Washington State Department of Health

DOH 422-156 October 2019

Washington State Surrogate Birth Filing Form
INTENDED PARENT FORM

Fields with asterisk (*) appear on the Birth Certificate.

For Hospital Use Only		
Surrogate's Medical Record #:	Child's Medical Record #:	Intended Parent Prefer Parent/Parent Labels on Birth Certificate ☐ Yes ☐ No (Default Labels are Mother/Father)
Plurality: ☐ 1- single birth ☐ 2- twin ☐ 3- triplet ☐ Other _____		
If multiple, this worksheet is for child: ☐ 1- first born ☐ 2- second born ☐ 3- third born ☐ Other _____		

Child's Information		
*1. Child's Name First	Middle	Last

*2. Child's Date of Birth (MM/DD/YYYY) / /	*3. Time of Birth	*4. Child's Sex ☐ Male ☐ Female	Number of Intended Parents (1 or 2)	Intended Mother/Parent Last Name of Their Birth Certificate

5. Place of Birth ☐ Hospital ☐ Home ☐ Enroute ☐ Clinic/Doctor's Office ☐ Freestanding Birth Center ☐ Other (specify):	6. Planned Birth Place, if different (specify):

*7. Name of Facility (If not a facility, enter name of place and address)	*8. County of Birth	*9. City of Birth

Intended Mother/Parent's information		
10. Intended Mother/Parent's Current Legal Name First	Middle	Last
*11. Intended Mother/Parent's Name on Their Birth Certificate First	Middle	Last

*12. Intended Mother/Parent's Date of Birth (MM/DD/YYYY) / /	*13. Intended Mother/Parent's Birthplace (State, Territory, or Foreign Country)	14. Intended Mother/Parent's Social Security Number

15. Intended Mother/Parent's Permission to Request Social Security Number for child? ☐ Yes ☐ No
16a. Intended Mother/Parent's Residence Address, Number and Street, or PO Box

16b. If not U.S.; Country	16c. State	16d. County

16e. Lives on Tribal Reservation, Provide Name	16f. City or Town	16g. Zip Code + 4

16h. Inside City Limits? ☐ Yes ☐ No ☐ Unknown	17. How long at Current Residence? Years: Months:	18. Intended Mother/Parent's Telephone Number ( )

19a. Intended Mother/Parent Mailing Address, Number and Street, or PO Box Same as Residence ☐ Yes			
19b. If not U.S.; Country	19c. State	19d. City	19e. Zip Code +4

Intended Father/ Parent's Information		
*30. Father/Parent's Current Legal Name First	Middle	Last
*31. Father/Parent's Date of Birth (MM/DD/YYYY) / /	*32. Father/Parent's Birthplace (State, Territory, or Foreign Country)	33. Father/Parent's Social Security Number

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Washington State Surrogate Birth Filing Form
SURROGATE FORM

Data collection of Surrogate information is REQUIRED but only used for statistical purposes about the facts of the pregnancy and birth. Surrogate information does not appear on the Child's Birth Certificate.

Surrogate's Information

Surrogate Current Legal Name		
First	Middle	Last
Surrogate Name on Their Birth Certificate		
First	Middle	Last

Surrogate Date of Birth (MM/DD/YYYY) / /	Surrogate Social Security Number	Surrogate Telephone Number	Surrogate Birthplace (State, Territory, or Foreign Country)

Surrogate Residence Address, Number and Street, or PO Box		
If not U.S.; Country	State	County
Lives on Tribal Reservation, give name	City or Town	Zip Code + 4
Inside City Limits? ☐ Yes ☐ No ☐ Unknown	How long at Current Residence? Years: Months:	Surrogate Telephone Number

20. Surrogate's Occupation (type of work done during last year)	21. Surrogate's Kind of Business/Industry (do not use company name)

22. Surrogate's Education Level
(Check the box that best describes the highest degree or level of school completed at the time of delivery.)

1 ☐ 8th grade or less (specify):_____
2 ☐ 9th – 12th grade; no diploma
3 ☐ High school graduate or GED
4 ☐ Some college credit, but no degree
5 ☐ Associate degree (AA, AS, etc.)
6 ☐ Bachelor's degree (BA, AB, BS, etc.)
7 ☐ Master's degree (MA, MS, MEd, MSW, MBA, etc.)
8 ☐ Doctorate (PhD, EdD, etc.) or professional degree (MD, DDS, DVM, LLB, JD, etc.)

23. Surrogate's Hispanic Origin?
(Check the box that best describes whether the mother is Spanish/Hispanic/Latina or check "No" box if not Spanish/Hispanic/Latina.)

1 ☐ No, not Spanish/Hispanic/Latina
2 ☐ Yes, Mexican, Mexican American, Chicana
3 ☐ Yes, Puerto Rican
4 ☐ Yes, Cuban
5 ☐ Yes, Other Spanish/Hispanic/Latina
(specify):

24. Surrogate's Race (check one or more)

1 ☐ White
2 ☐ Black or African American
3 ☐ American Indian or Alaska Native
(Name of enrolled or principal tribe) _____
4 ☐ Asian Indian
5 ☐ Chinese
6 ☐ Filipino
7 ☐ Japanese
8 ☐ Korean
9 ☐ Vietnamese
10 ☐ Other Asian (specify) _____
11 ☐ Native Hawaiian
12 ☐ Guamanian or Chamorro
13 ☐ Samoan
14 ☐ Other Pacific Islander (specify) _____
15 ☐ Other (specify) _____

25. Surrogate's Current Height Feet: Inches:	26. Surrogate's Pre-Pregnancy Weight (pounds)	27. Were WIC benefits utilized by Surrogate during pregnancy? ☐ Yes ☐ No

28. Surrogate Cigarette Smoking Before and During Pregnancy

☐ Yes ☐ No

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	

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Surrogate's Statistical Information

39. Date of First Prenatal Care Visit (MM/DD/YYYY)
/ / ☐ No Prenatal Care

40. Date of Last Prenatal Care Visit (MM/DD/YYYY)
/ /

41. Total Number of Prenatal Visits for this Pregnancy
(If none, enter '0') _____

42. Number of Previous Live Births (Do not include this child)
Number Now Living _____ ☐ None
Number Now Dead _____ ☐ None

43. Date of Last Live Birth (MM/YYYY) (Do not include this child)
/ /

44. Number of Other Pregnancy Outcomes
(Spontaneous or induced losses or ectopic pregnancies)
Number of Other Outcomes _____ ☐ None

45. Date of Last Other Pregnancy Outcome (MM/YYYY)
/ /

46. Date Last Normal Menses Began (MM/DD/YYYY)
/ /

47. Mother'/Parent's Weight at Delivery(pounds)

48. Was mother/parent transferred to higher level care for maternal medical or fetal indications for delivery?
☐ Yes ☐ No

If yes, name of facility mother/parent was transferred from:

49. Principal Source of Payment for this Delivery

☐ Medicaid	☐ Self-Pay	☐ Private Insurance
☐ Other Gov't	☐ Tricare	☐ Indian Health
☐ Charity Care	☐ Other _____	

Child's Statistical Information

50. Birth Weight
lbs: ozs: **or** grams:

51. Infant Head Circumference (cm)

52. Obstetric Estimate of Gestation (completed weeks)

53. Apgar score at 5 minutes _____ If score is less than 6, score at 10 minutes _____

54. Plurality: ☐ single ☐ twins ☐ triplets ☐other _____

55. If not single birth; birth order: ☐ first ☐ second ☐third ☐other _____

56. Was infant transferred within 24 hours of delivery? ☐ Yes ☐ No
If yes, name of facility infant was transferred to:

57. Is infant living at the time of report?
☐ Yes ☐ No ☐ Transferred, status unknown

58. Is infant being breastfed?
☐ Yes ☐ No

Surrogate and Child's Medical and Health Information

59. Risk Factors in this Pregnancy (check all that apply):

1 Diabetes
- ☐ Prepregnancy (Diagnosis prior to this pregnancy)
- ☐ Gestational (Diagnosis in this pregnancy)

2 Hypertension
- ☐ Prepregnancy (Chronic)
- ☐ Gestational (PIH, preeclampsia)
- ☐ Eclampsia

3 ☐ Previous preterm births
4 ☐ Other previous poor pregnancy outcome (includes perinatal death, small-for-gestational age/intrauterine growth restricted birth)
5 ☐ Vaginal bleeding during this pregnancy prior to the onset of labor
6 ☐ 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)]

7 ☐ Mother had a previous cesarean delivery?
If Yes, how many_____
8 ☐ Group B Streptococcus culture positive
9 ☐ None of the above

60. Infections Present and/or Treated During this Pregnancy (check all that apply):

1 ☐ Gonorrhea
2 ☐ Syphilis
3 ☐ Herpes Simplex Virus (HSV)
4 ☐ Chlamydia
5 ☐ Hepatitis B
6 ☐ Hepatitis C
7 ☐ HIV Infection
8 ☐ Other
Specify:_____
9 ☐ None of the above

61. Maternal Morbidity (complications associated with labor and delivery) (Check all that apply):

1 ☐ Maternal transfusion
2 ☐ Third or fourth degree perineal laceration
3 ☐ Ruptured uterus
4 ☐ Unplanned hysterectomy
5 ☐ Admission to intensive care unit
6 ☐ Unplanned operating room procedure following delivery
7 ☐ None of the above

62. 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 ☐ Forceps ☐ Vacuum
OR
Cesarean: ☐
If cesarean, was a trial of labor attempted?
☐ Yes ☐ No

63. Obstetric procedures (Check all that apply):

1 ☐ Cervical cerclage
2 ☐ Tocolysis
3 ☐ External cephalic version:
- ☐ Successful
- ☐ Failed

4 ☐ None of the above

64. Onset of Labor (Check all that apply):

1 ☐ Premature rupture of the membranes (Prolonged, ≥ 12hr)
2 ☐ Precipitous Labor (< 3hr)
3 ☐ Prolonged Labor (≥ 20hr)
4 ☐ None of the above

65. Characteristics of Labor and Delivery (Check all that apply):

1 ☐ Induction of labor
2 ☐ Augmentation of labor
3 ☐ Non-vertex presentation
4 ☐ Epidural or spinal anesthesia during labor
5 ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
6 ☐ Antibiotics received by the mother during labor
7 ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥38°C (100.4°F)
8 ☐ Moderate/heavy meconium staining of the amniotic fluid
9 ☐ 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 ☐ None of the above

66. Abnormal Conditions of the Newborn
(Occurring within 24 hours of delivery) (check all that apply):

1 ☐ Assisted ventilation required immediately following delivery
2 ☐ Assisted ventilation required for more than six hours
3 ☐ NICU admission
4 ☐ Newborn given surfactant replacement therapy
5 ☐ Antibiotics received by the newborn for suspected neonatal sepsis
6 ☐ Seizure or serious neurologic dysfunction
7 ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, soft tissue or solid organ hemorrhage which requires intervention)
8 ☐ None of the above

67. Congenital Anomalies of the Newborn
(Observed within 24 hours of delivery) (Check all that apply)

1 ☐ Anencephaly
2 ☐ Meningomyelocele / Spina bifida
3 ☐ Cyanotic congenital heart disease
4 ☐ Congenital diaphragmatic hernia
5 ☐ Omphalocele
6 ☐ Gastroschisis
7 ☐ Limb reduction defect (excluding congenital amputation and dwarfing syndrome)
8 ☐ Cleft Lip with or without Cleft Palate
9 ☐ Cleft Palate alone
10 Down Syndrome
- ☐ Karyotype confirmed
- ☐ Karyotype pending

11 Chromosomal disorder
- ☐ Karyotype confirmed
- ☐ Suspected, Karyotype pending

12 ☐ Hypospadias
13 ☐ None of the above

Attendant and Certifier Information

68. Certifier – Name and Title

69. Date Certified (MM/DD/YYYY)
/ /

70. Attendant – Name and Title (If other than Certifier)

71. NPI of person delivering the baby: