



North Dakota Certifier's Worksheet for Birth

ND Department of Health
Division of Vital Records
(01-01-2022)

< Apply Hospital label here >

Certifier's Worksheet for Completing the North Dakota Birth Certificate

This worksheet is to be completed by the facility using the prenatal record, mother's medical records and the labor and delivery records. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record or a copy of the prenatal care information. Please do not provide information from sources other than those listed.

This worksheet should not be completed by the parents except in the case of a home birth. In the case of a home birth, this worksheet should be completed by the certifier (person delivering the child) or the mother.

Child's Information

First Middle Last Suffix (Jr, III, Etc)

Certifier/Attendant Information

- 1. Certifier's Name & Title (The individual, who certifies to the fact that the birth occurred. May be, but need not be the same as the attendant)
2. Attendant's Name & Title (The individual physically present at the delivery, who is responsible for the delivery. If an intern or nurse midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant)
3. Certifier Signature: 4. Date:

Birth Information

- 1. Child's Medical Record Number:
2. Date of Birth? MM/DD/YYYY 3. Time of Birth? (Use Military Time)
4. Sex? Male Female Not yet determined
5. Birth Weight: Grams or Pounds / Ounces (Only complete one)
6. Obstetric estimation of gestation? Number of Completed Whole Weeks (Not computed on LMP)
7. Facility Name (If home birth - address, if enroute list hospital name where first removed from the vehicle.)
8. County of Birth Zip Code
9. City, Town or Location of Birth Inside City Limits? Yes No

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
- Meningocele/ Spina bifida
- Microcephaly
- Cyanotic congenital heart disease
- Acyanotic congenital heart disease
- Congenital diaphragmatic hernia
- Omphalocele
- 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:

- | | | |
|---------------------------------------|---------------------------------------|--|
| <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 Pulse Oximetry (CCHD) Screening? ____/____/____
MM DD YYYY

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

- | | |
|---------------------------------|--|
| <input type="checkbox"/> Passed | <input type="checkbox"/> Not Screened: (specify reason) |
| <input type="checkbox"/> Failed | <input type="checkbox"/> Screening refused by parent |
| | <input type="checkbox"/> Infant transferred to another facility before screening completed |
| | <input type="checkbox"/> Infant on supplement oxygen when worksheet completed |
| | <input type="checkbox"/> Equipment failure/Not working |
| | <input type="checkbox"/> Infant Died |
| | <input type="checkbox"/> 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
 - 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
 - COVID-19
 - 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 _____