GEORGIA DEPARTMENT OF PUBLIC HEALTH

Georgia Department of Public Health
Georgia Birth Defects Registry (GBDR)
Reporting Worksheet

Child's Information

Last Name:	First Name:	M.I.:
Alt Last Name:	Alt First Name:	
Street Address: _____	City: _____	
County: _____	State: _____	Zip Code: _____ - _____
Home Phone: ( ) -	Alt Phone: ( ) -	
Date of Birth (mm/dd/yyyy): / /	Birth Status: ☐ Live birth ☐ Fetal death (<20 weeks) ☐ Fetal death (≥20 weeks)	Child's Medical Record Number:
Birth Weight (grams):	Sex: ☐ Male ☐ Female ☐ Unknown	Birth Hospital:

Mother's Information

Mother's Last Name:	First Name:	M.I.:	Maiden Name:	Medical Record No.:
Alt Last Name: _____		Alt First Name: _____		
Date of Birth (mm/dd/yyyy): ____/____/_____	Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other ☐ Unknown		Hispanic/Latino: ☐ Yes ☐ No ☐ Unknown	

Diagnostic Information

Date of Diagnosis (mm/dd/yyyy): ____/____/_____

ICD-10-CM Code	Narrative
1)	
2)	
3)	
4)	
5)	
6)	
7)	
8)	
9)	
10)	

Reporting Source

(Stamp Acceptable)
Name
Street Address
City State Zip Code

Person Completing Form:
Last Name: First Name:
Phone: ( ) - Date of Report (mm/dd/yyyy): / /