WORKSHEET FOR REPORTING MEDICAL INFORMATION

1. Birth information may be used for health or population analysis or for public health programs.
2. Data collected for statistical use only is indicated by an asterisk (*).

PENALTIES: Any person who willfully and knowingly supplies any false information to be used in the preparation of a birth certificate is guilty of a Class I felony [a fine of not more than $10,000 or imprisonment of not more than three years and six months, or both, per Wis. Stat. § 69.24(1)].

For Birthing Facility Use

Medical Record Number of Parent giving birth: _____

Child's Medical Record Number _____

Child's Date of Birth ___ ___ /___ ___ /___ ___ ___ ___ (MM/DD/YYYY)

***Special Circumstances Regarding this Birth (Check one.)**

☐ Adoption (potential) ☐ Surrogate ☐ Safe Haven ☐ Foundling ☐ Refusal ☐ No Special Circumstances

BIRTHPLACE

Place of birth

☐ Hospital ☐ Clinic/Doctor's Office ☐ Midwife Facility ☐ Other (specify) _____

☐ Home – If born at home, did the parent giving birth plan to deliver at home? ☐ **Yes** ☐ **No** ☐ **Unknown**

If birth occurred out-of-hospital, provide facility name or street address	Zip code

City, Village, or Town of birth	County of birth

PRENATAL INFORMATION

Information for the following items should come from the prenatal care records of the parent giving birth and from other medical reports, as well as the infant's medical record. Contact the prenatal care provider to obtain a copy of the prenatal care information, if necessary.

Did parent giving birth receive prenatal care? ☐ **Yes** ☐ **No** ☐ **Unknown**	*Date of first prenatal care visit ___ ___ /___ ___ /___ ___ ___ ___	*Date of last prenatal care visit ___ ___ /___ ___ /___ ___ ___ ___
*Total number of prenatal care visits	*Date last normal menses began ___ ___ /___ ___ /___ ___ ___ ___	

For the items below, do not include the current birth. For multiple deliveries, do not include the first born twin/triple. The second or later born twin/triplet should include previous born (e.g. twin 1 would not be included in the numbers below, but twin 2 should contain twin 1.)

*Number of previous live births now living	*Number of previous live births now dead	*Date of last live birth (MM/YYYY)
_____Number ☐ None	_____Number ☐ None	___ ___ /___ ___ ___ ___

*Total number of other pregnancy outcomes	*Date of last other pregnancy outcome (MM/YYYY)
_____Number ☐ None	___ ___ /___ ___ ___ ___

***Risk factors** diagnosed in this pregnancy – Check all that apply

A. ☐ None
B. ☐ Prepregnancy diabetes (both B and C cannot be checked)
C. ☐ Gestational diabetes
D. ☐ Prepregnancy hypertension
E. ☐ Gestational hypertension
F. ☐ Eclampsia
G. ☐ Previous preterm births
H. ☐ Other previous poor pregnancy outcome
I. ☐ Pregnancy resulted from infertility treatment –
J. ☐ Fertility enhancing drugs, AI, or Intrauterine insemination
K. ☐ Assisted reproductive technology
L. ☐ Parent giving birth had previous c-section –
Number of previous c-sections _____

***Infections** present and/or treated during this pregnancy – Check all that apply

A. ☐ None **B.** ☐ Gonorrhea **C.** ☐ Syphilis **D.** ☐ Chlamydia **E.** ☐ Hepatitis B **F.** ☐ Hepatitis C

***Obstetric procedures** *(medical treatment or invasive/manipulative procedure performed during this pregnancy)* – Check all that apply

A. ☐ None **B.** ☐ Cervical cerclage **C.** ☐ Tocolysis **D.** ☐ External cephalic version – **E.** ☐ Successful **F.** ☐ Failed

LABOR

***Onset of Labor** – Check all that apply.

A. ☐ None
B. ☐ Premature rupture of the membranes (prolonged >=12 hours)
C. ☐ Precipitous labor (<3 hours)
D. ☐ Prolonged labor (>=20 hours)

DELIVERY

Child's date of birth ___ ___ /___ ___ /___ ___ ___ ___	**Child's time of birth** (0000-2359) ___ ___ ___ ___

Principal source of payment for this delivery *(at the time of delivery)*

☐ Private Insurance
☐ Self Pay (no third party identified)
☐ CHAMPUS/TRICARE
☐ Medicaid/BadgerCare Plus (comparable State program)
☐ Indian Health Service
☐ Other Government (federal, state, local)
☐ Other (specify)_____

*Was the parent giving birth transferred to this facility for medical or fetal indications for delivery? ☐ **Yes** ☐ **No** ☐ **Unknown**	*If the parent giving birth was transferred, name the facility transferred from _____

ATTENDANT

The attendant at birth is the individual physically present at the delivery who is responsible for the delivery.

Attendant's last name	Attendant's first name	Wisconsin license number (if applicable)

Attendant's title - ☐ MD ☐ LM (Licensed midwife) ☐ CNM (Certified Nurse Midwife) ☐ DO ☐ Other (specify): _____

*Attendant's NPI (if applicable)

CHARACTERISTICS

*Parent giving birth's weight at delivery
Pounds: _____

***Characteristics** of labor and delivery – Check all that apply

A. ☐ None
B. ☐ Induction of labor
C. ☐ Augmentation of labor
D. ☐ Non-vertex presentation (e.g., breech, shoulder, brow, face presentations, and transverse lie)
E. ☐ Steroids (glucocorticoids) for fetal lung maturation received by the parent giving birth prior to delivery
F. ☐ Antibiotics received by the parent giving birth during labor
G. ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature=38 degrees C (100.4 degrees F)
H. ☐ Moderate/heavy meconium staining of the amniotic fluid
I. ☐ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
J. ☐ Epidural or spinal anesthesia during labor

METHOD

*Was delivery with **forceps** attempted but unsuccessful? ☐ **Yes** ☐ **No**

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

***Fetal presentation** at birth – Check one
☐ Cephalic (vertex, occiput anterior (OA), occiput posterior (OP))
☐ Breech (breech, complete breech, frank breech, footling breech)
☐ Other (any other presentation not listed above)

***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**

MORBIDITY

***Maternal morbidity** (*serious complications associated with labor and delivery*) – Check all that apply

A. ☐ None
B. ☐ Maternal transfusion
C. ☐ Third or fourth degree perineal laceration
D. ☐ Ruptured uterus
E. ☐ Unplanned hysterectomy
F. ☐ Admission to intensive care unit
G. ☐ Unplanned operating room procedure following delivery

NEWBORN

Birth weight – enter pounds and ounces **OR** grams, not both
_____ pounds _____ounces OR _____grams

Birth length – enter inches and quarter inches **OR** centimeters (cm)
_____inches _____quarter inches OR _____cm

Sex ☐ Female ☐ Male ☐ Not yet determined

***Obstetric estimate of gestation** at delivery
_____ (completed weeks)

***Apgar score** Score at 5 minutes _____ Score at 10 minutes_____

Plurality (*include all live births and fetal losses **from this pregnancy***)
Specify: **1** (singleton), **2** (twin), **3** (triplet), etc. _____

If not single birth, specify birth order (1st, 2nd, 3rd, etc.) _____

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

***Abnormal conditions** of the newborn (*disorders or significant morbidity experienced by the newborn*) – Check all that apply

A. ☐ None
B. ☐ Assisted ventilation required immediately following delivery
C. ☐ Assisted ventilation required for more than six hours
D. ☐ NICU Admission
E. ☐ Newborn given surfactant replacement therapy
F. ☐ Antibiotics received by the newborn for suspected neonatal sepsis
G. ☐ Seizure or serious neurologic dysfunction
H. ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)

***Congenital anomalies** of the newborn (*malformations of the newborn diagnosed prenatally or after delivery)* – Check all that apply

A. ☐ None
B. ☐ Anencephaly
C. ☐ Meningomyelocele/Spina bifida
D. ☐ Cyanotic congenital heart disease
E. ☐ Congenital diaphragmatic hernia
F. ☐ Omphalocele
G. ☐ Gastroschisis
H. ☐ Limb reduction defect
I. ☐ Cleft Lip with or without Cleft Palate
J. ☐ Cleft Palate alone
K. ☐ Down Syndrome (Trisomy 21) –
L. ☐ Karyotype confirmed
M. ☐ Karyotype pending
N. ☐ Suspected chromosomal disorder –
O. ☐ Karyotype confirmed
P. ☐ Karyotype pending
Q. ☐ Hypospadias

*Is infant being breastfed at discharge? ☐ **Yes** ☐ **No**

***Newborn screening blood card ID number** _____

*Vaccine administered to infant?
☐ HEPB *Date administered __ __ /__ __ /__ __ __ __
☐ HBIG *Date administered __ __ /__ __ /__ __ __ __
☐ RSV *Date administered __ __ /__ __ /__ __ __ __
☐ None

*Was infant transferred within 24 hours of delivery? ☐ **Yes** ☐ **No** *If yes, enter the name of the facility _____

MORTALITY

Infant died? ☐ **Yes** ☐ **No** ☐ **Infant transferred, status unknown**

*If yes, date of death __ __ /__ __ /__ __ __ __

*Time of death (0000-2359) __ __ __ __

*Group responsible for disposition: ☐ Funeral Home ☐ Family ☐ Hospital ☐ Coroner/Medical Examiner ☐ Unknown

*Funeral home responsible for the disposition

*City of funeral home

*Phone number of funeral home
( )

***Certifier's name**	***Certifier's title**	***Date certified**
		__ __ /__ __ /__ __ __ __

Complete both pages

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