Maryland Department of Health and Mental Hygiene

Vital Statistics Administration

Maryland Facility Worksheet for the Live Birth Certificate

To be completed by Facility Staff

- For pregnancies resulting in the births of two or more live-born infants, this worksheet should be completed for the 1st live born infant in the delivery. For each subsequent live-born infant, complete the *"Attachment for Multiple Births."*
- For any fetal loss in the pregnancy reportable under State reporting requirements, complete the *"Facility Worksheet for the Fetal Death Report."* For detailed definitions, instructions, information on sources, and common key words and abbreviations please see *"The Guide to Completing Facility Worksheets for the Certificate of Live Birth."*

Mother's Name:

Mother's Medical Record Number:

Child's Name:

Child's Medical Record Number:

Child Number: ____ **of** ____ **total deliveries (living or stillborn) resulting from this pregnancy**

Child's Sex: ❑ Male ❑ Female ❑ Not Yet Determined

Child's Date of Birth: ____ (Month) ____ (Day) 20____ (Year)

Child Being Placed Up for Adoption? ❑ Yes

Signature of Person Completing Facility Worksheet: _____

SCREEN FACILITY

Did mother have prenatal care?

❑ Yes ❑ No → If NO, go to Question # 8

6a. Date of first prenatal care visit

___ /_____ /_____
Month Day Year

6b. Date of last prenatal care visit

___ /_____ /_____
Month Day Year

7. Total number of prenatal care visits for this pregnancy

_____ total prenatal care visits

8. Date last normal menses began

___ /_____ /_____
Month Day Year

9. Number of previous live births now living — Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child:

_____ ❑ None

SCREEN: FACILITY – (Continued)

10. Number of previous live births now dead — (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):

_____ ❑ None

11. Date of last live birth

____ /_____

Month Year

12. Total number of other pregnancy outcomes — (Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy):

_____ ❑ None → If NONE, go to Question # 14

13. Date of last other pregnancy outcome

____ /_____

Month Year

14. Risk factors in this pregnancy *(Check all that apply)*

- ❑ Diabetes Prepregnancy
- ❑ Diabetes Gestational
- ❑ Hypertension Prepregnancy
- ❑ Hypertension Gestational
- ❑ Eclampsia
- ❑ Previous preterm births
- ❑ Other previous poor pregnancy outcome—Includes peri natal death, small for gestational age/intrauterine growth restricted birth)
- ❑ Previous cesarean delivery → Number _____
- ❑ None of the above

15. Infections present and/or treated during this pregnancy *(Check all that apply)*

- ❑ Gonorrhea
- ❑ Syphilis
- ❑ Chlamydia
- ❑ Hepatitis B
- ❑ Hepatitis C
- ❑ None of the above

SCREEN: LABOR/DELIVERY

16. Obstetric procedures *(Check all that apply)*

- ❑ Cervical cerclage
- ❑ Tocolysis
- ❑ External cephalic version SUCCESSFUL
- ❑ External cephalic version FAILED
- ❑ None of the above

17. Onset of Labor *(Check all that apply):*

- ❑ Premature Rupture of the Membranes (12 hours or more)
- ❑ Precipitous labor (less than 3 hours)
- ❑ Prolonged labor (20 hours or more)
- ❑ None of the above

19. Time of birth:

____ :____ 24 hour clock

20. Certifier's name:

_____

FIRST Name MIDDLE Name(s) LAST Name Suffix

Certifier's title:

- ❑ M.D.
- ❑ D.O.
- ❑ Hospital Admin.
- ❑ CNM/CM
- ❑ Other Midwife
- ❑ Other *(Specify)* _____

21. Date record certified:

____ /_____ /_____

Month Day Year

22. Principal source of payment for this delivery? *(At time of delivery)*

- ❑ Private Insurance
- ❑ Medicaid
- ❑ Self-pay
- ❑ Other *(Specify)* _____

SCREEN LABOR/DELIVERY — (Continued)

23. Infant's Medical Record Number

_____

24. Was mother transferred to this facility for delivery?

❑ Yes ❑ No

If YES, name of facility transferred from:

_____

25. Attendant's name:

_____

FIRST Name MIDDLE Name(s) LAST Name Suffix

Attendant's title:

❑ M.D.
❑ D.O.
❑ CNM/CM
❑ Other Midwife
❑ Other *(Specify)* _____

Attendant's NPI

_____

26. Mother's Weight at Delivery :

_____ (pounds)

27. Characteristics of labor and delivery *(Check ALL that apply)*:

❑ Induction of labor
❑ Augmentation of labor
❑ Non-vertex presentation
❑ Steroids for fetal lung maturation
❑ Antibiotics received by the mother during labor
❑ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F)
❑ Moderate/heavy meconium staining of the amniotic fluid
❑ Fetal intolerance of labor was 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

28. Method of delivery *(Complete A, B, C, and D)*:

❑ (A) Forceps attempted - UNSUCCESSFUL

❑ (B) Vacuum extraction attempted - UNSUCCESSFUL

(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 → trial of labor attempted? ❑ Yes ❑ No

29. Maternal morbidity *(Check all that apply)*:

❑ 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

SCREEN NEWBORN

30. Birthweight *If weight in GRAMS is not available, please indicate LB/OZ. Do not convert lb/oz to grams.*

Grams: _____

OR

Pounds: _____ lb _____ oz

SCREEN: NEWBORN — (Continued)

31. Obstetric estimate of gestation *(completed weeks):*

_____ weeks

33. Apgar score

Score at 5 minutes _____

If 5 minute score is less than 6, Score at 10 minutes _____

34. Plurality *(Include all live births and fetal losses resulting from this pregnancy)*

❑ Single birth (01) → Go to Question # 37

_____ live births and fetal losses from this pregnancy

35. If NOT single birth, order delivered in the pregnancy *(Include all live births and fetal losses resulting from this pregnancy)*

_____ birth order delivered in pregnancy

36. If NOT single birth, specify number of infants in this delivery born ALIVE

_____ infants born ALIVE

37. Abnormal conditions of the newborn— Disorders or signify cant morbidity experienced by 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
- ❑ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage requiring intervention)
- ❑ None of the above

38. Congenital anomalies of the newborn — Malformations of the newborn diagnosed prenatally or after delivery. *Check all that apply:*

- ❑ Anencephaly
- ❑ Meningomyelocele/Spina bifida
- ❑ Cyanotic congenital heart disease
- ❑ Congenital diaphragmatic hernia
- ❑ Omphalocele
- ❑ Gastroschisis
- ❑ Limb reduction (excluding congenital amputation and dwarfing syndromes)
- ❑ Cleft Lip with or without Cleft Palate
- ❑ Cleft Palate alone
- ❑ Down Syndrome - (Trisomy 21)
  - ❑ Karyotype confirmed
  - ❑ Karyotype pending
- ❑ Suspected chromosomal disorder
  - ❑ Karyotype confirmed
  - ❑ Karyotype pending
- ❑ Hypospadias
- ❑ None of the above

39. Was infant transferred within 24 hours of delivery?

❑ Yes ❑ No

If YES, name of facility infant transferred to :

_____

40. Is infant living at time of report?

- ❑ Yes
- ❑ No
- ❑ Infant transferred, status unknown

41. Is infant being breastfed at discharge?

❑ Yes ❑ No