LIVE BIRTH NOTIFICATION FORM REFERENCE MANUAL

Januarv 1st. 2020



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Acknowledgements

The stakeholders would like to thank the many health care professionals who take the time to complete these forms. Your participation is invaluable in helping maintain accurate and reliable information on live births within our province.

The cooperation of all the participating agencies and members of the Live Birth/Mortality System Advisory Committee is gratefully acknowledged. Without their input and continued support, the ability to maintain relevant and accurate data would not be possible.

Changes/Revisions for 2020 Live Birth Notification (LBN) Form

The guide on how to complete each field is located on pages 8-19.

The following changes were made to 2020 form:

Field 43: Changed to: Prenatal Care Provider (check all that apply):
Family Doctor/GP
RN
Midwife
OBS/GYN
NP
None
Other Specialty
This was changed to identify the various care providers who can provide prenatal care.
Field 48: Delivery Complications
Shoulder Dystocia
This was added as a Delivery Complication as it is often written in on the form.

Information required for completing the 2020 LBN form

The recently revised LBN form (January 2020) will replace the form currently in use (2019). Please destroy all remaining copies of the 2019 LBN form on January 1, 2020. If you have not received your 2020 LBN forms by then, please notify Service NL – Vital Statistics Registrar immediately.

This manual can be downloaded from www.nlchi.nl.ca

Any 2020 births not recorded on 2020 forms may be returned for the completion on the correct form.

*It is recommended that you review the 2020 LBN as well as the Guide for Completion before commencing use of the new form.

Special Notice

The Reference Manual guide has been updated. It is recommended that you review pages 8-19 for guidance on how to complete each field of the 2020 LBN form.

The LBN form must be completed within 48 hours of delivery and submitted within five days of delivery to:

Vital Statistics Division
Service Newfoundland and Labrador
P.O. Box 8700
St. John's, NL Canada A1B 4J6
T (709) 729-3308

Please specify **CONFIDENTIAL** on all envelopes.

For additional copies of the 2020 Live Birth Notification Form, please contact:

Vital Statistics Division
Service Newfoundland and Labrador
P.O. Box 8700
St. John's, NL Canada A1B 4J6
T (709) 729-3308

All comments and questions concerning the LBN form content and the LBN Reference Manual are welcome and can be directed to the Centre at (709) 752-6003 or by completing and forwarding the Comment form in the back of the Guide.

Manager, Clinical/Administrative Standards Health Analytics and Evaluation Services Newfoundland and Labrador Centre for Health Information 70 O'Leary Avenue St. John's, NL A1B 2C7 T (709) 752-6003

Introduction

In 1981, a Physicians Notification of Birth was introduced to improve the timeliness and accuracy of health statistics regarding live births in our province. In 1986, the Division of Health Research and Statistics, with the assistance of a multidisciplinary committee, revised the Notification of Birth Form and introduced it into the hospital system.

Since 1986, there have been several revisions, and in 2002, the LBN form underwent major revisions to accommodate the ever changing need to capture new data and eliminate the capturing of data that is no longer relevant. Since 2002, the LBN form is reviewed annually to consider end user requests and to ensure the data collect is relevant.

This notification of birth provides information to the Department of Health & Community Services, Service NL - Vital Statistics Division, Regional Health Authority Health & Community Services, Statistics Canada, Newfoundland Statistics Agency, and the Newfoundland and Labrador Centre for Health Information (the Centre). It also serves as a referral notification for the Healthy Beginnings Program as well as a working document for Regional Health Authority Health & Community Services.

This revised form had the input of many stakeholders. The provincial committee – the Live Birth/Mortality System (LB/MS) Advisory Committee has the following representatives:

- ♦ Registrar, Vital Statistics Division, Service NL
- ◆ Perinatal Program Newfoundland and Labrador (PPNL)
- Clinical Educator, Child/Women's Health Program, Janeway Children's Health and Rehabilitation Centre
- ♦ Department of Health and Community Services
- ♦ Newfoundland and Labrador Centre for Health Information

The Live Birth Notification form is a multi-part document (Parts A & B).

PART A:

- ♦ Registration
- ♦ Infant
- ♦ Mother
- ♦ Other Parent
- ♦ Health History and Medical Certification of Birth

PART B:

- ♦ Referral to Health and Community Services
- ♦ Hospital Nursing Discharge Summary
- ♦ Healthy Beginnings Follow-Up
- ♦ Referral Priority Assessment for Follow-Up

Information on Part A is used by:

- ♦ Vital Statistics to ensure all births are registered, to verify births registered by parent(s), and issue birth certificates.
- ◆ The Centre to classify each birth according to ICD-10-CA coding guidelines and to support the NLCHI Live Birth Database, which contains information concerning the number of births, types of births, and related information.
- Statistics Canada to gather data to meet the requirements of the Federal Government.
- Researchers and government departments & agencies (e.g. PPNL) use the information gathered on the LBN form.

Parts A & B are used by Health & Community Services to obtain pertinent medical information on the mother and infant for follow up purposes; therefore, it is important that all the questions be answered. It is also used as a referral to the Healthy Beginnings Program.

The referral to Health & Community Services <u>must</u> contain both parts A & B.

The Newfoundland and Labrador Centre for Health Information will continue to support education/training through provision of materials and consultation.

Regional Health Authorities have permission from the Newfoundland and Labrador Centre for Health Information to reproduce this entire guide or any section of this guide. Copies can be downloaded from www.nlchi.nl.ca, under STANDARDS > CLINICAL STANDARDS AND INFORMATION (CSI), at the following link:

https://www.nlchi.nl.ca/index.php/quality-information/standards/clinical-standards-and-information

Definitions

For the purpose of data collection for the Live Birth Notification System; the following definitions apply:

Birth: The birth of one infant.

Delivery: The birth of one or more infants in the same event.

E.g. Twin would be one delivery.

Live Birth: The complete expulsion or extraction from the mother, irrespective of

the duration of the pregnancy, of a fetus in which, after the expulsion or extraction, there is breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement of voluntary muscle, whether

or not the umbilical cord has been cut or the placenta attached.

Multiple Birth: A delivery that results in more than one birth, whether live born or

stillborn.

Stillbirth: The complete expulsion or extraction from the mother of a fetus of at

least 500 grams or more in weight or at least 20 weeks gestation in which, after the expulsion or extraction, there is no breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement

of voluntary muscle.

Total Births: The combined total of live births plus stillbirths.

The live birth and stillbirth definitions are the legal definitions as outlined by the Service NL - Vital Statistics Division.

These definitions have been adapted from Statistics Canada.

Guidelines for completion of the Live Birth Notification (LBN) Form

Parents have the right to refuse to answer any or all questions on the LBN form. If the parents refuse to have the form completed, they should be advised that obtaining a birth certificate and/or a MCP number for their infant may be difficult and/or prolonged. If the parents refused to have the LBN form completed, this should be noted on the mother's health record.

The LBN form is printed on carbonless copy paper, and therefore it is recommended that a **ball point pen** be used to complete this form. You will be making multiple copies and are asked to please **press firmly** so that the information is reflected on the multiple copies. Please ensure ALL fields are completed. It is also important that forms are not placed on top of each other when completing, as the information from one form may copy through to the next, making it illegible, and/or provide conflicting information.

Each health care facility is responsible for ensuring that both Part A & Part B of the form is completed by the appropriate staff and sent to the appropriate agencies. Facilities are directed to <u>staple both the white and green copy together</u> before forwarding to Vital Statistics to ensure forms are not separated. Each copy is labeled indicating where it should be sent:

White -- Vital Statistics Green -- Vital Statistics

Goldenrod -- Hospital Health Record
Pink -- Health & Community Services

Shaded blocks on the form (Hospital Code, ICD-10-CA Codes, etc.) are for Vital Statistics and/or the Centre use only.

Part B is to be completed upon discharge of the mother <u>and/or</u> infant and sent to the appropriate Health & Community Services Board <u>along with Part A</u>. If a mother or infant is not discharged on the same date, a referral (Part B) for each will be required upon discharge.

This Reference Manual is divided into sections identical to those on the LBN form. It begins with Part A, questions 1 to 51 and continues through to Part B, questions 57 to 80.

THE FOLLOWING ARE VALID INDICATORS:

When completing the LBN form, **please do not leave any question blank**. If the information is non-applicable or unknown, use the indicators below.

	VALID INDICATORS				
N/A	Meaning Non-Applicable				
U/K	To be used ONLY when the information is not found on the patient				
	chart, is unavailable, or is truly unknown.				
	ALL questions from Part A (LBN) and Part B (Referral to Health &				
	Community Services), except for the shaded areas (office use)				
	should be completed. Questions beyond #79 on Part B are for				
	Health & Community Services use.				

Surname of Infant

An infant may be given the surname of <u>the mother</u>, the <u>father/other parent</u>, <u>hyphenated</u> <u>combination of both</u>, or <u>any surname chosen by the parents</u>.

Vital Statistics requires a Birth Registration form be completed by the parent(s). It is the responsibility of the parent(s) to complete and return this form to Vital Statistics.

Health care facilities will provide birth registration packages to birth mothers. The birth registration packages are also available at Vital Statistics.

Vital Statistics Division Service Newfoundland and Labrador P.O. Box 8700 St. John's, NL Canada A1B 4J6 T (709) 729-3308 **For The Information of the Parents – Please Note:** When applying for a MCP number for the infant, if the applicant does not have the same surname as the infant, MCP will require a birth certificate of the infant. Birth Certificates are available through Vital Statistics. There is a \$20.00 cost for each birth certificate.

Infant's Surname While in Hospital

To ensure safety and continuity of care while the infant is in hospital, it is recommended that the surname given to an infant on delivery remain the same for the length of stay in hospital.

Information on Other Parent

Information regarding the other parent is desired, however, if the other parent is not identified, use the appropriate valid indicator. Draw a diagonal line through the section and enter U/K. This does not indicate that the other parent is unknown; rather it indicates that the information about the other parent is unknown, or has not been provided.

Live Birth Notification - Part B: Referral to Health & Community Services

If parents refuse to have the LBN Referral sent to Health & Community Services and leave the hospital because they do not wish follow-up, the parents' request is to be respected. The refusal of referral by the parents should be noted on the mother's health record.

The Hospital Nursing Discharge Summary provides for early follow-up of the infant and mother with Health and Community Services. Prompt transmittal of completed forms allows continuity of care for infants and families.

If immediate follow-up is required (within 48 hours), the referring nurse is requested to telephone the referral to a Health & Community Services Nurse (follow up with the form). This requirement may vary depending upon the regional policy; therefore, check your local policy to ensure the correct procedure is followed.

Inform the Parents

Before asking the parents for the information required on this form, you can use the following explanation to help minimize questions about who is using this information.

The information on the LBN form is required by several government agencies:

- Vital Statistics to register the birth of the infant and issue birth certificates. Information is also shared with the Centre, for input into the provincial database.
- ♦ Statistics Canada, for input into the national database.
- ◆ A copy is sent to Health & Community Services as a referral to the Healthy Beginnings Program.

SPECIAL REFERRAL INSTRUCTIONS:

If immediate follow-up is required (within 48 hours), the referring nurse is requested to telephone the request to the Community Health nurse.

- If infant remains in hospital following discharge of mother:
 Complete and process Part B for mother
 Forward second referral (Part B) at the time of infant's discharge, with information on infant's hospitalization and recommendations for follow-up.
- If mother remains in hospital following discharge of infant:
 Complete and process Part B for infant
 Forward second referral (Part B) at the time of mother's discharge, with information on mother's hospitalization and recommendations for follow-up.
- ♦ If infant is transferred: Include on mother's referral (Part B) as much information as possible regarding infant's condition.
- ♦ If following discharge, the mother stays for more than one week in a Community Health nursing district other than her place of residence, send the Health & Community Services Nursing Referral to the district where the mother is staying immediately following discharge. Also, Part B has an area entitled "Alternate Address"; complete this section when the mother is not returning to her usual place of residence within a week after discharge.

Ensure all sections of the LBN form are legible prior to sending.

<u>Live Birth Notification Form – Part A</u>

Registration Information

FIELD	QUESTION	INFORMATION REQUIRED:	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
		CERTIFICATION		
#1	Registration Number		Vital Statistics	

Infant Information

FIELD	QUESTION	INFORMATION REQUIRED:	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
#2	Surname, Full Given Name(s)	Record surname and full given names of infant (NO INITIALS). If infant's given names are not known, record B/B (Baby Boy) or B/G (Baby Girl)	Health Care Staff	Parents
# 3	Sex of Infant	Check (v) one as applicable: M – Male F – Female Unknown	Health Care Staff	Labour & Delivery Record
# 4	Date of Birth	Record infant's date of birth using MONTH, DAY, YEAR format, e.g. December 31, 2009 should be written: 12 31 2009.	Health Care Staff	Labour & Delivery Record
# 5	Locality of Birth	Check (V) the appropriate locality of birth. If Other is selected, record the locality of birth; e.g. baby born in a taxi en route to hospital.	Health Care Staff	Labour & Delivery Record or Admit Note
#6	Hospital	Record the full name of the hospital whose staff is completing this form. Hospital Code is completed by the Centre.	Health Care Staff	Health Care Staff
# 7	Place of Occurrence (City/Town)	Full name of the town, city, municipality where birth occurred.	Health Care Staff	Health Care Staff
# 8	Infant's Admit #	Record infant's hospital admitting number.	Health Care Staff	Admitting Documentation
# 9	Infant's Hospital Chart #	Record infant's hospital chart number.	Health Care Staff	Admitting Documentation

Mother Information

FIELD	QUESTION	INFORMATION REQUIRED: MOTHER	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
# 10	Surname, Full Given Name(s)	Record the surname of the mother followed by full given name(s) (no initials).	Health Care Staff	Admitting Documentation
# 11	Maiden Name & Initials	Record the mother's maiden surname and initials. Although the mother's full name is completed in the above answer, Statistics Canada also requires the initials in this answer. If there is no maiden name, (e.g. mother never changed her name) use the indicator N/A for surname.	Health Care Staff	Admitting Documentation
# 12	Health Care Number	For residents of Newfoundland and Labrador, record the MCP number.	Health Care Staff	Prenatal Record or Admitting Documentation

FIELD	QUESTION	INFORMATION REQUIRED:	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
		MOTHER		INFORMATION
		If from another province or country, enter: Health Care number for out of Province/Country, if available. If not available or unknown, enter the		
		valid indicator U/K.		
# 13	Date of Birth	Record mother's date of birth using MONTH, DAY, YEAR format, E.g. December 31, 1972 should be written: 12 31 1972.	Health Care Staff	Admitting Documentation or Mother
# 14	Age at Delivery	Record mother's age, in years, at time of delivery.	Health Care Staff	Admitting Documentation or Mother
# 15	Birth Place (Province/Territory- Country if Outside Canada)	Record the mother's place of birth followed by province or territory if born in Canada. e.g. Corner Brook, NL If born outside of Canada, record the place of birth followed by the country. E.g. London, England.	Health Care Staff	Admitting Documentation or Mother
#16	Usual Home Address	Record mother's complete home address (street number, community, postal code, etc.) and phone number. The postal code is an important part of the home address and is a required field. This is also applicable to out of province/country mothers. (SGC is completed by the Centre)	Health Care Staff	Mother
# 17	Complete Mailing Address	Record mother's complete mailing address if different from usual home address, including the postal code. If the usual home address is IDENTICAL to the mailing address, enter the indicator N/A.	Health Care Staff	Mother
#18	Legal Marital Status of Birth Mother	Check (v) one as applicable: This is required by Statistics Canada. Commonlaw is not included because the term common-law is not recognized as a legal term. DO NOT WRITE IN COMMON-LAW. Never Married – Mothers who have never been married Legally Married and not Separated – When infant's parents are married to each other and living together Legally Married but Separated – When infant's parents are married to each other but not living together Divorced – Mothers who are legally divorced Widowed – Mothers whose spouses are deceased Unknown – Mothers whose legal marital status is unknown	Health Care Staff	Prenatal Record and Admission Documentation or Mother

FIELD	QUESTION	INFORMATION REQUIRED:	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
		MOTHER		
# 19	Living Arrangements of Birth Parents	 Check (v) one as applicable: Living together as a couple: Infant's parents are living together Not living together as a couple: Infant's parents are not living together Unknown: Living arrangements of birth parents are unknown 	Health Care Staff	Mother
# 20	Marital Relationship	This question relates to the parents of	Health Care Staff	Mother
	of Birth Parents of	this Live Birth delivery (not the		
	this delivery	mother's parents)		
		Yes - if the mother is legally married to		
		the infant's other parent.		
		No - if the mother is not legally married to the infant's other parent.		
		Unknown - if the marital relationship is		
		unknown		
# 21	Education	Check (V) one only; the highest level attained. Has not Graduated High School: Does not have a high school graduation certificate Graduated High School: Has a high school graduation certificate Beyond High School: Attended college or university but does not have a post-secondary certificate, diploma or degree College or University Degree/Diploma: Completed post-secondary education and has a certificate, diploma and/or degree Unknown — If education level unknown e.g. If the mother has completed high school, but has not completed any education beyond high school, check "Graduated High School".	Health Care Staff	Mother
		and has one or more courses completed from a post-secondary institution, check "Beyond High School". If the mother has received a certificate, diploma and/or degree from a post-secondary institution, check "College or University Degree/Diploma", although she may not have a high school graduation certificate.		

Other Parent Information

Information regarding the other parent is desired. However, if the other parent is not identified, use the appropriate valid indicator, (draw a diagonal line through the section and enter U/K). This does not indicate that the other parent is unknown; it indicates that the <u>information</u> on the other parent is unknown, or has not been provided.

FIELD	QUESTION	INFORMATION REQUIRED:	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
		OTHER PARENT		
# 22	Surname, Full Given	Record the surname of the other parent	Health Care Staff	Mother or Other Parent
	Name(s)	followed by full given name(s) (no		
		initials).		
# 23	Date of Birth	Record other parent's date of birth	Health Care Staff	Mother or Other Parent
		using MONTH, DAY, YEAR format,		
		e.g. December 31, 1972 should be		
		written as: 12 31 1972.		
# 24	Age	Record other parent's age, in years, at	Health Care Staff	Mother or Other Parent
		<u>last birthday</u> .		
# 25	Birth Place	Record the other parent's place of birth	Health Care Staff	Mother or Other Parent
	(Province/Territory-	followed by province or territory if born		
	County if Outside	in Canada, e.g. Labrador City, NL. If		
	Canada	born outside of Canada record the place		
		of birth followed by the country, e.g.		
		Boston, USA.		
#26	Reserved for future			
	use			

Health History and Medical Certification of Birth

This section contains information on both mother and baby and is completed after delivery. For questions that have multiple check boxes, please check all that apply. If the answer is unknown, or not applicable, record the appropriate indicator (U/K or N/A).

PLEASE NOTE: It is recommended that the attending physician (in some facilities this may be the oncall physician or other primary health care provider) complete the following questions: 32, 37, 38, 44, 45, 46, 47, 48 & 49.

For referral instructions to Perinatal Program NL see Appendix A.

# 27 Total Number of Children Ever Born to this Mother (including this delivery) *Note: Please see Page 4 for definition of "Delivery" *Note: Please see Page 2 for definition of "Delivery" *Note: For multiple births. *Note: For multiple births (e.g. twins) enter '2' in the 'liveborn' field on each form (for first time mother, increase total number of liveborn by two on each form). # 28 Complete Date of Last *Record the number of live births and the number of stillbirths ever born to this mother, including all infants in this delivery. Infants born alive, who may have subsequently died, are considered "live births". Enter "0 "(zero) if no stillbirths. **Note: For multiple births (e.g. twins) enter '2' in the 'liveborn' field on each form (for first time mothers). If not a first time mother, increase total number of liveborn by two on each form). # 28 Complete Date of Last **Record the date (MONTH, DAY, YEAR Health Care Staff **Prenatal Record**)	EIELD QUESTION	INFORMATION REQUIRED: COMP	PLETED BY	WHERE YOU MAY
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		of liveborn by two on each form).		
Delivery (prior to this format) of last live or stillbirth delivery			h Care Staff	Prenatal Record
	Delivery (prior to this	format) of last live or stillbirth delivery		
delivery) NOT including this delivery. If no		,		
(see Delivery previous birth, use the indicator N/A.	'			
definition on P. 4) For multiple births, do not enter the	definition on P. 4)			
birth of the first infant of this current				
delivery as the date of last delivery. For				
example, mother had a previous		· · ·		
singleton in 2004, in 2010 has a twin		·		
delivery; the correct date to enter for		• •		
both Twin A and Twin B is previous		•		
delivery of 2004.	Tatal Name have a	·	l- C C+-ff	Labarra C. Dalinaan
			n Care Staff	Labour & Delivery
Infants in this singleton, twin, triplet, etc. Delivery (including Check (V) applicable selection. Record	· · · · · · · · · · · · · · · · · · ·			Record
Live and Stillborn)		Check (v) applicable selection.		
·		Check (V) None if applicable or record Health	h Care Staff	Labour & Delivery
this Delivery the number of stillborn in this delivery, Record		` ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	ii Care Stair	1
i.e. if multiple birth, enter a numeric				
value if one or more infant was stillborn.		· ·		

FIELD	QUESTION	INFORMATION REQUIRED:	COMPLETED BY	WHERE YOU MAY
		HEALTH HISTORY & MEDICAL CERTIFICATION – CONTINUED		INFORMATION
#31	Multiple Birth – Birth Order	Used to identify multiple birth order (1 st , 2 nd , etc.) Check (V) as applicable. If Other is selected, enter appropriate information.	Health Care Staff	Labour & Delivery Record
# 32	Gestation Age (Weeks/Days)	Record gestational age, Weeks followed by Days e.g. 34 & 5 – indicates 34 weeks plus 5 days gestation.	Health Care Staff or Physician	Labour & Delivery Record
#33	Was this Birth due to Medical Termination of Pregnancy?	This field refers to Medical or Therapeutic Termination/Abortion Check (V) Yes or No - this information is necessary. Rationale: Information on medical terminations that may result in a live birth is necessary: • to enable researchers to accurately interpret data pertaining to premature births and neonatal deaths • to alert Vital Statistics employees not to contact the mother.	Health Care Staff	Labour & Delivery Record, Admission Documentation, and/or History and Physical
# 34	Birth Weight	Record infant's weight (<u>measured in</u> grams) at time of birth.	Health Care Staff	Labour & Delivery Record
# 35	Delivered By	Print surname and first name of person who assisted with the delivery of the	Health Care Staff or Physician	Labour & Delivery Record
	Identify only ONE person	infant. Do not use initials. There may be several people involved, but only the person who assisted the mother in the delivery should be indicated. E.g. If a clinical clerk, under the supervision of a physician, assists the mother with the delivery, record the clinical clerk's name. If the attending physician wishes to be listed, record the attending physician's name only. If a nurse assists the mother with a delivery and a physician is not present, record the nurse's name.		
# 36	Designation of Attendant	Check (V) <u>one</u> as applicable. If Other is selected, record additional information.	Health Care Staff or Physician	Labour & Delivery Record
	Attendant	serected, record additional information.	Titysician	necora

FIELD	QUESTION	INFORMATION REQUIRED:	COMPLETED BY	WHERE YOU MAY
		HEALTH HISTORY & MEDICAL CERTIFICATION – CONTINUED		INFORMATION
# 37	Signature for Certification of Birth	This is the signature of the attending physician (in some regions this may be the on call physician, nurse or midwife) whose signature certifies the Medical Certification of Birth. This could be a different signature than the person who actually delivered the infant.	Physician or person who assisted with the delivery	Labour & Delivery Record
# 38	Date	Record the date (MONTH, DAY, YEAR format) when the Health History and Medical Certification of Birth section has been completed and signed, E.g. December 31, 2009 should be written: 12 31 2009.	Physician or person who assisted with the delivery	Labour & Delivery Record
# 39	Prior C/Section(s)	Check (V) as applicable. This refers to any past C/Section.	Health Care Staff	Prenatal Record
# 40	Substance Use During Pregnancy	This is for substance use <u>during the</u> <u>pregnancy</u> , from the time of conception. Check (V) as applicable, more than one, if necessary. "Other" refers to illicit substance use (NOT appropriate use of prescription or OTC drugs).	Health Care Staff	Prenatal Record or Mother
# 41	Prenatal Care began at: Num. of weeks	Record the Gestational Age, in Weeks, when prenatal care began	Health Care Staff	Prenatal Record
# 42	Support Available	Check (V) as applicable. This refers to social support and is required by the Community Health Nurse to indicate the presence of someone at home to assist the mother.	Health Care Staff	Mother
# 43	Prenatal Care Provider	Check (V) as applicable. If 'Other' is selected, enter the appropriate information.	Health Care Staff	Mother or Prenatal Record
# 44	Maternal Risk Factors	Check (V), as applicable, any maternal risk factors during this pregnancy. If Other is selected specify appropriate information. All of these maternal risk factors should be verified by documentation on the chart or prenatal record. The following definitions have been determined with input from medical personnel.	Health Care Staff or Physician	Prenatal Record/Physician

	T	
		Anemia (< 100 G/L): if recorded
		anytime during this pregnancy prior
		to delivery.
		Pre-existing Diabetes: confirmed
		diagnosis of diabetes prior to this
		pregnancy.
		Gestational Diabetes: medically
		confirmed diagnosis of gestational
		diabetes during this pregnancy.
		Antepartum Hemorrhage: any
		vaginal bleeding after 20 weeks
		gestation. Must be verified by
		physician or documented by a
		physician <i>(may be on prenatal</i>
		record).
		Hypertension (Chronic): patient has
		history of medically diagnosed
		hypertension prior to pregnancy.
		Hypertension Associated with Programmy nations has been
		Pregnancy: patient has been
		medically diagnosed with
		hypertension during this pregnancy
		or has a diastolic greater than 90 on
		two occasions in a 24 hour period.
		Violence during Pregnancy: the
		woman is a victim of violence during
		this pregnancy.
		Depression: the woman has been and itself and a second with decreasing.
		medically diagnosed with depression.
		Include previous post-partum
		depression.
		UTI - Urinary Tract Infection: the
		patient has been medically
	Maternal Risk	diagnosed and treated for a UTI after
#44	Factorscont'd	20 weeks gestation.
		IUGR - Intrauterine Growth
		Restriction: any type of restriction
		identified on Pre-natal ultrasound,
		e.g. symmetrical or asymmetrical. If
		not identified during the prenatal
		period, do not check.
		Isoimmunization: Rh disease –
		positive Coombs. Mother has been
		exposed and has some level of
		antibodies against fetal red cell
		antigen.
		Pre-pregnancy BMI: The pre-
		pregnancy BMI was documented as
		either 25.0 - 29.9 or 30+
		Other: any other maternal risk factor
		diagnosed and/or treated during this
		pregnancy which may present a risk
		to the mother and/or the fetus.
		(Dx Code completed by the Centre)

# 45	Labour Onset	Check (V) ONE only:	Health Care Staff or	Labour & Delivery
# 43	Labour Offset	 Spontaneous: contractions in a pregnant woman that started spontaneously without any medical assistance. Induction: the medically assisted initiation of contractions in a pregnant woman who was not in labour. No Labour: no labour has occurred. 	Physician	Record
# 46	Delivery Presentation	Check one (V) as applicable. Field should be completed even in the event of a C/Section. If "Other" presentation, please specify. (Dx Code completed by the Centre)	Health Care Staff or Physician	Labour & Delivery Record
# 47	Method of Delivery	Check one (v) one as applicable; if C/Section is selected – the reason(s) must be listed. These indicators are a required field and should not be omitted. (Dx Code completed by the Centre)	Health Care Staff or Physician	Labour & Delivery Record
#48	Interventions and/or Complications of Delivery	Check (V) as applicable in each column. Tears: Only 3 rd or 4 th degree tears are collected. Do not record 1 st or 2 nd degree tears. If 'Other' Complication of Delivery, please specify. Please do not enter C/Section in this field. C/S is considered a Method of Delivery.	Health Care Staff or Physician	Labour & Delivery Record
# 49	Apgar Score	Record infant's One minute and Five minute Apgar Scores. Enter as a double digit e.g., 01, 02 A score above 10 is invalid.	Health Care Staff	Labour & Delivery Record
# 50	Mother's Admit #	Record mother's hospital admitting number.	Health Care Staff	Admitting Documentation
# 51	Mother's Chart #	Record mother's hospital chart number.	Health Care Staff	Admitting Documentation
#52 - #56	Fields reserved for future use			

<u>Live Birth Notification Part B – Health and Community Services Referral</u>

COMPLETED BY HEALTH & COMMUNITY SERVICES

FIELD	QUESTION	INFORMATION REQUIRED – HEALTH & COMMUNITY
		SERVICES
	Mother's Name	Full first and last name
	Mother's MCP	Required to confirm identity and documentation
	Infant's Name	Include full name if known
	Infant's DOB	Confirm date of birth from Part A. Enter as Month/Day/Year
	Infant's Time of Birth	Confirm time of infant's birth indicating AM or PM
	Address	Mother's usual home address, street and/or mailing address
		Provide directions if no street number or name for mother's
	Directions to Home	usual home address
	Phone number	Mother's usual phone number and cell number if available
	Alternate/ temporary address	Complete if mother is staying with relative or not at her usual address following discharge
	Alternate Phone	Include alternative or relative number if available
#57	Infant's Status	Check (V) as applicable. If transferred selected, indicate where. If in care / adoption selected, add address for infant
#58	Infant Birth Weight Infant Discharge Weight	Record the infant's weight (measured in grams) at birth (from Part A) and upon discharge.
#30	mant bischarge weight	Record the infant's head circumference (measured in
#59	Discharge Head Circumference	centimeters) at time of discharge.
	Discharge fread encounterence	Record the infant's length (measured in centimeters) at time
#60	Length at Birth	of birth.
		Check (v) only one
		Exclusive Breastfeeding or Breast Milk only means no supplements ever given
		 Non-exclusive Breastfeeding Any Breastfeeding and supplements given including G/W, formula or other substitute
#61		Breastmilk Substitute No Breastfeeding
	Facilities	Add additional information in # 74 Follow up
	Feeding	recommendations if there is a particular concern re feeding
#62	Previous Breastfeeding Experience	Check (√) as applicable. If yes, duration in weeks.
#63	Jaundice	Check (V) as applicable. Record bilirubin levels at peak and discharge if known. Indicate if infant received phototherapy.
#64	Congenital anomaly confirmed by discharge	Check (√) as applicable. If type known, please indicate
	Familial Conditions	Check (V) as applicable. If selected, add additional information. Includes up to and including second cousins of parents. Includes high risk deafness (see criteria and note referral)
#65	Neonatal Screening	Check (√) as applicable.

FIELD	QUESTION	INFORMATION REQUIRED – HEALTH & COMMUNITY
		SERVICES
66	Critical Congenital Heart Disease Screening	CCHD screening uses pulse oximetry measurement of pre and post-ductal oxygen saturations between 24 and 36 hours of life, prior to discharge, for all healthy term and late preterm infants (34 +0 weeks gestation and greater). A screening algorithm and/or evaluation chart is used for interpretation of results. Check (V) if completed, yes/ no or N/A (May be due to: prenatal diagnosis, post-natal diagnosis before screening timeframe, less than 34 weeks gestation at birth, NICU admission for longer than 7 days, required oxygen therapy for more than 7 days or parental refusal. Check result applicable, PASS, REFER (Did not obtain a PASS on the screen and was referred to Most Responsible Physician for further assessment to rule out or diagnose a CCHD).
#67	Newborn Hearing Screening	Check (V) as applicable. If yes is selected, indicate result (Pass or Did not pass). If repeat appointment given, note date
#68	Mother's Condition on Discharge	Check (V), as applicable, more than one if necessary. If Rhogam given, record the date. MMR is not given in any hospitals; it is done in community. Therefore removed from form. HgB is the post-delivery hemoglobin. B/P is the last one recorded Record the mother's length of stay (number of days) after delivery; this includes day of delivery and excludes day of
#69	Post Delivery Length of Stay (LOS)	discharge.
#70	Postpartum Parent Support Program (PPSP)	Check (V) as indicated if record of parent learning was completed
#71	Prenatal Education and Support	Check (V) as applicable. Indicate if classes, Healthy Baby Club or individual support given through BABIES
#72	Immunosuppressive Therapy	Indicate if mother has taken immunosuppressive therapy while pregnant or during postpartum. If yes, has the health care provider discussed the issue of implications for when baby is due to receive first live virus vaccine which is the Rotavirus vaccine at age 2 month. Mother should have information from her specialist to make an informed decision on whether baby should have the Rotavirus vaccine at 2 months.
#73	Community Health Nurse Contact in Hospital	Check as applicable.

FIELD	QUESTION	INFORMATION REQUIRED – HEALTH & COMMUNITY
		SERVICES
#74	Follow up recommendations	Complete as necessary. Can include additional information re infant feeding, postpartum maternal care recommendations, including incision care, follow up on blood work or other applicable medical orders on discharge.
#75	Priority	Complete and comment if needed.
#77	Date of Discharge	Record the date of mother's discharge (month, day, year format).
#78	Referral sent via	Check (V) as applicable, more than one if necessary.
#79	Nurse's name and signature	Printed name and signature of the nurse completing the Hospital Nursing Discharge Summary.
#80	Date	Record the date (month, day, year format) the Hospital Nursing Discharge Summary section of the LBN form was completed.

Healthy Beginnings Follow-Up Referral

All areas after question #80 are to be completed by the appropriate Health & Community Services employee. This section is used to initiate the Priority Assessment for Follow up.

- Record the date the referral was received.
- If other Health and Community Services are involved with the family as part of the circle of care, it can be noted here. Examples include: Mental Health, Addictions, Community Supports Program.
- If a Global All Programs Search is initiated as per regional policy, additional follow up with other service providers may be indicated.
- Indicate if the child has been referred to the Perinatal High Risk Clinic (see Appendix A)
- Indicate if the child has been referred to Audiology for a family history of High Risk Deafness (see Appendix E)
- Note any other referrals for follow up at the Janeway (Child Development, Neuromotor, Craniofacial Clinic, Cardiology or other specialist)
- On the reverse side complete mother's name, MCP#, Infant's name and DOB. Identifying information must be on each page if form is copied, emailed or faxed.
- The Priority Assessment for Follow-up form on the reverse side may be initiated at the referral site, and completed by the Nurse receiving the referral (See Appendix F for a copy)
- Complete the Priority Score and indicate the degree of priority
- A Client Risk/Staff Safety Risk * Assessment may be completed as per regional policy
- See CRMS for Priority Assessment, progress notes and further documentation

The appendices in this guide that are used by Health & Community Services are:

APPENDIX A -Referral for Perinatal Program NL

APPENDIX B – Procedure for Immediate Follow-up

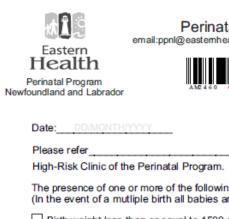
APPENDIX C – Community Health Nursing Postnatal Follow-up Guide

APPENDIX D - Edinburgh Postnatal Depression Scale Guide

APPENDIX E - High Risk Deafness Criteria

APPENDIX F - Priority Assessment for Follow-up

Appendix A: Referral for High Risk Follow-Up Clinic of the Perinatal Program NL



Perinatal Referral email:ppnl@eastemhealth.ca or Fax:709-777-4125



Date: DD/MONTH/YYYY
Please refer(name) for follow-up in the
High-Risk Clinic of the Perinatal Program.
The presence of one or more of the following criterion that occurred or was recognized in the first 28 days of life (In the event of a mutliple birth all babies are followed if one baby meets admission criteria):
☐ Birth weight less than or equal to 1500 grams or gestation less than or equal to 32 weeks ☐ Mechanical ventilation for 48 hours or more
Central Nervous System:
Seizure confirmed by abnormal EEG, or as a result of metabolic etiology (such as hypoglycemia) Hypoxic Ischemic Encephalopathy (HIE) Stroke
□ Meningitis/Encephalitis/Intrauterine virus infection, such as Cytomegalovirus (CMV) □ Hydrocephalus □ Intraventricular hemorrage, grade 3 or greater
Periventricular leukomalacia (PVL)
Complex Surgery:
☐ Thoracic ☐ Gastrointestinal (GI) ☐ Genital Urinary (GU)
Cardiac:
☐ Cyanotic Congenital Heart Disease ☐ Cardiac surgery requiring bypass less than 30 days of age
☐ Prolonged hypoglycemia greater than 3 episodes of blood glucose less than 2.6 mmol/L in a 24 hour period
History of prenatal exposure to alcohol as a result of maternal alcohol intake characterized by substantial, regular intake or periodic binge drinking during pregnancy (Motherisk Program 2006)
History of prenatal exposure to illicit substances, such as amphetamines (e.g. Adderall), cannabis, club drugs (e.g. ecstasy), stimulants (e.g. cocaine, Ritalin), opioids (e.g. heroin, Oxycodone, Percocet) and solvents, as a result of maternal habitual (regular) use during pregnancy
☐ Prenatal exposure to Methadone, as a result of maternal participation in a Methadone Maintenance Treatment (MMT) Program during pregnancy
Physician request, specify:
Name:Signature:

ch-0766 2018/07

White Copy - Chart Yellow Copy - Perinatal Program

Appendix B: Procedure for Immediate Follow-up

IF IMMEDIATE FOLLOW-UP IS REQUIRED (WITHIN 48 HOURS), THE REFERRING NURSE IS REQUESTED TO TELEPHONE THE REQUEST TO COMMUNITY HEALTH NURSE.

- ♦ If infant remains in hospital following discharge of mother:
 Forward second referral at time of infant's discharge with information on infant's hospitalization and recommendations for follow-up.
- If mother remains in hospital following discharge of infant:
 Forward second referral at time of mother's discharge with information on mother's hospitalization and recommendations for follow-up.
- ♦ If infant is transferred:
 Include on mother's referral as much information as possible regarding infant's condition.
- If infant In Care/Adoption:
 Send infant referral to Community Health Nurse of receiving foster parents/adopted parents.

Send mother's referral to mother's district Community Health Nurse.

• If, following discharge, the mother stays for more than one week in a community health nursing district other than her place of residence, send the Health & Community Services Nursing Referral to the district where mother is staying immediately following discharge.

NOTE that Part B has an area "Alternate/Temporary Address"; complete this section when the mother is not returning to her usual place of residence within a week after discharge.

Appendix C: Healthy Beginnings Follow-up Referral

I Priority Assessment

1. Perinatal Program NL High Risk Follow-up Clinic

Compare the criteria from Perinatal Program NL with the information on the LBN form. If the infant meets any <u>one</u> of the criteria, contact Perinatal Program NL or make a referral. Most infants who meet the high risk criteria will be identified by the Perinatal Program Nurse through referrals from the Janeway Neonatal Intensive Care Unit. See Appendix A for the Provincial Perinatal High Risk Follow-up Program Criteria.

2. High Risk Deafness

Compare the criteria from the High Risk Deafness Criteria with the information on the LBN form. If the infant meets any one of the criteria refer infant or confirm if prior referral has been made, for audiology assessment and follow-up. See Appendix E for High Risk Deafness Criteria.

3. Priority Assessment for Follow-up

See Appendix F for detailed explanation and procedure for use of the Priority Assessment for Follow-up.

II Record of Parent Learning

- Review the Record of Parent Learning Form and the LBN form and transfer areas of followup, e.g. learning needs identified but not taught, or areas taught that needs reinforcement or confidence building.
- Record newly identified learning needs.
- Implement the PPSP following the same procedure as outlined in the PPSP Implementation Plan.
- Provide parents with an additional copy of the PPSP booklet: *You and Your New Baby:* Questions You May Have if they do not have it at home.
- Use the questionnaire to assess parent learning during telephone, postnatal clinic and home visits.
- Parent Information Sheets are distributed by the nurse to reinforce teaching. They are not to be provided as a series of information sheets for parents.
 - Although copies of the Parent Information Sheets may be available in both hospital and health units, some are more appropriate for distribution in one place than the other.

The comments section can be used to document any contact that does not identify a Nursing Diagnosis/Health Issue requiring a plan of action for follow-up. Follow the regional procedure for documentation on progress notes, problem list, etc. to chart plan of care and follow-up action.

Appendix D: Edinburgh Postnatal Depression Scale Guide

Postnatal Depression

Research indicates that postnatal depression affects at least 10% of women and that many remain untreated. These mothers may cope with their baby and with household tasks, but their enjoyment of life is affected, and there may be long-term effects on the family.

Edinburgh Postnatal Depression Scale (EPDS)

This tool has been developed to assist primary care health professionals to detect mothers suffering from postnatal depression; a distressing disorder more prolonged than the "blues' but less severe than postpartum psychosis. It consists of 10 short statements and can usually be completed within 5 minutes. Validation studies have shown that those scoring above a threshold of 12-13 were likely to be suffering from a depressive illness of varying severity.

Referral

Referral to the appropriate professional is indicated if the EPDS score is above 13. The nurse will discuss the results of the test with the client and encourage her to seek counseling either through her family physician, obstetrician or mental health professional.

Source:

Cox. J.L.; Holden, J.M.; and Sagovsky, R. (1987). Detection of postnatal depression: development of the 10-item Edinburgh depression scale. <u>British Journal of Psychiatry</u> 150, 782-886.

Instructions

- 1. The client is asked to underline the response which comes closest to how she has been feeling in the previous 7 days.
- 2. All **10** items must be completed.
- 3. The client should complete the scale herself, unless she has limited reading or language skills.
- 4. Care should be taken to avoid the possibility of the client discussing her answers with others.

Scoring

Question 1, 2 and 4 are scored 0, 1, 2 and 3 according to increased severity of the symptoms.

Questions 3, 5, 6, 7, 8, 9 and 10 (those with asterisk) are reverse scored 3, 2, 1 and 0.

Note: The questions in this document have the number score at the end of each option. This is provided for nurses' information only and should never be used if the woman herself completes the form. In that case, a blank form should be used.

The total score is calculated by adding scores for each of the **10** items.

A score of 12-13 or above may reflect a depressive illness of varying severity.

In doubtful cases, the EPDS may be repeated in 2 weeks.

The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. A score just below the cut-off should not be taken to indicate absence of depression, especially if the nurse has other reasons to consider this diagnosis. The scale will not detect mothers with anxiety neurosis, phobias or personality disorders.

Name:	 	
Address:	 	
Baby's Age:		

As you have recently had a baby, we would like to know how you are feeling. Please **UNDERLINE** the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example already completed:

I have felt happy:

Yes, all the time
Yes, most of the time
No, not very often
No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days: Score

1.	I have been able to laugh and see the funny side of things	
	As much as I always could (0) Not quite so much now (1) Definitely not so much now (2) Not at all (3)	
2.	I have looked forward with enjoyment to things	
	As much as I ever did (0) Rather less than I used to (1) Definitely less than I used to (2) Hardly at all (3)	
*3.	I have blamed myself unnecessarily when things went wrong	
	Yes, most of the time (3) Yes, some of the time (2) Not very often (1) No, never (0)	
4.	I have been anxious or worried for no good reason	
	No, not at all (0) Hardly ever (1) Yes, sometimes (2) Yes, very often (3)	
*5	I have felt scared or panicky for no very good reason	
	Yes, quite a lot (3) Yes, sometimes (2) No, not much (1) No, not at all (0)	
*6.	Things have been getting on top of me	
	Yes, most of the time I haven't been able to cope at all (3) Yes, sometimes I haven't been coping as well as usual (2) No, most of the time I have coped quite well (1) No, I have been coping as well as ever (0)	

	Score
*7.	I have been so unhappy that I have had difficulty sleeping Yes, most of the time (3) Yes, sometimes (2) Not very often (1) No, not at all (0)
*8.	I have felt sad or miserable
	Yes, most of the time (3) Yes, quite often (2) Not very often (1) No, not at all (0)
*9.	I have been so unhappy that I have been crying
	Yes, most of the time (3) Yes, quite often (2) Only occasionally (1) No, never (0)
*10.	The thought of harming myself has occurred to me
	Yes, quite often (3) Sometimes (2) Hardly ever (1) Never (0)
	TOTAL SCORE

Source:

In the past 7 days:

Cox. J.L.; Holden, J.M.; and Sagovsky, R. (1987). Detection of postnatal depression: development of the 10-item Edinburgh depression scale. <u>British Journal of Psychiatry</u> 150, 782-886.

Appendix E: High Risk Deafness Criteria

<u>Indicators for Sensorineural and/or Conductive Hearing Loss</u>

- A. For use with neonates, birth through age 28 days, when universal screening is not available.
- 1. Family history of hereditary childhood sensorineural hearing loss. (Includes parents, grandparents, siblings, aunts, uncles and first cousins of the child).
- 2. In-utero infection such as cytomegalovirus, rubella, syphilis, herpes and toxoplasmosis.
- 3. Craniofacial anomalies, including those with morphologic abnormalities of the pinna and ear canal, absent or abnormal philtrum, low hairline, etcetera.
- 4. Birth weight less than 1500 grams (3.3 lbs.).
- 5. Hyperbilirubinemia at a serum level requiring exchange transfusion.
- 6. Ototoxic medications (to the baby (> 5 days) or breastfeeding mother), including but not limited to, the amino glycosides, e.g., gentamicin, tobramycin, kanamycin, streptomycin, used in multiple courses, or in combination with loop diuretics and some combination chemotherapy regimens.
- 7. Bacterial meningitis.
- 8. APGAR scores of 0-4 at 1 minute or 0-6 at 5 minutes.
- 9. Mechanical ventilation lasting 5 days or longer.
- 10. Stigmata or other findings associated with a syndrome known to include sensorineural and/or conductive hearing loss (e.g., Waardenburg, Usher's or Down Syndrome).
- B. For use with infants, age 29 days to 2 years, when certain health conditions develop that require rescreening.
- 1. Parent/caregiver concern regarding hearing, speech, language and/or developmental delay.
- 2. Bacterial meningitis and other infections associated with sensorineural hearing loss.
- 3. Head trauma associated with loss of consciousness or skull fracture.

- 4. Stigmata or other findings associated with syndromes known to include sensorineural and/or conductive hearing loss (e.g., Waardenburg, Usher's or Down Syndrome).
- 5. Ototoxic medications, including but not limited to, chemotherapeutic agents or amino glycosides used in multiple courses or in combination with loop diuretics.
- 6. Recurrent or persistent otitis media with effusion for at least three months.
- C. For use with infants age 29 days through 3 years who require periodic monitoring of hearing.

Some newborns and infants may pass initial hearing screening but require periodic monitoring of hearing to detect delayed onset sensorineural and/or conductive hearing loss. Infants with these indicators require hearing evaluation at least every six months until age three years and at appropriate intervals thereafter.

<u>Indicators associated with delayed onset sensorineural hearing loss include:</u>

- 1. Family history of hereditary childhood hearing loss.
- 2. In-utero infection, such as, cytomegalovirus, rubella, syphilis, herpes or toxoplasmosis.
- 3. Neurofibromatosis Type II and neurodegenerative disorders.

Indicators associated with conductive hearing loss include:

- 1. Recurrent or persistent otitis media with effusion.
- 2. Anatomic deformities and other disorders that affect Eustachian tube function.
- 3. Neurodegenerative disorders.

Appendix F: Priority Assessment for Follow-Up

Purpose:

A mechanism to:

- a) Provide standardized screening of all parturient women.
- b) Identify infants and children up to the age of 5 years with potential for:
 - physical or emotional stressors secondary to known health challenge(s)
 - developmental delays
 - difficulties resulting from family interaction/social factors
- c) Collect data to evaluate portions of the Healthy Beginnings Program.

Target Populations:

- All newborns who will reside in the province of Newfoundland and Labrador.
- Any infant or child up to age 5 years where the PHN observes or receives additional information indicating that she/he may be eligible for the program.

Procedure:

- Priority Assessment for Follow-up is to be initiated within 48 hours of receipt of Postnatal Referral.
- The Priority Assessment for Follow-up form can also be used for any infant or child beyond the newborn period when the PHN observes or receives additional information indicating that a child may fit the eligibility criteria for the Healthy Beginnings Program. Use the Priority Assessment Form in this situation, writing the parents/guardians surname and given name, date, address, and phone number and child's MCP number in the upper right-hand corner.

If a condition or situation exists, circle the corresponding score at the right side of the form. Where more than one choice is provided, please circle the specific item pertaining to the situation being assessed. Then total the circled score(s) and enter the number of the Total Priority Score Box at the bottom. The nurse completing the assessment signs in the bottom right-hand corner noting date. The Scoring may also be completed in CRMS.

Explanation of Items:

A. Child with Known Disability

- 1. Congenital
 - a) Major (probability of permanent disability), e.g. Down Syndrome.
 - b) Moderate (correction may be possible), e.g. cleft palate.
- **2.** Acquired
 - a) Major disability, acquired during the first five years of life, with probability of permanent disability, e.g., Cerebral Palsy, severe head injury.
 - b) Moderate disability, acquired during the first five years of life, with correction possible, e.g. loss of limb.

B. Developmental Priority Factors

- **3.** Low Birth Weight
 - a) 0-1499 grams
 - b) 1400-1999 grams
 - c) 2000-2499 grams
- **4.** Bilirubin Level

Note if bilirubin was ever/is over 20 gm or 342 umol/L (or exchange level if premature)

- **5.** Complications of Pregnancy
 - a) Infections that can be transmitted in utero:

Includes: Infections that can be transmitted in utero and may damage the

fetus (e.g., rubella in the first 3-4 months, AIDS,

cytomegalovirus, congenital herpes).

Excludes: Hepatitis B where the mother is a carrier and where the child

has received prophylaxis according to provincial guidelines, Herpes, unless the child acquires the illness during delivery.

b) Drugs that <u>were used</u> during pregnancy:

Includes: Street drugs, any drugs that have a known teratogenic effects

on baby. May also include if mother has a known addiction

diagnosis

Excludes: Non-teratogenic prescription drugs, small amounts of over-the-

counter drugs, cigarette use (See 17, "Other" if this is a

particular factor).

- **6.** Complications of Labor and Delivery
 - a) Labour requiring mid forceps including breech delivery with forceps.
 - b) Infant trauma or illness, e.g., seizures, respiratory distress syndrome. Applies to infants in the first 28 days of life or until discharge where an infant has been continuously hospitalized beyond the neonatal period.
 - c) APGAR: APGAR at 5 minutes only if less than 7. If the Apgar score is less than 7 at 5 minutes, the point value is calculated by deducting the APGAR score from 10. E.g., if APGAR at 5 minutes is 5, the score is 10-5 = 5 points.
- **7.** Family history (up to level of second cousins) of a disability not detectable at birth that could affect development, e.g., hearing loss, developmental delay in a family member.
- **8.** Developmental concerns not already covered in any category above.
 - a) Acquired potential for developmental delay due to illness or trauma in the first five years, i.e. child developed complications from meningitis at age 2.
 - b) Delayed developmental assessment in first five years. This category is used when the developmental delay is confirmed by diagnosis, not after screening when it is only suspected. If the delay is such that the nurse in her professional judgment and after consultation with her supervisor sees no need for Community Health Nursing follow-up, i.e. in the event of a language delay with no other factors present and the child is receiving service form a speech pathologist, the child need not be admitted to or continued with the priority program.

C. Family Interaction Priority Factors

- **9.** Age of Mother:
 - a) 15 years or under
 - b) 16 years or 17 years
 - c) 18 years or 19 years

10. Social Situation

- a) Father of infant not resident but other support available. Consider family, friends, church, and community resources.
- b) Father not resident and no support.
- c) Father resident and supportive but no other social support; or severe isolation by language or geography. Items (a), (b), and (c) would also apply if the mother was not a resident during the infant period (one-year) but the father was. When a child is seen in a single parent home after one year of age, the situation should be individually assessed to determine if this social situation is having an adverse effect on the child.

Support includes family, friends, community, and spiritual. It is important to assess support as it relates to culture, geography, and language as well as the client's perception of the support available.

11. Receiving Financial Assistance or Having Financial Difficulties

This category includes those clients who are receiving income support or other financial benefits (e.g. drug card) as well as those having insufficient finances to meet basic needs after meeting financial commitments.

12. No Prenatal Care Before Six Months

If mother did not receive prenatal care from a qualified medical/health care practitioner during the first two trimesters, this should be noted.

- **13.** Mental Illness or Developmental Delay in Mother or Father
 - Schizophrenic or Bipolar affective disorder (a close family history of psychiatric illness should be noted)
 - b) Mother has a postpartum psychosis or postpartum depression or
 - c) Developmental delay of either parent

*Double score if both parents are positive in (a) or (c).

14. Prolonged Postpartum Maternal Separation

If separated over 5 days, note:

- a) If frequent infant contacts (phone or visits as feasible)
- b) Little or no contact

Consider location, geography, ability to call, mother's illness.

- **15.** Assessed Lack of Bonding, e.g., minimal eye contact, touching, etc.

 Consider eye contact, touching, handling of infant, discussion of child, disappointment in sex. Note if unrealistic expectation of the infant, negative comments about mothering abilities and a high level of anxiety.
- **16.** Three+ Hospitalizations in a Year, in the first two years of life, in the Absence of Known Disability of Chronic Illness.
- **17.** Other

Nursing assessment and judgment will be used to assign a score between 0 and 9 for other priority items. The reason for the score is to be specified on the line provided on the Priority Assessment for Follow-Up Form. If space is inadequate, give detailed information in the notes section in CRMS. The reasons may include, but not be limited to the following:

Child Factors:

- failure to thrive
- behavioral problems
- diagnosed mental health problem
- Including ADD and ADHD

Parental Factors:

parenting difficulties

- first time parenthood (specify age of parents)
- low literacy level/low educational

Family Factors:

- major chronic illness in family
- marital difficulties
- family violence

18. Scoring

Total Score: Total the score(s) and enter the number in the "Total Score" box at the bottom.

Priority Score	
High Priority	9 and over
Medium Priority	5-8
Low Priority	3-4
Minimal Priority	0-2

Incomplete Score:

It may not always be possible to obtain all assessment data required to give a final score prior to contact with the family.

When information is missing and the available data does not already indicate a moderate or high priority rating, the nurse will:

- a) make a telephone visit to determine the appropriate priority rating; or
- b) failing this, make a home visit to assess

When all information is gathered the "total score" will be completed.

Appendix G: List of Tables used throughout Questions 1 to 80

VALID INDICATORS						
N/A	N/A Meaning Non-Applicable					
U/K	To be used ONLY when the information is not found on the patient					
	chart, is unavailable, or is truly unknown.					
ALL questions from Part A (LBN) and Part B (Referral to Health &						
	Community Services), except for the shaded areas (office use)					
should be completed. Questions beyond #79 on Part B are for Healt						
& Community Services use.						

Marital Status -- Adapted from Statistics Canada definition

Never Married	Mothers who have never been married				
Legally Married and NOT Separated	When infant's parents are married to each other and				
	living together				
Legally Married but Separated	When infant's parents are married but not living				
	together				
Divorced	Mothers who are legally divorced				
Widowed	Mothers whose spouses are deceased				
Unknown	Mothers whose legal marital status is unknown				
DO NOT Indicate "Common Law" as this is not a valid legal term					

CODE	EDUCATION
	Definitions adapted from Statistics Canada
Less than Secondary	Does not have a high school graduation certificate
Secondary School Graduation	Has a high school graduation certificate
Beyond High School	Attended college or university but does not have a
	post-secondary certificate, diploma or degree
College or University Degree/Diploma	Completed post-secondary education and has a
	certificate, diploma and/or degree



Government of Newbundland and Labrador Service NL, Vital Statistics Division

LIVE BIRTH NOTIFICATION 2020

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2020 PART B LIVE BIRTH NOTIFICATION Referral to HEALTH AND COMMUNITY SERVICES



MUST accompany Part A, BEFORE sending to	Community Health Nursing			
Mother's Name:		Mother's MCP#:		
Mother's DOB:				
Infant's Name:		Infant DOB and time:	O AM	
Address:	Alternate/Te			
Phone Number: (home)	(oel)	Alternate Addre	ss Phone:	
67. Infant Status: Home	Viternate address Hos	spital 🗆 Decease	ed	
□ In Care/Adoption Address:		Transferred to:		
	HOSPITAL NURSING DI	SCHARGE SUMMARY	1	
58. Infant Weight: Birth Discharge 58. Head Circumference: (at discharge) 60. Length at Birth:	81. Infant Feeding: Exclusive Breastfeedi Non-exclusive Breast Breastmik substitute 82. Previous Breastfeedin Yes duration (week	stfeeding e Bilirubin Peak level Bilirubin Level at D/C		
84. Congenital Anomalies: Confirmed by Discharge Yes No Type Familial Conditions: Yes No Specify:	85. Neo-natal Screening: Bloodwork completed 88.Critical Congenital Hear		87. Newborn Hearing Screening: ☐ Yes ☐ No ☐ Pass ☐ Refer Audiology F/U Required: ☐ Yes ☐ No Applidate:	
88. Mother's Condition on D/C:		70. PPSP Record of P	arent Learning completed? 🗆 Yes 🗆 No	
□ Incision □ Suture/Staples □ Tubal	Ligation	71. Prenatal Educatio	n and Support Received? Yes No	
B/P Bab 8	Id Group		□ Unknown	
Shogan: □ Yes □ No		Type:		
If Yes Date Given			ken immunosuppressive therapy? □ No □ Unknown	
Bubella status: Immune Non-in	mmune	2		
		If Yes has Mom dis baby with her doct	scussed live vaccine administration for this or? Yes No Unknown	
89. Post Delivery Length of Stay:				
73. Community Health Nurse Contact in i 74. Follow up Recommendations (includ	-	3 No r blood work and other	medical orders on discharge if needed)	
75. Priority (contact required) I No II	Ves Comment required			
78. Family Physiolan/Other Provider			_	
78. Referral centivia: D Fax		OMall DE-Ma		
79. Nurse's Name (Print)	8ignature		80. Date	
1				

Other

HEALTHY BEGINNINGS FOLLOW-UP REFERRAL					
Date Received: DD/M/WYYYY	Mother's Name	Mother's MC1'4			
Intent's Name:		Infant DDB: DD/MM/YYYY			
Are there other service providers involved with the family? GYes GNo Specify.					
Pollow-up/ Referrate: Perinatal Program NL?	Yes ONe Audiology High Ris	k Deafness Program? Yes No			

PRIORITY ASSESSMENT FOR FOLLOW-UP

		circi	LEI	F YES	NYA = place x in Box		
Γ	А	CHILDREN WITH KNOWN DISABILITY			C. FAMILY INTERACTION FACTORS		_
ı		Congenital anomaly			9. Age of Mother		
ı	a)	Major (probability of permanent disability)	9		-,		
l		e.g. Down Syndrome, Spina Bifida etc.		_	-,	_	
l	b)	Moderate (correction may be possible)	6		c) 18 or 19	5	
l		e.g. Cleft palate					
ı	Z.	Major disability acquired during first 5 years of life (probability of permanent disability)			10. Social Situation	_	п
l		e.g. Cerebral Palsy, severe head injury	0	0	-,	2	ш
ı		b) Moderate disability acquired during	_	_	support available b) father not resident and no support	7	0
ı		first 5 years (correction may be possible)			7	-	0
l		e.g. loss of limb	6		support or severe isolation by language or geography	•	_
l	В	DEVELOPMENTAL FACTORS			11. On spoial assistance or financial difficulties		_
ı		Low birth weight			11. On coolal accistance or financial dimourties	3	ш
ı	•	a) 1-1499 gm	9	0	12. No prenatal care before sixth month	1	п
ı		b) 1500-1999 gm		0	12. No prematar care perore exter month	•	_
l		c) 2000-2499 gm		0	13. Mental illness or developmental delay in mother and/ or father		
ı	4.	Billirubin level over 20 gm or 342 uppgi/L.			a) Schizophrenia or bipolar affective disorder 7	7	0
ı		(or exchange level if premature)	8		b) Postpartum depression 9		
ı					c) Developmental delay of a parent	3	
ı		Complications of pregnancy					
ı	a)	Infections that can be transmitted in utero and may damage the fetus (e.g. rubella)		0	14. Prolonged postpartum maternal separation		
ı	ls/i	Drugs, e.g. alcohol abuse diagnosed in mother			(5 days or more): a) With frequent infant contacts (visits or phone as feasible)	2	_
ı	D)	brugs, e.g. aconor acose diagnosed in morrer	-			3	_
ı	8	Complications of labour and delivery			b) Link of the contact		•
ı		Labour requiring mid forceps including			15. Assessed lack of bonding		
ı		Breech Delivery with forceps	4		_	5	0
l	b)	Infant trauma or illness (e.g. seizures					
ı		Respiratory Distress Syndrome)	6		18. > 3 hospitalizations in 1 year in absence of known		
ı	o)	Apgar at 5 minutes only if less than 7,			chronic illness or condition	7	
ı		Deduct score at 5 minutes from 10 points					
ı	7	Family history of a disability not detectable			17. Other e.g.: marital distress, low education status,		
ı		at birth that could affect development e.g. Hearing io	vee		(Score 0 to 9)		
ı		developmental delay		0	(00000000)		_
ı		,		_	Specify reason:		
l	8.	Development concerns not already covered in an category	ny a	bove			
I	a)	acquired risk of developmental delay due to an					
ı		illness or trauma in the first 5 years	_				
l	b)	Delayed developmental assessment in first 5 years	9				
				Chant	t Resk/Staff Resk * Assessment Completed?		
1		RITY SCORE: Total Priority Score:			er regional policy)		
_		9 High Priority					
_		8 Moderate Priority		See Cl	IRMS for Priority Assessment, Progress Notes and further documentate	on	
_		4 Low Priority		Marana and	de Name (Sant)		

PRIORITY &CORE. TOTAL PRIORITY SCORE.	Client Risk/Staff Misk * Assessment Completed? One
F. D. Mandanada, Walanda,	See CRMS for Priority Assessment, Progress Notes and further documentation
	Nurse's Name (I'nnt)
Date: DD/MM/YYYY	Nurse's Signature

Comments

All comments and questions concerning the LBN form and the Reference Manual are welcome. All suggestions will be considered for the next revision.

Please do not mail com	ments with the LBN form.			
70 O'Leary Avenue St. John's, NL A1B 2C7	nistrative Standards aluation Services ador Centre for Health Info			
Optional:				
Name:	Facility:	Date:	_	

