

IDAHO CERTIFICATE OF LIVE BIRTH

-- How to Complete --

A PAPER CERTIFICATE

WebEBC: For Instructions on the completion of an electronic birth certificate, refer to the on screen instructions or the WebEBC Manual.

For each live birth which occurs in this state, a birth certificate is legally required to be filed with the Local Registrar of the county in which the birth occurred, or as otherwise directed by the State Registrar, within 15 days of the date of birth. The person in charge of the hospital or freestanding birthing center (or a designated representative) and the physician are responsible for completing and filing the certificate. If the birth occurs outside an institution, the physician or other person in attendance at or immediately after such birth is responsible for completing and filing the certificate.

“Live Birth” means the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. [Idaho Code §39-241(10)]

The current version (at the time of birth) of the Idaho Certificate of Live Birth is to be completed and filed. *(An original Acknowledgment of Paternity Affidavit or certified copy of a court determination of paternity or non-paternity must accompany the birth certificate if applicable.)*

Since the birth certificate is a permanent legal document, it must be legibly completed using a typewriter with good black ribbon and clean keys, a computer printer with high resolution, or by printing legibly using permanent, unfading black ink. Certificates completed in other colored ink or pencil is not acceptable.

When the birth occurs outside a hospital or freestanding birthing center, original signatures are required. The certificate must be personally signed by the certifier and the parent in black or dark blue ink; other colored ink, pencil, rubber stamps, or facsimile signatures are not acceptable. *(When a birth occurs in an institution [hospital or freestanding birthing center], the signature of the certifier may be typed on the birth certificate only if the original signature of the certifier is on the medical record of birth.)*

A certificate that is prepared on an improper form, is a photo or carbon copy, is defaced, contains lined-through information, excessive white-out, messy alterations or erasures, is incomplete, or contains improper or inconsistent data will not be accepted for filing.

All items must be completed or the reason for their omission explained. Entries such as “Unknown,” “Not available,” “Refused,” or a dash “-” may be given when appropriate. Vital Statistics may question a high usage of “Unknown” entries.

Worksheets are useful in obtaining information for completing the birth certificate. (Please be sure the wording on the worksheet matches the birth certificate.) Review all

information before and during completion of the birth certificate to avoid errors, which can involve a great deal of time, inconvenience, and expense to correct.

If you encounter any unusual problems in completing a birth certificate, contact your Local Registrar or **Vital Statistics**.

The following pages contain a description of every item on the birth certificate and instructions for the completion of each.

The two unnumbered items at the top of the birth certificate, DATE FILED BY STATE REGISTRAR: (top left) and STATE FILE NO. (top right), will be completed by **Vital Statistics** staff when the certificate is accepted for permanent filing.

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)

Enter the child's first, middle, and last names exactly as given by the parent(s) on the worksheet or on the paternity affidavit *. Be especially careful with names for which several different spellings are possible. Include any suffix to the child's name if applicable, such as Jr., Sr., II, III.

Note: Adequate spacing should be entered to distinguish between first, middle, and last names.

A last name (surname) must always be entered for the child.

- * Paternity affidavit - If an Acknowledgment of Paternity Affidavit has been completed, the child's name must be listed on the birth certificate the same as it is in the mother's section of the paternity affidavit (including spelling and punctuation).

- No first name - If the parents do not specify a first name for the child, leave the space blank. DO NOT add entries such as "Baby girl" or "Infant boy."

- No middle name - If the child was not given a middle name or initial, leave the middle name field blank. DO NOT enter "NMI" or "NMN."

- No last name - If no last name is given for this child and the parents cannot be contacted, use the current legal last name of the mother.

The child must have both a first and last name entered on the birth certificate to use the Social Security Administration's Enumeration at Birth Program. (Refer to item #15.)

2. **TIME OF BIRTH** (24hr)

Enter the exact time (hour and minute) the child was born, based on a 24-hour clock, as four digits (0000 through 2359) with no colon and no a.m. or p.m. designation.

Midnight belongs to the beginning of the new day (enter as "0000").

The time/date sequence is:

| | | |
|------|--------------|----------------------|
| 2359 | (11:59 p.m.) | End of day |
| 0000 | (12:00 a.m.) | Midnight |
| 0001 | (12:01 a.m.) | Beginning of new day |

3. **SEX**

Enter the sex of the child as "Male" or "M" or "Female" or "F".

Unknown - If the sex of the child has not yet been determined, enter "Unknown" or "U".

4. **DATE OF BIRTH** (Mo/Day/Yr)

Enter the complete date of birth of the child - month, day, and four-digit year. Write out in full (January, February, March, etc.) or abbreviate (Jan., Feb., Mar., etc.) the name of the month. Do not use a number to designate the month.

Note: Midnight belongs to the beginning of the new day.

5. **FACILITY NAME** (If not facility, give street and number)

Enter the full name of the facility (hospital or freestanding birthing center) where the birth occurred or the street address of the location where the birth occurred if not in a facility. (DO NOT enter a P.O. Box or Rural Route and Box Number.)

(A freestanding birthing center has no direct physical connection with an operative delivery center.)

The facility or street address entered here must be located within or near the city, town, or location entered in item #6.

En route - If the birth occurred on a moving conveyance en route to or on arrival at a facility, enter the full name of the facility.

Moving conveyance - If the birth occurred on a moving conveyance not en route to a facility, enter as the place of birth the street name and number where the child was first removed from the conveyance.

At home or other place - If the birth occurred at home or some other place, enter the street name and number of the house, building, or location where the birth occurred.

No street address - If this location has no street name and number, enter a brief description that will identify the physical location.

6. CITY, TOWN, OR LOCATION OF BIRTH

Enter the name of the city, town, or other location where the birth occurred; this may be different from the city or town used in the mailing address of the birth location.

This location must be within the county entered in item #7.

Moving conveyance - If the birth occurred on a moving conveyance, enter the city, town, or location where the child was first removed from the conveyance.

7. COUNTY OF BIRTH

Enter the name of the county where the birth occurred.

Moving conveyance - If the birth occurred on a moving conveyance, enter the county where the child was first removed from the conveyance.

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)

Enter the mother's full legal name at the time of this child's birth, including any suffix to her name if applicable.

(In all cases the birth mother is to be listed, including surrogate births and pending adoptions. The father's information is to be completed according to the birth mother's marital status.)

8b. DATE OF BIRTH (Mo/Day/Yr) [MOTHER'S]

Enter the complete date of birth of the mother - month, day, and four-digit year. Write out in full (January, February, March, etc.) or abbreviate (Jan., Feb., Mar., etc.) the name of the month. Do not use a number to designate the month.

Not known - If any part of the mother's date of birth is not known, enter the known information and enter a "?" for the part(s) not known. Enter "Unknown" if all parts of the date are not known.

8c. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)

Enter the full name of the mother as given at birth or by adoption, including any suffix to her name if applicable.

Not available - If the maiden last name is not given, refused, or not known, enter "Unknown." Do not leave blank.

Do not list a previous married name and do not enter "Same" or "Refused."

8d. BIRTHPLACE (State, Territory, or Foreign Country) *[MOTHER'S]*

Enter the place of birth of the mother.

United States - If the mother was born in the United States, enter the name of the state or territory. If the state or territory is not known, enter "U.S." only.

Canada - If the mother was born in Canada, enter the name of the province and "Canada." If the province is not known, enter "Canada" only.

Foreign - If the mother was born in any other foreign country, enter the name of the country. If the specific country is not known, enter "Foreign-unknown".

Not known - If no information is available regarding the place of birth, enter "Unknown."

9a. RESIDENCE OF MOTHER - STATE

Enter the name of the state in which the mother currently lives. This is where her household is located and where she is actually residing.

The mother's residence is not necessarily the same as her "home state," "voting residence," "mailing address," or "legal residence."

Temporary - Never enter a temporary residence such as one used during a visit, business trip, vacation, or short time stay at the home of a relative or friend or home for unwed mothers for the purpose of awaiting the birth of the child.

Note: Place of residence during a tour of military duty or during attendance at college is *not* considered temporary and should be entered as the mother's residence.

9b. COUNTY *[RESIDENCE OF MOTHER]*

Enter the name of the county in which the mother lives. The county entered here must be located within the state entered in item #9a.

9c. CITY, TOWN, OR LOCATION *[RESIDENCE OF MOTHER]*

Enter the name of the city, town, or location where the mother lives, which may not be the same as the city, used for the mailing address. This location must be within the state and county entered in items #9a-b.

9d. STREET AND NUMBER *[RESIDENCE OF MOTHER]*

Enter the full street address of the place where the mother lives. (DO NOT enter a P.O. Box or Rural Route and Box Number.)

No street address - If this location has no street name and number, enter a brief description that will identify the physical location.

Unit or space - If there is a unit or space number (number, letter, or combination of the two) associated with this address that distinguishes between buildings (e.g., mobile homes), enter it as part of the street and number address.

(No entry for city or town should be made in this item.)

9e. APT. NO. [RESIDENCE OF MOTHER]

Enter the apartment or room number of the place where the mother lives if applicable.

Note: Complete this item only if there is a number (number, letter, or combination of the two) associated with this address that distinguishes between residences located within a building.

9f. ZIP CODE [RESIDENCE OF MOTHER]

Enter the nine-digit Zip Code of the place where the mother lives.

Five-digit Zip Code - If only the five-digit Zip Code is known, enter those five digits only.

Foreign - Enter the appropriate postal code for the place where the mother lives, if applicable.

9g. INSIDE CITY LIMITS? [RESIDENCE OF MOTHER]

9 Yes 9 No

Check "Yes" or "No" to indicate if the mother's street address, entered in item #9d, is located inside the city limits of the city, town, or location entered in item #9c.

Unincorporated or outside city limits - If the city, town, or location entered in item #9c is unincorporated or if the street address entered in item #9d is outside the city limits, enter "No."

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)

Enter the father's full legal name at the time of this child's birth, including, if applicable, any suffix to his name.

(Refer to the following information regarding who is or is not to be entered as the father, based on marital status of the mother.)

--- If mother was **married** (at birth, conception, or any time between) refer to the following:

Mother married

- If the mother was married at conception, at any time during pregnancy, or at birth; enter the full legal name of the husband. (The husband is the legal father.)

Married multiple times

- If the mother was married at conception, at any time during pregnancy, or at birth, and there has been more than one husband during that time, the husband at the time of the birth should be listed as the father. If the mother is not married at the time of the birth, but was married at conception or during the interval between conception and birth, the most recent husband during that time should be listed. (The husband is the legal father.)

Refusing husband info.

- If the mother refuses to give the husband's information, leave the father's information blank and notify **Vital Statistics** that the mother refused to provide this information. Do not enter "Refused" or "Unknown."

Note: The parent(s) will not be able to obtain a copy of the birth certificate, nor will information be sent to the Social Security Administration for issuance of a Social Security number (refer to item #15) until the paternity issue is resolved with **Vital Statistics**.

Husband not natural father

- If the legal father (husband) is not the natural father, the natural father may be entered on the birth certificate in place of the husband only if you have in your possession either an Acknowledgment of Paternity Affidavit signed by the mother, the natural father, and the legal father (husband) in the presence of a notary public (three-party affidavit -- all three must sign), or a certified copy of a court order that establishes paternity of this child; a divorce decree may suffice, depending on content. (Contact **Vital Statistics** if you are unsure if a divorce decree is adequate.)

Note: An Acknowledgment of Paternity Affidavit signed by the mother and the natural father may be used in conjunction with a certified copy of a court order of non-paternity establishing that the husband is not the natural father of this child without establishing who the natural father is; a divorce decree may suffice, depending on content. (Contact **Vital Statistics** if you are unsure if a divorce decree is adequate.)

No father to be listed

- If the legal father (husband) is not the natural father, and neither the natural father nor the legal father (husband) will be entered on the birth certificate, you must have in your possession a certified copy of a court order of non-paternity establishing that the husband is not the natural

father of this child without establishing who the natural father is; a divorce decree may suffice, depending on content. (Contact **Vital Statistics** if you are unsure if a divorce decree is adequate.)

Note: You must have the properly completed, notarized, original (three-party) paternity affidavit or certified copy of the court order in your possession and file it with the birth certificate. If you have not received the affidavit or court order by the 15th day after delivery, the birth certificate must be submitted with the legal father's (husband's) information listed; the parent(s) will then have to contact **Vital Statistics** to amend paternity.

If a person is biologically old enough to produce a child, he or she is old enough to sign an Acknowledgment of Paternity Affidavit.

(Idaho recognizes common-law marriages established prior to January 1, 1996; treat as married.)

*---- If mother was **not married** (at birth, conception, or any time between) refer to the following:*

Mother not married - If the mother was not married at conception, at any time during pregnancy, or at birth, leave the father's information blank, except as provided below.

Note: If this item (father's name) is left blank, all other items pertaining to the father must also be left blank.

Establishing paternity - The name of the natural father may be entered only if you have in your possession either a properly completed, notarized, original Acknowledgment of Paternity Affidavit signed by both the mother and the natural father, or a certified copy of a court order establishing paternity. The paternity affidavit may be completed prior to delivery or after delivery.

You must have the properly completed, notarized, original paternity affidavit or certified copy of the court order in your possession and file it with the birth certificate. If you have not received the affidavit or court order by the 15th day after delivery, the certificate must be submitted without the father's information listed; the parents will then have to contact **Vital Statistics** to add the natural father.

If a person is biologically old enough to produce a child, he or she is old enough to sign an Acknowledgment of Paternity Affidavit.

*----If **not known** if mother married (at birth, conception, or any time between) refer to the following:*

Not known if mother married - If the marital status of the mother is not known and cannot be determined, the father's name and other

information are to be left blank. Notify **Vital Statistics** that the marital status is not known.

Note: The parent(s) will not be able to obtain a copy of the birth certificate, nor will information be sent to the Social Security Administration for issuance of a Social Security number (refer to item #15) until the marital status and paternity issue are resolved with **Vital Statistics**.

10b. DATE OF BIRTH (Mo/Day/Yr) [FATHER'S]

.... Complete only if the father's name is entered in item #10a.

Enter the complete date of birth of the father - month, day, and four-digit year. Write out in full (January, February, March, etc.) or abbreviate (Jan., Feb., Mar., etc.) the name of the month. Do not use a number to designate the month.

Not known - If any part of the father's date of birth is not known, enter the known information and enter a "?" for the part(s) not known. If the complete date is not known, enter "Unknown."

10c. BIRTHPLACE (State, Territory, or Foreign Country) [FATHER'S]

.... Complete only if the father's name is entered in item #10a.

Enter the place of birth of the father.

United States - If the father was born in the United States, enter the name of the state or territory. If the state or territory is not known, enter "U.S." only.

Canada - If the father was born in Canada, enter the name of the province and "Canada."
If the province is not known, enter "Canada" only.

Foreign - If the father was born in any other foreign country, enter the name of the country.
If the specific country is not known, enter "Foreign-unknown."

Not known - If no information is available regarding the place of birth, enter "Unknown."

INFORMANT

11. INFORMANT'S SIGNATURE: I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.
(Name of Parent or Guardian)ᅃ

Enter the name of the parent (or guardian of the child) that supplied the information to complete the personal information items on the birth certificate and signed the facility worksheet.

Worksheet not signed - If the facility worksheet has not been signed, enter "Taken from medical records."

Father not listed - If the father signed the facility worksheet, but his name is not entered in item #10a on the birth certificate, his name cannot be entered as the informant. Enter "Taken from medical records."

CERTIFIER

12a. CERTIFIER'S SIGNATURE: I certify that stated information concerning this child is true to the best of my knowledge and belief.

Certifier's Signature
Name (Type or print)

Obtain the signature of the certifier on the top line and type or print the name of the certifier on the lower line.

Note: The certifier's typed or printed name must match the certifier's signature.

Certifier's Signature

Obtain the personal signature* in permanent black or dark blue ink, of the physician or other person in attendance at or immediately after the birth, or other person as authorized by state law. Rubber stamps or other facsimile signatures are not permitted.

* Signature - If the birth occurred in an institution (hospital or freestanding birthing center), the certifier's name may be typed on the "Certifier's Signature" line only if the signature of the certifier is on the medical record of birth.

Name (Type or print)

Type or print the name of the certifier (i.e., the individual who certifies to the fact that the birth occurred) on the "Name" line, just below the "Certifier's Signature" line.

12b. CERTIFIER'S MAILING ADDRESS (Street and Number, City, State, Zip Code)

Enter the complete mailing address of the certifier.

12c. CERTIFIER'S LICENSE NUMBER

Enter the state issued medical license number of the certifier.

If the certifier is not a state licensed M.D., D.O., or Midwife, this item will be left blank.

12d. DATE SIGNED
MM / DD / YYYY

The certifier is to enter the date that he or she signs the birth certificate.

Institution - If the birth occurred in an institution (hospital or freestanding birthing center), and the certifier's name is typed on the "Certifier's Signature" line, the date the certificate is completed should be entered as the date signed.

12e. CERTIFIER'S TITLE

Check the appropriate box to identify the title of the certifier.

Other - If "Other (Specify)" is checked, type or print the title of the certifier.

Note: If the father is the certifier on the birth certificate, list his title as "Father" only if his name is entered in item #10a on the birth certificate. Otherwise, list his title as "Friend" or other appropriate title.

LIST / DEFINITIONS

MD Doctor of medicine
DO Doctor of osteopathy
Hospital Administrator Hospital Administrator
CNM/CM Certified nurse midwife / certified midwife
Other Midwife Midwife other than a CNM/CM
Other (Specify) _____ (E.g., grandmother, family friend, father, nurse, EMT)

-- INFORMATION FOR MEDICAL AND HEALTH USE ONLY - COMPLETE EACH ITEM --

(The following information is for medical and health use only and does not appear on certified copies of the birth certificate.)

Note: Information on the father should be entered in this section only if there is a father's name entered on the birth certificate in item #10a.

ADMINISTRATIVE USE ONLY

13. MOTHER'S MAILING ADDRESS:

9 Same as residence, OR: State _____ City, Town, or Location _____
Street and Number _____ Apartment Number _____ Zip Code _____

Check the "Same as residence" box or complete the address information.

- Same as residence - If the mailing address is the same as the residence address, check only the "Same as residence" box.
- Different mailing - Enter the complete mailing address of the mother (State, City, Town, or Location, Street and Number, Apartment Number, Zip Code) if any part differs from the residence address.
- No street address - If the mailing address is a Post Office Box or Rural Route and Box Number, enter this information on the "Street and Number" line.

14. MOTHER MARRIED? (at birth, conception, or any time between)

9Yes 9No

IF "NO", HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED?

9Yes 9No

Check "Yes" or "No" to indicate if the mother was married at birth, conception, or any time between.

(Idaho recognizes common-law marriages established prior to January 1, 1996; follow the procedures for Married.)

- Married - Check "Yes" if the mother was married at the time of birth, at the time of conception, or at any time during the pregnancy.

A person is legally married, even if separated, until the final divorce papers are signed and filed.

Note: If "Yes," the husband is the legal father and must be listed on the birth certificate as the father unless either a properly completed, notarized, original Acknowledgment of Paternity Affidavit (three-party) signed by the mother, natural father, and legal father (husband), or a certified copy of a court determination of paternity or non-paternity is in your possession and filed with the birth certificate.

If a three-party paternity affidavit is completed, the question "If 'No', has Paternity Acknowledgment Been Signed?" should be checked as "Yes," even though "Yes" is checked for the question "Is Mother Married."

- Not married - Check "No" if the mother was not married at the time of birth, at the time of conception, or at any time during the pregnancy. Also, check "Yes" or "No" to the question on signed paternity acknowledgment.

Note: If "No," the father's information must be left blank unless you have in your possession a properly completed, notarized, original Acknowledgment of Paternity Affidavit signed by both the mother and natural father, or a certified copy of a court determination of paternity.

- Not known - Enter a "?" if the marital status of the mother is not known and the information cannot be obtained. The father's information must be left

blank. A paternity affidavit will not be accepted if the marital status for the mother is not known.

-- **IF "NO", HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED?**

9Yes 9No

Check "Yes" or "No" to indicate if you have a signed paternity affidavit in hand to send in with the birth certificate.

If a person is biologically old enough to produce a child, he or she is old enough to sign an Acknowledgment of Paternity Affidavit.

Paternity affidavit - Check "Yes" only if you have in your possession a properly completed, notarized, original Acknowledgment of Paternity Affidavit signed by both the mother and natural father. The paternity affidavit is to be filed with the birth certificate. (The natural father will be entered on the birth certificate as the father.)

Three-party affidavit - If the mother was married to someone other than the natural father, check "Yes" only if you have in your possession a properly completed, notarized, original Acknowledgment of Paternity Affidavit signed by the mother, the natural father, and the husband. The three-party paternity affidavit is to be filed with the birth certificate. (The natural father will be entered on the birth certificate as the father.)

Note: In order to be acceptable, the Acknowledgment of Paternity Affidavit must be the current original form provided by **Vital Statistics** with the Rights and Responsibilities printed on the back. The information must be completed in ink or typed. The affidavit must include the full names and signatures of the mother and father (and husband when applicable); both the mother's and father's sections must include the child's date of birth (or approximate date), the child's place of birth, and a minimum of the child's surname. All required signatures must be individually notarized.

No paternity affidavit - Check "No" if you do not have in your possession a properly completed, notarized, original Acknowledgment of Paternity Affidavit.

Note: The parents may have signed a paternity affidavit at another location prior to the birth of their child. However, unless you have in your possession and file with the birth certificate the properly completed, notarized, original Acknowledgment of Paternity Affidavit or a certified copy of a court determination of paternity, you must mark "No" and the natural father's name cannot be entered on the birth certificate.

15. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? 9Yes 9No

Check “Yes” or “No” to indicate if the parents would like the birth information sent to the Social Security Administration to establish their child’s Social Security Number.

THE CHILD MUST HAVE BOTH A FIRST AND LAST NAME ENTERED ON THE BIRTH CERTIFICATE TO USE THIS ENUMERATION AT BIRTH PROGRAM.

Send to SSA - The parent must indicate “Yes” and *sign* an Authorization for Issuance of Social Security Number form. The authorization form may be included as part of the hospital worksheet but must have a separate signature. If the birth was not at a hospital or freestanding birthing clinic, the signed authorization form is to be kept by the midwife/helper.

Do not send - If “No” is checked or if this item is left blank, the parents will have to apply with their local Social Security office to obtain a Social Security Number for their child.

Note: Information on newborns that are to be adopted or have paternity questions* will **not be sent to Social Security until issue is resolved.**

** If a paternity question is resolved in a short time, the information on the newborn will then be sent to the Social Security Administration.*

16. MOTHER’S SOCIAL SECURITY NUMBER

Enter the mother’s nine-digit Social Security Number.

No SSN - If the mother does not have a Social Security Number, enter “None.”

Furnishing mother’s SSN is required by Federal Law, 42USC405(c) [section 205(c) of the Social Security Act]. The SSN will be used by the IRS for determining compliance with tax laws (Earned Income Credit). Also, the SSN will be released to the Idaho child support agency only if an official child support action regarding this child has been initiated.

17. FATHER’S SOCIAL SECURITY NUMBER

.... Complete only if the father’s name is entered in item #10a.

Enter the father’s nine-digit Social Security Number.

No SSN - If the father does not have a Social Security Number, enter “None.”

Furnishing father’s SSN is required by Federal Law, 42USC405(c) [section 205(c) of the Social Security Act]. The SSN will be used by the IRS for determining compliance with tax laws (Earned Income Credit). Also, the SSN will be released to the Idaho child support agency only if an official child support action regarding this child has been initiated.

18. CONSENT OBTAINED FOR IMMUNIZATION REGISTRY ENROLLMENT?

9Yes 9No

Check "Yes" for the child to be enrolled in the statewide immunization registry.

- The Immunization Reminder Information System (IRIS) will automatically enroll the child in the Immunization Registry.
- If the parent does not want the child to be enrolled in the Immunization Reminder Information System (IRIS), they will receive a letter with the abstract of birth that has the info needed to "opt-out" of the program.

MEDICAL AND HEALTH SECTION Complete Each Item

19. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

Check the category that best describes the highest degree or level of school completed by the mother at the time of delivery. An entry should be made in only one box.

Not known - If the education of the mother is not known, enter "Unknown" in the area above the first box.

LIST

8th grade or less (includes none)

9th-12th grade, but no diploma

High school graduate or GED completed

Some college credit, but no degree

Associate degree (e.g., A.A., A.S.)

Bachelor's degree (e.g., A.B., B.A., B.S.)

Master's degree (e.g., M.A., M.B.A., M.Ed, M.Eng, M.S., M.S.W.)

Doctorate or professional degree (e.g., D.D.S., D.O., D.V.M., Ed.D, J.D., L.L.B., M.D., Ph.D)

20. MOTHER OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/ Latina)

Check "No" or the appropriate "Yes" box (es). The entry should reflect the response of the informant.

Not Hispanic - If the mother is not of Hispanic origin, check the box which indicates *No, not Spanish/Hispanic/Latina*.

Of Hispanic origin - If the mother is identified as Spanish/Hispanic/Latina, check the appropriate "Yes" box (es); if "other Spanish/Hispanic/Latina," specify the origin.

Multiple Hispanic origins - Multiple origins can be checked, such as Mexican, Puerto Rican, and Cuban.

Not known - If the Hispanic origin of the mother is not known, enter "Unknown" in the area above the first box.

For the purposes of this item, "Hispanic" refers to people whose origins are from Spain, Mexico, or the Spanish-speaking countries of Central or South America.

LIST

- No, not Spanish/Hispanic/Latina
- Yes, Mexican, Mexican American, Chicana
- Yes, Puerto Rican
- Yes, Cuban
- Yes, other Spanish/Hispanic/Latina (Specify) _____

21. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

Enter the race(s) of the mother as indicated by the informant.

- Mixed race - If the mother is of mixed race or national origin, enter all races indicated, such as Japanese, Hawaiian, and American Indian.
- Tribe - For American Indian or Alaska Native, enter the name of the enrolled or principal tribe on the line provided.
- Specify - If the checked box (es) indicates "(Specify)," enter the race(s) on the line provided.
- Not known - If the race of the mother is not known, enter "Unknown" in the area above the first box.

LIST

- White
- Black or African American
- American Indian or Alaska Native (Name of the 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) _____

22. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

.... Complete only if the father's name is entered in item #10a.

Check the category that best describes the highest degree or level of school completed. An entry should be made in only one box.

Not known - If the education of the father is not known, enter "Unknown" in the area above the first box.

LIST

8th grade or less (includes none)
9th-12th grade, but no diploma
High school graduate or GED completed
Some college credit, but no degree
Associate degree (e.g., A.A., A.S.)
Bachelor's degree (e.g., A.B., B.A., B.S.)
Master's degree (e.g., M.A., M.B.A., M.Ed, M.Eng, M.S., M.S.W.)
Doctorate or professional degree (e.g., D.D.S., D.O., D.V.M., Ed.D, J.D., L.L.B., M.D., Ph.D)

23. FATHER OF HISPANIC ORIGIN? (Check one or more boxes to best describe whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)

.... Complete only if the father is entered in item #10a.

Check "No" or the appropriate "Yes" box (es). The entry should reflect the response of the informant.

Not Hispanic - If the father is not of Hispanic origin, check the first box, which indicates *No, not Spanish/Hispanic/Latino*.

Of Hispanic origin - If the father is identified as Spanish/Hispanic/Latino, check the appropriate "Yes" box (es); if "other" Spanish/Hispanic/Latino, specify the origin.

Multiple Hispanic origins - Multiple origins can be checked, such as Mexican, Puerto Rican, and Cuban.

Not known - If the Hispanic origin of the father is not known, enter "Unknown" in the area above the first box.

For the purposes of this item, "Hispanic" refers to people whose origins are from Spain, Mexico, or the Spanish-speaking countries of Central or South America.

LIST

No, not Spanish/Hispanic/Latino
Yes, Mexican, Mexican American, Chicano
Yes, Puerto Rican
Yes, Cuban
Yes, other Spanish/Hispanic/Latino (Specify) _____

24. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)

.... Complete only if the father's name is entered in item #10a.

Enter the race(s) of the father as indicated by the informant.

- Mixed race - If the father is of mixed race or national origin, enter all races indicated, such as Japanese, Hawaiian, and American Indian.
- Tribe - For American Indian or Alaska Native, enter the name of the enrolled or principal tribe on the line provided.
- Specify - If the checked box (es) indicates "(Specify)," enter the race(s) on the line provided.
- Not known - If the race of the father is not known, enter "Unknown" in the space above the first box.

LIST

White

Black or African American

American Indian or Alaska Native (Name of the 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) _____

25. PLACE WHERE BIRTH OCCURRED (Check one)

Check the box that best describes the type of place where the birth occurred.

- Home birth - If "Home birth" is checked, also check "Yes" or "No" to indicate if the birth was planned to be at home.
 - Planned* -- Check "Yes" if the infant was delivered in a home and it was planned to be delivered at home.
 - Not planned* -- Check "No" if the infant was delivered in a home and it was not planned to be delivered at home.
 - Not known* -- If not known whether this was a planned home birth, enter "?" after the "No" option.
- En route - If the birth occurred on a moving conveyance en route to a facility, check the box for "Other" and specify "En route."
- Other - If "Other" is checked, and the birth did not occur on a moving conveyance en route to a facility, specify the place where the birth occurred (e.g., fire station, restaurant, store parking lot, pick-up truck, taxi cab).

LIST / DEFINITIONS

Hospital ..
Freestanding birthing center No direct physical connection with an operative delivery center
Home birth The birth occurred at a private residence
Planned to deliver at home? ..
Clinic / Doctor's office ..
Other (Specify) ..

26. ATTENDANT'S NAME AND TITLE

NAME
TITLE

Type or print the full name of the person responsible for delivering the child only if the certifier was not the attendant; check the appropriate box to identify his or her title.

This is to be completed only if the person signing as certifier was not present at the delivery.

NAME

Type or print the full name of the attendant at birth (i.e., the person who was physically present at the delivery who was responsible for the delivery) only if this person is not the certifier.

Example: If a nurse, intern, EMT, the child's father, or some other person delivers an infant prior to the obstetrician being physically present in the delivery room, the obstetrician would be the certifier and the person who was physically present and delivered the infant would be entered as the attendant.

TITLE

Check the appropriate box to identify the title of the attendant.

Other - If "Other (Specify)" is checked, enter the specific title of the attendant (e.g., nurse, father, police officer, EMS technician)

Note: If the father is named as the attendant on this birth certificate, enter his title as "Father" only if his name is entered as the father in item #10a of the birth certificate. Otherwise, enter his title as "Friend" or other appropriate title.

LIST / DEFINITIONS

MD Doctor of Medicine
DO Doctor of Osteopathy
CNM/CM Certified Nurse Midwife / Certified Midwife
Other Midwife Midwife other than a CNM/CM

Other (Specify) _____ (E.g., grandmother, family friend, father, nurse, EMT, Licensed Midwife)
Hospital Administrator Hospital Administrator

27. WAS MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY?

9 Yes 9 No

IF "YES", NAME OF FACILITY MOTHER TRANSFERRED FROM: _____

Check "Yes" or "No" to indicate if the mother was transferred before delivery, from another facility (hospital or freestanding birthing center) for medical indications.

Transfers include hospital to hospital, birth facility to hospital, etc. Transfers do not include home to hospital or home to freestanding birthing center.

Medical transfer - Check "Yes" if the mother was transferred from one facility to another facility for maternal medical or fetal indications before the child was delivered.

Enter the name of the facility the mother was transferred from, on the line following.

Only facility - Check "No" if this is the only facility the mother was admitted to for delivery.

Other transfer - Check "No" if the mother was transferred for circumstances other than for maternal medical or fetal indications or if she was transferred after delivery.

Home birth - Check "No" if the mother was transferred from home.

-- **IF "YES", NAME OF FACILITY MOTHER TRANSFERRED FROM:**

If "Yes" is checked, enter on the line provided the name of the facility that the mother was transferred from for maternal medical or fetal indications before the child was delivered.

Not known - If the name of the facility is not known, enter "Unknown."

MEDICAL AND HEALTH SECTION Complete Each Item

28a. DATE OF FIRST PRENATAL CARE VISIT

MM / DD / YYYY 9 No prenatal care

Enter the date (month, day, year) the mother first received an examination and/or counseling from a physician, other licensed health care provider, or midwife as part of an ongoing program of care for this pregnancy.

No prenatal care - If no prenatal care was received, check the box "No prenatal care."

Not known - If any part of the date is not known, enter the known information and enter a “?” for the part(s) not known.

28b. DATE OF LAST PRENATAL CARE VISIT

MM / DD / YYYY 9 No prenatal care

Enter the date (month, day, year) of the mother’s last recorded prenatal visit to a physician, other licensed health care provider, or midwife.

No prenatal care - If no prenatal care was received, check the box “No prenatal care.”

Not known - If any part of the date is not known, enter the known information and enter a “?” for the part(s) not known.

29. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY

(IF NONE, ENTER “0”)

Enter the total number of recorded visits made by the mother for medical supervision of the pregnancy by a physician, other licensed health care provider, or midwife.

No prenatal visits - If no prenatal care was received, enter “0”. The “No prenatal care” box should be checked in items #28a and #28b.

Not known - If the number of prenatal visits is unknown, enter “Unknown.”

30. MOTHER’S HEIGHT

(feet/inches)

Enter the height of the mother in feet and inches. Enter whole inches only; drop fractions of inches - do not “round up.”

31. MOTHER’S PREPREGNANCY WEIGHT

(pounds)

Enter the weight (in pounds) of the mother prior to this pregnancy. Enter whole pounds only; drop fractions or ounces - do not “round up.”

Not known - If the mother’s pre-pregnancy weight is not known, enter “Unknown.”

32. MOTHER’S WEIGHT AT DELIVERY

(pounds)

Enter the weight (in pounds) of the mother at the time of delivery. Enter whole pounds only; drop fractions or ounces - do not “round up.”

Not known - If the mother’s delivery weight is not known, enter “Unknown.”

33. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

9Yes 9No

Enter "Yes" or "No" to indicate if the mother got WIC food for herself at any time during this pregnancy.

Not known - If it is not known if the mother got WIC food for herself at any time during this pregnancy, enter "Unknown" in the space after the "No" option.

PREGNANCY HISTORY (Complete each section)

Include all previous pregnancies or deliveries to this mother. For multiple births/deliveries, include the information for the previous birth(s)/loss(es) of this same pregnancy. Do not include children by adoption. Do not include this child.

----- **PREVIOUS LIVE BIRTHS**

(Do not include this child)
Complete Items 34a-34c

34a. Now Living

Number
9 None

Enter the number of children who were born alive to this mother *before* this child was born, who were still living at the time of this birth.

None living - Check "None" if this is the first birth to this mother or if all previous children were dead at the time this child was born.

Note: Include all live born infants in previous deliveries who are still living, and if this was a multiple delivery, include all live born infants who preceded this child in this delivery who were still alive when this child was born. Do not include this child.

34b. Now Dead

Number
9 None

Enter the number of children who were born alive to this mother *before* this child was born, who were no longer living at the time of this child's birth.

None dead - Check "None" if this is the first birth to this mother or if all previous children were still living at the time this child was born.

Note: Include all live born infants in previous deliveries who were no longer living at the time of delivery of this child, and if this was a multiple delivery, include all live born infants who preceded this child in this delivery who were no longer living when this child was born. Do not include this child.

34c. DATE OF LAST LIVE BIRTH

MM / YYYY Enter the date of birth (month, year) of the *last (previous) child born alive* to this mother if applicable.

Not known - If any part of the date is not known, enter the known information and enter a “?” for the part(s) not known.

None - If this is the first child born alive to this mother (items #33a and #33b are checked “None”), this item will be blank.

- - - - - **OTHER PREGNANCY OUTCOMES**

(spontaneous or induced losses or ectopic pregnancies)
Complete Items 35a-35b

35a. OTHER OUTCOMES

Number ____
9 None

Enter the total number of fetuses of any gestational age that were *not* delivered alive. Include all previous pregnancy losses that resulted in other than a live birth.

No other outcomes - Check “None” if this is the first pregnancy for this mother or if all previous pregnancies resulted in live born infants.

Note: Include all losses from previous pregnancies, and if this was a multiple delivery, include all losses that preceded this child in this delivery.

35b. DATE OF LAST OTHER PREGNANCY OUTCOME

MM / YYYY

Enter the date of delivery (month, year) of the last spontaneous or induced loss or ectopic pregnancy, regardless of the length of gestation, if applicable.

Not known - If any part of the date is not known, enter the known information and enter a “?” for the part(s) not known.

None - If the mother had no previous pregnancy losses (item #34a is checked “None”), this item will be blank.

36. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked (IF NONE, ENTER “0”)

Average number of cigarettes or packs of cigarettes smoked per day:

- Three months before pregnancy
- First three months of pregnancy
- Second three months of pregnancy
- Last three months of pregnancy

Enter the average number of cigarettes or the average number of packs of cigarettes smoked for each of the four time periods listed.

Both given - If both the number of cigarettes and the number of packs are listed on the worksheet, enter only the number of cigarettes.

Range - If a range is given on the worksheet, enter only the highest number.

37. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY

Check the box that best describes the principal source of payment for this delivery.

Other - If "Other" is checked, specify the payer.

Not known - If the principal source of payment is not known, enter "Unknown" in the area above the first box.

LIST / DEFINITIONS

Private Insurance Blue Cross/Blue Shield, Aetna, etc.
Medicaid Medicaid program or comparable state program
Self-pay No third party identified
Indian Health Service ..
CHAMPUS/TRICARE ..
Other government
(federal, state, local) ..
Other Third party to pay - not listed above
None No delivery charges to pay

38. DATE LAST NORMAL MENSES BEGAN

MM / DD / YYYY

Enter the exact date (month, day, year) that the last normal menstrual period began.

Part known - Enter the known part(s) of the date and enter a "?" for any part(s) of the date that is not known.

Not known - If no parts of the date are known, enter "Unknown."

39. WAS SYPHILIS SEROLOGY PERFORMED FOR THIS PREGNANCY?

9 Yes 9 No 9 Refused

Check "Yes" or "No" to indicate if a syphilis serology test was done for the infant's mother.

Not done - Check "No" if it was not done but not refused.

Refused - Check "Refused" if the test was not done because it was refused for any reason including religious objection.

MEDICAL AND HEALTH SECTION Complete Each Item

40. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

Check all boxes that apply to the risk factors of the mother during this pregnancy.

- Diabetes - If diabetes is present, check either pre-pregnancy or gestational diabetes. Do not check both.
- Hypertension - If hypertension is present, check either pre-pregnancy or gestational hypertension. Do not check both.
- Previous cesarean - If the mother has had a cesarean delivery in a previous pregnancy, indicate the number of previous cesarean deliveries she has had.
- None / Not listed - If the mother has none of the risk factors identified in this list, check "None of the above."

LIST / DEFINITIONS

- Diabetes: Glucose intolerance requiring treatment
 - Pre-pregnancy (diagnosis prior to this pregnancy) ..
 - Gestational (diagnosis during this pregnancy) ..
- Hypertension: Elevation of blood pressure above normal for age, gender, and physiological condition
 - Pre-pregnancy (chronic) Diagnosis prior to this pregnancy
 - Gestational (PIH, preeclampsia, eclampsia).
 - Diagnosis during this pregnancy (PIH = Pregnancy-induced hypertension)
- Previous preterm birth History of pregnancy (ies) terminating in a live birth of less than 37 completed weeks of gestation

Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) History of pr

- resulting in any of the listed outcomes:
 - Perinatal death (including fetal and neonatal deaths)
 - Small for gestational age
 - Intrauterine-growth-restricted birth

Vaginal bleeding during this pregnancy prior to the onset of labor.
 Any vaginal bleeding occurring at any time in the pregnancy prior to the onset of labor

Pregnancy resulted from infertility treatment
 Any assisted reproduction treatment used to initiate the pregnancy.

- Includes:
- Artificial insemination
 - Drugs (e.g., Clomid, Pergonal)
 - Technical procedures (e.g., in-vitro fertilization)

Mother had a previous cesarean delivery
 Previous operative delivery by extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls

If yes, how many? ..
 None of the above ..

41. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

Check all boxes that apply to infections that were present and/or were treated during this pregnancy.

(Infections present at the time of pregnancy diagnosis or confirmed diagnosis during the pregnancy, with or without documentation of treatment. Documentation of treatment is adequate if a definitive diagnosis is not present in the available record.)

Other infection - If an infection was present and/or treated during this pregnancy that is not identified in the list, check "Other" and specify the infection(s) on the line provided.

No infection - If no infections were present and/or treated during this pregnancy, check "None."

LIST / DEFINITIONS

| | | |
|-----------------------|-------|--|
| Gonorrhea | ..... | A positive test/culture for <i>Neisseria gonorrhoeae</i> . |
| Syphilis | ..... | (Also called lues) - A positive test for <i>Treponema pallidum</i> |
| HIV Infection | ..... | A positive test for human immunodeficiency virus (HIV) |
| Herpes Simplex Virus | ..... | (HSV) - A positive test for the herpes simplex virus |
| Chlamydia | ..... | A positive test for <i>Chlamydia trachomatis</i> |
| Listeria | ..... | (LM) - A positive test for <i>Listeria monocytogenes</i> |
| Group B streptococcus | ..... | (GBS) - A positive test for <i>Streptococcus agalactiae</i> or group B streptococcus |
| Cytomegalovirus | ..... | (CMV) - A positive test for <i>Cytomegalovirus</i> |
| Parvovirus | ..... | (B19) - A positive test for Parvovirus B19 |
| Toxoplasmosis | ..... | (Toxo) - A positive test for <i>Toxoplasma gondii</i> |
| 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 |
| Other (Specify) | .. | |
| None | .. | |

42. OBSTETRIC PROCEDURES (Check all that apply)

Check all boxes that apply to obstetric procedures performed during this pregnancy.

(Medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.)

External cephalic version - If external cephalic version procedure was done, check whether the procedure was a success or a failure.

Not listed - If the mother did not have any of the procedures identified, check "None of the above."

LIST / DEFINITIONS

| | | |
|-------------------|-------|--|
| Cervical cerclage | ..... | Circumferential banding or suture of the cervix to prevent or treat passive dilation. Includes: MacDonald's suture, Shirodkar procedure, abdominal cerclage via laparotomy |
| Tocolysis | ..... | Administration of any agent with the intent to inhibit preterm uterine contractions to extend the length of the pregnancy. Medications: <ul style="list-style-type: none"> - Magnesium sulfate (for preterm labor) - Terbutaline |

External cephalic version:
 - Indocin (for preterm labor)
 Attempted conversion of a fetus from a non-vertex presentation to a vertex presentation by external manipulation
 Successful Fetus was converted to a vertex presentation
 Failed Fetus was not converted to a vertex presentation
 None of the above ..

43. ONSET OF LABOR (Check all that apply)

Check all descriptions of labor that apply to this delivery. (Prolonged labor and precipitous labor should not both be checked.)

Not listed - If none of the descriptions of labor identified in the list apply to this delivery, check "None of the above."

LIST / DEFINITIONS

Premature rupture of the membranes (prolonged, \geq 12 hrs.)
 Spontaneous tearing of the amniotic sac (natural breaking of the bag of waters), 12 hours or more before labor begins
 Precipitous labor (< 3 hrs.) Labor that progresses rapidly and lasts for less than 3 hours
 Prolonged labor (\geq 20 hrs.) Labor that progresses slowly and lasts for 20 hours or more
 None of the above ..

44. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

Check all characteristics that apply to this labor and delivery.

Not listed - If none of the characteristics identified in the list pertain to this labor and delivery, check "None of the above."

LIST / DEFINITIONS

Induction of labor Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor
 Augmentation of labor Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery
 Non-vertex presentation Includes any non-vertex fetal presentation (e.g., breech, shoulder, brow, face presentations) or transverse lie, in the active phase of labor or at the delivery
Note: Non-vertex is presentation of *other than* the upper and back part of the infant's head. Vertex is presentation of the upper or back part of the infant's head
 Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
 Medications given *before* the delivery. Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to the mother as an anti-inflammatory treatment
 Antibiotics received by the mother during labor
 Medications received 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, Cefataxime, Ceftriaxone, etc.

Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{EC}$ (100.4 $^{\circ}\text{EF}$) . . .

..... 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, and fetal tachycardia. Any recorded maternal temperature at or above 38 $^{\circ}\text{EC}$ (100.4 $^{\circ}\text{EF}$)

Moderate/heavy meconium staining of the amniotic fluid

..... Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or delivery that is more than enough to cause a greenish color change of an otherwise clear fluid

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

..... *In-utero resuscitative measures* such as any of the following: maternal position change, oxygen administration to the mother, intravenous fluids administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents. *Further fetal assessment* includes any of the following: scalp pH, scalp stimulation, acoustic stimulation. *Operative delivery*: operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery

Epidural or spinal anesthesia during labor

..... Administration to the mother of a regional anesthetic for control of the pain of labor (delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body)

None of the above ..

45. METHOD OF DELIVERY

(The physical process by which the complete delivery of the fetus was affected.)

Complete every section: A, B, C, and D.

A. Was delivery with forceps attempted but unsuccessful? 9Yes 9No

(Obstetric forceps were applied to the fetal head in an unsuccessful attempt at vaginal delivery.)

Check "Yes" or "No" to indicate if delivery with forceps was attempted but was not successful.

B. Was delivery with vacuum extraction attempted but unsuccessful? 9Yes 9No

(Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)

Check "Yes" or "No" to indicate if delivery with vacuum extraction was attempted but was not successful.

C. Fetal presentation at birth (Check one)

Check the appropriate box that describes the fetal presentation at the time of delivery.

LIST / DEFINITION:

- Cephalic Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP) (face, brow, sinciput, mentum - chin)
- Breech Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech (buttocks, sacrum)
- Other Any other presentation not listed above, including shoulder, transverse lie, funis, compound

D. Final route and method of delivery (Check one)

Check the final route and method of delivery for this birth.

Cesarean - If "Cesarean" is checked, also check "Yes" or "No" to indicate if a trial of labor was attempted.

Enter "Unknown" after the "No" option if not known whether a trial of labor was attempted.

LIST / DEFINITIONS

- 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 entire fetus 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? 9Yes 9No
..... Labor was allowed, augmented, or induced with plans for a vaginal delivery

46. MATERNAL MORBIDITY (complications associated with labor and delivery) (Check all that apply)

Check all serious medical complications experienced by the mother, associated with this labor and delivery.

None / Not listed - If none of the complications identified in this list pertain to this labor and delivery, check "None of the above."

LIST / DEFINITIONS

- Maternal transfusion Includes infusion of whole blood or packed red blood cells associated with labor and delivery
- Third or fourth degree perineal laceration
..... 3E laceration extends completely through the perineal skin, vaginal mucosa, perineal body, and anal sphincter; 4E laceration is all of the above with extension through the rectal mucosa
- Ruptured uterus Tearing of the uterine wall

- Unplanned hysterectomy Surgical removal of the uterus that was not planned prior to the mother's 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 or unit designated as providing intensive care (ICU - Intensive Care Unit, MICU - Medical Intensive Care Unit, SICU - Surgical Intensive Care Unit)
- Unplanned operating room procedure following delivery
 Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery; *excludes* postpartum tubal ligations
- None of the above ..

47. MOTHER'S MEDICAL RECORD NUMBER

Enter the mother's medical record number on file with your facility.

No number - If the mother has no medical record number for reasons such as a home birth, leave blank.

MEDICAL AND HEALTH SECTION Complete Each Item

48. NEWBORN'S MEDICAL RECORD NUMBER

Enter the medical record number assigned to the infant.

No number - If the infant has no medical record number for reasons such as a home birth, leave blank.

49. BIRTH WEIGHT (Check unit, grams preferred)

9 grams OR 9 lb/oz

Enter the birth weight as recorded in the hospital or birth attendant's record, in either grams or pounds and ounces. Check the type of measure used. (The use of grams is preferred.)

Note: If the weight in grams is not available, enter the birth weight in pounds and ounces. Do not convert from pounds and ounces to grams.

50. OBSTETRIC ESTIMATE OF GESTATION

(completed weeks)

Enter the obstetric estimate of the infant's gestation in completed weeks, based on the birth attendant's final estimate of gestation. (The estimate of gestation should be determined by all perinatal factors and assessments such as ultrasound, but not the neonatal exam.)

Not known - If the obstetric estimate of gestation is not known, enter "Unknown."

Do not complete this item based on the infant's date of birth and the mother's date of last menstrual period.

51. APGAR SCORE

(A systematic measure for evaluating the physical condition of the infant at specific intervals following birth.)

Score at 5 minutes

Enter the Apgar score (0 through 10) as assigned by the delivery room personnel five (5) minutes after birth.

Enter the score at ten (10) minutes only if this score is less than six (6).

If 5 minute score is less than 6,

Score at 10 minutes

Enter the Apgar score (0 through 10) as assigned by the delivery room personnel ten (10) minutes after birth, if the (five) 5 minute score is less than six (6).

Note: If the (five) 5 minute Apgar score was six (6) or greater, this score should be left blank.

52. PLURALITY (single, twin, triplet, etc.) (Specify)

Specify the birth as single, twin, triplet, quadruplet, etc., based upon the number of fetuses (live or dead) delivered at any time in this pregnancy, regardless of gestational age.

Reabsorbed fetuses - "Reabsorbed" fetuses (those that are not delivered, expelled, or extracted from the mother) should not be counted.

When a plural delivery occurs, prepare and file a separate certificate of birth or stillbirth for each child or fetus as applicable. (Make sure you have accounted for each one of the birth set with Vital Statistics.)

53. IF NOT SINGLE BIRTH (born first, second, third, etc.) (Specify)

Specify the order in which this child was born -- first, second, etc. (Include all live births and fetal deaths from this pregnancy.)

Single birth - If this is a single birth, leave the item blank.

54. IS INFANT BEING BREASTFED?

9 Yes 9 No

(The action of breast-feeding or pumping (expressing) milk, not the intent to breast-feed.)

Check "Yes" or "No" to indicate if the infant is being breastfed.

55. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)

Check all abnormal conditions (disorders or significant morbidity) of the newborn that apply.

None / Not listed - If the infant has none of the abnormal conditions identified in the list, check "None of the above."

LIST / DEFINITIONS

- 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 oxygen only and laryngoscopy for aspiration of meconium
- Assisted ventilation required for more than 6 hours
..... Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours; includes conventional, high frequency, and/or continuous positive pressure (CPAP)
- 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 treating 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 (penicillin, ampicillin, gentamicin, cefotaxime, etc.) given systemically (intravenous or intramuscular)
- Seizure or serious neurologic dysfunction
..... Seizure -- Any involuntary repetitive, convulsive movement or behavior
..... Serious neurologic dysfunction -- Severe alteration of alertness Excludes: - Lethargy or hypotonia in the absence of other neurologic findings; symptoms associated with CNS congenital anomalies
- Significant birth injury (skeletal fractures, peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
..... Present immediately following or soon after delivery
..... Includes any bony fracture or weakness or loss of sensation, but excludes fractured clavicles and transient facial nerve palsy
..... Soft tissue hemorrhage requiring subgaleal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial, and/or extremity ecchymosis accompanied by evidence of anemia and/or hypovolemia and/or hypotension
..... Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma
- Failed newborn hearing test ..
None of the above ..

56. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)

Check all congenital anomalies of the newborn that apply. Include all malformations of the newborn diagnosed prenatally or after delivery. Do not include birth injuries.

- Down syndrome - Check the appropriate box if a diagnosis of Down syndrome, Trisomy 21, is confirmed or pending.
- Other chromosomal disorder - Check the appropriate box if a diagnosis of a suspected chromosomal disorder is confirmed or pending, other than Down syndrome.
- None / Not listed - If the child has none of the anomalies identified in this list, check "None of the above."

LIST / DEFINITIONS

- Anencephaly Partial or complete absence of the brain and skull; also called anencephalus, acrania, or absent brain; includes craniorachischisis (anencephaly with a contiguous spine defect)
- Meningomyelocele/Spina bifida
..... Meningomyelocele - herniation of meninges and spinal cord tissue; also includes meningocele (herniation of meninges without spinal cord tissue)
Spina bifida - herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges)
Both open and closed (covered with skin) lesions should be included
- Cyanotic congenital heart disease
..... Congenital heart defects that 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, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis [see below]), although this sac may rupture. Also called exomphalos. Does not include umbilical hernia (completely covered by skin)
- 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 the absence of a protective membrane)
- Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
..... Complete or partial absence of a portion of extremity, secondary to failure to develop; excludes congenital amputation and dwarfing syndromes
- 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 "Cleft lip with or without cleft palate"*)
- Down syndrome: (Karyotype confirmed Karyotype pending)

..... Trisomy 21, a chromosomal disorder
Suspected other chromosomal disorder: (Karyotype confirmed Karyotype pending) . . .

..... Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure; this category excludes Down syndrome
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)
- Third degree (on the penile shaft)

None of the above ..

57. WAS AN APPROVED PROPHYLACTIC AGENT USED IN INFANT'S EYES?

Yes No If "No", reason: ____

Check "Yes" or "No" to indicate if a proven germicide was applied to the infant's eyes.

No germicide - Check "No" if this was not done and specify the reason, such as died, transferred, or religious objection.

58. WAS SAMPLE COLLECTED FOR NEWBORN METABOLIC SCREENING TESTS?

Yes No If "No", reason: ____

Check "Yes" or "No" to indicate if a blood sample was taken from the infant for metabolic screening tests (including PKU).

No sample taken - Check "No" if a blood sample was not taken and specify the reason, such as died, transferred, or religious objection.

59. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY?

Yes No

IF "YES", NAME OF FACILITY INFANT TRANSFERRED TO: ____

Check "Yes" or "No" to indicate if the infant was transferred to another medical facility (hospital or freestanding birthing center) within 24 hours of birth.

Transfers include hospital to hospital, birth facility to hospital, etc. Transfers do not include home to hospital or home to freestanding birthing center.

Home birth - Check "No" if the infant was born at home.

-- IF "YES", NAME OF FACILITY INFANT TRANSFERRED TO:

If "Yes" is checked, enter on the line provided the name of the medical facility the infant was transferred to.

Not known - If the name of the facility is not known, enter "Unknown."

Multiple transfers - If the infant was transferred more than once, enter the name of the first facility to which the infant was transferred.

60. IS INFANT LIVING AT TIME OF REPORT?

9 Yes 9 No 9 Infant transferred, status unknown

Check "Yes" or "No" to indicate if the infant is living at the time this birth certificate is completed.

Living - Check "Yes" if the infant is living.

Died - Check "No" if it is known that the infant has died.

Discharged - Check "Yes" if the infant has already been discharged to home care.

Transferred - If the status of the infant is not known because it was transferred to a different facility, check "Infant transferred, status unknown." If the status of the infant is known, indicate accordingly.

PATERNITY AFFIDAVIT

If the original completed paternity affidavit or a certified copy of the court determination of paternity or non-paternity is not in the possession of the person completing the birth certificate, the certificate must be filed without the natural father's information. The parents will then need to work with **Vital Statistics**.

ADOPTION

If the child is to be adopted, type or print "Adoption Pending" on the front of the birth certificate in the lower left margin of the Medical and Health Section.

DIED

If the infant died, type or print "Baby Died" on the front of the birth certificate in the lower left margin of the Medical and Health Section.

BLANK ITEMS

All items must be completed or accounted for; blank items not accounted for will be queried or the certificate may be returned to the certifier for completion.

MEDICAL AND HEALTH INFORMATION REFUSED

The medical and health use information is legally required. If the informant refuses to provide information to complete the items in these sections of the birth certificate, note on the certificate that this information has been refused. However, certification is not possible without some of these items, such as mother's marital status and paternity acknowledgment.

TRANSMITTAL

The Local Registrar should forward (as legally required) all properly completed original Certificates of Live Birth to **Vital Statistics** within five (5) working days with a transmittal report form. (A copy of the transmittal report form is available online at www.vitalrecords.dhw.idaho.gov.)

Each birth certificate should be screened before being mailed to **Vital Statistics** in the preaddressed, postage-paid envelopes supplied for that purpose. It is extremely important that all birth certificates reach **Vital Statistics** promptly in order that requests for copies can be processed quickly and the Social Security Administration notified of the birth so the child can receive a Social Security number. It is also important, however, that the certificates are complete and accurate when they are received by **Vital Statistics** so that further delay is avoided.

A completed transmittal report form indicating the number of birth, death, and stillbirth certificates being sent should accompany each batch of certificates sent to **Vital Statistics**.

Birth, death, and stillbirth certificates must be listed on separate transmittal forms.

When a new year begins, watch the dates of birth carefully, the old year births must be listed on separate transmittal forms than the new year births.