

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

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:	Child's Medical Record Number:							
	Live birth								
/ /	Fetal death (<20 weeks)								
Birth Weight Sex: Male	\Box Fetal death (≥ 20 weeks)	Birth Hospital:							
(grams): Even Female		_							
Unknown									

Mother's Information

Mother's Last Name:	First Name:	e: 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 Rep	oort (mm/dd/yyyy):	/	/	
Form 3221 (rev. 04/2019)	Information on this form is CONFIDENT	IAL			