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STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES

MISSOURI BIRTH CERTIFICATE FACILITY WORKSHEET

FOR HOSPITAL/PROFESSIONAL USE ONLY

MOTHER'S MEDICAL RECORD #	MOTHER'S NAME	MOTHER'S DATE OF BIRTH

NEWBORN'S MEDICAL RECORD #	NEWBORN'S NAME	NEWBORN'S DATE OF BIRTH	PLURALITY	BIRTH ORDER

Questions 1-4 are not shown on this worksheet. These fields are default hospital information stored in the MoEVR program. This worksheet should be used, along with the mother's worksheet, to complete the registration of a Missouri birth. Enter "9"s where unknown. For assistance in completing this worksheet, review Facility Worksheet Guide or call Bureau of Vital Records: (573) 751-6387.

PRENATAL

5. Place of birth:
- ☐ Hospital
- ☐ Freestanding birthing center
- ☐ Home birth
  - Planned to deliver at home: ☐ Yes ☐ No
- ☐ Clinic/Doctor's Office
- ☐ En route
- ☐ Other (specify) _____

6(a). Date of first prenatal care visit
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

☐ No prenatal care

6(b). Date of last prenatal care visit
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

7. Total number of prenatal care visits for this pregnancy
_____ Number

8. Date last normal menses began
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

9. Number of previous live births now living (Do not include this child. For multiple births, include all live-born children before this child.)
_____ Number ☐ None

10. Number of previous live births now deceased (Do not include this child. For multiple births, include all live-born children before this child now deceased.)
_____ Number ☐ None

11. Date of last live birth
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

12. Total number of other pregnancy outcomes *(Spontaneous or induced losses or ectopic pregnancies. For multiple deliveries, include all other deliveries in this pregnancy and in previous pregnancies.)*
_____ Number ☐ None

13. Date of last other pregnancy outcome
__ __ / __ __ __ __
M M Y Y Y Y

14. Risk factors in this pregnancy - *check ALL that apply*
- Diabetes: (specify)
  - ☐ Prepregnancy
  - ☐ Gestational
  - ☐ Insulin Dependent
- Hypertension: (specify)
  - ☐ Prepregnancy
  - ☐ Gestational
  - ☐ Eclampsia
- ☐ Previous preterm births
- ☐ Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- ☐ Pregnancy resulted from infertility treatment; if YES, 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? _____
- ☐ None of the above

15. Infections present and/or treated during this pregnancy– *check ALL that apply*
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ HIV
  - If HIV checked, was mother treated with anti-retroviral medication during labor? ☐ Yes ☐ No
  - If HIV checked, was infant treated with anti-retroviral medication? ☐ Yes ☐ No
- ☐ Hepatitis C
- ☐ Hepatitis B
  - If Hepatitis B checked, was mother positive for HBsAg? ☐ Yes ☐ No
  - If YES, to HBsAg question, did newborn receive HBIG within 12 hours of birth? ☐ Yes ☐ No
- ☐ Zika Virus
- ☐ None of the above

16. Was mother tested during pregnancy for:
Syphilis? ☐ Yes ☐ No ☐ Unknown
HIV? ☐ Yes ☐ No ☐ Unknown
Hepatitis B? ☐ Yes ☐ No ☐ Unknown

17. Obstetric procedures - *check ALL that apply*
- ☐ Cervical cerclage
- ☐ Tocolysis
- ☐ External cephalic version: ☐ Successful ☐ Failed
- ☐ None of the above

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LABOR AND DELIVERY

18. Mother's weight at delivery
_____ pounds

19. Onset of labor - *check ALL that apply*
- ☐ Prem. rupture of membranes (≥12 hrs)
- ☐ Precipitous labor (< 3 hrs)
- ☐ Prolonged labor (≥ 20 hrs)
- ☐ None of the above

20. Characteristics of labor and delivery - *check ALL that apply*
- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation rec'd by mother prior to delivery
- ☐ Antibiotics received by the mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

21. Method of delivery

A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No

C. Fetal presentation at birth - *check ONE:*
☐ Cephalic ☐ Breech ☐ Other

D. Final route and method of delivery - *check ONE:*
- ☐ Vaginal / Spontaneous
- ☐ Vaginal / Forceps
- ☐ Vaginal / Vacuum
- ☐ Cesarean: if yes, was a trial of labor attempted?
  ☐ Yes ☐ No

22. Maternal morbidity - *check ALL that apply*
- ☐ Maternal transfusion
- ☐ Third or fourth degree perineal laceration
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admission to intensive care unit
- ☐ Unplanned operating room procedure following delivery
- ☐ None of the above

23. Attendant (individual physically present at the delivery who is responsible for the delivery):

Name: _____

MO License No. _____ NPI: _____

Title: ☐ MD ☐ DO ☐ CNM/CM ☐ CPM ☐ Other midwife
☐ Other (specify) _____

24. Was the mother transferred to this facility for maternal medical or fetal indications for delivery? ☐ Yes ☐ No
If yes, enter the name of the facility mother transferred from:

_____

25. Principal source of payment for this delivery (at time of delivery):
- ☐ Private insurance
- ☐ Medicaid
- ☐ Self-pay
- ☐ Other (specify) _____

NEWBORN

26. Newborn's medical record number:
_____

27. Date of birth:
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y

28. Time of birth: _____ ☐ a.m. ☐ p.m.

29. Birthweight: _____ **grams** or _____ **lb/oz**

30. Obstetric est. of gestation at delivery (comp wks): _____

31. Sex: ☐ Male ☐ Female ☐ Undetermined

32. Apgar scores: ____ 5 min. ____ 10 min. (if 5 min < 6)

33. Plurality (single, twin, triplet, etc.): _____

34. If not single birth, order delivered in the pregnancy; _____ **and number of infants born alive in this delivery** _____

35. Abnormal conditions of the 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 rec'd by the newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury
- ☐ None of the above

36. Congenital anomalies of the newborn - *check ALL that apply*
- ☐ Anencephaly
- ☐ Microcephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ 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 ☐ Karyotype pending
- ☐ Other chromosomal disorder:
  ☐ Karyotype confirmed ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None
- ☐ Other (specify) _____

37. Was newborn transferred within 24 hours of delivery?
☐ Yes ☐ No ☐ If yes, enter the name of the facility newborn transferred to: _____

38. Is newborn living at time of report?
☐ Yes ☐ No ☐ Newborn transferred, status unknown

39. Is newborn being breastfed at discharge?
☐ Yes ☐ No

40. Is adoption pending?
☐ Yes

41. Prophylactic drug used in baby's eyes?
☐ Yes ☐ No
If yes, name of drug: _____

42. Did newborn receive Hepatitis B vaccination?
☐ Yes ☐ No If yes, date of vaccination:
__ __ / __ __ / __ __ __ __
M M D D Y Y Y Y