbox"/> Omphalocele
<input type="checkbox"/> Gastroschisis
<input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
<input type="checkbox"/> Cleft lip with or without cleft palate
<input type="checkbox"/> Cleft palate
<input type="checkbox"/> Down Syndrome Karyotype Confirmed
<input type="checkbox"/> Down Syndrome Karyotype Pending
<input type="checkbox"/> Suspected Chromosomal disorder – Karyotype Confirmed
<input type="checkbox"/> Suspected Chromosomal disorder – Karyotype Pending
<input type="checkbox"/> Hypospadias
<input type="checkbox"/> None of the above
<input type="checkbox"/> Unknown

ATTENDANT

First Name	Middle Name	Last Name	Suffix

Attendant Information

Title:
Relationship to Child:
NPI Number:
License Number:
Address:

CERTIFIER

First Name	Middle Name	Last Name	Suffix

Certifier Information

Title:
Relationship to Child:
NPI Number:
License Number:
Address:
Date Certified: