DELAWARE BIRTH DEFECTS REGISTRY

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

REGISTRY REPORTING FORM

The registry will collect information on all births after viability and any child under the age of five (5) who is a resident of the state of Delaware or whose parent is a resident of Delaware, and who is diagnosed at any time prior to age five (5) as having a birth defect.

CHILD INFORMATION

PLEASE PRINT

Child's Name: _____ (Last) _____ (First) _____ (MI) Date of Birth: ____/____/____ (MM/DD/YYYY)

Hospital of Birth: (or home or other)_____ Sex: _____M _____ F ____Undetermined

Child's Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____ Birth Weight: _____ g APGAR: 1 min ____ 5 min ____ 10 min ____ Gestational Age _____ wks.

Still Birth > 20 weeks ☐ Spontaneous AB ☐ Induced AB ☐ Neonatal Death (Birth to 28 days) ☐ Post-natal death 29-365days ☐

Race – check all that apply:

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

Ethnicity – Hispanic: ☐ Yes ☐ No

If Yes, please specify:

☐ Mexican, Mexican American, Chicano
☐ Puerto Rican
☐ Cuban
☐ Other: _____

Parent/Legal Guardian (name): _____ (Last) _____ (First) _____ (MI)

Address (if different than child): _____ City: _____ State: _____ Zip: _____

Primary Care Physician: _____ City: _____

Major Diagnosis: _____ ICD-9: _____ (Use separate sheet for other diagnoses)

Cytogenetic Studies performed: Yes ☐ No ☐
Comments:

Autopsy performed: Yes ☐ No ☐
Comments:

MOTHER INFORMATION

PLEASE PRINT

Summary of All Pregnancies
Total Previous Preg _____
Live Births _____
Still Births >20 wks _____
Spontaneous Abortions _____
Induced Abortions _____
Neonatal Deaths _____
Post Neonatal Deaths _____

During Pregnancy
Weight gained (lbs.) _____
Folic Acid Taken Y N
Vitamins Taken Y N
Other Medications/
Drugs Taken Y N
Details _____

Teratogenic Exposures Y N
Details:

Average # alcoholic _____ drinks / wk.
Cigarette usage _____ during pregnancy / day
Use 0 = none for both ques.

DIAGNOSTICIAN INFORMATION

PLEASE PRINT

Name: _____ (Last) _____ (First) _____ (MI) _____ (Title)

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: (____)_____ Fax: (____)_____ Licensure Type: _____

Specialty: _____ Subspecialty: _____

Facility where diagnosis was made:
_____ Private Practice (name): _____
_____ Specialty Clinic (name): _____
_____ Practice (name): _____
_____ Hospital (name): _____
_____ Other (name of facility): _____

Diagnostician Signature: _____ Reporting Date: _____

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SUBMIT TO: Delaware Division of Public Health, Birth Defects Registry
Attention: Newborn Screening Program
RETAIN A COPY 417 Federal St. Dover, DE 19901
FOR FILE Phone: 1-800-262-3030 or (302) 741-2990 Fax: (302) 741-8576

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Instructions for Completing the Delaware Birth Defects Registry Reporting Form

PATIENT INFORMATION

Child's name: last name, first name, middle initial **Date of Birth:** child's date of birth**,** month/day/year

Hospital of Birth: name of hospital where child was born, or home address, or other specifics

Sex: check male, female or undetermined

Child's address: street address, city, state, and zip code

Phone number: area code and phone number

Birth Weight: provide weight in grams at birth **APGAR:** provide score for 1 and 5 or 5 and 10 minutes

Gestation: write gestational week baby was born

Still Birth: only check one of these boxes if it is applicable

Race: check all that apply; fill in "other" if needed

Ethnicity: check Hispanic Yes, or No; If Hispanic Yes, check the origin listed, or fill in "other" if needed

Parent or legal guardian: last name, first name

Parent or legal guardian address: (if different than child's)

Primary Care Physician: name and city of practice for PCP

Diagnosis: brief description and ICD-9 code.

Cytogenetic Studies Performed: check appropriate box and add comments if applicable

Autopsy Performed: check appropriate box and add comments if applicable

Summary of All Pregnancies: please fill in all 7 lines. Lines 2-7 include this birth also

During Pregnancy: circle yes or no for each item and fill in names of medications/drugs on lines

Teratogenic Exposures: leave box empty if there were no teratogenic exposures. Fill in names of teratogens if exposure occurred in home, workplace or other

DIAGNOSTICIAN INFORMATION

Name: name of diagnostician: last name, first name, middle initial, title

Address: street address, city, state, and zip code

Phone number: area code and phone number **Fax number:** area code and phone number

Licensure Type: type of licensure, if any, attained by diagnostician

Highest Degree and Year Attained: highest degree and year attained by diagnostician

Specialty: diagnostician area of specialty **Subspecialty:** diagnostician area of subspecialty, if any

Facility where diagnosis was made: check type of facility and fill in name of facility where diagnosis was made

Diagnostician Signature: signature of the person/diagnostician who made the diagnosis

Please make a copy of this Reporting Form for your records. Fax or mail form to address given. Thank you.