PREPARER'S HANDBOOK

Specifications for the completion of the 2004 revisions for Reporting of Births, 2004 revisions of Fetal Death Certificates, and the Certificate of Birth Resulting in a Stillbirth

Prepared by:
The Office of Vital Statistics

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INTRODUCTION

This handbook is designed to help hospital personnel complete and file birth and fetal death certificates. In Montana more than 99-percent of all live births and 98-percent of reported fetal deaths (stillbirths) occur in hospitals, the quality of birth and fetal death registration depends upon hospital personnel.

A birth certificate is a legal document of great importance that is in active use throughout an individual's lifetime. A clean, legible, correct, complete, and promptly filed birth certificate indicates a recognition of the importance of this document by the hospital.

Why Register Births and Fetal Deaths?

A birth certificate is a legal statement of facts important to an individual throughout his/her life. This record is proof of age, proof of parentage, and proof of citizenship. It is needed to enter school, to register to vote, and to obtain a driver's license, marriage license, passport, veteran's benefits, welfare aid, and Social Security benefits.

Furthermore, statistical information from the birth certificates is extremely valuable for many purposes. The data provides information on the number of births and the associated birth rates by characteristics such as place of birth, place of residence of mother, education of mother, age of mother and birth order. The birth information is frequently used to estimate population growth and changes, the knowledge of which is helpful to many governmental agencies and business concerns. The data from birth and fetal death certificates are essential in planning and evaluating a broad range of health activities, including various aspects of maternal and child health programs. Medical data on the certificates are used for scientific research. The records may also be used to provide a base for sampling various segments of the population for additional research purposes in follow back studies.

The fetal death report is recommended as a legally required statistical report designed primarily to collect information for statistical and research purposes. These reports are maintained in the official files of the State health department, and certified copies of these reports are rarely issued. The record, whether a certificate or a report, provides valuable health and research data. The information is used to study the causes of poor pregnancy outcome. These data are also essential in planning and evaluating prenatal care services and obstetrical programs. They are also used to examine the consequences of possible environmental and occupational exposure of parent on the fetus. Certificates of birth resulting in a stillbirth are filed only at the request of the parent.

What are the Specific Responsibilities of the Hospital?

Hospital personnel assemble and record the medical and personal data to be entered on the birth and fetal death certificates. Necessary procedures usually cut across departmental lines. This fact makes it desirable that one hospital staff member be given the overall responsibility and authority to request and obtain the cooperation needed.

Specifically, the hospital should:

A. Develop efficient procedures for prompt preparation, signing, and filing of certificates.

B. Collect and record the information about the parents and the medical data required on the birth and fetal death certificates.

C. Prepare a correct and legible certificate; making certain that every item is completed.

D. Secure all necessary signatures on the certificate.

E. File birth certificates with the local registrar within ten (10) days after birth. If the hospital is in charge of disposition of a fetus, file fetal death certificates within ten (10) days after delivery.

F. Assist the State or local registrar by answering inquiries promptly.

G. Assist parents of children born in the hospital by completing any forms or statements needed to correct any errors on the original certificates.

H. Provide a routine for preparing and filing a birth certificate for an infant born en route to the hospital.

I. Call the local registrar or the Office of Vital Statistics for advice and assistance when necessary.

Helpful contacts:

- Questions pertaining to filing a birth certificate, fetal death certificate, acknowledgement of paternity and non-paternity form - Please contact:

  Dean Vig, Supervisor, Vital Records Administration 444-5249

- Questions pertaining to filing an electronic birth certificate - Please contact:

  Kathy Thompson, Supervisor, Data Acquisition 444-0692
  Kathy Farrar, Data Acquisition 444-1986

- If they are not available, please contact:

  Karin Ferlicka, Supervisor, Office of Vital Statistics 444-4250

Or you may contact your local Registrar:

COUNTY	NAME	TELEPHONE
BEAVERHEAD	DEBBIE SCOTT	683-3720
BIG HORN	NELLIE LITTLE LIGHT	665-9730
BLAINE	SANDRA BOARDMAN	357-3240
BROADWATER	DOUGLAS ELLIS	266-3443
CARBON	MARCIA HENIGMAN	446-1220
CARTER	JUDY WRIGHT	775-8749
CASCADE	SHERI KEIRN	454-6718
CHOUTEAU	LANA K CLAASSEN	622-5151
CUSTER	LINDA CORBETT	874-3343
DANIELS	JOAN BJARKO	487-2651
DAWSON	SHIRLEY KREIMAN	377-3058
DEER LODGE	SUSAN MAVRINAC	563-4062
FALLON	JERALDINE NEWELL	778-7114
FERGUS	CARRI CRAIG	538-7433
FLATHEAD	TONYA BUXTON	751-8104 or 8109
GALLATIN	CINDY NIELSON	582-3100
GARFIELD	CARLA MCWILLIAMS	557-2480
GLACIER	MANDI KENNERLY	873-3608
GOLDEN VALLEY	MARY LU RINGLER	568-2231
GRANITE	BLANCHE McLURE	859-3771
HILL	KACI HIPPLE	265-5481 ext 209
JEFFERSON	BONNIE RAMEY	225-4020
JUDITH BASIN	AMANDA KELLY	566-2277 ext 109
LAKE	JUDY MUNIZ	883-7208
LEWIS & CLARK	MICKEY NELSON	442-7398
LIBERTY	RHONDA PIMLEY	759-5365
LINCOLN	JEANNIE DENNIS	293-7781 ext 205
MCCONE	MARIDEL KASSNER	485-3505
MADISON	PEGGY KAATZ	843-4270
MEAGHER	DAYNA OGLE	547-3612 ext 104
MINERAL	CATHRYN STROMBO	822-4626
MISSOULA	BRENDA JACKSON	258-4752
MUSSELSHELL	JANE MANG	323-1104
PARK	DENISE NELSON	222-4110 or 4117
PETROLEUM	LESLIE MITCHELL	429-5311
PHILLIPS	MARIAN EREAUX	654-2429
PONDERA	KODY FARKELL	271-4000
POWDER RIVER	ALETTA SHANNON	436-2320
POWELL	DIANE GREY	846-9723
PRAIRIE	TONI KALFELL	635-5575
RAVALLI	KELLY OLIN	375-6549
RICHLAND	RENAE YOUNG	433-1709
ROOSEVELT	CHERYL HANSEN	653-6229
ROSEBUD	DAWN PREBLE	346-7318
SANDERS	JENNINE ROBBINS	827-6922
SHERIDAN	JUNE A JOHNSON	765-3403
SILVER BOW	SALLY HOLLIS	497-6346
STILLWATER	PAULINE MISHLER	322-8000
SWEET GRASS	SHERRY BJORNDAL	932-5152
TETON	PAULA JACONETTY	466-2693
TOOLE	JEWEL MORITZ	424-8300
TREASURE	RUTH BAKER	342-5547
VALLEY	LYNN NYQUIST	228-6226
WHEATLAND	MARY MILLER	632-4891
WIBAUX	PATRICIA ZINDA	796-2481
YELLOWSTONE	TRICIA HERGETT	247-3200

Suggested Procedure for Preparing Birth Certificates

Montana hospitals vary in size and complexity. Specific procedures followed in a hospital should be adapted to the conditions in that facility. The following, however, is a procedure that works well in many Montana hospitals:

A. The hospital has a worksheet, which is used to collect the information necessary to complete the birth certificate. The birth certificate is divided into two sections: 1. Legal section (containing information about the child, parents and signed by the physician); and 2. Confidential section (containing medical, health and socio-economic information about parents, mothers especially).

The hospital worksheet is given to the mother after she is sufficiently recovered to complete the form comfortably and with a clear mind. The mother is to complete the upper or "legal" portion of the certificate.

The lower portion of the certificate is "Confidential Information for Medical and Health Use Only". Information in this section should be obtained from the mother's prenatal chart and the delivery record and completed by hospital personnel, e.g., maternity nurse, ward clerk, or medical records person.

A suggested hospital birth worksheet may be found in Appendix B. Additional worksheets can be obtained by writing to the Office of Vital Statistics, State Department of Public Health & Human Services, PO Box 4210, Helena, Montana 59604.

B. The completed worksheet is taken to the medical records office where the birth certificate is typed or entered into the electronic birth registration system. The legal portion should be completed first and the confidential section completed after the mother has signed the legal portion.

C. The original certificate (upper section) is then returned to the mother. She is asked to read the certificate carefully. If there are errors, these should be noted and returned to the staff responsible

for filing the birth certificate, so **a <u>new</u> certificate is typed or corrected in the electronic birth registration system. Then print corrected copy to be filed.**

If the certificate is correct, the mother signs in item 16. The green quadruplicate copy, or Parents Informational Copy, of the birth certificate is given to the mother. It is not necessary for the doctor to sign the certificate before the mother receives her copy.

Though the green informational copy or Parents Informational Copy is not a certified copy, the parents can use it to correct the record if they discover an error within a year. It is important that the mother receive the Parents Informational Copy, even if it must be mailed to her.

D. The certificate is returned to medical records to have the confidential section (items 24-45) typed or entered into the electronic birth registration system from the medical records.

The full certificate is then printed and clipped to the top of the mother's chart. When the mother's physician makes his rounds, he signs and dates the certificate and provides any medical information, which may have been incomplete.

E. The certificate is returned to the staff responsible for filing the birth certificate. Certificates should be forwarded to the local registrar at least once or twice a week (every 1-2 days in larger hospitals). **<u>The certificates must be filed with the registrar within ten (10) days.</u>**

Who Else Has a Responsibility?

A. **Physician**

For births which occur in a hospital or en route to a hospital, the physician in attendance is responsible for certifying to the facts of birth and providing the medical information required on the certificate. If the physician who provided all or nearly all the prenatal care is not actually present at the delivery, we prefer that he sign the birth certificate as certifier. If it is necessary to query for additional information, this physician would have the necessary information in his records. There is an item on the certificate for the name and title of attendant, if not the certifier, which would be completed in this case. If the physician is unavailable to sign the birth certificate, obtain the signature of one of the persons as listed in order of priority: Physician's assistant, Midwife or R.N. who attended the birth, Hospital Administrator, Authorized designee (appointed by Hospital Administrator), Other attendant (i.e., father, relative, owner of premises if home delivery, etc.; or Local Registrar.

When a birth occurs outside a hospital, the certificate is prepared and filed by the physician in attendance at or immediately after the delivery.

For fetal deaths, the physician in attendance is responsible for the medical certification of cause-of-death unless an inquiry is requested by the coroner.

B. **Midwife or Other Person Who Delivers a Child**

When a birth occurs outside a hospital and no physician is in attendance at or immediately after the birth, the responsibility for completing and filing the birth certificate rests on one of the following: the midwife or other person in attendance, the father, the mother, or in the absence of the father and the inability of the mother, the person in charge of the place where the birth occurred. Additional evidence may be required to prove the pregnancy, that the infant was born alive, and the birth occurred within this state.

C. **Informant**

The informant, preferably the mother (or the father or another adult having knowledge of the personal facts concerning the birth), is responsible for providing the facts.

D. **Funeral Director**

When a fetal death occurs and the services of a mortuary are used, the mortician is responsible for completing the fetal death certificate items and filing the certificate with the local registrar within ten (10) days of the fetal death.

E. **State Department of Public Health & Human Services**

The State Department of Public Health & Human Services, Office of Vital Statistics, administers the birth and fetal death registration system under the laws and regulations of the State of Montana. Certificates are placed on permanent file in the Office of Vital Statistics after they have been filed with the local registrars and forwarded to the state office.

The Confidential Nature of Vital Records

Because of the many legal, public health, research, and social welfare uses of vital records, each certificate should be prepared as completely and accurately as possible. Some items of information are personal and may be embarrassing or stigmatizing to the individual. The Office of Vital Statistics is aware of this fact and provides a number of safeguards to protect this information from unwarranted or indiscriminate disclosure:

A. State law and supporting rules specify who may obtain copies of individual records.

B. The certificates are designed to separate the data that will be used only for medical, statistical, and research purposes from all other information. Items in the confidential section never appear on a certified copy of the certificate. The parent(s) should be assured that every legal administrative measure possible is employed to protect the unwarranted disclosure of personal information.

GENERAL INSTRUCTIONS

Standards for Completing Birth and Fetal Death Certificates

Birth and fetal death certificates are permanent records and official copies are made from them. Therefore, it is essential that the certificates be prepared in accordance with the following standards:

A. Use the Electronic Birth Registration System (VSIMS) or the current form provided by the Office of Vital Statistics.

B. Signatures should be in Black ink. Black ink provides the best copies.

C. Make **No Corrections** of errors on the certificate. If an error is made, **type a new certificate or make corrections on the electronic birth certificate and reprint the certificate**.

D. Complete all items or attach a note explaining any omissions or questionable entries.

E. **Do Not Make Alterations or Erasures.**

F. All signatures must be written. Rubber stamp or other facsimile signatures are not acceptable.

G. Do not submit carbon copies, reproductions, or duplicates for filing. The local registrar will accept originals only.

H. Avoid abbreviations. Type out month; do not use numbers for the month.

I. Spell entries correctly. Verify names which sound the same but have different spellings (Smith VS Smyth, Gail VS Gayle, Wolf VS Wolfe, etc.).

J. If unable to get correct information on a particular item in the confidential section, type "unknown" in that space. Do not leave the item blank.

SOURCES OF INFORMATION

The necessary information for preparation of certificates is obtained from several sources. These sources are:

1. Informant
   a. mother
   b. father
   c. other person who has knowledge of the facts

2. Certifying physician

3. Hospital records.

The following two chapters of this handbook contain specific instructions for each item on the certificate. Chapter I deals with the birth certificate; Chapter II covers the fetal death certificate. The instructions appear in the same order and have the same numbers as the items on the certificate.

CHAPTER I

SPECIFIC INSTRUCTIONS FOR COMPLETING

THE LIVE BIRTH CERTIFICATE

The "legal" portion of the birth certificate is all information above the block entitled "INFORMATION FOR MEDICAL AND HEALTH USE ONLY". These items are necessary for the identification of the individual and for a description of where and when the birth occurred.

In most instances, these are the items of information that are furnished when a person requests a copy of a birth certificate from a county clerk and recorder or the state office.

1. **Item #1- CHILD - NAME: FIRST, MIDDLE, LAST, SUFFIX**
   Type in the child's first, middle, last name, and suffix (if applicable)

   Enter the full name of the child exactly as given by the parent(s).
   The parent(s) may choose any last name they wish.

   Entries of Jr. and II, following the last name, are acceptable. On the electronic system, Jr. etc. should be entered in the suffix field.

   If the parent(s) do not have a given name selected for the child, leave this item blank. **Never enter "Baby Girl, "Infant Boy", or NMI**

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

2. **Item #4- DATE OF BIRTH (Month, Day, Year)**
   Enter the exact month, day and year that 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 (type written certificates- Make no correction on the date of birth. If an error is made, type a new certificate)

Pay particular attention to the entry of month, day and year when the birth occurs around midnight or December 31. Consider a birth at midnight to have occurred at the end of one day, rather than the beginning of the next day.

**In the case of Foundlings; if the date of birth is unknown, enter the date the infant was found. (See Appendix "A")

The name of the child and the date of birth are the most important items on the certificate. This is a legal item used to establish the date of birth of the individual named on the certificate. It establishes the age of the individual named on the certificate and is used for entering school, obtaining a driver's license, establishing eligibility for Social Security benefits, etc. Statistically, it allows for the tabulation of data by month of occurrence. Together with the date last normal menses began, date of birth is used to calculate the length of gestation.

3. **Item #3- SEX**

   Enter Male or Female. Verify the entry of sex against the given name.

   In cases where the sex cannot be determined, enter "unknown".

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.

4. **Item #5- PLACE OF BIRTH – FACILITY NAME**

   Facility – Name (If not in hospital, give street and number)

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

   If the birth occurred on a moving conveyance en route to or on arrival at the facility, enter the full name of the facility.

   If the birth occurred at home, enter the house number and street name of the place where the birth occurred.

   If the birth occurred at some place other than those described above, enter the number and street name of the location.

   If the birth occurred in a moving conveyance that was not enroute to the facility, enter as the place of birth the address where the child was first removed from the conveyance. (Hospital name) However, if the birth occurred in international

waters, airspace or a foreign country, contact the Office of Vital Statistics for proper completion.

This item is used to determine the location of birth. It enables the development of statistics on in- and out-of-hospital births. It can be used to compare the health of children based on place of birth. Data can also be produced for specific hospitals**.**

5. **Item 6- CITY, TOWN, OR LOCATION OF BIRTH**

   Enter the name of the city, town or location where the birth occurred.

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

These are legal items identifying the place of birth, which is important in establishing citizenship. While most birth statistics are calculated on the basis of residence of mother rather than place of occurrence, these items provide data on where births are actually occurring. This information may be used with the residency items to determine service areas for obstetrical services.

6. **Item #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.

   If the birth occurred in a moving conveyance in the United States and the child was first removed from the conveyance in this State, complete a birth certificate showing the place of birth as this State.

   If the birth occurred in a moving conveyance in international waters, international airspace, or in a foreign country or its airspace, and the child was first removed from the conveyance in this State, complete a birth certificate in this State, but enter the actual place of birth insofar as can be determined.

These 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.

7. **Item #2- TIME OF BIRTH**

Enter the exact time (Hour and Minutes) that the child was born according to local time.
Enter 12 NOON as "12:00 p.m.". One minute after 12 NOON is entered as "12:01 p.m." or 12:01 Military Time.

Enter 12 MIDNIGHT as "12:00 a.m.". One minute after 12 MIDNIGHT is entered as "12:01 a.m." or 00:01 Military Time.

This item established the exact time during the day when the birth occurred. It is used in some areas to monitor physician's scheduling of deliveries'. It is also an item of considerable interest to parents.

8. **Item #26- PLACE OF BIRTH**

Check the appropriate box:
□ Hospital, □ Freestanding Birthing Center, □ Clinic\Doctor's office, □ Home Birth: Planned to deliver at Home? □ Yes □ No, □ Other (Specify) _____

Do Not Leave Blank

9. **CERTIFIER INFORMATION/ATTENDANT INFORMATION**

Item 11a- CERTIFICATION STATEMENT AND SIGNATURE
I certify that this child was born alive at the place and time and date as stated.

Obtain the signature of the physician, who provided most of the prenatal care. If not applicable, obtain the signature of one of the persons listed below in order of priority:

1. Physician or physician's assistant in attendance at or immediately after the delivery, or
2. Midwife or R.N. who attended the birth, or
3. Hospital administrator, authorized designee (appointed by hospital administrator) or
4. Other attendant, i.e., father, relative, owner of premises if home delivery, etc.; or
5. Local registrar.

These are legal items indicating that the facts of birth are correct. They add authenticity to the document and indicate who the attendant at the delivery actually was. It will provide some indication of the extent to which personnel other than physicians are in

attendance at birth. Item 11b, mailing address of certifier, is needed for querying purposes and possible follow back studies obtaining additional information concerning the birth.

10. **Item #12- DATE SIGNED (Month, Day, Year)**
    - Enter the date the certifier signed the certificate.

11. **Item #27- NAME AND TITLE OF ATTENDANT AND I.D. AT BIRTH IF OTHER THAN CERTIFIER**
    Type the name and title and I.D. (National Provider Identification Number – NPI) of the person in attendance at birth if the certifier (person named in 8) was not the attendant.

Note: If the partner or associate of the certifier attended at the birth, his name and title should be entered. If a nurse attended the birth, her name and title should be entered. The father's name, for example, would be entered if the delivery was at home, but the mother's physician signed as certifier.

Specify the title of attendant:

M.D.
Physician's Assistant
D.O.
Midwife
R.N.
Husband
Etc.

Enter the National Provider Identification Number – NPI of the person responsible for delivering the child (do not complete if birth occurred in other than a facility)

12. **Item #11- CERTIFIER - NAME & TITLE (TYPE)**
    Enter the name and title of the person whose signature appears as certifier in item 11a.
    Specify the title of certifier:

M.D.
Physician's Assistant
D.O.
Midwife
R.N.
Husband
Etc.

13. Item #11b- MAILING ADDRESS (Street Num. or Rural Route Number, City or Town, State, Zip Code)

Enter the mailing address of Certifier.

14. LOCAL REGISTRAR SIGNATURE AND DATE FILED BY REGISTRAR

These are legally required items to authenticate the certificate and to prove that the birth certificate was properly filed within the time period specified by law.

Item #13a- LOCAL REGISTRAR SIGNATURE

Omit this item. It will be completed by the local registrar when the certificate is filed.

Item #13- DATE FILED BY REGISTRAR (Month, Day, Year)

Omit this item. It will be completed by the local registrar when the certificate is filed.

15. Item #8a- MOTHER - MAIDEN NAME (First, Middle, Last)

Enter the first, middle and **maiden name** of the mother. (The mother's first and middle and maiden last name should be the same as what is recorded on her legal birth certificate.)

If the mother is married, widowed, or divorced, be sure to enter her maiden name, not a last name acquired by marriage.

This is a legal item establishing parentage. It is also used administratively for indexing.

16. Item #8d- STATE OF BIRTH (If not in U.S.A., name country)

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

If the mother was not born in the United States, enter the name of the country.

If the mother was born in Canada, enter Canada in Country and in the state, enter the name of the Province.

If the mother is known to have been born in the United States, but the state is unknown, enter "U.S. – Unknown".

If the mother is known to have been born in a foreign country, but the country is unknown, enter "Unknown".

If no information is available regarding place of birth, enter "unknown".

This is a statistical item used with Census data to study fertility as related to mobility. It may also be used by genealogists in tracing family histories.

17. Item #8b- DATE OF BIRTH (Month, Day, Year)

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

Verify the date of birth with mother's record to avoid errors.

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 40 have a higher percentage of low-birth-weight and premature infants than women of other ages. This item is also useful for genealogical research.

18. MOTHER'S RESIDENCE

The mother's residence is the place where her household is located. This is not necessarily the same as her "Home State", "voting residence," "mailing address," or "legal residence". The State or Country, county, city, and street address should be for the place where the mother actually lives.

Never enter a temporary residence such as one used during a visit, business trips, or a vacation. Residence for a short time at the home of a relative, friend, or home for unwed mothers for the purposes of awaiting the birth of a child is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and therefore, should be shown as place of residence of mother on the certificate.

Most statistics on births are tabulated by place of residence of the mother. Birth rates are computed using population estimates prepared by place of residence. Local officials use residence data in planning the need for services and facilities, including maternal and child health programs, schools, etc. Private industry also uses this data for planning.

Item #9a- MOTHER'S RESIDENCE–STATE (If not in U.S.A., name country)

Enter the name of the state or country in which the mother lives. This may differ from the State in her mailing address (item 14). 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.

Item #9b- MOTHER'S RESIDENCE - COUNTY
Enter the name of the county in which the mother lives.

For electronic system, enter "other" and leave specify county blank, if the mother lives in a country other than the U.S.A.

Item #9c- MOTHER'S RESIDENCE - CITY, TOWN OR LOCATION
Enter the name of the city, town or location where the mother lives. This may differ from the city, town or location used in her mailing address (item 14).

Item #9d- MOTHER'S RESIDENCE - STREET AND NUMBER
Enter the house number and street name of the place where the mother lives. This may differ from the city, town, or location in her mailing address.

Do not enter a post office box; the post office box should be entered in the mailing address. (Item 14)

Item #9g- MOTHER'S RESIDENCE - INSIDE CITY LIMITS (yes or no)
Enter "Yes" if the mother's residence in item 9c is inside the city limits of an incorporated city, town or location. Otherwise enter "no". If unknown enter "Unknown".

MOTHER LIVES ON RESERVATION (yes or no) Enter "Yes" if the mother lived on a reservation. This will prompt you to **Select Reservation** from a drop down menu. Otherwise enter "No".

19. Item #14- MOTHER'S MAILING ADDRESS (If same as above, enter zip code only)

Enter the mailing address of the mother only if it is different from the residence address. It is important to distinguish between the mother's mailing address and her residence address. Because each serves a different purpose, they are not substitutes for one another.

The Social Security Administration will send the child's SSA card to the mailing address, so the post office box should always be in Item #14.

This item is used for querying and follow back studies. By distinguishing between residence and mailing address, data on residence should be improved.

EXAMPLES:
A mother lives in Your Town, Montana. She has a street and house number but receives her mail at a post office box. She lives inside the city limits.

ITEM 9c Your Town, 59602
ITEM 9d 1001 Lynn Rd
ITEM 9g Yes
ITEM 14 P.O. Box 123, Your Town, MT 59602

A mother lives in My Town. She has no street and house number and receives her mail in a post office box. She lives outside the city limits.

ITEM 9c My Town, 59602
ITEM 9d "-"
ITEM 9g No
ITEM 14 P.O. Box 123, Your Town, MT 59602

A mother lives in Helena. She has a street and house number and also a post office box where she receives all her mail. She lives inside the city limits.

ITEM 9c Helena, 59602
ITEM 9d 123 SE Her Street
ITEM 9g Yes
ITEM 14 P.O. Box 123, Helena, MT 59602

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20. Item #10a- FATHER - NAME: First, Middle, Last
The title of this item can be misleading. The man listed must be the Mother's Husband.

The person gathering information for the birth certificate should always be careful how they ask these questions. Rather than asking about the father of the child we would suggest when interviewing the mother, that you should always refer to her husband rather than use the words "Father of the Child"

If the child was born to a mother who was married at the time of birth, or had been married to the husband within 10 months of the birth or 300 days of the birth, enter the name of her husband.

If the child was conceived and born out of wedlock to a divorced, widowed, or never married mother, make no entry regarding the father's name and omit items 10a, 10b and 10c, except as authorized by State law. If affidavits of paternity from both the mother and father accompany the certificate, enter the name of the father.

The surname of the father and child are usually the same. When they are different, carefully review this information with the parent(s) to ensure that there is no mistake. Remember the parent(s) can give the child any last name they wish.

Refer problems regarding the entry of the father's name to the local registrar or the Office of Vital Statistics. (406-444-2685)

This item is used for identification and as documentary evidence of parentage.

NOTE: If the name of the father is shown in item 10a, supply the other items of information regarding the father: state of birth, age, race, and education (items 10b, 10c, 23, 24, 25). If the father's name is omitted in item 10a, omit items 10b, 10c, 23, 24, 25 also.
If the child was conceived in-wedlock but the mother refuses to give you her husband's name and does not want her husband's name to appear on the certificate, leave the item blank. If she wants another man's name as father on the birth certificate, a non-paternity affidavit from the husband acknowledging he is not the father of the child along with an affidavit from both the mother and alleged natural father acknowledging the paternity of the child must accompany the certificate. This must be received by the hospital before the discharge of the child. If this paperwork is not completed by discharge, the father's information must be omitted from the birth certificate.

21. Item #10c- STATE OF BIRTH (If not in U.S.A., name country)

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

If the father was not born in the United States, enter the name of the country.

If the father born in Canada, enter Canada in country and in the state, enter the name of the Province.

If the father is known to have been born in the United States, but the state is unknown, enter "U.S. – Unknown".

If the father is known to have been born in a foreign country, but the country is unknown, enter "Unknown".

If no information is available regarding place of birth, enter "unknown".

This is a statistical item used with census data to study fertility as related to mobility. It may also be used by genealogists in tracing family histories.

FATHER LIVES ON RESERVATION (yes or no) Enter "Yes" if the father lived on a reservation. This will prompt you to **Select Reservation** from a drop down menu. Otherwise enter "No".

22. Item #10b- DATE OF BIRTH (Month, Day, Year)

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

Verify the date of birth with father's record to avoid errors. This is one of the most important variables in the study of fertility.

23. I CERTIFY THAT THE PERSONAL INFORMATION PROVIDED ON THIS CERTIFICATE IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF (Signature of Parent or Informant)

Obtain the signature of the parent(s) or other person who provided the personal facts about the family after the information has been entered on the certificate and reviewed by the informant. It is important that the mother not be asked to do this until she is sufficiently recovered so that she can review the certificate carefully. **DO NOT REQUIRE ANYONE TO SIGN A BLANK BIRTH CERTIFICATE**.

If unable to get the mother's signature within ten days, send the certificate to the local registrar without her signature.

In the event the mother or father is not able to sign, the informant who provided the information may sign indicating his/her relationship to the child. If it is not possible to get a signature in this item, show the name of the person who supplied the personal facts about the family.

If the parents decide to have the father sign rather than the mother, obtain his signature.

This item should aid in improving the quality of the personal information included on the record.

24. Item #16- PERMISSION IS GIVEN TO PROVIDE THE SOCIAL SECURITY ADMINISTRATION WITH INFORMATION FROM THIS CERTIFICATE TO OBTAIN A SOCIAL SECURITY CARD FOR THIS CHILD

____Yes ____ No Signature of Parent

If the **mother/father does not <u>sign</u> and <u>check</u> the box labeled YES, we <u>cannot</u>**

send in the information to the Social Security Administration. If the parents have checked "yes" but did not sign on the electronic birth certificate, you will need to change "yes" to "no".

The Social Security Administration will reject a request for a social security card if:

(1) The mother/father doesn't do both-sign and check the box yes
(2) The child is unnamed
(3) Mother's residence indicates only a town - the address must include: PO Box, street address, etc.
(4) The child's first name is "Baby", "Baby Boy" or "Baby Girl".

THE LOWER PORTION OF THE LIVE BIRTH CERTIFICATE

Items 20-59 are contained in the lower portion of the certificate is labeled "Information for Medical and Health Use Only", which is confidential. These items do not appear on certified copies of the certificate but are used for a variety of important purposes.

For example, the race and education of parents are used with other information on the certificate to evaluate the effect of socio-economic factors. Because of the racial and educational differences, groups in the population have different birth characteristics, such as fertility, amount of prenatal care, birth weight, etc. Statistical analysis of these characteristics enables the influence of social factors on fertility, infant mortality, birth weight, etc., to be studied and also the social and health problems of these groups to be evaluated.

Pregnancy histories including both live births and other terminations assist in estimating future birth rates and examining the effect of changing social and economic conditions on the number of children couples decide to have.

Dates of the mother's last live birth and last termination allow for studies of child-spacing practices. To interpret and predict changes in birth rate trends, child-spacing patterns must be studied. Time interval between children is important in determining health problems of the infant and mother with close spacing. Physicians and medical researchers are interested in the outcome of a pregnancy following a fetal death.

Date of last normal menses, amount of prenatal care and birth weight are important items to those interested in improving health and medical services for mothers and babies. The date of last normal menses is used to calculate the length of pregnancy which is correlated with birth weight. The birth weight of an infant is closely related to its chances for survival, especially for premature babies. It is also related to the amount of prenatal care, socio-economic status, legitimacy and other factors surrounding the birth. The month of pregnancy in which a mother began her prenatal care and the number of prenatal visits is also related to the health and survival of her infant as well as her own health.

The apgar score is a means of evaluating the health of the infant at birth. Briefly, the apgar score is a summary measure of the infant's condition and reflects heart rate, respiration, muscle tone, reflex activity and skin coloration. A score between 0 and 10 is assigned to an infant at five minutes after birth and ten minutes after birth. In general,

a score of 8 thru 10 is considered satisfactory, 4 thru 7 indicates a need for careful observation, and 0 thru 3 serves as an alert for possible emergency procedures, and raises doubts about the survival of the infant. Studies confirm that the apgar score is a sensitive indicator of infant health and that the score is affected by or related to a wide variety of social, demographic, maternal health and infant characteristics. With the collection of the apgar scores on birth certificates from all states, further study of these relationships will become possible. The other items in this section are similarly useful for statistical research and for medical purposes.

25. EDUCATION - Specify only the highest diploma or degree received

Item #20- MOTHER
Item #23- FATHER

- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no Degree
- ☐ Associates Degree (e.g. AA, AS)
- ☐ Bachelor's Degree (e.g. BA, AB, BS)
- ☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g.PhD, EdD)or Professional Degree(e.g.MD, DDS, DVM, LLB, JD)

Education is used to measure the effect of socio-economic status on fertility, infant mortality, birth weight, etc. Through analysis of socio-economic differentials, social and health problems can be better evaluated.

26. OF HISPANIC ORIGIN?
(Check the box that best describes whether the mother and/or father is Spanish/Hispanic/Latino. Check the "NO" box if the mother of father is not Spanish/Hispanic/Latino.)

Item #21- MOTHER
Item #24- FATHER

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

(Specify)_____

If "yes" is checked, check the appropriate box that best describes the mother and/or father's Hispanic origin.

This entry in this item should reflect the response of the informant and is not based on percentages of ancestry.

For the purposes of this item, "Hispanic" refers to those 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.

27. RACE - White, Black, American Indian, Etc. (Specify)

Item #22- MOTHER
Item #25- FATHER

Enter the race of the mother and/or father as obtained from the parent(s) or other information. The entry in this item should reflect the response of the informant.

Check all that apply, if "other" is selected, enter description of race:

- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify) _____
- ☐ Other Pacific Islander (Specify)_____
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____
- ☐ Other (Specify) _____

If the mother and/or father is an American Indian, it is desirable to enter the specific name of the indian tribe, such as Crow, Assiniboine, etc. **Do not leave this item blank.**

This item and the race of the mother and/or the father are used to determine the race of the child. It is used to study demographic and health differentials among various racial groups (fertility trends, infant mortality, birth weight, etc.). Race is an important tool in planning, locating and evaluating health programs. This item is also used in preparing population estimates.

28. SOCIAL SECURITY NUMBERS:

Item #18- MOTHER
Item #19- FATHER

The following criteria is to be used in recording the social security numbers.

Enter "9 digit social security number"
Enter "999 99 9999" if the parent(s) does not know or refuse to release the social security number for either or both of the parent(s)

Do not leave this item blank.

29. Item #38- PRINCIPAL OF PAYMENT FOR DELIVERY

Check the box that best describes the principal source of payment for this delivery.

If "other" is checked, specify the payer.

If the principal source of payment is not known, enter "unknown" in the space.

This item should be completed by the facility. If the birth did not occur in a facility, the attendant or certifier should complete it.

30. Item #17- FACILITY ID. (NATIONAL PROVIDER IDENTIFIFER)

Enter the facility's National Provider identification number (NPI)

If no NPI, enter the state hospital code.

31. Item #15a- MOTHER MARRIED EVER?

Check the appropriate box**.**

32. Item #15- MOTHER MARRIED? At birth, conception or any time between (Yes or no)

Enter "yes" if the mother was married at time of conception, at the time of birth or at any time between conception and birth. Otherwise, enter "no". A woman is legally married even if she is separated. A person is no longer legally married when the divorce papers are signed. It may be necessary to check with your state or local registrar to determine how to complete this item.

If it is not known if the mother is married "unknown" may be selected.

If "NO" is checked, has paternity acknowledgment been signed at the hospital? (The addition of the father's name to the birth certificate)

This information is used to monitor the substantial differences in health and fertility between married and unmarried women.

Within the actual database, the next question will be **Mother married to father?** If "yes" this will then take you to the paternal screen. If "yes" is selected for **mother married?**, and "no" to **married to father?, Husband sign Non-Pat?** If "yes" THE HUSBAND MUST SIGN AN AFFIDAVIT OF NONPATERNITY, otherwise the husband's name must go into the paternal screen. If the husband will sign the **affidavit of non paternity** his name should not go onto the birth certificate. At this point if there is also a father that would like his name on the birth certificate the next question is **Will father sign paternity affidavit?** If the answer is "yes" then the father's name may be placed into the paternal screen. If the mother refuses to give her husbands name, you may answer "yes" to **Mother married?, Married to father,** is "unknown" and **Will father sign paternity affidavit?**, is "unknown".

You should then contact the Office of Vital Statistics and let them know the situation

**** Special Note****

When completing a birth certificate for a child when the parents are not married and the father is going to complete an acknowledge of paternity so that his name will appear on the child's birth certificate, the following fields will need to be completed.

Father's residence address and mailing address

Father's telephone number

Father's occupation and place of employment

If the parents are married theses field are not required to be completed

MONTANA PATERNITY QUESTIONS

Situation	Procedure
Mother was married at time of conception but not to the father of the child and wants father of child's name on the birth certificate *** Montana Law states that if a mother is married at the time of conception, or birth or between conception and birth, the name of the husband must be entered on the birth certificate: unless the mother and the husband signed non-paternity papers attesting that the husband is not the father of the child. Non-paternity papers must be signed before the mother and the father of the child can sign acknowledgment of paternity papers***	1. The mother and husband will need to sign non-paternity papers, you must have these in your possession before the mother of the child, and the father of the child can sign paternity papers Paternity papers need also to be in your possession 2. Answer the birthing questions as follows: 1. Was mother ever married — Yes 2. Was mother married at conception, birth or any time between? — Yes 3. Was mother married to father — No 4. Was marriage a Common Law marriage? — N/A 5. Has husband signed paternity denial? — Yes 6. Has father signed paternity acknowledgment? — Yes 3. Now, you may keep the father's name on the birth certificate. Forward to the State, the non-paternity and paternity papers at the time you submit the certificate to our office (Do Not Hold Forms)
Mother was married at time of conception but not to the father of the child and does not want to list husband or the father of the child on birth certificate.	1. The mother and husband will need to sign non-paternity papers; you must have these in your` possession. 2. Answer the birthing questions as follows: 1. Was mother ever married — Yes 2. Was mother married at conception, birth or any time between? — Yes 3. Was mother married to father — No 4. Was marriage a Common Law marriage? — N/A 5. Has husband signed paternity denial? — Yes 6. Has father signed paternity acknowledgment? — No 3. Make sure no data has been placed in the father tab, then forward to the state, the non-paternity papers at the time you submit the certificate to our office (Do Not Hold Forms)
Mother was married at time of conception but not to the father of the child and the Husband will not sign non-paternity papers. ***If the mother refuses to give information on her husband. Please leave father tab blank. Eventually the husband or father of the child will be place on the certificate. The State will handle this situation when it happens***	1. The mother's birth information and the husband's birth information must be placed on the birth certificate. 2. Answer the birthing questions as follows: 1. Was mother ever married — Yes 2. Was mother married at conception, birth or any time between? — Yes 3. Was mother married to father — No 4. Was marriage a Common Law marriage? — N/A 5. Has husband signed paternity denial? — No 6. Has father signed paternity acknowledgment? — N/A

Mother is claiming to be common law married to the father of the child	1. The mother and father's birth information must be place on the birth certificate 2. Answer the birthing questions as follows: 1. Was mother ever married — Yes 2. Was mother married at conception, birth or any time between? — Yes 3. Was mother married to father — Yes 4. Was marriage a Common Law marriage? — Yes 5. Has husband signed paternity denial? — N/A 6. Has father signed paternity acknowledgment? — Yes or No The mother and father have an option to sign paternity papers. It is suggested that they do sign paternity papers to ensure benefit rights for the child. 3. Forward to the state the signed paternity papers (if applicable)at the time you submit the certificate to our office (Do Not Hold Forms)
Mother was not married at time of conception and father of child wants to be listed on the birth certificate. ***If mother wants father of child on birth certificate and father is not at hospital to sign paternity papers. **DO NOT** place father's name on birth certificate and change the question: Will father sign paternity to **NO.** Print out a blank acknowledgment of paternity form and give to mother of child. The mother and father can sign these papers after leaving the hospital and forward the paternity papers to the state. We will place the father on the birth certificate.	1. Mother and father of the child will need to sign paternity papers. These paternity papers must be in your possession. 2. Answer the birthing questions as follows: 1. Was mother ever married — No or Yes 2. Was mother married at conception, birth or any time between? — N/A or No 3. Was mother married to father — N/A 4. Was marriage a Common Law marriage? — N/A 5. Has husband signed paternity denial? — N/A 6. Has father signed paternity acknowledgment? — Yes 3. Forward to the state the signed paternity papers at the time you submit the certificate to our office (Do Not Hold Forms)

Note: Anytime you remove the father from the birth certificate (no paternity papers signed etc.) You need to first go to the Marital Page, change the "Will Father Sign Paternity Affidavit" question to NO, then SAVE this change. This will remove all information concerning the father form the birth certificate.

If the mother of the child is not married and her boyfriend is not the father of the child they **can not** sign acknowledgment of paternity papers to have the boyfriend name added to the child's birth certificate. The only way that the boyfriend's name can be added to the child's birth certificate is by adoption or court order. Please refer these situations to the Office of Vital Statistics.

33. Item #39- DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)

Enter the exact date (month, day, year) of the beginning 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 herself. **Do not leave this item blank.**

If any part of the date is unknown, enter "9" as unknown
Example: 99/12/2004 or 99/99/9999

This item is used to determine the length of gestation (with the date of birth), which is related to infant morbidity and mortality. Length of gestation is associated with birth weight in determining the maturity of the infant at birth and this is important in medical research.

34. Item #34 DID MOTHER GET WIC FOOD DURING PREGNANCY?

Check the appropriate box. □ Yes □ No

35. PREGNANCY HISTORY

These items are used to determine live birth order and total birth order which are important in studying trends in fertility and child spacing. They are also useful in studying health problems, e.g., first births to older mothers. It has been observed that infant mortality is higher if a mother has a higher number of births.

The dates of last live birth and other termination of pregnancy are used to compute the intervals between live births and between pregnancies in studying child spacing. They are also important in determining whether there is health problems associated with close spacing and with the outcome of the previous pregnancy (whether or not it was a live birth).

LIVE BIRTH (Do not include this child)

NOTE: When certificates are prepared for a multiple birth, the certificate for the infant born first should exclude all outcomes of the present delivery just as if it were being prepared for a single birth. However, the certificate for the second-born of a twin set should **include** information about the first and second-born.

Item #35a- NOW LIVING

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

If this is the first live birth to this mother or if all previous children are dead, check "none" box. **Do not leave this item blank.**

Item #35b- NOW DEAD
Enter the number of other children born alive to this mother but who are no longer living at the time of this birth. **Do not include this birth.**

If this is the first live birth to this mother or if all previous children are still living, check "none" box. **Do not leave this item blank.**

If this birth is one member of a multiple birth (twins, triplets, etc.), see **NOTE**.

Item #35c- DATE OF LAST LIVE BIRTH (Month, Year)
Enter the date (month and year) of the last previous live birth to the mother.

If the mother has not had a previous live birth, enter "none", and leave the date of last live birth blank.

Use the number for the named month, for example, "06/1999"

Double check items 35a and 35b. If a number is entered in either space, make sure a date is entered in this space.

NOTE: If this certificate is for the second-born of twin set, enter the date of birth for the first baby of the set if it 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 previous born members of a multiple set were born dead, enter the mother's last delivery that resulted in a live birth.

36. NUMBER OF OTHER PREGNANCY OUTCOMES (Spontaneous and induced losses or ectopic pregnancies).

Item #36a- Include each recognized loss of a product of conception, such as ectopic pregnancy, miscarriage, stillbirth, or abortion (spontaneous and induced losses or ectopic pregnancies).

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” box if this is the first pregnancy for this mother or if all previous pregnancies resulted in live-born infants. **Do not leave this item blank.**

Item #36b- DATE OF LAST OTHER PREGNANCY OUTCOME
NOTE: If this certificate is for the second-born of a twin set and the first was born dead, enter the date of delivery of that fetal death. Similarly, for other multiple births, if any member of the set was born dead, enter the date of delivery of that fetal death. 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.

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

If the mother has never had a pregnancy termination, enter “none” and leave the date of last other pregnancy outcome blank.

If the date is unknown, or unobtainable, enter “99/9999”.

You must use the number for the named month, for example “06/1999”.

Double check item 36a. If a number is entered in the space, make sure a date is entered in this space.

37. PRENATAL CARE

This information is sought to determine the relationship of prenatal care to the health of the child at birth. It is commonly felt that if care is begun early, the physician’s instructions on nutrition, drug use, etc., would have a major impact on the health of the fetus. This information is useful in planning for the location and evaluation of the utilization of prenatal care programs.

Item #29a- DATE OF FIRST PRENATAL CARE VISIT
Enter the month, day and year for when prenatal care first began.

If no prenatal care was received, check “no” prenatal care.

Do not leave item blank.

Item #29b- DATE OF LAST PRENATAL CARE VISIT
Enter the month, day and year for when prenatal care ended.

If no prenatal care was received, enter "99/99/9999". **Do not leave this item blank.**

Item #29c- TOTAL NUMBER OF PRENATAL VISITS
Enter the total number of prenatal 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, check "no" prenatal care.

Do not leave this item blank

38. **Item #49- BIRTH WEIGHT**
    Enter the birth weight of the child as it is recorded in the hospital record. **Do not leave this item blank.**

    Entries should be made in either grams or pounds and ounces, depending on the scales used. Do not convert from one measure to the other.

    Specify the type of measure used that is "grams" or "pounds and ounces".

This is the single most important characteristic associated with infant mortality. It is strongly related to amount of prenatal care, socio-economic status, out of wedlock and other factors surrounding the birth. This makes it a useful tool in health planning and evaluation.

39. **Item #50- OBSTETRIC ESTIMATE OF GESTATION (completed 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 clinical estimate of gestation is unknown, enter "unknown". If a fraction of a week is given (e.g. 32.2 weeks) round down to the next whole week (e.g. 32 weeks).

    Do not leave this item blank.

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 crosscheck with length of gestation based on ultrasound or other techniques

40. PLURALITY

These items, along with birth weight and other items, have significant health implications for the child. They are also of demographic interest in their relationship to the age of the mother and birth order of the child.

When a plural birth occurs, prepare a separate certificate for each child or fetus. File certificates relating to the same multiple birth set at the same time. However, do not hold completed certificates while waiting for uncompleted ones, if it will result in late filing.

Item #52- PLURALITY - Single, Twin, Triplet, etc. (Specify)
Specify the birth as single = 1, twin = 2, triplet = 3, quadruplet = 4, etc.,

Do not leave this item blank.

Item #53- IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)
Specify the order in which this child was born - first, second, third, etc.

If a single birth, leave blank.

41. Item #51- APGAR SCORE

The Apgar Score is a means of evaluating the health of the infant at birth. It has been shown that there are correlations between the apgar score and other significant health variables.

APGAR SCORE - 5 Minutes
Enter the Apgar Score (from 0 thru 10) as assigned by the delivery room personnel five minutes after birth.

If unknown, enter "99"

Do not leave this item blank.

APGAR SCORE - 10 Minutes
Enter the Apgar Score (from 0 thru 10) as assigned by the delivery room personnel Ten minutes after birth.

If unknown, enter "99" **Do not leave this item blank.**

42. **Item #58- IS INFANT BEING BREASTFED AT DISCHARGE?**

Information on whether the infant was being breast-fed during the period between birth and discharge from the hospital.

Check "yes" if the infant is being breast-fed
Check "no" if the infant is being breast-fed

43. Item #57- IS INFANT LIVING AT TIME OF REPORT

Check "yes" if the infant is living
Check "yes" if the infant has already been discharged to home care
Check "no" if it is known that the infant has died

If the infant was transferred and the status is known, indicate the known status.

44. Item #28- MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? (yes or no)

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.

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

45. Item #56- INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY?

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.

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.

46. **Item #37- CIGARETTE SMOKING BEFORE AND DURING PREGNANCY**

For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

Do not leave this item blank.

47. Item #59- ALCOHOL USE DURING PREGNANCY

Check the appropriate box

Check "yes" for alcohol use if the mother consumed alcoholic beverages at any time during her pregnancy. If "yes" is checked, specify the average number of drinks she consumed **per week. O**ne 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", for EBC hospitals enter "1". Check "no" if the mother did not consume any alcoholic beverages during the entire pregnancy. If "no" is checked, do not make any entry on the line requesting the average number of cigarettes per day. **Do not leave this item blank.** If "yes" enter the average number of drinks per week

48. Item #31- MOTHER'S HEIGHT

Enter the mother's height at the time of delivery

If the mother's height is unknown, enter "unknown"

49. Item #32- MOTHER'S PREPREGNANCY WEIGHT

Enter the mother's Prepregnancy weight (before pregnancy)

If the mother's Prepregnancy weight is unknown, enter "unknown"

50. Item #33- MOTHER'S WEIGHT AT DELIVERY

Enter the mother's weight at the time of delivery. Use pounds only, for example enter 140 1/2 pounds as 140 pounds.

If the mother's delivery weight is unknown, enter "unknown".

CHECK BOX ITEMS

The following medical and health items are formatted into check boxes. It has been demonstrated that this format produces higher quality and more complete information than open-ended items do. Please review each check box listed, and carefully check in the appropriate block(s). Clearly check in the block. The mark should not overlap more than one box.

HEP B VACCINATION INFORMATION – INFANT

Hep B Birth Dose Given □ Yes □ No □ Parent Refused □ Unknown
HBsAg Test Date: (mm,dd,yyyy) _____

HEP B TESTING INFORMATION- MOTHER

Hep B Administration Date: (mm,dd,yyyy)_____Time:_____am / pm
HBsAg Test Result □ Positive-Reactive □ Negative-Nonreactive □ Unknown

Consent Obtained for INLCUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? □ Yes □ No □ Unknown
(This answer should be identical to the parent response on page one)

51. Item #54- ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)

- □ Assisted ventilation required immediately following delivery
  Excludes free flow oxygen only, laryngoscopy for aspiration of meconium and nasal cannula
- □ Assisted ventilation required for more than six hours
  Excludes free flow oxygen only, laryngoscopy for aspiration of meconium and nasal cannula.
- □ NICU admission
- □ Newborn given surfactant replacement therapy
- □ Antibiotics received by the newborn for suspected neonatal sepsis
- □ Seizure or serious neurologic dysfunction
- □ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and /or soft tissue/solid organ hemorrhage which requires intervention
- □ None of the above

This 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.

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 “none of the above”.

Do not leave this item blank.

<u>What constitutes assisted ventilation</u>:

Assisted ventilation required for more than 6 hours.

Infant given mechanical ventilation (breathing assistance) by any method for more than 6 hours.

Includes conventional, high frequency and/or continuous positive pressure (CPAP).

If in use for more than 6 hours:
CPAP -Continuous positive airway pressure
IPPV -Intermittent positive pressure ventilation
HFV -High frequency ventilation
IMV -Intermittent mandatory volume ventilation
HFOV -High frequency oscillatory ventilation
IPPV -Intermittent positive pressure ventilation
PIP -Peak inspiratory pressure
PEEP -Positive end expiratory pressure
CMV -Continuous mandatory ventilation
HFPPV -High frequency positive pressure ventilation
HFFI -High frequency flow interruption ventilation
HFJV -High frequency jet ventilation
Inhaled Nitric Oxide

Assisted ventilation required immediately following delivery:

Infant given manual breaths for any duration with bag and mask or bag and endotracheal tube within the first several minutes from birth.

Excludes free flow oxygen only and laryngoscopy for aspiration of meconium.

Bag and mask ventilation
Intubation
Intubation and PPV -Positive pressure ventilation
PPV bag/mask or ET -Positive pressure ventilation via bag, mask or endotracheal intubation
IPPV Bag -Intermittent positive pressure ventilation via bag
IPPV ET -Intermittent positive pressure ventilation via endotracheal intubation
O2 via ET -Oxygen via endotracheal intubation
Oxygen

52. Item #55- CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)

- Anencephaly
- Cyanotic congenital heart disease
- Omphalocele
- Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
- Cleft Lip with or without Cleft palate
- Down Syndrome
  - Karyotype confirmed
  - Karyotype pending
- Hypospadias
- Meningomyelocele/Spina bifida
- Congenital diaphragmatic hernia
- Gastroschisis
- Cleft Palate alone
- Suspected Chromosomal disorder
  - Karyotype confirmed
  - Karyotype pending
- None of the anomalies listed above

This 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 cluster 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.

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 "none of the anomalies listed above"

Do not leave this item blank.

53. Item #41- MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

Diabetes

- □ Prepregnancy (Diagnosis prior to this pregnancy)
- □ Gestational (Diagnosis during this pregnancy)

Hypertension

- □ Prepregnancy (Chronic)
- □ Gestational (PIH, Preeclampsia)
- □ Eclampsia

□ Previous preterm birth

□ Other previous poor pregnancy outcome (Includes Perinatal death, small for gestational age intrauterine growth restricted birth)

□ Pregnancy result from infertility treatment-if yes, check all that apply

- □ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination

□ Assisted reproductive technology (e.g., in vetro Fertilization (IVF), gamete intrafallopian transfer (GIFT)

□ Mother had a previous cesarean delivery
If yes, how many _____

□ None of the above

Check each of the medical risk factors that the mother experienced during this pregnancy. Medical factors should be identified from the hospital or physician record. If there were no medical factors for this pregnancy, check "none of the above".

Do not leave this item blank.

54. Item #42- INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

- □ Gonorrhea
- □ Syphilis
- □ Chlamydia
- □ Hepatitis B
- □ Hepatitis C
- □ None of the above

This item documents any infections present at the time of the pregnancy diagnosis or a confirmed diagnosis during the pregnancy with or without documentations of treatment. Documentation of treatment during this pregnancy is adequate if a definitive diagnosis is not present in the available record.

Check all boxes that apply. The mother may have more than one infection. If the mother has none of the infections, check "none of the above".

Do not leave this item blank.

55. Item #43- OBSTETRIC PROCEDURES (Check all that apply)

- ☐ Cervical cerciage
- ☐ Tocolysis

External cephalic version:

- ☐ Successful
- ☐ Failed

☐ None of the above

This information documents medical treatment or invasive/manipulative procedure performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery.

Check all boxes that apply. The mother may have more than one procedure. If the Mother has had none of the procedures; check "none of the above".

Do not leave this item blank.

56. Item #44- ONSET OF LABOR (Check all that apply)

- ☐ Premature Rupture of the Membranes (prolonged,≥12 hrs.)
- ☐ Precipitous Labor (<3 hrs.)
- ☐ Prolonged Labor (≥20 hrs.)
- ☐ None of the above

Check all that apply (prolonged labor and precipitous labor should not both be checked.)

If none apply, check "none of the above".

Do not leave this item blank.

57. Item #45- CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother

prior to delivery

- Antibiotics received by the mother during labor
- Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38ºC (100.4ºF)
- Moderate/heavy Meconium staining of the amniotic fluid
- Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- Epidural or spinal anesthesia during labor
- None of the above

This item shows information about the course of labor and delivery

Check all characteristics that apply. If none of the characteristics of labor and delivery apply, check "none of the above." **Do not leave this item blank.**

58. Item #46- METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?

□ Yes □ No

B. Was delivery with vacuum extraction attempted but unsuccessful?

□ Yes □ No

C. Fetal presentation at birth

□ Cephalic □ Breech □ Other

D. Final route and method of delivery (Check one)

□ a. Vaginal/Spontaneous

□ b. Vaginal/Forceps

□ c. Vaginal/Vacuum

□ d. Cesarean

If cesarean, was a trial of labor attempted?

□ Yes

□ No

This information can be used to monitor delivery trends across the United Sates.

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.

59. Item #47- MATERNAL MORBIDITY (Check all that apply)

(Complications associated with labor and delivery)

□ Maternal transfusion
□ Third or fourth degree perineal laceration
□ Ruptured uterus
□ Unplanned hysterectomy
□ Admission to intensive care unit
□ Unplanned operative room procedure following delivery
□ None of these above

This information monitors serious complications experienced by the mother associated with labor and delivery

Check all boxes that apply. If the mother has none of the complications, check "none of the above." **Do not leave this item blank**.

CHAPTER II

SPECIFIC INSTRUCTIONS FOR COMPLETING THE FETAL DEATH CERTIFICATE AND A CERTIFICATE OF BIRTH RESULTING IN A STILLBIRTH

PLEASE NOTE - Senate Bill 518 "An act providing for a Certificate of Birth Resulting in a Stillbirth" will be effective January 1, 2008

The Office of Vital Statistics is providing the following guidelines for filing a "Certificate of Birth Resulting in a Stillbirth":

- For all Fetal Deaths that meet the requirements "fetus weighs at least 350 grams at death or, if the weight is unknown, has reached 20 completed weeks of gestation", file the Montana Certificate of Fetal Death.

- If a Fetal Death does not meet the filing requirements, but has "reached at least 20 weeks of gestation", and a Certificate of Birth Resulting in a Stillbirth is request by either parent, a Montana Certificate of Fetal Death must be filed.

1. **Item #1- CHILD - NAME: FIRST, MIDDLE, LAST, SUFFIX (OPTIONAL)**
   Type in the child's first, middle, last name, and suffix (if applicable)

   If the parent (s) do not wish to name the fetus, then only a last name is required

   Enter the full name of the child exactly as given by the parent(s).
   The parent(s) may choose any last name they wish.

   Entries of Jr. and II, following the last name, are acceptable.

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

2. **Item #3- SEX**
   Enter Male or Female. Verify the entry of sex against the given name.

   In cases where the sex cannot be determined, enter "unknown"

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

3. **Item #4- DATE OF DELIVERY (Month, Day, Year)**

Enter the exact month, day and year that 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 (type written certificates- make no correction on the date of delivery. If an error is made, type a new certificate)

Pay particular attention to the entry of month, day and year when the delivery occurs around midnight or December 31. Consider a delivery at midnight to have occurred at the end of one day rather than the beginning of the next day.

The name of the fetus and the date of delivery are the most important items on the certificate. This is a legal item used to establish the date of delivery of the individual named on the certificate. Statistically, it allows for the tabulation of data by month of occurrence. Together with the date last normal menses began, date of delivery is used to calculate the length of gestation.

4. **Item #8- PLACE OF DELIVERY – FACILITY NAME**

Facility – Name (If not in hospital, give street and number)

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

If the delivery occurred on a moving conveyance en route to or on arrival at the 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 the 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 reroute to the facility, enter as the place of delivery, the address where the fetus was first removed from the conveyance. (Hospital name)

However, if the delivery occurred in international waters, airspace or a foreign country, contact the Office of Vital Statistics for proper completion.

5. **Item #5- CITY, TOWN, OR LOCATION OF DELIVERY and ZIP CODE**

Enter the name of the city, town or location where the delivery occurred.

If the delivery occurred in moving conveyance, see note under 4 (Place of delivery – Facility name).

6. **Item #6- 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.

   If the delivery occurred in a moving conveyance in the United States and the fetus was first removed from the conveyance in this State, complete a fetal death certificate showing the place of delivery as this State.

7. **Item #2- TIME OF DELIVERY**

   Enter the exact time (Hour and Minutes) that the fetus was delivered according to local time.
   Enter 12 NOON as "12:00 p.m.". One minute after 12 NOON is entered as "12:01 p.m." or 12:01 Military Time.

   Enter 12 MIDNIGHT as "12:00 a.m.". One minute after 12 MIDNIGHT is entered as "12:01 a.m." or 00:01 Military Time.

This item established the exact time during the day when the delivery occurred. It is used in some areas to monitor physician's scheduling of deliveries'. It is also an item of considerable interest to parents.

8. **Item #7- PLACE WHERE DELIVERY OCCURED**

   Check the appropriate box:
   □ Hospital, □ Freestanding Birthing Center, □ Clinic\Doctor's office, □ Home Birth: Planned to deliver at Home? □ Yes □ No, □ Other (Specify) _____

   Do not leave this item blank.

9. **Item #9- FACILITY ID. (NPI)**

   Enter the national provider identification number (NPI) of the facility responsible for delivering the fetus.

   If the delivery did not occur in a facility, enter "none"

   Do not leave this item blank.

10. Item# 14- NAME AND TITLE OF ATTENDANT AND NPI

Type the name and title and I.D. (National Provider Identification Number – NPI) of the person in attendance of delivery, if the certifier (person named in 8) was not the attendant.

Note: If a doctor attended the delivery, his name and title should be entered. If a nurse attended the delivery, her name and title should be entered. The father's name, for example, would be entered if the delivery was at home.

Specify the title of attendant:

□ M.D.
□ D.O.
□ CNM/CM
□ Other Midwife
□ Other (Specify) _____

Enter the National Provider Identification Number – NPI of the person responsible for delivering the fetus (do not complete if delivery occurred in other than a facility)

11. Item #10a- MOTHER - MAIDEN NAME (First, Middle, Last)

Enter the first, middle and maiden name of the mother. (The mother's first and middle and maiden last name should be the same as what is recorded on her legal birth certificate.)

If the mother is married, widowed, or divorced, be sure to enter her maiden name, not a last name acquired by marriage.

This is a legal item establishing parentage. It is also used administratively for indexing.

Item #10d- STATE OF BIRTH (If not in U.S.A., name country)

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

If the mother was not born in the United States, enter the name of the country.

If the mother is known to have been born in the United States, but the state is unknown, enter "U.S. – Unknown".

If the mother is known to have been born in a foreign country, but the country is unknown, enter "Foreign-Unknown".

If no information is available regarding place of birth, enter "unknown".

This is a statistical item used with census data to study fertility as related to mobility. It may also be used by genealogists in tracing family histories.

Item #10b- DATE OF BIRTH (Month, Day, Year)
Enter the exact month, day and year that the mother was born.

Verify the date of birth with mother's record to avoid errors.

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 40 have a higher percentage of low-birth-weight and premature infants than women of other ages. This item is also useful for genealogical research.

12. MOTHER'S RESIDENCE

The mother's residence is the place where her household is located. This is not necessarily the same as her "Home State", "voting residence," "mailing address," or "legal residence". The state, county, city, and street address should be for the place where the mother actually lives.

Never enter a temporary residence such as one used during a visit, business trips, or a vacation. Residence for a short time at the home of a relative, friend, or home for unwed mothers for the purposes of awaiting the birth of a child is considered to be temporary and should not be entered here. Place of residence during a tour of military duty or during attendance at college is not considered as temporary and therefore, should be shown as place of residence of mother on the certificate.

Most statistics on births are tabulated by place of residence of the mother. Birth rates are computed using population estimates prepared by place of residence. Local officials use residence data in planning the need for services and facilities, including maternal and child health programs, schools, etc. Private industry also uses this data for planning.

Item #11a- MOTHER'S RESIDENCE - STATE
Enter the name of the state in which the mother lives. This may differ from the State in her mailing address (item 14). 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.

Item #11b- MOTHER'S RESIDENCE - COUNTY
Enter the name of the county in which the mother lives.

Item #11c- MOTHER'S RESIDENCE - CITY, TOWN OR LOCATION AND ZIP CODE
Enter the name of the city, town or location where the mother lives. This may differ from the city, town or location used in her mailing address (item 14).

Item #11d- MOTHER'S RESIDENCE - STREET AND NUMBER
Enter the house number and street name of the place where the mother lives. This may differ from the city, town, or location in her mailing address.

Do not enter a post office box, the post office box should be entered in the mailing address. (Item 14)

Item #11e- APT NO.
Enter the mother's apartment number if applicable.

Item #11g- MOTHER'S RESIDENCE - INSIDE CITY LIMITS (yes or no)
Enter "Yes" if the mother's residence in item 11c is inside the city limits of an incorporated city, town or location. Otherwise enter "No".

13. **Item #12a- FATHER - NAME: First, Middle, Last**
The title of this item can be misleading. The man listed must be the Mother's Husband.
The person gathering information for the birth certificate should always be careful how they ask this question. Rather than asking about the father of the child we would suggest when interviewing the mother, that you should always refer to her husband rather than use the words "Father of the Child"

If the child was born to a mother who was married at the time of birth, or had been married to the husband within 10 months of the birth or 300 days for birth, enter the name of her husband.

If the child was conceived and born out of wedlock to a divorced, widowed, or never married mother, make no entry regarding the father's name and omit items 10 a, 10B and 10c, except as authorized by State law. If affidavits of paternity from both the mother and father accompany the certificate, enter the name of the father.

The surname of the father and child are usually the same. When they are different,

carefully review this information with the parent(s) to ensure that there is no mistake. Remember the parent(s) can give the child any last name they wish.

Refer problems regarding the entry of the father's name to the local registrar or the Office of Vital Statistics. (406-444-2685)

This item is used for identification and as documentary evidence of parentage.

NOTE: If the name of the father is shown in item 12a, supply the other items of information regarding the father: state of birth, age, race, and education (items 12b, 12c, 19, 20 & 21a.). If the father's name is omitted in item 12a, omit items 12b, 12c, 19, 20, 21a. also.

If the child was conceived in-wedlock but the mother refuses to give you her husband's name and does not want her husband's name to appear on the certificate, leave the item blank. If she wants another man's name as father on the birth certificate, an non-paternity affidavit from the husband acknowledging he is not the father of the child along with an affidavit from both the mother and alleged natural father acknowledging the paternity of the child must accompany the certificate. This must be received by the hospital before the discharge of the child. If this paperwork is not completed by discharge, the father's information must be omitted from the birth certificate.

Item12c- STATE OF BIRTH (If not in U.S.A., name country)
If the father was born in the United States, enter the name of the state

If the father was not born in the United States, enter the name of the country.

If the father is known to have been born in the United States, but the state is unknown, enter "U.S. – Unknown".

If the father is known to have been born in a foreign country, but the country is unknown, enter "Foreign-Unknown".

If no information is available regarding place of birth, enter "unknown".

This is a statistical item used with census data to study fertility as related to mobility. It may also be used by genealogists in tracing family histories.

Item #12b- DATE OF BIRTH (Month, Day, Year)
Enter the exact month, day and year that the father was born.

Verify the date of birth with father's record to avoid errors.

FATHER LIVES ON RESERVATION (YES OR NO) If Father lives on reservation enter "Yes". It will prompt you to **Select Reservation** from a drop down menu. Otherwise enter "No".

14. Item #13- METHOD OF DISPOSITION
Enter the method of disposition of the fetus

Check only one method of the following: □ Burial, □ Cremation, □ Hospital Disposition, □Donation, □Removal from State, or □ Other (Specify) _____

Do not leave this item blank.

15. Item #15- NAME AND TITLE OF PERSON COMPLETING REPORT
Enter the name and title of the person in charge of final disposition.

If a mortuary is handling the fetal death, omit this item. It will be completed by the mortician.

If the hospital has disposed of the remains, the hospital administrator or his designee shall sign here.

Do not leave this item blank.

16. Item #16- DATE REPORT COMPLETED
Enter the date this report was completed

Do not leave this item blank.

17. LOCAL REGISTRAR SIGNATURE AND DATE FILED BY REGISTRAR
These are legally required items to authenticate the certificate and to prove that the birth certificate was properly filed within the time period specified by law.

Item #17a- LOCAL REGISTRAR SIGNATURE
Omit this item. It will be completed by the local registrar when the certificate is filed.

Item #17- DATE FILED BY REGISTRAR (Month, Day, Year)
Omit this item. It will be completed by the local registrar when the certificate is filed.

LOWER PORTION OF THE FETAL DEATH CERTIFICATE

The "Information for Medical and Health Use Only", items are confidential. These items do not appear on certified copies of the certificate, but are used for a variety of important purposes.

For example, the ancestry, race and education of the parents are used with other information on the certificate to evaluate the effect of socio-economic factors. Because of these racial and educational differences, groups in the population have different birth characteristics, such as fertility, amount of prenatal care, birth weight, etc. Statistical analysis of these characteristics enables the influence of social factors on fertility, infant mortality, etc., to be studied and the social and health problems of these groups to be evaluated.

Pregnancy histories, including both live births and other terminations, assist in estimating future birth rates and examining the effect of changing social and economic conditions on the number of children couples decide to have.

Dates of the mother's last live birth and last termination allow studies of child-spacing practices. To interpret and predict changes in birth rate trends, child-spacing patterns must be studied. Time interval between children is important in determining health problems of the infant and mother with close spacing. Physicians and medical researchers are also interested in the outcome of a pregnancy following a fetal death.

The weight of a fetus is closely related to its gestational age. The date of last normal menses also is used to calculate gestational age, which is useful in the study of fetal loss. The month of pregnancy in which a mother began her prenatal care and the number of prenatal visits she had; are also related to the outcome of pregnancy as well as to her own health. These items are important to those interested in improving health and medical services for mothers and babies.

The other items in this section are similarly useful for statistical research and for medical purposes.

18. EDUCATION - Specify only the highest diploma or degree received

Item #19 - MOTHER

- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no Degree
- ☐ Associates Degree (e.g. AA, AS)
- ☐ Bachelor's Degree (e.g. BA, AB, BS)
- ☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g. PhD,EdD) or Professional Degree(e.g.MD,DDS, DVM, LLB,JD)

Education is used to measure the effect of socio-economic status on fertility, infant mortality, birth weight, etc. Through analysis of socio-economic differentials, social and health problems can be better evaluated.

20. OF HISPANIC ORIGIN?

(Check the box that best describes whether the mother and/or father is Spanish/Hispanic/Latino. Check the "NO" box if the mother of father is not Spanish/Hispanic/Latino.)

Item #20 - MOTHER

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

(Specify)_____

If "yes" is checked, check the appropriate box that best describes the mother's Hispanic origin.

This entry in this item should reflect the response of the informant and is not based on percentages of ancestry.

For the purposes of this item, "Hispanic" refers to those 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.

21. RACE - White, Black, American Indian, Etc. (Specify)

Item #21 - MOTHER

Enter the race of the mother as obtained from the parent(s) or other information. The entry in this item should reflect the response of the informant.

Check all that apply, if "other" is selected, enter description of race:

- □ White
- □ Black or African American
- □ Native Hawaiian
- □ Asian Indian
- □ Chinese
- □ Filipino
- □ Japanese
- □ Guamanian or Chamorro
- □ Korean
- □ Vietnamese
- □ Samoan
- □ Other Asian (Specify) _____
- □ Other Pacific Islander (Specify) _____
- □ American Indian or Alaska Native (Name of the enrolled or principal tribe)_____
- □ Other (Specify) _____

If the mother and/or father is an American Indian, it is desirable to enter the specific name of the Indian tribe, such as Crow, Assiniboine, etc.

Do not leave this item blank.

This item and the race of the mother and/or the father are used to determine the race of the child. It is used to study demographic and health differentials among various racial groups (fertility trends, infant mortality, birth weight, etc.). Race is an important tool in planning, locating and evaluating health programs. This item is also used in preparing population estimates.

21. Item #22- MOTHER MARRIED? At delivery, conception or any time between (Yes or No)

Enter "yes" if the mother was married at time of conception, at the time of delivery or at any time between conception and delivery. Otherwise, enter "no". A woman is legally married even if she is separated. A person is no longer legally married when the divorce papers are signed. It may be necessary to check with your State or local registrar to determine how to complete this item.

If it is not known if the mother is married "unknown" may be selected.
This information is used to monitor the substantial differences in health and fertility between married and unmarried women.

22. Item #22a- MOTHER MARRIED EVER?

Check the appropriate box**.** □ Yes □ No

23. PRENATAL CARE

This information is sought to determine the relationship of prenatal care to the health of the child at birth. It is commonly felt that if care is begun early, the physician's instructions on nutrition, drug use, etc., would have a major impact on the health of the fetus. This information is useful in planning for the location and evaluation of the utilization of prenatal care programs.

Item #23a- DATE OF FIRST PRENATAL CARE VISIT

Enter the month, day and year for when prenatal care first began.
If no prenatal care was received, check "no" prenatal care.

Do not leave item blank.

Item #23b- DATE OF LAST PRENATAL CARE VISIT

Enter the month, day and year for when prenatal care ended.

If no prenatal care was received, enter "99/99/9999". **Do not leave this item blank.**

24. Item #24- TOTAL NUMBER OF PRENATAL VISITS

Enter the total number of prenatal 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 "0"

Do not leave this item blank

25. Item #25- MOTHER'S HEIGHT

Enter the mother's height at the time of delivery

If the mother's height is unknown, enter "unknown"

26. Item #26- MOTHER'S PREPREGNANCY WEIGHT

Enter the mother's prepregnancy weight (before pregnancy) Use pounds only, for example enter 140 1/2 pounds as 140 pounds.

If the mother's prepregnancy weight is unknown, enter "unknown"

27. Item #27- MOTHER'S WEIGHT AT DELIVERY

Enter the mother's weight at the time of delivery. Use pounds only, for example enter 140 1/2 pounds as 140 pounds.

If the mother's delivery weight is unknown, enter "unknown".

28. Item #28- DID MOTHER GET WIC FOOD DURING PREGNANCY?

Check the appropriate box. □ Yes □ No

PREGNANCY HISTORY

These items are used to determine live birth order and total birth order which are important in studying trends in fertility and child spacing. They are also useful in studying health problems, e.g., first births to older mothers. It has been observed that infant mortality is higher if a mother has a higher number of births.

The dates of last live birth and other termination of pregnancy are used to compute the intervals between live births and between pregnancies in studying child spacing. They are also important in determining whether there are health problems associated with close spacing and with the outcome of the previous pregnancy (whether or not it was a live birth).

29. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child)

NOTE: When completing these items, do not include this fetal death; include all previous live-born infants. For multiple deliveries, include all live-born infants preceding this fetal death in the delivery. If first delivered in a multiple delivery, do not include this fetus. If second delivered, include the first live born, etc.

Item #29a- NOW LIVING

Enter the number of other children previously born alive to this mother who are still living at the time of this delivery.

Item #29b- NOW DEAD

Enter the number of other children born alive to this mother but who are no longer living at the time of this delivery. **Do not leave this item blank.**

If this is the first delivery to this mother or if all previous children are still living, check "none" box. **Do not leave this item blank.**

If this delivery is one member of a multiple delivery (twins, triplets, etc.), see **NOTE**.

Item #29c- DATE OF LAST LIVE BIRTH (Month, Year)

Enter the date (month and year) of the last previous live birth to the mother.

If the mother has not had a previous live birth, enter "none" and leave the date of last live birth blank.

Use the number for the named month, for example, "06/1999"

Double check items 29a and 29b. If a number is entered in either space, make sure a date is entered in this space.

NOTE: If this certificate is for the second-born of a twin set, enter the date of birth for the first baby of the set if it 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 previous born members of a multiple set were born dead, enter the mother's last delivery that resulted in a live birth.

30. NUMBER OF OTHER PREGNANCY OUTCOMES (Spontaneous and induced losses or ectopic pregnancies).

Item #30a- Include each recognized loss of a product of conception, such as ectopic pregnancy, miscarriage, stillbirth, or abortion (spontaneous and induced losses or ectopic pregnancies).

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" box if this is the first pregnancy for this mother or if all previous pregnancies resulted in live-born infants. **Do not leave this item blank.**

Item #30b- DATE OF LAST OTHER PREGNANCY OUTCOME

NOTE: If this certificate is for the second-born of a twin set and the first was born dead, enter the date of delivery of that fetal death. Similarly, for other multiple births, if any member of the set was born dead, enter the date of delivery of that fetal death. 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.

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

If the mother has never had a pregnancy termination, enter "none".

If the date is unknown, or unobtainable, enter "99/9999".

You must use the number for the named month, for example "06/1999".

Double check item 36a. If a number is entered in the space, make sure a date is entered in this space.

31. Item #32- DATE LAST NORMAL MENSES BEGAN (Month, Day, Year)

Enter the exact date (month, day, year) of the beginning 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 herself.

Do not leave this item blank.

If any part of the date is unknown, enter "9" as unknown
Example: 99/12/2004 or 99/99/9999

This item is used to determine the length of gestation (with the date of birth), which is related to infant morbidity and mortality. Length of gestation is associated with birth weight in determining the maturity of the infant at birth and this is important in medical research.

32. Item #33- PLURALITY - Single, Twin, Triplet, etc. (Specify)

Specify the birth as single = 1, twin = 2, triplet = 3, quadruplet = 4, etc.

Do not leave this item blank.

33. Item #34- IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify)

Specify the order in which this child was born - first, second, third, etc.

If a single birth, leave blank

34. Item #35- MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? (Yes or No)

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.

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

35. Item #31- CIGARETTE SMOKING BEFORE AND DURING PREGNANCY

For each time period, enter either the number of cigarettes or the number of packs of cigarettes smoked. IF NONE, ENTER "0".

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

Do not leave this item blank.

36. Item #59- ALCOHOL USE DURING PREGNANCY

Check the appropriate box

Check "yes" for alcohol use if the mother consumed alcoholic beverages at any time during her 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", for EBC hospitals enter "1". Shade "no" if the mother did not consume any alcoholic beverages during the entire pregnancy. If "no" is checked, do not make any entry on the line requesting the average number of drinks per day.

Do not leave this item blank.

CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

Cause of death allows for the tabulation of fetal deaths by cause and the selection of the leading causes of fetal death. Tabulations are also produced with other variables such as length of gestation and prenatal care.

This information should be provided by the certifying physician.

18a-39. CHECK BOX ITEMS

The following medical and health items are formatted into check boxes. It has been demonstrated that this format produces higher quality and more complete information than open-ended items do. Please review each check box listed, and carefully shade in the appropriate block(s). Clearly check in the block. The mark should not overlap more than one box.

37. Item #18a- INITIATING CAUSE/CONDITION

Among the choices below, please select the one, which most likely began the sequence of events resulting in the death of the fetus

Maternal Conditions/Diseases
(Specify)_____
Complications of Placenta, Cord, or Membranes
- □ Rupture of membranes prior to onset of labor
- □ Placental insufficiency
- □ Prolapsed cord
- □ Chorioamnionitis
- □ Other (specify) _____

Other Obstetrical or Pregnancy Complications
(Specify)_____
Fetal Anomaly (Specify) _____
Fetal Injury (Specify)_____
Fetal Infection (Specify) _____
Other Fetal Conditions/Disorders (Specify)_____
□ Unknown

38. Item #18b- OTHER SIGNIFICANT CAUSES OR CONDITIONS

Select or specify all other conditions contributing to the death in item 18a

Maternal Conditions/Diseases (Specify)_____
Complications of Placenta, Cord, or Membranes

□ Rupture of membranes prior to onset of labor
□ Placental insufficiency
□ Prolapsed cord
□ Chorioamnionitis
□ Other (specify) _____

Other Obstetrical or Pregnancy Complications
(specify)_____
Fetal Anomaly (Specify) _____
Fetal Injury (Specify)_____
Fetal Infection (Specify) _____
Other Fetal Conditions/Disorders
(Specify)_____
□ Unknown

39. Item #18c- WEIGHT OF FETUS (grams preferred, specify Unit*)*

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

Enter the 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, either "grams", or "pounds and ounces".

40. Item #18d- OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY

Enter the estimated weeks of gestation at the time of delivery

Do not leave this item blank.

41. Item #18e- ESTIMATED TIME OF FETAL DEATH:

Check the appropriate box that best describes the estimated time of the fetal death.

□ Dead at first assessment, no labor ongoing
□ Dead at time of first assessment labor ongoing
□ Died during labor, after first assessment
□ Unknown time of fetal death

Do not leave this item blank.

42. Item #18f- WAS AN AUTOPSY PERFORMED?

Check the appropriate box.

□ Yes □ No □ Planned

43. Item #18g- WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?

Check the appropriate box.

□ Yes □ No □ Planned

44. Item #18h- WERE AUTOPSY RESULTS OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?

Check the appropriate box.

□ Yes □ No

45. Item #36- RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

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.

Diabetes

- □ Prepregnancy (Diagnosis prior to this pregnancy)
- □ Gestational (Diagnosis during this pregnancy)

Hypertension

- □ Prepregnancy (Chronic)
- □ Gestational (PIH, Preeclampsia)
- □ Eclampsia

□ Previous preterm birth

□ Other previous poor pregnancy outcome (Includes Perinatal death, small for gestational age intrauterine growth restricted birth)

□ Pregnancy result from infertility treatment-if yes, check all that apply

- □ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
- □ Assisted reproductive technology (e.g., in vetro Fertilization (IVF), gamete intrafallopian transfer (GIFT)

□ Mother had a previous cesarean delivery (If yes, how many _____)

□ None of the above

46. Item #37- INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

- □ Gonorrhea
- □ Syphilis
- □ Chlamydia
- □ Listeria
- □ Group B Streptococcus
- □ Cytomegalovirus
- □ Parvovirus
- □ Toxoplasmosis
- □ None of the above
- □ Other (specify) _____

47. Item #38- METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?

□ Yes □ No

B. Was delivery with vacuum extraction attempted but unsuccessful?

C. Fetal presentation at delivery

□Cephalic □Breech □ Other

D. Final route and method of delivery (Check one)

- □ Vaginal/Spontaneous
- □ Vaginal/Forceps
- □ Vaginal/Vacuum
- □ Cesarean

If cesarean, was a trial of labor attempted?

□ Yes □No

48. Item #39- MATERNAL MORBIDITY (Check al that apply) (Complications associated with labor and delivery)

- □ Maternal transfusion
- □ Third or forth degree perineal laceration
- □ Ruptured uterus
- □ Unplanned hysterectomy
- □ Admission to intensive care unit
- □ Unplanned operation room procedure following delivery
- □ None of the above

49. Item #40- CONGENITAL ANOMALIES OF THE FETUS (Check all that apply)

□ Anencephaly
□ Meningomyelocele/Spina bifida
□ Cyanotic congenital heart disease
□ Congenital diaphragmatic hernia
□ Omphalocele
□ Gastroschisis
□ Limb reduction defect (excluding congenital amputation and dwarfing syndromes)
□ Cleft lip with or without Cleft palate
□ Cleft palate alone
□ Down Syndrome: Karyotype □ confirmed □ pending
□ Suspected Chromosomal disorder: Karyotype □ confirmed □ pending
□ Hypospadias
□ None of the anomalies listed above

APPENDIX A

FOUNDLINGS

A foundling infant (a living infant of unknown parentage) may be brought to a hospital for examination and care. Montana law requires the filing of a written report for such infants (50-15-203, M.C.A). For specific instructions regarding the completion of a birth certificate for a foundling, contact the Office of Vital Statistics, State Department of Public Health and Human Services, PO Box 4210, Helena, MT 59604.

MONTANA'S SAFE HAVEN NEWBORN PROTECTION ACT

This law helps parents who decide they cannot take care of a newborn baby under the age of 30 days. Parents can "give up" a baby to a hospital, fire department, police or sheriff's department or to another emergency services provider. The law protects parents from being charged with a crime involving the abandonment as long as the baby does not show signs of abuse or neglect.

What information must the parent provide when giving up the baby?

No information is required. Any information they voluntarily provide will help Child and Family Services Division to keep the baby safe and healthy. All information they provide will be kept confidential and will follow the baby. The following information is important: The name of the baby's parents and the date, place and time of the birth of the baby. If a safe haven baby needs a birth certificate contact the Office of Vital Statistics for guidance @ 444-5249.

APPENDIX B

HOSPITAL BIRTH WORKSHEETS

Many hospitals use specially prepared worksheets for the accumulation of information on births or fetal deaths. Such worksheets frequently reflect the information required for the filling in of certificates of live birth or fetal deaths. Some hospitals use these worksheets as "pre-admission" forms and provide them for the use of expectant mothers.

The following worksheet is included only as an example of hospital birth worksheets. It is related to items on the Montana Certificate of Live Birth and Fetal Death.

APPENDIX B

HOSPITAL WORKSHEET

CHILD'S NAME (First)	(Middle)	(Last and Suffix if applicable)	DATE OF BIRTH	SEX

FACILITY-NAME (If not institution, give street and number	CITY OR LOCATION OF BIRTH	COUNTY OF BIRTH	TIME OF BIRTH

PLACE OF BIRTH:
□ Hospital □ Freestanding birthing center □ Clinic/Doctor's Office □ Home birth: planned to deliver at home? □Yes □ No □ Other (Specify)_____

I certify that this child was born alive at the place and Time and on the date stated Signature	DATE SIGNED	ATTENDANT'S NAME, TITLE and NPI (If other than certifier) NPI_____
CERTIFIER'S NAME AND TITLE	MAILING ADDRESS (Street Number or Rural Route Number, City or Town, State, Zip Code)	

MOTHER 'S FULL MAIDEN NAME (First, Middle, Maiden Last Name)	BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)

Does Mother live on a Reservation: Yes/No If yes list what reservation:_____

RESIDENCE – STATE	COUNTY	CITY OR TOWN, AND ZIP CODE	STREET AND NUMBER	INSIDE CITY LIMITS

FATHER'S CURRENT LEGAL NAME (First, Middle, Last)	BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)

Does Father live on a Reservation: Yes/No If yes list what reservation:_____

I certify that the personal information provided on this certificate is correct to the best Of my knowledge and belief Signature of Parent or Other Informant	MOTHER'S MAILING ADDRESS (If same as residence, enter Zip code Only)

Permission is given to provide Social Security Administration with information from this certificate to obtain a Social Security card for this child?

Yes / No Signature of Parent:

Consent to be notified of available health services? Yes/No

CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? □ Yes □ No □ Unknown

MOTHER'S EDUCATION *(Specify only the highest diploma or degree received)*
- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no Degree
- ☐ Associates Degree (e.g. AA, AS)
- ☐ Bachelor's Degree (e.g. BA, AB, BS)
- ☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD

MOTHER OF HISPANIC ORIGIN? Check the box that best describes whether the mother is Spanish/Hispanic/ Latino. Check the "No" box if the mother is not Spanish/ Hispanic/Latino.
- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino

(Specify)_____

MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify) _____
- ☐ Other Pacific Islander (Specify)_____
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Other (Specify) _____

FATHER'S EDUCATION *(Specify only the highest diploma or degree received)*
- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no Degree
- ☐ Associates Degree (e.g. AA, AS)
- ☐ Bachelor's Degree (e.g. BA, AB, BS)
- ☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD

FATHER OF HISPANIC ORIGIN? Check the box that best describes whether the father is Spanish/Hispanic/ Latino. Check the "No" box if the father is not Spanish/ Hispanic/Latino.
- ☐ No, not Spanish/Hispanic/Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latino

(Specify)_____

FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify) _____
- ☐ Other Pacific Islander (Specify)_____
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Other (Specify) _____

Was Mother Ever Married ☐ Yes ☐ No	Was Mother Married at Conception, Birth or Anytime between? ☐ Yes ☐ No	Was Mother Married to the Father? ☐ Yes ☐ No	Will Husband Sign Non-Paternity Affidavit? ☐ Yes ☐ No	Will Father sign Paternity Affidavit? ☐ Yes ☐ No

MOTHER'S SOCIAL SECURITY NUMBER:	FATHER'S SOCIAL SECURITY NUMBER:	PRINCIPAL OF PAYMENT FOR DELIVERY: ☐Private insurance ☐ Medicaid ☐ Self-pay ☐ Other (Specify)_____

FACILITY ID. (NPI)	DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)	DID MOTHER GET WIC FOOD DURING PREGNANCY? □Yes □ No

COMPLETE REVERSE SIDE

APPENDIX B
HOSPITAL WORKSHEET CONTINUED

NUMBER OF PREVIOUS LIVE BIRTHS *(Do not include this child)*		NUMBER OF OTHER PREGNANCY OUTCOMES *(Spontaneous & induced losses or ectopic pregnancies)*	DATE OF FIRST PRENATAL CARE VISIT (mm,dd,yyyy) or □ No prenatal care	DATE OF LAST PRENATAL CARE VISIT (mm,dd,yyyy)	TOTAL NUMBER OF PRENATAL VISITS- *(If none, enter "0")*
Now Living Number___ □ None	Now Dead Number___ □ None	Other Outcomes Number_____ □ None	BIRTH WEIGHT (*grams preferred, specify Unit)*	OBSTETRIC ESTIMATE OF GESTATION (Completed weeks)	PLURALITY—Single, Twin Triplet, etc. *(Specify)*
DATE OF LAST LIVE BIRTH *(mm,yyyy)*		DATE OF LAST OTHER PREGNANCY OUTCOME *(mm,yyyy)*	IS INFANT BEING BREASTFED AT DISCHARGE? □ Yes □ No	IF NOT SINGLE BIRTH –Born First, Second, Third, Etc. (Specify)	IS INFANT LIVING AT TIME OF REPORT □ Yes □No

APGAR SCORE		MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? □Yes □ No If yes, enter name of facility transferred from:	INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY If yes, enter name of facility transferred to: □ Yes □ No
5 Minute	10 Minutes		

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

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

Alcohol use during pregnancy □ Yes □No
If yes, average number of drinks per week _____

MOTHER'S HEIGHT _____ (feet/inches) | MOTHER'S PREPREGNANCY WEIGHT _____ (pounds) | MOTHER'S WEIGHT AT DELIVERY _____(pounds)

HEP B VACCINATION INFORMATION – INFANT
Hep B Birth Dose Given □ Yes □ No □ Parent Refused □ Unknown
Hep B Administration Date: (mm,dd,yyyy) _____ Time:_____ am / pm

HEP B TESTING INFORMATION- MOTHER
HBsAg Test Date: (mm,dd,yyyy) _____
HBsAg Test Result □ Positive-Reactive □ Negative-Nonreactive □ Unknown

CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? □ Yes □ No □ Unknown

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

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

MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

Diabetes
- □ Prepregnancy (Diagnosis prior to this pregnancy)
- □ Gestational (Diagnosis during this pregnancy)

Hypertension
- □ Prepregnancy (Chronic)
- □ Gestational (PIH, Preeclampsia)
- □ Eclampsia
- □ Previous preterm birth
- □ Other previous poor pregnancy outcome (Includes Perinatal death, small for gestational age intrauterine growth restricted birth)
- □ Pregnancy result from infertility treatment-if yes, check all that apply
  - □ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
  - □ Assisted reproductive technology (e.g., in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT)
- □ Mother had a previous cesarean delivery
  If yes, how many _____
- □ None of the above

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

OBSTETRIC PROCEDURES (Check all that apply)
- □ Cervical cerciage
- □ Tocolysis

External cephalic version:
- □ Successful
- □ Failed
- □ None of the above

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

CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
- □ Induction of labor
- □ Augmentation of labor
- □ Non-vertex presentation
- □ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- □ Antibiotics received by the mother during labor
- □ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38ºC (100.4ºF)
- □ Moderate/heavy Meconium staining of the amniotic fluid
- □ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- □ Epidural or spinal anesthesia during labor
- □ None of the above

METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?
   □ Yes □ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
   □ Yes □ No

C. Fetal presentation at birth
   □ Cephalic □ Breech □ Other

D. Final route and method of delivery (Check one)
   a. Vaginal/Spontaneous
   b. Vaginal/Forceps
   c. Vaginal/Vacuum
   d. Cesarean

   If cesarean, was a trial of labor attempted?
   □ Yes
   □ No

MATERNAL MORBIDITY (Check all that apply)
(Complications associated with labor and delivery)
- □ Maternal transfusion
- □ Third or fourth degree perineal laceration
- □ Ruptured uterus
- □ Unplanned hysterectomy
- □ Admission to intensive care unit
- □ Unplanned operative room procedure following delivery
- □ None of these above

APPENDIX C

REQUIREMENTS FOR FILING AN UNATTENDED HOMEBIRTH

A completed home birth worksheet should be used to collect the birth information prior to completing the blank birth certificate form.

Documentation to substantiate the facts of this birth are required unless the certifier is a midwife who is on the Office of Vital Statistics approved list or a physician or physician's designee is involved in the delivery. Documents used as proof of the fact of birth must be dated within 30 days of the date of birth and must establish the following:

1. Proof of live birth and proof of pregnancy,
    a. Mom's lab test
    b. Ultrasound
    c. Record of office visits
2. Proof of residence in Montana at the time of birth or proof that the birth occurred in Montana.

The following may be submitted as proof of live birth:

1. A copy of the medical record of the child if he or she was seen shortly after birth by any of the following: physician, registered nurse, nurse practitioner or public health nurse.
2. The laboratory results of the metabolic screening test (PKU). The blood sample must have been collected within ten days of the birth and forwarded to the laboratory within twenty-four hours following collection.
3. A notarized affidavit from the mother's employer confirming the dates of her pregnancy or the fact that she had a live baby recently.
4. A notarized affidavit by a public official that confirms the live birth of the child to this mother. The public official must have personal knowledge of the live birth.
5. Insurance policy that identities the child's date and place of live birth.
6. The child's certified blessing or baptismal certificate. The blessing or baptismal certificate must either have a raised seal of the church or be accompanied by a notarized statement from the church minister or other church official.

The following may be submitted as proof of pregnancy:

1. Copy of mother's pregnancy lab tests
2. Copy of ultrasound
3. Copy of doctor record of pregnancy visits
4. A copy of the mother's prenatal or postnatal medical care record.

These should have mother's name, date of service, name of lab, hospital, or clinic

The following documents (listing street address or rural route) may be submitted as proof of residence:

1. Utility service or telephone statements at the time of the child's birth.
2. Bank statement at the time of the child's birth.
3. Social service records at the time of the child's birth if parent(s) or child were receiving public assistance (e.g. WIC, Food Stamps, Medicaid), or child support records
4. Mail- Personalized delivery through the U.S. Postal Service and cancelled by said agency. This must be postmarked at or near time of child's birth.
5. Rent or mortgage receipts at the time of the child's birth; a notarized statement from the landlord may also be required.

Note: Other documents may be accepted as proof of birth or proof of residence at the discretion of the State Registrar.

APPENDIX C

HOMEBIRTH WORKSHEET

CHILD'S NAME (First)	(Middle)	(Last and Suffix if applicable)	DATE OF BIRTH	SEX

FACILITY-NAME (If not institution, give street and number	CITY OR LOCATION OF BIRTH	COUNTY OF BIRTH	TIME OF BIRTH

PLACE OF BIRTH:
□ Hospital □ Freestanding birthing center □ Clinic/Doctor's Office □ Home birth: planned to deliver at home? □Yes □ No □ Other (Specify)_____

I certify that this child was born alive at the place and Time and on the date stated Signature	DATE SIGNED	ATTENDANT'S NAME, TITLE and NPI (If other than certifier) NPI_____
CERTIFIER'S NAME AND TITLE	MAILING ADDRESS (Street Number or Rural Route Number, City or Town, State, Zip Code)	

MOTHER 'S FULL MAIDEN NAME (First, Middle, Maiden Last Name)	BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)

Does Mother live on a Reservation: Yes/No If yes list what reservation:_____

RESIDENCE – STATE	COUNTY	CITY OR TOWN, AND ZIP CODE	STREET AND NUMBER	INSIDE CITY LIMITS

FATHER'S CURRENT LEGAL NAME (First, Middle, Last)	BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)

Does Father live on a Reservation: Yes/No If yes list what reservation:_____

I certify that the personal information provided on this certificate is correct to the best Of my knowledge and belief Signature of Parent or Other Informant	MOTHER'S MAILING ADDRESS (If same as residence, enter Zip code Only)

Permission is given to provide Social Security Administration with information from this certificate to obtain a Social Security card for this child?

Yes / No Signature of Parent:

Consent to be notified of available health services? Yes/No
CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? □ Yes □ No □ Unknown

MOTHER'S EDUCATION *(Specify only the highest diploma or degree received)*	MOTHER OF HISPANIC ORIGIN? Check the box that best describes whether the mother is Spanish/Hispanic/ Latino. Check the "No" box if the mother is not Spanish/ Hispanic/Latino.	MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
☐ 8th grade or less ☐ 9th-12th grade: No Diploma ☐ High School graduate or GED completed ☐ Some college but no Degree ☐ Associates Degree (e.g. AA, AS) ☐ Bachelor's Degree (e.g. BA, AB, BS) ☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA) ☐ Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD	☐ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (Specify)_____	☐ White ☐ Black or African American ☐ Native Hawaiian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Guamanian or Chamorro ☐ Korean ☐ Vietnamese ☐ Samoan ☐ Other Asian (Specify) _____ ☐ Other Pacific Islander (Specify)_____ ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ ☐ Other (Specify) _____

FATHER'S EDUCATION *(Specify only the highest diploma or degree received)*	FATHER OF HISPANIC ORIGIN? Check the box that best describes whether the father is Spanish/Hispanic/ Latino. Check the "No" box if the father is not Spanish/ Hispanic/Latino.	FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)
☐ 8th grade or less ☐ 9th-12th grade: No Diploma ☐ High School graduate or GED completed ☐ Some college but no Degree ☐ Associates Degree (e.g. AA, AS) ☐ Bachelor's Degree (e.g. BA, AB, BS) ☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA) ☐ Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD	☐ No, not Spanish/Hispanic/Latino ☐ Yes, Mexican, Mexican American, Chicano ☐ Yes, Puerto Rican ☐ Yes, Cuban ☐ Yes, other Spanish/Hispanic/Latino (Specify)_____	☐ White ☐ Black or African American ☐ Native Hawaiian ☐ Asian Indian ☐ Chinese ☐ Filipino ☐ Japanese ☐ Guamanian or Chamorro ☐ Korean ☐ Vietnamese ☐ Samoan ☐ Other Asian (Specify) _____ ☐ Other Pacific Islander (Specify)_____ ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ ☐ Other (Specify) _____

Was Mother Ever Married	Was Mother Married at Conception, Birth or Anytime between?	Was Mother Married to the Father?	Will Husband Sign Non-Paternity Affidavit?	Will Father sign Paternity Affidavit?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

MOTHER'S SOCIAL SECURITY NUMBER:	FATHER'S SOCIAL SECURITY NUMBER:	PRINCIPAL OF PAYMENT FOR DELIVERY: ☐Private insurance ☐ Medicaid ☐ Self-pay ☐ Other (Specify)_____	17. FACILITY ID. (NPI)

DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)	MOTHER'S BLOOD TESTED (Yes or No and Date)(mm,yyyy) □Yes □ No /	DID MOTHER GET WIC FOOD DURING PREGNANCY? □Yes □ No

COMPLETE REVERSE SIDE

APPENDIX C
HOMEBIRTH WORKSHEET CONTINUED

NUMBER OF PREVIOUS LIVE BIRTHS *(Do not include this child)*		NUMBER OF OTHER PREGNANCY OUTCOMES *(Spontaneous & induced losses or ectopic pregnancies)*	DATE OF FIRST PRENATAL CARE VISIT (mm,dd,yyyy) or □ No prenatal care	**DATE OF LAST PRENATAL CARE VISIT (mm,dd,yyyy)**	TOTAL NUMBER OF PRENATAL VISITS- *(If none, enter "0")*
Now Living Number___ □ None	Now Dead Number___ □ None	Other Outcomes Number_____ □ None	BIRTH WEIGHT (*grams preferred, specify Unit)*	**OBSTETRIC ESTIMATE OF GESTATION (Completed weeks)**	PLURALITY—Single, Twin Triplet, etc. *(Specify)*
DATE OF LAST LIVE BIRTH *(mm,yyyy)*		DATE OF LAST OTHER PREGNANCY OUTCOME *(mm,yyyy)*	IS INFANT BEING BREASTFED AT DISCHARGE? □ Yes □ No	**IF NOT SINGLE BIRTH –Born First, Second, Third, Etc. (Specify)**	IS INFANT LIVING AT TIME OF REPORT □ Yes □No

APGAR SCORE		MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? □Yes □ No If yes, enter name of facility transferred from:	INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY If yes, enter name of facility transferred to: □ **Yes** □ **No**
5 Minute	10 Minutes		

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

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

Alcohol use during pregnancy
□ Yes □No
If yes, average number of drinks per week
_____

MOTHER'S HEIGHT _____ (feet//inches) | MOTHER'S PREPREGNANCY WEIGHT _____ (pounds) | MOTHER'S WEIGHT AT DELIVERY _____(pounds)

HEP B VACCINATION INFORMATION – INFANT
Hep B Birth Dose Given □ Yes □ No □ Parent Refused □ Unknown
Hep B Administration Date: (mm,dd,yyyy) _____ Time:_____ am / pm

HEP B TESTING INFORMATION- MOTHER
HBsAg Test Date: (mm,dd,yyyy) _____
HBsAg Test Result □ Positive-Reactive □ Negative-Nonreactive □ Unknown

CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? □ Yes □ No □ Unknown

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

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

MEDICAL RISK FACTORS FOR THIS PREGNANCY (Check all that apply)

Diabetes
- □ Prepregnancy (Diagnosis prior to this pregnancy)
- □ Gestational (Diagnosis during this pregnancy)

Hypertension
- □ Prepregnancy (Chronic)
- □ Gestational (PIH, Preeclampsia)
- □ Eclampsia
- □ Previous preterm birth
- □ Other previous poor pregnancy outcome (Includes Perinatal death, small for gestational age intrauterine growth restricted birth)
- □ Pregnancy result from infertility treatment-if yes, check all that apply
  - □ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
  - □ Assisted reproductive technology (e.g., in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT)
- □ Mother had a previous cesarean delivery
  If yes, how many _____
- □ None of the above

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

OBSTETRIC PROCEDURES (Check all that apply)
- □ Cervical cerciage
- □ Tocolysis

External cephalic version:
- □ Successful
- □ Failed
- □ None of the above

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

CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
- □ Induction of labor
- □ Augmentation of labor
- □ Non-vertex presentation
- □ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- □ Antibiotics received by the mother during labor
- □ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38ºC (100.4ºF)
- □ Moderate/heavy Meconium staining of the amniotic fluid
- □ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- □ Epidural or spinal anesthesia during labor
- □ None of the above

METHOD OF DELIVERY

E. Was delivery with forceps attempted but unsuccessful?
□ Yes □ No

F. Was delivery with vacuum extraction attempted but unsuccessful?
□ Yes □ No

G. Fetal presentation at birth
□ Cephalic □ Breech □ Other

H. Final route and method of delivery (Check one)
- e. Vaginal/Spontaneous
- f. Vaginal/Forceps
- g. Vaginal/Vacuum
- h. Cesarean

If cesarean, was a trial of labor attempted?
□ Yes
□ No

MATERNAL MORBIDITY (Check all that apply)
(Complications associated with labor and delivery)
- □ Maternal transfusion
- □ Third or fourth degree perineal laceration
- □ Ruptured uterus
- □ Unplanned hysterectomy
- □ Admission to intensive care unit
- □ Unplanned operative room procedure following delivery
- □ None of these above

APPENDIX D

FORM V.S. 6 (2003 revision)

MONTANA CERTIFICATE OF LIVE BIRTH

Local File Number

State File Number

CHILD

1. CHILD'S NAME *(First)*	*(Middle)*	*(Last and Suffix if applicable)*	4. DATE OF BIRTH *(Month, Day, Year)*	3. SEX
5. FACILITY—NAME *(If not institution, give street and number)*	6. CITY, TOWN, OR LOCATION OF BIRTH	7. COUNTY OF BIRTH	2. TIME OF BIRTH (2400 hour clock)	

CERTIFIER

26. PLACE OF BIRTH: ☐ Hospital ☐ Freestanding birthing center ☐ Clinic/Doctor's Office ☐ Home birth: planned to deliver at home? ☐Yes☐ No ☐ Other (Specify) _____

11a. I certify that this child was born alive at the place and time and the date stated; Signature:	12. DATE CERTIFIED *(Mo, Day, Yr)*	27. ATTENDANT'S NAME , TITLE AND NPI *(If other than Certifier)* NPI_____
11. CERTIFIER'S NAME AND TITLE	11b, MAILING ADDRESS (Street Number or Rural Route Number, City, Town, State, Zip Code)	
13a. LOCAL REGISTRAR'S SIGNATURE	13. DATE FILED BY REGISTRAR *(Month, Day, Year)*	

MOTHER

8a. MOTHER'S FULL MAIDEN NAME (*First, Middle, & Maiden Last Name)*			8d. BIRTHPLACE *(State or Foreign Country)*	8b. DATE OF BIRTH *(Month, Day, Year)*
9a. RESIDENCE – S	9b. COUNTY	9c. CITY, OR TOWN AND ZIP CODE	9d. STREET AND NUMBER	9g. INSIDE CITY LIMITS (Yes or No) ☐ Yes ☐No

FATHER

10a. FATHER'S CURRENT LEGAL NAME *(First, Middle, Last)*	10c. BIRTHPLACE *(State or Foreign Country)*	10b. DATE OF BIRTH *(Month, Day, Year)*

I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief. **Signature of Parent or Informant**	14. MOTHERS MAILING ADDRESS *(If same as residence Enter Zip Code only)*

16. Permission is given to provide the Social Security Administration with information from this certificate to obtain a Social Security card for this child.
☐ Yes ☐No Signature of Parent _____

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

20. MOTHER'S EDUCATION *(Specify only the highest diploma or degree r*
- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no Degree
- ☐ Associates Degree (e.g. AA, AS)
- ☐ Bachelor's Degree (e.g. BA, AB, BS)
- ☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD

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

No, not Spanish/Hispanic/Latino
Yes, Mexican, Mexican American, Chicano
Yes, Puerto Rican
Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify)_____

22.MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify) _____
- ☐ Other Pacific Islander (Specify)_____
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Other (Specify) _____

23. FATHER'S EDUCATION (Specify only the highest diploma or degree r
- ☐ 8th grade or less
- ☐ 9th-12th grade: No Diploma
- ☐ High School graduate or GED completed
- ☐ Some college but no Degree
- ☐ Associates Degree (e.g. AA, AS)
- ☐ Bachelor's Degree (e.g. BA, AB, BS)
- ☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
- ☐ Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD)

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

No, not Spanish/Hispanic/Latino
Yes, Mexican, Mexican American, Chicano
Yes, Puerto Rican
Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify)_____

25.FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)
- ☐ White
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Guamanian or Chamorro
- ☐ Korean
- ☐ Vietnamese
- ☐ Samoan
- ☐ Other Asian (Specify) _____
- ☐ Other Pacific Islander (Specify)_____
- ☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
- ☐ Other (Specify) _____

18. MOTHER'S SOCIAL SECURITY NUMBER:	19. FATHER'S SOCIAL SECURITY NUMBER	38. PRINCIPAL SOURCE OF PAYMENT FOR DELIVERY ☐ Private insurance ☐ Medicaid ☐ Self-pay ☐ Other (Specify)_____	17. FACILITY ID. (NPI)

15a. MOTHER MARRIED EVER? ☐ Yes ☐No	15. MOTHER MARRIED? *(At birth, conception, or any time between)* ☐ Yes ☐No If No, has Paternity Acknowledgment been signed In the hospital? ☐ Yes ☐No	39. DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)	**34.** DID MOTHER GET WIC FOOD DURING PREGNANCY? ☐ Yes ☐No

APPENDIX D

Montana Certificate of Live Birth

35. NUMBER OF PREVIOUS LIVE BIRTHS *(Do not include this child)*	36. NUMBER OF OTHER PREGNANCY OUTCOMES *(Spontaneous & induced losses or ectopic pregnancies)*	29a. DATE OF FIRST PRENATAL CARE VISIT (mm,dd,yyyy) or ☐ No prenatal care	**29b. DATE OF LAST PRENATAL CARE VISIT (mm,dd,yyyy)**	30. TOTAL NUMBER OF PRENATAL VISITS- *(If none, enter "0")*

35aNow Living Number___ ☐	35b. Now Dead Number___ ☐ None	36a. Other Outcomes Number_____ ☐ None	49. BIRTH WEIGHT (*grams preferred, specify Unit)*	**50. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY. IF A FRACTION OF A WEEK IS GIVEN (E.G. 32.2 WEEKS) ROUND DOWN TO THE NEXT WHOLE WEEK (E.G. 32 WEEKS) (Completed weeks)**	52. PLURALITY—Single, Twin Triplet, etc. ***(Specify)***

35c.DATE OF LAST LIVE BIRTH *(mm,*	36b. DATE OF LAST OTHER PREGNANCY OUTCOME *(mm,yyyy)*	58. IS INFANT BEING BREASTFED AT DISCHARGE? INFORMATION ON WHETHER THE INFANT WAS BEING BREAST-FED DURING THE PERIOD BETWEEN BIRTH AND DISCHARGE FROM THE HOSPITAL ☐ **Yes** ☐**No**	**53. IF NOT SINGLE BIRTH –Born First, Second, Third, Etc. (Specify)**	57. IS INFANT LIVING AT TIME OF REPORT ☐ Yes ☐No

51. APGAR SCORE		28. MOTHER TRANSFERRED FOR MAINTENANCE MEDICAL OR FETAL INDICATIONS FOR DELIVERY ☐ Yes ☐No If yes, enter name of facility transferred from:	56. INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY If yes, enter name of facility transferred to: ☐ **Yes** ☐**No**
5 Minute	10 Minutes		

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

Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_____	OR	_____
First Three Months of Pregnancy	_____	OR	_____
Second Three Months of Pregnancy	_____	OR	_____
Third Trimester of Pregnancy	_____	OR	_____

59. Alcohol use during pregnancy
☐ Yes ☐No
If yes, average number of drinks per week
_____

31. MOTHER'S HEIGHT _____ (feet//inches)

32. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)

33. MOTHER'S WEIGHT AT DELIVERY _____(pounds)

54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)
- ☐ Assisted ventilation required immediately following delivery
  Excludes free flow oxygen only, laryngoscopy for aspiration of meconium and nasal cannula
- ☐ Assisted ventilation required for more than six hours
  Excludes free flow oxygen only, laryngoscopy for aspiration of meconium and nasal cannula
- ☐ NICU admission
- ☐ Newborn given surfactant replacement therapy
- ☐ Antibiotics received by the newborn for suspected neonatal sepsis
- ☐ Seizure or serious neurologic dysfunction
- ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and /or soft tissue/solid organ hemorrhage which requires intervention
- ☐ None of the above

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

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

Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis during this pregnancy)

Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, Preeclampsia)
- ☐ Eclampsia

☐ Previous preterm birth

☐ Other previous poor pregnancy outcome (Includes Perinatal death, small for gestational age intrauterine growth restricted birth)

☐ Pregnancy result from infertility treatment-if yes, check all that apply
- ☐ Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination
- ☐ Assisted reproductive technology (e.g., in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT)

☐ Mother had a previous cesarean delivery
If yes, how many _____

☐ None of the above

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

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

External cephalic version:
- ☐ Successful
- ☐ Failed

☐ None of the above

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

45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)
- ☐ Induction of labor
- ☐ Augmentation of labor
- ☐ Non-vertex presentation
- ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
- ☐ Antibiotics received by the mother during labor
- ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38ºC (100.4ºF)
- ☐ Moderate/heavy Meconium staining of the amniotic fluid
- ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
- ☐ Epidural or spinal anesthesia during labor
- ☐ None of the above

46. METHOD OF DELIVERY

A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐No

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐No

C. Fetal presentation at birth
☐ Cephalic ☐ Breech ☐ Other

D. Final route and method of delivery (Check one)
- ☐ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum
- ☐ Cesarean

If cesarean, was a trial of labor attempted?
☐ Yes ☐No

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

FORM V.S. 7 (2003 revision)

MONTANA CERTIFICATE OF FETAL DEATH

Local File Number

File Number

CHILD

1. NAME (Optional)*(First)* | *(Middle)* | *(Last and Suffix if applicable)* | 3. SEX *(F/M OR UNK)* | 4. DATE OF DELIVERY (*Month, Day, Year)*

8. FACILITY—NAME *(If not institution, give street and numbe* | 5. CITY, TOWN, OR LOCATION OF DELIVERY and ZIP CODE | 6. COUNTY OF DELIVER | 2. TIME OF DELIVERY **(2400 hour clock)**

CERTIFIER

7. PLACE OF WHERE DELIVERY OCCURRED (check one)
☐ Hospital ☐ Freestanding birthing center ☐ Clinic/Doctor's Office ☐ Home birth: planned to deliver at home? ☐Yes ☐ No ☐ Other (Specify) _____

9. FACILITY ID. (NPI) | 14. ATTENDANT'S NAME, TITLE AND NPI
NAME: NPI: TITLE: ☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (Specify)_____

MOTHER

10a. MOTHER'S FULL MAIDEN NAME *(First, Middle and Maiden Last)* | 10d. BIRTHPLACE *(State or Foreign Count* | 10b. DATE OF BIRTH *(Month, Day, Year)*

11a. RESIDENCE – STATE | 11b. COUNTY | 11c. CITY, OR TOWN AND ZIP CODE | 11d. STREET AND NUMBER | 11e. APT NO. | 11g. INSIDE CITY LIMITS? ☐ Yes ☐ No

FATHER

12a. FATHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)* | 12c. BIRTHPLACE *(State or Foreign Count* | 12b. DATE OF BIRTH *(Month, Day, Year)*

Registration and Disposition

15. NAME AND TITLE OF PERSON COMPLETING REPORT | 16. DATE REPORT COMPLETED

17a. LOCAL REGISTRAR'S SIGNATURE | 17. DATE FILED BY REGISTRAR *(Month, Day, Year)*

13. METHOD OF DISPOSITION
☐ Burial ☐ Cremation ☐ Hospital Disposition ☐ Donation ☐ Removal from State ☐ Other (Specify) _____

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

19. MOTHER'S EDUCATION *(Specify only the highest diploma or degree received)*
☐ 8th grade or less
☐ 9th-12th grade: No Diploma
☐ High School graduate or GED completed
☐ Some college but no Degree
☐ Associates Degree (e.g. AA, AS)
☐ Bachelor's Degree (e.g. BA, AB, BS)
☐ Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA)
☐ Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD

20. MOTHER OF HISPANIC ORIGIN? Check the box that best describes whether the mother is Spanish/Hispanic/Latino. Check the "No" box if the mother is not Spanish/Hispanic/Latino.
☐ No, not Spanish/Hispanic/Latino
☐ Yes, Mexican, Mexican American, Chicano
☐ Yes, Puerto Rican
☐ Yes, Cuban
☐ Yes, other Spanish/Hispanic/Latino
(Specify)_____

21.MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)
☐ White
☐ Black or African American
☐ Native Hawaiian
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Guamanian or Chamorro
☐ Korean
☐ Vietnamese
☐ Samoan
☐ Other Asian (Specify) _____
☐ Other Pacific Islander (Specify)_____
☐ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____
☐ Other (Specify) _____

22.MOTHER MARRIED? *(At delivery, conception, or any time between)* ☐ Yes ☐ No

22a. MOTHER EVER MARRIED? ☐ Yes ☐ No

23a. DATE OF FIRST PRENATAL CARE *(mm,dd,yyyy)* _____/_____/_____or ☐ No prenatal care

23b. DATE OF LAST PRENATAL CARE VISIT *(mm,dd,yyyy)* ____/____/____

24.TOTAL NUMBER OF PRENATAL VISITS (If none, enter "0") _____

25. MOTHER'S HEIGHT _____*(feet/inches)*

26. MOTHER'S PREPREGNANCY WEIGHT _____*(Pounds)*

27. MOTHER WEIGHT AT DELIVERY _____*(Pounds)*

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

29. NUMBER OF PREVIOUS LIVE BIRTHS *(Do not include this child)*

30. NUMBER OF OTHER PREGNANCY OUTCOMES *(Spontaneous & induced losses or ectopic pregnancies)*

32. DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year) ____/____/____

29a. Now Living Number_____

29b. Now Dead Number_____ ☐ None

30a. Other Outcomes Number (do not include this fetus) _____ ☐ None

33. PLURALITY—Single, Tw *(Specify)*

34. IF NOT SINGLE BIRTH –Born First, Second, Third, etc *(Speci*

29c.DATE OF LAST LIVE BIRTH *(mm,yyyy)* _____/_____

30b. DATE OF LAST OTHER PREGNANCY OUTCOME *(mm,yyyy)* _____/_____

35. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No If yes, enter name of facility transferred from

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

	# of cigarettes	# of
Three Months Before Pregnancy	_____ OR	_____
First Three Months of Pregnancy	_____ OR	_____
Second Three Months of Pregnancy	_____ OR	_____
Third Trimester of Pregnancy	_____ OR	_____

41. Alcohol use during pregnancy ☐ Yes ☐ No
If yes, average number of drinks per week _____

CAUSE/CONDITIONS CONTRIBUTING TO FETAL DEATH

18a. INITIATING CAUSE/CONDITION
(AMONG THE CHOICES BELOW, PLEASE SELECT THE **ONE** WHICH MOST LIKELY BEGAN THE SEQUENCE OF EVENTS RESULTING IN THE DEATH OF THE FETUS)

Maternal Conditions/Diseases
(Specify)_____

Complications of Placenta, Cord, or Membranes
- ☐ Rupture of membranes prior to onset of labor
- ☐ Abruption placenta
- ☐ Placental insufficiency
- ☐ Prolapsed cord
- ☐ Chorioamnionitis
- ☐ Other (specify) _____

Other Obstetrical or Pregnancy Complications
(specify)_____

Fetal Anomaly (Specify) _____

Fetal Injury (Specify)_____

Fetal Infection (Specify) _____

Other Fetal Conditions/Disorders (Specify)_____
- ☐ Unknown

18b. OTHER SIGNIFICANT CAUSES OR CONDITIONS
(SELECT OR SPECIFY ALL OTHER CONDITIONS CONTRIBUTING TO DEATH IN ITEM 18b)

Maternal Conditions/Diseases
(Specify)_____

Complications of Placenta, Cord, or Membranes
- ☐ Rupture of membranes prior to onset of labor
- ☐ Abruption placenta
- ☐ Placental insufficiency
- ☐ Prolapsed cord
- ☐ Chorioamnionitis
- ☐ Other (specify) _____

Other Obstetrical or Pregnancy Complications
(specify)_____

Fetal Anomaly (Specify) _____

Fetal Injury (Specify)_____

Fetal Infection (Specify) _____

Other Fetal Conditions/Disorders
(Specify)_____
- ☐ Unknown

18c. WEIGHT OF FETUS (*grams preferred, specify Unit)*
_____

18d. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY. IF A FRACTION OF A WEEK IS GIVEN (E.G. 32.2 WEEKS) ROUND DOWN TO THE NEXT WHOLE WEEK (E.G. 32 WEEKS)
(Completed weeks) _____

18e. ESTIMATED TIME OF FETAL DEATH:
- ☐ Dead at time of first assessment, no labor ongoing
- ☐ Dead at time of first assessment labor ongoing
- ☐ Died during labor, after first assessment
- ☐ Unknown time of fetal death

18f. WAS AN AUTOPSY PERFORMED?
☐ Yes ☐ No ☐ Planned

18g. WAS A HISTOLOGICAL PLACENTAL EXAMINATION PERFORMED?
☐ Yes ☐ No ☐ Planned

18h. WERE AUTOPSY OR HISTOLOGICAL PLACENTAL EXAMINATION RESULTS USED IN DETERMINING THE CAUSE OF FETAL DEATH?
☐ Yes ☐ No

36. RISK FACTORS FOR THIS PREGNANCY
(Check all that apply)

Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis during this pregnancy)

Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, Preeclampsia)
  - ☐ Eclampsia
- ☐ Previous preterm birth
- ☐ Other previous poor pregnancy outcome (includes Perinatal death, small for gestational age/intrauterine growth restricted birth)
- ☐ Pregnancy result from infertility treatment-if yes, check all that appl
- ☐ Fertility-enhancing drugs, Artificial or Intrauterine insemination
- ☐ Assisted reproductive technology (e.g., in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT))
- ☐ Mother had a previous cesarean delivery
  If yes, how many _____
- ☐ None of the above

37. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)
- ☐ Gonorrhea
- ☐ Syphilis
- ☐ Chlamydia
- ☐ Listeria
- ☐ Group B Streptococcus
- ☐ Cytomegalovirus
- ☐ Parvovirus
- ☐ Toxoplasmosis
- ☐ None of the above
- ☐ Other (specify) _____

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

38. METHOD OF DELIVERY
A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No

C. Fetal presentation at delivery
☐ Cephalic ☐ Breech ☐ Other

D. Final route and method of delivery (Check one)
- ☐ Vaginal/Spontaneous
- ☐ Vaginal/Forceps
- ☐ Vaginal/Vacuum
- ☐ Cesarean

If cesarean, was a trial of labor attempted?
☐ Yes ☐ No

E. Hysterotomy/Hysterectomy ☐ Yes ☐ No

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

MONTANA CERTIFICATE OF BIRTH RESULTING IN A STILLBIRTH

Local File Number

File Number

CHILD

1. NAME (Optional)(*First)*	*(Middle)*	*(Last and Suffix if applicable)*	3. SEX *(F/M OR UNK)*	4. DATE OF DELIVERY (*Month, Day, Year)*
8. FACILITY—NAME *(If not institution, give street and number*	5. CITY, TOWN, OR LOCATION OF DELIVERY and ZIP CODE		6. COUNTY OF DELIVERY	2. TIME OF DELIVERY (**2400 hour clock)**

CERTIFIER

7. PLACE OF WHERE DELIVERY OCCURRED (check one)

☐ Hospital ☐ Freestanding birthing center ☐ Clinic/Doctor's Office ☐ Home birth: planned to deliver at home? ☐Yes ☐ No ☐ Other (Specify) _____

9. FACILITY ID. (NPI)	14. ATTENDANT'S NAME, TITLE AND NPI NAME: NPI: TITLE: ☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (Specify)_____

MOTHER

10a. MOTHER'S FULL MAIDEN NAME *(First, Middle and Maiden Last)*			10d. BIRTHPLACE *(State or Foreign Country)*		10b. DATE OF BIRTH *(Month, Day, Year)*
11a. RESIDENCE – ST	11b. COUNTY	11c. CITY, OR TOWN AND ZIP CODE	11d. STREET AND NUMBER	11e. APT NO.	11g. INSIDE CITY LIMITS? ☐ Yes ☐ No

FATHER

12a. FATHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*	12c. BIRTHPLACE *(State or Foreign Country)*	12b. DATE OF BIRTH *(Month, Day, Year)*

Registration

15. NAME AND TITLE OF PERSON COMPLETING REPORT	16. DATE REPORT COMPLETED
17a. LOCAL REGISTRAR'S SIGNATURE	17. DATE FILED BY REGISTRAR *(Month, Day, Year)*

APPENDIX F

MONTANA DEPARTMENT OF
PUBLIC HEALTH & HUMAN SERVICES
VITAL RECORDS & STATISTICS BUREAU
PO BOX 4210
HELENA, MT 59604-4210

PATERNITY ACKNOWLEDGMENT

PLEASE PRINT USING A BLUE PEN

CHILD'S NAME (*First, Middle, Last*)	DATE OF BIRTH	SOCIAL SECURITY NUMBER
CITY OF BIRTH	HOSPITAL	
MOTHER'S NAME (*First, Middle, Last* (***MAIDEN SURNAME***))		MOTHER'S DATE OF BIRTH
MOTHER'S STATE OF BIRTH (*If Not U.S.A. Give Country*)	MOTHER'S RACE	MOTHER'S SOCIAL SECURITY NUMBER
FATHER'S NAME (*First, Middle, Last*)	FATHER'S RACE	FATHER'S DATE OF BIRTH
FATHER'S ANCESTRY	Education (Elementary/Secondary) (0-12) College (1-4 or 5+)	FATHER'S SOCIAL SECURITY NUMBER
FATHER'S STATE OF BIRTH (*If Not U.S.A. Give Country*)	FATHER'S OCCUPATION	FATHER'S PLACE OF EMPLOYMENT

BOTH PARENTS MUST SIGN BEFORE A NOTARY PUBLIC

We the natural mother and father, declare under penalty of perjury under the laws of the State of Montana that the following statements are true and correct. When completed and filed with the state registrar this Voluntary Declaration of Paternity establishes a father-child relationship identical to the relationship established when a child is born to married parents. **NOTICE TO BOTH PARENTS: THIS IS A LEGALLY BINDING DOCUMENT.** Upon signing this declaration, it becomes your duty under law to provide support and care for the child as the parent. **Do not sign** this declaration if you do not understand the legal effect of the document or you have doubts about the paternity of the child. **If you wish to withdraw this Acknowledgement, you must do so within 60 days, or before a support or paternity order for the child is entered, whichever is earlier.**

I certify that I am the natural mother. The above information is true and the man named above is the only possible father. I make this affidavit to name the natural father on my child's birth certificate. I understand the rights, responsibilities, alternatives, and consequences of signing this affidavit.

Mother's Signature:_____
Address:_____
City, State, Zip:_____
Phone Number: _____

State of: _____
County of: _____

On this_____day of_____20_____

_____ personally appeared before me. Her identity as the signer of the above instrument was proved to me, and she acknowledged that she executed it.

_____
Notary Public Signature

_____
Printed Name of Notary
(Seal) Notary Public for the State of:_____
Residing at: _____
My Commission Expires:_____

I certify that the above information is true. I make this affidavit to show that I am the natural father on my child's birth certificate. I also understand that by acknowledging paternity of this child, I accept an obligation to provide child support under the laws of the State of Montana. I understand the rights, responsibilities, alternatives, and consequences of signing this affidavit.

Father's Signature:_____
Address:_____
City, State, Zip:_____
Phone Number: _____

State of: _____
County of: _____

On this_____day of_____20_____

_____ personally appeared before me. His identity as the signer of the above instrument was proved to me, and he acknowledged that he executed it.

_____
Notary Public Signature

_____
Printed Name of Notary
(Seal) Notary Public for the State of:_____
Residing at: _____
My Commission Expires:_____

Rev. 2/05

AFFIDAVIT OF NONPATERNITY

I, _____, being duly sworn, deposes and says that: I was married
Husband's Name

to _____ on _____ in _____,
Wife's Name Date of Marriage City

_____. My wife gave birth to a _____ child in _____,
State Sex City

_____ on _____.
County Date of Birth

The name of the child is

_____. I now state that although legally married at the
Child's Name

time of this birth, I am not the father of the named child. I request that my name not

be listed on the birth certificate.

_____
Husband's Signature

_____
Street Address

_____
City, State and Zip Code

State of:_____
County of:_____

_____ Personally appeared before me and whose identity I proved on the basis of satisfactory evidence to be the signer of the above instrument.
Subscribed and sworn to before me this _____ day of _____, 20____

_____
Printed Name:_____
Notary Public for the State of:_____
Residing at:_____
My commission expires: _____

SEAL

==========

I, _____, am the mother of _____ and
Mother's Name Child's Name

I state that I was legally married at the time of the birth. My husband as listed is not the father of the above named child and I request that his name not be listed on the birth certificate.

_____
Wife's Signature (Mother)

_____
Street Address

_____
City, State and Zip Code

State of:_____
County of:_____

_____ Personally appeared before me and whose identity I proved on the basis of satisfactory evidence to be the signer of the above instrument.
Subscribed and sworn to before me this _____ day of _____, 20____

_____
Printed Name:_____
Notary Public for the State of:_____
Residing at:_____
My commission expires: _____

SEAL

APPENDIX H

THE VITAL STATISTICS REGISTRATION SYSTEM IN THE UNITED STATES

Registration of births, deaths, and fetal deaths in the United States, and other vital events*, is a state and local function. The civil laws of every state provide for a continuous and permanent birth and death registration system. Each system depends, to a very great extent, upon the conscientious efforts of the physicians, hospital personnel, funeral directors, coroners, and medical examiners in preparing or certifying information needed to complete the original records.

Each state is divided geographically into local registration districts or units, which facilitates collection of the vital records. These districts may be a township, village, town, city, county (Other geographic place), or a combination of two or more of these areas.

A local registrar is required to see that a completed certificate is filed promptly with him/her for each vital event occurring in his/her district. When a death or fetal death certificate is filed, it is his/her duty to issue an Authorization For Removal, Transportation and Final Disposition of a Dead Body form which authorizes disposition of the remains. He/She keeps a record of each event filed with him/her (and sends a copy to the local registrar).

The state vital statistics office inspects the records for promptness of filing, completeness and consistency of information, queries, if necessary, numbers, indexes, processes, and binds for permanent reference and safekeeping. Statistical information from the records is tabulated for use of state and local health departments, other governmental agencies, and various private and voluntary organizations. The data is used to evaluate health problems and to plan programs and service to the public.

An important function of the state office is to issue certified copies of the certificates to individuals in need of such records and to verify the facts of birth and death for agencies requiring legal evidence of such facts.

Copies of individual records registered in the state offices are transmitted to the National Center for Health Statistics (NCHS)**. From these copies, monthly, annual, and special statistical reports are prepared for the United States. Reports are also made for the component parts - cities, counties, states and regions. These reports show data by various characteristics; such as age, sex, race, and cause of death. The statistics are essential in the field of social welfare, public health, and demography. They are also used for various administrative purposes, both in business and in government. The NCHS serves as a focal point which exercises leadership in establishing uniform practices through model laws, standard certificate forms, handbooks, and other instructional materials.

*Vital events may be defined as live births, deaths, fetal deaths, marriages, divorces, and all other events which have to do with an individual's entrance into or departure from life, together with any changes in the civil status which may occur to him/her during his/her lifetime.

**The NCHS in the Public Health Service is vested with the authority for administering the vital statistics functions of the Federal level.

APPENDIX I

Live birth defined:
‘‘Live birth’’ means the complete expulsion or extraction from the mother as a product of conception, notwithstanding the duration of pregnancy. The birth is indicated by the fact that after expulsion or extraction, the child breathes or shows any other evidence of life, such as beating of the heart, pulsation
of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are distinguished from transient cardiac contractions. Respirations are distinguished from fleeting respiratory efforts or gasps. (Section 50-15-101, (7), Montana Code Annotated, January 1, 1996)

Fetal death defined:
‘‘Fetal Death’’ means death of the fetus prior to the complete expulsion or extraction from its mother as a product of conception, notwithstanding the duration of pregnancy. The death is indicated by the fact that after expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Heartbeats are distinguished from transient cardiac contractions. Respirations are distinguished from fleeting respiratory efforts or gasps. (Section 50-15-101, (4), Montana Code Annotated, January 1, 1996)

When fetal death reporting is required:
A person in charge of disposition of a dead body or fetus that weighs at least 350 grams at death or, if the weight is unknown, has reached 20 completed weeks of gestation at death shall obtain personal data
on the deceased or, in the case of a fetal death, on the parents that is required by the department from persons best qualified to supply the data and enter it on the death or fetal death certificate. (Section 50-15-403, (1), Montana Code Annotated, January 1, 1996)

APPENDIX J

BRIEF HISTORY OF VITAL STATISTICS IN MONTANA

The Tenth Legislative Assembly of the State of Montana, meeting in 1907, established a State Bureau of Vital Statistics and placed it under the supervision of the Secretary of the State Board of Health. The legislation provided for the "registration of births and deaths and other statistical matter relative to affairs…". It also provided for sub-registrars and the payment of a fee of 25 cents for each birth and death certificate that is filed. Section 20 of the Act provided that the Act would be effective after its passage and approval by the Governor, which was given February 20, 1907.

After passage of the Act, several months were required for Dr. Thomas Tuttle, the Secretary of the State Board of Health and first State Registrar, to appoint Local Registrars and set up the vital registration system. The first records filed, in the several Montana counties existing at that time, were filed in May, June and July of 1907. The following counties filed birth records in 1907, Beaverhead, Blaine, Broadwater, Carbon, Cascade, Choteau, Custer, Dawson, Deer Lodge, Fergus, Flathead, Gallatin, Granite, Jefferson, Lewis & Clark, Madison, Meagher, Missoula, Park, Powell, Ravalli, Rosebud, Sanders, Silver Bow, Sweet Grass, Teton, Valley and Yellowstone.

Marriages, divorces and annulments were first reported to the central state filing in 1943.

The Office of Vital Statistics is now a function of the Department of Public Health and Human Services since the merging of Health and Environmental Sciences, Social & Rehabilitative Services and Natural Resource departments. The collection of this pertinent information has continued since the beginning and the support and efforts at the local levels are a vital part of this process.