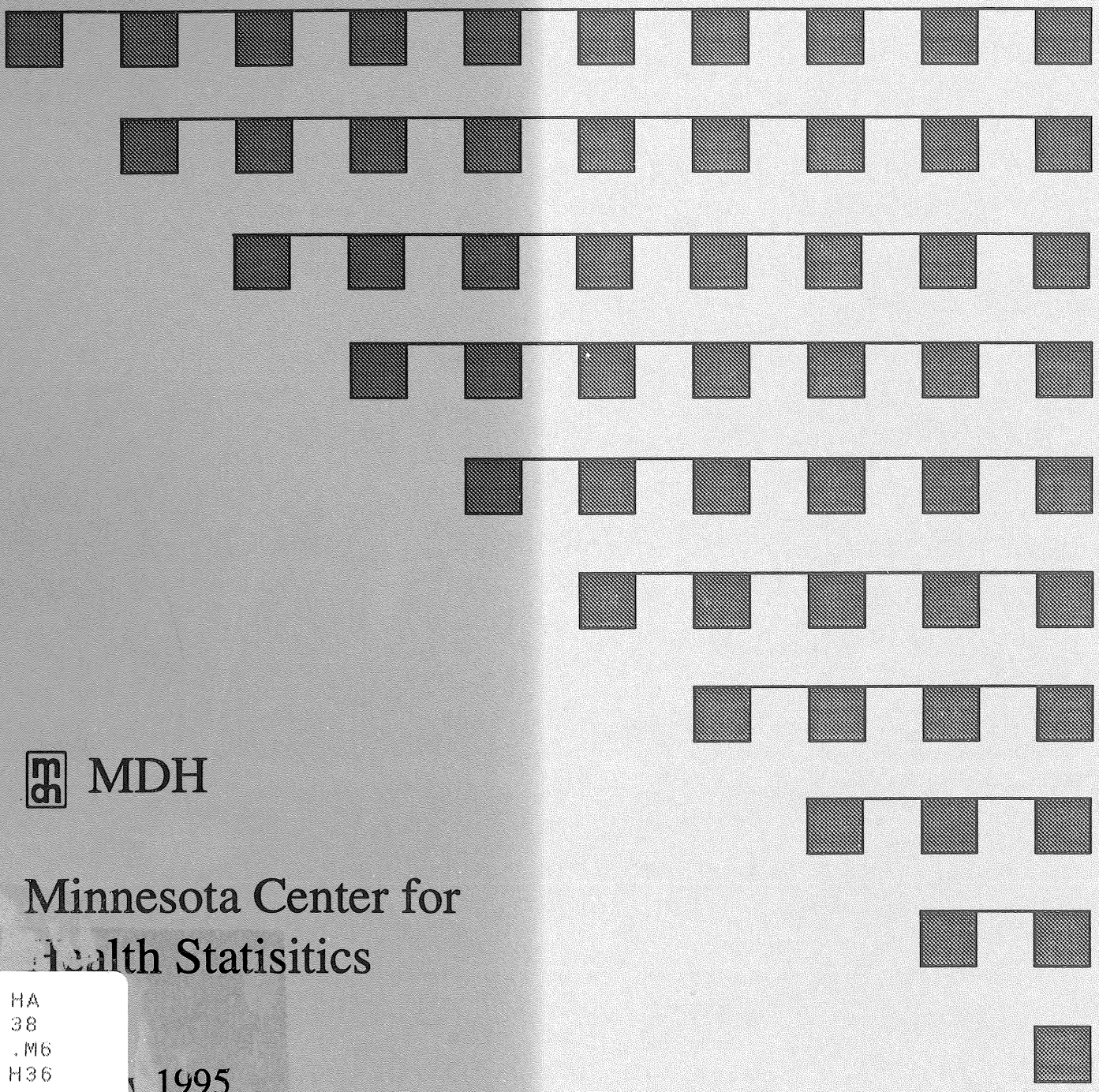
Handbook on Birth Registration and Fetal Death Reporting



MDH

Minnesota Center for Health Statisitics

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Purpose

This handbook is designed to provide hospital personnel and physicians with instructions for completing and filing certificates of live birth, the medical supplement to the birth certificate, and the report of fetal death. It includes background information on the importance of these documents for legal and statistical purposes and contains specific instructions for recording entries.

The purpose of this handbook is to achieve improved reporting by promoting better understanding of the forms and the uses of information entered on them. Since most births occur in hospitals, the quality of birth registration depends on hospital personnel.

Importance of Birth and Fetal Death Registration

A birth record is a statement of facts concerning an individual. It is a permanent legal record. Throughout life, a person uses the birth certificate to prove age, parentage, and citizenship. Birth certificates are required for entrance to school, voter registration, obtaining a driver's license, marriage license, passport, veterans' benefits, public assistance, and social security benefits, and for many other purposes.

The fetal death report is a legally required report for the death of a fetus for whom 20 or more weeks of gestation have elapsed. The report provides valuable health and research data.

Society would be greatly misserved if the birth certificate was used only for legal purposes. Annual vital statistics are compiled on the number and rate of births by characteristics such as place of birth, place of residence of mother, age of mother, plurality, and birth weight. Population composition and growth are estimated using these data. Educational systems and institutions, government agencies and private industry find this information essential in planning and evaluating programs in public health and other important areas.

The medical and health information on the birth certificate and fetal death report are used to study the causal, contributory and risk factors that may lead to infant and fetal death. This information also helps to establish programs to address the factors associated with infant and fetal death. These data are also essential in planning and evaluating prenatal care services and obstetrical programs. When fetal death and neonatal death data are linked, a composite picture of perinatal outcome is provided.

U.S. Standard Certificates and Reports

The National Center for Health Statistics, U.S. Public Health Service, Department of Health and Human Services provides leadership and coordination in the development of standard certificates and reports to serve as models for use by states. These certificates and reports are revised periodically in collaboration with state health officials, registrars and statisticians, federal agencies and other providers and users of vital statistics such as physicians, medical examiners, coroners, local registrars, certified nurse midwives, medical record personnel and morticians. The purpose of each revision is to ensure that the data collected relate to current and future needs. In the revision process, each item on the standard certificate and report is evaluated thoroughly for its registration, legal, statistical, medical and research value. Each state is encouraged to adopt the recommended standard certificates and reports as a means of developing a uniform national vital registration and statistics system.

The State Health Department

The Minnesota Department of Health administers the birth registration and fetal death reporting system under the laws and regulations of the state. Birth certificates are placed on permanent file by the state registrar's office after they have been accepted for filing by the local registrar.

The Local Registrar

In Minnesota, the local registrar performs vital record activities under the direction and supervision of the state registrar and under the laws and regulations of the state. Birth certificates should be filed with the local registrar in the county courthouse within five days after the birth. The local registrar transmits the records to the state registrar on a monthly basis. Reports of fetal death should be filed directly with the state office; the address is given in the upper left-hand corner of the report.

The Legal Definitions of Live Birth and Fetal Death

When a delivery results in a live birth, a birth certificate must be filed, even if the infant lives for only a very short period of time. A **live birth** is defined by Minnesota Department of Health Rule 4600.0100 as "the complete expulsion or extraction of a product of conception from the mother, irrespective of the duration of pregnancy, which after this separation shows any evidence of life, such as breathing, beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether the umbilical cord has been cut or the placenta is attached. Each product of such a birth shall be considered live-born."

A **fetal death**, also defined by MDH Rule 4600.0100, is "death prior to the complete expulsion or extraction of a product of conception from the mother, irrespective of the duration of pregnancy. Death after such separation is indicated by the absence of any evidence of life, such as breathing, beating of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles."

Pursuant to Minnesota Department of Health Rule 4600.1000, the physician or other person operating under the supervision of a physician in attendance at the birth, shall file a certificate of birth with the local registrar within five days.

Part I

General Guidelines for Completing Birth Cerificates

Part I - GENERAL GUIDELINES FOR COMPLETING BIRTH CERTIFICATES AND MONTHLY REPORTS

The birth registration process may be expedited if parents are given a chance to complete a hospital worksheet and read the pamphlet "Your Baby's Birth Certificate". This pamphlet is available to hospital staff from the state health department; to obtain a supply call (612) 623-5123.

Each birth certificate consists of an original legal document (white copy) and a supplement (yellow copy). The legal document will be used to prepare official copies for a lifetime; therefore, it must be accurate, complete and letter-perfect. The birth certificate supplement is used for statistical purposes and for generating a social security number; therefore, it is acceptable if it is legible.

Call the field representative at the Minnesota Center for Health Statistics for assistance when necessary (612/623-5130).

1. **Prepare only one birth certificate per child.** If local registrars request that you retype a certificate, refer them to the Current Registration Unit at the Minnesota Department of Health (612) 623-5134 where the birth certificate will be replaced if necessary.

2. **When a child is born at home,** refer the parents to the local registrar's office to file the birth certificate unless the mother or child were admitted to the hospital after the birth.

3. **Do not erase or use "white-out" on the original birth certificate (white copy).** "White-out" cracks and peels with time and jeopardizes the integrity of the legal certificate. A self-correcting typewriter that lifts off a typographical error is acceptable. To correct an error on an original birth certificate, send a written statement to the local registrar documenting the error; the local registrar will amend the certificate as provided for in the MDH Rules.

4. A portion of the birth certificate supplement (yellow copy) is a carbon copy of the original birth certificate; if you use a self-correcting typewriter to correct something, you will have to type over the white copy, therefore, the supplement will contain items that have been obliterated. **Be certain that every item on the supplement is legible since this is the form that generates the social security number.** You may make erasures on the **yellow** copy or correct it in any way (including "white-out") as long as it is legible; "white-out" is acceptable on the yellow copy only. Birth certificate supplements may be handwritten as long as they are legible.

5. **Verify spellings of names** with the informant, especially those that have different spellings for the same sound (Smith or Smyth, Gail or Gayle, Wolf or Wolfe, etc.).

6. **Encourage unmarried parents to complete a Recognition of Parentage** form. Refer to your instructions from the Department of Human Services regarding the recording of paternity information for single parents. For questions regarding paternity, contact the Department of Human Services at (612) 296-2542.

7. **Ask the parents if they would like a social security number for their child.** Record their response in the left-hand margin of the birth certificate. Notify the parents that it will take approximately 4 to 5 months from the date the birth certificate supplement was sent to the state registrar's office to get the social security number. In facilities using the electronic birth certificate (ebc), it takes

office to get the social security number. In facilities using the electronic birth certificate (ebc), it takes approximately 4 to 6 weeks from the date the ebc was sent to get the social security number. If parents want proof of having requested the social security number, complete the form that states that the SSN was requested; this form is provided by the Social Security Administration.

8. **Secure the signature of the physician on the original certificate (white copy).** An original signature is a legal requirement; stamped signatures are not acceptable.

9. **Have one of the parents verify the information recorded on the certificate and sign item 25.** A careful check for accuracy by the parent may prevent the need for future corrections to the birth certificate. **Note, however, that the parent's signature is not a legal requirement.** Do not delay filing the certificate if the parent is unavailable to sign.

10. **File the original birth certificate** (white copy) with the local registrar.

11. **File the birth certificate supplement** (yellow copy) within five days of the birth with the state office: Minnesota Department of Health, Vital Records Data Management, 717 Delaware Street S.E., P.O. Box 9441, Minneapolis, MN 55440.

12. On or before the tenth day of each month, hospital staff (with the exception of hospitals in Hennepin and Ramsey Counties) submit a monthly list of births, infant deaths, and fetal deaths to the state registrar. Monthly report forms are supplied by the Minnesota Department of Health.

    For the exceptions;

    a) hospital staff in Hennepin County send a report of monthly births to the local registrar (Director of Licensing),

    b) hospital staff in the city of St. Paul send the monthly report to the St. Paul City Health Department,

    c) hospital staff in Ramsey County (outside of St. Paul) send the monthly report to the local registrar at the Ramsey County Courthouse.

13. On or before the tenth day of each month, hospital staff in Hennepin and Ramsey Counties send a monthly report of infant deaths and fetal deaths to the state registrar. Blank report forms are available from the Minnesota Department of Health.

Part II

Completing the Certificate of Live Birth

Part II - COMPLETING THE CERTIFICATE OF LIVE BIRTH

1. Name of Child

Type the child's first, middle, and last names. Do not abbreviate. Space the names properly to avoid confusion as to whether a name is a first, middle, or last name.

If the parents have not decided on the child's given name, do not wait for a decision; simply omit the given name. The first and middle names may be added at the state or local registrar's office at no charge for up to one year from the date of birth. The surname (last name) of the child should be entered in every case and written well to the right so that space will be available for the local or state registrar to add the given names at a later date. Never enter "Baby Girl" or "Infant Boy" or "NMI" (no middle initial). Entries of Jr. or II, III, IV, etc. following the last name, are acceptable.

Neither Minnesota Statute nor Health Department Rule specifies what surname a child must be given. Parents should be encouraged to give careful thought to naming the child because a court-ordered legal change of name may be required to correct the record once it has been filed. Court fees are the responsibility of the parent(s).

(This item identifies the individual for whom the certificate is being prepared.)

2. Date of Birth

Enter the exact month, day, and year the child was born.

Enter the full name of the month -- January, February, March, etc. Do not use a number or abbreviation to designate the month.

Pay particular attention to the entry of month, day, or year when the birth occurs around midnight. Consider a birth at midnight to have occurred at the end of one day rather than the beginning of the next day and record it as "12 midnight."

(This item records the date of birth of the individual named on the certificate. It is used to establish an age for such purposes as school entrance, obtaining a driver's license and social security benefits. This information is used in conjunction with the date the last normal menses began to calculate the length of gestation, which is used to study survivorship of low-birth-weight and premature infants. It is also used in conjunction with dates of last live birth and other terminations to compute intervals between births and pregnancies.)

3. Time of Birth

Enter the exact time (hour and minute) the child was born according to local time. Be sure to indicate whether the time of birth was A.M. or P.M.

Enter 12 noon as "12 noon." One minute after 12 noon is entered as "12:01 P.M."
Enter 12 midnight as "12 midnight." One minute after 12 midnight is entered as "12:01 A.M."

In cases of plural births, the exact time that each child was delivered should be recorded as the hour and minute of birth for that child.

(This item documents the exact time of birth for various legal uses, such as the order of birth in plural deliveries. When the birth occurs around midnight, the exact hour and minute may affect the date of birth. For births occurring at the end of the year, the hour and minute affect not only the day but the year of birth, a factor in establishing dependency for income tax purposes.)

4. Sex

Enter male or female. Do not abbreviate or use other symbols. If sex and name are obviously inconsistent, verify both entries. If sex cannot be determined after verification with medical records, mother of child, informant, or other sources, make no entry and attach a note to the certificate stating the reason for omission.

(This item aids in identification of the child. It is also used for measuring sex differentials in health-related characteristics and for making population estimates and projections.)

5. Plurality

Specify the birth as single, twin, triplet, quadruplet or quintuplet. If this was a multiple pregnancy but one or more of the infants died or was a fetal death, report the birth as "twin", "triplet", etc.

6. If Not Single Birth - Born First, Second, Third, etc.

Specify the order of birth (first, second, etc.) for every multiple birth. For single births enter the word "single" in item 5 and leave item 6 blank.

(The frequency of multiple births and their characteristics are of interest to many medical professionals and to scientists engaged in the study of heredity.)

7. County of Birth

Enter the name of the county where the birth occurred. For births occurring in a moving conveyance, enter the county where the child was first removed from the conveyance.

(These two items identify the place of birth, which is used to determine U.S. citizenship. Information on the place of occurrence, together with information on the place of residence, is used to evaluate the supply and distribution of obstetrical services.)

8. City or Township of Birth

Enter the name of the city or township where the birth occurred. For births occurring in a moving conveyance, enter the city or township where the child was first removed from the conveyance.

9. Place of Birth

Check one of the boxes to reflect the place where the birth occurred. Identify the place of birth as a hospital birth, a home birth, a birth in a freestanding birthing center, a birth in a clinic/doctor's office, or a birth in some other place.

(Such information permits analysis of the number and characteristics of births by type of facility and is helpful in determining the level of utilization and characteristics of births occurring in such facilities.)

10. Facility Name (if not a facility, give street and number where birth occurred)

Enter the full name of the facility where the birth occurred.

If the birth occurred in a moving conveyance enroute to a facility, enter the full name of the facility followed by "En route."

If the birth occurred in a moving conveyance that was not enroute to a facility, enter the address where the child was first removed from the conveyance as the place of birth.

(The facility name is used for followup and query programs in the state's vital statistics office and is of historical value to the parents and child. It is also used to produce statistical data by specific facility.)

11-14. Certifier-Attendant Information

These sections consist of several items relating to the certifying official who, as a general rule, will have been the attendant at the birth. Physicians and other persons operating under the supervision of a physician in attendance at a birth (such as residents and certified nurse midwives) are authorized to sign birth certificates.

A physician may sign a birth certificate even if that physician did not attend the birth. In this event, cross out the words "I attended" in item #11.

If the birth was not attended by a physician or someone under a physician's supervision, one of the parents should sign item #11. The certificate cannot be accepted for filing without this signature; it is a legal requirement on all birth certificates.

12. Date Signed

Enter the exact month, day, and year the attendant signed the certificate.

Do not use a number to designate the month.

(The certification validates the accuracy of the date, time, and place of birth of the child recorded on the certificate.)

13. Attendant's Name and Title

Type or print the attendant's first, middle (initial), and last names. Specify M.D. (doctor of medicine), D.O. (doctor of osteopathy), C.N.M. (certified nurse midwife).

(The attendant's name is important when queries are required to correct or complete birth certificates. The title provides information on the type of attendant, which is used to assess the service rendered.)

14. Attendant's Mailing Address

Enter the mailing address of the person whose name appears in item #11.

(The mailing address is used for inquiries to correct or complete items on the record and for followback studies to obtain additional information about the birth.)

15. Registrar's Signature

This item is signed by the local registrar when the certificate is filed.

(The signature documents the fact that the certificate has been accepted by and filed with the registrar.)

16. Date Filed by Registrar

This item is completed by the local registrar when the certificate is filed.

(This item documents whether the certificate was filed within the time period specified and identifies delayed registrations.)

17a. Mother's Present Name

Type or print the first, middle, and last name of the mother. This is the mother's current legal name.

17b. Maiden Surname

Type or print the last name of the mother as given at birth or adoption, not a name acquired by marriage. It is important to complete this item in all cases and not just for married mothers.

(Items 17a and 17b are used for identification and as documentary evidence of parentage. The mother's maiden surname is important because it remains constant throughout her life, in contrast to other names, which may change because of marriage or divorce.)

18. Date of Birth (of mother)

Enter the exact month, day, and year that the mother was born.

Enter the full name of the month--January, February, March, etc. Do not use a number or abbreviation to designate the month.

(This item is used to calculate the age of the mother, which is one of the most important factors in the study of childbearing. Studies have shown a relationship between the health of the child and age of the mother. For example, teenage women and women over age 40 have a higher percentage of low-birth-weight and premature infants than do women of other ages. This item is also useful for genealogical research.)

19. Birthplace of Mother (State or Foreign Country)

If the mother was born in the United States, enter the name of the state.

If the mother was born in a foreign country or a U.S. territory, enter the name of the country or territory.

If the mother was born in the United States but the state is unknown, enter "U.S.-Unknown."

If the mother was born in a foreign country but the country is unknown, enter "Foreign-Unknown."

(This item provides information on recent immigrant groups and is used for tracing family histories. It is also used with the U.S. Bureau of the Census data to compare the childbearing of women who were born in the United States with that of foreign-born women.)

20a. Residence of Mother (State)

Enter the name of the state in which the mother lives. If the mother is not a U.S. resident, enter the name of the country and the name of the nearest unit of government that is the equivalent of a state (e.g., Canada - Ontario).

20b. Residence of Mother (County)

Enter the name of the county in which the mother lives.

20c. Residence of Mother (City or Township)

Enter the name of the city or township where the mother lives. This may differ from the city of her mailing address in item #21. Always enter the most specific subdivision; if the mother lives in a rural area, provide the name of the **township** in #20c and the **city** she gets her mail through in item #21. If you do not know the name of the township of residence but you do know that the mother lives outside of city limits, you may leave this item blank if you enter "no" in item #20e (not inside city limits) and provide the mailing address in items #20d and #21.

20d. Mother's Address (Street and Number)

Enter the number and street name of the place where the mother lives.

If this location has no number and street name, enter the Rural Route number or a description of the place that will aid in identifying the precise location.

20e. Mother's Address Inside City Limits? (yes or no)

Enter "yes" if the mother lives inside city limits; enter "no" if she lives in a rural area outside of city limits.

(Statistics on births are tabulated by place of residence of the mother. This makes it possible to compute birth rates based on the population residing in the area. Data on births by place of residence of the mother are used to prepare population estimates and projections. These data are used in planning for and evaluating community services and facilities, including maternal and child health programs, schools, etc. Private businesses and industries also use these data for estimating demands for services. "Inside City Limits" is used to properly assign residence to either the city or the remainder of the county.)

21. Mother's Mailing Address

Enter the mailing address of the mother only if it is different from the residence address given in items #20c and #20d. If the mother lives in the city limits given in item #20c, enter the zip code only. It is important to distinguish between the mother's mailing address and her residence address; each serves a different purpose.

(This information is used to mail a birth notification record or a copy of the certificate to the mother and to ask for clarification of birth certificate entries or obtain missing information. It is used by the Social Security Administration to mail a social security card for the child to the mother. In the left hand margin of the birth certificate is the question, "Do parents want social security number for child? (yes or no)." If "yes" is checked, a social security number will be sent to the mother's mailing address. This address is also used for followback studies to obtain additional details about the birth.)

22. Father's Name

If the mother is married, enter her husband's name in item #22. If the mother is separated from her husband or if she states that her husband is not the father of the child, her husband's name should still be entered in item #22 pursuant to the Parentage Act (Minnesota Statute 257.55). The Parentage Act provides that a man is presumed to be the biological father of a child if he and the child's mother are married to each other and the child is conceived during the marriage. If the mother refuses to provide her husband's information, enter "Mother refused information on husband" in item #22.

If the mother is single, enter the father's information only if you have a completed Recognition of Parentage in your office. Refer to your written instructions provided by the Department of Human Services for information pertaining to the Recognition of Parentage. Questions regarding the Recognition of Parentage should be addressed to the Department of Human Services at 296-2542.

23. Date of Birth (of father)

Enter the exact month, day, and year that the father was born.

Enter the full name of the month--January, February, March, etc. Do not use a number or abbreviation to designate the month.

(This item is used to calculate the age of the father, which is used in the study of childbearing and health and genealogical research.)

24. Birthplace (of father)

If the father was born in the United States, enter the name of the state.

If the father was born in a foreign country or a U.S. territory, enter the name of the country or territory.

If the father was born in the United States, but the state is unknown, enter "U.S.-Unknown." If the father was born in a foreign country, but the country is unknown, enter "Foreign-Unknown."

(This item provides information on recent immigrant groups and is used for tracing family histories.)

25. Parent's Signature

Do not delay filing the birth certificate if the parents are unable to sign. The parent's signature is not a legal requirement, however, item #25 may be signed by one or both of the parents to verify that the information on the birth certificate is correct. Verifying the information at this time may prevent having to pay fees at a later date to have the birth certificate altered.

If the mother is single and wishes to designate the birth certificate public (item #27a), she must sign item #25.

(The certification validates the accuracy of the personal information recorded on the certificate.)

26. Birth Weight (specify unit)

Enter the birth weight of the child as it is recorded in the hospital record.

Enter the weight as shown in the hospital record, in either grams or pounds and ounces. Do not convert from one measure to the other. Specify the type of measure used (grams or pounds and ounces).

(This is the single most important characteristic associated with infant mortality. It is also related to prenatal care, socioeconomic status, marital status, and other factors surrounding the birth. Consequently, it is used with other information to plan for and evaluate the effectiveness of health care.)

27. Child Born in Wedlock? (Specify Yes or No)

Enter "Yes" if the mother was married at the time of conception, at the time of birth, or at any time between conception and birth; otherwise, enter "No." The father's name cannot be entered if the mother is not married, unless a Recognition of Parentage is signed by the parents. A woman is legally married even if she is separated from her husband. This information will not appear on certified copies of the birth certificate.

(This information is used to monitor the substantial differences in health and fertility between married and unmarried women. It enables the study of health problems encountered during and after pregnancies of unmarried women. This information allows researchers to measure medical risk factors of out-of-wedlock children and their mothers. These children tend to have lower birth weight and higher infant mortality, and they may be born to mothers with less prenatal care. Because of these differences, unmarried women and their babies are more likely to require additional health services.)

27a. If Item #27 is "No", Does Mother Designate Birth Record Public? (Yes or No)

In the case of an out-of-wedlock birth, Minnesota Statutes 144.225, Subd. 5 classifies the certificate of live birth as a private document unless the mother indicates on the birth certificate that she wants the data to be public. This means that unless the mother indicates she wants it public, information on the birth certificate may be disclosed only to the parent or guardian of the child, to the child if 18 years of age or older, or pursuant to a court order. If the mother indicates that she wants the record to be public she must sign the certificate in item #25.

MEDICAL SUPPLEMENT TO THE BIRTH CERTIFICATE (yellow copy)

Items 28-43 appear only on the medical supplement to the birth certificate. The information collected on the medical supplement to the certificate of live birth below the title INFORMATION FOR MEDICAL AND HEALTH USE ONLY may relate to the identification, description, prevention and control of disease and is part of an ongoing epidemiologic investigation necessary to analyze, describe, and protect the public health. Any information that permits identification of the child or either parent is classified as private under Minnesota Statutes. The information on the medical supplement to the certificate of live birth is used primarily for summary statistical purposes; however, private identifying information may be provided to local public health officials who are responsible for providing preventive health care services directed toward promoting the health and well being of the mother and/or the health and development of the child.

The failure to provide the known information sought on the certificate of live birth or the medical supplement to the certificate of live birth, or the failure to file these forms as prescribed by law, is a misdemeanor under Minnesota law.

28a. Mother's Social Security Number
28b. Father's Social Security Number

The social security numbers of the parents on the birth certificate are for purposes of locating an absent parent for child support enforcement. It is required by both state and federal law.

29a. Of Hispanic Origin? (Mother)
29b. Of Hispanic Origin? (Father)

Check "Yes" or "No." If "Yes" is checked, enter the specific hispanic group as obtained from the parent(s) or other informant.

Items 29a and 29b should be checked for the mother on all certificates and for the father in all cases where the name of the father is shown on the certificate. The entry in this item should reflect the response of the informant.

For the purposes of this item, "hispanic" refers to people whose origins are from Spain, Mexico, or the Spanish-speaking countries of Central or South America. Origin may be viewed as the ancestry, nationality, lineage, or country in which the person or his or her ancestors were born before their arrival in the United States.

There is no set rule as to how many generations are to be taken into account in determining hispanic origin. A person may report hispanic origin based on the country of origin of a parent, grandparent, or some far-removed ancestor. The response to this item should reflect what the parent considers himself or herself to be and is not based on percentages of ancestry.

Although the prompts include the major hispanic groups of Cuban, Mexican, and Puerto Rican, other hispanic groups should also be identified in the space provided.

If a person indicates that he or she is of multiple hispanic origin, enter the origins as reported (for example, Mexican-Puerto Rican).

If a person indicates that he or she is Mexican-American or Cuban-American, enter the hispanic origin as stated.

This item is not a part of the Race item. A person of hispanic origin may be of any race. Each question, race and hispanic origin, should be asked independently.

(Hispanic people comprise the second largest ethnic minority in this country. This item provides data to measure differences in fertility and pregnancy outcome as well as variations in health care for people of hispanic and non-hispanic origin. Without collection of data on persons of hispanic origin, it is impossible to obtain valid demographic and health information on this important group of Americans.)

30a. Race of Mother (Specify below)
30b. Race of Father - American Indian, Black, White, etc. (Specify below)

Items 30a and 30b should be checked for the mother on all certificates and for the father in all cases where the name of the father is shown on the certificate. The entry in this item should reflect the response of the informant.

Enter White, Black, Indian, Hmong, Laotian, Chinese, Japanese, Hawaiian, Filipino, Asian Indian, Korean, Samoan, Vietnamese, Guamian, Other. Do not enter "hispanic" in this item; hispanic origin is considered an ethnicity, not a race (see description of items #29a and #29b).

If the parent(s) are of multiple races, list the races in this item.

The response to this item should reflect the race that the parent considers himself or herself to be and is not based on percentages of ancestry.

31a. Education of Mother
31b. Education of Father (Specify only highest grade completed)

Enter the highest number of years of regular schooling completed by the mother and father in either the space of elementary/secondary school or the space for college. An entry should be made in only one of the spaces. The other space should be left blank. Report only those years of school that were completed. A person who enrolls in college but does not complete one full year should not be identified with any college education in this item.

(Education is correlated with fertility and birth outcome, and is used as an indicator of socioeconomic status. It is used to measure the effect of education and socioeconomic status on health, childbearing, and infant mortality.)

32a. Live Births (Now living)

Enter the number of prior children born alive to this mother who are still living at the time of this birth. **Do not include this child.** Do not include children by adoption.

Enter "None" if this is the first live birth to this mother or if all previous children are dead.

32b. Live Births (Now dead)

Enter the number of prior children born alive to this mother who are no longer living. Do not include this birth or any children by adoption.

Check "None" if this is the first live birth to this mother or if all previous children are still living.

32c. Date of Last Live Birth

Enter the date of birth of the last live-born child of the mother.

If this certificate is for the second birth of a twin set, enter the date of birth for the first baby of the set, if twin #1 was born alive. Similarly, for triplets or other multiple births, enter the date of birth of the previous live birth of the set. If all previously born members of a multiple set were born dead, enter the date of the mother's last delivery that resulted in a live birth.

Enter the full name of the month--January, February, March, etc. Do not use a number or abbreviation to designate the month.

Enter "None" if the mother has not had a previous live birth.

32d. Other Terminations (Spontaneous and induced at any time after conception)

Enter the number of fetuses that were delivered dead regardless of the length of gestation. Include each recognized loss of a product of conception, such as ectopic pregnancy, miscarriage, stillbirth, and spontaneous or induced abortion.

Check "None" if this is the first pregnancy for this mother or if all previous pregnancies resulted in live-born infants.

32e. Date of Last Other Termination (Month, Year)

Enter the date (month and year) of the last termination of pregnancy that was not a live birth regardless of the length of gestation.

If the mother has never had such a termination, enter "None."

If this certificate is for the second birth of a twin set and the first was born dead, enter the month and year of delivery of twin #1. Similarly, for other multiple births, if any previous member of the set was born dead, enter the month and year of delivery of that fetus. If all previously-born members of a multiple set were born alive, enter the month and year of the mother's **last** delivery that resulted in a fetal death.

(These items are used to determine live-birth order and total-birth order, which are important in studying trends in childbearing and child spacing. They are also useful in studying health problems associated with birth order--for example, first births to older women--and determining the relationship of birth order to infant and perinatal mortality.

In studying child spacing, the dates of last live birth and other terminations are used to compute the intervals between live births and fetal deaths and between pregnancies. This information allows researchers to measure known risk factors associated with the mother's previous pregnancies, such as prior fetal loss, short interpregnancy interval, and high parity.)

33. Date Last Normal Menses Began (Month, Day, Year)

Enter the exact date (month, day, and year) of the first day of the mother's last normal menstrual period, as obtained from the physician or hospital record. If the information is unavailable from these sources, obtain it from the mother.

Enter the full name of the month--January, February, March, etc. Do not use a number or abbreviation to designate the month.

If the exact day is unknown but the month and year are known, obtain an estimate of the day from the mother, her physician, or the medical record. If an estimate of the date cannot be obtained, enter the month and year only.

Enter "Unknown" if the date cannot be determined. Do not leave this item blank.

(This item is used in conjunction with the date of birth to determine the length of gestation, which is closely related to infant morbidity and mortality. Length of gestation is linked with birth weight to determine the maturity of the child at birth. It is also used in assessing the adequacy of the number of prenatal care visits by the gestational age at birth.)

34. Month of Pregnancy Prenatal Care Began - First, Second, Third, etc. (Specify)

Enter the number of the month in this pregnancy when the mother first received care from a physician or other health professional or attended a prenatal clinic. Do **not** enter the name of a month.

The month of pregnancy in which prenatal care began is measured from the date the last normal menses began and not from the date of conception.

Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman.

If no prenatal care was received, enter "None."

35. Prenatal Visits - Total Number

Enter the number of visits made for medical supervision of the pregnancy by a physician or other health care provider during the pregnancy. If no prenatal care was received, enter "None." If item #34 is reported as "None," this item should also be completed as "None."

(This information, in conjunction with "month prenatal care began", is used to determine the relationship of prenatal care to the health of the child at birth. Women receiving delayed care or no care are of considerable interest to public health officials because inadequate care may be harmful to both the mother and fetus.)

36. Clinical Estimate of Gestation (Weeks)

Enter the length of gestation as estimated by the attendant. Do not compute this information from the date last normal menses began and date of birth. If the attendant has not done a clinical estimate of gestation, enter "None."

(This item provides information on gestational age when the item on date last normal menses began contains invalid or missing information. For a record with a plausible date last normal menses began, it provides a cross-check with length of gestation based on ultrasound or other techniques.)

37a-b. APGAR SCORE

37a. 1 Minute

Enter the Apgar score (0 through 10) as assigned by the delivery room personnel 1 minute after birth.

37b. 5 Minutes

Enter the Apgar score (0 through 10) as assigned by the delivery room personnel 5 minutes after birth.

(The Apgar score is regarded as a reliable summary measure for evaluating the physical condition of the infant at birth.)

38a-b. Mother - Child Transfers

38a. Mother Transferred Prior to Delivery?

Check "No" if this is the first facility the mother was admitted to for delivery. Check "Yes" if the mother was transferred from one facility to another facility before the child was delivered. If the mother was transferred before delivery, enter the name of the facility that transferred her. If the mother was transferred more than once, enter the name of the last facility from which she was transferred.

(This information is used to study transfer patterns and determine whether timely identification and movement of high-risk patients is occurring.)

38b. Child Transferred?

Check "No" if the infant was not transferred to another facility. Check "Yes" if the infant was transferred from this facility to another facility after delivery. If the infant was transferred, enter the name of the facility the infant was transferred to. If the infant was transferred more than once, enter the name of the first facility to which the infant was transferred.

(This information is used to examine transfer patterns and perinatal outcomes by type of hospital or level of care. It may also be used to follow up and determine the survival status of an infant transferred to a different facility.)

39a-44. CHECKBOX ITEMS

The following medical and health items are formatted into checkboxes. Please review each checkbox listed, and carefully check the appropriate box(es). Clearly mark an "X" or check the box. The mark should not overlap more than one box.

39a. Medical Risk Factors for This Pregnancy (Check all that apply)

Check each of the medical risk factors that the mother experienced during this pregnancy. If the mother experienced medical risk factor(s) not identified in the list--for example, other infectious diseases, AIDS, or syphilis--check "Other" and enter the risk factor on the line provided. Medical risk factors should be identified from the hospital or physician record. If there were no medical risk factors, check "None." Do not leave this item blank.

(This information allows for the identification of specific maternal conditions that are often predictive of poor maternal and infant outcome. It may be used for planning intervention and prevention strategies.)

ANEMIA (Hct. less than 30 or Hgb. less than 10): A symptom of some underlying disease (e.g., iron deficiency, chronic blood loss, sickle cell anemia) which manifests itself by weakness, ease of fatigue, and drowsiness. It is clinically defined as a hemoglobin level of less than 10.0 g/dl during pregnancy or a hematocrit of less than 30 percent during pregnancy. ICD-9 codes 280-2819, 2830-2859.

CARDIAC DISEASE: Mother has diagnosis of a disease of the heart, such as rheumatic heart disease, congenital heart disease, cyanotic heart disease, coronary thrombosis, bacterial endocarditis, cardiomyopathy, mitral valve prolapse, cardiovascular complications from Marfan syndrome, coarctation of the aorta, or kyphoscoliotic heart disease during this pregnancy. ICD-9 codes 6485-6486, 390-3989, 404, 410-4299.

Synonyms to be included in this item:

Angina	Aortic/Mitral stenosis
Arrhythmia	Atrial/ventricular fibrillation
Cardiomyopathy	Cardiomegaly
Congenital heart disease (mother)	Cardiovascular disease
Cor pulmonale	Congestive heart failure (CHF)
Myocardial infarction (MI)	Endocarditis
Pericarditis	Mitral valve prolapse (MVP)
Tachycardia	Myocarditis
	Rheumatic heart disease
	Valvular Disease

ACUTE OR CHRONIC LUNG DISEASE: Mother has diagnosis of a disease of the lungs during this pregnancy. Acute is a short and sharp course of lung disease like pneumonia, acute bronchitis. Chronic is of long duration, denoting a disease of slow progress and long continuance like tuberculosis, cystic fibrosis, chronic bronchitis, chronic obstructive bronchitis, pulmonary edema, chronic obstructive emphysema, persistent asthma, chronic asthmatic bronchitis (the last six make up chronic obstructive pulmonary disease). ICD-9 codes 0100-0119, 1620-1639, 480-487, 490-496, 500-5199.

Synonyms to be included in this item:

Asthma	Atelectasis
Bronchiectasis	Bronchiolitis
Bronchitis	Emphysema
Chronic obstructive pulmonary disease (COPD)	Pulmonary fibrosis
Tuberculosis	Pneumonia

DIABETES: Mother has diagnosis of type 1, juvenile onset diabetes, type 2, adult onset diabetes, or gestational diabetes mellitus during this pregnancy. Do not include family history of diabetes. Also note that juvenile diabetes can occur at any age.

(Insulin Dependent) A syndrome resulting from a variable interaction of hereditary and environmental factors, and characterized by abnormal insulin secretion, inappropriately elevated blood glucose levels, and a variety of end organ complications including nephropathy, retinopathy, neuropathy, and accelerated atherosclerosis. Insulin dependent defines a group who are literally dependent on exogenous insulin to prevent ketoacidosis and death. (Former names: juvenile d., juvenile-onset d., ketosis-prone d., and Brittle d.). ICD-9 codes 2500-2509, 6480.

(Other Diabetes) Non-insulin dependent diabetes mellitus (non-obese or obese) individuals who may or may not use insulin for symptom control but who do not need it for survival. (Former names: adult-onset diabetes, maturity-onset d., ketosisresistant d., stable d., maturity-onset diabetes of youth).

Gestational diabetes, where glucose intolerance develops or is discovered during pregnancy (often during 2nd or 3rd trimester). It usually disappears or becomes subclinical following the end of pregnancy. ICD-9 codes 6488, 7902.

Secondary diabetes, where it is associated with certain conditions and symptoms such as pancreatic disease, changes in other hormones besides insulin, insulin receptor abnormalities, genetic syndromes and malnourished populations.

GENITAL HERPES: Infection of the skin of the genital area by herpes simplex virus. Lesions frequently develop four to seven days after contact. The condition tends to recur because the virus establishes latent infection of the sacral sensory nerve ganglia, from which it reactivates and reinfects the skin. Most fetal infection occurs because the virus was shed from the cervix or lower genital tract and then either invades the uterus following rupture of the membranes or contacts the fetus with passage through the genital tract. ICD-9 code 0541.

HYDRAMNIOS/OLIGOHYDRAMNIOS: Any noticeable excess or lack of amniotic fluid. Hydramnios or polyhydramnios is an excessive volume of amniotic fluid, somewhat arbitrarily defined as greater than 2,000 ml. Diagnosis is usually based on clinical impression or sonographic estimation. Hydramnios sufficient to cause clinical symptoms (usually >3,000 ml.) occurs in about 1 in 1,000 pregnancies excluding multifetal pregnancies. Hydramnios is associated with central nervous system, gastrointestinal tract and other birth defects. Also the incidence is increased by diabetes, hydropic variety of erythroblastosis and multifetal pregnancies. ICD-9 code 657.

OLIGOHYDRAMNIOS - Volume of amniotic fluid falls or is far below normal, sometimes only a few ml. of viscid fluid. Cause is not understood. It is often observed with post-term births. Risk of cord compression and, in turn, fetal distress is increased. Oligohydramnios is almost always evident when there is either obstruction of the fetal urinary tract or renal agenesis. Fetal pulmonary hypoplasia is very common with oligohydramnios. ICD-9 code 6580.

HEMOGLOBINOPATHY: A hematologic disorder caused by alteration in the genetically determined molecular structure of hemoglobin, which results in a characteristic complex of clinical and laboratory abnormalities and often, but not always, overt anemia. Most common sickle cell hemoglobinopathies are sickle cell anemia, sickle cell-hemoglobin C disease and sickle cell-B-thalassemia disease. Other hemoglobinopathies are hemoglobin E and C disease. Hb E is found mostly in Southeast Asians and Black populations whereas HbC and HbS-C is mostly observed in the Black population. Thalassemias is particularly common in persons of Mediterranean, African and Southeast Asian ancestry. Maternal morbidity and mortality, abortion, and perinatal mortality are appreciably but not uniformly increased with all of these diseases. ICD-9 codes 2820-2829.

HYPERTENSION, CHRONIC: Blood pressure persistently greater than 140/90 diagnosed prior to the onset of the pregnancy or before the 20th week of gestation. ICD-9 codes 6420-6423, 4010-4059.

HYPERTENSION, PREGNANCY-ASSOCIATED: An increase in blood pressure of at least 30 mm Hg systolic or 15 mm Hg diastolic on two measurements taken 6 hours apart after the 20th week of gestation. The development of hypertension plus proteinuria or edema that is generalized and overt with onset rarely earlier than the 20th week of gestation. The blood pressure is 140/90 or greater, or there has been an increase of 30 mm Hg systolic or 15 mm Hg diastolic over baseline values on at least two occasions six or more hours apart. It is almost exclusively a disease of the nulliparous woman. Factors associated with the disease are: extremes of reproductive age; multifetal pregnancy; fetal hydrops; vascular disease, including essential chronic hypertension and diabetes mellitus; coexisting renal disease; pre-eclampsia; and toxemia. ICD-9 codes 6424-6425, 6427-6429.

ECLAMPSIA: The occurrence of convulsions and/or coma unrelated to other cerebral conditions in women with signs and symptoms of pre-eclampsia. Occurs in neglected or, less often, fulminant cases of pregnancy-induced hypertension. Seizures are of grand mal type and may first appear before labor, during labor up to 48 hours postpartum. ICD-9 code 6426.

Synonyms to be included in this item:

Toxemia with seizures

INCOMPETENT CERVIX: Characterized by painless dilation of the cervix in the second trimester or early in the third trimester of pregnancy, with prolapse of membranes through the cervix and ballooning of the membranes into the vagina, followed by rupture of the membranes and subsequent expulsion of a fetus. ICD-9 code 6545.

Synonyms to be included in this item:
Cerclage
McDonald cerclage
Shirodkar suture or procedure

PREVIOUS INFANT 4000+ GRAMS: The birth weight of a previous live-born child was over 4,000 grams (8 pounds, 13 ounces).

PREVIOUS PRETERM INFANT: Previous birth of an infant prior to term, usually considered earlier than 37 completed weeks of gestation. Do not include fetal deaths.

PREVIOUS SMALL FOR GESTATIONAL AGE INFANT: Previous birth of an infant weighing less than the tenth percentile for gestational age using a standard weight for age chart. Check this item only for live births.

RENAL DISEASE: Mother has diagnosis of a kidney disease such as, acute or chronic pyelonephritis, glomerulonephritis, nephrosis, acute tubular necrosis, renal cortical necrosis, obstructive renal failure, diabetic nephropathy or polycystic kidney disease during this pregnancy. This is one of the most frequent medical complications of pregnancy. ICD-9 codes 5800-5899, 5900-5932, 6462, 7530, 7531, and 7533.

Synonyms to be included in this item:

Glomerulonephritis	Hydronephrosis
Kidney stone	Nephritis
Nephropathy	Nephrosis
Pyelonephritis	Renal Failure

Rh SENSITIZATION: The process or state of becoming sensitized to the Rh factor (i.e., Rh antigen(s), especially D antigen) as when an Rh-negative woman is pregnant with an Rh-positive fetus. Unless the mother was previously sensitized by transfusion, a first pregnancy is rarely affected. The risks of sensitization increase with each subsequent pregnancy. ICD-9 code 6561.

Synonyms to be included in this item:

Rh incompatibility	Rh antibodies
Rh isoimmunization	

Do not include preventive measures such as the use of Rhogam.

UTERINE BLEEDING: Any clinically significant bleeding during the pregnancy taking into consideration the gestational age of the patient. Any second or third trimester bleeding of the uterus prior to the onset of labor. Conditions that predispose to uterine bleeding prior to labor onset are any abnormal placental implantation or development, trauma, overdistended uterus (multifetal pregnancy, hydramnios, distended with blood), small maternal blood volume and coagulation defects. ICD-9 codes 6400-6409, 6411, 6413-6419.

OTHER: (Specify): Other medical risk factors experienced by the mother that may cause or contribute to complications of this pregnancy. Examples are cocaine use during pregnancy, rubella, syphilis, gonorrhea, early onset of delivery and mental disorder. Any ICD code 630-6769 not included in the above definitions.

THE FOLLOWING CONDITIONS SHOULD NOT BE LISTED IN QUESTION 39a.

Twins
Previous C-section
Advanced Maternal Age
Teenage Mother
No/Late prenatal care
Previous fetal death
Heart or lung complications resulting from anesthesia, surgery, or drugs used in this delivery

39b. Other Risk Factors For This Pregnancy

Complete each question/statement. Enter the amount of weight **gained** by the mother during the pregnancy in pounds. Do not enter the total weight of the mother. If no weight was gained, enter "None". If the mother lost weight during her pregnancy, enter the amount of weight lost (for example, "Lost 10 pounds"). Do not leave this item blank.

Check "Yes" for tobacco use if the mother smoked tobacco at any time during the pregnancy. Check "No" if the mother did not smoke during the entire pregnancy. If "Yes" is checked, specify the average number of cigarettes the mother smoked per day during her pregnancy. If, on the average, she smoked less than one cigarette per day, check "Less than 1." If "No" is checked, do not make any entry on the line requesting the average number of cigarettes per day.

Check "Yes" for alcohol use if the mother consumed alcoholic beverages at any time during her pregnancy. Check "No" if the mother did not consume any alcoholic beverages during the entire pregnancy. If "Yes" is checked, specify the average number of drinks she consumed **per week**. One drink is equivalent to 5 ounces of wine, 12 ounces of beer, or 1-1/2 ounces of distilled liquor. If, on the average, she drank less than one drink per week, enter "Less than 1." If "No" is checked, do not make any entry on the line requesting the average number of drinks per week.

Check appropriate box(es) for drug use during pregnancy.

Information for this item should be obtained from the mother's medical chart or the physician. If the medical chart is not available or does not include this information and the physician is unavailable, the informant should be asked to respond to these items.

(Smoking, drinking, and drug use during pregnancy may have an adverse impact on pregnancy outcome. This information is used to evaluate the relationship between certain lifestyle factors and pregnancy outcome and to determine at what levels these factors clearly begin to affect pregnancy outcome.)

40. Obstetric Procedures (check all that apply)

Check each type of procedure that was used during this pregnancy. More than one procedure may be checked. If a procedure was used that is not identified in the list, check "Other" and specify the procedure on the line provided. If no procedures were used, check "None". Do not leave this item blank. This information should be obtained from the mother's medical chart or the physician.

(Information on obstetric procedures is used to measure the use of advanced medical technology during pregnancy and labor and to investigate the relationship of these procedures to type of delivery and pregnancy outcome.)

AMNIOCENTESIS: Surgical transabdominal perforation of the uterus to obtain amniotic fluid to be used in the detection of genetic disorders, fetal abnormalities (especially neural tube defects), and fetal lung maturity. The procedure is done between the 15th and 16th week of gestation with results available in weeks.

ELECTRONIC FETAL MONITORING: Monitoring with external devices applied to the maternal abdomen, detect and record fetal heart tones and uterine contractions. External fetal monitoring can also be used as a non-stress test (NST) or as a contraction stress test (CST), sometimes called the oxytocin challenge test (OCT). In these tests, fetal heart rate is recorded and compared to fetal movement (NST), or to contractions induced by oxytocin (OCT) or those occurring spontaneously. These tests are frequently used to monitor problem pregnancies. Internal leads may also be placed, with an electrode attached to the fetal scalp and a catheter through the cervix into the uterus to measure amniotic fluid pressure. Internal fetal monitoring provides more reliable information about fetal heart rate patterns and uterine contraction patterns than external.

Synonyms to be included in this item:
Fetal scalp electrode (FSE)
Intrauterine pressure catheter (IUPC)
Internal pressure monitor

INDUCTION OF LABOR: The initiation of uterine contractions before the spontaneous onset of labor by medical and/or surgical means for the purpose of delivery.

Synonyms to be included in this item:
Amniotomy/AROM-if labor not yet begun
Pitocin
Prostaglandin
Prostin gel

STIMULATION OF LABOR: Augmentation of previously established labor by use of oxytocin.

Synonyms to be included in this item:
Amniotomy/AROM-if labor is stalled
Augmentation

TOCOLYSIS: Use of medications to inhibit preterm uterine contractions to extend the length of pregnancy and therefore avoid a preterm birth. Bedrest and tocolytic agents (e.g., magnesium sulfate, B-Adrenergic receptor stimulants (ritodrine, terbutaline, fenoterol) are used to attempt to arrest labor. Delivery is considered more advantageous than pharmacologic intervention if the pregnancy is beyond the 32nd week.

ULTRASOUND: Visualization of the fetus and the placenta by means of sound waves. Its primary usages are to date the fetus; detect sudden changes in fetal growth; detect multifetal pregnancies, certain fetal abnormalities, and complications of pregnancy (e.g., placenta previa).

Synonyms to be included in this item:
Sonogram

OTHER: (Specify): Examples are x-rays and chorionic villus sampling (CVS) - A sample of chorionic villi is obtained by inserting a flexible catheter through the vagina and cervix, and advancing it to the site of fetal implantation under direct ultrasound guidance. About 10 to 30 mg of villi are then aspirated into a syringe; any contaminating maternal tissue is removed under a dissecting microscope; and kearyotypes can then be prepared directly from the villi. It is done at 8 to 10 weeks of gestation and results are available within hours or days. It is done to detect genetic defects.

41. Complications of Labor and/or Delivery

Check each medical complication present during labor and/or delivery. If a complication was present that is not identified in the list, check "Other" and specify the complication on the line provided. If there were no complications, check "None". Do not leave this item blank. This information should be obtained from the mother's medical chart or the physician.

(This information is used to identify pregnancy complications during labor and delivery and their relationship to method of delivery and birth outcome.)

FEBRILE (more than 100 degrees F. or 38 C.): A fever greater than 100 degrees F. or 38 degrees C. occurring during labor and/or delivery. ICD-9 code 6592.

MECONIUM, MODERATE/HEAVY: Meconium consists of undigested debris from swallowed amniotic fluid, various products of secretion, excretion and desquamation by the gastrointestinal tract. Moderate to heavy amounts of meconium in the amniotic fluid noted during labor and/or delivery.

PREMATURE RUPTURE OF MEMBRANES (more than 12 hours): Rupture of the membranes at any time during pregnancy and greater than 12 hours before the onset of labor. Preterm premature rupture of the membranes is an important cause of perinatal morbidity and mortality. ICD-9 code is 6581.

Synonyms to be included in this item:
PROM (if greater than 12 hours)

ABRUPTIO PLACENTA: Premature separation of a normally implanted placenta from the uterus. Hemorrhage may be external (pass through the cervix) or concealed (retained behind the placenta). The placenta is an organ joining mother and offspring, providing endocrine secretion and selective exchange of soluble, but not particulate. The condition is associated with poor perinatal outcome. ICD-9 code 6412.

PLACENTA PREVIA: Implantation of the placenta over or near the internal os (opening) of the cervix. The placenta may cover the internal os completely (total previa) or partially (partial previa) or it may encroach on the internal os (low implantation or marginal previa). The most characteristic event in placenta previa is painless hemorrhage, which usually does not appear until near the end of the second trimester or later. It frequently cannot be distinguished from abruptio placenta by clinical findings. Best way to differentiate is by ultrasound. ICD-9 codes 6410, 6411.

OTHER EXCESSIVE BLEEDING: The loss of a significant amount of blood from conditions other than abruptio placenta or placenta previa. There are many other causes of hemorrhage during labor and/ or delivery (e.g., trauma, uterine atony, small maternal blood volume, coagulation defects). ICD-9 codes 6413-6419.

SEIZURES DURING LABOR: Seizures occurring during labor because of epilepsy, encephalitis, meningitis, cerebral tumor, acute porphyria, ruptured cerebral aneurysm, hysteria, eclampsia or any other etiology. ICD-9 code 6691.

PRECIPITOUS LABOR (less than 3 hours): Extremely rapid labor and delivery lasting less than three hours. ICD-9 code 6613.

PROLONGED LABOR (greater than 20 hours): Abnormally slow progress of labor (greater than 20 hours) because of weak or non-coordinated uterine forces, inadequate forces generated by the voluntary muscles, faulty presentation or abnormal development of the fetus and/or abnormalities of the birth canal. ICD-9 code 662.

DYSFUNCTIONAL LABOR: Same as dystocia (literally difficult labor) and same things as noted for prolonged labor. ICD-9 codes 6610-6612, 6614-6619.

<u>Synonyms to be included in this item:</u>
Arrest of dilation
Atony of uterus
Arrest/non-progression of labor
Desultory labor
Failure to progress
Hypertonic/incoordinate/prolonged contractions
Irregular labor
Prolonged active/latent phase
Transverse arrest
Uninducible cervix
Uterine inertia

BREECH/MALPRESENTATION: At birth, the presentation of the fetal buttocks rather than the head. There are several varieties of breech presentation: frank breech, complete breech, and single or double footling presentation. ICD-9 codes 6521, 6522, 6696.

Other malpresentations other than breech (e.g., face, brow, shoulder, compound). ICD-9 codes 6523-6529, 6604.

Synonyms to be included in this item:

Face/brow presentation	Footling
Oblique presentation	Persistent occiput posterior
Prolapsed arm	Transverse lie
Unstable lie	

CEPHALOPELVIC DISPROPORTION: A condition in which the relationship of the size, presentation and position of the fetal head to the maternal pelvis prevents dilation of the cervix and/or descent of the fetal head. ICD-9 code 6530-6539.

Synonyms to be included in this item:

Contracted pelvis
Abnormality of pelvis
Fetal abnormality causing disproportion
Fetopelvic disproportion
CPD

CORD PROLAPSE: Premature expulsion of the umbilical cord in labor before the fetus is delivered. Occult prolapse occurs with intact membranes when the cord presents ahead of the presenting part or is trapped in front of a shoulder. Overt prolapse occurs with ruptured membranes when the cord presents in front of the presenting part, most commonly with breech presentation. Unless prompt delivery is accomplished, fetal death results from compression of the cord between the presenting part and the margin of the pelvic inlet. ICD-9 code 6630.

ANESTHETIC COMPLICATIONS: Any complication during labor and/or delivery brought on by an anesthetic agent/s (e.g., aspiration, hypotension, spinal blockage with respiratory paralysis, hypertension, bladder dysfunction). ICD-9 codes 6680-6689.

FETAL DISTRESS: Signs indicating fetal hypoxia which may include persistent abnormal fetal heart rate patterns, low scalp ph, significant meconium staining of amniotic fluid, low cord ph, a minute Apgar score less than 3, or a 5 minute Apgar less than 5. ICD-9 code 6563.

Synonyms to be included in this item:

Fetal intolerance to labor
Extended fetal bradycardia
Decreased FHT variability
Multiple late decelerations

OTHER: Conditions included in ICD-9 codes 6600-6699 that are not listed above.

DO NOT LIST THE FOLLOWING CONDITIONS IN QUESTION 41.
Post-term
Premature/preterm labor
Previous C-section
Pre-eclampsia

42. Method of Delivery

Check the method of delivery of the child. If more than one method was used, check all methods that apply to this delivery. This information should be obtained from the mother's medical chart or the physician.

(This information is used to relate method of delivery with birth outcome, to monitor changing trends in obstetric practice, and to determine which groups of women are most likely to have cesarean delivery. The method of delivery is relevant to the health of mothers, especially if it is by cesarean section. Information from this item can be used to monitor delivery trends across the United States.)

43. Abnormal Conditions of the Child

Check each abnormal condition associated with the newborn infant. If more than one abnormal condition exists, check each condition. If an abnormal condition is present that is not identified in the list, check "Other" and specify the condition on the line provided. This information should be obtained from the mother's and infant's physicians or the medical records (obstetric and pediatric).

(Information on abnormal conditions of the newborn helps measure the extent infants experience medical problems and can be used to plan for their health care needs. This item also provides a source of information on abnormal outcome in addition to congenital anomaly or infant death. These data allow researchers to estimate the number of high-risk infants who may benefit from special medical services.)

ANEMIA: A symptom of some underlying disease (e.g. iron deficiency, chronic blood loss, sickle cell anemia) which manifests itself by weakness, ease of fatigue, and drowsiness. It is clinically defined as a hemoglobin level of less than 13.0 g/dl or a hematocrit of less than 39 percent. ICD-9 codes 7732, 7730-7735.

BIRTH INJURY: Impairment of infant's body function or structure due to adverse influences which occurred at birth. This item is to be checked only if the injuries require evaluation by a physician. Some noted injuries (birth trauma) are subdural and cerebral hemorrhage, injuries to scalp, fracture of clavicle, injury to spine and spinal cord, facial palsy. About 40 percent of very low birth weight (<1500 gram) infants have intracranial hemorrhage. ICD-9 codes 7670-7679.

Synonyms to be included in this item:

Bruising/abrasion	Facial nerve injury
Cephalhematoma	Fractures of bones
Facial/Erb's palsy	Klumpke's palsy
Scalpel wound	Subdural hematoma

Hematoma of liver/testes/vulva
Nerve injury Rupture of liver/spleen
Swollen eye Tentorial tear
Traumatic glaucomaTraumatic hemorrhage

FETAL ALCOHOL SYNDROME: A syndrome of altered prenatal growth and morphogenesis occurring in infants born of women who consumed excessive amounts of alcohol during pregnancy.

The minimal criteria for diagnosis of FAS is:

1) Growth retardation (below the 10th percentile);
2) Characteristic facial anomalies (at least two of three): a) microcephaly (below 3rd percentile), b) microphthalmia or short palpebral fissures, c) underdeveloped philtrum, thin upper lip and maxillary hypoplasia; and
3) Central nervous system dysfunction (neurological abnormality, mental deficiency, developmental delay). ICD-9 code 7607.

HYALINE MEMBRANE DISEASE/RDS: Condition of newborn marked by dyspnea with cyanosis, heralded by such prodromal signs as dilatation of the alae nasi, expiratory grunt, and retraction of the suprasternal notch or costal margins. Check this item only if X-Ray findings include at least two of the following: granularity, air bronchograms, hypoaeration with poor lung expansion or clinical treatment of 40% or more oxygen requirement. A disorder primarily of prematurity, manifested clinically by respiratory distress and pathologically by pulmonary hyaline membranes and incomplete expansion of the lungs at birth. RDS is also more likely to develop in infants of diabetic mothers. ICD-9 code 769.

Synonyms to be included in this item:
Respiratory distress syndrome

MECONIUM ASPIRATION SYNDROME: Aspiration of meconium by the fetus or newborn, which may result in atelectasis, emphysema, or pneumonia. Check only if the meconium affected the lower respiratory system. Complete bronchial obstruction results in incomplete expansion of the lungs, while partial blockage leads to hyperinflation of the lungs and pulmonary air leaks. Do not check this item if the meconium was successfully managed at the time of delivery so that no meconium entered the lower airway (trachae). ICD-9 code 7701.

ASSISTED VENTILATION (less than 30 minutes): A mechanical method of assisting respiration for newborns with respiratory failure. In this case, the ventilation assistance lasts for less than 30 minutes.

Synonyms to be included in this item:
Intubated with 0_2 less than 30 minutes

ASSISTED VENTILATION (30 minutes or more): Newborn placed on assisted ventilation for 30 minutes or longer.

Synonyms to be included in this item:
Intubated with 0_2 30 minutes or more

SEIZURES: A seizure of any etiology. Frequent and serious neonatal problem usually focal, migratory clonic jerks of extremities, alternating hemiseizures, or primative subcortical seizures. A sudden, brief attack of altered consciousness, motor activity, sensory phenomena, or inappropriate behavior. ICD-9 code 7790.

OTHER (Specify): Ex: Neonatal group B strep infection, hemangioma, drug addiction of newborn, congenital infection or congenital neoplasm.

DO NOT INCLUDE THESE CONDITIONS IN QUESTION 43.
Transient tachypnea
Cord with knot
Heart murmur
Ecchymosis
Weak cry
Hip Click

44. Congenital Anomalies Of Child

Check each anomaly of the child. Do not include birth injuries. The checklist of anomalies is grouped according to major body systems. If an anomaly is present that is not identified in the list, check "Other" and specify the anomaly on the line provided. Note that each group of system-related anomalies includes an "Other" category for anomalies related to that particular system. If there is a question as to whether the anomaly is related to a specific system, enter the description of the anomaly in "Other (Specify)" at the bottom of the list. If there are no congenital anomalies of the child, check "None." This information should be obtained from the mother's and infant's physicians or the medical records (obstetric and pediatric).

(Information on congenital anomalies is used to identify health problems that require medical care and monitor the incidence of the stated conditions. It is also used to study unusual clusters of selected anomalies, to track trends among different segments of the population, and to relate the prevalence of anomalies to other characteristics of the mother, infant, and the environment.)

ANENCEPHALUS: Absence of the cerebral hemispheres. Varying portions of the brainstem and spinal cord may be misssing or malformed. These infants either are stillborn or die within a few days. ICD-9 codes 740-7402.

Synonyms to be included in this item:

Acrania	Amyelencephalus
Anencephalic	Anencephaly
Hemianencephaly	Hemicephaly

SPINA BIFIDA/MENINGOCELE: Developmental anomaly characterized by defective closure of the bony encasement of the spinal cord, through which the cord and meninges may or may not protrude. Spina bifida is a defective closure of the vertebral column. In spina bifida cystica, the protruding sac can contain meninges (meningocele) spinal cord (myelecele), or both (myelomeningocele). ICD-9 codes 741-7419.

Synonyms to be included in this item:

Meningomyelocele	Hydromeningocel
Myelocystocele	Myelocele
Syringomyelocele	Rachischisis

HYDROCEPHALUS: Excessive accumulation of cerebrospinal fluid within the ventricles of the brain with consequent enlargement of the cranium. Associated defects are common, with spina bifida occurring in about one-third of the cases. ICD-9 code 7423.

MICROCEPHALUS: A significantly small head usually associated with DeLange's syndrome, rubella, toxoplasmosis, cytomegalic inclusion disease, cebocephaly, and various chromosomal abnormalities. ICD-9 code 7421.

Synonyms to be included in this item:

Hydromicrocephaly	Micrencephalon
Microcephaly	

OTHER CENTRAL NERVOUS SYSTEM ANOMALIES (Specify): Other anomalies of the central nervous system such as encephalocele, reduction deformities of the brain, and other specified anomalies of brain, spinal cord, and nervous system. ICD-9 codes 7420, 7422, 7424-7429.

HEART MALFORMATIONS: Congenital anomalies of the heart such as transposition of great vessels, tetralogy of Fallot, ventricular septal defect, endocardial cushion defects, anomalies of pulmonary valve, tricuspid atresia and stenosis, stenosis and insufficiency of aortic valve. All conditions having ICD-9 codes 745-746.

Synonyms to be included in this item:

Atresia/insufficiency/stenosis of pulmonary valve
Common atrium/AV canal/truncus/ventricle
Atrial septal defect
Cor Biloculare
Dextrocardia

Ectopia cordis
Endocardial cushion defects
Epstein's anomaly
Hypoplastic left heart syndrome
Pericardial defect
Malposition of heart
Single ventricle
Septal defect
Taussig-Bing syndrome
Uhls disease

OTHER CIRCULATORY ANOMALIES (Specify): Such as patent ductus arteriosis, coarction of the aorta, etc.

RESPIRATORY ANOMALIES (Specify): Anomalies of the respiratory systems such as, choanal atresia, congenital cystic lung and agenesis, hypoplasia and dysplasia of lung. ICD-9 codes 747-748.

RECTAL ATRESIA/STENOSIS: Congenital absence, closure or narrowing of the rectum. ICD-9 code 7512 also includes atresia and stenosis of large intestine and anal canal.

Symptoms to be included in this item:
Imperforate anus/rectum
Stricture of anus/rectum

TRACHEO-ESOPHAGEAL FISTULA/ESOPHAGEAL ATRESIA: An abnormal passage between the trachea and the esophagus. Esophageal atresia is the congenital absence or closure of the esophagus. ICD-9 code is 7503 which also includes stenosis of the esophagus.

Synonyms to be included in this item:
Congenital fistula - esophagobronchial/esophagotracheal
Imperforate esophagus
Absent esophagus
Webbed esophagus
Stricture of esophagus

OMPHALOCELE/GASTROSCHISIS: An omphalocele is a protrusion of variable amounts of abdominal viscera from a midline defect at the base of the umbilicus. The herniation is covered by a thin membrane and may be small, including only a few loops of bowel, or may contain most of the abdominal viscera, including all the intestines, the stomach, and the liver. ICD-9 code is 5531 which has it also noted as umbilical hernia, parumbilical hernia. In gastroschisis, the abdominal viscera protrude through an abdominal wall defect, usually on the right side of the umbilical cord insertion. There is no membranous covering and the intestines have large amounts of fluid and appear shortened from being bathed in amniotic fluid containing fetal urine. ICD-9 code 7567.

OTHER GASTROINTESTINAL ANOMALIES (Specify): Other congenital anomalies of the gastrointestinal system such as Meckel's diverticulum, atresia and stenosis of small intestine. ICD-9 codes are 7505-7509, 7510-7511, 7513-7525, 7518-7519.

MALFORMED GENITALIA: Congenital anomalies of the reproductive organs such as of the ovaries, fallopian tubes, uterus, cervix, vagina, undescended testicle, hypospadias, epispadias, indeterminate sex and pseudohermaphroditism. ICD-9 codes are 7520-7529.

Synonyms to be included in this item:
Absence of penis/prostate/spermatic cord
Anaspadias
Anomaly of ovary/fallopian tubes/broad ligaments
Anomaly of cervix/clitoris/uterus/vagina/vulva
Aplasia of prostate /round/ligament/testicle
Bicornate uterus
Cryptorchism
Curvature of penis
Double uterus
Ectopic testis
Fusion of testes
Gyunandrism
Hermaphroditism
Hypospadias/epispadias
Imperforate hymen
Monorchism
Ovotestis
Paraspadias
Pseudohermaphroditism

RENAL AGENESIS: One or both kidneys are completely absent because of failure to develop. ICD-9 code is 7530 which also includes renal dysgenesis which is a defective development of the kidney or kidneys.

Synonyms to be included in this item:
Absence of kidney
Atrophy of kidney
Hypoplasia of kidney

OTHER UROGENITAL ANOMALIES (Specify): Other congenital anomalies of the organs concerned in the production and excretion of urine, together with organs of reproduction. Other anomalies of the urinary system could be cystic kidney disease, obstructive defects of renal pelvis and ureter, exstrophy of urinary bladder, atresia and stenosis and urethra and bladder neck. ICD-9 codes are 7531-7539.

CLEFT LIP/PALATE: Cleft lip is a fissure or elongated opening of the lip due to a failure to fuse during the embryonic development. It is also called a harelip. Cleft palate is a fissure in the roof of the mouth due to a failure of the soft or soft and bony palate to unite during embryonic development. ICD-9 codes are 7490-7492.

Synonyms to be included in this item:

Cheiloschisis	Cleft uvula
Palate fissure	Harelip
Labium leporinum	Palatoschisis

POLYDACTYLY/SYNDACTYLY/ADACTYLY: Polydactyly is the presence of more than five digits on either hands and/or feet (ICD-9 code 7550). Syndactyly is having fused or webbed fingers and/or toes (ICD-9 code 7551). Adactyly is the absence of fingers and/or toes (ICD-9 codes 7554, 7553, 7552).

Synonyms to be included in this item:

Accessory fingers/toes	Absence of fingers/toes
Supernumerary digits	Fusion of finger or toes
Webbed fingers/toes	Symphalangy

CLUB FOOT: Talipes equinovarus, arcuatus, calcaneus, cavus, percavus, valgus, varus and/or other deformities of the foot, which is twisted out of shape or position. ICD-9 codes are 7545-7547.

DIAPHRAGMATIC HERNIA: Herniation of the abdonimal contents through the diaphragm into the thoracic cavity usually resulting in respiratory distress. ICD-9 code is 7566 which includes other anomalies of the diaphragm.

OTHER MUSCULOSKELETAL/INTEGUMENTAL ANOMALIES: Other congenital anomalies of the muscles, skeleton or the enveloping membrane of the body (skin). Examples of musculoskeletal anomalies are congenital dislocation of hip, varus and valgus deformities of feet, reduction deformities of upper and/or lower limbs, anomalies of shoulder girdle, pelvic girdle, skull and face bone, spine, chondrodystrophy, osteodystrophies, and specified anomalies of muscle, tendon, fascia and connective tissue. ICD-9 codes are 7540-7546, 7548, 7552-7569. Some congenital anomalies of the integument are hereditary edema of legs, ichthyosis congenital, vascular hamartomas, specified and unspecified anomalies of hair, nails and breast or a large hemangioma. ICD-9 codes are 7570-7579.

DOWN SYNDROME: (Mongolism, Translocation Down Syndrome, Trisomy 21 or 22, G). The most common chromosomal defect with most cases resulting from an extra chromosome (trisomy 21). The faces of the infants are mongoloid, with narrow, slanting, closely set palpebral fissures. The tongue is thick and fissured, and the palatal arch is often high. Fingers are stubby and mental retardation subsequently becomes apparent. Congenital heart disease is found in about 35 percent of patients with atrioventricular canal defects and ventricular septal defects being the most common. The risk of having a child with Down Syndrome increases with age. However, the majority are born to women in their twenties because of the high drop off of the fertility rate after that period. ICD-9 code is 7580.

Synonyms to be included in this item:

Mongolism	Trisomy 21

OTHER CHROMOSOMAL ANOMALIES (Specify): All other chromosomal aberrations, for example, Patau's syndrome, Trisomy 13-15, Trisomy 16-18, Edward's syndrome, autosomal deletion syndromes, Cri-du-chat syndrome, autosomal translocation, XO syndrome, Klinefelter's syndrome, XXX syndrome. ICD-9 codes 7581-7589.

OTHER (Specify): Other congenital anomalies not mentioned above. This includes the following anomalies:

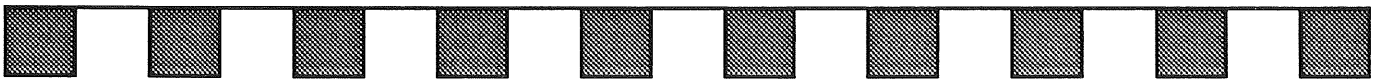
anomalies of eye	7430-7439
anomalies of ear, face, neck	7440-7449
other - upper alimentary tract	7501, 7502, 7504-7506 7508, 7509
other - digestive system	7510, 7513, 7516, 7519
other and unspecified congenital anomalies	7590-7599

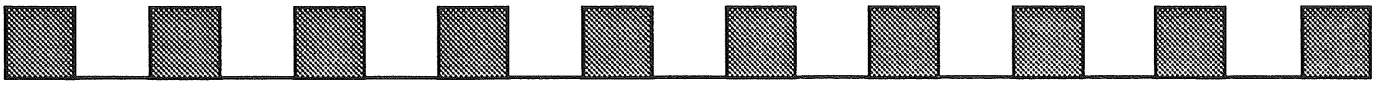
DO NOT INCLUDE THESE CONDITIONS IN QUESTION 43.

Congenital hemangioma
Congenital neoplasm
Premature birth
Respiratory distress
Ankyloglossia
Heart murmur
Hip click
Skin tags
Tongue tie

Part III

Completing the Fetal Death Report





Part III. COMPLETING THE FETAL DEATH REPORT

The Minnesota Vital Statistics Act requires that a report be filed for the death of each fetus for whom 20 or more weeks of gestation have elapsed. The mortician, funeral director, hospital administrator, or other person in charge of the disposition of the remains, shall be responsible for making this report. If the fetal death occurred in the state of Minnesota and was 20 or more weeks of gestation, it should be reported within five days to the state registrar on a Report of Fetal Death form which is provided by the state registrar. To order a supply of blank fetal death report forms, call (612) 623-5123.

1. Fetus Name (First, Middle, Last)

Type or print the full first, middle, and last names of the fetus. Do not abbreviate. Space names properly to avoid confusion as to whether a name is a first, middle, or last name.

2a. Date of Delivery (Month, Day, Year)

Enter the exact month, day, and year the fetus was delivered. Enter the full name of the month - January, February, March, etc. Do not use a number or abbreviation to designate the month. Pay particular attention to the entry of month, day or year when the delivery occurs around midnight or on December 31. Consider a delivery at midnight to have occurred at the end of one day rather than the beginning of the next day.

(This item is used in conjunction with "Date Last Normal Menses Began" to calculate length of gestation, which is an essential element in the study of low-birth-weight deliveries.)

2b. Time of Delivery

Enter the exact time of delivery (hours and minutes) according to local time. Be sure to indicate whether the time of death is a.m. or p.m. Enter 12 noon as "12 noon". One minute after 12 noon is entered as "12:01 p.m." Enter 12 midnight as "12 midnight." A death that occurs at 12 midnight belongs to the night of the previous day, not the start of the new day. One minute after midnight is entered as "12:01 a.m." of the new day. If the exact time of delivery is unknown, the time should be approximated by the person responsible for filing the report. "Approx." should be placed before the time.

3. Sex of Fetus

Enter male, female, or undetermined. Do not abbreviate or use other symbols.
(This information is used to measure fetal and perinatal mortality by sex. It helps identify differences in the impact of environmental and biological factors between the sexes.)

4a. Plurality

Specify the fetal death as single, twin, triplet, quadruplet or quintuplet. If this was a multiple pregnancy, report this as twin, triplet, etc.

4b. If Not Single Delivery, Born First, Second, Third, etc.

Specify the order of birth (first, second, etc.) for every multiple pregnancy. For single pregnancies, enter the word "single" in item #4a and leave #4b blank.

(The frequency of multiple births/fetal deaths and their characteristics are of interest to medical professionals and to scientists engaged in the study of heredity.)

5. County of Delivery

Enter the name of the county where the delivery occurred. For deliveries occurring in a moving conveyance, enter the county where the fetus was first removed from the conveyance.

(This item identifies the place of delivery, which is used to study relationships of hospital and nonhospital pregnancy terminations. It is also used by many states to produce statistical data by specific facility. Information on place of delivery, together with residence information, provides data to evaluate the utilization and distribution of health services.)

6. City or Township of Delivery

Enter the name of the city or township where the delivery occurred. For deliveries occurring in a moving conveyance, enter the city or township where the fetus was first removed from the conveyance. If a fetus is found in Minnesota and the place of fetal death is unknown, the place where the fetus was found should be entered with the word "found" preceding the name of the city.

7. Place of Delivery

Check the appropriate box to reflect the place where the fetal death occurred. A birthing center located in and operated by a hospital is considered part of the hospital and should be reported as occurring in the hospital. Freestanding birthing centers include facilities that are operated independently from hospitals. The "clinic/doctor's office" category includes other nonhospital outpatient facilities where births occasionally occur.

(This item identifies home deliveries, deliveries in freestanding birthing centers and deliveries in nonhospital clinics or physicians' offices. Such information permits analysis of the number and characteristics of births by type of facility and is helpful in determining the level of utilization and characteristics of deliveries occurring in such facilities.)

8. Facility Name

Enter the full name of the hospital, freestanding birthing center, or other facility where the delivery occurred. If the delivery occurred in a moving conveyance en route to or on arrival at a facility, enter the full name of the facility followed by "En route." If the delivery occurred at home, enter the house number and street name of the place where delivery occurred. If the delivery occurred at some place other than those described above, enter the number and street name of the location. If the delivery occurred in a moving conveyance that was not en route to a facility, enter as the place of delivery the address where the fetus was first removed from the conveyance.

(This item identifies the place of delivery, which is used to study relationships of hospital and nonhospital pregnancy terminations. It is also used by many states to produce statistical data by specific facility. Information on place of delivery, together with residence information, provides data to evaluate the utilization and distribution of health services.)

9a. Mother's Present Name (First, Middle, Last)

Type or print the first, middle, and last name of the mother. This is the mother's current legal name.

9b. Maiden Surname

Enter the last name of the mother as given at the time of her birth or adoption, not a name acquired by marriage. It is important to complete this item in all cases and not just for married women.

(The mother's name is used to identify the record. The maiden surname is important for matching the record with other records because maiden surnames remain constant throughout a lifetime, in contrast to other names, which may change because of marriage or divorce.)

10. Mother's Date of Birth (Month, Day, Year)

Enter the exact month, day, and year that the mother was born. Enter the full name of the month - January, February, March, etc. Do not use a number or abbreviation to designate the month.

(This item is used to calculate the age of the mother, which is one of the most important factors in the study of childbearing and pregnancy outcome.)

11. Mother's Birthplace (State or Foreign Country)

If the mother was born in the United States, enter the name of the state.

If the mother was born in a foreign country or a U.S. territory, enter the name of the country or territory.

If the mother was born in the United States but the state is unknown, enter "U.S. - Unknown."

If the mother was born in a foreign country but the country is unknown, enter "Foreign - Unknown."

(This item provides information on recent immigrant groups and is used for tracing family histories. It is also used with the U.S. Bureau of the Census data to compare the childbearing of women who were born in the United States with that of foreign-born women.)

12a.-13. General Information on Mother's Residence

The mother's residence is the place where her household is located; this is not necessarily the same as her mailing address. If the mother lives in a rural area, try to obtain the name of the **township** she lives in as well as the name of the city of her mailing address. Never enter a temporary residence, such as one used during a visit, business trip, or vacation. Residence for a short time at the home of a relative, friends, or home for unmarried mothers for the purpose of awaiting the delivery is considered temporary and should

not be entered here. However, place of residence during a tour of military duty or during attendance at college is not considered temporary and should be entered on the report as the mother's place of residence. If the mother had been living in a facility where an individual usually resides for a long period of time, such as a group home, psychiatric institution, nursing home, penitentiary, or hospital for the chronically ill, this facility should be entered as the place of residence.

12a. Residence of Mother - State

Enter the name of the state in which the mother lives. If the mother is not a U.S. resident, enter the name of the country and the name of the unit of government that is the nearest equivalent of a state.

12b. Residence of Mother - County

Enter the name of the county in which the mother lives.

12c. Residence of Mother - City or Township

Enter the name of the city or township where the mother lives. This may differ from the city used in her mailing address, especially if she lives in a rural area and receives her mail through the post office in the nearest city. Always enter the most specific subdivision (township) when she lives in a rural area.

12d. Residence of Mother - Street and Number

Enter the number and street name of the place where the mother lives. If this location has no number and street name, enter the rural route number or a description of the place that will aid in identifying the precise location.

12e. Residence of Mother - Inside city limits? (yes or no)

Enter "yes" if the mother lives inside city limits; enter "no" if she lives in a rural area outside of city limits.

(Statistics on births are tabulated by place of residence of the mother. This makes it possible to compute birth rates based on the population residing in the area. Data on births by place of residence of the mother are used to prepare population estimates and projections. These data are used in planning for and evaluating community services and facilities, including maternal and child health programs, schools, etc. Private businesses and industries also use these data for estimating demands for services. "Inside City Limits" is used to properly assign residence to either the city or the remainder of the county.)

13. Mother's Mailing Address

Enter the mailing address of the mother only if it is different from the residence address given in item #12d. If the mother lives in the city limits given in item #12c, enter the zip code only. If the mother lives outside of city limits and the name of a township is given in item #12c, provide the city and zip code of her mailing address.

(Statistics on fetal deaths are tabulated by place of residence of the mother. These data are used in

planning for and evaluating community services and facilities, including maternal health programs. "Inside City Limits" is used to properly assign residence to either the city or the remainder of the county. Zip code information may also be used for environmental impact studies for small geographic areas.)

14. Father's Name

Enter the father's name as given by the mother.

15. Father's Date of Birth

Enter the exact month, day, and year that the father was born. Enter the full name of the month - January, February, March, etc. Do not use a number or abbreviation to designate the month.

(This item is used to calculate the age of the father, which is important in the study of childbearing and health and genealogical research.)

16a. Mother's Social Security Number
16b. Father's Social Security Number

Enter social security numbers of the parents.

17a. Of Hispanic Origin? (Mother)
17b. Of Hispanic Origin? (Father)

Check "no" or "yes." If "yes" is checked, enter the specific hispanic group as obtained from the parent(s) or other informant. This item should be completed for the mother on all certificates and for the father in all cases where the name of the father is shown on the certificate. Do not leave this item blank. The entry in this item should reflect the response of the informant.

For the purposes of this item, "hispanic" refers to people whose origins are from Spain, Mexico, or the Spanish-speaking countries of Central or South America. Origin can be viewed as the ancestry, nationality, lineage, or country in which the person or his or her ancestors were born before their arrival in the United States.

There is no set rule as to how many generations are to be taken into account in determining hispanic origin. A person may report hispanic origin based on the country of origin of a parent, grandparent, or some far-removed ancestor. The response should reflect what the person considers himself or herself to be and is not based on percentages of ancestry. Although the prompts include the major hispanic groups of Cuban, Mexican, and Puerto Rican, other hispanic groups should also be identified in the space provided.

If a person indicates that he or she is of multiple hispanic origin, enter the origins as reported (for example, Mexican-Puerto Rican).

If a person indicates that he or she is Mexican-American or Cuban-American, enter the hispanic origin as stated.

This item is not a part of the Race item. A person of hispanic origin may be of any race. Each question, race and hispanic origin, should be asked independently.

(Hispanic people comprise the second largest ethnic minority in this country. Reliable data are needed to identify and assess public health problems of hispanic people and to target efforts to their specific needs. This item provides data to measure differences in fertility and pregnancy outcome as well as variations in health care for people of hispanic and non-hispanic origin. Without collection of data on persons of hispanic origin, it is impossible to obtain valid demographic and health information on this important group of Americans.)

18a. Race of Mother (Specify below)
18b. Race of Father - American Indian, Black, White, etc. (Specify below)

Items 18a and 18b should be checked for the mother on all certificates and for the father in all cases where the name of the father is shown on the certificate. The entry in this item should reflect the response of the informant.

Enter White, Black, Indian, Hmong, Laotian, Chinese, Japanese, Hawaiian, Filipino, Asian Indian, Korean, Samoan, Vietnamese, Guamian, Other. Do not enter "hispanic" in this item; hispanic origin is considered an ethnicity, not a race (see description of items #17a and #17b).

If the parent(s) are of multiple races, list the races in this item.

The response to this item should reflect the race that the parent considers himself or herself to be and is not based on percentages of ancestry.

19a. Education of Mother
19b. Education of Father (Specify only highest grade completed)

Enter the highest number of years of regular schooling completed by the mother and father in either the space of elementary/secondary school or the space for college. An entry should be made in only one of the spaces. The other space should be left blank. Report only those years of school that were completed. A person who enrolls in college but does not complete one full year should not be identified with any college education in this item.

(Education is correlated with fertility and birth outcome, and is used as an indicator of socioeconomic status. It is used to measure the effect of education and socioeconomic status on health, childbearing, and infant mortality.)

20. Weight of Fetus (specify unit)

Enter the birth weight of the fetus as it is recorded in the hospital record.

Enter the weight as shown in the hospital record, in either grams or pounds and ounces. Do not convert from one measure to the other. Specify the type of measure used (grams or pounds and ounces).

(This is the single most important characteristic associated with infant mortality. It is also related to prenatal care, socioeconomic status, marital status, and other factors surrounding the birth. Consequently, it is used with other information to plan for and evaluate the effectiveness of health care.)

21. Fetus Delivered in Wedlock? (yes or no)

Enter "Yes" if the mother was married at the time of conception, at the time of fetal death, or at any time between conception and fetal death; otherwise, enter "No."

(This information is used to monitor the substantial differences in health and fertility between married and unmarried women. It enables the study of health problems encountered during and after pregnancies of unmarried women. This information allows researchers to measure medical risk factors of out-of-wedlock children and their mothers. These children tend to have lower birth weight and higher infant mortality, and they may be born to mothers with less prenatal care. Because of these differences, unmarried women and their babies are more likely to require additional health services.)

22a. Live Births (Now Living)

Enter the number of prior children born alive to this mother who are still living at the time of this fetal death. Do not include children by adoption.

22b. Live Births (Now Dead)

Enter the number of prior children born alive to this mother who are no longer living. Do not include any children by adoption.

Check "None" if all previous children are still living.

22c. Date of Last Live Birth (Month, Day, Year)

Enter the date (month and year) of birth of the last live-born child of the mother.

If this report is for the second delivery of a twin set, enter the date of birth for the first baby of the set, if twin #1 was born alive. Similarly, for triplets or other multiple deliveries, enter the date of birth of the previous live birth of the set. If all previously born members of a multiple set were born dead, enter the date of the mother's last delivery that resulted in a live birth.

Enter "None" if the mother has not had a previous live birth. Do not leave this item blank.

Enter the full name of the month--January, February, March, etc. Do not use a number or abbreviation to designate the month.

22d. Other Terminations - Spontaneous and induced at any time after conception (Do not include this fetus)

Enter the number of fetuses that were delivered dead regardless of the length of gestation. Include each recognized loss of a product of conception, such as ectopic pregnancy, miscarriage, fetal death, and spontaneous or induced abortion.

Check "None" if this is the first pregnancy for this mother or if all previous pregnancies resulted in live-born infants.

22e. Date of Last Other Termination (Month, Year)

Enter the date (month and year) of the last termination of pregnancy that was not a live birth regardless of the length of gestation.

If the mother has never had such a termination, enter "None."

Enter the full name of the month--January, February, March, etc. Do not use a number or abbreviation to designate the month.

If this report is for the second delivery of a twin set and the first was born dead, enter the date of delivery of twin #1. Similarly, for other multiple deliveries, if any previous member of the set was born dead, enter the date of delivery of that fetus. If all previously-born members of a multiple set were born alive, enter the date of the mother's **last** delivery that resulted in a fetal death.

(These items are used to determine live-birth order and total-birth order, which are important in studying trends in childbearing and child spacing. They are also useful in studying health problems associated with birth order--for example, first births to older women--and determining the relationship of birth order to infant and perinatal mortality.

In studying child spacing, the dates of last live birth and other terminations are used to compute the intervals between live births and fetal deaths and between pregnancies. This information allows researchers to measure known risk factors associated with the mother's previous pregnancies, such as prior fetal loss, short interpregnancy interval, and high parity.)

23. Date Last Normal Menses Began (Month, Day, Year)

Enter the exact date (month, day, and year) of the first day of the mother's last normal menstrual period, as obtained from the physician or hospital record. If the information is unavailable from these sources, obtain it from the mother.

Enter the full name of the month--January, February, March, etc. Do not use a number or abbreviation to designate the month.

If the exact day is unknown but the month and year are known, obtain an estimate of the day from the mother, her physician, or the medical record. If an estimate of the date cannot be obtained, enter the month and year only.

(This item is used in conjunction with the date of birth to determine the length of gestation, which is closely related to infant morbidity and mortality. Length of gestation is linked with birth weight to determine the maturity of the child at birth.)

24. Clinical Estimate of Gestation (Weeks)

Enter the length of gestation as estimated by the attendant. Do not compute this information from the date last normal menses began and date of fetal death. If the attendant has not done a clinical estimate of gestation, enter "None."

(This item provides information on gestational age when the item on date last normal menses began contains invalid or missing information. For a record with a plausible date last normal menses began, it provides a cross-check with length of gestation based on ultrasound or other techniques.)

25. Month of Pregnancy Prenatal Care Began - First, Second, Third, etc. (Specify)

Enter the number of the month in this pregnancy when the mother first received care from a physician or other health professional or attended a prenatal clinic. Do **not** enter the name of a month.

The month of pregnancy in which prenatal care began is measured from the date the last normal menses began and not from the date of conception.

Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman.

If no prenatal care was received, enter "None." If item #34 is reported as "None," this item should also be completed as "None."

26. Prenatal Visits - Total Number

Enter the number of visits made for medical supervision of the pregnancy by a physician or other health care provider during the pregnancy. If no prenatal care was received, enter "None." If item #25 is reported as "None," this item should also be completed as "None."

(This information is used to determine the relationship of prenatal care to the outcome of the pregnancy. The number of prenatal visits can be used in conjunction with month of pregnancy prenatal care began to assess the adequacy of prenatal care. In addition, this information can be used with length of gestation to compute the Kessner Index, a quantitative measure of the adequacy of prenatal care.)

27a. Medical Risk Factors For This Pregnancy (Check all that apply)

SEE PAGE 20 OF THIS HANDBOOK FOR MEDICAL RISK FACTOR DEFINITIONS.

Check each of the medical risk factors that the mother experienced during this pregnancy. Complications should be entered even if they are a part of the cause of fetal death in item 30. If the mother experienced medical risk factor(s) not identified in the list (for example, other infectious diseases, AIDS, or syphilis) check "Other" and enter the risk factor on the line provided. Medical risk factors should be identified from the hospital or physician record. If there were no medical risk factors check "None."

(This information allows for the identification of specific maternal conditions that are often predictive of poor maternal and infant outcome. It can be used for planning intervention and prevention strategies.)

27b. Other Risk Factors For This Pregnancy

Complete each question/statement. Enter the amount of weight **gained** by the mother during the pregnancy in pounds. Do not enter the total weight of the mother. If no weight was gained, enter "None". If the mother lost weight during her pregnancy, enter the amount of weight lost (for example, "Lost 10 pounds"). Check "Yes" for tobacco use if the mother smoked tobacco at any time during the pregnancy. Check "No" if the mother did not smoke during the entire pregnancy. If "Yes" is checked, specify the average number of cigarettes the mother smoked per day during her pregnancy. If, on the average, she smoked less than one cigarette per day, check "Less than 1." If "No" is checked, do not make any entry on the line requesting the average number of cigarettes per day.

Check "Yes" for alcohol use if the mother consumed alcoholic beverages at any time during her pregnancy. Check "No" if the mother did not consume any alcoholic beverages during the entire pregnancy. If "Yes" is checked, specify the average number of drinks she consumed **per week**. One drink is equivalent to 5 ounces of wine, 12 ounces of beer, or 1-1/2 ounces of distilled liquor. If, on the average, she drank less than one drink per week, enter "Less than 1." If "No" is checked, do not make any entry on the line requesting the average number of drinks per week.

Check appropriate box(es) for drug use during pregnancy.

Information for this item should be obtained from the mother's medical chart or the physician. If the medical chart is not available or does not include this information and the physician is unavailable, the informant should be asked to respond to these items.

(Smoking, drinking, and drug use during pregnancy may have an adverse impact on pregnancy outcome. This information is used to evaluate the relationship between certain lifestyle factors and pregnancy outcome and to determine at what levels these factors clearly begin to affect pregnancy outcome.)

28. Obstetric Procedures (check all that apply)

Check each type of procedure that was used during this pregnancy. More than one procedure may be checked. If a procedure was used that is not identified in the list, check "Other" and specify the procedure on the line provided. If no procedures were used, check "None". Do not leave this item blank. This information should be obtained from the mother's medical chart or the physician.

(Information on obstetric procedures is used to measure the use of advanced medical technology during pregnancy and labor and to investigate the relationship of these procedures to type of delivery and pregnancy outcome.)

29. Complications of Labor and/or Delivery

Check each medical complication present during labor and/or delivery. If a complication was present that is not identified in the list, check "Other" and specify the complication on the line provided. If there were no complications, check "None". Do not leave this item blank. This information should be obtained from the mother's medical chart or the physician.

(This information is used to identify pregnancy complications during labor and delivery and their relationship to method of delivery and birth outcome.)

30. Method of Delivery

Check the method of delivery of the child. If more than one method was used, check all methods that apply to this delivery. Do not leave this item blank. This information should be obtained from the mother's medical chart or the physician.

(This information is used to relate method of delivery with birth outcome, to monitor changing trends in obstetric practice, and to determine which groups of women are most likely to have cesarean delivery. The method of delivery is relevant to the health of mothers, especially if it is by cesarean section. Information from this item can be used to monitor delivery trends across the United States.)

31. Congenital Anomalies Of Child

Check each anomaly of the child. Do not include birth injuries. The checklist of anomalies is grouped according to major body systems. If an anomaly is present that is not identified in the list, check "Other" and specify the anomaly on the line provided. Note that each group of system-related anomalies includes an "Other" category for anomalies related to that particular system. If there is a question as to whether the anomaly is related to a specific system, enter the description of the anomaly in "Other (Specify)" at the bottom of the list. If there are no congenital anomalies of the child, check "None." This information should be obtained from the mother's and infant's physicians or the medical records (obstetric and pediatric).

(Information on congenital anomalies is used to identify health problems that require medical care and monitor the incidence of the stated conditions. It is also used to study unusual clusters of selected anomalies, to track trends among different segments of the population, and to relate the prevalence of anomalies to other characteristics of the mother, infant, and the environment.)

32. Cause of Death

Enter on line (a) the fetal or maternal condition directly causing the fetal death. Enter on lines (b) and (c) fetal and/or maternal conditions, if any, that gave rise to the immediate cause(s) on line (a), stating the underlying cause last. Also, specify whether the condition was fetal or maternal.

Part II: Other Significant Conditions

Enter any conditions contributing to the fetal death but not resulting in the underlying cause listed in Part I. Cause of fetal death should include information provided by the pathologist if an autopsy or other type of postmortem exam was done. If microscopic exams for a fetal death are still pending at the time the report is filed, the hospital should report the additional information as soon as it is available.

(This item provides medical information for ranking causes of fetal death and for analyzing the conditions leading to fetal death. Information on cause of fetal death is correlated with information from other items on the report, such as length of gestation and prenatal care.)

33. Fetal Death Occurred (Specify)

Indicate whether the fetal death occurred before labor, during labor or delivery, or unknown.

(This item is used as a check to ensure that the delivery was properly reported as a fetal death and was not a live birth.)

34a. Autopsy (Yes or No)

Enter "Yes" if a partial or complete autopsy was performed. Otherwise, enter "No."

34b. If #34a is "Yes" Were Findings Considered In Determining Cause of Death? (Yes or No)

Enter "Yes" if autopsy findings were considered in determining cause of death. Otherwise, enter "No." If no autopsy was performed, leave this item blank.

(Knowing whether the autopsy results were used in determining the cause of death gives insight into the quality of the cause-of-death data.)

35a. Attendant's Signature

The person who certifies to the cause of death in item #32 signs the certificate in permanent black ink. Rubber stamps or facsimile signatures are not permitted.

35b. Attendant's License Number

Enter the Minnesota license number of the physician who signs the certificate in item #35a. This number assists in Minnesota quality control programs when it is necessary to contact the attendant for additional information concerning the death.

35c. Date signed (Month, Day, Year)

Enter the exact month, day, and year that the attendant signed the report. Enter the full name of the month - January, February, March, etc. Do not use a number or abbreviation to designate the month.

35d. Attendant's Name and Title (Type or print)

Type or print the full name and address of the physician or other person signing the report in item #35a.

35e. Attendant's Mailing Address

Type or print the full name and address of the physician or other person signing the report in item #35a.

(Items #35a - #35e identify the attendant who signed the fetal death report and the date the report was signed. This allows the person to be contacted for missing information.)

36a. Signature of Person Completing Report

The mortician, funeral director, hospital administrator, or other person in charge of the disposition of the remains signs in permanent black ink. Rubber stamps or facsimile signatures are not permitted.

36b. Establishment Number of Funeral Home

Enter the Minnesota license number of the funeral service if a funeral home is given in item #37.

36c. Date Signed

Enter the exact month, day, and year that the person completing the report signed the report. Enter the full name of the month - January, February, March, etc. Do not use a number or abbreviation to designate the month.

36d. Name and Title of Person Completing Report

Type or print the name of the person who completed the report and signed in item #36a. Check one of the boxes to designate the title of this person.

37. Name and City of Hospital or Funeral Home

Type or print the name and city of the funeral home or hospital facility having disposition of the remains.

38. Method Of Disposition

Check the box corresponding to the method of disposition of the fetus. If "Other (Specify)" is checked, enter the method of disposition on the line provided (for example, "entombment").