Maine Center for Disease Control and Prevention
An Office of the Department of Health and Human Services

Maine Center for Disease Control and Prevention (Maine CDC)
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State of Maine
Medical Worksheet for Birth Certificate

Mother's Medical Record Number_____ Case Number_____

Child

1. Child's Name (First, middle, last, suffix)

2. Date of Birth | 3. Time of Birth ☐ AM ☐ PM ☐ Military ☐ Unknown | 4. Gender ☐ Male ☐ Female ☐ Unknown

5. Type of Place of Birth
☐ Hospital ☐ Home Birth Unplanned ☐ Hospital Unknown if Planned Home Birth
☐ Freestanding Birthing Center ☐ Home Birth Unknown if Planned ☐ Other
☐ Home Birth Planned ☐ Clinic/Doctor's Office ☐ Unknown

6. Facility Name (If not an institution give street number, street name, city, town and zip code) | 7. Facility NPI Number

8. Facility Address

Mother/Parent

9. Mother/Parent Current Legal Name (First, middle, last, suffix)

10. Mother/Parent Height (Feet, inches) | 11. Mother/Parent Pre-Pregnancy Weight (Pounds) | 12. Mother/Parent Weight at Delivery (Pounds)

13. Cigarette Smoking per day before and/or during Pregnancy *(For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked, if none, enter "0".)*
Average number of cigarettes or packs of cigarettes smoked per day

	No. of Cigarettes (Per day)		No. of Packs (Per day)		No. of Cigarettes (Per day)		No. of Packs (Per day)
Three Months before Pregnancy	_____	or	_____	Second Three Months of Pregnancy	_____	or	_____
First Three Months of Pregnancy	_____	or	_____	Last Trimester of Pregnancy	_____	or	_____

Prenatal

14. Date of Last Menses (mm, dd, yyyy) | 15. No Prenatal Care ☐ | 16. Date of First Prenatal Care Visit (mm,dd, yyyy) | 17. Date of Last Prenatal Care Visit (mm,dd,yyyy) | 18. Total Number of Prenatal Care Visits

19. Total Number of Previous Live Births *(Do not include this child)*
Now Living _____ Now Dead _____
Date of Last Live Birth _____ mm/yyyy

20. Number of Other Pregnancy Outcomes (Spontaneous or induced losses or ectopic pregnancies)
Other Outcomes (Number) _____
Date of Last Other Pregnancy Outcome _____ mm/yyyy

Medical and Health Information

21. Pregnancy Factors / Risk Factors for This Pregnancy (Check all that apply)
☐ Pre-Pregnancy Diabetes ☐ Hypertension-Eclampsia ☐ Multifetal Gestation
☐ Gestational Diabetes ☐ Previous Preterm Birth ☐ Pregnancy Resulted from Infertility Treatment
☐ Alcohol Dependency ☐ Other Previous Poor Pregnancy ☐ Pregnancy Resulted from Infertility Treatment
☐ Drug Dependency Outcomes Gamete Intrafallopian Transfer (GIFT)
☐ Group B Strep ☐ Mother Had a Previous Cesarean ☐ None of the Above
☐ Pre-Pregnancy Hypertension Delivery (If yes specify how
☐ Gestational Hypertension many) _____

22. Infections Present and/or Treated during This Pregnancy (Check all that apply)
☐ Gonorrhea ☐ Chlamydia ☐ Measles ☐ Varicella
☐ Group B Strep ☐ Hepatitis B ☐ Rubella ☐ Unknown
☐ Syphilis ☐ Hepatitis C ☐ Toxoplasmosis ☐ None of the Above
☐ Herpes Simplex Virus (HSV) ☐ HIV/AIDS ☐ Tuberculosis

23. Obstetric Procedures (Check all that apply)
☐ Cervical Cerclage ☐ External Cephalic Version-Successful ☐ Unknown
☐ Tocolysis ☐ External Cephalic Version-Failed ☐ None of the Above

24. Onset of Labor (Check all that apply)
☐ Artificial Rupture of Membranes ☐ Prolonged Labor (≥ 20 hours) ☐ Spontaneous Labor ☐ None of the Above
☐ Premature Rupture of the Membranes ☐ Precipitous Labor (< 3 hours) ☐ Unknown

Medical and Health Information

25. Characteristics of Labor and Delivery (Check all that apply)

☐ Induction of Labor
☐ Augmentation of Labor
☐ Non-Vertex Presentation
☐ Steroids (Glucosteroids)
☐ Antibiotics
☐ Clinical Chorioamnionitis
☐ Moderate/Heavy Meconium Staining
☐ Fetal Intolerance of Labor
☐ Anesthesia during Labor
☐ Unknown
☐ None of the Above

26. Method of Delivery

A. Was delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No ☐ Unknown
B. Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No ☐ Unknown
C. Fetal presentation at birth ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown
D. Final route and method of delivery (Check one)
☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown
If cesarean, was a trial of labor attempted? ☐ Yes ☐ No

27. Maternal Morbidity (Check all that apply)

☐ Maternal Transfusion
☐ Midline Episiotomy
☐ Perineal Laceration, 3rd Degree
☐ Perineal Laceration, 4th Degree
☐ Ruptured Uterus
☐ Unplanned Hysterectomy
☐ Admission to Intensive Care
☐ Unplanned Operation
☐ Unknown at This Time
☐ None of the Above

28. Mother/Parent Transferred for Maternal Medical or Fetal Indication Prior to Delivery

☐ Yes ☐ No ☐ Unknown

If Yes, name of facility mother transferred from

29. Infant Transferred within 24 Hours of Delivery

☐ Yes ☐ No ☐ Unknown

If Yes, name of facility infant transferred to

Newborn

30. Newborn Medical Record Number

31. Infant Birth Weight
(Grams preferred, specify unit)

_____ Pounds/Ounces

_____ Grams

32. APGAR Score
(Score at 5 minutes) _____

If 5 minute score is less than 6,
(Score at 10 minutes) _____

33. Obstetric Estimate of Gestation (Completed weeks)

34. Plurality (Single, Twin, Triplet, etc.)
(Specify)
_____ Birth Order _____

35. If Not Single Birth (Number of infants in this delivery born alive, specify)
_____

36. Is Infant Living at Time of Report

☐ Yes ☐ No ☐ Unknown ☐ Infant Transferred Status Unknown

37. Is the Infant Being Breastfed at Discharge

☐ Yes ☐ No ☐ Unknown

38. Abnormal Conditions of Newborn (Check all that apply)

☐ Assisted Ventilation Required Immediately Following Delivery
☐ Assisted Ventilation Required for More Than 6 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
☐ Unknown
☐ None of the Above

39. Congenital Anomalies of Newborn (Check all that apply)

☐ Anencephaly
☐ Meningomyelocele (Spina Bifida) Confirmed
☐ Cyanotic Congenital Heart Disease
☐ Congenital Diaphragmatic Hernia
☐ Omphalocele
☐ Gastroschisis
☐ Limb Reduction Defect
☐ Cleft Lip with or without Cleft Palate
☐ Cleft Palate Alone
☐ Down Syndrome Karyotype Confirmed
☐ Down Syndrome Karyotype Pending
☐ Suspected Chromosomal Disorder Karyotype Confirmed
☐ Suspected Chromosomal Disorder Karyotype Pending
☐ Hypospadias
☐ Unknown
☐ None of the Above

Attendant

40. Attendant's Name (Please print name)

_____

Attendant's Name (Signature please)

_____

Title ☐ MD ☐ DO ☐ Certified Nurse Midwife (CNM) ☐ Certified Professional Midwife (CPM)
☐ Certified Midwife (CM) ☐ Other Midwife ☐ Unknown ☐ Other (Specify)

Certifier

41. Certifier's Name (Please print name)

_____

Title ☐ MD ☐ DO ☐ Certified Nurse Midwife (CNM) ☐ Certified Professional Midwife (CPM)
☐ Certified Midwife (CM) ☐ Other Midwife ☐ Unknown ☐ Other (Specify)

42. I certify that this child was born alive at the place and time and on the date stated.

Signature

43. Date Certified