

Birth Facility Worksheet

Mother _____

Child _____

Date of Birth ____/____/____ Time _____ Gender Male Female

MOTHER HEALTH
 WIC food Yes No
 Height ____ ft ____ in
 Pre-pregnancy weight _____
 Delivery weight _____
 Tobacco use Didn't smoke
 3 mths before _____ Cig Pck
 1st 3 mths _____ Cig Pck
 2nd 3 mths _____ Cig Pck
 3rd 3 mths _____ Cig Pck

PLACE OF BIRTH
 At this facility
 Home birth: Planned? Yes No
 Address _____
 Other _____

PRENATAL
 Mother's medical record number _____
 Mother's Medicaid number _____
Principal payment for delivery
 Medicaid/OHP
 Private insurance
 Self-pay
 Indian Health Services
 Champus/Tricare
 Other government
 Other _____
 Unknown
 Date of last menses
 Month ____ Day ____ Yr ____
Prenatal Care
 No prenatal care
 First prenatal visit
 Month ____ Day ____ Yr ____
 Last prenatal visit
 Month ____ Day ____ Yr ____
 Total prenatal visits _____
 Previous live births living
 None Number _____
 Previous live births dead
 None Number _____
 Date last live birth
 Month ____ Year ____
 Other pregnancy outcomes
 None Number _____
 Date - Month ____ Year ____

PREGNANCY FACTORS
Risk Factors (Check all that apply)
 Diabetes
 Pre-pregnancy Gestational
 Hypertension
 Pre-pregnancy Gestational
 Eclampsia
 Previous preterm birth
 Other previous poor outcome
 Bleeding during pregnancy
 Infertility treatment
 Drugs or insemination
 Technology (IVF, GIFT)
 Previous cesarean How many _____
 Alcohol use Yes # wk _____ No
 None of the above
Mother tested
 HIV Yes No
 Group B Strep Yes No

PREGNANCY FACTORS continued
Infections present and/or treated
 (Check all that apply)
 Gonorrhea
 Syphilis
 Herpes Simplex (HSV)
 Chlamydia
 Hepatitis B
 Hepatitis C
 None of the above
Obstetric Procedures (Check all that apply)
 Cervical cerclage
 Tocolysis
 External cephalic version
 Successful Failed
 None of the above

LABOR
Onset of Labor (Check all that apply)
 Premature rupture ≥ 12 hrs
 Precipitous labor < 3 hrs
 Prolonged labor ≥ 20 hrs
 None of the above
Characteristics of Labor and Delivery
 (Check all that apply)
 Induction of labor
 Augmentation of labor
 Non-vertex presentation
 Steroids prior to delivery
 Antibiotics during labor
 Clinical chorioamnionitis
 Moderate/heavy meconium
 Fetal intolerance of labor
 Epidural or spinal anesthesia
 None of the above

DELIVERY
Method of Delivery
 A Fetal presentation at birth
 Cephalic
 Breech
 Other
 B Final route
 Vaginal/Spontaneous
 Vaginal/Forceps
 Vaginal/Vacuum
 Cesarean Trial labor Yes No
 C Delivery with forceps unsuccessful?
 Yes No
 D Delivery with vacuum unsuccessful?
 Yes No
Maternal Morbidity (Check all that apply)
 Maternal transfusion
 3rd/4th degree perineal laceration
 Ruptured uterus
 Unplanned hysterectomy
 Admission to ICU
 Unplanned op procedure
 None of the above
 Unknown at this time
 Mother transferred to this facility prior to delivery Yes No
 From _____
 Infant transferred from facility
 Yes No
 To _____

NEWBORN
 Infant Medical Rec Number _____
 Birth weight _____ lb/oz grams
 APGAR 5 min ____ 10 min ____
 Estimated gestation _____ weeks
 Plurality _____ Birth order _____
 Number born alive this delivery _____
 Infant alive at time of report Yes No
 Infant breastfed at discharge
 Yes No Unknown

NEWBORN FACTORS
Abnormal conditions of newborn
 Assisted ventilation required immediately
 Assisted ventilation more than 6 hrs
 NICU admission
 Newborn given surfactant-replacement Therapy
 Antibiotics for suspected neonatal sepsis
 Seizure/serious neurologic dysfunction
 Significant birth injury
Congenital Anomalies
 Anencephaly
 Meningocele/Spina bifida
 Cyanolic congenital heart disease
 Congenital diaphragmatic hernia
 Omphalocele
 Gastroschisis
 Limb reduction defect
 Cleft Lip with or without Cleft Palate
 Cleft Palate alone
 Down Syndrome
 Karotype confirmed
 Karotype pending
 Suspected chromosomal disorder
 Karotype confirmed
 Karotype pending
 Hypospadias
 None of the anomalies listed above

ATTENDANT/CERTIFIER
Attendant
 Name _____
 Address _____
 NPI _____
Certifier
 Name _____

METABOLIC SCREENING
 Barcode number _____
 Date _____ Time _____

IMMUNIZATION
 Infant Hep B vaccine Yes No
 Date _____
 Manufacturer Glaxo Merck
 Lot number _____
 Infant HBIG 7 Yes No
 Date _____
 Manufacturer Glaxo Merck Other
 Lot number _____
 Mother HbsAg+ status
 Pos Neg Unk Not Scr