

Recorded District
Register Number

New York State Department of Health

# CERTIFICATE OF LIVE BIRTH

State File Number:

<b>INFANT</b>	1A. Name: <i>First</i> <span style="margin-left: 150px;"><i>Middle</i></span> <span style="margin-left: 150px;"><i>Last</i></span>					
	1B. Medical Record No.:	2A. Date of Birth:	2B. Hour:	3. Sex:	4A. Birth Is: ( <i>Single, Twin, etc.</i> )	4B. If Not Single, Specify Birth Order:
	5. Place of Birth: <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birth Center <input type="checkbox"/> Home Delivery: <i>Planned to deliver at home?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Other ( <i>specify</i> )					
	6A. Facility Name:			6B. Locality of Birth:		6C. County of Birth:

<b>MOTHER</b>	7A-1. Name: <i>First</i> <span style="margin-left: 150px;"><i>Middle</i></span> <span style="margin-left: 150px;"><i>Current Last Name</i></span>		
	7A-2. Maiden Last Name:	7B. Date of Birth:	7C. City & State of Birth: ( <i>Country, if not U.S.A.</i> )
	8A. Residence, State: ( <i>Country, if not U.S.A.</i> )		8B. County: ( <i>Terr. or Prov., if not USA</i> )
	8C. Locality:		8D. If City or Village, Is Residence within City or Village Limits? ( <i>If NO, specify town:</i> )
	8E. Street and Number of Residence:		8F. Zip Code:
	8G. Mailing Address:		8H. Zip Code:

<b>FATHER</b>	9A. Name: <i>First</i> <span style="margin-left: 150px;"><i>Middle</i></span> <span style="margin-left: 150px;"><i>Last</i></span>		
	9B. Date of Birth:	9C. City & State of Birth: ( <i>Country, if not U.S.A.</i> )	

<b>ATTENDANT</b>	10A. I certify that the stated information concerning this child is true to the best of my knowledge and belief.			10B. Date Signed: <table border="1" style="display: inline-table;"><tr><td>Month</td><td>Day</td><td>Year</td></tr></table>			Month	Day	Year
	Month	Day	Year						
	Signature			Title:					
	10C. Name of Certifier, If Not Attendant:			10D-1. NYS License Number: ( <i>Certifier</i> )					
	10E. Attendant's Name:			10F-1. NYS License Number: ( <i>Attendant</i> )					
11A. Registrar Name:									
11B. Signature of the Registrar:			11C. Date Filed: <table border="1" style="display: inline-table;"><tr><td>Month</td><td>Day</td><td>Year</td></tr></table>			Month	Day	Year	
Month	Day	Year							

*	12. Information Added or Corrected: <i>Item No.      Date of Correction      Authorization      Original Information</i>
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<b>Child's Name:</b> First Middle Last	<b>Date of Birth:</b> MM DD YYYY	<b>Locality of Birth:</b>
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**13. Office Use Only:**

**Institution**

**14A. Primary Payor**  
 Medicaid / Family Health Plus  
 Private Insurance  
 Indian Health Service  
 CHAMPUS / TRICARE  
 Other government / CHPlusB  
 Other  
 Self-pay  Unknown

**14B. Is Medicaid a secondary payor for this delivery?**  
 Yes  No

**14C. Is mother enrolled in HMO?**  
 Yes  No

**Labor and Delivery**

**28C. Maternal Morbidity (Select all that apply)**  
 Maternal transfusion  
 Perineal laceration (3rd or 4th degree)  
 Ruptured uterus  
 Unplanned hysterectomy  
 Admit to ICU  
 Unplanned operating room procedure following delivery  
 None of the above

**29A. Anesthesia:**  
 Epidural  
 General inhalation  
 General intravenous  
 Spinal  
 Paracervical  
 Pudendal  
 Local  
 None

**29B. Analgesia:**  
 Yes  No

**30. Other Procedures:**  
 Episiotomy & repair  
 Sterilization  
 None of the above

**Prenatal Care**

**41. Risk Factors in This Pregnancy (Select all that apply)**  
 Pre-pregnancy diabetes  
 Gestational diabetes  
 Pre-pregnancy hypertension  
 Gestational hypertension  
 Other serious chronic illness  
 Previous preterm birth  
 Abruptio placenta  
 Eclampsia  
 Other previous poor pregnancy outcome  
 Prelabor referral for high risk care  
 Other vaginal bleeding  
 Previous cesarean section, Number: \_\_\_\_\_  
 Infertility treatment  
 Fertility drugs, artificial / intrauterine insemination  
 Assisted reproductive technology (eg. IVF, GIFT, etc.)  
 None of the above

**15. Birth Weights**  
 Pounds/Ounces \_\_\_\_\_ Or Grams \_\_\_\_\_

**16. Infant Transferred:**  
 Within 24 hours of delivery  After 24 hours  Not transferred  
 If transferred, name of facility transferred to: \_\_\_\_\_  
 State or Province/Territory \_\_\_\_\_

**Parent's Race & Education**

**Note:** For the questions on Education, Hispanic Origins & Race, please use the check boxes on the left side of the column for the mother's information and the boxes on the right side for the father's information. For the question on Race you may check one or more races.

**Parent's Education**  
**31A. Mother:**  
 8<sup>th</sup> grade or less  
 9<sup>th</sup> - 12<sup>th</sup> grade; no diploma  
 High school graduate or GED  
 Some college credit, but no degree  
 Associate's degree  
 Bachelor's degree  
 Master's degree  
 Doctorate/Professional degree

**32A. Father:**  
 8<sup>th</sup> grade or less  
 9<sup>th</sup> - 12<sup>th</sup> grade; no diploma  
 High school graduate or GED  
 Some college credit, but no degree  
 Associate's degree  
 Bachelor's degree  
 Master's degree  
 Doctorate/Professional degree

**42. Infections (Select all that apply)**  
 Gonorrhea  
 Syphilis  
 Herpes Simplex (HSV)  
 Chlamydia  
 Hepatitis B  
 Hepatitis C  
 Tuberculosis  
 Rubella  
 Bacterial Vaginosis  
 None of the above

**17. Apgar score at 1 minute:**  
 Score at 5 minutes: \_\_\_\_\_  
 Score at 10 minutes: \_\_\_\_\_

**18. Is the infant alive?**  
 Yes  No

**Parent's Hispanic Origins**  
**31B. Mother:**  
 No, not Spanish/Hispanic/Latino/Latina  
 Yes, Mexican, Mexican American, Chicana  
 Yes, Mexican, Mexican American, Chicano  
 Yes, Puerto Rican  
 Yes, Cuban  
 Yes, Other Spanish/Hispanic/Latina  
 (Mother) Specify \_\_\_\_\_  
 Yes, Other Spanish/Hispanic/Latino  
 (Father) Specify \_\_\_\_\_

**32B. Father:**  
 No, not Spanish/Hispanic/Latino/Latina  
 Yes, Mexican, Mexican American, Chicana  
 Yes, Mexican, Mexican American, Chicano  
 Yes, Puerto Rican  
 Yes, Cuban  
 Yes, Other Spanish/Hispanic/Latino  
 (Mother) Specify \_\_\_\_\_  
 Yes, Other Spanish/Hispanic/Latino  
 (Father) Specify \_\_\_\_\_

**43A. Daily Tobacco Use (Number of Cigarettes OR Packs)**  
 None  
 3 months prior to pregnancy  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**19. Clinical Estimate of Gestation (completed weeks)**

**20. Newborn Treatment Given:**  
 Conjunctivitis  Both  
 Vitamin K  Neither

**21. How is infant being fed?**  
 Breast Milk  Both  
 Formula  Neither

**22. Hepatitis B Inoculation:**  
 Immunization administered? Yes  No  Date: MM DD YYYY  
 Immunoglobulin administered? Yes  No  Date: MM DD YYYY

**Parent's Education**  
**31A. Mother:**  
 8<sup>th</sup> grade or less  
 9<sup>th</sup> - 12<sup>th</sup> grade; no diploma  
 High school graduate or GED  
 Some college credit, but no degree  
 Associate's degree  
 Bachelor's degree  
 Master's degree  
 Doctorate/Professional degree

**32A. Father:**  
 8<sup>th</sup> grade or less  
 9<sup>th</sup> - 12<sup>th</sup> grade; no diploma  
 High school graduate or GED  
 Some college credit, but no degree  
 Associate's degree  
 Bachelor's degree  
 Master's degree  
 Doctorate/Professional degree

**43B. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**23. Abnormal Conditions of the Newborn (Select all that apply)**  
 Assisted ventilation required immediately following delivery  
 Assisted ventilation required for more than six (6) 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 fx, peripheral nerve injury, soft tissue/solid organ hemorrhage which requires intervention)  
 None of the above

**31D. Employed during this pregnancy?** Yes  No

**31E. Current / Most Recent Occupation:**

**31F. Kind of Business or Industry:**

**31G. Name and Address of Firm:**

**43C. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**Congenital Anomalies**

**24. Congenital Anomalies (Select all that apply)**  
 Anencephaly  
 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 of the above

**Mother**

**31D. Employed during this pregnancy?** Yes  No

**31E. Current / Most Recent Occupation:**

**31F. Kind of Business or Industry:**

**31G. Name and Address of Firm:**

**Father**

**32D. Current / Most Recent Occupation:**

**32E. Kind of Business or Industry:**

**32F. Name and Address of Firm:**

**43D. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**43E. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**Labor and Delivery**

**25. If birth occurred in hospital, was mother transferred in before giving birth?** Yes  No   
 If YES, name of facility transferred from: \_\_\_\_\_  
 State or Province/Territory: \_\_\_\_\_

**Prenatal History**

**33. Did mother receive prenatal care?**  Yes  No

**34. Primary Prenatal Care Provider:**  
 MD or DO  Clinic  Other

**35. Did mother participate in WIC?**  Yes  No

**36A. Date of Last Menses:** MM DD YYYY

**36B. Estimated Due Date:** MM DD YYYY

**36C. Date of First Prenatal Care Visit:** MM DD YYYY

**36D. Date of Last Prenatal Care Visit:** MM DD YYYY

**37. Total Number of Prenatal Visits:**

**43F. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**43G. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**26. Mother's Weight at Delivery:**

**27 a, b, c & d. Method of Delivery:**  
 a. Fetal Presentation:  
 Cephalic  Breech  Other

b. Final Route & Method: (Check one)  
 Spontaneous  
 Forceps - Mid  
 Forceps - Low/outlet  
 Vacuum  
 Cesarean

c. Attempted but failed: Yes  No   
 Forceps  Vacuum

d. If cesarean, was trial labor attempted? Yes  No

**38. Number of Prior Live Births:**  
 Now Living None Number \_\_\_\_\_  
 Now Dead None Number \_\_\_\_\_

**38A. Date of First Live Birth:** MM DD YYYY

**38B. Date of Last Live Birth:** MM DD YYYY

**38C. Date of Last Other Pregnancy Outcome:** MM DD YYYY

**39A. Date of First Live Birth:** MM DD YYYY

**39B. Date of Last Live Birth:** MM DD YYYY

**39C. Date of Last Other Pregnancy Outcome:** MM DD YYYY

**43H. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**43I. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**28A. Onset of Labor (Select all that apply)**  
 Prolonged rupture membranes (12 hours or more)  
 Premature rupture membranes (prior to labor)  
 Precipitous labor (less than 3 hours)  
 Prolonged labor (20 hours or more)  
 None of the above

**40A. Mother's Pre-pregnancy Weight:**

**40B. Mother's Height:**

**43J. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**43K. Alcohol Use During This Pregnancy:**  
 None Average Drinks \_\_\_\_\_ per Week  
 None  
 First 3 months of pregnancy  
 Second 3 months of pregnancy  
 Third trimester of pregnancy

**28B. Characteristics of Labor & Delivery (Select all that apply)**  
 Induction of labor - AROM  
 Induction of labor - Medicinal  
 Augmentation of Labor  
 Steroids  
 Antibiotics  
 Chorioamnionitis

Meconium staining  
 Fetal intolerance  
 External electronic fetal monitor  
 Internal electronic fetal monitor  
 None of the above

**Release of Information**

I have read the form regarding the Release of Birth Information and the collection of Social Security numbers (DOH-1963i), and I agree to the release of information for the following purpose, as stated in that form: Social Security Release (EAB)  Yes  No

Mother's Signature & Date Signed: \_\_\_\_\_  
 Father's Signature & Date Signed: \_\_\_\_\_

Mother's Telephone Number: \_\_\_\_\_  
 Mother's Social Security Number: \_\_\_\_\_  
 Father's Social Security Number: \_\_\_\_\_