

Connecticut Department  
of Public Health

# Registration of a Home Birth

## Parent's Guide

Prepared by  
State of Connecticut  
Department of Public Health  
Vital Records Unit

## CONGRATULATIONS ON THE BIRTH OF YOUR BABY!

The State of Connecticut wishes to make the filing of your home birth an easy task. There is information that you will need to provide to the Registrar of Vital Records *in the town in which your child was born* in order to register this birth. This booklet will detail the information required for filing this birth event with the town of birth.

The State of Connecticut requires that the birth worksheets be completed immediately following the birth. The parent(s) is responsible for completing the demographic **MOTHER'S WORKSHEET FOR CHILD BIRTH CERTIFICATE (v2003) FOR HOME BIRTHS.**

The **Facility Worksheet for the Live Birth Certificate** is completed by:

- a) the attending practitioner in attendance at or immediately after the birth, or in the absence of such a person;
- b) the mother, the father, or in the absence of the father and the inability of the mother;
- c) any other person in attendance at or immediately after the birth.

The birth must be filed with the Registrar of Vital Records in the town in which the child was born not later than ten days after the birth. Prior to the preparation and filing of the birth certificate, the parent(s) need to provide the town Registrar of Vital Records with documentation to prove both pregnancy and birth.

Affidavit forms are provided in this packet for you to establish proof of pregnancy and proof of birth. They must be completed and signed in front of a Notary Public.

If mother and father are not married, an Acknowledgment of Paternity form must be completed and signed by the mother and the father before the father's information can be placed on the birth certificate. This form is available at the Vital Records Office in the town of birth.

If mother is in a legally recognized same sex partnership, the non-birth mother may be added to the birth certificate. Complete the Mother's Worksheet for Birth Mothers in a Legally Recognized Same Sex Partnership.

The State of Connecticut Department of Public Health works in coordination with the Social Security Administration to provide the opportunity for parents to secure a Social Security Number for their newborn. If you would like to have this service provided then read, complete and sign the form entitled Social Security Number for Newborns, which is provided in this packet.

Also included in this packet is the CT Department of Public Health's Connecticut Immunization Registry and Tracking System form for you to complete. This registry maintains a permanent record of your child's immunization record for you and your pediatrician.

In addition, at the time of registration, the Registrar will also request to be provided with proof of residency and with photographic identification. Please refer to the list of acceptable documents.

## REQUIRED DOCUMENTATION

The following lists detail the documentation that you need to provide to the Registrar of Vital Records in order to properly file your home birth. *Please keep in mind that the Registrar has the authority and responsibility to determine that the evidence presented is authentic and true.*

### Proof of Pregnancy

(ONE of the following must be provided):

A. Signed and dated report from physician, clinic, or CT licensed midwife that provided prenatal care to the mother (this report must be made on physician, clinic or midwife's letterhead stationery),

-OR-

B. Notarized affidavits from **two adults**, other than the mother or the father, having firsthand knowledge of the pregnancy,

-OR-

C. A signed and dated report from a practitioner or clinic that provided postpartum care to the mother within twenty-four hours after the birth (this report must be made on physician or clinic letterhead stationery).

### Proof of Birth

(ALL of the following are required)

A. A notarized affidavit by the mother attesting to the date, time, and place of the live birth as well as notarized affidavits from all adult witnesses to this birth,

-AND-

B. A signed and dated report from either the physician or clinic providing medical care to the newborn within 24 hours after the birth, or, documentation of the earliest date of medical care given to the infant.

<b>Proof of Residency</b>	<b>Proof of Identity</b>
<p>(one of the following may be submitted)</p> <ul style="list-style-type: none"><li>• Mortgage statement or lease agreement which includes mother's name and address</li><li>• Utility bill showing mother's name and address</li><li>• Mother's Driver's license</li><li>• Automobile registration showing mother's name and address</li><li>• Checking account deposit slip showing mother's name and address</li><li>• Mother's Voter Registration card</li><li>• State issued identification card which includes mother's residency</li><li>• Any additional form of documentation deemed necessary by the Registrar of Vital Records</li></ul>	<ul style="list-style-type: none"><li>• Government issued photographic identification, or if a photo ID is not available, at least <u>two</u> of the following:<ul style="list-style-type: none"><li>• Social Security card</li><li>• Automobile registration</li><li>• Utility bill showing name and address</li><li>• Checking account deposit slip showing name and address</li><li>• Voter registration card</li><li>• Written verification of identity from employer</li></ul></li></ul>

## PARENT'S CHECKLIST

Did you remember to provide the following information?

- Proof of Pregnancy Documentation
- Proof of Birth Documentation
- Proof of Residency
- Proof of Identity
- Completed Mother's Worksheet For Child Birth Certificate (v2003) for Home Births
- Completed Facility Worksheet for the Live Birth Certificate
- Completed Acknowledgment of Paternity form (if applicable)
- Completed Social Security Number for Newborns form
- Completed CT Immunization Registry and Tracking System form
- Connecticut Higher Education Trust (CHET)

## PARENT'S CHECKLIST

**Did you remember to provide the following information?**

- Proof of Pregnancy Documentation
- Proof of Birth Documentation
- Proof of Residency
- Proof of Identity
- Completed Mother's Worksheet For Child Birth Certificate (v2003) for Home Births
- Completed Facility Worksheet for the Live Birth Certificate
- Completed Acknowledgment of Paternity form (if applicable)
- Completed Social Security Number for Newborns form
- Completed CT Immunization Registry and Tracking System form

**AFFIDAVIT OF MOTHER TO BIRTH**

**STATE OF CONNECTICUT**

TOWN OF \_\_\_\_\_

I, \_\_\_\_\_, under penalty of perjury, hereby depose and say:  
(full name of mother)

1. I am over 18 years of age and understand the obligations of an oath.

2. I am a resident of \_\_\_\_\_  
(town and state)

3. On \_\_\_\_\_ at \_\_\_\_\_ I gave birth to my son/daughter (circle one),  
(date) (time-denote am or pm)

\_\_\_\_\_ at \_\_\_\_\_  
(full name of child) (number and street address of birthplace)

\_\_\_\_\_ (town) \_\_\_\_\_ (state) \_\_\_\_\_ (zip code)

\_\_\_\_\_  
(printed name of mother)

\_\_\_\_\_  
(residence no. and street)

\_\_\_\_\_ (town) \_\_\_\_\_ (state) \_\_\_\_\_ (zip code)

\_\_\_\_\_  
(signature of mother)

Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

Date Commission Expires: \_\_\_\_\_

**AFFIDAVIT OF FATHER or SAME SEX PARENT TO BIRTH**

**STATE OF CONNECTICUT**

TOWN OF \_\_\_\_\_

I, \_\_\_\_\_, under penalty of perjury, hereby depose and say:  
(full name of father)

1. I am over eighteen years of age and understand the obligations of an oath.

2. I am a resident of \_\_\_\_\_.  
(town and state)

3. On \_\_\_\_\_ at \_\_\_\_\_, I witnessed \_\_\_\_\_  
(date) (time- denote am or pm) (full name of mother)

give birth to our son/daughter (circle one), \_\_\_\_\_  
(full name of child)

at \_\_\_\_\_,  
(number and street address of birthplace) (town) (state) (zip code)

\_\_\_\_\_  
(printed name of father or same sex parent)

\_\_\_\_\_  
(residence no. and street)

\_\_\_\_\_  
(town) (state) (zip code)

\_\_\_\_\_  
(signature of father or same sex parent)

Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

Date Commission Expires: \_\_\_\_\_

AFFIDAVIT OF WITNESS TO BIRTH

STATE OF CONNECTICUT

TOWN OF \_\_\_\_\_

I, \_\_\_\_\_, under penalty of perjury, hereby depose and say:  
(full name of witness)

1. I am over eighteen years of age and understand the obligations of an oath.

2. I am a resident of \_\_\_\_\_.  
(town and state)

3. My relationship to the mother is \_\_\_\_\_.  
(state relationship)

4. On \_\_\_\_\_ at \_\_\_\_\_, I witnessed \_\_\_\_\_  
(date) (time-denote am or pm) (full name of mother)

give birth to her son/daughter (circle one) at \_\_\_\_\_,  
(number and street address of birthplace)

\_\_\_\_\_  
(town) (state) (zip code)

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(residence no. and street)

\_\_\_\_\_  
(town) (state) (zip code)

\_\_\_\_\_  
(signature of witness)

Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

Date Commission Expires: \_\_\_\_\_



**AFFIDAVIT OF WITNESS TO PREGNANCY**

**STATE OF CONNECTICUT**

TOWN OF \_\_\_\_\_

I, \_\_\_\_\_, under penalty of perjury, hereby depose and say:  
(full name of witness)

1. I am over eighteen years of age and understand the obligations of an oath.

2. I am a resident of \_\_\_\_\_  
(town and state)

3. I have known \_\_\_\_\_ for \_\_\_\_\_ months/years (circle one).  
(full name of mother) (number)

4. My relationship to the mother is \_\_\_\_\_  
(state relationship)

5. I met with \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_  
(full name of mother) (date) (place)

6. I observed that she was pregnant at the time.

\_\_\_\_\_  
(printed name of witness)

\_\_\_\_\_  
(residence no. and street)

\_\_\_\_\_  
(town)

\_\_\_\_\_  
(state)

\_\_\_\_\_  
(zip code)

\_\_\_\_\_  
(signature of witness)

Subscribed and sworn to before me  
this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

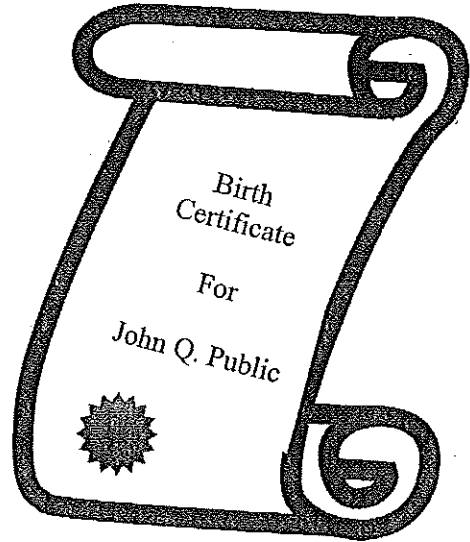
\_\_\_\_\_  
Notary Public

Date Commission Expires: \_\_\_\_\_

## USES OF BIRTH CERTIFICATES

Some of the most common uses of birth certificates are:

1. Establishing the date of birth and age for purposes, such as:
  - entering school
  - obtaining a driver's license
  - proving age for work for minors
  - proving sports eligibility for minors
  - proving age of majority or minority in court cases
  - qualifying for pensions or Social Security benefits
  - voting
  - entering military service
  - obtaining a Social Security number
  
2. Establishing a birthplace to prove citizenship for purposes, such as:
  - obtaining a passport
  - entering employment limited to citizens
  - obtaining licenses limited to citizens
  
3. Establishing family relationships for purposes, such as;
  - proving legal dependency
  - obtaining inheritance benefits
  - receiving insurance payments
  - conducting genealogy research
  
4. Providing public health information for purposes, such as:
  - evaluating prenatal care
  - immunizing children
  - caring for children with congenital anomalies or abnormal conditions
  - evaluating the needs for health facilities
  - planning and evaluating the effectiveness of family planning programs
  - monitoring risk factors that cause poor pregnancy outcomes



## Social Security Numbers for Newborns

The State of Connecticut Department of Public Health and the Federal Social Security Administration are offering you this valuable service.

### A NOTE FROM SSA:

The easiest time to get a Social Security Number for your child is when you give information for your child's birth certificate. If you wait to apply at a Social Security office, you will need to provide proof of your child's U.S. Citizenship, age and identity. Social Security will also need to verify your child's birth certificate which may take up to 12 weeks.

By completing this form and requesting a Social Security number for your new baby, the State of Connecticut Department of Public Health will electronically transmit your request to the Federal Social Security Administration. A Social Security card will be mailed to you within 3 weeks, eliminating the need for you to personally visit a Social Security office with evidence of your child's identity, birth date and citizenship.

Must your child have a Social Security Number? No, it is voluntary. However, your child will need a Social Security Number in order for you to claim your child on your income tax return, open a bank account for your child, buy savings bonds for your child, obtain medical coverage for your child, apply for government services for your child.

Social Security rarely uses the information you supply for any purpose other than for issuing a Social Security number and card. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g. to the Government Accountability Office and Department of Veteran's Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, state, and local level; and
4. To facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

Social Security may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies.

FOR INFORMATION OR ANSWERS TO YOUR SOCIAL SECURITY QUESTIONS, Please contact the Federal Social Security Administration at [www.socialsecurity.gov](http://www.socialsecurity.gov) or call toll free: 1-800-772-1213 (for deaf or hard of hearing: call the TTY line at 1-800-325-0778).

### ENUMERATION AT BIRTH CONSENT FORM

Baby's Name as Reported on Birth Certificate:

\_\_\_\_\_ (A Social Security number cannot be issued for a child that has not been named)

1) Do you want a Social Security Number issued for your baby?

YES  NO

2) Do you authorize the Social Security Administration to provide the Social Security number to the State of Connecticut to add it to the State's birth file? (The confidentiality of Connecticut birth records is protected by state statute (§CGS 7-51))

YES  NO

Signature of Parent \_\_\_\_\_ Date \_\_\_\_\_

# Connecticut Immunization Registry and Tracking System (CIRTS)

Connecticut Department of Public Health Immunization Program

410 Capitol Ave. MS 11 MUN Hartford, CT 06134-0308 Phone: 860-509-7929 Fax: 860-509-8370 Website: www.ct.gov/dph/immunizations

## The Department of Public Health congratulates you on the birth of your baby!

CIRTS is a confidential, computerized information system that keeps track of your child's shots at no cost to you.

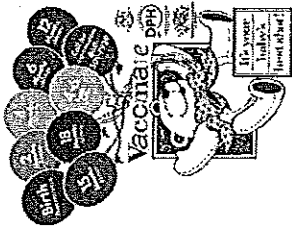
### CIRTS can:

- Give you a permanent record of your child's shots;
- Let your doctor know if your child has missed a shot;
- Give you a back-up shot record if your child's records are destroyed, if you change clinics, or if the clinic closes;
- Give your doctor the health forms needed for daycare, school, camp or college.

*For more information, please ask the nurse for a brochure.*

**THIS INFORMATION WILL BE KEPT  
CONFIDENTIAL**

*According to regulation s19a-7h-4 of the CT General Statutes*



### Please fill out ALL fields if you live in and/or your baby's doctor is in Connecticut

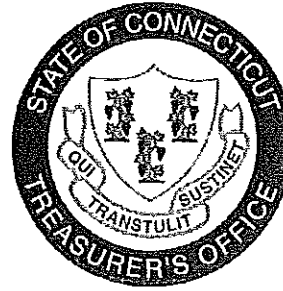
Baby's Name \_\_\_\_\_ (first) \_\_\_\_\_ (middle) \_\_\_\_\_ (last) Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Sex: Boy Girl  
 Mother's Name \_\_\_\_\_ (first) \_\_\_\_\_ (maiden) \_\_\_\_\_ (last) Mother's Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (please circle)  
 Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Phone # (\_\_\_\_) \_\_\_\_\_ Cell Phone # (\_\_\_\_) \_\_\_\_\_ Work Phone # (\_\_\_\_) \_\_\_\_\_  
 Name of Emergency Contact \_\_\_\_\_ Emergency Phone # (\_\_\_\_) \_\_\_\_\_ BABY'S Birth Hospital \_\_\_\_\_  
 Name of BABY's Doctor \_\_\_\_\_ Name of BABY's Clinic/Practice \_\_\_\_\_ Town of Clinic \_\_\_\_\_

\*Your child will be automatically enrolled if you live in Connecticut.

If you DO NOT want your child enrolled, you must send a signed written request to opt out of CIRTS.

Please include your child's full name and date of birth. By opting out, your child's shot record will no longer be available in CIRTS.

Mail to: CIRTS, 410 Capitol Avenue MS 11 MUN, Hartford, CT 06134 or Fax to: 860-509-8370



January 2016

Congratulations on your new baby!

As trustee of the Connecticut Higher Education Trust (CHET) I am pleased to inform you about a current initiative called CHET Baby Scholars. To help families save for college, as long as funds remain available, the state will deposit the first \$100 when you open a CHET account. No minimum contribution from you is required. Then, if you contribute \$150, or save \$150 within the first four years, the state will give you an additional \$150!

How do you get started and earn up to \$250? If you are interested in receiving information about CHET, please complete the information at the bottom of this form. I urge you to check the box to get started and earn \$250 from CHET Baby Scholars.

If you agree to receive information from the program, CHET will send you a packet of information to help you open the account. All you have to do is fill out the application and send it in. Or you can go to [www.aboutchet.com/babyscholars](http://www.aboutchet.com/babyscholars) and sign up online.

As soon as the account has been successfully opened, the state will put in the \$100 deposit. It's just that easy to get started on a path to higher education for your child.

If you have any questions about CHET or the Baby Scholars program I urge you to visit our website at [www.aboutchet.com](http://www.aboutchet.com). In the meantime, please remember to CHECK THAT BOX!

Together, we can set your newborn on a path to higher education success!

Denise L. Nappier

Connecticut State Treasurer

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Yes, please send me information about the CHET Program.

Child's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_ Date Signed \_\_\_\_\_

MOTHER'S NAME:

Rev. 1/2016

STATE OF CONNECTICUT  
DEPARTMENT OF PUBLIC HEALTH



MOTHER'S WORKSHEET FOR CHILD'S BIRTH CERTIFICATE (v2003)

FOR HOME BIRTHS

FOR BIRTH MOTHERS IN A LEGALLY RECOGNIZED SAME SEX PARTNERSHIP

Adapted by CT DPH from the NVSS Mother's Worksheet for the 2003 Live Birth Certificate

The information you provide below will be used to create your child's birth certificate. The birth certificate is a document that will be used for legal purposes to prove your child's age, citizenship and parentage. This document will be used by your child throughout his/her life. State laws provide protection against the unauthorized release of identifying information from the birth certificates to ensure the confidentiality of the parents and their child.

It is very important that you provide complete and accurate information to all of the questions. In addition to information used for legal purposes, other information from the birth certificate is used by health and medical researchers to study and improve the health of mothers and newborn infants. Items such as parent's education, race, and smoking will be used for studies but will not appear on copies of the birth certificate issued to you or your child.

**PARENTS – PLEASE COMPLETE, SIGN, AND RETURN THIS FORM TO THE REGISTRAR OF VITAL RECORDS  
IN THE TOWN OF BIRTH**

**CHILD'S INFORMATION**

1a. Child's legal name (as it should appear on the birth certificate)  Child's name not yet chosen

\_\_\_\_\_  
First Middle Last Generational ID

Date of birth of this child

\_\_\_ / \_\_\_ / \_\_\_\_\_  
Month Day Year

Plurality of this birth

Include all infants delivered (alive or dead) in this pregnancy when determining plurality and birth order.

- Singleton
- Twins
- Triplets
- Quadruplets
- Other \_\_\_\_\_

Birth Order of this child

If a multiple birth, check the birth order of the child named above.

- 1st born
- 2nd born
- 3rd born
- 4th born
- Other \_\_\_\_\_

Sex of this child

- Male
- Female
- Undetermined

**BIRTH MOTHER'S INFORMATION  
(WOMAN GIVING BIRTH TO THIS CHILD)**

2a. Birth Mother's current legal name

\_\_\_\_\_  
First Middle Last Generational ID

2b. Birth Mother's name prior to her first marriage (Maiden name; Last name given at birth or on Birth Certificate)

SAME AS CURRENT LEGAL NAME

\_\_\_\_\_  
First Middle Last Generational ID

**2c. Birth Mother's date of birth**

\_\_\_ / \_\_\_ / \_\_\_  
Month Day Year

**2d. Birth Mother's Place of Birth**

U.S. State \_\_\_\_\_

U.S. territory \_\_\_\_\_

(i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas)

Foreign country \_\_\_\_\_

If CANADA, provide province \_\_\_\_\_

**2e. Birth Mother's Marital Status**

Were you joined in a legally recognized partnership to the Non-Birth Mother listed at the time you conceived this child, at the time of birth, or at any time between conception and giving birth?

YES  NO If "NO" is answered, only the name of the mother giving birth will be included on the child's birth certificate.

**2f. Birth Mother's Residence:**

Provide the actual street location and the official name of the town/city where mother's residence is located. For example, the location for paying taxes, voting, etc., but not necessarily used for mailing address.

House Number \_\_\_\_\_ Street (Do not enter PO Boxes or Rural Route numbers) \_\_\_\_\_ Apt / Unit \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

County: \_\_\_\_\_ If not United States, country \_\_\_\_\_

Is the residence inside city limits? (Non-CT residents only)  Yes  No  Don't know

How long has the Birth Mother lived at the current residence reported above? \_\_\_\_\_ Years \_\_\_\_\_ Months

**2g. Address where mail is received:**  Same as residence address above

House Number \_\_\_\_\_ Street, Rural Route, P.O. Box \_\_\_\_\_ Apt / Unit \_\_\_\_\_

City/Town \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

County: \_\_\_\_\_ If not United States, country \_\_\_\_\_

**3a. Birth Mother's spoken language (check all that apply):**

American sign language (ASL)

Gujarathi

Russian

Armenian

Khmer

Serbo-Croatian

Chinese, Cantonese

Korean

Spanish

Chinese, Mandarin

Laotian

Vietnamese

English

Persian

Other Language -specify: \_\_\_\_\_

French (including Cajun, Patois)

Polish

French Creole (for example, Haitian)

Portuguese

**Race and Hispanic Ethnicity:** Race and ethnicity are self-identification data items in which respondents choose the race or races with which they most closely identify and indicate whether or not they are of **Hispanic, Latino/a, or Spanish origin**. Race and ethnicity are considered separate and distinct identities.

**Please complete both items.**

**Definition of Hispanic, Latino/a, or Spanish Origin:**

Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be any race.

- "Hispanic, Latino/a, or Spanish origin" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin – *regardless of race*.

**Definition of Race Categories:**

A person may indicate self-identification with two or more races by selecting multiple race categories.

- "White" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race(s) as "White" or report entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.
- "Black or African American" refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicate their race(s) as "Black, African American, or Negro"; or report entries such as African American, Kenyan, Nigerian, or Haitian.
- "American Indian and Alaska Native" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- "Asian" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- "Native Hawaiian and Other Pacific Islander" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**3b. Is the Birth Mother Spanish/Hispanic/Latina?**

- No, not Spanish/Hispanic/Latina
- Yes, Mexican, Mexican American, Chicana
- Yes, Puerto Rican
- Yes, Cuban
- Yes, other Spanish/Hispanic/Latina:

\_\_\_\_\_ (e.g. Spaniard, Salvadoran, Dominican, Columbian)

**3c. Birth Mother's Race:** Please check one or more races to indicate what she considers herself to be.

- White
- Black or African American
- American Indian or Alaska Native:

\_\_\_\_\_ (name of enrolled or principal tribe)

**Asian**

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian:

\_\_\_\_\_ (e.g., Thai, Cambodian, Malaysian)

**Pacific Islander**

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander:

- Other Race:



**4a. Birth Mother's Social Security Number:**

Furnishing parent Social Security Numbers (SSNs) is required by Federal Law, 42 USC 405(c) (section 205(c) of the Social Security Act). The numbers will be made available to the Connecticut Department of Social Services to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance.

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I DO NOT HAVE A SOCIAL SECURITY NUMBER

**4b. Birth Mother's occupation:**

**4c. Birth Mother's business/industry:**

**4d. Highest level of schooling the Birth Mother has completed at time of delivery:**

Check the box that best describes her education. If currently enrolled, check the box that indicates the previous grade or highest degree received.

- 8th grade or less
- 9<sup>th</sup>-12<sup>th</sup> grade, no diploma
- High school graduate or GED completed
- Some college credit, but no degree
- Associate degree (e.g. AA, AS) [Technical school?]
- Bachelor's degree (e.g. BA, AB, BS)
- Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA)
- Doctorate or Professional degree (e.g. PhD, EdD, MD, LLB)

**4e. Did the Birth Mother receive WIC (Women's, Infant & Children) food for herself because she was pregnant with this child?**

- Yes
- No
- Don't know

**4f. Did the Birth Mother smoke just before or during this pregnancy? (Do not include e-cigarettes or vaping cigarettes)**

- Yes, I smoked during the three months before I became pregnant and/or while I was pregnant.

For the three months before pregnancy, on an average day I smoked: \_\_\_\_\_cigs or \_\_\_\_\_ packs.  
During the first 3 months of pregnancy, on an average day I smoked: \_\_\_\_\_cigs or \_\_\_\_\_ packs.  
During the second 3 months of pregnancy, on an average day I smoked: \_\_\_\_\_cigs or \_\_\_\_\_ packs.  
During the last 3 months of pregnancy, on an average day I smoked: \_\_\_\_\_cigs or \_\_\_\_\_ packs.

- No, I did not smoke during the three months before I became pregnant or while I was pregnant.

**4g. Did the Birth Mother use alcohol regularly during this pregnancy? If so, how many drinks did she consume in an average week?**

- No, I did not drink regularly during this pregnancy.
- Yes, I drank \_\_\_\_\_ drinks in *an average week* during this pregnancy.

**4h. Birth Mother's height:**

\_\_\_\_\_ feet \_\_\_\_\_ inches

**4i. Birth Mother's weight immediately before she became pregnant with this child:**

Pre-pregnancy weight was \_\_\_\_\_ pounds

## INFORMATION ON SAME SEX PARENT

Fill in the Non-Birth Mother's information only if the parents are in a same sex partnership legally recognized in Connecticut. Refer to Birth Mother's Marital Status box, page 2.

**5a. Non-Birth Mother's current legal name**

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Generational ID \_\_\_\_\_

**5b. Non-Birth Mother's name prior to her first marriage** (Last name given at birth or on Birth Certificate)

SAME AS CURRENT LEGAL NAME

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Generational ID \_\_\_\_\_

**5c. Non-Birth Mother's date of birth**

\_\_ / \_\_ / \_\_  
Month Day Year

**5d. Non-Birth Mother's Place of Birth:**

U.S. State \_\_\_\_\_

U.S. territory \_\_\_\_\_

(i.e., Puerto Rico, U.S. Virgin Islands, Guam, American Samoa or Northern Marianas)

Foreign country \_\_\_\_\_

If CANADA, provide province \_\_\_\_\_

**6a. Non-Birth Mother's spoken language:**

- |   |                                     |   |
|---|-------------------------------------|---|
| <input type="checkbox"/> American sign language (ASL)         | <input type="checkbox"/> Gujarathi  | <input type="checkbox"/> Russian                        |
| <input type="checkbox"/> Armenian                             | <input type="checkbox"/> Khmer      | <input type="checkbox"/> Serbo-Croatian                 |
| <input type="checkbox"/> Chinese, Cantonese                   | <input type="checkbox"/> Korean     | <input type="checkbox"/> Spanish                        |
| <input type="checkbox"/> Chinese, Mandarin                    | <input type="checkbox"/> Laotian    | <input type="checkbox"/> Vietnamese                     |
| <input type="checkbox"/> English                              | <input type="checkbox"/> Persian    | <input type="checkbox"/> Other Language –specify: _____ |
| <input type="checkbox"/> French (including Cajun, Patois)     | <input type="checkbox"/> Polish     |   |
| <input type="checkbox"/> French Creole (for example, Haitian) | <input type="checkbox"/> Portuguese |   |

**Race and Hispanic Ethnicity:** Race and ethnicity are self-identification data items in which respondents choose the race or races with which they most closely identify and indicate whether or not they are of Hispanic, Latino/a, or Spanish origin. Race and ethnicity are considered separate and distinct identities.

Please complete both items.

**Definition of Hispanic, Latino/a, or Spanish Origin:**  
Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identify their origin as Hispanic, Latino, or Spanish may be any race.

"Hispanic, Latino/a, or Spanish origin" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin – *regardless of race.*

**6b. Is the Non-Birth Mother Spanish/Hispanic/Latina?**

- No, not Spanish/Hispanic/Latina  
 Yes, Mexican, Mexican American, Chicana  
 Yes, Puerto Rican  
 Yes, Cuban  
 Yes, other Spanish/Hispanic/Latino:

\_\_\_\_\_ (e.g. Spaniard, Salvadoran, Dominican, Columbian)

**Definition of Race Categories:**

- "White" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race(s) as "White" or report entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.
- "Black or African American" refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicate their race(s) as "Black, African American, or Negro"; or report entries such as African American, Kenyan, Nigerian, or Haitian.
- "American Indian and Alaska Native" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- "Asian" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- "Native Hawaiian and Other Pacific Islander" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

**6c. Non-Birth Mother's Race:** Please check one or more races to indicate what she considers herself to be.

- White
- Black or African American
- American Indian or Alaska Native:

\_\_\_\_\_ (name of enrolled or principal tribe)

**Asian**

- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian: \_\_\_\_\_

(e.g., Thai, Cambodian, Malaysian)

**Pacific Islander**

- Native Hawaiian
- Guamanian or Chamorro
- Samoan
- Other Pacific Islander: \_\_\_\_\_

- Other Race: \_\_\_\_\_

**7a. Non-Birth Mother's Social Security Number:**

Furnishing parent Social Security Numbers (SSNs) is required by Federal Law, 42 USC 405(c) (section 205(c) of the Social Security Act). The numbers will be made available to the Connecticut Department of Social Services to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance.

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I DO NOT HAVE A SOCIAL SECURITY NUMBER

**7b. Non-Birth Mother's occupation:**

**7c. Non-Birth Mother's business/industry:**

**7d. Highest level of schooling the Non-Birth Mother has completed at time of delivery:** Check the box that best describes her education. If currently enrolled, check the box that indicates the previous grade or highest degree received.

- 8<sup>th</sup> grade or less
- 9<sup>th</sup>-12<sup>th</sup> grade, no diploma
- High school graduate or GED completed
- Some college credit, but no degree
- Associate degree (e.g. AA, AS) [Technical school?]
- Bachelor's degree (e.g. BA, AB, BS)
- Master's degree (e.g. MA, MS, Meng, Med, MSW, MBA)
- Doctorate or Professional degree (e.g. PhD, EdD, MD, LLB)

**IMMUNIZATION INFORMATION**

This additional information is requested by the CT Immunization Registry and Tracking System which will keep track of your child's preschool immunizations. If you do not wish to participate, you must sign the refusal box on the separate CT Immunization Registry and Tracking System (CIRTS) enrollment form.

**8a. Pediatrician Information:**

Name of baby's doctor: \_\_\_\_\_  
First Middle Last Generational ID

Name of doctor's practice: \_\_\_\_\_

Town of doctor/clinic: \_\_\_\_\_

**8b. Emergency Contact Name:** \_\_\_\_\_

Contact's Telephone #: \_\_\_\_\_

**8c. Mother's Telephone #** \_\_\_\_\_

**INFORMANT INFORMATION**

**8d. Informant's Information:**

Relationship to this child:  Birth Mother  Non-Birth Mother  Other relative  Hospital employee  
 Other – specify: \_\_\_\_\_

Full name of person providing information in this form:

\_\_\_\_\_  
First Middle Last Generational ID

Signature of Informant: \_\_\_\_\_ Date \_\_\_\_\_

**Parents: Please provide this completed and signed worksheet to the Registrar of Vital Records in the town of birth.**

MOTHER'S MEDICAL RECORD #

CHILD'S MEDICAL RECORD #

IF MULTIPLE BIRTH, this worksheet is for:

Rev. 1/2016

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH



FACILITY WORKSHEET for the LIVE BIRTH CERTIFICATE (v2003)

Connecticut General Statute §7-48 requires the medical practitioner in attendance of a birth and the practitioner providing prenatal care to provide the medical information required by the certificate not later than 72 hours after the birth.

Mother's Name:

First Middle Last Generational ID

1b. Date of birth of this child

Month / Day / Year

1c. Time of birth of this child

hour minute AM PM Military

1d. Sex of this child

Male Female Not yet determined/Unknown

1e. Place of Birth Type:

- Hospital
Free Standing Birthing Center
Clinic/Doctor's Office
Born En-route or on Arrival
Residence:

Was this a planned delivery at home? Yes No Unknown

1f. Birthplace Name and Address:

Facility Name:

Street address of birth location:

Street Apt #
City/Town County State

MEDICAL CERTIFICATION

I HEREBY CERTIFY THAT THE CHILD WAS BORN AT THE HOUR, DATE, AND PLACE STATED ABOVE

Certifier's Title:

- MD
DO
CNM
Other Midwife-CPM
Mother
Father
Other - specify:

Certifier's Printed Name:

First MI Last Generational ID

Certifier's Signature:

First MI Last Generational ID

Date Signed:

CT License Number: National Provider ID:

Certifier's Address:

Street/Apt # City/Town State ZIP code

8h. Birth Attendant's Information: The attendant at birth is the person physically present at the delivery room who is responsible for the delivery even if they do not themselves deliver the infant.

Title of Birth Attendant:

- MD DO CNM Other Midwife-CPM Mother Father Other (specify):

Name of Birth Attendant:

SAME AS CERTIFIER

First MI Last Generational ID

CT License Number: National Provider ID (NPI):

## PRENATAL INFORMATION

**Sources: Prenatal care records, mother's medical records, labor and delivery records**

Information for the following items should come from the mother's prenatal care records and from other medical reports in the mother's chart, as well as the infant's medical record. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record, or a copy of the prenatal care information.

Preferred and acceptable sources are given before each section.  
Please do not provide information from sources other than those listed.

ALL INFORMATION ON THIS FORM SHOULD BE REPORTED PLEASE WRITE "UNKNOWN" ON THE SPACES FOR "NO" OR "NONE"

**9a. Did Mother Have Prenatal Care:**

- YES    NO    Unknown

Is the prenatal care record available for this mother? Is it current? If the prenatal care record is not available or if the record is not current (i.e., from pre-registration), please contact the prenatal care provider for an updated record before completing the remaining items.

**9b. Principal Source of Payment for Prenatal Care:**

- Husky or Medicaid  
 Private/Employer Insurance  
 Self-pay (No third party identified)  
 Indian Health Service  
 CHAMPUS/TRICARE  
 Other Government  
 Other – specify: \_\_\_\_\_

**9c. Date of FIRST prenatal care visit:**

\_\_\_ / \_\_\_ / \_\_\_  
 Month      Day      Year

Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy.

**9d. Total number of prenatal care VISITS for this pregnancy:**

\_\_\_\_\_

Count only those visits recorded in the record. If the prenatal records do not appear to be current, please contact the prenatal care provider for updated information.

**9e. Date last normal menses began:**

\_\_\_ / \_\_\_ / \_\_\_  
 Month      Day      Year

Do NOT calculate the date if it is not specified in the prenatal care record. If any part of the date is available, enter the available parts (e.g., 04/99/2014). Otherwise, enter 99-99-9999.

**9f. Method of Determining EDD:** Method used by prenatal care provider to establish the Estimated Date of Delivery (EDD).  
 Check one:

- Known LMP consistent with an ultrasound (the earliest possible >7 weeks)  
 Ultrasound (the earliest possible >7 weeks) NOT consistent with known LMP  
 Ultrasound alone, for women whose LMP date is only partially known or not known  
 LMP alone, for women who do not have an ultrasound prior to labor and delivery  
 ART: Date of Assisted Reproductive Technology (ART) established the EDD  
 No EDD determined  
 Method unknown

Known LMP means that all parts of the LMP date (MM-DD-YYYY) were recorded in the mother's prenatal records. If only a partial LMP date is available, do not select the first two options.

ART (Assisted Reproductive Technology) includes embryo transfer, intrauterine insemination (IUI), ZIFT, GIFT.

If no prenatal care was received, then select "No EDD determined" since a prenatal provider did not date the pregnancy.

If the prenatal care record is not available or does not specify the method used to determine EDD, then select "Method unknown".

**9g. Number of previous LIVE births now LIVING:**

\_\_\_       None

Do not include this child. Include all live births delivered before this infant in this pregnancy and in previous pregnancies.

**9h. Number of previous LIVE births now DEAD:**

\_\_\_       None

Do not include this child. Include all live-births-now-dead delivered before this infant in this pregnancy and in previous pregnancies.

**9i. Date of last live birth:**

\_\_\_ / \_\_\_ / \_\_\_  
 Month      Year

<p><b>9j. Total number of other pregnancy outcomes that did not result in a live birth:</b> _____ <input type="checkbox"/> None</p> <p>Include pregnancy 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 this pregnancy and in previous pregnancies.</p>	<p><b>9k. Date of last other pregnancy outcome:</b></p> <p>____ / ____ / ____  Month                      Year</p> <p>Date when last pregnancy that did not result in a live birth ended.</p>	<p><b>9l. Did mother's blood test positive for syphilis during this pregnancy?</b> If yes, provide test date(s).</p> <p><b>1<sup>st</sup> test:</b></p> <p><input type="checkbox"/> YES, positive test result on ____ / ____ / ____  Month      Day      Year</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Unknown</p> <p><b>2nd test:</b></p> <p><input type="checkbox"/> YES, positive test result on ____ / ____ / ____  Month      Day      Year</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Unknown</p>
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**9m. Was mother's prenatal care record available for completing worksheet?**

YES       NO       Unknown

**10a. Mother's risk factors for this pregnancy: Check all that apply.**

**Diabetes:** Glucose intolerance requiring treatment. If diabetes is present, check either pre-pregnancy or gestational. Do not check both.

- Pre-pregnancy:** Diagnosis prior to this pregnancy
- Gestational:** Diagnosis in this pregnancy

**Hypertension:** Elevation of blood pressure above normal for age, gender, and physiological condition. If hypertension is present, check either pre-pregnancy or gestational. Do not check both.

- Pre-pregnancy (Chronic):** Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy.
- Gestational (PIH, preeclampsia):** Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face).
- Eclampsia:** Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema.

- Previous preterm birth:** History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.
- Pregnancy resulted from infertility treatment** - Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g., IVF, GIFT and ZIFT).

**If Yes, check all that apply:**

- Fertility-enhancing drugs, artificial insemination or intrauterine insemination:** Any fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.
- Assisted reproductive technology:** Any assisted reproduction technology (ART)/technical procedures (e.g., In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT) used to initiate the pregnancy.

- Mother had a previous cesarean delivery:** Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.

**If Yes, how many previous cesareans?** \_\_\_\_\_

- Mother used tobacco cigarettes during this pregnancy:** Prenatal care record indicates that mother used tobacco cigarettes during pregnancy. Include any reported use during this pregnancy, even if mother reported cessation upon learning of her pregnancy. Do not include e-cigarettes or vaping cigarettes.
- Mother used alcohol during this pregnancy:** Prenatal care record indicates that mother used alcohol during pregnancy. Include any reported use during this pregnancy, even if mother reported cessation upon learning of her pregnancy.
- None of the above**
- Unknown**

**10b. Infections present and/or treated during this pregnancy:**

Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.

Check all that apply.

- Chlamydia:** a diagnosis of or positive test for Chlamydia trachomatis
- Gonorrhea:** a diagnosis of or positive test for Neisseria gonorrhoeae
- Syphilis:** also called lues - a diagnosis of or positive test for Treponema pallidum
- Hepatitis B:** HBV, serum hepatitis - a diagnosis of or positive test for the hepatitis B virus
- Hepatitis C:** non A, non B hepatitis, HCV - a diagnosis of or positive test for the hepatitis C virus
- HIV+:** a diagnosis of or positive test for human immunodeficiency virus
- None of the above**

**10c. Obstetric procedure:** Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically in the treatment of the pregnancy, management of labor and/or delivery.

- External cephalic version:** Attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation.
  - Successful     Failed
- None of the above**

**LABOR AND DELIVERY**

Sources: Labor and delivery records, mother's medical records

**11a. Principal Source of Payment for Delivery:**

- Husky or Medicaid
- Private/Employer Insurance
- Self-pay (No third party identified)
- Indian Health Service
- CHAMPUS/TRICARE
- Other Government
- Other – specify: \_\_\_\_\_

**11b,c. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?**

- Yes, from: \_\_\_\_\_  
Name of facility mother transferred from
- No
- Unknown

Transfers include hospital to hospital, birth facility to hospital, etc.

**11d. Mother's weight at delivery:** \_\_\_\_\_ (in pounds)

**11e. Characteristics of labor and delivery:** Check all that apply.

- Induction of labor:** Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor.
- Augmentation of labor:** Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery.
- Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery:** Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to the mother as an anti-inflammatory treatment.
- Antibiotics received by the mother during labor:** Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.
- Clinical chorioamnionitis diagnosed during labor or maternal temperature  $\geq 38^{\circ} \text{C}$  ( $100.4^{\circ} \text{F}$ ):** Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis and fetal tachycardia. Any maternal temperature at or above  $38^{\circ} \text{C}$  ( $100.4^{\circ} \text{F}$ ).
- Epidural or spinal anesthesia during labor:** Administration to the mother of a regional anesthetic for control of the pain of labor, i.e., delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.
- None of the above**



**11f. Method of Delivery:**

**Fetal presentation at birth:** Check one.

- Cephalic:** Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP)
- Breech:** Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech
- Other:** Any other presentation not listed above

**Final route and method of delivery:** Check one.

- Vaginal/Spontaneous:** Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.
- Vaginal/Forceps:** Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.
- Vaginal/Vacuum:** Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.
- Cesarean:** Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.

**If cesarean, was a trial of labor attempted?** Labor was allowed, augmented or induced with plans for a vaginal delivery.

- Yes     No

**11g. Maternal morbidity:** Serious complications experienced by the mother associated with labor and delivery. Check all that apply.

- Maternal transfusion:** Includes infusion of whole blood or packed red blood cells associated with labor and delivery.
- Third or fourth degree perineal laceration:** 3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.
- Ruptured uterus:** Tearing of the uterine wall.
- Unplanned hysterectomy:** Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.
- Admission to intensive care unit:** Any admission of the mother to a facility/unit designated as providing intensive care.
- None of the above**

**NEWBORN**

**Sources: Labor and delivery records, Newborn's medical records, mother's medical records**

**12a. Plurality of this birth:**

- Singleton     Other: \_\_\_\_\_
- Twins
- Triplets
- Quadruplets

Include all infants delivered (alive or dead) in this pregnancy when determining plurality.

**12c. Total LIVE births in this pregnancy:** \_\_\_\_\_

If not single birth, specify number of infants in this pregnancy born alive.

**12b. Birth Order of this infant:**

- 1st born     Other: \_\_\_\_\_
- 2nd born
- 3rd born
- 4th born

If a multiple birth, circle the birth order of this child named above. Include all infants delivered (alive or dead) in this pregnancy when determining birth order.

**12d. Birthweight:**

Choose one.

GRAMS: \_\_\_\_\_

or

LBS/OZS: \_\_\_\_ / \_\_\_\_

**12e. Apgar score:**

Score at 5 minutes: \_\_\_\_\_

*If 5 minute score is less than 6:*

Score at 10 minutes: \_\_\_\_\_

**12f. Obstetric estimate of gestation at delivery:**

Completed weeks: \_\_\_\_\_

The birth attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam. Do not compute based on date of the last menstrual period and the date of birth.

**12g. Abnormal conditions of the**

**newborn:** Disorders or significant morbidity experienced by the newborn.

Check all that apply.

- Assisted ventilation required immediately following delivery:** Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes oxygen only and laryngoscopy for aspiration of meconium.
- Assisted ventilation required for more than six hours:** Infant given mechanical ventilation (breathing assistance) by any method for > 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).
- NICU admission:** Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.
- Newborn given surfactant replacement therapy:** Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.
- Antibiotics received by the newborn for suspected neonatal sepsis:** Any antibacterial drug (e.g., penicillin, ampicillin, gentamicin, cefotaxime etc.) given systemically (intravenous or intramuscular).
- Seizure or serious neurologic dysfunction:** Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.
- Neonatal Abstinence Syndrome:** Infant diagnosed with Neonatal Abstinence Syndrome based on the results of the hospital's standard screening policy for maternal drugs of abuse and newborn NAS screening.
- None of the above**

**13a. Congenital anomalies of the newborn:**

Malformations of the newborn diagnosed prenatally or after delivery.

Check all that apply.

- Anencephaly:** Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).
- Meningomyelocele/Spina bifida:** Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).
- Cyanotic congenital heart disease:** Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetralogy of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.
- Congenital diaphragmatic hernia:** Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.
- Omphalocele:** A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.
- Gastroschisis:** An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.
- Limb reduction defect (excluding congenital amputation and dwarfing syndromes):** Complete or partial absence of a portion of an extremity associated with failure to develop.
- Cleft Lip with or without Cleft Palate:** Incomplete closure of the lip. May be unilateral, bilateral or median.
- Cleft Palate alone:** Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft lip with or without Cleft Palate category above.
- Down Syndrome - (Trisomy 21)**
  - Karyotype confirmed**     **Karyotype pending**
- Suspected chromosomal disorder:** Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.
  - Karyotype confirmed**     **Karyotype pending**
- Hypospadias:** Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.
- None of the above**

**13b. Immunization Information:**

Did newborn receive Hepatitis B vaccine:  Yes, Date of vaccine: \_\_\_/\_\_\_/\_\_\_ Lot no. \_\_\_\_\_  
 No  
 Unknown

Did newborn receive HBIG vaccine:  Yes, Date of vaccine: \_\_\_/\_\_\_/\_\_\_  
Time of vaccine: \_\_\_:\_\_\_ am / pm / military  
 No  
 Unknown

**13c. Was infant transferred within 24 hours of delivery?**

Check "yes" if the infant was transferred from this facility to another facility within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.

Yes, to: \_\_\_\_\_  
Name of facility infant transferred to  
 No  
 Unknown

**13d. Is infant living at time of report?**

Yes  No  Infant transferred, status unknown

Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care.

**13e. Is infant being breastfed at discharge?**

Yes  No  Unknown

If the infant was receiving breastmilk/colostrum during the period between birth and discharge from the hospital. Include attempts to establish breastmilk production prior to discharge by breastfeeding or pumping (expressing) milk.

**14a. Medical Informant:**

Name and date of person completing this Facility Worksheet:

First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_ Gen. ID \_\_\_\_\_ Title \_\_\_\_\_

Signature \_\_\_\_\_ Date Completed \_\_\_\_\_

**14b. COMMENTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_