Northwest Territories Health and Social Services

Office Use only	Registration Number	Birth Registration Number	Death Registration Number

N.W.T. Disease Registry

Congenital Anomalies Reporting Form

Medical Confidential

Fetus / Infant / Child

Please Print Clearly

Name *(Last, First, Middle)*	Date of Birth / Pregnancy Outcome *Month by Name* | *Day* | *Year*
Type of Birth ☐ Livebirth ☐ Fetus less than 20 weeks gestation ☐ Stillbirth Elective termination ☐ Yes ☐ No	Name of Hospital of Birth / Pregnancy Outcome
Gender ☐ Male ☐ Female ☐ Unknown	Child's Health Care Number ☐ Not available
Plurality of Birth ☐ Single ☐ Twin ☐ First ☐ Second ☐ Triplets ☐ First ☐ Second ☐ Third	Attending Physician's/Health Care Provider's Name
	Physician Responsible for Ongoing Care *(if different from above)*

Birthweight *Grams*	Gestation Age *(Completed Weeks)*	Hospital Chart Number ☐ Not available	Date of Death *(if applicable)* *Month by Name* | *Day* | *Year*

Parents

Biological Mother's Name *(Last, First, Middle)*		Mother's Date of Birth *Month by Name* | *Day* | *Year*
Mother's Community of Residence	Postal Code	Letter Prefix Mother's Health Care Number
Father's Name *(Last, First, Middle)*		Father's Date of Birth *Month by Name* | *Day* | *Year*

Reporting Hospital/Clinic/Agency

Name of Facility	Location *(Community)*

Please describe congenital anomaly(ies) and/or syndrome diagnoses in as much detail as possible. Use the back of form for additional space and add confirmatory documentation if available (radiology report, consultant record etc).

Completed by	Position	Date *Month by Name* | *Day* | *Year*

RETURN To: **Office of the Chief Public Health Officer**
Department of Health & Social Services
Box 1320 CST-6, Yellowknife NT X1A 2L9

Phone: (867) 920 8646
Fax: (867) 873 0442