Introduction to

**Birth Registration in Minnesota**

Birth registration is important work. The birth registrar plays an essential, but often invisible, role in the life of a child as the creator of the birth record. Birth registrars also indirectly help research, social service agencies, public health, counties and the state through quality data reporting. And, when needed or requested, birth registrars assist families to establish paternity and communicate the parents’ desire to participate in the Social Security’s Enumeration at Birth program to receive an automatic Social Security number for the new baby. Occasionally, birth registrars are required to do some sad work too, as they must report data collected on fetal losses.

In the state of Minnesota, birth registration is governed by Minnesota Statute 144.215 as modified by Minnesota Rule 4601, which lays out specific requirements for birth registration in this state. The Statutes and Rules establish definitions, guidelines, requirements and uses for proper reporting of birth data. Births that occur anywhere in the state must be reported, without regard to the location of the event, meaning that births that occur in licensed birthing facilities, homes and other locations are all subject to the same Statutes and Rules.

On a national level, the Centers for Disease Control and Prevention’s (CDC) National Center for Health Statistics (NCHS) works with states to engineer the process through which vital statistics are produced in the US, including implementation of national standards for birth and death registration. The NCHS has studied the process of birth recording as well as the birth data to develop model law for national vital statistics gathering and use.

In 2011, the Minnesota Office of the Vital Records, in conjunction with the Minnesota Department of Health and in collaboration with NCHS, implemented the Minnesota Registration & Certification System (MR&C). This integrated web-based vital record system allows state and local registrars, funeral directors, physicians, medical examiners and their assistants, and hospital birth registrars to enter, maintain, and use birth and death data.
Collecting birth data

Although birth certificates display only the legal facts about the birth, birth records contain nearly 80 separate fields of data including medical information on the mother and child, and demographic data on one or both parents. Studies have shown that the mothers are the best source of information regarding parent demographics such as addresses, birth dates and places, education and race, but they are not the best reporters of their own medical information.

Although much data can be pulled from prenatal records and medical (electronic) health records and charts, delivery attendants are the preferred source for the following data fields:

- Maternal medical risk factors
- Onset of labor
- Infections during pregnancy or delivery
- Maternal morbidity
- Congenital anomalies of the baby
- Perinatal obstetric procedures
- Characteristics of labor and delivery
- Method of delivery
- Abnormal conditions of the newborn

Minnesota Department of Health does not find birth registrar chart review without additional medical training, to be a best practice for birth data reporting.

Worksheets have been created for use as data gathering tools for homebirth midwives and birthing facilities. These worksheets are available electronically from the Minnesota Department of Health’s website for birth registrars, located at:

http://www.health.state.mn.us/divs/chs/osr/birthreg/index.html. Reproducible copies are also included within this manual. These worksheets are designed to be separated for the intended sources of the data, into the Mother’s worksheet and Facility worksheets.

The mother’s worksheet collects demographic data about the parent(s) and provides a place to indicate the name she/they have chosen for the new baby. This document also introduces availability of paternity establishment at birth and provides a place for single mothers to indicate their desire to make this record public or confidential.
The facility worksheets are intended to be completed by the practitioners attending the delivery and/or staff with access to the mother’s medical records. This can often be done as a joint venture, with the birth registrar pulling data from prenatal records for clinician review, and then the birth attendant checks the appropriate data for this patient and this delivery. This team approach to birth registration will provide the most accurate record of the pregnancy and delivery.

**HIPAA and Data Privacy**

The Health Insurance Portability and Accountability Act’s (HIPAA) Privacy Rule regulates the use and release of protected health information and compliance is strictly monitored. Most HIPAA training provided by hospitals and health facilities is centered on why data cannot be released and what data is considered *protected health information*. However, public health use – and governmentally required data is integrated into this act, and *birth data disclosure is not a HIPAA violation.*

*HIPAA recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission....The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions.* Excerpted from Health Insurance Portability and Accountability Act, Privacy Rule; 45 CFR 164.512(b)(1)(i).

Additionally, Minnesota Statute 144.225 requires that personal, not-public data (such as birth records) be de-identified prior to release for research or study and HIPAA does not restrict the use or disclosure of health information that is de-identified. Birth data is treated very confidentially by MDH, and we are required by law to adhere to our own data privacy restrictions and policies.
Marital status and Paternity Establishment

Although determining the mother of the baby is relatively easy at the time of the baby’s birth, knowing whom to name as the father on a birth record is not always quite as simple.

A father’s name can be put on a child’s birth record only when he is the legal father – the man that the law recognizes as the father. A mother’s marital status as the time of her baby’s birth is an important factor for paternity establishment.

**Marital Status**

A mother’s marital status at the time of her child’s birth is an important factor in determining what information will go on her child’s birth record. A birth registrar must determine the mother’s marital status. Ask the mother if she is married or single. If she is single, ask if she has ever been married or divorced. If she says she is divorced or widowed, ask her when her divorce was final or when her husband died. Her word is enough for paternity establishment purposes – do not request documentation for her marital status.

NOTE: Paternity establishment documents such as the Recognition of Parentage (ROP) apply only to parents who are of the opposite sex – the mother who gave birth and the biological father.

**Married Mothers**

**MN Statute 257.55 PRESUMPTION OF PATERNITY.** Subdivision 1. A man is presumed to be the biological father of a child if:

(a) he and the child’s biological mother are or have been married to each other and the child is born during the marriage, or within 280 days after the marriage is terminated by death, annulment, declaration of invalidity, dissolution, or divorce, or after a decree of legal separation is entered by a court. The presumption in this paragraph does not apply if the man has joined in a recognition of parentage recognizing another man as the biological father under section 257.75, subdivision 1a;

In the state of Minnesota, the spouse of a married mother is presumed to be the parent of her baby. By statute, if a woman was married at any time during the 280 days preceding the
delivery (regardless of gestational age of the baby) the spouse is presumed to be the legal parent and should be named on the birth record.

If a mother is married, but her spouse (the presumed legal parent) is not the biological father, she and the biological father may complete and file a Voluntary Recognition of Parentage (ROP) form and the spouse may complete a Husband’s Non-Paternity Statement (HNPS). When this situation arises, birth registrars enter the names of both the spouse and the biological father in the appropriate fields to create a birth record. If both forms are valid, the biological father’s name will be recorded as the father on the child’s birth record.

**Married mothers who are not married to the father of the baby**

Because Minnesota presumes a spouse is the parent of the wife’s baby, additional documentation is required to accurately record the biological father if he is not the spouse. Replacing or removing the presumed parent (the spouse) from the birth record and adding the biological father requires a Recognition of Parentage (ROP) to be completed by the biological father and the mother together AND that a Husband’s Non-Paternity Statement (HNPS) is completed and filed by the spouse. Both forms must be filed with MDH. These forms can be completed and signed at different times and locations, but neither document will be filed (valid) until the ROP and the HNPS are both received and accepted at MDH.

A spouse has only one year after a child’s birth to file an HNPS. An ROP can be filed at any time after the child’s birth. If both documents are not filed (valid) then the only alternative for the mother, presumed parent, or biological father is to file an action in court.

**Same Sex Marriages**

Effective August 1, 2013, Minnesota defines civil marriage to include marriage between persons of the same sex and recognizes same sex marriages from other jurisdictions. This means married female couples’ names can both be entered on the birth record. Unless a court order is
presented, the gestational carrier’s information should be entered at the mother/parent 1, and her spouse’s information should be entered as the second parent on the birth record.

Married male couples can also be named on the birth record, but not at the time of birth. Follow the process for Unmarried Mothers, or Married mothers as appropriate.

**Unmarried Mothers**

An unmarried mother can be the sole parent on her child’s birth record if she chooses not to name a father or if she and the father do not complete an ROP. The birth certificate will be printed with the baby’s name and the mother’s name, but the second parent portion of the certificate will be blank. This is a legal and acceptable format for a birth record. The mother may choose to give her baby any name; including naming her baby after the biological father even when no ROP is completed.

Paternity may never be established and this child’s birth record may never show a father’s name. Or paternity may be established later if an ROP is filed or a court action orders it, and the child’s birth record will be updated to reflect the father’s name.

**MN Statute 257.75 RECOGNITION OF PARENTAGE** Subdivision 1
The mother and father of a child born to a mother who is not married to the child’s father nor to any other man when the child was conceived nor when the child was born may, in writing, signed by both of them before a notary public and filed with the state registrar of vital statistics, state and acknowledge under oath that they are the biological parents of the child and wish to be recognized as the biological parents. The recognition must be in the form prepared by the commissioner of human services under subdivision 5, except that it may also include the joinder in recognition provisions under subdivision 1a. The requirement that the mother not be married when the child was conceived nor when the child was born does not apply if her husband or former husband joins in the recognition under subdivision 1a.

Unmarried mothers can name a biological father on the birth record only if both parents complete a Recognition of Parentage (ROP) form together. Establishing paternity by signing and filing an ROP provides parents with certain rights and waives other legal rights, so it is important that parents understand what they are signing. Federal and state laws obligate hospitals to provide written and oral information about the rights and responsibilities
associated with establishing paternity with an ROP. The Minnesota Department of Human Services provides educational materials (DVDs and booklets) for parents at no cost to help with this communication. See the DHS website at [www.dhs.state.mn.us](http://www.dhs.state.mn.us) for more information or to order supplies.

The ROP must be signed by both parents in front of a Notary Public. Both parents must sign the same document, although they do not need to sign at the same time, date or in front of the same notary. Hospital staff should give each parent their own copy of the completed ROP document, including the signature page and the other three supporting pages. The signed and notarized form should be faxed to MDH for filing at [651-215-5834](tel:651-215-5834). If the father is not available to sign an ROP at the time of birth, the record should be filed with the mother and baby’s names and an ROP can be filed at a later date. There is never any cost to file an ROP, and there is no deadline or time limit. As long as both parents are living, an ROP can be filed. When ROPs are filed after a birth record is finalized (even after the first year), staff at the Office of Vital Records will update the father’s name on the child’s birth certificate without a fee.

**Divorced or widowed mothers**

If a mother is divorced or widowed, determine when her divorce was final or when her spouse died. If the marriage ended more than 280 days before her baby is born, the mother is considered single. If the divorce or death is recent – within 280 days of her baby’s birth, the mother would still be considered married for paternity establishment purposes. A mother’s word is enough. No documentation is required for paternity establishment purposes.

**Unmarried minor parents**

Unmarried parents who are younger than 18 years of age can sign a Recognition of Parentage form. Minor parents who sign a ROP should be treated the same way as parents who are 18 or older; they must be allowed to make their own decisions about establishing paternity through
this document. When minor parents sign the ROP, the father’s name can be placed on the record and he is presumed to be the legal father.

When filed, the ROP presumes that the man who signed the form is the father. The ROP is valid, but it will not be a final determination of paternity until the youngest of both parents turn 18½ years old, because they can petition a court to vacate the Recognition of Parentage.

**Revoking / rescinding / vacating ROP and HNPS**

Parents should sign ROPs and HNPS documents with the intention of permanence. If parents express any doubt, or desire to pursue paternity testing, they can file an ROP / HNPS later. Encourage these parents to wait to sign until after they get the information or answers they need. Ideally, birth registrars should give unmarried parents information about paternity establishment without the other parent present.

However, sometimes parents sign these forms with good intentions or they feel pressured to sign. Later, some parents wish to “undo” the forms for various reasons. The ROP and/or the HNPS can be revoked by either parent within 60 days of the date the form was executed (signed). When this happens, MDH will send a letter to the other parent to let them know that paternity establishment has been revoked. MDH will also change the child’s birth record without a fee. Revocation forms are available from the DHS website.

After 60 days, only a court order can “undo” either form. Different restrictions apply. Parents requesting to terminate paternity established through a Recognition of Parentage or ROP with Husbands Non-Paternity Statement can be referred to DHS or MDH for more information.

**NOTE:** If one or both parents sign the ROP at the hospital and they change their minds BEFORE the form is sent to MDH, do not prevent the form from being filed. Do not destroy the completed form. Fax the signed form to MDH and instruct the parent to complete a revocation
form. This is important so that the other parent is properly notified and their actions are properly documented.

**Replacement record**

If an ROP or an ROP and HNPS are filed after a birth record is finalized, the original birth record is replaced by a new one containing the new paternity information. There is no cost for this. The replaced (original) record is now confidential and is treated the same way as a record of birth prior to adoption. This means the record becomes invisible to the original owner of the record (the birth registrar or facility where the birth was recorded). Contact MDH for information about these records.

**Corrections to a record with an ROP or ROP & HNPS**

During the time that paternity establishment is pending (if any) a record is not available for corrections of any kind. If an ROP or an ROP and HNPS form are filed and the birth record is finalized, the facility that created the original birth record should limit corrections to minor spelling corrections or correcting medical, like time of birth. Do not make corrections to marital status, refer these to MDH.

**Surrogate Mothers**

If a woman is a surrogate, paternity may still be established. Follow the instructions based on the mother’s marital status. If the mother is a surrogate, an ROP and an ROP and HNPS can be completed and filed.

Sometimes in surrogacy situations, a court order is already in place with instructions for birth record data entry. If parents present a certified copy of a court order, birth registrars may enter
the record as directed in the court order. Use the surrogacy checkbox in the MR&C system, and fax a copy of the court order to MDH.

**Notary Tips**

Parents must sign the ROP form in front of a notary. Hospitals must provide an opportunity for parents to sign the ROP form at the hospital at the time of their child’s birth. Thus, hospitals are required to have notary publics accessible for their patients. Ideally, a notary will be available at all times to provide the best customer service to unmarried parents. However, around-the-clock notary resources may be unrealistic. If parents leave the hospital before a notary is available for them to sign the ROP, facilities should allow the parents to return to the hospital to sign the ROP forms.

It is the notary’s responsibility to identify the person signing the document. Follow the guidelines outlined by the Minnesota Secretary of State. Unless the person is known to you, check for photo identifications and don’t be afraid to refuse to notarize an ROP if the ID does not look right.

If either parent reveals the man is NOT the biological father, or if either parent has not read or heard information about establishing paternity through the ROP, do not notarize their forms. Obviously, if the notary is suspicious of fraud for any reason, he or she should refuse to notarize the signatures.

**Parent Questions & Resources**

Sometimes unmarried parents are overwhelmed with the birth event and all of the information and activities that follow. Family circumstances and relationships can be complicated. In addition, many unmarried parents are unaware of how birth record data is collected and that they will have an opportunity to establish paternity at the hospital. These parents may have questions. DHS does not expect hospital staff to know all of the many and sometimes involved
answers to these questions. However, DHS does expect birth registrars to provide resources to direct parents for assistance.

**Only one parent wants to sign the ROP**

The ROP is designed for both parents to voluntarily agree that a man is the biological father of a child. Both the mother and biological father must sign the same form. However, one parent can file an action to establish paternity through the courts.

If the FATHER desires to sign an ROP but the mother is unwilling, consider providing information to him about the Minnesota Father’s Adoption Registry (MFAR).

**Parents want genetic testing**

Establishing paternity by filing an ROP does not require genetic testing to prove a man is the biological father of a child. However, parents can have genetic testing before they sign the form. It is important for parents to understand that once the ROP is filed, they give up their right to genetic testing.

Many laboratories will do genetic testing. Parents may make appointments directly with the laboratory and they will arrange for the actual testing (usually a saliva swab). Results are generally available within a couple of weeks. In some cases, the county child support office may assist unmarried parents who are interested in genetic testing. Have the parent contact their county child support office for more information about this.

**Parents are concerned about financial support**

Establishing paternity is an important step – it establishes a legal relationship between a father and his child when the father is not married to the mother. Establishing paternity does not
create a financial obligation or child support order. Other actions must take place for a parent to be ordered to provide medical, childcare or child support. If a parent has questions about child support, refer the parent to their county child support office or direct them to the DHS website.

**Parents want to change their child’s name**

The ROP is a form that establishes paternity for newborns and older children – even adult children. When parents sign the ROP at the time of birth, the child does not yet have a birth record, so the name on the ROP form should match the name being created (filed) for the child on the birth record. If the ROP is signed after a child has a birth record (after the record has been finalized) the parents may change the child’s last name at the time they establish paternity with an ROP.

**Parents want a copy of the forms they signed**

Birth registrars are required to provide parents with a copy of the paternity paperwork they sign. For an ROP both the mother and the father should receive their own copy of the completed form – all 4 pages. For the HNPS, the spouse should receive his own copy of the completed form – all 3 pages. These are courtesy copies only. Parents should keep them for their own records.

If a parent returns later to get another copy, the birth registrar is not obligated to provide more copies. They may need certified copies for court. Direct the parent to the MDH website to request a certified copy of the ROP or HNPS. Only the state MDH office can supply certified copies. They are not available at the county registrar or license office. Fees apply.
Special Situations

Multiple Births

Entering a multiple birth record can be confusing – especially if not all babies were born at the same time or if not all babies were born alive. Here are some tips to help you enter multiple births:

Begin entering one of the babies (it does not matter if you begin with the first-born, but you may find it easier to keep things straight). Indicate the birth order of this child and how many babies were born of this gestation.

Enter the information as you would with any other birth.

If this child is the first-born of this pregnancy, enter mother’s live birth and other pregnancy outcome information only if she has had previous pregnancies.

If this child is the second-born (or greater) of this pregnancy, included the baby or babies that were delivered earlier in the live birth or other pregnancy outcomes as appropriate. The date of the last live birth/other outcome would be the date the earlier baby was delivered (usually the same day).

When you have finished entering one record, you do not have to finalize it (although you can). Save the record and then select Create Multiple Birth Record from the follow-on action drop-down menu. A new record will open that is pre-populated with the parent(s) data and mother’s medical information, ready for you to enter the next baby.

Adoptions

MN Statute 144.218 REPLACEMENT BIRTH RECORDS Subdivision 1 Adoption
Upon receipt of a certified copy of an order, decree or certificate of adoption, the state registrar shall register a replacement vital record in the new name of the adopted person. The original record of birth is confidential pursuant to section 13.02, subdivision 3, and shall not be disclosed except pursuant to court order or section 144.2252. The information contained on the original birth record, except for the
registration number, shall be provided on request to a parent who is named on the original birth record. Upon the receipt of a certified copy of a court order of annulment of adoption, the state registrar shall restore the original vial record to its original place in the file.

Most adoptions affect birth records long after the birth registrar has filed the record. This is done through the courts with an adoption decree at the time the legal adoption takes place.

Even if you know a baby will be adopted, generally the record is filed with the birth mother listed as the mother on the record. If she is married, her spouse will be listed as the other parent. If she is unmarried, the biological father can complete a Recognition of Parentage (ROP) form. It is beneficial for unmarried biological fathers to complete an ROP as this establishes a clean history of the birth and actually speeds up the adoption process because there is no need to search for a birth father.

The birth mother always has the right to name her baby, although sometimes she does not want to, or sometimes she will give the baby the name the adoptive parents have chosen. It is very common for the baby’s name to be legally changed during the adoption process. If the biological mother wishes to name her baby, you can reassure her that selecting a name (however temporary) will not slow down the adoption process.

There are different types of adoptions: Open adoption – the adoptive parents and the birth parents are known to each and have an ongoing relationship. A closed adoption is exactly the opposite – neither set of parents know anything about each other. Of course, there are variations like “semi-open” and “semi-closed” adoptions, too; but this does not affect your role with the birth record. It is easy to become confused by custody documents. Even if you see documentation releasing the child to the parents who intend to adopt the baby, you must follow your normal birth registration process with the gestational carrier/mother.

When an original birth record is replaced by adoption, the original record is confidential and unavailable to you, the originator of the record. Replaced records become invisible in MR&C and you will not be able to search for them or make any changes or corrections. A new birth record will be created by the Office of Vital Records to replace the original birth record.
**Surrogacy**

Surrogacy situations are handled very similarly to adoptions, except the parents are more likely to present a copy of a court order in the hospital.

If you receive a copy of a court order (not a letter from an attorney):
Court documents are difficult to understand. If you are presented with one, please fax it to MDH for review prior to entering the birth record. You do not need to see the original, unless you have doubts about the authenticity of the document. If the court order instructs you to enter the birth record with the “new,” “adoptive,” or “permanent” parents on the birth record, you may do so. The medical data on the birth record will be “unknown” unless the adoptive mother provides this information (this is rare). Check the Surrogacy check box in MR&C and enter the specifics from the court order in the new window that appears. Fax a copy of the court order to MDH at 651-201-5740.

If you do not get a copy of the court order:
Or if it has not yet been filed, enter the birth record with the delivering mother as the mother and all of her information on the record. If she is married, her husband will be listed as the father. If she is unmarried, the biological father can complete a Recognition of Parentage (ROP) form. The birth record will be replaced later through the legal adoption process.

**Same gender parents**

After August 1, 2013, civil marriage is defined to include marriage between persons of the same sex and recognizes same sex marriages from other jurisdictions. This will permit the addition of the second married parent’s name to their child’s birth records at the time of birth. Married female couples’ names can both be entered on the birth record. Married male couples will follow the process based on the marital status of the gestational carrier. Unless you receive a court order directing you to enter the birth record differently, enter the record with the delivering mother’s information. If she is married, her husband will be listed as the father. If the
husband is not the father, he can complete a Husband’s Non-Paternity Statement (HNPS) if a ROP is also completed by the mother and the biological father. If the biological father (sperm donor) is one of the “permanent” parents, he can sign a ROP with the mother. The other father will adopt the baby through the court. A ROP cannot be completed by the other mother (this form is specifically for biological fathers) she will adopt the baby through the court.

Foundling or Safe Haven babies

MN Statute145.902 SAFE PLACE FOR NEWBORNS; HOSPITAL DUTIES; IMMUNITY
Subdivision 1 General
(a) …A “safe place” means a hospital licensed under sections 144.50 to 144.56, a health care provider who provides urgent care medical services, or an ambulance service licensed under chapter 144E dispatched in response to a 911 call from a mother or a person with the mother’s permission to relinquish a newborn infant.
(b) A safe place shall receive a newborn left with an employee on the premises of the safe place during its hours of operation, provided that:
(1) the newborn was born within seven days of being left at the safe place, as determined within a reasonable degree of medical certainty; and
(2) the newborn is left in an unharmed condition.
(b) The safe place must not inquire as to the identity of the mother or the person leaving the newborn or call the police, provided the newborn is unharmed when presented to the hospital. The safe place may ask the mother or the person leaving the newborn about the medical history of the mother or newborn but the mother or the person leaving the newborn is not required to provide any information. The safe place may provide the mother or the person leaving the newborn with information about how to contact relevant social service agencies.
Subd. 2. Reporting.
Within 24 hours of receiving a newborn under this section, the hospital must inform the responsible social service agency that a newborn has been left at the hospital, but must not do so in the presence of the mother or the person leaving the newborn. The hospital must provide necessary care to the newborn pending assumption of legal responsibility by the responsible social service agency pursuant to section 260C.139, subd. 5.
Subd. 3. Immunity.
(a) A safe place with responsibility for performing duties under this section, and any employee, doctor, or other medical professional working at the hospital, are immune from any criminal liability that otherwise might result from their actions, if they are acting in good faith in receiving a newborn, and are immune from any civil liability that otherwise might result from merely receiving a newborn.
(b) A hospital performing duties under this section, or an employee, doctor, ambulance personnel, or other medical professional working at the hospital who is a mandated reporter under section 626.556, is immune from any criminal or civil liability that otherwise might result from the failure to make a report under that section if the person is acting in good faith in complying with this section.
Legislation about the Safe Place for Newborns or Safe Haven babies was created to protect babies and mothers with unwanted pregnancies and provide a way to legally care for the babies without prosecution for the mothers.

If a facility receives a Safe Place baby, they must report the acceptance of this infant to MDH within 24 hours. Documentation of a newborn physical examination may be required – this is usually a signature indicating an exam exists in the medical record. Do not attempt to create a birth record for this infant. MDH will search for possible duplicate birth records and create a new birth record.
Enter a birth record electronically

MN Statute 144.215 BIRTH REGISTRATION Subdivision 1. When and where to file.
A record of birth for each live birth which occurs in this state shall be filed with the state registrar within five days after the birth.
Subd. 2 Rules Governing birth registration.
The commissioner shall establish by rule an orderly mechanism for the registration of births including at least a designation for who must file the birth record, a procedure for registering births which occur in moving conveyances, and a provision governing the names of the parent or parents to be entered on the birth record

As per statute, births in Minnesota are registered electronically into the Minnesota Registration and Certification System (MR&C), a web-based integrated birth, death and issuance system implemented March 21, 2011. Access to MR&C is granted by MDH to authorized users only. Authorized users must sign an application and user agreement indicating their compliance and adherence to terms and conditions of use including protecting their password and user ID, limiting access to MR&C and printing documents from MR&C to business needs, as well and confidentiality agreements. Penalties exist for unlawful use of data and inappropriate system use.

The following pages in this section will explain how to enter a birth record in MR&C, with definitions from the National Center for Health Statistics (NCHS) where appropriate.
Basic information page

Sign in with your username and password. Click on the “Birth” tab and select “Enter birth record” from the Tasks menu. A new screen will appear:

![Image of the Enter birth record page]

1. Enter the child’s date of birth from the delivery record.

2. If you are entering the record prenatally, enter the estimated date of delivery (EDC) and check the "Pre-registered expected date of birth" box next to the date field. If you have received a court order (surrogacy or gestational agreement) with specific instructions for entering the maternal information, check the appropriate box and enter the requested information found on the court order.

3. Enter the mother’s current legal name and her name before any marriages (maiden name). Note that first and last names are required.
4. Enter mother’s medical record number – If you or your facility does not use medical record numbers, you may leave this blank or re-enter the last name.

5. Enter mother’s 9-digit Social Security Number numerically, without dashes. Disclosure of parent Social Security Numbers is required by state statute. If the Social Security Number is unknown, not available, or if the mother does not have one, please indicate by clicking the appropriate box.

6. Enter birth plurality – if this is a singleton birth, enter “single.” The next data field, order of birth, will become unavailable. If this birth is one of a multiple gestation, enter the total number of fetuses in this pregnancy, even if not all babies were born alive or if all babies were not born at this time.

7. Enter birth order – If this birth is part of a multiple gestation, enter the birth order of this baby, even if not all babies were born alive or born at this time.

8. Click the red **Save & Continue** button at the bottom of the page.

MR&C will automatically perform a duplicate check.

If no potential matches can be found, the user will be moved to the Child’s Birth Information page. If MR&C finds any records matching the same date of birth, mother’s name, Social Security and/or medical record numbers, the user will see a list of potential duplicates. Review this list carefully to ensure a duplicate record is not already in the system.
Childs Birth Information

Continue entering data about this birth

1. Enter the name of the child from the parents’ worksheet. The child’s first and last names are mandatory fields.
   - If the child does not have a middle name, simply leave this field blank. Do not enter “no middle name” or “NMN” as these will become part of the child’s legal name.
   - Hyphens and apostrophes are the only special characters allowed.

2. Enter the sex of the baby.

3. Using the drop-down menu, indicate if the parents want to apply for an automatic Social Security Number for the baby.
### Place where birth occurred

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
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<tbody>
<tr>
<td>Place of birth type *</td>
<td>HOSPITAL</td>
</tr>
<tr>
<td>Facility name *</td>
<td>ABBOTT NORTHWESTERN HOSPITAL</td>
</tr>
<tr>
<td>NPI number</td>
<td></td>
</tr>
<tr>
<td>State facility number</td>
<td></td>
</tr>
<tr>
<td>Country</td>
<td>UNITED STATES</td>
</tr>
<tr>
<td>State</td>
<td>MINNESOTA</td>
</tr>
<tr>
<td>County</td>
<td>HENNEPIN</td>
</tr>
<tr>
<td>City/Town</td>
<td>MINNEAPOLIS</td>
</tr>
<tr>
<td>Address 1</td>
<td>800 F 28TH ST</td>
</tr>
<tr>
<td>Address 2</td>
<td></td>
</tr>
<tr>
<td>Zip code</td>
<td>55407</td>
</tr>
<tr>
<td>Birth Recorded by *</td>
<td>MEDICAL FACILITY</td>
</tr>
<tr>
<td>Facility name *</td>
<td>ABBOTT NORTHWESTERN HOSPITAL</td>
</tr>
</tbody>
</table>

1. You have the ability to enter births that occurred in your facility, en route, or off-site. Select the type of facility (“HOSPITAL” or “RESIDENCE” for example) from the first drop-down list. In the second data field, if you select the name of the facility associated with your user id, the data fields will automatically populate.

2. If the birth occurred outside of the facility, select proper response from Place of birth type menu.

3. Country and State should default to United States and Minnesota. Select appropriate County from menu.

4. To enter the city where birth occurred, begin entering the name of the city, press the red Search button and select the name of the city from the drop-down menu. The name of the city must appear on the drop-down list for MR&C’s automatic linking and verification system to work. If the correct name is not on the list, select “other” and enter the name in the new data field.

5. Remember to also enter the place where the birth is recorded at the bottom of this section.

### Birth attendant’s information
1. If the delivery attendant is already linked to your facility, you may enter all or part of the attendant’s name or license number in one of the three fields across the top of the section and click the red **Search** button.

2. After searching, select the attendant from the drop-down list. This field cannot be left blank. The rest of the data fields will automatically pre-populate.

3. If the delivery attendant is not listed, such as the case when the father or someone from outside of the facility delivers the baby, choose “OTHER” from the Attendant’s license number drop-down list and then enter “none” in the new data field that appears.
   - Avoid entering “UNKNOWN” in the license number field as this deactivates all other fields in this section.
   - Select the title of the birth attendant from the drop-down menu if this field is not pre-populated.
   - If the delivery attendant has an NPI number, enter it in the appropriate field. This may be left blank if no number exists.

4. Enter the rest of the requested information: attendant names, address, and title.

5. Contact MDH to add new birth attendants to the list for your facility.

6. Click **Save** if you are leaving the page. You may return at any time.

7. Or click **Continue** to continue entering the same record. Clicking Continue will prompt you to save your work. Always save your work on every page.

Although the record is only partially complete, you may use any of the follow-on actions to convert this to a fetal death record, or view the birth record history to see who has searched for, printed, or entered data in this record. Selecting “View birth record” brings you into the record...where you are right now.
Child’s Medical Information Page

Continue entering data about this birth

1. Was the baby transferred within 24 hours of birth? Select “Yes” from the drop-down menu if the child was transferred to another facility for care. You will be prompted to choose the name of the receiving facility from the new drop-down list that opens.

2. Enter the baby’s medical record number. If no number is used, enter the baby’s last name or you may leave this field blank.

3. Baby weight - Select the unit of weight (pounds or grams) then enter baby’s birth weight as recorded. Gram weight is the preferred unit of measurement if available, but DO NOT convert pounds to grams for the birth record.

4. Gestation – enter the number of completed weeks of gestation as recorded by the delivery attendant.

5. Apgar score (5 Minutes) – enter the Apgar score at 5-minutes of age. The one-minute Apgar is no longer recorded. If the 5-minute Apgar is a seven or greater, a 10-minute Apgar is not needed and not required.

6. Apgar score (10 Minutes) – enter as recorded if applicable. If the baby was not scored at 10 minutes, select “not applicable”.

Child’s medical information

<table>
<thead>
<tr>
<th>Child’s Birth Information</th>
<th>Child’s Medical Information</th>
<th>Mother’s Demographic Information I</th>
<th>Mother’s Demographic Information II</th>
<th>Father’s Demographic Information</th>
<th>Mother’s Medical Information I</th>
<th>Mother’s Medical Information II</th>
<th>Finalize Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth record of:</td>
<td>BABY P TEST JRL</td>
<td>State file number:</td>
<td>State file number:</td>
<td>State file number:</td>
<td>State file number:</td>
<td>State file number:</td>
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<tr>
<td>Date of birth:</td>
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<td>Legal filing date:</td>
<td>Legal filing date:</td>
<td>Legal filing date:</td>
<td>Legal filing date:</td>
<td>Legal filing date:</td>
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</tr>
<tr>
<td>Birth record status:</td>
<td>UNFINISHED</td>
<td>Address verification status:</td>
<td>Address verification status:</td>
<td>Address verification status:</td>
<td>Address verification status:</td>
<td>Address verification status:</td>
<td>Address verification status:</td>
</tr>
</tbody>
</table>
Plurality – this field should pre-populate from the first data entry page. Select from the drop-down menu if the data is incorrect.

- Enter total number of infants and Birth Order – these fields should be pre-populated. Simply check to ensure the information is correct.

7. Mother’s Hepatitis B status – enter mother’s Hepatitis B surface antigen status from the prenatal or history and physical (H&P) records.

8. Hepatitis B vaccine given – if the baby received the first dose of the Hep B vaccine, select "Yes" and enter the date given.

9. Hepatitis B Immune Globulin (HBIG) given to baby? – HBIG is given to babies of Hepatitis B positive mothers and mothers with unknown Hep B status. If baby received the HBIG, select “Yes,” then enter the date and time given.

**Abnormal conditions of the newborn child** – this is a required field. Check all boxes that apply. If none of the conditions apply, check “none.”

- Assisted ventilation immediately following delivery – check this if the baby was given manual breaths with bag and mask, or bag and endotracheal tube, for any duration within the first several minutes of life. Do not include free-flow oxygen only or laryngoscopy for aspiration of meconium.

- Assisted ventilation required for more than 6 hours – select if the baby was given mechanical ventilation (breathing assistance) by any method for more than 6 hours. This includes conventional, high frequency and/or continuous positive pressure (CPAP).

- NICU admission – check this box if baby was admitted into a facility or unit staffed and equipped to provide continuous mechanical ventilatory support for a newborn.

- Newborn surfactant replacement therapy – select if the baby was given endotracheal instillation of a surface-active suspension for treating surfactant deficiency due to preterm birth or pulmonary injury resulting in respiratory distress. Includes both artificial and extracted natural surfactant.

- Antibiotics received for suspected neonatal sepsis – if the baby was given any antibacterial drug (penicillin, ampicillin, gentamicin, cefotaxime, etc.) systemically (intravenous or
intramuscular) specifically for treatment of suspected sepsis. Do not include antibiotics given for any other reason.

☐ Confirmed bacterial infection – check this box if baby has tested positive for any invasive bacterial infection such as Streptococcus (Strep B or A) Staphylococcus (Staph) Escherichia coli (e-coli), salmonella, etc.

☐ Seizure or serious neurologic dysfunction – any involuntary repetitive, convulsive movement or behavior or severe alteration of alertness. This excludes: lethargy or hypotonia in the absence of other neurologic findings and symptoms associated with CNS congenital anomalies.

☐ Significant birth injury – this refers to any skeletal fracture(s), peripheral nerve injury, and/or soft tissue or solid organ hemorrhage that requires intervention, which were present at or immediately following delivery. Include any bony fracture, weakness or loss of sensation, but exclude fractured clavicles and transient facial nerve palsy. Soft tissue hemorrhage requiring evaluation and/or treatment includes subgaleal (progressive extravasation within the scalp) hemorrhage, giant cephalohematoma, extensive truncal, facial, and/or extremity ecchymosis accompanied by evidence of anemia and/or hypovolemia and/or hypotension. Solid organ hemorrhage includes sub capsular hematoma of the liver, fractures of the spleen or adrenal hematoma.

☐ Anemia – check this box if anemia is documented in the baby’s chart. Hematocrit (HCT) and Hemoglobin levels are relative to size and gestational age of baby.

☐ Other – enter any other significant birth injury as applicable

**Congenital anomalies of the newborn** – this is a required field. Check all boxes that apply. If none of the conditions apply, check “none.”

☐ Anencephaly – partial or complete absence of the brain and skull. Also called anencephalus, acrania, or absent brain. Includes infants with craniorachischisis (anencephaly with a contiguous spine defect).

☐ Meningomyelocele/Spina Bifida – Meningomyelocele is herniation of meninges and spinal cord tissue. Meningocele (herniation of meninges without spinal cord tissue) should also be
included in the category. Both open and closed (covered with skin) lesions should be included. Spina bifida is herniation of the meninges and/or spinal cord tissue through a bony defect of the spine closure. Do not include Spina bifida occulta, which is a midline bony spinal defect without protrusion of the spinal cord or meninges.

- **Hypospadias** – incomplete closure of the male urethra resulting in the urethral metus opening on the ventral surface of the penis. Include first, second and third degree hypospadias (on the glans ventral to the tip, in the coronal sulcus or on the penile shaft).

- **Other urogenital anomalies** – include any other urogenital anomalies diagnosed at birth in this data field.

- **Cyanotic congenital heart disease** – any congenital heart defects causing cyanosis, including transposition of the greater arteries, tetratology of Fallot, pulmonary or pumonic valvular atresia, Tricuspid atresia, truncus arteriosus, total or partial anomalous pulmonary venous return with or without obstruction, coarctation of the aorta and hypoplastic left heart syndrome.

- **Congenital diaphragmatic hernia** – a defect in the formation of the diaphragm allowing herniation of abdominal organs into the thoracic cavity.

- **Omphalocele** – a defect in the anterior abdominal wall, accompanied by herniation of some abdominal organs through a widened umbilical ring into the umbilical stalk. The defect is covered by a membrane (different from gastroschisis) although this sac may rupture. Also called exomphalos. Do not include umbilical hernia (completely covered by skin) in this category.

- **Gastroschisis** – an abnormality of the anterior abdominal wall, lateral to the umbilicus, resulting in herniation of the abdominal contents directly into the amniotic cavity. Differentiated from omphalocele by the location of the defect and the absence of a protective membrane.

- **Limb reduction defect** – Complete or partial absence of a portion of an extremity, secondary to failure to develop. Exclude congenital amputation and dwarfing syndromes.
- **Polydactyly/syndactyly/adactyly** – check this box if any one of the following conditions are present: greater than five fingers or toes on one limb, partial or complete webbing or fusing together of two or more fingers or toes, absence of one or more fingers or toes.

- **Club foot** – one or both feet are turned inward and downward. Also called Talipes.

- **Other musculoskeletal integumental anomalies** – specify

- **Cleft lip** – incomplete closure of the lip. May be unilateral, bilateral or median.

- **Cleft palate** – incomplete fusion of the palatal shelves. May be limited to the soft palate, or may extend into the hard palate.

- **Down syndrome** – Check this box if Trisomy 21 is positive/confirmed or if possible Down syndrome karyotyping is ordered. Indicate if karyotype is confirmed or pending in the data field on the right.

- **Other suspected chromosomal disorder** – Check this box if other any other Trisomy or chromosomal disorder is confirmed or being tested. This includes any constellation of congenital malformations resulting from or compatible with known syndromes caused by detectable defects in chromosome structure. Indicate karyotype status in the data field on the right.

- **Other anomalies** – any other congenital anomalies not listed above

**Other information**

1. Was baby breastfed or fed breast milk during stay? Select appropriate response.

2. Was baby breastfed or fed breast milk at discharge? Select appropriate response.

3. Was infant alive at the time of filing record? Select appropriate response.

   If yes, the baby was alive, click **Save** if you are leaving the page. You may return at any time. Or click **Continue** to continue entering the same record. Clicking Continue will prompt you to save your work. Always save your work on every page.

   If your answer is *No, the baby was not alive at filing*; more questions will appear to indicate disposition information for the baby.
1. Enter the country and state of the funeral home by using the drop-down menus.

2. To enter the city, begin entering the name of the city, press the red **Search** button and select the name of the city from the drop-down menu. The name of the city must appear on the drop-down list for MR&C’s automatic linking and address verification system to work. If the correct name is not on the list, select “other” and enter the name in the new data field.

3. Funeral homes are linked to the city in which they are located. If you do not see the name of the funeral home, try a different city or enter “other” and enter the name of the funeral home the family has chosen.

4. When the disposition information is complete, click **Save** or **Continue** to continue entering the same record. Clicking Continue will prompt you to save your work. Always save your work on every page.
Mother’s Demographic Information I Page

Continue entering data about this birth.

Mother’s information

Mother’s legal name and name prior to first marriage - These fields should be pre-populated from data entered on the first page of this record. You can make corrections on this page if necessary. If you have received a court order (surrogacy or gestational agreement) specifically instructing you to enter the maternal information differently, check the box and enter the data from the court order in the new window.

1. Mother’s date of birth – enter date in mm/dd/yyyy format (with slashes). The “Age at the time of child’s birth” field will automatically populate with her calculated age.
2. Social Security Number – this should be pre-populated. Review the number and change it here if you need to make any corrections.
3. Enter the mother’s place of birth by selecting the country of her birth from the drop-down menu. Do the same thing to locate the state (if applicable) where she was born.
To enter the city, begin entering the name of the city, press the red **Search** button then select the name of the city from the drop-down menu. *This is a mandatory field.*
If the correct city name is not on the list, select “other” and enter the name in the new data field.

**Mother’s residence address** – the country and state of the mother’s residence will default to United States and Minnesota; change them using the drop-down menus if appropriate.

4. Select the county of mother’s residence from the drop-down menu.

5. To enter the city or township of mother’s home, begin entering the name of the city, press the red **Search** button and select the name of the city or township from the drop-down menu. The name must appear on the drop-down list for MR&C’s automatic linking and address verification system to work.

   - If you are unable to search for the city or township, you may need to change the spelling or change or remove the name of the county from the field above.

6. Continue entering the street address, apartment number (if applicable) and zip code.

7. Indicate if this address is within city limits.

**Mother’s mailing address** – follow the instructions above for entering mother’s mailing address.

Or, if the mailing address is the same as the residence address, click **Copy mother’s residence**.

---

**Other information**

1. Did mother get WIC food during this pregnancy? The Women, Infants and Children’s food assistance program is collecting data about its effectiveness and the effect on newborn outcomes. Please indicate if mother used their services and if so, what prenatal month (first through ninth) did she start? Select the appropriate answer from the drop-down menus.

2. Smoking – indicate if mother smoked at any time during the pregnancy or in the three months before conception. If yes, select “cigarettes” or “packs” and indicate quantity.
used during each of the 4 trimesters. This data will help researchers study the effect of quitting smoking during a pregnancy.

Click **Save** and log out, or **Continue** then OK to continue entering data.
Marital Status and Paternity Information

1. Was mother married at any time during this pregnancy?
   - If she was married at any time during the 280 days prior to delivery she is considered married and the answer is “yes” (even if she is divorced or widowed by delivery time). The legal husband is presumed to be the father of the baby.
   - If mother was unmarried – Select “no.”
   - If the mother was married, but not to the baby’s father, select “yes.”

2. Will paternity forms be submitted? –
   - If mother is married to the baby’s father, select “no.”
   - If mother is not married and does not wish to establish paternity at this time or if the father is not available, select “no.”
   - If mother is not married and both parents wish to complete a Voluntary Recognition of Parentage (ROP) form, answer “yes”
• If mother is married, but not to the baby’s father – answer “yes’ if the mother and biological father will complete a ROP AND the husband will complete a HNPS.

• If the mother is married, but not to the baby’s father and she does not wish to establish paternity or if either the father or the husband will not be completing a ROP or HNPS, answer “no” NOTE – the birth registrar will have to enter “unknown” in the father’s demographic data fields if this option is selected.

Minnesota Voluntary Recognition of Parentage (ROP) forms can be printed from MR&C (enter baby’s name and both parents’ data first) using the follow-on action located at the bottom of each page. Completion of ROP will allow you to put the father’s information on the birth record for unmarried parents and give the biological father certain rights. See the DHS website for more paternity information. Husband’s Non-Paternity Statement (HNPS) forms can be printed from MR&C (enter the baby’s name, the husband’s and both parents data first) using the follow-on action located at the bottom of each page. Both the ROP and the HNPS forms are required to remove the husband’s data from the birth record and replace it with the father’s data. See the DHS website for more paternity information.

3. Public Record? – Birth records for babies born out of wedlock can be “Confidential” or “Public” records.

• A public birth record can be viewed by anyone and obtained by the child or parents, a grandparent or child of the subject, an attorney or someone with a court order. See the MDH website for details.

• A confidential birth record cannot be viewed or shared. Purchasers of this birth certificate are limited to, for example, the subject of the record at age 16, the mother or father listed on the record, a representative of DHS, or someone with a court order. See the MDH website for details.

• Birth records for babies born to married parents are always public records unless paternity documents are submitted. See the MDH website for details.

Mother’s educational information
Select the description on the drop-down menu that best fits the highest level or degree of completed (not intended) education at the time of delivery. Select only one response.

**Mother’s Hispanic origin and race information**
Check the boxes that correspond to the mother’s responses on the worksheet. Check as many boxes as applicable. Do not “correct” her assessment of her racial or national identity.

Click **Save** and log out, or **Continue** then OK to continue entering data.

If you have entered “No” to both the marriage and the paternity documents questions, the system will ask if you want to disable the father’s demographic page. Selecting OK will allow you to skip data entry on this page.

If you select Cancel, the system will force you to enter data in the father’s demographic page, but you can return to the Mother’s demographic II page, select Continue at the bottom of the page to reset the question, if needed.
Father’s Demographic Information Page

Continue entering data about this birth.

Father’s Information

1. Father’s name – enter the father’s legal name. First and last names are mandatory.
   - If he identifies himself with a suffix (Jr., Sr. III, etc.) select that from the drop-down list.
   - If this birth causes the father to begin identifying himself as a Sr., you may add that to his name now.

2. Father’s date of birth – enter date in mm/dd/yyyy format (with slashes). The “Age at the time of child’s birth” field will automatically populate with his calculated age.

3. Social Security Number – enter the nine digit Social Security Number numerically, without dashes. Disclosure of parent Social Security Numbers is required by state statute. If the Social Security Number is unknown, not available, or if the father does not have one, indicate by clicking the appropriate box.

4. Birth place – enter the father’s place of birth by first selecting the country of birth from the drop-down menu. Do the same thing to locate the state (if applicable) where he was born. To enter the city, begin entering the name of the city, press the red search button then select the name of the city from the drop-down menu. This is a mandatory field. If the correct name is not on the list, select “other” and enter the name in the new data field.
**Father’s mailing information**

5. The father’s mailing address is required, and especially important when filing Recognition of Parentage and Husband’s Non-paternity Statements.

6. If both parents live at the same address, use the Copy mother’s mailing address button to automatically populate this section.

7. If the father’s mailing information is different from the mothers, begin entering the address by selecting the country, state and county using the drop-down menus if appropriate. To enter the city, begin entering the name of the city and press red Search button. Select the name of the city from the drop-down menu.
   
   - The name of the city or township must appear on the drop-down list for MR&C’s automatic linking and address verification system to work. If you do not see the name of the city, try changing the spelling of the city or township, or changing or removing the name of the county above to search for it.
   - Continue entering the street address, apartment number (if applicable) and zip code.

8. Indicate if this address is within city limits.

**Father’s educational information**

9. Select the description on the drop-down menu that best fits the highest level or degree of completed (not intended) education at the time of delivery

**Father’s Hispanic origin and race information**

10. Check the boxes that correspond to the responses on the worksheet. Check as many boxes as applicable. Do not “correct” the parent’s assessment of his racial or national identity.

Click Save and log out, or Continue then OK to continue entering data.
Mother’s Medical Information I Page

Continue entering data about this birth.

Mother’s prenatal information The prenatal care record is the preferred source for answers to these questions. If this record is not available, please contact the prenatal care provider and obtain a current copy of the record before completing these data fields.

1. Did mother receive prenatal care – select the appropriate response.

2. Date of first visit – enter the date a physician or other health care professional first examined and/or counseled the pregnant woman for the pregnancy. Enter the month, day and year in the separate fields. Months are entered by name, dates and year are numeric (i.e. 1/6/10 is entered as January 06 2010). If the exact date is not available, enter “unknown” in one or all of the data fields. TIP – if you are unable to enter data in these fields, it is because the mother’s date of birth is not completed. Go back and complete the mother’s date of birth on the Mother’s Demographic I page, then return to this page to complete the previous pregnancy fields.

3. Date of last visit – enter the last or most recent date a physician or other health care professional examined and/or counseled the pregnant woman for the pregnancy.
4. Total number of prenatal visits – this is the total number of visits recorded in the medical record. Count only recorded visits; do not estimate additional visits when the prenatal record is not current.

5. Month prenatal care began – enter “first”, “second” etc. to correspond with the month of pregnancy in which the first prenatal visit occurred.

Mother’s height and pre-pregnancy weight – this data is used to calculate BMI (Body Mass Index) which affects the recommended weight gain for the pregnancy.

6. Enter the mother’s height in feet and inches.

7. Enter the mother’s pre-pregnancy weight or weight at first prenatal visit. If prenatal care was limited or absent, this data may not be obtainable.

8. Mother’s weight at delivery – enter the most recent weight available. (This may be the weight at the last prenatal visit.) If prenatal care was limited or absent, this data may not be obtainable.

9. Date last normal menses – find this in the prenatal record or admission H&P. Enter all known parts of the date the mother’s last normal menstrual period began. If no parts of the date are known, select “unknown” in each of the three fields. This item is used to compute the gestational age of the infant.

Mother’s live birth information – this section records all babies born alive to this mother.

10. Number of previous live births now living – include all babies (if any) born to this mother who are still living at the time of this birth. Do not include this baby. For multiple deliveries, include live born babies delivered before this one in the pregnancy. If no previous live births, select “none.”

11. Number of previous live births now dead – record the number of babies who were born alive and have died (if any) at the time of this birth. Do not include this infant. If this is a multiple delivery and a baby delivered prior to this one was born alive but died before this baby was born, include that baby in the number recorded.

12. Date of last live birth prior to this baby – If applicable, enter the year and month of birth of the last live-born infant. Include the most recent live birth – even if that baby is now
If this baby is part of a multiple gestation and is not the first-born, today’s date can be recorded.

**Mother’s other pregnancy outcomes** – this section records all pregnancy losses.

13. Number of other pregnancy outcomes – enter the total number of pregnancies that did not result in a live birth. Include pregnancy losses of any gestational age. Include spontaneous or induced abortions, ectopic pregnancies, tubal and molar pregnancies, miscarriages, IUFD.

14. Date of last other pregnancy outcome – enter the date of delivery or termination of the most recent pregnancy that did not result in a live birth.

**Risk Factors of this pregnancy** – the mother may have had more than one risk factor. Check all boxes that apply. If the mother has none of these risk factors, check “None.”

- Diabetes – if diabetes is present, check either pre-pregnancy or gestational diabetes. Do not check both.
- Hypertension – if hypertension is present, check either pre-pregnancy or gestational hypertension. Do not check both.
- Eclampsia – this is hypertension with proteinuria with generalized seizures or coma, which may include pathologic edema. If eclampsia is present, one type of hypertension (gestational or chronic) may be checked.
- Infertility treatments – if this pregnancy is the result of infertility treatments, check the box and a second and third option will appear. Check the appropriate box to indicate if this pregnancy was the result of fertility enhancing drugs, artificial insemination or intrauterine insemination. Or, indicate if this pregnancy is the result of assisted reproductive technology such as in-vetro fertilization (IVF), gamate intra-fallopian transfer (GIFT), Zygote intra-fallopian transfer (ZIFT), donor embryo, or embryo adoption.
- Anemia – check this box if maternal anemia is present.
☐ Previous preterm birth – check this box if this mother has a history of any pregnancies ending in a live birth at less than 37 completed weeks of gestation.

☐ Other previous poor pregnancy outcomes – indicate any history of pregnancies continuing at least 20 weeks of gestation and resulting in perinatal death, small for gestational age (SGA), or intrauterine growth restricted (IUGR) birth. Include any gestational losses at 20 weeks or greater, regardless of whether the baby was born alive or not.

☐ Other risk factors – enter any other risk factors noted in the prenatal or delivery record but not recorded above.

Toxicology

15. Mother’s drug usage information – select answer “Yes” if any toxicology tests were administered to either mother or baby to screen for non-medical or prescribed drugs or chemicals. Include meconium toxicology screens. Specify any positive results or indicate if confirmative tests are still pending. If known, list the names of the drugs.

Payment information

16. The mother’s medical information number should automatically pre-populate with the data from the earlier page. Select the type of insurance or assistance used by the mother for payment of this delivery. This information is usually available from the admitting office or hospital face sheet.

Click [Save] and log out, or [Continue] then OK to continue entering data.
Infections present/treated this pregnancy – include infections present at the time of pregnancy finding, or any confirmed diagnosis during the pregnancy with or without documentation of treatment. Documentation of treatment during this pregnancy is adequate if definitive diagnosis is not present in the medical record. Check all boxes that apply. The mother may have more than one infection.

- [ ] Chlamydia
- [ ] Genital herpes
- [ ] Gonorrhea
- [ ] Group B Streptococcus (GBS, Group beta Strep)
- [ ] Hepatitis B (HPV, serum hepatitis)
- [ ] Hepatitis C (non-A, non-B hepatitis, HCV)
- [ ] Syphilis
- [ ] HIV positive

Perinatal obstetric procedure – record medical treatments or invasive/manipulative procedures performed during this pregnancy to treat the pregnancy or to manage labor and/or delivery. Check all boxes that apply. The mother may have more than one procedure.
- Cervical cerclage – banding or suture of the cervix to prevent or treat passive dilatation, incompetent cervix or incompetent os. Includes: MacDonald’s suture, shirodkar procedure, abdominal cerclage via laparotomy.

- Tocolysis – administration of any agent with the intent to inhibit preterm uterine contractions to extend the length of the pregnancy. Includes Magnesium sulfate (MgSO4) Terbutaline, Indocin, Brethine, etc.

- External cephalic version – attempted conversion of a fetus from a non-vertex to a vertex presentation by external manipulation. If checked, also indicate whether the procedure was a success (fetus was converted to a vertex presentation) or a failure.

**Mother’s transfer information** – was the mother transferred for her medical or fetus’s medical indications prior to delivery? If so, select the name of the facility the mother transferred from. If mother transferred from a planned home birth, do not record that in this field; go to the FINALIZE page and enter “planned homebirth” in the notes section.

**Onset of labor** – check all that apply (note that prolonged labor and precipitous labor should not both be checked).

- Premature rupture of membranes (prolonged > 12 hours) – check this box to indicate spontaneous rupture of membranes more than 12 hours prior to the onset of labor.
- Precipitous labor – check to indicate labor lasting less than 3 hours
- Prolonged labor – select for active labor lasting longer than 20 hours

**Characteristics of labor and delivery** – check all the characteristics that apply.

- Induction of labor – initiation of uterine contractions by medical and/or surgical means for the purpose of delivery before the spontaneous onset of labor. Check this if medications were given or procedures to induce labor were performed BEFORE labor began.
- Augmentation of labor – stimulation of uterine contractions by drug or manipulative technique with the intent to reduce the time of delivery. Check this box if medication was given or procedures to augment labor were performed AFTER labor began.
☐ Non-vertex presentation – presentation of anything other than the upper and back part of the infant’s head. Check this box to indicate breech, transverse, compound, shoulder, brow or face presentation during the active phase of labor and delivery.

☐ Steroids (glucocorticoids) – medications given to the mother before the delivery for fetal lung maturation. Includes: betamethasone, dexamethasone, or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Do not include steroid medication given to the mother as an anti-inflammatory treatment before or after delivery.

☐ Antibiotics during delivery – include antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery.

☐ Chorioamnionitis diagnosed during labor / Maternal temperature greater than or equal to 38°C or 100.4°F. Check both of these boxes to indication a clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes fever (febrile), uterine tenderness and/or irritability, leukocytosis or fetal tachycardia.

☐ Meconium – moderate or heavy meconium staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or at delivery that is more than enough to cause a greenish color change of an otherwise clear fluid.

☐ Fetal intolerance of labor requiring intervention or assessment such as in-utero resuscitative measures, further fetal assessment or operative delivery. Includes: maternal position change, oxygen administration to the mother, intravenous fluids administered to the mother, Amnioinfusion, support of maternal blood pressure, administration of uterine relaxing agents; fetal scalp stimulation, acoustic stimulation, scalp pH; operative delivery to shorten time to delivery of the fetus such as forceps, vacuum or cesarean delivery.

☐ Epidural or spinal anesthesia during labor – administration to the mother of a regional anesthetic to control the pain of labor. Delivery of the agent into a limited space with the distribution of the analgesic effect limited to the lower body.
Date & Time of birth

**Date and time of birth** – the date should be pre-populated from data entered earlier. Check to ensure this entry matches the actual date of delivery and make adjustments if needed. **TIP:** You may find you need to TAB out of the date field in order for the new entry to save.

Child’s time of birth – enter the exact time of birth and select the proper time format: “am” “pm” or “24 hour” (military time) from the drop-down menu. **Tip:** enter time of birth as four numbers, without a separating colon. For example, enter 0456, not 4:56.

**Method of birth** – complete every question in this section.

**Forceps attempted** – if obstetric forceps were applied to the fetal head in an attempt at a vaginal delivery, select “Yes.” If yes, indicate if the forceps delivery was successful.

**Vacuum attempted** – if a ventouse or vacuum cup was applied to the fetal head in an attempt at a vaginal delivery select “Yes.” If yes, indicate if the vacuum delivery was successful.

**Fetal presentation** – select one of the following options:

**Cephalic** – select if presenting part of the fetus is listed as vertex, occiput anterior (OA) occiput posterior (OP) Face, Brow, Sinciput (forehead), or Mentum (chin) on the medical record.

**Breech** – presenting part of the fetus listed as breech, complete breech, frank breech, footlong breech.

**Other** – any other presentation not listed above, including shoulder, transverse lie, funis (cord) or compound.

**Final route and method of birth** – select one of the following options:

**Vaginal/spontaneous** – delivery of the entire fetus through the vagina by the natural force of labor with or without manual assistance from the delivery attendant.

**Vaginal/forceps** – delivery of the fetal head through the vagina by the application of obstetrical forceps to the fetal head.
Vaginal/vacuum – delivery of the fetal head through the vagina by the application of obstetrical vacuum to the fetal head.

Cesarean – extraction of the fetus, placenta and membranes through a surgical incision in the maternal abdominal and uterine walls.

If Cesarean, was a trial of labor attempted? – check yes if labor was allowed, augmented or induced with plans for a vaginal delivery.

Vaginal birth after Cesarean – check this box if mother had any previous delivery by cesarean section.

Maternal Morbidity -

☐ Maternal transfusion – includes infusion of whole blood or packed red blood cells associated with labor and delivery.

☐ Third or fourth degree perineal laceration – a 3° laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4° laceration is all of the above with extension through the rectal mucosa.

☐ Cord prolapse – when the umbilical cord enters the vagina beneath the fetal head and becomes compressed/obstructed by pressure from the fetus.

☐ Seizure during labor – any involuntary repetitive, convulsive maternal movement or behavior or severe alteration of alertness.

☐ Placental abruption – separation of the placenta from the uterine wall, usually causing hemorrhaging.

☐ Placenta previa – location of the placenta close to or covering the cervix, usually causing hemorrhaging.

☐ Ruptured uterus – tearing of the uterine wall.

☐ Unplanned hysterectomy – surgical removal of the uterus that was not planned before admission. Includes an anticipated, but not definitively planned, hysterectomy.

☐ Admission to intensive care unit – any admission, planned or unplanned, of the mother to a facility or unit designated as providing intensive care.
Unplanned operating room procedure following delivery – any transfer of the mother back to a surgical area for an operative procedure that was not planned before the admission for delivery. Excludes postpartum tubal ligations.
**Finalize Page**

Finish entering data about this birth and submit the record.

During the finalize record process, the MR&C system will check for omitted or improperly entered data and verify unusual responses.

**Enter the birth data and save**

Use the follow-on actions to print any necessary parentage forms and the verification of birth facts for parent review and proofing.

After confirming data is entered correctly, click **Finalize record** to file the birth record.

The MR&C automatically verifies the mother’s mailing address to ensure delivery of the baby’s Social Security Card and the Parents’ Notice. If you believe the data is correct as entered, click the corresponding button, otherwise use the red Save Verified Address button.

**NOTE:** if you receive the message “verification FAILED”, “Address verification DISABLED,” you can disregard this message. The record can be submitted without address verification.

**Error messages:** Any data listed in a red error message must be acknowledged, corrected or completed. Birth records cannot be finalized with error messages.
• Omitted data errors (Mandatory)  This is an example of an error message where required data has been omitted.
To correct, click on the blue heading to return to the page were the error occurred. After entering any missing data, be sure to click **Save** on the data page and look for the following green message:

**Birth record updated successfully.**

• Verify data errors (Confirmation)  These are examples of “soft” error messages where data needs to be verified.
Click on the blue heading to return to the page where the data was entered. Review all error messages and make corrections if necessary.
Then simply check the box to confirm that the data is correct as entered.

If you make any changes to the record or after entering any incorrect data, be sure to click **Save** on the data page and look for the **Birth record updated successfully.** message.

After verifying and correcting any error messages, simply click **Submit birth record** to finish.
You should immediately see the following changes in the birth record viewing window.

- State file number
- Birth record status
- If paternity papers were faxed, a date will appear next to ROP status when the ROP has been filed.
Experiencing a fetal loss is emotionally difficult for the families and for the caregivers. Every situation is different and birth registration procedures change slightly depending on gestational age and outcomes. Additionally, it is human nature to take a step back and try to forget intense emotional situations, so it is no wonder birth registrars struggle when faced with a loss.

**Baby born alive, lives briefly and expires**

Babies that born alive – at any gestational age – are live-born babies and their births are recorded the same as any other birth. It does not matter if this lifetime is a few moments or many years, if signs of life are present at the birth, a birth record is required. The funeral home will (generally) file the death records for these babies.

When an unmarried mother gives birth to a live baby – even if the baby expires shortly after birth – the mother and father must complete a Recognition of Parentage (ROP) to put the father’s information on the birth record.

These seem particularly difficult when the birth occurs at a pre-viable age, or the baby is born with fatal fetal anomalies and no resuscitative measures are taken. Even when the baby is born and not expected to live, the birth is recorded the same as a live birth. Follow the instruction for entering a birth record, but answer “No” to the question at the bottom of the *Child’s Medical Information II* page (Is baby alive at the time of filing the birth record) and enter the disposition information. MDH matches birth and death records, and completion of the disposition information will make it easier to contact the funeral home to inquire about the death if necessary.

**Fetus delivered at 20+ weeks of gestation**

**MN Statute 144.222 REPORTS OF FETAL OR INFANT DEATH** Subd.1 Fetal death report required. A fetal death report must be filed within five days of the death of a fetus for whom 20 or more weeks of gestation have elapsed, except for abortions defined under section 145.4241. A fetal
Stillborn babies at any gestation over twenty weeks must be reported in the same manner live births are reported – using the Minnesota Registration and Certification System (MR&C) – however, these deliveries are recorded in Enter fetal death report available from the Tasks menu of the system. Additional data items appear on a fetal death report pertaining to the cause of the fetal death and the time the fetus died. Do not guess at the answer to these questions. Often the delivery attendant will note an estimated cause of death in the maternal chart. If this is not available, the birth registrar may have to contact the delivery attendant who examined the fetus or wait for autopsy results.

Because a fetal death or stillbirth will never become a child support or custody issue, the father’s name can be placed on the birth certificate, even if the mother is not married to the father of the baby. No Recognition of Parentage (ROP) is required.

**Fetus delivered at less than 20 weeks gestation**

Stillborn fetuses delivered at less than 20 weeks gestation are not covered by state statute. You are not legally obligated to file a report of fetal death. However, you can report these deliveries via Enter fetal death report available in the Tasks menu of MR&C – the data will be reported to NCHS and may be valuable for research. If you believe the family will request a Certificate of Birth Resulting in Stillbirth, a fetal death report will need to be filed. Do not give an application or information about the Certificate of Birth Resulting in Stillbirth to a family without filing a report of fetal death.

**Definitions of live birth**

**MN Administrative Rules 4601.0100 Subp. 17 Live birth** "Live birth" means the complete expulsion or extraction of a product of human conception from its mother, irrespective of the
duration of pregnancy, that, after expulsion or extraction, breathes, or shows any other
evidence of life, including beating of the heart, pulsation of the umbilical cord, or definite
movement of voluntary muscles, whether or not the umbilical cord has been cut or the
placenta is attached. Heartbeats are to be distinguished from transient cardiac contractions.
Respirations are to be distinguished from fleeting respiratory efforts or gasps.


"Fetal death" means death of a product of human conception before the complete expulsion
or extraction from its mother, irrespective of the duration of pregnancy, that is not an
induced termination of pregnancy. The death is indicated by the fact that after expulsion or
extraction, the fetus does not breathe or show any other evidence of life, including beating
of the heart, pulsation of the umbilical cord, or definite movement of the voluntary muscles.
Heartbeats are to be distinguished from transient cardiac contractions. Respirations are to be
distinguished from fleeting respiratory efforts or gasps.

Until you are presented with a situation, it seems as if it would be easy to tell the difference
between life and death. But sometimes stillbirths seem to be very brief lives – and babies who
live only a moment can seem like stillbirths. The legal definitions of live birth and fetal death are
reprinted above from the Minnesota Administrative Rules for your use if this question ever
arises in your facility or practice. Most importantly, whenever there is a question like this, the
medical professionals make the determination – not the birth registrars or the parents. Part of
the problem is that sometimes it seems less dramatic to call a pre-viable birth a “fetal death,”
when that title isn’t really appropriate in birth registration terms. Do not get hung up on these
terms. Just remember: if a baby is born alive, it will have at least one Apgar score, it will have a
time of birth and a time of death, and a birth record must be filed. If a baby is stillborn at 20
weeks of gestation or more, a fetal death report must be filed.

Disposition

Birth registrars do not usually get involved in disposition, but due to the ongoing relationship
with MDH, other hospital personnel may look to the birth registrar for information regarding
disposition of fetuses or fetal tissue. If you have been asked to investigate the appropriateness
of a disposition method, do not call the Office of the State Registrar – this is not a question
about vital records. Please call the MDH’s Mortuary Science Section at (651) 201-3829. They
have prepared a consumer manual to answer questions about human disposition and help navigate the Minnesota laws.

The following is an excerpt from their manual relative to Fetal and Infant Death:

**Fetal Death and Infant Death**
A Report of Fetal Death must be filed within five days of a miscarriage or stillbirth of a fetus for whom 20 or more weeks of gestation have elapsed. The report is usually filed by the hospital, doctor, midwife, parent or mortician working with the family. More information on fetal deaths can be obtained at: [https://www.revisor.mn.gov/statutes/?id=144.222](https://www.revisor.mn.gov/statutes/?id=144.222) [http://www.health.state.mn.us/divs/chs/osr/birthreg/#brm](http://www.health.state.mn.us/divs/chs/osr/birthreg/#brm)

There are precise regulations following a fetal or infant death. Fetal remains from an abortion, miscarriage or stillbirth that meet the criteria found in MN 145.1621 ([https://www.revisor.mn.gov/statutes/?id=145.1621](https://www.revisor.mn.gov/statutes/?id=145.1621)) must be buried or cremated. A Fetal Death Disposition Permit for burial or cremation of fetal remains from a miscarriage or stillbirth is available from the Mortuary Science Section’s website: [http://www.health.state.mn.us/divs/hpsc/mortsci/forms.htm](http://www.health.state.mn.us/divs/hpsc/mortsci/forms.htm)

Hospitals, clinics, and medical facilities must inform a woman of available options for fetal disposition when a woman experiences a miscarriage or is expected to experience a miscarriage. [https://www.revisor.mn.gov/statutes/?id=145.1622](https://www.revisor.mn.gov/statutes/?id=145.1622)

When a birth occurs and the infant lives for any amount of time, but then the infant dies, both a birth certificate and a death certificate must be filed. Once there is a live birth, the regulations are the same for final disposition of the infant death as would be for an adult death.

The entire manual, entitled “Choices” Information on the regulations and requirements of the final disposition of a dead human body in Minnesota is available online at [http://www.health.state.mn.us/divs/hpsc/mortsci/consumer.html](http://www.health.state.mn.us/divs/hpsc/mortsci/consumer.html)
Correcting a birth record

Mistakes happen and birth registrars can correct their data entry errors. In fact, parents are directed to return to the hospital for birth record error correction.

If you receive updated information about a birth record after it has been filed, you may be able to correct the record. Before you do, however, it is your responsibility to briefly assess the situation. Think about the elements required to make a hospital correction:

- Identify the requestor
- Identify the record in more than one way
- Review the record as it was entered
- Verify that the new or updated information is correct
- Make the correction

**Identify the requestor** – Not everyone has the right to request a change, so make certain you are talking to a parent named on the record. It is preferred that you meet the requestor in person, so you can check his or her identification.

**Identify the record in more than one way** – No matter how unique a name seems, it is quite possible to have more than one baby (or parent) with the same name. Always work with two identifiers like State File Number and baby’s name, or baby’s and mom’s names, or name and date of birth, etc. This may mean calling the parent back to confirm a second identifier.

**Review the record as it was entered** – Verify that a correction is necessary. Sometimes the parent may not have the most complete or up-to-date information about the birth record. For example, if one parent has already made a change, or if the parent notice prints incorrectly, their notice may not be correct. The birth record you see in MR&C is the current record. Any previous corrections, changes or amendments will be visible to the birth registrar unless the record has been replaced.
Verify the new or updated information is correct. Data-entry error corrections are easily verified with the medical records. To avoid repeated corrections to the same data item, take the time to confirm your new entry is accurate.

Make the correction. After you have properly identified the record, requester, and verified the new information, log in to MR&C and search for the existing record. Select Correct Birth Record from the Select a Follow-on Action drop down menu. This will open the record so you can erase the old/incorrect data and replace it with the new information. Make all necessary corrections at the same time and finalize them. A screen will appear for you to confirm the new information is entered correctly.

Do not correct the following things

Do not make corrections you are unable to verify. Only parents have the right to change their baby’s name so if you are unable to verify that the requestor is one of the parents listed on the birth record, do not make the change. Do not change any data to something other than what appears in the medical record.

Do not change the marital status of the parents.

Do not change the name of the mother, father or baby if a Recognition of Parentage has been filed. Only minor spelling corrections are permitted.

Records that cannot be corrected by the birth registrar

Although birth registrars can always complete a hospital statement instructing MDH to make a change, some records cannot be corrected or changed in MR&C by the birth registrar. If Correct Birth Record is not available in your drop down menu, the record is not correctable by you at this time. Some of the reasons records cannot be changed are listed below.
**Status: ROP Pending** – a record is not available for correction during the time paternity documents are pending.

**The record has been (or is being) replaced** – Birth records are replaced by late-filed ROPs, paternity adjudications and adoption. Records that have been replaced become invisible to the birth registrar, although the names (from the original record) will continue to appear in birth registration reports printed by the facility. If you need to confirm a record was entered, print a Chronological Birth Log for the time the birth occurred. You will not have access to the replacement (new) record.

**A certificate has already been issued** – If a parent has already purchased a birth certificate, the record becomes “locked” and you will be unable to make any changes to it. *Correct Birth Record* will not be available in your drop-down menu.

**One year has elapsed since the birth** – A grace period is given to parents so they can review their baby’s birth record and make desired changes. After the one year grace period ends, changes become *amendments*; fees and additional documentation is required. *Correct Birth Record* will not be available in your drop-down menu.

**Hospital Statements to correct**

A hospital or birth registrar’s statement is used to instruct MDH to make corrections to a birth record. This written statement is reviewed by Special Processing staff for accuracy and completeness. Essentially, the statement must do all the things a birth registrar does before making a correction:

- Identify the record in at least two ways
- State the reason the record needs correcting – what is wrong and how the error occurred
- State how the record should be corrected
- Include a statement from the birth registrar indicating that she or he has personally verified the new information is correct
- The statement must be on an MDH form or on facility letterhead and faxed or mailed directly to MDH
- The statement must be signed and dated by the birth registrar
A blank hospital statement is included in this manual.
Birth registration resources

MDH Birth and death registration helpline ................................................................. 651-201-5961

MDH birth registrar’s website
........................................................................................................ http://www.health.state.mn.us/divs/chs/osr/birthreg/index.html

MDH OVR field representative ...................................Sally Almond .................. 651-201-5973

MDH OVR field representative ...................................Maria Schaff ................. 651-201-5971

MDH OVR field representative ....................................Kirsti Taipale .................. 651-201-4832

MDH Special processing ................................................................. 651-201-5990

MDH Deputy State Registrar ........................................Heidi Granlund .............. 651-201-5987

MDH State Registrar .................................................................Molly Crawford ......... 651-201-5972

DHS Paternity program administrator ....................Kristi Phetdara ............... 651-431-4435

DHS Paternity supplies .............................................................. http://www.four51.com/UI/Customer.aspx

MDH Minnesota Registration & Certification (MR&C) Support .......................... 888-692-2733

MDH – General Information – all topics .......................... 651-201-5000
Other resources

MDH – General Information – all topics.......................................................... 651-201-5000

MDH Public information – vital records ......................................................... 651-201-5961
http://www.health.state.mn.us/divs/chs/osr/birth.html

MDH Immunization information ................................................................. 651-201-5503

MDH Father’s Adoption Registry ................................................................. 651-201-5994

DHS Minnesota Department of Human Services................................. 651-431-2000

Child protection ................................................................. dhs.child.safety-permanency@state.mn.us

Child support – call the local county child support office first .......... 651-431-4346

MDH Newborn screening program.......................................................... 800-664-7772
http://www.health.state.mn.us/newbornscreening/index.html

MDH Mortuary Science Section ............................................................... (651) 201-3829
http://www.health.state.mn.us/divs/hpsc/mortsci/index.htm