OREGON HEALTH AUTHORITY
Center for Health Statistics

Birth Record
FACILITY WORKSHEET

Please print neatly

CHILD *(Page 1 of 2)*

Name — First | Middle | Last | Suffix

Date of Birth: ___/___/___ (MM DD YYYY)

Time of Birth: ☐ AM ☐ PM ☐ Military

Sex: ☐ Female ☐ Male ☐ Undetermined ☐ X

MOTHER HEALTH

Did Mother get WIC food for herself during pregnancy? ☐ Yes ☐ No ☐ Unknown

Height	Weight (Pre-pregnancy)	Weight (At delivery)
ft in	lbs	lbs

Cigarette Smoking ☐ Check if none

Number per day

- 3 months before pregnancy # _____ Cigarettes
- 1st 3 months of pregnancy # _____ Cigarettes
- 2nd 3 months of pregnancy # _____ Cigarettes
- 3rd 3 months of pregnancy # _____ Cigarettes

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

PLACE OF BIRTH

☐ At this facility ☐ Home delivery Was home delivery planned? ☐ Yes ☐ No ☐ Unknown

☐ Other location (specify):_____

Specify address if not this facility:_____
No. & Street | Apt/Unit/Space | City | County | State | ZIP

PRENATAL

Mother's Medical Record # (optional):_____

Mother's Medicaid #:_____

Date of Last Menses (date of last period): ___/___/___ (MM DD YYYY)

Principal Method of Payment
- ☐ Medicaid/Oregon Health Plan
- ☐ Private insurance
- ☐ Self-pay
- ☐ Indian Health Services
- ☐ Champus/Tricare
- ☐ Other government
- ☐ Other: _____
- ☐ Unknown

Prenatal Care ☐ Check if none

Date of 1st visit ___/___/___ (MM DD YYYY) Total # of visits _____

Previous Live Births

now living_____ # now dead_____ Date of last live birth ___/___ (MM YYYY)

Other Pregnancy Outcomes (Spontaneous, induced terminations or ectopic pregnancy)

Combined # of other outcomes _____ Date of last other outcome ___/___ (MM YYYY)

Mother tested for HIV? ☐ Yes ☐ No ☐ Unknown

PREGNANCY FACTORS

Risk Factors
- ☐ Diabetes – Gestational
- ☐ Diabetes – Pre-pregnancy
- ☐ Hypertension – Pre-pregnancy (Chronic)
- ☐ Hypertension – Gestational (PIH, Preeclampsia)
- ☐ Hypertension – Eclampsia
- ☐ Previous Preterm Births (<37 Completed Wks. Gestation)
- ☐ Pregnancy Resulted From Infertility Treatment – Fertility-enhancing drugs
- ☐ Pregnancy Resulted From Infertility Treatment – Assisted Reproductive Technology
- ☐ Mother Had A Previous Cesarean Delivery How Many? _____
- ☐ None Of The Above

Mother tested for:
- ☐ Syphilis
- ☐ Group B Strep

Infections Present and/or Treated
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ COVID-19 (Confirmed or Presumed)
- ☐ None Of The Above

Obstetric Procedures

External cephalic version: ☐ Successful ☐ Failed

LABOR

Characteristics of Labor and Delivery
- ☐ Induction of labor
- ☐ Augmentation of labor (if labor has begun)
- ☐ Steroids for fetal lung maturation prior to delivery
- ☐ Antibiotics during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temp. > = 38C
- ☐ Epidural or spinal anesthesia during labor
- ☐ Unknown
- ☐ None of the above

DELIVERY

Method of Delivery

Fetal Presentation at Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown

Final Route and Method of Delivery: ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown

If Cesarean, was a Trial of Labor Attempted? ☐ Yes ☐ No (If "No" is selected DO NOT check Epidural or spinal anesthesia in the LABOR section.)

Maternal Morbidity (check all that apply)
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ None of the above
- ☐ Unknown at this time

Mother transferred to this facility prior to delivery? ☐ Yes ☐ No If yes, name of facility _____

Infant transferred from this facility after delivery? ☐ Yes ☐ No If yes, name of facility _____

Updated: 12/25

Hospital Staff

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

NEWBORN *(Page 2 of 2)*

Medical Rec # (optional):_____ Birth Weight:_____ ☐ lb/oz ☐ g APGAR _____5min _____10min

Obstetric Estimate of Gestation: (weeks) _____ Plurality: (Single, Twin, Triplet, etc.) _____ Birth Order: (1st, 2nd, 3rd, 4th, etc.)_____

Number born alive this delivery: _____Infant alive at time of report ☐ Yes ☐ No Infant breastfed at discharge ☐ Yes ☐ No

NEWBORN FACTORS

Abnormal Conditions of the Newborn

- ☐ Assisted ventilation required immediately
- ☐ Assisted ventilation for more than 6 hours
- ☐ NICU admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Antibiotics received by newborn for suspected neonatal sepsis
- ☐ Seizure/serious neurologic dysfunction
- ☐ Other significant birth injury
- ☐ None of the above

Congenital Anomalies

- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Cleft lip with or without cleft palate
- ☐ Cleft palate alone
- ☐ Down Syndrome, karyotype confirmed
- ☐ Down Syndrome, karyotype pending
- ☐ Down Syndrome, karyotype unknown
- ☐ Suspected chromosomal disorder, karyotype confirmed
- ☐ Suspected chromosomal disorder, karyotype pending
- ☐ Suspected chromosomal disorder, karyotype unknown
- ☐ Hypospadias
- ☐ None of the anomalies listed above

ATTENDANT

Attendant at delivery First Middle Last Title

The below items should be reported as soon as information is available.
These items are not required to certify the birth and can be added after the birth report is certified.

HEARING SCREENING

Was hearing test performed?
☐ Inpatient ☐ Outpatient ☐ Missed ☐ Not Screened – Medical Reason
☐ Deceased ☐ Transfer ☐ Refused ☐ Refused – Religion

Test date: ___/___/____ MM DD YYYY

Test Results

Left Ear: ☐ Pass ☐ Refer ☐ Equip. failure ☐ Physical condition Equipment type used: ☐ A-ABR ☐ OAE

Right Ear: ☐ Pass ☐ Refer ☐ Equip. failure ☐ Physical condition Equipment type used: ☐ A-ABR ☐ OAE

IMMUNIZATION

Did Infant receive Hepatitis B Vaccine?
☐ Yes ☐ No ☐ Refused Date administered:____/____/____ MM DD YYYY

Manufacturer ☐ Glaxo ☐ Merck ☐ Other:_____

Lot number:_____

Mother HBsAg+
☐ Positive ☐ Negative ☐ Unknown ☐ Not screened

Did Infant receive Hepatitis B Immune Globulin (HBIG)?
☐ Yes ☐ No ☐ Refused Date administered:____/____/____ MM DD YYYY

Manufacturer ☐ Glaxo ☐ Merck ☐ Other:_____

Lot number:_____

Can't find the record in OVERS after it is registered?

If a legal change occurs on the record that creates a new record, facility staff might not be able to access the original record. If you cannot locate the original record when adding information or when amending the birth record for any reason, please contact the Registration Unit by email at CHS.Registration@oha.oregon.gov for assistance.

Hospital Staff

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