

NATIONAL CENTER FOR HEALTH STATISTICS

Guide to Completing the Facility Worksheets for the Certificate of Live Birth and Report of Fetal Death

(2003 revision)

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Training for completing medical and health information for the birth certificate and report of fetal death is available online!

To access

“Applying Best Practices for Reporting Medical and Health Information on Birth Certificates”

go to:

www.cdc.gov/nchs/training/BirthCertificateElearning

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How to Use This Guide

This guide was developed to assist in completing the facility worksheets for the revised Certificate of Live Birth and Report of Fetal Death (birth certificate [BC], facility worksheet for the report of fetal death [FDFWS], report of fetal death [FDR]).

Definitions	Instructions	Sources	Keywords and abbreviations
Defines the items in the order they appear on the facility worksheet.	Provides specific instructions for completing each item.	Identifies the sources in the medical records where information for each item can be found. The specific records available will differ somewhat from facility to facility. The source listed first is considered the best or preferred source. Please use this source whenever possible. All subsequent sources are listed in order of preference. The precise location within the records where an item can be found is further identified by <i>under</i> and <i>or</i>. Example: To determine whether gestational diabetes is recorded as a “Risk factor in this pregnancy” (item #14) in the records: The first or best source is the prenatal care record. Within the prenatal care record, information on diabetes may be found <i>under</i>: • Medical history • Previous obstetric (OB) history • Problem list or initial risk assessment • Historical risk summary • Complications of previous pregnancies • Factors this pregnancy	► Identifies alternative, usually synonymous terms and common abbreviations and acronyms for items. The keywords and abbreviations given in this guide are not intended as inclusive. Facilities and practitioners will likely add to the lists. Example: Keywords and abbreviations for pregnancy diabetes are: DM–Diabetes mellitus Type 1 diabetes IDDM–Insulin dependent diabetes mellitus Type 2 diabetes Noninsulin dependent diabetes mellitus Class B DM Class C DM Class D DM Class F DM Class R DM Class H DM ► Medications commonly used for items. Example: “Clomid” for “Assisted reproduction treatment.”

How to Use This Guide—Continued

This guide was developed to assist in completing the facility worksheets for the revised Certificate of Live Birth and Report of Fetal Death. (birth certificate [BC], facility worksheet for the report of fetal death [FDFWS], report of fetal death [FDR])

Definitions	Instructions	Sources	Keywords and abbreviations
			► <i>Look for</i> is used to indicate terms that may be associated with, but are not synonymous with, an item. Terms listed under <i>look for</i> may indicate that an item should be reported for the pregnancy, but additional information will be needed before it can be determined whether the item should be reported. Example: “Trial of labor” for “cesarean delivery”
MISSING INFORMATION	Where information for an item cannot be located, please check “unknown” or write “unknown” (if using the paper copy of the worksheet).		

Guide to Completing the Facility Worksheet for the Certificate of Live Birth and Report of Fetal Death

Definitions	Instructions	Sources	Keywords and abbreviations
Mother			
The woman who gave birth to, or delivered the infant.	All birth certificate information reported for the mother should be for the woman who delivered the infant. In cases of surrogacy or gestational carrier, the information reported should be for the surrogate or the gestational carrier, that is, the woman who delivered the infant.		
FACILITY INFORMATION			
1. Facility name (BC #5, FDFWS #1, FDR #8)			
The name of the facility where the delivery took place.	Enter the name of the facility where the birth occurred. If this birth did not occur in a hospital or freestanding birthing center, enter the street and number of the place where the birth occurred. If this birth occurred en route to a hospital or freestanding birthing center, that is, in a moving conveyance, enter the city, town, village, or location where the child was first removed from the conveyance. If the birth occurred in international waters or air space, enter "boat" or "plane."		

Definitions	Instructions	Sources	Keywords and abbreviations
2. Facility ID (BC #17, FDFWS #2, FDR #9)			
National Provider Identifier.	Enter the facility's National Provider Identifier (NPI) number. If no NPI, enter the state hospital code.		NPI
3. City, town, or location of birth (BC #6, FDFWS #3, FDR #5)			
The name of the city, town, township, village, or other location where the birth occurred.	Enter the name of the city, town, township, village, or other location where the birth occurred. If the birth occurred in international waters or air space, enter the location where the infant was first removed from the boat or plane.		
4. County of birth (BC #7, FDFWS #4, FDR #6)			
The name of the county where the birth occurred.	Enter the name of the county where the birth occurred. If the birth occurred in international waters or air space, enter the name of the county where the infant was removed from the boat or plane.		

Definitions	Instructions	Sources	Keywords and abbreviations
5. Place where birth occurred (Birthplace) (BC #26, FDFWS #5, FDR #7)			
The type of place where the birth occurred. Hospital Freestanding birthing center No direct physical connection with an operative delivery center. Home birth The birth occurred at a private residence. Clinic/doctor's office Other	Check the box that best describes the type of place where the birth occurred. If home birth is checked, check whether the home birth was planned. If unknown whether a planned home birth, write "unknown." Specify taxi, train, plane, etc.	1st Admission history and physical (H&P) <i>under</i>–General Admission <i>under</i>– - Admitted from home, doctor's office, other <i>or</i>– - Problem list or findings 2nd Delivery record <i>under</i>– - Delivery information - Labor and delivery summary (L&D) - Maternal obstetric (OB) or labor summary <i>under</i>–delivery 3rd Basic admission data 4th Progress notes or Note	FBC–Freestanding birthing center

Definitions	Instructions	Sources	Keywords and abbreviations
PRENATAL CARE AND PREGNANCY HISTORY The prenatal care record is the preferred source for items 6 through 16. If the prenatal care record is not in the mother's file, please contact the prenatal care provider and obtain a copy of the record.			
6. Date of first prenatal care visit (BC #29a, FDFWS #6a, FDR #23a)			
The date a physician or other health care professional first examined or counseled the pregnant woman for the pregnancy. Information obtained on prenatal care received in countries other than the United States and in languages other than English is permitted and should be used.	Enter the month, day, and year of the first prenatal care visit. If date information is incomplete, enter all parts of the date that are known. Report "unknown" for any parts of the date that are missing. If mother's earliest prenatal care records are not available (e.g., the date of the first prenatal care visit is unavailable because the mother transferred her prenatal care and the first records are unavailable), report "unknown." If "no prenatal care," check the box and enter "0" for item "total number of prenatal care visits."	1st Prenatal care record <i>under</i>– • Intake information • Initial physical examination • Prenatal visit flow sheet • Current pregnancy	PNC–Prenatal care

Definitions	Instructions	Sources	Keywords and abbreviations
7. Total number of prenatal care visits for this pregnancy (BC #30)			
The total number of visits recorded in the record. A prenatal visit is one in which the physician or other health care professional examines or counsels the pregnant woman for her pregnancy. <u>Do not include</u> visits for laboratory and other testing in which a physician or health care professional did not examine or counsel the pregnant woman. <u>Do not include</u> classes, such as childbirth classes, where the physician or health care professional did not provide individual care to the pregnant woman. Information obtained on prenatal care received in countries other than the United States and in languages other than English is permitted and should be used.	Access the most recent prenatal records available. If up-to-date records are not available, contact the prenatal care provider for the most current information. Count the prenatal visits recorded in the record. Exclude visits for laboratory and other tests or classes in which the mother was not seen by a physician or other health care professional for pregnancy-related care. If it is not clear whether the mother was seen by a physician or other health care professional, include the visit(s) in the total number. Count only visits recorded in the most current record available. <u>Do not estimate additional prenatal visits when the prenatal record is not up to date.</u> If the mother transferred prenatal care and records from previous providers are not available, count records from the most recent provider. Enter the total number of prenatal visits. If no visits are recorded, enter "0." If the number of prenatal visits is equal to 0, the "no prenatal care" box should also be checked for item "Date of first prenatal care visit." NOTE: If the mother is hospitalized for pregnancy-related reasons, check the hospital medical records for information on the mother's stay and count 1 visit for each week in the hospital. For example, if the hospital stay is 3 weeks, add 3 visits to the total number of visits; if less than one week (1-6 days), one visit should be added.	1st Prenatal care record <i>under</i>– Prenatal visit flow sheet (count visits)	PNC–Prenatal care

Definitions	Instructions	Sources	Keywords and abbreviations
8. Date last normal menses began (BC #30, FDFWS #8, FDR #32)			
The date the mother's last normal menstrual period began. This item is used to compute the gestational age of the infant.	Enter <u>all</u> known parts of the date the mother's last normal menstrual period began. Report "unknown" for any parts of the date that are missing. <u>Do not estimate the date.</u>	1st Prenatal care record <i>under</i>– • Menstrual history • Labor and delivery nursing admission triage form 2nd Admission history and physical (H&P) <i>under</i>–Medical history	LMP–Last menstrual period
9. Number of previous live births now living (BC #35a, FDFWS #9, FDR #29a)			
The total number of previous live-born infants now living.	<u>Do not include this infant.</u> Include all previous live-born <u>infants who are still living.</u> For multiple deliveries: Include all live-born infants <u>before</u> this infant in the pregnancy. <u>If the first born, do not include this infant.</u> If the second born, include the first born, etc. If no previous live-born infants, check "none." See "Attachment to the Facility Worksheet for the Live Birth Certificate for Multiple Births."	1st Prenatal care record <i>under</i>– • Intake information • Gravida section–L (living)–last number in series • Para section–L–last number in series • Pregnancy history information • Previous OB history • Past pregnancy history 2nd Labor and delivery nursing admission triage form <i>under</i>–Patient data 3rd Admission history and physical (H&P)	L–Now living <i>Look for:</i> G–Gravida–Total number of pregnancies P–Para–Previous live births and fetal deaths > 28 weeks of gestation T–Term–Delivered at 37 to 40 weeks gestation

Definitions	Instructions	Sources	Keywords and abbreviations
10. Number of previous live births now dead (BC #35b, FDFWS #10, FDR #29b)			
The total number of previous live-born infants now dead.	<u>Do not include this infant.</u> Include all previous live-born infants who are no longer living. For multiple deliveries: Include all live-born infants <u>before</u> this infant in the pregnancy who are now dead. If the first born, do not include this infant. If the second born, include the first born, etc. If no previous live-born infants now dead, check “none.” See “Attachment to the Facility Worksheet for the Live Birth Certificate for Multiple Births.”	1st Prenatal care record <i>under</i>– • Pregnancy history information– comments, complications • Previous OB history–comments, complications • Past pregnancy history–comments, complications 2nd Admission history and physical (H&P)	See above Expired
11. Date of last live birth (BC #35c, FDFWS #11, FDR #29c)			
The date of birth of the last live-born infant.	If applicable, enter the month and year. <u>Include live-born infants now living and now dead.</u> If date information is incomplete, enter all parts of the date that are known. Report “unknown” for any parts of the date that are missing. Do not estimate or guess a date.	1st Prenatal care record <i>under</i>– • Pregnancy history information– date • Previous OB history–date • Past pregnancy history–date 2nd Admission history and physical (H&P)	DOB–Date of birth

Definitions	Instructions	Sources	Keywords and abbreviations
12. Number of other pregnancy outcomes (BC #36a)			
Total number of other pregnancy outcomes that <u>did not result in a live birth</u>. Includes pregnancy losses of any gestational age. Examples: spontaneous or induced losses or ectopic pregnancy	Include all <u>previous</u> pregnancy losses <u>that did not result in a live birth</u>. If no previous pregnancy losses, check “none.” For multiple deliveries: Include any losses regardless of gestational age that occurred before the delivery of this infant. This could include losses occurring in this pregnancy or in a previous pregnancy.	1st Prenatal care record <i>under</i>– - Gravida section–“A” (abortion or miscarriage) - PARA section–“A” - Pregnancy history information–comments, complications - Previous OB history–comments, complications - Past pregnancy history–comments, complications 2nd Labor and delivery nursing admission triage form 3rd Admission history and physical (H&P)	Miscarriages Fetal demise AB–Abortion induced SAB–Spontaneous abortion TAB–Therapeutic abortion Abortion spontaneous Septic abortion Ectopic pregnancy Tubal pregnancy FDIU–Fetal death in utero IUFD–Intrauterine fetal death
13. Date of last other pregnancy outcome (BC #36b)			
The date the last pregnancy that <u>did not result in a live birth</u> ended. Includes pregnancy losses at any gestational age. Examples: spontaneous or induced losses or ectopic pregnancy	If applicable, enter the month and year. If date information is incomplete, enter all parts of the date that are known. Report “unknown” for any parts of the date that are missing. Do not estimate or guess a date.	1st Prenatal care record <i>under</i>– - Pregnancy history information - Previous OB history - Past pregnancy history 2nd Admission history and physical (H&P)	
14. Risk factors in this pregnancy (BC #41, FDFWS #14, FDR #36)			
Risk factors of the mother during this pregnancy.	Check all boxes that apply. The mother may have more than one risk factor. If the mother has none of the risk factors, check “none of the above.”	See below	See below

Definitions	Instructions	Sources	Keywords and abbreviations
14. Risk factors in this pregnancy (BC #41, FDFWS #14, FDR #36)—Continued			
Diabetes Glucose intolerance requiring treatment. Prepregnancy Diagnosis before this pregnancy. Gestational Diagnosis during this pregnancy.	If diabetes is present, check either prepregnancy or gestational diabetes. <u>Do not check both.</u>	1st Prenatal care record <i>under</i>– • Medical history • Previous OB history <i>under</i>–summary of previous pregnancies • Problem list <i>or</i>–initial risk assessment • Historical risk summary • Complications of previous pregnancies • Factors this pregnancy 2nd Labor and delivery nursing admission triage form <i>under</i>– • Medical complications • Comments 3rd Admission history and physical (H&P) <i>under</i>– • Current pregnancy history • Medical history • Previous OB history <i>under</i>–pregnancy related • Problem list or findings 4th Delivery record <i>under</i>– • Maternal OB or labor summary • Labor and delivery admission history • Labor summary record	Prepregnancy: DM–Diabetes mellitus Type 1 diabetes IDDM–Insulin dependent diabetes mellitus Type 2 diabetes Non-insulin dependent diabetes mellitus Class B DM Class C DM Class D DM Class F DM Class R DM Class H DM Gestational: GDM–Gestational diabetes mellitus IDGDM–Insulin dependent gestational diabetes mellitus Class A1 or A2 diabetes mellitus

Definitions	Instructions	Sources	Keywords and abbreviations
14. Risk factors in this pregnancy (BC #41, FDFWS #14, FDR #36)—Continued			
Hypertension Elevation of blood pressure above normal for age, sex, and physiological condition. Prepregnancy (chronic) Diagnosis prior to the onset of this pregnancy—<u>does not include gestational (pregnancy-induced hypertension [PIH])</u>. Gestational Diagnosis in this pregnancy (Pregnancy-induced hypertension or preeclampsia).	If hypertension is present, check either prepregnancy or gestational hypertension. <u>Do not check both.</u>	See Diabetes	Prepregnancy: CHT—Chronic hypertension Benign essential hypertension Essential hypertension Preexisting hypertension Gestational: PIH—Pregnancy-induced hypertension Preeclampsia Eclampsia Transient hypertension HELLP Syndrome
Eclampsia Hypertension with proteinuria <u>with</u> generalized seizures or coma. May include pathologic edema.	If eclampsia is present, one type of hypertension (either gestational or prepregnancy) may be checked.	See Diabetes	See Hypertension

Definitions	Instructions	Sources	Keywords and abbreviations
14. Risk factors in this pregnancy (BC #41, FDFWS #14, FDR #36)—Continued			
Previous preterm births History of pregnancy(ies) terminating in a <u>live birth</u> of less than 37 completed weeks of gestation.		1st Prenatal care record <i>under</i> – • Medical history • Previous OB history <i>under</i>–summary of previous pregnancies • Problem list <i>or</i>–initial risk assessment • Historical risk summary • Complications of previous pregnancies 2nd Labor and delivery nursing admission triage form <i>under</i> – • Medical complications • Comments 3rd Admission history and physical (H&P) <i>under</i> – • Medical history • Previous OB history <i>under</i>–pregnancy related • Problem list/findings	PTL–Preterm labor P–Premature

Definitions	Instructions	Sources	Keywords and abbreviations
14. Risk factors in this pregnancy (BC #41, FDFWS #14, FDR #36)—Continued			
Pregnancy resulted from infertility treatment Any assisted reproductive treatment used to initiate the pregnancy. Includes: - Drugs (e.g., Clomid or Pergonal) - Artificial insemination - Technical procedures (e.g., in vitro fertilization)	Check if any infertility treatment was used to initiate the pregnancy. This information is included on both the mother's and the facility worksheets. Check "yes" if treatment is reported on either worksheet.	1st Prenatal care record <i>under</i>– • Medical history • Current pregnancy history • Problem list <i>or</i>–initial risk assessment • Medications this pregnancy 2nd Labor and delivery nursing admission triage form <i>under</i>– • Comments • Medications 3rd Admission history and physical (H&P) <i>under</i>– • Current pregnancy history • Problem list/findings	See below
Fertility-enhancing drugs, artificial insemination, or intrauterine insemination Any fertility-enhancing drugs (e.g., Clomid or Pergonal), artificial insemination, or intrauterine insemination used to initiate the pregnancy.	Check if <u>specific</u> therapy (drugs or insemination) was used. This information is included on both the mother's and the facility worksheets. Check "yes" if treatment is reported on either worksheet.	See Pregnancy resulted from infertility treatment	Fertility-enhancing drugs, or artificial or intrauterine insemination: Medications Clomid, Serophene Pergonal Metrodin Profasi Progesterol Crinone (progesterone gel) Follistim FSH–Follicle stimulating hormone Gonadotropins Hcg–Human chorionic gonadotropin IUI– Intrauterine insemination

Definitions	Instructions	Sources	Keywords and abbreviations
14. Risk factors in this pregnancy (BC #41, FDFWS #14, FDR #36)—Continued			
Assisted reproductive technology (e.g., in-vitro fertilization [IVF] gamete intrafallopian transfer [GIFT]) Any assisted reproductive technology ([ART]/technical procedures [e.g., IVF, GIFT, or ZIFT]) used to initiate the pregnancy.	Check if <u>assisted reproductive therapy</u> was used. This information is included on both the mother's and the facility worksheets. Check "yes" if treatment is reported on either worksheet.	See Pregnancy resulted from infertility treatment	Assisted reproductive technology: ART Artificial insemination AIH—Artificial insemination by husband AID/DI—Artificial insemination by donor In vitro fertilization IVF-ET—In vitro fertilization embryo transfer GIFT—Gamete intrafallopian transfer ZIFT—Zygote intrafallopian transfer Ovum donation Donor embryo Embryo adoption
Mother had a previous cesarean delivery Previous delivery by extracting the fetus, placenta, and membranes through an incision in the mother's abdominal and uterine walls. If yes, how many? _____	If the mother has had a <u>previous</u> cesarean delivery, indicate the number of previous cesarean deliveries she has had.	1st Prenatal care record <i>under</i>— • Past pregnancy history • Past OB history • Problem list <i>or</i>—initial risk assessment 2nd Labor and delivery nursing admission triage form <i>under</i>— Comments 3rd Admission history and physical (H&P) <i>under</i>— • Past OB history • Past pregnancy history <i>under</i>—problem list/findings	C/S—Cesarean section Repeat C/S VBAC—Vaginal delivery after cesarean LSTCS (or LTCS) low segment transverse cesarean section Classical cesarean section Low vertical C/S Low transverse C/S <i>Look for:</i> TOL—Trial of labor

Definitions	Instructions	Sources	Keywords and abbreviations
15. Infections present and/or treated during this pregnancy (BC #42)			
Infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.	Check all boxes that apply. The mother may have more than one infection. If the mother has none of the infections, check “none of the above.”	See below	“+” indicates that the test for the infection was positive and the woman has the infection. “-” indicates that the test was negative, and the woman does not have the infection. <i>Look for:</i> treatment or Rx for specific infection.
Gonorrhea A positive test or culture for <i>Neisseria gonorrhoeae</i>.		1st Prenatal record <i>under</i>– • Infection history • Sexually transmitted diseases • Problem list • Complications this pregnancy • Factors this pregnancy • Medical history 2nd Labor and delivery nursing admission triage form <i>under</i>– Comments 3rd Admission history and physical (H&P) <i>under</i>– • Current pregnancy history • Medical history • Problem list/findings 4th Delivery record <i>under</i>– • Maternal OB/labor summary • Labor and delivery admission history	GC Gonorrheal Gonococcal Treatment or Rx for Gonorrhea NAAT–Nucleic amplification tests

Definitions	Instructions	Sources	Keywords and abbreviations
15. Infections present and/or treated during this pregnancy (BC #42)—Continued			
Syphilis (also called lues) A positive test for <i>Treponema pallidum</i> .		See Gonorrhea	TP-PA–T. pallidum particle agglutination STS–Serologic test for syphilis RPR–Rapid plasma regain VDRL–Venereal disease research laboratories FTA-AS–Fluorescent antibody test Lues Treatment or Rx for syphilis or lues
Chlamydia A positive test for <i>Chlamydia trachomatis</i> .		See Gonorrhea	Treatment or Rx for chlamydia
Hepatitis B (HBV, serum hepatitis) A positive test for the hepatitis B virus.		See Gonorrhea	Hep B HBV Treatment or Rx for hepatitis B
Hepatitis C (non A or non B hepatitis [HCV]) A positive test for the hepatitis C virus.		See Gonorrhea	Hep C HCV Treatment or Rx for hepatitis C

Definitions	Instructions	Sources	Keywords and abbreviations
16. Obstetric procedures (BC #43)			
Medical treatment or invasive or manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor or delivery.	If the mother has had none of the procedures, check "none of the above."	See below	See below
External cephalic version Attempted conversion of a fetus from a nonvertex to a vertex presentation by external manipulation. <i>Successful</i> Fetus was converted to a vertex presentation. <i>Failed</i> Fetus was not converted to a vertex presentation.	If checked, also indicate whether the procedure was a success or a failure. If more than one attempt, report results of most recent attempt.	1st Prenatal care record <i>under</i>– • Problem list • Historical risk summary • Complications this pregnancy • Factors this pregnancy 2nd Labor and delivery nursing admission triage form <i>under</i>– • Complications • Comments 3rd Admission history and physical (H&P) <i>under</i>– • Current pregnancy history • Medical history • Problem list/findings 4th Delivery record <i>under</i>– • Maternal OB/labor summary • Labor and delivery admission history • Labor summary record	Successful version: Breech version External version Failed version: Unsuccessful external version Attempted version Failed version <i>Look for:</i> malpresentation

Definitions	Instructions	Sources	Keywords and abbreviations
LABOR AND DELIVERY			
17. Date of birth (BC #4, FDFWS #16, FDR #4)			
The infant's date of birth.	Enter the month, day, and four-digit year of birth. If the date of birth of the infant is unknown because the infant is a foundling, enter the date the infant was found.	1st Labor and delivery <i>under-Delivery</i> record 2nd Newborn admission H&P	DOB – Date of birth
18. Time of birth (BC #2, FDFWS #17, FDR #2)			
The infant's time of birth.	Enter the time the infant was born based on a 24-hour clock (military time). If time of birth is unknown (foundling), enter "unknown."	1st Labor and delivery <i>under-Delivery</i> record 2nd Newborn admission H&P	
19. Certifier's name and title (BC #11)			
The individual who certified to the fact that the birth occurred: M.D. (doctor of medicine) D.O. (doctor of osteopathy) Hospital administrator or designee CNM/CM (certified nurse midwife or certified midwife, includes APRN) Other midwife (midwife other than CNM/CM, includes CPM) Other (specify)	Enter the name and title of the individual who certified to the fact that the birth occurred. The individual may be, <u>but need not be</u> , the same as the attendant at birth.		
20. Date certified (BC #12)			
The date the birth was certified.	Enter the date the birth was certified.		

Definitions	Instructions	Sources	Keywords and abbreviations
21. Principal source of payment (BC #38)			
The primary source of payment for the delivery at the time of delivery: Private insurance (Blue Cross/Blue Shield, Aetna, etc.) Medicaid (or a comparable state program) Self-pay (no third party identified) Other (Indian Health Service; CHAMPUS or TRICARE; other government [federal, state, or local]; or charity) The principal source of payment is important public health information and is needed to monitor access to care during delivery.	Check the box that best describes the primary source of payment for this delivery. If more than one source of payment for the delivery is recorded, choose the source that appears to pay for most of the delivery. Check the source of payment for the delivery, not the payer for the newborn care or prenatal care, if different. <u>If “other” is checked, specify the payer.</u> If the principal source of payment is not known, enter “unknown” in the space. If unsure what source of payment a given insurance falls under, check with the billing office.	1st Hospital face sheet 2nd Admitting office face sheet	
22. Infant’s medical record number (BC #48)			
The medical record number assigned to the newborn.	Enter the medical record number.	1st Infant’s medical record 2nd Admitting office face sheet <i>under</i>–History number	

Definitions	Instructions	Sources	Keywords and abbreviations
23. Was the mother transferred to this facility for maternal medical or fetal indications for delivery? (BC #28)			
Transfers include hospital to hospital, birth facility to hospital, etc. Does not include home to hospital.	If the mother was transferred from another <u>facility</u> to this facility for medical reasons related to the pregnancy, check “yes.” If yes, enter the name of the facility the mother was transferred from. If the name of the facility is not known, enter “unknown.” Check “no” if the mother was transferred from home.	1st Labor and delivery nursing admission triage form <i>under-</i> • Reason for admission • Comments 2nd Admission history and physical (H&P) 3rd Labor & delivery – Delivery record • Maternal OB/labor summary • Labor and delivery admission history • Labor summary record	

Definitions	Instructions	Sources	Keywords and abbreviations
24. Attendant's name, title, and ID (BC #27, FDFWS #21, FDR #14)			
The name, title, and National Provider Identifier (NPI) number of the person responsible for delivering the child. M.D. (doctor of medicine) D.O. (doctor of osteopathy) CNM/CM (certified nurse midwife or certified midwife, includes APRN) Other midwife (midwife other than CNM/CM, includes CPM) Other (specify) The attendant at birth is the individual <u>physically present</u> 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 <u>is present</u> in the delivery room, the obstetrician should be reported as the attendant. If the obstetrician is not physically present, the intern or nurse midwife <u>must</u> be reported as the attendant.	Enter the name, title, and NPI number of the person responsible for delivering the child. Check one box to specify the attendant's title. If "other" is checked, enter the specific title of the attendant. Examples include nurse, father, police officer, and EMS technician. This item should be completed by the facility. If the birth did not occur in a facility, the attendant or certifier should complete it.	1st Delivery record <i>under</i>–Signature of delivery attendant (medical)	
25. Mother's weight at delivery (BC #33)			
The mother's weight at the time of delivery.	Enter the mother's weight at the time of delivery. Use pounds in whole numbers only. For example, enter 140½ pounds as 140 pounds. If the mother's delivery weight is unknown, enter "unknown."	1st Labor and delivery nursing admission triage form <i>under</i>–Physical assessment–Weight 2nd Admission history and physical (H&P) <i>under</i>–Physical examination–Weight	Wgt–Weight

Definitions	Instructions	Sources	Keywords and abbreviations
26. Characteristics of labor and delivery (BC #45)			
Information about the course of labor and delivery.	Check all characteristics that apply. If none of the characteristics of labor and delivery apply, check “none of the above.”	See below	See below
Induction of labor Initiation of uterine contractions by medical or surgical means for the purpose of delivery before the spontaneous onset of labor (<i>i.e., before labor has begun</i>). Examples of methods include, but are not limited to: artificial rupture of membranes, balloons, oxytocin, prostaglandin, laminaria, or other cervical ripening agents.	Check this item if medication was given or procedures to induce labor were performed <u>before</u> labor began. If it is not clear whether medication or procedures were performed before or after labor had begun, review records to determine when labor began and when medications were given or procedures performed. If this information is unclear or unavailable, check with the birth attendant. Induction of labor should be checked even if the attempt to initiate labor is not successful or the induction follows a spontaneous rupture of the membrane without contractions. NOTE: Does not include augmentation of labor, which applies only after labor or contractions have begun. Do not report augmentation of labor if induction of labor is reported.	1st Delivery record <i>under</i>-Maternal OB/labor summary • Labor and delivery admission history • Labor summary record 2nd Physician progress note 3rd Labor and delivery nursing admission triage form	IOL–Induction of labor Pit Ind–Pitocin induction ROM/NIL–Amniotomy induction or induction for rupture of membranes, not in labor AROM–Artificial rupture of membranes done before labor Balloons Oxytocin Prostaglandin Laminaria Cervidil

Definitions	Instructions	Sources	Keywords and abbreviations
26. Characteristics of labor and delivery (BC #45)—Continued			
Augmentation of labor Stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time of delivery (i.e., <u>after labor has begun</u>).	Check this item if medication was given or procedures to augment labor were performed <u>after</u> labor began. If it is not clear whether medication or procedures were performed before or after labor had begun, review records to determine when labor began and when medications were given or procedures performed. If this information is unclear or unavailable, check with the birth attendant. NOTE: Do not include if induction of labor was performed. Do not report induction of labor if augmentation of labor is reported.	Same as 1st and 2nd sources for Induction of labor	Pit stim–Pitocin stimulation Pit aug–Pit augmentation AROM–Artificial rupture of membranes done during labor Cervidil
Steroids (glucocorticoids) for fetal lung maturation received by the mother before delivery Steroids received by the mother prior to delivery to accelerate fetal lung maturation. Typically administered in anticipation of preterm (less than 37 completed weeks of gestation) delivery. Steroids include: betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation. Does not include steroid medication given to the mother for anti-inflammatory treatment before or after delivery.	Three conditions must be met for this item. Check this item when 1) steroid medication was given to the mother 2) prior to delivery 3) for fetal lung maturation. Steroids may be administered to the mother prior to admittance to the hospital for delivery. Review the mother's prenatal care and other hospital records for mention of steroid administration for this purpose.	1st Delivery record <i>under</i> – • Maternal OB/labor summary–comments • Labor summary record–comments 2nd Maternal medication record 3rd Newborn admission H&P 4th Maternal physician order sheet 5th Prenatal care records	Medications (before delivery): Betamethasone (Celestone) Betamethasone phosphate Beta-P04 Betamethasone acetate Beta-Ac Dexamethasone

Definitions	Instructions	Sources	Keywords and abbreviations
26. Characteristics of labor and delivery (BC #45)—Continued			
Antibiotics received by the mother during delivery Includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery. Includes: Ampicillin Penicillin Clindamycin Erythromycin Gentamicin Cefotaxime Ceftriaxone	Mother should have undergone labor, regardless of method of delivery; antibiotics administered solely for surgery such as cesarean delivery should not be reported. Check the timing of the administration of the antibacterial medications. Check this item only if medications were received systemically by the mother during labor. If information on onset of labor cannot be determined from the records, check with the birth attendant.	See steroids (glucocorticoids)	Medications (during delivery): Ampicillin Penicillin Clindamycin Erythromycin Gentamicin Cefotaxime Ceftriaxone Vancomycin <i>Look for:</i> SBE (sub-acute bacterial endocarditis) prophylaxis GBS positive or GBS + (Group B streptococcus) Maternal fever Mother febrile
Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{C}$ (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 or irritability, leukocytosis, fetal tachycardia, maternal tachycardia, or malodorous vaginal discharge. Any recorded maternal temperature at or above 38°C (100.4°F).	Check that recorded maternal temperature is at or above 38°C (100.4°F).	1st Delivery record <i>under</i>– - Maternal OB/labor summary– comments/complications - Labor summary record– comments/complications 2nd Newborn admission H&P 3rd Physician progress note 4th Maternal vital signs record <i>under</i>–Temperature recordings	Chorioamnionitis Chorio Temp $> 38^{\circ}\text{C}$ or 100.4°F <i>Look for:</i> Maternal fever Mother febrile

Definitions	Instructions	Sources	Keywords and abbreviations
26. Characteristics of labor and delivery (BC #45)—Continued			
Epidural or spinal anesthesia during labor Administration to the mother of a regional anesthetic to control the pain of labor. Delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.	Mother should have undergone labor, regardless of method of delivery; anesthesia administered solely for surgery such as cesarean delivery should not be reported.	1st Delivery record <i>under</i> – • Maternal OB labor summary <i>under</i> –analgesia or anesthesia • Labor summary record <i>under</i> –analgesia or anesthesia	Epidural analgesia Epid. given Spinal given
27. Method of delivery (BC #46, FDFWS #23, FDR #38)			
The physical process by which the complete delivery of the fetus was affected.	Complete sections C and D.	See below	See below
C. Fetal presentation at birth <i>Cephalic</i> —presenting part of the fetus listed as vertex, occiput anterior (OA), or occiput posterior (OP). <i>Breech</i> —presenting part of the fetus listed as breech, complete breech, frank breech, or footling breech. <i>continued on next page</i>	Check <u>one</u> of the three boxes. Check only the final presentation at birth.	1st Delivery record <i>under</i> –Fetal birth presentation	Cephalic: Vertex–OA, OP, LOA, ROA, LOP, ROP, LOT, ROT Face–LMA, LMT, LMP, RMA, RMP, RMT Brow Sinciput Mentum–chin Breech: (Buttocks, sacrum) Frank breech–LSA, LST, LSP, RSP, RST Single footling breech Double footling breech Complete breech <i>continued on next page</i>

Definitions	Instructions	Sources	Keywords and abbreviations
27. Method of delivery (BC #46, FDFWS #23, FDR #38)—Continued			
C. Fetal presentation at birth—Continued <i>Other</i> —any other presentation not listed above.	See above	See above	Other: Shoulder Transverse lie Funis Compound (i.e., vertex with hand)
D. Final route and method of delivery <i>Vaginal/spontaneous</i> Delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant. <i>Vaginal/forceps</i> Delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head. <i>Vaginal/vacuum</i> Delivery of the fetal head through the vagina by the application of a vacuum cup or ventouse to the fetal head. <i>Cesarean</i> Extraction of the fetus, placenta, and membranes through an incision in the maternal abdominal and uterine walls.	Check <u>one</u> of the boxes.	1st Delivery record <i>under</i> —Method of delivery 2nd Newborn admission H&P 3rd Recovery room record <i>under</i> —Maternal data—Delivered	Vaginal/spontaneous: VAG Del—Vaginal delivery SVD—Spontaneous vaginal delivery Vaginal/forceps: LFD—Low forceps delivery Vaginal/vacuum: Vac Ext vacuum Cesarean: C/S—Cesarean section LSTCS—Low segment transverse <i>Look for:</i> TOL—Trial of labor

Definitions	Instructions	Sources	Keywords and abbreviations
27. Method of delivery (BC #46, FDFWS #23, FDR #38)—Continued			
If cesarean, was a trial of labor attempted? Labor was allowed, augmented, or induced with plans for a vaginal delivery.	Check “yes” or “no.”		TOL–Trial of labor
28. Maternal morbidity (BC #47, FDFWS #24, FDR #39)			
Serious complications experienced by the mother associated with labor and delivery.	Check all boxes that apply. If the mother has none of the complications, check “none of the above.”	See below	See below
Maternal transfusion Includes infusion of whole blood or packed red blood cells associated with labor and delivery.		1st Delivery record <i>under</i> – • Labor summary • Delivery summary 2nd Physician delivery notes or Operative notes 3rd Intake & output form	Transfused Blood transfusion <i>Look for:</i> PRBC–Packed red blood cells Whole blood
Third- or fourth-degree perineal laceration 3° laceration extends through the perineal skin, vaginal mucosa, perineal body, and partially or completely through the anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.		1st Delivery record <i>under</i> – • Episiotomy section • Lacerations section 2nd Recovery room record <i>under</i> – Maternal data–Delivered	4th degree lac. 4° LAC degree 3rd degree lac. 3° LAC degree 3a 3b 3c

Definitions	Instructions	Sources	Keywords and abbreviations
28. Maternal morbidity (BC #47, FDFWS #24, FDR #39)—Continued			
Ruptured uterus Tearing of the uterine wall. Uterine rupture is a full-thickness disruption of the uterine wall that also involves the overlying visceral peritoneum (uterine serosa). Does not include uterine dehiscence (window), in which the fetus, placenta, and umbilical cord remain contained with the uterine cavity. Does not include a silent or incomplete rupture or an asymptomatic separation.		1st Delivery record <i>under</i> – • Delivery summary note– • Comments or Complications 2nd Operative note 3rd Physician progress note	
Unplanned hysterectomy Surgical removal of the uterus that was not planned before the admission. Includes an anticipated, but not definitively planned, hysterectomy.		See Ruptured uterus	Hysterectomy <i>Look for:</i> laparotomy
Admission to an intensive care unit Any admission, planned or unplanned, of the mother to a facility or unit designated as providing intensive care.		1st Physician progress note 2nd Transfer note	ICU–Intensive care unit MICU–Medical intensive care unit SICU–Surgical intensive care unit L&D ECU–Labor and delivery emergency care unit

Definitions	Instructions	Sources	Keywords and abbreviations
NEWBORN INFORMATION			
29. Birthweight or weight of fetus (BC #49, FDFWS #25, FDR #18c)			
The weight of the infant at birth.	Enter the weight (in grams) of the infant at birth. Do not convert pounds (lbs.) and ounces (oz.) to grams. If the weight in grams is unavailable, enter the birth weight in lbs. and oz.	1st Delivery record <i>under</i> – Infant data	BW–Birthweight Gms–Grams kg–Kilograms Lbs–Pounds oz–Ounces
30. Obstetric estimate of gestation at delivery (BC #50, FDFWS #26, FDR #18d)			
The <u>best</u> obstetric estimate of the infant's gestational age (OE) <u>in completed weeks</u> is based on the clinician's final estimate of gestation. For the clinician: The best estimated delivery date (EDD) is determined by the date of the last menstrual period (LMP) if confirmed by early ultrasound. If ultrasound is not performed or is unknown, the best EDD is determined by the LMP. If the LMP is unknown or inconsistent with the early ultrasound, the best EDD is determined by early ultrasound. For deliveries resulting from the use of assisted reproductive technology, the best EDD is based on the known date of fertilization.* Accurate pregnancy dating is important to improve outcomes and is a research and public health imperative. The best estimated due date should be documented clearly in the medical records.* <i>continued on next page</i>	For the nonclinician: Enter the final <u>best</u> obstetric estimate of the infant's gestational age in <u>completed weeks</u>. The OE should be based on the clinician's estimate of gestational age at delivery. Look for the most recent gestational age estimate in the records (this can often be found in the labor and delivery records under "gestational age"). If the most recent gestational age is dated on or after the infant's date of delivery, enter this estimate. If the most recent gestational age is dated <u>before</u> the date of delivery, add the number of days between the most recent gestational age and the date of delivery to the gestational age estimate. For example, if the most recent gestational age in the records is 32 weeks, 5 days and is dated 3/24, and the date of delivery is 3/31, add 7 days to the gestational age for the final total of 33 weeks, 5 days. <i>continued on next page</i>	1st OB admission H&P <i>under</i>– • Weeks • Gestational age	Gestation _____ weeks (wks) _____ weeks gestational age GA–Gestational age EGA–Estimated gestational age

Definitions	Instructions	Sources	Keywords and abbreviations
30. Obstetric estimate of gestation at delivery (BC #50, FDFWS #26, FDR #18d)—Continued			
* Adopted from: ACOG reVITALize “Obstetric Data Definitions” (available from: https://www.acog.org/-/media/Departments/Patient-Safety-and-Quality-Improvement/2014reVITALizeObstetricDataDefinitionsV10.pdf) and “Method for Estimating Due Date” (available from: https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Methods-for-Estimating-the-Due-Date).	The gestational age for the OE is reported in completed weeks. If the OE includes a fraction of a week (e.g., 33 weeks, 5 days) always <u>round down</u> to the nearest whole week (e.g., 33 weeks). If a final best obstetric estimate of gestation cannot be found, search for the best obstetrical estimated due date (EDD) and calculate the OE as shown below. If both the EDD and the OE are not known, enter “unknown.” If the date of delivery occurs before the EDD, then use the following calculation: 1) Find the most recent best EDD (this may only be found in the prenatal care records) and the date of delivery. 2) Calculate the difference between the EDD and the date of delivery in days (e.g., EDD of 1/7/2015 – date of delivery of 12/30/2014 = 8 days). 3) <u>Subtract</u> difference between the EDD and the date of delivery from 280 days (e.g., 280 days – 8 days = 272 days). 4) Divide the total number of days from step 3 by 7 days (e.g., 272 days ÷ 7 days = 38.9 weeks) to determine the OE in weeks. 5) Enter the OE in <u>completed weeks</u> (e.g., 38 weeks). <i>continued on next page</i>	See above	See above

Definitions	Instructions	Sources	Keywords and abbreviations
30. Obstetric estimate of gestation at delivery (BC #50, FDFWS #26, FDR #18d)—Continued			
See above	If the date of delivery occurs after the EDD, then use the following calculation: 1) Find the most recent best EDD (this may only be found in the prenatal care records) and the date of delivery. 2) Calculate the difference between the date of delivery and EDD in days (e.g., date of delivery of 1/5/2015 – EDD of 12/28/2014 = 8 days). 3) <u>Add</u> the difference between the date of delivery and the EDD to 280 days (e.g., 280 + 8 = 288 days). 4) Divide the total number of days from step 3 by 7 days (e.g., 288 days ÷ 7 days = 41.1 weeks) to determine the OE in weeks. 5) Enter the OE in <u>completed weeks</u> (e.g., 41 weeks).	See above	See above
31. Sex of child (BC #3, FDFWS #27, FDR #3)			
The sex of the infant.	Enter whether the infant is male, female, or if the sex of the infant is ambiguous, enter “unknown.”	1st Delivery record <i>under</i> – Infant data	M–Male F–Female A–Ambiguous or Not yet determined (same as unknown) U–Unknown

Definitions	Instructions	Sources	Keywords and abbreviations
32. Apgar score (BC #51)			
A systematic measure for evaluating the physical condition of the infant at specific intervals following birth.	Enter the infant's Apgar score at 5 minutes. If the score at 5 minutes is less than 6, enter the infant's Apgar score at 10 minutes.	1st Delivery record <i>under</i> –Infant data	
33. Plurality (BC #52, FDFWS #28, FDR #33)			
The number of fetuses delivered live or dead at any time in the pregnancy regardless of gestational age, or if the fetuses were delivered at different dates in the pregnancy. “Reabsorbed” fetuses/“vanishing twin” (those that are not delivered: expelled or extracted from the mother) <u>should not</u> be counted.	Enter the number of fetuses delivered in this pregnancy. If two or more live births in this delivery, see “Attachment to the Facility Worksheet for the Live Birth Certificate for Multiple Births.”	1st Delivery record 2nd Admission history and physical (H&P)	Single Twin, triplet, quadruplet, etc. Multiple (a, b, c ...) or (1, 2, 3 ...)
34. If not a single birth, order born in the delivery (BC #53, FDFWS #29, FDR #34)			
The order born in the delivery, live born or fetal death (1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.).	If this is a single birth, leave this item blank. Include all live births and fetal deaths from this pregnancy.	1st Delivery record <i>under</i> –Birth order 2nd Infant data	Baby A, B, or Baby 1, 2, etc. Twin A, B, or Twin 1, 2 Triplet A, B, C, or Triplet 1, 2, 3, etc. <i>Look for:</i> Birth order or Set order
35. If not a single birth, number of infants in the delivery born alive (FDFWS #30)			
The number of infants in this delivery <u>born alive</u> at any point in the pregnancy.	If this is a single birth, leave this item blank. If this is not a single birth, specify the number of infants in this delivery born alive at any point in the pregnancy. Include this birth.	1st Delivery record 2nd Admission history and physical (H&P)	<i>Look for:</i> Condition

Definitions	Instructions	Sources	Keywords and abbreviations
36. Abnormal conditions of the newborn (BC #54)			
Disorders or significant morbidity experienced by the newborn.	Check all boxes that apply. If none of the conditions apply, check "none of the above."	See below	See below
Assisted ventilation required immediately following delivery Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth. Excludes free-flow (blow-by) oxygen only, laryngoscopy for aspiration of meconium, nasal cannula, and bulb suction.		1st Labor delivery summary <i>under</i> – Infant Data or Breathing	Bag and mask ventilation Intubation Intubation and PPV–Positive pressure ventilation PPV bag/mask or ET–Positive pressure ventilation via bag, mask, or endotracheal intubation IPPV bag–Intermittent positive pressure ventilation via bag IPPV ET–Intermittent positive pressure ventilation via endotracheal intubation O2 via ET–Oxygen via endotracheal intubation Oxygen

Definitions	Instructions	Sources	Keywords and abbreviations
36. Abnormal conditions of the newborn (BC #54)—Continued			
Assisted ventilation required for more than six hours Infant given mechanical ventilation (breathing assistance) by any method for more than six hours. Includes conventional, high frequency, or continuous positive pressure (CPAP). Excludes free-flow oxygen only, laryngoscopy for aspiration of meconium, and nasal cannula.	Count the number of hours of mechanical ventilation given.	1st Newborn respiratory care flow sheet	If in use for more than 6 hours: CPAP—Continuous positive airway pressure IPPV—Intermittent positive pressure ventilation HFV—High frequency ventilation IMV—Intermittent mandatory volume ventilation HFOV—High frequency oscillatory ventilation IPPV—Intermittent positive pressure ventilation PIP—Peak inspiratory pressure PEEP—Positive end expiratory pressure CMV—Continuous mandatory ventilation HFPPV—High frequency positive pressure ventilation HFFI—High frequency flow interruption ventilation HFJV—High frequency jet ventilation Inhaled nitric oxide

Definitions	Instructions	Sources	Keywords and abbreviations
36. Abnormal conditions of the newborn (BC #54)—Continued			
NICU admission Admission into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.	Include NICU admission at any time during the infant's hospital stay following delivery. Do not include units that do not provide continuous mechanical ventilation. Do not include well-baby nurseries or special care nurseries (i.e., Level II nursery). Do not include if the newborn was taken to the NICU for observation but is not admitted to the NICU.	1st Labor and delivery summary record <i>under</i> —Disposition <i>under</i> — • Intensive care nursery (ICN)	ICN—Intensive care nursery NICU—Neonatal intensive care unit PICU—Pediatric intensive care unit
Newborn given surfactant replacement therapy Endotracheal instillation of a surface-active suspension for treating surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.	Check both 1st and 2nd sources before completion.	1st Labor and delivery summary <i>under</i> —Neonatal medication 2nd Newborn medication administration record	If given to newborn after birth: Medications (given to newborn): Surfactant Survanta Exosurf Curosurf Infasurf
Antibiotics received by the newborn for suspected neonatal sepsis Any antibacterial drug (penicillin, ampicillin, gentamicin, cefotaxime, etc.) given systemically (intravenous or intramuscular). Does not include antibiotics given to infants who are <u>not</u> suspected of having neonatal sepsis.		1st Newborn medication administration record	Medications (given to newborn for sepsis): Nafcillin, Chloramphenicol Penicillin, Penicillin G Ampicillin, Gentamicin, Kanamycin, Cefotaxime, Cefoxitin, Vancomycin, Acyclovir, Amikacin, Ceftazidime, Ceftriaxone, Cefazolin

Definitions	Instructions	Sources	Keywords and abbreviations
36. Abnormal conditions of the newborn (BC #54)—Continued			
Seizure or serious neurologic dysfunction Seizure is any involuntary repetitive, convulsive movement or behavior. Serious neurologic dysfunction is severe alteration of alertness. Excludes: - Lethargy or hypotonia in the absence of other neurologic findings - Symptoms associated with CNS congenital anomalies		1st Newborn H&P 2nd Physician progress notes <i>under</i> -Neuro examination	Seizures Tonic/Clonic/Clonus Twitching Eye rolling Rhythmic jerking Hypotonia Obtundation Stupor Coma HIE-Hypoxic-ischemic encephalopathy
37. Congenital anomalies of the newborn (BC #55)			
Malformations of the newborn diagnosed prenatally or after delivery.	Check all boxes that apply.	See below	See below
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).		1st Labor and delivery summary record <i>under</i> -Infant data 2nd Newborn admission H&P	Anencephalus Acrania Absent brain Craniorachischisis Exencephaly Hydraencephaly

Definitions	Instructions	Sources	Keywords and abbreviations
37. Congenital anomalies of the newborn (BC #55)—Continued			
Meningomyelocele/Spina bifida Spina bifida is herniation of the meninges 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. <u>Do not include</u> spina bifida occulta (a midline bony spinal defect without protrusion of the spinal cord or meninges).		See Anencephaly	Meningocele Rachischisis
Cyanotic congenital heart disease Congenital heart defects that cause cyanosis.		1st Physician progress notes <i>under</i> — • Circulation • Cardiovascular	TGA—Transposition of the great arteries TOF—Tetralogy of Fallot Pulmonary or pulmonic valvular atresia Tricuspid atresia Truncus arteriosus TAPVR—Total/partial anomalous pulmonary venous return with or without obstruction COA—Coarctation of the aorta HLHS—Hypoplastic left heart syndrome IAA—Interrupted aortic arch

Definitions	Instructions	Sources	Keywords and abbreviations
37. Congenital anomalies of the newborn (BC #55)—Continued			
Congenital diaphragmatic hernia Defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.		1st Infant H&P 2nd Labor and delivery summary record <i>under</i> –Infant data	
Omphalocele A defect in the anterior abdominal wall in which the umbilical ring is widened, allowing herniation of abdominal organs into the umbilical cord. The herniating organs are covered by a nearly transparent membranous sac (different from gastroschisis [see below]), although this sac may rupture. Also called exomphalos. <u>Do not include</u> umbilical hernia (completely covered by skin) in this category.		1st Labor and delivery summary record <i>under</i> –Infant data 2nd Admission history and physical (H&P) <i>under</i> –G.I.	Exomphalos
Gastroschisis An abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and the absence of a protective membrane.		See Omphalocele	

Definitions	Instructions	Sources	Keywords and abbreviations
37. Congenital anomalies of the newborn (BC #55)—Continued			
Limb reduction defect excluding congenital amputation and dwarfing syndromes. Complete or partial absence of a portion of an extremity, secondary to failure to develop.		1st Labor and delivery summary record <i>under</i> —Infant data 2nd Newborn H&P	<i>Look for:</i> Amniotic bands ABS—Amniotic band syndrome
Cleft lip with or without cleft palate Incomplete closure of the lip. May be unilateral, bilateral, or median.		See Limb reduction defect	Cleft lip (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 category above.		See Limb reduction defect	
Down syndrome Trisomy 21—A chromosomal abnormality caused by the presence of all or part of a third copy of chromosome 21. <i>Karyotype confirmed</i> <i>Karyotype pending</i>	Check if a diagnosis of Down syndrome, Trisomy 21 is confirmed or pending.	1st Infant progress notes 2nd Genetic consult	Trisomy 21 Positive (confirmed) Possible Down (pending) Rule out (R/O) Down (pending) Trisomy 21 mosaicism

Definitions	Instructions	Sources	Keywords and abbreviations
37. Congenital anomalies of the newborn (BC #55)—Continued			
Suspected chromosomal disorder Includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure. <i>Karyotype confirmed</i> <i>Karyotype pending</i>	Check if a diagnosis of a suspected chromosomal disorder is confirmed or pending. (May include Trisomy 21.)	See Down syndrome	Trisomy and then a number such as: 13–Patau syndrome 17 or 18–Edward syndrome Positive (confirmed) Possible trisomy ____ (pending) Rule out (R/O) (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) - Third degree (on the penile shaft)		1st Labor and delivery summary <i>under</i> –Infant data 2nd Newborn H&P <i>under</i> –Genitourinary (GU)	

Definitions	Instructions	Sources	Keywords and abbreviations
38. Was the infant transferred within 24 hours of delivery? (BC #56)			
Transfer status of the infant from this facility to another within 24 hours after delivery.	Check “yes” if the infant was transferred from this facility to another within 24 hours of delivery. Enter the name of the facility to which the infant was transferred. If the name of the facility is not known, enter “unknown.” If the infant was transferred more than once, enter the name of the first facility to which the infant was transferred.	1st Infant progress notes 2nd Transfer form	<i>Look for:</i> Disposition
39. Is infant living at time of the report? (BC #57)			
Information on the infant’s survival.	Check “yes” if the infant is living. Check “yes” if the infant has already been discharged to home care. Check “no” if it is known that the infant has died. If the infant has died, make sure that a death certificate is filed. If the infant was transferred and the status is known, indicate the known status.	1st Infant progress notes	

Definitions	Instructions	Sources	Keywords and abbreviations
40. Is the infant being breastfed at discharge? (BC #58)			
Information on whether the infant was receiving breastmilk or colostrum during the period between birth and discharge from the hospital. Breastfeeding refers to the establishment of breastmilk through the action of breastfeeding or pumping (expressing). Include any attempt to establish breastmilk production during the period between birth and discharge from the hospital. Include if the infant received formula in addition to being breastfed. Does <u>not</u> include the intent to breastfeed.	Check “yes” if the infant was breastfed at any time before being discharged from the hospital or received breast milk (including donor milk) between breastfed and at any time. Check “no” if the infant was not breastfed or did not receive breast milk before being discharged from the hospital.	1st Labor and delivery summary record <i>under</i>–Infant data 2nd Maternal progress note 3rd Newborn flow record <i>under</i>–Feeding 4th Lactation consult	Pumping Lactation consultation LATCH score (Latch on, Audible swallow, Type of nipple, Comfort, and Help—used to measure position and attachment of the baby on the breast) Breast pump Breast pump protocol Breast milk MM–Mother’s milk FBM–Fresh breast milk Attempt to breastfeed
41. Method of disposition* (FDFWS #32, FDR #13)			
Burial Cremation Hospital disposition Donation Removal from state Other (specify) * Applicable to fetal deaths only.	Check only one method.	1st Labor and delivery summary record <i>under</i>–Infant data 2nd Nursing note 3rd Attending death note 4th Social work note	

The use of trade names is for identification only and does not imply endorsement by the Centers for Disease Control and Prevention,
U.S. Department of Health and Human Services.

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