

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)
- Assisted Ventilation required immediately following delivery
 - Assisted ventilation required for more than six hours
 - NICU Admission
 - Newborn given surfactant replacement therapy
 - Antibiotics received by the newborn for suspected neonatal sepsis
 - Seizure or serious neurologic dysfunction
 - Significant birth injury
 - Fetal Alcohol Syndrome
 - None of the abnormal conditions listed
23. Congenital anomalies of newborn
- Anencephaly
 - Meningomyelocele/ Spina bifida
 - Cyanotic congenital heart disease
 - Acyanotic congenital heart disease
 - Congenital diaphragmatic hernia
 - Omphalacele
 - Gastroschisis
 - Limb reduction defect
 - Cleft lip with or without a cleft palate
 - Cleft palate alone
 - Down Syndrome
 - Karotype confirmed
 - Karotype pending
 - Suspected chromosomal disorder
 - Karotype confirmed
 - Karotype pending
 - Hypospadias
 - 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:

- Not Eligible
- Medicaid
- Native American or Alaskan Native
- No Insurance
- Underinsured
- Other State Eligible

25. Hearing screening test results.

- Left Ear Passed Referred
- Right Ear Passed Referred

Not Screened: (specify reason)

- Refused by Parent
- Missed
- Child Transferred to another facility
- Child in NICU, not ready to be screen
- Child died
- Out of screening supplies
- Equipment failure/not working

26. Newborn screening test results. (Obtained from the Iowa Neonatal Metabolic Screening Form)

Form IA number: _____ (Example: IA0123456)

Not Screened: (specify reason)

- Refused by Parent
- Child Transferred to another facility
- Child died
- Other: _____

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 (Do not include this child. For multiple deliveries, do not include any of the children born during this event) _____ Number
7. Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include any of the children born during this event) _____ Number

8. Date of last live birth? _____/_____/_____
MM YYY
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 before this infant in the pregnancy):
_____Number
10. Date of last other pregnancy outcome (Date when last pregnancy ended, which did not result in a live birth):
_____/_____/_____
MM YYY
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)

<Apply Hospital Label Here>

- Premature Rupture of the membranes
- Precipitous Labor
- Prolonged Labor
- None of the Above.

5. Characteristics of labor and delivery (Check all that apply)

- 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)
- Epidural or spinal anesthesia during labor
- None of these characteristics

6. Maternal Morbidity - 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 these complications

Completed by _____