BIRTH PARENT'S MEDICAL RECORD #	CHILD'S MEDICAL RECORD #
	IF MULTIPLE BIRTH, this worksheet is for:

Rev. 01/2022

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH



MEDICAL DATA WORKSHEET for the LIVE BIRTH CERTIFICATE (v2003)

Connecticut General Statute §7-48 requires the medical practitioner in attendance of a birth and the practitioner providing prenatal care to provide the medical information required by the certificate not later than 72 hours after the birth. When a birth occurs in an institution, the institution's decignated corresponds two shall obtain all available data required by the cortificate

prepare the certificate, certilater than ten days after suc require and shall be comple	ify that the child was b ch birth. Each birth cert	orn alive at the p	lace and	time and on tl	ne date stated, ar	d file the certificate not
Birth Parent's Name:						
First	Middle		ıst			Generational ID
1b. Date of birth of this of	child 1c. Ti	me of birth of t	this child		1d. Sex of this	child
/ / /	Year hour	: : AM PM Military		□ Military	☐ Male ☐ Female ☐ Not yet determined/Unknown	
1e. Place of Birth Type: ☐ Hospital ☐ Free Standing Birthin ☐ Clinic/Doctor's Office ☐ Born En-route or on	e		me:			
□ Residence: Was this a <u>planned</u> delivery at home? □ Yes □ No □ Unknown		Street				Apt #
		City/Town			County	State
		EDICAL CER				
I HEREBY CERTIFY	Y THAT THE CHILD	WAS BORN A	T THE H	OUR, DATE,	AND PLACE ST	TATED ABOVE
Certifier's Title:	Certifier's Prin	Certifier's Printed Name:				Generational ID
□ MD □ DO	Certifier's Sign	ature:	First	IVII	Last	Generational iD
□ CNM					Date Sign	ed:
□ Other Midwife-CPM□ Birth Parent	First	MI L	.ast	Generational	ID	
□ Non-Birth Parent	CT License Nur	CT License Number:		National Provider ID:		
□ Other – specify:	Certifier's Add	ress:				
	Street	/Apt #		City/Town	State	ZIP code
8h. Birth Attendant's Inf Title of Birth Attendant: DO DO CNM Other (specify): Name of Birth Attendant: SAME AS CERTIFIER	delivery <u>ev</u> Other Midwife-CPM	en if they do not th	nemselves	deliver the infa	•	who is responsible for the
	First	MI		Last		Generational ID
CT License Number:		Nationa	I Provide	r ID (NPI):		

PRENATAL INFORMATION

Sources: Prenatal care records, Birth Parent's medical records, labor and delivery records

Information for the following items should come from the Birth Parent's prenatal care records and from other medical reports in the Birth Parent's chart, as well as the infant's medical record. If the Birth Parent's prenatal care record is not in the hospital chart, please contact the Birth Parent's prenatal care provider to obtain the record, or a copy of the prenatal care information.

Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.

WHERE INFORMATION FOR AN ITEM CANNOT BE LOCATED. PLEASE WRITE "UNKNOWN" ON THE PAPER COPY OF THE WORKSHEET.

9a. Did Birth Parent Have Prenatal Care:		9b. Principal Source of Payment for Prenatal Care:			
□ YES □ NO □ Unknown		☐ Husky or Medicaid			
Is the prenatal care record available for this Birth Parent? Is it current? If the prenatal care record is not available <i>or</i> if the record is not current (i.e., from pre-registration), please contact the prenatal care provider for an updated record before completing the remaining items.		 □ Private/Employer Insurance □ Self-pay (No third party identified) □ Indian Health Service □ CHAMPUS/TRICARE □ Other Government □ Other – specify: 			
9c. Date of FIRST prenatal care visit:		•		te last normal menses began:	
/ / Year	VISITS for this pregnancy:		— Mo	/ /	
Prenatal care begins when a physician or other health professional first examines and/or counsels as part of an ongoing program of care for the pregnancy.	Count only those visits recorded in the record. If the prenatal records do not appear to be current, please contact the prenatal care provider for updated information.		specified any part available	calculate the date if it is not If in the prenatal care record. If of the date is available, enter the parts (e.g., 04/99/2014). se, enter 99-99-9999.	
9f. Method of Determining EDD: Method used by prenatal care provider to establish the Estimated Date of Delivery (EDD). Check one:					
 □ Known LMP consistent with an ultrasound (the earliest possible >7 weeks) □ Ultrasound (the earliest possible >7 weeks) NOT consistent with known LMP □ Ultrasound alone, LMP date is only partially known or not known □ LMP alone, did not have an ultrasound prior to labor and delivery □ ART: Date of Assisted Reproductive Technology (ART) established the EDD □ No EDD determined □ Method unknown Known LMP means that all parts of the LMP date (MM-DD-YYYY) were recorded in the Birth Parent's prenatal records. If only a					
partial LMP date is available, do not select the first two options. ART (Assisted Reproductive Technology) includes embryo transfer, intrauterine insemination (IUI), ZIFT, GIFT. If no prenatal care was received, then select "No EDD determined" since a prenatal provider did not date the pregnancy. If the prenatal care record is not available or does not specify the method used to determine EDD, then select "Method unknown".					
9g. Number of previous LIVE births now LIVING:	9h. Number of DEAD:	previous LIVE births	now	9i. Date of last live birth: /	
□ None Do not include this child. Include all live births delivered before this infant in this pregnancy and in previous pregnancies.	now-dead delive	☐ None <u>nis</u> child. Include all live- red before this infant in previous pregnancies.	n this	Month Year	

9j. Total number of other pregnancy	9k. Date of last other	91. Did Birth Parent's blood test positive for		
outcomes that did not result in a	pregnancy outcome:	syphilis during this pregnancy? If yes, provide test		
live birth:	,	date(s).		
□ None	/ Month Year			
Include programmy losses of any		1 st test:		
Include pregnancy losses of any gestational agespontaneous losses,	Date when last pregnancy	□ YES, positive test result on / / /		
induced losses, and/or ectopic	that did not result in a live	Month Day Year		
pregnancies. If this was a multiple	birth ended.	□ No		
delivery, include all fetal losses delivered		□ Unknown		
before this infant in this pregnancy and in		2nd test:		
previous pregnancies.		☐ YES, positive test result on / / /		
		Month Day Year		
		□ No		
		□ Unknown		
9m. Was Birth Parent's prenatal care re	ecord available for complet	ting worksheet?		
·	·			
□ YES □ NO	□ Unknown			
10a. Birth Parent's risk factors for this	prognancy: Check all that a	nnly		
Toa. Diftii Farent 3 risk factors for this	pregnancy. Check an that a	ppiy.		
Diabetes: Glucose intolerance requiring tr	eatment. If diabetes is present, c	heck either pre-pregnancy or gestational. Do not check both.		
□ Pre-pregnancy: Diagnosis <u>prior</u> t	to this pregnancy			
☐ Gestational: Diagnosis <u>in this</u> pre	egnancy			
Hypertension: Flevation of blood pressur	e above normal for age, gender, a	and physiological condition. If hypertension is present, check		
	estational. Do not check both.	and physiological contained. If hypertension is present, check		
		rmal for age, gender, and physiological condition diagnosed		
prior to the onset of		, , , , , , , , , , , , , , , , , , ,		
		above normal for age, gender, and physiological condition		
	diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and			
pathologic edema (g	generalized swelling, including sw	elling of the hands, legs and face).		
□ Eclampsia: Pregnancy induced hy	pertension with proteinuria with	generalized seizures or coma. May include pathologic edema.		
☐ Previous preterm birth: History of p	regnancy(ies) terminating in a live	e birth of less than 37 completed weeks of gestation.		
□ Pregnancy resulted from infertilit	v treatment - Any assisted ren	roduction technique used to initiate the pregnancy. Includes		
fertility-enhancing drugs (e.g., Clomid, Per	gonal), artificial insemination, or	intrauterine insemination and assisted reproduction		
technology (ART) procedures (e.g., IVF, GI	Fi and ZiFi).			
If Yes, check all that apply:				
	- ·	or intrauterine insemination: Any fertility- enhancing		
		uterine insemination used to initiate the pregnancy.		
•	technology: Any assisted repro trafallopian transfer (GIFT), ZIFT) i	duction technology (ART)/technical procedures (e.g., in vitro		
		, - ,		
•		ve delivery by extraction of the fetus, placenta, and		
membranes through an incision in the ma		IS.		
If Yes, how many previous cesarea				
_		Prenatal care record indicates that Birth Parent used tobacco		
		ncy, even if Birth Parent reported cessation upon learning of		
the pregnancy. Do not include e-cigarette				
-		record indicates that Birth Parent used alcohol during		
	ring this pregnancy, even if Birth F	Parent reported cessation upon learning of the pregnancy.		
□ None of the above				
□ Unknown				

10b. Infections present and/or treated during this pregnancy: Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.		10c. Obstetric procedure: Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically in the treatment of the pregnancy, management of labor and/or delivery.		
Check all that apply.				
☐ Chlamydia : a diagnosis of or positive test for Chlamydia trachomatis☐ Gonorrhea : a diagnosis of or positive test for Neisseria gonorrhoeae		☐ External cephalic version: Attempted conversion		
		of a fetus from a non-vertex to a vertex presentation by external manipulation.		
□ Syphilis : also called lues - a diagnosis of or positive test for Treponer pallidum	ma	□ Successful □ Failed		
☐ Hepatitis B: HBV, serum hepatitis - a diagnosis of or positive test for hepatitis B virus	r the	□ None of the above		
☐ Hepatitis C : non A, non B hepatitis, HCV - a diagnosis of or positive to for the hepatitis C virus	test			
$\hfill \label{eq:HIV+:} \square$ HIV+: a diagnosis of or positive test for human immunodeficiency vir	us			
□ None of the above				
LABOR AND	DELI	VERY		
Sources: Labor and delivery records	s, Birtl	h Parent's medical records		
11a. Principal Source of Payment for Delivery:	11b,	c. Was the Birth Parent transferred to this facility		
☐ Husky or Medicaid	for maternal medical or fetal indications for deliv			
☐ Private/Employer Insurance	_ v	es from:		
□ Solf pay (No third party identified)		Name of facility Birth Parent transferred from		
□ Indian Health Service		•		
□ CHANADIIC/TDICADE		Jnknown		
□ Other Government				
□ Other – specify:	Trans	sfers include hospital to hospital, birth facility to hospital, etc.		
11d. Birth Parent's weight at delivery: (in pounds	s)			
11e. Characteristics of labor and delivery: Check all that app	ly.			
☐ Induction of labor: Initiation of uterine contractions by medical a spontaneous onset of labor.	and/or s	surgical means for the purpose of delivery before the		
 Augmentation of labor: Stimulation of uterine contractions by of delivery. 	drug or i	manipulative technique with the intent to reduce the time to		
Steroids (glucocorticoids) for fetal lung maturation rece betamethasone, dexamethasone, or hydrocortisone specifically given delivery. Excludes steroid medication given to the Birth Parent as an	n to acce	elerate fetal lung maturation in anticipation of preterm		
Antibiotics received by the Birth Parent during labor: Indicate intramuscular) to the Birth Parent in the interval between the onset of Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.				
Clinical chorioamnionitis diagnosed during labor or mat chorioamnionitis during labor made by the delivery attendant. Usual and/or irritability, leukocytosis and fetal tachycardia. Any maternal to	ly includ	des more than one of the following: fever, uterine tenderness		
☐ Epidural or spinal anesthesia during labor: Administration labor, i.e., delivery of the agent into a limited space with the distribu				
□ None of the above				

11f. Method of Delivery:		11g. Maternal morbidity: Serious complications		
Fetal presentation at birth Cephalic: Presenting parameterior (OA), occiput post	rt of the fetus listed as vertex, occiput	experienced by the Birth Parent associated with labor and delivery. Check all that apply.		
 Breech: Presenting part breech, frank breech, foot 	of the fetus listed as breech, complete cling breech	☐ Maternal transfusion: Includes infusion of whole blood or packed red blood cells associated with labor and delivery.		
□ Other: Any other presen	tation not listed above	□Third- or fourth-degree perineal laceration: 3°		
Final route and method of	delivery: Check one.	laceration extends completely through the perineal skin, vaginal mucosa, perineal body, and anal sphincter. 4°		
	S : Delivery of the entire fetus through the ce of labor with or without manual ery attendant.	laceration is all of the above with extension through the rectal mucosa.		
□ Vaginal/Forceps: Deliv	very of the fetal head through the vagina by forceps to the fetal head.	□ Ruptured uterus: Tearing of the uterine wall. □ Unplanned hysterectomy: Surgical removal of the		
□ Vaginal/Vacuum: Deli	ivery of the fetal head through the vagina by cup or ventouse to the fetal head.	uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.		
□ Cesarean: Extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.		□ Admission to intensive care unit: Any admission of the Birth Parent to a facility/unit designated as providing intensive care.		
	trial of labor attempted? Labor was induced with plans for a vaginal delivery.	□ None of the above		
□ Yes □ No				
Sources: Labor and	NEWBORN Sources: Labor and delivery records, Newborn's medical records, Birth Parent's medical records			
12a. Plurality of this birth:		12b. Birth Order of this infant:		
☐ Singleton ☐ Other: ☐ Twins ☐ Triplets ☐ Quadruplets		☐ 1st born ☐ Other: ☐ 2nd born ☐ 3rd born ☐ 4th born		
Include all infants <u>delivered</u> (<u>alive or dead</u>) in this <u>pregnancy</u> when determining plurality.		If a multiple birth, circle the birth order of this child named above. Include all infants delivered (alive or dead) in this		
12c. Total LIVE births in this pregnancy:		pregnancy when determining birth order.		
If not single birth, specify numb	er of infants in this pregnancy born alive.			
12d. Birthweight:	12e. Apgar score:	12f. Obstetric estimate of gestation at delivery:		
Choose one.	Score at <u>5</u> minutes:	Completed weeks:		
GRAMS:	If 5 minute score is less than 6:	The birth attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam.		

12g. Abnormal conditions of the newborn: Disorders or significant morbidity	13a. Congenital anomalies of the newborn: Malformations of the newborn diagnosed prenatally or after delivery.
experienced by the newborn.	Check all that apply.
Check all that apply.	☐ Anencephaly: Partial or complete absence of the brain and skull. Also called
 □ Assisted ventilation required immediately following delivery: Infant 	anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).
given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes oxygen only and laryngoscopy for aspiration of meconium.	☐ Meningomyelocele/Spina bifida: Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida
☐ Assisted ventilation required for more	occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).
than six hours: Infant given mechanical ventilation (breathing assistance) by any method for > 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).	□ Cyanotic congenital heart disease: Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetratology of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.
□ NICU admission: Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.	□ Congenital diaphragmatic hernia: Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.
☐ Newborn given surfactant replacement	□ Omphalocele: A defect in the anterior abdominal wall, accompanied by herniation
therapy: Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.	of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis, see below), although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.
□ Antibiotics received by the newborn for suspected neonatal sepsis: Any antibacterial drug (e.g., penicillin, ampicillin, gentamicin, cefotoxine etc.) given systemically (intravenous or intramuscular).	 □ Gastroschisis: An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and absence of a protective membrane. □ Limb reduction defect (excluding congenital amputation and dwarfing
☐ Seizure or serious neurologic	syndromes): Complete or partial absence of a portion of an extremity associated with failure to develop.
dysfunction: Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe	□ Cleft Lip with or without Cleft Palate: Incomplete closure of the lip. May be unilateral, bilateral or median.
alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings.	□ Cleft Palate alone: Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft lip with or without Cleft Palate category above.
Exclude symptoms associated with CNS congenital anomalies.	□ Down Syndrome - (Trisomy 21)
□ Neonatal Abstinence Syndrome: Infant diagnosed with Neonatal Abstinence Syndrome based on the results of the hospital's standard screening policy for maternal drugs of abuse and	☐ Karyotype confirmed ☐ Karyotype pending
	□ Suspected chromosomal disorder: Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.
newborn NAS screening.	☐ Karyotype confirmed ☐ Karyotype pending
□ None of the above	□ Hypospadias: Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.
	□ None of the above

13b. Immunization Information:			
Did newborn receive Hepatitis B vaccine: ☐ Yes, D.☐ No☐ Unkno			
Did newborn receive HBIG vaccine: ☐ Yes, Date of	vaccine://		
	vaccine:: am / pm / military		
□ No □ Unknown	,,		
13c. Was infant transferred within 24 hours of	13d. Is infant living at time of report?		
delivery? Check "yes" if the infant was transferred from this facility to	☐ Yes ☐ No ☐ Infant transferred, status unknown		
another facility within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.	Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care.		
	13e. Is infant being breastfed at discharge?		
☐ Yes, to:	□ Yes □ No □ Unknown		
□ No □ Unknown	If the infant was receiving breastmilk/colostrum during the period between birth and discharge from the hospital. Include attempts to establish breastmilk production prior to discharge by breastfeeding or pumping (expressing) milk.		
Name and date of person completing this Facility Works	sheet:		
First Middle Last	Gen. ID Title		
Signature	Date Completed		
14b. COMMENTS:			