COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

CERTIFICATE OF LIVE BIRTH – MEDICAL CERTIFICATE FORM (MCF) WORKSHEET

NEWBORN'S HOSP NUMBER: ___________________ MOTHER'S HOSP NUMBER: _________________

MCF PART 1 — CHILD, MOTHER, AND BIRTH ATTENDANT INFORMATION

C H I L D

1. DATE OF BIRTH (Mo/Day/Year) _______/ _______/ ________

2. TIME OF BIRTH : ______ : ______ [ ] AM [ ] PM

3. SEX : [ ] Male or [ ] Female

4. PLACE WHERE BIRTH OCCURRED:

[ ] HOSPITAL : [ ] CHC [ ] RHC [ ] THC

[ ] FREESTANDING BIRTHING CENTER

[ ] HOME BIRTH: PLANNED? [ ] Yes [ ] No

[ ] CLINIC/DOCTOR'S OFFICE

[ ] OTHER *(specify)* ________________________________

5. CITY, TOWN, OR LOCATION OF BIRTH

[ ] GARAPAN

[ ] SONGSONG VILLAGE

[ ] SAN JOSE VILLAGE

[ ] OTHER (specify):

____

6. COUNTY OF BIRTH

[ ] SAIPAN

[ ] TINIAN

[ ] ROTA

[ ] NORTHERN ISLANDS (specify)

____

M O T H E R

7. MOTHER'S CURRENT LEGAL NAME (First, Middle, Last, Suffix)

8. DATE OF BIRTH (Mo/Day/Yr)

CLINICIAN

9a. ATTENDANT'S NAME, TITLE AND NPI :

NAME: ________________________________

TITLE: □ MD □ DO □ CNM/CM □ OTHER MIDWIFE

□ OTHER (Specify) ________________________________

9b. CERTIFYING CLINICIAN

NAME: ________________________________

TITLE: □ MD □ DO □ CNM/CM □ OTHER MIDWIFE

□ OTHER (Specify) ________________________________

Name of Nurse Completing MCF PART 1: ________________________________ **Date** ______________________

MCF PART 2 — MATERNAL RISK FACTORS INFORMATION

41. 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

43. OBSTETRIC PROCEDURES (Check all that apply)

- □ Cervical cerclage
- □ Tocolysis

External cephalic version:
- □ Successful
- □ Failed

□ None of the above

44. 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

46. 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 (Check one)
- □ Vaginal/Spontaneous
- □ Vaginal/Forceps
- □ Vaginal/Vacuum
- □ Cesarean

If cesarean, was a trial of labor attempted?
- □ Yes
- □ No

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

- □ Gonorrhea
- □ Syphilis
- □ Chlamydia
- □ Hepatitis B
- □ Hepatitis C
- □ NONE OF THE ABOVE

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

- □ 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 $\geq$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
(Note: Mother should have undergone labor, regardless of method of delivery; anesthesia administered solely for surgery such as cesarean should not be reported.)
- □ NONE OF THE ABOVE

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

- □ 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

Name of Nurse Completing MCF PART 2: ________________________________ **Date** ________________

As the reviewing clinician, I hereby certify that the medical information provided on the Certificate of Live Birth are true and correct.

Name of the Reviewing Clinician : ________________________________

Signature & Date : ________________________________ Date signed: ________________________

HVSO-FORM-MCF001_20230921

Pursuant to 1CMC § 26007, Birth Registration statute, the physician or other person in attendance shall provide the medical information required by the certificate within 72 hours after the birth.

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

CERTIFICATE OF LIVE BIRTH – MEDICAL CERTIFICATE FORM (MCF) WORKSHEET

MCF PART 3 — MATERNAL PRENATAL CARE INFORMATION

28. MOTHER TRANSFERRED FOR MATERNAL MEDICAL OR FETAL INDICATIONS FOR DELIVERY? ☐ Yes ☐ No

IF YES, ENTER NAME OF FACILITY MOTHER TRANSFERRED FROM: ______________________________

29. ☐ No Prenatal Care	29a. DATE OF FIRST PRENATAL CARE VISIT ______ /________/ __________ MM DD YYYY	29b. DATE OF LAST PRENATAL CARE VISIT ______ /________/ __________ M M D D YYYY	30. TOTAL NUMBER OF PRENATAL VISITS FOR THIS PREGNANCY ________________________ (If none, enter "0".)

31. MOTHER'S HEIGHT _______ (feet/inches)	32. MOTHER'S PREPREGNANCY WEIGHT _________ (pounds)	33. MOTHER'S WEIGHT AT DELIVERY _________ (pounds)	34. DID MOTHER GET WIC FOOD FOR HERSELF DURING THIS PREGNANCY? ☐ Yes ☐ No

35. NUMBER OF PREVIOUS LIVE BIRTHS (Do not include this child) : #_______

- 35a. Now Living — Number _____ ☐ None
- 35b. Now Dead — Number _____ ☐ None

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

- 36a. Other Outcomes — Number _____ ☐ None

37a. 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".
(SEE SUPPLEMENTAL SUBSTANCE USE FORM 37b-37e)
Average number of cigarettes or packs of cigarettes smoked per day.

	# of cigarettes		# of packs
Three Months Before Pregnancy	_________	OR	________
First Three Months of Pregnancy	_________	OR	________
Second Three Months of Pregnancy	_________	OR	________
Third Trimester of Pregnancy	_________	OR	________

38. PRINCIPAL SOURCE OF PAYMENT FOR THIS DELIVERY

- ☐ Private Insurance
- ☐ Medicaid
- ☐ Self-pay
- ☐ Other (Specify) _______________

35c. DATE OF LAST LIVE BIRTH ________/__________ MM YYYY	36b. DATE OF LAST OTHER PREGNANCY OUTCOME ________/__________ MM YYYY	39. DATE LAST NORMAL MENSES BEGAN: ______ /________/ _________ M M D D YYYY

MOTHER'S SUBSTANCE USE DURING PREGNANCY

37b. MOTHER BETEL NUT CHEWING DURING PREGNANCY ☐ Yes ☐ No - . IF YES, BETEL NUT CHEWING WITH TOBACCO? ☐ Yes ☐ No

37c. MOTHER USE OF ILLICIT DRUGS DURING PREGNANCY: ☐ Yes ☐ No - IF YES, SPECIFY: (Check one or more) ☐ CANNABIS ☐ CRYSTAL METHAMPHETAMINE ☐ OPIOID ☐ OTHER (Specify):___________________________

37d. MOTHER CONSUMED ALCOHOL DURING PREGNANCY ☐ Yes ☐ No

37e. MOTHER E-CIGARETTE (VAPING) USE DURING PRENANCY: ☐ Yes ☐ No - IF YES, SPECIFY: (Check frequency of use)
- ☐ THREE MONTHS BEFORE PREGNANCY
- ☐ FIRST THREE MONTHS DURING PREGNANCY
- ☐ SECOND THREE MONTHS DURING PREGNANCY
- ☐ THIRD TRIMESTER OF PREGNANCY

Name of Nurse Completing MCF PART 3: ______________________________ **Date** ________________

MCF PART 4 — NEWBORN'S CLINICAL INFORMATION

49. BIRTHWEIGHT (grams preferred, specify unit)
____
9 grams 9 lb/oz
HEIGHT (cm) :_________
HEAD CIRCUMFERENCE (cm): __________

50. OBSTETRIC ESTIMATE OF GESTATION:
_________________ (completed weeks)

51. APGAR SCORE:
Score at 5 minutes:________________________
If 5 minute score is less than 6,
Score at 10 minutes: _______________________

52. PLURALITY - Single, Twin, Triplet, etc.
(Specify)________________________

53. IF NOT SINGLE BIRTH - Born First, Second, Third, etc. (Specify) ________________

54. 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

55. CONGENITAL ANOMALIES OF THE NEWBORN (Check all that apply)
- ☐ Anencephaly
- ☐ Microcephaly
- ☐ 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

56. WAS INFANT TRANSFERRED WITHIN 24 HOURS OF DELIVERY? ☐ Yes ☐ No IF YES, NAME OF FACILITY INFANT TRANSFERRED TO:______________________________	57. IS INFANT LIVING AT TIME OF REPORT? ☐ Yes ☐ No ☐ Infant transferred, status unknown	58. IS THE INFANT BEING BREASTFED AT DISCHARGE? ☐ Yes ☐ No

Name o Nurse Completing MCF PART 4: ______________________________ **Date** ________________

HEALTH & VITAL STATISTICS OFFICE USE ONLY

MEDICAL CERTIFICATE FORM REVIEW FOR DATA QUALITY AND COMPLETENESS

DATE RECEIVED: ________________

DATE COMPLETED:

MEDICAL CERTIFICATE FORM		**INDICATE MCF FIELDS INCOMPLETE BELOW**
MCF1 QAPI PASSED:	[ ] Yes [ ] No	______________________________
MCF2 QAPI PASSED:	[ ] Yes [ ] No	______________________________
MCF3 QAPI PASSED:	[ ] Yes [ ] No	______________________________
MCF4 QAPI PASSED:	[ ] Yes [ ] No	______________________________

SPECIAL REMARK: