DEPARTMENT OF HEALTH

Birth Record Medical Information

This form is an optional data collection tool. It is not required.
The preferred source of birth record medical information is the medical professional in attendance at delivery or newborn examination.

Medical Information - Child

Birth attendant name	Mother's name or med record number	Infant's date of birth (MM/DD/YYYY) MM/DD/YYYY Time of birth (HHmm) ☐ 24 hr ☐ AM ☐ PM

Infant transferred to another facility within 24 hours of birth? ☐ No ☐ Yes If yes, WHERE?	Infant's med rec number	Infant's sex ☐ Female ☐ Male

Birthweight ☐ grams ☐ lb. /oz.	Obstetric estimate of gestation in completed weeks	5 minute Apgar score 5 minute _____ (If < 6, give 10 min)	10 minute Apgar score 10 minute _____ (if applicable)	Plurality (1 (single), 2 (twins), etc.)

If not a single, total # infants born alive in this birth	If not a single, birth order	Mother's HEP B surface antigen status ☐ Negative ☐ Positive ☐ Unknown	Did infant get HEP B vaccine? ☐ No ☐ Refused	If YES, date given MM/DD/YYYY

Hepatitis B Immune Globulin (HBIG) given to infant? ☐ No ☐ Yes If YES Date given MM/DD/YYYY Time given HHmm

Abnormal conditions of the newborn (check all that apply)

- ☐ Assisted ventilation required immediately after birth
- ☐ Assisted ventilation required for more than six hours
- ☐ NICU admission
- ☐ Newborn surfactant replacement therapy
- ☐ Antibiotics given to newborn for suspected neonatal sepsis
- ☐ Lab confirmation of invasive bacterial infection (from blood) within 0-2 days of life
- ☐ Seizure or serious neurologic dysfunction
- ☐ Serious birth injury requiring intervention
- ☐ Anemia (hct<39 / hgb<13)
- ☐ Other
  Specify _____
- ☐ None of the above

Congenital anomalies (check all that apply)

- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Hypospadias
- ☐ Other urogenital anomalies
  Specify _____
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect (exclude congenital amputation and dwarfing syndromes)
- ☐ Polydactyly /syndactyly /adactyly
- ☐ Club foot
- ☐ Other musculoskeletal/integumental anomalies
  Specify _____
- ☐ Cleft lip
- ☐ Cleft palate
- ☐ Down syndrome
  Karyotype status ☐Confirmed ☐Pending ☐Unknown
- ☐ Other suspected chromosomal disorder
  Karyotype status ☐Confirmed ☐Pending ☐Unknown
- ☐ Other anomalies
  Specify _____
- ☐ None of the above

Was infant breastfed or fed breast milk **during stay**? ☐ Yes ☐ No	Was infant breastfed or fed breast milk **at discharge**? ☐ Yes ☐ No

Infant alive at time of filing birth record? ☐ Yes – go to next page ☐ No – go to next page

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Mother - Medical Information I

Mother's Name or Med Record Number

Did mother receive any prenatal care? ☐ Yes ☐ No

Date of first prenatal visit	Date of last prenatal visit	Total # prenatal visits	Month of pregnancy prenatal care began (1st, 2nd, etc.)
MM/DD/YYYY	MM/DD/YYYY	(If none, enter zero)	

Mother's height (ft/in)	Pre-pregnancy weight (lbs.)	Weight at delivery (lbs.)	Date last normal menses began
			MM/DD/YYYY

Previous live births		Month & year of last live birth prior to this baby	# Other previous pregnancy outcomes	Month & year of last other pregnancy outcome
# now living	# now dead	MM/YYYY		MM/YYYY

Risk factors this pregnancy (check all that apply)

- ☐ Diabetes – diagnosed pre-pregnancy
- ☐ Diabetes – gestational – diagnosed this pregnancy
- ☐ Hypertension – pre-pregnancy (chronic)
- ☐ Hypertension – gestational (PIH, preeclampsia)
- ☐ Eclampsia
- ☐ Pregnancy resulted from infertility treatment
  - ☐ Fertility drugs, insemination (artificial, intrauterine)
  - ☐ Assisted reproductive technology (IVF, GIFT)
- ☐ Anemia (hct<30 / hgb<10)
- ☐ Previous preterm birth
- ☐ Other previous poor outcome (perinatal death, SGA, IUGR)
- ☐ Previous cesarean birth How many? _____
- ☐ Other risk factors
  Specify _____
- ☐ None of the above

Mother's drug usage information

Were toxicology tests administered to mother and/or the newborn to indicate possible use of a controlled substance for non-medical purposes?

☐ No ☐ Yes If yes, results:

Principal source of payment for this delivery

- ☐ Medical Assistance/Minnesota Care/Medicaid
- ☐ Private insurance
- ☐ Self-pay (uninsured)
- ☐ Other (TRICARE/Indian Health Service/other government)

Mother - Medical Information II

Infections present / Treated this pregnancy (check all that apply)

- ☐ Chlamydia
- ☐ Genital herpes
- ☐ Gonorrhea
- ☐ Group B streptococcus (GBS)
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ HIV positive
- ☐ Syphilis
- ☐ Other (specify) _____
- ☐ None of the above

Prenatal OB procedure (check all that apply)

- ☐ Cervical cerclage
- ☐ Tocolysis
- ☐ External cephalic version — successful
- ☐ External cephalic version — failed
- ☐ None of the above

Was mother transferred to your facility for maternal medical or fetal indications for birth? ☐ Yes ☐ No

Facility transferred from (specify):

Onset of labor (check all that apply)

- ☐ PROM (> 12 hours)
- ☐ Prolonged labor (>20 hours)
- ☐ Precipitous labor (< 3 hours)
- ☐ None of the above

Characteristics of labor (check all that apply)

- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids for fetal lung maturation prior to birth
- ☐ Antibiotics received during labor
- ☐ Chorioamnionitis diagnosed during labor
- ☐ Maternal temp ≥38 C
- ☐ Meconium staining (moderate - heavy)
- ☐ Fetal intolerance of labor requiring corrective action: In-utero resuscitative measures, further fetal assessment, or operative birth
- ☐ Epidural or spinal anesthesia
- ☐ Other (specify) _____
- ☐ None of the above

Method of birth (check all that apply)

☐ Forceps attempted	☐ Successful	☐ No
☐ Vacuum attempted	☐ Successful	☐ No

Fetal presentation at birth

☐ Cephalic ☐ Breech ☐ Other (specify)

Final route and method of delivery

- ☐ Vaginal/spontaneous
- ☐ Vaginal/vacuum
- ☐ Vaginal / forceps
- ☐ VBAC
- ☐ Cesarean **If cesarean,** was trial of labor attempted? ☐ Yes ☐ No

Maternal morbidity (check all that apply)

- ☐ Maternal transfusion
- ☐ Cord prolapse
- ☐ Placental abruption
- ☐ Ruptured uterus
- ☐ Admission to ICU
- ☐ 3rd or 4th deg. perineal laceration
- ☐ Seizure during labor
- ☐ Placenta previa
- ☐ Unplanned hysterectomy
- ☐ Unplanned operating room procedure
- ☐ None of the above
- ☐ Other (specify)

For scheduled inductions, or cesareans,* without trial of labor, at less than 39 complete weeks *of gestation:

Based on the medical record, was a "hard stop" process used to schedule this delivery? ☐ Yes ☐ No