LEERS FACILITY WORKSHEET

STATE FILE NUMBER:

CHILD

1. FACILITY NAME	2. STREET ADDRESS OF BIRTH	3. FACILITY ID. (NPI)	4. CITY OF BIRTH	5. PARISH OF BIRTH	6. ZIP CODE

7. CHILD'S LAST NAME	8. FIRST NAME	9. MIDDLE NAME	10. SUFFIX	11. SEX	12. TIME OF BIRTH (AM / PM)	13. DATE OF BIRTH (MM / DD /YY)

14. MOTHER'S MAIDEN NAME	15. NEWBORN MEDICAL RECORD NUMBER	16. MOTHER'S MEDICAL RECORD NUMBER

17. PLACE WHERE BIRTH OCCURRED

□ HOSPITAL □ FREESTANDING □ BIRTHING CENTER □ HOME BIRTH PLANNED □ HOME BIRTH UNPLANNED □ CLINIC/DOCTOR'S OFFICE □ OTHER

NEWBORN

18. BIRTHWEIGHT (grams preferred, specify unit)

_____

□ grams □ lb / oz

19. OBSTETRIC ESTIMATE OF GESTATION:

_____ (completed weeks)

20. APGAR SCORE:

Score at 5 minutes:_____

If 5 minute score is less than 6,

Score at 10 minutes: _____

21. PLURALITY - Single, Twin, Triplet, etc.

(Specify)_____

21a. IF NOT SINGLE BIRTH - Born First, Second, Third, etc.

(Specify) _____

21b. IF NOT SINGLE BIRTH – Number born alive in this delivery:

(Specify) _____

25. 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

26. 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

22. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? □ Yes □ No □ Unknown
IF YES, NAME OF FACILITY INFANT TRANSFERRED
TRANSFERRED TO:_____

23. IS INFANT LIVING AT TIME OF REPORT?
□ Yes □ No
□ Infant transferred, status unknown

24. IS THE INFANT BEING BREASTFED AT DISCHARGE?
□ Yes □ No □ Unknown

MEDICAL AND HEALTH INFORMATION

27. 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

28. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)

□ Gonorrhea □ CMV
□ Syphilis □ Herpes Simplex Virus
□ Chlamydia □ Rubella
□ Hepatitis B □ Toxoplasmosis
□ Hepatitis C □ None of the above

29. OBSTETRIC PROCEDURES (Check all that apply)

□ Cervical cerclage
□ Tocolysis
External cephalic version:
□ Successful
□ Failed
□ None of the above

30. ONSET OF LABOR (Check all that apply)

□ Premature Rupture of the Membranes (prolonged ≥12 hrs.)
□ Precipitous Labor (<3 hrs.)
□ Prolonged Labor (≥ 20 hrs.)
□ None of the above

31. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)

□ Induction of labor
□ Augmentation of labor
□ 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)
□ Epidural or spinal anesthesia during labor
□ None of the above

32. METHOD OF DELIVERY

A. Fetal presentation at birth
□ Cephalic
□ Breech
□ Other

B. 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

33. MATERNAL MORBIDITY (Complications associated with labor and delivery) (Check all that apply)

□ 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

MOTHER'S MEDICAL

34. DID MOTHER RECEIVE PRENATAL CARE?	34a. DATE OF FIRST PRENATAL CARE VISIT	34b. DATE OF LAST PRENATAL CARE VISIT	34c. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY
□ Yes □ No	_____/_____/_____ MM DD YYYY	_____/_____/_____ MM DD YYYY	_____ (If none, enter " 0")

35. MOTHER'S HEIGHT	36. MOTHER'S PREPREGNANCY WEIGHT	37. MOTHER'S WEIGHT AT DELIVERY
_____ (feet/inches)	_____ (pounds)	_____ (pounds)

38. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY?

□ Yes
□ No
□ Unknown

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

Now Living Number ____ □ None

Now Dead Number ____ □ None

DATE OF LAST LIVE BIRTH
_____/_____
MM YYYY

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

Other Outcomes Number _____ □ None

DATE OF LAST OTHER PREGNANCY OUTCOME _____/_____
MM YYYY

41. 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.

Three Months Before Pregnancy
# of cigarettes # of packs
_____ OR _____

First Three Months of Pregnancy
# of cigarettes # of packs
_____ OR _____

Second Three Months of Pregnancy
# of cigarettes # of packs
_____ OR _____

Third Trimester of Pregnancy
# of cigarettes # of packs
_____ OR _____

42. ALL SOURCES OF PAYMENT FOR THIS DELIVERY

□ Private Insurance
□ Medicaid (Specify ID #)
_____
□ Self-pay
□ Other (Specify)
_____

43. ALCOHOL USE DURING PREGNANCY?

□ Yes
□ No
□ Unknown

44. DATE LAST NORMAL MENSES BEGAN

_____/_____/_____
MM DD YYYY

45. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY?

□ Yes □ No

46. IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM:

_____

Mother's Name

Mother's Medical Record No.

CERTIFIER

47. CERTIFIER SAME AS ATTENDANT?

□ Yes

□ No

48. CERTIFIER/ATTENDANT'S NAME:

_____

TITLE: □ MD □ DO □ HOSPITAL ADMIN.

□ CNM/CM □ OTHER MIDWIFE

□ OTHER (Specify)_____

49. DATE CERTIFIED

_____/_____/_____
MM DD YYYY

50. DATE FACILITY WORKSHEET WAS COMPLETED

_____/_____/_____
MM DD YYYY