

**Birth Record
FACILITY WORKSHEET**

CHILD							<i>(Page 1 of 2)</i>	
Name	First	Middle	Last	Suffix	Date of Birth	Time of Birth	Sex	
					MM / DD / YYYY		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined	

MOTHER HEALTH			Cigarette Smoking <input type="checkbox"/> Check if none	
Did she get WIC food for herself during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Number per day 3 months before pregnancy # _____ Cigarettes 1 st 3 months of pregnancy # _____ Cigarettes 2 nd 3 months of pregnancy # _____ Cigarettes 3 rd 3 months of pregnancy # _____ Cigarettes	
Height	Weight (Pre-pregnancy)	Weight (At delivery)		
ft in.	lbs	lbs		

Alcohol use during this pregnancy? Yes No If yes, average number of drinks per week? _____

PLACE OF BIRTH					
<input type="checkbox"/> At this facility		<input type="checkbox"/> Home delivery		Was home delivery planned? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<input type="checkbox"/> Other location (specify): _____					
Specify address if not this facility: _____					
No. & Street		Apt/Unit/Space		City	
State		County		ZIP	

PRENATAL	
Mother's Medical Record # (optional): _____ Mother's Medicaid #: _____ Date of Last Menses ____ / ____ / ____ MM DD YYYY	Principal Method of Payment <input type="checkbox"/> Medicaid/Oregon Health Plan <input type="checkbox"/> Champus/Tricare <input type="checkbox"/> Private insurance <input type="checkbox"/> Other government <input type="checkbox"/> Self-pay <input type="checkbox"/> Other: _____ <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Unknown

Prenatal Care <input type="checkbox"/> Check if none Date of 1 st visit ____ / ____ / ____ Total # of visits _____ MM DD YYYY	Previous Live Births # now living _____ # now dead _____ Date of last live birth ____ / ____ MM YYYY
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Other Pregnancy Outcomes (Spontaneous, induced terminations or ectopic pregnancy) Combined # of other outcomes _____ Date of last other outcome ____ / ____ MM YYYY	Mother tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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PREGNANCY FACTORS		
Risk Factors <input type="checkbox"/> Diabetes – Gestational <input type="checkbox"/> Diabetes – Pre-pregnancy <input type="checkbox"/> Hypertension – Pre-pregnancy (Chronic) <input type="checkbox"/> Hypertension – Gestational	<input type="checkbox"/> Hypertension – Eclampsia <input type="checkbox"/> Previous Preterm Births (<37 Completed Wks. Gestation) <input type="checkbox"/> Pregnancy Resulted From Infertility Treatment – Fertility-enhancing drugs	<input type="checkbox"/> Pregnancy Resulted From Infertility Treatment – Assisted Reproductive Technology <input type="checkbox"/> Mother Had A Previous Cesarean Delivery How Many? ____ <input type="checkbox"/> None Of The Above

Mother tested for: <input type="checkbox"/> Syphilis <input type="checkbox"/> Group B Strep	Infections Present and / or Treated <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Syphilis <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Chlamydia <input type="checkbox"/> None of the above	Obstetric Procedures <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> External cephalic version: <input type="checkbox"/> Tocolysis <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the above
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LABOR			
Onset of Labor <input type="checkbox"/> Premature rupture ≥ 12 hours <input type="checkbox"/> Precipitous labor < 3 hours <input type="checkbox"/> Prolonged labor ≥ 20 hours <input type="checkbox"/> None of the above			

Characteristics of Labor and Delivery		
<input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Steroids for fetal lung maturation prior to delivery	<input type="checkbox"/> Antibiotics during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temp. ≥=38C	<input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> Unknown <input type="checkbox"/> None of the above

DELIVERY	
Method of Delivery	
Fetal Presentation at Delivery: <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Final Route and Method of Delivery: <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean <input type="checkbox"/> Unknown	
If Cesarean, was a Trial of Labor Attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Maternal Morbidity (check all that apply)		
<input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus	<input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operating room procedure following delivery	<input type="checkbox"/> None of the above <input type="checkbox"/> Unknown at this time

Mother transferred to this facility prior to delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of facility _____
Infant transferred from this facility after delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of facility _____

Hospital Staff

No individual or agency other than the Center for Health Statistics should be provided with a copy of this worksheet.

