North Dakota Certifier's Worksheet for Birth
ND Department of Health
Division of Vital Records
(01-01-2022)

< Apply Hospital label here>

Certifier's Worksheet for Completing the North Dakota Birth Certificate

This worksheet is to be completed by the facility using the prenatal record, mother's medical records and the labor and delivery records. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record or a copy of the prenatal care information. Please do not provide information from sources other than those listed.

This worksheet should not be completed by the parents except in the case of a home birth. In the case of a home birth, this worksheet should be completed by the certifier (person delivering the child) or the mother.

Child's Information

_____ _____ _____ _____ (Jr, III, Etc)
First Middle Last Suffix

Certifier/Attendant Information

1. Certifier's Name & Title_____
(The individual, who certifies to the fact that the birth occurred. May be, but need not be the same as the attendant)
☐ Physician – M.D. ☐ CNM ☐ Other (Includes the father, etc.)
☐ D.O. ☐ Other Midwife

2. Attendant's Name & Title_____
(The individual physically present at the delivery, who is responsible for the delivery. If an intern or nurse midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant)
☐ Same as Certifier ☐ D.O. ☐ Other Midwife
☐ Physician – M.D. ☐ Nurse Practitioner ☐ Other (Includes the father, etc.)

3. Certifier Signature: _____ 4. Date: _____

Birth Information

1. Child's Medical Record Number: _____

2. Date of Birth? _____/_____/_____ 3. Time of Birth? _____:_____ (Use Military Time)
MM DD YYYY

4. Sex? ☐ Male ☐ Female ☐ Not yet determined

5. Birth Weight: _____ Grams **or** _____ Pounds / Ounces (**Only complete one**)

6. Obstetric estimation of gestation? _____ Number of Completed Whole Weeks (**Not computed on LMP**)

7. Facility Name_____
(If home birth - address, if enroute list hospital name where first removed from the vehicle.)

8. County of Birth _____ Zip Code _____

9. City, Town or Location of Birth_____ Inside City Limits? ☐ Yes ☐ No

10. Type of Place of Birth? <Apply Hospital Label Here>
    - ☐ Clinic/ Doctor's Office
    - ☐ Freestanding Birthing Center
    - ☐ Hospital
    - ☐ Other_____
      (Named place – describe e.g. McDonalds)
    - ☐ Home Birth
      Planned to Deliver at Home?
      - ☐ Yes
      - ☐ No
    - ☐ Unknown

11. Plurality? (Include all live births and fetal losses resulting from this pregnancy) _____ (1,2,3,4,5,6,7 etc.)

12. If not a single birth, birth order? (Include all live births and fetal losses resulting from this pregnancy) _____
    (1^{st}, 2^{nd}, 3^{rd}, 4^{th}, 5^{th}, 6^{th},7^{th}, etc)

13. If not single birth, specify number of infants born alive? _____

14. Is infant living at the time of this report? ☐ Yes ☐ No ☐ Infant Transferred, status unknown

15. Is infant being breastfed at time of discharge? ☐ Yes ☐ No ☐ Unknown

16. Was infant transferred within 24 hours of delivery? ☐ Yes ☐ No

    If yes, name of facility infant transferred to? _____

17. Apgar Score? **5** minute score _____ (If 5 minute score **is less than 6** enter score at **10** minutes _____)

18. Was the delivery with forceps attempted but unsuccessful? ☐ Yes ☐ No

19. Was delivery with vacuum extraction attempted but unsuccessful? ☐ Yes ☐ No

20. Fetal presentation at birth (Check one)
    ☐ Cephalic ☐ Breech ☐ Other

21. What was the final route and method of delivery? (Check one)
    - ☐ Vaginal/Spontaneous
    - ☐ Vaginal/Forceps
    - ☐ Vaginal/Vacuum
    - ☐ Hysterectomy/Hysterotomy
    - ☐ Cesarean
      - ☐ If Cesarean, was a trial of labor attempted? ☐ Yes ☐ No

22. Abnormal conditions of the newborn (Check all that apply)
    - ☐ Assisted Ventilation required immediately following delivery
    - ☐ Assisted ventilation required for more than six 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
    - ☐ Fetal Alcohol Syndrome
    - ☐ None of the abnormal conditions listed

23. Congenital anomalies of newborn
    - ☐ Anencephaly
    - ☐ Meningomyelocele/ Spina bifida
    - ☐ Microcephaly
    - ☐ Cyanotic congenital heart disease
    - ☐ Acyanotic congenital heart disease
    - ☐ Congenital diaphragmatic hernia
    - ☐ Omphalacele
    - ☐ Gastroschisis
    - ☐ Limb reduction defect
    - ☐ Cleft lip with or without a cleft palate
    - ☐ Cleft palate alone
    - ☐ Down Syndrome
      - ☐ Karotype confirmed
      - ☐ Karotype pending
    - ☐ Suspected chromosomal disorder
      - ☐ Karotype confirmed
      - ☐ Karotype pending
    - ☐ Hypospadias
    - ☐ None of above

24. Was child given any immunizations? < Apply hospital label here >

☐ Yes
☐ No
☐ Not Given – Parent Refused
☐ Not Given – Medical Risk

If yes, please complete vaccine information below:

	Vaccination	Date	Lot #
☐	Hepatitis B		
☐	Hepatitis B Immune Globulin		

Vaccine for Children (VFC) Status:

☐ Not Eligible ☐ Medicaid ☐ Native American or Alaskan Native
☐ No Insurance ☐ Underinsured ☐ Other State Eligible

25. Hearing screening test results.

Date of Screening? _____/_____/_____
MM DD YYYY

Testing Technology ☐ OAE ☐ AABR ☐ Unknown

Left Ear ☐ Passed ☐ Referred
Right Ear ☐ Passed ☐ Referred
Not Screened: (specify reason)
☐ Refused by Parent
☐ Missed
☐ Child Transferred to another facility
☐ Child in NICU, not ready to be screened
☐ Child died
☐ Equipment failure/not working

26. Newborn screening test results. (Obtained from the North Dakota Newborn Screening Program Form)

Form IA number: _____ (Example: IA0123456)

(If sticker is available, place it here over this area)

Not Screened: (specify reason)
☐ Refused by Parent
☐ Child Transferred to another facility
☐ Child died
☐ Other: _____

27. Critical Congenital Heart Disease Screening results:

Date of Pulse Oximetry (CCHD) Screening? _____/_____/_____
MM DD YYYY

Results from CCHD Screening (after birth): ***– Passed, Failed or Not Screened - Specify why not screened***

☐ Passed
☐ Failed
☐ Not Screened: (specify reason)
☐ Screening refused by parent
☐ Infant transferred to another facility before screening completed
☐ Infant on supplement oxygen when worksheet completed
☐ Equipment failure/Not working
☐ Infant Died
☐ Other: _____

<Apply Hospital Label Here>

Mother Prenatal

1. Mother's medical record number: _____
2. Number of Prenatal visits _____ (If no prenatal care was provided, enter all 9's for both dates and 0 for number of visits)

   First Visit: _____/_____/_____
   MM DD YYYY
3. Was the mother transferred to this facility for maternal medical or fetal indications for delivery? ☐ Yes ☐ No
   a. If yes, enter the name of the facility mother transferred from_____
4. What is the Mother's height? _____Feet _____Inches
5. Mother's Weights (Pounds): Pre-pregnancy weight? _____ Weight at delivery? _____
6. Number of previous live births now living (For single births, do not include this child. For multiple deliveries, include the children born during this event) _____Number
7. Number of previous live births now dead (For single births, do not include this child. For multiple deliveries, include the children born during this event) _____Number
8. Date of last live birth? _____/_____
   MM YYYY
9. Total number of other pregnancy outcomes (Include fetal losses of any gestational age – spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered during this pregnancy): _____Number
10. Date of last other pregnancy outcome (Date when last pregnancy ended, which did not result in a live birth): _____/_____
    MM YYYY
11. Date the last normal menses began? _____/_____/_____ (Enter 9's for unknown portions of the date)

Mother Labor and Delivery

1. Medical Risk Factors for this Pregnancy (Check all the apply)
   - ☐ Diabetes
     - ☐ Type I
     - ☐ Type II
     - ☐ Gestational
   - ☐ Hypertension
     - ☐ Pre-pregnancy
     - ☐ Gestational
     - ☐ Eclampsia
   - ☐ Previous pre-term births
   - ☐ Pregnancy resulted from infertility treatment (Check all that apply)
     - ☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination
     - ☐ Assisted reproductive technology
   - ☐ Mother had a previous cesarean delivery
     If Yes, how many _____
   - ☐ Exposure to illegal drugs
     - ☐ Methamphetamines
     - ☐ Marijuana
     - ☐ Cocaine
     - ☐ Other
   - ☐ Exposure to alcohol
   - ☐ None of these risk factors

2. Infections present and/or treated during this pregnancy (Check all that apply)
   - ☐ Gonorrhea
   - ☐ Syphilis
   - ☐ Chlamydia
   - ☐ Hepatitis B
   - ☐ Hepatitis C
   - ☐ Group B Strep
   - ☐ Rubella
   - ☐ HIV/AIDS
   - ☐ Cytomegalovirus
   - ☐ Parvo Virus
   - ☐ Toxoplasmosis
   - ☐ COVID-19
   - ☐ Other
   - ☐ None of these infections

3. Obstetric procedures performed during the pregnancy? (Check all that apply)
   - ☐ Cervical Cerclage
   - ☐ Tocolysis
   - ☐ External cephalic version
     - ☐ Successful
     - ☐ Failed
   - ☐ None of the Above

4. Onset of Labor (Check all that apply)
   - ☐ Premature Rupture of the membranes
   - ☐ Precipitous Labor
   - ☐ Prolonged Labor
   - ☐ None of the Above.

5. Characteristics of labor and delivery (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 the mother during labor
   - ☐ Clinical chorioamnionitis diagnosed during labor maternal temperature >= 38 C (100.4 F)
   - ☐ Epidural or spinal anesthesia during labor
   - ☐ None of these characteristics

6. Maternal Morbidity - Complications of the mother experienced during labor and delivery (Check all that apply)
   - ☐ Maternal transfusion
   - ☐ Third or fourth degree perineal laceration
   - ☐ Ruptured uterus
   - ☐ Unplanned hysterectomy
   - ☐ Admission to the intensive care unit
   - ☐ Unplanned operating procedure following delivery
   - ☐ None of these complications

Completed by _____