

ARIZONA DEPARTMENT OF HEALTH SERVICES
OFFICE OF VITAL RECORDS

CERTIFICATE OF LIVE BIRTH WORKSHEET

Attention Parent/Informant – Please complete and carefully review the information that you have provided for fields 1A-1D, 9, 16A-16D, 17-19, 20A-20E, 21-42, 48, 52A-52D, 53-63, 73, and 74 on this worksheet **before** signing your name in field 18. By signing field 18, you agree that the worksheet has been verified and is true and accurate to the best of your knowledge. *Please note: Only the English version of the Certificate of Live Birth Worksheet may be completed. The Spanish version of the worksheet is available for reference only. Thank you for your cooperation.*

1A. CHILD'S FIRST NAME <input type="checkbox"/> Child Not Named		1B. MIDDLE NAME		1C. LAST NAME		1D. SUFFIX	
2. SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not yet determined		3. DATE OF BIRTH		4. TIME OF BIRTH ____:____ <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Military <input type="checkbox"/> Unknown		5. COUNTY OF BIRTH (e.g., Maricopa, Pima, etc.)	
6. CITY OF BIRTH		7. PLACE WHERE BIRTH OCCURRED <input type="checkbox"/> Clinic/doctor's office <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Home birth <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____ Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
8. BIRTHING FACILITY -- Or full address, if birth did not occur in a hospital or freestanding birthing center							
9. DO YOU WANT A SOCIAL SECURITY NUMBER ISSUED FOR YOUR BABY? <input type="checkbox"/> Yes <input type="checkbox"/> No I request that the Social Security Administration assign a Social Security number to the child named on this form and authorize the State to provide the Social Security Administration with the information from this form, which is needed to assign a number. Signature _____							
10. IS INFANT LIVING AT TIME OF REPORT? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant transferred, status unknown				11. IS INFANT BEING BREASTFED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
12A. ATTENDANT FIRST NAME		12B. MIDDLE NAME		12C. LAST NAME		12D. SUFFIX	
12E. ATTENDANT TITLE <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> C.N.M./C.M. (Certified Nurse Midwife/Certified Midwife) <input type="checkbox"/> C.P.M./L.M. <input type="checkbox"/> Other Midwife <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) _____							
13. ATTENDANT SIGNATURE			14. DATE SIGNED		15. NPI (to be completed by healthcare agent) _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown		
16A. PARENT/INFORMANT FIRST NAME		16B. MIDDLE NAME		16C. LAST NAME		16D. SUFFIX	
						17. RELATIONSHIP TO CHILD <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent <input type="checkbox"/> Other (Specify) _____	
18. PARENT/INFORMANT SIGNATURE					19. DATE SIGNED (DATE PARENT/INFORMANT SIGNED WORKSHEET)		
20A. MOTHER'S FIRST NAME PRIOR TO FIRST MARRIAGE			20B. MOTHER'S MIDDLE NAME PRIOR TO FIRST MARRIAGE			20C. MOTHER'S LAST NAME PRIOR TO FIRST MARRIAGE	
20D. SUFFIX		20E. CURRENT LEGAL LAST NAME				21. SOCIAL SECURITY NUMBER _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown	

Mother's Name _____
 Medical Record Number _____

22. MOTHER'S DATE OF BIRTH (mm/dd/yyyy)	23. MOTHER'S PLACE OF BIRTH – U.S. State or Territory	24. MOTHER'S PLACE OF BIRTH - COUNTRY	
25. MOTHER'S EDUCATION What is the highest level of schooling that you will have completed at the time of delivery? Check the box that best describes your education. If you are currently enrolled, check the box that indicates the previous grade or highest degree received. <input type="checkbox"/> 8 th grade or less; or none <input type="checkbox"/> 9 th – 12 th grade, no diploma <input type="checkbox"/> High school graduate or GED completed <input type="checkbox"/> Some college credit, but no degree <input type="checkbox"/> Associate degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's degree (e.g. BA, AB, BS) <input type="checkbox"/> Unknown due to parents have left the facility <input type="checkbox"/> Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD) <input type="checkbox"/> Unknown			
26. HAS THE MOTHER EVER BEEN MARRIED? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown at this time	27. WAS THE MOTHER MARRIED AT DELIVERY, CONCEPTION, OR ANY TIME BETWEEN? <input type="checkbox"/> Yes <input type="checkbox"/> Refused <input type="checkbox"/> No <input type="checkbox"/> Yes, Divorced <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, Waiver	28. HAS THE FATHER SIGNED AN ACKNOWLEDGMENT OF PATERNITY? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Court ordered paternity AOP Date _____	
29. MOTHER OF HISPANIC ORIGIN? (Check all that apply) <input type="checkbox"/> Not Spanish, Hispanic, or Latina <input type="checkbox"/> Mexican, Mexican American, Chicana <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Not Obtainable <input type="checkbox"/> Cuban <input type="checkbox"/> Unknown <input type="checkbox"/> Refused <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (e.g. Spaniard, Salvadoran, Dominican, Columbian) Specify _____			
30. MOTHER'S RACE (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Chinese <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese Primary or Enrolled Tribe _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan Additional Tribe _____ <input type="checkbox"/> Refused <input type="checkbox"/> Not Obtainable <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Other Asian Additional Tribe _____ <input type="checkbox"/> Other (Specify) _____ (Specify) _____ (Specify) _____ Additional Tribe _____ <input type="checkbox"/> (Specify) _____ (Specify) _____ (Specify) _____ <input type="checkbox"/> Unknown			
31. MOTHER'S RESIDENCE ADDRESS Complete number, street, apt. # <input type="checkbox"/> Non USA Address (Do not enter rural route numbers) Address Line 1 _____ Apt. # _____ Address Line 2 _____		32. STATE or U.S. territory or Canadian province	
33. ZIP CODE	34. CITY	35. COUNTY (e.g., Maricopa, Pima, Pinal, etc.)	36. INSIDE CITY LIMITS? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
37. IS MOTHER'S RESIDENCE IN AN AZ TRIBAL COMMUNITY? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, check <u>only</u> one <input type="checkbox"/> Ak Chin Indian Community <input type="checkbox"/> Camp Verde Yavapai Apache <input type="checkbox"/> Cocopah Tribe <input type="checkbox"/> Colorado River Indian Tribes <input type="checkbox"/> Fort Mojave Tribe <input type="checkbox"/> Ft. McDowell Mohave-Apache Community <input type="checkbox"/> Gila River Indian Community (Pima) <input type="checkbox"/> Havasupai Tribe <input type="checkbox"/> Hopi Tribe <input type="checkbox"/> Hualapai Tribe <input type="checkbox"/> Kaibab Band of Paiute Indian <input type="checkbox"/> Navajo Tribe <input type="checkbox"/> Pasqua Yaqui <input type="checkbox"/> Prescott Yavapai Indian Community <input type="checkbox"/> Quechan Tribe <input type="checkbox"/> Salt River Indian Community (Pima) <input type="checkbox"/> San Carlos Apache Tribe <input type="checkbox"/> San Juan So. Paiute Band <input type="checkbox"/> Tonto Apache <input type="checkbox"/> Tohono O'dham Tribe (Papago) <input type="checkbox"/> White Mountain Apache Tribe (Fort Apache)			

Mother's Name _____
 Medical Record Number _____

38. MOTHER'S MAILING ADDRESS Complete number, street, Apt. # or P.O. Box <input type="checkbox"/> Non USA Address (Do not enter rural route numbers) Address Line 1 _____ Apt. # _____ Address Line 2 _____		39. MAILING ADDRESS SAME AS RESIDENCE? <input type="checkbox"/> Yes <input type="checkbox"/> No	
40. STATE (U.S. territory or Canadian province)		41. ZIP CODE	
42. CITY			
43. PRIOR PREGNANCY INFORMATION Number of previous live births now living _____ <input type="checkbox"/> None Number of live births now deceased _____ <input type="checkbox"/> None Date of last live birth (mm/yyyy) _____ Number of other pregnancy outcomes _____ <input type="checkbox"/> None Date of last other pregnancy outcome (mm/yyyy) _____		44. CHILD BIRTHING INFORMATION APGAR score 5 minutes _____ APGAR score 10 minutes _____ <input type="checkbox"/> Birth weight in grams _____ <input type="checkbox"/> Birth length in Inches _____ <input type="checkbox"/> Birth weight in pounds/ounces _____ <input type="checkbox"/> Birth length in centimeters _____ <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown	
45. PLURALITY <input type="checkbox"/> Single <input type="checkbox"/> Triplet <input type="checkbox"/> Quintuplet <input type="checkbox"/> Septuplet <input type="checkbox"/> Nonuplet <input type="checkbox"/> Undecaplet <input type="checkbox"/> Twin <input type="checkbox"/> Quadruplet <input type="checkbox"/> Sextuplet <input type="checkbox"/> Octuplet <input type="checkbox"/> Decaplet <input type="checkbox"/> Duodecaplet If not single, please specify (First, second, third, etc.) _____		46. PRENATAL INFORMATION Date last normal menses began (mm/dd/yyyy) _____ <input type="checkbox"/> Date or part of date unknown Obstetric estimate of gestation: Completed weeks _____ <input type="checkbox"/> Unknown	
47. TOTAL PRENATAL VISITS _____ (If none, enter "0") <input type="checkbox"/> Unknown Date of first prenatal visit (mm/dd/yy) _____ <input type="checkbox"/> Date or part of date unknown Date of last prenatal visit (mm/dd/yy) _____ <input type="checkbox"/> Date or part of date unknown		48. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Was the prenatal record used for completion of birth certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No	
49A. MOTHER WAS TRANSFERRED FROM ANOTHER FACILITY FOR MATERNAL OR FETAL INDICATIONS FOR DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No		49B. IF YES, SPECIFY NAME OF FACILITY (no acronyms)	
50A. INFANT WAS TRANSFERRED TO ANOTHER FACILITY WITHIN 24 HOURS OF DELIVERY? <input type="checkbox"/> Yes <input type="checkbox"/> No		50B. IF YES, SPECIFY NAME OF FACILITY (no acronyms)	
51. PRINCIPLE SOURCE OF PAYMENT FOR THIS DELIVERY (Check one) <input type="checkbox"/> AHCCCS <input type="checkbox"/> CHAMPUS/TRICARE <input type="checkbox"/> IHS <input type="checkbox"/> Private Insurance <input type="checkbox"/> Self-Pay <input type="checkbox"/> Unknown <input type="checkbox"/> Other Government (Fed, State, Local) <input type="checkbox"/> Other (specify) _____			
52A. FATHER'S CURRENT LEGAL FIRST NAME		52B. CURRENT LEGAL MIDDLE NAME	
		52C. CURRENT LEGAL LAST NAME	
		52D. SUFFIX	
53. SOCIAL SECURITY NUMBER _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown		54. DATE OF BIRTH (mm/dd/yyyy)	
		55. PLACE OF BIRTH – U.S. State or Territory	
		56. PLACE OF BIRTH - COUNTRY	

Mother's Name _____
Medical Record Number _____

57. FATHER'S EDUCATION

What is the highest level of schooling that you will have completed at the time of delivery?

Check the box that best describes your education. If you are currently enrolled, check the box that indicates the previous grade or highest degree received.

- 8th grade or less; or none 9th – 12th grade, no diploma High school graduate or GED completed Some college credit, but no degree
 Associate degree (e.g. AA, AS) Bachelor's degree (e.g. BA, AB, BS) Unknown due to parents have left the facility
 Master's degree (e.g. MA, MS, MEng, MEd, MSW, MBA) Doctorate (e.g. PhD, EdD) or Professional degree (e.g. MD, DDS, DVM, LLB, JD)
 Unknown

58. FATHER'S MAILING ADDRESS Complete number, street, Apt. # or P.O. Box (Do not enter rural route numbers) Non USA Address Check here if same as mother's mailing address

Address Line 1 _____ Apt. # _____

Address Line 2 _____

59. STATE (U.S. territory or Canadian province)

60. ZIP CODE

61. CITY

62. FATHER OF HISPANIC ORIGIN? (Check all that apply)

- Not Spanish, Hispanic, or Latino Mexican, Mexican American, Chicano Puerto Rican Not Obtainable
 Cuban Unknown Refused
 Yes, other Spanish/Hispanic/Latino (e.g. Spaniard, Salvadoran, Dominican, Columbian) Specify _____

63. FATHER'S RACE (Check all that apply)

- White Asian Indian Black or African American Chinese American Indian or Alaska Native
 Filipino Japanese Korean Vietnamese Primary or Enrolled Tribe _____
 Native Hawaiian Guamanian or Chamorro Samoan Additional Tribe _____
 Refused Not Obtainable Other Pacific Islander Other Asian Additional Tribe _____
 Other (Specify) _____ (Specify) _____ (Specify) _____ Additional Tribe _____
 (Specify) _____ (Specify) _____ (Specify) _____ Unknown

64. MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

- Diabetes Hypertension Previous preterm birth (< 37 completed weeks gestation)
 Prepregnancy (Diagnosis prior to this pregnancy) Prepregnancy (Chronic) Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
 Gestational (Diagnosis in this pregnancy) Gestational (PIH, preeclampsia)
 Eclampsia
 Pregnancy resulted from infertility treatment; (if checked, check all sub items that apply)
 Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
 Assisted reproductive technology [e.g., in vitro fertilization (IVF), gamete Intrafallopian transfer (GIFT)]
- Has the mother had a previous cesarean delivery?
 Yes If Yes, how many _____ Unknown
 None of the above

65. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

- Gonorrhea Syphilis Chlamydia Hepatitis B Hepatitis C None of the above

66. ONSET OF LABOR (Check all that apply)

- Yes No Premature rupture of the membranes (prolonged, >= 12 hours) Yes No Precipitous labor (< 3 hours) Yes No Prolonged labor (>= 20 hours)
 None of the above Unknown

Mother's Name _____

Medical Record Number _____

67. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

- | | |
|--|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Induction of labor | Yes <input type="checkbox"/> No <input type="checkbox"/> Augmentation of labor |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Non-vertex presentation | Yes <input type="checkbox"/> No <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Antibiotics received by the mother during labor | Yes <input type="checkbox"/> No <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature > = 38° C (100.4° F) | Yes <input type="checkbox"/> No <input type="checkbox"/> 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 |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Epidural or spinal anesthesia during labor | <input type="checkbox"/> None of the above |

68. MATERNAL MORBIDITY (Check all that apply) (Occurring 24 hours before delivery or within 24 hours of delivery)

- | | | |
|---|---|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Maternal transfusion | Yes <input type="checkbox"/> No <input type="checkbox"/> Unplanned hysterectomy | Yes <input type="checkbox"/> No <input type="checkbox"/> Third or fourth degree perineal laceration |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Admission to intensive care unit | Yes <input type="checkbox"/> No <input type="checkbox"/> Ruptured uterus | Yes <input type="checkbox"/> No <input type="checkbox"/> Unplanned operating room procedure following delivery |
| <input type="checkbox"/> None of the above | | |

69. CONGENITAL ANOMALIES OF THE CHILD (Check all that apply)

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Anencephaly | <input type="checkbox"/> Meningomyelocele / Spina Bifida | <input type="checkbox"/> Cyanotic congenital heart disease | <input type="checkbox"/> Congenital diaphragmatic hernia |
| <input type="checkbox"/> Omphalocele | <input type="checkbox"/> Gastroschisis | <input type="checkbox"/> Cleft Lip with or without cleft palate | <input type="checkbox"/> Cleft palate alone |
| <input type="checkbox"/> Hypospadias | <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) | <input type="checkbox"/> Unknown at this time | |
| <input type="checkbox"/> Down Syndrome (if checked, at least one sub-item must be checked) | | <input type="checkbox"/> Suspected chromosomal disorder (if checked, at least one sub-item must be checked) | |
| <input type="checkbox"/> Karyotype confirmed | <input type="checkbox"/> Karyotype pending | <input type="checkbox"/> Karyotype confirmed | <input type="checkbox"/> Karyotype pending |
| <input type="checkbox"/> None of the anomalies listed above | | | |

70. OBSTETRIC PROCEDURES (Check all that apply)

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

71. METHOD OF DELIVERY

- | | |
|---|--|
| A. Was delivery with forceps attempted but unsuccessful? Yes <input type="checkbox"/> No <input type="checkbox"/> | B. Was delivery with vacuum extraction attempted but unsuccessful? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| C. Fetal presentation at birth (Check one) | D. Final route and method of delivery (Check one) |
| <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other <input type="checkbox"/> Unknown | <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum |
| | <input type="checkbox"/> Cesarean If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No |

72. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply) (Occurring within 24 hours of delivery)

- | | |
|--|--|
| Yes <input type="checkbox"/> No <input type="checkbox"/> Assisted ventilation required immediately following delivery | Yes <input type="checkbox"/> No <input type="checkbox"/> Assisted ventilation required for more than six hours |
| Yes <input type="checkbox"/> No <input type="checkbox"/> NICU admission | Yes <input type="checkbox"/> No <input type="checkbox"/> Newborn given surfactant replacement therapy |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis | Yes <input type="checkbox"/> No <input type="checkbox"/> Seizure or serious neurologic dysfunction? |
| Yes <input type="checkbox"/> No <input type="checkbox"/> Significant birth injury [skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention] | |
| If Yes (specify) _____ | |
| <input type="checkbox"/> None of the above | |

73. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY

Please answer for each time period the average number of cigarettes per day. (If none, enter "0." Note: 1 pack = 20 cigarettes)

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Never smoked in lifetime | Number of Cigarettes Per Day |
| Three Months Before Pregnancy _____ | First Three Months of Pregnancy _____ |
| Second Three Months of Pregnancy _____ | Third Trimester of Pregnancy _____ |

74. MOTHER'S HEIGHT AND WEIGHT

Mother's height _____ feet _____ inches
 Mother's prepregnancy weight _____ pounds
 Mother's weight immediately prior to delivery _____ pounds

Mother's Name _____
 Medical Record Number _____

75. IMMUNIZATION

Vaccination #1 (Check one of the choices below)

HBIG (Hepatitis B Immune Globulin) Hepatitis B Other None Unknown Date administered _____

Site -- check one of the choices below

Thigh, Left Deltoid, Left Forearm, Right Oral
 Thigh, Right Deltoid, Right Forearm, Left Other Unknown Lot # _____

Manufacturer – check one of the choices below

Glaxo Smith Kline Merck Other

Provider (Person's) Name _____ Provider Title _____ (M.D., D.O., RN, Other)

Vaccination #2 (Check one of the choices below)

HBIG (Hepatitis B Immune Globulin) Hepatitis B Other None Unknown Date administered _____

Site -- check one of the choices below

Thigh, Left Deltoid, Left Forearm, Right Oral
 Thigh, Right Deltoid, Right Forearm, Left Other Unknown Lot # _____

Manufacturer – check one of the choices below

Glaxo Smith Kline Merck Other

Provider (Person's) Name _____ Provider Title _____ (M.D., D.O., RN, Other)

76. MEDICAL RECORD NO.

Child's Medical Record _____ Mother's Medical Record _____

Arizona Revised Statute §36-342. Disclosure of information; prohibition

- A. The state registrar may provide information contained in vital records to persons, including federal, state, local and other agencies, as required by law and for statistical or research purposes.
- B. Except as authorized by law, a local registrar, a deputy local registrar or the state registrar or their employees shall not:
 1. Permit inspection of a vital record or evidentiary document supporting the vital record.
 2. Disclose information contained in a vital record.
 3. Transcribe or issue a copy of all or part of a vital record.

Registered by (please print or type):

Name: _____

Phone Number: _____

Registration Date: _____

Mother's Name _____
Medical Record Number _____