BIRTH PARENT'S MEDICAL RECORD #	**CHILD'S** MEDICAL RECORD #
	IF MULTIPLE BIRTH, this worksheet is for:

Rev. 01/2022

STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

MEDICAL DATA WORKSHEET for the LIVE BIRTH CERTIFICATE (v2003)

Connecticut General Statute §7-48 requires the medical practitioner in attendance of a birth and the practitioner providing prenatal care to provide the medical information required by the certificate not later than 72 hours after the birth. When a birth occurs in an institution, the institution's designated representative shall obtain all available data required by the certificate, prepare the certificate, certify that the child was born alive at the place and time and on the date stated, and file the certificate not later than ten days after such birth. Each birth certificate shall contain such information as the Department of Public Health may require and shall be completed in its entirety.

Birth Parent's Name:

_____ _____ _____ _____
First Middle Last Generational ID

1b. Date of birth of this child

__ __ / __ __ / __ __ __ __
Month Day Year

1c. Time of birth of this child

__ __ : __ __ ☐ AM ☐ PM ☐ Military
hour minute

1d. Sex of this child

❑ Male ❑ Female
❑ Not yet determined/Unknown

1e. Place of Birth Type:

- ☐ Hospital
- ☐ Free Standing Birthing Center
- ☐ Clinic/Doctor's Office
- ☐ Born En-route or on Arrival
- ☐ Residence:
  - Was this a planned delivery at home?
  - ☐ Yes ☐ No ☐ Unknown

1f. Birthplace Name and Address:

Facility Name: _____

Street address of birth location:

_____ _____
Street Apt #

_____ _____ _____
City/Town County State

MEDICAL CERTIFICATION

I HEREBY CERTIFY THAT THE CHILD WAS BORN AT THE HOUR, DATE, AND PLACE STATED ABOVE

Certifier's Title:

- ☐ MD
- ☐ DO
- ☐ CNM
- ☐ Other Midwife-CPM
- ☐ Birth Parent
- ☐ Non-Birth Parent
- ☐ Other – specify: _____

Certifier's Printed Name: _____
First MI Last Generational ID

Certifier's Signature:

_____ **Date Signed:** _____
First MI Last Generational ID

CT License Number: _____ **National Provider ID:** _____

Certifier's Address:

_____
Street/Apt # City/Town State ZIP code

8h. Birth Attendant's Information: The attendant at birth is the person physically present at the delivery room who is responsible for the delivery even if they do not themselves deliver the infant.

Title of Birth Attendant:

☐ MD ☐ DO ☐ CNM ☐ Other Midwife-CPM ☐ Birth Parent ☐ Non-Birth Parent

☐ Other (specify): _____

Name of Birth Attendant:

☐ SAME AS CERTIFIER

_____
First MI Last Generational ID

CT License Number: _____ **National Provider ID (NPI):** _____

PRENATAL INFORMATION

Sources: Prenatal care records, Birth Parent's medical records, labor and delivery records

Information for the following items should come from the Birth Parent's prenatal care records and from other medical reports in the Birth Parent's chart, as well as the infant's medical record. If the Birth Parent's prenatal care record is not in the hospital chart, please contact the Birth Parent's prenatal care provider to obtain the record, or a copy of the prenatal care information.

Preferred and acceptable sources are given before each section.
Please do not provide information from sources other than those listed.

WHERE INFORMATION FOR AN ITEM CANNOT BE LOCATED, PLEASE WRITE "UNKNOWN" ON THE PAPER COPY OF THE WORKSHEET.

9a. Did Birth Parent Have Prenatal Care:

□ YES □ NO □ Unknown

Is the prenatal care record available for this Birth Parent? Is it current? If the prenatal care record is not available *or* if the record is not current (i.e., from pre-registration), please contact the prenatal care provider for an updated record before completing the remaining items.

9b. Principal Source of Payment for Prenatal Care:

□ Husky or Medicaid
□ Private/Employer Insurance
□ Self-pay (No third party identified)
□ Indian Health Service
□ CHAMPUS/TRICARE
□ Other Government
□ Other – specify: _____

9c. Date of FIRST prenatal care visit:

__ __ / __ __ / __ __ __ __
Month Day Year

Prenatal care begins when a physician or other health professional first examines and/or counsels as part of an ongoing program of care for the pregnancy.

9d. Total number of prenatal care VISITS for this pregnancy:

_____

Count only those visits recorded in the record. If the prenatal records do not appear to be current, please contact the prenatal care provider for updated information.

9e. Date last normal menses began:

__ __ / __ __ / __ __ __ __
Month Day Year

Do NOT calculate the date if it is not specified in the prenatal care record. If any part of the date is available, enter the available parts (e.g., 04/99/2014). Otherwise, enter 99-99-9999.

9f. Method of Determining EDD: Method used by prenatal care provider to establish the Estimated Date of Delivery (EDD). Check one:

□ Known LMP consistent with an ultrasound (the earliest possible >7 weeks)
□ Ultrasound (the earliest possible >7 weeks) NOT consistent with known LMP
□ Ultrasound alone, LMP date is only partially known or not known
□ LMP alone, did not have an ultrasound prior to labor and delivery
□ ART: Date of Assisted Reproductive Technology (ART) established the EDD
□ No EDD determined
□ Method unknown

Known LMP means that all parts of the LMP date (MM-DD-YYYY) were recorded in the Birth Parent's prenatal records. If only a partial LMP date is available, do not select the first two options.
ART (Assisted Reproductive Technology) includes embryo transfer, intrauterine insemination (IUI), ZIFT, GIFT.
If no prenatal care was received, then select "No EDD determined" since a prenatal provider did not date the pregnancy.
If the prenatal care record is not available or does not specify the method used to determine EDD, then select "Method unknown".

9g. Number of previous LIVE births now LIVING:

____ □ None

Do not include this child. Include all live births delivered before this infant in this pregnancy and in previous pregnancies.

9h. Number of previous LIVE births now DEAD:

____ □ None

Do not include this child. Include all live-births-now-dead delivered before this infant in this pregnancy and in previous pregnancies.

9i. Date of last live birth:

__ __ / __ __ __ __
Month Year

9j. Total number of other pregnancy outcomes that did not result in a live birth:

_____ □ None

Include pregnancy losses of any gestational age--spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in this pregnancy and in previous pregnancies.

9k. Date of last other pregnancy outcome:

__ __ / __ __ __ __
Month Year

Date when last pregnancy that did not result in a live birth ended.

9l. Did Birth Parent's blood test positive for syphilis during this pregnancy? If yes, provide test date(s).

1st test:

□ YES, positive test result on __ __ /__ __ /__ __ __ __
Month Day Year

□ No

□ Unknown

2nd test:

□ YES, positive test result on __ __ /__ __ /__ __ __ __
Month Day Year

□ No

□ Unknown

9m. Was Birth Parent's prenatal care record available for completing worksheet?

□ YES □ NO □ Unknown

10a. Birth Parent's risk factors for this pregnancy: Check all that apply.

Diabetes: Glucose intolerance requiring treatment. If diabetes is present, check either pre-pregnancy or gestational. Do not check both.

- □ **Pre-pregnancy:** Diagnosis prior to this pregnancy
- □ **Gestational:** Diagnosis in this pregnancy

Hypertension: Elevation of blood pressure above normal for age, gender, and physiological condition. If hypertension is present, check either pre-pregnancy or gestational. Do not check both.

- □ **Pre-pregnancy** (Chronic): Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy.
- □ **Gestational** (PIH, preeclampsia): Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face).
- □ **Eclampsia:** Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema.

□ **Previous preterm birth:** History of pregnancy(ies) terminating in a live birth of less than 37 completed weeks of gestation.

□ **Pregnancy resulted from infertility treatment** - Any assisted reproduction technique used to initiate the pregnancy. Includes fertility-enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination and assisted reproduction technology (ART) procedures (e.g., IVF, GIFT and ZIFT).

If Yes, check all that apply:

- □ **Fertility-enhancing drugs, artificial insemination or intrauterine insemination:** Any fertility- enhancing drugs (e.g., Clomid, Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.
- □ **Assisted reproductive technology:** Any assisted reproduction technology (ART)/technical procedures (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), ZIFT) used to initiate the pregnancy.

□ **Birth Parent had a previous cesarean delivery:** Previous operative delivery by extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.

If Yes, how many previous cesareans? ____

□ **Birth Parent used tobacco cigarettes during this pregnancy:** Prenatal care record indicates that Birth Parent used tobacco cigarettes during pregnancy. Include any reported use during this pregnancy, even if Birth Parent reported cessation upon learning of the pregnancy. Do not include e-cigarettes or vaping cigarettes.

□ **Birth Parent used alcohol during this pregnancy:** Prenatal care record indicates that Birth Parent used alcohol during pregnancy. Include any reported use during this pregnancy, even if Birth Parent reported cessation upon learning of the pregnancy.

□ **None of the above**

□ **Unknown**

10b. Infections present and/or treated during this pregnancy:
Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.

Check all that apply.

- □ **Chlamydia**: a diagnosis of or positive test for Chlamydia trachomatis
- □ **Gonorrhea**: a diagnosis of or positive test for Neisseria gonorrhoeae
- □ **Syphilis**: also called lues - a diagnosis of or positive test for Treponema pallidum
- □ **Hepatitis B**: HBV, serum hepatitis - a diagnosis of or positive test for the hepatitis B virus
- □ **Hepatitis C**: non A, non B hepatitis, HCV - a diagnosis of or positive test for the hepatitis C virus
- □ **HIV+:** a diagnosis of or positive test for human immunodeficiency virus
- □ **None of the above**

10c. Obstetric procedure: Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically in the treatment of the pregnancy, management of labor and/or delivery.

- □ **External cephalic version:** Attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation.
  - □ **Successful** □ **Failed**
- □ **None of the above**

LABOR AND DELIVERY

Sources: Labor and delivery records, Birth Parent's medical records

11a. Principal Source of Payment for Delivery:

- □ Husky or Medicaid
- □ Private/Employer Insurance
- □ Self-pay (No third party identified)
- □ Indian Health Service
- □ CHAMPUS/TRICARE
- □ Other Government
- □ Other – specify: _____

11b,c. Was the Birth Parent transferred to this facility for maternal medical or fetal indications for delivery?

- □ Yes, from: _____
  Name of facility Birth Parent transferred from
- □ No
- □ Unknown

Transfers include hospital to hospital, birth facility to hospital, etc.

11d. Birth Parent's weight at delivery: _____ (in pounds)

11e. Characteristics of labor and delivery: Check all that apply.

- □ **Induction of labor:** Initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor.
- □ **Augmentation of labor:** Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery.
- □ **Steroids (glucocorticoids) for fetal lung maturation received by the Birth Parent prior to delivery:** Includes betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to the Birth Parent as an anti-inflammatory treatment.
- □ **Antibiotics received by the Birth Parent during labor:** Includes antibacterial medications given systemically (intravenous or intramuscular) to the Birth Parent in the interval between the onset of labor and the actual delivery: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.
- □ **Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F):** Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis and fetal tachycardia. Any maternal temperature at or above 38°C (100.4°F).
- □ **Epidural or spinal anesthesia during labor:** Administration to the Birth Parent of a regional anesthetic for control of the pain of labor, i.e., delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.
- □ **None of the above**

11f. Method of Delivery:

Fetal presentation at birth: Check one.

- □ **Cephalic:** Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP)
- □ **Breech:** Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech
- □ **Other:** Any other presentation not listed above

Final route and method of delivery: Check one.

- □ **Vaginal/Spontaneous**: Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.
- □ **Vaginal/Forceps:** Delivery of the fetal head through the vagina by application of obstetrical forceps to the fetal head.
- □ **Vaginal/Vacuum:** Delivery of the fetal head through the vagina by application of a vacuum cup or ventouse to the fetal head.
- □ **Cesarean:** Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.

  If cesarean, was a trial of labor attempted? Labor was allowed, augmented or induced with plans for a vaginal delivery.

  □ Yes □ No

11g. Maternal morbidity: Serious complications experienced by the Birth Parent associated with labor and delivery.

Check all that apply.

- □ **Maternal transfusion:** Includes infusion of whole blood or packed red blood cells associated with labor and delivery.
- □**Third- or fourth-degree perineal laceration:** 3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body, and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.
- □**Ruptured uterus:** Tearing of the uterine wall.
- □ **Unplanned hysterectomy:** Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.
- □ **Admission to intensive care unit:** Any admission of the Birth Parent to a facility/unit designated as providing intensive care.
- □ **None of the above**

NEWBORN

Sources: Labor and delivery records, Newborn's medical records, Birth Parent's medical records

12a. Plurality of this birth:

❑ Singleton ❑ Other:
❑ Twins _____
❑ Triplets
❑ Quadruplets

Include all infants delivered (alive or dead) in this pregnancy when determining plurality.

12b. Birth Order of this infant:

❑ 1st born ❑ Other:
❑ 2nd born _____
❑ 3rd born
❑ 4th born

If a multiple birth, circle the birth order of this child named above. Include all infants delivered (alive or dead) in this pregnancy when determining birth order.

12c. Total LIVE births in this pregnancy: _____

If not single birth, specify number of infants in this pregnancy born alive.

12d. Birthweight:

Choose one.

GRAMS: _____

or

LBS/OZS: ____ /____

12e. Apgar score:

Score at 5 minutes: _____

If 5 minute score is less than 6:

Score at 10 minutes: _____

12f. Obstetric estimate of gestation at delivery:

Completed weeks: _____

The birth attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam. **Do not compute based on date of the last menstrual period and the date of birth.**

12g. Abnormal conditions of the newborn: Disorders or significant morbidity experienced by the newborn.

Check all that apply.

□ **Assisted ventilation required immediately following delivery:** Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes oxygen only and laryngoscopy for aspiration of meconium.

□ **Assisted ventilation required for more than six hours:** Infant given mechanical ventilation (breathing assistance) by any method for > 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).

□ **NICU admission:** Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.

□ **Newborn given surfactant replacement therapy:** Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.

□ **Antibiotics received by the newborn for suspected neonatal sepsis:** Any antibacterial drug (e.g., penicillin, ampicillin, gentamicin, cefotoxine etc.) given systemically (intravenous or intramuscular).

□ **Seizure or serious neurologic dysfunction:** Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.

□ **Neonatal Abstinence Syndrome:** Infant diagnosed with Neonatal Abstinence Syndrome based on the results of the hospital's standard screening policy for maternal drugs of abuse and newborn NAS screening.

□ **None of the above**

13a. Congenital anomalies of the newborn:
Malformations of the newborn diagnosed prenatally or after delivery.

Check all that apply.

□ **Anencephaly:** Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).

□ **Meningomyelocele/Spina bifida:** Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).

□ **Cyanotic congenital heart disease:** Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.

□ **Congenital diaphragmatic hernia:** Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.

□ **Omphalocele:** A defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.

□ **Gastroschisis:** An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane.

□ **Limb reduction defect (excluding congenital amputation and dwarfing syndromes):** Complete or partial absence of a portion of an extremity associated with failure to develop.

□ **Cleft Lip with or without Cleft Palate:** Incomplete closure of the lip. May be unilateral, bilateral or median.

□ **Cleft Palate alone:** Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft lip with or without Cleft Palate category above.

□ **Down Syndrome - (Trisomy 21)**

□ **Karyotype confirmed** □ **Karyotype pending**

□ **Suspected chromosomal disorder:** Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.

□ **Karyotype confirmed** □ **Karyotype pending**

□ **Hypospadias:** Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.

□ **None of the above**

13b. Immunization Information:

Did newborn receive Hepatitis B vaccine: □ Yes, Date of vaccine: ___/___/_____ Lot no._____
□ No
□ Unknown

Did newborn receive HBIG vaccine: □ Yes, Date of vaccine: ___/___/_____
Time of vaccine: _____:_____ am / pm / military
□ No
□ Unknown

13c. Was infant transferred within 24 hours of delivery?

Check "yes" if the infant was transferred from this facility to another facility within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.

□ Yes, to: _____
Name of facility infant transferred to
□ No
□ Unknown

13d. Is infant living at time of report?

□ Yes □ No □ Infant transferred, status unknown

Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care.

13e. Is infant being breastfed at discharge?

□ Yes □ No □ Unknown

If the infant was receiving breastmilk/colostrum during the period between birth and discharge from the hospital. Include attempts to establish breastmilk production prior to discharge by breastfeeding or pumping (expressing) milk.

14a. Medical Informant:

Name and date of person completing this Facility Worksheet:

First	Middle	Last	Gen. ID	Title

Signature_____ **Date Completed**_____

14b. COMMENTS: