

U.S. STANDARD CERTIFICATE OF LIVE BIRTH

LOCAL FILE NO.

BIRTH NUMBER:

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 institution, give street and number)		6. CITY, TOWN, OR LOCATION OF BIRTH		7. COUNTY OF BIRTH
MOTHER	8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		8b. DATE OF BIRTH (Mo/Day/Yr)		
	8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (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)	
CERTIFIER	11. CERTIFIER'S NAME: _____		12. DATE CERTIFIED ____/____/____		13. DATE FILED BY REGISTRAR ____/____/____
	TITLE: ☐ MD ☐ DO ☐ HOSPITAL ADMIN. ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (Specify) _____				
MOTHER	INFORMATION FOR ADMINISTRATIVE USE				
	14. MOTHER'S MAILING ADDRESS: ☐ Same as residence, or: State: _____ City, Town, or Location: _____ Street & Number: _____ Apartment No.: _____ Zip Code: _____				
	15. MOTHER MARRIED? (At birth, conception, or any time between) ☐ Yes ☐ No IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED IN THE HOSPITAL? ☐ Yes ☐ No		16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? ☐ Yes ☐ No		17. FACILITY ID. (NPI)
MOTHER	18. MOTHER'S SOCIAL SECURITY NUMBER:		19. FATHER'S SOCIAL SECURITY NUMBER:		
	INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY				
	20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery) ☐ 8th grade or less ☐ 9th - 12th grade, no diploma ☐ High school graduate or GED completed ☐ Some college credit but no degree ☐ Associate degree (e.g., AA, AS) ☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina) ☐ No, not Spanish/Hispanic/Latina ☐ Yes, Mexican, Mexican American, Chicana ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latina (Specify) _____	22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be) ☐ 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) _____		
23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery) ☐ 8th grade or less ☐ 9th - 12th grade, no diploma ☐ High school graduate or GED completed ☐ Some college credit but no degree ☐ Associate degree (e.g., AA, AS) ☐ Bachelor's degree (e.g., BA, AB, BS) ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)	24. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if mother is not Spanish/Hispanic/Latino) ☐ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (Specify) _____	25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be) ☐ White ☐ Black or African American ☐ American Indian or Alaska Native (Name of 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) _____			
FATHER	26. 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) _____		27. ATTENDANT'S NAME, TITLE, AND NPI NAME: _____ NPI: _____ TITLE: ☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (Specify) _____		28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: _____

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Mother's Name _____

Mother's Medical Record No. _____

MOTHER	29a. DATE OF FIRST PRENATAL CARE VISIT MM / DD / YYYY ☐ No Prenatal Care		29b. DATE OF LAST PRENATAL CARE VISIT MM / DD / YYYY		30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY _____ (If none, enter "0".)			
	31. MOTHER'S HEIGHT _____ (feet/inches)		32. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)		33. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)			
	34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No		35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)		36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)			
	37. 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 _____ # of cigarettes OR # of packs First Three Months of Pregnancy _____ OR _____ Second Three Months of Pregnancy _____ OR _____ Last Three Months of Pregnancy _____ OR _____		38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY ☐ Private Insurance ☐ Medicaid ☐ Self-pay ☐ Other (Specify) _____					
35a. Now Living Number _____ ☐ None		35b. Now Dead Number _____ ☐ None		36a. Other Outcomes Number _____ ☐ None		35c. DATE OF LAST LIVE BIRTH MM / YYYY		
36b. DATE OF LAST OTHER PREGNANCY OUTCOME MM / YYYY		39. DATE LAST NORMAL MENSES BEGAN MM / DD / YYYY		40. MOTHER'S MEDICAL RECORD NUMBER				
MEDICAL AND HEALTH INFORMATION	41. RISK FACTORS IN THIS PREGNANCY (Check all that apply) Diabetes ☐ Prepregnancy (Diagnosis prior to this pregnancy) ☐ Gestational (Diagnosis in this pregnancy) Hypertension ☐ Prepregnancy (Chronic) ☐ Gestational (PIH, preeclampsia, eclampsia) ☐ Previous preterm birth ☐ Other previous poor pregnancy outcome (Includes, perinatal death, small-for-gestational age/intrauterine growth restricted birth) ☐ Vaginal bleeding during this pregnancy prior to the onset of labor ☐ Pregnancy resulted from infertility treatment ☐ Mother had a previous cesarean delivery If yes, how many _____ ☐ None of the above		44. ONSET OF LABOR (Check all that apply) ☐ Premature Rupture of the Membranes (prolonged, >12 hrs.) ☐ Precipitous Labor (<3 hrs.) ☐ Prolonged Labor (> 20 hrs.) ☐ None of the above		46. 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 ☐ 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		47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery) ☐ Maternal transfusion ☐ Third or fourth degree perineal laceration ☐ Ruptured uterus ☐ Unplanned hysterectomy ☐ Admission to intensive care unit ☐ Unplanned operating room procedure following delivery ☐ None of the above	
	42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply) ☐ Gonorrhea ☐ Syphilis ☐ Herpes Simplex Virus (HSV) ☐ Chlamydia ☐ Hepatitis B ☐ Hepatitis C ☐ None of the above		45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply) ☐ Induction of labor ☐ Augmentation of labor ☐ Non-vertex presentation ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery ☐ Antibiotics received by the mother during labor ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{C}$ (100.4°F) ☐ Moderate/heavy meconium staining of the amniotic 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 ☐ Epidural or spinal anesthesia during labor ☐ None of the above					
	43. OBSTETRIC PROCEDURES (Check all that apply) ☐ Cervical cerclage ☐ Tocolysis External cephalic version: ☐ Successful ☐ Failed ☐ None of the above							
NEWBORN INFORMATION								
NEWBORN	48. NEWBORN MEDICAL RECORD NUMBER:		54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply) ☐ Assisted ventilation required immediately following delivery ☐ Assisted ventilation required for more than six hours ☐ NICU admission ☐ Newborn given surfactant replacement therapy ☐ Antibiotics received by the newborn for suspected neonatal sepsis ☐ Seizure or serious neurologic dysfunction ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) ☐ None of the above		55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply) ☐ Anencephaly ☐ Meningomyelocele/Spina bifida ☐ Cyanotic congenital heart disease ☐ Congenital diaphragmatic hernia ☐ Omphalocele ☐ Gastroschisis ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes) ☐ Cleft Lip with or without Cleft Palate ☐ Cleft Palate alone ☐ Down Syndrome ☐ Karyotype confirmed ☐ Karyotype pending ☐ Suspected chromosomal disorder ☐ Karyotype confirmed ☐ Karyotype pending ☐ Hypospadias ☐ None of the anomalies listed above			
	49. BIRTHWEIGHT (grams preferred, specify unit) _____ ☐ grams ☐ 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) _____								
56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: _____		57. IS INFANT LIVING AT TIME OF REPORT? ☐ Yes ☐ No ☐ Infant transferred, status unknown		58. IS INFANT BEING BREASTFED? ☐ Yes ☐ No				

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