New York City Department of Health and Mental Hygiene
Bureau of Vital Statistics

Facility Worksheet for Newborn Registration
To be completed by Facility Staff

- This worksheet contains items to be completed by the facility staff. Items in GREEN will be provided by the Mother/Parent and should be entered into the Electronic Birth Registration System (EBRS) from the Mother/Parent's Worksheet. If ALL items on a specific EBRS Screen are from the Mother/Parent's worksheet, instructions will indicate: See MOTHER/PARENT'S WORKSHEET for all items on this screen.
- The items on the Mother/Parent's Worksheet and this Facility Worksheet are listed in order of the EBRS data entry screens. Please follow the instructions below to obtain and enter accurate data into EBRS.

For Facility Birth Registration Tracking Purposes

Mother/Parent's Name:		Number delivered this pregnancy		If more than one, birth order of this child	

SCREEN: START A NEW CASE

Once you have completed the form below, you will be ready to **Start a New Case** in EBRS. You *must* have the following information to start a new case:

Child's Last Name		Date of Child's Birth ___ ___/___ ___/___ ___ ___ ___ *Month Day Year*
Child's Sex ☐ Female ☐ Male ☐ Undetermined	Mother/Parent's Medical Record Number	Child's Medical Record Number

SCREEN: CHILD

Name of Child *(Last name (and any other name) is automatically filled from Start New Case Screen)*	Date of Child's Birth *(Automatically filled from Start New Case Screen)*	Time of Child's Birth ___ ___ : ___ ___ ☐ AM ☐ PM No military time accepted; 12 PM is noon; 12 AM is midnight	Social Security number for Child?	Safe Haven / Foundling Baby ☐ Yes ☐ No *Defaults to No*

SCREENS: MOTHER/PARENT, MOTHER/PARENT ADDRESS, MOTHER/PARENT ATTRIBUTES

See Mother/Parent's Worksheet for all items on these screens

SCREEN: MOTHER/PARENT HEALTH

See Mother/Parent's Worksheet for most items on this screen; 2 additional items are listed here.	Mother/Parent Weight at Delivery ___ ___ ___ lbs.	Illicit and other drugs used during this pregnancy?	☐ Yes *If yes, Check ALL that apply:* ☐ No	☐ Heroin ☐ Cocaine ☐ Methadone	☐ Methamphetamine ☐ Marijuana ☐ Sedatives	☐ Tranquilizers ☐ Anticonvulsants ☐ None of the above (Other illicit drug(s) were used—not listed above.)

SCREEN: PATERNITY

Are you entering the Father/Parent's information?	☐ Yes, Married	☐ Yes, Acknowledgment of Paternity (AOP) *(See link to print AOP with corresponding tracking number)*	☐ No

SCREENS: FATHER/PARENT, FATHER/PARENT ATTRIBUTES

(See Father/Parent's section of Mother/Parent's Worksheet for all items on this screen)

SCREEN: PLACE OF BIRTH

Type of Place (of birth):
- ☐ Hospital *(if logged in as a hospital site, your facility will be automatically filled in)*
- ☐ Freestanding Birthing Center *(if logged in as a birthing center, your facility will be automatically filled in)*
- ☐ Clinic/Doctor's Office *(please complete name and address below)*
- ☐ Home Delivery Planned *(please complete address of birth below)*
- ☐ Home Delivery Unplanned *(please complete address of birth below)*
- ☐ Home Delivery Unknown if Planned *(please complete address of birth below)*
- ☐ Other *(Specify)* ____________________

Place of Birth (NYC borough):
- ☐ Manhattan
- ☐ Bronx
- ☐ Brooklyn
- ☐ Queens
- ☐ Staten Island

Name of hospital or other facility; if not facility, street address (*If logged in as hospital or birthing center, the facility name and address will be filled automatically)*

Street Address	City	State	ZIP Code

SCREEN: PRENATAL

Mother/Parent Medical Record Number *(Automatically filled in from Start New Case screen)*

If Medicaid, enter Medicaid Number:

Primary Payer *(Check ONE):*
- ☐ Medicaid/Family Health Plus
- ☐ Private Insurance
- ☐ Other Govt/CHPlusB
- ☐ CHAMPUS/TRICARE
- ☐ Other
- ☐ Self-pay
- ☐ Unknown

Date last normal menses began ___ ___ / ___ ___ / ___ ___ ___ ___ (*Month* / *Day* / *Year*)

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

☐ No prenatal care

Date of first prenatal care visit ___ ___ / ___ ___ / ___ ___ ___ ___ (*Month* / *Day* / *Year*)

Date of last prenatal care visit ___ ___ / ___ ___ / ___ ___ ___ ___ (*Month* / *Day* / *Year*)

Total number of prenatal care visits for this pregnancy ___ ___

Primary prenatal care provider type *(Check ONE):*
- ☐ MD/DO
- ☐ C(N)M/NP/PA/Other Midwife
- ☐ Clinic
- ☐ No provider
- ☐ No information
- ☐ Other

TOTAL number of previous live births: (a + b =) ________
- a) Number born alive and now living ________
- b) Number born alive and now dead ________

Date of first live birth ___ ___ / ___ ___ ___ ___ (*Month* / *Year*)

Date of last live birth ___ ___ / ___ ___ ___ ___ (*Month* / *Year*)

Those born alive may have been preterm, low birth weight or both. *(Indicate only live births resulting from PRIOR PREGNANCIES):*
Number preterm (<37 wks): __________
Number low birth weight (<2500 grams or 5 lbs. 8 oz.): ________

A spontaneous termination can be called a miscarriage, missed abortion, or spontaneous abortion —usually when < 20 weeks and a stillbirth or fetal death when 20 weeks or more. An induced termination can be called an abortion.

TOTAL number of other pregnancy outcomes: (c + d + e =) ________
- c) Number of spontaneous terminations of pregnancy less than 20 weeks: ________
- d) Number of spontaneous terminations of pregnancy 20 weeks or more: ________
- e) Number of induced terminations of pregnancy: ________

Date of last other pregnancy outcome *(spontaneous or induced termination):* ___ ___ / ___ ___ ___ ___ (*Month* / *Year*)

SCREEN: PREGNANCY FACTORS

Risk factors in this pregnancy *(Check ALL that apply):*
- ☐ Pre-pregnancy diabetes
- ☐ Gestational diabetes
- ☐ Pre-pregnancy hypertension
- ☐ Gestational hypertension
- ☐ Cardiac disease: Structural defect
- ☐ Cardiac disease: Functional defect
- ☐ Other serious chronic illness
- ☐ Anemia (Hct.<30/Hgb.<10)
- ☐ Asthma/Acute or chronic lung disease
- ☐ Rh sensitization
- ☐ Polyhydramnios
- ☐ Oligohydramnios
- ☐ Hemoglobinopathy
- ☐ Abruptio placenta
- ☐ Eclampsia
- ☐ Other previous poor pregnancy outcome
- ☐ Prelabor referral for high risk care
- ☐ Other vaginal bleeding
- ☐ Previous cesarean section
  Number previous cesarean sections: ___________
- ☐ Infertility treatment: Fertility drugs, artificial/intrauterine insemination
- ☐ Infertility treatment: Assisted reproductive technology (e.g. IVF, GIFT)
  Number of embryos implanted *(if applicable)* ___________
- ☐ Fetal reduction
- ☐ None of the above

Infections present and/or treated during (this) pregnancy *(Check ALL that apply):*
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Herpes simplex (HSV)
- ☐ Chlamydia
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Tuberculosis
- ☐ Rubella
- ☐ Bacterial vaginosis
- ☐ None of the above

Obstetric procedures *(Check ALL that apply):*
- ☐ Cervical cerclage
- ☐ Tocolysis
- ☐ External cephalic version: Successful
- ☐ External cephalic version: Failed
- ☐ Fetal genetic testing
- ☐ None of the above

If woman was 35 or over, was fetal genetic testing offered?
- ☐ Yes
- ☐ No, too late
- ☐ No, other reason

SCREEN: LABOR

Onset of labor *(Check ALL that apply):*
- ☐ Prolonged rupture of membranes (12 hours or more)
- ☐ Premature rupture of membranes (prior to labor)
- ☐ Precipitous labor (less than 3 hours)
- ☐ Prolonged labor (20 hours or more)
- ☐ None of the above

Characteristics of labor and delivery *(Check ALL that apply):*
- ☐ Induction of labor – AROM
- ☐ Induction of labor – Medicinal
- ☐ Augmentation of labor
- ☐ Placenta previa
- ☐ Other excessive bleeding
- ☐ Steroids
- ☐ Antibiotics
- ☐ Chorioamnionitis
- ☐ Febrile (>100.4F or 38C)
- ☐ Meconium staining
- ☐ Fetal intolerance
- ☐ External electronic fetal monitor
- ☐ Internal electronic fetal monitor
- ☐ None of the above

SCREEN: DELIVERY

Was delivery with forceps attempted but unsuccessful?
- ☐ Attempted and successful
- ☐ Attempted but unsuccessful
- ☐ Forceps were not used

Indication for forceps *(Check ALL that apply):*
- ☐ Failure to progress
- ☐ Fetus at risk
- ☐ Other
- ☐ Unknown

Was delivery with vacuum extraction attempted but unsuccessful?
- ☐ Attempted and successful
- ☐ Attempted but unsuccessful
- ☐ Vacuum extraction was not used

Indications for vacuum *(Check ALL that apply):*
- ☐ Failure to progress
- ☐ Fetus at risk
- ☐ Other
- ☐ Unknown

Fetal presentation at birth *(Check ONE):*
- ☐ Cephalic
- ☐ Breech
- ☐ Other

FINAL route and method of delivery *(Check ONE):*
- ☐ Vaginal/spontaneous
- ☐ Vaginal/forceps
- ☐ Vaginal/vacuum
- ☐ Cesarean

If cesarean, was trial of labor attempted?
- ☐ Yes
- ☐ No

Indications for C-section *(Check ALL that apply):*
- ☐ Failure to progress
- ☐ Malpresentation
- ☐ Previous C-section
- ☐ Fetus at risk/NFS
- ☐ Maternal condition, not pregnancy related
- ☐ Maternal condition, pregnancy related
- ☐ Refused VBAC
- ☐ Elective
- ☐ Other
- ☐ Unknown

Other procedures performed at delivery *(Check ALL that apply):*
- ☐ Episiotomy and repair
- ☐ Sterilization
- ☐ Repair of lacerations
- ☐ None of the above

Anesthesia *(Check ALL that apply):*
- ☐ Epidural
- ☐ General inhalation
- ☐ General intravenous
- ☐ Spinal
- ☐ Paracervical
- ☐ Pudendal
- ☐ Local
- ☐ None of the above

Complications from any of the above? ☐ Yes ☐ No

Maternal morbidity (Did any of the following complications occur?) *(Check ALL that apply):*
- ☐ Maternal transfusion
- ☐ Perineal laceration (3rd or 4th degree)
- ☐ Ruptured uterus
- ☐ Unplanned hysterectomy
- ☐ Admit to ICU
- ☐ Unplanned operating room procedure following delivery
- ☐ Hemorrhage
- ☐ Postpartum transfer to a higher level of care
- ☐ None of the above

If birth occurred in hospital, was mother/parent transferred in before giving birth?
☐ Yes ☐ No

If yes, name of facility transferred from:

____

Infant transferred (to another hospital)?
- ☐ Within 24 hours of delivery
- ☐ After 24 hours of delivery
- ☐ Not transferred

If transferred, name of facility transferred to:

____

SCREEN: NEWBORN

Child's Medical Record Number

(Automatically filled in from Start New Case screen)

Infant birth weight *(Preferable to enter grams):*

___ ___ *Pounds* ___ ___ *Ounces* or ___ ___ ___ ___ *Grams*

If birth weight <1250 grams (2 lbs. 12 oz.), reason(s) for delivery at a less than Level III hospital *(Check ALL that apply):*
- ☐ Rapid/Advanced labor
- ☐ Bleeding
- ☐ Fetus at risk
- ☐ Severe pre-eclampsia
- ☐ Woman (Mother) refused transfer
- ☐ Other *(Specify):* ______________
- ☐ None of the above

If None of the above was checked, select one:
- ☐ No reason
- ☐ Unknown at this time

Clinical estimate of gestation *(Completed weeks):* ____ ____

Apgar score at:
- 1 minute ________
- 5 minutes* ________
- 10 minutes ________

* if 5 min. score is < 6 then provide 10 min. score

Number delivered in this pregnancy *(TOTAL number delivered: include stillborn, live born, and fetal reduction):* ________
- If more than one, number of this child in order of delivery: ________
- If more than one, number of infants in this delivery born alive: ________

Is infant living at the time of report? ☐ Yes ☐ No

How is infant being fed? *(Check ONE):*
- ☐ Breast milk only
- ☐ Formula only
- ☐ Both
- ☐ Neither (i.e. infant may be on IV fluids)

Hepatitis B Inoculation

IMMUNIZATION administered? ☐ Yes ☐ No

___ ___ / ___ ___ / ___ ___ ___ ___ (*Month* / *Day* / *Year*)

IMMUNOGLOBULIN administered? ☐ Yes ☐ No

___ ___ / ___ ___ / ___ ___ ___ ___ (*Month* / *Day* / *Year*)

SCREEN: NEWBORN FACTORS

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 neurological dysfunction
- ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
- ☐ None of the above

Congenital Anomalies *(Check ALL that apply):*		Diagnosed Prenatally?	If Yes, please indicate all methods used:
Anencephaly	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ MSAFP/triple screen ☐ Amniocentesis ☐ Other ☐ Unknown
Meningomyelocele/Spina bifida	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ MSAFP/triple screen ☐ Amniocentesis ☐ Other ☐ Unknown
Cyanotic congenital heart disease	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ Other ☐ Unknown
Congenital diaphragmatic hernia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ Other ☐ Unknown
Omphalocele	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ Other ☐ Unknown
Gastroschisis	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ Other ☐ Unknown
Limb reduction defect	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ Other ☐ Unknown
Cleft lip with or without cleft palate	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ Other ☐ Unknown
Cleft palate alone	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ Other ☐ Unknown
Down syndrome ☐ Karyotype confirmed ☐ Karyotype pending	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ CVS ☐ Other ☐ Amniocentesis ☐ MSAFP/triple screen ☐ Unknown
Other chromosomal disorder ☐ Karyotype confirmed ☐ Karyotype pending	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ CVS ☐ Other ☐ Amniocentesis ☐ MSAFP/triple screen ☐ Unknown
Hypospadias	☐ Yes ☐ No	☐ Yes ☐ No	☐ Level II ultrasound ☐ Other ☐ Unknown
☐ None of those listed above			

SCREEN: ADMISSIONS AND DISCHARGES

VR-204 (12/09)

Copy of prenatal record in chart?	Was formal risk assessment in prenatal chart?	Was MSAFP/triple screen test offered?	Was MSAFP/triple screen test done?	How many times was the mother/parent hospitalized during this pregnancy, not including hospitalization for delivery?
☐ Yes, full record ☐ Yes, prenatal summary only ☐ No	☐ Yes, with social assessment ☐ Yes, without social assessment ☐ No	☐ Yes ☐ No, too late ☐ No, other reason	☐ Yes ☐ No	______

Mother/Parent admission date for delivery	If mother/parent has been discharged *(at time of report)*, Mother/Parent discharge date	If infant discharged, discharge date	Infant discharge status
__ __ / __ __ / __ __ __ __ *Month* *Day* *Year*	__ __ / __ __ / __ __ __ __ *Month* *Day* *Year*	__ __ / __ __ / __ __ __ __ *Month* *Day* *Year*	☐ Discharged home ☐ Infant still in hospital ☐ Infant transferred out ☐ Infant died at birth hospital ☐ Infant discharged to foster care/adoption ☐ Unknown

SCREEN: ATTENDANT/CERTIFIER

Name of attendant at delivery:	FIRST Name	MIDDLE Name(s)	LAST Name	Suffix *(Jr., III, 3rd, etc.)*

Attendant Title

☐ M.D. ☐ D.O. ☐ Licensed Midwife ☐ RPA ☐ R.N. ☐ Other *(Specify)* ____________________

Name of certifier	FIRST Name	MIDDLE Name(s)	LAST Name	Suffix *(Jr., III, 3rd, etc.)*
☐ Same as attendant				

Certifier Title

☐ M.D. ☐ D.O. ☐ Licensed Midwife ☐ RPA ☐ R.N. ☐ Other *(Specify)* ____________________

Street Address	Apt or Suite No.	City	State	Country	ZIP Code

YOU ARE NOW READY TO ENTER DATA INTO NYC EBRS