Checklist for Registration of an Out of Institution Birth

Please utilize the following checklist to document evidence for all births occurring outside of an institution. Evidence from each section must be presented to completely fulfill the requirements of Rule 3701-5-16. * All evidence should be submitted via fax to 614-564-2514 for approval BEFORE a birth record shall be created for filing. A copy of all documentation should be clipped to the final birth record when submitted to ODH/VS for filing.

Section 1: Evidence of Pregnancy

Please select one (1) that applies and attach supporting documentation to this list:

☐ A prenatal record or postnatal medical record consistent with the date of delivery, **OR**

☐ A statement from a physician or other health care provider (e.g., a registered nurse, nurse practitioner, public health nurse, licensed midwife, or EMS employee) qualified to determine pregnancy. Statement shall include mother's name, mother's date of birth, date of health exam, provider's signature, provider's printed name, signature date, and license number, **OR**

☐ A home visit exam by a public health nurse or other health care provider, **OR**

☐ _____other evidence as accepted by the State Registrar (Please see listing on page 4) *

Section 2: Evidence that the infant was born alive.

Please select one (1) that applies and attach supporting documentation to this list:

☐ A statement from the physician or other health care provider who saw or examined the infant, **OR**

☐ An observation of the infant during a home visit by a public health nurse or health care provider, **OR**

☐ _____other evidence as accepted by the State Registrar (Please see listing on page 4) *

Section 3: Evidence of the mother's presence in Ohio and proof of residence.

If the birth occurred outside of the mother's place of residence, please skip Section 3 and provide documentation for Section 4. Please select one (1) that applies and attach supporting documentation to this list:

☐ A valid driver's license, or a state issued identification card, which includes the mother's current residence on the face of the license or card, **OR**

☐ A recent rent receipt of any type of utility, telephone or other bill that includes the mother's name and address, **OR**

☐ A social service record at the time of the child's birth if the mother was receiving public assistance (e.g. WIC, food stamps, child support record), **OR**

☐ A recent bank statement that includes the mother's name and address, **OR**

☐ _____other evidence as accepted by the State Registrar (Please see listing on page 4) *

Ohio
Department of

For Hospital Use Only:
Mother's Medical Record # _____
Mother's Name _____
Newborn's Date of Birth _____
Newborn's Medical Record # _____

Birth Parent's Worksheet

Ohio Department of Health Bureau of Vital Statistics

The information you provide below will be used to create your child's birth certificate and will be used for other public health purposes. The birth certificate is a document that will be used for important purposes including proving your child's age, citizenship and parentage. The birth certificate will be used by your child throughout his/her life.

It is very important that you provide complete and accurate information to all of the questions. In addition, this information is used by health and medical researchers to study and improve the health of mothers and newborn infants. Items such as education, race, and smoking will be used for studies but will not appear on copies of your child's birth certificate (unless requested by a person listed on the certificate). State of Ohio law provides protection against the unauthorized release of health and medical information, but mandates the release of identifying information from the birth certificate under public record law.

Please print clearly in black or dark blue ink. If needed, please ask hospital staff for help.

BABY'S INFORMATION

1. Baby's Legal Name As It Should Appear On The Birth Certificate

Notice: You may name your baby whatever you want; however, it will take a legal change of name court order to change it after registration. Only hyphens (-) and apostrophes (') will be printed as part of the birth record.

First	Middle, if any	Last	Generational suffix (if any)

Newborn's Sex	Date of Birth	Was this delivery a:
☐ Male ☐ Female	/ /	☐ Single birth ☐ Multiple birth

If multiple, this worksheet is for baby: ☐ (First born) ☐ (Second born) ☐ (Third born) ☐ (Fourth born)

BIRTH PARENT INFORMATION

PREFERRED PARENTAGE TITLE (Check one)	GENDER (Check one)
☐ Mother ☐ Father ☐ Parent	☐ Female ☐ Male

2. Birth Parent Current Legal Name

First	Middle, if any	Last

What was your last name prior to your first marriage or your last name as it appears on your birth record if you were never married.

3. Birth Parent Current Residence (Actual physical location of where you live)

Street Address (Street Name and Number)	Address Line 2/Apt. Number
Country (United States or Name of Foreign Country)	State, U.S. Territory, or Canadian Province

County	City	Zip Code

Is your current residence located within the city limits? (Check one) ☐ Yes ☐ No ☐ don't know

4. **Birth Parent Mailing Address** Same as resident ☐ (Check if the mailing and residence addresses are the same, then go to Item #5)

Complete below only if the birth parent mailing address is different from the residence address

Street Name and Number and /or P.O. Box Number		Address Line 2/Apt. Number
Country (United States or Name of Foreign Country)		State, U.S. Territory, or Canadian Province
County	City	Zip Code

5. **Birth Parent Phone Information**

Primary ( )	Secondary ( )	Type of Contact ☐ Cell ☐ Other ☐ Relative ☐ Work
☐ I do not have a phone number where I can be contacted		

6. **Birth Parent Date of Birth**

Month	Day	Year	Current Age

7. **Birth Parent Place of Birth** (Please check only one and write in the state, province or foreign country).

☐ U.S. State or Territory _____

☐ Canada/Province _____ ☐ Other Foreign Country _____

8. **What is the highest level of schooling that you have completed?** (Check one)

☐ Grade 8 or Less
☐ Grade 9-12 With No Diploma
☐ High School Graduate or GED Completed
☐ College Credit, 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 Degree (e.g., PhD, EdD) or Professional Degree (e.g., MD, DO, DDS, LLP, DVM, JD)

9. **Are you of Spanish/Hispanic/Latino Origin?** (Check all that apply)

☐ No, not Spanish/Hispanic/Latino
☐ Yes (Check one) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other _____
☐ Unknown

10. **What is your race?** (Check all that apply)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native (specify) _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify) _____
☐ Native Hawaiian Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify)
☐ Other (Specify) _____

11. **Did you receive WIC (Women's Infant & Children) assistance during this pregnancy?** ☐ Yes ☐ No

12. **What is your current height?**

Feet _____ Inches _____

13. **What was your weight before pregnancy?** _____

14. **How many cigarettes or packs of cigarettes did you smoke on an average day for each of the time periods? If you never smoked enter zero (0) for # of cigarettes for each time period.**

Three months before pregnancy # of cigarettes	_____	OR # of packs of cigarettes	_____
First three months of pregnancy # of cigarettes	_____	OR # of packs of cigarettes	_____
Second three months of pregnancy # of cigarettes	_____	OR # of packs of cigarettes	_____
Last three months of pregnancy # of cigarettes	_____	OR # of packs of cigarettes	_____

15. **How many alcoholic beverages did you consume on an average day during the following time periods? If you never drank, enter zero (0) for # of drinks for each time period.**

Number Of Drinks			
Three months before pregnancy	_____	First three months of pregnancy	_____
Second three months of pregnancy	_____	Last three months of pregnancy	_____

16. **Birth Parent's Marital Status – Required to Register Birth Record and to Establish Parentage**

Were you married at the time you conceived this child, at the time of birth, or within 300 days prior to the birth of your child?

☐ 16a. Yes [Please go to Question #18]

☐ 16b. Yes, but I can provide legal documentation (court order, separation agreement, journal entry, divorce decree) stating my husband is not to be listed as the father of my child. [Please go to Question #17]. This documentation is subject to approval by the Ohio Department of Health, Bureau of Vital Statistics

☐ 16c. Yes, but I refuse to provide my husband's name as the father of my child. [Please go to Question #24]. *Please note that under State of Ohio law, by refusing to complete your husband's information, your child's birth certificate will not be registered as a legal document and your child's birth information will not be electronically transmitted for a Social Security number to be issued.

☐ 16d. No, [Please go to Question #17]

17. **Has a paternity acknowledgment been completed? (That is, have you and the other parent signed an Affidavit of Paternity form in which the father accepted legal responsibility for the child?)**

☐ Yes [Please go to Question #18]

☐ No [Please go to Question #24.] If you were not married, or if an Affidavit of Paternity form has not been completed, information about the father cannot be included on the birth certificate.

SECOND PARENT INFORMATION

PREFERRED PARENTAGE TITLE (Check one)	GENDER (Check one)
☐ Mother ☐ Father ☐ Parent	☐ Female ☐ Male

18. **Second Birth Parent Current Legal Name**

First	Middle, if any	Last	Generational suffix (if any)
What was your last name prior to your first marriage or your last name as it appears on your birth record if you were never married.			

19. **Second Parent Date of Birth**

Month	Day	Year	Current Age

20. **Second Parent Place of Birth** (Please check only one and write in the state, province or foreign country).

☐ U.S. State or Territory _____

☐ Canada/Province_____ ☐ Other Foreign Country _____

21. **What is the highest level of schooling of the second parent?** (Check one)

☐ Grade 8 or Less
☐ Grade 9- 12 With No Diploma
☐ High School Graduate or GED Completed
☐ College Credit, 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 Degree (e.g., PhD, EdD) or Professional Degree (e.g., MD, DO, DDS, LLP, DVM, JD)

22. **Is the second parent of Spanish/Hispanic/Latino origin?** (Check all that apply)

☐ No, not Spanish/Hispanic/Latino
☐ Yes (Check one) ☐ Mexican ☐ Puerto Rican ☐ Cuban ☐ Other _____
☐ Unknown

23. **What is your race?** (Check all that apply)

☐ White
☐ Black or African American
☐ American Indian or Alaska Native (specify) _____
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian (Specify) _____
☐ Native Hawaiian Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (Specify)
☐ Other (Specify) _____

Furnishing parent(s) Social Security Number(s) (SSNs) is required by Federal Law, 42 USC 405c section 205c of the Social Security Act. The number(s) will be made available to the State Social Services Agency to assist with child support enforcement activities and to the Internal Revenue Service for the purpose of determining Earned Income Tax Credit compliance. The SSN is also collected as authorized by Ohio law to be used for public health purposes.

24. **What is your Social Security Number? If you do not have a Social Security Number, please mark "None".**

None ☐

25. **If a second parent was listed on the form, what is the Second Parent's Social Security Number? If the second parent does not have a Social Security Number, please mark "None".**

None ☐

26. **Do you want a Social Security Number issued for your child?**

☐ Yes (Please sign request below)*

☐ No (Go to Question #27)

I request that the Social Security Administration assign a Social Security Number to the child named on this form and authorize the State to provide the Social Security Administration with the information from this form which is needed to assign a number.

I understand that if I was married at any time during the 300 days prior to the birth or my child; and I refuse to list my husband as the father; and do not have legal documentation (court order, separation agreement, journal entry, divorce decree) stating that my husband is not to be listed as the father of my child, my child's birth information will not be electronically transmitted to receive a Social Security number.

*Signature of Birth Parent	Date

27. **What is the relationship of the person providing information for this worksheet?**

☐ Birth Parent ☐ Second Parent

☐ Other, Please Specify _____

28. **What is the birth parent's primary language (that is, what language do you feel the most comfortable speaking)?**

☐ English ☐ Spanish ☐ Somali

☐ Other, please specify _____

Please return your completed Birth Parent's Worksheet to:

Prenatal

Sources: Prenatal care records, mother's medical records, labor and delivery records

Information for the following items should come from the mother's prenatal care records and from other medical reports in the mother's chart, as well as the infant's medical record. If the mother's prenatal care record is not in her hospital chart, please contact her prenatal care provider to obtain the record, or a copy of the prenatal care information. Preferred and acceptable sources are given before each section. Please do not provide information from sources other than those listed.

4. Date of first prenatal care visit (Prenatal care begins when a physician or other health professional first examines and/or counsels the pregnant woman as part of an ongoing program of care for the pregnancy):

_ _ _ _ _ _ _ _
M M D D Y Y Y Y Unknown portions of the date should be entered as "99"

☐ No prenatal care (Please go to Question #6)
☐ Unknown

5. Date of last prenatal care visit (Enter the date of the last visit as recorded in the mother's prenatal records):

_ _ _ _ _ _ _ _
M M D D Y Y Y Y Unknown portions of the date should be entered as "99"

☐ Unknown

6. Total number of prenatal care visits for this pregnancy (Count only those visits recorded in the record. If none enter "0"): _____
☐ Unknown

7. Date last normal menses began:

_ _ _ _ _ _ _ _
M M D D Y Y Y Y Unknown portions of the date should be entered as "99"

☐ Unknown

8. Number of previous live births now living (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):
____ Number
☐ Unknown

9. Number of previous live births now dead (Do not include this child. For multiple deliveries, do not include the 1st born in the set if completing this worksheet for that child):
____ Number
☐ Unknown

10. Date of last live birth:

_ _ _ _ _ _ _ _
M M D D Y Y Y Y Unknown portions of the date should be entered as "99"

☐ Unknown

11. Total number of other pregnancy outcomes (Include fetal losses of any gestational age)

____ Number

☐ Unknown

12. Date of last other pregnancy outcome (Date when last pregnancy which did not result in a live birth ended):

M M D D Y Y Y Y Unknown portions of the date should be entered as "99"

☐ Unknown

13. Risk factors in this pregnancy (Check all that apply):

a. ☐ None
b. ☐ Prepregnancy diabetes
c. ☐ Gestational diabetes
d. ☐ Prepregnancy hypertension (chronic)
e. ☐ Gestational hypertension w/o eclampsia
f. ☐ Eclampsia
g. ☐ Previous preterm births – (a live birth of less than 37 weeks of gestation)
h. ☐ Other previous poor pregnancy outcome (Please see desk reference for conditions covered)
i. ☐ Pregnancy resulted from fertility-enhancing drugs, artificial insemination or intrauterine insemination
j. ☐ Pregnancy resulted from assisted reproductive technology
k. ☐ Mother had a previous cesarean delivery
If Yes, how many____
l. ☐ Anemia (Hct,30/Hgb. < 10)
m. ☐ Cardiac Disease
n. ☐ Acute or Chronic Lung Disease
o. ☐ Hydramnios/Oligohydramnios
p. ☐ Hemoglobinopathy
q. ☐ Unknown

14. Infections present and/or treated during this pregnancy – (Check all that apply):

a. ☐ None
b. ☐ Bacterial Vaginosis
c. ☐ Chlamydia
d. ☐ CMV
e. ☐ Gonorrhea
f. ☐ Hepatitis B
g. ☐ Hepatitis C
h. ☐ Herpes Simplex Virus
i. ☐ In Utero Infection (TORCHS)
j. ☐ Maternal Group B Strep Colonization
k. ☐ Measles
l. ☐ Mumps
m. ☐ PID
n. ☐ Rubella
o. ☐ Syphilis
p. ☐ Trichimoniasis
q. ☐ Toxoplasmosis
r. ☐ Varicella
s. ☐ Unknown

15. Obstetric procedures – (Check all that apply):

a. ☐ None
b. ☐ External cephalic version - Successful
c. ☐ External cephalic version - Failed
d. ☐ Cervical cerclage
e. ☐ Tocolysis
f. ☐ Unknown

Mother's medical record # _____
Mother's name _____
Child's Date of Birth _____
Child's medical record # _____

FACILITY WORKSHEET FOR THE LIVE BIRTH CERTIFICATE

Child's Last Name: _____ **Plurality:** ____ **Birth Order:** ____

1. Place of birth:

☐ Hospital/Birthing Center (Please go to Question #3)
☐ En Route (Please go to Question #3)
☐ Home birth*
Planned to deliver at home ☐ Yes ☐ No
☐ Other * (specify, e.g., taxi cab, car, plane, etc.)_____

*(If Home birth or Other, please complete Question #2)

2. Address of birth (if Home Birth or Other is marked):

State: _____
County: _____
City, Town, or Township: _____
Street Address: _____
Apartment Number: _____Zip Code/Postal Code: _____

3. Principal source of payment for this delivery (At time of delivery):

a. ☐ Health insurance through Private insurance current or former employer or union.
b. ☐ Medicare
c. ☐ Medicaid – (e.g. Healthy Start, Medicaid waiver programs, disability assistance, Healthy Families)
d. ☐ Purchased directly
e. ☐ Other (Specify, e.g., Indian Health Service, CHAMPUS/TRICARE, Other Government (federal, state, local))
_____
f. ☐ Uninsured
g. ☐ Unknown

Labor and Delivery

Sources: Labor and delivery records, mother's medical records

16. Was the mother transferred to this facility for maternal medical or fetal indications for delivery?

☐ Yes* ☐ No ☐ Unknown

*If Yes, enter the name of the facility mother transferred from:

_____

Other (specify): _____

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

a. ☐ None
b. ☐ Premature Rupture of the Membranes (prolonged >=12 hours)
c. ☐ Precipitous labor (<3 hours)
d. ☐ Prolonged labor (>=20 hours)
e. ☐ Unknown

18. Date of birth:

_ _ _ _ _ _ _ _
M M D D Y Y Y Y

19. Time of birth: _____ 24 hour clock

☐ Unknown

20. Attendant's name, title, and N.P.I. (National Provider Identifier) (The attendant at birth is the individual physically present at the delivery who is responsible for the delivery. For example, if an intern or nurse-midwife delivers an infant under the supervision of an obstetrician who is present in the delivery room, the obstetrician is to be reported as the attendant):

_____ _____

Attendant's name N.P.I.

Attendant's title:

a. ☐ M.D.
b. ☐ D.O.
c. ☐ CNM/CM -(Certified Nurse Midwife/Certified Midwife)
d. ☐ Other Midwife - (Midwife other than CNM/CM)
e. ☐ Other specify):_____

21. Mother's weight at delivery (pounds):_____

☐ Unknown

22. Characteristics of labor and delivery (Check all that apply):

a. ☐ None
b. ☐ Induction of labor
c. ☐ Augmentation of labor
d. ☐ Non-vertex presentation
e. ☐ Steroids (glucocorticoids) for fetal lung maturation received by the mother prior to delivery
f. ☐ Antibiotics received by the mother during labor
g. ☐ Clinical chorioamnionitis diagnosed during labor or maternal temperature ≥ 38° C (100.4° F)
h. ☐ Moderate/heavy meconium staining of the amniotic fluid
i. ☐ Fetal intolerance of labor was such that one or more of the following actions was taken: in-utero resuscitative measures, further fetal assessment, or operative delivery
j. ☐ Epidural or spinal anesthesia during labor
k. ☐ Abruptio Placenta
l. ☐ Placenta Previa
m. ☐ Cephalopelvic disproportion
n. ☐ Other excessive bleeding
o. ☐ Cord prolapse
p. ☐ Anesthetic complications
q .☐ Unknown

23. Method of delivery:

A. Was delivery with forceps attempted but unsuccessful?
☐ Yes ☐ No ☐ Unknown

B. Was delivery with vacuum extraction attempted but unsuccessful?
☐ Yes ☐ No ☐ Unknown

C. Fetal presentation at birth (Check one):
☐ Cephalic ☐ Breech ☐ Other ☐ Unknown

D. Final route and method of delivery (Check one):

a. ☐ Vaginal/Spontaneous
b. ☐ Vaginal/Forceps
c. ☐ Vaginal/Vacuum
d. ☐ Cesarean – (no labor attempted)
e. ☐ Cesarean – (labor attempted)
f. ☐ Unknown

24. Maternal morbidity (Check all that apply):

a. ☐ None
b. ☐ Maternal transfusion
c. ☐ Third or fourth degree perineal laceration
d. ☐ Ruptured uterus
e. ☐ Unplanned hysterectomy
f. ☐ Admission to intensive care unit
g. ☐ Unplanned operating room procedure following delivery
h. ☐ Unknown

Newborn

Sources: Labor and delivery records, Newborn's medical records, mother's medical records

25. Infant's medical record number: _____

26. Birth weight: _____ (grams) (Do not convert lb/oz to grams)
If weight in grams is not available, birth weight: _____ (lb/oz)

27. Obstetric estimate of gestation at delivery (completed weeks): _____ ☐ Unknown

28. Sex: ☐ Male ☐ Female ☐ Undetermined

29. Apgar score
Score at **5** minutes _____ ☐ Unknown
If 5 minute score **is less than 6:**
Score at **10** minutes _____ ☐ Unknown

30. Plurality (Specify 1 (single), 2 (twin), 3 (triplet), 4 (quadruplet), 5 (quintuplet), 6 (sextuplet), 7 (septuplet), etc.) (Include all live births and fetal losses resulting from this pregnancy.):_____

31. Order of Delivery (Order delivered in the pregnancy, specify 1st, 2nd, 3rd, 4th, 5th, 6th, 7th, etc.) (Note: Delivery includes all live births and fetal losses resulting from this pregnancy): _____

32. If not single birth, for this delivery specify:
Number born alive: _____
Number of fetal deaths: _____

33. Metabolic Kit Number: _____

34. Name of Prophylactic Used in Eyes of Child (Check one):

a. ☐ Ilotycin Opthalmic
b. ☐ Ilotycin Ointment
c. ☐ Ilotycin
d. ☐ Erythromycin Opthalmic
e. ☐ Erythromycin Ointment
f. ☐ Erythromycin
g. ☐ AGNO3 (Silver Nitrate)
h. ☐ Neosporin
i. ☐ EES
j. ☐ Cholostrum
k. ☐ Boric Acid
l. ☐ Breast Milk
m. ☐ Unknown
n. ☐ None
o. ☐ Other (Specify)_____

35. Abnormal conditions of the newborn (Check all that apply):

a. ☐ None
b. ☐ • ssisted ventilation required immediately following delivery
c. ☐ Assisted ventilation required for more than six hours
d. ☐ NICU admission
e. ☐ Newborn given surfactant replacement therapy
f. ☐ Antibiotics received by the newborn for suspected neonatal sepsis
g. ☐ Seizure or serious neurologic dysfunction
h. ☐ Significant birth injury (skeletal fracture(s), peripheral nerve injury, and/or soft tissue/solid organ hemorrhage which requires intervention)
i. ☐ Unknown

36. Congenital anomalies of the newborn (Check all that apply):

a. ☐ None
b. ☐ Anencephaly
c. ☐ Craniofacial Anomalies
d. ☐ Meningomyelocele/Spina bifida
e. ☐ Hydrocephalus w/o Spina bifida
f. ☐ Encephalocele
g. ☐ Microcephalus
h. ☐ Cyanotic congenital heart disease
i. ☐ Tetralogy of Fallot
j. ☐ Congenital diaphragmatic hernia
k. ☐ Omphalocele
l. ☐ Gastroschisis
m. ☐ Bladder exstrophy
n. ☐ Rectal/large intestinal atresia/stenosis
o. ☐ Hirshsprung's disease
p. ☐ Congenital hip dislocation
q. ☐ Amniotic bands
r. ☐ Limb reduction defect
s. ☐ Congenital cataract
t. ☐ Cleft Lip with/without Cleft Palate
u. ☐ Cleft Palate alone
v. ☐ Down Syndrome – Karyotype pending
w. ☐ Down Syndrome –Karyotype confirmed
x. ☐ Suspected chromosomal disorder – Karyotype confirmed
y. ☐ Suspected chromosomal disorder - Karyotype pending
z. ☐ Hypospadias
aa. ☐ Unknown

37. Was infant transferred within 24 hours of delivery?

☐ Yes* ☐ No ☐ Unknown

*If Yes, enter the name of the facility infant was transferred to:

_____

Other (specify): _____

38. Is infant living at time of report?

☐ Yes ☐ No ☐ Infant transferred, status unknown

If No, complete a death record.

39. Is infant being breastfed at discharge?

☐ Yes ☐ No ☐ Unknown

AFFIDAVIT

COMPLETE ONLY IF DOING SECTION 4

(Evidence that the birth occurred outside of the mother's residence and proof of residence)

BIRTH LOCATION Verification for Out-of-Institution Births

I, _____, verify that _____
(PRINT: Property Owner's Name) (PRINT: Mother's Name)

Gave birth on _____ at _____,
(Infant's Date of Birth) (Print: Street Address)

_____.
(Print: City, State, Zip Code)

Property Owner's Signature: _____
Date: _____
Owner's Phone Number: _____

Before me appeared the above-named person and signed this statement by affirmation, on this _____ day of _____ in the year _____.

Signature of Notary: _____

Seal

My Commission Expires: _____

PREGNANCY Verification for Out-of-Institution Births

I, _____, verify that _____
(PRINT: Health Care Provider's Name) (PRINT: Woman's Name)

(born _____), whom I saw on _____ is pregnant.
(Woman's Date of Birth) (PRINT: Visit Date)

_____ _____
Health Care Provider's Signature Date

_____
Health Care Provider's License Number

INFANT Verification for Out-of-Institution Births

I, _____, verify that _____
(PRINT: Health Care Provider's Name) (PRINT: Infant's Name)

was born alive on _____ to _____.
(Infant's Date of Birth) (PRINT: Mother's Name)

_____ _____
Health Care Provider's Signature Date

_____
Health Care Provider's License Number

Newborn Hearing Screening

learning begins at birth and beyond!

Hearing Screening


OAE


ABR

- **Hearing screening** is a simple way to know if your baby can hear or if more testing is needed. Your baby may have one or both types of screening tests at birth.
- **OAE** is an otoacoustic emissions test. This test sends sounds into your baby's ear using small ear tips and records an echo from the inner ear.
- **ABR** is an auditory brainstem response test. This test sends clicks into your baby's ear using small ear tips or earphones and three small patches. The test records how well your baby's hearing nerve is working.

Screening Results

PASS results: Your baby passed the hearing screening. Hearing can change as a baby grows, so it is important to monitor your baby's speech, language, and communication.

Pass with risk factor(s): Your baby passed the hearing screening, but there is a risk factor(s). Your baby may have a higher chance for hearing loss. Follow the recommendations for follow up testing and monitor your baby's communication.

NON-PASS results: Your baby did not pass the hearing screening and a more detailed test, called a hearing evaluation, is needed.

Questions About Hearing Screening

» Talk to your baby's doctor

» Contact the Ohio Department of Health
Screening Questions
614-387-0135
Infanthearingprogram@odh.ohio.gov
Learn more at: http//bit.ly/OHEHDI

Ohio Department of Health

Hearing Evaluation Follow Up

Hearing Evaluation

The hearing evaluation is important and should be scheduled soon- between 2-4 weeks after discharge and testing should be completed by 3 months. Your baby will see a pediatric audiologist who tests hearing.

Please ask about special instructions when scheduling. It is important for your baby to sleep for the testing. When you arrive at the appointment feeding your baby will help relax your baby for the testing.

Early Intervention

Babies with hearing loss can have special services to help them learn how to communicate. Early Intervention provides supports and resources for parents and caregivers to enhance children's learning and development through everyday routines.

Ohio Department of Health

Infanthearingprogram@odh.ohio.gov

For hearing evaluation questions 614-728-4676 • http//bit.ly/OHEHDI

Ohio Local Health District Name:

_____

I received the Universal Newborn Hearing Screening Parent Brochure, "A sound beginning..." and have completed the information on this form. I understand that my local health district will assist me in finding a provider who can screen my baby's hearing.

Date: _____

Child's Name	
Date of Birth	
Parent/Guardian/Custodian Name	
Parent/Guardian/Custodian Address	
Parent/Guardian/Custodian Phone Number	
Parent/Guardian/Custodian Signature	

I received the Universal Newborn Hearing Screening Parent Brochure, "A sound beginning..." and have completed the information on this form. I understand that my local health district will assist me in finding a provider who can screen my baby's hearing.

Date: _____

Child's Name	
Date of Birth	
Parent/Guardian/Custodian Name	
Parent/Guardian/Custodian Address	
Parent/Guardian/Custodian Phone Number	
Parent/Guardian/Custodian Signature	