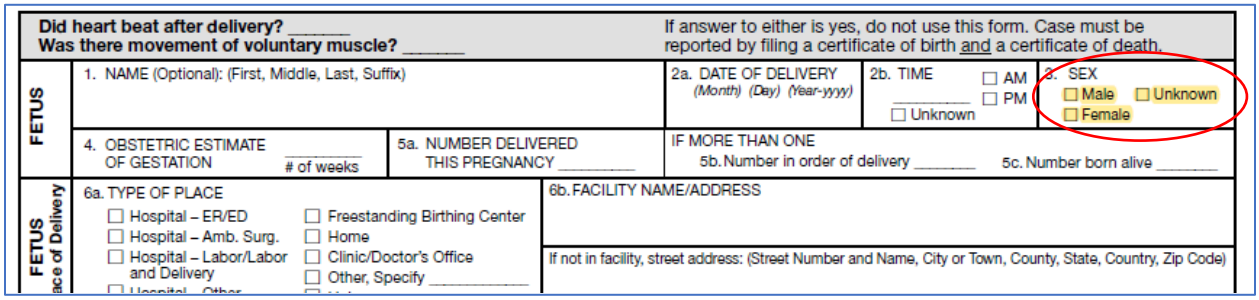
NEW YORK CITY DEPARTMENT OF
HEALTH AND MENTAL HYGIENE
Oxiris Barbot, MD
Commissioner

Guidance on Changes to New York City Department of Health and Mental Hygiene's Certificate of Spontaneous Termination of Pregnancy (STOP) (VR 17)

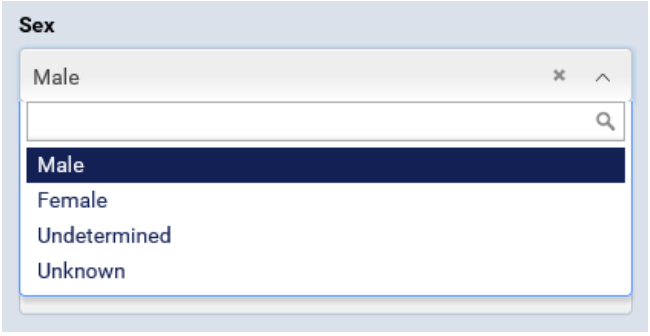
The below guidance pertains to changes to New York City Vital Record forms that will be in effect January 2, 2020. Question numbers correspond to the box numbers on the certificates. Before and after images are included to show the changes that were made.

1. **Question 3**: Add 'undetermined' as option for fetal sex
    a. **Original**: Male, Female, Unknown
    b. **New**: Male, Female, Unknown, Undetermined
    c. **Purpose**: To match the Birth Certificate

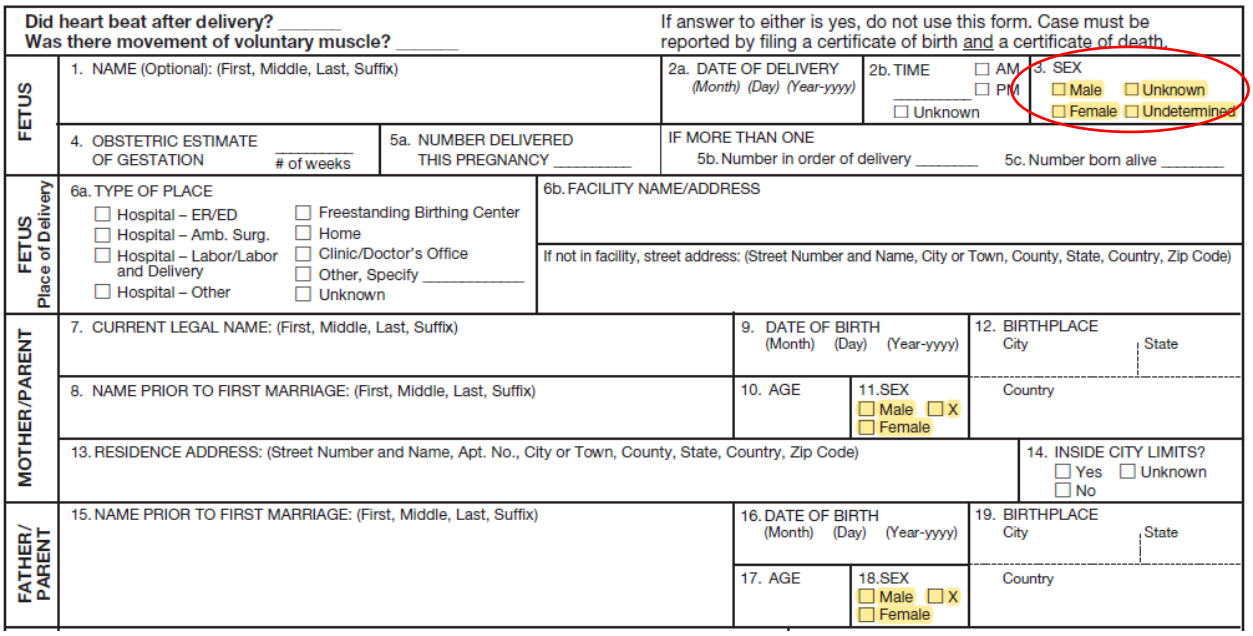
Current STOP certificate



Current eVital screen (Fetus Page), no changes made to eVital



Updated STOP certificate



Did heart beat after delivery? _____
Was there movement of voluntary muscle? _____

If answer to either is yes, do not use this form. Case must be reported by filing a certificate of birth and a certificate of death.

FETUS

1. NAME (Optional): (First, Middle, Last, Suffix)

2a. DATE OF DELIVERY (Month) (Day) (Year-yyyy)

2b. TIME _____ ☐ AM ☐ PM ☐ Unknown

3. SEX ☐ Male ☐ Female ☐ Unknown ☐ Undetermined

4. OBSTETRIC ESTIMATE OF GESTATION _____ # of weeks

5a. NUMBER DELIVERED THIS PREGNANCY _____

IF MORE THAN ONE
5b. Number in order of delivery _____ 5c. Number born alive _____

FETUS Place of Delivery

6a. TYPE OF PLACE
☐ Hospital – ER/ED ☐ Freestanding Birthing Center
☐ Hospital – Amb. Surg. ☐ Home
☐ Hospital – Labor/Labor and Delivery ☐ Clinic/Doctor's Office
☐ Hospital – Other ☐ Other, Specify _____
☐ Unknown

6b. FACILITY NAME/ADDRESS

If not in facility, street address: (Street Number and Name, City or Town, County, State, Country, Zip Code)

MOTHER/PARENT

7. CURRENT LEGAL NAME: (First, Middle, Last, Suffix)

9. DATE OF BIRTH (Month) (Day) (Year-yyyy)

12. BIRTHPLACE City State Country

8. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

10. AGE

11. SEX ☐ Male ☐ X ☐ Female

13. RESIDENCE ADDRESS: (Street Number and Name, Apt. No., City or Town, County, State, Country, Zip Code)

14. INSIDE CITY LIMITS? ☐ Yes ☐ Unknown ☐ No

FATHER/PARENT

15. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

16. DATE OF BIRTH (Month) (Day) (Year-yyyy)

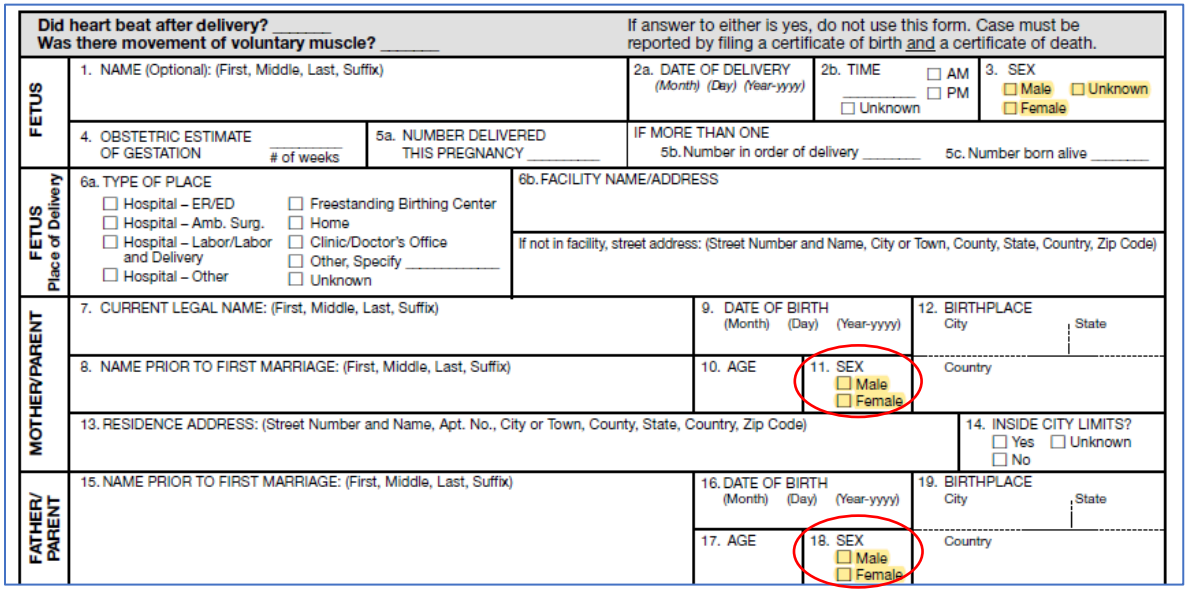
19. BIRTHPLACE City State Country

17. AGE

18. SEX ☐ Male ☐ X ☐ Female

2. **Question 11 and 18**: Adding option of 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 STOP certificate



Did heart beat after delivery? _____
Was there movement of voluntary muscle? _____

If answer to either is yes, do not use this form. Case must be reported by filing a certificate of birth and a certificate of death.

FETUS

1. NAME (Optional): (First, Middle, Last, Suffix)

2a. DATE OF DELIVERY (Month) (Day) (Year-yyyy)

2b. TIME _____ ☐ AM ☐ PM ☐ Unknown

3. SEX ☐ Male ☐ Female ☐ Unknown

4. OBSTETRIC ESTIMATE OF GESTATION _____ # of weeks

5a. NUMBER DELIVERED THIS PREGNANCY _____

IF MORE THAN ONE
5b. Number in order of delivery _____ 5c. Number born alive _____

FETUS Place of Delivery

6a. TYPE OF PLACE
☐ Hospital – ER/ED ☐ Freestanding Birthing Center
☐ Hospital – Amb. Surg. ☐ Home
☐ Hospital – Labor/Labor and Delivery ☐ Clinic/Doctor's Office
☐ Hospital – Other ☐ Other, Specify _____
☐ Unknown

6b. FACILITY NAME/ADDRESS

If not in facility, street address: (Street Number and Name, City or Town, County, State, Country, Zip Code)

MOTHER/PARENT

7. CURRENT LEGAL NAME: (First, Middle, Last, Suffix)

9. DATE OF BIRTH (Month) (Day) (Year-yyyy)

12. BIRTHPLACE City State Country

8. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

10. AGE

11. SEX ☐ Male ☐ Female

13. RESIDENCE ADDRESS: (Street Number and Name, Apt. No., City or Town, County, State, Country, Zip Code)

14. INSIDE CITY LIMITS? ☐ Yes ☐ Unknown ☐ No

FATHER/PARENT

15. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

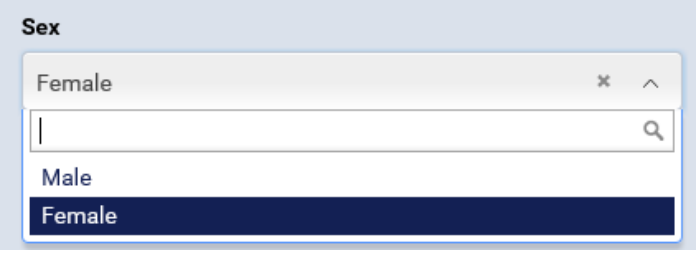
16. DATE OF BIRTH (Month) (Day) (Year-yyyy)

19. BIRTHPLACE City State Country

17. AGE

18. SEX ☐ Male ☐ Female

Current eVital screen (Mother/Parent Information or Father/Parent Information pages)



Updated STOP certificate

Did heart beat after delivery? _____
Was there movement of voluntary muscle? _____

If answer to either is yes, do not use this form. Case must be reported by filing a certificate of birth and a certificate of death.

FETUS

1. NAME (Optional): (First, Middle, Last, Suffix)

2a. DATE OF DELIVERY (Month) (Day) (Year-yyyy)

2b. TIME _____ ☐ AM ☐ PM ☐ Unknown

3. SEX ☐ Male ☐ Female ☐ Unknown ☐ Undetermined

4. OBSTETRIC ESTIMATE OF GESTATION _____ # of weeks

5a. NUMBER DELIVERED THIS PREGNANCY _____

IF MORE THAN ONE
5b. Number in order of delivery _____ 5c. Number born alive _____

FETUS Place of Delivery

6a. TYPE OF PLACE
☐ Hospital – ER/ED ☐ Freestanding Birthing Center
☐ Hospital – Amb. Surg. ☐ Home
☐ Hospital – Labor/Labor and Delivery ☐ Clinic/Doctor's Office
☐ Hospital – Other ☐ Other, Specify _____
☐ Unknown

6b. FACILITY NAME/ADDRESS

If not in facility, street address: (Street Number and Name, City or Town, County, State, Country, Zip Code)

MOTHER/PARENT

7. CURRENT LEGAL NAME: (First, Middle, Last, Suffix)

9. DATE OF BIRTH (Month) (Day) (Year-yyyy)

12. BIRTHPLACE City State Country

8. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

10. AGE

11. SEX ☐ Male ☐ X ☐ Female

13. RESIDENCE ADDRESS: (Street Number and Name, Apt. No., City or Town, County, State, Country, Zip Code)

14. INSIDE CITY LIMITS? ☐ Yes ☐ No ☐ Unknown

FATHER/PARENT

15. NAME PRIOR TO FIRST MARRIAGE: (First, Middle, Last, Suffix)

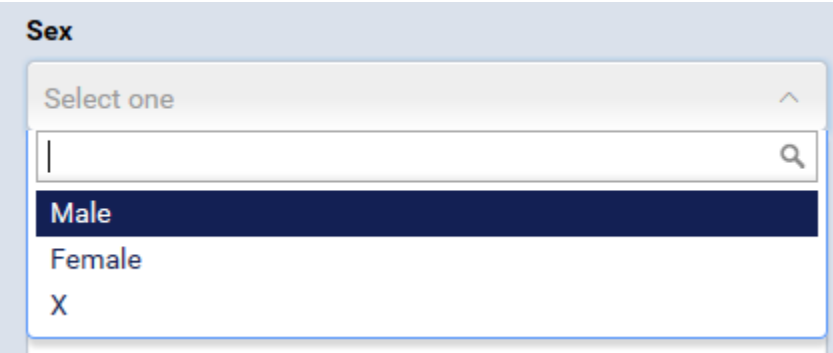
16. DATE OF BIRTH (Month) (Day) (Year-yyyy)

19. BIRTHPLACE City State Country

17. AGE

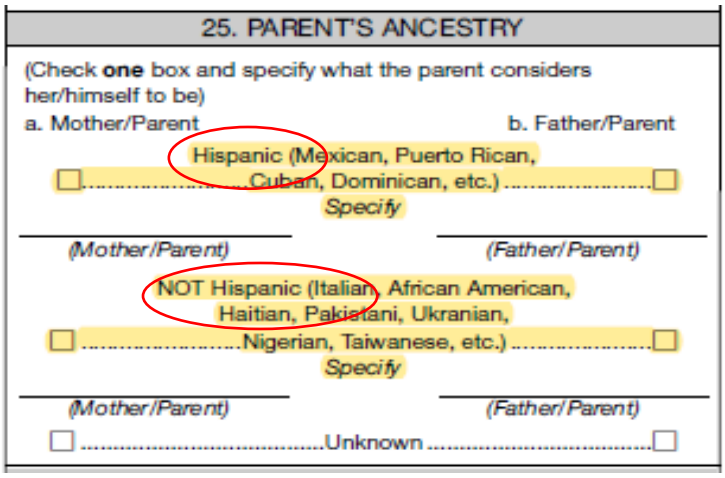
18. SEX ☐ Male ☐ X ☐ Female

New eVital screen (Mother/Parent Information and Father /Parent Information pages)



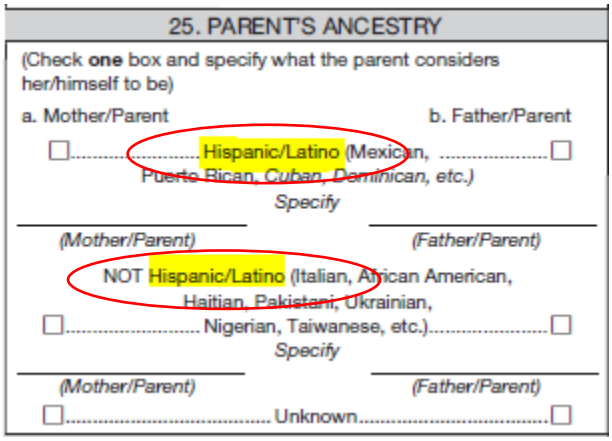
3. **Question 25**: Adding Latino to Parent's ancestry label
    a. **Original**: Hispanic
    b. **New**: Hispanic/Latino
    c. **Purpose**: To be more inclusive and match the US Standard Birth Certificate

Current STOP certificate



Current eVital screen (Mother/Parent Attributes and Father/Parent Attributes pages)

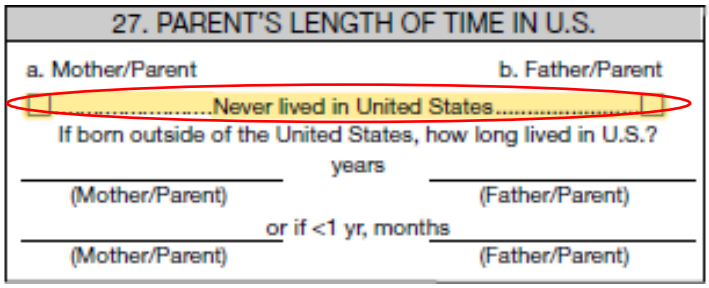
Updated STOP Certificate



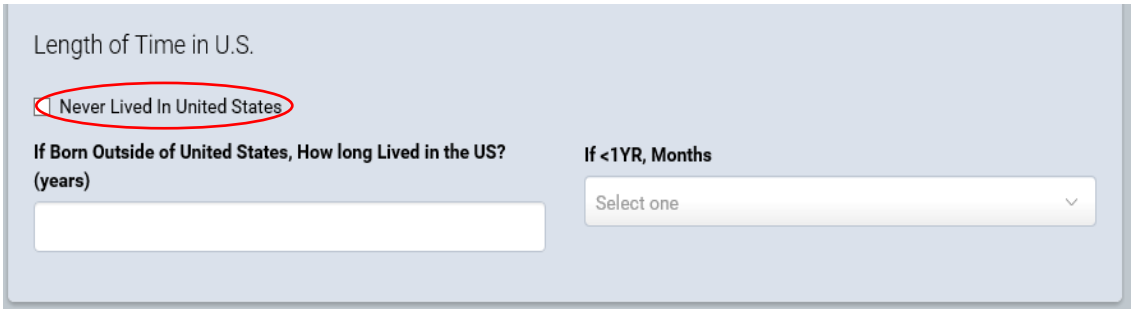
New eVital screen (Mother/Parent Attributes and Father/Parent Attributes pages)

4. **Question 27**: Remove 'Never Lived in US"
    a. **Original**: Never lived in United States
    b. **New**: Removed
    c. **Purpose**: Match Certificate of Birth (VR6S)

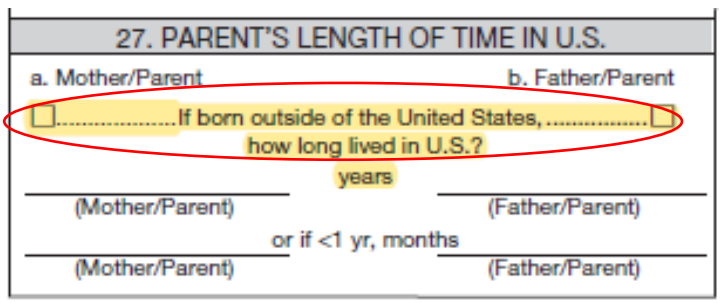
Current STOP Certificate



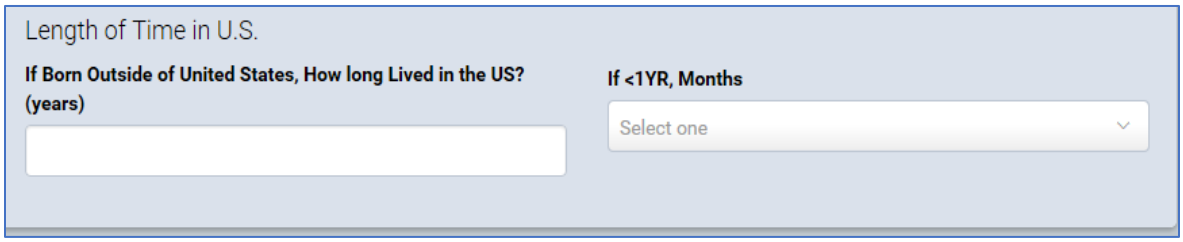
Current eVital screen (Mother/Parent Attributes and Father/Parent Attributes pages)



Updated STOP Certificate



New eVital screen (Mother/Parent Attributes and Father/Parent Attributes pages)



5. **Question 31a**: Change label and re-order pregnancy factors
    a. **Original**:

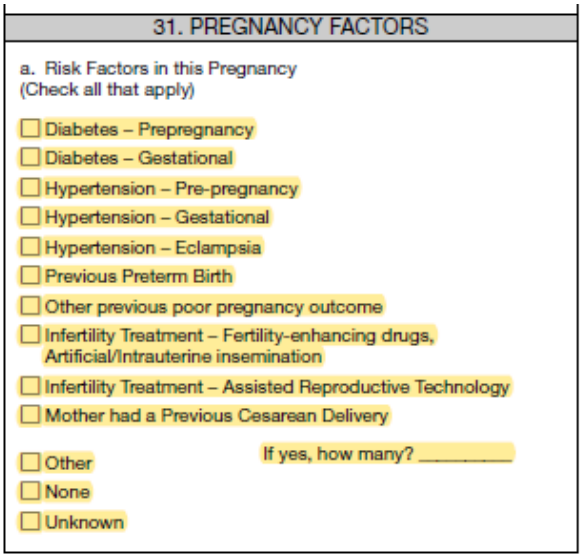
        □ Diabetes – Pre-pregnancy
        □ Diabetes – Gestational
        □ Hypertension – Pre-pregnancy
        □ Hypertension – Gestational
        □ Hypertension – Eclampsia
        □ Previous Preterm Birth
        □ Other previous poor pregnancy outcome
        □ Infertility Treatment – Fertility-enhancing drugs, Artificial/Intrauterine insemination
        □ Infertility Treatment – Assisted Reproductive Technology
        □ Mother had a Previous Cesarean Delivery
        If yes, how many? _____
        □ Other
        □ None
        □ Unknown

    b. **New**:

        □ Pre-pregnancy diabetes
        □ Gestational diabetes
        □ Pre-pregnancy hypertension
        □ Gestational hypertension
        □ Eclampsia
        □ Previous Preterm Birth
        □ Other previous poor pregnancy outcome
        □ Infertility Treatment *Fertility-enhancing drugs, Artificial/Intrauterine insemination*
        □ Infertility Treatment – *Assisted Reproductive Technology (eg. IVF, GIFT)*
        □ Previous cesarean section: Number _____
        □ Other
        □ None
        □ Unknown

    c. **Purpose**: Match VR6S

Current STOP Certificate



31. PREGNANCY FACTORS

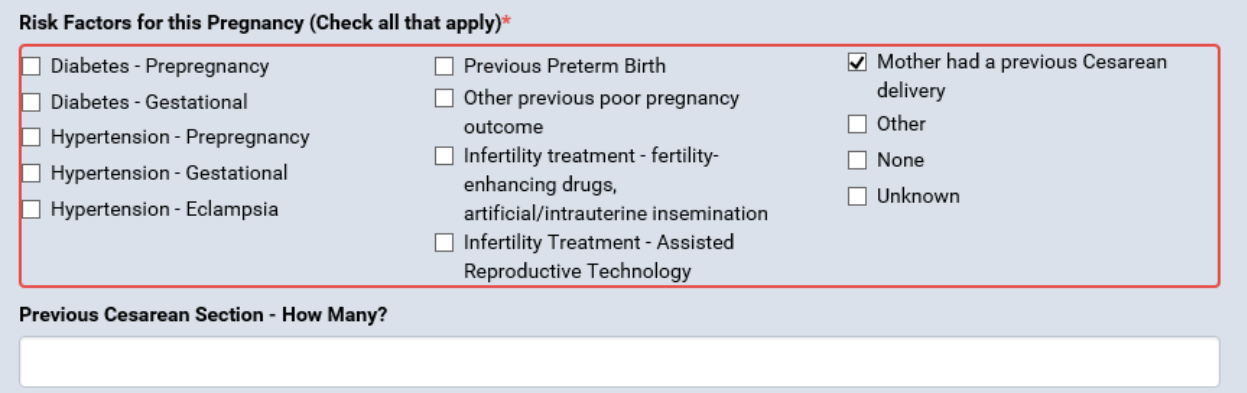
a. Risk Factors in this Pregnancy
(Check all that apply)

- ☐ Diabetes – Prepregnancy
- ☐ Diabetes – Gestational
- ☐ Hypertension – Pre-pregnancy
- ☐ Hypertension – Gestational
- ☐ Hypertension – Eclampsia
- ☐ Previous Preterm Birth
- ☐ Other previous poor pregnancy outcome
- ☐ Infertility Treatment – Fertility-enhancing drugs, Artificial/Intrauterine insemination
- ☐ Infertility Treatment – Assisted Reproductive Technology
- ☐ Mother had a Previous Cesarean Delivery

If yes, how many? _____

- ☐ Other
- ☐ None
- ☐ Unknown

Current eVital labels for the Pregnancy Factors page

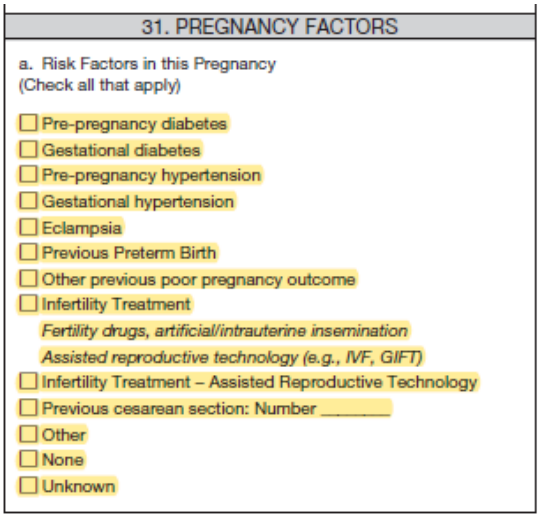


Risk Factors for this Pregnancy (Check all that apply)*

- ☐ Diabetes - Prepregnancy
- ☐ Diabetes - Gestational
- ☐ Hypertension - Prepregnancy
- ☐ Hypertension - Gestational
- ☐ Hypertension - Eclampsia
- ☐ Previous Preterm Birth
- ☐ Other previous poor pregnancy outcome
- ☐ Infertility treatment - fertility-enhancing drugs, artificial/intrauterine insemination
- ☐ Infertility Treatment - Assisted Reproductive Technology
- ☑ Mother had a previous Cesarean delivery
- ☐ Other
- ☐ None
- ☐ Unknown

Previous Cesarean Section - How Many?

Updated STOP Certificate



31. PREGNANCY FACTORS

a. Risk Factors in this Pregnancy
(Check all that apply)

- ☐ Pre-pregnancy diabetes
- ☐ Gestational diabetes
- ☐ Pre-pregnancy hypertension
- ☐ Gestational hypertension
- ☐ Eclampsia
- ☐ Previous Preterm Birth
- ☐ Other previous poor pregnancy outcome
- ☐ Infertility Treatment
  - *Fertility drugs, artificial/intrauterine insemination*
  - *Assisted reproductive technology (e.g., IVF, GIFT)*
- ☐ Infertility Treatment – Assisted Reproductive Technology
- ☐ Previous cesarean section: Number _____
- ☐ Other
- ☐ None
- ☐ Unknown

Updated eVital labels for the Pregnancy Factors page

Risk Factors for this Pregnancy (Check all that apply)

- ☐ Pre-pregnancy diabetes
- ☐ Gestational diabetes
- ☐ Pre-pregnancy hypertension
- ☐ Gestational hypertension
- ☐ Eclampsia
- ☐ Previous Preterm Birth
- ☐ Other previous poor pregnancy outcome
- ☐ Infertility Treatment – Fertility drugs, artificial/intrauterine insemination
- ☐ Infertility Treatment – Assisted Reproductive Technology(e.g., IVF, GIFT)
- ☐ Previous cesarean section
- ☐ Other
- ☐ None
- ☐ Unknown