LIVE BIRTH NOTIFICATION FORM REFERENCE MANUAL

January 1st, 2022

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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 2022 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 the 2022 form:

#	Change	Description of Change with Rationale
10.	10. Surname, Full Given Name(s): ☐ Gestational Carrier	Gestational carrier has other risk factors that need to be captured; different from legal mother. Added check box for Gestational Carrier
41.	41. Prenatal Care began at Num. of Weeks → _____ ☐ Unknown	Left blank frequently, this may be blank because unsure or uncertain. Added checkbox for "unknown".
47.	47. Method of Delivery ☐ Vaginal Spontaneous ☐ Vaginal Assisted ☐ C/Section → **Reason(s) for C/Section:** ☐ Previous C/Section ☐ Failure to Progress ☐ Breech Presentation ☐ Fetal Heart Rate Complication ☐ Other: (Please Specify)_____	Reason for C/section is often left blank. Top reasons for C-section were added as check boxes, as well as the option of 'Other'.

Information required for completing the 2022 LBN form

The recently revised LBN form (January 2022) will replace the form currently in use (2021). Please destroy all remaining copies of the 2021 LBN form on January 1, 2022. If you have not received your 2022 LBN forms by then, please notify Service NL – Vital Statistics Registrar immediately.

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

Any 2022 births not recorded on 2022 forms may be returned for the completion on the correct form.

*It is recommended that you review the 2022 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 2022 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 2022 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) 752-6000 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) 752-6000

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 collected 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 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 **must** 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.

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 staple both the white and green copy together 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 and/or infant and sent to the appropriate Health & Community Services Board along with Part A. 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 the mother, the father/other parent, hyphenated combination of both, or any surname chosen by the parents.

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.

Live Birth Notification Form – Part A

Registration Information

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

Infant Information

FIELD	QUESTION	INFORMATION REQUIRED: INFANT	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 (√) 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 (√) 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). If the mother is the Gestational Carrier for **THIS BIRTH**, please check the "Gestational Carrier" box.	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*

FIELD	QUESTION	INFORMATION REQUIRED: MOTHER	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
# 12	**Health Care Number**	For residents of Newfoundland and Labrador, record the MCP number. 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.	Health Care Staff	*Prenatal Record or Admitting Documentation*
# 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, <u>at time of delivery</u>.	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 (√) one as applicable: This is required by Statistics Canada. Common-law 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: MOTHER	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
# 19	**Living Arrangements of Birth Parents**	Check (√) 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 of Birth Parents of this delivery**	**This question relates to the parents of this Live Birth delivery (not the 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	Health Care Staff	*Mother*
# 21	**Education**	Check (√) 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". If the mother has completed high school 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.	Health Care Staff	*Mother*

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 information on the other parent is unknown, or has not been provided.

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

FIELD	QUESTION	INFORMATION REQUIRED: HEALTH HISTORY & MEDICAL CERTIFICATION	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
# 27	**Total Number of Children Ever Born to this Mother (including *this delivery*)** *Note: Please see Page 4 for definition of "Delivery"	**Do not enter (√) in this field; a numeric value is required.** 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).	Health Care Staff	*Prenatal Record*
# 28	**Complete Date of Last Delivery (prior to this delivery) (see Delivery definition on P. 4)**	Record the date (**MONTH, DAY, YEAR** format) of last live or stillbirth delivery NOT including this delivery. If no previous birth, use the indicator N/A. For multiple births, do not enter the 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.	Health Care Staff	*Prenatal Record*
# 29	**Total Number of Infants in this Delivery (including Live and Stillborn)**	This field is used to denote birth of a singleton, twin, triplet, etc. Check (√) applicable selection.	Health Care Staff	*Labour & Delivery Record*
# 30	**Number of Stillborn in *this* Delivery**	Check (√) None, if applicable, or record the number of stillborn in this delivery, i.e. if multiple birth, enter a numeric value if one or more infant was stillborn.	Health Care Staff	*Labour & Delivery Record*

FIELD	QUESTION	INFORMATION REQUIRED: HEALTH HISTORY & MEDICAL CERTIFICATION – CONTINUED…	COMPLETED BY	WHERE YOU MAY FIND INFORMATION
# 31	**Multiple Birth – Birth Order**	Used to identify multiple birth order (1st, 2nd, etc.) Check (√) 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 (√) 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 (**measured in grams**) at time of birth.	Health Care Staff	*Labour & Delivery Record*
# 35	**Delivered By** ***Identify only ONE person***	Print surname and first name of person who assisted with the delivery of the 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.	Health Care Staff or Physician	*Labour & Delivery Record*
# 36	**Designation of Attendant**	Check (√) ***one*** as applicable. If Other is selected, record additional information.	Health Care Staff or Physician	*Labour & Delivery Record*

FIELD	QUESTION	INFORMATION REQUIRED: HEALTH HISTORY & MEDICAL CERTIFICATION – CONTINUED…	COMPLETED BY	WHERE YOU MAY FIND 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 (√) as applicable. This refers to <u>any past</u> C/Section.	Health Care Staff	*Prenatal Record*
# 40	**Substance Use During Pregnancy**	This is for substance use <u>during the pregnancy, from the time of conception.</u> Check (√) 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. If unknown, check (√) Unknown.	Health Care Staff	*Prenatal Record*
# 42	**Supports Available**	Check (√) 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 (√) as applicable. If 'Other' is selected, enter the appropriate specialty.	Health Care Staff	*Mother or Prenatal Record*
# 44	**Maternal Risk Factors**	Check (√), as applicable, any maternal risk factors **<u>during this pregnancy</u>**. 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. • Anemia (< 100 G/L): if recorded anytime during this pregnancy prior to delivery.	Health Care Staff or Physician	*Prenatal Record/Physician*

#44	**Maternal Risk Factors…cont'd**	• 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 ***(may be on prenatal record)***. • Hypertension (Chronic): patient has history of medically diagnosed hypertension prior to pregnancy. • Hypertension Associated with 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 medically diagnosed with depression. Include previous post-partum depression. • UTI - Urinary Tract Infection: the patient has been medically diagnosed and treated for a UTI after 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 (√) **ONE** only: ♦ **Spontaneous**: contractions in a pregnant woman that started	Health Care Staff or Physician	*Labour & Delivery Record*

		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.		
# 46	**Delivery Presentation**	Check one (√) as applicable. Field should be completed <u>even in the event of a C/Section.</u> 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 (√) one as applicable; **if C/Section is selected – the reason(s) for C/Section must also be checked** (√): o Previous C/Section o Failure to Progress o Breech Presentation o Fetal Heart Rate Complication o Other: (Please Specify)_____ If Other is selected, please specify the reason. *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 (√) as applicable in each column. <u>**Tears**</u>: **Only** 3rd or 4th degree tears are collected. <u>**Do not**</u> record 1st or 2nd degree tears. If 'Other' Complication of Delivery is selected, please specify the complication. **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 <u>**One minute and Five minute**</u> 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**			

Live Birth Notification Part B – Health and Community Services Referral

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
	Directions to Home	Provide directions if no street number or name for mother's 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 (√) 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.
#59	**Discharge Head Circumference**	Record the infant's head circumference (measured in centimeters) at time of discharge.
#60	**Length at Birth**	Record the infant's length (measured in centimeters) at time of birth.
#61	**Feeding**	Check (√) 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 • Breastmilk Substitute No Breastfeeding Add additional information in **#74 Follow up recommendations** if there is a particular concern re feeding
#62	**Previous Breastfeeding Experience**	Check (√) as applicable. If yes, duration in weeks.
#63	**Jaundice**	Check (√) as applicable. Record bilirubin levels at peak and discharge if known. Indicate if infant received phototherapy.
#64	**Congenital anomaly confirmed by discharge** **Familial Conditions**	Check (√) as applicable. If type known, please indicate Check (√) 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 (√) 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 (√) 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 (√), 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
#69	**Post Delivery Length of Stay (LOS)**	Record the mother's length of stay (number of days) after delivery; this includes day of delivery and excludes day of discharge.
#70	**Postpartum Parent Support Program (PPSP)**	Check (√) as indicated if record of parent learning was completed
#71	**Prenatal Education and Support**	Check (√) 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 (√) 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

Eastern Health
Perinatal Program
Newfoundland and Labrador

Perinatal Referral

email:ppnl@easternhealth.ca or Fax:709-777-4125

Name:

HCN:

Date of Birth:

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 one 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 follow-up, 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. British Journal of Psychiatry 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
<u>Yes, most of the time</u>
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) _____

In the past 7 days:

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

Appendix E: High Risk Deafness Criteria

Indicators for Sensorineural and/or Conductive Hearing Loss

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.

<u>Indicators associated with conductive hearing loss include:</u>

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
a) 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	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.

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

2022 Forms

Government of Newfoundland and Labrador
Digital Government and Service NL, Vital Statistics Division

LIVE BIRTH NOTIFICATION 2022

1. Registration number: ____ 10 ____

Department Use Only

Privacy Notice
Personal information contained on this form is collected under the authority of the Vital Statistics Act 2009, and will be used to register the birth, update or amend other vital event records, and provide extracts or search notices for administrative, statistical, research, medical and law enforcement purposes. If you have any questions about the collection or use of this information, please contact a Vital Statistics Client Representative at the following location: →

Vital Statistics Division
Digital Government and Service NL
PO Box 8700
St. John's, NL Canada A1B 4J6
T (709) 729-3308

Part A – Mandatory for Registration of Birth (Required within 48 hours of delivery)

INFANT

2. Surname | Full Given Name(s) | 3. Sex: ☐M ☐F ☐Unknown

4. Date of Birth MM/DD/YYYY | 5. Locality of Birth: ☐Hospital ☐Private Home ☐Other Health Care Facility ☐Unknown ☐Other (Specify) →

6. Hospital | Hospital Code | 7. Place of Occurrence City / Town | 8. Infant's Admit # | 9. Infant's Hospital Chart #

MOTHER

10. Surname, Full Given Name(s) ☐Gestational Carrier | 11. Maiden Name and Initials

12. Health Care Number | 13. Date of Birth MM/DD/YYYY | 14. Age at Delivery | 15. Birth Place (Province/Territory-Country if Outside Canada)

16. Usual Home Address | SGC Code | Postal Code | Telephone Number ( ) -

17. Complete Mailing Address | Postal Code

18. Legal Marital Status of Birth Mother
☐Never Married ☐Legally Married and Not Separated ☐Legally Married but Separated ☐Divorced ☐Widowed ☐Unknown

19. Living Arrangements of Birth Parents: ☐Living Together as a Couple ☐Not Living Together as a Couple ☐Unknown

20. Marital Relationship of Birth Parents of this delivery (Legally Married to Each Other) ☐Yes ☐No ☐Unknown

21. Education: ☐Has not Graduated High School ☐Graduated High School ☐Beyond High School ☐College or University Degree (Including trade) ☐Unknown

OTHER PARENT

22. Surname, Full Given Name(s) | 23. Date of Birth MM/DD/YYYY | 24. Age

25. Birth Place (Province/Territory-Country if Outside Canada)

HEALTH HISTORY AND MEDICAL CERTIFICATION OF BIRTH

27. Total Number of Children Ever Born to this Mother (Including this delivery) Number Liveborn ____ Number Stillborn ____

28. Complete Date of Last Delivery (prior to this delivery) MM/DD/YYYY

29. Total Number of Infants in this Delivery (Including Live & Stillborn)
☐Single birth ☐Twin ☐Triplet ☐Quadruplet ☐Quintuplet

30. Number of Stillborn in this Delivery ☐None Number: ____

31. Multiple Birth–Birth Order: ☐1st ☐2nd ☐Other (Specify) ____

32. Gestational Age ____ weeks ____ days

33. Was this Birth due to Medical Termination of Pregnancy? ☐Yes ☐No

34. Birth Weight: ____ grams

35. Delivered by (Surname, Given Name) - Identify Only One Person

36. Designation of Attendant (Select one only) ☐Medical Doctor ☐Midwife ☐RN ☐Unknown ☐Other (Specify) ____

37. Signature for Certification of Birth

38. Date MM/DD/YYYY

39. Prior C/Section(s) ☐Yes ☐No

40. Substance Use During Pregnancy
☐Cigarette Smoking ☐Alcohol ☐Methadone/ Suboxone ☐Inhalants/ Solvents ☐Other
☐Vaping (nicotine/non-nicotine) ☐Cannabis/ Cannabinoids ☐Opioids ☐Stimulants ☐None

41. Prenatal Care began at: Num. of Weeks → ____ ☐Unknown

42. Supports Available (check one only)
☐Husband / Partner ☐Lives Alone ☐Living with Parents / Other supports

43. Prenatal Care Provider (Check all that apply)
☐Family Doctor/GP ☐RN ☐Midwife ☐OBS / GYN ☐NP ☐None ☐Other (Specialty) ____

44. Maternal Risk Factors
☐None ☐Gestational Diabetes ☐Pre-existing Diabetes ☐Hypertension (Chronic)
☐Anemia (<100G/L) ☐Violence during pregnancy ☐Antepartum Hemorrhage ☐Depression ☐Hypertension (Assoc. Pregnancy)
Pre-pregnancy BMI: ☐25.0 - 29.9 ☐30+
☐Isoimmunization ☐IUGR ☐UTI ☐Other (Specify) ____

45. Labour Onset (check one only)
☐Spontaneous ☐Induction ☐No labour

46. Delivery Presentation
☐Vertex ☐Breech ☐Other (Specify) ____

47. Method of Delivery
☐Vaginal Spontaneous ☐Vaginal Assisted
☐C/Section → Reason(s) for C/Section:
◯Previous C/Section ◯Failure to Progress ◯Breech Presentation ◯Fetal Heart Rate Complication ◯Other (Please specify) ____

48. Interventions / Complications of Delivery (check all that apply)
Delivery Interventions:
☐None ☐Episiotomy ☐Forceps ☐Vacuum Extraction

Delivery Complications:
☐None ☐3rd Degree Tear ☐4th Degree Tear (Do not record 1st and 2nd degree tears)
☐Shoulder Dystocia ☐Postpartum Hemorrhage ☐Other (Specify) ____

49. Apgar Score At 1 ____ At 5 ____

50. Mother's Admit Number

51. Mother's Chart Number

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DISTRIBUTION: White and Green - Vital Statistics Goldenrod - Hospital Pink - Health and Community Services

Name:

HCN:

DOB:

2022 PART B LIVE BIRTH NOTIFICATION
Referral to HEALTH AND COMMUNITY SERVICE

MUST accompany Part A, BEFORE sending to Community Health Nursing

Infant Name:_____ **Infant DOB and Time:**_____ ☐ **Am** ☐ **PM**

Additional Demographic Info: _____ **Phone Number:** _____

57. Infant Status: ☐ Home ☐ Alternate address ☐ Hospital ☐ Deceased

☐ In Care/Adoption Address: _____ ☐ Transferred to: _____

HOSPITAL NURSING DISCHARGE SUMMARY

58. Infant Weight:
Birth _____

Discharge _____

59. Head Circumference: _____
(at discharge**)**

60. Length at Birth: _____

61. Infant Feeding:
☐ Exclusive Breastfeeding
☐ Non-exclusive Breastfeeding
☐ Breastmilk substitute

62. Previous Breastfeeding Experience:
☐ Yes duration (weeks) _____
☐ No ☐ Unknown

63. Jaundice: ☐ Yes ☐ No

Bilirubin Peak level _____

Bilirubin Level at D/C _____

Phototherapy received**:** ☐ Yes ☐ No

64. Congenital Anomalies:
Confirmed by Discharge
☐ Yes ☐ No
Type_____

Familial Conditions: ☐ Yes ☐ No

Specify:_____

65. Neo-natal Screening:
Bloodwork completed ☐ Yes ☐ No

66.Critical Congenital Heart Disease Screening:
☐ Yes ☐ No ☐ N/A

Result: ☐ Pass ☐ Refer
Appt Date: _____

67. Newborn Hearing Screening:
☐ Yes ☐ No
☐ Pass ☐ Refer

Audiology F/U Required: ☐ Yes ☐ No

Appt date:

68. Mother's Condition on D/C:
☐ Incision ☐ Suture/Staples ☐ Tubal Ligation

B/P _____ Hgb _____ Bld Group _____

Rhogam: ☐ Yes ☐ No

If Yes Date Given

Rubella status: ☐ Immune ☐ Non-immune

69. Post Delivery Length of Stay:_____

70. PPSP Record of Parent Learning completed? ☐ Yes ☐ No

71. Prenatal Education and Support Received? ☐ Yes ☐ No ☐ Unknown

Type:_____

72. Has the mother taken immunosuppressive therapy?
☐ Yes ☐ No ☐ Unknown

If **Yes** has Mom discussed live vaccine administration for this baby with her doctor? ☐ Yes ☐ No ☐ Unknown

73. Community Health Nurse Contact in Hospital ☐ Yes ☐ No

74. Follow up Recommendations (include incision care, follow up for blood work and other medical orders on discharge if needed)

_____

_____

_____

_____

_____

75. Priority (contact required) ☐ **No** ☐ **Yes** **Comment required** _____

76. Family Physician/Other Provider_____ **77. Date of Discharge**_____

78. Referral sent via: ☐ **Fax** ☐ **Phone** ☐ **Mail** ☐ **E- Mail**

79. Nurse's Name (Print) _____**Signature**_____**80. Date**_____

To be completed by Community Health Nurse:

HEALTHY BEGINNINGS FOLLOW-UP REFERRAL

Date Received: DD/MM/YYYY **Mother's Name:** **Mother's MCP#**

Infant's Name: **Infant DOB:** DD/MM/YYYY

Are there other service providers involved with the family? ☐ Yes ☐ No **Specify:**

Follow-up/ Referrals: Perinatal Program NL? ☐ Yes ☐ No Audiology High Risk Deafness Program? ☐ Yes ☐ No

Other:

PRIORITY ASSESSMENT FOR FOLLOW-UP

CIRCLE IF YES NYA = place x in Box

A CHILDREN WITH KNOWN DISABILITY

1. Congenital anomaly

a) Major (probability of permanent disability) 9 ☐
e.g. Down Syndrome, Spina Bifida etc.

b) Moderate (correction may be possible) 6 ☐
e.g. Cleft palate

2. a) **Major disability** acquired during first 5 years of life (probability of permanent disability)
e.g. Cerebral Palsy, severe head injury 9 ☐

b) Moderate disability acquired during first 5 years (correction may be possible)
e.g. loss of limb 6 ☐

B DEVELOPMENTAL FACTORS

3. Low birth weight

a) 1-1499 gm 9 ☐
b) 1500-1999 gm 8 ☐
c) 2000-2499 gm 6 ☐

4. Bilirubin level over 20 gm or 342 umol/L (or exchange level if premature) 8 ☐

5. Complications of pregnancy

a) Infections that can be transmitted in utero and may damage the fetus (e.g. rubella) 9 ☐
b) Drugs, e.g. alcohol abuse diagnosed in mother 9 ☐

6. Complications of labour and delivery

a) Labour requiring mid forceps including Breech Delivery with forceps 4 ☐
b) Infant trauma or illness (e.g. seizures Respiratory Distress Syndrome) 6 ☐
c) Apgar at 5 minutes only if less than 7, Deduct score at 5 minutes from 10 points _____

7. Family history of a disability not detectable at birth that could affect development e.g. Hearing loss, developmental delay 4 ☐

8. Development concerns not already covered in any above category

a) acquired risk of developmental delay due to an illness or trauma in the first 5 years 6 ☐
b) Delayed developmental assessment in first 5 years 9 ☐

C. FAMILY INTERACTION FACTORS

9. Age of Mother

a) 15 and Under 9 ☐
b) 16 or 17 8 ☐
c) 18 or 19 5 ☐

10. Social Situation

a) father of infant not resident but other support available 2 ☐
b) father not resident and no support 7 ☐
c) father resident and supportive but no other social support or severe isolation by language or geography 4 ☐

11. On social assistance or financial difficulties 3 ☐

12. No prenatal care before sixth month 4 ☐

13. Mental illness or developmental delay in mother and/ or father

a) Schizophrenia or bipolar affective disorder 7 ☐
b) Postpartum depression 9 ☐
c) Developmental delay of a parent 6 ☐

14. Prolonged postpartum maternal separation (5 days or more):

a) With frequent infant contacts (visits or phone as feasible) 2 ☐
b) Little or no contact 6 ☐

15. Assessed lack of bonding (e.g.: minimal eye contact or touching) 6 ☐

16. > 3 hospitalizations in 1 year in absence of known chronic illness or condition 7 ☐

17. Other e.g.: marital distress, low education status, failure to thrive, difficulty raising an older child, etc. (Score 0 to 9) _____

Specify reason:

PRIORITY SCORE: Total Priority Score: _____

___≥ 9 High Priority
___5-8 Moderate Priority
___3-4 Low Priority
___0-2 Minimal Priority

Date: DD/MM/YYYY

Client Risk/Staff Risk * Assessment Completed? ☐ Yes ☐ No
(*as per regional policy)

See **CHNS** for **Priority Assessment, Progress Notes** and **further documentation.**

Nurse's Name (Print) _____

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 comments with the LBN form.

Please mail your comments to:
Manager, Clinical/Administrative Standards
Data & Information Services
Newfoundland and Labrador Centre for Health Information
70 O'Leary Avenue
St. John's, NL A1B 2C7

_____

_____

_____

_____

_____

_____

_____

_____

_____

Optional:

Name: _____ Facility: _____ Date: _____

Newfoundland and Labrador Centre for Health Information
www.nlchi.nl.ca
70 O'Leary Avenue, St. John's, NL A1B 2C7