



# Maryland Department of Health and Mental Hygiene

## Vital Statistics Administration

### Attachment to the Facility Worksheet for the Certificate of Live Birth for Multiple Births

- This attachment is to be completed when at least two infants in a multiple pregnancy are born alive.\* Complete a full worksheet for the first-born infant and an attachment for each additional live-born infant.

\*For "Delayed Interval Births" (births in a multiple pregnancy delivered at least 24 hours apart) a full worksheet, not an attachment, should be completed.

Mother's Name:  Mother's Record #

Child's Name:  Child's Record #

Child Number:  of  total deliveries (living or stillborn) resulting from this pregnancy

Child's Sex:  Male  Female  Not Yet Determined Child's Date of Birth:    20

Child Being Placed for Adoption?  Yes

Signature of Person Completing Worksheet: \_\_\_\_\_

|   |  |
|---|--|
| <b>SCREEN: FACILITY</b>   | 31. Obstetric estimate of gestation—Completed weeks. _____   |
| 9. Number of previous live births now living _____ <input type="checkbox"/> None  | 33. Apgar score<br>5 minutes _____ if < 6, Score 10 minutes _____  |
| 10. Number of previous live births now dead _____ <input type="checkbox"/> None   | 35. If NOT single birth, order delivered in the pregnancy—Include all live births and fetal losses resulting from this pregnancy.<br>_____ birth order delivered in pregnancy  |
| 12. Total number of other pregnancy outcomes _____ <input type="checkbox"/> None  | 37. Abnormal conditions of the newborn—Disorders or significant morbidity. Mark (X) all that apply.  |
| <b>SCREEN: LABOR/DELIVERY</b>   | <input type="checkbox"/> Assisted ventilation required immediately following delivery<br><input type="checkbox"/> Assisted ventilation required for more than 6 hours<br><input type="checkbox"/> NICU admission<br><input type="checkbox"/> Newborn given surfactant replacement therapy<br><input type="checkbox"/> Antibiotics received by newborn for suspected neonatal sepsis<br><input type="checkbox"/> Seizure or serious neurologic dysfunction<br><input type="checkbox"/> Significant birth injury<br><input type="checkbox"/> None of the above   |
| 19. Time of birth: _____ : _____ 24 hour clock  | 38. Congenital anomalies of the newborn Mark (X) all that apply.   |
| 27. Characteristics of labor and delivery (Mark (X) all that apply.)  | <input type="checkbox"/> Anencephaly <input type="checkbox"/> Cleft lip with/without cleft palate<br><input type="checkbox"/> Meningocele/Spina bifida <input type="checkbox"/> Cleft Palate alone<br><input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Down Syndrome - Trisomy 21<br><input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Karyotype confirmed<br><input type="checkbox"/> Omphalocele <input type="checkbox"/> Karyotype pending<br><input type="checkbox"/> Gastroschisis <input type="checkbox"/> Suspected chromosomal disorder<br><input type="checkbox"/> Limb reduction <input type="checkbox"/> Karyotype confirmed<br><input type="checkbox"/> Karyotype pending |
| 28. Method of delivery (Complete A and B)   | 39. Was infant transferred within 24 hours of delivery?  |
| (A) Fetal presentation at birth Mark (X) one.   | <input type="checkbox"/> Yes, transferred to: _____ <input type="checkbox"/> No  |
| <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other                              | 40. Is infant living at time of this report?   |
| (B) Final route and method of delivery Mark (X) one.  | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Infant transferred, status unknown   |
| <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum | 41. Is infant being breastfed at time of discharge?  |
| <input type="checkbox"/> Cesarean → trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No        | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 29. Maternal morbidity Mark (X) all that apply.   |  |
| <input type="checkbox"/> Maternal transfusion <input type="checkbox"/> Unplanned hysterectomy                                 |  |
| <input type="checkbox"/> Perineal laceration (3° or 4° laceration) <input type="checkbox"/> Admission to intensive care unit  |  |
| <input type="checkbox"/> Ruptured uterus <input type="checkbox"/> Unplanned OR procedure following delivery                   |  |
| <input type="checkbox"/> None of the above  |  |
| <b>SCREEN: NEWBORN</b>  |  |
| 30. Birthweight—If weight in GRAMS is not available, please indicate LB/OZ. Do not convert lb/oz to grams.                    |  |
| Grams: _____ OR Pounds: _____ lb _____ oz   |  |