Recorded District	New York State Department of Health	State File Number:
Register Number	**CERTIFICATE OF LIVE BIRTH**	

INFANT

1A. Name: *First*	*Middle*	*Last*			
1B. Medical Record No.:	2A. Date of Birth:	2B. Hour:	3. Sex:	4A. Birth is: *(Single, Twin, etc.)*	4B. If Not Single, Specify Birth Order:
5. Place of Birth: ☐ Hospital ☐ Freestanding Birth Center ☐ Home Delivery: *Planned to deliver at home?* ☐ Yes ☐ No ☐ Unknown ☐ Clinic/Doctor's Office ☐ Other *(specify)*					
6A. Facility Name:	6B. Locality of Birth:	6C. County of Birth:			

MOTHER

7A-1. Name: *First*	*Middle*	*Current Last Name*	
7A-2. Maiden Last Name:	7B. Date of Birth:	7C. City & State of Birth: (*Country, if not U.S.A.*)	
8A. Residence, State: (*Country, if not U.S.A.*)	8B. County: (*Terr. or Prov., if not USA*)		
8C. Locality:	8D. If City or Village, Is Residence within City or Village Limits? (*If NO, specify town:*)		
8E. Street and Number of Residence:			8F. Zip Code:
8G. Mailing Address:	8H. Zip Code:	8I. Medical Record No.:	

FATHER

9A. Name: *First*	*Middle*	*Last*
9B. Date of Birth:	9C. City & State of Birth: (*Country, if not U.S.A.*)	

ATTENDANT

10A. I certify that the stated information concerning this child is true to the best of my knowledge and belief. Signature ▶		10B. Date Signed: Month / Day / Year	
10C. Name of Certifier, If Not Attendant:	Title:		10D-1. NYS License Number: *(Certifier)*
10E. Attendant's Name:	Title:		10F-1. NYS License Number: *(Attendant)*
11A. Registrar Name:			
11B. Signature of the Registrar: ▶		11C. Date Filed: Month / Day / Year	

* 12. Information Added or Corrected:

Item No. *Date of Correction* *Authorization* *Original Information*

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See instructions to complete this section

Child's Name: (First / Middle / Last)

Date of Birth: (MM / DD / YYYY)

Locality of Birth:

13. Office Use Only:

Institution

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

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

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

Infant

15. Birth Weight: (Pounds / Ounces)

16. Infant Transferred: ☐ Within 24 hours of delivery ☐ After 24 hours ☐ Not transferred

If transferred, name of facility transferred to:

State or Province/Territory

17. Apgar score at 1 minute:

Score at 5 minutes:

Score at 10 minutes:

18. Is the infant alive? Yes ☐ No ☐

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

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

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

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

23. Abnormal Conditions of the Newborn: *(Select all that apply)*
- ☐ Assisted ventilation required immediately following delivery
- ☐ Assisted ventilation required for more than six (6) hours
- ☐ NICU Admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Antibiotics received by the newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury (skeletal fx, peripheral nerve injury, soft tissue/solid organ hemorrhage which requires intervention)
- ☐ None of the above

Congenital Anomalies

24. Congenital Anomalies: *(Select all that apply)*
- ☐ Anencephaly
- ☐ Meningomyelocele/Spina bifida
- ☐ Cyanotic congenital heart disease
- ☐ Congenital diaphragmatic hernia
- ☐ Omphalocele
- ☐ Gastroschisis
- ☐ Limb reduction defect
- ☐ Cleft lip with or without cleft palate
- ☐ Cleft palate alone
- ☐ Down Syndrome
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Other chromosomal disorder
  - ☐ Karyotype confirmed
  - ☐ Karyotype pending
- ☐ Hypospadias
- ☐ None of the above

Labor and Delivery

25. If birth occurred in hospital, was mother transferred in before giving birth? Yes ☐ No ☐ *If YES, name of facility transferred from:*

State or Province/Territory:

26. Mother's Weight at Delivery:

27 a, b, c & d. Method of Delivery:

a. Fetal Presentation: ☐ Cephalic ☐ Breech ☐ Other

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

c. Attempted but failed: Yes / No
- Forceps ☐ ☐
- Vacuum ☐ ☐

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

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

28B. Characteristics of Labor & Delivery: *(Select all that apply)*
- ☐ Induction of labor - AROM
- ☐ Induction of labor - Medicinal
- ☐ Augmentation of Labor
- ☐ Steroids
- ☐ Antibiotics
- ☐ Chorioamnionitis
- ☐ Meconium staining
- ☐ Fetal intolerance
- ☐ External electronic fetal monitor
- ☐ Internal electronic fetal monitor
- ☐ None of the above

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Labor and Delivery

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

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

29B. Analgesia: Yes ☐ No ☐

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

Parent's Race & Education

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

Parent's Education

31A. Mother	32A. Father
☐ 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/Professional degree	☐

Parent's Hispanic Origins

31B. Mother	32B. Father
☐ No, not Spanish/Hispanic/Latino/Latina	☐
☐ Yes, Mexican, Mexican American, Chicana	
Yes, Mexican, Mexican American, Chicano	☐
☐ Yes, Puerto Rican	☐
☐ Yes, Cuban	☐
☐ Yes, Other Spanish/Hispanic/Latina	
(Mother) Specify	
Yes, Other Spanish/Hispanic/Latino	☐
(Father) Specify	

Parent's Race

31C. Mother	32C. Father
☐ White/Caucasian	☐
☐ Black or African American	☐
☐ American Indian or Alaska Native	
(Mother) Specify	
American Indian or Alaska Native	☐
(Father) Specify	
☐ Asian Indian	☐
☐ Chinese	☐
☐ Filipino	☐
☐ Japanese	☐
☐ Korean	☐
☐ Vietnamese	☐
☐ Other Asian	
(Mother) Specify	
Other Asian	☐
(Father) Specify	
☐ Native Hawaiian	☐
☐ Guamanian or Chamorro	☐
☐ Samoan	☐
☐ Other Pacific Islander	
(Mother) Specify	
Other Pacific Islander	☐
(Father) Specify	
☐ Other	
(Mother) Specify	
Other	☐
(Father) Specify	

Mother

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

31E. Current / Most Recent Occupation:

31F. Kind of Business or Industry:

31G. Name and Address of Firm:

Father

32D. Current / Most Recent Occupation:

32E. Kind of Business or Industry:

32F. Name and Address of Firm:

Prenatal History

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

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

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

36A. Date of Last Menses: (MM / DD / YYYY)

36B. Estimated Due Date: (MM / DD / YYYY)

36C. Date of First Prenatal Care Visit: (MM / DD / YYYY)

36D. Date of Last Prenatal Care Visit: (MM / DD / YYYY)

37. Total Number of Prenatal Visits:

38. Number of Prior:

Live Births: Now Living (None / Number)	Live Births: Now Dead (None / Number)	Spontaneous Terminations: Less than 20 wks (None / Number)	Spontaneous Terminations: 20 weeks or more (None / Number)	Induced Terminations (None / Number)	Pregnancies (None / Number)
☐	☐	☐	☐	☐	☐

39A. Date of First Live Birth: (MM / YYYY)

39B. Date of Last Live Birth: (MM / YYYY)

39C. Date of Last Other Pregnancy Outcome: (MM / YYYY)

40A. Mother's Pre-pregnancy Weight:

40B. Mother's Height:

Prenatal Care

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

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

43A. Daily Tobacco Use: *(Number of)* *Cigarettes* OR *Packs* ☐ None

3 months prior to pregnancy	OR
First 3 months of pregnancy	OR
Second 3 months of pregnancy	OR
Third trimester of pregnancy	OR

43B. Alcohol Use During This Pregnancy: None ☐ / Average Drinks per Week

43C. Illegal Drugs Used During This Pregnancy: ☐ Yes ☐ No

44. Obstetric Procedures: *(Select all that apply)*
- ☐ Cervical cerclage
- ☐ Tocolysis
- ☐ External cephalic version
  - ☐ Successful
  - ☐ Failed
- ☐ None of the above

45. Serological Test for Syphilis: *(Positive if none)* (MM / DD / YYYY)

Release of Information

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

Mother's Telephone Number:

Mother's Signature & Date Signed: ▶

Mother's Social Security Number:

Father's Signature & Date Signed: ▶

Father's Social Security Number: