CHILD'S INFORMATION

First Name	Middle Name	Last Name	Suffix

Date of Birth	Time of Birth	Sex/Gender
	AM ☐ PM ☐	Male ☐ Female ☐

Request Social Security Number?	Safe Surrender?
Yes ☐ No ☐	Yes ☐ No ☐

MOTHER'S INFORMATION

Mother's Current Legal Name:

First Name	Middle Name	Last Name

Mother's Name Prior to First Marriage:

First Name	Middle Name	Last Name

Date of Birth	Age	Social Security Number

Birthplace State	Birthplace Country

Residence Address	Mailing Address
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
County: HENDERSON	County:
Country:	Country:
Inside City Limits: Yes ☐ No ☐	Inside City Limits: Yes ☐ No ☐
Telephone Number:	Telephone Number:

Highest Level of Education
☐ Eighth grade or less
☐ 9th-12th Grade – No Diploma
☐ High School Graduate or GED
☐ Some College, no Degree
☐ Associates Degree
☐ Bachelor's Degree
☐ Master's Degree
☐ Doctorate
☐ Unknown

Is mother of Hispanic Origin?
☐ No, Spanish/ Hispanic/Latina
☐ Yes, Mexican/Mexican-American-Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, Other Spanish/Hispanic/Latina (Specify)
☐ Unknown

Mother's Race?	
☐ Black or African American	☐ Guamanian or Chamorro
☐ American Indian or Alaska Native (Specify)	☐ White
☐ Asian Indian	☐ Vietnamese
☐ Chinese	☐ Other Asian (Specify)
☐ Filipino	☐ Samoan
☐ Japanese	☐ Other Pacific Island (Specify)
☐ Korean	☐ Other (Specify)
☐ Native Hawaiian	☐ Unknown

WIC
Did the mother receive WIC food for herself? YES ☐ NO ☐ Unknown ☐

Mother's Health Information
Mother's Height Feet: Inches:

Mother's Weight
Mother's prepregnancy weight in lbs.:
Mother's weight at the time of delivery in lbs.:

Cigarettes Smoking Before and During Pregnancy
Did Mother use Tobacco use during this pregnancy? Yes ☐ No ☐
Three months before pregnancy Cigarettes per day:
First trimester (first three months of pregnancy) Cigarettes per day:
Second trimester (second three months of pregnancy) Cigarettes per day:
Third trimester (third three months of pregnancy) Cigarettes per day:

Marital Information	
☐ Currently Married	☐ Preemptive Court Order
☐ Never Married	☐ Married but refusing husbands information
☐ Divorced	☐ Widow
☐ Separated	

Was mother married at conception, birth or anytime between conception or birth?
☐ Yes, Spouse is legal parent
☐ No
☐ Yes, but Spouse is not Legal Parent
☐ Mother Refusing Father Information

Paternity Information
Did a court rule the husband is NOT the father? YES ☐ NO ☐ Unknown ☐ Not Applicable ☐
Date of Divorce
Do you plan to file an Affidavit of Parentage? YES ☐ NO ☐ Unknown ☐ Not Applicable ☐

FATHER/PARENT'S INFORMATION

Father/Parent's Name:

First Name	Middle Name	Last Name	Suffix

Date of Birth	Age	Social Security Number

Birthplace State	Birthplace Country

Residence Address	Mailing Address
Street Address:	Street Address:
City/State/Zip:	City/State/Zip:
County: HENDERSON	County:
Country:	Country:
Inside City Limits: Yes ☐ No ☐	Inside City Limits: Yes ☐ No ☐
Telephone Number:	Telephone Number:

Highest Level of Education
☐ Eight grade or less
☐ 9th-12 – No Diploma
☐ High School Diploma or GED
☐ Some College
☐ Associates Degree
☐ Bachelor's Degree
☐ Master's Degree

Is Father/Parent of Hispanic Origin?
☐ No, Spanish/ Hispanic/Latina
☐ Yes, Mexican/Mexican-American-Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, Other Spanish/Hispanic/Latina (Specify)
☐ Unknown

Father/Parent's Race?	
☐ Black or African American	☐ Guamanian or Chamorro
☐ American Indian or Alaska Native (Specify)	☐ White
☐ Asian Indian	☐ Vietnamese
☐ Chinese	☐ Other Asian (Specify)
☐ Filipino	☐ Samoan
☐ Japanese	☐ Other Pacific Island (Specify)
☐ Korean	☐ Other (Specify)
☐ Native Hawaiian	☐ Unknown

Informant Information

Informant Relation to Child
☐ Mother
☐ Father
☐ Other (Specify):

Informant Name

First Name	Middle Name	Last Name

Place of Birth

Type of Place:	
☐ Hospital	☐ Home Delivery Unknown if Planned
☐ Freestanding Birth Center	☐ Clinic/Doctor's Office
☐ Home – Planned	☐ Other (Specify)
☐ Home – Unplanned	☐ Unknown

Place of Birth Address
Facility Name:
Street Address:
City/State/Zip:
County:
Country: **United States**

PRENATAL:

Principal source of payment for this delivery:
☐ Medicaid
☐ Private Insurance
☐ Self Pay
☐ Other
☐ Unknown

Mother's Date last normal menses began

Mother's Transfer Status

Was mother transferred into this facility for maternal medical or fetal indications for delivery?	**If "YES", which facility?**
Yes ☐ No ☐ Unknown ☐	

Prenatal Care Information

Did mother receive prenatal care? Yes ☐ No ☐ Unknown ☐
First visit date:
Last visit date:
Total number of prenatal visits for this pregnancy:

Pregnancy History

Total Number of Live Births Now Living:
Total Number of Live Births Now Dead:
Date of last live birth:
Number of other pregnancy outcomes:
Date of last other pregnancy outcome:

Risk Factors

Risk Factor in this pregnancy *(check all that apply):*
☐ Diabetes - Gestational (diagnosis in this pregnancy)
☐ Diabetes - Prepregnancy (diagnosis prior to this pregnancy)
☐ Hypertension - Prepregnancy (chronic)
☐ Hypertension - Gestational (PIH, Preclampsia)
☐ Hypertension – Eclampsia
☐ Previous preterm birth
☐ Other Previous poor pregnancy outcome (Includes perinatal death, SGA, IUGR birth)
☐ Pregnancy Resulted from Infertility Treatment - Fertility-enhancing drugs, artificial insemination or intrauterine insemination
☐ Pregnancy Resulted from Infertility Treatment – Assisted reproductive technology (e.g. In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT)
☐ Mother had a previous cesarean delivery
☐ None of the above:
☐ Unknown

Was Mother Tested for HBsAG?	**Date Tested**	**Test Results**
Yes ☐ No ☐		Positive ☐ Negative ☐

Infections Present and/or treated during this pregnancy (check all that apply)
☐ Gonorrhea
☐ Syphilis
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ None of the above

Obstetric Procedures (check all that apply):
☐ Cervical cerclage
☐ Tocolysis
☐ External cephalic version - Successful
☐ External cephalic version – Failed
☐ None of the above

Onset of Labor (check all that apply):
☐ Premature rupture of the membranes (prolonged greater than or equal to 12 hours)
☐ Precipitous Labor (less than 3 hours)
☐ Prolonged Labor (greater than or equal to 20 hours)
☐ None of the above:
☐ Unknown

Characteristics of Labor & Delivery (check all that apply):
☐ Induction of labor
☐ Augmentation of labor
☐ Non-vertex presentation
☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
☐ Antibiotics received by mother during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature is greater than or equal to 38° C (100.4°F)
☐ Moderate/heavy meconium staining of the amniotic fluid
☐ Fetal intolerance of labor such that one or more of the following actions was taken: In-utero resuscitative measures, further fetal assessment or operative delivery
☐ Epidural or spinal anesthesia during labor
☐ None of the above
☐ Unknown

Method of Delivery

Was Delivery with Forceps attempted but unsuccessful?	**Was Delivery with Vacuum Extraction Attempted by unsuccessful?**
Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐

Fetal Presentation at Birth
☐ 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 ☐ Unknown ☐ Not Applicable ☐

Maternal Morbidity *(check all that apply)*:
☐ Maternal transfusion
☐ Third of fourth degree perineal laceration
☐ Ruptured uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the above
☐ Unknown

Mother Transferred for maternal medical or fetal indication prior to delivery	Infant Transferred within 24 hours of delivery?
Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐

NEWBORN

Birth Weight
Pounds: Ounces:

APGAR Score
Score at 5 minutes:
If the 5 minute score is less than 6, score at 10 minutes:

Obstetric Estimate of Gestation
Obstetric Estimate of gestation (completed weeks):

Plurality	Birth Order	Number Born Alive

Is infant living at the time of report?	Is infant being breastfed at discharge?
Yes ☐ No ☐ Unknown ☐	Yes ☐ No ☐ Unknown ☐

Infant's Vaccination

Did infant receive Hepatitis B vaccine?	Date Hepatitis vaccine administered
Yes ☐ No ☐ Unknown ☐ Refused ☐	

Was infant immunized with Nirsevimab (RSV)?	Nirsevimab (RSV) dosage amount?	Nirsevimab (RSV) date administered
Yes ☐ No ☐ Unknown ☐	☐ **50 mg** ☐ **100 mg** ☐ **Unknown**	

Abnormal Conditions *(check all that apply)*:
☐ Assisted ventilation required immediately following delivery
☐ Assisted ventilation required for more than six (6) hours
☐ NICU admission
☐ Newborn given surfactant replacement therapy
☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Seizure or serious neurologic dysfunction
☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention
☐ None of the above
☐ Unknown

Congenital Anomalies *(check all that apply)*:
☐ Anencephaly
☐ Meningomyelocele/Spina bifida
☐ Cyanotic congenital heart disease
☐ Congenital diaphragmatic hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
☐ Cleft lip with or without cleft palate
☐ Cleft palate
☐ Down Syndrome Karyotype Confirmed
☐ Down Syndrome Karyotype Pending
☐ Suspected Chromosomal disorder – Karyotype Confirmed
☐ Suspected Chromosomal disorder – Karyotype Pending
☐ Hypospadias
☐ None of the above
☐ Unknown

ATTENDANT

First Name	Middle Name	Last Name	Suffix

Attendant Information
Title:
Relationship to Child:
NPI Number:
License Number:
Address:

CERTIFIER

First Name	Middle Name	Last Name	Suffix

Certifier Information
Title:
Relationship to Child:
NPI Number:
License Number:
Address:
Date Certified: