Draft

WV Birth Score-Developmental Risk Screen And Newborn Hearing Screen

Delivery Hospital

Mother's Last Name

Mother's First Name

Mother's Maiden Name

Mother's SS #

Mother's Race: ○ White ○ Hispanic ○ Black ○ Mixed Race ○ Asian ○ Other

Payment Method
○ Insurance ○ WV Medicaid ○ Self-Pay ○ Other

Infant's Last Name

Infant's First Name

Infant's Birth Date __ / __ / __

Street Address

City

Parent Phone ___ - ___ - ____

○ WV ○ OH ○ KY ○ PA ○ MD ○ VA ○ Other

Zip Code

DEVELOPMENTAL RISK Automatic High Score
Answer each. Definition of abnormalities on back.

Birth Weight 1500 gms or less ○ YES ○ NO

5 Minute APGAR 3 or less ○ YES ○ NO

Congenital Abnormalities

ITEM	ANSWER CODE	SCORE
Birth Weight (grams)	○ <1501 (90) ○ 1501-2000 (77) ○ 2001-2500 (55) ○ 2501-3000 (10) ○ >3000 (0)	
Maternal Age	○ <17 (75) ○ 17-19 (60) ○ >19 (0)	
Infant's Sex	○ Male (40) ○ Female (0)	
Feeding Intention	○ Breast Only (0) ○ Bottle or Both (36)	
Previous Pregnancies	○ None (0) ○ 1-3 (3) ○ 4-6 (12) ○ 7-8 (18) ○ 9 or more (21)	
Maternal Education	○ 10th grade or lower (12) ○ 11th grade or above (0)	
Nicotine use during pregnancy	○ No (0) ○ Yes (12) ○ Smoking ○ Oral tobacco ○ Patch	

Gestational Age

Birth Score Total

High Birth Score is above 99.

PRIMARY CARE PHYSICIAN/CLINIC

City

Office Phone ___ - ___ - ____

○ WV ○ OH ○ KY ○ PA ○ MD ○ VA ○ Other

Zip Code

Was infant transferred to NICU?
○ NO ○ YES ○ Cabell Huntington ○ WVU Hospital ○ Women & Childrens ○ Other

QUESTIONS FOR MOTHER:

Which of the following substances / drugs have you used during pregnancy?
○ alcohol ○ methadone
○ cocaine ○ heroine
○ marijuana ○ methamphetamine

Please indicate if you experienced prolonged periods of stress during your pregnancy
○ Not at all
○ Yes, moderate stress
○ Yes, very stressed

Height - self reported by mom
ft inches

All in all, would you say your health is:
○ Excellent
○ Good
○ Fair
○ Poor

Have you ever been diagnosed by a physician with the following conditions?
○ Type I diabetes (juvenile type)
○ Type II diabetes (adult onset)
○ Gestational diabetes (pregnancy related)
○ I have never been diagnosed with diabetes

Mom's weight at admission

NEWBORN HEARING

1. **Type of Test:** ○ ABR ○ OAE
2. **Test Results:**
   Left Ear ○ Pass ○ Fail ○ Not Screened
   Right Ear ○ Pass ○ Fail ○ Not Screened
3. **Reason if not screened:** ○ Infant Death ○ Parent Refusal ○ Equipment Failure ○ Other

My baby's Birth Score, Developmental Risk Screen and Newborn Hearing Screen have been explained to me. I understand my baby may be eligible for a special service such as case management or early intervention.

For Office Use
____RFTS Region _____ ______Outreach county _________
____Birth to Three Site _______
____OMCFH Hearing Referral_______

Packet Sent _______Yes ______ No
Date ______________ Initials _________

Parent/guardian signature Date

Distribution Copies: BirthScore Office, Chart, Parent/Guardian

Witness' signature Date

GENERAL INSTRUCTIONS

Complete **ALL** items on the form using only blue or black ink. For block responses, clearly print only one number or letter per block.

Completely fill bubble responses (● correct response). Do not use check marks or crosses to mark through bubbles.

Enter your hospital/birth center three or four digit code in the space at the top of the form marked **Delivery Hospital.**

After all sections of the form have been completed, explain the baby's **Birth Score, Developmental Risk Screen and Newborn Hearing Screen** results to the baby's parent/guardian and obtain parent/guardian signature. Hand out appropriate education brochures.

At the time of the baby's discharge from the nursery, forward the Risk Screening form to the Birth Score Office.

BIRTH SCORE FACTORS

Fill in the bubble next to the appropriate response for each factor and enter the score value in the score boxes.

Previous Pregnancies: Count all pregnancies prior to this pregnancy. Include ectopic pregnancies, miscarriages and abortions.

Feeding Intentions: The score is based upon the mother's **original intent**. Did the mother plan to breast-feed or bottle-feed.

Nicotine Use During Pregnancy: If the response is yes, select those forms of nicotine used and fill in all bubbles (●) that apply.

Add the scores of the seven factors and enter the total. If the Birth Score is **100 or greater** this baby is a **HIGH SCORE** infant.

QUESTIONS FOR MOTHER

Five questions directed toward identification of maternal behaviors/conditions that potentially may affect a baby's health are included to help identify new information associated with unfavorable infant outcomes. **Encourage mothers to answer.**

Drug Use in Pregnancy: In addition to the mother's response, drug use already documented in the mother's medical record should be recorded on the form.

Stress during Pregnancy: Mothers should indicate if they have experienced prolonged periods of stress during their pregnancy.

Diabetes: Mothers should indicate if they have ever been diagnosed by a physician with diabetes. Diabetes already documented in the mother's medical record should be recorded on the form.

Self-perceived overall health: Mothers should indicate how their overall health is best described.

Height & Weight: Height and weight are asked to determine the mother's body mass index. Height should be self-reported by the mother. Weight should be documented at admission pre-delivery in the medical record. Weight should not be self-reported.

******All responses to these questions shall be kept strictly confidential and if the baby is eligible for referral to special services the responses to these questions shall not be shared.**

DEVELOPMENTAL RISK SCREEN

If there is an identified **Congenital Abnormality** or one or more **Yes** responses noted on the Developmental Screen, the baby is **AT RISK FOR DEVELOPMENTAL DELAY.**

Congenital Abnormality numeric codes: If the newborn has one or more of the following Congenital Abnormalities select from the list below **ONE** (1) condition that best describes the infant's risk for developmental delay and insert the number corresponding to that condition in the block provided.

01. Down Syndrome (Trisomy 21)
02. Other Trisomies (13,18)
03. Sex Chromosome Abnormalities (Examples include Fragile X, XXX, XYY, XXY)
04. Other Chromosomal Abnormalities (Examples include Cri Du Chat; deletions, duplications of chromosomes)
05. Seizures
06. Grade III or IV intracranial hemorrhages
07. Birth weight less than 10% for gestational age (SGA)
08. Microcephaly less that 5%
09. Neural tube defects (Examples include spina bifida, encephalocele)
10. Hydrocephaly greater than 95%
11. Sensory impairment (hearing loss, visual impairment, glaucoma, cataracts, etc.)
12. Malformation of the brain or spinal cord
13. Any other serious neurologic condition
14. Cleft Palate/Lip
15. Limb reduction abnormalities, skeletal dysplasias
16. Bronchopulmonary dysplasia (BPD)
17. Congenital infections (TOXO, CMV, Rubella, Herpes, HTLV III positive)
18. Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effect (FAE)
19. Fetal Hydantoin Syndrome
20. Metabolic disorders
21. Any diagnosed non-chromosomal syndrome