Birth Information Specialist and Midwife Training 2024

Oregon Health Authority

Training Requirement

- This training is required to file Oregon birth records and to use the Oregon Vital Events Registration System (OVERS).

- If you are a new Birth Information Specialist (BIS) or Midwife needing to file Oregon birth records and use OVERS, this training must be completed before you can get a login and password to OVERS.

- Certificates of completion must be provided.

Agenda

- ❑ Laws, Policies & Procedures
- ❑ An introduction to the worksheets
- ❑ A link to a demonstration of OVERS entry
- ❑ Birth Information Specialist training from CDC Train
- ❑ What is needed for an OVERS account
- ❑ Resources and Contacts

The work you do is of VITAL importance

For the individual:

The birth certificate is the most important document used to establish an individual's identity.

For the family:

It allows the parents to establish the child's identity and claim a range of benefits like tax credits and health care.

For public health partners:

It helps identify trends and indicators of health, which can assist in policy development, funding and research.

Laws, policies and procedures

Highlights of the laws and policies

- All births that occur in Oregon must be filed with the state.
- Each birth must be submitted to the state within 5 calendar days after the live birth.
- The hospital or licensed birthing facility where the birth occurred is responsible for filing the birth record with the state.
- Births that occur in a hospital or licensed birthing facility must be filed electronically using OVERS.

Highlights of the laws and policies

- The hospital or licensed birthing facility must make voluntary acknowledgment of paternity forms available to unmarried parents.
- Once filed and registered with the state, the birth record becomes the permanent record of the birth.
- Any changes to the birth record after it is registered must be done through an official amendment process and the change becomes permanent.

Oregon Revised Statutes

Chapter 432 (2021 Edition)

432.088 Mandatory submission and registration of reports of live birth; persons required to report; rules.

(1) A report of live birth for each live birth that occurs in this state shall be submitted to the Center for Health Statistics, or as otherwise directed by the State Registrar of the Center for Health Statistics, within five calendar days after the live birth and shall be registered if the report has been completed and filed in accordance with this section.

Oregon Revised Statutes

Chapter 432 (2021 Edition)

ORS 432.093 Availability of voluntary acknowledgment of paternity form; responsibility of health care facility and parents. Any health care facility as defined in ORS 442.015 shall make available to the biological parents of any child born live or expected to be born in the health care facility, a voluntary acknowledgment of paternity form when the facility has reason to believe that the mother of the child is unmarried. The responsibility of the health care facility is limited to providing the form and submitting the form with the report of live birth to the State Registrar of the Center for Health Statistics. The biological parents are responsible for ensuring that the form is accurately completed. This form shall be as prescribed by ORS 432.098. [Formerly 432.285]

In 2022, 39,388* births occurred in Oregon

****2022 preliminary data***

PUBLIC HEALTH DIVISION
Center for Health Statistics

99%

of birth records are electronically registered at medical facilities and birthing centers.

How are birth records completed?

1. Birth Information Specialists or Midwives gather information from parents and medical record.
2. Information is entered into OVERS.
3. The birth records will automatically register and become the official birth record once it is certified by the Birth Information Specialist or Midwife.

All within 5 days

Worksheets

- There are two worksheets used to collect the information for the completing the birth record.
    1. Parent worksheet
    2. Facility worksheet

- The worksheets are standardized so that all information is collected the same way for all births in Oregon.

- The worksheets provided or approved by the Center for Health Statistics must be used to collect the information.

- Completed worksheets should be filed in a separate file and are not part of the medical record. They need to be kept for two years and then shredded.

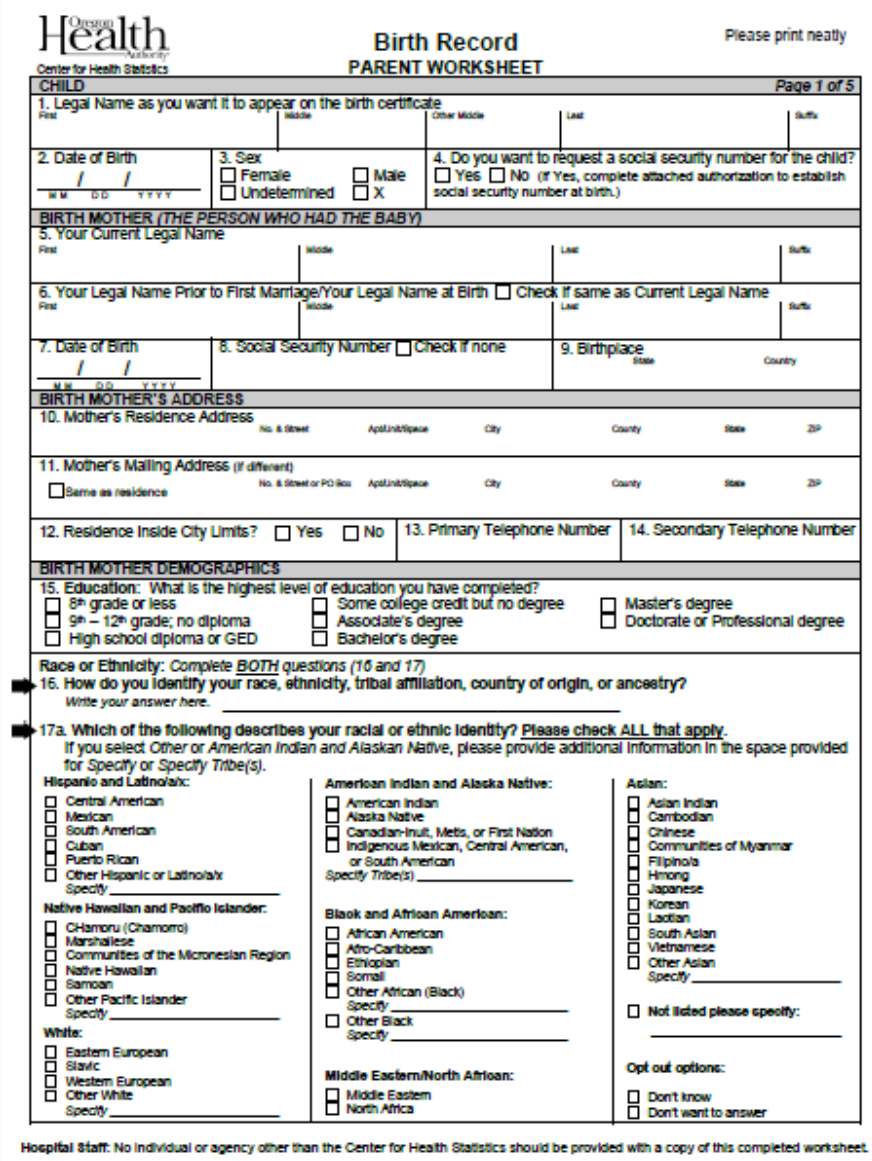
Parent Worksheet

Completed by the parent(s)

This is where the parents name the baby and provide information for their baby's legal birth certificate.

Please remind parents to:

- Read the cover sheet carefully.
- Write clearly and review the information.
- Provide precise and correct information.
- Answer every question as much as possible, even if the answer is "don't want to answer."
- Sign the worksheet.



Oregon Health Authority
Center for Health Statistics

Birth Record
PARENT WORKSHEET

Please print neatly

CHILD — Page 1 of 5

1. Legal Name as you want it to appear on the birth certificate
First | Middle | Other Middle | Last | Suffix

2. Date of Birth ___/___/___ (M M D D Y Y Y Y)

3. Sex ☐ Female ☐ Male ☐ Undetermined ☐ X

4. Do you want to request a social security number for the child? ☐ Yes ☐ No (If Yes, complete attached authorization to establish social security number at birth.)

BIRTH MOTHER (THE PERSON WHO HAD THE BABY)

5. Your Current Legal Name
First | Middle | Last | Suffix

6. Your Legal Name Prior to First Marriage/Your Legal Name at Birth ☐ Check if same as Current Legal Name
First | Middle | Last | Suffix

7. Date of Birth ___/___/___ (M M D D Y Y Y Y)

8. Social Security Number ☐ Check if none

9. Birthplace State | Country

BIRTH MOTHER'S ADDRESS

10. Mother's Residence Address
No. & Street | Apt/Unit/Space | City | County | State | ZIP

11. Mother's Mailing Address (if different)
☐ Same as residence
No. & Street or PO Box | Apt/Unit/Space | City | County | State | ZIP

12. Residence Inside City Limits? ☐ Yes ☐ No

13. Primary Telephone Number

14. Secondary Telephone Number

BIRTH MOTHER DEMOGRAPHICS

15. Education: What is the highest level of education you have completed?
☐ 8th grade or less
☐ 9th – 12th grade; no diploma
☐ High school diploma or GED
☐ Some college credit but no degree
☐ Associate's degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate or Professional degree

Race or Ethnicity: *Complete BOTH questions (16 and 17)*

16. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?
Write your answer here. _____

17a. Which of the following describes your racial or ethnic identity? Please check ALL that apply.
If you select *Other* or *American Indian and Alaskan Native*, please provide additional information in the space provided for *Specify* or *Specify Tribe(s)*.

Hispanic and Latino/a/x:
☐ Central American
☐ Mexican
☐ South American
☐ Cuban
☐ Puerto Rican
☐ Other Hispanic or Latino/a/x
Specify _____

Native Hawaiian and Pacific Islander:
☐ CHamoru (Chamorro)
☐ Marshallese
☐ Communities of the Micronesian Region
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander
Specify _____

White:
☐ Eastern European
☐ Slavic
☐ Western European
☐ Other White
Specify _____

American Indian and Alaska Native:
☐ American Indian
☐ Alaska Native
☐ Canadian-Inuit, Metis, or First Nation
☐ Indigenous Mexican, Central American, or South American
Specify Tribe(s) _____

Black and African American:
☐ African American
☐ Afro-Caribbean
☐ Ethiopian
☐ Somali
☐ Other African (Black)
Specify _____
☐ Other Black
Specify _____

Middle Eastern/North African:
☐ Middle Eastern
☐ North Africa

Asian:
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Communities of Myanmar
☐ Filipino/a
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ South Asian
☐ Vietnamese
☐ Other Asian
Specify _____

☐ Not listed please specify:
_____

Opt out options:
☐ Don't know
☐ Don't want to answer

Hospital Staff: No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

Parent Worksheet

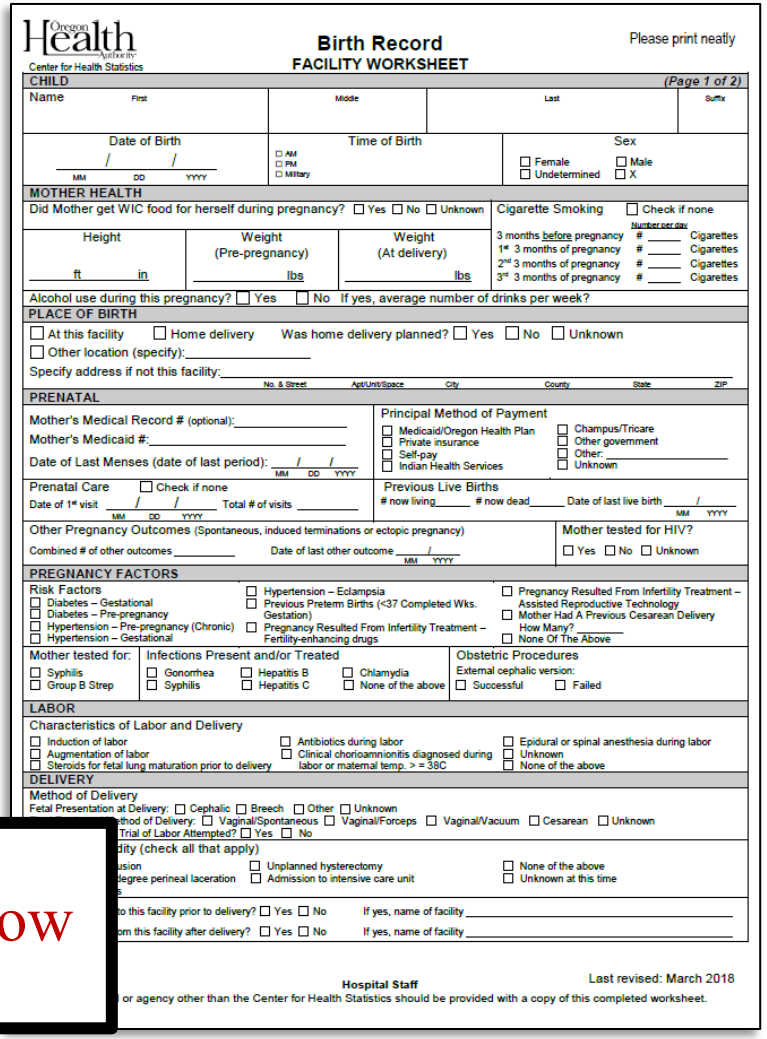
- Baby's information
- Parents' address and demographics
- Legal relationship of parents
- Mother's health
- Prenatal information
- Social Security Number authorization

Facility Worksheet

- Completed by the BIS or designee. The process for gathering the information may vary among hospitals or birthing facilities.
- Usually from medical record or provided by labor and delivery nurses at time of birth.
- You must use the facility worksheet provided or approved by the Center for Health Statistics.
- Parents do not see this worksheet.
- Completed worksheets should be filed in a separate file and are not part of the medical record. They need to be kept for two years and then shredded.

Facility Worksheets

- Medical and health information for the mother
- Prenatal information
- Pregnancy factors
- Labor and delivery information
- Newborn factors
- Hearing screening
- Immunization



Oregon Health Authority
Center for Health Statistics

Birth Record
FACILITY WORKSHEET

Please print neatly

(Page 1 of 2)

CHILD

Name (First, Middle, Last, Suffix)

Date of Birth (MM / DD / YYYY) | Time of Birth (☐ AM ☐ PM ☐ Military) | Sex (☐ Female ☐ Male ☐ Undetermined ☐ X)

MOTHER HEALTH

Did Mother get WIC food for herself during pregnancy? ☐ Yes ☐ No ☐ Unknown

Height (ft / in) | Weight (Pre-pregnancy) (lbs) | Weight (At delivery) (lbs)

Cigarette Smoking ☐ Check if none (Number per day)
3 months before pregnancy # _____ Cigarettes
1st 3 months of pregnancy # _____ Cigarettes
2nd 3 months of pregnancy # _____ Cigarettes
3rd 3 months of pregnancy # _____ Cigarettes

Alcohol use during this pregnancy? ☐ Yes ☐ No If yes, average number of drinks per week?

PLACE OF BIRTH

☐ At this facility ☐ Home delivery Was home delivery planned? ☐ Yes ☐ No ☐ Unknown
☐ Other location (specify):_____
Specify address if not this facility:_____ (No. & Street, Apt/Unit/Space, City, County, State, ZIP)

PRENATAL

Mother's Medical Record # (optional):_____
Mother's Medicaid #:_____
Date of Last Menses (date of last period): ___/___/___ (MM DD YYYY)

Principal Method of Payment
☐ Medicaid/Oregon Health Plan ☐ Champus/Tricare
☐ Private insurance ☐ Other government
☐ Self-pay ☐ Other: _____
☐ Indian Health Services ☐ Unknown

Prenatal Care ☐ Check if none
Date of 1st visit ___/___/___ (MM DD YYYY) Total # of visits _____

Previous Live Births
now living_____ # now dead_____ Date of last live birth ___/___ (MM YYYY)

Other Pregnancy Outcomes (Spontaneous, induced terminations or ectopic pregnancy)
Combined # of other outcomes _____ Date of last other outcome ___/___ (MM YYYY)

Mother tested for HIV?
☐ Yes ☐ No ☐ Unknown

PREGNANCY FACTORS

Risk Factors
☐ Diabetes – Gestational
☐ Diabetes – Pre-pregnancy
☐ Hypertension – Pre-pregnancy (Chronic)
☐ Hypertension – Gestational
☐ Hypertension – Eclampsia
☐ Previous Preterm Births (<37 Completed Wks. Gestation)
☐ Pregnancy Resulted From Infertility Treatment – Fertility-enhancing drugs
☐ Pregnancy Resulted From Infertility Treatment – Assisted Reproductive Technology
☐ Mother Had A Previous Cesarean Delivery How Many? _____
☐ None Of The Above

Mother tested for:
☐ Syphilis
☐ Group B Strep

Infections Present and/or Treated
☐ Gonorrhea ☐ Hepatitis B ☐ Chlamydia
☐ Syphilis ☐ Hepatitis C ☐ None of the above

Obstetric Procedures
External cephalic version:
☐ Successful ☐ Failed

LABOR

Characteristics of Labor and Delivery
☐ Induction of labor
☐ Augmentation of labor
☐ Steroids for fetal lung maturation prior to delivery
☐ Antibiotics during labor
☐ Clinical chorioamnionitis diagnosed during labor or maternal temp. > = 38C
☐ Epidural or spinal anesthesia during labor
☐ Unknown
☐ None of the above

DELIVERY

Method of Delivery
Fetal Presentation at Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown
Method of Delivery: ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown
Trial of Labor Attempted? ☐ Yes ☐ No

dity (check all that apply)
usion
degree perineal laceration
☐ Unplanned hysterectomy
☐ Admission to intensive care unit
☐ None of the above
☐ Unknown at this time

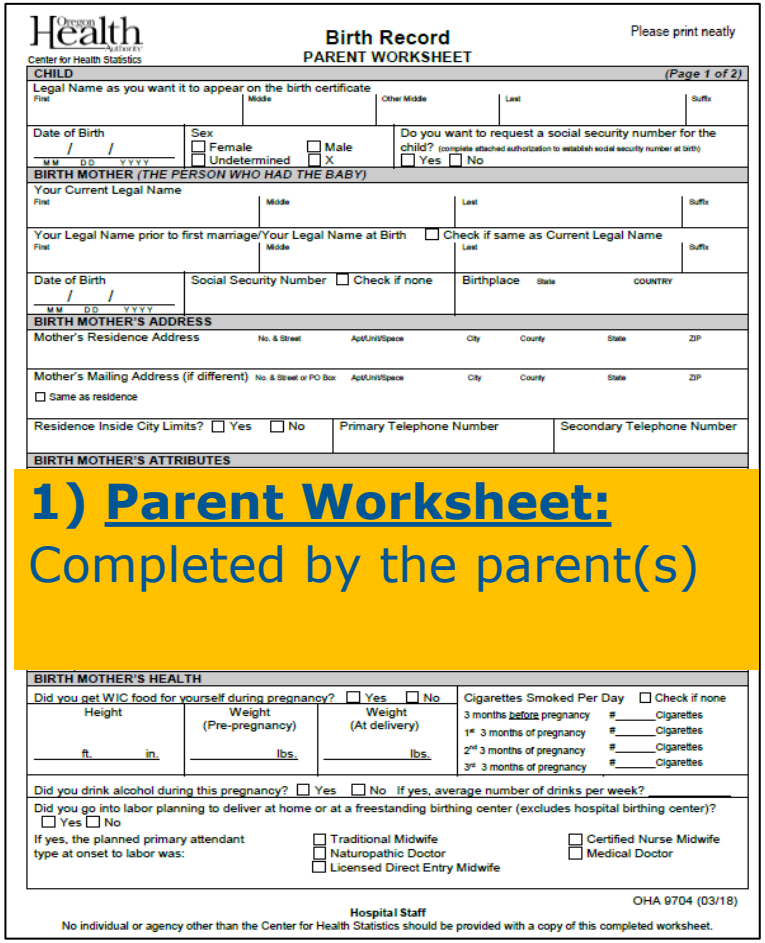
to this facility prior to delivery? ☐ Yes ☐ No If yes, name of facility _____
om this facility after delivery? ☐ Yes ☐ No If yes, name of facility _____

Hospital Staff
or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

Last revised: March 2018

IMPORTANT:
The worksheet is designed to flow with OVERS data entry

Recap: Parent and Facility Worksheets



Oregon Health Authority
Center for Health Statistics

Birth Record
PARENT WORKSHEET

Please print neatly

CHILD (Page 1 of 2)

Legal Name as you want it to appear on the birth certificate
First | Middle | Other Middle | Last | Suffix

Date of Birth (MM DD YYYY) | Sex: ☐ Female ☐ Male ☐ Undetermined ☐ X | Do you want to request a social security number for the child? (complete attached authorization to establish social security number at birth) ☐ Yes ☐ No

BIRTH MOTHER (THE PERSON WHO HAD THE BABY)

Your Current Legal Name
First | Middle | Last | Suffix

Your Legal Name prior to first marriage/Your Legal Name at Birth ☐ Check if same as Current Legal Name
First | Middle | Last | Suffix

Date of Birth (MM DD YYYY) | Social Security Number ☐ Check if none | Birthplace State COUNTRY

BIRTH MOTHER'S ADDRESS

Mother's Residence Address — No. & Street | Apt/Unit/Space | City | County | State | ZIP

Mother's Mailing Address (if different) No. & Street or PO Box | Apt/Unit/Space | City | County | State | ZIP
☐ Same as residence

Residence Inside City Limits? ☐ Yes ☐ No | Primary Telephone Number | Secondary Telephone Number

BIRTH MOTHER'S ATTRIBUTES

BIRTH MOTHER'S HEALTH

Did you get WIC food for yourself during pregnancy? ☐ Yes ☐ No

Height: ft. in. | Weight (Pre-pregnancy): lbs. | Weight (At delivery): lbs.

Cigarettes Smoked Per Day ☐ Check if none
3 months before pregnancy #_____Cigarettes
1st 3 months of pregnancy #_____Cigarettes
2nd 3 months of pregnancy #_____Cigarettes
3rd 3 months of pregnancy #_____Cigarettes

Did you drink alcohol during this pregnancy? ☐ Yes ☐ No If yes, average number of drinks per week?_____

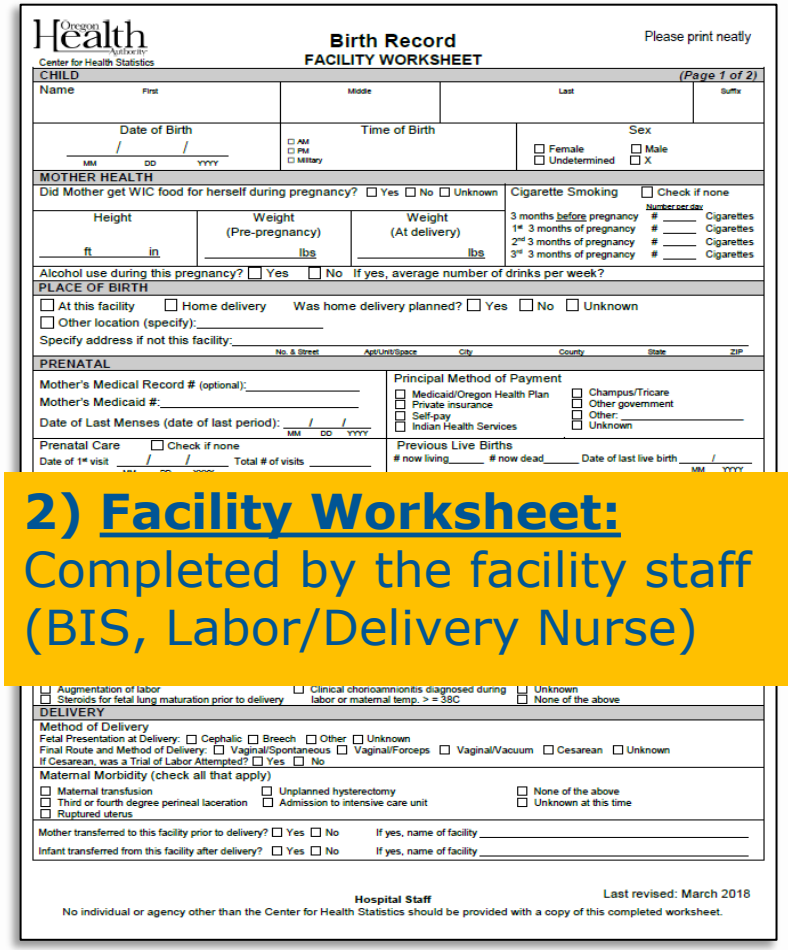
Did you go into labor planning to deliver at home or at a freestanding birthing center (excludes hospital birthing center)? ☐ Yes ☐ No

If yes, the planned primary attendant type at onset to labor was:
☐ Traditional Midwife ☐ Naturopathic Doctor ☐ Licensed Direct Entry Midwife ☐ Certified Nurse Midwife ☐ Medical Doctor

OHA 9704 (03/18)

Hospital Staff
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

1) Parent Worksheet:
Completed by the parent(s)



Oregon Health Authority
Center for Health Statistics

Birth Record
FACILITY WORKSHEET

Please print neatly

CHILD (Page 1 of 2)

Name: First | Middle | Last | Suffix

Date of Birth (MM DD YYYY) | Time of Birth: ☐ AM ☐ PM ☐ Military | Sex: ☐ Female ☐ Male ☐ Undetermined ☐ X

MOTHER HEALTH

Did Mother get WIC food for herself during pregnancy? ☐ Yes ☐ No ☐ Unknown

Height: ft in | Weight (Pre-pregnancy): lbs | Weight (At delivery): lbs

Cigarette Smoking ☐ Check if none (Number per day)
3 months before pregnancy # _____ Cigarettes
1st 3 months of pregnancy # _____ Cigarettes
2nd 3 months of pregnancy # _____ Cigarettes
3rd 3 months of pregnancy # _____ Cigarettes

Alcohol use during this pregnancy? ☐ Yes ☐ No If yes, average number of drinks per week?

PLACE OF BIRTH

☐ At this facility ☐ Home delivery Was home delivery planned? ☐ Yes ☐ No ☐ Unknown
☐ Other location (specify):_____
Specify address if not this facility:_____
No. & Street | Apt/Unit/Space | City | County | State | ZIP

PRENATAL

Mother's Medical Record # (optional):_____
Mother's Medicaid #:_____
Date of Last Menses (date of last period): ___/___/___ (MM DD YYYY)

Prenatal Care ☐ Check if none
Date of 1st visit ___/___/___ Total # of visits _____

Principal Method of Payment
☐ Medicaid/Oregon Health Plan ☐ Champus/Tricare
☐ Private insurance ☐ Other government
☐ Self-pay ☐ Other:_____
☐ Indian Health Services ☐ Unknown

Previous Live Births
now living_____ # now dead_____ Date of last live birth ___/___ (MM YYYY)

☐ Augmentation of labor ☐ Clinical chorioamnionitis diagnosed during labor or maternal temp. > = 38C ☐ Unknown
☐ Steroids for fetal lung maturation prior to delivery ☐ None of the above

DELIVERY

Method of Delivery
Fetal Presentation at Delivery: ☐ Cephalic ☐ Breech ☐ Other ☐ Unknown
Final Route and Method of Delivery: ☐ Vaginal/Spontaneous ☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean ☐ Unknown
If Cesarean, was a Trial of Labor Attempted? ☐ Yes ☐ No

Maternal Morbidity (check all that apply)
☐ Maternal transfusion ☐ Unplanned hysterectomy ☐ None of the above
☐ Third or fourth degree perineal laceration ☐ Admission to intensive care unit ☐ Unknown at this time
☐ Ruptured uterus

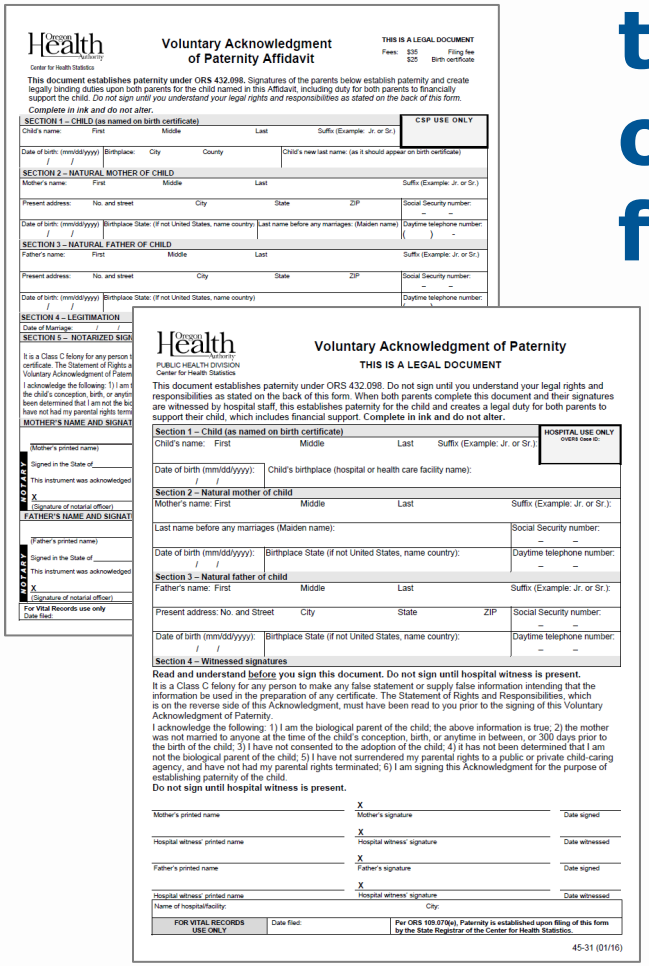
Mother transferred to this facility prior to delivery? ☐ Yes ☐ No If yes, name of facility_____
Infant transferred from this facility after delivery? ☐ Yes ☐ No If yes, name of facility_____

Last revised: March 2018

Hospital Staff
No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

2) Facility Worksheet:
Completed by the facility staff (BIS, Labor/Delivery Nurse)

Did you know there are two Acknowledgement of Paternity (AOP) forms?



Voluntary Acknowledgment of Paternity Affidavit

THIS IS A LEGAL DOCUMENT

Fees: $35 Filing fee, $25 Birth certificate

This document establishes paternity under ORS 432.098. Signatures of the parents below establish paternity and create legally binding duties upon both parents for the child named in this Affidavit, including duty for both parents to financially support the child. *Do not sign until you understand your legal rights and responsibilities as stated on the back of this form.*

Complete in ink and do not alter.

SECTION 1 – CHILD (as named on birth certificate) — CSP USE ONLY

Child's name: First Middle Last Suffix (Example: Jr. or Sr.)

Date of birth: (mm/dd/yyyy) Birthplace: City County Child's new last name: (as it should appear on birth certificate)

SECTION 2 – NATURAL MOTHER OF CHILD

Mother's name: First Middle Last Suffix (Example: Jr. or Sr.)

Present address: No. and street City State ZIP Social Security number:

Date of birth: (mm/dd/yyyy) Birthplace State: (if not United States, name country: Last name before any marriages: (Maiden name) Daytime telephone number:

SECTION 3 – NATURAL FATHER OF CHILD

Father's name: First Middle Last Suffix (Example: Jr. or Sr.)

Present address: No. and street City State ZIP Social Security number:

Date of birth: (mm/dd/yyyy) Birthplace State: (if not United States, name country) Daytime telephone number:

SECTION 4 – LEGITIMATION

Date of Marriage:

SECTION 5 – NOTARIZED SIGN

It is a Class C felony for any person t... certificate. The Statement of Rights a... Voluntary Acknowledgment of Paterni...

I acknowledge the following: 1) I am t... the child's conception, birth, or anytin... been determined that I am not the bio... have not had my parental rights term...

MOTHER'S NAME AND SIGNAT...

(Mother's printed name)

Signed in the State of

This instrument was acknowledged

X

(Signature of notarial officer)

FATHER'S NAME AND SIGNAT...

(Father's printed name)

Signed in the State of

This instrument was acknowledged

X

(Signature of notarial officer)

For Vital Records use only

Date filed:

Voluntary Acknowledgment of Paternity

PUBLIC HEALTH DIVISION
Center for Health Statistics

THIS IS A LEGAL DOCUMENT

This document establishes paternity under ORS 432.098. Do not sign until you understand your legal rights and responsibilities as stated on the back of this form. When both parents complete this document and their signatures are witnessed by hospital staff, this establishes paternity for the child and creates a legal duty for both parents to support their child, which includes financial support. **Complete in ink and do not alter.**

Section 1 – Child (as named on birth certificate) — HOSPITAL USE ONLY, OVERS Case ID:

Child's name: First Middle Last Suffix (Example: Jr. or Sr.):

Date of birth (mm/dd/yyyy): Child's birthplace (hospital or health care facility name):

Section 2 – Natural mother of child

Mother's name: First Middle Last Suffix (Example: Jr. or Sr.):

Last name before any marriages (Maiden name): Social Security number:

Date of birth (mm/dd/yyyy): Birthplace State (if not United States, name country): Daytime telephone number:

Section 3 – Natural father of child

Father's name: First Middle Last Suffix (Example: Jr. or Sr.):

Present address: No. and Street City State ZIP Social Security number:

Date of birth (mm/dd/yyyy): Birthplace State (if not United States, name country): Daytime telephone number:

Section 4 – Witnessed signatures

Read and understand before you sign this document. Do not sign until hospital witness is present.

It is a Class C felony for any person to make any false statement or supply false information intending that the information be used in the preparation of any certificate. The Statement of Rights and Responsibilities, which is on the reverse side of this Acknowledgment, must have been read to you prior to the signing of this Voluntary Acknowledgment of Paternity.

I acknowledge the following: 1) I am the biological parent of the child; the above information is true; 2) the mother was not married to anyone at the time of the child's conception, birth, or anytime in between, or 300 days prior to the birth of the child; 3) I have not consented to the adoption of the child; 4) it has not been determined that I am not the biological parent of the child; 5) I have not surrendered my parental rights to a public or private child-caring agency, and have not had my parental rights terminated; 6) I am signing this Acknowledgment for the purpose of establishing paternity of the child.

Do not sign until hospital witness is present.

Mother's printed name — X Mother's signature — Date signed

Hospital witness' printed name — X Hospital witness' signature — Date witnessed

Father's printed name — X Father's signature — Date signed

Hospital witness' printed name — X Hospital witness' signature — Date witnessed

Name of hospital/facility: City:

FOR VITAL RECORDS USE ONLY — Date filed: — Per ORS 109.070(4), Paternity is established upon filing of this form by the State Registrar of the Center for Health Statistics.

45-31 (01/16)

- Choose the right form:
- Hospital **45-31** or
- notarized affidavit **45-21**?

AOP's are required to establish paternity if the mom is unmarried at conception, delivery or within 300 days prior to delivery.

PUBLIC HEALTH DIVISION
Center for Health Statistics

Oregon Health Authority

Use AOP 45-31: Hospital or Birthing Center

Use AOP 45-31

- While the mother is **still a patient at the facility**
- It must be signed and dated WITHIN 5 days after the date of birth
- Must be signed and dated IN FRONT of birth facility witness

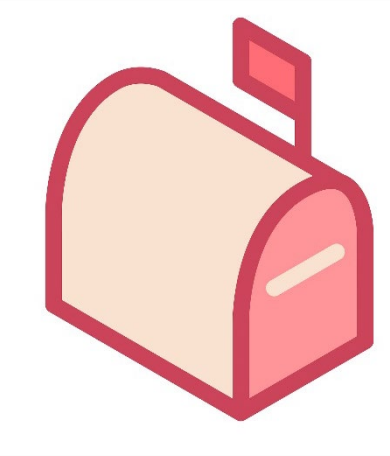
...OR

- Send parents home with the Affidavit 45-21 if the parents leave without signing the hospital form
- It must be signed before a notary

Responsibilities of the Birth Information Specialist or Midwives within a Facility:

- ✓ Provide the Voluntary Acknowledgment of Paternity (45-31) form.
- ✓ Ensure parents have heard the Rights and Responsibilities before completing form. They are found on the back of the form.
- ✓ Check the form for accuracy and completeness before submitting to the state.
- ✓ Make sure parents have signed and dated the form.
- ✓ Make sure the form is witnessed and dated by hospital staff.
- ✓ Make sure the dates the parents sign match the witness dates.

Submitting the AOP form to the State



- The form should be submitted as soon as possible – do not hold to mail in batches.
- Order and use white prepaid envelopes.
- The form ***must*** be mailed by the facility and **postmarked** within **14 days** of the child's date of birth.

Want more information on paternity establishment?

FAQ: Establishing Paternity

Paternity Forms and Instructions

Responsibilities of Birth Information Specialists: Reporting Fetal Deaths

What is a fetal death?

ORS 432.005 (14) "Fetal death" means death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, that is not an induced termination of pregnancy. The death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of the voluntary muscles.

Highlights of the laws and policies related to fetal deaths

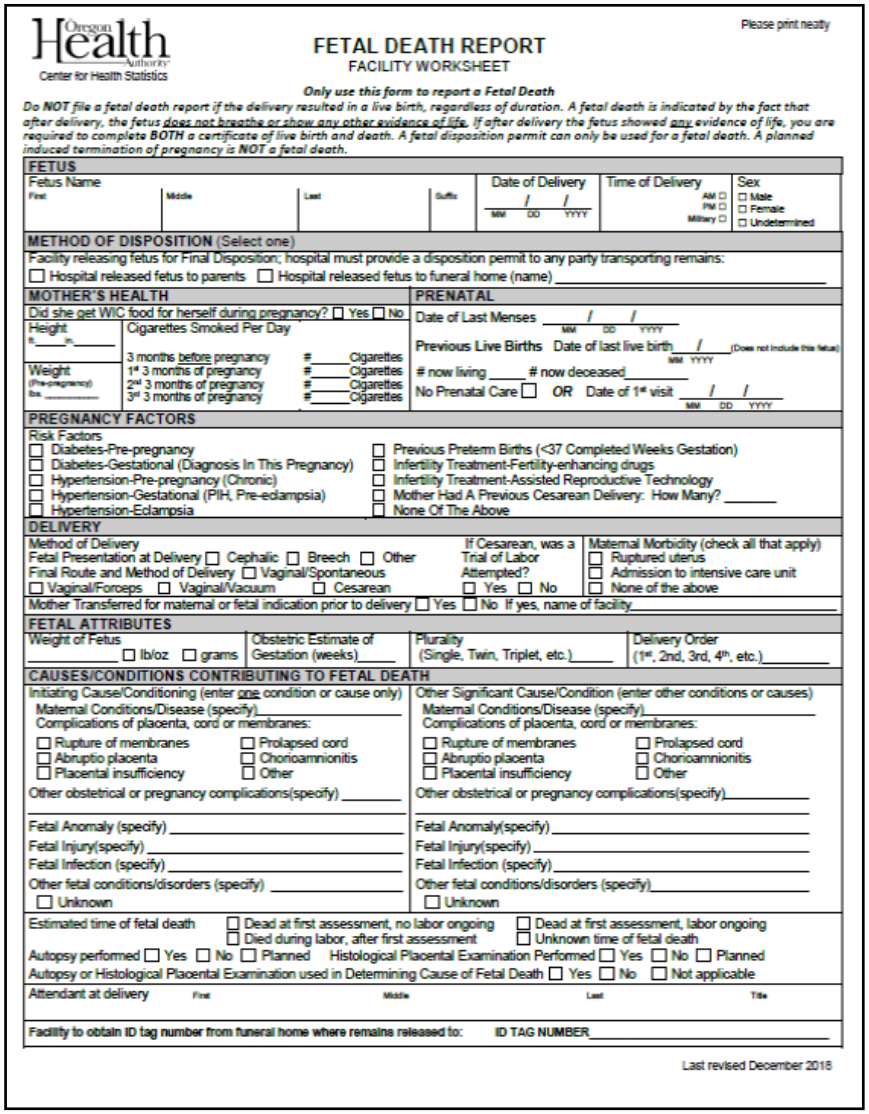
- All fetal deaths that occur in Oregon must be filed with the state.
- Each fetal death of 350 grams or more or if the weight is unknown, of 20 completed weeks gestation or more, must be submitted to the state within 5 calendar days after delivery.
- The hospital or licensed birthing facility where the fetal death occurred is responsible for filing the record with the state.
- Fetal deaths that occur in a hospital or licensed birthing facility must be filed electronically using OVERS.
- Information is gathered using the fetal death report worksheets.

Responsibilities of Birth Information Specialist: Fetal Deaths

- **432.143 Mandatory submission and registration of reports of fetal death; persons required to report; rules.** (1)(a) A report of each fetal death of 350 grams or more or, if the weight is unknown, of 20 completed weeks gestation or more, calculated from the date the last normal menstrual period began to the date of the delivery, that occurs in this state shall be submitted within five calendar days after the delivery to the Center for Health Statistics …
- (2) When fetal death occurs in an institution or on route to an institution, the person in charge of the institution or an authorized designee shall obtain all data required by the state registrar, prepare the report of fetal death, certify by electronic signature that the information reported is accurate and complete and submit the report as described in subsection (1) of this section.

For more information specific to Fetal Death

Visit our [Fetal Death website.]



Oregon Health Authority
Center for Health Statistics

Please print neatly

FETAL DEATH REPORT
FACILITY WORKSHEET

Only use this form to report a Fetal Death

Do NOT file a fetal death report if the delivery resulted in a live birth, regardless of duration. A fetal death is indicated by the fact that after delivery, the fetus does not breathe or show any other evidence of life. If after delivery the fetus showed any evidence of life, you are required to complete BOTH a certificate of live birth and death. A fetal disposition permit can only be used for a fetal death. A planned induced termination of pregnancy is NOT a fetal death.

FETUS

Fetus Name (First, Middle, Last, Suffix) | Date of Delivery (MM / DD / YYYY) | Time of Delivery (AM ☐ PM ☐ Military ☐) | Sex (☐ Male ☐ Female ☐ Undetermined)

METHOD OF DISPOSITION (Select one)

Facility releasing fetus for Final Disposition; hospital must provide a disposition permit to any party transporting remains:
☐ Hospital released fetus to parents ☐ Hospital released fetus to funeral home (name) _____

MOTHER'S HEALTH

Did she get WIC food for herself during pregnancy? ☐ Yes ☐ No

Height ft. ____ in. ____

Weight (Pre-pregnancy) lbs. ____

Cigarettes Smoked Per Day
3 months before pregnancy # ____ Cigarettes
1st 3 months of pregnancy # ____ Cigarettes
2nd 3 months of pregnancy # ____ Cigarettes
3rd 3 months of pregnancy # ____ Cigarettes

PRENATAL

Date of Last Menses ____ / ____ / ____ (MM DD YYYY)

Previous Live Births Date of last live birth ____ / ____ (Does not include this fetus) (MM YYYY)

now living ____ # now deceased ____

No Prenatal Care ☐ *OR* Date of 1st visit ____ / ____ / ____ (MM DD YYYY)

PREGNANCY FACTORS

Risk Factors
☐ Diabetes-Pre-pregnancy
☐ Diabetes-Gestational (Diagnosis In This Pregnancy)
☐ Hypertension-Pre-pregnancy (Chronic)
☐ Hypertension-Gestational (PIH, Pre-eclampsia)
☐ Hypertension-Eclampsia
☐ Previous Preterm Births (<37 Completed Weeks Gestation)
☐ Infertility Treatment-Fertility-enhancing drugs
☐ Infertility Treatment-Assisted Reproductive Technology
☐ Mother Had A Previous Cesarean Delivery: How Many? ____
☐ None Of The Above

DELIVERY

Method of Delivery
Fetal Presentation at Delivery ☐ Cephalic ☐ Breech ☐ Other
Final Route and Method of Delivery ☐ Vaginal/Spontaneous
☐ Vaginal/Forceps ☐ Vaginal/Vacuum ☐ Cesarean

If Cesarean, was a Trial of Labor Attempted? ☐ Yes ☐ No

Maternal Morbidity (check all that apply)
☐ Ruptured uterus
☐ Admission to intensive care unit
☐ None of the above

Mother Transferred for maternal or fetal indication prior to delivery ☐ Yes ☐ No If yes, name of facility ____

FETAL ATTRIBUTES

Weight of Fetus ____ ☐ lb/oz ☐ grams | Obstetric Estimate of Gestation (weeks) ____ | Plurality (Single, Twin, Triplet, etc.) ____ | Delivery Order (1st, 2nd, 3rd, 4th, etc.) ____

CAUSES/CONDITIONS CONTRIBUTING TO FETAL DEATH

Initiating Cause/Conditioning (enter one condition or cause only)
Maternal Conditions/Disease (specify) ____
Complications of placenta, cord or membranes:
☐ Rupture of membranes ☐ Prolapsed cord
☐ Abruptio placenta ☐ Chorioamnionitis
☐ Placental insufficiency ☐ Other
Other obstetrical or pregnancy complications(specify) ____
Fetal Anomaly (specify) ____
Fetal Injury(specify) ____
Fetal Infection (specify) ____
Other fetal conditions/disorders (specify) ____
☐ Unknown

Other Significant Cause/Condition (enter other conditions or causes)
Maternal Conditions/Disease (specify) ____
Complications of placenta, cord or membranes:
☐ Rupture of membranes ☐ Prolapsed cord
☐ Abruptio placenta ☐ Chorioamnionitis
☐ Placental insufficiency ☐ Other
Other obstetrical or pregnancy complications(specify) ____
Fetal Anomaly(specify) ____
Fetal Injury(specify) ____
Fetal Infection (specify) ____
Other fetal conditions/disorders (specify) ____
☐ Unknown

Estimated time of fetal death ☐ Dead at first assessment, no labor ongoing ☐ Dead at first assessment, labor ongoing ☐ Died during labor, after first assessment ☐ Unknown time of fetal death

Autopsy performed ☐ Yes ☐ No ☐ Planned Histological Placental Examination Performed ☐ Yes ☐ No ☐ Planned

Autopsy or Histological Placental Examination used in Determining Cause of Fetal Death ☐ Yes ☐ No ☐ Not applicable

Attendant at delivery (First, Middle, Last, Title)

Facility to obtain ID tag number from funeral home where remains released to: ID TAG NUMBER ____

Last revised December 2018

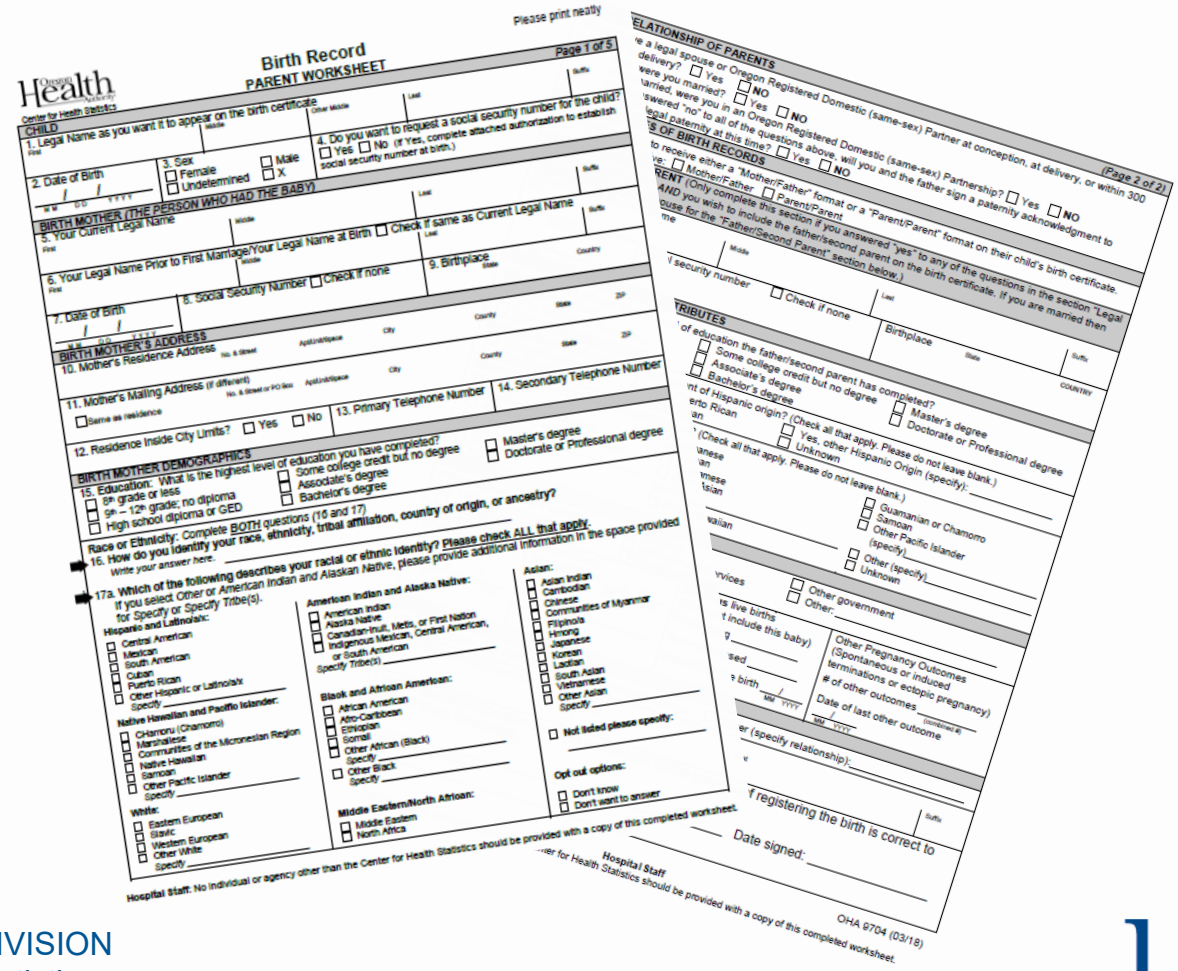
PUBLIC HEALTH DIVISION
Center for Health Statistics

Oregon Health Authority

The Oregon Vital Events Registration System (OVERS)

A brief introduction and live demonstration

Use the *Birth Record Parent Worksheet* to create a record in OVERS



Please print neatly

Birth Record
PARENT WORKSHEET

Page 1 of 5

Oregon Health Authority
Center for Health Statistics

CHILD
1. Legal Name as you want it to appear on the birth certificate
2. Date of Birth
3. Sex ☐ Female ☐ Undetermined ☐ Male ☐ X
4. Do you want to request a social security number for the child? ☐ Yes ☐ No (If Yes, complete attached authorization to establish social security number at birth.)

BIRTH MOTHER (THE PERSON WHO HAD THE BABY)
5. Your Current Legal Name
6. Your Legal Name Prior to First Marriage/Your Legal Name at Birth ☐ Check if same as Current Legal Name
7. Date of Birth
8. Social Security Number ☐ Check if none
9. Birthplace

BIRTH MOTHER'S ADDRESS
10. Mother's Residence Address
11. Mother's Mailing Address (if different) ☐ Same as residence
12. Residence Inside City Limits? ☐ Yes ☐ No
13. Primary Telephone Number
14. Secondary Telephone Number

BIRTH MOTHER DEMOGRAPHICS
15. Education: What is the highest level of education you have completed?
☐ 8th grade or less
☐ 9th – 12th grade; no diploma
☐ High school diploma or GED
☐ Some college credit but no degree
☐ Associate's degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate or Professional degree

Race or Ethnicity: Complete BOTH questions (16 and 17)
16. How do you identify your race, ethnicity, tribal affiliation, country of origin, or ancestry?
Write your answer here.

17a. Which of the following describes your racial or ethnic identity? Please check ALL that apply.
If you select Other or American Indian and Alaskan Native, please provide additional information in the space provided for Specify or Specify Tribe(s).

Hispanic and Latino/a/x:
☐ Central American
☐ Mexican
☐ South American
☐ Cuban
☐ Puerto Rican
☐ Other Hispanic or Latino/a/x
Specify

Native Hawaiian and Pacific Islander:
☐ CHamoru (Chamorro)
☐ Marshallese
☐ Communities of the Micronesian Region
☐ Native Hawaiian
☐ Samoan
☐ Other Pacific Islander
Specify

White:
☐ Eastern European
☐ Slavic
☐ Western European
☐ Other White
Specify

American Indian and Alaska Native:
☐ American Indian
☐ Alaska Native
☐ Canadian Inuit, Metis, or First Nation
☐ Indigenous Mexican, Central American, or South American
Specify Tribe(s)

Black and African American:
☐ African American
☐ Afro-Caribbean
☐ Ethiopian
☐ Somali
☐ Other African (Black)
Specify
☐ Other Black
Specify

Middle Eastern/North African:
☐ Middle Eastern
☐ North Africa

Asian:
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Communities of Myanmar
☐ Filipino/a
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ South Asian
☐ Vietnamese
☐ Other Asian
Specify

☐ Not listed please specify:

Opt out options:
☐ Don't know
☐ Don't want to answer

Hospital Staff: No individual or agency other than the Center for Health Statistics should be provided with a copy of this completed worksheet.

(Page 2 of 2)

ELATIONSHIP OF PARENTS
e a legal spouse or Oregon Registered Domestic (same-sex) Partner at conception, at delivery, or within 300 delivery? ☐ Yes ☐ NO
were you married? ☐ Yes ☐ NO
arried, were you in an Oregon Registered Domestic (same-sex) Partnership? ☐ Yes ☐ NO
swered "no" to all of the questions above, will you and the father sign a paternity acknowledgment to egal paternity at this time? ☐ Yes ☐ NO

S OF BIRTH RECORDS
to receive either a "Mother/Father" format or a "Parent/Parent" format on their child's birth certificate.
re: ☐ Mother/Father ☐ Parent/Parent
RENT (Only complete this section if you answered "yes" to any of the questions in the section "Legal AND you wish to include the father/second parent on the birth certificate. If you are married then ouse for the "Father/Second Parent" section below.)
me
Middle
Last
Suffix
security number ☐ Check if none
Birthplace
State
COUNTRY

TRIBUTES
of education the father/second parent has completed?
☐ Some college credit but no degree
☐ Associate's degree
☐ Bachelor's degree
☐ Master's degree
☐ Doctorate or Professional degree
nt of Hispanic origin? (Check all that apply. Please do not leave blank.)
erto Rican
an
☐ Yes, other Hispanic Origin (specify):
☐ Unknown
(Check all that apply. Please do not leave blank.)
anese
an
mese
sian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander (specify)
waiian
☐ Other (specify)
☐ Unknown
rvices
☐ Other government
Other:
s live births
include this baby)
g
sed
e birth
Other Pregnancy Outcomes (Spontaneous or induced terminations or ectopic pregnancy)
# of other outcomes
Date of last other outcome
(continued #)
er (specify relationship):
e
registering the birth is correct to
Suffix
Date signed:

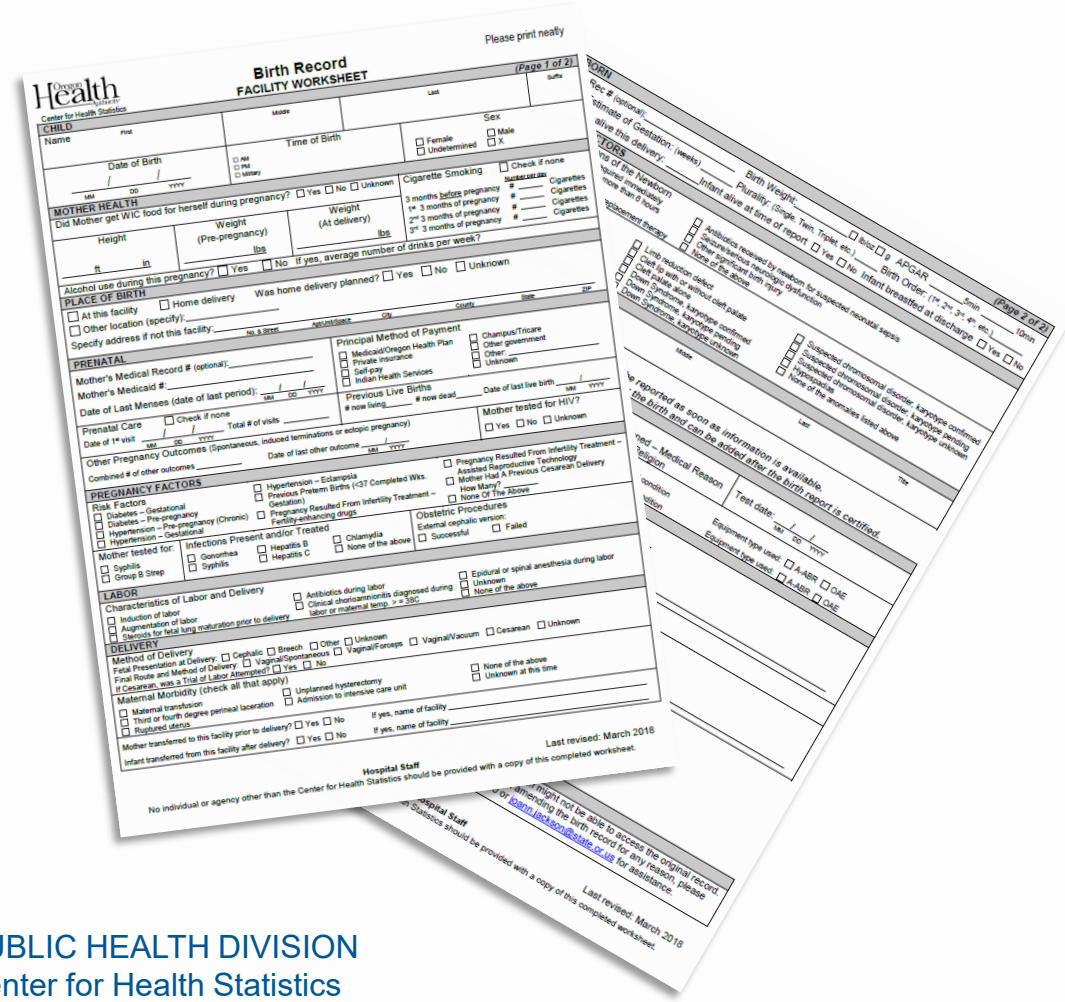
Hospital Staff
er for Health Statistics should be provided with a copy of this completed worksheet.

OHA 9704 (03/18)

PUBLIC HEALTH DIVISION
Center for Health Statistics

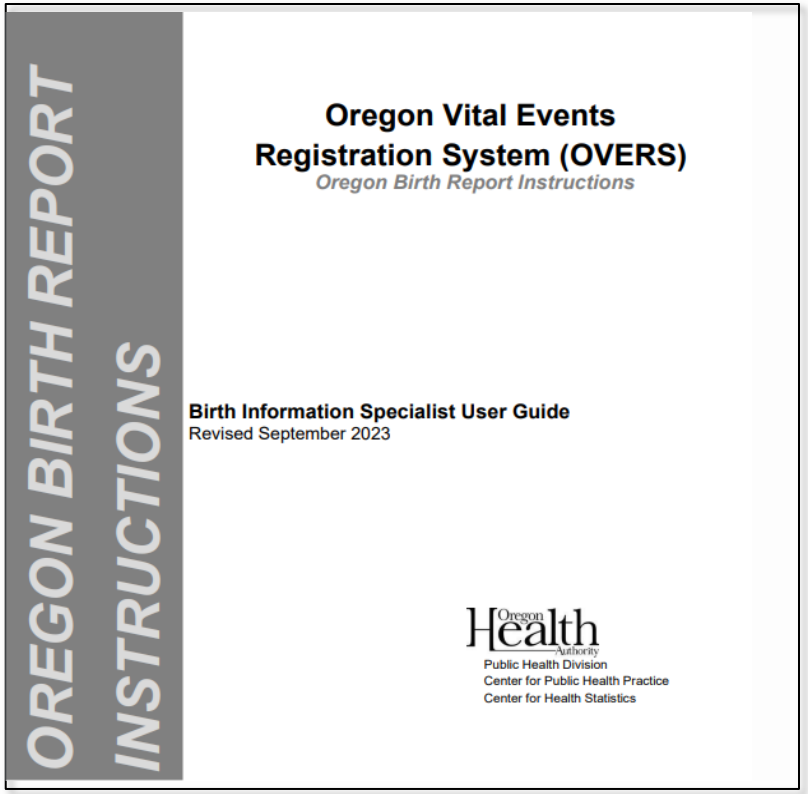
Oregon Health Authority

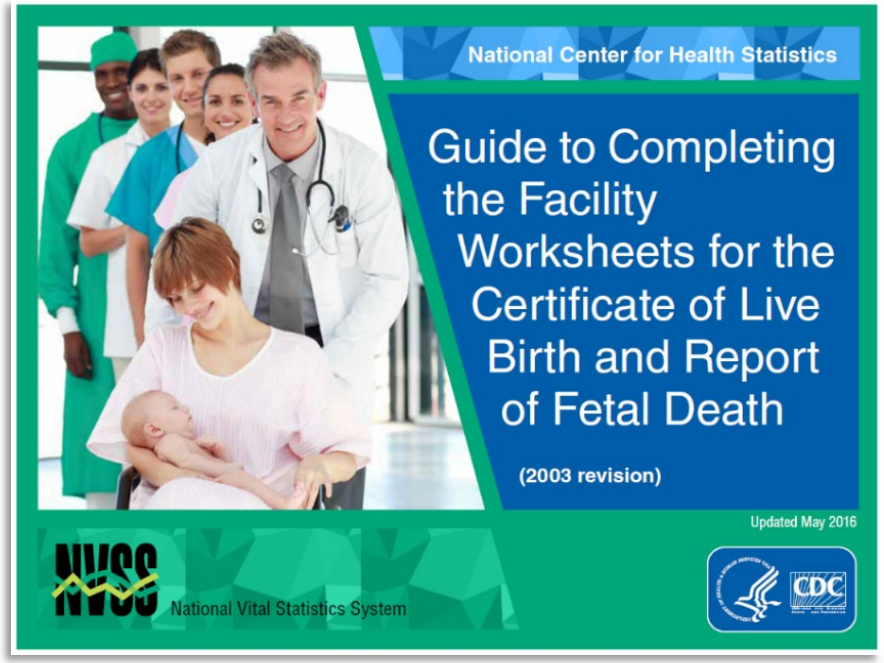
Birth Record Facility Worksheet and OVERS



- Consult with your facility about correct ways to gather information for the worksheet.
- Use the Guidebook to locate detailed definitions

Use the Guides for help with definitions.
Click the image to view the guides.





Watch the OVERS Demonstration Tutorial

[Click here for the OVERS Demonstration tutorial]

Learn how to:

- Become familiar with OVERS
- Enter a birth record
- What to do in case of errors
- Certify a record

Remember!

- ❑ Entries in OVERS create an official birth record.
- ❑ Review your entries for errors.
- ❑ Amendments are listed on the certificate permanently.
- ❑ Worksheets should inform OVERS entry.

Print your Certificate of Completion

- After completing this training and watching the OVERS Demonstration Tutorial, print your Certificate of Completion by clicking here.
- Enter your name on the certificate before printing it.


CERTIFICATE *of* COMPLETION

THIS ACKNOWLEDGES THAT

Enter BIS Name

HAS SUCCESSFULLY COMPLETED THE

Oregon Birth Information Specialist Training 2024

2024

Kathy Ellis *Vital Records Trainer*

Signatory Name, Signatory Title

Oregon Health Authority

Birth Information Specialist training from CDC Train

NEXT

Take the required eLearning training and print the certificate found at the link below:

Applying Best Practices for Reporting Medical and Health Information on Birth Certificates*

(Created by CDC Train).

***You must create a CDC Train account to receive a certificate at the end of the training.**

Login to CDC Train and complete your profile.

- You can find step-by-step instructions by clicking here.

Print the certificate for the Applying Best Practices for Reporting Medical and Health Information on Birth Certificates course.

- Click on the Certificate button which will appear when the course is complete.
- Click the download link.
- Print the certificate.

What is needed for an OVERS account

To complete your enrollment in OVERS

Fax the following completed documentation to 971-673-1201:

1. OVERS Enrollment Form
2. OVERS Training Certificate of Completion
3. Applying Best Practices Certificate from CDC Train.
4. Letter on letterhead from your supervisor granting you permission to access the records at your facility.
5. Two pieces of ID

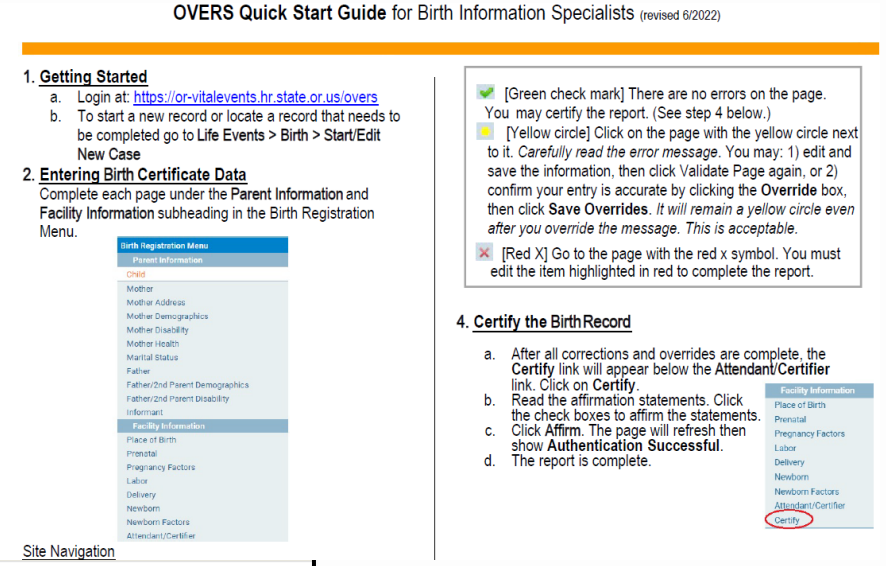
Once we receive the documentation, you will receive your OVERS log in and password information.

PUBLIC HEALTH DIVISION
Center for Health Statistics

Resources and Contacts

CHS Resources

- Quick Start Guide
- Birth Facility User Guide
- Instructions and Worksheets
- Birth Page



OVERS Quick Start Guide for Birth Information Specialists (revised 6/2022)

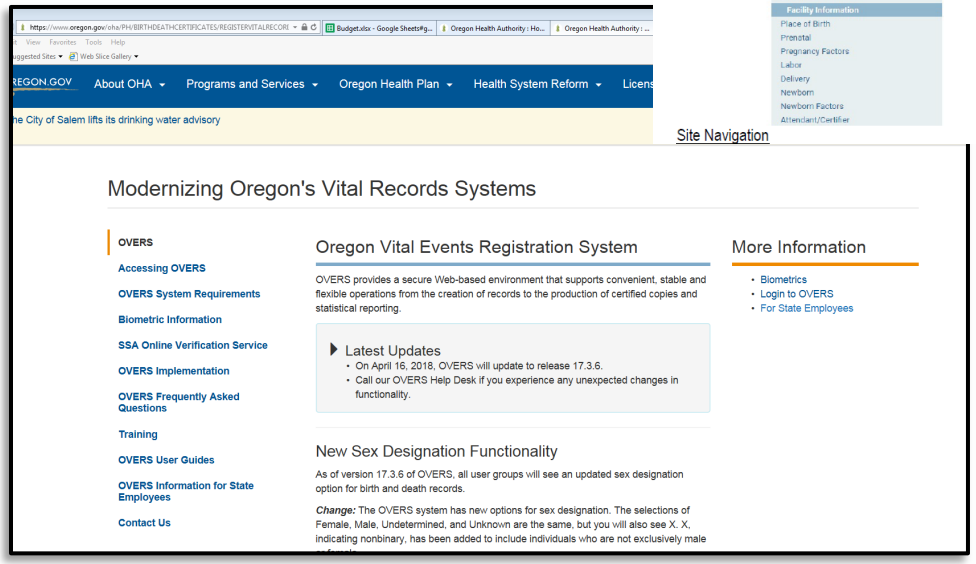
1. **Getting Started**
   a. Login at: https://or-vitalevents.hr.state.or.us/overs
   b. To start a new record or locate a record that needs to be completed go to **Life Events > Birth > Start/Edit New Case**
2. **Entering Birth Certificate Data**
   Complete each page under the **Parent Information** and **Facility Information** subheading in the Birth Registration Menu.

Birth Registration Menu
Parent Information
Child
Mother
Mother Address
Mother Demographics
Mother Disability
Mother Health
Marital Status
Father
Father/2nd Parent Demographics
Father/2nd Parent Disability
Informant
Facility Information
Place of Birth
Prenatal
Pregnancy Factors
Labor
Delivery
Newborn
Newborn Factors
Attendant/Certifier

[Green check mark] There are no errors on the page. You may certify the report. (See step 4 below.)
[Yellow circle] Click on the page with the yellow circle next to it. *Carefully read the error message*. You may: 1) edit and save the information, then click Validate Page again, or 2) confirm your entry is accurate by clicking the **Override** box, then click **Save Overrides**. *It will remain a yellow circle even after you override the message. This is acceptable.*
[Red X] Go to the page with the red x symbol. You must edit the item highlighted in red to complete the report.

4. **Certify the Birth Record**
   a. After all corrections and overrides are complete, the **Certify** link will appear below the **Attendant/Certifier** link. Click on **Certify**.
   b. Read the affirmation statements. Click the check boxes to affirm the statements.
   c. Click **Affirm**. The page will refresh then show **Authentication Successful**.
   d. The report is complete.

Facility Information
Place of Birth
Prenatal
Pregnancy Factors
Labor
Delivery
Newborn
Newborn Factors
Attendant/Certifier
Certify



Contacts

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