NORTH MISSISSIPPI
MEDICAL CENTER

# Welcome to NMMC Women's Hospital!

To start the process for your child's birth certificate, please:

- Complete the **Hospital Worksheet – Certificate of Live Birth**
    - The information on this form is required by the State of Mississippi
    - The Birth Registrar will pick up the completed worksheets on the day after delivery.
        - Answer questions **1-19e** to the best of your ability
            - If you are unsure of any of the answers, please ask your nurse or the Birth Registrar when they come to collect your packet.

- Review the **Acknowledgement of Paternity/Name of Child** form
    - If you are **not married** to the child's father, but you want to list him as the legal father on the birth certificate, both parents must sign a legal document called an Acknowledgement of Paternity (AOP) and provide a copy of their photo identification card or driver's license. The AOP can be signed:
        - Before the birth of the baby and at the time of birth in the hospital
            - If the father is not going to be here at the time of birth, please call us at (662) 377-4935 to set up a time that both you and the biological father can come to the hospital and sign the AOP. We will keep the AOP on file and send it to the Mississippi State Department of Health (the State) with the birth certificate information.
        - After you leave the hospital
            - If the father cannot make it to the hospital before you are discharged, you will need to contact the State to complete the AOP.

- Apply for your child's birth certificate
    - After you have reviewed and signed the finalized Certificate of Live Birth form, the Birth Registrar will submit the information to the State.
        - You will receive a copy of the **Proof of Birth** to keep for your records until the official birth certificate arrives. You can use this for insurance purposes.
    - Once the birth certificate is processed by the State, your child's Social Security Card will be automatically mailed to you within 6 to 12 weeks.
    - To get the official Birth Certificate, you must complete the **Application for Certified Mississippi Birth Certificate** form and mail it to the State along with the payment and a copy of your ID.

If you have any questions about the birth certificate and/or acknowledgement of paternity process, please contact the Birth Certificate Office at (662) 377-4935.

Mother's Medical Record # _____

Child's Medical Record # _____

# HOSPITAL WORKSHEET

TYPE OR PRINT WITH BLACK INK

## CERTIFICATE OF LIVE BIRTH

STATE OF MISSISSIPPI

**CHILD**

1. CHILD-NAME First Middle Last Suffix | 2a. DATE OF BIRTH (Month, Day, Year) | 2b. TIME OF BIRTH (24 hr)

3. SEX | 4a. THIS BIRTH SINGLE, TWIN, TRIPLET, ETC. (Specify) | 4b. IF NOT SINGLE BIRTH, BORN FIRST, SECOND, ETC. (Specify) | 5. BIRTH WEIGHT (Enter only in the type of measure on the scales used) lbs. ozs. OR grams

6a. FACILITY NAME (If not institution, give street and number) | 6b. CITY, TOWN OR LOCATION OF BIRTH | 6c. COUNTY OF BIRTH

**FATHER**

7a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix) | 7b. DATE OF BIRTH (Month, Day, Year) | 7c. BIRTHPLACE (State, Territory, or Foreign Country)

7d. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)

☐ White ☐ Black or African American ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan

☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____ ☐ Other Pacific Islander (Specify) _____

☐ Other Asian (Specify) _____ ☐ Other (Specify) _____

**MOTHER**

8a. MOTHER'S NAME PRIOR TO FIRST MARRIAGE (First, Middle, Maiden) | 8b. DATE OF BIRTH (Month, Day, Year) | 8c. BIRTHPLACE (State, Territory, or Foreign Country)

8d. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)

☐ White ☐ Black or African American ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Hawaiian ☐ Guamanian or Chamorro ☐ Samoan

☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____ ☐ Other Pacific Islander (Specify) _____

☐ Other Asian (Specify) _____ ☐ Other (Specify) _____

9a. RESIDENCE - STATE | 9b. COUNTY | 9c. CITY OR TOWN | 9d. INSIDE CITY LIMITS (Specify Yes or No) | 9e. STREET AND NUMBER OR RURAL LOCATION

10a. MAILING ADDRESS - STREET AND NUMBER OR ROUTE AND BOX NUMBER | 10b. CITY OR TOWN | 10c. STATE AND ZIP CODE

11a. ATTENDANT'S NAME AND TITLE _____

TITLE: ☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (Specify)_____ | 11b. ATTENDANT'S NPI NPI: _____

11c. SOCIAL SECURITY CARD REQUESTED FOR NEWBORN? ☐ Yes ☐ No

11d. I request that the Social Security Administratiuon assign a Social Security number to the child named on this form and authorize the State of Mississippi to provide the Social Security Administration with the information from the form which is needed to assign a number.
SIGNATURE OF EITHER PARENT ▶ _____

11e. I CERTIFY THAT THE PERSONAL INFORMATION CONCERNING THIS CHILD IS TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF
SIGNATURE OF EITHER PARENT ▶ _____ | 11f. DATE SIGNED (Month, Day, Year)

**FATHER**

12a. FATHER'S SOCIAL SECURITY NUMBER | 12b. 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). ☐ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, Other Spanish/Hispanic/Latino (Specify)_____

13. 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, 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 Progessional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ Unknown

**MOTHER**

14a. MOTHER;S SOCIAL SECURITY NUMBER | 14b. MOTHER OF HISPANIC ORIGIN? (Check the box that best describes whether the mother is Spanish/Hispanic/Latino). Check the "No" box if mother is not Spanish/Hispanic/Latino). ☐ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, Other Spanish/Hispanic/Latino (Specify)_____

15. 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 ☐ Some college, 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 Progessional degree (e.g., MD, DDS, DVM, LLB, JD) ☐ Unknown

16. DATE LAST NORMAL MENSES BEGAN ___/___/___ MM DD YYYY | 17a. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY Number _____ ☐ None | 17b. DATE OF FIRST PRENATAL CARE VISIT ___/___/___ MM DD YYYY | 17c. DATE OF LAST PRENATAL CARE VISIT ___/___/___ MM DD YYYY

18. MOTHER MARRIED AT BIRTH, CONCEPTION, OR AT ANY TIME BETWEEN? ☐ Yes ☐ No
IF NO, HAS ACKNOWLEDGEMENT OF PATERNITY BEEN SIGNED IN THE HOSPITAL? ☐ Yes ☐ No

PREVIOUS LIVE BIRTHS (Do not include this child or children adopted by mother)

19a. NOW LIVING Number _____ ☐ None | 19b. NOW DEAD Number _____ ☐ None | 19c. DATE OF LAST LIVE BIRTH ___/___/___ MM DD YYYY | 19d. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or etopic pregnancies) Number _____ ☐ None | 19e. DATE OF LAST OTHER PREGNANCY OUTCOME ___/___/___ MM DD YYYY

**CHILD**

20a. IS INFANT LIVING AT TIME OF REPORT? ☐ Yes ☐ No
If no, give Month, Day, Year of death _____

20b. IS BABY TO BE ADOPTED? ☐ Yes ☐ No

20c. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No
If yes, Name of facility infant transferred to: _____

**MOTHER**

20d. OBSTETRIC ESTIMATE OF GESTATION ☐ Yes ☐ No
_____ (completed weeks)

20e. APGAR SCORE
Score at 5 minutes _____, if less than 6, Score at 10 minutes _____

21a. MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ Yes ☐ No
If yes, Name of facility mother transferred from: _____

21b. IS THE INFANT BEING BREASTFED AT DISCHARGE? ☐ Yes ☐ No

22a. MOTHER'S HEIGHT _____ (feet/inches)

22b. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)

22c. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)

22d. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No

23. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY
For each time period, enter 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 | or | # of packs |
|---|---|---|---|
| Three Months Before Pregnancy | _____ | or | _____ |
| First Three Months of Pregnancy | _____ | or | _____ |
| Second Three Months of Pregnancy | _____ | or | _____ |
| Third Trimester of Pregnancy | _____ | or | _____ |

24. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY
☐ Private Insurance
☐ Medicaid
☐ Self-Pay
☐ Other (Specify) _____

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

Diabetes
☐ 01 Prepregnancy (Diagnosis prior to this pregnancy)
☐ 02 Gestational (Diagnosis in this pregnancy)

Hypertension
☐ 03 Prepregnancy (Chronic)
☐ 04 Gestational (PIH, preeclampsia)
☐ 05 Eclampsia

☐ 06 Previous preterm birth
☐ 07 Other previous poor pregnancy outcome (Includes perinatal death, small-for-gestational age/Intrauterine growth restricted birth)
☐ 08 Pregnancy resulted from infertility treatment - If yes, check all that apply:
☐ 09 Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
☐ 10 Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT))
☐ 11 Mother had a previous cesarean delivery. If yes, how many _____
☐ 00 None of the above

26. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY
☐ 01 Gonorrhea
☐ 02 Syphilis
☐ 03 Chlamydia
☐ 04 Hepatitis B
☐ 05 Hepatitis C
☐ 00 None of the above

27. OBSTETRIC PROCEDURES (Check all that apply)
☐ 01 Cervical cerclage
☐ 02 Tocolysis

External Cephalic version:
☐ 03 Successful
☐ 04 Failed

☐ 00 None of the above

28. ONSET OF LABOR (Check all that apply)
☐ 01 Premature rupture of the Membranes (prolonged, >= 12 hrs.)
☐ 02 Precipitious Labor (< 3 hrs.)
☐ 03 Prolonged Labor (>= 20 hrs.)
☐ 00 None of the above

29. MATERNAL MORBIDITY (Complications associated with labor and delivery) (Check all that apply)
☐ 01 Maternal transfusion
☐ 02 Third or fourth degree perineal laceration
☐ 03 Ruptured uterus
☐ 04 Unplanned hysterectomy
☐ 05 Admission to intensive care unit
☐ 06 Unplanned operating room procedure following delivery
☐ 00 None of the above

30. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
☐ 01 Induction of labor
☐ 02 Augmentation of labor
☐ 03 Non-vertex presentation
☐ 04 Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery)
☐ 05 Antibiotics received by the mother during labor
☐ 06 Clinical chorioamnionitis diagnosed during labor or maternal temperature >= 38° C (100.4° F)
☐ 07 Moderate/heavy meconium staining of the amniotic fluid
☐ 08 Fetal intolerance of labor such that one or more of the following actions was taken: In-utero resusciative measures, further fetal assessment, or operative delivery
☐ 09 Epidural or spinal anesthesia during labor
☐ None of the above

31. 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?
☐ 01 Cephalic
☐ 02 Breech
☐ 03 Other
D. Final route and method of delivery (Check one)
☐ 04 Vaginal/Spontaneous
☐ 05 Vaginal/Forceps
☐ 06 Vaginal/Vacuum
☐ 07 Cesarean
If cesarean, was a trial of labor attempted? ☐ Yes ☐ No

## NEWBORN INFORMATION

**NEWBORN**

32. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
☐ 01 Assisted ventilation required immediately following delivery
☐ 02 Assisted ventilation required for more than six hours
☐ 03 NICU admission
☐ 04 Newborn given surfactant replacement therapy
☐ 05 Antibiotics received by the newborn for suspected neonatal sepsis
☐ 06 Seizure or serious neurologic dysfunction
☐ 07 Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
☐ 00 None of the above

33. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
☐ 01 Anencephaly
☐ 02 Meningomyelocele/Spina bifida
☐ 03 Cyanotic congenital heart disease
☐ 04 Congenital diaphragmatic hernia
☐ 05 Omphalocele
☐ 06 Gastroschisis
☐ 07 Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
☐ 08 Cleft Lip with or without Cleft Palate
☐ 09 Cleft Palate alone
☐ 10 Down Syndrome
☐ 11 Karyotype confirmed
☐ 12 Karyotype pending
☐ 13 Suspected chromosomal disorder
☐ 14 Karyotype confirmed
☐ 15 Karyotype pending
☐ 16 Hypospadias
☐ 17 Microcephaly
☐ 18 Intracranial calcifications
☐ 19 Hydrocephalus/ventriculomegaly
☐ 20 Abnormalities of the cortex, cerebellum or corpus callosum
☐ 21 Congenital contractures with associated/suspected brain abnormality
☐ 22 Eye abnormalities
☐ 23 Congenital deafness
☐ 00 None of the above

**Mother's Medical Record #** _____

**Child's Medical Record #** _____