SOUTH DAKOTA DEPARTMENT OF HEALTH

Certifier's Worksheet for Completing the Birth Certificate

This worksheet is to be completed by the facility using the prenatal record, mother's medical records and the labor and delivery records. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record or a copy of the prenatal care information. Please do not provide information from sources other than those listed.

This worksheet should not be completed by the parents except in the case of a home birth. In the case of a home birth, this worksheet should be completed by the certifier (person delivering the child) or the mother.

Birth Information

1. Twins? ☐ No ☐ Yes, Baby 1/A ☐ Yes, Baby 2/B
2. Sex? ☐ Male ☐ Female ☐ Not yet determined
3. Date of Birth? _____ MM/DD/YYYY 4. Time of Birth? _____ (Use Military Time)
5. Facility Name _____
   (If home birth - address, if enroute list hospital name where first removed from the vehicle.)
6. County of Birth _____ Zipcode _____
7. City, Town or Location of Birth _____ Inside City Limits? ☐ Yes ☐ No
8. Type of Place of Birth?
   - ☐ Clinic/Doctor's Office
   - ☐ Freestanding Birthing Center
   - ☐ Hospital
   - ☐ Other _____ (Named place - describe e.g. McDonalds)
   - ☐ Home Birth
     Planned to Deliver at Home?
     - ☐ Yes
     - ☐ No
     - ☐ Unknown

Certifier /Attendant Information

1. Certifer's Name & Title _____
   (The individual who certifies to the fact that the birth occurred. May be, but need not be the same as the attendant.)
   - ☐ CNM
   - ☐ D.O.
   - ☐ EMT
   - ☐ Nurse (RN, LPN, NC)
   - ☐ Nurse Practitioner
   - ☐ Other (Includes the father, etc.)
   - ☐ Other Midwife
   - ☐ Physician (MD, Resident, Intern)
   - ☐ Physician's Assistant
   - ☐ Unknown
2. Attendant's Name & Title _____
   (The individual physically present at the delivery, who is responsible for the delivery. If an intern or nurse midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant)
   - ☐ CNM
   - ☐ D.O.
   - ☐ EMT
   - ☐ Nurse (RN, LPN, NC)
   - ☐ Nurse Practitioner
   - ☐ Other (Includes the father, etc.)
   - ☐ Other Midwife
   - ☐ Physician (MD, Resident, Intern)
   - ☐ Physician's Assistant
   - ☐ Unknown
3. Principal Source of Payment for this Delivery (At the time of delivery):
   - ☐ Private Insurance
   - ☐ Medicaid
   - ☐ CHAMPUS/TRICARE
   - ☐ Other government (federal, state, local)
   - ☐ Self Pay
   - ☐ Indian Health Services

4. Date Completed by Certifier _____

INFORMATION FOR MEDICAL & HEALTH USE ONLY

Prenatal Information Source: Prenatal Care Records, Mother's Medical Records, Labor and Delivery Records

1. Number of previous live births now living (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child): _____ Number live births now living ☐ None
2. Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child): _____ Number live births now deceased ☐ None
3. Date of last live birth? _____ MM/YYYY
4. Total number of other pregnancy outcomes - not including any live births (Includes fetal losses of any gestational age - spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in the pregnancy): _____ Number of other pregnancy outcomes ☐ None

Mother's Current Legal Name _____ Hospital Medical Record # _____

5. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended): _____
MM/YYYY

6. Date the last normal menses began? _____; or if not sure of exact date, check one
MM/DD/YYYY

☐ Beginning of month: 07 ☐ Middle of month: 15 ☐ End of month 24

7. Date of first prenatal care visit (Prenatal care begins when a physician or other health provider first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy):

_____ ☐ None, if this box is checked skip 8
MM/DD/YYYY

8. Date of last prenatal care visit (Enter the date of the last visit recorded in the mother's prenatal records): _____
MM/DD/YYYY

9. Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record).

_____Number ☐ None

10. Medical risk factors for this pregnancy (Check all that apply)

- ☐ Diabetes, pre-existing
- ☐ Diabetes, gestational
- ☐ Previous preterm births
- ☐ Hypertension
  - ☐ Pre-pregnancy
  - ☐ Gestational (includes preeclampsia)
  - ☐ Eclampsia
- ☐ Other previous poor pregnancy outcomes
- ☐ Pregnancy resulted from infertility treatment (Check all that apply)
  - ☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination
  - ☐ Assisted reproductive technology
- ☐ Mother had a previous cesarean delivery
  If Yes, how many _____
- ☐ None of the above

11. Infections present and/or treated during this pregnancy (Check all that apply)

- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Hepatitis B
  - ☐ HBsAG+
- ☐ Hepatitis C
- ☐ Cytomegolovirus (CMV)
- ☐ Rubella
- ☐ Genital Herpes
- ☐ Toxoplasmosis
- ☐ HIV
- ☐ None of the above

12. Obstetric procedures performed during the pregnancy (Check all that apply)

- ☐ Cervical Cerclage
- ☐ Tocolysis
- ☐ External Cephalic - Success
- ☐ External Cephalic - Failed
- ☐ None of the above

Labor and Delivery Information Source: Labor and delivery records, Mother's medical record

1. Mother's weight at delivery _____lbs.

2. Was the mother transferred to this facility for maternal medical or fetal indications for delivery? ☐ Yes ☐ No
   a. If yes, enter the name of the facility mother transferred from _____

3. Onset of labor (Check all that apply)

- ☐ Premature Rupture of the membranes (tearing of amniotic sac, 12 or more hours before labor begins)
- ☐ Precipitous Labor (<3 hours) (Labor that progresses rapidly and lasts for less that 3 hours.)
- ☐ Prolonged Labor (>=20 hours) (Labor that progresses slowly and lasts for 20 hours or more.)
- ☐ None of the above

4. Characteristics of labor and delivery

- ☐ 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 maternal temperature >= 38 C (100.4 F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor requiring in-utero resuscitative measures, further fetal assessment or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

Mother's Current Legal Name _____ Hospital Medical Record # _____

5. Was vaginal delivery with forceps attempted? ☐ Successful ☐ Unsuccessful ☐ No, Not used

6. Was vaginal delivery with vacuum attempted? ☐ Successful ☐ Unsuccessful ☐ No, Not used

7. Fetal presentation at birth (Check one) ☐ Cephalic ☐ Breech ☐ Other

8. What was the 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

9. Complications of the mother experienced during labor and delivery (Check all that apply)
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to the intensive care unit
- ☐ Unplanned operating procedure following delivery
- ☐ None of the above

Newborn Information Source: Labor and delivery record, Newborn's Medical Record, Mother's Medical Records

1. APGAR score at **1 minute**? _____

APGAR score at **5 minutes**? _____

If 5 minute score is **less than 6,** score at **10 minutes**? _____

2. Birth Weight _____ Grams If weight in grams is not available, birth weight _____ lb/oz

3. Obstetric estimation of gestation? _____ Completed Weeks (ultrasound taken in early pregnancy preferred)

4. Plurality? (Include all live births and fetal losses resulting from this pregnancy) _____ (1,2,3,4,5,6,7 etc.)

5. If not a single birth, birth order? (Include all live births and fetal losses resulting from this pregnancy) _____ (1st, 2nd, 3rd, 4th, 5th, etc.)

6. If not single birth, specify number of infants born alive? _____

7. Was infant transferred within 24 hours of delivery? ☐ Yes ☐ No

If yes, name the facility infant transferred to? _____

8. Is infant living at the time of this report? ☐ Yes ☐ No ☐ Infant transferred, status unknown

9. Is infant being breastfed at time of this report? ☐ Yes ☐ No

10. Abnormal conditions of the newborn (Check all that apply)
- ☐ Assisted ventilation required immediately following delivery (Not to include freeflow oxygen)
- ☐ Assisted ventilation required for more than six hours (Not to include freeflow oxygen)
- ☐ NICU admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Antibiotics received by the newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury
- ☐ None of the above listed conditions

11. Congenital anomalies of newborn
- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalacele
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Cleft lip with or without a cleft palate
- ☐ Cleft palate alone
- ☐ Other craniofacial abnormality
- ☐ Down Syndrome (Trisomy 21)
  - ☐ Karotype confirmed
  - ☐ Karotype pending
- ☐ Suspected chromosomal disorder
  - ☐ Karotype confirmed
  - ☐ Karotype pending
- ☐ Hypospadias
- ☐ None of the above

Mother's Current Legal Name _____ Hospital Medical Record # _____

Screening:

1. Immunization

Vaccination

☐ Declined Immunization

Date & Time Site Manufacturer Lot #

☐ Hepatitis B _____

☐ Hepatitis B Immune Globulin _____

Provider Name _____

Provider Title

☐ R.N.
☐ D.O.
☐ M.D.
☐ Other

☐ None

2. Metabolic Screening Number

○ (Laboratory requisition 9 digit number) ____/____/____/____/____/____/____/____/____/ (do not include - NN)

or

○ (place sticker here)

☐ Screen not done

Reason not done:

☐ Infant deceased
☐ Refused (If refused, notify the South Dakota Newborn Metabolic Screening Program at 1-800-738-2301)
☐ Infant transferred to _____

3. Hearing Screening

Hearing Screen date: _____
MM/DD/YYYY

4. Type of Screen

☐ AABR
☐ OAE
☐ Unsure

a. Test given:

☐ Yes
☐ No

Reason if no:

☐ Deceased
☐ Discharged
☐ Hearing equipment broken
☐ Home birth
☐ Infant in ICU
☐ No hearing screening equipment
☐ Refused
☐ To be screened in Primary Care Provider's (PCP) office
☐ Transferred

b. Time of Screen Military Time _____

c. Results of Test

Pass (P)

☐ Right ear
☐ Left ear

Not pass (N)

☐ Right ear
☐ Left ear

☐ Return for rescreen
☐ Referred to

☐ PCP: (name) _____
First Last

Completed by _____

Mother's Current Legal Name _____ Hospital Medical Record # _____