Washington State Department of Health

Washington State Birth Filing Form

For Hospital Use Only

Mother's Medical Record #:	Child's Medical Record #:

Plurality: ☐ 1- single birth ☐ 2- twin ☐ 3- triplet ☐ Other _____

If multiple, this worksheet is for child: ☐ 1- first born ☐ 2- second born ☐ 3- third born ☐ Other _____

Child's Information

Child's Information

*1. Child's Name First	Middle	Last
*2. Child's Date of Birth (MM/DD/YYYY) / /	*3. Time of Birth	*4. Child's Sex ☐ Male ☐ Female

5. Type of Birthplace
☐ Hospital ☐ Home
☐ Enroute ☐ Clinic/Doctor's Office
☐ Freestanding Birth Center ☐ Other (specify):

6. Planned Birth Place, if different (specify):

*7. Name of Facility (If not a facility, enter name of place and address)	*8. County of Birth	*9. City of Birth

Mother's Information

Mother's Information

10. Mother's Current Legal Name First	Middle	Last
*11. Mother's Name on her Birth Certificate First	Middle	Last/Maiden
*12. Date of Birth (MM/DD/YYYY) / /	*13. Birthplace (State, Territory, or Foreign Country)	14. Social Security Number

15. Do you want to get a Social Security Number for your child? ☐ Yes ☐ No

16a. Residence: Number and Street (e.g., 624 SE 5th St.)	Apt No.

16b. If not U.S.; Country	16c. State	16d. County

16e. If you live on Tribal Reservation, give name	16f. City or Town	16g. Zip Code + 4

16h. Inside City Limits? ☐ Yes ☐ No ☐ Unknown	17. How Long at Current Residence? Years: Months:	18. Telephone Number ( )

19a. Mailing Address, if different: Number and Street, or PO Box	Apt. No.

19b. If not U.S.; Country	19c. State	19d. City	19e. Zip Code + 4

20. Occupation (type of work done during last year)	21. Kind of Business/Industry (do not use company name)

22. Mother's Education
(Check the box that best describes the highest degree or level of school completed at the time of delivery.)

1 ☐ 8th grade or less (specify):_____
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (AA, AS, etc.)
6 ☐ Bachelor's degree (BA, AB, BS, etc.)
7 ☐ Master's degree (MA, MS, MEd, MSW, MBA, etc.)
8 ☐ Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)

23. Mother of Hispanic Origin?
(Check the box that best describes whether the mother is Spanish/Hispanic/Latina or check "No" box if not Spanish/Hispanic/Latina.)

1 ☐ No, not Spanish/Hispanic/Latina
2 ☐ Yes, Mexican, Mexican American, Chicana
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, Other Spanish/Hispanic/Latina (specify):

24. Mother's Race (check one or more)

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
(Name of enrolled or principal tribe)

4 ☐ Asian Indian 5 ☐ Chinese
6 ☐ Filipino 7 ☐ Japanese
8 ☐ Korean 9 ☐ Vietnamese
10 ☐ Other Asian (specify):

11 ☐ Native Hawaiian 12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (specify):

15 ☐ Other (specify):

Continue on next page

Mother's Information

25. Mother's Height Feet: Inches:	26. Mother's Pre-Pregnancy Weight (pounds)	27. Did Mother get WIC food for herself during pregnancy? ☐ Yes ☐ No

28. Cigarette Smoking Before and During Pregnancy
☐ Yes ☐ No

Average number of cigarettes or packs per day:

	# of cigarettes		# of packs
Three months before pregnancy		or	
First three months of pregnancy		or	
Second three months of pregnancy		or	
Last three months of pregnancy		or	

Mother's Marital Status

Mother's Marital Status

29. Is mother married? (Check only one box)

Important - Read before responding to marital status question:
If you were married at any time during your pregnancy, your spouse or partner is considered the other legal parent unless he or she completes a denial of paternity and another man acknowledges that he is the father (chapter 26.26 RCW). To add someone other than your spouse or partner to the birth certificate, an acknowledgment and denial of paternity needs to be completed by all parties (DOH form 422-032). Under Washington State law, a state-registered domestic partnership is considered the same as a marriage (chapter 26.60 RCW).

If you were not married at any time during the pregnancy, an acknowledgment of paternity needs to be completed to add the father to the birth certificate.

Married - Yes	Married - No
29a. ☐ Yes, I am married to the other parent identified in box #30.	29d. ☐ No, I am not married and I am providing information about the father in box #30. *Ask hospital staff for a Paternity Acknowledgment form (#DOH 422-032). If you were married any time during the pregnancy and your previous spouse is not the parent identified in box #30, the spouse's Denial of Paternity must also be completed.*
29b. ☐ Yes, I am married but not to the other person identified in box #30. *Ask hospital staff for a Paternity Acknowledgment form (# DOH 422-032).You must complete this form, including the spouse's Denial of Paternity.*	29e. ☐ No, I am not married now, but I was married to the other parent identified in box #30 at some time during this pregnancy.
29c. ☐ Yes, I am married but I refuse to provide the spouse or partner's information. *If this box is checked, the other parent will be listed on the birth certificate as "None Named".*	29f. ☐ No, I am not married and I refuse to provide the father's information. *If this box is checked, the other parent will be listed on the birth certificate as "None Named".*

Father/ Parent's Information

Father/Parent's Information

*30. Current Legal Name First	Middle	Last
*31. Date of Birth (MM/DD/YYYY) / /	*32. Birthplace (State, Territory, or Foreign Country)	33. Social Security Number

34. Occupation (type of work done during last year.)	35. Kind of Business/Industry (do not use Company Name)

36. Father/Parent Education
(Check the box that best describes the highest degree or level of school completed at the time of delivery.)

1 ☐ 8th grade or less (specify):_____
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (AA, AS, etc.)
6 ☐ Bachelor's degree (BA, AB, BS, etc.)
7 ☐ Master's degree (MA, MS, MEd, MSW, MBA, etc.)
8 ☐ Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)

37. Father/Parent of Hispanic Origin?
(Check the box that best describes whether the father/parent is Spanish/Hispanic/Latino or check "No" box if not Spanish/Hispanic/Latino.)

1 ☐ No, not Spanish/Hispanic/Latino
2 ☐ Yes, Mexican, Mexican American, Chicano
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, other Spanish/Hispanic/Latino (specify):

38. Father/Parent Race (check one or more)

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
(Name of enrolled or principal tribe)

4 ☐ Asian Indian 5 ☐ Chinese
6 ☐ Filipino 7 ☐ Japanese
8 ☐ Korean 9 ☐ Vietnamese
10 ☐ Other Asian (specify):

11 ☐ Native Hawaiian 12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (specify):

15 ☐ Other (specify):

For Hospital Use Only

Mother's Statistical Information

39. Date of First Prenatal Care Visit (MM/DD/YYYY) / / ☐ No Prenatal Care

40. Date of Last Prenatal Care Visit (MM/DD/YYYY) / /

41. Total Number of Prenatal Visits for this Pregnancy (If none, enter '0') _____

42. Number of Previous Live Births (Do not include this child)
Number Now Living _____ ☐ None
Number Now Dead _____ ☐ None

43. Date of Last Live Birth (MM/YYYY) (Do not include this child) / /

44. Number of Other Pregnancy Outcomes (Spontaneous or induced losses or ectopic pregnancies)
Number of Other Outcomes _____ ☐ None

45. Date of Last Other Pregnancy Outcome (MM/YYYY) / /

46. Date Last Normal Menses Began (MM/DD/YYYY) / /

47. Mother's Weight at Delivery(pounds)

48. Was mother transferred to higher level care for maternal medical or fetal indications for delivery? ☐ Yes ☐ No
If yes, name of facility mother was transferred from:

49. Principal Source of Payment for this Delivery
☐ Medicaid ☐ Self-Pay ☐ Private Insurance
☐ Other Gov't ☐ Tricare ☐ Indian Health
☐ Charity Care ☐ Other _____

Child's Statistical Information

50. Birth Weight
lbs: ozs: **or** grams:

51. Infant Head Circumference (cm)

52. Obstetric Estimate of Gestation (completed weeks)

53. Apgar score at 5 minutes _____ If score is less than 6, score at 10 minutes _____

54. Plurality: ☐ Single ☐ twins ☐ triplets ☐other _____

55. If not single birth; birth order: ☐ first ☐ second ☐third ☐other _____

56. Was infant transferred within 24 hours of delivery? ☐ Yes ☐ No
If yes, name of facility infant was transferred to:

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

58. Is infant being breastfed?
☐ Yes ☐ No

Medical and Health Information

59. Risk Factors in this Pregnancy (check all that apply):

1 Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

2 Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

3 ☐ Previous preterm births
4 ☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
5 ☐ Vaginal bleeding during this pregnancy prior to the onset of labor
6 ☐ Pregnancy resulted from infertility treatment - If yes-check all that apply:
- ☐ Fertility-enhancing drugs, artificial insemination or intrauterine insemination
- ☐ Assisted reproductive technology [e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)]

7 ☐ Mother had a previous cesarean delivery? If Yes, how many_____
8 ☐ Group B Streptococcus culture positive
9 ☐ None of the above

60. Infections Present and/or Treated During this Pregnancy (check all that apply):

1 ☐ Gonorrhea
2 ☐ Syphilis
3 ☐ Herpes Simplex Virus (HSV)
4 ☐ Chlamydia
5 ☐ Hepatitis B
6 ☐ Hepatitis C
7 ☐ HIV Infection
8 ☐ Other Specify:_____
9 ☐ None of the above

61. Maternal Morbidity (complications associated with labor and delivery) (Check all that apply):

1 ☐ Maternal transfusion
2 ☐ Third or fourth degree perineal laceration
3 ☐ Ruptured uterus
4 ☐ Unplanned hysterectomy
5 ☐ Admission to intensive care unit
6 ☐ Unplanned operating room procedure following delivery
7 ☐ None of the above

62. Method of Delivery

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

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

C. Fetal presentation at birth ☐ Cephalic ☐ Breech ☐ Other

D. Final route and method of delivery (Check One)

Vaginal: ☐ Spontaneous ☐ Forceps ☐ Vacuum
OR
Cesarean: ☐
If cesarean, was a trial of labor attempted? ☐ Yes ☐ No

63. Obstetric procedures (Check all that apply):

1 ☐ Cervical cerclage
2 ☐ Tocolysis
3 ☐ External cephalic version:
- ☐ Successful
- ☐ Failed

4 ☐ None of the above

64. Onset of Labor (Check all that apply):

1 ☐ Premature rupture of the membranes (Prolonged, ≥ 12hr)
2 ☐ Precipitous Labor (< 3hr)
3 ☐ Prolonged Labor (≥ 20hr)
4 ☐ None of the above

65. Characteristics of Labor and Delivery (Check all that apply):

1 ☐ Induction of labor
2 ☐ Augmentation of labor
3 ☐ Non-vertex presentation
4 ☐ Epidural or spinal anesthesia during labor
5 ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
6 ☐ Antibiotics received by the mother during labor
7 ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
8 ☐ Moderate/heavy meconium staining of the amniotic fluid
9 ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery
10 ☐ None of the above

66. Abnormal Conditions of the Newborn (Occurring within 24 hours of delivery) (check all that apply):

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

67. Congenital Anomalies of the Newborn (Observed within 24 hours of delivery) (Check all that apply)

1 ☐ Anencephaly
2 ☐ Meningomyelocele / Spina bifida
3 ☐ Cyanotic congenital heart disease
4 ☐ Congenital diaphragmatic hernia
5 ☐ Omphalocele
6 ☐ Gastroschisis
7 ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndrome)
8 ☐ Cleft Lip with or without Cleft Palate
9 ☐ Cleft Palate alone
10 Down Syndrome
- ☐ Karyotype confirmed
- ☐ Karyotype pending

11 Chromosomal disorder
- ☐ Karyotype confirmed
- ☐ Suspected, Karyotype pending

12 ☐ Hypospadias
13 ☐ None of the above

Attendant and Certifier Information

68. Certifier – Name and Title

69. Date Certified (MM/DD/YYYY) / /

70. Attendant – Name and Title (If other than Certifier)

71. NPI of person delivering the baby: