Washington State Department of Health

DOH 422-020 January 2019

# Washington State Birth Filing Form

Fields with asterisk (*) are required and appear on the Birth Certificate.

## For Hospital Use Only

| Mother/Parent's Medical Record #: | Child's Medical Record #: | Prefer Parent / Parent Labels on Birth Certificate (Default Labels are Mother / Father) ☐ Yes ☐ No |
|---|---|---|

Plurality: ☐ 1- single birth ☐ 2- twin ☐ 3- triplet ☐ Other _____

If multiple, this worksheet is for child: ☐ 1- first born ☐ 2- second born ☐ 3- third born ☐ Other _____

## Child's Information

Child's Information

| *1. Child's Name First | Middle | Last |
|---|---|---|
| *2. Child's Date of Birth (MM/DD/YYYY) / / | *3. Time of Birth | *4. Child's Sex ☐ Male ☐ Female |
| 5. Type of Birthplace ☐ Hospital ☐ Enroute ☐ Freestanding Birth Center ☐ Home ☐ Clinic/Doctor's Office ☐ Other (specify): | | 6. Planned Birth Place, if different (specify): |
| *7. Name of Facility (If not a facility, enter name of place and address) | *8. County of Birth | *9. City of Birth |

## Mother/Parent's information

Mother/ Parent Information

| 10. Mother/Parent's Current Legal Name First | Middle | Last |
|---|---|---|
| *11. Full name as it appears on your Birth Certificate First | Middle | Last |
| *12. Date of Birth (MM/DD/YYYY) / / | *13. Birthplace (State, Territory, or Foreign Country) | 14. Social Security Number |
| 15. Do you want to get a Social Security Number for your child? ☐ Yes ☐ No | | |
| 16a. Residence: Number and Street (e.g., 624 SE 5th St.) | | Apt No. |
| 16b. If not U.S.; Country | 16c. State | 16d. County |
| 16e. If you live on Tribal Reservation, give name | 16f. City or Town | 16g. Zip Code + 4 |
| 16h. Inside City Limits? ☐ Yes ☐ No ☐ Unknown | 17. How Long at Current Residence? Years: Months: | 18. Telephone Number ( ) |
| 19a. Mailing Address, if different: Number and Street, or PO Box | | Apt. No. |
| 19b. If not U.S.; Country | 19c. State | 19d. City / 19e. Zip Code + 4 |
| 20. Occupation (type of work done during last year) | 21. Kind of Business/Industry (do not use company name) | |

**22. Mother/Parent Education Level**
(Check the box that best describes the highest degree or level of school completed at the time of delivery.)

1 ☐ 8th grade or less (specify):_____
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (AA, AS, etc.)
6 ☐ Bachelor's degree (BA, AB, BS, etc.)
7 ☐ Master's degree (MA, MS, MEd, MSW, MBA, etc.)
8 ☐ Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)

**23. Mother/Parent Hispanic Origin?**
(Check the box that best describes whether the mother is Spanish/Hispanic/Latina or check "No" box if not Spanish/Hispanic/Latina.)

1 ☐ No, not Spanish/Hispanic/Latina
2 ☐ Yes, Mexican, Mexican American, Chicana
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, Other Spanish/Hispanic/Latina (specify):

**24. Mother/Parent Race** (check one or more)

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
(Name of enrolled or principal tribe)

4 ☐ Asian Indian 5 ☐ Chinese
6 ☐ Filipino 7 ☐ Japanese
8 ☐ Korean 9 ☐ Vietnamese
10 ☐ Other Asian (specify):

11 ☐ Native Hawaiian 12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (specify):
15 ☐ Other (specify):

Continue on next page

**Mother/Parent Information**

| 25. Current Height | 26. Pre-Pregnancy Weight (pounds) | 27. Were WIC benefits utilized during pregnancy? |
|---|---|---|
| Feet: Inches: | | ☐ Yes ☐ No |

**28. Cigarette Smoking Before and During Pregnancy**
☐ Yes ☐ No

Average number of cigarettes or packs per day:

| | # of cigarettes | | # of packs |
|---|---|---|---|
| Three months before pregnancy | | or | |
| First three months of pregnancy | | or | |
| Second three months of pregnancy | | or | |
| Last three months of pregnancy | | or | |

## Marital Status of Mother/Parent

**Mother's Marital Status**

**29. Is Mother/Parent married?** (Check only one box)

**Important - Read before responding to marital status question:**
*If you were married at any time during your pregnancy, your spouse or partner is considered the other legal parent unless they complete a denial of parentage and another person acknowledges that they are the father/parent (chapter 26.26A RCW). To add someone other than your spouse or partner to the birth certificate, an Acknowledgment of Parentage form (DOH 422-159) and Denial of Parentage form (DOH 422-158) needs to be completed by all parties. Under Washington State law, a state-registered domestic partnership is considered the same as a marriage (chapter 26.60 RCW).*

*If you were not married at any time during the pregnancy, complete an Acknowledgment of Parentage form to add the father/parent to the birth certificate.*

| Married - Yes | Married - No |
|---|---|
| 29a. ☐ Yes, I am married to the other person identified in box #30. | 29d. ☐ No, I am not married. I am providing information about the father/parent in box #30. I will complete an Acknowledgement of Parentage form at the hospital.<br><br>*Ask hospital staff for an Acknowledgment of Parentage form (DOH 422-159).* |
| 29b. ☐ Yes, I am married but not to the other person identified in box #30.<br><br>*Ask hospital staff for an Acknowledgment of Parentage form (DOH 422-159).You must complete this form, including the spouse's Denial of Parentage form (DOH 422-158).* | 29e. ☐ No, I am not married now, but I was married to the other person identified in box #30 at some time during this pregnancy. |
| 29c. ☐ Yes, I am married but not providing the spouse or partner's information.<br><br>*If this box is checked, the other parent will be listed on the birth certificate as "None Named".* | 29f. ☐ No, I am not married and not submitting a completed Acknowledgment of Parentage form with the father/parent's information.<br><br>*If this box is checked, the other parent will be listed on the birth certificate as "None Named".* |

## Father/ Parent's Information

**Father/Parent's Information**

| *30. Father/Parent's Current Legal Name | | |
|---|---|---|
| First | Middle | Last |
| *31. Date of Birth (MM/DD/YYYY)<br>/ / | *32. Birthplace (State, Territory, or Foreign Country) | 33. Social Security Number |

| 34. Occupation (type of work done during last year.) | 35. Kind of Business/Industry (do not use Company Name) |
|---|---|
| | |

**36. Father/Parent Education Level**
(Check the box that best describes the highest degree or level of school completed at the time of delivery.)

1 ☐ 8th grade or less (specify):_____
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (AA, AS, etc.)
6 ☐ Bachelor's degree (BA, AB, BS, etc.)
7 ☐ Master's degree (MA, MS, MEd, MSW, MBA, etc.)
8 ☐ Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)

**37. Father/Parent of Hispanic Origin?**
(Check the box that best describes whether the father/parent is Spanish/Hispanic/Latino or check "No" box if not Spanish/Hispanic/Latino.)

1 ☐ No, not Spanish/Hispanic/Latino
2 ☐ Yes, Mexican, Mexican American, Chicano
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, other Spanish/Hispanic/Latino (specify):

**38. Father/Parent Race** (check one or more)

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
(Name of enrolled or principal tribe)

4 ☐ Asian Indian 5 ☐ Chinese
6 ☐ Filipino 7 ☐ Japanese
8 ☐ Korean 9 ☐ Vietnamese
10 ☐ Other Asian (specify):
11 ☐ Native Hawaiian 12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (specify):
15 ☐ Other (specify):

## For Hospital Use Only

### Mother/Parent's Statistical Information

**39. Date of First Prenatal Care Visit** (MM/DD/YYYY)
/ / ☐ No Prenatal Care

**40. Date of Last Prenatal Care Visit** (MM/DD/YYYY)
/ /

**41. Total Number of Prenatal Visits for this Pregnancy**
(If none, enter '0') _____

**42. Number of Previous Live Births** (Do not include this child)
Number Now Living _____ ☐ None
Number Now Dead _____ ☐ None

**43. Date of Last Live Birth** (MM/YYYY) (Do not include this child)
/ /

**44. Number of Other Pregnancy Outcomes**
(Spontaneous or induced losses or ectopic pregnancies)
Number of Other Outcomes _____ ☐ None

**45. Date of Last Other Pregnancy Outcome** (MM/YYYY)
/ /

**46. Date Last Normal Menses Began** (MM/DD/YYYY)
/ /

**47. Mother'/Parent's Weight at Delivery**(pounds)

**48. Was mother/parent transferred to higher level care for maternal medical or fetal indications for delivery?**
☐ Yes ☐ No

If yes, name of facility mother/parent was transferred from:

**49. Principal Source of Payment for this Delivery**

| | | |
|---|---|---|
| ☐ Medicaid | ☐ Self-Pay | ☐ Private Insurance |
| ☐ Other Gov't | ☐ Tricare | ☐ Indian Health |
| ☐ Charity Care | ☐ Other _____ | |

### Child's Statistical Information

**50. Birth Weight**
lbs: ozs: **or** grams:

**51. Infant Head Circumference** (cm)

**52. Obstetric Estimate of Gestation** (completed weeks)

**53. Apgar score** at 5 minutes _____ If score is less than 6, score at 10 minutes _____

**54. Plurality**: ☐ Single ☐ twins ☐ triplets ☐other _____

**55. If not single birth; birth order**: ☐ first ☐ second ☐third ☐other _____

**56. Was infant transferred within 24 hours of delivery?** ☐ Yes ☐ No
If yes, name of facility infant was transferred to:

**57. Is infant living at the time of report?**
☐ Yes ☐ No ☐ Transferred, status unknown

**58. Is infant being breastfed?**
☐ Yes ☐ No

### Medical and Health Information

**59. Risk Factors in this Pregnancy** (check all that apply):

1 Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

2 Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

3 ☐ Previous preterm births
4 ☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
5 ☐ Vaginal bleeding during this pregnancy prior to the onset of labor
6 ☐ Pregnancy resulted from infertility treatment - If yes-check all that apply:
- ☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination
- ☐ Assisted reproductive technology [e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)]

7 ☐ Mother had a previous cesarean delivery? If Yes, how many_____
8 ☐ Group B Streptococcus culture positive
9 ☐ None of the above

**60. Infections Present and/or Treated During this Pregnancy** (check all that apply):

1 ☐ Gonorrhea
2 ☐ Syphilis
3 ☐ Herpes Simplex Virus (HSV)
4 ☐ Chlamydia
5 ☐ Hepatitis B
6 ☐ Hepatitis C
7 ☐ HIV Infection
8 ☐ Other Specify:_____
9 ☐ None of the above

**61. Maternal Morbidity** (complications associated with labor and delivery) (Check all that apply):

1 ☐ Maternal transfusion
2 ☐ Third or fourth degree perineal laceration
3 ☐ Ruptured uterus
4 ☐ Unplanned hysterectomy
5 ☐ Admission to intensive care unit
6 ☐ Unplanned operating room procedure following delivery
7 ☐ None of the above

**62. Method of Delivery**

A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No

C. Fetal presentation at birth
☐ Cephalic ☐ Breech ☐ Other

D. Final route and method of delivery (Check One)

Vaginal: ☐ Spontaneous ☐ Forceps ☐ Vacuum
**OR**
Cesarean: ☐
If cesarean, was a trial of labor attempted?
☐ Yes ☐ No

**63. Obstetric procedures** (Check all that apply):

1 ☐ Cervical cerclage
2 ☐ Tocolysis
3 ☐ External cephalic version:
- ☐ Successful
- ☐ Failed

4 ☐ None of the above

**64. Onset of Labor** (Check all that apply):

1 ☐ Premature rupture of the membranes (Prolonged, ≥ 12hr)
2 ☐ Precipitous Labor (< 3hr)
3 ☐ Prolonged Labor (≥ 20hr)
4 ☐ None of the above

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

1 ☐ Induction of labor
2 ☐ Augmentation of labor
3 ☐ Non-vertex presentation
4 ☐ Epidural or spinal anesthesia during labor
5 ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
6 ☐ Antibiotics received by the mother during labor
7 ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
8 ☐ Moderate/heavy meconium staining of the amniotic fluid
9 ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery
10 ☐ None of the above

**66. Abnormal Conditions of the Newborn**
(Occurring within 24 hours of delivery) (check all that apply):

1 ☐ Assisted ventilation required immediately following delivery
2 ☐ Assisted ventilation required for more than six hours
3 ☐ NICU admission
4 ☐ Newborn given surfactant replacement therapy
5 ☐ Antibiotics received by the newborn for suspected neonatal sepsis
6 ☐ Seizure or serious neurologic dysfunction
7 ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention)
8 ☐ None of the above

**67. Congenital Anomalies of the Newborn**
(Observed within 24 hours of delivery) (Check all that apply)

1 ☐ Anencephaly
2 ☐ Meningomyelocele / Spina bifida
3 ☐ Cyanotic congenital heart disease
4 ☐ Congenital diaphragmatic hernia
5 ☐ Omphalocele
6 ☐ Gastroschisis
7 ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndrome)
8 ☐ Cleft Lip with or without Cleft Palate
9 ☐ Cleft Palate alone
10 Down Syndrome
- ☐ Karyotype confirmed
- ☐ Karyotype pending

11 Chromosomal disorder
- ☐ Karyotype confirmed
- ☐ Suspected, Karyotype pending

12 ☐ Hypospadias
13 ☐ None of the above

### Attendant and Certifier Information

**68. Certifier** – Name and Title

**69. Date Certified** (MM/DD/YYYY)
/ /

**70. Attendant – Name and Title** (If other than Certifier)

**71. NPI of person delivering the baby:**