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

LOCAL FILE NO. BIRTH NUMBER:

C H I L D

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

M O T H E R

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? □ Yes □ No

F A T H E R

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)
10b. DATE OF BIRTH (Mo/Day/Yr)
10c. BIRTHPLACE (State, Territory, or Foreign Country)

CERTIFIER

11. CERTIFIER'S NAME: ___________________________
TITLE: □ MD □ DO □ HOSPITAL ADMIN. □ CNM/CM □ OTHER MIDWIFE
□ OTHER (Specify)______________________
12. DATE CERTIFIED ____/____/______ MM DD YYYY
13. DATE FILED BY REGISTRAR ____/____/______ MM DD YYYY

INFORMATION FOR ADMINISTRATIVE USE

M O T H E R

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) □ Yes □ No
IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? □ Yes □ No
16. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD? □ Yes □ No
17. FACILITY ID. (NPI)
18. MOTHER'S SOCIAL SECURITY NUMBER:
19. FATHER'S SOCIAL SECURITY NUMBER:

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

M O T H E R

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
- □ 8th grade or less
- □ 9th - 12th grade, no diploma
- □ High school graduate or GED completed
- □ Some college credit but no degree
- □ Associate degree (e.g., AA, AS)
- □ Bachelor's degree (e.g., BA, AB, BS)
- □ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- □ 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)
- □ No, not Spanish/Hispanic/Latina
- □ Yes, Mexican, Mexican American, Chicana
- □ Yes, Puerto Rican
- □ Yes, Cuban
- □ Yes, other Spanish/Hispanic/Latina

(Specify)_____________________

22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
- □ White
- □ Black or African American
- □ American Indian or Alaska Native (Name of the enrolled or principal tribe)___________
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian (Specify)______________________
- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Other Pacific Islander (Specify)________________
- □ Other (Specify)_________________________

F A T H E R

23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)
- □ 8th grade or less
- □ 9th - 12th grade, no diploma
- □ High school graduate or GED completed
- □ Some college credit but no degree
- □ Associate degree (e.g., AA, AS)
- □ Bachelor's degree (e.g., BA, AB, BS)
- □ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- □ 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)
- □ No, not Spanish/Hispanic/Latino
- □ Yes, Mexican, Mexican American, Chicano
- □ Yes, Puerto Rican
- □ Yes, Cuban
- □ Yes, other Spanish/Hispanic/Latino

(Specify)_____________________

25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)
- □ White
- □ Black or African American
- □ American Indian or Alaska Native (Name of the enrolled or principal tribe)___________
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Korean
- □ Vietnamese
- □ Other Asian (Specify)______________________
- □ Native Hawaiian
- □ Guamanian or Chamorro
- □ Samoan
- □ Other Pacific Islander (Specify)________________
- □ Other (Specify)_________________________

26. PLACE WHERE BIRTH OCCURRED (Check one)
- □ Hospital
- □ Freestanding birthing center
- □ Home Birth: Planned to deliver at home? 9 Yes 9 No
- □ Clinic/Doctor's office
- □ Other (Specify)__________________

27. ATTENDANT'S NAME, TITLE, AND NPI
NAME: ________________ NPI:______
TITLE: □ MD □ DO □ CNM/CM □ OTHER MIDWIFE
□ OTHER (Specify)_______________

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? □ Yes □ No
IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:
____

Mother's Name ________

Mother's Medical Record No. ________

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INFORMATION

Hypertension
- ◻ Prepregnancy (Chronic)
- ◻ Gestational (PIH, preeclampsia)
- ◻ Eclampsia

◻ Previous preterm birth

◻ 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 (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))

◻ Mother had a previous cesarean delivery
If yes, how many __________

◻ None of the above

42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- ◻ Gonorrhea
- ◻ Syphilis
- ◻ Chlamydia
- ◻ Hepatitis B
- ◻ Hepatitis C
- ◻ None of the above

External cephalic version:
- ◻ Successful
- ◻ Failed

◻ None of the above

44. ONSET OF LABOR (Check all that apply)
- ◻ Premature Rupture of the Membranes (prolonged, ∃12 hrs.)
- ◻ Precipitous Labor (<3 hrs.)
- ◻ Prolonged Labor (∃ 20 hrs.)
- ◻ None of the above

45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
- ◻ Induction of labor
- ◻ Augmentation of labor
- ◻ Non-vertex presentation
- ◻ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ◻ Antibiotics received by the mother during labor
- ◻ Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq$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

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

C. Fetal presentation at birth
- ◻ Cephalic
- ◻ Breech
- ◻ Other

D. 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

47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)
- ◻ 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

NEWBORN INFORMATION

NEWBORN

48. NEWBORN MEDICAL RECORD NUMBER

49. BIRTHWEIGHT (grams preferred, specify unit)
____
9 grams 9 lb/oz

50. OBSTETRIC ESTIMATE OF GESTATION:
_________________ (completed weeks)

51. APGAR SCORE:
Score at 5 minutes:________________________
If 5 minute score is less than 6,
Score at 10 minutes: ______________________

52. PLURALITY - Single, Twin, Triplet, etc.
(Specify)_______________________

53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) ________________

54. 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 (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)

9 None of the above

55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
- ◻ Anencephaly
- ◻ Meningomyelocele/Spina bifida
- ◻ Cyanotic congenital heart disease
- ◻ Congenital diaphragmatic hernia
- ◻ Omphalocele
- ◻ Gastroschisis
- ◻ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- ◻ Cleft Lip with or without Cleft Palate
- ◻ Cleft Palate alone
- ◻ Down Syndrome
  - ◻ Karyotype confirmed
  - ◻ Karyotype pending
- ◻ Suspected chromosomal disorder
  - ◻ Karyotype confirmed
  - ◻ Karyotype pending
- ◻ Hypospadias
- ◻ None of the anomalies listed above

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? 9 Yes 9 No
IF YES, NAME OF FACILITY INFANT TRANSFERRED TO:____

57. IS INFANT LIVING AT TIME OF REPORT?
◻ Yes ◻ No ◻ Infant transferred, status unknown

58. IS THE INFANT BEING BREASTFED AT DISCHARGE?
◻ Yes ◻ No

Mother's Name ____________

Mother's Medical Record No. ____________

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 1st 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 1st 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 >=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 (>=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 Indentifier) (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° C (100.4° 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°C (100.4°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, cefotoxine 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), tetratology 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