

Exhibit No. 2

Date 1/30/2015

Bill No. SB 217

APPENDIX D

FORM V.S. 6 (2003 revision)  
Local File Number

MONTANA CERTIFICATE OF LIVE BIRTH

State File Number

<b>CHILD</b>	1. CHILD'S NAME (First) (Middle) (Last and Suffix if applicable)		4. DATE OF BIRTH (Month, Day, Year)		3. SEX
	5. FACILITY—NAME (If not institution, give street and number)		6. CITY, TOWN, OR LOCATION OF BIRTH		7. COUNTY OF BIRTH
<b>CERTIFIER</b>	26. PLACE OF BIRTH: <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home birth: planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (Specify)				
	11a. I certify that this child was born alive at the place and time and the date stated;		12. DATE CERTIFIED (Mo, Day, Yr)		27. ATTENDANT'S NAME, TITLE AND NPI (If other than Certifier)
	Signature:				NPI
	11. CERTIFIER'S NAME AND TITLE		11b. MAILING ADDRESS (Street Number or Rural Route Number, City, Town, State, Zip Code)		
<b>MOTHER</b>	8a. MOTHER'S FULL MAIDEN NAME (First, Middle, & Maiden Last Name)			8d. BIRTHPLACE (State or Foreign Country)	8b. DATE OF BIRTH (Month, Day, Year)
	9a. RESIDENCE - S	9b. COUNTY	9c. CITY, OR TOWN AND ZIP CODE	9d. STREET AND NUMBER	9g. INSIDE CITY LIMITS (Yes or No) <input type="checkbox"/> Yes <input type="checkbox"/> No
	10a. FATHER'S CURRENT LEGAL NAME (First, Middle, Last)			10c. BIRTHPLACE (State or Foreign Country)	10b. DATE OF BIRTH (Month, Day, Year)
<b>FATHER</b>	I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.			14. MOTHERS MAILING ADDRESS (If same as residence Enter Zip Code only)	
	Signature of Parent or Informant				
16. Permission is given to provide the Social Security Administration with information from this certificate to obtain a Social Security card for this child. <input type="checkbox"/> Yes <input type="checkbox"/> No Signature of Parent					
<b>INFORMATION FOR MEDICAL AND HEALTH USE ONLY</b>					
20. MOTHER'S EDUCATION (Specify only the highest diploma or degree) <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> grade: No Diploma <input type="checkbox"/> High School graduate or GED completed <input type="checkbox"/> Some college but no Degree <input type="checkbox"/> Associates Degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's Degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA) <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/Latino. Check the "No" box if the mother is not Spanish/Hispanic/Latino.  No, not Spanish/Hispanic/Latino Yes, Mexican, Mexican American, Chicano Yes, Puerto Rican Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		22. MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be) <input type="checkbox"/> White <input type="checkbox"/> Korean <input type="checkbox"/> Black or African American <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Chinese <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Filipino <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other (Specify) _____	
23. FATHER'S EDUCATION (Specify only the highest diploma or degree) <input type="checkbox"/> 8 <sup>th</sup> grade or less <input type="checkbox"/> 9 <sup>th</sup> -12 <sup>th</sup> grade: No Diploma <input type="checkbox"/> High School graduate or GED completed <input type="checkbox"/> Some college but no Degree <input type="checkbox"/> Associates Degree (e.g. AA, AS) <input type="checkbox"/> Bachelor's Degree (e.g. BA, AB, BS) <input type="checkbox"/> Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA) <input type="checkbox"/> Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD)		24. FATHER OF HISPANIC ORIGIN? Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if the father is not Spanish/Hispanic/Latino.  No, not Spanish/Hispanic/Latino Yes, Mexican, Mexican American, Chicano Yes, Puerto Rican Yes, Cuban <input type="checkbox"/> Yes, other Spanish/Hispanic/Latino (Specify) _____		25. FATHER'S RACE (Check one or more races to indicate what the father considers himself to be) <input type="checkbox"/> White <input type="checkbox"/> Korean <input type="checkbox"/> Black or African American <input type="checkbox"/> Vietnamese <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian (Specify) _____ <input type="checkbox"/> Chinese <input type="checkbox"/> Other Pacific Islander (Specify) _____ <input type="checkbox"/> Filipino <input type="checkbox"/> American Indian or Alaska Native (Name of the enrolled or principal tribe) <input type="checkbox"/> Japanese <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Other (Specify) _____	
18. MOTHER'S SOCIAL SECURITY NUMBER:		19. FATHER'S SOCIAL SECURITY NUMBER:		17. FACILITY ID. (NPI)	
15a. MOTHER MARRIED EVER? <input type="checkbox"/> Yes <input type="checkbox"/> No		15. MOTHER MARRIED? (At birth, conception, or any time between) <input type="checkbox"/> Yes <input type="checkbox"/> No If No, has Paternity Acknowledgment been signed In the hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No		38. PRINCIPAL SOURCE OF PAYMENT FOR DELIVERY <input type="checkbox"/> Private insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-pay <input type="checkbox"/> Other (Specify)	
		39. DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)		34. DID MOTHER GET WIC FOOD DURING PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## APPENDIX D

### Montana Certificate of Live Birth

35. NUMBER OF PREVIOUS LIVE BIRTHS <i>(Do not include this child)</i>		36. NUMBER OF OTHER PREGNANCY OUTCOMES <i>(Spontaneous &amp; induced losses or ectopic pregnancies)</i>		29a. DATE OF FIRST PRENATAL CARE VISIT (mm,dd,yyyy) or <input type="checkbox"/> No prenatal care		29b. DATE OF LAST PRENATAL CARE VISIT (mm,dd,yyyy)		30. TOTAL NUMBER OF PRENATAL VISITS- <i>(If none, enter "0")</i>					
35a. Now Living Number <input type="checkbox"/>	35b. Now Dead Number <input type="checkbox"/> None	36a. Other Outcomes Number <input type="checkbox"/> None		49. BIRTH WEIGHT (grams preferred, specify Unit)		50. OBSTETRIC ESTIMATE OF GESTATION AT DELIVERY. IF A FRACTION OF A WEEK IS GIVEN (E.G. 32.2 WEEKS) ROUND DOWN TO THE NEXT WHOLE WEEK (E.G. 32 WEEKS) (Completed weeks)		52. PLURALITY—Single, Twin Triplet, etc. <i>(Specify)</i>					
35c. DATE OF LAST LIVE BIRTH (mm,yy)		36b. DATE OF LAST OTHER PREGNANCY OUTCOME (mm,yyyy)		48. IS INFANT BEING BREASTFED AT DISCHARGE? INFORMATION ON WHETHER THE INFANT WAS BEING BREAST-FED DURING THE PERIOD BETWEEN BIRTH AND DISCHARGE FROM THE HOSPITAL <input type="checkbox"/> Yes <input type="checkbox"/> No		53. IF NOT SINGLE BIRTH —Born First, Second, Third, Etc. (Specify)		57. IS INFANT LIVING AT TIME OF REPORT <input type="checkbox"/> Yes <input type="checkbox"/> No					
51. APGAR SCORE		28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enter name of facility transferred from:				56. INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY If yes, enter name of facility transferred to: <input type="checkbox"/> Yes <input type="checkbox"/> No							
5 Minute		10 Minutes											
37. CIGARETTE SMOKING BEFORE AND DURING PREGNANCY Average number of cigarettes or packs of cigarettes smoked per day. For each time period, enter either the number of cigarettes or the Number of packs of cigarettes smoked. IF NONE, ENTER "0".						59. Alcohol use during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, average number of drinks per week							
31. MOTHER'S HEIGHT _____ (feet/inches)						32. MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)				33. MOTHER'S WEIGHT AT DELIVERY _____ (pounds)			
54. ABNORMAL CONDITIONS OF THE NEWBORN (Check all that apply)						55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)							
<input type="checkbox"/> Assisted ventilation required immediately following delivery Excludes free flow oxygen only, laryngoscopy for aspiration of meconium and nasal cannula <input type="checkbox"/> Assisted ventilation required for more than six hours Excludes free flow oxygen only, laryngoscopy for aspiration of meconium and nasal cannula <input type="checkbox"/> NICU admission <input type="checkbox"/> Newborn given surfactant replacement therapy <input type="checkbox"/> Antibiotics received by the newborn for suspected neonatal sepsis <input type="checkbox"/> Seizure or serious neurologic dysfunction <input type="checkbox"/> Significant birth injury (skeletal fracture(s), peripheral nerve injury, and /or soft tissue/solid organ hemorrhage which requires intervention) <input type="checkbox"/> None of the above						<input type="checkbox"/> Anencephaly <input type="checkbox"/> Cyanotic congenital heart disease <input type="checkbox"/> Omphalocele <input type="checkbox"/> Limb reduction defect (excluding congenital amputation and dwarfing syndromes) <input type="checkbox"/> Cleft Lip with or without Cleft palate <input type="checkbox"/> Down Syndrome <input type="checkbox"/> Karyotype pending <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Hypospadias <input type="checkbox"/> Meningomyelocele/Spina bifida <input type="checkbox"/> Congenital diaphragmatic hernia <input type="checkbox"/> Gastroschisis <input type="checkbox"/> Cleft Palate alone <input type="checkbox"/> Suspected Chromosomal disorder <input type="checkbox"/> Karyotype confirmed <input type="checkbox"/> Karyotype pending <input type="checkbox"/> None of the anomalies listed above							
41. RISK FACTORS FOR THIS PREGNANCY (Check all that apply)			43. OBSTETRIC PROCEDURES (Check all that apply)			46. METHOD OF DELIVERY							
Diabetes <input type="checkbox"/> Prepregnancy (Diagnosis prior to this pregnancy) <input type="checkbox"/> Gestational (Diagnosis during this pregnancy) Hypertension <input type="checkbox"/> Prepregnancy (Chronic) <input type="checkbox"/> Gestational (PIH, Preeclampsia) <input type="checkbox"/> Eclampsia  <input type="checkbox"/> Previous preterm birth  <input type="checkbox"/> Other previous poor pregnancy outcome (Includes Perinatal death, small for gestational age intrauterine growth restricted birth)  <input type="checkbox"/> Pregnancy result from infertility treatment-if yes, check all that apply <input type="checkbox"/> Fertility-enhancing drugs, Artificial insemination or Intrauterine insemination <input type="checkbox"/> Assisted reproductive technology (e.g., in vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT)) <input type="checkbox"/> Mother had a previous cesarean delivery If yes, how many _____ <input type="checkbox"/> None of the above			<input type="checkbox"/> Cervical cerclage <input type="checkbox"/> Tocolysis External cephalic version: <input type="checkbox"/> Successful <input type="checkbox"/> Failed <input type="checkbox"/> None of the above			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) <input type="checkbox"/> Vaginal/Spontaneous <input type="checkbox"/> Vaginal/Forceps <input type="checkbox"/> Vaginal/Vacuum <input type="checkbox"/> Cesarean If cesarean, was a trial of labor attempted? <input type="checkbox"/> Yes <input type="checkbox"/> No							
42. INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY (Check all that apply)			44. ONSET OF LABOR (Check all that apply)			47. MATERNAL MORBIDITY (Check all that apply) (Complications associated with labor and delivery)							
<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> None of the above			<input type="checkbox"/> Premature Rupture of the Membranes (prolonged, ≥12 hrs.) <input type="checkbox"/> Precipitous Labor (<3 hrs.) <input type="checkbox"/> Prolonged Labor (≥20 hrs.) <input type="checkbox"/> None of the above			<input type="checkbox"/> Maternal transfusion  <input type="checkbox"/> Third or fourth degree perineal laceration  <input type="checkbox"/> Ruptured uterus  <input type="checkbox"/> Unplanned hysterectomy  <input type="checkbox"/> Admission to intensive care unit  <input type="checkbox"/> Unplanned operative room procedure following delivery  <input type="checkbox"/> None of these above							
45. CHARACTERISTICS OF LABOR AND DELIVERY (Check all that apply)													
<input type="checkbox"/> Induction of labor <input type="checkbox"/> Augmentation of labor <input type="checkbox"/> Non-vertex presentation <input type="checkbox"/> Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery <input type="checkbox"/> Antibiotics received by the mother during labor <input type="checkbox"/> Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38°C (100.4°F) <input type="checkbox"/> Moderate/heavy Meconium staining of the amniotic fluid <input type="checkbox"/> 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 <input type="checkbox"/> Epidural or spinal anesthesia during labor <input type="checkbox"/> None of the above													

# HOSPITAL WORKSHEET

CHILD'S NAME (First)	(Middle)	(Last and Suffix if applicable)	DATE OF BIRTH	SEX
FACILITY NAME (If not institution, give street and number)		CITY OR LOCATION OF BIRTH	COUNTY OF BIRTH	TIME OF BIRTH
PLACE OF BIRTH: <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding birthing center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home birth: planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other (Specify) _____				
I certify that this child was born alive at the place and Time and on the date stated Signature		DATE SIGNED	ATTENDANT'S NAME, TITLE and NPI (If other than certifier) _____ NPI _____	
CERTIFIER'S NAME AND TITLE		MAILING ADDRESS (Street Number or Rural Route Number, City or Town, State, Zip Code)		
MOTHER'S FULL MAIDEN NAME (First, Middle, Maiden Last Name)		BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)	
Does Mother live on a Reservation: Yes/No If yes list what reservation: _____				
RESIDENCE - STATE	COUNTY	CITY OR TOWN, AND ZIP CODE	STREET AND NUMBER	INSIDE CITY LIMITS
FATHER'S CURRENT LEGAL NAME (First, Middle, Last)		BIRTHPLACE (State or Foreign County)	DATE OF BIRTH (Month, Day, Year)	
Does Father live on a Reservation: Yes/No If yes list what reservation: _____				
I certify that the personal information provided on this certificate is correct to the best Of my knowledge and belief Signature of Parent or Other Informant			MOTHER'S MAILING ADDRESS (If same as residence, enter Zip code Only)	
Permission is given to provide Social Security Administration with information from this certificate to obtain a Social Security card for this child?				
Yes / No Signature of Parent: _____				
Consent to be notified of available health services? Yes/No				
CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
MOTHER'S EDUCATION (Specify only the highest diploma or degree received) 8 <sup>th</sup> grade or less 9 <sup>th</sup> -12 <sup>th</sup> grade: No Diploma High School graduate or GED completed Some college but no Degree Associates Degree (e.g. AA, AS) Bachelor's Degree (e.g. BA, AB, BS) Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA) Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD)	MOTHER OF HISPANIC ORIGIN? Check the box that best describes whether the mother is Spanish/Hispanic/Latino. Check the "No" box if the mother is not Spanish/Hispanic/Latino.  No, not Spanish/Hispanic/Latino Yes, Mexican, Mexican American, Chicano Yes, Puerto Rican Yes, Cuban Yes, other Spanish/Hispanic/Latino (Specify) _____	MOTHER'S RACE (Check one or more races to indicate what the mother considers herself to be)  White Black or African American Native Hawaiian Asian Indian Chinese Filipino Japanese Guamanian or Chamorro  Korean Vietnamese Samoan Other Asian (Specify) _____ Other Pacific Islander (Specify) _____ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ Other (Specify) _____		
FATHER'S EDUCATION (Specify only the highest diploma or degree received) 8 <sup>th</sup> grade or less 9 <sup>th</sup> -12 <sup>th</sup> grade: No Diploma High School graduate or GED completed Some college but no Degree Associates Degree (e.g. AA, AS) Bachelor's Degree (e.g. BA, AB, BS) Master's Degree (e.g. MA, MS, MEng, Med, MSW, MBA) Doctorate (e.g. PhD, EdD) or Professional Degree (e.g. MD, DDS, DVM, LLB, JD)	FATHER OF HISPANIC ORIGIN? Check the box that best describes whether the father is Spanish/Hispanic/Latino. Check the "No" box if the father is not Spanish/Hispanic/Latino.  No, not Spanish/Hispanic/Latino Yes, Mexican, Mexican American, Chicano Yes, Puerto Rican Yes, Cuban Yes, other Spanish/Hispanic/Latino (Specify) _____	FATHER'S RACE (Check one or more races to indicate what the father considers himself to be)  White Black or African American Native Hawaiian Asian Indian Chinese Filipino Japanese Guamanian or Chamorro  Korean Vietnamese Samoan Other Asian (Specify) _____ Other Pacific Islander (Specify) _____ American Indian or Alaska Native (Name of the enrolled or principal tribe) _____ Other (Specify) _____		
Was Mother Ever Married <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Mother Married at Conception, Birth or Anytime between? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was Mother Married to the Father? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will Husband Sign Non-Paternity Affidavit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Will Father sign Paternity Affidavit? <input type="checkbox"/> Yes <input type="checkbox"/> No
MOTHER'S SOCIAL SECURITY NUMBER:	FATHER'S SOCIAL SECURITY NUMBER:	PRINCIPAL OF PAYMENT FOR DELIVERY: <input type="checkbox"/> Private insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Self-pay <input type="checkbox"/> Other (Specify) _____		
FACILITY ID. (NPI)	DATE OF LAST NORMAL MENSES BEGAN (Month, Day, Year)	DID MOTHER GET WIC FOOD DURING PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**COMPLETE REVERSE SIDE**

# HOSPITAL WORKSHEET CONTINUED

NUMBER OF PREVIOUS LIVE BIRTHS <i>(Do not include this child)</i>		NUMBER OF OTHER PREGNANCY OUTCOMES <i>(Spontaneous &amp; induced losses or ectopic pregnancies)</i>		DATE OF FIRST PRENATAL CARE VISIT (mm,dd,yyyy) or <input type="checkbox"/> No prenatal care	DATE OF LAST PRENATAL CARE VISIT (mm,dd,yyyy)	TOTAL NUMBER OF PRENATAL VISITS- <i>(If none, enter "0")</i>
Now Living Number ___ <input type="checkbox"/> None	Now Dead Number ___ <input type="checkbox"/> None	Other Outcomes Number ___ <input type="checkbox"/> None		BIRTH WEIGHT <i>(grams preferred, specify Unit)</i>	OBSTETRIC ESTIMATE OF GESTATION (Completed weeks)	PLURALITY—Single, Twin Triplet, etc. <i>(Specify)</i>
DATE OF LAST LIVE BIRTH (mm,yyyy)		DATE OF LAST OTHER PREGNANCY OUTCOME (mm,yyyy)		IS INFANT BEING BREASTFED AT DISCHARGE? <input type="checkbox"/> Yes <input type="checkbox"/> No	IF NOT SINGLE BIRTH—Born First, Second, Third, Etc. <i>(Specify)</i>	IS INFANT LIVING AT TIME OF REPORT <input type="checkbox"/> Yes <input type="checkbox"/> No
APGAR SCORE 5 Minute		10 Minutes		MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? Yes No If yes, enter name of facility transferred from:		INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY If yes, enter name of facility transferred to: <input type="checkbox"/> Yes <input type="checkbox"/> No
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. # of cigarettes # of packs		Alcohol use during pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, average number of drinks per week
MOTHER'S HEIGHT _____ (feet/inches)				MOTHER'S PREPREGNANCY WEIGHT _____ (pounds)		MOTHER'S WEIGHT AT DELIVERY _____ (pounds)
HEP B VACCINATION INFORMATION – INFANT Hep B Birth Dose Given <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Parent Refused <input type="checkbox"/> Unknown HBsAg Test Date: (mm,dd,yyyy) _____				HEP B TESTING INFORMATION- MOTHER Hep B Administration Date: (mm,dd,yyyy) _____ Time: _____ am / pm HBsAg Test Result <input type="checkbox"/> Positive-Reactive <input type="checkbox"/> Negative-Nonreactive <input type="checkbox"/> Unknown		
CONSENT OBTAINED for INCLUSION in the MONTANA IMMUNIZATION INFORMATION SYSTEM? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
ABNORMAL CONDITIONS OF THE NEWBORN <i>(Check all that apply)</i> 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				CONGENITAL ANOMALIES OF THE NEWBORN <i>(Check all that apply)</i> Anencephaly Cyanotic congenital heart disease Omphalocele Limb reduction defect (excluding congenital amputation and dwarfing syndromes) Cleft Lip with or without Cleft palate Down Syndrome Karyotype confirmed Karyotype pending Hypospadias Meningocele/Spina bifida Congenital diaphragmatic hernia Gastroschisis Cleft Palate alone Suspected Chromosomal disorder Karyotype confirmed Karyotype pending None of the anomalies listed above		
MEDICAL RISK FACTORS FOR THIS PREGNANCY <i>(Check all that apply)</i> Diabetes Prepregnancy (Diagnosis prior to this pregnancy) Gestational (Diagnosis during 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 result 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		OBSTETRIC PROCEDURES <i>(Check all that apply)</i> Cervical cerclage Tocolysis External cephalic version: Successful Failed None of the above ONSET OF LABOR <i>(Check all that apply)</i> Premature Rupture of the Membranes (prolonged, ≥12 hrs.) Precipitous Labor (<3 hrs.) Prolonged Labor (≥20 hrs.) None of the above		METHOD OF DELIVERY A. Was delivery with forceps attempted but unsuccessful? Yes No B. Was delivery with vacuum extraction attempted but unsuccessful? Yes No C. Fetal presentation at birth Cephalic Breech Other D. Final route and method of delivery <i>(Check one)</i> Vaginal/Spontaneous Vaginal/Forceps Vaginal/Vacuum Cesarean If cesarean, was a trial of labor attempted? Yes No		
INFECTIONS PRESENT AND/OR TREATED DURING THIS PREGNANCY <i>(Check all that apply)</i> Gonorrhea Syphilis Chlamydia Hepatitis B Hepatitis C None of the above		CHARACTERISTICS OF LABOR AND DELIVERY <i>(Check all that apply)</i> Induction of labor Augmentation of labor Non-vertex presentation 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) Moderate/heavy Meconium staining of the amniotic fluid 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 Epidural or spinal anesthesia during labor None of the above		MATERNAL MORBIDITY <i>(Check all that apply)</i> <i>(Complications associated with labor and delivery)</i> Maternal transfusion Third or fourth degree perineal laceration Ruptured uterus Unplanned hysterectomy Admission to intensive care unit Unplanned operative room procedure following delivery None of these above		