Appendix D: Sample forms

OREGON DEPARTMENT OF HUMAN SERVICES
CENTER FOR HEALTH STATISTICS

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

136-

Local File Number

CERTIFICATE OF LIVE BIRTH

State File Number

CHILD

1. CHILD — NAME First Middle Last | 2. SEX | 3a DATE OF BIRTH *(Month, Day, Year)*

3b. TIME OF BIRTH M | 4a. FACILITY — NAME *(If not in hospital or clinic, give address)* | 4b. CITY, TOWN OR LOCATION OF BIRTH | 4c. COUNTY OF BIRTH

CERTIFIER

5a. I certify that this child was born alive at the place and time and on the date stated above. 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

11. 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)**

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

STATE USE ONLY

13. Social Security Number Requested? ☐ No ☐ Yes

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?

14a. ☐ No ☐ Yes *Specify* | 15a. | 16a. | ☐ No ☐ Yes | ☐ No ☐ Yes

DAD

14b. ☐ No ☐ Yes *Specify* | 15b. | 16b. | 19. APGAR SCORE 1 min. 19a. 5 min. 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 OF 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 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 (04/05)