

MICHIGAN BIRTH DEFECTS REGISTRY REPORT
 Vital Records and Health Data Development Section
 Michigan Department of Community Health

Correction

1. Name of Child (Last) _____ (First) _____ (Middle Initial) _____		
2. If the child has been identified by another name (AKA – also known as) _____		
3. Child's Current Street Address _____		Apartment No. _____
City _____		State _____
Zip Code _____		Telephone No. _____
4. Child's Social Security Number (if known) _____	5. Medical Record Number _____	6. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undesignated
8. Child's Medicaid # (if known) _____	9. Date of Birth (Month) (Day) (Year) _____	7. Plurality <input type="checkbox"/> Single <input type="checkbox"/> First <input type="checkbox"/> Second <input type="checkbox"/> Third or More
10. Hospital / Place of Birth _____		
City _____	State _____	11. Mother's Social Security Number _____
12. Mother's Name (Last) _____ (First) _____ (Middle Initial) _____		
13. Name of Facility Submitting Form _____ City _____ State _____		
14. Patient Status <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient	15. Admission Status <input type="checkbox"/> Any Admission <input type="checkbox"/> Transferred	16. Admission Date (Month) (Day) (Year) _____
		17. Discharge Status <input type="checkbox"/> Alive <input type="checkbox"/> Transferred <input type="checkbox"/> Dead
		18. Discharge Date (Month) (Day) (Year) _____
		19. Birth Status <input type="checkbox"/> Live Birth <input type="checkbox"/> Stillborn Birth Weight _____
20. Diagnoses (attach additional forms if more than 5 diagnoses)		ICD-9-CM Code
1. _____		_____
2. _____		_____
3. _____		_____
4. _____		_____
5. _____		_____
Syndrome _____		_____
22. Cytogenetics		_____
<input type="checkbox"/> Not Stated <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Pending <input type="checkbox"/> No Growth <input type="checkbox"/> Not Done		_____
If Abnormal, Describe _____		ICD-9-CM Code _____
23. Name of Laboratory _____ City _____		
24. Name of Person Completing Form _____		
(Last) _____ (First) _____		
Telephone Number _____		

INSTRUCTIONS FOR COMPLETING THE BIRTH DEFECTS REGISTRY REPORT FORM

Accuracy and thoroughness in case identification and data abstracting determine the quality of the data and the usefulness of a registry. The quality of the information reported is dependent on the ability of personnel to abstract relevant data from the hospital chart. For more information on birth defects reporting, please refer to the Birth Defects Reporting Manual at www.michigan.gov/mdch. Click on the link for “providers”, then “departmental forms”.

It is important to fill out the form completely and as accurately as possible. The majority of the information requested on the Michigan Birth Defects Registry report form is self-explanatory. However, each item is reviewed to offer further clarification and provide a rationale for collection. To minimize the time required to complete the form, the number of data items is restricted to include only information deemed necessary for demographic and diagnostic analysis.

ITEM REVIEW

Initial and Follow-up Report

- Please review the patient’s medical record to determine if a Birth Defects Registry report has been filed. **If one has been filed and the diagnosis has changed, please file a follow-up report. If you are not sure, please file a report.**
- Check the box in the top left hand corner to indicate if this is an initial report of a follow-up report.
- Enter month, day, and year the form was completed.

1. **Child’s Name**

Enter the child’s last name, first name and middle initial. If the child was not named, indicate name used on medical chart.

2. **AKA – Also Known As**

Enter any other name by which the child is also known. Give last name, first name and middle initial. Write “unknown” if there is no indication that the child has been known by any other name.

3. **Child’s Address and Telephone Number**

Enter the number and street, area code, telephone number, city, state and zip code where the child presently resides (or will reside when discharged). When there is no telephone at the residence, write “unknown.”

4. **Child’s Social Security Number**

If a social security number for the child is not available, write “unknown.”

5. **Medical Record Number**

Enter the child’s medical record number as assigned by your facility.

6. **Sex**

Enter an “X” in the appropriate box indicating male, female or undesignated. One of the boxes must be checked.

7. **Plurality**

Indicate if the child was a single birth. If a multiple birth, indicate birth order as first born, second born, third born. If fourth born or higher, enter number.

8. **Child’s Medicaid Number**

Enter the child’s Medicaid number. If a child does not have a Medicaid number listed in available records, write “unknown.”

9. **Date of Birth**

Enter the child’s numerical date of birth (month, day, year). If the date of birth is not in the medical record, attach a note stating reason for absence.

10. Hospital, City and State of Birth

Enter the city, county and state where the child was born. If it is impossible to determine this information, write “unknown.”

11. Mother’s Social Security Number

Enter the mother’s social security number. If not determined, write “unknown.”

12. Mother’s Name

Enter the current last name, first name and middle initial of the child’s natural mother. If it is impossible to determine this information, write “unknown.”

13. Hospital/Place of Diagnosis and City

Enter the full name of the facility, city and state from which this report is being generated.

14. Patient Status

Enter an “X” in the appropriate box indicating inpatient or outpatient.

15. Admission Status

Enter an “X” in the appropriate box indicating if patient was transferred from another facility or if admitted in any other circumstance.

16. Admission Date

Enter the date the patient was admitted to the facility (or born in the facility).

17. Discharge Status

Enter an “X” indicating if patient was discharged alive, deceased or to another facility.

18. Discharge Date

Enter month, day and year patient was discharged.

19. Birth Status

Enter an “X” indicating if patient was born alive, or stillborn. Enter birth weight of the patient.

20. Diagnoses

- List **ALL** reportable diagnoses. **Do not report “V codes”**. List each diagnosis separately on a corresponding numbered line. Almost all items in the congenital Anomalies section of the ICD-9-CM are reportable to the Michigan Birth Defects Registry. In addition, parts of other sections are reportable. These include inborn errors of metabolism, hearing loss, some endocrine disorders, hereditary blood, eye, nervous system and muscle disorders. Certain conditions in the perinatal period such as congenital rubella are required. **Please refer to Section II of the Birth Defects Reporting Manual for a detailed list of reportable conditions.**
- Report only permanent conditions. Do not report transient conditions like transient hypoglycemia and hyperbilirubinemia of the newborn. There are diagnoses that are not collected by the Michigan Birth Defects Registry such as retinopathy of prematurity, ankyloglossia, umbilical hernia completely covered by skin and gastroesophageal reflux (chalasia). **Please refer to Section II of the Birth Defects Reporting Manual for a detailed listing of conditions that are not reportable if occurring alone without any other reportable defect.**
- Enter the **exact words** used by the physician to describe the condition. **Quote the portions of the medical record where the diagnosis is explained in the most detailed, complete terms.** Try to be as specific as possible in your written description, with respect to location, bilateral, unilateral involvement and size of certain conditions. For example, “limb reduction” is not sufficient for coding. Instead, it is desirable to write “absence of upper arm and forearm with hand present, bilateral involvement.”

- **Do not submit congenital anomaly data in the form of an ICD-9CM code** as many of these ICD codes include very common minor defects and rarer major defects. The surveillance system wishes to have individual entities and not grouped entities.
- **Do not use abbreviations in your reporting.** For example, “CHD” or “CDH” will cause confusion. Instead, report “congenital heart disease” or “congenital dislocation of the hip.” Avoid using words like “possible, query, borderline, likely, transient, suspect, ?,” etc. Report confirmed diagnosis whenever possible.
- **Once a reportable condition is found** within a patient’s medical record, **carefully** check for additional reportable conditions that may be listed elsewhere in the medical record.
- **Congenital heart disease** is a descriptive term that encompasses many different types of congenital heart defects. Please provide as much information as possible on specific heart defects. For example, patent ductus arteriosus, pulmonary valvular stenosis or Tetralogy of Fallot instead of congenital heart disease.
- The reporting of hip anomalies appears to be a difficult task and currently there is little agreement among orthopedic surgeons over which hip problems are congenital anomalies. **Please report all hip anomalies except 754.32 and 754.33** “Subluxation of the hip – unilateral and bilateral.”
- **Jaundice**, on its own, is a frequent condition that is not reportable to the Registry. However, if there is some underlying cause for the jaundice, such as glycogen storage disease or congenital biliary atresia, etc. **please report these underlying conditions.**
- Another frequent reporting problem is that of tyrosine where it is mentioned as being increased or elevated or transient elevation. These events are extremely common and quite normal especially in premature infants. With a little vitamin C, the tyrosine metabolism is restored to normality. There is, however, a very rare inborn error of metabolism involving tyrosine that is hereditary tyrosinemia or tyrosinosis. These inborn errors of metabolism should be reported to the Registry.
- **If there is a syndrome diagnosis**, list **both** the syndrome name and all the individual anomalies that comprise the syndrome. It is still necessary to describe each component defect individually as it appears in the medical record for coding.

21. Procedure Codes

Report all procedure codes (up to fifteen) using ICD-9-CM procedure listing.

ICD-9-CM Code

List the ICD-9-CM code assigned by your facility

22. Cytogenetics

- Put an “X” in the box which best describes the chromosome testing status of the case.
- Check “not stated” if you are uncertain as to whether a cytogenetics study was performed or requested.
- The box listed as “normal” is reserved for cases that have had a cytogenetics study done, and the results are described as “normal.”
- If the labeled “abnormal” is checked, it should be followed by a complete description of the abnormality on the line below. Do not use abbreviations in this description.
- If there is an indication that a cytogenetics study was requested but there are no results, put an “X” in the box labeled “pending.”
- The box listed as “no growth” is reserved for cases that have had a cytogenetics study done, and the results are described as “no growth.”
- If it is known that cytogenetics study was not requested or performed, put an “X” in the box labeled “not done.”

23. Name of Laboratory and City

- Give the name of the laboratory where the cytogenetics study was sent or performed. Include the city where the laboratory is located.
- If you checked the boxes labeled “not stated”, “normal”, “Pending” or “no growth” but are uncertain which laboratory is performing the test, put a “U” in the first box. If you checked the box labeled “not done” write “none” next to the first four boxes.

24. Person Completing Form

Enter the last name and first name in the spaces provided. Enter the area code and telephone number of the medical records department where you can be reached.