

STATE OF GEORGIA BIRTH WORKSHEET

1. THIS BIRTH (Single, Twin, Triplet, etc)

2. IF NOT SINGLE, SPECIFY (1st, 2nd, 3rd, 4th, etc.)

3. CHILD'S NAME: (FIRST MIDDLE LAST SUFFIX)

4. DATE OF BIRTH (mm/dd/yyyy)

5. TIME OF BIRTH (24 hr)

6. SEX

7. HOSPITAL FACILITY NAME AND ADDRESS (if not Hospital, give street and number)

- Hospital Birthing center Enroute/BOA Clinic/Doctor's Office ER
 Other (specify) _____

8. CITY, TOWN OR LOCATION OF BIRTH

9. FACILITY ID (NPI)

10. SPECIFY BIRTHPLACE

11. COUNTY, STATE AND ZIP CODE OF BIRTH

12. MOTHER'S NAME (FIRST MIDDLE LAST)

13. NAME PRIOR TO FIRST MARRIAGE (FIRST MIDDLE LAST)

14. DATE OF BIRTH (mm/dd/yyyy)

15. BIRTHPLACE (State, Territory or Foreign Country)

16. MOTHER'S SSN

17a. MOTHER'S MARITAL STATUS Married at the time of conception or time of birth?

If not married, has an order of paternity or legitimation been issued by a court?

Have both mother and father consented in writing to have father's name on the certification or have they both signed a paternity acknowledgment?

- Yes No Unknown
 Yes No Unknown

- Yes No Unknown

17b. DATE PATERNITY ACKNOWLEDGMENT OR LEGITIMATION SIGNED (mm/dd/yyyy)

18. NUMBER AND STREET OF RESIDENCE

19. CITY, TOWN OR LOCATION

20. RESIDENCE STATE

Phone Number: _____

Residing at current residence for: _____ Years _____ Months

Inside city limits? Yes No Unknown

21. COUNTY

22. ZIP CODE

23. MOTHER'S MAILING ADDRESS (Street, City, State, Zip, County)

Mailing address same as above

24. MOTHER'S EDUCATION LEVEL (Choose **only one** option that represents the highest level of education attained)

- Completed 1st Grade Completed 2nd Grade Completed 3rd Grade Completed 4th Grade Completed 5th Grade Completed 6th Grade
 Completed 7th Grade Completed 8th Grade Completed 9th Grade Completed 10th Grade Completed 11th Grade
 Completed 12th Grade but did NOT Graduate High school graduate or GED completed
 Some college credit leading to an Associate degree but did **NOT** Graduate Associate degree (e.g. AA, AS) Bachelor's degree (e.g. BA, BS)
 Some college credit leading to a Bachelor's degree but did **NOT** Graduate Master's degree (e.g. MA, MS) Doctorate (e.g. PhD, EdD, MD)
 None Unknown

25. Primary Language spoken at Home _____

26. Employed during last year Yes No Unknown

27. Mother's Occupation _____

28. Kind of business or industry _____

29. Employer's name/address: _____

Name

Street

City

State/Country

Zip Code

30. MOTHER'S ETHNICITY No, not Spanish/Hispanic/Latino Refused Unknown

Yes, Cuban

Yes, Puerto Rican

Yes, Mexican, American, Chicano

Yes, Other Hispanic (Specify) _____

31. MOTHER'S RACE (Check all that apply)

- White Chinese Korean Guamanian or Chamorro
 Black or African American Filipino Vietnamese Samoan
 Asian Indian Japanese Native Hawaiian Other (Specify) _____
 Other Pacific Islander (Specify) _____ Other Asian (Specify) _____
 American Indian or Alaska Native; *Specify enrolled or principal tribe _____ Refused Unknown

32. FATHER'S NAME (FIRST MIDDLE LAST SUFFIX)

33. DATE OF BIRTH (mm/dd/yyyy)

34. BIRTHPLACE (State, Territory or Foreign Country)

35. FATHER'S SSN

36. FATHER'S RESIDENCE ADDRESS (STREET

CITY

STATE

ZIP

COUNTY)

Address same as mother's residence

37. FATHER'S EDUCATION LEVEL (Check only one option that represents the highest level of education attained)

- Completed 1st Grade Completed 2nd Grade Completed 3rd Grade Completed 4th Grade Completed 5th Grade Completed 6th Grade
 Completed 7th Grade Completed 8th Grade Completed 9th Grade Completed 10th Grade Completed 11th Grade
 Completed 12th Grade but did NOT Graduate High school graduate or GED completed
 Some college credit leading to an Associate degree but did **NOT** Graduate Associate degree (e.g. AA, AS) Bachelor's degree (e.g. BA, BS)
 Some college credit leading to a Bachelor's degree but did **NOT** Graduate Master's degree (e.g. MA, MS) Doctorate (e.g. PhD, EdD, MD)
 None Unknown

38. Father's Occupation _____ 39. Father's Industry _____ 40. Employed during last year Yes No Unknown

41. Employer's name/address: _____
 Name _____ Street _____ City _____ State/Country _____ Zip Code _____

42. **FATHER'S ETHNICITY** No, not Spanish/Hispanic/Latino Refused Unknown
 Yes, Cuban Yes, Puerto Rican Yes, Mexican, American, Chicano Yes, Other Hispanic (Specify) _____

43. FATHER'S RACE (Check all that apply)

- White Chinese Korean Guamanian or Chamorro
 Black or African American Filipino Vietnamese Samoan
 Asian Indian Japanese Native Hawaiian Other (Specify) _____
 Other Pacific Islander (Specify) _____ Other Asian (Specify) _____
 American Indian or Alaska Native; *Specify enrolled or principal tribe _____ Refused Unknown

44. Mother's Med Record #: _____ 45a. Mother's pre-pregnancy weight: _____ lbs Unknown 45b. Mother's weight at delivery _____ lbs Unknown

46. Mother's height: _____ feet _____ inches Unknown 47. Did Mother receive WIC during this pregnancy? Yes No Unknown

48a. Did mother use alcohol during pregnancy? Yes No Unknown 48b. If yes, how many drinks per week? _____

49. Did Mother smoke cigarettes before OR during this pregnancy Yes No Unknown

of cigarettes _____ or # of packs _____ Three months before pregnancy # of cigarettes _____ or # of packs _____ first trimester
 # of cigarettes _____ or # of packs _____ second trimester # of cigarettes _____ or # of packs _____ third trimester

50. Principal Source of Payment Tricare Medicaid Self Pay Other Government (Federal, State, Local) Indian Health Service
 Private Insurance Other: _____ Unknown

51. Vaccinations during pregnancy (Note trimester) TDAP Trimester _____ Flu Trimester _____ Other Trimester _____ None

52. MOTHER PREGNANCY HISTORY

- a. Is this the mother's first pregnancy? Yes No Unknown
 b. Number of previous live births now living _____ (Do not include this child)
 c. Number of previous live births now dead _____
 d. Date of last live birth _____ (mm/dd/yyyy)
 e. Number of fetal deaths less than 20 weeks (including ectopic loss, induced terminations or miscarriages) _____
 f. Number of previous fetal deaths 20 weeks or greater (including induced terminations, miscarriages or stillbirths) _____
 g. Date of last other pregnancy outcome _____ (mm/dd/yyyy)

53. MOTHER PRENATAL CARE

- a. Did mother receive prenatal care? Yes No Unknown d. Date of last prenatal care visit _____ (mm/dd/yyyy)
 b. Date of first prenatal care visit _____ (mm/dd/yyyy) e. Total number of prenatal care visits _____ (If none, enter '0')
 c. Enter month prenatal care began _____ (1st, 2nd, 3rd month of pregnancy) f. Date last normal menses began _____ (mm/dd/yyyy)

54. Mother transferred for delivery? Yes No If yes, from what location: _____

55. METHOD OF DELIVERY

- a. Was delivery with forceps attempted but unsuccessful? Yes No Unknown
- b. Was delivery with vacuum extraction attempted but unsuccessful? Yes No Unknown
- c. Fetal presentation at birth? Cephalic Breech Other Unknown
- d. Final route and method of delivery? Vaginal/Spontaneous Vaginal/Forceps Vaginal/Vacuum Cesarean Unknown
- e. If cesarean, was a trial labor attempted? Yes No Unknown

56. EXPOSURE/INFECTIONS PRESENT/ TREATED DURING PREGNANCY (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Bacterial meningitis | <input type="checkbox"/> Congenital Toxoplasmosis | <input type="checkbox"/> Listeria |
| <input type="checkbox"/> Carrier/suspected carrier or vital hepatitis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Parvovirus |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Group B streptococcus | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Congenital cytomegalovirus infection (CMV) | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Congenital rubella | <input type="checkbox"/> Herpes (active at the time of delivery) | <input type="checkbox"/> Other (specify) _____ |
| | <input type="checkbox"/> HIV | |

57. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

- a. **DIABETES** (Select one of the following) Prepregnancy (diagnosis prior to this pregnancy) Gestational (diagnosis in this pregnancy)
- b. **HYPERTENSION** (Select one of the following) Prepregnancy (chronic) Gestational (PIH, preeclampsia) Eclampsia
- c. Previous preterm birth
- d. Pregnancy resulted from infertility treatment (Check all that apply):
 - Fertility enhancing drugs Artificial insemination Intrauterine insemination
 - In vitro fertilization (IVF) Gamete intrafallopian transfer (GIFT) Other (specify) _____
- e. Other poor pregnancy outcome Perinatal death Small for gestational age Intrauterine growth restriction Other (specify) _____
- f. Mother had a previous cesarean delivery? If selected, how many? _____
- g. None of the above
- h. Unknown

58. OBSTETRIC PROCEDURES (Check all that apply)

- Cervical cerclage
- Tocolysis
- External Cephalic Version Successful Failed
- None of the Above
- Unknown

59. ONSET OF LABOR (Check all that apply)

- Premature rupture of the membranes (prolonged > 18 hours)
- Precipitous labor (less than 3 hours)
- Prolonged labor (greater than 20 hours)
- None of the above
- Unknown

60. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

- Induction of labor
- Augmentation of labor
- Non-vertex presentation
- Steroids (glucocorticoids of fetal lung maturation received by the mother prior to delivery) Partial Complete
- Antibiotics received by mother during labor
- Clinical chorioamnionitis diagnosed during labor or maternal temperature is >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

61. MATERNAL MORBIDITY (Check all that apply)

- Maternal transfusion
number of units 1 2 3 or more
- Third or fourth degree perineal laceration
- Ruptured uterus
- Unplanned hysterectomy
- Admission to intensive care unit
- Unplanned operating room procedure following delivery
- None of the above
- Unknown

62. Infant's Medical Record # _____

63. OB Estimated Gestation (completed weeks) _____ Unknown

64a. Apgar score (at 5 min) _____ Unknown

64b. Apgar score (at 10 min) _____ Unknown

65. Was infant transferred within 24 hours of delivery? Yes No Unknown

If yes, where? _____

66. Is infant living at time of report? Yes No Unknown

67. Is infant being breast fed, even partially? Yes No Unknown

68a. Weight unit Grams Pounds Unknown

68b. Weight Grams _____ Pounds _____ Ounces _____ Unknown

69. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)

- Assisted ventilation required immediately following delivery
- Assisted ventilation required for more than six hours
- NICU admission
- Newborn given surfactant replacement therapy
- Culture Positive Postnatal (Blood, CSF or other sources)
- Antibiotics received by 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 requiring intervention)
- None of the above
- Unknown

70. CONGENITAL ANAMOLIES OF THE NEWBORN (Check all that apply)

- Anencephaly
- Microcephaly
- Meningomyelocele/Spina bifida
- Cleft lip with cleft palate Cleft lip alone Cleft palate alone
- Craniofacial anomalies
- Cyanotic congenital heart disease
- Congenital diaphragmatic hernia
- Omphalocele
- Gastroschisis
- Limb reduction defect (not congenital amputation/dwarfing syndromes)
- Down Syndrome (Karyotype confirmed pending)
- Syndromes associated with hearing loss (neurofibromatosis, osteopetrosis, Usher, Waardneburg, Alport, Pendred, and Jervell and Lange-Nielson)
- Suspected chromosomal disorder (Karyotype confirmed pending)
- Hypospadias
- None of the above
- Other (specify) _____

71. OTHER EXPOSURES/CONDITIONS PRESENT IN UTERO OR POSTNATAL (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Caregiver concern related to hearing loss | <input type="checkbox"/> Fetal Growth Restriction (IUGR) | <input type="checkbox"/> Neonatal intensive care of > 5 days |
| <input type="checkbox"/> Congenital Hypothyroidism | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Neurodegenerative disorders |
| <input type="checkbox"/> Drug Withdrawal Syndrome in Newborn | <input type="checkbox"/> History of Positive Drug Screen (newborn) | <input type="checkbox"/> Neuromuscular Disorder |
| <input type="checkbox"/> Drug Use/Abuse/Withdrawal Syndrome in Mother | <input type="checkbox"/> HIV Present in infant | <input type="checkbox"/> Prenatal jaundice d/t hepatocellular damage |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Hydrocephaly | <input type="checkbox"/> Stage III necrotizing enterocolitis in newborn |
| <input type="checkbox"/> Exposure to ototoxic medications or loop diuretics | <input type="checkbox"/> Hyperbilirubinemia requiring exchange transfusion | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Extracorporeal Membrane Oxygenation (ECMO) or Assisted Mechanical Ventilation >48 hours | <input type="checkbox"/> Intraventricular hemorrhage (IVH), Grade III or IV | <input type="checkbox"/> Other (specify) _____ |

72. HEPATITIS VACCINATION

- | | |
|---|---|
| a. Did the infant receive Hepatitis B vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Refused | e. Hepatitis B vaccine Date _____ |
| b. If infant received Hepatitis B vaccine, number of hours after birth _____ | f. Hepatitis B vaccine Lot Number _____ |
| c. Did the infant receive Hepatitis B Immune Globulin (HBIG)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | g. HBIG Lot Number _____ |
| d. If infant received HBIG, number of hours after birth _____ | h. If infant received HBIG, date administered _____ |

73. NEWBORN SCREENING

- a. Was a metabolic screening performed for this infant? Yes No – Missed (transferred) No – Parent refusal No – Other _____ Unknown
- b. Newborn Metabolic screening number _____
- c. Was Hearing Screening performed for this infant? Yes Unable to screen in NICU No- Missed (Transfer) No- Missed (equipment down) No- parent refusal No- Missed (Other reason) _____ Unknown
- d. Final Hearing Screening Completed Date _____ (mm/dd/yyyy) Unknown
- e. Final Hearing Screening Right Ear Result Pass Refer Unknown Unable to test
- f. Final Hearing Screening Left Ear Result Pass Refer Unknown Unable to test
- g. Family History of Permanent childhood hearing loss? Yes No Unknown
- h. Final Newborn Hearing Test Type (select one) AABR AOAE AABR and AOAE

| | | |
|--|-----------------------|---|
| 74. INFORMANT'S NAME (FIRST MIDDLE LAST) | 75. RELATION TO CHILD | 76. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE CHILD A SOCIAL SECURITY NUMBER. <input type="checkbox"/> Yes <input type="checkbox"/> No |
|--|-----------------------|---|

| | | |
|--|-------------------------------------|---|
| 77. I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature) | 78. DATE CERTIFIED (mm/dd/yyyy) | 79. ATTENDANT AT BIRTH (OTHER THAN CERTIFIER (Name and Title)) <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Hospital Staff <input type="checkbox"/> CMN/CM <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other |
| 80. CERTIFIER (Name and Title) <input type="checkbox"/> Certifier same as Attendant <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Hospital Staff <input type="checkbox"/> CMN/CM <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other | 81. PHYSICIAN'S MEDICAL LICENSE NO. | 82. CERTIFIER'S MAILING ADDRESS (street, city, state, zip) |
| 83. REGISTRAR (Signature) | | 84. DATE RECEIVED BY STATE REGISTRAR (mm/dd/yyyy) |