Washington State Department of Health

Washington State Birth Filing Form

Child's Information

***1. Child's Name**
First
Middle
LAST

***2. Date of Birth (MM/DD/YYYY)** / /

***3. Time of Birth (24 Hrs)**

Suffix (Sr., Jr., II, III, etc.)

4a. Type of Birthplace (Specify Type)
1 ☐ Hospital 2 ☐ Enroute 3 ☐ Freestanding Birth Center
4 ☐ Clinic/Doctor's Office 5 ☐ Home–Planned ☐Yes ☐No
6 ☐ Other(Specify):

4b. Planned Birth Place, If different
Specify:

5. Sex ☐ Male ☐ Female

***6. Name of Facility (If not a facility, enter name of place and address)**

***7. City, Town, or Location of Birth**

***8. County of Birth**

Mother's Information

***9. Mother's Name Before First Marriage**
First
Middle
LAST

***10. Date of Birth (MM/DD/YYYY)** / /

***11. Birthplace (State, Territory, or Foreign Country)**

12. Mother's Social Security Number

13. Mother's Current Legal Last Name, if different from above

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

15. Is Mother Married to the Father? ☐ Yes ☐ No
If NO: Was Mother Married to anyone during this pregnancy? ☐ Yes ☐ No
Has the Paternity Acknowledgment been signed? ☐ Yes ☐ No

16a. Residence: Number and Street (e.g., 624 SE 5th St.)

Apt No.

16b. City or Town

16c. County

16d. If you live on Tribal Reservation, give name

16e. State or Foreign Country

16f. Zip Code + 4

16g. Inside City Limits? ☐ Yes ☐ No ☐ Unk

17. Telephone Number ( ) -

18. How Long at Current Residence? Years: Months:

19. Mother's Mailing Address, if different: Number & Street: Apt No.
City or Town: State: Zip Code:

20. 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 completed
4 ☐ Some college credit, but no degree
5 ☐ Associate degree(e.g., AA, AS)
6 ☐ Bachelor's degree(e.g., BA, AB, BS)
7 ☐ Master's degree(e.g., MA, MS, MEng, MEd, MSW, MBA)
8 ☐ Doctorate(e.g., PhD, EdD) or Professional degree(e.g., MD, DDS, DVM, LLB, JD)

21. Mother of Hispanic Origin? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina or check the "No" box if mother is 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):

22. Mother's Race (Check one or more races to indicate what the mother considers herself to be.)
☐ White ☐ Black or African American
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)
☐ Asian Indian ☐ Chinese
☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese
☐ Other Asian(Specify):
☐ Native Hawaiian ☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander(Specify):
☐ Other(Specify):

23. Occupation (Indicate type of work done during last year.)

24. Kind of Business/Industry (Do not use Company Name)

Father's Information

***25. Father's Current Legal Name**
First
Middle
LAST Suffix

***26. Date of Birth (MM/DD/YYYY)** / /

***27. Birthplace (State, Territory, or Foreign Country)**

28. Father' s Social Security Number

29. Father'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 completed
4 ☐ Some college credit, but no degree
5 ☐ Associate degree(e.g., AA, AS)
6 ☐ Bachelor's degree(e.g., BA, AB, BS)
7 ☐ Master's degree(e.g., MA, MS, MEng, MEd, MSW, MBA)
8 ☐ Doctorate(e.g., PhD, EdD) or Professional, degree(e.g MD, DDS, DVM, LLB, JD)

30. Father of Hispanic Origin? Check the box that best describes whether the father is Spanish/Hispanic/Latino or check the "No" box if father is 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):

31. Father's Race (Check one or more races to indicate what the father considers himself to be)
☐ White ☐ Black or African American
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)
☐ Asian Indian ☐ Chinese
☐ Filipino ☐ Japanese
☐ Korean ☐ Vietnamese
☐ Other Asian(Specify):
☐ Native Hawaiian ☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander(Specify):
☐ Other(Specify):

32. Occupation (Indicate type of work done during last year.)

33. Kind of Business/Industry (Do not use Company Name)

Optional Signature:

I agree that the above information is accurate: Date:

* *Only these items will be displayed on Legal Certificate. However all items are required by law* ***(RCW 70.58.080)****.*

Mother's Statistical Information

34. Mother's Medical Record Number

35. Mother's Prepregnancy Weight (Pounds)

36. Mother's Weight at Delivery (Pounds)

37. Mother's height
Feet: Inches:

38. Did Mother get WIC food for herself during pregnancy?
☐ Yes ☐ No

39. Cigarette Smoking Before and During Pregnancy
If none enter "0"
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

40a. Number of Previous Live Births
(Do not include this child)
Number Now Living _____ ☐ None
Number Now Dead _____ ☐ None

41a. Number of Other Pregnancy Outcomes
(Spontaneous or induced losses or ectopic pregnancies)
Number of Other Outcomes_____ ☐ None

40b. Date of Last Live Birth (MM/YYYY) (Do not include this child)
/ /

41b. Date of Last Other Pregnancy Outcome (MM/YYYY)
/ /

42a. Date of First Prenatal Care Visit (MM/DD/YYYY)
/ / ☐ No Prenatal Care

42b. Date of Last Prenatal Care Visit (MM/DD/YYYY)
/ /

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

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

45. 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:

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

Newborn's Statistical Information

47. Newborn Medical Record Number

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

49. Infant Head Circumference (cm)

50. Obstetric Estimate of Gestation (Completed weeks)

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

52. Plurality – Single, Twin, Triplet, etc. (Specify)

53. If not single birth – Born 1st, 2nd, 3rd, etc. (Specify)

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

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

56. Is infant being breastfed?
☐ Yes ☐ No

Medical and Health Information

57. 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

58. 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

59. 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

60. Obstetric procedures
(Check all that apply):
1 ☐ Cervical cerclage
2 ☐ Tocolysis
3 ☐ External cephalic version:
☐ Successful
☐ Failed
4 ☐ None of the above

61. 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

62. 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

63. 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

64. 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

65. 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

Attendant and Certifier Information

66. **Certifier – Name and Title**

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

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

69. NPI of person delivering the baby: