

Birth Defects Reporting Form

Today's Date: / /
(mm/dd/yyyy)

Person Completing Form: _____

Medical Facility Name: _____

Patient Last Name: _____

Patient First Name: _____

Patient Middle Name: _____

Patient DOB: / /
(mm/dd/yyyy)

Patient Community of Birth: _____

Patient Race (Check Only One):

- Alaska Native/American Indian Asian Black
 Native Hawaiian/Pacific Islander White Unknown Other _____

Is patient of Hispanic Ethnicity? Yes No

Patient Sex: Male Female

Patient Community of Residence: _____

ICD-9 Code	Diagnosis Description	Date of Diagnosis
_____	_____	___/___/___
_____	_____	___/___/___
_____	_____	___/___/___
_____	_____	___/___/___

If you have a large number of reports, please contact our office for an alternate method of reporting.

Alaska Birth Defects Registry
3601 C Street, Suite 424
P.O. Box 240249
Anchorage, Alaska 99524-0249



To reach Alaska Birth Defects Registry:

Phone: 1-907-269-8097

Fax: 1-907-269-3493