Attachment 1
Study Elements --Vital Statistics Data Quality Study

Data Components	Principal Program	Data Fields	Source Checking Order *	Field Name(s)
Child's Name	OVS	4	3 1 8 5	NMF, NMM, NML, NMG
Date of Birth	OVS	3	1 5 8	BIRDT
Time of Birth	OVS	1	1 5 8	TIMEBR
City of Birth	OVS	1	1 3 5 8	CTYOCCDS
County of Birth	BOTH	1	1 3 5 8	COUOCCDS
Place of Birth	OVS	1	1 3 8	INSTYPDS
Certifier Title	BOTH	1	1	CRTCDDS
Mother's Name	OVS	4	1 2 3 5 8	MONMF, MONMM, MONML, MONMG
Mother's Maiden Surname	OVS	1	1 2 3 8	MONMMD
Mother's Birthdate	BOTH	3	1 2 3 8	MOBRDY, MOBRMO, MOBRYR
Mother's Birth State	OVS	1	1 2 3 8	STMOBR
Mother's Residence State	BOTH	1	1 2 3 8	STMORSDS
Mother's Residence County	BOTH	1	1 2 3 8	COURESDS
Mother's Residence City	BOTH	1	1 2 3 8	CTYRESDS
Mother's Street Address	OVS	1	1 2 3 8	MOADR1, MOADR2
Mother's Mailing Address	OVS	5	1 2 3 8	MOMAD1, MOMAD2, MOMCTY, MOMST, MOMZIP
Mother's Ancestry	BOTH	1	1 2 3 8	ETHCDMDS
Mother's Race	BOTH	1	1 2 3 8	RACCDMDS
Mother's Education	BOTH	2	1 2 3 8	MOEDEL, MOEDCO
Mother's SSN	OVS	1	1 2 3 8	MOSSN
Father's Name	OVS	4	1 2 3 8 5	FANMF, FANMM, FANML, FANMG
Father's Birth Date	BOTH	3	1 2 3 8	FABRDY, FABRMO, FABRYR
Father's Birth State	OVS	1	1 2 3 8	STFABR
Father's Ancestry	BOTH	1	1 2 3 8	ETHCDFDS
Father's Race	BOTH	1	1 2 3 8	RACCDFDS
Father's Education	BOTH	2	1 2 3 8	FAEDEL, FAEDCO
Father's SSN	OVS	1	1 2 3 8	FASSN
Date Certificate Signed	BOTH	1	1 2 8	DTSGN
Live Births: Living	OHCI	1	1 2 8	HSTLV
Live Births: Dead	OHCI	1	1 2 8	HSTDE
Terminations < 20 Weeks	OHCI	1	1 2 8	TRMB20
Terminations ≥ 20 Weeks	OHCI	1	1 2 8	TRMA20
Date Last Normal Menses	OHCI	3	1 2 8	HSLMEN
Estimation of Gestation	OHCI	1	1 2 8	HSGTPR
Month Prenatal Care Began	OHCI	1	1 2 8	HSPRCR
Number of Prenatal Visits	OHCI	1	1 2 8	HSPRVS
Plurality	OHCI	1	1 2 8	HSPLURDS
Birth Order (if Multiple Birth)	OHCI	1	1 2 8	HSORDDS
Birth weight	BOTH	1	1 2 8	HSWTGM
Mother Married	OHCI	1	1 2 8	MOMAR

Data Components	Principal Program	Data Fields	Source Checking Order *	Field Name(s)
Medical Risk Factors	OHCI	27	1 2 8	FCTG1, FCTG1D, FCTG1D1 - FCTG1D25
Prenatal Procedures	OHCI	10	1 2 8	FCTG2, FCTG2D, FCTG2D1 - FCTG2D8
Conditions of Labor/Delivery	OHCI	24	1 2 8	FCTG3, FCTG3D, FCTG3D1 - FCTG3D22
Method of Delivery	OHCI	13	1 2 8	FCTG4, FCTG4D, FCTG4D1 - FCTG4D12
Condition of Newborn	OHCI	12	1 2 8	FCTG5, FCTG5D, FCTG5D1 - FCTG5D10
Apgar Score(s)	OHCI	3	1 2 8	HSAP1, HSAP5, HSAP10
Birth Anomalies	OHCI	27	1 2 8	FCTG7, FCTG7D, FCTG7D1 - FCTG7D25

* Source Checking Codes

1 Mother's Hospital Record
2 Mother's Doctor's Record within Hospital Record
3 Other Source within Mother's Hospital Record (Billing Record)
4 2nd Other Source within Mother's Hospital Record
5 Child's Hospital Record
6 Other Source within Child's Hospital Record
7 2nd Source within Child's Hospital Record
8 Mother's Recollection from Mother's Hospital Worksheet
9 Unknown/Missing

Attachment 2

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
OFFICE OF VITAL STATISTICS

Hospital Record No.

Hospital Worksheet for **Birth Registration**

PART 1—Personal Data

STATE FILE NUMBER

1. CHILD'S NAME FIRST	MIDDLE	LAST	2. DATE OF BIRTH *(Month, Day, Year)*	3. TIME OF BIRTH M.

4. SEX	5. CITY, TOWN, OR LOCATION OF BIRTH	6. COUNTY OF BIRTH

7. PLACE OF BIRTH: ☐ Hospital ☐ Freestanding Birthing Center ☐ Residence ☐ Clinic/Doctor's Office ☐ Other *(Specify)*	8. FACILITY NAME (If not institution, give street and number)

14. MOTHER'S PRESENT NAME *(First, Middle, Last)*	15. MAIDEN SURNAME	16. DATE OF BIRTH *(Month, Day, Year)*

17. STATE OF BIRTH *(If not in U.S.A., name country)*	18. PRESENT RESIDENCE—STATE	19. COUNTY	20. CITY, TOWN, OR LOCATION

21. STREET AND NUMBER OF PRESENT RESIDENCE	22. INSIDE CITY LIMITS? ☐ YES ☐ NO	23. MOTHER'S MAILING ADDRESS *(If same as residence, enter Zip Code only)*

24. FATHER'S NAME *(First, Middle, Last)*	25. DATE OF BIRTH *(Month, Day, Year)*	26. STATE OF BIRTH *(If not in U.S.A., name country)*

27. Parents request Social Security No. for child? ☐ YES ☐ NO	28. IMMUNIZATION REGISTRY I wish to enroll my child in the Immunization Registry. ☐ YES ☐ NO

31. Mother's Social Security Number	32. Father's Social Security Number	33. MOTHER MARRIED? (At birth, conception or any time between) ☐ YES ☐ NO

	34. ANCESTRY—*Cuban, Mexican, Puerto Rican, Vietnamese, Hmong, etc. (Specify)*	35. RACE—*Nat. Amer., Black, White, etc. (Specify)*	36. EDUCATION *(Specify only highest grade completed)*		37. OCCUPATION AND BUSINESS/INDUSTRY	
			Elementary/Secondary (0-12)	College (1-4 or 5 +)	Occupation	Business/Industry (Do not give name of company)
MOTHER	34a.	35a.	36a.		37a. (Most recent)	37c.
FATHER	34b.	35b.	36b.		37b. (Usual)	37d.

INFORMATION FOR MEDICAL AND HEALTH USE ONLY
(This Section MUST Be Filled Out)

38. PREGNANCY HISTORY (Complete each section)				39. DATE LAST NORMAL MENSES BEGAN *(Month, Day, Year)*	40. CLINICAL ESTIMATE OF GESTATION *(Weeks)*
LIVE BIRTHS *(Do not include this child)*		OTHER TERMINATIONS *(Spontaneous and Induced)*			
38a. Now living Number ____ ☐ None	38b. Now dead Number ____ ☐ None	38d. Before 20 weeks Number ____ ☐ None	38e. 20 weeks & over Number ____ ☐ None	41. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. *(Specify)*	42. PRENATAL VISITS—Total Number *(If none, so state)*
				43. PLURALITY—Single, Twin, Triplet, etc. *(Specify)*	44. IF NOT SINGLE BIRTH—Born First, Second, Third, etc. *(Specify)*
38c. DATE OF LAST LIVE BIRTH *(Month, Year)*		38f. DATE OF LAST OTHER TERMINATION *(as indicated in d or e above) (Month, Year)*		45. BIRTH WEIGHT (Grams)	46. HOSPITAL USE ONLY

PRENATAL

47. Nutrition of Mother
    1. Height _____
    2. Prepregnancy weight _____
    3. Total pregnancy weight gain _____

* Numbers will correlate with numbers on original certificate.

Delivered by: _____

I HEREBY CERTIFY THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

PARENT'S SIGNATURE _____

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Attachment 3

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
OFFICE OF VITAL STATISTICS

Hospital Record No.

Hospital Worksheet for **Birth Registration**

PART 2—Medical and Statistical Research Data

The information below is required by K.S.A. 65-2415 and is part of the Standard Certificate of Live Birth. This information is strictly confidential and is not released in identifiable form. Once entered into the computer system, the hard copy is destroyed.

(Please use X to mark boxes. Mark all that apply.)

1. CHILD'S NAME	FIRST	MIDDLE	LAST	2. DATE OF BIRTH *(Month, Day, Year)*	3. TIME OF BIRTH M.

PRENATAL

48. Medical Risk Factors
- 1. ☐ None
- 2. ☐ Uterine bleeding
- 3. ☐ Incompetent cervix
- 4. ☐ Isoimmunization*
- 5. ☐ Hydramnios/ Oligohydramnios*
- 6. ☐ Eclampsia
- 7. ☐ Pre-eclampsia (PIH)*
- 8. ☐ Previous preterm or SGA infant*
- 9. ☐ Previous infant, > 4000 grams
- 10. ☐ Hepatitis B/HBsAg
- 11. ☐ Genital herpes
- 12. ☐ AIDS or HIV antibody
- 13. ☐ Other STD*
- 14. ☐ Anemia (Hct. < 30/Hgb. < 10)
- 15. ☐ Hemoglobinopathy
- 16. ☐ Cardiac disease
- 17. ☐ Diabetes
- 18. ☐ Hypertension, chronic
- 19. ☐ Acute/chronic lung dis.
- 20. ☐ Renal disease
- 21. ☐ Underweight (< 10%)
- 22. ☐ Obesity (> 20%)
- 23. ☐ Tobacco use—No. of cig. per day ____
- 24. ☐ Alcohol use—No. of drinks per wk. ____
- 25. ☐ Other*

*Specify

49. Prenatal Procedures
- 1. ☐ None
- 2. ☐ Diabetes screening
- 3. ☐ Alpha-fetoprotein (serum)
- 4. ☐ Ultrasound
- 5. ☐ Chorionic villus sampling
- 6. ☐ Amniocentesis
- 7. ☐ Tocolysis
- 8. ☐ Other*

*Specify

50. Conditions of Labor and Delivery
- 1. ☐ Normal
- 2. ☐ Placenta previa
- 3. ☐ Placenta abruptio
- 4. ☐ Other intrapartum hemorrhage
- 5. ☐ PROM (> 12 hrs.)
- 6. ☐ Induction of labor
- 7. ☐ Stimulation of labor
- 8. ☐ Dysfunctional labor
- 9. ☐ Precipitous labor (< 3 hrs.)
- 10. ☐ Prolonged labor (> 20 hrs.)
- 11. ☐ Cephalopelvic disproportion
- 12. ☐ Electronic fetal monitoring
- 13. ☐ Fetal distress
- 14. ☐ Febrile (> 100° F./38° C.)
- 15. ☐ Meconium, moderate/ heavy
- 16. ☐ Breech presentation
- 17. ☐ Seizures during labor
- 18. ☐ Cord prolapse
- 19. ☐ Anesthetic complications
- 20. ☐ Placenta/Cord normal
- 21. ☐ Placenta/Cord abnormal
- 22. ☐ Other*

*Specify

LABOR-DELIVERY/NEWBORN

51. Method of Delivery
- 1. ☐ Spontaneous vertex
- 2. ☐ VBAC
- 3. ☐ C-Sec.—Prim.
- 4. ☐ C-Sec.—Repeat
- 5. ☐ C-Sec.—Elect.
- 6. ☐ C-Sec.—Unsched.
- 7. ☐ C-Sec.—Emerg.
- 8. ☐ Vaginal breech
- 9. ☐ Forceps
- 10. ☐ Vacuum
- 11. ☐ Other*

*Specify

52. Conditions of Newborn
- 1. ☐ Normal
- 2. ☐ Asst. ventilation < 30 min.
- 3. ☐ Asst. ventilation > 30 min.
- 4. ☐ Resuscitation
- 5. ☐ Meconium aspir. synd.
- 6. ☐ Hyaline membrane dis./RDS
- 7. ☐ Seizures
- 8. ☐ Birth injury*
- 9. ☐ Anemia (Hct. < 39/ Hgb. < 13)
- 10. ☐ Other*

*Specify

53. Vaccines Administered to Newborn
- 1. ☐ None
- 2. ☐ Hepatitis B
- 3. ☐ Other*

*Specify

54.

Apgar Score	1 Min.	5 Min.	10 Min.

55. Congenital Anomalies of Infant
- 1. ☐ None
- 2. ☐ Spina bifida/ Meningocele
- 3. ☐ Anencephalus
- 4. ☐ Hydrocephalus
- 5. ☐ Microcephalus
- 6. ☐ Other CNS anomalies*
- 7. ☐ PDA
- 8. ☐ Heart malformations, except PDA
- 9. ☐ Other circulatory/ respiratory anomalies*
- 10. ☐ Rectal atresia/stenosis
- 11. ☐ Tracheo-esophageal fistula/Esophageal atresia
- 12. ☐ Omphalocele/ Gastroschisis
- 13. ☐ Other gastrointestinal anomalies*
- 14. ☐ Malformed genitalia
- 15. ☐ Renal agenesis
- 16. ☐ Other urogenital anomalies*
- 17. ☐ Cleft lip/palate
- 18. ☐ Polydactyly/Syndactyly/ Adactyly
- 19. ☐ Club foot
- 20. ☐ Diaphragmatic hernia
- 21. ☐ Other musculoskeletal/ integumental anomalies*
- 22. ☐ Down's syndrome
- 23. ☐ Other chromosomal anomalies*
- 24. ☐ Fetal alcohol syndrome
- 25. ☐ Other*

*Specify

THIS IS NOT A PART OF THE CERTIFICATE OF LIVE BIRTH

Test required by K.S.A. 65-153F, 153G

Serological Test Made: ___ 1st ___ 2nd ___ 3rd (Trimester) ___ At Delivery ___ Not Performed

If no test made state reason: _____

Test required by K.S.A. 65-180

Infant Neonatal Screening specimen taken: _____ Yes _____ No

If no specimen taken state reason: _____

VS 200P

Attachment 4

TYPE IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE HANDBOOK

Kansas Department of Health and Environment
Office of Vital Statistics

CERTIFICATE OF LIVE BIRTH

115— STATE FILE NUMBER

CHILD

1. CHILD'S NAME — FIRST — MIDDLE — LAST | 2. DATE OF BIRTH (Month, Day, Year) | 3. TIME OF BIRTH

4. SEX | 5. CITY, TOWN, OR LOCATION OF BIRTH | 6. COUNTY OF BIRTH

7. PLACE OF BIRTH: ☐ Hospital ☐ Freestanding Birthing Center ☐ Residence ☐ Clinic/Doctor's Office ☐ Other (Specify) _____ | 8. FACILITY NAME (If not institution, give street and number)

CERTIFIER ATTENDANT

9. I certify that the stated information concerning this child is true to the best of my knowledge and belief. Signature X _____ | 10. DATE SIGNED (Month, Day, Year) | 11. ATTENDANT'S NAME AND TITLE (Type) Name _____ ☐ M.D. ☐ D.O. ☐ C.N.M. ☐ Other Midwife ☐ Other (Specify) _____

12. CERTIFIER'S TITLE ☐ M.D. ☐ D.O. ☐ Hosp. Adm. ☐ C.N.M. ☐ Other Midwife ☐ Other (Specify) _____ | 13. ATTENDANT'S MAILING ADDRESS (Street and Number or Rural Route, City or Town, State, Zip Code)

DEATH UNDER ONE YEAR OF AGE Enter State File Number of death certificate for this child

MOTHER

14. MOTHER'S PRESENT NAME (First, Middle, Last) | 15. MAIDEN SURNAME | 16. DATE OF BIRTH (Month, Day, Year)

17. STATE OF BIRTH (If not in U.S.A., name country) | 18. PRESENT RESIDENCE—STATE | 19. COUNTY | 20. CITY, TOWN, OR LOCATION

21. STREET AND NUMBER OF PRESENT RESIDENCE | 22. INSIDE CITY LIMITS? ☐ YES ☐ NO | 23. MOTHER'S MAILING ADDRESS (If same as residence, enter Zip Code only)

FATHER

24. FATHER'S NAME (First, Middle, Last) | 25. DATE OF BIRTH (Month, Day, Year) | 26. STATE OF BIRTH (If not in U.S.A., name country)

PARENT

27. PARENTS REQUEST SOCIAL SECURITY NO. ISSUANCE? ☐ YES ☐ NO | 28. IMMUNIZATION REGISTRY I wish to enroll my child in the Immunization Registry. ☐ YES ☐ NO

29. 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) ▶ | 30. DATE SIGNED

CONFIDENTIAL INFORMATION FOR INTERNAL USE ONLY

SS#

31. MOTHER'S SOCIAL SECURITY NUMBER | 32. FATHER'S SOCIAL SECURITY NUMBER | 33. MOTHER MARRIED? (At birth, conception or any time between) ☐ YES ☐ NO

	34. ANCESTRY—Cuban, Mexican, Puerto Rican, Vietnamese, Hmong, etc. (Specify)	35. RACE—Nat. Amer., Black, White, etc. (Specify)	36. EDUCATION (Specify only highest grade completed)		37. OCCUPATION AND BUSINESS/INDUSTRY	
			Elementary/Secondary (0-12)	College (1-4 or 5 +)	Occupation	Business/Industry (Do not give name of company)
MOTHER	34a.	35a.	36a.		37a. (Most recent)	37c.
FATHER	34b.	35b.	36b.		37b. (Usual)	37d.

38. PREGNANCY HISTORY (Complete each section)

LIVE BIRTHS (Do not include this child)		OTHER TERMINATIONS (Spontaneous and Induced)	
38a. Now living	38b. Now dead	38d. Before 20 weeks	38e. 20 weeks & over
Number ____ ☐ None	Number ____ ☐ None	Number ____ ☐ None	Number ____ ☐ None
38c. DATE OF LAST LIVE BIRTH (Month, Year)		38f. DATE OF LAST OTHER TERMINATION (as indicated in d or e above) (Month, Year)	

39. DATE LAST NORMAL MENSES BEGAN (Month, Day, Year) | 40. CLINICAL ESTIMATE OF GESTATION (Weeks)

41. MONTH PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. (Specify) | 42. PRENATAL VISITS—Total Number (If none, so state)

43. PLURALITY—Single, Twin, Triplet, etc. (Specify) | 44. IF NOT SINGLE BIRTH—Born First, Second, Third, etc. (Specify)

45. BIRTH WEIGHT (Grams) | 46. FOR VITAL STATISTICS USE ONLY

MULTIPLE BIRTHS Enter State File Number for Mate(s) LIVE BIRTH(S)

FETAL DEATH(S)

SAMPLE

PRENATAL

47. Nutrition of Mother
1. Height _____
2. Prepregnancy weight _____
3. Total pregnancy weight gain _____

48. Medical Risk Factors
1. ☐ None
2. ☐ Uterine bleeding
3. ☐ Incompetent cervix
4. ☐ Isoimmunization *
5. ☐ Hydramnios/ Oligohydramnios *
6. ☐ Eclampsia
7. ☐ Pre-eclampsia (PIH) *
8. ☐ Previous preterm or SGA infant *
9. ☐ Previous infant, > 4000 grams
10. ☐ Hepatitis B/HBsAg
11. ☐ Genital herpes
12. ☐ AIDS or HIV antibody
13. ☐ Other STD *
14. ☐ Anemia (Hct. < 30/Hgb. < 10)
15. ☐ Hemoglobinopathy
16. ☐ Cardiac disease
17. ☐ Diabetes
18. ☐ Hypertension, chronic
19. ☐ Acute/chronic lung dis.
20. ☐ Renal disease
21. ☐ Underweight (< 10%)
22. ☐ Obesity (> 20%)
23. ☐ Tobacco use— No. of cig. per day ____
24. ☐ Alcohol use—No. of drinks per wk. ____
25. ☐ Other *
* Specify

49. Prenatal Procedures
1. ☐ None
2. ☐ Diabetes screening
3. ☐ Alpha-fetoprotein (serum)
4. ☐ Ultrasound
5. ☐ Chorionic villus sampling
6. ☐ Amniocentesis
7. ☐ Tocolysis
8. ☐ Other *
* Specify

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Rev. 8/94

LABOR-DELIVERY/NEWBORN

50. Conditions of Labor and Delivery
1. ☐ Normal
2. ☐ Placenta previa
3. ☐ Placenta abruptio
4. ☐ Other intrapartum hemorrhage
5. ☐ PROM (> 12 hrs.)
6. ☐ Induction of labor
7. ☐ Stimulation of labor
8. ☐ Dysfunctional labor
9. ☐ Precipitous labor (< 3 hrs.)
10. ☐ Prolonged labor (> 20 hrs.)
11. ☐ Cephalopelvic disproportion
12. ☐ Electronic fetal monitoring
13. ☐ Fetal distress
14. ☐ Febrile (> 100° F./38° C.)
15. ☐ Meconium, moderate/ heavy
16. ☐ Breech presentation
17. ☐ Seizures during labor
18. ☐ Cord prolapse
19. ☐ Anesthetic complications
20. ☐ Placenta/Cord normal
21. ☐ Placenta/Cord abnormal
22. ☐ Other *
* Specify

51. Method of Delivery
1. ☐ Spontaneous vertex
2. ☐ VBAC
3. ☐ C-Sec.—Prim.
4. ☐ C-Sec.—Repeat
5. ☐ C-Sec.—Elect.
6. ☐ C-Sec.—Unsched.
7. ☐ C-Sec.—Emerg.
8. ☐ Vaginal breech
9. ☐ Forceps
10. ☐ Vacuum
11. ☐ Other *
* Specify

52. Conditions of Newborn
1. ☐ Normal
2. ☐ Asst. ventilation < 30 min.
3. ☐ Asst. ventilation ≥ 30 min.
4. ☐ Resuscitation
5. ☐ Meconium aspir. synd.
6. ☐ Hyaline membrane dis./RDS
7. ☐ Seizures
8. ☐ Birth injury *
9. ☐ Anemia (Hct. <39/Hgb. <13)
10. ☐ Other *
* Specify

53. Vaccines Administered to Newborn
1. ☐ Hepatitis B
2. ☐ Other *
*Specify

54. Apgar Score

	1 Min.	5 Min.	10 Min.
Apgar Score			

55. Congenital Anomalies of Infant
1. ☐ None
2. ☐ Spina bifida/Meningocele
3. ☐ Anencephalus
4. ☐ Hydrocephalus
5. ☐ Microcephalus
6. ☐ Other CNS anomalies *
7. ☐ PDA
8. ☐ Heart malformations, except PDA
9. ☐ Other circulatory/respiratory anomalies *
10. ☐ Rectal atresia/stenosis
11. ☐ Tracheo-esophageal fistula/Esophageal atresia
12. ☐ Omphalocele/Gastroschisis
13. ☐ Other gastrointestinal anomalies *
14. ☐ Malformed genitalia
15. ☐ Renal agenesis
16. ☐ Other urogenital anomalies *
17. ☐ Cleft lip/palate
18. ☐ Polydactyly/Syndactyly/Adactyly
19. ☐ Club foot
20. ☐ Diaphragmatic hernia
21. ☐ Other musculoskeletal/integumental anomalies *
22. ☐ Down's syndrome
23. ☐ Other chromosomal anomalies *
24. ☐ Fetal alcohol syndrome
25. ☐ Other *
* Specify

THIS IS NOT A PART OF THE CERTIFICATE OF LIVE BIRTH

Test required by K.S.A. 65-153F, 153Q | Test required by K.S.A. 65-180

Attachment 5

Birth Clerk Telephone Survey Questions

We wish to thank you for your work in completing the birth certificate. In addition to providing identity for each newborn, at the state and national level birth certificates provide invaluable information regarding health status of newborns and their mothers. Kansas is in the process of upgrading its Vital Statistics data collection process. In order to do that we need to better understand how you handle birth registrations at your hospital. We have informed your administrator and shared the subject matter of this brief telephone survey.

We have informed your administrator the birth clerks have the first hand information we need in order to understand the process at your hospital.
Your answers to our questions will help us to better understand your work. There are no wrong answers and your candor is appreciated. You may not know the answer to a question and that is okay. But your information is important to what we need to do.

1.) Who completes the Hospital Worksheet for Birth Registration (Part 1 - Personal Data)?

A.) Mother, exclusively _____
B.) Birth Clerk, exclusively _____
C.) Birth Clerk and Mother _____

If answer other than B.)
1a.) When does the mother get the Hospital Worksheet for Birth Registration (Part 1 – Personal Data)?

A.) Before she is admitted for delivery _____
B.) On admission for delivery _____
C.) After birth of baby _____
D.) No set time _____
E.) Other _____

2.) What is the primary job responsibility of the person who completes the Hospital Worksheet for Birth Registration (Part 2 - Medical and Statistical Research Data)?

A.) Nurse in the birth unit _____
B.) Birth clerk _____
C.) Ward clerk in birth Unit _____
D.) Doctor _____
E.) Medical record clerk _____
D.) Other _____

Who _____

3.) Are the Hospital Worksheets for Birth Registration Part 1 and Part 2 included as part of the hospital medical record?

Yes _____
No _____
Do not know _____

if no then:

4.) Since the Hospital worksheets for birth registration are not included as part of the hospital medical record, are they….

Discarded _____
Kept elsewhere in the facility _____ Length of time _____
Kept elsewhere for a time, then discarded _____ Length of time _____
Do not know _____

5.) After the worksheet is completed, do you give the mother a copy?

Yes _____

No _____

6.) In your opinion how often does a mother supply information that is different than you find in the medical record or the prenatal care record?

Never _____
Not Frequently _____
Occasionally _____
Frequently _____

7a.) From what source do you obtain information regarding the mother's pre-pregnancy weight?

Mother _____
Doctors prenatal care record _____
Facility medical record _____
Other _____

7b.) From what source do you obtain information regarding the month prenatal care began?

Mother _____
Doctors Prenatal Care record _____
Facility Medical record _____
Other _____

7c.) From what source do you obtain information regarding the mother's smoking history?

Mother _____
Doctors Prenatal Care record _____
Facility Medical record _____
Other _____

7d.) From what source do you obtain information regarding the mother's alcohol use history?

Mother _____
Doctors Prenatal Care record _____
Facility Medical record _____
Other _____

7e.) From what source do you obtain information regarding the date the last normal menses began?

Mother _____
Doctors Prenatal Care record _____
Facility Medical record _____
Other _____

8.) Do you agree or disagree with this statement? Mothers may misinterpret the question about when they began prenatal care.

Agree _____

Disagree _____

9.) The Hospital Worksheet for Birth Registration (Part 1- Personal Data) question reads " month of pregnancy prenatal care began, First, Second Third, Etc." Should this item be written differently? Yes_____ No____

If so how: _____

10.) One way to deal with conflicting information would be to move the items from the Hospital Worksheet for Birth Registration Part 1 to Part 2. I will read a list of items that we would like you to indicate your opinion about moving each item. Based on your experience working with the worksheets, please tell me if each item that follows should be left on Part 1 or moved to Part 2.

Live Births living and Dead	Part 1 ____ Part 2_____
Terminations <20weeks, = 20weeks	Part 1 ____ Part 2_____
Date Last Menses Began	Part 1 ____ Part 2_____
Month of Preg. Prenatal Care Began	Part 1 ____ Part 2_____
Plurality	Part 1 ____ Part 2_____
Birth weight	Part 1 ____ Part 2_____
Clinical Estimate of Gestation	Part 1 ____ Part 2_____
Prenatal Visits	Part 1 ____ Part 2_____
If Not Single Birth, Order	Part 1 ____ Part 2_____

11.) If Mother indicates several European ancestries, do you indicate all ancestries (example: ital/ger/eng) or do you indicate European as the ancestry?

All ancestries_____
European _____
Other _____
Don't know _____

The following questions deal with computer and internet issues. We plan to provide means to complete the birth certificate in two methods. One will be the traditional paper method. One will be on an internet site. It will offer pull down menus, help screens and other help as you complete and submit a electronic birth registration. The system will be, we hope, much easier to use than the current EBC system.

12.) Which process do you currently use: the Electronic Birth Certification (EBC) or the paper entry system?

EBC _____ Paper _____

13.) Do you have access to a computer at your work location with internet capability?
Yes_____ No_____

14.) Do you have authority to use the computer at your work location to access internet?
Yes_____ No_____

15.) Which of the following best describes your ability to access the Internet overall:

Yes, I can do it. _____
I think I could do it but may need some training _____
I do not know if I can. _____
I would not try (No comment) _____

16.) Which of the following best describes your ability to locate an Internet site:

Yes, I can do it. _____
I think I could do it but may need some training _____
I do not know if I can. _____
I would not try (No comment) _____

17.) Which of the following best describes your ability to use a password on an Internet site:

Yes, I can do it. _____
I think I could do it but may need some training _____
I do not know if I can. _____
I would not try (No comment) _____

18.) Which of the following best describes your ability to use an interactive Internet site:

Yes, I can do it. _____
I think I could do it but may need some training _____
I do not know if I can. _____
I would not try (No comment) _____

19.) Would you be interested in using the new electronic system for completing birth certificates on a secure internet site when it is completed?

Yes_____ No, I plan to use the paper form _____

The last section of this survey deals with training issues. As we prepare to upgrade our birth registration process we need to know more about your training needs as we introduce a new electronic birth system.

20.) How long have you been responsible for birth registrations?

Less Than Six Months _____
Six Months to a Year _____
One to Three Years _____
Three to Five Years _____
More than Five Years _____

21.) If we provide an in depth training on a regional basis with several sites around the state that would start at 9 AM and end between 3 and 4 PM, would you be able to attend?

Yes _____
No _____

22.) Would a well designed regional training that closely simulated the new internet based process we are developing be adequate training to use the new system?

Yes _____
No _____

23.) Do you currently use e-mail to contact Office of Vital Statistics staff?

Yes _____
No _____

Attachment 6

NEWBORN MATURITY RATING & CLASSIFICATION

ESTIMATION OF GESTATIONAL AGE BY MATURITY RATING

Symbols: X - 1st Exam O - 2nd Exam

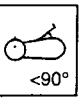
Side 1

Gestation by Dates _____ wks

Birth Date _____ Hour _____ am pm

APGAR _____ 1 min _____ 5 min

NEUROMUSCULAR MATURITY

	-1	0	1	2	3	4	5
Posture							
Square Window (wrist)	 >90°	 90°	 60°	 45°	 30°	 0°	
Arm Recoil		 180°	 140°-180°	 110°-140°	 90°-110°	 <90°	
Popliteal Angle	 180°	 160°	 140°	 120°	 100°	 90°	 <90°
Scarf Sign							
Heel to Ear							

MATURITY RATING

score	weeks
-10	20
-5	22
0	24
5	26
10	28
15	30
20	32
25	34
30	36
35	38
40	40
45	42
50	44

PHYSICAL MATURITY

Skin	sticky; friable; transparent	gelatinous; red; translucent	smooth; pink; visible veins	superficial peeling &/or rash; few veins	cracking; pale areas; rare veins	parchment; deep cracking; no vessels	leathery; cracked; wrinkled
Lanugo	none	sparse	abundant	thinning	bald areas	mostly bald	
Plantar Surface	heel-toe 40-50 mm: -1 <40 mm: -2	>50 mm; no crease	faint red marks	anterior transverse crease only	creases ant. 2/3	creases over entire sole	
Breast	imperceptible	barely perceptible	flat areola; no bud	stippled areola; 1-2 mm bud	raised areola; 3-4 mm bud	full areola; 5-10 mm bud	
Eye/Ear	lids fused loosely: -1 tightly: -2	lids open; pinna flat; stays folded	sl. curved pinna; soft; slow recoil	well-curved pinna; soft but ready recoil	formed & firm; instant recoil	thick cartilage; ear stiff	
Genitals male	scrotum flat; smooth	scrotum empty; faint rugae	testes in upper canal; rare rugae	testes descending; few rugae	testes down; good rugae	testes pendulous; deep rugae	
Genitals female	clitoris prominent; labia flat	prominent clitoris; small labia minora	prominent clitoris; enlarging minora	majora & minora equally prominent	majora large; minora small	majora cover clitoris & minora	

Scoring system: Ballard JL, Khoury JC, Wedig K, Wang L, Eilers-Walsman BL, Lipp R. New Ballard Score, expanded to include extremely premature infants. *J Pediatr.* 1991;119:417-423.

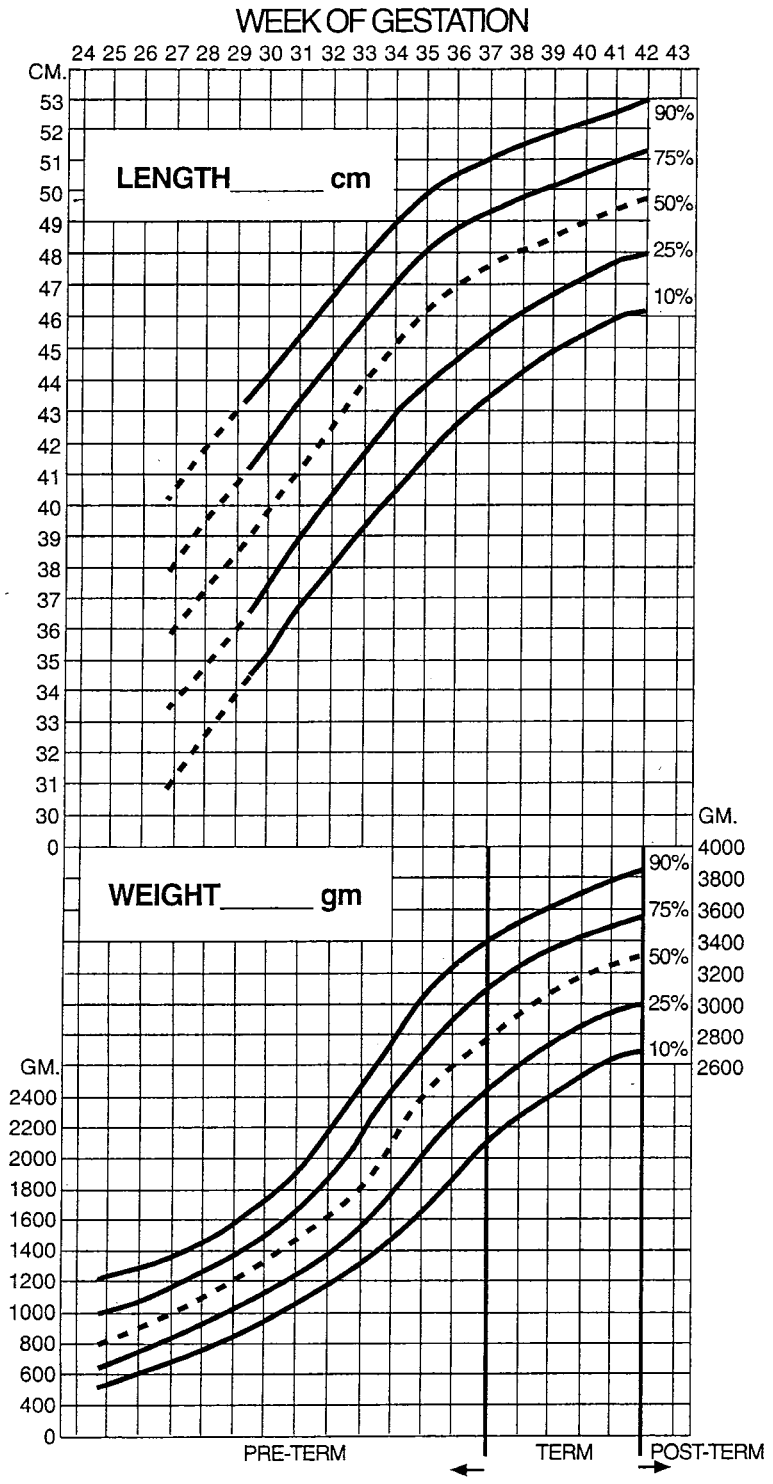
SCORING SECTION

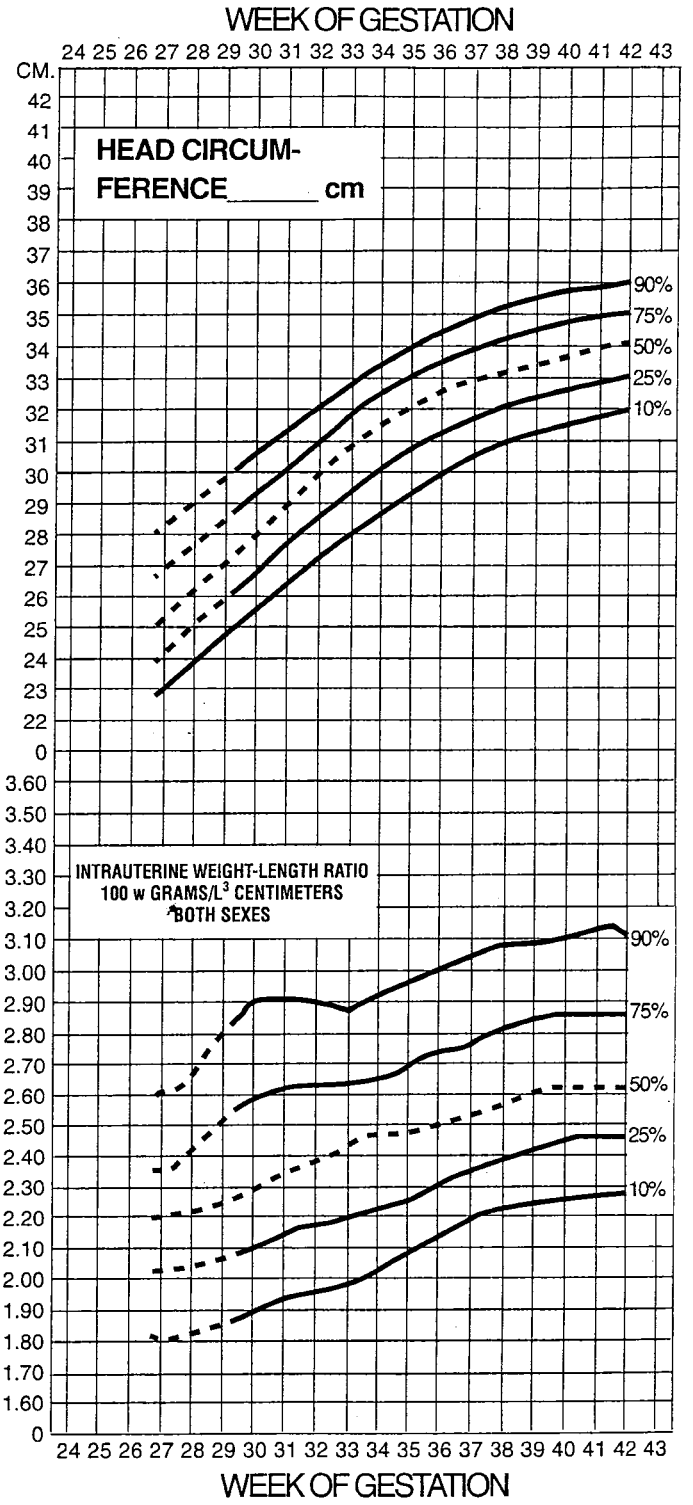
	1st Exam=X	2nd Exam=O
Estimating Gest Age by Maturity Rating	_____ Weeks	_____ Weeks
Time of Exam	Date _____ Hour _____ am pm	Date _____ Hour _____ am pm
Age at Exam	_____ Hours	_____ Hours
Signature of Examiner	_____ _____ M.D./R.N.	_____ _____ M.D./R.N.

CLASSIFICATION OF NEWBORNS - BASED ON MATURITY AND INTRAUTERINE GROWTH

Side 2

Symbols: X - 1st Exam O - 2nd Exam





	1st Exam (X)	2nd Exam (O)
LARGE FOR GESTATIONAL AGE **(LGA)**		
APPROPRIATE FOR GESTATIONAL AGE **(AGA)**		
SMALL FOR GESTATIONAL AGE **(SGA)**		
Age at Exam	hrs	hrs
Signature of Examiner	M.D./R.N.	M.D./R.N.

Adapted from Lubchenco LO, Hansman C, and Boyd E: *Pediatr.* 1966;37:403; Battaglia FC, and Lubchenco LO: *J Pediatr.* 1967;71:159.

References

Saadi, E., Keeling, C., Evaluation of Birth Certificate Data Collection Followback Survey. Kansas Department of Health and Environment, Division of Information Systems. January 1992.

Crawford, G., Meyer, C., Saadi, E., Keeling, C., Evaluation of Birth Certificate Data Collection Survey. Kansas Department of Health and Environment, Center for Health and Environmental Statistics. November 1998

Buescher, P., Pinnex, K., Davis, M., Bowling, J.,Quality of the New Birth Certificate: A Followback Study in North Carolina. North Carolina Department of Environment, Health, and Natural Resources. June 1992.

Comparability of the Birth Certificate and 1988 Maternal and Infant Health Survey, March 1989. CDC/NCHS, Vital and Health Statistics, Series 2, No. 116.