Birthing parent's name _____

Birthing parent's medical record # _____

Newborn's medical record # _____

Birth Facility Worksheet

1. **Newborn's Name:** _____ _____ _____ _____
(First) (Middle) (Current last) (Suffix: Jr., III, etc.)

CHILD

2. **Date of birth:** _____/_____/_____
MM DD YYYY
3. **Time of birth:** _____ ☐ AM ☐ PM
4. **Sex:** ☐ Male ☐ Female
5. ☐ **Gestational carrier birth**
6. **Plurality (single twin, triplet, etc.)**
☐ Specify _____
Birth Order (born first, second, third, etc.)
☐ Specify _____
7. **Is newborn living at the time of report?**
☐ Yes
☐ No
☐ Newborn transferred and status is unknown
8. **Adoption pending:**
☐ Yes
☐ No
☐ Unknown

BIRTHING PARENT HEALTH

9. **Birthing parent's weight at delivery:** _____ (pounds)

PRENATAL

10. **Principle source of payment:**
☐ Private insurance
☐ Medicaid
☐ Self-pay
☐ Unknown
☐ Other – specify _____
11. **Date last normal menses began:** _____/_____/_____
MM DD YYYY
12. **Prenatal Care**
☐ No prenatal care
12(a). Date of first prenatal care visit: _____/_____/_____
MM DD YYYY
12(b). Total number of prenatal care visits for this pregnancy
Number _____
13. **Previous live births** *(does not include this newborn)*
13(a). Number now living: _____ (If 2nd born twin, include 1st born here if alive.)
☐ None
13(b). Number now deceased: _____(Do not include stillborn/fetal deliveries here.)
☐ None
13(c). Date of last live birth: _____/_____/_____
MM DD YYYY
14. **Other pregnancy outcomes** - Spontaneous losses, induced losses and/or ectopic pregnancies.
14(a). Number of other pregnancy outcomes: _____
(If 2nd born twin, include 1st born here if stillborn.)
☐ None
14(b). Date of last other pregnancy outcome: _____/_____/_____
MM DD YYYY

PREGNANCY FACTORS

15. **Risk factors in this pregnancy** (Check all that apply.)
Diabetes (Do not check both.)
☐ Pre-pregnancy (diagnosis prior to this pregnancy)
☐ Gestational (diagnosis in this pregnancy)
Hypertension (Do not check both.)
☐ Pre-pregnancy – (chronic)
☐ Gestational – (pregnancy-induced hypertension or preeclampsia)
☐ Eclampsia
☐ Previous cesarean delivery
☐ If yes, how many _____
☐ Infertility treatment
☐ Fertility drugs, artificial/intrauterine insemination
☐ Assisted reproductive technology (e.g., IVF, GIFT)
☐ Previous preterm births
☐ None of the above
16. **Infections present and/or treated during this pregnancy**
(Check all that apply)
☐ Gonorrhea
☐ Syphilis
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ COVID-19 (SARS-CoV-2 -- confirmed or presumed)
☐ None of the above
17. **Obstetrical Procedures**
☐ External cephalic version
☐ Successful
☐ Failed
☐ None of the above

LABOR

18. **Characteristics of labor and delivery** (Check all that apply.)
☐ Induction of labor
☐ Augmentation of labor
☐ Steroids (glucocorticoids) for fetal lung maturation received by the birthing parent prior to delivery.
☐ Antibiotics received by birthing parent during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F)
☐ Epidural or spinal anesthesia during labor
☐ None of the above

DELIVERY

19. **Method of delivery**
Fetal presentation at birth (check one):
☐ Cephalic
☐ Breech
☐ Other
Final route and method of delivery (check one):
☐ Vaginal/spontaneous
☐ Vaginal/forceps
☐ Vaginal/vacuum
☐ Cesarean
If cesarean, was a trial of labor attempted
☐ Yes ☐ No
20. **Maternal Morbidity** (Check all that apply.)
☐ Maternal transfusion
☐ Perineal laceration (3rd or 4th degree)
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care
☐ None of the above

21. **Was the birthing parent transferred from a hospital to this facility for maternal medical or fetal indication for delivery?**
☐ Yes (if yes, name of facility birthing parent transferred from)
_____
☐ No
☐ Unknown

22. **Was newborn transferred within 24 hours of delivery?**
☐ Yes (if yes, name of facility newborn transferred to)
_____
☐ No
☐ Unknown

NEWBORN

23. **Birth weight: (grams preferred, specify unit)**
_____ ☐ grams ☐ lbs/oz

24. **Obstetric estimate of gestation (completed weeks)** _____

25. **Apgar Score**
☐ Score at 5 minutes _____
☐ Score at 10 minutes _____ **(If score at 5 minutes is < 6)**

26. **Is newborn being breastfed?**
☐ Yes

NEWBORN FACTORS

27. **Abnormal condition of the newborn** (Check all that apply.)
☐ Assisted ventilation required immediately following delivery
☐ Assisted ventilation required for more than 6 hours
☐ NICU admission
☐ Newborn given surfactant replacement therapy
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ None of the above

28. **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 above

ATTENDANT/CERTIFIER

29. **Attendant's name and title**
Name _____
☐ MD ☐ DO
☐ CNM/CM ☐ Lay midwife
☐ Other (specify) _____

30. **Certifiers's name and title**
Name _____
☐ MD ☐ DO
☐ CNM/CM ☐ Lay midwife
☐ Other (specify) _____

IMMUNIZATION

31. **Did newborn receive Hepatitis-B vaccination?**
☐ Yes ☐ No
Hepatitis-B vaccination type?
☐ Hepatitis-B
☐ Hepatitis-B Immune Globulin
If yes, date administered: _____/_____/_____
MM DD YYYY
Manufacturer ☐ GSK ☐ Merck
☐ Other(specify) _____
Lot# _____