

NHS No.

Maternity Unit

ANTENATAL SUMMARY



Planned Place of Birth	Lead Professional	Unit Number	Information overleaf <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Midwife ☎

Other ☎

Multi-agency professionals

☎

Ethnic Origin

Interpreter

First Name Surname

Address

Post code Date of birth

Risk Assessment EDD Para + Age BMI BP booking

Relevant Factors	No	Yes	Comments	Relevant Factors	No	Yes	Comments	Relevant Factors	No	Yes	Comments
Medical	<input type="checkbox"/>	<input type="checkbox"/>		OGTT booked	<input type="checkbox"/>	<input type="checkbox"/>		Management plan commenced	<input type="checkbox"/>	<input type="checkbox"/>	
Obstetric	<input type="checkbox"/>	<input type="checkbox"/>		Mental health	<input type="checkbox"/>	<input type="checkbox"/>		Smoking	<input type="checkbox"/>	<input type="checkbox"/>	
VTE assessment performed	<input type="checkbox"/>	<input type="checkbox"/>		Social	<input type="checkbox"/>	<input type="checkbox"/>		Drug/alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	
VTE pathway initiated	<input type="checkbox"/>	<input type="checkbox"/>	Low/Med High Risk	Anaesthetic assessment	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin required	<input type="checkbox"/>	<input type="checkbox"/>		GP records reviewed	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	
BMI pathway initiated	<input type="checkbox"/>	<input type="checkbox"/>		Manual handling/ tissue viability assessment	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	

Investigations

Booking	Date taken	Result	Screening / additional tests	Date taken	Result/Action
MSU	<input type="text"/>			<input type="text"/>	
Haemoglobin	<input type="text"/>			<input type="text"/>	
Blood group	<input type="text"/>			<input type="text"/>	
Antibodies	<input type="text"/>			<input type="text"/>	
Hepatitis B	<input type="text"/>			<input type="text"/>	
Syphilis	<input type="text"/>			<input type="text"/>	
HIV	<input type="text"/>			<input type="text"/>	
Sickle cell	<input type="text"/>			<input type="text"/>	
Thalassaemia	<input type="text"/>			<input type="text"/>	
MRSA	<input type="text"/>			<input type="text"/>	
OGTT	<input type="text"/>			<input type="text"/>	
OGTT	<input type="text"/>			<input type="text"/>	

Emergency Contact

Name Relationship

☎ ☎ ☎

Completed by: Date



Special features	Antenatal Plan	Labour, delivery & postnatal plan	Paediatric alert form <input type="checkbox"/>
Flu vaccine given Yes <input type="checkbox"/> Declined <input type="checkbox"/>			
SGA or FGR on scan Yes <input type="checkbox"/>			
Medication	Allergies	Paediatrician to be present <input type="checkbox"/>	Seniority _____ Reason _____

Domestic Abuse	Booking	2nd Assessment	Details (inc. any referrals)
	No Yes	No Yes	
Seen alone	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Routine enquiry question asked	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Abuse disclosed	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
Date	D D M M Y Y	D D M M Y Y	
Signed			

Anyone living in the household (list below)

Name	Date of birth	Relationship to Mother	Name	Date of birth	Relationship to Mother

Partners' other children (list below)

Name	Date of birth	Level of contact	Name	Date of birth	Level of contact

Date	Gestation	Details	Signed
D D M M Y Y	W ks+D	H H M M	

Name	
Unit No/ NHS No	