



Maryland Department of Health and Mental Hygiene

Vital Statistics Administration

Attachment to the Facility Worksheet for the Certificate of Live Birth for Multiple Births

- This attachment is to be completed when at least two infants in a multiple pregnancy are born alive.* Complete a full worksheet for the first-born infant and an attachment for each additional live-born infant.

*For "Delayed Interval Births" (births in a multiple pregnancy delivered at least 24 hours apart) a full worksheet, not an attachment, should be completed.

Mother's Name:
Mother's Record #

Child's Name:
Child's Record #

Child Number: of **total deliveries (living or stillborn) resulting from this pregnancy**

Child's Sex: Male Female Not Yet Determined
 Child's Date of Birth: / / 20

Month Day Year

Child Being Placed for Adoption? Yes

Signature of Person Completing Worksheet: _____

SCREEN: FACILITY	31. Obstetric estimate of gestation —Completed weeks. _____
9. Number of previous live births now living (do not include this child) _____ <input type="checkbox"/> None	33. Apgar score 5 minutes _____ IF < 6, Score 10 minutes _____
10. Number of previous live births now dead (do not include this child) _____ <input type="checkbox"/> None	35. Order delivered in the pregnancy —Include all live births and fetal losses resulting from this pregnancy. _____ (2nd, 3rd, etc.)
12. Total number of other pregnancy outcomes (do not include this child) _____ <input type="checkbox"/> None	37. Abnormal conditions of the newborn —Disorders or significant morbidity. <i>Mark (X) all that apply.</i> <ul style="list-style-type: none"> <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than 6 hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> None of the above
SCREEN: LABOR/DELIVERY	38. Congenital anomalies of the newborn <i>Mark (X) all that apply.</i> <ul style="list-style-type: none"> <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"/> Microcephaly <input type="checkbox"/> Limb reduction <input type="checkbox"/> Cleft lip with/without cleft palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome - Trisomy 21 <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 above
19. Time of birth: _____ : _____ 24 hour clock	39. Infant transferred to another facility within 24 hours of delivery? <input type="checkbox"/> Yes, transferred to: _____ <input type="checkbox"/> No
27. Characteristics of labor and delivery <i>(Mark (X) all that apply.)</i> <ul style="list-style-type: none"> <input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Steroids-fetal lung maturation <input type="checkbox"/> Antibiotics-mother during labor <input type="checkbox"/> Chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{C}$ (100.4$^{\circ}\text{F}$) <input type="checkbox"/> Epidural/spinal anesthesia <input type="checkbox"/> None of the above 	40. Is infant living at time of this report? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant transferred, status unknown
28. Method of delivery <i>(Complete A and B)</i> (A) Fetal presentation at birth <i>Mark (X) one.</i> <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other (B) Final route and method of delivery <i>Mark (X) one.</i> <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean \rightarrow trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No	41. Is infant being breastfed at time of discharge? <input type="checkbox"/> Yes <input type="checkbox"/> No
29. Maternal morbidity <i>Mark (X) all that apply.</i> <ul style="list-style-type: none"> <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Perineal laceration (3$^{\circ}$ or 4$^{\circ}$ laceration) <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned hysterectomy <input type="checkbox"/> Admission to intensive care unit <input type="checkbox"/> None of the above 	
SCREEN: NEWBORN	
30. Birthweight —If weight in GRAMS is not available, please indicate LB/OZ. Do not convert lb/oz to grams. Grams: _____ OR Pounds: _____ lb _____ oz	