Form R-3H 02.26.2018 – PART A

Commonwealth of Massachusetts
Department of Public Health
Registry of Vital Records and Statistics

Hospital Worksheet for Mandatory Birth Reporting

Please use this worksheet to complete the legal and confidential statistical items collected on the birth certificate.

Items containing an asterisk (*) appear on the child's legal birth certificate. The remainder are not part of the legal record, but are confidential items collected in accordance with Massachusetts General Law (Ch. 111, § 24B) and submitted directly to the Massachusetts Department of Public Health. All items must be completed.

If you have questions about this worksheet, or any of the items collected on the birth certificate, please contact the Registry of Vital Records and Statistics (RVRS) at (617) 740-2623.

Administrative Use Only

Birth Mother MRN:

Child MRN:

Log #:

CHILD Information

Child's Name: If the child's name from hospital records and parent worksheets is different, be certain to reconcile any differences prior to releasing the birth certificate for registration.

***First Name:** ☐ Check if the child's certificate will *not* have a first name

***Middle Name:** ☐ Check if your child's certificate will *not* have a middle name

***Surname:** *(Last Name)*

***Generational, if any:** *(e.g., JR, III)*

Child's Facts of Birth: Enter the date and time the child was born, whether male or female, and indicate whether the child was a singleton or multiple. If the child's sex is undetermined at birth, contact RVRS for more information.

***Date of Birth:** *(e.g., Mar. 15 2011)*

Month *Day* *Year*

***Time:**

☐ Military ☐ AM ☐ PM

***Sex:**

☐ Female
☐ Male
☐ Undetermined

***Plurality:**

☐ 1-Single ☐ 2-Twin ☐ 3-Triplet ☐ 4-Quadruplet
☐ *Other:*

***Birth Order:** *(if not single)* ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ _____ *Other*

MOTHER/PARENT Information

Mother/Parent Current Name:

Mother/Parent Surname at Birth or Adoption (Maiden Surname):

CERTIFIER Information

The Certifier is the physician or other authorized individual responsible for reporting the delivery of the newborn at a hospital facility according to M.G.L. c.46 §§3 and 3A.

***First Name, Middle Name, Last Name (with Generational, if any):**

***Title:**
☐ MD ☐DO ☐CNM ☐Other Midwife ☐Hospital Administrator
☐Other (specify): _____

***License Number:**

***Type:**
☐At Birth ☐Post-Natal ☐Certifier Only

***National Provider ID:**

Mailing Address:

Street number and name or PO Box	*City/Town, State*	*Zip Code*

Was the Certifier the Attendant at Birth? ☐Yes ☐No ***If no, please complete the following:***

Attendant At Birth - First Name, Middle Name, Last Name (with Generational, if any):

Title:
☐ MD ☐DO ☐CNM ☐Other Midwife ☐Hospital Administrator
☐Other (specify): _____

License Number:

National Provider ID:

Mailing Address:

Street number and name or PO Box	*City/Town, State*	*Zip Code*

MOTHER/PARENT RELATIONSHIP TO CHILD

Mother/Parent Relationship to Child:
Please indicate the relationship of the individual who will be listed on the birth certificate as Mother/Parent:

- ☐ Mother (Delivering and Legal)
- ☐ Surrogate - Genetic
- ☐ Surrogate - Non-Genetic
- ☐ Legal Genetic (court order)
- ☐ Legal Non-Genetic (court order)
- ☐ Unknown

Father/Parent Relationship to Child:
Please indicate the relationship of the individual who will be listed on the birth certificate as Father/Parent:

- ☐ Father (Spouse or by Acknowledgment)
- ☐ Legal Genetic (court order)
- ☐ Legal Non-Genetic (court order)
- ☐ Unknown

Form R-3H 02.26.2018 – PART B

Commonwealth of Massachusetts
Department of Public Health
Registry of Vital Records and Statistics

Worksheet for Mandatory Birth Reporting – Prenatal Care

Please use this worksheet to complete the confidential statistical items collected for birth certificate reporting. The items on this worksheet relate to the prenatal care of the delivering mother.

Items containing an asterisk (*) appear on the child's legal birth certificate. The remainder are not part of the legal record, but are confidential items collected in accordance with Massachusetts General Law (Ch. 111, § 24B) and submitted directly to the Massachusetts Department of Public Health. All items must be completed.

If you have questions about this worksheet, or any of the items collected about births, please contact the Registry of Vital Records and Statistics (RVRS) at (617) 740-2623.

Administrative Use Only

Birth Mother MRN:

Child MRN:

Log #:

MOTHER/PARENT

Mother/Parent Current Name:

ADEQUACY OF PRENATAL CARE

Did the Mother have Prenatal Care?
☐ Yes ☐ No

Date of First Prenatal Care Visit (MM/DD/YYYY)
Month *Day* *Year*

Total # of Prenatal Care Visits: _____

Date of Last Prenatal Care Visit (MM/DD/YYYY)
Month *Day* *Year*

MOTHER'S PREGNANCY HISTORY

Mother's Height: _____ feet _____ inches

Date of Last Menses (MM/DD/YYYY)
Month *Day* *Year*

Previous Live Births:
Do not include this child or multiples of higher birth order:

Now living: _____ # Born live, now dead: _____

Date of Last Live Birth (MM/DD/YYYY)
Month *Day* *Year*

Number of Other Pregnancy Outcomes:
Include fetal losses of any gestational age- spontaneous losses, induced losses, and/or ectopic pregnancies. If this was a multiple delivery, include all fetal losses delivered before this infant in this pregnancy.

Other Pregnancy Outcomes _____

Date of Last Other Pregnancy Outcome (MM/DD/YYYY)
Month *Day* *Year*

PRENATAL CARE PRACTITIONER *(choose all that apply)*

☐ MD – OBN/GYN	☐ MD – Other	☐ MD – Family Practitioner
☐ DO	☐ CNM	☐ NP
☐ RN	☐ Midwife	☐ PA
☐ Other – *specify:*		

PRIMARY PRENATAL CARE SITE *(choose one)*

☐ Private physician's office	☐ Hospital clinic *(specify name):*
☐ Community health center *(specify name):*	
☐ Health Maintenance Organization (HMO) site *(specify name):*	
☐ Other *(specify):*	

RISK FACTORS for this Pregnancy *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Acute or chronic lung disease	☐ Hypertension, pre-eclampsia	☐ Previous preterm birth
☐ Anemia (HCT<30, HGB<T 10)	☐ Hypertension, eclampsia	☐ Previous cesarean delivery:
☐ Cardiac disease	☐ Hypertension, gestational *(PIH, preeclampsia)*	If yes, how many? _____
☐ Diabetes, Prepregnancy	☐ Incompetent cervix	☐ Other previous poor outcome
☐ Pre-diabetes	☐ Lupus erythematosus	☐ Renal disease
☐ Gestational diabetes	☐ Maternal cancers	☐ RH sensitization
☐ Hemoglobinopathy, non-sickle cell anemia	☐ Maternal PKU	☐ Seizure disorders
☐ Sickle cell anemia	☐ Oligohydramnios	☐ Vaginal bleeding
☐ Hydramnios	☐ Pre-term labor this pregnancy	☐ Weight loss inappropriate for mother
☐ Hypercoagulable conditions	☐ Previous infant with birth defects	☐ Weight gain inappropriate for mother
☐ Hypertension, Prepregnancy *(Chronic)*	☐ Previous infant 4000+ grams	☐ None of the above
☐ Other (specify):		

INFECTIONS Present or Treated in this Pregnancy *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*
Include those present at start of pregnancy or confirmed diagnosis during pregnancy with or without documentation of treatment.

☐ Chlamydia	☐ Gonorrhea	☐ Hepatitis C	☐ Syphilis
☐ Genital Herpes	☐ Hepatitis B	☐ Rubella infection during pregnancy	☐ None of the above

PRENATAL TESTS AND PROCEDURES *(choose all that apply)*

For definitions of the terms listed below, please refer to the *Manual for Completing the Massachusetts Standard Certificate of Live Birth in VIP (Form R-3)*

☐ Amniocentesis	☐ Fetal surgery	☐ Ultrasound
☐ Cervical cerclage	☐ Hospitalization (prenatal for this pregnancy)	☐ Tdap Vaccine
☐ CVS (Chorionic villus sampling)	☐ Tocolysis	☐ Influenza (Flu) Vaccine
☐ None of the above		
☐ Other *(specify):*		

ASSISTED REPRODUCTIVE TECHNOLOGY (ART)

Did this pregnancy result from infertility treatment? ☐ Yes ☐ No *If "Yes," then check all that apply:*

☐ Fertility enhancing drugs:
- *Progesterone*
- *Gonadotrophins (e.g., Clomid®, Serophene)*
- *Gonadotrophin-releasing Hormone Agonists (GnRH Agonists) (e.g., Synarel, Zolodex)*
- *Gonadotrophins-releasing Hormone Antagonists (GnRH Antagonists) (e.g., Cetrotide)*

☐ Artificial insemination
- *Fertility treatment in which sperm were collected and placed in the female reproductive tract. Do not include intrauterine insemination.*

☐ Intrauterine insemination
- *Fertility treatment in which sperm were collected and placed in the woman's uterus.*

☐ Assisted reproductive technology
- *Include in vitro fertilization [IVF], gamete intrafallopian transfer [GIFT], zygote intrafallopian transfer [ZIFT], intracytoplasmic sperm injection [ICSI], frozen embryo transfer, or donor embryo transfer.*

PRENATAL CARE – SOURCE OF PAYMENT

Name of Health Insurer: _____

Type of Health Plan: *(choose one)*

☐ Non-Managed Care ☐ CommCare ☐ Free Care ☐ Self-Pay

☐ Managed Care ☐ Health Safety Net ☐ Government ☐ Other (specify type): _____

Type of Managed Care: *(choose one)*

☐ BCBS ☐ EPO ☐ MCD ☐ POS ☐ Unspecified Managed Care

☐ CommCare ☐ HMO ☐ MCR ☐ PPO ☐ Other *(specify)*: _____

Are Prenatal Care Expenses Paid Through a Government Program? ☐ Yes ☐ No *If "Yes," then select one:*

☐ Commonhealth ☐ Health Safety Net ☐ Indian Health Service ☐ Medicare ☐ Worker's Compensation

☐ Commonwealth Care ☐ Healthy Start ☐ Medicaid/MassHealth ☐ Military *(Champus, Tricare VA, etc.)* ☐ Other *(specify)*: _____