

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
OFFICE OF HEALTH FACILITY REGULATION
BIRTH CENTER ANNUAL REPORT**

Report data from July 1 through June 30 of each calendar year.

SECTION 1: BIRTH CENTER INFORMATION (please attached additional sheets as necessary)

1. BIRTH CENTER

NAME: _____

ADDRESS: _____

2. OWNER AND/OR GOVERNING BODY

NAME: _____

ADDRESS: _____

(If more than one owner, please list the names and addresses on the back of this sheet or attach an additional page.)

3. CLINICAL STAFF

CLINICAL STAFF DIRECTOR:

NAME: _____

ADDRESS: _____

QUALIFICATIONS:

CLINICAL STAFF MEMBERS:

NAME	ADDRESS	QUALIFICATIONS (I.E., ARNP, CNM, MD, RN, etc.)
------	---------	---

4. CONSULTANTS

NAME	ADDRESS	QUALIFICATIONS

5. OTHERS WHO PROVIDE CLINICAL/DIRECT CARE SERVICES

NAME	ADDRESS	QUALIFICATIONS	TYPE OF SERVICE

6. ACCREDITATION STATUS:

Yes No ORGANIZATION: _____
 DATES: _____

SECTION II. CLIENT CARE SERVICES (include data for the report year only)

1. a. Number of deliveries in the birth center: _____
- b. Number of mothers who withdrew or transferred before delivery: _____
- c. Number of mothers transferred intrapartum: _____
- d. TOTAL number of maternity clients accepted for care: _____
2. Number of deliveries in the birth center of low birth weight infants: (live births only) _____
 _____ > 2500 gms. _____ 2000-2499 gms. _____ 1500-1999 gms. _____ < 1500 gms.
3. Length of total stay at birth center, in hours (includes labor, delivery & postpartum) = _____
 (a) range: _____ to _____ (b) average: _____
4. Length of stay after birth, in hours:
 (a) range: _____ to _____ (b) average: _____

SECTION III. SURGICAL PROCEDURES

1. Type of surgical procedures performed at the birth center:

(a) Number of circumcisions: _____

(b) Other surgical procedures: _____
 (please provide specific details, i.e., procedure and number perform)

SECTION IV. TRANSFER INFORMATION

1. TRANSFER AGREEMENTS:

(a) **Hospital** (to be completed only by those birth centers which do not have a physician with hospital privileges who accepts their clients.)

NAME	ADDRESS	WRITTEN AGREEMENT (YES OR NO)

(b) **Ambulance Service** (if not 911):

NAME	ADDRESS

2. INTRAPARTUM TRANSFERS: (List each transfer separately. Do not list names. Complete or attach transfer log)

(a) **Mothers:** **Total** _____

DATE	TRANSFER DURING		REASON FOR TRANSFER	MOTHER	INFANT	
	LABOR	POST PARTUM		DAYS IN HOSPITAL	BIRTH WEIGHT	APGARS

(b) Newborns: Total _____

DATE	BIRTH WEIGHT	APGARS	REASON FOR TRANSFER	DAYS IN HOSPITAL	CONDITION ON DISCHARGE

(if necessary, please attach extra sheets.)

SECTION V: DEATHS

1. NEWBORNS (of clients registered at birth center and died within seven days of life. Do not include clients transferred or physician care, if transferred more than 48 hour before birth.)

DATE	BIRTH WEIGHT	DATE AND SITE OF DEATH	CAUSE OF DEATH	REPORTED TO MEDICAL EXAMINER

2. STILLBIRTH/FETAL DEATHS (delivered at birth center only)

DATE	BIRTH WEIGHT	DEATH OCCURRED			CAUSE OF DEATH	REPORTED TO MEDICAL EXAMINER
		BEFORE LABOR	DURING LABOR	DURING DELIVERY		

3. IF A MATERNAL DEATH OCCURRED, PLEASE SUBMIT A SEPARATE REPORT.

Date: _____

Signature: _____

Print Name: _____

Title: _____

Telephone Number: _____