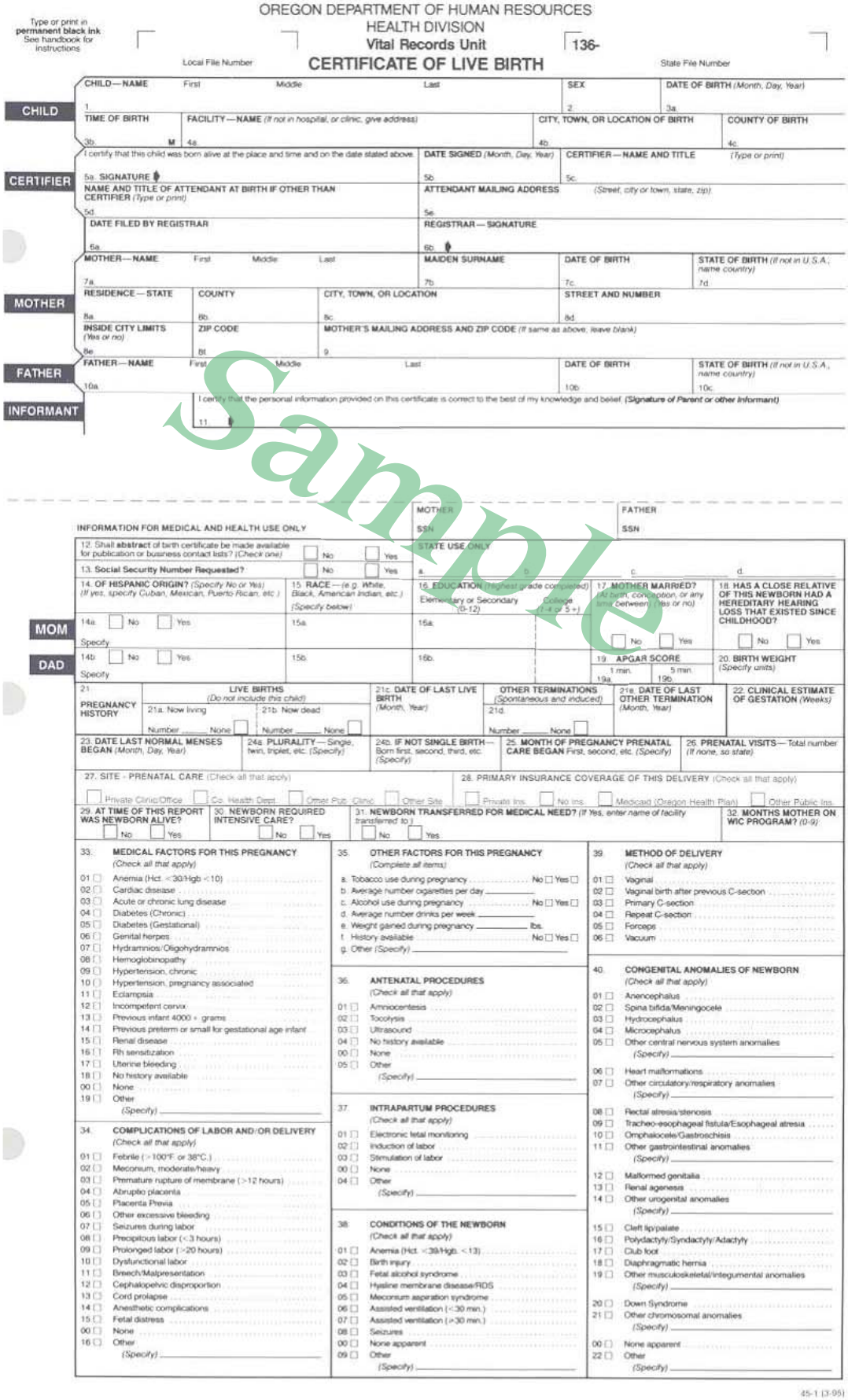
# Appendix D: Sample forms



OREGON DEPARTMENT OF HUMAN RESOURCES
HEALTH DIVISION
Vital Records Unit
CERTIFICATE OF LIVE BIRTH

Type or print in permanent black ink. See handbook for instructions.

Local File Number: 136-

State File Number

CHILD
1. CHILD—NAME (First, Middle, Last)
2. SEX
3a. DATE OF BIRTH (Month, Day, Year)
3b. TIME OF BIRTH
4a. FACILITY—NAME (If not in hospital, or clinic, give address)
4b. CITY, TOWN, OR LOCATION OF BIRTH
4c. COUNTY OF BIRTH

CERTIFIER
I certify that this child was born alive at the place and time and on the date stated above.
5a. SIGNATURE
5b. DATE SIGNED (Month, Day, Year)
5c. CERTIFIER—NAME AND TITLE (Type or print)
5d. NAME AND TITLE OF ATTENDANT AT BIRTH IF OTHER THAN CERTIFIER (Type or print)
5e. ATTENDANT MAILING ADDRESS (Street, city or town, state, zip)

6a. DATE FILED BY REGISTRAR
6b. REGISTRAR—SIGNATURE

MOTHER
7a. MOTHER—NAME (First, Middle, Last)
7b. MAIDEN SURNAME
7c. DATE OF BIRTH
7d. STATE OF BIRTH (If not in U.S.A., name country)
8a. RESIDENCE—STATE
8b. COUNTY
8c. CITY, TOWN, OR LOCATION
8d. STREET AND NUMBER
8e. INSIDE CITY LIMITS (Yes or no)
8f. ZIP CODE
9. MOTHER'S MAILING ADDRESS AND ZIP CODE (If same as above, leave blank)

FATHER
10a. FATHER—NAME (First, Middle, Last)
10b. DATE OF BIRTH
10c. STATE OF BIRTH (If not in U.S.A., name country)

INFORMANT
I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. (Signature of Parent or other Informant)
11.



INFORMATION FOR MEDICAL AND HEALTH USE ONLY

MOTHER SSN

FATHER SSN

12. Shall abstract of birth certificate be made available for publication or business contact lists? (Check one) ☐ No ☐ Yes
13. Social Security Number Requested? ☐ No ☐ Yes

STATE USE ONLY
a. b. c. d.

MOM
14. OF HISPANIC ORIGIN? (Specify No or Yes) (If yes, specify Cuban, Mexican, Puerto Rican, etc.)
15. RACE—(e.g. White, Black, American Indian, etc.) (Specify below)
16. EDUCATION (Highest grade completed) Elementary or Secondary (0-12) College (1-4 or 5+)
17. MOTHER MARRIED? (At birth, conception, or any time between) (Yes or no)
18. HAS A CLOSE RELATIVE OF THIS NEWBORN HAD A HEREDITARY HEARING LOSS THAT EXISTED SINCE CHILDHOOD?

DAD
14a. ☐ No ☐ Yes Specify
15a.
16a.
17. ☐ No ☐ Yes
18. ☐ No ☐ Yes
14b. ☐ No ☐ Yes Specify
15b.
16b.
19. APGAR SCORE 1 min. 5 min. 19a. 19b.
20. BIRTH WEIGHT (Specify units)

21. PREGNANCY HISTORY
LIVE BIRTHS (Do not include this child)
21a. Now living Number ____ None ☐
21b. Now dead Number ____ None ☐
21c. DATE OF LAST LIVE BIRTH (Month, Year)
OTHER TERMINATIONS (Spontaneous and induced)
21d. Number ____ None ☐
21e. DATE OF LAST OTHER TERMINATION (Month, Year)
22. CLINICAL ESTIMATE OF GESTATION (Weeks)

23. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)
24a. PLURALITY—Single, twin, triplet, etc. (Specify)
24b. IF NOT SINGLE BIRTH—Born first, second, third, etc. (Specify)
25. MONTH OF PREGNANCY PRENATAL CARE BEGAN First, second, etc. (Specify)
26. PRENATAL VISITS—Total number (If none, so state)

27. SITE - PRENATAL CARE (Check all that apply)
☐ Private Clinic/Office ☐ Co. Health Dept. ☐ Other Pub. Clinic ☐ Other Site
28. PRIMARY INSURANCE COVERAGE OF THIS DELIVERY (Check all that apply)
☐ Private Ins. ☐ No Ins. ☐ Medicaid (Oregon Health Plan) ☐ Other Public Ins.

29. AT TIME OF THIS REPORT WAS NEWBORN ALIVE? ☐ No ☐ Yes
30. NEWBORN REQUIRED INTENSIVE CARE? ☐ No ☐ Yes
31. NEWBORN TRANSFERRED FOR MEDICAL NEED? (If Yes, enter name of facility transferred to.) ☐ No ☐ Yes
32. MONTHS MOTHER ON WIC PROGRAM? (0-9)

33. MEDICAL FACTORS FOR THIS PREGNANCY (Check all that apply)
01 ☐ Anemia (Hct. <30/Hgb <10)
02 ☐ Cardiac disease
03 ☐ Acute or chronic lung disease
04 ☐ Diabetes (Chronic)
05 ☐ Diabetes (Gestational)
06 ☐ Genital herpes
07 ☐ Hydramnios/Oligohydramnios
08 ☐ Hemoglobinopathy
09 ☐ Hypertension, chronic
10 ☐ Hypertension, pregnancy associated
11 ☐ Eclampsia
12 ☐ Incompetent cervix
13 ☐ Previous infant 4000 + grams
14 ☐ Previous preterm or small for gestational age infant
15 ☐ Renal disease
16 ☐ Rh sensitization
17 ☐ Uterine bleeding
18 ☐ No history available
00 ☐ None
19 ☐ Other (Specify)

34. COMPLICATIONS OF LABOR AND/OR DELIVERY (Check all that apply)
01 ☐ Febrile (>100°F. or 38°C.)
02 ☐ Meconium, moderate/heavy
03 ☐ Premature rupture of membrane (>12 hours)
04 ☐ Abruptio placenta
05 ☐ Placenta Previa
06 ☐ Other excessive bleeding
07 ☐ Seizures during labor
08 ☐ Precipitous labor (<3 hours)
09 ☐ Prolonged labor (>20 hours)
10 ☐ Dysfunctional labor
11 ☐ Breech/Malpresentation
12 ☐ Cephalopelvic disproportion
13 ☐ Cord prolapse
14 ☐ Anesthetic complications
15 ☐ Fetal distress
00 ☐ None
16 ☐ Other (Specify)

35. OTHER FACTORS FOR THIS PREGNANCY (Complete all items)
a. Tobacco use during pregnancy ☐ No ☐ Yes
b. Average number cigarettes per day
c. Alcohol use during pregnancy ☐ No ☐ Yes
d. Average number drinks per week
e. Weight gained during pregnancy lbs.
f. History available ☐ No ☐ Yes
g. Other (Specify)

36. ANTENATAL PROCEDURES (Check all that apply)
01 ☐ Amniocentesis
02 ☐ Tocolysis
03 ☐ Ultrasound
04 ☐ No history available
00 ☐ None
05 ☐ Other (Specify)

37. INTRAPARTUM PROCEDURES (Check all that apply)
01 ☐ Electronic fetal monitoring
02 ☐ Induction of labor
03 ☐ Stimulation of labor
00 ☐ None
04 ☐ Other (Specify)

38. CONDITIONS OF THE NEWBORN (Check all that apply)
01 ☐ Anemia (Hct. <39/Hgb. <13)
02 ☐ Birth injury
03 ☐ Fetal alcohol syndrome
04 ☐ Hyaline membrane disease/RDS
05 ☐ Meconium aspiration syndrome
06 ☐ Assisted ventilation (<30 min.)
07 ☐ Assisted ventilation (>30 min.)
08 ☐ Seizures
00 ☐ None apparent
09 ☐ Other (Specify)

39. METHOD OF DELIVERY (Check all that apply)
01 ☐ Vaginal
02 ☐ Vaginal birth after previous C-section
03 ☐ Primary C-section
04 ☐ Repeat C-section
05 ☐ Forceps
06 ☐ Vacuum

40. CONGENITAL ANOMALIES OF NEWBORN (Check all that apply)
01 ☐ Anencephalus
02 ☐ Spina bifida/Meningocele
03 ☐ Hydrocephalus
04 ☐ Microcephalus
05 ☐ Other central nervous system anomalies (Specify)
06 ☐ Heart malformations
07 ☐ Other circulatory/respiratory anomalies (Specify)
08 ☐ Rectal atresia/stenosis
09 ☐ Tracheo-esophageal fistula/Esophageal atresia
10 ☐ Omphalocele/Gastroschisis
11 ☐ Other gastrointestinal anomalies (Specify)
12 ☐ Malformed genitalia
13 ☐ Renal agenesis
14 ☐ Other urogenital anomalies (Specify)
15 ☐ Cleft lip/palate
16 ☐ Polydactyly/Syndactyly/Adactyly
17 ☐ Club foot
18 ☐ Diaphragmatic hernia
19 ☐ Other musculoskeletal/integumental anomalies (Specify)
20 ☐ Down Syndrome
21 ☐ Other chromosomal anomalies (Specify)
00 ☐ None apparent
22 ☐ Other (Specify)

45-1 (3-95)