



Maryland Department of Health and Mental Hygiene

Vital Statistics Administration

Maryland Facility Worksheet for the Certificate of Live Birth

To be completed by Local Health Department Staff

For detailed definitions, instructions, information on sources, and common key words and abbreviations, see the Guide to Completing Facility Worksheets for the Certificate of Live Birth.

Mother's Name:

Child's Name:

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: / /
Month Day Year

Child Being Placed for Adoption? Yes No

Signature of Person Completing Worksheet: _____

SCREEN: FACILITY	
<p>5. Place of birth</p> <p><input type="checkbox"/> Clinic or doctor's office <input type="checkbox"/> Homebirth —unknown if planned</p> <p><input type="checkbox"/> Freestanding birth center <input type="checkbox"/> Hospital _____</p> <p><input type="checkbox"/> Homebirth — not planned <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Homebirth — planned <input type="checkbox"/> Unknown</p> <p>Address if birth occurred outside hospital:</p> <p>_____</p>	<p>12. Total number of other pregnancy outcomes—Include fetal losses of any gestational age— including 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.</p> <p style="text-align: right;">_____ <input type="checkbox"/> None</p>
<p>6. Did mother receive prenatal care?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No → <input style="width: 80px; height: 20px; border: 1px solid black;" type="text" value="If NO, go to # 8"/></p>	<p>13. Date of last other pregnancy outcome</p> <p style="text-align: right;">____ / ____</p> <p style="text-align: right;"><small>Month Year</small></p>
<p>6a. Date of <u>first</u> prenatal care visit</p> <p style="text-align: right;">____ / ____ / 20____</p> <p style="text-align: right;"><small>Month Day Year</small></p>	<p>14. Risk factors in this pregnancy <i>Mark (X) all that apply.</i></p> <p><input type="checkbox"/> Diabetes (Prepregnancy) <input type="checkbox"/> Previous preterm live births</p> <p><input type="checkbox"/> Diabetes (Gestational) <input type="checkbox"/> Previous cesarean delivery</p> <p><input type="checkbox"/> Hypertension (Prepregnancy) Number _____</p> <p><input type="checkbox"/> Hypertension (Gestational) <input type="checkbox"/> None of the above</p> <p><input type="checkbox"/> Eclampsia</p>
<p>7. Total number of prenatal care visits</p> <p style="text-align: right;">_____</p>	<p>15. Infections present/treated during pregnancy <i>Mark (X) all that apply.</i></p> <p><input type="checkbox"/> Gonorrhea <input type="checkbox"/> Hepatitis B</p> <p><input type="checkbox"/> Syphilis <input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> Chlamydia <input type="checkbox"/> None of the above</p>
<p>8. Date last normal menses began</p> <p style="text-align: right;">____ / ____ / 20____</p> <p style="text-align: right;"><small>Month Day Year</small></p>	<p>16. Obstetric procedures <i>Mark (X) all that apply.</i></p> <p><input type="checkbox"/> External cephalic version SUCCESSFUL</p> <p><input type="checkbox"/> External cephalic version FAILED</p> <p><input type="checkbox"/> Neither of the above</p>
<p>9. Number of previous live births now living—Don't include this child.</p> <p style="text-align: right;">_____ <input type="checkbox"/> None</p>	<p style="text-align: center; margin: 0;">SCREEN: LABOR/DELIVERY</p>
<p>10. Number of previous live births now dead—Don't include this child.</p> <p style="text-align: right;">_____ <input type="checkbox"/> None</p>	<p>19. Time of birth</p> <p style="text-align: right;">_____ : _____ 24 hour clock</p>
<p>11. Date of last live birth (do not include this child)</p> <p style="text-align: right;">____ / ____ / 20____</p> <p style="text-align: right;"><small>Month Year</small></p>	

<p>20. Certifier's name (Local Health Department representative)</p> <p>_____ FIRST Name MIDDLE Name(s) LAST Name Suffix</p> <p>Certifier's title <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> Hospital Administrator</p> <p><input type="checkbox"/> CNM/CM <input type="checkbox"/> Other Midwife <input type="checkbox"/> Other _____</p>	SCREEN: NEWBORN
<p>21. Date record certified</p> <p>____ / ____ / 20____ Month Day Year</p>	<p>30. Birthweight—If weight in GRAMS is not available, indicate LB/OZ. Do not convert lb/oz to grams.</p> <p>Grams: _____ OR Pounds: _____ lb _____ oz</p>
<p>22. Principal source of payment for delivery?</p> <p><input type="checkbox"/> Private Insurance <input type="checkbox"/> Self-pay <input type="checkbox"/> Medicaid</p> <p><input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Unknown</p>	<p>31. Obstetric estimate of gestation—Completed weeks. _____</p>
<p>25. Attendant's name</p> <p>_____ FIRST Name MIDDLE Name(s) LAST Name Suffix</p>	<p>33. Apgar score</p> <p>5 minutes _____ IF < 6, Score 10 minutes _____</p>
<p>Attendant's title</p> <p><input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> CNM/CM <input type="checkbox"/> Other Midwife</p> <p><input type="checkbox"/> Other (Specify) _____</p>	<p>34. Plurality—Include all live births and fetal losses resulting from this pregnancy.</p> <p>_____ live births and fetal losses</p>
<p>26. Mother's weight at delivery</p> <p>_____ (pounds)</p>	<p>35. If NOT single birth, order delivered in the pregnancy—Include all live births and fetal losses resulting from this pregnancy.</p> <p>_____ birth order delivered in pregnancy</p>
<p>27. Characteristics of labor and delivery <i>Mark (X) all that apply.</i></p> <p><input type="checkbox"/> Induction of labor <input type="checkbox"/> Epidural/spinal anesthesia</p> <p><input type="checkbox"/> Augmentation of labor <input type="checkbox"/> None of the above</p> <p><input type="checkbox"/> Steroids-fetal lung maturation</p> <p><input type="checkbox"/> Antibiotics-mother during labor</p> <p><input type="checkbox"/> Chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{C}$ (100.4°F)</p>	<p>36. If NOT single birth—Specify number of infants in this delivery born <u>ALIVE</u>.</p> <p>_____ infants born ALIVE</p>
<p>28. Method of delivery (Complete A and B)</p> <p>(A) Fetal presentation at birth <i>Mark (X) one.</i></p> <p><input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other</p> <p>(B) Final route and method of delivery <i>Mark (X) one.</i></p> <p><input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum</p> <p><input type="checkbox"/> Cesarean trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>37. Abnormal conditions of the newborn—Disorders or significant morbidity. <i>Mark (X) all that apply.</i></p> <p><input type="checkbox"/> Assisted ventilation required immediately following delivery</p> <p><input type="checkbox"/> Assisted ventilation required for more than 6 hours</p> <p><input type="checkbox"/> NICU admission</p> <p><input type="checkbox"/> Newborn given surfactant replacement therapy</p> <p><input type="checkbox"/> Antibiotics received by newborn for suspected neonatal sepsis</p> <p><input type="checkbox"/> Seizure or serious neurologic dysfunction</p> <p><input type="checkbox"/> None of the above</p>
<p>29. Maternal morbidity <i>Mark (X) all that apply.</i></p> <p><input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Unplanned hysterectomy</p> <p><input type="checkbox"/> Perineal laceration (3° or 4° laceration) <input type="checkbox"/> Admission to intensive care unit</p> <p><input type="checkbox"/> Ruptured uterus <input type="checkbox"/> None of the above</p>	<p>38. Congenital anomalies of the newborn <i>Mark (X) all that apply.</i></p> <p><input type="checkbox"/> Anencephaly <input type="checkbox"/> Cleft lip with/without cleft palate</p> <p><input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cleft Palate alone</p> <p><input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Down Syndrome - (Trisomy 21)</p> <p><input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Karyotype confirmed</p> <p><input type="checkbox"/> Omphalocele <input type="checkbox"/> Karyotype pending</p> <p><input type="checkbox"/> Gastroschisis <input type="checkbox"/> Suspected chromosomal disorder</p> <p><input type="checkbox"/> Microcephaly <input type="checkbox"/> Karyotype confirmed</p> <p><input type="checkbox"/> Limb reduction <input type="checkbox"/> Karyotype pending</p> <p><input type="checkbox"/> Hypospadias</p> <p><input type="checkbox"/> None of the above</p>
	<p>39. Infant transferred to another facility within 24 hours of delivery?</p> <p><input type="checkbox"/> Yes, transferred to: _____ <input type="checkbox"/> No</p>
	<p>40. Is infant living at time of this report?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant transferred, status unknown</p>
	<p>41. Is infant being breastfed?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>