SAN BERNARDINO COUNTY

Public Health
Vital Statistics

Out of Hospital Birth – Submission Form

Midwife Name: _____

License Number: _____

Location of Birth

- ☐ Home Birth: _____
- ☐ Birthing Center: _____

Was the newborn screen completed?

- ☐ Yes
- ☐ No
- ☐ Unknown

Voluntary Declaration of Paternity (VDOP) Completed?

- ☐ Yes
- ☐ No

Enclosed documents:

- ☐ Out of Hospital Worksheet
- ☐ Proof of Pregnancy
- ☐ Copy VDOP

Certification Statement

I certify that all the information I provided is true and correct to the best of my knowledge.

Signature of Midwife: _____ Date: _____

What You Need to Know about Your Child's Birth Certificate

Your child's birth certificate lasts forever. Please be certain the information on the certificate is accurate and complete *before* you sign it.

- The birth certificate is a legal document.
- An amendment form is required to make corrections to the birth certificate.
- The birth certificate will become a two-page document if an amendment is requested after the original has been processed.
- Many changes on the birth certificate require the applicant to go to court for a court order, including reversing the order of last names (surnames).
- Parents may have problems receiving benefits, traveling on an airline, or obtaining a passport or Social Security number for their child if the birth certificate is not true and correct.
- It can take several weeks to apply an amendment. The processing time for amendments can be located on the California Department of Public Health-Vital Records website at https://www.cdph.ca.gov/Programs/CHSI/Pages/Vital-Records.aspx.

Common mistakes that require amendments or court orders:

- Misspelled first, middle, or last names of child and/or parents
- Incorrect birth place or date of birth of parent(s)
- Reversed order of last names (surnames)
- Adding additional names to parent(s) or child later
- Incorrect sex of child
- Incorrect birth date

Errors on birth certificates
cannot be corrected on the original certificate.

The **original** birth certificate **does not** change, but an amendment is attached to create a **two-page** document.

✓ Parents, please review the information on the birth certificate carefully before you sign it.

✓ Your signature confirms that you have reviewed the information and that the facts are correct.

Amendment forms may be obtained at the local health department or county recorder's office, or online at https://www.cdph.ca.gov/Programs/CHSI/Pages/Vital-Records.aspx**.**

Importance of Collecting Complete and Accurate Birth Certificate Information

Why is the birth certificate information collected?	The birth certificate information is collected based on California Health and Safety Code (HSC) sections 102425 and 102426. This law lists all the information required on the California birth certificate. This law also makes all medical information confidential.
What is the birth certificate information used for?	The information collected is used to record what happened during pregnancy, labor and delivery, and any issues the newborn experienced. The information will be used to understand and help prevent birth defects, preterm births, maternal deaths, and other labor, delivery and birth outcomes. Information collected also assists local and state public health leaders in making decisions that address programs needed in the community such as diabetes care, teen pregnancy, Women, Infants & Children (WIC), etc.
What birth certificate information is confidential on the birth certificate?	All medical information is considered confidential and is not released to the public. This includes the parents' race, education, occupation, Social Security number(s), and address. Access to the confidential portion of the birth certificate is limited to the California Department of Public Health, California Department of Health Care Services, California Department of Finance, ScholarShare Investment Board, local health department, persons with a valid scientific interest as determined by the State Registrar, Committee for Protection of Human Subjects, parent who signed the certificate or parent giving birth, the child named on the birth certificate, and the hospital responsible for preparing and submitting the birth record. Reference HSC 102430.
What if the parent does not want to provide the information?	All information is required by law with the exception of the parents' race, occupation, education, and Social Security number(s). Although not required, race, occupation, and education are very important for understanding negative outcomes and developing needed programs.
Who collects the birth certificate information?	The birth certificate information is collected by the birth clerk and it is sent to the local health department who forwards it to the California Department of Public Health - Vital Records. State registered birth certificate information is then sent to the National Center for Health Statistics, Centers for Disease Control and Prevention.
Who should I contact if I still have questions?	Please contact the California Department of Public Health - Vital Records at (916) 445-2684.

FOR HOSPITAL OR ATTENDANT USE ONLY:

Room: _____ MR: _____

Attendant: _____

Clerk Initial: _____

Date Given to Parent(s): _____

Date Completed: _____

Certificate of Live Birth Worksheet

Please complete this information to prepare your child's birth certificate.

Name of Child:

1A. First Name: _____

1B. Middle Name: _____

1C. Last Name: _____

Suffix (Optional): ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐ VII ☐ VIII ☐ IX ☐ X ☐ JR ☐ SR

2. Sex: ☐ Male ☐ Female ☐ Nonbinary ☐ Unknown/Undetermined

3A. Plurality:
☐ Single ☐ Twin ☐ Triplet ☐ Quadruplet
☐ Quintuplet ☐ Sextuplet ☐ Septuplet ☐ Octuplet or More ☐ Unknown

3B. Birth Order: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th or more ☐ Unknown

4A. Date of Birth: _____ **4B.** Time of Birth: _____

Birth name of *Parent Giving Birth* (fields 9A, 9B, 9C, on child's birth certificate), unless a certified copy of a surrogate court order is presented. If only one parent is listed on the birth certificate, they must be listed in fields 9A, 9B, 9C.

9A. First Name: _____

9B. Middle Name: _____

9C. Last Name: _____

Suffix: ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐ VII ☐ VIII ☐ IX ☐ X ☐ JR ☐ SR

9D. Relationship to Child (Optional): ☐ Mother ☐ Father ☐ Parent

10. Birth State/Foreign Country:
☐ US State. State Name: _____
☐ US Territory. Territory Name: _____
☐ Canadian Province. Province Name: _____
☐ Mexican State. State Name: _____
☐ Other Country. Country Name: _____
☐ Other Country Unknown
☐ Unknown
(Specify the Birth State/Foreign Country from the dropdown in EBRS)

11. Birth Date: _____

Are the Parents Married and/or in a State Registered Partnership (SRDP), or is there a certified surrogate court order?
☐ Yes ☐ No ☐ Unknown

Has a Voluntary Declaration of Parentage (VDOP) form been completed and signed? ☐ Yes ☐ No

If the parents are not married or in an SRDP, then the biological or intended parents may sign the Voluntary Declaration of Parentage (VDOP) form to list the biological parent not giving birth or intended parent in fields 6A, 6B, 6C at the time of birth. Reference Health and Safety Code Section 102425(a)(4). Additional parents may be added through the amendment process after the certificate is registered.

Birth Name of Parent Not Giving Birth or Intended Parent (Fields 6A, 6B, 6C, on child's birth certificate):

6A. First Name: _____

6B. Middle Name: _____

6C. Last Name: _____

Suffix: ☐ I ☐ II ☐ III ☐ IV ☐ V ☐ VI ☐ VII ☐ VIII ☐ IX ☐ X ☐ JR ☐ SR

6D. Relationship to Child (Optional): ☐ Mother ☐ Father ☐ Parent

7. Birth State/Foreign Country:

☐ US State. State Name: _____
☐ US Territory. Territory Name: _____
☐ Canadian Province. Province Name: _____
☐ Mexican State. State Name: _____
☐ Other Country. Country Name: _____
☐ Other Country Unknown
☐ Unknown
(Specify the Birth State/Foreign Country from the dropdown in EBRS)

8. Birth Date: _____

Names of Parent(s)/Informant(s) Signing the Birth Certificate:

12A. Printed Name of Parent/Informant 1 who will sign the Birth Certificate **(Required)**

_____
Your name should be printed as you want it to appear in field 12A in lieu of an ink signature.

12B. Relationship of Parent/Informant 1:

☐ Mother
☐ Father
☐ Parent
☐ Other: _____

12A. Printed Name of Parent/Informant 2 who will sign the Birth Certificate (Optional)

_____
Your name should be printed as you want it to appear in field 12A in lieu of an ink signature.

12B. Relationship of Parent/Informant 2:

☐ Mother
☐ Father
☐ Parent
☐ Other: _____

Father or Parent Information

Field 19 (Father or Parent)

Is the father or parent Hispanic, Latino, or Spanish?

☐Yes If Yes, please specify: ☐Cuban
☐No ☐Mexican
☐Unknown ☐Puerto Rican
☐Withheld ☐Other _____

Mother Information

Field 22 (Mother)

Is the mother Hispanic, Latina, or Spanish?

☐Yes If Yes, please specify: ☐Cuban
☐No ☐Mexican
☐Unknown ☐Puerto Rican
☐Withheld ☐Other _____

Fields 18 and 21

Up to three races may be entered for each parent on the birth certificate. Unless otherwise specified, the selected race(s) will print on the certificate. If the parent(s) would like a different description to print on the certificate, enter it in the space provided.

Field 18 (Father or Parent)

White
☐White _____
☐Caucasian _____

Black or African American
☐Black _____
☐African American _____

Hispanic
☐Mexican _____
☐Mexican American _____
☐Other Hispanic, specify _____

American Indian or Alaskan Native
☐Alaska Native _____
☐Eskimo _____
☐Aleut _____
☐Native American _____
☐American Indian _____

Asian
☐Chinese _____
☐Japanese _____
☐Filipino _____
☐Korean _____
☐Vietnamese _____
☐Asian Indian _____
☐Cambodian _____
☐Thai _____
☐Laotian _____
☐Hmong _____
☐Other Asian, specify _____

Native Hawaiian or Other Pacific Islander
☐Native Hawaiian _____
☐Guamanian _____
☐Samoan _____
☐Other Pacific Islander, specify _____

Unknown or Other
☐Unknown
☐Other _____
☐Other _____
☐Other _____

Withheld
☐Withheld

Field 21 (Mother)

White
☐White _____
☐Caucasian _____

Black or African American
☐Black _____
☐African American _____

Hispanic
☐Mexican _____
☐Mexican American _____
☐Other Hispanic, specify _____

American Indian or Alaskan Native
☐Alaska Native _____
☐Eskimo _____
☐Aleut _____
☐Native American _____
☐American Indian _____

Asian
☐Chinese _____
☐Japanese _____
☐Filipino _____
☐Korean _____
☐Vietnamese _____
☐Asian Indian _____
☐Cambodian _____
☐Thai _____
☐Laotian _____
☐Hmong _____
☐Other Asian, specify _____

Native Hawaiian or Other Pacific Islander
☐Native Hawaiian _____
☐Guamanian _____
☐Samoan _____
☐Other Pacific Islander, specify _____

Unknown or Other
☐Unknown
☐Other _____
☐Other _____
☐Other _____

Withheld
☐Withheld

20C. Father or Parent Education: (Enter Highest Level or Degree of School Completed)

☐ 0-11th Grade. Highest Grade Completed: _____
☐ High School Diploma
☐ Some College (No degree)
☐ Bachelor's Degree
☐ Doctorate Degree
☐ 12th Grade with No Diploma
☐ General Equivalency Diploma (GED)
☐ Associate's Degree
☐ Master's Degree
☐ Professional Degree

20A. Father or Parent Usual Occupation:

_____
Work done for the longest period of time. Do ***not*** enter company name.

20B. Father or Parent Kind of Business/Industry:

_____
Do ***not*** enter company name.

23C. Mother Education: (Enter Highest Level or Degree of School Completed)

☐ 0-11th Grade. Highest Grade Completed: _____
☐ High School Diploma
☐ Some College (No degree)
☐ Bachelor's Degree
☐ Doctorate Degree
☐ 12th Grade with No Diploma
☐ General Equivalency Diploma (GED)
☐ Associate's Degree
☐ Master's Degree
☐ Professional Degree

23A. Mother Usual Occupation:

_____
Work done for the longest period of time. Do ***not*** enter company name.

23B. Mother Kind of Business/Industry:

_____
Do ***not*** enter company name.

24D. Parent Giving Birth Residence Address **(Required. P.O. Boxes Are Not Acceptable.)**

Street Number and Name: _____ Apt/Suite/Unit: _____

City: _____ State/Province:_____

Zip Code/Postal Code: _____ Country: _____

Medical and Health Data: Birth Parent and Newborn

Did the person giving birth receive Women, Infants and Children (WIC) food while pregnant?
☐ Yes
☐ No
☑ Unknown

Did the person giving birth smoke before or during the pregnancy? Enter number of cigarettes smoked per day as follows:

During the three months prior to becoming pregnant:
☐ Did not smoke
☐ Cigarettes. # per day_____
☐ Packs. # per day_____
☐ Unknown

During the first three months of pregnancy:
☐ Did not smoke
☐ Cigarettes. # per day_____
☐ Packs. # per day_____
☐ Unknown

During the second three months of pregnancy:

- ☐ Did not smoke
- ☐ Cigarettes. # per day_____
- ☐ Packs. # per day_____
- ☐ Unknown

During the last three months of pregnancy:

- ☐ Did not smoke
- ☐ Cigarettes. # per day_____
- ☐ Packs. # per day_____
- ☐ Unknown

Birth Parent: Prepregnancy Weight: _____ Delivery Weight: _____ Height: _____

APGAR score (5 minute): _____ APGAR score (10 minute): _____

25A. Date Last Normal Menses Began: (if exact date is unknown, enter the month and year) _____

25AA. Date of First Prenatal Care Visit: (if exact date is unknown, enter the month and year) _____

25B. Month Prenatal Care Began: _____ **25BA.** Date of Last Prenatal Care Visit: _____
(e.g., 1st, 2nd, 3rd, Unknown, etc.) (Do not enter delivery date)

25C. Number of Prenatal Visits: _____
(Count only visits recorded in the most current record available. Do not estimate additional prenatal visits when the prenatal record is not up to date. Do not include non-pregnancy related visits to ER; visit to confirm pregnancy; nutritionist; dietitian; health educator, etc. Normal prenatal visits are approximately 16.)

25D. Principal Source of Payment for Prenatal Care:

- ☐ No Prenatal Care (00)
- ☐ Medi-Cal, without CPSP Support Services (02)
- ☐ Other Governmental Programs (Federal, State, Local) (05)
- ☐ Private Insurance Company (07)
- ☐ Self Pay (09)
- ☐ Medi-Cal, with CPSP Support Services (13)
- ☐ Other (14)
- ☐ Unknown (99)

26. Birthweight in Grams: _____ **26A.** Obstetric Estimate of Gestation: _____ (Completed Weeks)

26B. Hearing Screening:

- ☐ Pass Both
- ☐ Refer One
- ☐ Refer Both
- ☐ Results Pending
- ☐ Waived
- ☐ Not Med Indicated
- ☐ Test Not Available

27A. Number of Previous Live Births Now Living: _____ **27B.** Number of Previous Live Births Now Dead: _____

27C. Date of Last Live Birth: _____ (Do not count this child.)

27D. Number of Miscarriages Before 20 Weeks: (Do not count abortions) _____ **27E.** After 20 Weeks: _____

27F. Date of Last Miscarriage: _____

28A. Method of Delivery

28AA. Final Delivery Route: _____

28AB. Number of Previous Cesarean(s): _____

28AC. Fetal Presentation:_____

28AD. Forceps Attempted, But Unsuccessful:

- ☑ Yes
- ☐ No
- ☐ Unknown

28AE. Vacuum Attempted, But Unsuccessful:

- ☑ Yes
- ☐ No
- ☐ Unknown

28B. Expected Source of Payment for Delivery:

- ☐ Medically Unattended Birth (00)
- ☐ Medi-Cal (02)
- ☐ Other Governmental Programs (Federal, State, Local) (05)
- ☐ Private Insurance (07)
- ☐ Self Pay (09)
- ☐ Other (14)
- ☐ Indian Health Service (15)
- ☐ CHAMPUS/TRICARE (16)
- ☐ Unknown (99)

HOSPITAL OR ATTENDANT USE ONLY

29. Complications and Procedures of Pregnancy and Concurrent Illnesses:

Codes to Enter? ☐ Yes ☐ No ☑ Unknown

(If Yes, Hospital Staff or Attendant Circle the Appropriate Codes on VS 10A)

30. Complications and Procedures of Labor and Delivery:

Codes to Enter? ☐ Yes ☐ No ☐ Unknown

(If Yes, Hospital Staff or Attendant Circle the Appropriate Codes on VS 10A)

31. Abnormal Conditions and Clinical Procedures Relating to the Newborn:

Codes to Enter? ☐ Yes ☐ No ☐ Unknown

(If Yes, Hospital Staff or Attendant Circle the Appropriate Codes on VS 10A)

32. 6A-6C/Parent Social Security Number: _____

☐ Withheld ☐ None ☐ Unknown

33. 9A-9C/Parent Social Security Number: _____

☐ Withheld ☐ None ☐ Unknown

F. Social Security Number Requested for Child: ☐ Yes ☐ No

Mailing Address for Child's Social Security Card. P.O. Boxes are allowed. The Social Security Administration guidance limits the Enumeration at Birth program to hospital births.

Street Number and Name: _____ Apt/Suite/Unit: _____

City: _____ State/Province: _____

Zip Code/Postal Code: _____ Country: _____

HOSPITAL OR ATTENDANT USE ONLY

CERTIFICATES OF LIVE BIRTH AND FETAL DEATH
MEDICAL DATA SUPPLEMENTAL WORKSHEET
VS 10A (Rev. 1/2006)

Use the codes on this Worksheet to report the appropriate entry in items numbered 25D and 28A through 31 on the "Certificate of Live Birth" and for items 29D and 32B through 35 on the "Certificate of Fetal Death."

Item 25D. (Birth)
Item 29D. (Fetal Death)

PRINCIPAL SOURCE OF PAYMENT FOR PRENATAL CARE
(Enter only 1 code)

02 Medi-Cal, without CPSP Support Services
13 Medi-Cal, with CPSP Support Services
05 Other Government Programs (Federal, State, Local)
07 Private Insurance Company
09 Self Pay
14 Other
99 Unknown
00 No Prenatal Care

Item 28A. (Birth)
Item 32A (Fetal Death)

METHOD OF DELIVERY
(Enter only 1 code/number under each section, separated by commas: A,B,C,D,E,F)

A. Final delivery route

01 Cesarean—primary
11 Cesarean—primary, with trial of labor attempted
21 Cesarean—primary, with vacuum
31 Cesarean—primary, with vacuum & trial of labor attempted
02 Cesarean—repeat
12 Cesarean—repeat, with trial of labor attempted
22 Cesarean—repeat, with vacuum
32 Cesarean—repeat, with vacuum & trial of labor attempted
03 Vaginal—spontaneous
04 Vaginal—spontaneous, after previous Cesarean
05 Vaginal—forceps
15 Vaginal—forceps, after previous Cesarean
06 Vaginal—vacuum
16 Vaginal—vacuum, after previous Cesarean
88 Not Delivered (Fetal Death Only)

B. If mother had a previous Cesarean—How many? _____
(Enter 0 – 9, or U if Unknown)

C. Fetal presentation at birth

20 Cephalic fetal presentation at delivery
30 Breech fetal presentation at delivery
40 Other fetal presentation at delivery
90 Unknown

D. Was vaginal delivery with forceps attempted, but unsuccessful?

50 Yes 58 No 59 Unknown

E. Was vaginal delivery with vacuum attempted, but unsuccessful?

60 Yes 68 No 69 Unknown

F. Hysterotomy/Hysterectomy (Fetal Death Only)

70 Yes 78 No

Item 28B. (Birth)
Item 32B (Fetal Death)

EXPECTED PRINCIPAL SOURCE OF PAYMENT FOR DELIVERY
(Enter only 1 code)

02 Medi-Cal
15 Indian Health Service
16 CHAMPUS/TRICARE
05 Other Government Programs (Federal, State, Local)
07 Private Insurance
09 Self Pay
14 Other
99 Unknown
00 Medically Unattended Birth

Item 29. (Birth)
Item 33. (Fetal Death)

COMPLICATIONS AND PROCEDURES OF PREGNANCY AND CONCURRENT ILLNESSES
(Enter up to 16 codes, separated by commas, for the most important complications/procedures.)

DIABETES

09 Prepregnancy (Diagnosis prior to this pregnancy)
31 Gestational (Diagnosis in this pregnancy)

HYPERTENSION

03 Prepregnancy (Chronic)
01 Gestational (PIH, Preeclampsia)
02 Eclampsia

OTHER COMPLICATIONS/PREGNANCIES

32 Large fibroids
33 Asthma
34 Multiple pregnancy (more than 1 fetus this pregnancy)
35 Intrauterine growth restricted birth this pregnancy
23 Previous preterm birth (less than 37 weeks gestation)
36 Other previous poor pregnancy outcomes (Includes perinatal death, small-for-gestational age/intrauterine growth restricted birth, large for gestational age, etc.)

OBSTETRIC PROCEDURES

24 Cervical cerclage
28 Tocolysis
37 External cephalic version—Successful
38 External cephalic version—Failed
39 Consultation with specialist for high risk obstetric services

PREGNANCY RESULTED FROM INFERTILITY TREATMENT

40 Fertility-enhancing drugs, artificial insemination or intrauterine insemination
41 Assisted reproductive technology (e.g., in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT)

INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY

42 Chlamydia
43 Gonorrhea
44 Group B streptococcus
18 Hepatitis B (acute infection or carrier)
45 Hepatitis C
16 Herpes simplex virus (HSV)
46 Syphilis
47 Cytomegalovirus (Fetal Death Only)
48 Listeria (Fetal Death Only)
49 Parvovirus (Fetal Death Only)
50 Toxoplasmosis (Fetal Death Only)

PRENATAL SCREENING DONE FOR INFECTIOUS DISEASES

51 Chlamydia
52 Gonorrhea
53 Group B streptococcal infection
54 Hepatitis B
55 Human immunodeficiency virus (offered)
56 Syphilis

NONE OR OTHER COMPLICATIONS/PROCEDURES NOT LISTED

00 None
30 Other Pregnancy Complications/Procedures not Listed

EPIDEMICS AND/OR DISASTERS

91 COVID-19 Confirmed
92 COVID-19 Presumed

See reverse side for codes to Birth Items 30 and 31 and Fetal Death Items 34 and 35.

Do not enter any identification by patient name or number on this worksheet. Discard after use.
Do not retain the worksheet in the medical records or submit with the "Certificates of Live Birth or Fetal Death."

Item 30 (Birth) ***COMPLICATIONS AND PROCEDURES OF LABOR AND DELIVERY***
Item 34 (Fetal Death) *(Enter up to 9 codes, separated by commas, for the most important complications/procedures.)*

ONSET OF LABOR

10 Premature rupture of membranes (greater than or equal to 12 hours)

07 Precipitous labor (less than 3 hours)

08 Prolonged labor (greater than or equal to 20 hours)

CHARACTERISTICS OF LABOR AND DELIVERY

11 Induction of labor

12 Augmentation of labor

32 Non-vertex presentation

33 Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery

34 Antibiotics received by the mother during labor

35 Clinical chorioamnionitis diagnosed during labor or maternal temperature greater than or equal to 38°C (100.4°F)

19 Moderate/heavy meconium staining of the amniotic fluid

36 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

37 Epidural or spinal anesthesia during labor

25 Mother transferred for delivery from another facility for maternal medical or fetal indications

COMPLICATIONS OF PLACENTA, CORD, AND MEMBRANES

38 Rupture of membranes prior to onset of labor

13 Abruptio placenta

39 Placental insufficiency

20 Prolapsed cord

17 Chorioamnionitis

MATERNAL MORBIDITY

24 Maternal blood transfusion

40 Third or fourth degree perineal laceration

41 Ruptured uterus

42 Unplanned hysterectomy

43 Admission to ICU

44 Unplanned operating room procedure following delivery

NONE OR OTHER COMPLICATIONS/PROCEDURES NOT LISTED

00 None

31 Other Labor/Delivery Complications/Procedures not Listed

Item 31 (Birth) ***ABNORMAL CONDITIONS AND CLINICAL PROCEDURES RELATING TO THE NEWBORN***
Item 35 (Fetal Death) ***ABNORMAL CONDITIONS AND CLINICAL PROCEDURES RELATING TO THE FETUS***
(Enter up to 10 codes, separated by commas, for the most important conditions/procedures.)

CONGENITAL ANOMALIES (NEWBORN OR FETUS)

01 Anencephaly

02 Meningomyelocele/Spina bifida

76 Cyanotic congenital heart disease

77 Congenital diaphragmatic hernia

78 Omphalocele

79 Gastroschisis

80 Limb reduction defect (excluding congenital amputation and dwarfing syndromes)

28 Cleft palate alone

29 Cleft lip alone

30 Cleft palate with cleft lip

57 Down's Syndrome—Karyotype confirmed

81 Down's Syndrome—Karyotype pending

82 Suspected chromosomal disorder—Karyotype confirmed

83 Suspected chromosomal disorder—Karyotype pending

35 Hypospadias

88 Aortic stenosis

89 Pulmonary stenosis

90 Atresia

62 Additional and unspecified congenital anomalies not listed above

ABNORMAL CONDITIONS (NEWBORN OR FETUS)

66 Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)

ADDITIONAL ABNORMAL CONDITIONS/PROCEDURES (NEWBORN ONLY)

71 Assisted ventilation required immediately following delivery

85 Assisted ventilation required for more than 6 hours

73 NICU admission

86 Newborn given surfactant replacement therapy

87 Antibiotics received by the newborn for suspected neonatal sepsis

70 Seizure or serious neurological dysfunction

74 Newborn transferred to another facility within 24 hours of delivery

NONE OR OTHER ABNORMAL CONDITIONS/PROCEDURES NOT LISTED

00 None (Newborn or Fetus)

75 Other Conditions/Procedures not Listed (Newborn Only)

67 Other Conditions/Procedures not Listed (Fetal Death Only)

EPIDEMICS AND/OR DISASTERS

91 COVID-19 Confirmed

92 COVID-19 Presumed