STATE OF GEORGIA
BIRTH WORKSHEET

1. THIS BIRTH (Single, Twin, Triplet, etc) | **2. IF NOT SINGLE, SPECIFY (1st, 2nd, 3rd, 4th, etc.)**

NEWBORN - DEMOGRAPHIC

3. CHILD'S NAME: (FIRST MIDDLE LAST SUFFIX) | **4. DATE OF BIRTH (mm/dd/yyyy)** | **5. TIME OF BIRTH (24 hr)** | **6. SEX**

7. HOSPITAL FACILITY NAME AND ADDRESS (if not Hospital, give street and number)
☐ Hospital ☐ Birthing center ☐ Enroute/BOA ☐ Clinic/Doctor's Office ☐ ER
☐ Other (specify) _____

8. CITY, TOWN OR LOCATION OF BIRTH | **9. FACILITY ID (NPI)**

10. SPECIFY BIRTHPLACE | **11. COUNTY, STATE AND ZIP CODE OF BIRTH**

12. MOTHER'S NAME (FIRST MIDDLE LAST) | **13. NAME PRIOR TO FIRST MARRIAGE (FIRST MIDDLE LAST)**

14. DATE OF BIRTH (mm/dd/yyyy) | **15. BIRTHPLACE (State, Territory or Foreign Country)** | **16. MOTHER'S SSN**

17a. MOTHER'S MARITAL STATUS Married at the time of conception or time of birth? ☐ Yes ☐ No ☐ Unknown
If not married, has an order of paternity or legitimation been issued by a court? ☐ Yes ☐ No ☐ Unknown
Have both mother and father consented in writing to have father's name on the certification or have they both signed a paternity acknowledgment? ☐ Yes ☐ No ☐ Unknown

17b. DATE PATERNITY ACKNOWLEDGMENT OR LEGITIMATION SIGNED (mm/dd/yyyy)

MOTHER - DEMOGRAPHIC

18. NUMBER AND STREET OF RESIDENCE
Phone Number: _____ Residing at current residence for: ____ Years ____ Months

19. CITY, TOWN OR LOCATION
Inside city limits? ☐ Yes ☐ No ☐ Unknown

20. RESIDENCE STATE

21. COUNTY | **22. ZIP CODE** | **23. MOTHER'S MAILING ADDRESS (Street, City, State, Zip, County)** ☐ Mailing address same as above

24. MOTHER'S EDUCATION LEVEL (Choose **only one** option that represents the highest level of education attained)

☐ Completed 1st Grade ☐ Completed 2nd Grade ☐ Completed 3rd Grade ☐ Completed 4th Grade ☐ Completed 5th Grade ☐ Completed 6th Grade
☐ Completed 7th Grade ☐ Completed 8th Grade ☐ Completed 9th Grade ☐ Completed 10th Grade ☐ Completed 11th Grade
☐ Completed 12th Grade but did NOT Graduate ☐ High school graduate or GED completed

☐ Some college credit leading to an Associate degree but did **NOT** Graduate ☐ Associate degree (e.g. AA, AS) ☐ Bachelor's degree (e.g. BA, BS)
☐ Some college credit leading to a Bachelor's degree but did **NOT** Graduate ☐ Master's degree (e.g. MA, MS) ☐ Doctorate (e.g. PhD, EdD, MD)
☐ None ☐ Unknown

25. Primary Language spoken at Home _____ **26.** Employed during last year ☐ Yes ☐ No ☐ Unknown
27. Mother's Occupation _____ **28.** Kind of business or industry _____
29. Employer's name/address: _____ _____
Name Street City State/Country Zip Code

30. MOTHER'S ETHNICITY ☐ No, not Spanish/Hispanic/Latino ☐ Refused ☐ Unknown
☐ Yes, Cuban ☐ Yes, Puerto Rican ☐ Yes, Maxican, American, Chicano ☐ Yes, Other Hispanic (Specify) _____

31. MOTHER'S RACE (Check all that apply)

☐ White ☐ Chinese ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Filipino ☐ Vietnamese ☐ Samoan
☐ Asian Indian ☐ Japanese ☐ Native Hawaiian ☐ Other (Specify) _____
☐ Other Pacific Islander (Specify) _____ ☐ Other Asian (Specify) _____
☐ American Indian or Alaska Native; *Specify enrolled or principal tribe _____ ☐ Refused ☐ Unknown

FATHER

32. FATHER'S NAME (FIRST MIDDLE LAST SUFFIX) | **33. DATE OF BIRTH (mm/dd/yyyy)** | **34. BIRTHPLACE (State, Territory or Foreign Country)**

35. FATHER'S SSN | **36. FATHER'S RESIDENCE ADDRESS (STREET CITY STATE ZIP COUNTY)**
☐ Address same as mother's residence

FATHER - DEMOGRAPHIC

37. FATHER'S EDUCATION LEVEL (Check only one option that represents the highest level of education attained)

☐ Completed 1st Grade ☐ Completed 2nd Grade ☐ Completed 3rd Grade ☐ Completed 4th Grade ☐ Completed 5th Grade ☐ Completed 6th Grade
☐ Completed 7th Grade ☐ Completed 8th Grade ☐ Completed 9th Grade ☐ Completed 10th Grade ☐ Completed 11th Grade
☐ Completed 12th Grade but did NOT Graduate ☐ High school graduate or GED completed

☐ Some college credit leading to an Associate degree but did **NOT** Graduate ☐ Associate degree (e.g. AA, AS) ☐ Bachelor's degree (e.g. BA, BS)
☐ Some college credit leading to a Bachelor's degree but did **NOT** Graduate ☐ Master's degree (e.g. MA, MS) ☐ Doctorate (e.g. PhD, EdD, MD)
☐ None ☐ Unknown

38. Father's Occupation _____ **39.** Father's Industry _____ **40.** Employed during last year ☐ Yes ☐ No ☐ Unknown

41. Employer's name/address: _____ _____ _____ _____ _____
Name Street City State/Country Zip Code

42. FATHER'S ETHNICITY ☐ No, not Spanish/Hispanic/Latino ☐ Refused ☐ Unknown
☐ Yes, Cuban ☐ Yes, Puerto Rican ☐ Yes, Maxican, American, Chicano ☐ Yes, Other Hispanic (Specify) _____

43. FATHER'S RACE (Check all that apply)

☐ White ☐ Chinese ☐ Korean ☐ Guamanian or Chamorro
☐ Black or African American ☐ Filipino ☐ Vietnamese ☐ Samoan
☐ Asian Indian ☐ Japanese ☐ Native Hawaiian ☐ Other (Specify) _____
☐ Other Pacific Islander (Specify) _____ ☐ Other Asian (Specify) _____
☐ American Indian or Alaska Native; *Specify enrolled or principal tribe _____ ☐ Refused ☐ Unknown

MOTHER - MEDICAL

44. Mother's Med Record #: _____ **45a.** Mother's pre-pregnancy weight : _____ lbs ☐ Unknown **45b.** Mother's weight at delivery _____ lbs ☐ Unknown

46. Mother's height : _____ feet _____ inches ☐ Unknown **47.** Did Mother receive WIC during this pregnancy? ☐ Yes ☐ No ☐ Unknown

48a. Did mother use alcohol during pregnancy? ☐ Yes ☐ No ☐ Unknown **48b.** If yes, how many drinks per week ? _____

49. Did Mother smoke cigarettes before OR during this pregnancy ☐ Yes ☐ No ☐ Unknown

# of cigarettes _____ or # of packs _____ Three months before pregnancy # of cigarettes _____ or # of packs _____ first trimester
# of cigarettes _____ or # of packs _____ second trimester # of cigarettes _____ or # of packs _____ third trimester

50. Principal Source of Payment ☐ Tricare ☐ Medicaid ☐ Self Pay ☐ Other Government (Federal, State, Local) ☐ Indian Health Service
☐ Private Insurance ☐ Other : _____ ☐ Unknown

51. Vaccinations during pregnancy (Note trimester) ☐ TDAP Trimester _____ ☐ Flu Trimester _____ ☐ Other Trimester _____ ☐ None

52. MOTHER PREGNANCY HISTORY

a. Is this the mother's first pregnancy? ☐ Yes ☐ No ☐ Unknown
b. Number of previous live births now living _____ (Do not include this child)
c. Number of previous live births now dead _____
d. Date of last live birth _____ (mm/dd/yyyy)
e. Number of fetal deaths less than 20 weeks (including ectopic loss, induced terminations or miscarriages) _____
f. Number of previous fetal deaths 20 weeks or greater (including induced terminations, miscarriages or stillbirths) _____
g. Date of last other pregnancy outcome _____ (mm/dd/yyyy)

53. MOTHER PRENATAL CARE

a. Did mother receive prenatal care? ☐ Yes ☐ No ☐ Unknown
b. Date of first prenatal care visit _____ (mm/dd/yyyy)
c. Enter month prenatal care began _____ (1st, 2nd, 3rd month of pregnancy)
d. Date of last prenatal care visit _____ (mm/dd/yyyy)
e. Total number of prenatal care visits _____ (If none, enter '0')
f. Date last normal menses began _____ (mm/dd/yyyy)

54. Mother transferred for delivery? ☐ Yes ☐ No If yes, from what location : _____

MOTHER - MEDICAL

55. 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? ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown

e. If cesarean, was a trial labor attempted? ☐ Yes ☐ No ☐ Unknown

56. EXPOSURE/INFECTIONS PRESENT/ TREATED DURING PREGNANCY (Check all that apply)

- ☐ Bacterial meningitis
- ☐ Carrier/suspected carrier or vital hepatitis
- ☐ Chemotherapy
- ☐ Chlamydia
- ☐ Congenital cytomegalovirus infection (CMV)
- ☐ Congenital rubella
- ☐ Congenital Toxoplasmosis
- ☐ Gonorrhea
- ☐ Group B streptococcus
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes (active at the time of delivery)
- ☐ HIV
- ☐ Listeria
- ☐ Parvovirus
- ☐ Syphilis
- ☐ Unknown
- ☐ None of the above
- ☐ Other (specify) _____

57. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

a. DIABETES (Select one of the following) ☐ Prepregnancy (diagnosis prior to this pregnancy) ☐ Gestational (diagnosis in this pregnancy)

b. HYPERTENSION (Select one of the following) ☐ Prepregnancy (chronic) ☐ Gestational (PIH, preeclampsia) ☐ Eclampsia

c. ☐ Previous preterm birth

d. Pregnancy resulted from infertility treatment (Check all that apply):
☐ Fertility enhancing drugs ☐ Artificial insemination ☐ Intrauterine insemination
☐ In vitro fertilization (IVF) ☐ Gamete intrafallopian transfer (GIFT) ☐ Other (specify) _____

e. Other poor pregnancy outcome ☐ Perinatal death ☐ Small for gestational age ☐ Intrauterine growth restriction ☐ Other (specify) _____

f. ☐ Mother had a previous cesarean delivery? If selected, how many? _____

g. ☐ None of the above

h. ☐ Unknown

58. OBSTETRIC PROCEDURES (Check all that apply)

- ☐ Cervical cerclage
- ☐ Tocolysis
- ☐ External Cephalic Version ☐ Successful ☐ Failed
- ☐ None of the Above
- ☐ Unknown

59. ONSET OF LABOR (Check all that apply)

- ☐ Premature rupture of the membranes (prolonged > 18 hours)
- ☐ Precipitous labor (less than 3 hours)
- ☐ Prolonged labor (greater than 20 hours)
- ☐ None of the above
- ☐ Unknown

60. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids of fetal lung maturation received by the mother prior to delivery) ☐ Partial ☐ Complete
- ☐ Antibiotics received by mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature is >38 C (100.4 F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor 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
- ☐ Unknown

61. MATERNAL MORBIDITY (Check all that apply)

- ☐ Maternal transfusion
  number of units ☐ 1 ☐ 2 ☐ 3 or more
- ☐ 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
- ☐ Unknown

NEWBORN - MEDICAL

62. Infant's Medical Record # _____

63. OB Estimated Gestation (completed weeks) _____ ☐ Unknown

64a. Apgar score (at 5 min) _____ ☐ Unknown

64b. Apgar score (at 10 min) _____ ☐ Unknown

65. Was infant transferred within 24 hours of delivery? ☐ Yes ☐ No ☐ Unknown
If yes, where? _____

66. Is infant living at time of report? ☐ Yes ☐ No ☐ Unknown

67. Is infant being breast fed, even partially? ☐ Yes ☐ No ☐ Unknown

68a. Weight unit ☐ Grams ☐ Pounds ☐ Unknown

68b. Weight Grams _____ Pounds _____ Ounces _____ ☐ Unknown

NEWBORN - MEDICAL

69. 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
- ☐ Culture Positive Postnatal (Blood, CSF or other sources)
- ☐ Antibiotics received by newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage requiring intervention)
- ☐ None of the above
- ☐ Unknown

70. CONGENITAL ANAMOLIES OF THE NEWBORN (Check all that apply)

- ☐ Anencephaly
- ☐ Microcephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cleft lip with cleft palate ☐ Cleft lip alone ☐ Cleft palate alone
- ☐ Craniofacial anomalies
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect (not congenital amputation/dwarfing syndromes)
- ☐ Down Syndrome (Karyotype ☐ confirmed ☐ pending)
- ☐ Syndromes associated with hearing loss (neurofibromatosis, osteopetrosis, Usher, Waardneburg, Alport, Pendred, and Jervell and Lange-Nielson)
- ☐ Suspected chromosomal disorder (Karyotype ☐ confirmed ☐ pending)
- ☐ Hypospadias
- ☐ None of the above
- ☐ Other (specify) _____

71. OTHER EXPOSURES/CONDITIONS PRESENT IN UTERO OR POSTNATAL (Check all that apply)

- ☐ Caregiver concern related to hearing loss
- ☐ Congenital Hypothyroidism
- ☐ Drug Withdrawal Syndrome in Newborn
- ☐ Drug Use/Abuse/Withdrawal Syndrome in Mother
- ☐ Encephalitis
- ☐ Exposure to ototoxic medications or loop diuretics
- ☐ Extracorporeal Membrane Oxygenation (ECMO) or Assisted Mechanical Ventilation >48 hours
- ☐ Fetal Growth Restriction (IUGR)
- ☐ Head Trauma
- ☐ History of Positive Drug Screen (newborn)
- ☐ HIV Present in infant
- ☐ Hydrocephaly
- ☐ Hyperbilirubinemia requiring exchange transfusion
- ☐ Intraventicular hemorrhage (IVH), Grade III or IV
- ☐ Neonatal intensive care of > 5 days
- ☐ Neurodegenerative disorders
- ☐ Neuromuscular Disorder
- ☐ Prenatal jaundice d/t hepatocellular damage
- ☐ Stage III necrotizing enterocolitis in newborn
- ☐ None of the above
- ☐ Other (specify) _____

72. HEPATITIS VACCINATION

a. Did the infant receive Hepatitis B vaccine? ☐ Yes ☐ No ☐ Unknown ☐ Refused

b. If infant received Hepatitis B vaccine, number of hours after birth _____

c. Did the infant receive Hepatitis B Immune Globulin (HBIG)? ☐ Yes ☐ No ☐ Unknown

d. If infant received HBIG, number of hours after birth _____

e. Hepatitis B vaccine Date _____

f. Hepatitis B vaccine Lot Number _____

g. HBIG Lot Number _____

h. If infant received HBIG, date administered _____

73. NEWBORN SCREENING

a. Was a metabolic screening performed for this infant? ☐ Yes ☐ No – Missed (transferred) ☐ No – Parent refusal ☐ No – Other _____ ☐ Unknown

b. Newborn Metabolic screening number _____

c. Was Hearing Screening performed for this infant? ☐ Yes ☐ Unable to screen in NICU ☐ No- Missed (Transfer) ☐ No- Missed (equipment down) ☐ No- parent refusal ☐ No- Missed (Other reason) _____ ☐ Unknown

d. Final Hearing Screening Completed Date _____ (mm/dd/yyyy) ☐ Unknown

e. Final Hearing Screening Right Ear Result ☐ Pass ☐ Refer ☐ Unknown ☐ Unable to test

f. Final Hearing Screening Left Ear Result ☐ Pass ☐ Refer ☐ Unknown ☐ Unable to test

g. Family History of Permanent childhood hearing loss? ☐ Yes ☐ No ☐ Unknown

h. Final Newborn Hearing Test Type (select one) ☐ AABR ☐ AOAE ☐ AABR and AOAE

CERTIFIER

74. INFORMANT'S NAME (FIRST MIDDLE LAST)	**75. RELATION TO CHILD**	**76. PARENTS AUTHORIZE RELEASE OF INFORMATION TO SOCIAL SECURITY ADMINISTRATION TO ISSUE CHILD A SOCIAL SECURITY NUMBER.** ☐ Yes ☐ No
77. I CERTIFY THAT THE ABOVE NAMED CHILD WAS BORN ALIVE AT THE PLACE AND TIME AND ON THE DATE STATED ABOVE (Signature)	**78. DATE CERTIFIED (mm/dd/yyyy)**	**79. ATTENDANT AT BIRTH (OTHER THAN CERTIFIER (Name and Title))** ☐ MD ☐ DO ☐ Hospital Staff ☐ CMN/CM ☐ Other Midwife ☐ Other
80. CERTIFIER (Name and Title) ☐ Certifier same as Attendant ☐ MD ☐ DO ☐ Hospital Staff ☐ CMN/CM ☐ Other Midwife ☐ Other	**81. PHYSICIAN'S MEDICAL LICENSE NO.**	**82. CERTIFIER'S MAILING ADDRESS (street, city, state, zip)**
83. REGISTRAR (Signature)		**84. DATE RECEIVED BY STATE REGISTRAR (mm/dd/yyyy)**