

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. Fetal presentation at birth (Check one)

- Cephalic
- Breech
- Other
- Refused/Unknown

19. What was the final route and method of delivery? (Check one)

- Vaginal/Spontaneous
- Vaginal/Forceps
- Vaginal/Vacuum
- Cesarean
 If Cesarean, was a trial of labor attempted? Yes No
- Refused/Unknown

20. Abnormal conditions of the newborn (Check all that apply)

- Fetal Alcohol Syndrome
- 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
- None of the abnormal conditions listed

21. Congenital anomalies of newborn

- Acyanotic congenital heart disease
- Microcephaly
- None of above

22. Was child given any immunizations?

- 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	_____	_____
<input type="checkbox"/> RSV mAB	_____	_____

Vaccine for Children (VFC) Status:

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

23. 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)

- Refused by Parent
- Missed
- Child Transferred to another facility
- Child in NICU, not ready to be screened
- Child died
- Equipment failure/not working

24. 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)

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

25. Critical Congenital Heart Disease Screening results:

Date of Pulse Oximetry (CCHD) Screening? ____/____/____
MM DD YYYY

Results from CCHD Screening (after birth): – **Passed, Failed or Not Screened** - Specify why not screened

- Passed
- Failed
- Not Screened: (specify reason)
 - Screening refused by parent
 - Infant transferred to another facility before screening completed
 - Infant on supplement oxygen when worksheet completed
 - Equipment failure/Not working
 - Infant 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 (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
 - 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 alcohol
 - Exposure to illegal drugs
 - Methamphetamines
 - Marijuana
 - Cocaine
 - Other
 - None of these risk factors

2. Infections present and/or treated during this pregnancy (Check all that apply)
- Syphilis
 - Hepatitis B
 - Hepatitis C
 - Rubella
 - HIV
 - COVID-19
 - 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. 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"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery | <input type="checkbox"/> Epidural or spinal anesthesia during labor |
| <input type="checkbox"/> Antibiotics received by the mother during labor | <input type="checkbox"/> None of these characteristics |
5. Maternal Morbidity - Complications of the mother experienced during labor and delivery (Check all that apply)
- Ruptured uterus
 - Admission to the intensive care unit
 - None of these complications

Completed by _____