HOMEBIRTH WORKSHEET ONLY

NOT A LEGAL CERTIFICATE OF LIVE BIRTH

HOMEBIRTH WORKSHEET ONLY

Complete each item -- If information is not known, enter "Unknown" Certificates are to be filed within 15 days of birth

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)
2. TIME OF BIRTH (24hr)
3. SEX
4. DATE OF BIRTH (Mo/Day/Yr)
5. FACILITY NAME (If not facility, give street and number)
6. CITY, TOWN, OR LOCATION OF BIRTH
7. COUNTY OF BIRTH

MOTHER

TYPE/PRINT IN PERMANENT BLACK INK

FOR INSTRUCTIONS SEE HANDBOOK

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
8b. DATE OF BIRTH (Mo/Day/Yr)
8c. MOTHER'S MAIDEN NAME (First, Middle, Last, Suffix)
8d. BIRTHPLACE (State, Territory, or Foreign Country)
9a. RESIDENCE OF MOTHER - STATE
9b. COUNTY
9c. CITY, TOWN, OR LOCATION
9d. STREET AND NUMBER
9e. APT. NO.
9f. ZIP CODE
9g. INSIDE CITY LIMITS? ☐ Yes ☐ No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. BIRTHPLACE (State, Territory, or Foreign Country)

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)▶

CERTIFIER

12a. CERTIFIER'S NAME (Type or print)

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

WAS THE CERTIFIER LISTED ABOVE PRESENT AT THE CHILD'S DELIVERY?
☐ Yes ☐ No If "NO", Item 26 MUST be completed

12c. CERTIFIER'S TITLE
☐ MD ☐ DO ☐ Hospital Administrator
☐ CNM/CM ☐ Other Midwife ☐ Other (Specify)_____

INFORMATION FOR MEDICAL AND HEALTH USE ONLY - COMPLETE EACH ITEM

ADMINISTRATIVE USE ONLY

13. MOTHER'S MAILING ADDRESS: ☐ Same as residence, OR: State _____ City, Town, or Location _____
Street and Number _____ Apartment Number _____ Zip Code _____

14. MOTHER MARRIED? (at birth, conception, or any time between) ☐ Yes ☐ No
IF "NO", HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED? ☐ Yes ☐ No

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

16. MOTHER'S SOCIAL SECURITY NUMBER

17. FATHER'S SOCIAL SECURITY NUMBER

18. CONSENT OBTAINED FOR IMMUNIZATION REGISTRY ENROLLMENT? ☐ Yes ☐ No

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)
1☐ 8th grade or less (includes none)
2☐ 9th-12th grade, but no diploma
3☐ High school graduate or GED completed
4☐ Some college credit, but no degree
5☐ Associate degree (eg, AA, AS)
6☐ Bachelor's degree (eg, AB, BA, BS)
7☐ Master's degree (eg, MA, MBA, MEd, MEng, MS, MSW)
8☐ Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)

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)
0☐ No, not Spanish/Hispanic/Latina
1☐ Yes, Mexican, Mexican American, Chicana
2☐ Yes, Puerto Rican
3☐ Yes, Cuban
4☐ Yes, other Spanish/Hispanic/Latina
(Specify) _____

21. MOTHER'S RACE
(Check one or more races to indicate what the mother considers herself to be)
01☐ White
02☐ Black or African American
03☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
04☐ Asian Indian
05☐ Chinese
06☐ Filipino
07☐ Japanese
08☐ Korean
09☐ Vietnamese
10☐ Other Asian (Specify) _____
11☐ Native Hawaiian
12☐ Guamanian or Chamorro
13☐ Samoan
14☐ Other Pacific Islander (Specify) _____
15☐ 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)
1☐ 8th grade or less (includes none)
2☐ 9th-12th grade, but no diploma
3☐ High school graduate or GED completed
4☐ Some college credit, but no degree
5☐ Associate degree (eg, AA, AS)
6☐ Bachelor's degree (eg, AB, BA, BS)
7☐ Master's degree (eg, MA, MBA, MEd, MEng, MS, MSW)
8☐ Doctorate or professional degree (eg, DDS, DO, DVM, EdD, JD, LLB, MD, PhD)

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)
0☐ No, not Spanish/Hispanic/Latino
1☐ Yes, Mexican, Mexican American, Chicano
2☐ Yes, Puerto Rican
3☐ Yes, Cuban
4☐ Yes, other Spanish/Hispanic/Latino
(Specify) _____

24. FATHER'S RACE
(Check one or more races to indicate what the father considers himself to be)
01☐ White
02☐ Black or African American
03☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
04☐ Asian Indian
05☐ Chinese
06☐ Filipino
07☐ Japanese
08☐ Korean
09☐ Vietnamese
10☐ Other Asian (Specify) _____
11☐ Native Hawaiian
12☐ Guamanian or Chamorro
13☐ Samoan
14☐ Other Pacific Islander (Specify) _____
15☐ Other (Specify) _____

25. PLACE WHERE BIRTH OCCURRED (Check one)
☐ Hospital
☐ Freestanding birthing center
☐ Home birth
Planned to deliver at home? ☐ Yes ☐ No
☐ Clinic/Doctor's office
☐ Other (Specify) _____

26. ATTENDANT'S NAME AND TITLE
NAME _____
TITLE ☐ MD ☐ DO ☐ CNM/CM ☐ Other Midwife
☐ Other (Specify) _____

ATTENDANT REQUIRED ONLY IF CERTIFIER WAS NOT PRESENT AT BIRTH, BUT ARRIVED IMMEDIATELY AFTER THE BIRTH.

COMPLETE REVERSE SIDE

MEDICAL AND HEALTH SECTION Complete Each Item

28a. DATE OF FIRST PRENATAL CARE VISIT
___/___/_____ ☐ No prenatal care
MM DD YYYY

28b. DATE OF LAST PRENATAL CARE VISIT
___/___/_____ ☐ No prenatal care
MM DD YYYY

29. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
_____ (IF NONE, ENTER "0")

30. MOTHER'S HEIGHT
_____ (feet/inches)

31. MOTHER'S PREPREGNANCY WEIGHT
_____ (pounds)

32. MOTHER'S WEIGHT AT DELIVERY
_____ (pounds)

33. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?
☐ Yes ☐ No

PREGNANCY HISTORY (Complete each section)

PREVIOUS LIVE BIRTHS (Do not include this child)
Complete items 34a-34c

34a. Now Living
Number _____
☐ None

34b. Now Dead
Number _____
☐ None

OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)
Complete items 35a-35b

35a. Other Outcomes
Number _____
☐ None

34c. DATE OF LAST LIVE BIRTH
___/_____
MM YYYY

35b. DATE OF LAST OTHER PREGNANCY OUTCOME
___/_____
MM YYYY

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:

	# OF CIGARETTES		# OF PACKS
Three months before pregnancy	_____	OR	_____
First three months of pregnancy	_____	OR	_____
Second three months of pregnancy	_____	OR	_____
Last three months of pregnancy	_____	OR	_____

37. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
1☐ Private insurance
2☐ Medicaid
3☐ Self-pay
4☐ Indian Health Service
5☐ CHAMPUS/TRICARE
6☐ Other government (federal, state, local)
7☐ Other
9☐ None

38. DATE LAST NORMAL MENSES BEGAN
___/___/_____
MM DD YYYY

39. WAS SYPHILIS SEROLOGY PERFORMED FOR THIS PREGNANCY?
☐ Yes ☐ No ☐ Refused

MEDICAL AND HEALTH SECTION Complete Each Item

40. RISK FACTORS IN THIS PREGNANCY (Check all that apply)
Diabetes:
01☐ Prepregnancy (diagnosis prior to this pregnancy)
02☐ Gestational (diagnosis in this pregnancy)
Hypertension:
03☐ Prepregnancy (chronic)
04☐ Gestational (PIH, preeclampsia, eclampsia)
05☐ Previous preterm birth
06☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
07☐ Vaginal bleeding during this pregnancy prior to the onset of labor
08☐ Pregnancy resulted from infertility treatment
09☐ Mother had a previous cesarean delivery
If yes, how many? _____
00☐ None of the above

41. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
01☐ Gonorrhea
02☐ Syphilis
03☐ HIV Infection
04☐ Herpes Simplex Virus (HSV)
05☐ Chlamydia
06☐ Listeria
07☐ Group B Streptococcus
08☐ Cytomegalovirus
09☐ Parvovirus
10☐ Toxoplasmosis
11☐ Hepatitis B
12☐ Hepatitis C
13☐ Other
(Specify)_____
00☐ None

42. OBSTETRIC PROCEDURES (Check all that apply)
1☐ Cervical cerclage
2☐ Tocolysis
External cephalic version:
3☐ Successful
4☐ Failed
0☐ None of the above

43. ONSET OF LABOR (Check all that apply)
1☐ Premature rupture of the membranes (prolonged, ≥12 hrs.)
2☐ Precipitous labor (<3 hrs.)
3☐ Prolonged labor (≥20 hrs.)
0☐ None of the above

44. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
01☐ Induction of labor
02☐ Augmentation of labor
03☐ Non-vertex presentation
04☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
05☐ Antibiotics received by the mother during labor
06☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
07☐ Moderate/heavy meconium staining of the amniotic fluid
08☐ 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
09☐ Epidural or spinal anesthesia during labor
00☐ None of the above

45. METHOD OF DELIVERY
A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No
B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No
C. Fetal presentation at birth (Check one)
☐ Cephalic
☐ Breech
☐ Other
D. 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

46. MATERNAL MORBIDITY (complications associated with labor and delivery) (Check all that apply)
1☐ Maternal transfusion
2☐ Third or fourth degree perineal laceration
3☐ Ruptured uterus
4☐ Unplanned hysterectomy
5☐ Admission to intensive care unit
6☐ Unplanned operating room procedure following delivery
0☐ None of the above

47. MOTHER'S MEDICAL RECORD NUMBER

MEDICAL AND HEALTH SECTION Complete Each Item

48. NEWBORN'S MEDICAL RECORD NUMBER

49. BIRTH WEIGHT (Check unit, grams preferred)
☐ grams
OR
☐ lb/oz _____

50. OBSTETRIC ESTIMATE OF GESTATION
_____ (completed weeks)

51. APGAR SCORE
Score at 5 minutes _____
If 5 minute score is less than 6,
Score at 10 minutes _____

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

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

54. IS INFANT BEING BREASTFED?
☐ Yes ☐ No

55. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
1☐ Assisted ventilation required immediately following delivery
2☐ Assisted ventilation required for more than six hours
3☐ NICU admission
4☐ Newborn given surfactant replacement therapy
5☐ Antibiotics received by the newborn for suspected neonatal sepsis
6☐ Seizure or serious neurologic dysfunction
7☐ Significant birth injury (skeletal fracture, peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
8☐ Failed newborn hearing test
9☐ None of the above

56. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
01☐ Anencephaly
02☐ Meningomyelocele/Spina bifida
03☐ Cyanotic congenital heart disease
04☐ Congenital diaphragmatic hernia
05☐ Omphalocele
06☐ Gastroschisis
07☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
08☐ Cleft lip with or without cleft palate
09☐ Cleft palate alone
Down syndrome:
10☐ Karyotype confirmed
11☐ Karyotype pending
Suspected other chromosomal disorder:
12☐ Karyotype confirmed
13☐ Karyotype pending
14☐ Hypospadias
00☐ None of the above

57. WAS AN APPROVED PROPHYLACTIC AGENT USED IN INFANT'S EYES?
☐ Yes ☐ No If "No", reason: _____

58. WAS SAMPLE COLLECTED FOR NEWBORN METABOLIC SCREENING TESTS?
☐ Yes ☐ No If "No", reason: _____

59. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No
IF "YES", NAME OF FACILITY INFANT TRANSFERRED TO:
_____

60. IS INFANT LIVING AT TIME OF REPORT?
☐ Yes ☐ No ☐ Infant transferred, status unknown