Birth Center Annual Report

Report data from July 1, _____ through June 30, _____.

Completed reports must be received by the Agency no later than July 30.

1. Birth Center Information

Please complete the following.			
Name of Birth Center (List fictitious name, if applicable)			License #
Street Address			
City	County	State FL	Zip

2. Client Care Services

Number of Deliveries in the Birth Center by Weight. *Enter data in each field.*			
Total Number of Deliveries:			
< 1500 Grams	1500 - 1999 Grams	2000 - 2499 Grams	> 2500 Grams

Number of Maternity Clients Accepted for Care and Length of Stay. *Enter data in each field.*			
Total Number of Maternity Clients: ___			
Total Length of Stay, Hours	Shortest:	Longest:	Average:
Postpartum Length of Stay, Hours	Shortest:	Longest:	Average:

Surgical Services Performed at the Birth Center. *Enter data in each field.*		
Circumcisions	**Episiotomies**	**Episiotomy/Laceration Repair**

Other Surgical Services Performed at the Birth Center. *Enter data in each field. Attach additional sheets, if necessary.*		
Procedure	**Performed by (Name)**	**Professional License Number**

Section 59A-11.019(4), Florida Administrative Code
Form available at: http://ahca.myflorida.com/HQAlicensureforms

3. Transfer Information

Maternal Transfers. *Attach additional sheets, if necessary.*

Date	Reason for Transfer	Intrapartum or Postpartum	Days in Hospital

Newborn Transfers. *Attach additional sheets, if necessary.*

Date	Reason for Transfer	Birth Weight, Grams	Days in Hospital	APGAR (5 min) __/10

4. Deaths

Newborn Deaths. *Delivered at the Birth Center and Died within Seven Days of Life.*

Do not include clients transferred more than 48 hours before birth.

Date	Birth Weight, Grams	Death Occurred at				Cause of Death	Reported to Medical Examiner, Y/N
		Birth Center	Hospital	Home	Other		
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			
		☐	☐	☐			

Stillborn/Fetal Deaths. *Delivered at the Birth Center only.*

Date	Birth Weight, Grams	Death Occurred			Cause of Death	Reported to Medical Examiner, Y/N
		Before Labor	During Labor	During Delivery		
		☐	☐	☐		
		☐	☐	☐		
		☐	☐	☐		

5. Signature

The information presented on this form is true and correct. Prepared by:

Date of Submission: _____

Signature _____

Title _____

Printed Name _____

Telephone _____

RETURN THIS COMPLETED FORM TO
Fax: (850) 488-5897
Email: Hospitals@ahca.myflorida.com

Agency for Health Care Administration
Hospital and Outpatient Services Unit
2727 Mahan Dr., MS 31
Tallahassee, FL 32308-5407