U.S. STANDARD CERTIFICATE OF LIVE BIRTH

LOCAL FILE NO. BIRTH NUMBER:

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)
2. TIME OF BIRTH (24 hr)
3. SEX
4. DATE OF BIRTH (Mo/Day/Yr)
5. FACILITY NAME (If not institution, give street and number)
6. CITY, TOWN, OR LOCATION OF BIRTH
7. COUNTY OF BIRTH

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
8b. DATE OF BIRTH (Mo/Day/Yr)
8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)
8d. BIRTHPLACE (State, Territory, or Foreign Country)
9a. RESIDENCE OF MOTHER-STATE
9b. COUNTY
9c. CITY, TOWN, OR LOCATION
9d. STREET AND NUMBER
9e. APT. NO.
9f. ZIP CODE
9g. INSIDE CITY LIMITS? □ Yes □ No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. BIRTHPLACE (State, Territory, or Foreign Country)

CERTIFIER

11. CERTIFIER'S NAME: _____
TITLE: □ MD □ DO □ HOSPITAL ADMIN. □ CNM/CM □ OTHER MIDWIFE
□ OTHER (Specify)_____
12. DATE CERTIFIED _____/_____/_____ MM DD YYYY
13. DATE FILED BY REGISTRAR _____/_____/_____ MM DD YYYY

INFORMATION FOR ADMINISTRATIVE USE

MOTHER

14. MOTHER'S MAILING ADDRESS: 9 Same as residence, or: State: City, Town, or Location:
Street & Number: Apartment No.: Zip Code:
15. MOTHER MARRIED? (At birth, conception, or any time between) □ Yes □ No
IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? □ Yes □ No
16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? □ Yes □ No
17. FACILITY ID. (NPI)
18. MOTHER'S SOCIAL SECURITY NUMBER:
19. FATHER'S SOCIAL SECURITY NUMBER:

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
□ 8th grade or less
□ 9th - 12th grade, no diploma
□ High school graduate or GED completed
□ Some college credit but no degree
□ Associate degree (e.g., AA, AS)
□ Bachelor's degree (e.g., BA, AB, BS)
□ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
□ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)
□ No, not Spanish/Hispanic/Latina
□ Yes, Mexican, Mexican American, Chicana
□ Yes, Puerto Rican
□ Yes, Cuban
□ Yes, other Spanish/Hispanic/Latina
(Specify)_____

22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
□ White
□ Black or African American
□ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Other Asian (Specify)_____
□ Native Hawaiian
□ Guamanian or Chamorro
□ Samoan
□ Other Pacific Islander (Specify)_____
□ Other (Specify)_____

FATHER

23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
□ 8th grade or less
□ 9th - 12th grade, no diploma
□ High school graduate or GED completed
□ Some college credit but no degree
□ Associate degree (e.g., AA, AS)
□ Bachelor's degree (e.g., BA, AB, BS)
□ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
□ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

24. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)
□ No, not Spanish/Hispanic/Latino
□ Yes, Mexican, Mexican American, Chicano
□ Yes, Puerto Rican
□ Yes, Cuban
□ Yes, other Spanish/Hispanic/Latino
(Specify)_____

25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)
□ White
□ Black or African American
□ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____
□ Asian Indian
□ Chinese
□ Filipino
□ Japanese
□ Korean
□ Vietnamese
□ Other Asian (Specify)_____
□ Native Hawaiian
□ Guamanian or Chamorro
□ Samoan
□ Other Pacific Islander (Specify)_____
□ Other (Specify)_____

Mother's Name | Mother's Medical Record No.

26. PLACE WHERE BIRTH OCCURRED (Check one)
□ Hospital
□ Freestanding birthing center
□ Home Birth: Planned to deliver at home? 9 Yes 9 No
□ Clinic/Doctor's office
□ Other (Specify)_____

27. ATTENDANT'S NAME, TITLE, AND NPI
NAME: _____ NPI:_____
TITLE: □ MD □ DO □ CNM/CM □ OTHER MIDWIFE
□ OTHER (Specify)_____

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? □ Yes □ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:
_____

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MOTHER

29a. DATE OF FIRST PRENATAL CARE VISIT
_____/_____/_____ □ No Prenatal Care
M M D D YYYY

29b. DATE OF LAST PRENATAL CARE VISIT
_____/_____/_____
M M D D YYYY

30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
_____ (If none, enter "0".)

31. MOTHER'S HEIGHT
_____ (feet/inches)

32. MOTHER'S PREPREGNANCY WEIGHT
_____ (pounds)

33. MOTHER'S WEIGHT AT DELIVERY
_____ (pounds)

34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? □ Yes □ No

35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)

35a. Now Living
Number _____
□ None

35b. Now Dead
Number _____
□ None

36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

36a. Other Outcomes
Number _____
□ None

37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
□ Private Insurance
□ Medicaid
□ Self-pay
□ Other
(Specify) _____

35c. DATE OF LAST LIVE BIRTH
_____/_____
MM Y Y Y Y

36b. DATE OF LAST OTHER PREGNANCY OUTCOME
_____/_____
MM Y Y Y Y

39. DATE LAST NORMAL MENSES BEGAN
_____/_____/_____
M M D D YYYY

40. MOTHER'S MEDICAL RECORD NUMBER

MEDICAL AND HEALTH INFORMATION

41. RISK FACTORS IN THIS PREGNANCY
(Check all that apply)

Diabetes
□ Prepregnancy (Diagnosis prior to this pregnancy)
□ Gestational (Diagnosis in this pregnancy)

Hypertension
□ Prepregnancy (Chronic)
□ Gestational (PIH, preeclampsia)
□ Eclampsia

□ Previous preterm birth

□ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

□ 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))

□ Mother had a previous cesarean delivery
If yes, how many _____

□ None of the above

42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
□ Gonorrhea
□ Syphilis
□ Chlamydia
□ Hepatitis B
□ Hepatitis C
□ None of the above

43. OBSTETRIC PROCEDURES (Check all that apply)
□ Cervical cerclage
□ Tocolysis

External cephalic version:
□ Successful
□ Failed

□ None of the above

44. ONSET OF LABOR (Check all that apply)
□ Premature Rupture of the Membranes (prolonged, ≥12 hrs.)
□ Precipitous Labor (<3 hrs.)
□ Prolonged Labor (≥ 20 hrs.)
□ None of the above

45. 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 prior to delivery
□ Antibiotics received by the mother during labor
□ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
□ Moderate/heavy meconium staining of the amniotic fluid
□ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
□ Epidural or spinal anesthesia during labor
□ None of the above

46. 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
□ Vaginal/Forceps
□ Vaginal/Vacuum
□ Cesarean
If cesarean, was a trial of labor attempted?
□ Yes
□ No

47. MATERNAL MORBIDITY (Check all that apply)
(Complications associated with labor and delivery)
□ 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

NEWBORN INFORMATION

NEWBORN

48. NEWBORN MEDICAL RECORD NUMBER

49. BIRTHWEIGHT (grams preferred, specify unit)
_____
9 grams 9 lb/oz

50. OBSTETRIC ESTIMATE OF GESTATION:
_____ (completed weeks)

51. APGAR SCORE:
Score at 5 minutes:_____
If 5 minute score is less than 6,
Score at 10 minutes: _____

52. PLURALITY - Single, Twin, Triplet, etc.
(Specify)_____

53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) _____

54. ABNORMAL CONDITIONS OF THE NEWBORN
(Check all that apply)
□ Assisted ventilation required immediately following delivery
□ Assisted ventilation required for more than six 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)
9 None of the above

55. CONGENITAL ANOMALIES OF THE NEWBORN
(Check all that apply)
□ Anencephaly
□ Meningomyelocele/Spina bifida
□ 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
□ Karyotype pending
□ Suspected chromosomal disorder
□ Karyotype confirmed
□ Karyotype pending
□ Hypospadias
□ None of the anomalies listed above

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No
IF YES, NAME OF FACILITY INFANT TRANSFERRED TO:_____

57. IS INFANT LIVING AT TIME OF REPORT?
□ Yes □ No □ Infant transferred, status unknown

58. IS THE INFANT BEING BREASTFED AT DISCHARGE?
□ Yes □ No

Mother's Name _____ **Mother's Medical Record No.** _____

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NOTE: This recommended standard birth certificate is the result of an extensive evaluation process. Information on the process and resulting recommendations as well as plans for future activities is available on the Internet at: http://www.cdc.gov/nchs/vital_certs_rev.htm.