STATE OF NEW JERSEY

Birth Worksheet

State File Number: _____

ADMISSION

***Record Type (Select One):**
☐ Born at this facility – Labor and Delivery
☐ Born at this facility – Not in Labor and Delivery
☐ Home Birth – intended
☐ Born en-route/Non-Birthing Facility
☐ Home Birth – Unintended
☐ Foundling/Safe Haven

***Mother's Current Legal Name** _____ (FIRST) _____ (MIDDLE) _____ (LAST)

Current Legal Suffix _____ **Date of Birth** _____ (MM/DD/YYYY) **Age** _____

***Date of Admission** _____ (MM/DD/YYYY) **Time of Admission** ____ : ____ (HH MM) ***Mother's Medical Record Number** _____

Was mother transferred into this facility? ☐ Yes ☐ No ☐ Unknown **If 'YES' from which facility?** _____

Principal Source of Payment ☐ Medicaid/NJ Family Care ☐ Private Insurance ☐ Self-Pay/Charity Care ☐ Other _____

Insurance Policy Holder ☐ Mother policy holder ☐ Father policy holder ☐ Both parents have coverage

Mother's Insurance Carrier _____ **Mother's Insurance Policy Number** _____

Father's Insurance Carrier _____ **Father's Insurance Policy Number** _____

Did Mother participate in WIC during pregnancy? ☒ Yes ☐ No ☐ Unknown **If 'Yes', what was the mother's WIC Number?** _____

PRENATAL-1

Date last normal menses began _____ (MM/DD/YYYY) **Estimated date of confinement** _____ (MM/DD/YYYY)

Is this the mother's first pregnancy? ☐ Yes ☐ No

Number of Previous Live Births _____ **Number of Previous Live Births now living** _____ **Number of Previous Live Births now dead** _____

Date of last live birth _____ (MM/DD/YYYY) **Number of other pregnancy outcomes** _____ **Date of last pregnancy outcome** _____ (MM/DD/YYYY)

Number of Previous Induced Terminations (abortions) _____ **Number of Previous Fetal Deaths** _____

Does this mother have any children diagnosed with an Autism Spectrum Disorder? ☐ Yes ☐ No ☐ Unknown

Mother's height ____ Ft ____ In **Body Mass Index (BMI)** _____ **Mother's Pre-Pregnancy Weight (lbs)** _____

Was prenatal record available? ☐ Yes ☐ No **Did mother receive Prenatal Care?** ☐ Yes ☐ No ☐ Unknown

Date of First Prenatal Care Visit _____ (MM/DD/YYYY) **If unknown, then enter the calendar month prenatal care began** _____ (MM/DD/YYYY)

Date of Last Prenatal Care Visit _____ (MM/DD/YYYY) **Total Number of Prenatal Care Visits (if none, enter '0')** _____

Were any changes to the prenatal record needed? ☐ Yes ☐ No

Mother's Blood Type ☐ A ☐ B ☐ O ☐ AB **Mother's Rh** ☐ Positive ☐ Negative

Hepatitis B Serology Obtained? ☐ Yes ☐ No ☐ Unknown

Hepatitis B Virus Surface Antigen Positive? (HBSAg) ☐ Yes ☐ No ☐ Unknown **Date of HBSAg Test** _____ (MM/DD/YYYY)

Syphilis Serology Obtained? ☐ Yes ☐ No ☐ Unknown **If yes, Date Syphilis Serology Obtained** _____ (MM/DD/YYYY)

PRENATAL-2

Medications

Did mother take Prenatal vitamins?
☐ Yes ☐ No ☐ Unknown

When did mother take prenatal vitamins (check all that apply)
☐ Pre-Pregnancy ☐ First Trimester ☐ Second Trimester ☐ Third Trimester

Maternal Risk Factors NCHS (Check all that apply)

☐ Diabetes
- ☐ Pre-Pregnancy (Diagnosis prior to this pregnancy)
  - ☐ Insulin Dependent ☐ Non-Insulin Dependent
- ☐ Gestational (Diagnosis in this pregnancy)
  - ☐ Insulin Dependent ☐ Non-Insulin Dependent

☐ Hypertension (select one of the following)
- ☐ Pre-pregnancy (chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)

☐ Previous preterm birth

☐ Pregnancy Resulted from infertility treatment (check all that apply)
- ☐ Fertility-enhancing drugs taken by the mother
- ☐ Fertility-enhancing drugs taken by the father
- ☐ Artificial insemination / Intrauterine Insemination
- ☐ Other assisted reproductive technology (IVF, GIFT, ZIFT)

☐ Mother had a previous cesarean delivery How many? _____

☐ None of the above

PRENATAL-2

Maternal Risk Factors – Other (Check all that apply)

☐ Anemia (HCT <30% / Hgb > 10 g/dl)	☐ Cardiac Disease ("heart condition")	☐ Family history of congenital anomalies or syndromes
☐ Obesity	☐ Seizures	☐ Trauma
☐ Asthma, history	☐ Cystic Fibrosis	☐ Liver disease
☐ Phlebitis/DVT	☐ Sickle cell disease	☐ Tuberculosis
☐ Blood Dyscrasia	☐ Sickle cell trait	☐ Lupus
☐ Renal Disease	☐ Depression/Mental Illness	☐ Uterine abnormality
☐ Cancer	☐ Epilepsy/seizure disorder	☐ Neurologic condition
☐ Rh sensitization	☐ Thyroid disease	☐ None of the above

Mother's Infections – NCHS (Check all that apply)

☐ Chlamydia	☐ Hepatitis C	☐ Unknown
☐ Gonorrhea	☐ Syphilis	
☐ Hepatitis B	☐ None of the above	

Mother's Infections – Other (Check all that apply)

☐ CMV	☐ Influenza	☐ Parvovirus	☐ West Nile Virus
☐ Group B Streptococcus	☐ Listeria	☐ Rubella	☐ None of the above
☐ Hep A	☐ Lyme Disease	☐ Toxoplasmosis	☐ Unknown
☐ HPV	☐ Malaria	☐ Varicella Zoster	

Fever

Did mother have a fever over 100.4 degrees that lasted for more than 24 hours? ☐ Yes ☐ No ☐ Unknown

If 'Yes' check all that apply ☐ First Trimester ☐ Second Trimester ☐ Third Trimester

PRENATAL-3

Obstetric Procedures - NCHS (check all that apply)

- ☐ Cervical cerclage
- ☐ External cephalic version:
  - ☐ Successful
  - ☐ Failed
- ☐ Tocolysis
- ☐ None of the above
- ☐ Unknown

Obstetric Procedures – Other (Check all that apply)

☐ CVS	☐ Amino Assess Lung Maturity	☐ Selective Fetal Reduction	☐ None of the above
☐ Amino Genetic Screening	☐ Amino Other Purpose	☐ Cell Free Fetal DNA test	☐ Unknown

Prenatal fetal Ultrasound known to have been performed? ☐ Yes ☐ No ☐ Unknown Number of Ultrasounds Performed: _____

When were the ultrasounds done (Check all that apply): ☐ First Trimester ☐ Second Trimester ☐ Third Trimester

Prenatal fetal diagnoses made (Check all that apply):

☐ Coarctation of the Aorta	☐ Ebstein Anomaly	☐ Interrupted Aortic Arch	☐ Other Cardiac Anomaly _____
☐ Total Anomalous Pulmonary Venous Return	☐ Tricuspid Atresia	☐ Pulmonary Atresia	☐ Other Non-Cardiac Anomaly: _____
☐ Double Outlet Right Ventricle	☐ Hypoplastic Left Heart	☐ Single Ventricle	☐ None of the above
☐ Transposition of Great Arteries	☐ Truncus Arteriosus	☐ Tetralogy of Fallot	☐ Unknown

PRENATAL-4

HIV

Was mother known HIV positive entering prenatal care? ☐ Yes ☐ No ☐ Unknown

Counseling Information

Was mother counseled regarding the benefits of HIV testing during the pregnancy? ☐ Yes ☐ No ☐ Unknown

If counseling given, at what stage of pregnancy? ☐ First Trimester ☐ Second Trimester ☐ Third Trimester ☐ Labor and Delivery

If counseling given, where was it given? ☐ Provider Office ☐ Hospital labor and delivery

First Trimester HIV Specimen Information

Was specimen for HIV testing obtained upon receipt of prenatal care? ☐ Yes ☐ No ☐ Unknown ☐ Refused

Date first trimester HIV specimen obtained (MM/DD/YYYY)

Where first trimester HIV specimen obtained ☐ Prenatal provider ☐ HIV provider ☐ Hospital labor and delivery ☐ Other ☐ None of the Above

Third Trimester HIV Specimen Information

Was specimen for HIV testing obtained upon receipt of prenatal care? ☐ Yes ☐ No ☐ Unknown ☐ Refused

Date third trimester HIV specimen obtained (MM/DD/YYYY)

Where first trimester HIV specimen obtained ☐ Prenatal provider ☐ HIV provider ☐ Hospital labor and delivery ☐ Other ☐ None of the Above

Source of HIV Information

If mother's HIV status not known or not documented at the labor and delivery, was an HIV test done on baby after birth? ☐ Yes ☐ No ☐ Unknown

Source of HIV related information

☐ Mother's medical records ☐ Patient's verbal history ☐ Baby's medical records ☐ Medical provider interview ☐ None of the above

PRENATAL-5

Tobacco Use

Did mother smoke cigarettes before or during pregnancy? ☐ Yes ☐ No ☐ Unknown

	# of cigarettes per day	# of packs per day
Three months before pregnancy		
First trimester		
Second trimester		
Third trimester		

Alcohol Use

Did mother ever drink wine/beer/liquor ☐ Yes ☐ No

In the month before mother knew she was pregnant, how much wine/beer/liquor did mother drink? ☐ Any ☐ None

In the month before mother knew she was pregnant, about how many days a week did she drink wine/beer/liquor?

☐ Every Day ☐ 3-6 days/wk ☐ 1-2 days/wk ☐ < 1 day/wk

Drug Use

In the month before mother knew she was pregnant, how much marijuana did she smoke?

☐ Any ☐ None

In the month before mother knew she was pregnant, about how many days a week did she use *any* drug such as marijuana, cocaine, or opioids?

Every Day 3-6 days/wk ☐ 1-2 days/wk ☐ < 1 day/wk ☐ Did not use drugs

Environmental Exposure (check all that apply)

☐ Lead (Home built before 1978) ☐ Tobacco (2nd or 3rd hand smoke) ☐ Viral (Birds or Cats in home) ☐ None of the above

Record Filled From? ☐ PRA ☐ Hospital **PRA Identification Number/FHI ID** _____

Mental Health & Substance Abuse Risk Assessment (check all that apply)

☐ Did either of your parents have a problem with drugs or alcohol?
☐ Does your partner have any problem with drugs or alcohol?
☐ Have you ever felt manipulated by your partner?
☐ Have you ever felt out of control or hopeless?
☐ Over the past 2 weeks have you felt down, depressed or hopeless?
☐ Over the past 2 weeks have you felt little interest or pleasure in doing things?
☐ None of the above

Plan of Care

As a result of her assessment, was mother referred to any of the following (check all that apply):

☐ Tobacco Cessation	☐ TANF/GA	☐ DYFS	☐ Breastfeeding Consult
☐ Substance Abuse Prevention Education	☐ Emergency Assistance	☐ Community Home Visiting	☐ Maternal Fetal Medicine Consult
☐ Substance Abuse Assessment	☐ Food Stamps	☐ Preterm Labor Prevention	☐ Childbirth Education
☐ Mental Health Assessment	☐ WIC	☐ Diabetes Care Program	☐ None of the above
☐ Domestic Violence Assessment	☐ SSI	☐ Nutritional Consult	

LABOR & DELIVERY -1

General Information

Mother's Weight at delivery	_____	Lbs	**Hours of active labor prior to admission**	_____	Hrs
Centimeters Dilated at admission	_____	cm			
Date of active labor, if post admission	_____	MM/DD/YYYY	**Time of active labor, if post admission**	_____	HH:MM AM/PM
Child's Date of Birth:	_____	MM/DD/YYYY	**Time of Delivery:**	_____	HH:MM AM/PM
Date of finished delivery of Placenta:	_____	MM/DD/YYYY	**Time of finished delivery of placenta:**	_____	HH:MM AM/PM

Plurality

☐ Single ☐ Twins ☐ Triplets ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

Birth Order _____ Number Born Alive In This Pregnancy _____ Sex (M/F/Not Yet Determined) _____

Onset of Labor (check all that apply)

☐ Premature rupture of the membrane (prolonged greater than or equal to 12 hours)
☐ Precipitous labor (less than 3 hours)
☐ Prolonged labor (greater than or equal to 20 hours)
☐ None of the above

Method of Delivery

Was delivery with forceps attempted but unsuccessful?	☐ Yes	☐ No				
Was delivery with vacuum extraction attempted but unsuccessful?	☐ Yes	☐ No				
Fetal presentation at birth?	☐ Cephalic	☐ Breech	☐ Other			
Final route & method of delivery	☐ Vaginal/Spontaneous	☐ Vaginal/Forceps	☐ Vaginal/Vacuum	☐ Cesarean	☐ Unknown	
If cesarean, was a trial of labor attempted?	☐ Yes	☐ No	☐ Unknown			

Delivery Information

Obstetric estimate of gestation	_____	Weeks	_____	Days	
Weight	_____	Grams	_____	Lbs	_____ Ounces
Apgar score at 1 min	_____	(1-10)	☐ Not taken	☐ Unknown	
Apgar score at 5 min	_____	(1-10)	☐ Not taken	☐ Unknown	
Apgar score at 10 min (if score less than 6)	_____	(1-10)	☐ Not taken	☐ Unknown	
Maternal blood loss		cc			

LABOR & DELIVERY -2

Characteristic of Labor & Delivery – NCHS (check all that apply)

- ☐ Induction of Labor
- ☐ Augmentation of Labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ Antibiotics received by mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature is greater than or equal to 38° C (100.4° F)
- ☐ Moderate/heavy meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

Charateristics of Labor & Delivery – Other (check all that apply)

- ☐ Placenta Abruptio
- ☒ Placenta Accreta
- ☐ Placenta Previa
- ☐ Active Herpes
- ☒ Anesthetic Complication
- ☐ Cord Complication
- ☐ Cord Prolapse
- ☐ Excessive Blood Loss
- ☐ Fever
- ☐ Intrapartum Infection
- ☐ IUGR diagnosed by ultrasound
- ☐ Oligohydramnios diagnosed by ultrasound
- ☐ Seizure: Preexisting disorder
- ☐ Seizure: eclamptic
- ☐ Uterine atony
- ☐ Arrested Progress, 0-4 cm
- ☐ Arrested Progress, 5-10 cm
- ☐ Arrested Progress, 2nd state
- ☐ Shoulder Dystocia
- ☐ FH Pattern in Category III/3
- ☐ Tachysystole
- ☐ None of the above
- ☐ Unknown

CHILD

Child's Information **Medical Record #** _____

Child's Name _____ (FIRST NAME) _____ (MIDDLE NAME) _____ (LAST NAME) _____ (SUFFIX)

SSN requested for child? ☐ Yes ☐ No ☐ Unknown

Child's Place of Birth

Place of Birth Name _____

Place of Birth Facility Type ☐ Freestanding Birth Center ☐ Home Birth, Intended ☐ Home Birth, Not Intended ☐ Clinic/Doctor's Office ☐ Hospital ☐ Other _____

Place of Birth Street Num		**Place of Birth Street Address**		**Place of Birth Street Type**	
Place of Birth Apt		**Place of Birth State/Country**		**Place of Birth County**	
		Place of Birth Municipality		**Place of Birth City/Town**	
Place of Birth Zip Code		**Place of Birth Zip code ext.**			

Informant's Information

Name _____ (FIRST NAME) _____ (MIDDLE NAME) _____ (LAST NAME)

Relationship to child _____ **Date Signed** _____ (MM/DD/YYYY)

MOTHER DEMOGRAPHICS

Mother's Information

Mother's Maiden Name _____ (FIRST NAME) _____ (MIDDLE NAME) _____ (LAST NAME) _____ (SUFFIX)

Mother's SSN _____ **Mother's Birth Place (State/Country)** _____

Mother's Residence Address Information

Residence Street Number		**Residence Street Name**		**Residence Street Type**	
Residence Apt		**Residence State/Country**		**Residence County**	
Residence Municipality		**Residence City/Town**		**Residence Zip**	
Residence Zip		**Residence Phone Number**		**Is residence within city limits?**	☐ Yes ☐ No

Residing at current residence _____ years _____ months

Mother's Mailing Address Information

Mailing same as residence? ☐ Yes ☐ No

Mailing Street Number		**Mailing Street Name**		**Mailing Street Type**	
Mailing Apt		**Mailing State/Country**		**Mailing Country**	
Mailing Municipality		**Mailing City/Town**		**Mailing Zip**	
Mailing Zip Ext					

Mother's Marriage Information

Marital Status

☐ COP

- ☐ Never Married (COP required)
- ☐ Married (Husband Not Father)
- ☐ Divorced, 300 days or more
- ☐ Widowed, 300 days or more

☐ No COP

- ☐ Never Married
- ☐ Married
- ☐ Divorced, 300 days or more
- ☐ Widowed, 300 days or more
- ☐ Married, Husband information refused
- ☐ Not Stated/Unknown

If Unmarried, has paternity acknowledgement been signed? ☐ Yes ☐ No

COP signed in the Hospital? ☐ Yes ☐ No

Surrogacy? ☐ Yes ☐ No

COP Signed, witnessed ☐ Yes ☐ No

Date COP completed _____ (MM/DD/YYYY)

MOTHER

Mother's Education and Employment

Education (mark highest level of achievement)

- ☐ 8th grade or less
- ☐ 9th-12th grade, but no diploma
- ☐ High school grad, or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate or Professional Degree
- ☐ Unknown/Not Stated

Business/Industry _____ Occupation _____

Was Mother Employed during the past year? ☐ Yes ☐ No Employer Name _____

Employer Street # _____ Employer Street Name _____ Employer State/Country _____

Employer County _____ Employer City _____ Employer Zip Code _____

Hispanic Origin

- ☐ No, Not Spanish/Hispanic/Latino
- ☐ Yes, Mexican/Mexican-American/Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other Spanish/Hispanic/Latino (specify) _____
- ☐ Refused
- ☐ Unable to Obtain

Mother's Race?

- ☐ White
- ☐ Black or African-American
- ☐ American Indian or Alaska Native (name of the enrolled or principal tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other (specify) _____
- ☐ Other Pacific Islander (specify) _____
- ☐ Refused
- ☐ Unable to obtain

FATHER DEMOGRAPHICS

Is Father's Information Provided?

☐ Father's Information Not Provided

Father's Information

Father's Name _____ _____ _____ _____

FIRST NAME MIDDLE NAME LAST NAME SUFFIX

Father's SSN _____ **Father's Birth Place (State/Country)** _____

Father's Date of Birth _____ MM/DD/YYYY **Father's Age** _____ Years

Father's Residence Address Information

Is Father's residence same as mother's residence? ☐ Yes ☐ No

Residence Street Number _____ **Residence Street Name** _____ **Residence Street Type** _____

Residence Apt _____ **Residence State/Country** _____ **Residence County** _____

Residence Municipality _____ **Residence City/Town** _____ **Residence Zip** _____

Residence Zip Extension _____ **Residence Phone Num** _____

Father's Mailing Address Information

Mailing same as residence? ☐ Yes ☐ No

Mailing Street Number _____ **Mailing Street Name** _____ **Mailing Street Type** _____

Mailing Apt _____ **Mailing State/Country** _____ **Mailing Country** _____

Mailing Municipality _____ **Mailing City/Town** _____ **Mailing Zip** _____

Mailing Zip Ext _____

Father's Miscellaneous Information

Education (mark highest level of achievement)

- ☐ 8th grade or less
- ☐ 9th-12th grade, but no diploma
- ☐ High school grad, or GED completed
- ☐ Some college credit, but no degree
- ☐ Associate Degree
- ☐ Bachelor's Degree
- ☐ Master's Degree
- ☐ Doctorate or Professional Degree
- ☐ Unknown/Not Stated

Business/Industry _____ Occupation _____

Was Father Employed during the past year? ☐ Yes ☐ No Employer Name _____

Employer Street # _____ Employer Street Name _____ Employer State/Country _____

Employer County _____ Employer City _____ Employer Zip Code _____

Hispanic Origin

- ☐ No, Not Spanish/Hispanic/Latino
- ☐ Yes, Mexican/Mexican-American/Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, Other Spanish/Hispanic/Latino (specify) _____
- ☐ Refused
- ☐ Unable to Obtain

Father's Race?

- ☐ White
- ☐ Black or African-American
- ☐ American Indian or Alaska Native (name of the enrolled or principal tribe) _____
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian (specify) _____
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other (specify) _____
- ☐ Other Pacific Islander (specify) _____
- ☐ Refused
- ☐ Unable to obtain

NEWBORN SCREENING

Metabolic Screening

Was metabolic screening performed for this infant? ☐ Yes ☐ No – Infant Expired ☐ No – Parent Refused ☐ Missed – Infant Transferred ☐ Missed - Other

Newborn Metabolic Test Kit Number _____

NEWBORN SCREENING

Pulse Ox Screening

Facility _____ **Date of Screen Result:** _____ MM/DD/YYYY

Final Result of the screening ☐ Pass ☐ Fail ☐ Not done

Reason not done ☐ Refused ☐ Discharged <24 hr ☐ Still in NICU/SCN ☐ Other: _____

#1 Upper Extremity % _____ **#1 Lower Extremity %** _____ **Time of Screen #1** _____ HH:MM AM/PM

#2 Upper Extremity % _____ **#2 Lower Extremity %** _____ **Time of Screen #2** _____ HH:MM AM/PM

#3 Upper Extremity % _____ **#3 Lower Extremity %** _____ **Time of Screen #3** _____ HH:MM AM/PM

Location at time of screening ☐ NICU/SCN ☐ Newborn Nursery/Mother-Infant Unit ☐ Other Location

Hearing Screen

Family History of permanent childhood hearing loss? ☐ Yes ☐ No ☐ Unknown

Was Hearing Screening done for this infant? ☐ Completed ☐ Parent Refusal ☐ Missed (Transfer) ☐ Missed (other reason)

Date Right Ear Hearing Screening Completed _____ MM/DD/YYYY

Right Ear Hearing Screening Test Type	☐ AABR	☐ OAE	☐ AABR and OAE	☐ Diagnostic ABR
Hearing Screening Right Ear Result	☐ Pass ☐ Refer ☐ Unable to test	☐ Pass ☐ Refer ☐ Unable to test	☐ Pass both ☐ Refer both ☐ Pass AABR, Refer OAE ☐ Pass OAE, refer AABR	☐ Normal hearing ☐ Hearing loss

Date Left Ear Hearing Screening Completed _____ MM/DD/YYYY

Left Ear Hearing Screening Test Type	☐ AABR	☐ OAE	☐ AABR and OAE	☐ Diagnostic ABR
Hearing Screening Left Ear Result	☐ Pass ☐ Refer ☐ Unable to test	☐ Pass ☐ Refer ☐ Unable to test	☐ Pass both ☐ Refer both ☐ Pass AABR, Refer OAE ☐ Pass OAE, Refer AABR	☐ Normal hearing ☐ Hearing loss

NEWBORN -1

Neonatal Diagnoses (check all that apply)

☐ Head Trauma	☐ Syndromes associated with hearing loss
☐ HIE (hypoxic ischemic encephalopathy)	☐ Physical finding associated with hearing loss
☐ Neurodegenerative disorders	☐ Craniofacial anomalies
☐ Neuromuscular disorder	☐ Microcephaly
☐ TTN	☐ Fetal Alcohol Syndrome
☐ RDS/HMD	☐ Neonatal abstinence syndrome
☐ Chronic Lung Disease	☐ Stage III necrotizing enterocolitis in newborn
☐ Meconium Aspiration Syndrome	☐ Perinatal HIV exposure
☐ Hypoglycemia requiring IV glucose therapy	☐ Congenital Cytomegalovirus (CMV) infection

Hemorrhage Information

CNS Hemorrhage IVH grade ☐ 1 ☐ 2 ☐ 3 ☐ 4

CNS Hemorrhage type ☐ Trauma/Subdural ☐ Trauma/Subarchnoid ☐ Parenchymal

Newborn Procedures/Therapies 1

Antibiotics for suspected sepsis: ☐ IM Antibiotics Only ☐ IV Antibiotics ≤72 hrs ☐

Age at first surfactant treatment & units(min/hr) _____ Age _____ **Units**

Hypothermic Therapy ☐ Selective Head Treatment ☐ Whole Body Treatment

Bilirubin Assessment ☐ Serum ☐ Transcutaneous ☐ Both ☐

Duration of any O_2 Therapy ☐ < 4 hr ☐ 4 – ≤6 hr ☐ >6 – 24 hr ☐

Newborn Procedures/Therapies 2 (check all that apply)

☐ Phototherapy for hyperbilirubinemia	☐ Loop diuretics administered	☐
☐ Exchange transfusion for hyperbilirubinemia	☐ Endotracheal ventilation (conventional and high frequency)	☐
☐ HIV prophylaxis administered	☐ High pressure ventilation (CPAP and high flow cannula)	☐
☐ Ototoxic medications administered	☐ Other oxygen (oxyhood, low flow nasal cannula)	

HIV prophylaxis start date MM/DD/YYYY

NEWBORN -2

Congenital Anomalies (check all that apply)

These conditions are required for reporting to NCHS. These conditions must also separately be reported via the NJ Birth Defects Registration System

☐ Anencephaly	☐ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)	☐ Suspected chromosomal disorder
☐ Meningomyelocele/Spina bifida	☐ Cleft lip with or without cleft palate	☐ Karyotype confirmed
☐ Cyanotic congenital heart disease	☐ Cleft palate alone	☐ Karyotype pending
☐ Congenital diaphragmatic hernia	☐ Down Syndrome	☐ Hypospadias
☐ Omphalocele	☐ Karyotype confirmed	☐ None of the above
☐ Gastroschisis	☐ Karyotype pending	

Abnormal Conditions (check all that apply)

☐ Assisted ventilation required immediately following delivery	☐ Antibiotics received by the newborn for suspected neonatal sepsis
☐ Assisted ventilation required for more than 6 hours	☐ Seizure or serious neurologic dysfunction
☐ NICU admission	☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
☐ Newborn given surfactant replacement therapy	☐ None of the above

IMMUNIZATION & LABS

Immunization

Was infant vaccinated with Hepatitis B vaccine? ☐ Yes ☐ No

If Yes Vaccination Date _____ (MM/DD/YYYY) Vaccination Time _____ (HH:MM AM/PM) Vaccine lot # _____

Was Hepatitis B Immunoglobulin (HBIG) administered? ☐ Yes ☐ No ☐ Unknown

If Yes Date HBIG administered _____ (MM/DD/YYYY) Time administered _____ (HH:MM AM/PM) HBIG lot # _____

Infant Blood Type

☐ A ☐ B ☐ O ☐ AB

☐ Rh+ ☐ Rh-

HIV

Infant HIV test date _____ (MM/DD/YYYY) **Infant HIV Test results** ☐ Positive ☐ Negative ☐ Unknown

NEWBORN DISCHARGE

NICU/SCN

NICU/SCN nursery stay? ☐ Yes ☐ No

NICU/SCN History ☐ Add NICU stay ☐ Add Intermediate stay

Facility Name: _____

NICU/SCN stay start date _____ MM/DD/YYYY

NICU/SCN admission time _____ HH:MM AM/PM

NICU/SCN stay end date _____ MM/DD/YYYY

Newborn Discharge

Is infant living at time of report? ☐ Yes ☐ No ☐ Infant transferred, Status Unknown

Was infant transferred within 24 hrs? ☐ Yes ☐ No

Name of the facility infant transferred to: _____

Discharge status (select one)

☐ Home with parent ☐ DCP&P/Foster care ☐ Transfer to a lower level nursery ☐ Unknown

☐ Home with other relative ☐ Adoption ☐ Transfer to a higher or equal level nursery

☐ Expired ☐ Transfer to Long Term Care ☐ Other (specify): _____

Discharge/Transfer/Death date _____ MM/DD/YYYY **Discharge/Transfer/Death Time** _____ HH:MM AM/PM

Discharge weight (grams) _____

Home Monitoring (Respiratory) ☐ Yes ☐ No

Home on Oxygen ☐ Yes ☐ No

Feeding Method

Is infant being breastfed at discharge? ☐ Yes ☐ No

Exclusive breast milk feeding through entire stay? ☐ Yes ☐ No

Discharged To

Relationship of guardian to child ☐ Mother ☐ Father ☐ Other Guardian

Parent/Guardian/Agency at time of discharge

FIRST NAME OR NAME OF WORKER	MIDDLE NAME	LAST NAME OR NAME OF AGENGY	PHONE NUMBER

STREET NUMBER	STREET NAME	STREET TYPE	

APARTMENT	STATE/COUNTRY	COUNTY	

MUNICIPALITY	CITY/TOWN	ZIP	ZIP EXTENSION

Language Information

What language would be best to use when giving mother/guardian information about baby's health care? (select one)

☐ American Sign Language	☐ Haitian Creole/Kreyol	☐ Hebrew	☐ Polish	☐ Turkish
☐ Arabic	☐ English	☐ Greek	☐ Portuguese	☐ Ukrainian
☐ Bengali	☐ Farsi	☐ Hindi	☐ Punjabi	☐ Urdu
☐ Braille	☐ French	☐ Italian	☐ Russian	☐ Vietnamese
☐ Chinese	☐ German	☐ Japanese	☐ Spanish	☐ Other (specify) _____
☐ Mandarin/Cantonese	☐ Gujarati	☐ Korean	☐ Tagalog	

Future Care

Source of Future Care/Immune: _____

Type of Provider of Future Care/Immune (select one)

☐ Private Physician	☐ Community Health Center	☐ Other (specify) _____
☐ HMO or Health Plan	☐ Hospitals' Clinic	☐ None
☐ Healthstart	☐ Other Clinic	☐ Unknown

MATERNAL POSTPARTUM

Maternal PPD Screening

Patient Declined Screening ☐ Yes ☐ No

Total Score, Edinburgh Scale Score, E.S. question 10:

If Edinburgh not used, what alternate instrument? ☐ Zung Self-Rating Scale ☐ PHQ-9 ☐ CES-D ☐ PPD Predictors Inventory (Beck) ☐ Burns

If Edinburgh not used, result of alternate instrument? ☐ Positive ☐ Negative

Patient received referral info? ☐ Yes ☐ No

In-house consult? ☐ Yes ☐ No

Rh Immune Globulin

Was Rh Immune Globulin Given to the Mother? ☐ Yes ☐ No ☐ Refused

Maternal Morbidity (check all that apply)

☐ Maternal transfusion
☐ Third or fourth degree perineal laceration
☐ Ruptured Uterus
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ Unplanned operating room procedure following delivery
☐ None of the above
☐

Maternal Discharge

Type of discharge: ☐ Discharged ☐ Transferred ☐ Expired

Date of discharge/transfer/expiration

CERTIFICATION

Attendant's Information

PREFIX	FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX

TITLE	OTHER	NPI	LICENSE NUMBER

Certifier Information

Certifier same as attendant? ☐ Yes ☐ No

PREFIX	FIRST NAME	MIDDLE NAME	LAST NAME	SUFFIX

TITLE	OTHER	NPI	LICENSE NUMBER

COMMENTS

Enter any comments below: