

Washington State Birth Filing Form for Female Spouses or Domestic Partners

Child's Information

*1. Child's Name First		*2. Date of Birth (MM/DD/YYYY) / /	
Middle		*3. Time of Birth (24 Hrs)	
Birth Last Name		Suffix (Sr., Jr., II, III, etc.)	
4a. Type of Birthplace (Specify Type) 1 <input type="checkbox"/> Hospital 2 <input type="checkbox"/> Enroute 4 <input type="checkbox"/> Clinic/Doctor's Office 5 <input type="checkbox"/> Freestanding Birth Center 6 <input type="checkbox"/> Other (Specify): 5 <input type="checkbox"/> Home-Planned <input type="checkbox"/> Yes <input type="checkbox"/> No		4b. Planned Birth Place, If different Specify:	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
*6. Name of Facility (If not a facility, enter name of place and address)		*7. City, Town, or Location of Birth	*8. County of Birth

Mother's Information (Woman who gave birth)

*9. Mother's Name Before First Marriage First		*10. Date of Birth (MM/DD/YYYY) / /	
Middle		*11. Birthplace (State, Territory, or Foreign Country)	
Birth Last Name		12. Mother's Social Security Number	
13. Mother's Current Legal Last Name, if different from above		14. Do you want to get a Social Security Number for your Child? <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Is Mother in a Registered Domestic Partnership or Married? <input type="checkbox"/> Yes <input type="checkbox"/> No			
16a. Residence: Number and Street (e.g., 624 SE 5th St.)		Apt No.	16b. City or Town
16c. County	16d. If you live on Tribal Reservation, give name	16e. State or Foreign Country	16f. Zip Code + 4
16g. Inside City Limits? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk			17. Telephone Number () -
18. How Long at Current Residence? Years: Months:		19. Mother's Mailing Address, if different: Number & Street: Apt No. City or Town: State: Zip Code:	

20. Mother's Education -(Check the box that best describes the highest degree or level of school completed at the time of delivery.) 1 <input type="checkbox"/> 8 th grade or less (Specify): _____ 2 <input type="checkbox"/> 9 th - 12 th grade; no diploma 3 <input type="checkbox"/> High school graduate or GED completed 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree(e.g., AA, AS) 6 <input type="checkbox"/> Bachelor's degree(e.g., BA, AB, BS) 7 <input type="checkbox"/> Master's degree(e.g., MA, MS, MEng, Med, MSW, MBA) 8 <input type="checkbox"/> Doctorate(e.g., PhD, EdD) or Professional degree(e.g., MD, DDS, DVM, LLB, JD)		21. Mother of Hispanic Origin? (Check the box that best describes whether the mother is Spanish/Hispanic/Latina or check the "No" box if mother is not Spanish/Hispanic/Latina.) 1 <input type="checkbox"/> No, not Spanish/Hispanic/Latina 2 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicana 3 <input type="checkbox"/> Yes, Puerto Rican 4 <input type="checkbox"/> Yes, Cuban 5 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latina (Specify): _____		22. Mother's Race (Check one or more race to indicate what the mother considers herself to be.) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian(Specify): _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander(Specify): _____ <input type="checkbox"/> Other(Specify): _____	
23. Occupation (Indicate type of work done during last year.)		24. Kind of Business/Industry (Do not use Company Name)			

Spouse or Partner's Information

*25. Spouse or Partner's Current Legal Name First		*26. Date of Birth (MM/DD/YYYY) / /	
Middle		*27. Birthplace (State, Territory, or Foreign Country)	
Birth Last Name		Suffix	
29. Education -(Check the box that best describes the highest degree or level of school completed at the time of delivery.) 1 <input type="checkbox"/> 8 th grade or less (Specify): _____ 2 <input type="checkbox"/> 9 th - 12 th grade; no diploma 3 <input type="checkbox"/> High school graduate or GED completed 4 <input type="checkbox"/> Some college credit, but no degree 5 <input type="checkbox"/> Associate degree(e.g., AA, AS) 6 <input type="checkbox"/> Bachelor's degree(e.g., BA, AB, BS) 7 <input type="checkbox"/> Master's degree(e.g., MA, MS, MEng, MEd, MSW, MBA) 8 <input type="checkbox"/> Doctorate(e.g., PhD, EdD) or Professional degree(e.g. MD, DDS, DVM, LLB, JD)		30. Hispanic Origin? Check the box that best describes whether the partner is Spanish/Hispanic/Latino or check the "No" box if domestic partner is not Spanish/Hispanic/Latino. 1 <input type="checkbox"/> No, not Spanish/Hispanic/Latino 2 <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano 3 <input type="checkbox"/> Yes, Puerto Rican 4 <input type="checkbox"/> Yes, Cuban 5 <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify): _____	
31. Race (Check one or more races to indicate what the partner considers herself to be) <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian(Specify): _____ <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Other Pacific Islander(Specify): _____ <input type="checkbox"/> Other(Specify): _____		32. Occupation (Indicate type of work done during last year.)	
33. Kind of Business/Industry (Do not use Company Name)		33. Kind of Business/Industry (Do not use Company Name)	

Optional Signature:

I agree that the above information is accurate: _____ Date: _____

** Only these items will be displayed on Legal Certificate. However all items are required by law (RCW 70.58.080).*

Mother's Statistical Information					
34. Mother's Medical Record Number		35. Mother's Prepregnancy Weight (Pounds)		36. Mother's Weight at Delivery (Pounds)	
37. Mother's height Feet: _____ Inches: _____		38. Did Mother get WIC food for herself during pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No		39. Cigarette Smoking Before and During Pregnancy If none enter "0" Average number of cigarettes or packs per day: # of cigarettes # of packs Three months before pregnancy _____ OR _____ First three months of pregnancy _____ OR _____ Second three months of pregnancy _____ OR _____ Last three months of pregnancy _____ OR _____	
40a. Number of Previous Live Births (Do not include this child) Number Now Living _____ <input type="checkbox"/> None Number Now Dead _____ <input type="checkbox"/> None		41a. Number of Other Pregnancy Outcomes (Spontaneous or induced losses or ectopic pregnancies) Number of Other Outcomes _____ <input type="checkbox"/> None			
40b. Date of Last Live Birth (MM/YYYY) (Do not include this child) / /		41b. Date of Last Other Pregnancy Outcome (MM/YYYY) / /			
42a. Date of First Prenatal Care Visit (MM/DD/YYYY) / / <input type="checkbox"/> No Prenatal Care		42b. Date of Last Prenatal Care Visit (MM/DD/YYYY) / /		43. Total Number of Prenatal Visits for this Pregnancy (If none, enter '0') _____	
44. Date Last Normal Menses Began (MM/DD/YYYY) / /		45. Was mother transferred to higher level care for maternal medical or fetal indications for delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility mother was transferred from: _____		46. Principal Source of Payment for this Delivery <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-Pay <input type="checkbox"/> Private Insurance <input type="checkbox"/> Indian Health <input type="checkbox"/> CHAMPUS <input type="checkbox"/> Other Gov't <input type="checkbox"/> Other (Specify) _____	
Newborn's Statistical Information					
47. Newborn Medical Record Number		48. Birth Weight lbs: _____ ozs: _____ or grams: _____		49. Infant Head Circumference (cm)	
50. Obstetric Estimate of Gestation (Completed weeks)					
51. Apgar score at 5 minutes _____ If score is less than 6, score at 10 minutes _____		52. Plurality – Single, Twin, Triplet, etc. (Specify) _____		53. If not single birth – Born 1 st , 2 nd , 3 rd , etc. (Specify) _____	
54. Was infant transferred within 24 hours of delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of facility infant was transferred to: _____		55. Is infant living at the time of report? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Transferred, Status Unknown		56. Is infant being breastfed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical and Health Information					
57. Risk Factors in this Pregnancy (Check all that apply): 1 <input type="checkbox"/> Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis in this pregnancy) 2 <input type="checkbox"/> Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, preeclampsia, eclampsia) 3 <input type="checkbox"/> Previous preterm births 4 <input type="checkbox"/> Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth) 5 <input type="checkbox"/> Vaginal bleeding during this pregnancy prior to the onset of labor 6 <input type="checkbox"/> Pregnancy resulted from infertility treatment 7 <input type="checkbox"/> Mother had a previous cesarean delivery? If Yes, how many _____ 8 <input type="checkbox"/> Group B Streptococcus culture positive 9 <input type="checkbox"/> None of the above		58. Method of Delivery A. Was delivery with forceps attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No B. Was delivery with vacuum extraction attempted but unsuccessful? <input type="checkbox"/> Yes <input type="checkbox"/> No C. Fetal presentation at birth <input type="checkbox"/> Cephalic <input type="checkbox"/> Breech <input type="checkbox"/> Other D. Final route and method of delivery (Check One) Vaginal: <input type="checkbox"/> Spontaneous <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum Or, Cesarean: <input type="checkbox"/> If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No		59. Infections Present and/or Treated During this Pregnancy 1 <input type="checkbox"/> Gonorrhea 2 <input type="checkbox"/> Syphilis 3 <input type="checkbox"/> Herpes Simplex Virus (HSV) 4 <input type="checkbox"/> Chlamydia 5 <input type="checkbox"/> Hepatitis B 6 <input type="checkbox"/> Hepatitis C 7 <input type="checkbox"/> HIV Infection 8 <input type="checkbox"/> Other Specify: _____ 9 <input type="checkbox"/> None of the above	
61. Abnormal Conditions of the Newborn (Occurring within 24 hours of delivery) (Check all that apply): 1 <input type="checkbox"/> Assisted ventilation required immediately following delivery 2 <input type="checkbox"/> Assisted ventilation required for more than six hours 3 <input type="checkbox"/> NICU admission 4 <input type="checkbox"/> Newborn given surfactant replacement therapy 5 <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis 6 <input type="checkbox"/> Seizure or serious neurologic dysfunction 7 <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention) 8 <input type="checkbox"/> None of the above		62. Characteristics of Labor and Delivery (Check all that apply): 1 <input type="checkbox"/> Induction of labor 2 <input type="checkbox"/> Augmentation of labor 3 <input type="checkbox"/> Non-vertex presentation 4 <input type="checkbox"/> Epidural or spinal anesthesia during labor 5 <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery 6 <input type="checkbox"/> Antibiotics received by the mother during labor 7 <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature $\geq 38^{\circ}\text{C}$ (100.4°F) 8 <input type="checkbox"/> Moderate/heavy meconium staining of the amniotic fluid 9 <input type="checkbox"/> Fetal intolerance of labor such that one or more of the following actions was taken: in-utero resuscitation measures, further fetal assessment, or operative delivery 10 <input type="checkbox"/> None of the above		60. Obstetric procedures (Check all that apply): 1 <input type="checkbox"/> Cervical cerclage 2 <input type="checkbox"/> Tocolysis 3 <input type="checkbox"/> External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed 4 <input type="checkbox"/> None of the above	
64. Maternal Morbidity (complications associated with labor and delivery) (Check all that apply): 1 <input type="checkbox"/> Maternal transfusion 2 <input type="checkbox"/> Third or fourth degree perineal laceration 3 <input type="checkbox"/> Ruptured uterus 4 <input type="checkbox"/> Unplanned hysterectomy 5 <input type="checkbox"/> Admission to intensive care unit 6 <input type="checkbox"/> Unplanned operating room procedure following delivery 7 <input type="checkbox"/> None of the above		65. Onset of Labor (Check all that apply): 1 <input type="checkbox"/> Premature rupture of the membranes (prolonged, $\geq 12\text{hr}$) 2 <input type="checkbox"/> Precipitous Labor ($< 3\text{hr}$) 3 <input type="checkbox"/> Prolonged Labor ($\geq 20\text{hr}$) 4 <input type="checkbox"/> None of the above		63. Congenital Anomalies of the Newborn (Observed within 24 hours of delivery) (Check all that apply): 1 <input type="checkbox"/> Anencephaly 2 <input type="checkbox"/> Meningocele / Spina bifida 3 <input type="checkbox"/> Cyanotic congenital heart disease 4 <input type="checkbox"/> Congenital diaphragmatic hernia 5 <input type="checkbox"/> Omphalocele 6 <input type="checkbox"/> Gastroschisis 7 <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndrome) 8 <input type="checkbox"/> Cleft Lip with or without Cleft Palate 9 <input type="checkbox"/> Cleft Palate alone 10 <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending 11 <input type="checkbox"/> Chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Suspected, Karyotype pending 12 <input type="checkbox"/> Hypospadias 13 <input type="checkbox"/> None of the above	
Attendant and Certifier Information					
66. Certifier – Name and Title				67. Date Certified (MM/DD/YYYY) / /	
68. Attendant – Name and Title (If other than Certifier)				69. NPI of person delivering the baby:	