

CERTIFICATE OF LIVE BIRTH WORKSHEET (Hawaii 2014)

LOCAL FILE NO.

BIRTH NUMBER:

CHILD	1. CHILD'S NAME (First, Middle, Last, Suffix)		2. TIME OF BIRTH (24 hr)	3. SEX	4. DATE OF BIRTH (Mo/Day/Yr)
	5. FACILITY NAME (If not institution, give street and number)	6. CITY, TOWN, OR LOCATION OF BIRTH	7. COUNTY OF BIRTH	7b. BIRTH ISLAND	
MOTHER	8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)			8b. DATE OF BIRTH (Mo/Day/Yr)	
	8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)			8d. BIRTHPLACE (State, Territory, or Foreign Country)	
	9a. RESIDENCE OF MOTHER-STATE	9b. COUNTY	9c. CITY, TOWN, OR LOCATION		
	9d. STREET AND NUMBER	9e. APT. NO.	9f. ZIP CODE	9g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
FATHER	10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		10b. DATE OF BIRTH (Mo/Day/Yr)	10c. BIRTHPLACE (State, Territory, or Foreign Country)	
CERTIFIER	11. CERTIFIER'S NAME: _____ TITLE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> HOSPITAL ADMIN. <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify) _____		12. DATE CERTIFIED ____/____/____ MM DD YYYY		13. DATE FILED BY REGISTRAR ____/____/____ MM DD YYYY

INFORMATION FOR ADMINISTRATIVE USE

MOTHER	14. MOTHER'S MAILING ADDRESS: <input type="checkbox"/> Same as residence, or: State: _____		City, Town, or Location: _____		
	Street & Number: _____		Apartment No.: _____		Zip Code: _____
19b. Publish Child's Name: Y/N _____	15. MOTHER MARRIED? (At birth, conception, or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No		IF YES AND NO FATHER LISTED, REFUSAL SUBMITTED? <input type="checkbox"/> Yes <input type="checkbox"/> No		IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? <input type="checkbox"/> Yes <input type="checkbox"/> No
	16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? <input type="checkbox"/> Yes <input type="checkbox"/> No	17. FACILITY ID. (NPI) _____	18. MOTHER'S SOCIAL SECURITY NUMBER _____	19. FATHER'S SOCIAL SECURITY NUMBER _____	

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER	20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		21. MOTHER'S RACE Specify (Caucasian, Japanese, etc.) _____ _____ _____ _____ (Please spell out and list all races)		22. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina) <input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____	
FATHER	23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery) <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		24. FATHER'S RACE Specify (Caucasian, Japanese, etc.) _____ _____ _____ _____ (Please spell out and list all races)		25. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino) <input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____	
MOTHER'S NAME	26. PLACE WHERE BIRTH OCCURRED (Check one) <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home Birth: Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Clinic <input type="checkbox"/> Doctor's office <input type="checkbox"/> Other (Specify) _____		27. ATTENDANT'S NAME, TITLE, AND NPI NAME: _____ NPI: _____ TITLE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify) _____		28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: _____	

EMAIL ADDRESS

PHONE NUMBER

MOTHER'S NAME

MOTHER'S MEDICAL RECORD NO.

MOTHER	29a. DATE OF FIRST PRENATAL CARE VISIT ____/____/____ <input type="checkbox"/> No Prenatal Care MM DD YYYY		29b. DATE OF LAST PRENATAL CARE VISIT ____/____/____ MM DD YYYY		30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY _____ (If none, enter "0".)		
	31. MOTHER'S HEIGHT _____(feet/inches)		32. MOTHER'S PREPREGNANCY WEIGHT _____(pounds)		33. MOTHER'S WEIGHT AT DELIVERY _____(pounds)		
	34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No		35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)		36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)		
	35a. Now Living Number _____ <input type="checkbox"/> None		35b. Now Dead Number _____ <input type="checkbox"/> None		36a. Spontaneous or ectopic Number _____ <input type="checkbox"/> None		
36b. Induced Number _____ <input type="checkbox"/> None		37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0". Average number of cigarettes or packs of cigarettes smoked per day. Three Months Before Pregnancy _____ OR _____ First Three Months of Pregnancy _____ OR _____ Second Three Months of Pregnancy _____ OR _____ Third Trimester of Pregnancy _____ OR _____		38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY <input type="checkbox"/> Private Insurance <input type="checkbox"/> Medicaid or Quest <input type="checkbox"/> Self-pay <input type="checkbox"/> Tricare or Military Insurance <input type="checkbox"/> Other (Specify) _____			
35c. DATE OF LAST LIVE BIRTH ____/____/____ MM DD YYYY		36c. DATE OF LAST OTHER PREGNANCY OUTCOME ____/____/____ MM DD YYYY		39. DATE LAST NORMAL MENSES BEGAN ____/____/____ MM DD YYYY			
40. MOTHER'S MEDICAL RECORD NUMBER		41. RISK FACTORS IN THIS PREGNANCY (Check all that apply) Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia) <input type="checkbox"/> Eclampsia <input type="checkbox"/> Previous preterm birth <input type="checkbox"/> Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) <input type="checkbox"/> Pregnancy resulted from infertility treatment-If yes, check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)) <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many _____ <input type="checkbox"/> None of the above		42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply) <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the above		43. OBSTETRIC PROCEDURES (Check all that apply) <input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the above	
44. ONSET OF LABOR (Check all that apply) <input type="checkbox"/> Premature Rupture of the Membranes (prolonged, >=12 hrs.) <input type="checkbox"/> Precipitous Labor (<3 hrs.) <input type="checkbox"/> Prolonged Labor (>= 20 hrs.) <input type="checkbox"/> None of the above		45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply) <input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery <input type="checkbox"/> Antibiotics received by the mother during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature >=38°C (100.4°F) <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid <input type="checkbox"/> 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 <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above		46. METHOD OF DELIVERY A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other D. Final route and method of delivery (Check one) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No			
47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery) <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Third or fourth degree perineal laceration <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> Unplanned operating room procedure following delivery <input type="checkbox"/> None of the above		NEWBORN INFORMATION		48. NEWBORN MEDICAL RECORD NUMBER			
49. BIRTHWEIGHT (grams preferred, specify unit) _____ <input type="checkbox"/> grams <input type="checkbox"/> lb/oz		50. OBSTETRIC ESTIMATE OF GESTATION: _____(completed weeks)		51. APGAR SCORE: Score at 5 minutes: _____ If 5 minute score is less than 6, Score at 10 minutes: _____			
52. PLURALITY - Single, Twin, Triplet, etc. (Specify) _____		53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) _____		54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply) <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) <input type="checkbox"/> None of the above			
55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply) <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the anomalies listed above		56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: _____		57. IS INFANT LIVING AT TIME OF REPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant transferred, status unknown			
58. IS THE INFANT BEING BREASTFED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No		MOTHER'S NAME		MOTHER'S MEDICAL RECORD NO.			