Mother's Name:	Mother's Med. Rec. Number:

New York State Birth Certificate and Statewide Perinatal Data System Work Booklet

New Birth Registration

Parents — Mother

Mother's Name: *First* *Middle* *Maiden Last Name* *Current Last Name*

Social Security Number: – –

Mother's Date of Birth: *(MM/DD/YYYY)* / /

Infant

Infant's Name: *First* *Middle* *Last* *Suffix*

Sex: ☐ Male ☐ Female ☐ Undetermined

Plurality:

Birth Order:

Medical Record No.:

Date of Birth: *(MM/DD/YYYY)* / /

Time of Birth: *(HH:MM)* : ☐ am ☐ pm ☐ military (24-hour time)

Parents — Infant

Was child born in this facility?

☐ Yes ☐ No If child was **not** born in this facility, please answer the following questions:

In what type of place was the infant born?

☐ Freestanding Birth Center (regulated by DOH)
☐ Home (intended)
☐ Home (unintended)
☐ Home (unknown intent)
☐ Clinic / Doctor's Office (not regulated by DOH)
☐ Other

If New York State Birthing Center, enter its name:

In what county was the child born?

Birthplace

Institution

Site of Birth, If **Other** Type of Place:

Street Address – if other than Hospital / Birthing Center:

If place of infant's birth was other than Hospital or Birthing Center:

City, town or village where birth occurred:

Zip / Postal Code:

Attendant

Attendant's Information:

License Number:

Name: *First* *Middle* *Last*

Title: *(Select one)*

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Licensed Midwife (CNM) ☐ Licensed Midwife (CM) ☐ Other

Certifier

Certifier's Information:

☐ Check here if the Certifier is the same as the Attendant *(otherwise enter information below)*

License Number:

Name: *First* *Middle* *Last*

Title: *(Select one)*

☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Licensed Midwife (CNM) ☐ Licensed Midwife (CM) ☐ Other

Parents — Payor

Primary Payor for this Delivery:

Select one:

☐ Medicaid / Family Health Plus
☐ Private Insurance
☐ Indian Health Service
☐ CHAMPUS / TRICARE
☐ Other Government / Child Health Plus B
☐ Other
☐ Self-pay

If Medicaid is not the primary payor, is it a secondary payor for this delivery? ☐ Yes ☐ No

Is the mother enrolled in an HMO or other managed care plan? ☐ Yes ☐ No

New York State Birth Certificate and Statewide Perinatal Data System Quality Improvement Information Release Form

Mother's Name: *First*	*Middle*	*Last*	Mother's Med. Rec. Number:
Father's Name: *First*	*Middle*	*Last*	*Suffix*
Infant's Name: *First*	*Middle*	*Last* *Suffix*	Date of Birth

To the hospital:

1. Obtain the parent(s) signature(s).
2. File the original Release Form in the mother's hospital record.
   Note: It is not necessary to file the remainder of the Work Booklet.
3. Provide a copy to the parent(s).
4. Do **not** send copies to the New York State Department of Health or to any Social Security office, unless specifically requested by such agency.

To the parent(s):

1. Please read the following notice about the collection and use of Social Security Numbers on your child's birth certificate.
2. Please check "Yes" or "No" to indicate if you wish to participate in any of the listed programs.

NOTICE REGARDING COLLECTION OF PARENTS' SOCIAL SECURITY NUMBERS: The collection of parents' Social Security Numbers on the New York State Certificate of Live Birth is mandatory. They are required by Public Health Law Section 4132(1) and may be used for child support enforcement, public health related purposes, when requested by State, federal and municipal governments for official purposes, when required by Public Health Law Section 4173 or 4174 and when otherwise required or authorized by law.

Yes ☐ No ☐

Social Security Release

The Social Security Administration offers the parents of newborns an opportunity to apply for a Social Security Number for their child through the birth certificate registration process. This is referred to by the Social Security Administration as Enumeration at Birth (EAB). If you participate in the EAB, the New York State Department of Health will forward to the Social Security Administration information from your child's birth certificate. Please note that the Social Security Administration will not process your EAB request unless, the birth certificate includes your child's full name. If you participate in the EAB, disclosure of parents' Social Security Numbers is mandated by 42 U.S.C. 405(c)(2). The Social Security Number(s) will be used by the Internal Revenue Service (IRS) solely for the purpose of determining Earned Income Tax Credit compliance. Do you want to participate in the Social Security Administration EAB program?

Yes ☐ No ☐

Statewide Perinatal Data System (SPDS) – Quality Improvement Module (QI)

I consent to the disclosure by the hospital/birth center of identifiable health information (labeled "QI") to be reported in the Birth Certificate and Perinatal Data System sections of this Work Booklet. The information is to be used by the New York State Department of Health, the hospital and the Regional Perinatal Center for the purpose of improving services to pregnant women and their babies.

Mother's Signature ▸ _____ **Date** _____

Father's Signature ▸ _____ **Date** _____

Either parent's signature applies to all of the above releases.
If neither box is checked for a release, a 'No' response will be assumed.

Hospital Name:	
Signature of Hospital Representative: ▸	Date:

Mother's Name:	Mother's Med. Rec. Number:

NEW YORK STATE IMMUNIZATION PROGRAM
AUTHORIZATION FOR RELEASE OF INFORMATION

Enrollee/Patient Name: _____ ID Number: _____

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, except that a recipient may be prohibited from redisclosing substance abuse information under the federal substance abuse confidentiality requirements.

Persons/organizations providing the information:
Birthing hospitals/ birthing center

Persons/organizations receiving the information:
School/day care of attendance

1. Describe information to be released: Individual immunization information

2. Purpose of the use/disclosure: To disclose an individual's immunization information to the school/day care that is required by DOH to verify the individual has received adequate immunization/vaccinations.

3. The person/program requesting the authorization will not receive financial or in-kind compensation in exchange for using or disclosing the health information on immunization to the school/day care.

4. I understand that my health care and the payments for my health care will not be affected if I do not sign this form except in some situations when information is needed for payment, health plan enrollment, etc.

5. I understand that, with few exceptions, I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

6. This authorization is effective until it is revoked in writing by contacting the provider or until the minor reaches the age of 18.

==========

_____ _____
Signature of patient or legal representative Date

==========

Printed name of patient's legal representative: _____

Relationship to the patient: _____

Program contact #: _____

Federally protected substance abuse information:

I understand that my records are protected under the federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

(HIPAA Auth Release Information 45 C.F.R. §164.508) June 5, 2003

Mother's Name:	Mother's Med. Rec. Number:

Infant

Infant

If Multiple Births:
Number of Live Births:

Number of Fetal Deaths:

Birth Weight:
grams | *lbs.* *oz.*

If birth weight < 1250 grams (2 lbs. 12 oz.), reason(s) for delivery at a less than level III hospital: *(Only if applicable)*

☐ None ☐ Unknown at this time

QI

Select all that apply:

☐ Rapid / Advanced Labor ☐ Bleeding ☐ Fetus at Risk ☐ Severe pre-eclampsia

☐ Woman Refused Transfer ☐ Other *(specify)*

Infant Transferred:
☐ Within 24 hrs ☐ After 24 hrs. ☐ Not transferred

NYS Hospital Infant Transferred To:

State/Terr./Province:

Birth Information

Apgar Scores
1 minute: 5 minutes: 10 minutes:

Is the Infant Alive?
☐ Yes ☐ No
☐ Infant Transferred / Status Unknown

Clinical Estimate of Gestation:
(Weeks)

Newborn Treatment Given:
☐ Conjunctivitis only
☐ Vitamin K only
☐ Both
☐ Neither

How is infant being fed? *(Select one)*
☐ Breast Milk Only ☐ Formula Only ☐ Both Breast Milk and Formula
☐ Other ☐ Do Not Know

Mother's Name:	Mother's Med. Rec. Number:

Mother

Medical Record Number:

Parents

Mother's Demographics

Mother's Education: *(select one)*

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate; or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree

City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Other Spanish/Hispanic/Latina
- ☐ Yes, Puerto Rican

Specify:

Mother's Demographics

Race:

Select all that apply

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Korean
- ☐ Guamanian or Chamorro
- ☐ American Indian or Alaska Native **Tribe:**
- ☐ Other Asian **Specify:**
- ☐ Other Pacific Islander **Specify:**
- ☐ Other **Specify:**
- ☐ Black or African American
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian

Mother's Residence

Residence Address

Street Address:

State/Terr./Province:	County:	City, Town or Village:

Zip/Postal Code:	Mother's Country of Residence, if not USA:	U.S./Canadian Phone Number: ( ) –

Mother's Mailing Address

Mailing Address – Most Recent

☐ Check here if the mailing address is the same as the residence address *(otherwise enter information below)*

Mailing Address:

City, Town or Village:	State/Terr./Province:	Country, if not USA:	Zip/Postal Code:

Employment

Employment History

Employed while Pregnant: ☐ Yes ☐ No	Current / Most Recent Occupation:	Kind of Business / Industry:

Name of Company or Firm:	Address:

City:	State/Terr./Province:	Zip / Postal Code:

Mother's Name:	Mother's Med. Rec. Number:

Father

Will the mother and father be executing an Acknowledgement of Paternity? ☐ Yes ☐ No ☐ Not required

Parents

Father's Demographics

Father's Name: *First* *Middle* *Last* *Suffix*

Social Security Number: – –

Demographics

Father's Date of Birth: *(MM/DD/YYYY)* / /

Education: *(select one)*

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate; or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree

City of Birth: | State/Terr./Province of Birth: | Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Other Spanish/Hispanic/Latino
- ☐ Yes, Puerto Rican

Specify:

Race:

Select all that apply

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Korean
- ☐ Guamanian or Chamorro
- ☐ Black or African American
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian
- ☐ American Indian or Alaska Native **Tribe:**
- ☐ Other Asian **Specify:**
- ☐ Other Pacific Islander **Specify:**
- ☐ Other **Specify:**

Father's Residence

Residence Address

☐ Check here if the father's residence address is the same as the mother's address *(otherwise enter information below)*

Street Address:

City, Town or Village: | State / Territory / Province:

Father's Country of Residence, if not USA: | Zip / Postal Code:

Employment

Employment History

Current / Most Recent Occupation: | Kind of Business / Industry:

Name of Company or Firm: | Address:

City: | State / Territory / Province: | Zip / Postal Code:

Mother's Name:	Mother's Med. Rec. Number:

Prenatal History

Parents — Prenatal History

Did mother receive prenatal care?	Primary Prenatal Care Provider Type:	Did mother participate in WIC?
☐ Yes ☐ No	☐ MD / DO / C(N)M / HMO ☐ No Information ☐ Clinic ☐ No Provider ☐ Other	☐ Yes ☐ No

Key Pregnancy Dates *(MM/DD/YYYY)*

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
/ /	/ /	/ /	/ /

Prenatal Visits

Total Number of Prenatal Visits:	

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number ☐	Now Dead None or Number ☐	Less than 20 Weeks None or Number ☐	20 Weeks or More None or Number ☐	None or Number ☐	None or Number ☐

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
/	/	/	*lbs.*	*ft.* *in.*

Parents — Other Risk Factors

Other Risk Factors

Smoking Before or During Pregnancy?	List Number of Packs OR Cigarettes Smoked Per DAY			
	3 Months Prior to Pregnancy	First Three Months of Pregnancy	Second Three Months of Pregnancy	Last Trimester of Pregnancy
☐ Yes ☐ No	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes	Packs OR Cigarettes

Other Risk

Other Risk Factors

Alcohol Consumed During This Pregnancy?	Number of Drinks per Week:	Illegal Drugs Used During This Pregnancy?	QI
☐ Yes ☐ No		☐ Yes ☐ No	

Mother's Name:	Mother's Med. Rec. Number:

Interview/Records

Parents

Survey of Mother (in hospital)

Survey of Mother (in hospital)

Did you receive prenatal care? ☐ Yes ☐ No *(If 'Yes' please answer question 1. Otherwise skip to question 2.)*

1. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?

	Yes	No
a. How smoking during pregnancy could affect your baby?	☐	☐
b. How drinking alcohol during your pregnancy could affect your baby?	☐	☐
c. How using illegal drugs could affect your baby?	☐	☐
d. How long to wait before having another baby?	☐	☐
e. Birth control methods to use after your pregnancy?	☐	☐
f. What to do if your labor starts early?	☐	☐
g. How to keep from getting HIV (the virus that causes AIDS)?	☐	☐
h. Physical abuse to women by their husbands or partners?	☐	☐

2. How many times per week during your current pregnancy did you exercise for 30 minutes or more, above your usual activities? — Times per week:

3. Did you have any problems with your gums at any time during pregnancy, for example, swollen or bleeding gums? ☐ Yes ☐ No

4. During your pregnancy, would you say that you were: *(select one)*
   - ☐ Not depressed at all
   - ☐ A little depressed
   - ☐ Moderately depressed
   - ☐ Very depressed
   - ☐ Very depressed and had to get help

5. Thinking back to just before you were pregnant, how did you feel about becoming pregnant?
   - ☐ You wanted to be pregnant sooner
   - ☐ You wanted to be pregnant later
   - ☐ You wanted to be pregnant then
   - ☐ You didn't want to be pregnant then or at any time in the future

Chart Review (Prenatal and Medical)

Chart Review (Prenatal and Medical)

1a. Copy of prenatal record in chart?
- ☐ Yes, Full Record
- ☐ Yes, Prenatal Summary Only
- ☐ No

1b. Was formal risk assessment in prenatal chart?
- ☐ Yes, with Social Assessment
- ☐ Yes, without Social Assessment
- ☐ No

1c. Was MSAFP / triple screen test offered?
- ☐ Yes
- ☐ No
- ☐ No, Too Late

1d. Was MSAFP / triple screen test done?
- ☐ Yes
- ☐ No

2. How many times was the mother hospitalized during this pregnancy, not including hospitalization for delivery?

Admission and Discharge Information

Admission & Discharge

Mother

Admission Date for Delivery *(MM/DD/YYYY)*	Discharge Date *(MM/DD/YYYY)*
/ /	/ /

Infant

Discharge Date *(MM/DD/YYYY)* / /

- ☐ Discharged Home
- ☐ Infant Still in Hospital
- ☐ Infant Transferred Out
- ☐ Infant Died at Birth Hospital
- ☐ Infant Discharged to Foster Care/Adoption
- ☐ Unknown