



**NL Health  
Services**

**REFERENCE MANUAL**

# **Live Birth Notification Form Reference Manual**

**Prepared by:** Live Birth/Mortality System Advisory  
Committee

**Prepared on:** January 1, 2025

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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.

# 2025 Live Birth Notification (LBN) Form

Detailed guidance on completion of each field on the 2025 Live Birth Notification (LBN) form can be found on pages 9 through 28 of this manual.

## Changes/Revisions

The following changes/revisions were made to the 2025 form:

ITEM #	CHANGE	DESCRIPTION OF CHANGE WITH RATIONALE
17	Mother's Language	Collect Mother's Preferred Language as "English" or "Other (Specify) _____" - This information is helpful to clinical staff in communication with mother at post-natal check ups
44	Maternal Risk Factors	Add "Anxiety" as a check box - Anxiety increasingly being added by staff completing form
Part B	Removed item 'Record of Parent Learning'	Previously item #71 on form. Items have been renumbered to accommodate this deletion

## Completing the 2025 LBN Form

The recently revised LBN form (January 2025) will replace the form currently in use (2024). Please destroy all remaining copies of the 2024 LBN form on January 1, 2025. If you have not received your 2025 LBN forms by then, please notify Service NL – Vital Statistics Registrar immediately.

This 2025 Live Birth Notification Reference manual can be downloaded from [www.nlchi.nl.ca/index.php/quality-information/standards/clinical-standards-and-information](http://www.nlchi.nl.ca/index.php/quality-information/standards/clinical-standards-and-information)

Any 2025 births not recorded on 2025 forms may be returned for re-submission using the correct form.

## Special Notice

The LBN Reference Manual guide has been updated. It is recommended that you review pages 9-28 for guidance on how to complete each field of the 2025 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 2025 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 Digital Health, NLHS at (709) 752-6000 or by completing and forwarding the Comments form in the back of the manual.

Manager, Clinical/Administrative Standards  
Digital Health, NLHS  
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.

This notification of birth provides information to the Department of Health & Community Services, Service NL - Vital Statistics Division, NL Health Services-Central/Eastern-Rural/Eastern-Urban/Western/Labrador-Grenfell Zones, Statistics Canada, Newfoundland Statistics Agency, and NL Health Services-Digital Health. It serves as a referral notification for the Healthy Beginnings Program, as well as a working document for NL Health Services.

Since 1986, there have been several revisions, and in 2002, the Live Birth Notification (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 still relevant.

This revised form has had the input of many stakeholders. The provincial advisory 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
- ◆ NL Health Services-Digital Health

The LBN 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

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.
- ◆ NL Health Services-Digital Health to classify each birth according to ICD-10-CA coding guidelines and to support the 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.

NL Health Services-Digital Health will continue to support education/training through provision of materials and consultation.

**NL Health Services-Central/Eastern-Rural/Eastern-Urban/Labrador-Grenfell/Western Zones have permission to reproduce this entire guide or any section of this guide.**

**Copies can be downloaded from 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 the Completion of the 2025 Live Birth Notification (LBN) Form

Parents have the right to refuse to answer any or all information collected on the Live Birth Notification (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 refuse 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 NL Health Services-Digital Health use only.

Part B is to be completed upon discharge of the mother and/or infant and sent to the appropriate Health & Community Services site 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 item blank**. If the information is non-applicable or unknown, use the indicators below.

<b>VALID INDICATORS</b>	
N/A	Meaning Non-Applicable
U/K	To be used <b><u>ONLY</u></b> when the information is not found on the patient chart, is unavailable, or is truly unknown.
	<b>ALL</b> 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 Live 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 NL Health Services-Digital Health, 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.

## 2025 Live Birth Notification (LBN) Form – Part A

### Registration Information

Field	QUESTION	INFORMATION REQUIRED	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
#1	Registration Number	Certification	Vital Statistics	

### Infant Information

Field	QUESTION	INFORMATION REQUIRED	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
#2	Surname, Full Given Name(s)	Infant 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 <b>MONTH, DAY, YEAR</b> 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
#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

## Mother Information

Field	QUESTION	INFORMATION REQUIRED Mother	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 10	<b>Surname, Full Given Name(s)</b>	Record the surname of the mother followed by full given name(s) (no initials). If the mother is the Gestational Carrier for <b>THIS BIRTH</b> , please check the “Gestational Carrier” box.	Health Care Staff	<i>Admitting Documentation</i>
# 11	<b>Maiden Name &amp; Initials</b>	Record the mother’s maiden surname <u>and initials</u> . 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	<i>Admitting Documentation</i>
# 12	<b>Health Care Number</b>	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	<i>Prenatal Record or Admitting Documentation</i>
# 13	<b>Date of Birth</b>	Record mother’s date of birth using <b>MONTH, DAY, YEAR</b> format, E.g. December 31, 1972 should be written: 12 31 1972.	Health Care Staff	<i>Admitting Documentation or Mother</i>
# 14	<b>Age at Delivery</b>	Record mother’s age, in years, <u>at time of delivery</u> .	Health Care Staff	<i>Admitting Documentation or Mother</i>
# 15	<b>Birth Place (Province/Territory -Country if Outside Canada)</b>	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	<i>Admitting Documentation or Mother</i>

Field	QUESTION	INFORMATION REQUIRED	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 16	<b>Usual Home Address</b>	<b>Mother</b> 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	<i>Mother</i>
# 17	<b>Complete Mailing Address</b>	Record mother's complete mailing address <b>if different from usual home address</b> , including the postal code. If the usual home address is <b>IDENTICAL</b> to the mailing address, enter the indicator N/A.	Health Care Staff	<i>Mother</i>
	<b>Mother's Preferred Language</b>	Check ( ) as applicable: Mother's preferred language for communication with clinical staff. This is used, in particular, when setting up post-natal care visits.	Health Care Staff	<i>Mother</i>
# 18	<b>Legal Marital Status of Birth Mother</b>	Check (v) 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. <b>DO NOT WRITE IN COMMON-LAW.</b> <ul style="list-style-type: none"> <li>◆ Never Married – Mothers who have never been married</li> <li>◆ Legally Married and not Separated – When infant's parents are married to each other and living together</li> <li>◆ Legally Married but Separated – When infant's parents are married to each other but not living together</li> <li>◆ Divorced – Mothers who are legally divorced</li> <li>◆ Widowed – Mothers whose spouses are deceased</li> <li>◆ Unknown – Mothers whose legal marital status is unknown</li> </ul>	Health Care Staff	<i>Prenatal Record and Admission Documentation or Mother</i>

Field	QUESTION	INFORMATION REQUIRED	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 19	<b>Living Arrangements of Birth Parents</b>	<b>Mother</b> Check (✓) one as applicable: <ul style="list-style-type: none"> <li>• Living together as a couple: Infant’s parents are living together</li> <li>• Not living together as a couple: Infant’s parents are not living together</li> </ul> Unknown: Living arrangements of birth parents are unknown	Health Care Staff	<i>Mother</i>
# 20	<b>Marital Relationship of Birth Parents of this delivery</b>	<b>This question relates to the parents of this Live Birth delivery (not the mother’s parents)</b> 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	<i>Mother</i>



Field	QUESTION	INFORMATION REQUIRED	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 21	Education	<p data-bbox="589 291 943 352">Mother</p> <p data-bbox="589 296 943 352">Check (v) one only; the highest level attained.</p> <ul data-bbox="589 369 943 863" style="list-style-type: none"> <li data-bbox="589 369 943 451">• Has not Graduated High School: Does not have a high school graduation certificate</li> <li data-bbox="589 457 943 539">• Graduated High School: Has a high school graduation certificate</li> <li data-bbox="589 546 943 657">• Beyond High School: Attended college or university but does not have a post-secondary certificate, diploma or degree</li> <li data-bbox="589 663 943 804">• College or University Degree/Diploma: Completed post-secondary education and has a certificate, diploma and/or degree</li> <li data-bbox="589 810 943 863">• Unknown – If education level unknown</li> </ul> <p data-bbox="589 905 943 1037">e.g. If the mother has completed high school, but has not completed any education beyond high school, check “Graduated High School”.</p> <p data-bbox="589 1085 943 1255">If the mother has completed high school and has one or more courses completed from a post-secondary institution, check “Beyond High School”.</p> <p data-bbox="589 1304 943 1528">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.</p>	Health Care Staff	<i>Mother</i>

## Other Parent Information

Information regarding the other parent is desired. However, if the other parent is not identified, use the appropriate valid indicator (i.e., 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	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
		Other Parent		
# 22	<b>Surname, Full Given Name(s)</b>	Record the surname of the other parent followed by full given name(s) (no initials).	Health Care Staff	<i>Mother or Other Parent</i>
# 23	<b>Date of Birth</b>	Record other parent's date of birth using <b>MONTH, DAY, YEAR</b> format, e.g. December 31, 1972 should be written as: 12 31 1972.	Health Care Staff	<i>Mother or Other Parent</i>
# 24	<b>Age</b>	Record other parent's age, in years, <u>at last birthday</u> .	Health Care Staff	<i>Mother or Other Parent</i>
# 25	<b>Birth Place</b> <i>(Province/Territory-County if Outside Canada)</i>	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	<i>Mother or Other Parent</i>
#26	<b>Reserved for future use</b>			

## 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 appropriated 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 THE INFORMATION
# 27	<p><b>Total Number of Children Ever Born to this Mother (including <i>this delivery</i>)</b></p> <p>*Note: Please see Page 4 for definition of "Delivery"</p>	<p><b><u>Do not enter (√) in this field: a numeric value is required.</u></b></p> <p>Record the <u>number</u> of live births and the number of stillbirths <b><u>ever born</u></b> to this mother, <b>including all infants in this delivery.</b> Infants born alive, who may have subsequently died, are considered "live births". Enter "0 "(zero) if no stillbirths.</p> <p><b><u>NOTE:</u></b> 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).</p>	Health Care Staff	<i>Prenatal Record</i>
# 28	<p><b>Complete Date of Last Delivery (prior to this delivery) (see Delivery definition on P. 4)</b></p>	<p>Record the date (<b>MONTH, DAY, YEAR</b> format) <u>of last live or stillbirth delivery</u> 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.</p>	Health Care Staff	<i>Prenatal Record</i>

FIELD	QUESTION	INFORMATION REQUIRED: Health History & Medical Certification	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 29	<b>Total Number of Infants in <u>this Delivery</u> (including Live and Stillborn)</b>	This field is used to denote birth of a singleton, twin, triplet, etc. Check (√) applicable selection.	Health Care Staff	<i>Labour &amp; Delivery Record</i>
# 30	<b>Number of Stillborn in <u>this Delivery</u></b>	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	<i>Labour &amp; Delivery Record</i>
# 31	<b>Multiple Birth – Birth Order</b>	Used to identify multiple birth order (1 <sup>st</sup> , 2 <sup>nd</sup> , etc.) Check (√) as applicable. If Other is selected, enter appropriate information.	Health Care Staff	<i>Labour &amp; Delivery Record</i>
# 32	<b>Gestation Age (Weeks/Days)</b>	Record gestational age, Weeks followed by Days e.g. 34 & 5 – indicates 34 weeks plus 5 days gestation.	Health Care Staff or Physician	<i>Labour &amp; Delivery Record</i>
# 33	<b>Was this Birth due to Medical Termination of Pregnancy?</b>	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: <ul style="list-style-type: none"> <li>to enable researchers to accurately interpret data pertaining to premature births and neonatal deaths</li> </ul> to alert Vital Statistics employees not to contact the mother.	Health Care Staff	<i>Labour &amp; Delivery Record, Admission Documentation, and/or History and Physical</i>
# 34	<b>Birth Weight</b>	Record infant's weight ( <b><u>measured in grams</u></b> ) at time of birth.	Health Care Staff	<i>Labour &amp; Delivery Record</i>

FIELD	QUESTION	INFORMATION REQUIRED: Health History & Medical Certification	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 35	<b>Delivered By</b>  <u>Identify only ONE person</u>	Print surname and first name of person who assisted with the delivery of the infant. Do not use initials. <b>There may be several people involved, but only the person who assisted the mother in the delivery should be indicated.</b>  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	<i>Labour &amp; Delivery Record</i>
# 36	<b>Designation of Attendant</b>	Check (√) <u>one</u> as applicable. If Other is selected, record additional information.	Health Care Staff or Physician	<i>Labour &amp; Delivery Record</i>
# 37	<b>Signature for Certification of Birth</b>	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	<i>Labour &amp; Delivery Record</i>
# 38	<b>Date</b>	Record the date ( <b>MONTH, DAY, YEAR</b> 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	<i>Labour &amp; Delivery Record</i>
# 39	<b>Prior C/Section(s)</b>	Check (√) as applicable. This refers to <u>any past</u> C/Section.	Health Care Staff	<i>Prenatal Record</i>

FIELD	QUESTION	INFORMATION REQUIRED: Health History & Medical Certification	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 40	<b>Substance Use During Pregnancy</b>	<p>This is for substance use <u>during the pregnancy, from the time of conception.</u></p> <p>Check (√) as applicable, more than one, if necessary. “Other” refers to illicit substance use (<b>NOT</b> appropriate use of prescription or OTC drugs).</p>	Health Care Staff	<i>Prenatal Record or Mother</i>
# 41	<b>Prenatal Care began at: Num. of weeks</b>	Record the Gestational Age, in Weeks, when prenatal care began. If unknown, check (√) Unknown.	Health Care Staff	<i>Prenatal Record</i>
# 42	<b>Supports Available</b>	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	<i>Mother</i>
# 43	<b>Prenatal Care Provider</b>	Check (√) as applicable. If ‘Other’ is selected, enter the appropriate specialty.	Health Care Staff	<i>Mother or Prenatal Record</i>
# 44	<b>Maternal Risk Factors</b>	<p>Check (√), as applicable, any maternal risk factors <u>during this pregnancy</u>. If Other is selected specify appropriate information.</p> <p><b>All of these maternal risk factors should be verified by documentation on the chart or prenatal record.</b></p> <p>The following definitions have been determined with input from medical personnel.</p> <ul style="list-style-type: none"> <li>• Anemia (&lt; 100 G/L): if recorded anytime during this pregnancy prior to delivery.</li> <li>• Pre-existing Diabetes: confirmed diagnosis of diabetes prior to this pregnancy.</li> <li>• Gestational Diabetes: medically confirmed diagnosis of gestational diabetes during this pregnancy.</li> </ul>	Health Care Staff or Physician	<i>Prenatal Record/Physician</i>

FIELD	QUESTION	INFORMATION REQUIRED: Health History & Medical Certification	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
#44	Maternal Risk Factors...cont'd	<ul style="list-style-type: none"> <li>• Antepartum Hemorrhage: any vaginal bleeding after 20 weeks gestation. Must be verified by physician or documented by a physician (<b>may be on prenatal record</b>).</li> <li>• Hypertension (Chronic): patient has history of medically diagnosed hypertension prior to pregnancy.</li> <li>• 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.</li> <li>• Violence during Pregnancy: the woman is a victim of violence during this pregnancy.</li> <li>• Depression: the woman has been medically diagnosed with depression. Include previous post-partum depression.</li> <li>• Anxiety: the woman has been medically diagnosed with anxiety.</li> <li>• UTI - Urinary Tract Infection: the patient has been medically diagnosed and treated for a UTI after 20 weeks gestation.</li> <li>• IUGR - Intrauterine Growth Restriction: any type of restriction identified on Prenatal ultrasound, e.g. symmetrical or asymmetrical. <b>If not identified during the prenatal period, do not check.</b></li> <li>• Isoimmunization: Rh disease – positive Coombs. Mother has been exposed and has some level of antibodies against fetal red cell antigen.</li> <li>• Pre-pregnancy BMI: The pre-pregnancy BMI was documented as either 25.0 - 29.9 or 30+</li> <li>• Other: any other maternal risk factor diagnosed and/or treated during this pregnancy <b>which may present a risk to the mother and/or the fetus.</b></li> </ul> <p>(Dx Code completed by the Centre)</p>		

FIELD	QUESTION	INFORMATION REQUIRED: Health History & Medical Certification	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 45	Labour Onset	Check (√) <b>ONE</b> only: <ul style="list-style-type: none"> <li>◆ <b>Spontaneous:</b> contractions in a pregnant woman that started spontaneously without any medical assistance.</li> <li>◆ <b>Induction:</b> the medically assisted initiation of contractions in a pregnant woman who was not in labour.</li> <li>◆ <b>No Labour:</b> no labour has occurred.</li> </ul>	Health Care Staff or Physician	<i>Labour &amp; Delivery Record</i>
# 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	<i>Labour &amp; Delivery Record</i>
# 47	Method of Delivery	Check one (√) one as applicable; if <b>C/Section is selected – the reason(s) for C/Section must also be checked (√)</b> : <ul style="list-style-type: none"> <li>○ Previous C/Section</li> <li>○ Failure to Progress</li> <li>○ Breech Presentation</li> <li>○ Fetal Heart Rate Complication</li> <li>○ Other: (Please Specify)_____</li> </ul> If Other is selected, please specify the reason. <i>These indicators are a required field and should not be omitted.</i> (Dx Code completed by the Centre)	Health Care Staff or Physician	<i>Labour &amp; Delivery Record</i>
#48	Interventions and/or Complications of Delivery	Check (√) as applicable in each column.  <b>Tears: Only 3<sup>rd</sup> or 4<sup>th</sup> degree tears are collected. <u>Do not</u> record 1<sup>st</sup> or 2<sup>nd</sup> degree tears.</b>  If ‘Other’ Complication of Delivery is selected, please specify the complication.  <b>Please do not enter C/Section in this field. C/S is considered a Method of Delivery.</b>	Health Care Staff or Physician	<i>Labour &amp; Delivery Record</i>



FIELD	QUESTION	INFORMATION REQUIRED: Health History & Medical Certification	COMPLETED BY	WHERE YOU MAY FIND THE INFORMATION
# 49	<b>Apgar Score</b>	Record infant's <b><u>One minute and Five minute</u></b> Apgar Scores. Enter as a double digit e.g., 01, 02 A score above 10 is invalid.	Health Care Staff	<i>Labour &amp; Delivery Record</i>
# 50	<b>Mother's Admit #</b>	Record mother's hospital admitting number.	Health Care Staff	<i>Admitting Documentation</i>
# 51	<b>Mother's Chart #</b>	Record mother's hospital chart number.	Health Care Staff	<i>Admitting Documentation</i>
#52 - #56	<b>Fields reserved for future use</b>			

## 2025 Live Birth Notification (LBN) Form Part B – Health and Community Services Referral

FIELD	QUESTION	INFORMATION REQUIRED – Health & Community Services
	<b>Infant's Name</b>	Include full name if known
	<b>Infant's DOB</b>	Confirm date of birth from Part A. Enter as Month/Day/Year
	<b>Infant's Time of Birth</b>	Confirm time of infant's birth indicating AM or PM
	<b>Discharge Demographic Information</b>	Address that birthing person and/or infant will be going to upon discharge from hospital.
	<b>Phone number</b>	Birthing person's usual phone number and cell number if available
	<b>Alternate Phone Number</b>	Include alternate or relative number if available
<b>#57</b>	<b>Infant's Status</b>	Check (√) as applicable. If <i>transferred</i> selected, indicate where. If <i>in care / adoption</i> selected, add address for infant
<b>#58</b>	<b>Infant Birth Weight Infant Discharge Weight</b>	Record the infant's weight (measured in grams) at birth (from Part A) and upon discharge.
<b>#59</b>	<b>Discharge Head Circumference</b>	Record the infant's head circumference (measured in centimeters) at time of discharge.
<b>#60</b>	<b>Length at Birth</b>	Record the infant's length (measured in centimeters) at time of birth.
<b>#61</b>	<b>Infant Feeding</b>	<p>Check (√) only one</p> <ul style="list-style-type: none"> <li>• <b>Exclusive breastmilk:</b> no supplements ever given, strictly breastfed.</li> <li>• <b>Non-exclusive breastmilk:</b> any Breastfeeding <b>and</b> supplements given including G/W, formula or other substitute</li> <li>• <b>Medically supplemented:</b> supplementation given in addition to/in place of breast milk for a medical reason.</li> <li>• <b>Non-medically supplemented:</b> extra nutrition (i.e., breast milk substitute) given in addition to breast milk with no medical reason to supplement (supplementation is chosen by the parents).</li> <li>• <b>Breastmilk Substitute:</b> No Breastfeeding</li> </ul> <p>Add additional information in #74 Follow up recommendations</p>
<b>#62</b>	<b>Previous Breastfeeding Experience</b>	Check (√) as applicable. If yes, duration in weeks.
<b>#63</b>	<b>Breastfeeding concerns at D/C</b>	Check (√) yes/no and any other identified concerns at discharge as applicable.
<b>#64</b>	<b>Jaundice</b>	Check (√) as applicable. Record bilirubin levels at peak and discharge if known. Indicate if infant received phototherapy.
<b>#65</b>	<b>Congenital Anomalies Family Conditions</b>	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)

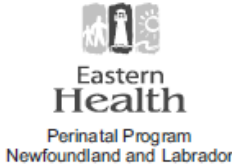
FIELD	QUESTION	INFORMATION REQUIRED – Health & Community Services
#66	<b>Newborn Hearing Screen</b>	Check (√) as applicable. If yes is selected, indicate result (Pass or Referral).
#67	<b>Critical Congenital Heart Disease Screen</b>	CCHD screening uses pulse oximetry measurement of pre and post-ductal 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 refer (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).
#68	<b>Birth Person's Condition on Discharge</b>	Check (√), as applicable, more than one if necessary. Hgb is the post-delivery hemoglobin. B/P is the last one recorded
#69	<b>Post Delivery Length of Stay (LOS)</b>	Record the birthing person's length of stay (number of days) after delivery; this includes day of delivery and excludes day of discharge.
#70	<b>Prenatal Education and Support</b>	Check (√) as applicable. Indicate if classes, Healthy Baby Club or individual support given through BABIES
#71	<b>Immunosuppressive Therapy</b>	Indicate if birthing person 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. Birthing person should have information from specialist to make an informed decision on whether baby should have the Rotavirus vaccine at 2 months.
#72	<b>Community Health Nurse Contact in Hospital</b>	Check (√) as applicable.
#73	<b>Follow up recommendations</b>	Complete as necessary. Can include additional information re infant feeding, postpartum maternal care recommendations, incision care, follow up on blood work or other applicable medical orders on discharge, involvement with other health care providers, etc.
#74	<b>Priority</b>	Complete and comment if needed.
#75	<b>Family Physician/Other Provider</b>	Identify primary care provider if known.
#76	<b>Date of Discharge</b>	Record the date of birthing person's discharge (month, day, year format).
#77	<b>Referral sent via</b>	Check (√) as applicable, more than one if necessary.

FIELD	QUESTION	INFORMATION REQUIRED – Health & Community Services
#78	<b>Nurse's name and signature</b>	Printed name and signature of the nurse completing the Hospital Nursing Discharge Summary.
#79	<b>Date</b>	Record the date (month, day, year format) the Hospital Nursing Discharge Summary section of the LBN form was completed.

The appendices in this guide 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 A: Referral for High Risk Follow-Up Clinic of the Perinatal Program NL



**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 multiple 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 hemorrhage, 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: \_\_\_\_\_

## 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
- 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) \_\_\_\_\_

<b>In the past 7 days:</b>	<b>Score</b>
*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)	_____
<b>TOTAL SCORE</b>	_____

*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.

Indicators associated with delayed onset sensorineural hearing loss include:

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: List of Tables used throughout Questions 1 to 80

VALID INDICATORS	
N/A	Meaning Non-Applicable
U/K	To be used <b>ONLY</b> when the information is not found on the patient chart, is unavailable, or is truly unknown.
	<b>ALL</b> 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
<b>DO NOT Indicate "Common Law" as this is not a valid legal term</b>	

CODE	EDUCATION <i>(Definitions adapted from Statistics Canada)</i>
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

# 2025 Forms



Government of Newfoundland and Labrador  
 Digital Government and Service NL, Vital Statistics Division  
**LIVE BIRTH NOTIFICATION 2025**

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  
 P.O. Box 8700  
 St. John's, NL, Canada A1B 4J6  
 T (709) 723-3308

Part A – Mandatory for Registration of Birth (Required within 48 hours of delivery)		
INFANT	2. Surname Full Given Name(s)	3. Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unknown
	4. Date of Birth MMDDYYYY	5. Locality of Birth <input type="checkbox"/> Hospital <input type="checkbox"/> Private Home <input type="checkbox"/> Other Health Care Facility <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify) →
	6. Hospital	7. Place of Occurrence City / Town
MOTHER	10. Surname, Full Given Name(s) <input type="checkbox"/> Gestational Carrier	11. Maiden Name and Initials
	12. Health Care Number	13. Date of Birth MMDDYYYY
	14. Age at Delivery	15. Birth Place (Province/Territory-Country if Outside Canada)
	16. Usual Home Address	17. Complete Mailing Address
	18. Legal Marital Status of Birth Mother <input type="checkbox"/> Never Married <input type="checkbox"/> Legally Married and Not Separated <input type="checkbox"/> Legally Married but Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Unknown	19. Living Arrangements of Birth Parents <input type="checkbox"/> Living Together as a Couple <input type="checkbox"/> Not Living Together as a Couple <input type="checkbox"/> Unknown
	20. Marital Relationship of Birth Parents of this delivery (Legally Married to Each Other) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	21. Education <input type="checkbox"/> Has not Graduated High School <input type="checkbox"/> Graduated High School <input type="checkbox"/> Beyond High School <input type="checkbox"/> College or University Degree (including trade) <input type="checkbox"/> Unknown
22. Surname, Full Given Name(s)	23. Date of Birth MMDDYYYY	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)	28. Complete Date of Last Delivery (prior to this delivery) MMDDYYYY	
29. Total Number of Infants in this Delivery (including Live & Stillborn)	30. Number of Stillborn in this Delivery	
31. Multiple Birth-Birth Order: <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> Other (Specify)	32. Gestational Age _____ weeks _____ days	
33. Was this Birth due to Medical Termination of Pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No	34. Birth Weight _____ grams	35. Delivered by (Surname, Given Name) - Identify Only One Person
36. Designation of Attendant (Select one only) <input type="checkbox"/> RN <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)	37. Signature for Certification of Birth	38. Date MMDDYYYY
39. Prior C/Section(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	40. Substance Use During Pregnancy <input type="checkbox"/> None <input type="checkbox"/> Cigarette Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Methadone/Suboxone <input type="checkbox"/> Inhalants/Solvents <input type="checkbox"/> Vaping (nicotine/non-nicotine) <input type="checkbox"/> Cannabis/Cannabinoids <input type="checkbox"/> Opioids <input type="checkbox"/> Stimulants <input type="checkbox"/> Other	41. Prenatal Care began at Num. of Weeks _____ <input type="checkbox"/> Unknown
42. Supports Available (check one only) <input type="checkbox"/> Husband / Partner <input type="checkbox"/> Lives Alone <input type="checkbox"/> Living with Parents / Other supports	43. Prenatal Care Provider (Check all that apply) <input type="checkbox"/> Family Doctor/GP <input type="checkbox"/> RN <input type="checkbox"/> Midwife <input type="checkbox"/> OBS / GYN <input type="checkbox"/> NP <input type="checkbox"/> None <input type="checkbox"/> Other (Specialty)	
44. Maternal Risk Factors <input type="checkbox"/> None <input type="checkbox"/> Anemia (<100G/L) <input type="checkbox"/> Violence during pregnancy <input type="checkbox"/> Pre-pregnancy BMI: <input type="checkbox"/> 25.0 - 29.9 <input type="checkbox"/> 30+ <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Antepartum Hemorrhage <input type="checkbox"/> IUGR <input type="checkbox"/> Pre-existing Diabetes <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> UTI <input type="checkbox"/> Hypertension (Chronic) <input type="checkbox"/> Hypertension (Gestational) <input type="checkbox"/> Other (Specify)	45. Labour Onset (check one only) <input type="checkbox"/> Spontaneous <input type="checkbox"/> Induction <input type="checkbox"/> No labour	
46. Delivery Presentation <input type="checkbox"/> Vertex <input type="checkbox"/> Breech <input type="checkbox"/> Other (Specify)	47. Method of Delivery <input type="checkbox"/> Vaginal Spontaneous <input type="checkbox"/> Vaginal Assisted <input type="checkbox"/> C/Section Reason(s) for C/Section: _____	<input type="radio"/> Previous C/Section <input type="radio"/> Fetal Heart Rate Complication <input type="radio"/> Failure to Progress <input type="radio"/> Other (Please specify) <input type="radio"/> Breech Presentation
48. Interventions / Complications of Delivery (check all that apply) Delivery Interventions <input type="checkbox"/> None <input type="checkbox"/> Episiotomy <input type="checkbox"/> Forceps <input type="checkbox"/> Vacuum Extraction	Delivery Complications <input type="checkbox"/> None <input type="checkbox"/> Shoulder Dystocia <input type="checkbox"/> 3 <sup>rd</sup> Degree Tear <input type="checkbox"/> Postpartum Hemorrhage <input type="checkbox"/> 4 <sup>th</sup> Degree Tear <input type="checkbox"/> Other (Specify) (Do not record 1 <sup>st</sup> and 2 <sup>nd</sup> degree tears)	
49. Apgar Score At 1 _____ At 5 _____	50. Mother's Admit Number	51. Mother's Chart Number

8-2300-73.1: 2022-10-03

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





**2025 PART B LIVE BIRTH NOTIFICATION**  
Referral to Newfoundland and Labrador Health Services

Name: \_\_\_\_\_

HCN: \_\_\_\_\_

DOB: \_\_\_\_\_

**MUST accompany Part A, BEFORE sending to Community Health Nursing**

Infant Name: \_\_\_\_\_ Infant DOB and Time: \_\_\_\_\_  AM  PM

Discharge Demographic Info (if different from home address): \_\_\_\_\_

Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_

67. Infant Status:  Home  Alternate address  Hospital  Deceased

In Care/Adoption Address: \_\_\_\_\_  Transferred to: \_\_\_\_\_

**HOSPITAL NURSING DISCHARGE SUMMARY**

<p>68. Infant Weight: Birth _____ Discharge _____</p> <p>69. Head Circumference: (at discharge) _____</p> <p>60. Length at Birth: _____</p>	<p>61. Infant Feeding: <input type="checkbox"/> Exclusive Breastmilk <input type="checkbox"/> Non-exclusive Breastmilk <input type="checkbox"/> Medically supplemented <input type="checkbox"/> Non medically supplemented <input type="checkbox"/> Breastmilk substitute</p> <p>62. Previous Breastfeeding Experience: <input type="checkbox"/> Yes duration (weeks) _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>63. Breastfeeding concerns at D/C: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> latch issues <input type="checkbox"/> Using breastfeeding aids Type _____ <input type="checkbox"/> Seen by LC in hospital <input type="checkbox"/> Other concerns: _____</p>
<p>64. Jaundice: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Bilirubin Peak level _____ Bilirubin Level at D/C _____ Phototherapy received: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>65. Congenital Anomalies: Confirmed by Discharge <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Familial Conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: _____</p>	<p>66. Newborn Hearing Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pass <input type="checkbox"/> Refer Audiology F/U Required <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>67. Critical Congenital Heart Disease Screen: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Pass <input type="checkbox"/> Refer</p>
<p>68. Birthing Person's Condition on D/C: <input type="checkbox"/> Incision <input type="checkbox"/> Suture/Staples <input type="checkbox"/> Vac Dressing <input type="checkbox"/> Tubal Ligation B/P _____ Hgb _____ Rubella status: <input type="checkbox"/> Immune <input type="checkbox"/> Non-immune</p> <p>69. Post Delivery Length of Stay: _____</p>		<p>70. Prenatal Education and Support Received: <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ <input type="checkbox"/> Unknown</p> <p>71. Has the birthing person taken Immunosuppressive therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes has birthing person discussed live vaccine administration for this baby with the doctor: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>

72. Community Health Nurse Contact in Hospital  Yes  No

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

74. Priority (contact required)  No  Yes Comment required \_\_\_\_\_

75. Family Physician/Other Provider \_\_\_\_\_ 76. Date of Discharge \_\_\_\_\_

77. Referral sent via:  Fax  Phone  Mail  E-Mail

78. Nurse's Name (Print) \_\_\_\_\_ Signature \_\_\_\_\_ 79. Date \_\_\_\_\_

165006



## Contact Us

### NL Health Services – Digital Health

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**t:** 709-752-6000 |

**w:** [NLHealthServices.ca](https://NLHealthServices.ca)