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

FACILITY WORKSHEET FOR LIVE BIRTH

CHILD

Child Name (First, Middle, Last, Suffix)

Date of Birth	**Time of Birth** _____ ☐ AM ☐ PM ☐ Military	**Sex** ☐ Male ☐ Female ☐ Undetermined

MOTHER / BIRTH PARENT

Mother/Birth Parent Current Name (First, Middle, Last, Suffix)

Weight at Delivery _____Pounds Only

PLACE OF BIRTH

Type of Birthplace

☐ Hospital
☐ Hospital – En route
☐ Home – Planned
☐ Home - Unplanned
☐ Home – Unknown if Intended
☐ Clinic / Doctor's Office
☐ Freestanding Birthing Center
☐ Birthing Center – En Route
☐ Unknown
☐ Other (Specify) _____

Facility Name (If not Facility, Provide Street Number and Name)

Place of Birth Address (City, Village or Township and County)

PRENATAL

Mother/Birth Parent Medical Record Number	**Mother/Birth Parent Medicaid Number**

Principal Source of Payment for this Delivery (Check one.)

☐ Medicaid
☐ Private Insurance
☐ Self-Pay
☐ Indian Health Services
☐ Champus / Tricare
☐ Unknown
☐ Other Government (Specify) _____
☐ Other (Specify) _____

Date of Last Menses

Prenatal Care Received? ☐ Yes ☐ No

Date of First Prenatal Care Visit	**Date of Last Prenatal Care Visit**	**Total Number of Prenatal Visits Prior to Delivery?**

Previous Live Births

Number Now Living	**Number Now Deceased**	**Date of Birth of the Last Live-Born Infant**
_____	_____	

Total Number of Other Pregnancy Outcomes (Spontaneous or Induced Terminations)	**Date of Last Other Pregnancy Outcome**

Mother/Birth Parent tested for HIV? ☐ Yes ☐ No ☐ Unknown

PREGNANCY FACTORS

Risk Factors For this Pregnancy (Check all that apply.)

☐ Diabetes - Pre-Pregnancy
☐ Diabetes - Gestational
☐ Hypertension - Pre-Pregnancy
☐ Hypertension – Gestational
☐ Hypertension - Eclampsia
☐ Previous Preterm Births
☐ Other Previous Poor Pregnancy Outcome
☐ Vaginal bleeding during this pregnancy prior to the onset of labor
☐ Pregnancy Resulted from Infertility Treatment – Fertility Enhancing Drug
☐ Pregnancy Resulted from Infertility Treatment – Artificial Insemination
☐ Pregnancy Resulted from Infertility Treatment – Intrauterine Insemination
☐ Alcohol Use During Pregnancy
☐ Pregnancy Resulted From Infertility Treatment – Assisted Reproductive Technology
☐ Mother had a previous cesarean delivery
If Yes, How Many _____
☐ None of the Above
☐ Unknown

PREGNANCY FACTORS

Testing for Infections Performed?

Syphilis ☐ Yes ☐ No ☐ Unknown

Group B Strep ☐ Yes ☐ No ☐ Unknown

Infections Present and / or Treated During this Pregnancy (Check all that apply.)

☐ Gonorrhea
☐ Genital Herpes
☐ Syphilis
☐ Chlamydia
☐ Hepatitis B
☐ Hepatitis C
☐ Group B Streptococcus
☐ None of the Above
☐ Unknown

Obstetric Procedures (Check all that apply.)

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

LABOR

Onset of Labor (Check all that apply.)

☐ Premature Rupture of the Membrane (prolonged, > = 12 hours)
☐ Precipitous Labor (< 3 hours)
☐ Prolonged Labor (> = 20 hours)
☐ None of the Above
☐ Unknown

Characteristics of Labor and Delivery (Check all that apply.)

☐ Induction of labor
☐ Augmentation of labor
☐ Non-vertex presentation
☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother/birth parent prior to delivery
☐ Antibiotics received by the mother/birth parent during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature greater than or =38C (100.4F)
☐ Moderate/heavy meconium staining of the amniotic fluid
☐ Fetal intolerance of labor
☐ Epidural or spinal anesthesia during labor
☐ None of the Above
☐ Unknown

DELIVERY

Method of Delivery

Was Delivery with Forceps Attempted but Unsuccessful? ☐ Yes ☐ No ☐ Unknown

Was Delivery with Vacuum Extraction Attempted but Unsuccessful? ☐ Yes ☐ No ☐ Unknown

Fetal Presentation at Birth? ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown

Final Route and Method of Delivery? (Check one.) ☐ Vaginal / Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/ Vacuum ☐ Cesarean (see below) ☐ Unknown

If Cesarean, Was a Trial of Labor Attempted? ☐ Yes ☐ No ☐ Unknown ☐ Not Applicable

Was Cesarean Needed to Prevent Disease Transmission? ☐ Yes ☐ No ☐ Unknown ☐ Not Applicable

Maternal Morbidity/Complications Associated with Labor & Delivery (Check all that apply.)

☐ Maternal transfusion
☐ 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 at This Time

Mother/Birth Parent Transferred for Maternal Medical or Fetal Indication Prior to Delivery? ☐ Yes ☐ No ☐ Unknown

If Yes, Transfer Facility _____

Infant Transferred Within 24 Hours of Delivery? ☐ Yes ☐ No ☐ Unknown

If Yes, Transfer Facility _____

NEWBORN

Newborn Medical Record Number

Newborn Screening Card Number

Infant's Birth Weight

_____Pounds _____Ounces **or** _____Grams

Apgar Score

5 Minute _____ 10 Minute (Only if 5 min. <6) _____

Obstetric Estimate of Gestation at Delivery (Number of Weeks)

Plurality ☐ Single ☐ Twin ☐ Triplet ☐ Other

(Specify) _____

Birth Order ☐ First ☐ Second ☐ Third ☐ Other

(Specify) _____

If Not Single Birth, Number of Infants in this Delivery Born Alive? _____

Are there Non-Reportable Events For This Pregnancy? ☐ Yes ☐ No

NEWBORN

Is Infant Living at Time Of Report? ☐ Yes ☐ No ☐ Unknown

If Not, Date Baby Died

If Baby Died, Name of Funeral Home or Funeral Facility Handling Disposition

Is Infant Being Breastfed at Discharge? ☐ Yes ☐ No ☐ Unknown

NEWBORN FACTORS

Abnormal Conditions of the Newborn (Check all that apply.)

- ☐ Assisted Ventilation Required Immediately Following Delivery
- ☐ Assisted Ventilation Required for More than 6 Hours
- ☐ NICU Admission
- ☐ Newborn given Surfactant Replacement Therapy
- ☐ Antibiotics received by the 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 which requires intervention)
- ☐ None of the Above
- ☐ Unknown

Congenital Anomalies of the Newborn (Check all that apply.)

- ☐ Anencephaly
- ☐ Meningomyelocele / Spina Bifida
- ☐ Congenital Heart Disease
- ☐ Cyanotic Congenital Heart Disease
- ☐ Congenital Diaphragmatic Hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb Reduction Defect (Excluding Congenital Amputation and Dwarfing Syndromes)
- ☐ Cleft Lip With or Without Cleft Palate
- ☐ Cleft Palate Alone
- ☐ Down Syndrome Karyotype Confirmed
- ☐ Down Syndrome Karyotype Pending
- ☐ Down Syndrome Karyotype Unknown
- ☐ Suspected Other Chromosomal Disorder Karyotype Confirmed
- ☐ Suspected Other Chromosomal Disorder Karyotype Pending
- ☐ Suspected Other Chromosomal Disorder Karyotype Unknown
- ☐ Hypospadias
- ☐ None of the Anomalies listed Above
- ☐ Other (Specify) _____
- ☐ Unknown

ATTENDANT

Attendant's Name

Attendant's Title (MD, DO, CNM, etc.)

Attendant's NPI Number

INFANT IMMUNIZATION

Did Infant receive Hepatitis B Vaccine? ☐ Yes ☐ No ☐ Unknown

If No, Why Not? ☐ Medically Unstable ☐ Less than 2,000 grams ☐ Doctor to Give at Office ☐ Parent / Guardian Refusal ☐ Other (Specify) _____

If Yes, Date Administered _____

Vaccine Manufacturer ☐ Glaxo Smith Kline ☐ Merck ☐ Other (Specify) _____

Lot Number _____

Did Infant receive Hepatitis B Immune Globulin (HBIG) 7? ☐ Yes ☐ No ☐ Unknown

If Yes, Date Administered _____

Vaccine Manufacturer ☐ Glaxo Smith Kline ☐ Merck ☐ Other (Specify) _____

Lot Number _____

Is the Mother/Birth Parent HbsAg+? ☐ Positive ☐ Negative ☐ Unknown ☐ Not Screened

HEARING

Hearing Performed? ☐ Yes ☐ No ☐ Pending

Test Date

Screen Method ☐ AABR ☐ ABR ☐ DPOAE ☐ TEOAE

Test Results

Left ☐ Pass ☐ Refer

Right ☐ Pass ☐ Refer

Reason Screening Not Performed

☐ Discharge without screen ☐ NICU Pending ☐ Parent Refused ☐ Equipment Failure ☐ Infant Died ☐ Restlessness ☐ Transfer ☐ Noise

Name and Title of Person Completing Form

Signature of Person Completing Form