

10. Type of Place of Birth? <Apply Hospital Label Here>
- 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
11. Plurality? (Include all live births and fetal losses resulting from this pregnancy) _____ (1,2,3,4,5,6,7 etc.)
12. If not a single birth, birth order? (Include all live births and fetal losses resulting from this pregnancy) _____
(1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc)
13. If not single birth, specify number of infants born alive? _____
14. Is infant living at the time of this report? Yes No Infant Transferred, status unknown
15. Is infant being breastfed at time of discharge? Yes No Unknown
16. Was infant transferred within 24 hours of delivery? Yes No
If yes, name of facility infant transferred to? _____
17. Apgar Score? 5 minute score _____ (If 5 minute score is less than 6 enter score at 10 minutes _____)
18. Was the delivery with forceps attempted but unsuccessful? Yes No
19. Was delivery with vacuum extraction attempted but unsuccessful? Yes No
20. Fetal presentation at birth (Check one)
 Cephalic Breech Other
21. What was the final route and method of delivery? (Check one)
 Vaginal/Spontaneous
 Vaginal/Forceps
 Vaginal/Vacuum
 Hysterectomy/Hysterotomy
 Cesarean
 If Cesarean, was a trial of labor attempted? Yes No
22. Abnormal conditions of the newborn (Check all that apply)
- | | |
|---|--|
| <input type="checkbox"/> Assisted Ventilation required immediately following delivery | <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis |
| <input type="checkbox"/> Assisted ventilation required for more than six hours | <input type="checkbox"/> Seizure or serious neurologic dysfunction |
| <input type="checkbox"/> NICU Admission | <input type="checkbox"/> Significant birth injury |
| <input type="checkbox"/> Newborn given surfactant replacement therapy | <input type="checkbox"/> Fetal Alcohol Syndrome |
| | <input type="checkbox"/> None of the abnormal conditions listed |
23. Congenital anomalies of newborn
- | | |
|---|---|
| <input type="checkbox"/> Anencephaly | <input type="checkbox"/> Cleft palate alone |
| <input type="checkbox"/> Meningomyelocele/ Spina bifida | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Cyanotic congenital heart disease | <input type="checkbox"/> Karotype confirmed |
| <input type="checkbox"/> Acyanotic congenital heart disease | <input type="checkbox"/> Karotype pending |
| <input type="checkbox"/> Congenital diaphragmatic hernia | <input type="checkbox"/> Suspected chromosomal disorder |
| <input type="checkbox"/> Omphalacele | <input type="checkbox"/> Karotype confirmed |
| <input type="checkbox"/> Gastroschisis | <input type="checkbox"/> Karotype pending |
| <input type="checkbox"/> Limb reduction defect | <input type="checkbox"/> Hypospadias |
| <input type="checkbox"/> Cleft lip with or without a cleft palate | <input type="checkbox"/> None of above |

24. Was child given any immunizations?

< Apply hospital label here >

- Yes
- No
- Not Given – Parent Refused
- Not Given – Medical Risk

If yes, please complete vaccine information below:

Vaccination	Date	Lot #
<input type="checkbox"/> Hepatitis B	_____	_____
<input type="checkbox"/> Hepatitis B Immune Globulin	_____	_____

Vaccine for Children (VFC) Status:

- | | | |
|---------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Not Eligible | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Native American or Alaskan Native |
| <input type="checkbox"/> No Insurance | <input type="checkbox"/> Underinsured | <input type="checkbox"/> Other State Eligible |

25. Hearing screening test results.

Date of Screening? ____/____/____
MM DD YYYY

Testing Technology OAE AABR Unknown

Left Ear Passed Referred

Right Ear Passed Referred

Not Screened: (specify reason)

- | | |
|--|--|
| <input type="checkbox"/> Refused by Parent | <input type="checkbox"/> Child in NICU, not ready to be screened |
| <input type="checkbox"/> Missed | <input type="checkbox"/> Child died |
| <input type="checkbox"/> Child Transferred to another facility | <input type="checkbox"/> Equipment failure/not working |

26. Newborn screening test results. (Obtained from the North Dakota Newborn Screening Program Form)

Form IA number: _____ (Example: IA0123456)

(If sticker is available, place it here over this area)

Not Screened: (specify reason)

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Refused by Parent | <input type="checkbox"/> Child died |
| <input type="checkbox"/> Child Transferred to another facility | <input type="checkbox"/> Other: _____ |

27. Critical Congenital Heart Disease Screening results.

Date of Screening? ____/____/____
MM DD YYYY

Passed

Failed

Follow-Up:

- Echo done prior to discharge
- Referral made to Pediatric Cardiologist
- Other: _____

Not Screened: (specify reason)

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Refused by Parent | <input type="checkbox"/> Child died |
| <input type="checkbox"/> Child Transferred to another facility | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Equipment failure/Not working | |

Mother Prenatal

1. Mother's medical record number: _____
2. Number of Prenatal visits _____ (If no prenatal care was provided, enter all 9's for both dates and 0 for number of visits)
First Visit: ____/____/_____
 MM DD YYYY
3. 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 _____
4. What is the Mother's height? _____ Feet _____ Inches
5. Mother's Weights (Pounds): Pre-pregnancy weight? _____ Weight at delivery? _____
6. Number of previous live births now living (For single births, do not include this child. For multiple deliveries, include the children born during this event) _____ Number
7. Number of previous live births now dead (For single births, do not include this child. For multiple deliveries, include the children born during this event) _____ Number
8. Date of last live birth? ____/____/_____
 MM YYYY
9. Total number of other pregnancy outcomes (Include 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 during this pregnancy):
 _____ Number
10. Date of last other pregnancy outcome (Date when last pregnancy ended, which did not result in a live birth):
 ____/____/_____
 MM YYYY
11. Date the last normal menses began? ____/____/____ (Enter 9's for unknown portions of the date)

Mother Labor and Delivery

1. Medical Risk Factors for this Pregnancy (Check all the apply)
 - Diabetes
 - Type I
 - Type II
 - Gestational
 - Hypertension
 - Pre-pregnancy
 - Gestational
 - Eclampsia
 - Previous pre-term births
 - 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 _____
 - Exposure to illegal drugs
 - Methamphetamines
 - Marijuana
 - Cocaine
 - Other
 - Exposure to alcohol
 - None of these risk factors

2. Infections present and/or treated during this pregnancy (Check all that apply)
- Gonorrhea
 - Syphilis
 - Chlamydia
 - Hepatitis B
 - Hepatitis C
 - Group B Strep
 - Rubella
 - HIV/AIDS
 - Cytomegalovirus
 - Parvo Virus
 - Toxoplasmosis
 - Other
 - None of these infections
3. Obstetric procedures performed during the pregnancy? (Check all that apply)
- Cervical Cerclage
 - Tocolysis
 - External cephalic version
 - Successful
 - Failed
 - None of the Above
4. Onset of Labor (Check all that apply)
- Premature Rupture of the membranes
 - Precipitous Labor
 - Prolonged Labor
 - None of the Above.
5. Characteristics of labor and delivery (Check all that apply)
- | | |
|--|---|
| <input type="checkbox"/> Induction of labor | <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor |
| <input type="checkbox"/> Augmentation of labor | maternal temperature ≥ 38 C (100.4 F) |
| <input type="checkbox"/> Non-vertex presentation | <input type="checkbox"/> Epidural or spinal anesthesia during labor |
| <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery | <input type="checkbox"/> None of these characteristics |
| <input type="checkbox"/> Antibiotics received by the mother during labor | |
6. Maternal Morbidity - Complications of the mother experienced during labor and delivery (Check all that apply)
- | | |
|---|---|
| <input type="checkbox"/> Maternal transfusion | <input type="checkbox"/> Admission to the intensive care unit |
| <input type="checkbox"/> Third or fourth degree perineal laceration | <input type="checkbox"/> Unplanned operating procedure following delivery |
| <input type="checkbox"/> Ruptured uterus | <input type="checkbox"/> None of these complications |
| <input type="checkbox"/> Unplanned hysterectomy | |

Completed by _____