Washington State Department of Health
Health

DOH 422-020 January 2019

Washington State Birth Filing Form

Fields with asterisk (*) are required and appear on the Birth Certificate.

For Hospital Use Only

Mother/Parent's Medical Record #:	Child's Medical Record #:	Prefer Parent / Parent Labels on Birth Certificate (Default Labels are Mother / Father)	☐ Yes ☐ No

Plurality: ☐ 1- single birth ☐ 2- twin ☐ 3- triplet ☐ Other _____

If multiple, this worksheet is for child: ☐ 1- first born ☐ 2- second born ☐ 3- third born ☐ Other _____

Child's Information

*1. Child's Name

First   Middle   Last

*2. Child's Date of Birth (MM/DD/YYYY)   ***3. Time of Birth**   ***4. Child's Sex**
        /   /   ☐ Male   ☐ Female

5. Type of Birthplace
☐ Hospital   ☐ Home
☐ Enroute   ☐ Clinic/Doctor's Office
☐ Freestanding Birth Center   ☐ Other (specify):

6. Planned Birth Place, if different (specify):

*7. Name of Facility (If not a facility, enter name of place and address)   ***8. County of Birth**   ***9. City of Birth**

Mother/Parent's information

10. Mother/Parent's Current Legal Name

First   Middle   Last

*11. Full name as it appears on your Birth Certificate

First   Middle   Last

*12. Date of Birth (MM/DD/YYYY)   ***13. Birthplace** (State, Territory, or Foreign Country)   **14. Social Security Number**
        /   /

15. Do you want to get a Social Security Number for your child? ☐ Yes ☐ No

16a. Residence: Number and Street (e.g., 624 SE 5th St.)   Apt No.

16b. If not U.S.; Country   **16c. State**   **16d. County**

16e. If you live on Tribal Reservation, give name   **16f. City or Town**   **16g. Zip Code + 4**

16h. Inside City Limits?   **17. How Long at Current Residence?**   **18. Telephone Number**
☐ Yes ☐ No ☐ Unknown   Years: Months: ( )

19a. Mailing Address, if different: Number and Street, or PO Box   Apt. No.

19b. If not U.S.; Country   **19c. State**   **19d. City**   **19e. Zip Code + 4**

20. Occupation (type of work done during last year)   **21. Kind of Business/Industry** (do not use company name)

22. Mother/Parent Education Level
(Check the box that best describes the highest degree or level of school completed at the time of delivery.)

1 ☐ 8th grade or less (specify):_____
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (AA, AS, etc.)
6 ☐ Bachelor's degree (BA, AB, BS, etc.)
7 ☐ Master's degree (MA, MS, MEd, MSW, MBA, etc.)
8 ☐ Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)

23. Mother/Parent Hispanic Origin?
(Check the box that best describes whether the mother is Spanish/Hispanic/Latina or check "No" box if not Spanish/Hispanic/Latina.)

1 ☐ No, not Spanish/Hispanic/Latina
2 ☐ Yes, Mexican, Mexican American, Chicana
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, Other Spanish/Hispanic/Latina (specify):

24. Mother/Parent Race (check one or more)
1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
(Name of enrolled or principal tribe)

4 ☐ Asian Indian   5 ☐ Chinese
6 ☐ Filipino   7 ☐ Japanese
8 ☐ Korean   9 ☐ Vietnamese
10 ☐ Other Asian (specify):
11 ☐ Native Hawaiian   12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (specify):
15 ☐ Other (specify):

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Mother/Parent Information	

25. Current Height
Feet: Inches:

26. Pre-Pregnancy Weight (pounds)

27. Were WIC benefits utilized during pregnancy?
☐ Yes   ☐ No

28. Cigarette Smoking Before and During Pregnancy
☐ Yes ☐ No

Average number of cigarettes or packs per day:

	# of cigarettes		# of packs
Three months before pregnancy		or	
First three months of pregnancy		or	
Second three months of pregnancy		or	
Last three months of pregnancy		or	

Marital Status of Mother/Parent

Mother's Marital Status

29. Is Mother/Parent married? (Check only one box)

Important - Read before responding to marital status question:
If you were married at any time during your pregnancy, your spouse or partner is considered the other legal parent unless they complete a denial of parentage and another person acknowledges that they are the father/parent (chapter 26.26A RCW). To add someone other than your spouse or partner to the birth certificate, an Acknowledgment of Parentage form (DOH 422-159) and Denial of Parentage form (DOH 422-158) needs to be completed by all parties. Under Washington State law, a state-registered domestic partnership is considered the same as a marriage (chapter 26.60 RCW).

If you were not married at any time during the pregnancy, complete an Acknowledgment of Parentage form to add the father/parent to the birth certificate.

Married - Yes	Married - No
29a. ☐ Yes, I am married to the other person identified in box #30.	29d. ☐ No, I am not married. I am providing information about the father/parent in box #30. I will complete an Acknowledgement of Parentage form at the hospital. *Ask hospital staff for an Acknowledgment of Parentage form (DOH 422-159).*
29b. ☐ Yes, I am married but not to the other person identified in box #30. *Ask hospital staff for an Acknowledgment of Parentage form (DOH 422-159). You must complete this form, including the spouse's Denial of Parentage form (DOH 422-158).*	29e. ☐ No, I am not married now, but I was married to the other person identified in box #30 at some time during this pregnancy.
29c. ☐ Yes, I am married but not providing the spouse or partner's information. *If this box is checked, the other parent will be listed on the birth certificate as "None Named".*	29f. ☐ No, I am not married and not submitting a completed Acknowledgment of Parentage form with the father/parent's information. *If this box is checked, the other parent will be listed on the birth certificate as "None Named".*

Father/ Parent's Information

Father/Parent's Information

*30. Father/Parent's Current Legal Name

First   Middle   Last

*31. Date of Birth (MM/DD/YYYY)
     /   /

*32. Birthplace (State, Territory, or Foreign Country)

33. Social Security Number

34. Occupation (type of work done during last year.)

35. Kind of Business/Industry (do not use Company Name)

36. Father/Parent Education Level
(Check the box that best describes the highest degree or level of school completed at the time of delivery.)

1 ☐ 8th grade or less (specify):_____
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (AA, AS, etc.)
6 ☐ Bachelor's degree (BA, AB, BS, etc.)
7 ☐ Master's degree (MA, MS, MEd, MSW, MBA, etc.)
8 ☐ Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)

37. Father/Parent of Hispanic Origin?
(Check the box that best describes whether the father/parent is Spanish/Hispanic/Latino or check "No" box if not Spanish/Hispanic/Latino.)

1 ☐ No, not Spanish/Hispanic/Latino
2 ☐ Yes, Mexican, Mexican American, Chicano
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, other Spanish/Hispanic/Latino (specify):

38. Father/Parent Race (check one or more)

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
(Name of enrolled or principal tribe)

4 ☐ Asian Indian   5 ☐ Chinese
6 ☐ Filipino   7 ☐ Japanese
8 ☐ Korean   9 ☐ Vietnamese
10 ☐ Other Asian (specify):
11 ☐ Native Hawaiian   12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (specify):
15 ☐ Other (specify):

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Mother/Parent's Statistical Information

39. Date of <u>First</u> Prenatal Care Visit (MM/DD/YYYY) / / ☐ No Prenatal Care	**40. Date of <u>Last</u> Prenatal Care Visit** (MM/DD/YYYY) / /	**41. Total Number of Prenatal Visits for this Pregnancy** (If none, enter '0') _____
42. Number of Previous Live Births (Do not include this child) Number Now Living _____ ☐ None Number Now Dead _____ ☐ None	**43. Date of Last Live Birth** (MM/YYYY) (Do not include this child) / /	**44. Number of Other Pregnancy Outcomes** (Spontaneous or induced losses or ectopic pregnancies) Number of Other Outcomes _____ ☐ None
45. Date of Last Other Pregnancy Outcome (MM/YYYY) / /	**46. Date Last Normal Menses Began** (MM/DD/YYYY) / /	**47. Mother'/Parent's Weight at Delivery** (pounds)

48. Was mother/parent transferred to higher level care for maternal medical or fetal indications for delivery? ☐ Yes ☐ No If yes, name of facility mother/parent was transferred from:	**49. Principal Source of Payment for this Delivery** ☐ Medicaid ☐ Self-Pay ☐ Private Insurance ☐ Other Gov't ☐ Tricare ☐ Indian Health ☐ Charity Care ☐ Other _____

Child's Statistical Information

50. Birth Weight lbs: ozs: **or** grams:	**51. Infant Head Circumference** (cm)	**52. Obstetric Estimate of Gestation** (completed weeks)

53. Apgar score at 5 minutes _____ If score is less than 6, score at 10 minutes _____

54. Plurality: ☐ Single ☐ twins ☐ triplets ☐ other _____	**55. If not single birth; birth order:** ☐ first ☐ second ☐ third ☐ other _____

56. Was infant transferred within 24 hours of delivery? ☐ Yes ☐ No If yes, name of facility infant was transferred to:	**57. Is infant living at the time of report?** ☐ Yes ☐ No ☐ Transferred, status unknown	**58. Is infant being breastfed?** ☐ Yes ☐ No

Medical and Health Information

59. Risk Factors in this Pregnancy (check all that apply):

1 Diabetes
  ☐ Prepregnancy (Diagnosis prior to this pregnancy)
  ☐ Gestational (Diagnosis in this pregnancy)
2 Hypertension
  ☐ Prepregnancy (Chronic)
  ☐ Gestational (PIH, preeclampsia)
  ☐ Eclampsia
3 ☐ Previous preterm births
4 ☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
5 ☐ Vaginal bleeding during this pregnancy prior to the onset of labor
6 ☐ Pregnancy resulted 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)]
7 ☐ Mother had a previous cesarean delivery?
  If Yes, how many_____
8 ☐ Group B Streptococcus culture positive
9 ☐ None of the above

60. Infections Present and/or Treated During this Pregnancy (check all that apply):

1 ☐ Gonorrhea
2 ☐ Syphilis
3 ☐ Herpes Simplex Virus (HSV)
4 ☐ Chlamydia
5 ☐ Hepatitis B
6 ☐ Hepatitis C
7 ☐ HIV Infection
8 ☐ Other
  Specify:_____
9 ☐ None of the above

61. Maternal Morbidity (complications associated with labor and delivery) (Check all that apply):

1 ☐ Maternal transfusion
2 ☐ Third or fourth degree perineal laceration
3 ☐ Ruptured uterus
4 ☐ Unplanned hysterectomy
5 ☐ Admission to intensive care unit
6 ☐ Unplanned operating room procedure following delivery
7 ☐ None of the above

62. 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)

<u>Vaginal:</u> ☐ Spontaneous ☐ Forceps ☐ Vacuum
OR
<u>Cesarean:</u> ☐
If cesarean, was a trial of labor attempted?
  ☐ Yes ☐ No

63. Obstetric procedures (Check all that apply):

1 ☐ Cervical cerclage
2 ☐ Tocolysis
3 ☐ External cephalic version:
  ☐ Successful
  ☐ Failed
4 ☐ None of the above

64. Onset of Labor (Check all that apply):

1 ☐ Premature rupture of the membranes (Prolonged, ≥ 12hr)
2 ☐ Precipitous Labor (< 3hr)
3 ☐ Prolonged Labor (≥ 20hr)
4 ☐ None of the above

65. Characteristics of Labor and Delivery (Check all that apply):

1 ☐ Induction of labor
2 ☐ Augmentation of labor
3 ☐ Non-vertex presentation
4 ☐ Epidural or spinal anesthesia during labor
5 ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
6 ☐ Antibiotics received by the mother during labor
7 ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
8 ☐ Moderate/heavy meconium staining of the amniotic fluid
9 ☐ Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery
10 ☐ None of the above

66. Abnormal Conditions of the Newborn
(Occurring within 24 hours of delivery) (check all that apply):

1 ☐ Assisted ventilation required immediately following delivery
2 ☐ Assisted ventilation required for more than six hours
3 ☐ NICU admission
4 ☐ Newborn given surfactant replacement therapy
5 ☐ Antibiotics received by the newborn for suspected neonatal sepsis
6 ☐ Seizure or serious neurologic dysfunction
7 ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention)
8 ☐ None of the above

67. Congenital Anomalies of the Newborn
(Observed within 24 hours of delivery) (Check all that apply)

1 ☐ Anencephaly
2 ☐ Meningomyelocele / Spina bifida
3 ☐ Cyanotic congenital heart disease
4 ☐ Congenital diaphragmatic hernia
5 ☐ Omphalocele
6 ☐ Gastroschisis
7 ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndrome)

8 ☐ Cleft Lip with or without Cleft Palate
9 ☐ Cleft Palate alone
10 Down Syndrome
  ☐ Karyotype confirmed
  ☐ Karyotype pending
11 Chromosomal disorder
  ☐ Karyotype confirmed
  ☐ Suspected, Karyotype pending
12 ☐ Hypospadias
13 ☐ None of the above

Attendant and Certifier Information

68. Certifier – Name and Title	**69. Date Certified** (MM/DD/YYYY) / /
70. Attendant – Name and Title (If other than Certifier)	**71. NPI of person delivering the baby:**