



**Michigan Department of Health and Human Services**  
 Division for Vital Records and Health Statistics

**FACILITY  
 WORKSHEET  
 FOR LIVE BIRTH**

<b>CHILD</b>	<b>Child Name</b> (First, Middle, Last, Suffix)		
	<b>Date of Birth</b>	<b>Time of Birth</b> _____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Military	<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undetermined
<b>MOTHER / BIRTH PARENT</b>	<b>Mother/Birth Parent Current Name</b> (First, Middle, Last, Suffix)		
	<b>Weight at Delivery</b> _____ Pounds Only		
<b>PLACE OF BIRTH</b>	<b>Type of Birthplace</b>		
	<input type="checkbox"/> Hospital <input type="checkbox"/> Home – Unknown if Intended <input type="checkbox"/> Birthing Center – En Route <input type="checkbox"/> Hospital – En route <input type="checkbox"/> Clinic / Doctor’s Office <input type="checkbox"/> Unknown <input type="checkbox"/> Home – Planned <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Home - Unplanned		
	<b>Facility Name</b> (If not Facility, Provide Street Number and Name)		
<b>Place of Birth Address</b> (City, Village or Township and County)			
<b>PRENATAL</b>	<b>Mother/Birth Parent Medical Record Number</b>		<b>Mother/Birth Parent Medicaid Number</b>
	<b>Principal Source of Payment for this Delivery</b> (Check one.)		
	<input type="checkbox"/> Medicaid <input type="checkbox"/> Indian Health Services <input type="checkbox"/> Other Government (Specify) _____ <input type="checkbox"/> Private Insurance <input type="checkbox"/> Champus / Tricare _____ <input type="checkbox"/> Self-Pay <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____		
	<b>Date of Last Menses</b>		
	<b>Prenatal Care Received?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
	<b>Date of First Prenatal Care Visit</b>	<b>Date of Last Prenatal Care Visit</b>	<b>Total Number of Prenatal Visits Prior to Delivery?</b>
	<b>Previous Live Births</b>		
	<b>Number Now Living</b>	<b>Number Now Deceased</b>	<b>Date of Birth of the Last Live-Born Infant</b>
	<b>Total Number of Other Pregnancy Outcomes (Spontaneous or Induced Terminations)</b>		<b>Date of Last Other Pregnancy Outcome</b>
	<b>Mother/Birth Parent tested for HIV?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>PREGNANCY FACTORS</b>	<b>Risk Factors For this Pregnancy</b> (Check all that apply.)		
	<input type="checkbox"/> Diabetes - Pre-Pregnancy <input type="checkbox"/> Pregnancy Resulted from Infertility Treatment – Artificial Insemination <input type="checkbox"/> Diabetes - Gestational <input type="checkbox"/> Pregnancy Resulted from Infertility Treatment – Intrauterine Insemination <input type="checkbox"/> Hypertension - Pre-Pregnancy <input type="checkbox"/> Alcohol Use During Pregnancy <input type="checkbox"/> Hypertension – Gestational <input type="checkbox"/> Pregnancy Resulted From Infertility Treatment – Assisted Reproductive Technology <input type="checkbox"/> Hypertension - Eclampsia <input type="checkbox"/> Mother had a previous cesarean delivery <input type="checkbox"/> Previous Preterm Births If Yes, How Many _____ <input type="checkbox"/> Other Previous Poor Pregnancy Outcome <input type="checkbox"/> None of the Above <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor <input type="checkbox"/> Unknown <input type="checkbox"/> Pregnancy Resulted from Infertility Treatment – Fertility Enhancing Drug		



