Mother's Name:	Mother's Med. Rec. Number:

New York State Birth Certificate and Statewide Perinatal Data System Work Booklet

A child's birth certificate is a very important document. It is the official record of the child's full name, date of birth and place of birth. Throughout the child's lifetime, it provides proof of identity and age. As a child grows from childhood to adulthood, information in the birth certificate will be needed for many important events such as: entrance to school, obtaining a work permit, driver's license or marriage license, entrance in the Armed Forces, employment, collection of Social Security and retirement benefits, and for a passport to travel in foreign lands.

Because the birth certificate is such an important document, great care must be taken to make certain that it is correct in every detail. By completing this work booklet carefully, you can help assure the accuracy of the child's birth certificate.

New York State Birth Certificate:

PARENTS, for the birth certificate, you must complete the unshaded portions of this work booklet, see pages 3 - 5, 10 - 12 & 14 (the shaded portions will be completed by hospital staff).

Information that is not labeled "QI", "IMM" or "NBS" in the work booklet will be used to prepare the official birth certificate. The completed birth certificate is filed with the Local Registrar of Vital Statistics of the municipality where the child was born within five (5) business days after the birth and with the New York State Department of Health. When the filing process is completed, the mother will receive a Certified Copy of the birth certificate. This is an official form that may be used as proof of age, parentage, and identity. Receiving it confirms that the child's birth certificate is officially registered in the State of New York. Additional copies of the birth certificate may be obtained from the Local Registrar or the New York State Department of Health, P.O. Box 2602, Albany, New York 12220-2602. For further information about obtaining copies, please call (518) 474-3077 or visit the New York State Department of Health web site at: *http://www.nyhealth.gov/vital_records/*.

All information (including personal/identifying information) is shared with the County Health Departments or other Local Health Units where the child was born and where the mother resides, if different. County Health Departments and Local Health Units may use this data for Public Health Programs. The Social Security Administration receives a minimal set of data ONLY when the parents have indicated, in this work booklet, that they wish to participate in the Social Security Administration's Enumeration at Birth program.

While individual information is important, public health workers will use medical and demographic data in their efforts to identify, monitor, and reduce maternal and newborn risk factors. This information also provides physicians and medical scientists with the basis to develop new maternal and childcare programs for New York State residents.

Statewide Perinatal Data System (SPDS) – Quality Improvement (QI), Immunization Registry (IMM) and Newborn Screening Program (NBS) Information:

The information labeled "QI" collected in this work booklet will be used by medical providers and scientists to perform data analyses aimed at improving services provided to pregnant women and their babies. Information labeled "IMM" will be used by New York State's Immunization Information System (NYSIIS). A birthing hospital's obligation to report immunizations for newborns can be met by recording all the information in SPDS. This includes the manufacturer and lot number as required by law. Information labeled "NBS" will result in significant improvements in the Newborn Screening Program such as better identification and earlier treatment of infants at risk for a variety of disorders.

ATTENTION HOSPITAL STAFF:

This work booklet has been designed to obtain information relating to the pregnancy and birth during the 72-hour period immediately following the birth of a live born child in New York State. Hospital staff, please complete the shaded portions of the work booklet.

New York State Public Health Law provides the basis for the collection of the birth certificate data. For pertinent information about the New York State Public Health Laws refer to sections 206(1)(e), 4102, 4130.5, 4132 and 4135. These laws are also described in the New York State Birth Certificate Guidelines. The Guidelines are available to SPDS users on the **Help** tab of the SPDS Core Module.

Help for Parents Completing This Work Booklet

Page 4: **Last Name on Mother's Birth Certificate**
This is commonly referred to as "maiden name." If the mother was adopted, it would be the last name on her birth certificate *after* the adoption.

Page 4: **Infant's Pediatrician/Family Practitioner**
Enter the name of the doctor who will care for the infant after he/she is released from the hospital. This may or may not be the same as the doctor who cared for the infant while in the hospital.

Page 11: **Last Name on Father's / Second Parent's Birth Certificate**

- **Father:** This is usually the same as his current last name. In the event that a man has changed his last name through marriage, the name on his birth certificate should be entered here. This may or may not be the same as his current last name depending on whether his name was changed by marriage only or changed through a court proceeding which resulted in an amendment to his birth certificate.

- **Mother (Second Parent):** This is commonly referred to as maiden name and is the name on her birth certificate.

- **In either case:** If the parent was adopted it would be the last name on his or her birth certificate *after* the adoption.

Mother's Name:	Mother's Med. Rec. Number:

New Birth Registration

Parents – Mother

Mother's First Name:	Mother's Middle Name:
Mother's Current Last Name :	Last Name on Mother's Birth Certificate:
Social Security Number: – –	Mother's Date of Birth: *(MM/DD/YYYY)* / /
Infant's First Name:	Infant's Middle Name:
Infant's Last Name:	Infant's Name Suffix *(e.g. Jr., 2nd, III)*:

Infant

Sex: ☐ Male ☐ Female ☐ Undetermined	Plurality:	Birth Order:	Medical Record No.:
Date of Birth: *(MM/DD/YYYY)* / /	Time of Birth: *(HH:MM)* :	☐ am ☐ pm ☐ military (24-hour time)	

Parents – Infant

Was child born in this facility? ☐ Yes ☐ No If child was **not** born in this facility, please answer the following questions:

In what type of place was the infant born?

☐ Freestanding Birth Center (regulated by DOH)
☐ Home (intended)
☐ Home (unintended)
☐ Home (unknown intent)
☐ Clinic / Doctor's Office (not regulated by DOH)
☐ Other

If New York State Birthing Center, enter its name:

In what county was the child born?

Parents – Birthplace

Institution

Site of Birth, If **Other** Type of Place:	Street Address – if other than Hospital / Birthing Center:

If place of infant's birth was other than Hospital or Birthing Center:

City, town or village where birth occurred:	Zip / Postal Code:

Infant's Pediatrician/Family Practitioner: NBS

Attendant

Attendant's Information:

License Number:	Name: *First*	*Middle*	*Last*

Title: *(Select one)*
☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Licensed Midwife (CNM) ☐ Licensed Midwife (CM) ☐ Other

Certifier

Certifier's Information:
☐ Check here if the Certifier is the same as the Attendant *(otherwise enter information below)*

License Number:	Name: *First*	*Middle*	*Last*

Title: *(Select one)*
☐ Medical Doctor ☐ Doctor of Osteopathy ☐ Licensed Midwife (CNM) ☐ Licensed Midwife (CM) ☐ Other

Parents – Payor

Primary Payor for this Delivery:

Select one:
☐ Medicaid / Family Health Plus
☐ Private Insurance
☐ Indian Health Service
☐ CHAMPUS / TRICARE
☐ Other Government / Child Health Plus B
☐ Other
☐ Self-pay

If Medicaid is not the primary payor, is it a secondary payor for this delivery? ☐ Yes ☐ No	Is the mother enrolled in an HMO or other managed care plan? ☐ Yes ☐ No QI

Mother's Name: *First*	*Middle*	*Last*	Mother's Med. Rec. Number:
Father / Second Parent Name: *First*	*Middle*	*Last*	*Suffix*
Infant's Name: *First*	*Middle*	*Last* *Suffix*	Date of Birth

To the hospital:

1. Obtain the parent(s) signature(s).
2. File the original Release Form in the mother's hospital record.
   Note: It is not necessary to file the remainder of the Work Booklet.
3. Provide a copy to the parent(s).
4. Do **not** send copies to the New York State Department of Health or to any Social Security office, unless specifically requested by such agency.

To the parent(s):

1. Please read the following notice about the collection and use of Social Security Numbers on your child's birth certificate.
2. Please check "Yes" or "No" to indicate if you wish to participate in the Social Security Administration's Enumeration at Birth program.

NOTICE REGARDING COLLECTION OF PARENTS' SOCIAL SECURITY NUMBERS: The collection of parents' Social Security Numbers on the New York State Certificate of Live Birth is mandatory. They are required by Public Health Law Section 4132(1) and may be used for child support enforcement, public health related purposes, when requested by State, federal and municipal governments for official purposes, when required by Public Health Law Section 4173 or 4174, and when otherwise required or authorized by law.

Social Security Release

The Social Security Administration offers the parents of newborns an opportunity to apply for a Social Security Number for their child through the birth certificate registration process. This is referred to by the Social Security Administration as Enumeration at Birth (EAB). If you participate in the EAB, the New York State Department of Health will forward to the Social Security Administration information from your child's birth certificate. Please note that the Social Security Administration will not process your EAB request unless, the birth certificate includes your child's full name. If you participate in the EAB, disclosure of parents' Social Security Numbers is mandated by 42 U.S.C. 405(c)(2). The Social Security Number(s) will be used by the Internal Revenue Service (IRS) solely for the purpose of determining Earned Income Tax Credit compliance. If you wish to participate in the Social Security Administration EAB program check "Yes" below.

May the Social Security Administration be furnished with information from this form to issue your child a social security number?

Yes ☐

No ☐

Mother's Signature ▶ _____ **Date** _____

Father's or Second Parent's Signature ▶ _____ **Date** _____

Either parent's signature applies to the above release.
If neither box is checked for the release, a 'No' response will be assumed.

Hospital Name:	
Signature of Hospital Representative: ▶	Date:

Mother's Name:	Mother's Med. Rec. Number:

Mother

Medical Record Number:

Parents

Mother's Demographics

Mother's Education: *(select one)*

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate; or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree

City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Other Spanish/Hispanic/Latina
  Specify:
- ☐ Yes, Puerto Rican

Mother's Demographics

Race:

Select all that apply

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Korean
- ☐ Guamanian or Chamorro
- ☐ American Indian or Alaska Native **Tribe:**
- ☐ Other Asian **Specify:**
- ☐ Other Pacific Islander **Specify:**
- ☐ Other **Specify:**
- ☐ Black or African American
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian

Mother's Residence

Residence Address

Street Address:

State/Terr./Province:	County:	City, Town or Village:

Zip/Postal Code:	Mother's Country of Residence, if not USA:	U.S./Canadian Phone Number: ( ) –

Mother's Mailing Address

Mailing Address – Most Recent

☐ Check here if the mailing address is the same as the residence address *(otherwise enter information below)*

Mailing Address:

City, Town or Village:	State/Terr./Province:	Country, if not USA:	Zip/Postal Code:

Employment

Employment History

Employed while Pregnant: ☐ Yes ☐ No	Current / Most Recent Occupation:	Kind of Business / Industry:

Name of Company or Firm:	Address:

City:	State/Territory/Province:	Zip / Postal Code:

Mother's Name:	Mother's Med. Rec. Number:

Father or Second Parent

Will the mother and father be executing an Acknowledgement of Paternity? ☐ Yes ☐ No ☐ Not required

What type of certificate is required? ☐ Mother / Father ☐ Mother / Mother

Parents

Father's or Second Parent's Demographics

Parent's First Name:	Parent's Middle Name:
Parent's Current Last Name:	Last Name on Parent's Birth Certificate:
Parent's Name Suffix *(e.g. Jr., 2nd, III)*:	Social Security Number: – –

Demographics

Parent's Date of Birth: *(MM/DD/YYYY)* / /

Education: *(select one)*

- ☐ 8th grade or less
- ☐ 9th – 12th grade; no diploma
- ☐ High school graduate; or GED
- ☐ Some college credit, but no degree
- ☐ Associate's degree
- ☐ Bachelor's degree
- ☐ Master's degree
- ☐ Doctorate degree

City of Birth:	State/Terr./Province of Birth:	Country of Birth, if not USA:

Hispanic Origin:

Select all that apply

- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Cuban
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Other Spanish/Hispanic/Latino
  Specify:
- ☐ Yes, Puerto Rican

Race:

Select all that apply

- ☐ White/Caucasian
- ☐ Chinese
- ☐ Korean
- ☐ Guamanian or Chamorro
- ☐ American Indian or Alaska Native **Tribe:**
- ☐ Other Asian **Specify:**
- ☐ Other Pacific Islander **Specify:**
- ☐ Other **Specify:**
- ☐ Black or African American
- ☐ Filipino
- ☐ Vietnamese
- ☐ Samoan
- ☐ Asian Indian
- ☐ Japanese
- ☐ Native Hawaiian

Parent's Residence

Residence Address

☐ Check here if the parent's residence address is the same as the mother's address *(otherwise enter information below)*

Street Address:	
City, Town or Village:	State / Territory / Province:
Parent's Country of Residence, if not USA:	Zip / Postal Code:

Employment

Employment History

Current / Most Recent Occupation:	Kind of Business / Industry:	
Name of Company or Firm:	Address:	
City:	State / Territory / Province:	Zip / Postal Code:

Mother's Name:	Mother's Med. Rec. Number:

Prenatal History

Parents — Prenatal History

Did mother receive prenatal care?	Primary Prenatal Care Provider Type:	Did mother participate in WIC?
☐ Yes ☐ No	☐ MD / DO / C(N)M / HMO ☐ No Information ☐ Clinic ☐ No Provider ☐ Other	☐ Yes ☐ No

Key Pregnancy Dates *(MM/DD/YYYY)*

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
/ /	/ /	/ /	/ /

Prenatal Visits

Total Number of Prenatal Visits:	

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number ☐	**Now Dead** None or Number ☐	**Less than 20 Weeks** None or Number ☐	**20 Weeks or More** None or Number ☐	None or Number ☐	None or Number ☐

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
/	/	/	*lbs.*	*ft.* *in.*

Prenatal Care

Risk Factors

Risk Factors in this Pregnancy

☐ None ☐ Unknown at this time

Select all that apply

☐ Prepregnancy Diabetes ☐ Gestational Diabetes ☐ Prepregnancy Hypertension ☐ Gestational hypertension
☐ Other Serious Chronic Illnesses ☐ Previous Preterm Births ☐ Abruptio Placenta ☐ Eclampsia
☐ Other Poor Pregnancy Outcomes ☐ Prelabor Referred for High Risk Care ☐ Other Vaginal Bleeding ☐ Previous Low Birthweight Infant QI

☐ Pregnancy resulted from infertility treatment (if yes, check all that apply)
☐ Fertility-enhancing drugs, artificial or intrauterine insemination
☐ Assisted reproductive technology (e.g. IVF, GIFT) **Number of Embryos Implanted:** (if applicable) ☐ QI

Infections

Infections Present and/or Treated During Pregnancy

☐ None ☐ Unknown at this time

Select all that apply

☐ Gonorrhea ☐ Syphilis ☐ Herpes Simplex Virus (HSV) ☐ Chlamydia
☐ Hepatitis B ☐ Hepatitis C ☐ Tuberculosis ☐ Rubella
☐ Bacterial Vaginosis

Parents — Other Risk Factors

Other Risk Factors

Smoking Before or During Pregnancy?	List Number of Packs OR Cigarettes Smoked Per DAY											
	3 Months Prior to Pregnancy			First Three Months of Pregnancy			Second Three Months of Pregnancy			Third Trimester of Pregnancy		
	Packs	OR	Cigarettes	Packs	OR	Cigarettes	Packs	OR	Cigarettes	Packs	OR	Cigarettes
☐ Yes ☐ No												

Mother's Name:	Mother's Med. Rec. Number:

Interview/Records

Parents

Survey of Mother (in hospital)

Survey of Mother (in hospital)

Did you receive prenatal care? ☐ Yes ☐ No *(If 'Yes' please answer question 1. Otherwise skip to question 2.)*

1. During any of your prenatal care visits, did a doctor, nurse, or other health care worker talk with you about any of the things listed below?

	Yes	No
a. How smoking during pregnancy could affect your baby?	☐	☐
b. How drinking alcohol during your pregnancy could affect your baby?	☐	☐
c. How using illegal drugs could affect your baby?	☐	☐
d. How long to wait before having another baby?	☐	☐
e. Birth control methods to use after your pregnancy?	☐	☐
f. What to do if your labor starts early?	☐	☐
g. How to keep from getting HIV (the virus that causes AIDS)?	☐	☐
h. Physical abuse to women by their husbands or partners?	☐	☐

2. How many times per week during your current pregnancy did you exercise for 30 minutes or more, above your usual activities? — Times per week:

3. Did you have any problems with your gums at any time during pregnancy, for example, swollen or bleeding gums? ☐ Yes ☐ No

4. During your pregnancy, would you say that you were: *(select one)*
   - ☐ Not depressed at all
   - ☐ A little depressed
   - ☐ Moderately depressed
   - ☐ Very depressed
   - ☐ Very depressed and had to get help

5. Thinking back to just before you were pregnant, how did you feel about becoming pregnant?
   - ☐ You wanted to be pregnant sooner
   - ☐ You wanted to be pregnant later
   - ☐ You wanted to be pregnant then
   - ☐ You didn't want to be pregnant then or at any time in the future

Chart Review (Prenatal and Medical)

Chart Review (Prenatal and Medical)

1a. Copy of prenatal record in chart?
- ☐ Yes, Full Record
- ☐ Yes, Prenatal Summary Only
- ☐ No

1b. Was formal risk assessment in prenatal chart?
- ☐ Yes, with Social Assessment
- ☐ Yes, without Social Assessment
- ☐ No

1c. Was MSAFP / triple screen test offered?
- ☐ Yes
- ☐ No
- ☐ No, Too Late

1d. Was MSAFP / triple screen test done?
- ☐ Yes
- ☐ No

2. How many times was the mother hospitalized during this pregnancy, not including hospitalization for delivery?

Admission & Discharge

Admission and Discharge Information

Mother

Admission Date for Delivery *(MM/DD/YYYY)*	Discharge Date *(MM/DD/YYYY)*
/ /	/ /

Infant

Discharge Date *(MM/DD/YYYY)* / /

- ☐ Discharged Home
- ☐ Infant Still in Hospital
- ☐ Infant Transferred Out
- ☐ Infant Died at Birth Hospital
- ☐ Infant Discharged to Foster Care/Adoption
- ☐ Unknown

IMPORTANT NOTICE

If the mother is not legally married to the father of the baby and wishes to add the father's name to the birth certificate, you must ask the registrar for the ACKNOWLEDGEMENT OF PATERNITY FORM. If you are married at the time of birth or at any time during the pregnancy and claim your husband is not the father, a court order is required to enter the father's name on the birth certificate.

AVISO IMPORTANTE

Si la madre no esta casada legalmente con el padre del bebe y desea poner en el certificado de nacimiento el apellido de el, se debera solicitor a la persona indicada, un Formulario "RECONOCIMIENTO DE PATERNIDAD", el cual debera ser llenado completamente y entregado a la persona indicada. Si la madre ha side casada anteriormente, pero no esta legalmente divorciada, y afirma que su esposo no es el padre de su bebe, tiene que presenter una Orden de la Corte, para poner el apellido del padre en el certificado de nacimiento del bebe.

Nota: Favor llenar este formulario con letra de imprenta y no se permite ninguna clase de borrones o tachaduras.