

**Attachment 1a – Forms to be used as starting points in evaluating the collection of birth certificate data using focus group and cognitive interview techniques.**

**U.S. STANDARD CERTIFICATE OF LIVE BIRTH**

<b>LOCAL FILE NO.</b>				<b>BIRTH NUMBER:</b>			
<b>C H I L D</b>	1. CHILD'S NAME (First, Middle, Last, Suffix)		2. TIME OF BIRTH (24 hr)	3. SEX	4. DATE OF BIRTH (Mo/Day/Yr)		
	5. FACILITY NAME (If not institution, give street and number)		6. CITY, TOWN, OR LOCATION OF BIRTH		7. COUNTY OF BIRTH		
<b>M O T H E R</b>	8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		8b. DATE OF BIRTH (Mo/Day/Yr)				
	8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)		8d. BIRTHPLACE (State, Territory, or Foreign Country)				
	9a. RESIDENCE OF MOTHER-STATE	9b. COUNTY	9c. CITY, TOWN, OR LOCATION				
	9d. STREET AND NUMBER		9e. APT. NO.	9f. ZIP CODE		9g. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>F A T H E R</b>	10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)		10b. DATE OF BIRTH (Mo/Day/Yr)	10c. BIRTHPLACE (State, Territory, or Foreign Country)			
<b>C E R T I F I E R</b>	11. CERTIFIER'S NAME: _____ TITLE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> HOSPITAL ADMIN. <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify) _____		12. DATE CERTIFIED ____/____/____ MM DD YYYY		13. DATE FILED BY REGISTRAR ____/____/____ MM DD YYYY		
	<b>INFORMATION FOR ADMINISTRATIVE USE</b>						
<b>M O T H E R</b>	14. MOTHER'S MAILING ADDRESS: 9 Same as residence, or: State: _____ City, Town, or Location: _____ Street & Number: _____ Apartment No.: _____ Zip Code: _____			15. MOTHER MARRIED? (At birth, conception, or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? <input type="checkbox"/> Yes <input type="checkbox"/> No		16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	18. MOTHER'S SOCIAL SECURITY NUMBER: _____			19. FATHER'S SOCIAL SECURITY NUMBER: _____			
	<b>INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY</b>						
<b>M O T H E R</b>	20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)  <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)  <input type="checkbox"/> No, not Spanish/Hispanic/Latina <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify) _____		22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)  <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____		
	<b>F A T H E R</b>	23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)  <input type="checkbox"/> 8th grade or less <input type="checkbox"/> 9th - 12th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit but no degree <input type="checkbox"/> Associate degree (e.g., AA, AS) <input type="checkbox"/> Bachelor's degree (e.g., BA, AB, BS) <input type="checkbox"/> Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)		24. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)  <input type="checkbox"/> No, not Spanish/Hispanic/Latino <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano <input type="checkbox"/> Yes, Puerto Rican <input type="checkbox"/> Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)  <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Other (Specify) _____	
<b>Mother's Name</b>		<b>Mother's Medical Record No.</b>	26. PLACE WHERE BIRTH OCCURRED (Check one) <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home Birth: Planned to deliver at home? 9 Yes 9 No <input type="checkbox"/> Clinic/Doctor's office <input type="checkbox"/> Other (Specify) _____		27. ATTENDANT'S NAME, TITLE, AND NPI NAME: _____ NPI: _____ TITLE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> CNM/CM <input type="checkbox"/> OTHER MIDWIFE <input type="checkbox"/> OTHER (Specify) _____		28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: _____

**INFORMATION**

<p>Hypertension</p> <input type="checkbox"/> Prepregnancy (Chronic)	<input type="checkbox"/> Gestational (PIH, preeclampsia)	<input type="checkbox"/> Eclampsia	<input type="checkbox"/> Previous preterm birth	<input type="checkbox"/> Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)	<input type="checkbox"/> Pregnancy resulted from infertility treatment-If yes, check all that apply: <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))	<input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many _____	<input type="checkbox"/> None of the above	<p>42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)</p> <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the above	<p>44. ONSET OF LABOR (Check all that apply)</p> <input type="checkbox"/> Premature Rupture of the Membranes (prolonged, ≥12 hrs.) <input type="checkbox"/> Precipitous Labor (<3 hrs.) <input type="checkbox"/> Prolonged Labor (≥ 20 hrs.) <input type="checkbox"/> None of the above	<p>45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)</p> <input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery <input type="checkbox"/> Antibiotics received by the mother during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F) <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid <input type="checkbox"/> 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 <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above	<p>B. Was delivery with vacuum extraction attempted but unsuccessful?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Fetal presentation at birth  <input type="checkbox"/> Cephalic  <input type="checkbox"/> Breech  <input type="checkbox"/> Other</p> <p>D. Final route and method of delivery (Check one)  <input type="checkbox"/> Vaginal/Spontaneous  <input type="checkbox"/> Vaginal/Forceps  <input type="checkbox"/> Vaginal/Vacuum  <input type="checkbox"/> Cesarean                  If cesarean, was a trial of labor attempted?  <input type="checkbox"/> Yes  <input type="checkbox"/> No</p> <p>47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)  <input type="checkbox"/> Maternal transfusion  <input type="checkbox"/> Third or fourth degree perineal laceration  <input type="checkbox"/> Ruptured uterus  <input type="checkbox"/> Unplanned hysterectomy  <input type="checkbox"/> Admission to intensive care unit  <input type="checkbox"/> Unplanned operating room procedure following delivery  <input type="checkbox"/> None of the above</p>
	<p>43. Cesarean delivery reason:  <input type="checkbox"/> Successful  <input type="checkbox"/> Failed  <input type="checkbox"/> None of the above</p>										

**NEWBORN**

<p>Mother's Name _____</p> <p>Mother's Medical Record No. _____</p>	<p>48. NEWBORN MEDICAL RECORD NUMBER _____</p>	<p>49. BIRTHWEIGHT (grams preferred, specify unit)</p> <p>_____ 9 grams 9 lb/oz _____</p>	<p>50. OBSTETRIC ESTIMATE OF GESTATION:                  _____ (completed weeks)</p>	<p>51. APGAR SCORE:                  Score at 5 minutes: _____  <b>If 5 minute score is less than 6,</b>                  Score at 10 minutes: _____</p>	<p>52. PLURALITY - Single, Twin, Triplet, etc.                  (Specify) _____</p>	<p>53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) _____</p>	<p>54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)</p> <input type="checkbox"/> Assisted ventilation required immediately following delivery <input type="checkbox"/> Assisted ventilation required for more than six hours <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention) <input type="checkbox"/> None of the above	<p>55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)</p> <input type="checkbox"/> Anencephaly <input type="checkbox"/> Meningomyelocele/Spina bifida <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Omphalocele <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft Palate <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Suspected chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Hypospadias <input type="checkbox"/> None of the anomalies listed above	<p>56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No                  IF YES, NAME OF FACILITY INFANT TRANSFERRED TO: _____</p>	<p>57. IS INFANT LIVING AT TIME OF REPORT?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant transferred, status unknown</p>	<p>58. IS THE INFANT BEING BREASTFED AT DISCHARGE?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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1. **Facility name:**\* \_\_\_\_\_  
(If not institution, give street and number)

2. **Facility I.D.** (National Provider Identifier): \_\_\_\_\_

3. **City, Town or Location of birth:** \_\_\_\_\_

4. **County of birth:** \_\_\_\_\_

5. **Place of birth:**

- Hospital
- Freestanding birthing center (Freestanding birthing center is defined as one which has no direct physical connection with an operative delivery center.)
- Home birth  
Planned to deliver at home     Yes                       No
- Clinic/Doctor's Office
- Other (specify, e.g., taxi cab, train, plane, etc.) \_\_\_\_\_

\*Facilities may wish to have pre-set responses (hard-copy and/or electronic) to questions 1-5 for births which occur at their institutions.

**Prenatal**

**Sources: Prenatal care records, mother's medical records, labor and delivery records**

**Information for the following items should come from the mother's prenatal care records and from other medical reports in the mother's chart, as well as the infant's medical record. 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. Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.**

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 deliveries, do not include the 1<sup>st</sup> born in the set if completing this worksheet for that child):  
     Number • None

10. Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include the 1<sup>st</sup> born in the set if completing this worksheet for that child):  
     Number • None

11. Date of last live birth:                                
M M Y Y Y Y

12. 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 before this infant in the pregnancy):  
     Number  None

13. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended):  
                               
M M Y Y Y Y

14. Risk factors in this pregnancy (Check all that apply):

Diabetes - (Glucose intolerance requiring treatment)

- Prepregnancy - (Diagnosis prior to this pregnancy)
- Gestational - (Diagnosis in this pregnancy)

Hypertension - (Elevation of blood pressure above normal for age, gender, and physiological condition.)

- Prepregnancy - (Chronic) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed prior to the onset of this pregnancy)
- Gestational - (PIH, preeclampsia) (Elevation of blood pressure above normal for age, gender, and physiological condition diagnosed during this pregnancy. May include proteinuria (protein in the urine) without seizures or coma and pathologic edema (generalized swelling, including swelling of the hands, legs and face).)
- Eclampsia - (Pregnancy induced hypertension with proteinuria with generalized seizures or coma. May include pathologic edema.)

- Mother had a previous cesarean delivery - (Previous operative delivery by extraction of the fetus, placenta and membranes through an incision in the maternal abdominal and uterine walls.)  
If Yes, how many \_\_\_\_\_

- None of the above

**15. Infections present and/or treated during this pregnancy** - (Present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.) (Check all that apply):

- Gonorrhea - (a diagnosis of or positive test for Neisseria gonorrhoeae)  
 Syphilis - (also called lues - a diagnosis of or positive test for Treponema pallidum)  
 Chlamydia - (a diagnosis of or positive test for Chlamydia trachomatis)  
 Hepatitis B - (HBV, serum hepatitis - a diagnosis of or positive test for the hepatitis B virus)  
 Hepatitis C - (non A, non B hepatitis, HCV - a diagnosis of or positive test for the hepatitis C virus)  
 None of the above

**16. Obstetric procedures** - (Medical treatment or invasive/manipulative procedure performed during this pregnancy specifically in the treatment of the pregnancy, management of labor and/or delivery.) (Check all that apply):

- Cervical cerclage - (Circumferential banding or suture of the cervix to prevent or treat passive dilatation. Includes MacDonald's suture, Shirodkar procedure, abdominal cerclage via laparotomy.)  
 Tocolysis - (Administration of any agent with the intent to inhibit preterm uterine contractions to extend length of the pregnancy.)  
 External cephalic version - (Attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation.)  
 Successful  Failed  
 None of the above

**Labor and Delivery**

**Sources: Labor and delivery records, mother's medical records**

**17. Onset of Labor** (Check all that apply):

- Premature Rupture of the Membranes (prolonged  $\geq 12$  hours)  
(Spontaneous tearing of the amniotic sac, (natural breaking of the bag of waters), 12 hours or more before labor begins.)  
 Precipitous labor ( $< 3$  hours) (Labor that progresses rapidly and lasts for less than 3 hours.)  
 Prolonged labor ( $\geq 20$  hours) (Labor that progresses slowly and lasts for 20 hours or more.)  
 None of the above

Other (Specify) \_\_\_\_\_

**21. Date certified:**                          
M M D D Y Y Y Y

**22. Principal source of payment for this delivery** (At time of delivery):

- Private Insurance
  - Medicaid (Comparable State program)
  - Self-pay (No third party identified)
  - Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal, state, local))
- 

**23. Infant's medical record number:** \_\_\_\_\_

**24. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?**

(Transfers include hospital to hospital, birth facility to hospital, etc.)

- Yes       No

If Yes, enter the name of the facility mother transferred from:

\_\_\_\_\_

**25. Attendant's name, title, and N.P.I.** (National Provider Identifier) (The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, 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):

\_\_\_\_\_  
Attendant's name

\_\_\_\_\_  
N.P.I.

**Attendant's title:**

- M.D.
- D.O.
- CNM/CM - (Certified Nurse Midwife/Certified Midwife)
- Other Midwife - (Midwife other than CNM/CM)
- Other specify): \_\_\_\_\_

**26. Mother's weight at delivery** (pounds): \_\_\_\_\_

- Antibiotics received by the mother during labor** - (Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery: Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.)
- Clinical chorioamnionitis diagnosed during labor or maternal temperature  $\geq 38^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ )** - (Clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever, uterine tenderness and/or irritability, leukocytosis and fetal tachycardia. Any maternal temperature at or above  $38^{\circ}\text{C}$  ( $100.4^{\circ}\text{F}$ ).
- Moderate/heavy meconium staining of the amniotic fluid** - (Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery which is more than enough to cause a greenish color change of an otherwise clear 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** - (*In Utero Resuscitative measures* such as any of the following - maternal position change, oxygen administration to the mother, intravenous fluids administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents. *Further fetal assessment* includes any of the following - scalp pH, scalp stimulation, acoustic stimulation. *Operative delivery* – operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery.)
- Epidural or spinal anesthesia during labor** - (Administration to the mother of a regional anesthetic for control of the pain of labor, i.e., delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.)
- None of the above**

**28. Method of delivery** (The physical process by which the complete delivery of the infant was effected)  
(Complete A, B, C, and D):

- A. **Was delivery with forceps attempted but unsuccessful?** - (Obstetric forceps was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)
  - Yes       No
- B. **Was delivery with vacuum extraction attempted but unsuccessful?** - (Ventouse or vacuum cup was applied to the fetal head in an unsuccessful attempt at vaginal delivery.)
  - Yes       No
- C. **Fetal presentation at birth (Check one):**
  - Cephalic** - (Presenting part of the fetus listed as vertex, occiput anterior (OA), occiput posterior (OP))
  - Breech** - (Presenting part of the fetus listed as breech, complete breech, frank breech, footling breech)
  - Other** - (Any other presentation not listed above)

- Maternal transfusion** - (Includes infusion of whole blood or packed red blood cells associated with labor and delivery.)
- Third or fourth degree perineal laceration** - (3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.)
- Ruptured uterus** - (Tearing of the uterine wall.)
- Unplanned hysterectomy** - (Surgical removal of the uterus that was not planned prior to the admission. Includes anticipated but not definitively planned hysterectomy.)
- Admission to intensive care unit** - (Any admission of the mother to a facility/unit designated as providing intensive care.)
- Unplanned operating room procedure following delivery** - (Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.)
- None of the above**

### Newborn

**Sources: Labor and delivery records, Newborn's medical records, mother's medical records**

- 30. Birthweight:** \_\_\_\_\_ (grams) (Do not convert lb/oz to grams)  
 If weight in grams is not available, birthweight: \_\_\_\_\_ (lb/oz)
- 31. Obstetric estimate of gestation at delivery (completed weeks):** \_\_\_\_\_  
 (The birth attendant's final estimate of gestation based on all perinatal factors and assessments, but not the neonatal exam. Do not compute based on date of the last menstrual period and the date of birth.)
- 32. Sex** (Male, Female, or Not yet determined): \_\_\_\_\_
- 33. Apgar score** (A systematic measure for evaluating the physical condition of the infant at specific intervals at birth):  
 Score at **5** minutes \_\_\_\_\_  
 If 5 minute score is less than 6:  
 Score at **10** minutes \_\_\_\_\_

- Assisted ventilation required for more than six hours** - (Infant given mechanical ventilation (breathing assistance) by any method for > 6 hours. Includes conventional, high frequency and/or continuous positive pressure (CPAP).)
- NICU admission** - (Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.)
- Newborn given surfactant replacement therapy** - (Endotracheal instillation of a surface active suspension for the treatment of surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.)
- Antibiotics received by the newborn for suspected neonatal sepsis** - (Any antibacterial drug (e.g., penicillin, ampicillin, gentamicin, cefotaxime etc.) given systemically (intravenous or intramuscular).)
- Seizure or serious neurologic dysfunction** - (Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness such as obtundation, stupor, or coma, i.e., hypoxic-ischemic encephalopathy. Excludes lethargy or hypotonia in the absence of other neurologic findings. Exclude symptoms associated with CNS congenital anomalies.)
- Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)** - (Defined as present immediately following delivery or manifesting soon after delivery. Includes any bony fracture or weakness or loss of sensation, but excludes fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes sub-galeal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial and/or extremity ecchymosis accompanied by evidence of anemia and/or hypovolemia and/or hypotension. Solid organ hemorrhage includes subcapsular hematoma of the liver, fractures of the spleen, or adrenal hematoma.)
- None of the above**

**38. Congenital anomalies of the newborn** (Malformations of the newborn diagnosed prenatally or after delivery.)

(Check all that apply):

- Anencephaly** - (Partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Also includes infants with craniorachischisis (anencephaly with a contiguous spine defect).)
- Meningomyelocele/Spina bifida** - (Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of spine closure. Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be included in this category. Both open and closed (covered with skin) lesions should be included. Do not include Spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).)
- Cyanotic congenital heart disease** - (Congenital heart defects which cause cyanosis. Includes but is not limited to: transposition of the great arteries (vessels), tetralogy of Fallot, pulmonary or pulmonic valvular atresia, tricuspid atresia, truncus arteriosus, total/partial anomalous pulmonary venous return with or without obstruction.)

- Cleft Lip with or without Cleft Palate - (Incomplete closure of the lip. May be unilateral, bilateral or median.)
- Cleft Palate alone - (Incomplete fusion of the palatal shelves. May be limited to the soft palate or may extend into the hard palate. Cleft palate in the presence of cleft lip should be included in the "Cleft Lip with or without Cleft Palate" category above.)
- Down Syndrome - (Trisomy 21)
  - Karyotype confirmed
  - Karyotype pending
- Suspected chromosomal disorder - (Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure.)
  - Karyotype confirmed
  - Karyotype pending
- Hypospadias - (Incomplete closure of the male urethra resulting in the urethral meatus opening on the ventral surface of the penis. Includes first degree - on the glans ventral to the tip, second degree - in the coronal sulcus, and third degree - on the penile shaft.)
- None of the anomalies listed above

**39. Was infant transferred within 24 hours of delivery ?** (Check "yes" if the infant was transferred from this facility to another within 24 hours of delivery. If transferred more than once, enter name of first facility to which the infant was transferred.)

Yes                       No

If yes, name of facility infant transferred to: \_\_\_\_\_

**40. Is infant living at time of report?** (Infant is living at the time this birth certificate is being completed. Answer "Yes" if the infant has already been discharged to home care.)

Yes                       No                       Infant transferred, status unknown

**41. Is infant being breastfed at discharge?**

Yes                       No

## Appendix 1b - Discussion Guide For Focus Groups

OMB #0920-0222; Expiration Date: 02/28/10

**Notice** - Public reporting burden for this collection of information is estimated to average 90 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0222).

**Assurances of Confidentiality** - All information which would permit identification of any individual, a practice, or an establishment will be held confidential, will be used only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

### Introduction

Welcome. My name is \_\_\_\_\_. Before we start, I want to make sure that you understand who we are and why you're here. The National Center for Health Statistics, a federal government statistical agency, is part of the Centers for Disease Control and Prevention (CDC). One of CDC's key missions is to monitor the health of people in the United States.

Birth certificate data are used to monitor the health of women giving birth and their infants, as well as to determine public policy and funding for maternal and child health at the local, state and national level.

Since the 2003 Revised U.S. Standard Certificate of Live Birth includes changes in the data items and in how these data are collected, it is crucial to ascertain how the data are collected and what problems if any are encountered along the way.

Today we will be discussing how you collect birth certificate data. For example, what sources are available to you? How easy/difficult is it to find a specific data item? What do you do if you cannot find a data item? We'll be using the 2003 Revised U.S. Standard Certificate of Live Birth and the facility worksheet as starting points for our interview, with the understanding that they may differ somewhat from those used in your hospital.

### Overview and Ground Rules

Before we continue, I'd like to go over some general information—we'd like to establish some ground rules for our discussion, and tell you about the confidentiality procedures we have in place.

I would like you to know that in the whole discussion today, you don't have to reveal anything that you are not comfortable revealing.

For purposes of the group discussion, we'd like you to pick a name that you would like to be called— a first name is fine, it doesn't even have to be your real name. [ASK THEM TO FILL OUT NAME CARDS.]

The consent form you just signed assures you that we will keep your information confidential. We would also like to ask everyone to treat this discussion as confidential. That is, if you learn anything private about another member of the group, we would like to ask you not to discuss that with anyone outside of this room. Although we are required by federal law to keep information private, we cannot guarantee that everyone else will honor your privacy. All we can do is ask that people please agree to that. And again, you should never feel obligated to share any information that you are not comfortable sharing.

We are planning to audio tape this focus group. This is for note-taking purposes in case we miss anything that was said. We will use the tape to double-check our notes and make sure they are complete.

One of the great things about this discussion is “group dynamic” – ideas that one person raises will remind someone else of a related issue. That’s great, feel free to speak up. But also don’t interrupt each other. We ask that there be only one speaker at a time so that responses can be accurately recorded. You may have more to say about some topics than others, and that’s OK too.

Don’t feel like you have to agree or disagree with anyone in this room. We want to hear about your personal experiences and thoughts and it’s OK to disagree with someone else. But please be respectful of the opinions or experiences of others in the room.

Sometimes groups start talking about subjects that are off the main topic. That’s natural; but please don’t be offended if we steer the conversation back to the material we most need to cover.

As a courtesy to everyone, please turn off your beepers and cell phones. The discussion will last 90 minutes. We will not have breaks built into it, but should you need to go to the restroom during the discussion, please feel free to leave. However, I would appreciate it if you would go one at a time.

Does anyone have any questions before we get started? [If yes, answer questions]. [If no, okay then, let’s proceed].

### **Moderator talking-points**

1. What sources are available to you to complete the information on the Facility Worksheet?
2. If a source that you need is not available, what do you do?
3. Is there Information you are asked to collect that you cannot find?
4. Are there instances when you are not sure what information you are being asked to collect?

**Wrap-Up** (5 minutes)

OK. We are pretty much out of time. Does anyone have any last thoughts or questions?

I want to thank all of you for coming today and sharing your opinions. The information you've shared today will be very useful in helping to improve the collection of birth certificate data. [Stop audio taping].

## Appendix 1c - Introduction to cognitive interview

OMB #0920-0222; Expiration Date: 02/28/10

**Notice** - Public reporting burden for this collection of information is estimated to average 60 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0222).

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### Introduction

Thank you for agreeing to participate in this interview today. You have read the Informed Consent form and you agree to take part in this research study. Is that correct? [Interviewer waits for verbal acknowledgment]. You have given your permission for me to tape record your interview today and, if needed, to play it to other people working on this study. Is that correct? [Interviewer waits for verbal acknowledgment].

Before we start, I want to make sure that you understand who we are and why you're here. The National Center for Health Statistics, a federal government statistical agency, is part of the Centers for Disease Control and Prevention (CDC). One of CDC's key missions is to monitor the health of people in the United States.

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I want to remind you that this interview is strictly confidential. Confidential means that your name will never be linked to the answers you give.

Do you have any questions you want to ask me before we begin?