

PLEASE PRINT CLEARLY – NO CURSIVE Contact Phone Number: _____

Name of Child:

1A. First Name: _____ Suffix (Optional): I II III IV V VI VII
 VIII VII VIII IX X JR SR

1B. Middle Name: _____

Sex: Male Female Nonbinary
 Unknown/Undetermined

1C. Last Name: _____

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: _____

5A. Place of Birth - Name of Hospital or Facility: _____

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

City: _____ County: _____ Zip Code/Postal Code: _____

Birth name of *Parent Giving Birth* (fields 9A, 98, 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, 98, 9C.

9A. First Name: _____

9B. Middle

Name: _____

9C. Last Name (Maiden): _____

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

9D. Relationship to Child: 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

11. Birth Date: _____

Birth Name of Parent Not Giving Birth or Intended Parent (Fields 6A, 68, SC, 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: 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

8. 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

Father or Parent Information

Field 19 (Father or Parent)

Is the father or parent Hispanic, Latino, or Spanish

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

Mother Information

Field 22 (Mother)

Is the Mother Hispanic, Latino, or Spanish

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

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 w/ 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.

Sex on Original Birth Certificate:

- Male
- Female
- Unknown
- Declined to respond

Gender Identity:

- Male
- Female
- Female-to-Male (FTM)/Transgender Male/Trans Man
- Male-to-Female (MTF)/Transgender Female/Trans Woman
- Nonbinary, Genderqueer, neither exclusively male nor female
- Other Gender Category
- Do not know/Unsure
- Declined to respond

Sexual Orientation:

- Lesbian, gay or homosexual
- Pansexual
- Do not know/Unsure
- Straight or heterosexual
- Other: Please Specify: _____
- Declined to respond
- Bisexual

I confirm the responses to the SOGI questions were self-reported by the parent identified in field (6A-6C):

- Yes
- No

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 w/ 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.

Sex on Original Birth Certificate:

- Male Female Unknown Declined to respond

Gender Identity:

- Male
 Female
 Female-to-Male (FTM)/Transgender Male/Trans Man
 Male-to-Female (MTF)/Transgender Female/Trans Woman
 Nonbinary, Genderqueer, neither exclusively male nor female
 Other Gender Category
 Do not know/Unsure
 Declined to respond

Sexual Orientation:

- Lesbian, gay or homosexual Straight or heterosexual Bisexual
 Pansexual Other: Please Specify: _____
 Do not know/Unsure Declined to respond

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

Street Number & Name: _____ **Apt/Suite/Unit:** _____

City: _____ **State/Province:** _____

Zip Code/Postal Code: _____ **County:** _____

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 _____
 Unknow

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 of Last 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:

- | | |
|---|---|
| <input type="checkbox"/> No Prenatal Care (00) | <input type="checkbox"/> Medi-Cal, without CPSP Support Services (02) |
| <input type="checkbox"/> Other Governmental Programs (Federal, State, Local) (05) | <input type="checkbox"/> Private Insurance Company (07) |
| <input type="checkbox"/> Self Pay (09) | <input type="checkbox"/> Medi-Cal, with CPSP Support Services (13) |
| <input type="checkbox"/> Other (14) | <input type="checkbox"/> Unknown (99) |

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

26B. Hearing Screening

- | | | | |
|------------------------------------|--|---|--|
| <input type="checkbox"/> Pass Both | <input type="checkbox"/> Refer One | <input type="checkbox"/> Refer Both | <input type="checkbox"/> Results Pending |
| <input type="checkbox"/> Waived | <input type="checkbox"/> Not Med Indicated | <input type="checkbox"/> 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 (provide day, month, and year if possible): _____ (Do not count this child)

27D. Number of Miscarriages before 20 Weeks: _____ 27E. After 20 Weeks: _____

27F. Date of Last Miscarriage: _____

28A. Method of Delivery

28AA. Final Delivery Route:

- | | |
|---|---|
| <input type="checkbox"/> Vaginal – spontaneous (03) | <input type="checkbox"/> Vaginal- spontaneous, after previous Cesarean (04) |
| <input type="checkbox"/> Vaginal- forceps (05) | <input type="checkbox"/> Vaginal- forceps, after previous Cesarean (15) |
| <input type="checkbox"/> Vaginal- vacuum (06) | <input type="checkbox"/> Vaginal- vacuum, after previous Cesarean (16) |

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

28AC. Fetal Presentation

- | | |
|---|---|
| <input type="checkbox"/> Cephalic fetal presentation at delivery (20) | <input type="checkbox"/> Other fetal presentation at deliver (40) |
| <input type="checkbox"/> Breech fetal presentation at delivery (30) | <input type="checkbox"/> Unknown (90) |

28AD. Forceps Attempted, But Unsuccessful:

- | | | |
|------------------------------|-----------------------------|----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
|------------------------------|-----------------------------|----------------------------------|

28AE. Vacuum Attempted, But Unsuccessful:

- | | | |
|------------------------------|-----------------------------|----------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
|------------------------------|-----------------------------|----------------------------------|

28B. Expected Source of Payment for Delivery:

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

29. Complications and procedures of Pregnancy and Concurrent Illnesses:

Codes to Enter? Yes No Unknown

If YES, Please list codes here: _____

30. Complications and procedures of Labor and Delivery:

Codes to Enter? Yes No Unknown

If YES, Please list codes here: _____

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

Codes to Enter? Yes No Unknown

If YES, Please list codes here: _____

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

Withheld None Unknown

32. 9A-9C/Parent Social Security Number: _____

Withheld None Unknown

Newborn Screening Test Information:

Newborn Screening Test performed?

Yes No Unknown If **YES**, date test performed: _____

If **NO**, date test declined: _____

Where was test performed? (Please select one of the following):

Hospital/Lab Home Birthing Center/Clinic Medical Office