MARYLAND STANDARD CERTIFICATE OF LIVE BIRTH

File No. 2010-00-00043

CHILD

1. CHILD'S NAME (First, Middle, Last, Suffix)	2. TIME OF BIRTH (24 hr)	3. SEX	4. DATE OF BIRTH (Mo/Day/Yr)
John Robert Doe	12:15	M	March 9, 2010

5. FACILITY NAME (If not institution, give street and number)	6. CITY, TOWN, OR LOCATION OF BIRTH	7. COUNTY OF BIRTH
Montgomery General Hospital	Olney	Montgomery

MOTHER

8a. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	8b. DATE OF BIRTH (Mo/Day/Yr)
Jane Ann Doe	January 1, 1980

8c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Last, Suffix)	8d. BIRTHPLACE (State, Territory, or Foreign Country)
Jane Ann Smith	Maryland

9a. RESIDENCE OF MOTHER-STATE	9b. COUNTY	9c. CITY, TOWN, OR LOCATION
Maryland	Baltimore City	Baltimore

9d. STREET AND NUMBER	9e. APT. NO.	9f. ZIP CODE	9g. INSIDE CITY LIMITS?
4201 Patterson Ave.		21215	[X] Yes [ ] No

FATHER

10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)	10b. DATE OF BIRTH (Mo/Day/Yr)	10c. BIRTHPLACE (State, Territory, or Foreign Country)
James Samuel Doe	January 1, 1975	Pennsylvania

CERTIFIER

11. CERTIFIER'S NAME: BETHANY JONES

TITLE: [ ] MD [ ] DO [ ] HOSPITAL ADMIN. [ ] CNM/CM [ ] OTHER MIDWIFE

[X] OTHER (Specify) FACILITY REGISTRAR

12. DATE CERTIFIED: 03/09/2010 (MM DD YYYY)

13. DATE FILED BY REGISTRAR: 03/09/2010 (MM DD YYYY)

INFORMATION FOR ADMINISTRATIVE USE

MOTHER

14. MOTHER'S MAILING ADDRESS: [X] Same as residence, or State: City, Town, or Location:

Street & Number: Apartment No.: Zip Code:

15. MOTHER MARRIED? (At birth, conception, or any time between) [X] Yes [ ] No

IF NO, HAS PATERNITY ACKNOWLEDGEMENT BEEN SIGNED IN THE HOSPITAL? [ ] Yes [ ] No

16. SOCIAL SECURITY NUMBER REQUESTED [X] Yes [ ] No

17. FACILITY ID. (NPI)

18. MOTHER'S SOCIAL SECURITY NUMBER: 123-45-6789

19. FATHER'S SOCIAL SECURITY NUMBER: 987-65-4321

INFORMATION FOR MEDICAL AND HEALTH PURPOSES ONLY

MOTHER

20. MOTHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- [ ] 8th grade or less
- [ ] 9th - 12th grade, no diploma
- [ ] High school graduate or GED completed
- [X] Some college credit but no degree
- [ ] Associate degree (e.g., AA, AS)
- [ ] Bachelor's degree (e.g., BA, AB, BS)
- [ ] 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)

21. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)

- [X] No, not Spanish/Hispanic/Latina
- [ ] Yes, Mexican, Mexican American, Chicana
- [ ] Yes, Puerto Rican
- [ ] Yes, Cuban
- [ ] Yes, other Spanish/Hispanic/Latina (Specify)

21a. NUMBER OF YEARS LIVING IN US

22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

- [X] White
- [X] 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)

FATHER

23. FATHER'S EDUCATION (Check the box that best describes the highest degree or level of school completed at the time of delivery)

- [ ] 8th grade or less
- [ ] 9th - 12th grade, no diploma
- [ ] High school graduate or GED completed
- [ ] Some college credit but no degree
- [ ] Associate degree (e.g., AA, AS)
- [X] Bachelor's degree (e.g., BA, AB, BS)
- [ ] 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)

24. FATHER OF HISPANIC ORIGIN? (Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if father is not Spanish/Hispanic/Latino)

- [X] No, not Spanish/Hispanic/Latino
- [ ] Yes, Mexican, Mexican American, Chicano
- [ ] Yes, Puerto Rican
- [ ] Yes, Cuban
- [ ] Yes, other Spanish/Hispanic/Latino (Specify)

24a. NUMBER OF YEARS LIVING IN US

25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)

- [ ] White
- [X] 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)

26. PLACE WHERE BIRTH OCCURRED (Check one)

- [X] Hospital
- [ ] Freestanding birthing center
- [ ] Home Birth: Planned to deliver at home? [ ] Yes [ ] No
- [ ] Clinic/Doctor's office
- [ ] Other (Specify)

27. ATTENDANT'S NAME, TITLE, AND NPI

Name: AMY AMPEY,MD

NPI:

TITLE: [X] MD [ ] CNM/CM [ ] DO [ ] OTHER MIDWIFE [ ] OTHER (specify)

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? [ ] Yes [X] No

IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM

Mother's Name Jane Ann Doe

Mother's Medical Record No. 99999

REV. 11/2003

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MOTHER

29a. DATE OF FIRST PRENATAL CARE VISIT: 07/01/2009 (MM DD YYYY) [ ] No Prenatal Care

29b. DATE OF LAST PRENATAL CARE VISIT: 02/28/2010 (MM DD YYYY)

30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY: 15 (If none, enter "0".)

31. MOTHER'S HEIGHT: 5'05" (feet/inches)

32. MOTHER'S PREPREGNANCY WEIGHT: 145 (pounds)

33. MOTHER'S WEIGHT AT DELIVERY: 177 (pounds)

34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? [ ] Yes [X] No

35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)
- 35a. Now Living — Number 01 [ ] None
- 35b. Now Dead — Number [X] None
- 35c. DATE OF LAST LIVE BIRTH: 05/2003 (MM YYYY)

36. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)
- 36a. Other Outcomes — Number [X] None
- 36b. DATE OF LAST OTHER PREGNANCY OUTCOME: 88/8888 (MM YYYY)

37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".
Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	30	OR	
First Three Months of Pregnancy	20	OR	
Second Three Months of Pregnancy	10	OR	
Third Trimester of Pregnancy	10	OR	

38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
- [ ] Private Insurance
- [X] Medicaid
- [ ] Self-pay
- [ ] Other (Specify)

39. DATE LAST NORMAL MENSES BEGAN: 06/20/2009 (MM DD YYYY)

40. MOTHER'S MEDICAL RECORD NUMBER: 99999

MEDICAL AND HEALTH INFORMATION

41. RISK FACTORS IN THIS PREGNANCY (Check all that apply)

Diabetes
- [ ] Prepregnancy (Diagnosis prior to this pregnancy)
- [ ] Gestational (Diagnosis in this pregnancy)

Hypertension
- [ ] Prepregnancy (Chronic)
- [ ] Gestational (PIH, preeclampsia)
- [ ] Eclampsia
- [ ] Previous preterm birth
- [ ] Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
- [ ] 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))
- [ ] Mother had a previous cesarean delivery — If yes, how many 00
- [X] None

42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- [ ] Gonorrhea
- [ ] Syphilis
- [ ] Chlamydia
- [ ] Hepatitis B
- [ ] Hepatitis C
- [X] None of the above

43. OBSTETRIC PROCEDURES (Check all that apply)
- [ ] Cervical cerclage
- [ ] Tocolysis

External cephalic version:
- [ ] Successful
- [ ] Failed
- [X] None of the above

44. ONSET OF LABOR (Check all that apply)
- [ ] Premature Rupture of the Membranes (prolonged, >12 hrs.)
- [X] Precipitous Labor (<3 hrs.)
- [ ] Prolonged Labor (> 20 hrs.)
- [ ] None of the above

45. 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 or maternal temperature >38°C (100.4°F)
- [ ] Moderate/heavy meconium staining of the amniotic fluid
- [ ] 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
- [X] Epidural or spinal anesthesia during labor
- [ ] None of the above

46. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful? [ ] Yes [X] No

B. Was delivery with vacuum extraction attempted but unsuccessful? [ ] Yes [X] No

C. Fetal presentation at birth
- [X] Cephalic
- [ ] Breech
- [ ] Other

D. Final route and method of delivery (Check one)
- [X] Vaginal/Spontaneous
- [ ] Vaginal/Forceps
- [ ] Vaginal/Vacuum
- [ ] Cesarean
  - If cesarean, was a trial of labor attempted? [ ] Yes [ ] No

47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)
- [ ] Maternal transfusion
- [X] Third or fourth degree perineal laceration
- [ ] Ruptured uterus
- [ ] Unplanned hysterectomy
- [ ] Admission to intensive care unit
- [ ] Unplanned operating room procedure following delivery
- [ ] None of the above

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NEWBORN

NEWBORN INFORMATION

48. NEWBORN MEDICAL RECORD NUMBER: 9999999

49. BIRTHWEIGHT (grams preferred, specify unit): 3780 [X] grams [ ] lb/oz

50. OBSTETRIC ESTIMATE OF GESTATION: 40 (completed weeks)

51. APGAR SCORE:
Score at 5 minutes: 09
If 5 minute score is less than 6,
Score at 10 minutes: 88

52. PLURALITY - Single, Twin, Triplet, etc. (Specify) 01

53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) 88

54. 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
- [X] Antibiotics received by the newborn for suspected neonatal sepsis
- [ ] Seizure or serious neurologic dysfunction
- [ ] Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
- [ ] None of the above

55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
- [ ] Anencephaly
- [ ] Meningomyelocele/Spina bifida
- [ ] Cyanotic congenital heart disease
- [ ] Congenital diaphragmatic hernia
- [ ] Omphalocele
- [ ] Gastroschisis
- [ ] Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- [ ] Cleft Lip with or without Cleft Palate
- [ ] Cleft Palate alone
- [ ] Down Syndrome
  - [ ] Karyotype confirmed
  - [ ] Karyotype pending
- [ ] Suspected chromosomal disorder
  - [ ] Karyotype confirmed
  - [ ] Karyotype pending
- [ ] Hypospadias
- [X] None of the anomalies listed above

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? [ ] Yes [X] No
IF YES, NAME OF FACILITY INFANT TRANSFERRED TO:

57. IS INFANT LIVING AT TIME OF REPORT? [X] Yes [ ] No [ ] Infant transferred, status unknown

58. IS THE INFANT BEING BREASTFED AT DISCHARGE? [X] Yes [ ] No

Mother's Name Jane Ann Doe
Mother's Medical Record No. 99999