



NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
Commissioner

**Guidance on Changes to NYC Department of Health and Mental Hygiene’s
Certificate of Birth and Confidential Medical Report of Birth (VR6S)**

The below guidance pertains to changes to New York City Vital Record forms that will be in effect January 2, 2020. Question numbers correspond to the box numbers on the certificates. Before and after images are included to show the changes that were made.

1. **Question 1:** Suffix added to Name of Child
 - a. **Original:** (First, Middle, Last)
 - b. **New:** (First, Middle, Last, Suffix)
 - c. **Purpose:** To make it easier for families to add a suffix, such as Junior, II, etc. to an infant’s name and to match the US Standard Birth Certificate

Current Birth certificate

DATE FILED		THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF BIRTH					
CERTIFICATE NO.					
1. NAME OF CHILD	(First, Middle, Last)				
2. SEX	3a. NUMBER DELIVERED of this pregnancy	4a. DATE OF CHILD'S BIRTH		4b. Time <input type="checkbox"/> AM <input type="checkbox"/> PM	
	3b. If more than one, number of this child in order of delivery				
5. PLACE OF BIRTH	5a. NEW YORK CITY BOROUGH	5b. Name of Hospital or other facility (if not facility, street address)			

Current eVital screenshot, no changes made to eVital

Child Demographic

<p>First</p> <input style="width: 90%;" type="text"/>	<p>Middle</p> <input style="width: 90%;" type="text"/>
<p>Other Middle</p> <input style="width: 90%;" type="text"/>	<p>Last</p> <input style="width: 90%;" type="text"/>
<p>Suffix</p> <div style="border: 1px solid #ccc; padding: 2px;"> Select one ▼ </div>	

Updated Birth certificate

DATE FILED		THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF BIRTH					
CERTIFICATE NO.					
1. NAME OF CHILD	(First, Middle, Last, Suffix)				
2. SEX	3a. NUMBER DELIVERED of this pregnancy	4a. DATE OF CHILD'S BIRTH	4b. TIME <input type="checkbox"/> AM <input type="checkbox"/> PM		
	3b. If more than one, number of this child in order of delivery				
5. PLACE OF BIRTH	5a. NEW YORK CITY BOROUGH	5b. Name of Hospital or other facility (if not facility, street address)			
5c. TYPE OF PLACE	<input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Delivery: Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other-specify: _____				
6a. MOTHER/PARENT'S NAME (Prior to first marriage)	6b. MOTHER/PARENT'S DATE OF BIRTH	6c. MOTHER/PARENT'S BIRTHPLACE			
(First, Middle, Last, Suffix) SEX ___M___F___X	(Month) (Day) (Year - yyyy)	City & State or foreign country			
7. MOTHER/PARENT'S USUAL RESIDENCE	7c. City or town	7d. Street and number	Apt. No.	ZIP Code	7e. Inside city limits of 7c? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
a. State b. County					
8a. FATHER/PARENT'S NAME (Prior to first marriage)	8b. FATHER/PARENT'S DATE OF BIRTH	8c. FATHER/PARENT'S BIRTHPLACE			
(First, Middle, Last, Suffix) SEX ___M___F___X	(Month) (Day) (Year - yyyy)	City & State or foreign country			

2. Question 6a and 8a: Suffix added to parental name

- a. **Original:** (First, Middle, Last)
- b. **New:** (First, Middle, Last, Suffix)
- c. **Purpose:** To provide the opportunity to make the birth certificate more accurate and to match the US Standard Birth Certificate

Current Birth certificate

DATE FILED		THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF BIRTH					
CERTIFICATE NO.					
1. NAME OF CHILD	(First, Middle, Last)				
2. SEX	3a. NUMBER DELIVERED of this pregnancy	4a. DATE OF CHILD'S BIRTH	4b. Time <input type="checkbox"/> AM <input type="checkbox"/> PM		
	3b. If more than one, number of this child in order of delivery				
5. PLACE OF BIRTH	5a. NEW YORK CITY BOROUGH	5b. Name of Hospital or other facility (if not facility, street address)			
5c. TYPE OF PLACE	<input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Delivery: Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other-specify: _____				
6a. MOTHER/PARENT'S NAME (Prior to first marriage)	6b. MOTHER/PARENT'S DATE OF BIRTH	6c. MOTHER/PARENT'S BIRTHPLACE			
(First, Middle, Last) SEX ___M___F___X	(Month) (Day) (Year - yyyy)	City & State or foreign country			
7. MOTHER/PARENT'S USUAL RESIDENCE	7c. City or town	7d. Street and number	Apt. No.	ZIP Code	7e. Inside city limits of 7c? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
a. State b. County					
8a. FATHER/PARENT'S NAME (Prior to first marriage)	8b. FATHER/PARENT'S DATE OF BIRTH	8c. FATHER/PARENT'S BIRTHPLACE			
(First, Middle, Last) SEX ___M___F___X	(Month) (Day) (Year - yyyy)	City & State or foreign country			

Updated Birth certificate

DATE FILED		THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF BIRTH					
CERTIFICATE NO. _____					
1. NAME OF CHILD		(First, Middle, Last, Suffix)			
2. SEX	3a. NUMBER DELIVERED of this pregnancy		4a. DATE OF CHILD'S BIRTH (Month) (Day) (Year - yyyy)		4b. TIME <input type="checkbox"/> AM <input type="checkbox"/> PM
	3b. If more than one, number of this child in order of delivery				
5. PLACE OF BIRTH	5a. NEW YORK CITY BOROUGH		5b. Name of Hospital or other facility (if not facility, street address)		
	5c. TYPE OF PLACE <input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Delivery: Planned to deliver at home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other-specify: _____				
6a. MOTHER/PARENT'S NAME (Prior to first marriage) (First, Middle, Last, Suffix) SEX ___M___F___X		6b. MOTHER/PARENT'S DATE OF BIRTH (Month) (Day) (Year - yyyy)		6c. MOTHER/PARENT'S BIRTHPLACE City & State or foreign country	
7. MOTHER/PARENT'S USUAL RESIDENCE a. State b. County		7c. City or town	7d. Street and number Apt. No.	ZIP Code	7e. Inside city limits of 7c? Yes <input type="checkbox"/> No <input type="checkbox"/>
8a. FATHER/PARENT'S NAME (Prior to first marriage) (First, Middle, Last, Suffix) SEX ___M___F___X		8b. FATHER/PARENT'S DATE OF BIRTH (Month) (Day) (Year - yyyy)		8c. FATHER/PARENT'S BIRTHPLACE City & State or foreign country	

Current eVital screen, no changes made to eVital

Mother/Parent Information

Legal Name

<p>First</p> <input style="width: 95%; height: 25px;" type="text"/>	<p>Middle</p> <input style="width: 95%; height: 25px;" type="text"/>
<p>Last</p> <input style="width: 95%; height: 25px;" type="text"/>	<p>Suffix</p> <input style="width: 95%; height: 25px;" type="text" value="Select one"/>

3. **Question 6a and 8a:** Adding option of Gender X for parental sex
 - a. **Original:** Male or Female
 - b. **New:** Male, Female, or X
 - c. **Purpose:** To provide option of a gender marker for persons who do not identify exclusively as female or male

Current Birth certificate

DATE FILED		THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF BIRTH					
CERTIFICATE NO.					
1. NAME OF CHILD	(First, Middle, Last)				
2. SEX	3a. NUMBER DELIVERED of this pregnancy	4a. DATE OF CHILD'S BIRTH	4b. Time		<input type="checkbox"/> AM <input type="checkbox"/> PM
5. PLACE OF BIRTH	5a. NEW YORK CITY BOROUGH	5b. Name of Hospital or other facility (if not facility, street address)			
5c. TYPE OF PLACE	<input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Delivery: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other-specify: _____				
6a. MOTHER/PARENT'S NAME (Prior to first marriage)	6b. MOTHER/PARENT'S DATE OF BIRTH	6c. MOTHER/PARENT'S BIRTHPLACE			
(First, Middle, Last) SEX ___M___F	(Month) (Day) (Year - yyyy)	City & State or foreign country			
7. MOTHER/PARENT'S USUAL RESIDENCE	7c. City or town	7d. Street and number	Apt. No.	ZIP Code	7e. Inside city limits of 7c?
a. State b. County					Yes <input type="checkbox"/> No <input type="checkbox"/>
8a. FATHER/PARENT'S NAME (Prior to first marriage)	8b. FATHER/PARENT'S DATE OF BIRTH	8c. FATHER/PARENT'S BIRTHPLACE			
(First, Middle, Last) SEX ___M___F	(Month) (Day) (Year - yyyy)	City & State or foreign country			

Current eVital screen

Sex

Female x ^

Male

Female

Unknown

Updated Birth certificate

DATE FILED		THE CITY OF NEW YORK – DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
CERTIFICATE OF BIRTH					
CERTIFICATE NO.					
1. NAME OF CHILD	(First, Middle, Last, Suffix)				
2. SEX	3a. NUMBER DELIVERED of this pregnancy	4a. DATE OF CHILD'S BIRTH	4b. TIME		<input type="checkbox"/> AM <input type="checkbox"/> PM
5. PLACE OF BIRTH	5a. NEW YORK CITY BOROUGH	5b. Name of Hospital or other facility (if not facility, street address)			
5c. TYPE OF PLACE	<input type="checkbox"/> Hospital <input type="checkbox"/> Freestanding Birthing Center <input type="checkbox"/> Clinic/Doctor's Office <input type="checkbox"/> Home Delivery: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Other-specify: _____				
6a. MOTHER/PARENT'S NAME (Prior to first marriage)	6b. MOTHER/PARENT'S DATE OF BIRTH	6c. MOTHER/PARENT'S BIRTHPLACE			
(First, Middle, Last, Suffix) SEX ___M___F___X	(Month) (Day) (Year - yyyy)	City & State or foreign country			
7. MOTHER/PARENT'S USUAL RESIDENCE	7c. City or town	7d. Street and number	Apt. No.	ZIP Code	7e. Inside city limits of 7c?
a. State b. County					Yes <input type="checkbox"/> No <input type="checkbox"/>
8a. FATHER/PARENT'S NAME (Prior to first marriage)	8b. FATHER/PARENT'S DATE OF BIRTH	8c. FATHER/PARENT'S BIRTHPLACE			
(First, Middle, Last, Suffix) SEX ___M___F___X	(Month) (Day) (Year - yyyy)	City & State or foreign country			

New eVital screen

A screenshot of a web form titled "Sex". The dropdown menu is open, showing the following options: "Male", "Female", "Unknown", and "X". The "X" option is currently selected and highlighted in a dark blue bar. The dropdown has a search icon in the top right corner.

- 4. **Question 11a and 11b:** Adding Latino to ancestry label
 - a. **Original:** Hispanic
 - b. **New:** Hispanic/Latino
 - c. **Purpose:** To be more inclusive and match the US Standard Birth Certificate

Current Birth certificate

A screenshot of a birth certificate form titled "11. PARENT'S ANCESTRY". The form asks the user to check one box and specify what the parent considers her/himself to be. There are two main sections: "a. Mother/Parent" and "b. Father/Parent". Each section has two radio button options. The first option in both sections is "Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.)" and is circled in red. The second option is "NOT Hispanic (Italian, African American, Haitian, Pakistani, Ukranian, Nigerian, Taiwanese, etc.)" and is also circled in red. Below each option is a line for "Specify".

Current eVital screen

A screenshot of an eVital screen titled "Ancestry". The dropdown menu is open, showing the following options: "Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.)", "Non-Hispanic (Italian, African American, Haitian, Pakistani, Ukranian, Nigerian, Taiwanese, etc.)", and "Unknown". The "Hispanic (Mexican, Puerto Rican, Cuban, Dominican, etc.)" option is currently selected and highlighted in a dark blue bar. The dropdown has a search icon in the top right corner.

Updated Birth certificate

11. PARENT'S ANCESTRY	
(Check one box and specify what the parent considers her/himself to be)	
a. Mother/Parent	b. Father/Parent
<input type="checkbox"/> Hispanic/Latino (Mexican, Puerto Rican, Cuban, Dominican, etc.) <input type="checkbox"/>	
<i>Specify</i>	
_____ (Mother/Parent)	_____ (Father/Parent)
<input type="checkbox"/> NOT Hispanic/Latino (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.) <input type="checkbox"/>	
<i>Specify</i>	
_____ (Mother/Parent)	_____ (Father/Parent)

New eVital screen

Ancestry

Hispanic/Latino (Mexican, Puerto Rican, Cuban, Dominican, etc.)

Hispanic/Latino (Mexican, Puerto Rican, Cuban, Dominican, etc.)

NOT Hispanic/Latino (Italian, African American, Haitian, Pakistani, Ukrainian, Nigerian, Taiwanese, etc.)

Unknown

5. **Question 16m:** Editing language for fetal genetic testing
- Original:** If woman was 35 or over, was fetal genetic testing offered?
 - New:** If mother/parent was 35 or over, was fetal genetic testing offered?
 - Purpose:** To make language consistent with the rest of the form

Current Birth certificate

I. Obstetric Procedures
(Check **all** that apply)

<input type="checkbox"/> Cervical cerclage	<input type="checkbox"/> Fetal genetic testing
<input type="checkbox"/> Tocolysis	<input type="checkbox"/> None of the above
<input type="checkbox"/> External cephalic version:	
<input type="checkbox"/> Successful	
<input type="checkbox"/> Failed	

m. If woman was 35 or over, was fetal genetic testing offered?

Yes No, Too Late No, Other Reason

Updated Birth certificate

I. Obstetric Procedures
(Check all that apply)

Cervical cerclage Fetal genetic testing
 Tocolysis None of the above
 External cephalic version:
 Successful
 Failed

m. If mother/parent was 35 or over, was fetal genetic testing offered?

Yes No, Too Late No, Other Reason

Current eVital screen, no changes made to eVital

Obstetric Procedures (Check all that apply)

Cervical cerclage External Cephalic Version: Failed Unknown
 Tocolysis Fetal genetic testing None of the above
 External Cephalic Version: Successful

Was Fetal Genetic Testing Offered?

Yes x v

6. **Question 17a:** Remove 'Family Health Plus' from primary payor
- Original:** Medicaid/Family Health Plus
 - New:** Medicaid
 - Purpose:** Family Health Plus no longer exists.

Current Birth Certificate

17. FINANCIAL COVERAGE

a. Primary Payor
(Check one)

Medicaid/Family Health Plus Other
 Private Insurance Self-pay
 Other govt/CHPlusB Unknown
 CHAMPUS/TRICARE

b. Is the mother/parent enrolled in an HMO or other managed care plan?

Yes No

c. Did mother/parent participate in WIC?

Yes No

Current eVital screen (Prenatal Page)

Primary Payer*

Select one ^

Medicaid/Family Health Plus
Other govt/CHPlusB
Private Insurance
CHAMPUS/TRICARE
Self pay
Other
Unknown

Updated Birth Certificate

17. FINANCIAL COVERAGE

a. Primary Payor
(Check **one**)

Medicaid Other
 Private Insurance Self-pay
 Other govt/CHPlusB Unknown
 CHAMPUS/TRICARE

b. Is the mother/parent enrolled in an HMO or other managed care plan?
 Yes No

c. Did mother/parent participate in WIC?
 Yes No

New eVital screen (Prenatal Page)

Primary Payer*

Select one ^

Medicaid
Other govt/CHPlusB
Private Insurance
CHAMPUS/TRICARE
Self pay
Other
Unknown