IOWA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Official Worksheet to Establish Legal Certificate of Live Birth

Hospital Medical Worksheet

AFFIX MOM & BABY MEDICAL LABELS HERE

Hospital Name _____

Mother's Medical Record # _____

Infant's Medical Record # _____

Infant's Date of Birth _____

Plurality _____ Birth Order _____

Date Entered in EBRS & Staff _____

Complete this medical worksheet attachment for all live-born infants based on medical records.
For any fetal loss in the pregnancy, see Fetal Death and Termination of Pregnancy reporting requirements.

If the Registration Status (page 4) is marked as any of the following: ADOPTION PENDING, BIRTH MOTHER DOES NOT HAVE CUSTODY, SURROGATE/GESTATIONAL CARRIER BIRTH, OR BIRTH MOTHER INVOKED SAFE HAVEN, the birth mother's worksheet and Medical worksheet must be entered into IVES immediately after completion.

PLACE OF BIRTH INFORMATION – *Obtain from admission history & physical, delivery record, basic admission information, progress notes.*

1. Type of Place Where Birth Occurred *(Check one)* ❑ This hospital ❑ En route to this hospital

PRENATAL

Obtain from prenatal care records and other medical charts

2. Prenatal Care Visits ❑ **No Prenatal Care**

Date of first visit (Mo., Day, Yr.) _____ **Number of prenatal visits** _____

3. Date last normal menses began *(Mo., Day, Yr.)*
Do not enter the same date as the first prenatal visit.

4. Previous live births *(Excludes this child)* ❑ **No Previous Live Births**

a. Now living _____ **b. Now dead** _____ **c. Date of last live birth** (Mo., Day, Yr.) _____
Use the 15th for an unknown "day" if the month and the year are known.

5. Other pregnancy outcomes not resulting in a live birth ❑ **No Other Outcomes**

a. Number of other outcomes _____ **b. Date of last other outcome** (Mo., Day, Yr.) _____
Use the 15th for an unknown "day" if the month and the year are known.

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

Diabetes *(If yes, check only one)*
- ❑ Chronic/Pre-pregnancy *(diagnosis prior to this pregnancy)*
- ❑ Gestational *(diagnosis in this pregnancy)*

Hypertension *(Check pre- or gestational, unless Eclampsia)*
- ❑ Pre-pregnancy *(Chronic)*
- ❑ Gestational *(PIH, pre-eclampsia)*
- ❑ Eclampsia

- ❑ Previous preterm live-born infant
- ❑ Pregnancy resulted from infertility treatment *(If yes, check as applies)*
  - ❑ Fertility-enhancing drugs, artificial insemination, or intrauterine insemination
  - ❑ Assisted reproductive technology *(e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))*
- ❑ Mother had a previous cesarean delivery, **If Yes, Number** _____
- ❑ None of the above are noted in the medical charts

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

- ❑ Gonorrhea – *positive Neisseria gonorrhoeae*
- ❑ Syphilis *(lues)* – *positive Treponema pallidum*
- ❑ Chlamydia – *positive Chlamydia trachomatis*
- ❑ Hepatitis B *(HBV, serum hepatitis)*
- ❑ Hepatitis C *(non A, non B hepatitis (HCV))*
- ❑ Rubella
- ❑ Group B Strep
- ❑ Toxoplasmosis
- ❑ Cytomegalovirus
- ❑ Herpes
- ❑ None of the above are noted in the medical charts

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

❑ Cervical cerclage ❑ External cephalic version *(If yes, check one)* ❑ Successful ❑ Failed
❑ Tocolysis ❑ None of the above are noted in the medical charts

LABOR & DELIVERY

Obtain from labor & delivery record

9. Onset of labor *(Check as applies)*
- ❑ Premature ROM *(prolonged, ≥ 12 hours)*
- ❑ Precipitous labor *(< 3 hours)*
- ❑ Prolonged labor *(≥ 20 hours)*
- ❑ None of the above are noted in the medical charts

10. Infant's date and time of birth **10a. Date of birth** _____ *(Mo., Day, Yr.)* **10b. Time of birth** _____ *(Military time—24 hr. clock. Start of new day = 0000)*

11. Attendant information
- ❑ M.D. ❑ D.O. ❑ CNM/ARNP License # _____
- Name _____
- ❑ Other midwife *(Name)* _____
- ❑ Other *(Title or relationship to child)* _____
- Name _____

12. Certifier information ❑ Same as attendant
- ❑ M.D. ❑ D.O. ❑ CNM/ARNP License # _____
- Name _____
- ❑ Other midwife *(Name)* _____
- ❑ Other *(Title or relationship to child)* _____
- Name _____

Date certified *(Mo., Day, Yr.)* _____

13. Primary source of payment for this delivery *(Check one)*
- ❑ Private insurance
- ❑ Medicaid *(Title XIX)*
- ❑ OB indigent program
- ❑ Self-pay *(No 3rd Party Identified)*
- ❑ Indian Health Service
- ❑ CHAMPUS/TRICARE
- ❑ Other government *(federal, state, local)*
- ❑ Other *(Specify)* _____

LABOR & DELIVERY *PG 2*

Obtain from labor & delivery record

14. Mother transferred from another hospital for maternal medical or fetal indications for delivery ❑ No ❑ Yes

If Yes, ❑ Iowa _____ Name of Iowa Hospital *(Include city and county)* ❑ Out-of-state _____ Name of Out-of-State Hospital *(Include city and state)*

15. Mother's weight at delivery _____ *Pounds*

16. Characteristics of labor and delivery *(Check all that apply)*
- ❑ Induction of labor
- ❑ Augmentation of labor
- ❑ Steroids (glucocorticoids) for fetal lung maturation received by mother prior to delivery
- ❑ Antibiotics received by the mother **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 are noted in the medical charts

17. Method of delivery

a. Fetal presentation at birth *(Check one)*
- ❑ Cephalic ❑ Breech ❑ Other *(Do NOT specify)*

b. Final route and method of delivery *(Check Vaginal or Cesarean)*
- ❑ Vaginal *(Check only the final one)* ❑ Spontaneous ❑ Forceps ❑ Vacuum
- ❑ Cesarean **If cesarean**, was a trial of labor attempted? ❑ Yes ❑ No

18. 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 are noted in the medical charts

NEWBORN

Obtain from labor & delivery summary, newborn history & physical, newborn medical admission record

19. Birth weight *(Report in grams – Do NOT convert lb./oz.)*

Grams _____ *(If not available in grams: ____ lbs. ____ oz.)*

20. Obstetric estimate of gestation *(Completed weeks only)*

21. Gender ❑ Female ❑ Male ❑ Not yet determined

22. Apgar Score

Score at **5** minutes: _____ ❑ 5 min. score not taken

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

❑ 10 min. score not taken

23. Plurality and Birth Order

Plurality _____

If not single birth – Birth Order _____

Number of infants born alive in this birth event _____

24. Abnormal conditions of the newborn *(Check all that apply that occurred within 24 hours of delivery)*

- ❑ Assisted ventilation required immediately following delivery
- ❑ Assisted ventilation required for more than 6 hours
- ❑ NICU admission
- ❑ Newborn given surfactant replacement therapy
- ❑ Seizure or serious neurologic dysfunction
- ❑ Significant birth injury requiring intervention (e.g., skeletal fractures, peripheral nerve injury, soft tissue/solid organ hemorrhage)

Specify injury _____

- ❑ Antibiotics for suspected neonatal sepsis
- ❑ None of the above are noted in the medical charts

25. Congenital anomalies of the newborn *(Check all that apply as observed within 24 hours of delivery)*

- ❑ Anencephaly
- ❑ Meningomyelocele/Spina bifida
- ❑ Cyanotic congenital heart disease
- ❑ Congenital diaphragmatic hernia
- ❑ Omphalocele
- ❑ Gastroschisis
- ❑ Limb reduction defect *(excludes congenital amputation & dwarfing syndromes)*
- ❑ Cleft lip with or without cleft palate
- ❑ Cleft palate alone
- ❑ Down syndrome *(Trisomy 21)* *(Check known status of Karyotype)*
  - ❑ Karyotype confirmed ❑ Karyotype pending
- ❑ Suspected chromosomal disorder *(Check known status of Karyotype)*
  - ❑ Karyotype confirmed ❑ Karyotype pending
- ❑ Hypospadias
- ❑ None of the above are noted in the medical charts

NEWBORN *PG 2*

Obtain from labor & delivery summary, newborn history & physical, newborn medical admission record

26. Infant transferred to another hospital within 24 hrs of delivery ❑ No ❑ Yes

If Yes, ❑ Iowa _____ (Name of Iowa Hospital *(Include city and county)*) ❑ Out-of-state _____ (Name of Out-of-State Hospital *(Include city and state)*)

27. Infant alive at the time of this report ❑ Yes ❑ No ❑ Infant transferred, status unknown

28. Mother breastfeeding or pumping at time of this report ❑ Yes ❑ No ❑ Unknown at this time

29. Prenatal Care Study – Barrier's Code *(Specify pre-printed code number from study's collection form)*

30. Infant received Newborn Screening

- ❑ Yes *(Specify pre-printed code number under the bar code on the collection form)*
- ❑ No *(Check the one that best describes why not)*
  - ❑ Infant transferred
  - ❑ Parent refused
  - ❑ Infant deceased
  - ❑ Missed

31. Infant received Newborn Hearing Screening

- ❑ Yes
- ❑ No *(Check the one that best describes why not)*
  - ❑ Infant transferred
  - ❑ Parent refused
  - ❑ Infant deceased
  - ❑ Missed or machine broke

32. Infant removed from birth mother's custody *(Includes adoption, other family member with custody, DHS removed – but not baby in NICU)*

❑ No ❑ Yes If **Yes**, verify with infant's discharge records

VITAL RECORDS FEE PAYMENT STATUS

MUST BE COMPLETED

33. Registration & Certified Copy Fees

- ❑ Paid
- ❑ Not paid
- ❑ Waived *(Check appropriate justification for waiving the fees)*
  - ❑ Medical assistance program *(e.g., Title XIX, Medicaid)*
  - ❑ Indigent patient care
  - ❑ Indigent parent
  - ❑ Birth mother does not have custody

If paid, Method of Payment *(Check payment method & specify warrant number if known at this time, otherwise write the number on the fee report printout)*

- ❑ Parent paid with check or money order to Iowa HHS # _____ Amount $ _____
- ❑ Parent paid with cash – Hospital check # _____ Amount $ _____
- ❑ Parent billed by hospital – Hospital check # _____ Amount $ _____

**** Please refer parents to the local County Recorder's office or the state Vital Records office for additional certified copies of the child's birth certificate. The entitled parent as named on the birth certificate will be required to provide a written application, notarized signature, valid government-issued photo identification, and fee payment for the search.*

PATERNITY AFFIDAVIT STATUS

34. A notarized Voluntary Paternity Affidavit, with satisfactory identification document(s) attached, is being mailed by the hospital to the Iowa Bureau of Health Statistics.

❑ Yes ❑ No

REGISTRATION STATUS

35. ❑ Adoption pending

36. ❑ Birth mother does not have custody

37. ❑ Surrogate/Gestational carrier birth

38. ❑ Birth mother invoked Safe Haven

STAFF COMPLETING THIS WORKSHEET

Signature of hospital staff	Hospital Department	Date Signed