NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NC VITAL RECORDS

CERTIFICATE OF LIVE BIRTH

Registration **District No.** Local No. BIRTH NO.

CHILD

1. CHILD'S NAME *(First, Middle, Last, Suffix)*

2. DATE OF BIRTH *(Month, Day, Year)*

3. TIME OF BIRTH

4. SEX

5. FACILITY NAME *(If not institution, give street and number)*

6. CITY, TOWN, OR LOCATION OF BIRTH

7. COUNTY OF BIRTH

FATHER

8a. FATHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*

8b. DATE OF BIRTH *(Month, Day, Year)*

8c. BIRTHPLACE *(State, Territory, or Foreign Country)*

MOTHER

9a. MOTHER'S CURRENT LEGAL NAME *(First, Middle, Last, Suffix)*

9b. DATE OF BIRTH *(Month, Day, Year)*

9c. MOTHER'S NAME PRIOR TO FIRST MARRIAGE *(First, Middle, Last, Suffix)*

9d. BIRTHPLACE *(State, Territory, or Foreign Country)*

10a. RESIDENCE OF MOTHER - STATE

10b. COUNTY

10c. CITY, TOWN, OR LOCATION

10d. STREET AND NUMBER

10e. ZIP CODE

10f. INSIDE CITY LIMITS? ☐ Yes ☐ No

11. MOTHER'S MAILING ADDRESS: ☐ Same as residence, or: State: City, Town, or Location:

Street and Number: Zip Code:

CERTIFIER

12. CERTIFIER'S NAME:

TITLE: ☐ MD ☐ DO ☐ HOSPITAL ADMIN. ☐ CNM/CM ☐ OTHER MIDWIFE
☐ OTHER (*Specify*)

13. DATE CERTIFIED ---------/---------/---------- MM DD YYYY

14. DATE REC'D BY LOCAL REGISTRAR ---------/---------/---------- MM DD YYYY

15. DATE NAME ADDED ---------/---------/---------- MM DD YYYY

16. DATE AMENDED ---------/---------/---------- MM DD YYYY

NEWBORN

17. BIRTHWEIGHT (grams preferred, specify unit)
☐ grams ☐ lb/oz

18. PLURALITY - Single, Twin, Triplet, etc.
(Specify)

19. IF NOT SINGLE BIRTH - Born First, Second, Third, etc.
(Specify)

RACE

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

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

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

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

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

IF NO, HAS PATERNITY ACKNOWLEDGMENT BEEN SIGNED IN THE HOSPITAL? ☐ Yes ☐ No

23. SOCIAL SECURITY NUMBER REQUESTED FOR CHILD?
☐ Yes
☐ No

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

FATHER

24. FATHER'S SOCIAL SECURITY NUMBER:

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

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

26. FATHER'S EDUCATION *(Check the box that best describes the highest degree or level of school completed at the time of delivery)*

- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

MOTHER

27. MOTHER'S SOCIAL SECURITY NUMBER:

28. MOTHER OF HISPANIC ORIGIN? *(Check the box that best describes whether the mother is Spanish/Hispanic/Latina. Check the "No" box if mother is not Spanish/Hispanic/Latina)*

- ☐ No, not Spanish/Hispanic/Latina
- ☐ Yes, Mexican, Mexican American, Chicana
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish/Hispanic/Latina (Specify)

29. MOTHER'S EDUCATION *(Check the box that best describes the highest degree or level of school completed at the time of delivery)*

- ☐ 8th grade or less
- ☐ 9th - 12th grade, no diploma
- ☐ High school graduate or GED completed
- ☐ Some college credit but no degree
- ☐ Associate degree (e.g., AA, AS)
- ☐ Bachelor's degree (e.g., BA, AB, BS)
- ☐ Master's degree (e.g., MA, MS, MEng, MEd, MSW, MBA)
- ☐ Doctorate (e.g., PhD, EdD) or Professional degree (e.g., MD, DDS, DVM, LLB, JD)

30. PLACE WHERE BIRTH OCCURRED *(Check one)*

- ☐ Hospital
- ☐ Freestanding birthing center
- ☐ Home Birth: Planned to deliver at Home? ☐ Yes ☐ No
- ☐ Clinic/Doctor's office
- ☐ Other (Specify)

31. FACILITY ID. (NPI)

32. ATTENDANT'S NAME, TITLE, AND NPI
NAME:
NPI:
TITLE: ☐ MD ☐ DO ☐ CNM/CM ☐ OTHER MIDWIFE ☐ OTHER (*Specify*)

33. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No

IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:

MOTHER

34a. DATE OF FIRST PRENATAL CARE VISIT
----------/----------/---------- ☐ No Prenatal Care
MM DD YYYY

34b. DATE OF LAST PRENATAL CARE VISIT
----------/----------/----------
MM DD YYYY

35. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
---------- (If none, enter "0".)

36. MOTHER'S HEIGHT
---------- (feet/inches)

37. MOTHER'S PREPREGNANCY WEIGHT ---------- (pounds)

38. MOTHER'S WEIGHT AT DELIVERY
---------- (pounds)

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

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

40a. Now Living
Number ---------
☐ None

40b. Now Dead
Number ---------
☐ None

41. NUMBER OF OTHER PREGNANCY OUTCOMES (spontaneous or induced losses or ectopic pregnancies)

41a. Other Outcomes
Number ----------
☐ None

42. 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	_____

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

40c. DATE OF LAST LIVE BIRTH
----------/----------
MM YYYY

41b. DATE OF LAST OTHER PREGNANCY OUTCOME
----------/----------
MM YYYY

44. DATE LAST NORMAL MENSES BEGAN
----------/----------/----------
MM DD YYYY

45. MOTHER'S MEDICAL RECORD NUMBER

MEDICAL AND HEALTH INFORMATION

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

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

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

☐ None of the above

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

Was mother tested for HBsAG? ☐ Yes ☐ No
If tested, include test date
----------/----------/----------
MM DD YYYY
and test results: ☐ Positive ☐ Negative

48. OBSTETRIC PROCEDURES *(Check all that apply)*
☐ Cervical cerclage
☐ Tocolysis

External cephalic version:
☐ Successful
☐ Failed

☐ None of the above

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

50. 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 ≥ 38°C (100.4°F)
☐ 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

51. 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

52. 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

NEWBORN INFORMATION

NEWBORN

53. NEWBORN MEDICAL RECORD NUMBER:

54. OBSTETRIC ESTIMATE OF GESTATION:
---------- (completed weeks)

55. APGAR SCORE:
Score at 5 minutes: ----------
If 5 minute score is less than 6,
Score at 10 minutes: ----------

56. INFANT VACCINATION
Infant vaccinated with Hepatitis B vaccine?
☐ Yes ☐ No
If yes, include vaccination date
----------/----------/----------
MM DD YYYY

57. 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

58. CONGENITAL ANOMALIES OF THE NEWBORN
(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

59. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No
IF YES, NAME OF FACILITY INFANT TRANSFERRED TO:
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60. IS INFANT LIVING AT TIME OF REPORT?
☐ Yes ☐ No
☐ Infant transferred, status unknown

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