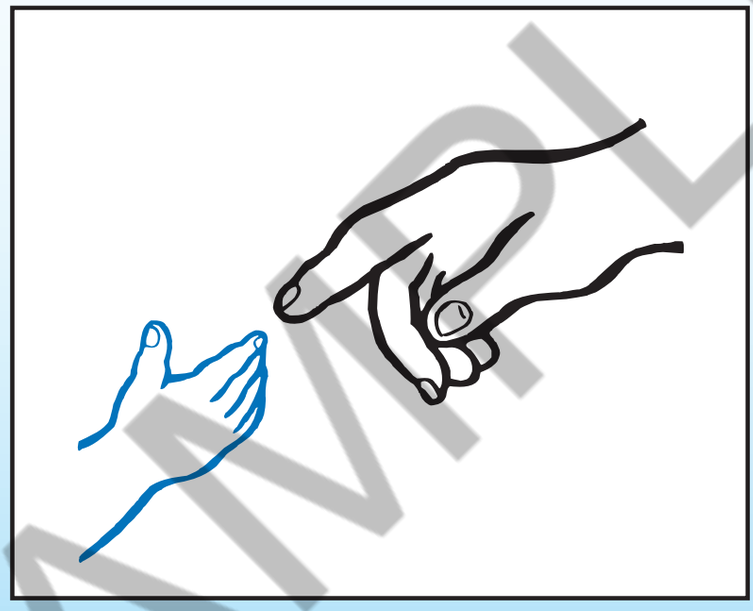

PRIVATE & CONFIDENTIAL

If found, please return the notes immediately to the owner, or her midwife or maternity unit.

Perinatal Notes

Trust

Maternity Unit

Address

Postcode

☎ ☎

These Maternity Notes are a guide to your options during pregnancy, childbirth and life with your new baby and are intended to help you and your partner make informed choices. The explanations in these notes are a general guide only, and not everything will be relevant to you.

If you are asked to make a choice, please feel free to ask any questions and talk about options with family/friends. Write down anything you want to discuss and take it to your appointment: there are spaces for you to write in the notes. **Key questions are:-** What are my options? What are the advantages/disadvantages for each option for me? How do I get support to help me make a decision that is right for me? Additional information is also available via NHS website - www.nhs.uk or in leaflets which you may be given by your health care professionals as and when needed.

You should keep these notes with you at all times and bring them to all appointments and when you go into labour. After the birth of your baby these notes will be kept by the hospital and filed in your records.

Support Groups/additional information

Alcohol Change	0300 123 1110	www.alcoholchange.org.uk
Antenatal Results and Choices	0845 077 2290	www.arc-uk.org
Birth Rights		www.birthrights.org.uk
Childline	0800 1111	www.childline.org.uk
Citizens Advice Bureaux	03444 111444	www.citizensadvice.org.uk
CMV Action Line	0808 802 0030	www.cmvaction.org.uk
Frank About Drugs	0300 123 6600	www.talktofrank.com
Group B Strep Support Group	0330 1200 796	www.gbss.org.uk
Mama Academy	07427 851670	www.mamaacademy.org.uk
MIND - for better mental health	0300 123 3393	www.mind.org.uk
National Breastfeeding Helpline	0300 100 0212	www.nationalbreastfeedinghelpline.org.uk
National Childbirth trust (NCT)	0300 330 0700	www.nct.org.uk
National Domestic Abuse Helpline	0808 200 0247	www.nationaldahelpline.org.uk
NHS Non-Emergencies	**111**	**www.111.nhs.uk**
NHS Smoking Helpline	0300 123 1044	www.nhs.uk/pregnancy/keeping-well/stop-smoking/
NSPCC's FGM Helpline	0800 028 3550	www.nspcc.org.uk
Samaritans	116 123	www.samaritans.org
Stillbirth & Neonatal Death Charity (SANDS)	0808 164 3332	www.sands.org.uk
Tommy's Pregnancy Line	0800 0147 800	www.tommys.org

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Personal details

First name | Surname

Address

Postcode | ☎ | ☎

Date of birth (D D M M Y Y) | Unit No. | NHS No.

Age | Booking BMI | Parity | EDD (D D M M Y Y)

Communication needs

Assistance required No ☐ Yes ☐ Details | Your preferred name

Do you speak English No ☐ Yes ☐ | What is your first language

Preferred language | Interpreter ☎

Plan of care

Depending on your circumstances, you and your partner will have the choice between midwifery based care or maternity team based care during your pregnancy. Please discuss your choices/options with your midwife. This will be based on your individual medical and obstetric history.

Date recorded	Planned place of birth	Lead professional	Job title	Reason if changed
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				

Maternity contacts

Named Midwife ☎

Midwifery Team ☎

Maternity Unit ☎

Antenatal Clinic ☎ | Delivery Suite ☎

Community Office ☎ | Ambulance ☎

Primary care contacts

Centre ☎ | Other(s)

Initial | Surname

GP ☎

Postcode (GP) ☎

Health Visitor/Family Nurse Practitioner

Next of Kin

Name

Address

☎ | Relation

Emergency Contact

Name

Address

☎ | ☎

Signatures Anyone writing in these notes should record their name and signature here.

Name (print clearly)	**GMC / NMC number**	**Post**	**Signature**

Name

Unit No/
NHS No

Appointments

You will be offered appointments during your pregnancy to check you and your baby's well-being. The date and time of these can be recorded below.

Date	Day of week	Time	Where	With	Reason
D D M M Y Y					

Name	
Unit No/ NHS No	

Mental health Complete risk assessment page 12 and personalised care plan page 13.

Pregnancy and having a baby can be an exciting but also a demanding time. This can result in pre-existing symptoms getting worse. It's not uncommon for women to feel anxious, worried or 'down' at this time. The range of mental health problems women may experience or develop is the same during pregnancy and after birth as at other times in her life, but some illnesses/ treatments may be different. Some women who have a mental health problem stop taking their medication when they find out they are pregnant. This can result in symptoms worsening. **You should not alter your medication without specialist advice from your GP, mental health team or midwife.**

Women with a severe mental illness such as psychosis, schizophrenia, schizoaffective disorder or bipolar disorders are more likely to become unwell again than at other times. Severe mental illness may develop more quickly immediately after childbirth and can be more serious requiring urgent treatment.

At your 1st appointment you will be asked how you are feeling now and if you have or have had any problems with your mental health in the past. You will be asked about your emotional wellbeing at your appointments during pregnancy and after the birth of your baby. These questions are asked to every pregnant woman and new mother.

The maternity team supporting you during pregnancy and after birth may identify that you are at risk of developing a mental health problem. If this happens they will discuss with you options for support and treatment. You may be offered a referral to a mental health team/specialist midwife/obstetrician.

If you are concerned about your thoughts, feelings or behaviour, you should seek help and advice.

Further information can be found about mental health including medication in pregnancy and breastfeeding via:
www.england.nhs.uk/mental-health/perinatal/
www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/what-are-perinatal-mental-health-services

1st Assessment. Have you ever been diagnosed with any of the following:	No	Yes
Psychotic illness, bipolar disorders, schizophrenia, schizoaffective disorder, post-partum psychosis	☐	☐
Depression	☐	☐
Generalised anxiety disorder, OCD, panic disorder, social anxiety, PTSD	☐	☐
Eating disorder e.g. anorexia nervosa, bulimia nervosa or binge eating disorder	☐	☐
Personality disorder	☐	☐
Self-harm	☐	☐
Is there anything in your life (past/present) which might make the pregnancy/childbirth difficult? e.g. tokophobia, trauma, childhood sexual abuse, sexual assault	☐	☐
Help received (current or previous):		
GP/Midwife/Health visitor support	☐	☐
Counselling/cognitive behavioural therapy (CBT)	☐	☐
Specialist perinatal mental health team	☐	☐
Hospital or community based mental health team	☐	☐

Inpatient (hospital name) _____ Date(s) _____

Psychiatrist _____ Psychiatric nurse/care coordinator _____

Medication (list current or previous) drug name, dose and frequency

Partner	No	Yes
Does your partner have any history of mental health illness?	☐	☐
Family History	No	Yes
Has anyone in your family had a severe perinatal mental illness? (first degree relative e.g. mother, sister)	☐	☐

Depression identification questions	1st No	1st Yes	2nd No	2nd Yes
During the past month, have you often been bothered by feeling down, depressed or hopeless?	☐	☐	☐	☐
During the past month, have you often been bothered by having little interest or pleasure in doing things?	☐	☐	☐	☐

If yes to either of these questions, consider offering self-reporting tools e.g. PHQ 9

Anxiety identification questions	No	Yes	No	Yes
During the past 2 weeks, have you been bothered by feeling nervous, anxious or on edge?	☐	☐	☐	☐
During the past 2 weeks, have you been bothered by not being able to stop or control worrying?	☐	☐	☐	☐
Do you find yourself avoiding places or activities and does this cause you problems?	☐	☐	☐	☐

If yes to any of these questions, consider offering self-reporting tool e.g. GAD 7

*** Signatures must be listed on page b for identification**

Name _____
Unit No/ NHS No _____

My Pregnancy Planner

During your pregnancy, you will be offered regular appointments with your healthcare team. The location of these appointments will depend on your individual circumstances and preferences. The purpose of these, are to check that you and your baby are well and provide support and information about your pregnancy to help you make informed choices. How often these are varies from woman to woman and the frequency may need to be adjusted if your circumstances change. As a minimum, you should be offered appointments at the following weeks of your pregnancy. You can write the date of these appointments in the space provided. After each of your appointments, it is important you know when your next one is, where it will take place and who it is with.

Date

First Contact

Booking Appointment
LMP D D M M Y Y
Estimated wks gestation W W + D

Dating scan
Screening tests

16 weeks
Screening results

Anomaly scan at 18 to 20 weeks

25 weeks -
for women having their first baby/or women receiving increased surveillance

28 weeks

Health Visitor
Antenatal visit from 28 weeks

31 weeks -
for women having their first baby/or women receiving increased surveillance

34 weeks

36 weeks

38 weeks

40 weeks -
for women having their first baby/or women receiving increased surveillance

41 weeks

42 weeks

Your Details

Single ☐ Married / CP ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed ☐

Family name at birth

Country of birth | If not UK, year of entry (Y Y Y Y)

Have you had a full medical exam since coming to the UK? (if no refer to GP) No ☐ Yes ☐

Faith / Religion | Citizenship status

Sensory/physical Disability No ☐ Yes ☐ Details

Partner's Details

First name | Surname

Address if different

Postcode:

Date of birth (D D M M Y Y) ☎

Employed ☐ U/E ☐ Occupation

Citizenship status | If not born in UK, year of entry (Y Y Y Y)

Social Assessment-booking

record plan on page 13

	No	Yes	2nd Assessment No	2nd Assessment Yes	Referred
Has difficulty understanding English	☐	☐	☐	☐	☐
Any difficulties reading / writing English	☐	☐	☐	☐	☐
Needs help understanding combined notes	☐	☐	☐	☐	☐
Needs help completing forms	☐	☐	☐	☐	☐

Employment status

Occupation | Age leaving full time education (Y Y)

F/T ☐ P/T ☐ Home ☐ Student ☐ Sick ☐ U/E ☐ Retired ☐ Voluntary ☐

Housing: Owns ☐ Rents ☐ With family/ friends ☐ UKBA ☐ NFA ☐

Care services ☐ Temporary accommodation ☐ Other

How long have you lived at your current address?

How many people live in your household?

Entitled to claim benefits (income support, child tax credits, job seeker etc.) ☐ ☐ ☐ ☐ ☐

Do you have support from partner / family / friend ☐ ☐ ☐ ☐ ☐

Which health or social care agencies have been involved in the past with you or anyone in your household? Or currently to support you or anyone in your household? e.g. social services

Name of social worker(s)/ other multi agency professionals

Does your partner have any other children. If yes, who looks after them? ☐ ☐

Tobacco use - booking

record plan on page 13

	No	Yes
Are you a smoker?	☐	☐
Have you ever used tobacco?	☐	☐
Was this in the last 12 months?	☐	☐

When did you stop? (D D M M Y Y)

If in pregnancy, how many weeks? (WKS)

Anyone else at home smoke? ☐ ☐

Do you:	1st No	1st Yes	1st No. per day	2nd No	2nd Yes	2nd No. per day
Smoke cigarettes	☐	☐		☐	☐	
Smoke roll ups	☐	☐		☐	☐	
Use e-cigarettes	☐	☐		☐	☐	
Use NRT	☐	☐		☐	☐	
Chew tobacco	☐	☐		☐	☐	
Smoking cessation referral	☐	☐	Declined ☐	☐	☐	Declined ☐
CO screening?	☐	☐	Result	☐	☐	Result

Drug use - booking

record plan on page 13

	1st No	1st Yes	2nd No	2nd Yes
Have you ever used street drugs, cannabis, or psychoactive substances (legal highs)?	☐	☐		
Have you ever injected drugs?	☐	☐		
Have you ever shared drugs paraphernalia?	☐	☐		
Do you currently use?	☐	☐	☐	☐
Details				
Are you receiving treatment?	☐	☐	☐	☐
Any drug or alcohol concerns in the home?	☐	☐		

Details

Alcohol - booking

record plan on page 13

	No	Yes	2nd No	2nd Yes
Do you drink alcohol?	☐	☐	☐	☐

Alcohol units per week: Pre-pregnancy | Currently | 2nd

In the last 12 months, how often have you had a drink containing alcohol?

e.g. daily, weekly

How many units of alcohol do drink on a typical day when you are drinking?

Substance misuse referral ☐ ☐ ☐ ☐

Consider using an alcohol screening tool e.g. AUDIT-C

Declined ☐ Declined ☐

Ethnic Origin

(If **mixed**, tick more than one box) - is to describe where your family originates from, as distinct from where you were born.

This information is needed to produce a customised growth chart for your baby (page 16).

Declined ☐ ☐

	You	Baby's father
British European (e.g. England, Wales)	☐	☐
East European (e.g. Poland, Romania)	☐	☐
Irish European (e.g. Northern Ireland, ROI)	☐	☐
North European (e.g. Sweden, Denmark)	☐	☐
South European (e.g. Greece, Spain)	☐	☐
West European (e.g. France, Germany)	☐	☐
North African (e.g. Egypt, Sudan)	☐	☐
East African (e.g. Ethiopia, Kenya)	☐	☐
Central African (e.g. Cameroon, Congo)	☐	☐
Southern African – Black (e.g. Botswana, S. Africa)	☐	☐
South African – Euro (South Africa)	☐	☐
West African (e.g. Gambia, Ghana)	☐	☐
Middle Eastern (e.g. Iraq, Turkey)	☐	☐
Indian (e.g. India, Sri Lanka)	☐	☐
Pakistani (i.e. Pakistan)	☐	☐
Bangladeshi (i.e. Bangladesh)	☐	☐
Chinese (i.e. China)	☐	☐
Other Far East (e.g. Japan, Korea)	☐	☐
South East Asian (e.g. Thailand, Philippines)	☐	☐
Caribbean (e.g. Barbados, Jamaica)	☐	☐
Other		

Complete risk assessment page 12 and personalised care plan page 13

Medical History Complete risk assessment page 12 and personalised care plan page 13.

Do you have / have you had:	No	Yes
Admission to ITU / HDU	☐	☐
Admission to A & E in last 12 months	☐	☐
Anaesthetic problems	☐	☐
Allergies (inc. latex)	☐	☐
Autoimmune disease	☐	☐
Back problems	☐	☐
Blood / clotting disorder	☐	☐
Blood transfusions	☐	☐
Cancer	☐	☐
Cardiac problems / heart disease	☐	☐
Cervical smear	☐	☐
Chickenpox / shingles	☐	☐
Diabetes	☐	☐
Epilepsy / neurological problems	☐	☐
Exposure to toxic substances	☐	☐
Fertility problems (this pregnancy)	☐	☐
Female circumcision / cutting	☐	☐
Gastro-intestinal problems (eg Crohns)	☐	☐
Gynae history / operations (excl. caesarean)	☐	☐
Haematological (Haemaglobinopathies)	☐	☐
High blood pressure	☐	☐
Incontinence (urinary / faecal)	☐	☐
Infections (eg MRSA, GBS)	☐	☐
Inherited disorders	☐	☐
Liver disease inc. hepatitis	☐	☐
Migraine or severe headache	☐	☐
MMR x2 doses	☐	☐
Musculo-skeletal problems	☐	☐
Operations	☐	☐
Pelvic injury	☐	☐
Renal disease	☐	☐
Respiratory diseases	☐	☐
Sexually transmitted infections (eg syphilis, herpes)	☐	☐
TB exposure	☐	☐
Thrombosis	☐	☐
Thyroid / other endocrine problems	☐	☐
Medication in the last 6 months	☐	☐
Vaginal bleeding in this pregnancy	☐	☐
Other (provide details)	☐	☐
Folic acid tablets	☐	☐
Physical Examination performed	☐	☐

Details

Date D D M M Y Y Result

On epilepsy medication? ☐

Hepatitis B ☐ C ☐

Start date D D M M Y Y 0.4mg ☐ 5mg ☐ Dose changed? No ☐ Yes ☐

Details

Family History The term 'family' here means blood relatives only - e.g. your children, your parents, grandparents, brothers and sisters, uncles and aunts and their children (i.e. first cousins). Update personalised care plan (page 13) if indicated.

Has anyone in your family had:	No	Yes
- diabetes Type	☐	☐
- thrombosis (blood clots)	☐	☐
- high blood pressure / eclampsia	☐	☐
- hip problems from birth	☐	☐
Is your partner the baby's father	☐	☐
Is the baby's father a blood relation	☐	☐

First cousin ☐ Second cousin ☐ Other ☐

Age of baby's father

Has anyone had:	in your family No	in your family Yes	in family of baby's father No	in family of baby's father Yes
- a disease that runs in families	☐	☐	☐	☐
- need for genetic counselling	☐	☐	☐	☐
- stillbirths or multiple miscarriages	☐	☐	☐	☐
- a sudden infant death	☐	☐	☐	☐
- learning difficulties	☐	☐	☐	☐
- hearing loss from childhood	☐	☐	☐	☐
- heart problems from birth	☐	☐	☐	☐
- abnormalities present at birth	☐	☐	☐	☐
- inherited metabolic disorder	☐	☐	☐	☐

Details

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Previous Pregnancies ?

Details of previous pregnancies and births are relevant when you and your healthcare team discuss options for you in this pregnancy. They will need to know important facts such as: where you gave birth, a summary of how your pregnancy went and if you developed any complications, the weight of your baby and how you and your baby were after the birth. Some of the main topics are outlined below and further information can be found on page 19 about pregnancy complications and page 24 about labour and types of birth. This information will help you and your healthcare team develop a personalised plan together which will support your choices/preferences. If there is anything else you think may be important, please tell your midwife or obstetrician.

Para / Parity. These are terms that describe how many pregnancies you have had that have gone to and beyond 24 weeks (regardless of number of babies) e.g.one previous pregnancy with twins born at 37 weeks = Para 1

High blood pressure and/or pre-eclampsia. If you had this condition last time, you are more likely to have it again, although it is usually less severe and starts later in pregnancy. It is more likely to happen again if you have a new partner (page 19).

Intrahepatic Cholestasis in Pregnancy (ICP) (obstetric cholestasis) is a liver condition in pregnancy that causes itching especially at night (page 19). If you were diagnosed with ICP in a previous pregnancy, you are at an increased risk of developing it again.

Gestational Diabetes (GDM) can develop during pregnancy causing blood glucose (sugar) levels to become too high (page 19). You are at increased risk if you developed GDM in a previous pregnancy.

Premature birth means having a baby before 37 weeks. The earlier the baby is born, the more likely they will need specialist care in a special care or neonatal unit. The chance of a premature birth is increased if you have a weak or incompetent cervix (neck of the womb), a uterine anomaly (e.g. bicornuate uterus), develop an infection, you have vaginal bleeding, growth restriction of your baby or you smoke. If you have had any type of previous surgery to your cervix e.g. laser treatment or previous stitch (cervical cerclage) to prevent premature labour, it is important to let your healthcare team know. Having had a previous baby prematurely increases the chances of it happening again.

Small babies (fetal growth restriction). If one of your previous babies was growth restricted, there is a chance of it happening again. Arrangements will be made to monitor this baby 's growth more closely, offering ultrasound scans and other tests as necessary (page 14). The risk of growth restriction is increased if you smoke, use drugs or alcohol during pregnancy.

Big babies (macrosomia). A baby over 4.5 kg is usually considered big - but this also depends on your size and how many weeks pregnant you were when the baby was born. You may be offered a blood test to check for gestational diabetes, which can be linked to having bigger babies.

Baby Weight Conversion Chart

lb	oz	g	lb	oz	g	lb	oz	g	lb	oz	g	lb	oz	g
2	0	907	4	0	1814	6	0	2722	8	0	3629	10	0	4536
2	2	964	4	2	1871	6	2	2778	8	2	3685	10	2	4593
2	4	1021	4	4	1921	6	4	2835	8	4	3742	10	4	4649
2	6	1077	4	6	1984	6	6	2892	8	6	3799	10	6	4706
2	8	1134	4	8	2041	6	8	2948	8	8	3856	10	8	4763
2	10	1191	4	10	2098	6	10	3005	8	10	3912	10	10	4819
2	12	1247	4	12	2155	6	12	3062	8	12	3969	10	12	4876
2	14	1304	4	14	2211	6	14	3118	8	14	4026	10	14	4933
3	0	1361	5	0	2268	7	0	3175	9	0	4082	11	0	4990
3	2	1417	5	2	2325	7	2	3232	9	2	4139	11	2	5046
3	4	1474	5	4	2381	7	4	3289	9	4	4196	11	4	5103
3	6	1531	5	6	2438	7	6	3345	9	6	4252	11	6	5160
3	8	1588	5	8	2495	7	8	3402	9	8	4309	11	8	5216
3	10	1644	5	10	2551	7	10	3459	9	10	4366	11	10	5273
3	12	1701	5	12	2608	7	12	3515	9	12	4423	11	12	5330
3	14	1758	5	14	2665	7	14	3572	9	14	4479	11	14	5386

Congenital conditions. These were previously known as congenital anomalies. Some congenital conditions are detected during pregnancy, at birth, or others as the baby grows older.

Sexually transmitted infections (e.g. HIV, syphilis and herpes). If you have had a previous pregnancy affected by a sexually transmitted infection, it is important to let your midwife know what type of infection and what treatment you received.

Placenta praevia describes the position of the placenta if it lies low in the womb. If you had this confirmed in the last months of any previous pregnancy, you are at an increased risk of this happening again.

Placenta accreta happens when the placenta embeds itself too deeply in the wall of the womb. This is more common with placenta praevia.

Bleeding after birth. Postpartum haemorrhage (PPH) means a significant loss of blood after birth (usually 500mls or more). Often this happens when the womb does not contract strongly and quickly enough. There is an increased risk of it happening again, so you will be advised to have a review with an obstetrician during this pregnancy to discuss birth options.

Postnatal wellbeing. The postnatal period lasts up to 6 weeks after the birth and it is during this time your body recovers. However, for some women problems can occur e.g. slow perineal or wound healing, concerns with passing urine, wind and/or stools. Some women may also experience mental health problems (page d).

Group B Streptococcus (GBS). If you have previously had a baby who was diagnosed with a GBS infection after birth, you will be offered intravenous (drip) antibiotics when labour begins. The aim of offering you antibiotics in labour is to reduce the risk of a GBS infection for this baby.

Miscarriages. A miscarriage (sometimes called spontaneous abortion) is when you lose a baby before 24 weeks of pregnancy. If this happens in the first 3 months of pregnancy, it is known as an early miscarriage. This is very common with 10-20% of pregnancies ending this way. Late miscarriages, after 3 months but before 24 weeks are less common, (only 1-2% of pregnancies). When a miscarriage happens 3 or more times in a row, this is called recurrent miscarriage. Sometimes there is a reason found for recurrent or late miscarriage.

What if I have had a termination (abortion) but do not want anyone to know? This information can be kept confidential between yourself, your midwife and obstetrician and can be recorded in the maternity unit's records.

? Feel free to ask your midwife or doctor – or look at NHS website: **www.nhs.uk**

Previous Births

Is current pregnancy with a new partner? **No** ☐ **Yes** ☐ **Para** +

Insert additional sheets here, and number them 5.1, 5.2 etc

Child's Name & Surname	Boy ☐ Girl ☐	Date of birth (D D M M Y Y)	Age	Birthweight (G m s)	Centile	Gestation (W ks+D)	Condition since	Where now

Place of booking / Place of birth | Antenatal summary | **Complications** ICP ☐ SGA or FGR ☐ GDM ☐ Congenital conditions ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐ | **Anaesthetic** None ☐ Epidural/Spinal ☐ General ☐ | **Delivery** Normal ☐ Assisted ☐ Caesarean ☐ | **3rd stage** Normal ☐ Haemorrhage ☐ Retained placenta ☐ | **Perineum** Intact ☐ Episiotomy ☐ Tear I° ☐ 2° ☐ 3°/4° ☐

Labour details | Breast ☐ Formula ☐ Mixed ☐ | Postnatal summary | PND ☐ PP ☐ Baby GBS Infection ☐

Child's Name & Surname	Boy ☐ Girl ☐	Date of birth (D D M M Y Y)	Age	Birthweight (G m s)	Centile	Gestation (W ks+D)	Condition since	Where now

Place of booking / Place of birth | Antenatal summary | **Complications** ICP ☐ SGA or FGR ☐ GDM ☐ Congenital conditions ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐ | **Anaesthetic** None ☐ Epidural/Spinal ☐ General ☐ | **Delivery** Normal ☐ Assisted ☐ Caesarean ☐ | **3rd stage** Normal ☐ Haemorrhage ☐ Retained placenta ☐ | **Perineum** Intact ☐ Episiotomy ☐ Tear I° ☐ 2° ☐ 3°/4° ☐

Labour details | Breast ☐ Formula ☐ Mixed ☐ | Postnatal summary | PND ☐ PP ☐ Baby GBS Infection ☐

Child's Name & Surname	Boy ☐ Girl ☐	Date of birth (D D M M Y Y)	Age	Birthweight (G m s)	Centile	Gestation (W ks+D)	Condition since	Where now

Place of booking / Place of birth | Antenatal summary | **Complications** ICP ☐ SGA or FGR ☐ GDM ☐ Congenital conditions ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐ | **Anaesthetic** None ☐ Epidural/Spinal ☐ General ☐ | **Delivery** Normal ☐ Assisted ☐ Caesarean ☐ | **3rd stage** Normal ☐ Haemorrhage ☐ Retained placenta ☐ | **Perineum** Intact ☐ Episiotomy ☐ Tear I° ☐ 2° ☐ 3°/4° ☐

Labour details | Breast ☐ Formula ☐ Mixed ☐ | Postnatal summary | PND ☐ PP ☐ Baby GBS Infection ☐

Child's Name & Surname	Boy ☐ Girl ☐	Date of birth (D D M M Y Y)	Age	Birthweight (G m s)	Centile	Gestation (W ks+D)	Condition since	Where now

Place of booking / Place of birth | Antenatal summary | **Complications** ICP ☐ SGA or FGR ☐ GDM ☐ Congenital conditions ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐ | **Anaesthetic** None ☐ Epidural/Spinal ☐ General ☐ | **Delivery** Normal ☐ Assisted ☐ Caesarean ☐ | **3rd stage** Normal ☐ Haemorrhage ☐ Retained placenta ☐ | **Perineum** Intact ☐ Episiotomy ☐ Tear I° ☐ 2° ☐ 3°/4° ☐

Labour details | Breast ☐ Formula ☐ Mixed ☐ | Postnatal summary | PND ☐ PP ☐ Baby GBS Infection ☐

Early Pregnancy Losses

Year	Gestation	Nature of loss	Comments
Y Y Y Y	W ks		
Y Y Y Y	W ks		
Y Y Y Y	W ks		

Complete risk assessment p12 and personalised care plan p13

Name

Unit No/ NHS No

Prenatal Screening and Diagnosis

For further information see the leaflet 'Screening tests for you and your baby' via www.gov.uk.

During your pregnancy you will be offered and recommended several blood tests and ultrasound scans. Whether or not to have each test is a personal choice. ***Discuss each test with your healthcare team.***

Blood Tests and Investigations

Sickle Cell and Thalassaemia are inherited blood disorders which affect haemoglobin and can be passed from parent to child. All pregnant women are offered a blood test to find out if they carry a gene for thalassaemia, and those at high risk of being a sickle cell carrier are offered a test for sickle cell. Depending on your results, a test from the baby's biological father may be requested. If both of you are carriers, you will be offered diagnostic tests to find out if the baby is affected.

Infectious diseases. Early treatment and follow on care can greatly reduce the chance of your baby having the infection and make sure you get care for your own health. If you screen positive, you will be cared for by a specialist team and your baby will be followed up after birth. If you decline any of these tests you will be seen by the specialist team to discuss your decision in more detail.

Hepatitis B is a virus that affects the liver and can cause immediate or long-term ill health including cancers. You may need extra treatment in pregnancy and after birth. Your baby will need extra vaccinations in their first year of life and a blood test aged 1 to check if they are infected and need further care. Your partner, other children and close family members may need testing and vaccinations too.

Syphilis is passed on by sexual contact. Untreated, it can cause miscarriage, stillbirth or serious problems for your baby. It can be treated if found early with antibiotics. Your sexual partner should also be tested and treated as you can become re-infected if they have syphilis too. Your baby will need an examination and blood tests at birth to see if they need antibiotics.

Human Immunodeficiency Virus (HIV) affects the body's ability to fight infection and cannot be cured. Untreated, it can be passed to your baby through your blood during pregnancy, at birth or by breastfeeding. Treatment in pregnancy and not breastfeeding can greatly reduce the chance of this happening.

A negative result for any of the infectious diseases means you are "negative now". You can request testing again anytime in pregnancy if you change your sexual partner, are a sex worker, have an infected partner or think you are at risk of infection.

Other Blood Tests

Anaemia is caused by too little haemoglobin (Hb) in the blood. Hb carries oxygen and nutrients around the body and to the baby. Anaemia can make you feel very tired, faint/feeling dizzy. If you have any of these symptoms, speak to your midwife. If you are anaemic, you will be offered iron supplements and advice on your diet.

Blood group & antibodies. It is important to know whether you are rhesus positive (Rh+ve) or negative (Rh-ve), and whether you have any antibodies (foreign blood proteins). If you are Rh-ve, you will be offered further blood tests to check for antibodies. If your baby has inherited the Rh+ve gene from the biological father, antibodies to the baby's blood cells can develop in your blood. To prevent this, you will be advised to have an anti-D injection if there is a chance of blood cells from the baby spilling into your blood stream (e.g. vaginal bleeding, amniocentesis and after the birth). It is recommended that anti-D is given routinely to all Rh-ve mothers in later pregnancy.

Oral Glucose Tolerance Test (OGTT) is to find out if you have gestational diabetes (page 19). A blood test is taken after fasting and you will be advised how long to not eat. You will then be asked to drink a glucose drink and a further blood test will be taken two hours later. You may be offered this test if you have a history of the following:

Gestational diabetes ☐ Family Origin ☐ Family history - first degree relative ☐ BMI 30> kg/m ☐
Antipsychotic medication ☐ Polycystic ovarian syndrome ☐ Previous baby's birth weight > 4.5kg or >90th centile ☐

Additional Tests

Additional tests are offered if required e.g. to check for infections. Contact your midwife /GP **immediately for advice,** if you have been in contact with anyone with: **Chickenpox, Cytomegalovirus (CMV), Parvovirus (slapped cheek) or Toxoplasmosis** (page 20)

Rubella (German measles). Avoid being in contact with anyone who has a rash during your pregnancy. Check with your GP that you have received 2 MMR (mumps, measles & rubella) vaccinations, if you haven't you will need them after the birth.

Chlamydia is a sexually transmitted infection which can cause problems for you and your baby e.g. miscarriage/premature birth. If you are under 25, you may be offered either a vaginal swab or urine test. If positive, you and your partner will be offered antibiotics.

Mid-stream urine. A sample of your urine is tested to look for asymptomatic bacteriuria (a bladder infection with no symptoms). Treating with antibiotics can reduce the risk of developing a kidney infection.

Methicillin Resistant Staphylococcus Aureus (MRSA) is a bacterium which sometimes causes wound infections and can be difficult to treat as it is resistant to some antibiotics. Hospitals may offer testing if you are booked for an elective caesarean section, have any wounds or have previously tested positive for MRSA.

Screening for Down's Syndrome (T21), Edwards' Syndrome (T18) and Patau's Syndrome (T13)

The screening tests are designed to find out how likely it is that the baby has Down's syndrome, Edwards' syndrome or Patau's syndrome. Inside the cells of our bodies there are tiny structures called chromosomes. There are 23 pairs of chromosomes in each cell. With each of the individual syndromes there is an extra copy of a chromosome in each cell. The tests available will depend on how many weeks pregnant you are. If you are too far on in your pregnancy (14 weeks and 2 days) to have the combined test for Down's syndrome, you can choose to have the quadruple test. If you are too far on in your pregnancy to have the combined test for Edwards' syndrome and Patau's syndrome, the only other screening test is a mid-pregnancy (fetal anomaly) scan which will look for physical conditions.

The combined test involves having a blood test and an ultrasound scan. A blood sample is taken from you, between 10 and 14 weeks to measure the levels of substances naturally found in the blood. An ultrasound scan is performed between 11 weeks and 2 days and 14 weeks and 1 day, to measure the fluid at the back of the baby's neck (nuchal translucency measurement, NT). A computer programme is used to work out a result for you. You will be given two separate results: - one for Down's syndrome and a joint one for Edwards' syndrome and Patau's syndrome.

The quadruple test is available if you are too far on in your pregnancy to have the combined test. This test is for Down's syndrome only. A blood sample is taken from you, between 14 weeks and 2 days and 20 weeks to measure the levels of substances naturally found in the blood. A computer program is used to work out a result for you. **The result:** your midwife or obstetrician will discuss your results with you. Higher-chance result: you will be offered a diagnostic test to find out for certain if your baby has Down's syndrome, Edwards' syndrome or Patau's syndrome. There are two tests: – CVS or amniocentesis (see page 8). Lower-chance result: if your result is lower than the recommended national cut off, you will not be offered a diagnostic test. A lower-chance result does not mean that there is no chance at all of the baby having Down's syndrome, Edwards' syndrome or Patau's syndrome.

Feel free to ask your midwife or doctor – or look at NHS website: **www.nhs.uk**

Investigations If additional blood tests / investigations are required update personalised care plan p13.

Booking	Explained	Accepted by mother No	Accepted by mother Yes	Date taken	Results	Action	Signed*	Date
Mid-stream urine	☐	☐	☐	D D M M Y Y				D D M M Y Y
Haemoglobin	☐	☐	☐					
Blood group	☐	☐	☐					
Antibodies	☐	☐	☐					
Sickle cell	☐	☐	☐					
Thalassaemia	☐	☐	☐					
Hepatitis B	☐	☐	☐					
Syphilis	☐	☐	☐					
HIV	☐	☐	☐					

Date: D D M M Y Y | D D M M Y Y — Comments — Signed*

Leaflet(s) given ☐ *Signed — Care provider | Care provider

Tests from Father	Explained	Accepted No	Accepted Yes	Date taken	Results	Action	Signed*	Date
	☐	☐	☐	D D M M Y Y				D D M M Y Y
				D D M M Y Y				D D M M Y Y

Date: D D M M Y Y | D D M M Y Y — Comments — Signed*

Leaflet(s) given ☐ *Signed — Care provider | Care provider

28-week check	Explained	Accepted No	Accepted Yes	Date taken	Results	Action	Signed*	Date
Haemoglobin	☐	☐	☐	D D M M Y Y				D D M M Y Y
Antibodies	☐	☐	☐	D D M M Y Y				D D M M Y Y
Re-offer tests for infections if declined at booking	☐	☐	☐	D D M M Y Y	Results to be recorded above			

Date: D D M M Y Y | D D M M Y Y — Comments — Signed*

*Signed — Care provider | Care provider

Additional tests (if indicated)	Explained	Accepted No	Accepted Yes	Date taken	Results	Action	Signed*	Date
MRSA	☐	☐	☐	D D M M Y Y				D D M M Y Y
OGTT	☐	☐	☐					
OGTT	☐	☐	☐					
	☐	☐	☐					

Date: D D M M Y Y | D D M M Y Y — Comments — Signed*

Leaflet(s) given ☐ *Signed — Care provider | Care provider

Anti D prophylaxis	If Rh-ve	Accepted No	Accepted Yes	Date given	Site	Batch No.	Dose	Signed*
Gestation W ks	☐	☐	☐	D D M M Y Y				
Gestation W ks	☐	☐	☐	D D M M Y Y				

Leaflet(s) given ☐ Date: D D M M Y Y | D D M M Y Y — Comments — Signed*

*Signed — Care provider | Care provider

Screening for Down's Syndrome (T21), Edwards' Syndrome (T18) and Patau's Syndrome (T13)

Screening explained No ☐ Yes ☐

NHS Screening Programme leaflet given No ☐ Yes ☐

Date: D D M M Y Y

*Signed — Care provider

Screening offered No ☐ Yes ☐ If no: why

Accepted by mother No ☐ Yes ☐ Test type

Choice of screening ☐ T21, T18/T13 (All the conditions) ☐ T21 only ☐ T18/13 only

Signed*

Date taken: D D M M Y Y

Results	Action	Signed*
T21 ☐		
T18 ☐		
T13 ☐		

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Ultrasound Scans

You will be offered one or two routine ultrasound scans in the first half of pregnancy (usually by 20 weeks). There are no known risks to the baby or you from having a scan, but it is important to think carefully about whether to have a scan or not. The scan may provide information that means you may have to make some difficult decisions. For example, you may be offered further tests that have a risk of miscarriage. Some people want to find out if their baby is developing unexpectedly and some don't. Further information can be found in the leaflet "Screening Tests for You and Your Baby" via www.gov.uk.

It is important to be aware of what the scans are intended for. Most scans fall into one of three categories:	Explained	Accepted by mother No	Accepted by mother Yes
▪ Early scan - date the pregnancy, check the number of babies, look for possible physical conditions and take specific measurements of the baby if you have agreed to first trimester screening.	☐	☐	☐
▪ Anomaly scan – looks for possible physical conditions with the baby and is recommended to be performed between 18 to 20+6 weeks of pregnancy.	☐	☐	☐
▪ Scans later in pregnancy are carried out to monitor the baby's wellbeing and development.	☐	☐	☐

D D M M Y Y — Date

Signed*: Care Provider

Reasons for Scans

Dating pregnancies. It is important to know the size of the baby in your womb so that we know how mature the fetus is. ***Scan dates are more accurate than menstrual dates*** if done before 22 wks. This is because it looks at the actual age of the fetus, whereas menstrual dates are based on the first day of the last period which assumes fertilisation occurred 14 days later, this is not always the case. Most babies are NOT born on their expected due date, but during a 4 week period around it.

First trimester (early pregnancy). All pregnant women are offered an ultrasound scan between 8-14 weeks of pregnancy. It is done to confirm the pregnancy and number of babies in the womb, calculate the expected date of delivery and to check for unexpected development of the baby that may be detected at this early stage. You may also be offered screening for Down's syndrome, Edwards' syndrome and Patau's syndrome at this time (page 6). This will depend on whether you have agreed to have the screening test done and how many weeks pregnant you are at the time of scan.

Mid-pregnancy (fetal anomaly). You will be offered a scan between 18 weeks and 20 weeks and 6 days. The purpose of this scan is to look for unexpected development of the baby, both structural and physical (sometimes called anomalies). The scan will look in detail at the baby's head, spinal cord, limbs, abdomen, face, kidneys, brain, bones and heart. In most cases the baby will be developing well, but sometimes a condition is found. If a condition is suspected, you will be referred to a specialist team to discuss the options available to you. However, it is important to know that ultrasound may not identify all conditions. Detection rates will vary depending on the type of condition, the position the baby is lying in, previous surgery to your abdomen and maternal size.

Later pregnancy scans can be performed to check the baby's growth and wellbeing. This may be required if there are concerns about how the baby is growing, or if you have any risk factors identified early in your pregnancy that may affect the growth and wellbeing of the baby e.g. high blood pressure, diabetes. The aim of the scan is to measure the baby's head, abdomen and a bone in the leg (femur). From these measurements an estimated fetal weight is calculated (this is not the actual weight of the baby) and plotted on the customised growth chart. An assessment of liquor (fluid around the baby) is performed and a check on the blood supply can be done if there are any concerns with the baby's growth (known as a Doppler scan). If any concerns are identified, you will be referred to a specialist doctor to discuss the options available to you. Scans are sometimes also done to identify the position of the placenta, which may have been low in the womb at an earlier scan. A low placenta increases the risk of heavy bleeding later in pregnancy so you will be monitored more frequently (page 19).

Sex of the Baby. Although we can sometimes tell the sex of the baby, they are NOT done for personal requests to find out what the sex of the baby is.

Diagnostic Tests for Chromosomal Abnormalities

Diagnostic tests (Amniocentesis or CVS) are usually offered to diagnose whether a baby has a chromosomal condition such as Down's syndrome, Edwards' syndrome and Patau's syndrome. They are not offered on a routine basis but in certain circumstances such as: a family history of an inherited condition, a result of a screening test reported as a higher-chance result (page 6), unexpected scan findings or you have had a previous pregnancy/or baby which has a genetic condition. The risk of miscarriage from either of these tests is about 1 or 2 in a 100 (0.5% to 1%). Whether or not to have each test is a personal choice and one which only you can make. The healthcare team looking after you will discuss the options available.

Amniocentesis: involves removing a small amount of the fluid from around the baby using a fine needle. It is usually performed after 15 weeks of pregnancy.

CVS (Chorionic Villus Sampling): involves removing a tiny sample of tissue from the placenta, using a fine needle. It is usually performed from 11 weeks to 14 weeks of pregnancy. The type of test you will have is dependent on your situation and will be discussed with you in detail with the specialist team.

Feel free to ask your midwife or doctor – or look at NHS website: **www.nhs.uk**

Pregnancy Assessment

Dates LMP D D M M Y Y — Method of dating — **Agreed EDD** D D M M Y Y

This date is used to determine the best time for the dating scan

To be entered also on page 17, and in the customised growth chart programme

Special points for screening

Anomaly leaflet

Dating Scan

FH - Fetal Heart, CRL - Crown Rump Length, BPD - Biparietal Diameter, HC - Head Circumference, FL - Femur Length, NT - Nuchal Translucency

Date	Print out (Y/N)	No. of fetuses	FH	CRL	BPD	HC	FL	NT	Gestation	Comments	Signed *
									W ks D		

Anomaly Scan

Date D D M M Y Y — Gestation W ks D — Print out attached to notes Yes ☐ No ☐

Skull & Ventricles ☐ Cerebellum ☐ Face ☐ Spine - long ☐ Spine - Transverse ☐

Heart 4-chamber view ☐ Heart outflows ☐ Stomach / Diaphragm ☐ Cord insertion ☐ Kidneys & Bladder ☐

Arms - 3 bones left ☐ Arms - 3 bones right ☐ Legs - 3 bones left ☐ Legs - 3 bones right ☐ Placental site

Comments

Signed*

Ultrasound Scan Details

GA - Gestational Age, Pres - Presentation, AC - Abdominal Circumference, EFW - Estimated Fetal Weight, Plac - Placenta, AF - Amniotic Fluid.

Date	GA	Lie/ Pres	BPD	HC	AC	FL	EFW	Plac	AF	Doppler	Signed *
Comments											
Comments											
Comments											
Comments											
Comments											
Comments											

MRI Scan Details

Comments

Diagnostic Tests

	No	Yes
Tests explained	☐	☐
NHS Fetal Anomaly Screening leaflet given	☐	☐

Date D D M M Y Y

*Signed

Care provider

Test type — Indication

	No	Yes
Test offered	☐	☐
Test accepted	☐	☐
Anti D required	☐	☐

Needle/cannula gauge — No. uterine insertions

Aspiration method — Blood stained tap

Date performed D D M M Y Y — *Signed

Results

Comments

Insert additional sheets here for multiples (eg twins or triplets)

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Covid-19

Vaccines are recommended and are considered to be safe and effective at any stage of pregnancy. Vaccination is the best way to protect against the known risks of COVID-19 for women and babies, including admission to intensive care and premature birth. The decision whether to have the vaccination is your choice. Your healthcare team can provide you with further information and answer any questions you have. For further information visit: www.rcog.org.uk/covid-vaccine

1st Covid-19 vaccine discussed No ☐ Yes ☐ Signature* Agrees to vaccine No ☐ Yes ☐ If no, reason

Vaccine given No ☐ Yes ☐ Date given D D M M Y Y Given by whom Batch number

2nd Covid-19 vaccine discussed No ☐ Yes ☐ Signature* Agrees to vaccine No ☐ Yes ☐ If no, reason

Vaccine given No ☐ Yes ☐ Date given D D M M Y Y Given by whom Batch number

Seasonal Flu

Pregnant women are more at risk from serious complications of seasonal flu such as bronchitis, chest infection and pneumonia therefore its recommended that you have the flu vaccine. Flu in pregnancy can increase the risk of miscarriage, prematurity, fetal growth restriction and stillbirth. It is safe to have at any stage in pregnancy and will pass on protection to your baby which will last for the first few months of their lives. The vaccine is available from September until March and is free to pregnant women. Ask your GP/pharmacist/midwife where you can get vaccinated. If you develop flu like symptoms, you must seek medical advice **immediately,** there is treatment to reduce the risk of complications.

Seasonal flu discussed No ☐ Yes ☐ Signature* Agrees to vaccine No ☐ Yes ☐ If no, reason

Flu vaccine given No ☐ Yes ☐ Date given D D M M Y Y Given by whom Batch number

	Date commenced	Medication	Dose	Duration of course	Signed*
Antiviral medication	D D M M Y Y				

Whooping Cough (Pertussis)

The aim of offering pregnant women the pertussis vaccination is to provide their baby with passive immunity until the baby starts routine vaccinations from 8 weeks of age. Young babies can die if they develop whooping cough. If you have been vaccinated before or had whooping cough yourself, the vaccine is still recommended. You should be offered the vaccine from 16 weeks of your pregnancy. If you have not been offered the vaccine, please ask your midwife or GP where you can get it done.

Pertussis discussed No ☐ Yes ☐ Signature* Agrees to vaccine No ☐ Yes ☐ If no, reason

Vaccination given No ☐ Yes ☐ Date given D D M M Y Y Given by whom Batch number

Blood Products

Blood or blood products are only ever prescribed in specific medical conditions or emergency situations. If you have any objections about receiving these, please discuss this with your midwife and obstetrician, so that a personalised plan of care can be made.

Treatment discussed No ☐ Yes ☐
Agrees to receiving blood or blood products No ☐ Yes ☐
Agrees to baby receiving blood or blood products No ☐ Yes ☐
Management plan initiated No ☐ Yes ☐

Date D D M M Y Y

Signed*

Important Symptoms

Care provider should sign, following discussion with mother

It is important to be aware that certain symptoms might suggest the possibility of serious pregnancy complications. The ticked boxes indicate which topics have been explained to you. (For further details see pages 14, 17 & 19). **Contact your midwife/GP or maternity unit immediately if any of these occur:**

Symptom or complaint		Further advice / Comments	Date	Signature*
Abdominal (stomach) pains	☐		D D M M Y Y	
Vaginal bleeding	☐			
Rash illness	☐			
Membranes (waters) breaking early	☐			
Severe chest pain spreading to your jaw, arm or back/breathlessness	☐			
Severe headaches	☐			
Blurred vision	☐			
Itching, especially at night	☐			
Changed or reduced fetal movements	☐	Leaflet given ☐		
Symptoms of infection/sepsis	☐			
Symptoms of Covid-19	☐			

Name
Unit No/ NHS No

Feel free to ask your midwife or doctor – or look at NHS website: **www.nhs.uk**
www.saferpregnancy.org.uk **www.sepsistrust.org**

Antenatal venous thromboembolism (VTE) assessment - booking and repeat if admitted

	Yes
Any previous VTE except a single event related to major surgery	☐
Hospital Admission	☐
Single previous VTE related to major surgery	☐
High risk thrombophilia and no VTE	☐
Medical Co-morbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU	☐
Any surgical procedure e.g. appendicectomy	☐
OHSS (first trimester only)	☐
Age>35 years	☐
BMI 30-39	☐
BMI ≥ 40 (= 2 risk factors)	☐
Parity ≥3	☐
Smoker	☐
Gross varicose veins	☐
Immobility e.g. paraplegia, PGP	☐
Current pre-eclampsia	☐
Family history of unprovoked or oestrogen-provoked VTE in first degree relative	☐
Low risk thrombophilia	☐
Multiple pregnancy	☐
IVF/ART	☐
Transient risk factors:	
Dehydration	☐
Hyperemesis (= 3 risk factors)	☐
Current systemic infection	☐
Long distance travel	☐

High risk
Requires antenatal prophylaxis with LMWH
Refer to Trust-nominated thrombosis in pregnancy expert team

Intermediate risk
Consider antenatal prophylaxis with LMWH
Seek Trust-nominated thrombosis in pregnancy expert team for advice

Four or more risk factors: prophylaxis from first trimester

Three risk factors: prophylaxis from 28 weeks

fewer than three risk factors

Lower risk
Mobilisation and avoidance of dehydration

Complete risk assessment and update personalised care plan as necessary **No risks identified** ☐

Signature* **Date** D D M M Y Y

	Yes	Yes	Yes
Any previous VTE except a single event related to major surgery	☐	☐	☐
Hospital Admission	☐	☐	☐
Single previous VTE related to major surgery	☐	☐	☐
High risk thrombophilia and no VTE	☐	☐	☐
Medical Co-morbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU	☐	☐	☐
Any surgical procedure e.g. appendicectomy	☐	☐	☐
OHSS (first trimester only)	☐	☐	☐
Age>35 years	☐	☐	☐
BMI 30-39	☐	☐	☐
BMI ≥ 40 (= 2 risk factors)	☐	☐	☐
Parity ≥3	☐	☐	☐
Smoker	☐	☐	☐
Gross varicose veins	☐	☐	☐
Immobility e.g. paraplegia, PGP	☐	☐	☐
Current pre-eclampsia	☐	☐	☐
Family history of unprovoked or oestrogen-provoked VTE in first degree relative	☐	☐	☐
Low risk thrombophilia	☐	☐	☐
Multiple pregnancy	☐	☐	☐
IVF/ART	☐	☐	☐
Transient risk factors:			
Dehydration	☐	☐	☐
Hyperemesis (= 3 risk factors)	☐	☐	☐
Current systemic infection	☐	☐	☐
Long distance travel	☐	☐	☐
No risks identified	☐	☐	☐
Update personalised care plan as necessary **Signature***			
Date	D D M M Y Y	D D M M Y Y	D D M M Y Y

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Risk Assessment document agreed plan of care on page 13

Aspirin checklist
Depending on your level of risk in early pregnancy, you may be asked to take a low dose of aspirin once a day until your baby is born. This is to reduce the risk of pre-eclampsia, high blood pressure, giving birth prematurely (before 37 weeks) and growth restriction.

Aspirin 75-150 mgs from 12 weeks until birth, if

Moderate risk – 2 or more factors:	Yes	**High risk – 1 or more factors:**	Yes
1st pregnancy	☐	Hypertensive disease during previous pregnancy	☐
Age 40 years or older at booking	☐	Chronic kidney disease	☐
Pregnancy interval of more than 10 years	☐	Autoimmune disease e.g. systemic lupus erythematosus	☐
BMI of 35 or more at first visit	☐	Type 1 or 2 diabetes	☐
Family history of pre-eclampsia in a 1st degree relative	☐	Chronic hypertension	☐
Multiple pregnancy	☐	Further information: www.nice.org.uk/guidance/ng133/	

Fetal Growth	Booking assessment		2nd Assessment (3rd trimester)		Additional assessments/referral
		Obs. Review if indicated		Obs. Review if indicated	
Gestational age	W ks + D		W ks + D		
Risk Assessment	Low ☐		Low ☐		
	Increased ☐	Moderate ☐ Obs. review ☐	Increased ☐	Moderate ☐ Obs. review ☐	
		High ☐ MFM review ☐		High ☐ MFM review ☐	
Signature*					
Date	D D M M Y Y		D D M M Y Y		D D M M Y Y

Further information: Perinatal Institute - GAP Guidance https://bit.ly/2C3jZKL; NHS England - SBLv2 https://bit.ly/2AodHFI

It is important to reassess your individual circumstances throughout the pregnancy as it may mean a change to your plan of care. Your care providers can record these below.

	Booking assessment			2nd assessment			Referral required		
	No	Yes	Comment	No	Yes	Comment	No	Yes	To
Gestational age	W ks + D			W ks + D					
Review of primary care/GP records	☐	☐		☐	☐		☐	☐	
Medical factors	☐	☐		☐	☐		☐	☐	
Obstetric factors	☐	☐		☐	☐		☐	☐	
VTE assessment performed	☐	☐		☐	☐		☐	☐	
VTE pathway initiated	☐	☐	Low/Med/ High Risk	☐	☐	Low/Med/ High Risk	☐	☐	
Aspirin required	☐	☐		☐	☐		☐	☐	
Preterm birth pathway initiated	☐	☐		☐	☐		☐	☐	
OGTT booked	☐	☐		☐	☐		☐	☐	
Mental health factors	☐	☐		☐	☐		☐	☐	
Social factors	☐	☐		☐	☐		☐	☐	
Smoking	☐	☐		☐	☐		☐	☐	
Drug/alcohol use	☐	☐		☐	☐		☐	☐	
BMI pathway initiated	☐	☐		☐	☐		☐	☐	
Management Plan updated	☐	☐		☐	☐		☐	☐	
Signature*									
Date	D D M M Y Y			D D M M Y Y			D D M M Y Y		

Manual Handling/Tissue Viability Risk Assessment

Referred: Yes ☐ No ☐ to: _____ Signature* _____ Date D D M M Y Y

Anaesthetic Assessment

Referred: Yes ☐ No ☐ to: _____ Signature* _____ Date D D M M Y Y

Name
Unit No/ NHS No

*** Signatures must be listed on page b for identification**

Maternity Payment Pathway System (Please tick which pathway is indicated)

Standard ☐ Intermediate ☐ Intensive ☐ Signature & date _____ D D M M Y Y

Regular Medication

If you are taking any medicines or tablets, your midwife or doctor will write them here. If your care providers need to change how much you take as your pregnancy progresses, or you need other medicines, they can also be written here.

Date recorded	Drug	Dose	Frequency	Comments e.g. discontinued, dose changed
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				

Personalised Care Plan Highlight key points in special features box (page 17). If necessary, update the lead professional box on page a.

A personalised care plan will outline specific treatment for you, considering any special issues in pregnancy. This will be discussed and agreed between you and your healthcare team, including any specialists at your first appointment. The aim is to keep you and your baby safe, and to ensure that everyone involved in your care is aware of your individual circumstances. This plan will be documented below and amended to reflect your changing needs. At each antenatal visit, a risk assessment will be carried out and the plan will be amended/updated if your risk changes. Part of this assessment will be a discussion about your chosen place of birth.

Place of birth discussed:

Maternity unit ☐ Freestanding birth centre ☐ Homebirth ☐ Alongside birth centre ☐

Signature* **Date** D D M M Y Y

Risk factor / special features	Personalised care plan	Discussed with mother	Referred to	Date/Signed *
Booking				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y

Insert continuation sheets here, and number them.

*** Signatures must be listed on page b for identification**

Name _____

Unit No/ NHS No _____

Antenatal Checks

It is very important to attend antenatal and scan appointments that are made for you. Your midwife or doctor will check you and your baby's health and wellbeing at each of these appointments. Please discuss any worries/concerns that you may have. If you have had any tests or investigations (pages 6 & 8), make sure that you ask for the results at your next appointment. If you cannot attend any appointments, please contact your midwife/doctor or the hospital to re-arrange.

Blood pressure (BP) is checked to detect pregnancy induced hypertension or pre-eclampsia (page 19). High blood pressure may cause severe headaches or flashing lights. If this happens, tell your midwife or doctor **immediately.**

Urine tests. You will be asked to supply a sample of your urine at each visit to check for protein which may be a sign of pre-eclampsia and glucose which may be a sign of gestational diabetes.

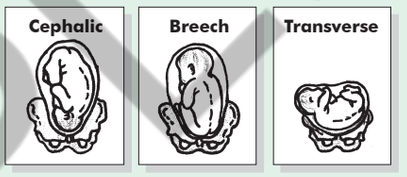
Fetal movements. You will usually start feeling some movements between 16 and 24 weeks. A baby's movements can be described as anything from a kick, flutter, swish or roll. You will very quickly get to know the pattern of your baby's movements. At each antenatal contact your midwife/doctor will talk to you about this pattern of movements, which you should feel each day up to the time you go into labour and whilst you are in labour too. They will also give you a leaflet explaining about the importance of monitoring your baby's movements by 28 weeks. Become familiar with your baby's usual daily pattern of movements and contact your midwife or maternity unit **immediately if you feel that the movements have altered.** Do not put off calling until the next day. It is important for your doctors and midwives to know if your baby's movements have slowed down or stopped. A change, especially slowing down or stopping, can sometimes be an important warning sign that the baby is unwell and the baby needs checking by ultrasound scan and Doppler. If, after your check up, you are still not happy with your baby's movements, you must contact either your midwife or maternity unit straight away, even if everything was normal last time. **NEVER HESITATE** to contact your midwife or maternity unit for advice, no matter how many times this happens.

Fetal heart Fetal heart (FH or FHHR - fetal heart heard and regular). If you wish, your midwife or doctor can listen to the baby's heart with either a Pinard (stethoscope) or a fetal Doppler. With a Doppler, you can hear the heartbeat yourself. Its recommended that you do not use any handheld monitors, Dopplers or phone apps to listen to your baby's heartbeat yourself. Even if you detect a heartbeat this does not mean your baby is well and you may be falsely reassured.

Liquor refers to the amniotic fluid, the water around the baby. A gentle examination of the abdomen can give an idea of whether the amount is about right (recorded as NAD - no abnormality detected, or just N), or whether there is suspicion of there being too much or too little, in which case an ultrasound is needed.

Lie and Presentation.

This describes the way the baby lies in the womb (e.g. L = longitudinal; O = oblique, T = transverse), and which part it presents towards the birth canal (e.g. headfirst or cephalic = C, also called vertex = Vx; bottom first or breech = B or Br).



Engagement is how deep the presenting part - e.g. the baby's head is below the brim of the pelvis. It is measured by how much can be still felt through the abdomen, in fifths: 5/5 = free; 4/5 = sitting on the pelvic brim; 3/5 = lower but most is still above the brim; 2/5 = engaged, as most is below the brim; and 1/5 or 0/5 = deeply engaged, as hardly still palpable from above. In first time mothers, engagement tends to happen in the last weeks of pregnancy; in subsequent pregnancies, it may occur later, or not until labour has commenced.

Assessing Fetal Growth

Accurate assessment of your baby's growth inside the womb is one of the key tasks of good antenatal care. Problems such as growth restriction can develop unexpectedly and is linked with a significantly increased risk of adverse outcomes, including stillbirth, fetal distress during labour, neonatal problems, or cerebral palsy. Therefore, it is essential that your baby's growth is monitored carefully.

Fundal height is measured every 2-3 weeks from 26-28 weeks onwards, ideally by the same midwife or doctor. The measurements are taken with a centimetre tape, from the fundus (top of the uterus) to the top of the symphysis (pubic bone), then plotted on the customised growth chart. The slope of the measurements should be similar to the slope of the three curves printed on the chart, which predict the optimal growth of your baby.

Ultrasound scans are performed if fundal height measurements suggest that there is a problem with the baby's growth (see below). They can also be arranged if fundal height measurements are difficult (e.g. maternal size, fibroids, twins), or if you are at increased risk of having a baby that may not grow as well as expected. Scans are then performed regularly (usually 3-4 weekly) during the last 3 months of your pregnancy to estimate the baby's weight and its rate of growth. Both fundal height and fetal weight measurements are plotted on the same customised chart to monitor the growth of the baby.

Customised Growth Charts. These notes have been developed to support the use of customised growth charts which are individually adjusted for you and your baby. The information required includes: • Your height and weight in early pregnancy • Your ethnic origin • Number of previous babies, their name, sex, gestation at birth and birthweight • The expected date of delivery (EDD) which is usually calculated from your first scan.

The chart is usually printed after your pregnancy dates have been determined by ultrasound (preferably) or by last menstrual period. If neither date is available, regular ultrasound scans are recommended to check that your baby is growing as expected. For further information about customised growth charts see **www.perinatal.org.uk.**

After the chart is printed, it is attached as page 16, using the stick-on tape on the right of this page. →

Growth restriction. Slow growth is one of the most common problems that can affect the baby in the womb. If ultrasound scan(s) have suggested that the baby is small, or growth is too slow, then additional investigations may be arranged called Doppler scans to see how well the placenta is managing the blood supply needed for the baby. If there is a serious problem, your obstetric team will need to discuss with you the best time to deliver your baby.

Large baby (macrosomia). Sometimes the growth curve is larger than expected. A fundal height measurement over the 90th centile is usually no cause for concern, but if the slope of subsequent measurements is too steep, your carers may refer you for an ultrasound scan to check the baby's size and amniotic fluid volume. They may also offer you a test to check for gestational diabetes (page 19). Big babies may occasionally cause problems either before or during birth (obstructed labour, shoulder dystocia etc). However, most often they are born normally without problems.

Insert customised growth chart here

PRINTER: Affix special tape here

Insert customised growth chart here

Feel free to ask your midwife or doctor – or look at NHS website: **www.nhs.uk**

Special Features

Height	Weight booking	BMI	BP booking	Age	Blood group	Weight 3rd trimester	Para	EDD
cms	kgs				+-	kgs	+	DDMMYY

Key points (from personalised care plan, page 13)	Labour, delivery & postnatal
	Paediatric alert form ☐
SGA or FGR on scan Yes ☐	
For vaccination status see pg 10	Paediatrician to be present ☐
Medications / Allergies	Seniority / Reason

Reduced Fetal Movements (RFM)

Record episodes of RFM reported by the mother and actions taken

	Episode reported	Gestation	Comments and actions
1	DDMMYY	Wks+D	
2	DDMMYY	Wks+D	
3	DDMMYY	Wks+D	

Antenatal Visits

Gest - Gestation; BP - Blood Pressure; Pres - Presentation; Eng - Engagement; Hb - Haemoglobin. Mat pulse = maternal pulse

Care provider should reiterate discussion of important pregnancy symptoms including altered or reduced fetal movements (pages 10 & 14)

Date/Time	Gest	BP	Urine	CO level	Fetal Movements: Felt	Fetal Movements: Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
DDMMYY HHMM	Wks+D	/												

Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ | Mother's page reviewed Yes ☐ | Accompanied No ☐ Yes ☐ With

Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

Date/Time	Gest	BP	Urine	CO level	Felt	Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
DDMMYY HHMM	Wks+D	/												

Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

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Date/Time	Gest	BP	Urine	CO level	Felt	Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
DDMMYY HHMM	Wks+D	/												

Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ | Mother's page reviewed Yes ☐ | Accompanied No ☐ Yes ☐ With

Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

Date/Time	Gest	BP	Urine	CO level	Felt	Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
DDMMYY HHMM	Wks+D	/												

Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ | Mother's page reviewed Yes ☐ | Accompanied No ☐ Yes ☐ With

Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

*** Signatures must be listed on page b for identification**

Name

Unit No/
NHS No

Antenatal Visits

Care provider should reiterate discussion of important pregnancy symptoms including altered or reduced fetal movements (pages 10 & 14

Date/Time	Gest	BP	Urine	CO level	Fetal Movements Felt	Fetal Movements Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
D D M M Y Y	W ks + D	/												

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ | Mother's page reviewed Yes ☐ | Accompanied No ☐ Yes ☐ With

Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

D D M M Y Y W ks + D /

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ | Mother's page reviewed Yes ☐ | Accompanied No ☐ Yes ☐ With

Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

D D M M Y Y W ks + D /

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Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

D D M M Y Y W ks + D /

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

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Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

D D M M Y Y W ks + D /

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

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Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

D D M M Y Y W ks + D /

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ | Mother's page reviewed Yes ☐ | Accompanied No ☐ Yes ☐ With

Risk assessment performed Yes ☐ | Personalised care plan: reviewed ☐ revised ☐ | Signed*

Insert continuation sheets here, and number them.

*** Signatures must be listed on page b for identification**

Pregnancy Symptoms/Complications

Common pregnancy symptoms include tiredness, sickness, headaches, mild aches and pains, heartburn, constipation. Most symptoms are normal but if you are worried, speak to your midwife/doctor for advice. Some complications in pregnancy require additional visits to monitor you and your baby's health and wellbeing. Many conditions will only improve after the birth.

Pregnancy sickness is common and can generally be managed with changes to diet and lifestyle. However, it is not uncommon for pregnancy sickness to be severe and have a serious negative impact on the quality of your life and your ability to eat and drink and function normally. If this happens, speak to your GP and request anti-sickness medication. These are safe to take at any stage of pregnancy. It is important to treat pregnancy sickness to prevent it from developing into the more serious condition called hyperemesis gravidarum. If you are sick, wait at least 30 minutes before brushing your teeth or using a mouthwash. This helps to protect your teeth from tooth decay.

Multiple pregnancies. Twins, triplets, or other multiple pregnancies need closer monitoring which includes frequent tests and scans, under the care of a specialist healthcare team. Your team will discuss your options on how best to deliver your babies. It will depend on how your pregnancy progresses, the position that your babies are lying and whether you have had a previous caesarean section.

Prematurity. Labour may start prematurely (before 37 weeks), for a variety of reasons. If you plan to give birth in a birth centre/midwifery unit or at home, you will be advised to transfer your care to a maternity unit with a neonatal unit/special care baby facility. If labour starts before 34 weeks, most maternity units have a policy of trying to stop labour for at least 1-2 days, whilst offering you steroid injections that help the baby's lungs to mature. Babies born earlier than 34 weeks may need extra help with breathing, feeding and keeping warm.

Breech. If your baby is presenting bottom or feet first this is called a breech position (page 14). If your baby is breech at 36 weeks, your health care team will discuss the following options with you: trying to turn your baby (ECV = external cephalic version); planned (elective) caesarean section or a planned vaginal breech birth.

Abdominal pain. Mild pain in early pregnancy is not uncommon and you may have some discomfort due to your body stretching and changing shape. If you experience severe pain, or pain with vaginal bleeding or need to pass urine more frequently - contact your midwife or nearest maternity unit **immediately** for advice.

Vaginal bleeding may come from anywhere in the birth canal, including the placenta. Occasionally, there can be an 'abruption', where a part of the placenta separates from the uterus, which puts the baby at great risk. If the placenta is low lying, tightening's or contractions may also cause bleeding. Any vaginal blood loss should be reported **immediately** to your midwife or nearest maternity unit. You will be asked to go into hospital for tests and you may be advised to stay until the bleeding has stopped or the baby is born.

Spontaneous Rupture of Membranes (SROM). Your waters may break before labour starts at any time during your pregnancy. If you have watery loss from your vagina, which you can't control, you need to contact your midwife or maternity unit **immediately** for advice.

Abnormal vaginal discharge. It is normal to have increased vaginal discharge when you are pregnant. It should be clear or white and not smell unpleasant. Seek medical advice if the discharge changes colour, smells offensive or you feel sore or itchy.

Infections. Your immune system changes when you are pregnant, and you are at a higher risk of infection. Wherever possible, keep away from people with any infection e.g. diarrhoea and sickness, cold/flu, any rash illness. Seek **urgent** medical advice: If you are unwell and are experiencing any of the following symptoms: • high temperature of 38°C or higher • fever and chills • pain or frequently passing urine • abdominal pain • rash • diarrhoea and vomiting • sore throat or respiratory infection • painful red blisters/sores around the vagina/bottom or thighs.

Rash illness. Wherever possible, keep away from people that are unwell and have any type of rash illness. If you develop a rash at any point in your pregnancy, you need to seek **immediate** advice from your midwife/GP. You will need to be assessed and may need a blood test to find out what is causing your rash and may be given treatment.

Sepsis (also known as blood poisoning) is the immune systems overreaction to an infection or injury. This is a rare but serious condition which can initially look like flu, gastroenteritis or a chest infection. If not treated immediately, sepsis can result in organ failure and death. With an early diagnosis, it can be treated with antibiotics. Seek **urgent medical help** if you experience signs of sepsis: • Slurred speech or confusion • Extreme shivering or muscle pain • Passing no urine (in a day) • Severe breathlessness • It feels like you're going to die • Skin mottled or discoloured.
For further information visit: www.sepsistrust.org.

Group B Streptococcus (GBS) is a common bacterium carried by some women and rarely causes symptoms or harm. It can be detected by testing a urine sample, a vaginal or rectal swab. In some pregnancies, it can be passed on to the baby around the time of birth, which can lead to serious illness in the baby. The national recommendation is to offer antibiotics to women as soon as labour starts if: • GBS has been detected during the current pregnancy • you have previously had a baby who developed a GBS infection • you have a high temperature (38°C or over) in labour • you go into labour prematurely. If GBS was detected in a previous pregnancy and your baby was not affected, you should be either offered antibiotics in labour or offered a test to screen for GBS late in pregnancy. If the test is positive you will be offered antibiotics in labour.

Thrombosis (clotting in the blood). Your blood naturally has more clotting factors during pregnancy which helps prevent losing too much blood during labour and birth. However, this means that all pregnant women are at a slightly increased risk of developing blood clots during pregnancy and the first weeks after the birth. The risk is higher if you are aged over 35, have a BMI >30, smoke, or have a family history of thrombosis. Contact your midwife or nearest maternity unit **immediately** if you have any pain or swelling in your leg, pain in your chest or cough up blood.

Severe chest pain spreading to your jaw, arm or back/breathless/increased heart rate. Some women can experience symptoms of coronary heart disease for the first time during pregnancy. Therefore, if you develop any of the following you must seek **urgent medical attention** by calling 999

- severe chest pain spreading to your jaw, arm or back
- your heart is persistently racing
- you are severely breathless when resting
- you experience fainting while exercising

High blood pressure. A rise in blood pressure can be the first sign of a condition known as pre-eclampsia or pregnancy induced hypertension. Contact your midwife or nearest maternity unit **immediately** if you have: • severe headache/s • blurred vision or spots before your eyes • obvious swelling (oedema) especially affecting your hands and face • severe pain below your ribs and/or vomiting. These can be signs that your blood pressure has risen sharply. If there is protein in your urine, you may have pre-eclampsia which in its severe form can cause blood clotting problems and fits. It can be linked to problems for the baby such as growth restriction. Treatment may start with rest, but some women will need medication that lowers high blood pressure. Occasionally, this may be a reason to deliver your baby early.

Diabetes is a condition that causes a person's blood glucose (sugar) level to become too high. Some women can develop diabetes during their pregnancy (gestational diabetes). High levels of glucose can cross the placenta and cause the baby to grow large (macrosomia - page 14). If you have pre-existing diabetes or develop gestational diabetes, you will be looked after by a specialist team to monitor you and your baby's health closely. Keeping your blood glucose levels as near normal as possible can help prevent problems/complications. Gestational diabetes usually disappears after the birth but can occur in another pregnancy. To reduce your future risks of diabetes: - be the right weight for your height (normal BMI), eat healthily, cut down on sugar, fatty and fried foods and increase your physical activity (page 20).

Intrahepatic cholestasis in pregnancy (ICP) also known as obstetric cholestasis, is a liver condition in pregnancy that causes itching on the hands and feet but may occur anywhere on your body and is usually worse at night. It affects around 5,500 women in the UK every year. Having this condition may increase your risk of having a stillbirth, so you will receive closer monitoring of you and your baby's health. If you have itching, blood tests will be offered to check if you have ICP. Treatment includes medication, regular blood tests and possibly an early birth for your baby. After the birth, the itching should disappear quite quickly. A blood test to check your liver function will be carried out and repeated about 6-12 weeks later.

General Information

Work and benefits. The 'Parents Guide to Money' is available via www.moneyadviceservice.org.uk and provides information on financial aspects of having baby. An FW8 certificate will be issued in early pregnancy to claim free prescriptions/dental treatment. A maternity certificate (Mat B1) can be issued from 20 weeks, you will need this for your employer or benefits office.

Dentist. Changes in your hormone levels and diet may make your mouth more prone to disease which can lead to tooth decay, therefore, it's important that you are registered with a dentist and have regular check-ups.

Health and Safety issues. If you are working, your employer has a responsibility to assess any health and safety risks to you.

Healthy eating. Make sure you eat a variety of different foods to get the right balance of nutrients for your growing baby and for your body to deal with the changes taking place. Although you may feel hungrier than usual, don't "eat for two". Maintaining a healthy weight can reduce the risk of complications for pregnancy, labour and birth. It is important to prepare and cook your food carefully to prevent food poisoning. Foods such as ready meals, meat, poultry, shellfish and eggs need to be thoroughly cooked. Avoid pâté and mould-ripened soft cheeses, liver, liver products, ready to eat cold smoked or cured fish products and unpasteurised milk. It is advised that you take folic acid, which helps to prevent abnormalities in the baby e.g. spina bifida. The dose is 0.4mg per day while you are planning to get pregnant and up to 13 weeks of pregnancy. An increased dose of 5mgs is recommended If you have: - diabetes, BMI >30, taking anti-epileptic drugs or have a family history of fetal anomalies.

Vitamin D is needed for healthy bones, teeth and muscle development. To protect you and your baby from any problems caused by low levels, a 10mcgs supplement is recommended.

Vitamin A can cause harm to your baby if you take too much, so do not take any supplements containing vitamin A (Retinol). If you have any questions about the food you can eat, discuss with your midwife who can refer you to a dietitian if needed.

Body Mass Index. There are increased risks of complications in pregnancy & labour if your BMI is less than 18 or more than 30.

Caffeine is a stimulant that is contained in tea, coffee, chocolate, energy and cola drinks. Its recommended that you limit your daily caffeine intake is 200mgs per day.

Alcohol increases the risk of miscarriage, stillbirth, fetal growth restriction, premature labour and may lead to fetal alcohol spectrum disorder (FASD) or fetal alcohol syndrome (FAS). Therefore, its recommended that pregnant women **AVOID** any alcohol during pregnancy. Alcohol crosses the placenta into the blood stream of the baby and could affect how the baby grows and develops. If you are finding it hard to stop, ask for help from your midwife/GP. They can refer you for specialist support.

Drugs. Taking street drugs, including cannabis and psychoactive substances e.g. spice, MCAT is **NOT** recommended, it may seriously harm you and your baby. Check with your pharmacist about taking over the counter medicines especially pain killer's containing codeine which can become addictive.

Carbon Monoxide (CO) is a poisonous gas produced when tobacco products are burnt. CO replaces some of the oxygen in your bloodstream which means that you and your baby have lower levels of oxygen overall. As part of routine care your midwife will test your CO levels. Environmental factors such as exhaust fumes or leaky gas appliances may also cause a high reading.

Smoking When you smoke, carbon monoxide, nicotine and other toxic chemicals cross the placenta directly into the baby's blood stream - so the baby smokes with you. This will reduce its oxygen and nourishment and put your baby at risk of low birth weight, stillbirth, premature birth and other problems. The sooner you stop smoking the better, to give your baby a healthy start in life. Your midwife can refer you to a stop smoking service for support. If your partner or other household members smoke, it's a good idea for them to stop too as this will provide you and your baby a smoke free environment.

Home fire safety checks are available free of charge by your local fire service. All homes should have a working smoke alarm.

Hygiene. During pregnancy your immune system changes and you are more prone to infections. It is important that you try to reduce the risk of infections with good personal hygiene: washing your hands properly before and after preparing food, using the toilet or sneezing/blowing your nose. If you feel unwell, have a sore throat or respiratory infection contact your midwife or GP **immediately**, you may need treatment.

Cytomegalovirus (CMV) infection in pregnancy can be passed to the unborn baby and can cause hearing loss or developmental problems for babies. You can reduce the risk of catching CMV by: -

- not sharing food, cutlery, cups or a dummy with young children
- kissing young children on the forehead instead of directly on the mouth or cheek
- washing your hands with soap and water, particularly if you have been changing nappies, or had contact with saliva

Toxoplasmosis is an infection that you can catch from the poo of infected cats or infected meat. If you test positive for toxoplasmosis during pregnancy, your GP can refer you for more tests to see if your baby has been infected. You can reduce the risk of getting toxoplasmosis by:

- wearing gloves while gardening/emptying cat litter trays
- wash your hands before preparing food and eating
- wash hands, knives and chopping boards after preparing raw meat
- wash fruit and vegetables to get rid of any soil

foods to avoid:

- raw or undercooked meat, or cured meats like salami or Parma ham
- unpasteurised goats' milk or any products made from it

Parvovirus (slapped cheek syndrome) is caused by a virus called parvovirus B19. Symptoms may include: a high temperature, runny nose or sore throat, headache. After 1-3 days, a bright red rash may appear on both cheeks. You should contact you midwife or GP **immediately** if you think you have been in contact with someone who has slapped cheek, even if you don't have a rash. You will be offered a blood test to check if you have it.

Travel. If you are planning to travel abroad, you should discuss flying, vaccinations and travel insurance with your midwife/GP.

Car safety. To protect you and your unborn baby, always wear a seatbelt with the diagonal strap across your body between your breasts and the lap belt over your upper thighs. The straps then lie above and below your 'bump', not over it.

Autism Sometimes women can 'mask' traits in childhood and are not diagnosed. Autism can also run-in families. If you have any concerns speak with your midwife or GP.

Relationships. Some women find pregnancy to be a time of increased stress and physical discomfort. It can greatly affect your emotional state, your body image and relationships. Discuss any problems or concerns you have with your midwife/GP.

Domestic abuse. 1 in 4 women experience domestic abuse at some point in their lives and many cases start or worsen during pregnancy or after the birth. It may take the form of physical, sexual, mental or emotional abuse, stalking and harassment, online/digital abuse or financial control. It can take place between couple relationships or between family members. Domestic abuse risks both your health and that of your baby. You can speak in confidence to your healthcare team who can offer help and support, or you can contact a support agency such as the National Domestic Violence Helpline (see inside cover).

Physical activity. Being active during pregnancy means you are likely to maintain a healthier weight and can cope better with the physical demands of pregnancy, labour and birth. Physical activity is known to improve fitness, reduce high blood pressure and prevent diabetes in pregnancy. There is no evidence of harm and walking for 150 minutes each week can keep you and your baby healthy. It can also give you more energy, help you sleep better and reduce feelings of stress, anxiety and depression. Every activity counts in bouts of at least 10 minutes. If you are active, keep going if you are not active, start gradually. Activities include walking, dancing, yoga, swimming and walking up the stairs.

Sleeping/resting position in later pregnancy. The safest position for going to sleep/resting is on your side, either left or right. If you lie on your back, the weight of the baby and uterus can affect the blood flow to your major organs and to your baby. Research has linked this with an increased risk of stillbirth. Don't worry if you wake up on your back – turn over onto your side again.

Family and friends test is a survey that has been designed for the NHS and your hospital to gain feedback on the services you have received. It is a quick and anonymous way to give your feedback. For further information discuss this with your midwife.

Feel free to ask your midwife or doctor – or look at NHS website: **www.nhs.uk**

Your Plans for Pregnancy

Update personalised care plan as required (page 13).

You may use the space below to write your comments to discuss with your healthcare team.

Topics	N/A	Discussed	Signature* and Date	Your wishes, intentions or preferences	Leaflets given
Employment rights	☐	☐			☐
Maternity benefits	☐	☐			
Health and safety issues	☐	☐			
Registered with a Dentist		☐			☐
Healthy eating		☐			
Vitamin D / Healthy Start Vitamins		☐		Start date: D D M M Y Y	
Caffeine		☐			
Alcohol consider using an alcohol screening tool (e.g. AUDIT-C)		☐			
Drugs		☐			
Hygiene		☐			
Cytomegalovirus (CMV)		☐			
Toxoplasmosis		☐			
Parvovirus		☐			
Smoking					
Effect on baby	☐	☐		First appointment with smoking cessation services D D M M Y Y	☐
Effect on mother	☐	☐			
Smoke free homes	☐	☐		Quit date set D D M M Y Y	
Working smoke alarm		☐			
Self referral - home fire safety check		☐			
Travel safety		☐			☐
Seat belts		☐			
Feelings about pregnancy		☐			
Stresses in pregnancy		☐			
Support at home		☐			
Sex in pregnancy		☐			
Sleeping/resting position		☐			
Physical activity		☐			☐
Pelvic floor exercises		☐			☐
Family and Friends test		☐			

Start4Life Information Service for Parents is a free NHS service for parents offering regular emails or texts throughout pregnancy and after the birth of your baby. Search **Start4Life** to sign up www.nhs.uk/start4life. Please supply your email address to receive regular information and advice throughout your pregnancy and afterwards.

Please supply your email address to receive regular information and advice throughout your pregnancy and afterwards.

Email:

Social & Health Assessment Completed

Signature* **Date** D D M M Y Y

Your Carers

Midwife. You will have a named midwife allocated to you at the beginning of your pregnancy, who usually works in a small team of midwives. A midwife's role is to provide care and support to women and their families during pregnancy, childbirth and the early days after the birth. They will work in partnership with you and your family to ensure you can make informed decisions about your care. Refer to page a of this booklet for their contact details.

Student Midwives work under the supervision of a qualified midwife. Students will be undertaking a degree course at a university but will spend time gaining experience in a clinical setting e.g. labour ward, antenatal clinic.

Maternity Support Workers support midwives as part of the midwifery team. They have had appropriate training and supervision to provide information, guidance, reassurance and support.

Obstetricians and Maternal-Fetal Medicine Specialists (MFM) are doctors who specialise in the care of women during pregnancy and childbirth. You may be referred to their care at the beginning of your pregnancy if you already have a medical problem, or during pregnancy if there are any concerns about your health or health of the baby.

Health Visitors are qualified nurses/midwives who have done additional training in family and child health, health promotion and public health development work. They work as part of a team alongside your GP, other community nurses and your midwifery team.

General Practitioner (GP) are doctors who work providing care for all aspects of health for you and your family throughout your lifetime.

Specialists. Some women with medical problems, such as diabetes, will be to be referred to a specialist for additional care during pregnancy. They may continue to provide care for you after you have had your baby.

Ultrasonographers are specially trained to carry out ultrasound scans.

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Preparing for your new Baby

Antenatal classes are an opportunity for you and your partner to find out about pregnancy, labour, birth and becoming new parents. Ask your midwife/health visitor what is available in your area to suit you. There are often special classes for teenagers and parents expecting multiple babies.

Safe sleeping. New babies have a strong desire to be close to you after birth as this will help them to feel secure and loved. Sudden Infant Death Syndrome (SIDS) is a sudden and unexpected death of a baby where no cause is found. While SIDS is rare, it can still happen and there are steps parents can take to reduce the risk of it happening. These include: • Your baby should have a clear, safe sleep space e.g. in a separate cot or Moses basket with a firm flat mattress without any raised or cushioned areas, no pillows/bumpers/quilts or duvets • Place your baby on his/her back with their feet against the foot of the cot/Moses basket • Your baby should always be in the same room as you day and night for the first 6 months of their life • Always keep your baby in a smoke free area, day and night • Do not share a bed with your baby if you have been drinking alcohol, taken drugs, you smoke, your baby was born prematurely or is a low birth weight • Never sleep with your baby on a sofa or armchair • Breastfeed your baby • Seek medical help if your baby is ill. For further information: www.lullabytrust.org.uk

Pet Safety. Many pets are tolerant of small children and babies, but it's important to be aware of the potential dangers. Pets can be jealous of having to share you and not receiving the same level of attention. Getting prepared for when you bring your baby home is something that you can do during pregnancy. Things to consider are: where will your baby sleep and how can you keep your pet away from this area? How will you ensure that your pet is not left unsupervised with your baby? For further information visit www.dogtrust.uk.org or www.rspca.org.uk

Equipment. Every new parent needs some essentials for their new baby. In the early days, you will need clothes and nappies. It may be advisable not to get too many things and wait until after your baby is born, so that you know what size to buy. You need something for your baby to sleep in such as a cot or Moses basket. If you have a car, you must have a car seat and your baby must travel in their seat. Think about other ways of carrying your baby when you are out, such as baby carriers/slings or prams/pushchairs.

Newborn screening. After birth, your baby will be offered and recommended some screening tests. The blood spot test is designed to identify those few babies who may be affected by PKU, cystic fibrosis, congenital hypothyroidism, MCADD, MSUD, HCU, IVA, GA1 and haemoglobinopathy disorders. Two detailed examinations of the baby will be performed, one within 72 hours of the birth and one is when your baby is 6-8 weeks old. These check your baby's eyes, heart and lungs, nervous system, abdomen, hips and testes (in boys). The hearing test is designed to find babies who have a hearing loss. Your midwife will give you a leaflet explaining these screening tests. For further information visit:
www.nhs.uk/conditions/pregnancy-and-baby/newborn-screening/

Vitamin K. We need vitamin K to make our blood clot properly, so we do not bleed easily. To reduce the risk of a bleeding disorder, your baby should be offered vitamin K after birth. The most effective way of giving this is by an injection (oral doses may be an option).

BCG. This is a vaccine offered to all babies who may be at higher than average risk from contact with Tuberculosis (TB). These include babies whose families come from countries with a high incidence of TB or babies born in a town or city where there is a high rate of TB. It is also offered to babies who have a relative or close contact with TB, have a family history of TB in the past or who plan to travel to a high-risk country to stay for more than three months. TB is a potentially serious infection which usually affects the lungs but can also affect other parts of the body. Treatment is with antibiotics. The BCG vaccination is usually given to the baby early in the postnatal period, but in some circumstances, it may be delayed. Some maternal medical conditions or specific medications taken in pregnancy can affect the immune system of the baby. In these instances, the vaccination should be delayed for about 6 months after the baby is born. Please discuss this with your midwife if you think this may apply to your baby. Further information can be found in the leaflet "TB, BCG vaccine and your baby" via:
www.nhs.uk/vaccinations

Hepatitis B. Babies born to mothers who have hepatitis B are at a higher chance of getting this infection and should receive a full course of vaccine in the first year of life. The first vaccination (sometimes with extra immunoglobulin) will be offered and recommended within 24 hours of birth and then at 4, 8, 12 and 16 weeks with a final dose at 1 year of age with a blood test to check their infection status. It is very important for your baby to have these.

Connecting with your baby. Taking time out to begin to develop a relationship with your unborn baby will have a positive impact on your baby's wellbeing and their brain to grow. You can begin to connect through talking or singing to your baby bump and noticing when your baby has a pattern of movements. It is lovely to include your partner and/or other children too.

Greeting your baby for the first time. Holding your baby in skin to skin contact soon after birth is the perfect way to say hello. Skin contact will help you both to feel calm, give you time to rest, keep warm and get to know each other. As your baby recognises your voice and smell, they will begin to feel safe and secure. Take time to notice the different stages your baby goes through to get ready their first feed.

Responding to your baby's needs. New babies have a strong desire to be close to their parents as this will help them to feel secure and loved. When babies feel secure, they release a hormone called oxytocin which helps their brain to grow and develop. If you are breastfeeding you can offer your baby your breast when he/she shows signs of wanting to feed, when they just want a cuddle, or fit in a quick feed when you want to sit down and rest. If you choose to bottle feed, your baby will enjoy being held close, and fed by you and your partner rather than by lots of different people.

Feeding your baby. You may already have some thoughts about how you will feed your baby, based on previous experience or what others have told you. However, you don't have to decide until after your baby is born. Breastfeeding provides everything your baby needs to grow and develop. It also helps protect and comfort your baby. Your midwife will be happy to talk to you about this. Further information can be found via: www.bestbeginnings.org.uk. If you decide to use formula milk to feed your baby, your midwife will give you information about how to hold your baby for feeding and how to make up feeds safely.

Contraception. You need to start using contraception from 3 weeks after the birth. Don't wait for your periods to return or until you have had your postnatal check-up before you use contraception, you can get pregnant again before then. Longer lasting methods e.g. Depo injection, implant and IUD/IUS (coil) are effective because you don't have to remember to take pills or do any preparation before you have sex and they are safe to use if you are breastfeeding. A coil can be fitted at the time of a planned caesarean section, if this is something you are interested in having, speak to your midwife or obstetrician about it. For further information about contraception visit:
www.nhs.uk/conditions/contraception/

Pelvic floor exercises. It is recommended that you do pelvic floor exercises during pregnancy to help strengthen this group of muscles.

Your Plans for Pregnancy and Parenthood

You may use the space below to write your comments to discuss with your healthcare team.

Topics	Discussed	Signature*& Date	Your wishes, intentions or preferences	Leaflets given
Preparing for your new baby Parent education Safe Sleeping Home environment Pet safety Equipment Newborn physical examination Newborn blood spot test Newborn hearing test Vitamin K	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	D D M M Y Y		☐ ☐
BCG discussed No ☐ Yes ☐ Baby BCG indicated No ☐ Yes ☐ Mother agrees to vaccine No ☐ Yes ☐		D D M M Y Y	Reason: If no, reason declined	☐
Connecting with your baby Talking to your baby Noticing/responding to baby's movements How this can help your baby's brain development	☐ ☐ ☐	D D M M Y Y		☐
Greeting your baby for the first time Skin to skin contact Keeping baby close Recognising feeding cues	☐ ☐ ☐	D D M M Y Y		☐
Responding to your baby's needs Importance of comfort and love to help baby's brain develop Responsive feeding	☐ ☐	D D M M Y Y		☐
Feeding your baby Value of breastfeeding as protection, comfort and food Getting off to a good start Understanding how a baby breastfeeds Where to get help including local support groups	☐ ☐ ☐ ☐	D D M M Y Y		☐

Confirmation that a conversation has taken place around the topics outlined above

Comments

*Signature & date

D D M M Y Y

D D M M Y Y

D D M M Y Y

Contraception

What methods of contraception have you used in the past?

Postnatal contraceptive plan made? No ☐ Yes ☐

Contraception method of choice and who will provide this

Measles Mumps Rubella (MMR) vaccinations

It is important to know if you have received a full course of the MMR vaccine (you can find this out at your GP surgery). If you haven't received 2 doses of this vaccine after your baby is born, book this as soon as possible with your GP surgery.

Discussed ☐

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Labour and Birth

Choosing where to have your baby. Depending upon your individual needs and what services are available locally, you and your partner will be able to choose where to have your baby. This may be at home, supported by a midwife, or in a midwifery unit or birth centre. These are either based in the community or in hospital and they promote natural labour and childbirth. Alternatively, you may choose to deliver in hospital supported by a maternity team. The team may include midwives, obstetricians, paediatricians and anaesthetists. When making your choice it is important to consider all your personal circumstances and any additional care needs you or your baby may need. You can discuss your wishes and options available with your midwife and/or obstetrician if there are any pregnancy concerns. It may be possible for you to visit the unit during your pregnancy. This will give you the opportunity to find out more about the facilities available. (Please note hospital sites are a smoke free environment.) You may be given a list of things to bring to the birth centre or hospital when you go into labour e.g. something comfortable for you to wear during labour, bras, pants, sanitary towels, toiletries, towels, dressing gown and slippers. For your baby: clothes and nappies, a shawl or blanket and outdoor clothing.

Signs of labour. Most labours start spontaneously with irregular contractions. They will become more often, last longer and feel stronger. It can take up to 24 hours for this to happen and you can stay at home until your contractions become stronger and more regular. You may also have backache. The contractions are widening and shortening the neck of the womb. Sometimes the waters break before labour starts, this is called spontaneous rupture of membranes (SROM). It can be a gush, leak or a trickle of amniotic fluid which you cannot control. If you think your waters have broken or you are having strong regular contractions you should contact staff in the delivery suite, who will advise you what you need to do. You may need an assessment, which could include a vaginal examination. If your waters have broken, but you are not in labour, swabs will be taken to check for infection. Labour often starts within a day of SROM. When you do go to hospital remember to take these notes and an overnight bag with you. If there have been any pregnancy complications e.g. you have developed diabetes in your pregnancy or scans have shown growth restriction with your baby, contact the delivery suite as soon as you start having regular contractions.

Inducing labour. It may be necessary to start your labour if there are problems in the pregnancy e.g. high blood pressure, concerns about the baby's growth or if you are 10-14 days overdue. If you are 'overdue' your midwife will offer you a membrane sweep at 41 weeks. This is a vaginal examination which stimulates the neck of the womb, which may trigger labour. Contractions can be started by inserting a pessary or gel into the vagina. It may take 24-48 hours to get you into labour, sometimes a hormone infusion (drip) is used to speed up the labour. You and your baby will be closely monitored.

Assessment of progress. Many factors play a part in the way your labour progresses – including the 'three Ps':

- POWERS (how strong and effective the contractions are)
- PASSAGE (the shape and size of your pelvis and birth canal)
- PASSENGER (the size of the baby, and which way it is lying)

Progress is assessed as necessary, and includes external and internal examinations to check whether the baby is moving down in the birth canal and whether the cervix is opening.

Monitoring the baby during labour. Your baby's heart beat will be monitored during labour. This is to detect any changes that could suggest your baby is becoming distressed. The midwife can use; a Pinard stethoscope or a fetal Doppler to listen intermittently, or continuously with a monitor. This will depend on your risk at the onset and during your labour.

Positions during labour and birth. If you can, try to keep upright and mobile, changing your position regularly. This can help ease pain; make you feel in control of your labour and increase your chances of a shorter labour. Positions to try during labour and birth are: standing, sitting, kneeling, all fours, squatting and lying on your side. It is important that you find the position which is most comfortable for you. You may find that birth aids such as birthing balls, mats and beanbags or even assistance from your midwife or birthing partner, help you to change or remain in a supported comfortable position throughout labour and birth.

Eating and drinking. If you feel like eating and drinking during labour, it is advisable you eat light meals and drink fluids, to keep your energy levels up. Sometimes it is recommended you do not eat and drink, the midwife caring for you during labour will advise you based on your individual circumstances.

Pain relief. Every woman experiences labour differently and most do not know how they will feel or what pain relief they may need until the day. It is important to be aware of the various options that are available to you. In early labour, you may find: a warm bath, 'TENS' machine, breathing exercises and massage helpful. Other methods include: Entonox (gas and air), intramuscular injections of pain relieving drugs, and epidurals. It is important to keep an open mind, choose what you feel you need.

Previous caesarean section. If you have had one caesarean section in the past you have a good chance (around 75%) of having a vaginal birth this time. This is known as VBAC (vaginal birth after caesarean section). Your midwife/obstetrician will discuss with you the reason for your last caesarean and options for childbirth this time. Labour after a previous caesarean section is monitored more closely, in hospital, to make sure the scar on your uterus (womb) does not tear. If you have had two or more caesarean sections in the past, your obstetrician will discuss with you the safest type of birth for this pregnancy.

Caesarean section. There are times when it is the safest option to have a caesarean section. A caesarean section involves major surgery and should only be carried out for good reasons. The operation involves delivering your baby through a cut in your abdomen. The cut is usually made just below the bikini line. It is usual for you to be awake during the operation, with an epidural or spinal anaesthetic. A caesarean section may be planned e.g. if your baby is breech and did not turn (page 19). It may be done as an emergency during labour, if your baby is distressed or the labour is unduly prolonged.

Instrumental delivery. Extra help may be needed if you have already progressed to pushing, but the delivery needs to be speeded up. This could be because you are tired or your baby is becoming distressed. The **ventouse** method uses a suction cup that fits on your baby's head, while **forceps** are a pair of spoon-shaped instruments that fit around the head. The obstetrician will decide which one to use at the time, based on the clinical situation.

Episiotomy and Tears. The perineum (area between the vagina and anus) stretches to allow the baby to be born. It usually stretches well, but sometimes may tear. An episiotomy is a cut to make the vaginal opening larger. It is not done routinely but may be necessary: to avoid a larger and more damaging tear, to speed up the birth if the baby is becoming distressed or at the time of an instrumental delivery. You will have a local anaesthetic to freeze the area, or if you've already had an epidural, the dose can be topped up before the cut is made. The same applies if stitches (sutures) are needed to repair the episiotomy or the tear. The stitches will dissolve and will not need to be removed.

The placenta (afterbirth). The placenta and membranes usually deliver soon your baby is born. You will be offered an oxytocin injection in your thigh which helps the uterus to contract more quickly and reduces the risk of heavy bleeding (postpartum haemorrhage, PPH). Putting the baby straight to the breast helps release natural oxytocin hormone. Your baby's umbilical cord will usually be clamped and cut within 1 and 5 minutes following birth. This delay allows your baby to carry on benefiting from blood from the placenta. This will depend on the way your baby responds immediately after birth.

Feel free to ask your midwife or doctor – or look at NHS website: **www.nhs.uk**

Your Preferences for Birth and after your Baby is Born

The birth of your baby is a very exciting time. The healthcare team looking after you will discuss the different options for where you can give birth e.g. at home, at a midwifery unit or maternity unit. They offer postnatal care to you and your baby after birth, the location of the appointments will be discussed with you and will depend on your individual circumstances or preferences. You may want to use the space below to record what you would like to happen e.g. what pain relief you would like or who you want to support you during labour and birth. If you have any special requirements e.g. certain religious customs to be observed, please discuss this with your healthcare team, who will develop a personalised plan of care with you. This plan outlines your choices and preferences.

Topics	Discussed	Signature* and Date	Your wishes, intentions or preferences	Leaflets given
Where to have your baby	☐	D D M M Y Y		☐
Hospital / birth centre visit	☐			
What to bring	☐			
Who will be present	☐			
Can students be present	☐			
Signs of labour		D D M M Y Y		
contractions	☐			☐
waters breaking	☐			
Inducing labour		D D M M Y Y		☐
methods used	☐			
reason	☐			
Assessment during labour		D D M M Y Y		☐
of progress	☐			
of mother	☐			
of baby - including fetal heart monitoring	☐			
Positions/posture		D D M M Y Y		☐
during labour	☐			
during birth	☐			
Eating and drinking	☐			
Pain relief		D D M M Y Y		☐
natural methods	☐			
entonox (gas and air)	☐			
injections	☐			
epidural/spinal	☐			
TENS	☐			
Vaginal birth	☐	D D M M Y Y		☐
Water birth	☐			
VBAC	☐			
Caesarean section	☐			
Ventouse	☐			
Forceps	☐			
Breech	☐			
Perineum		D D M M Y Y		☐
episiotomy	☐			
tear	☐			
Delivery of placenta				
Active management	☐			
Physiological	☐			
Delayed cord clamping	☐			
Postnatal care		D D M M Y Y		
Frequency/location of appointments	☐			

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Information Sharing

The information collected in this record will be shared with your healthcare team so that they can provide you and your baby with care. Some of this information will also be recorded electronically. The National Health Service (NHS) collects some of this information to help it to:

- monitor health trends
- strive towards the highest standards
- increase our understanding of adverse outcomes
- make recommendations for improving maternity care

The NHS has very strict confidentiality/data security procedures in place to ensure that personal information is not given to unauthorised persons. The data is recorded and identified by NHS number, and your name and address are removed to safeguard confidentiality. Information such as date of birth and postcode are included to help understand the influences of age and geography.

If there are concerns for you or your child's safety, the relevant information will be shared with other agencies such as safeguarding teams. In these cases, information will be shared without your consent.

Data collection and record keeping discussed ☐ Date D D M M Y Y Signed* Care Provider

Prematurity for use when preterm labour is threatened

Date of presentation: D D M M Y Y Gestation at presentation: Single or multiple pregnancy:

Known GBS Yes ☐ No ☐ Are GBS results to be chased? Yes ☐ No ☐

Steroids	1st dose	Date given D D M M Y Y	Time H H M M	Signed		
	2nd dose	Date given D D M M Y Y	Time H H M M	Signed		
Transfer needed		Date of IUT D D M M Y Y	Time H H M M	Signed		
Antibiotics (IV)		Date given D D M M Y Y	Time H H M M	Signed		
Mg	Loading	Date given D D M M Y Y	Time H H M M	Signed		
	Infusion	Date started D D M M Y Y	Time H H M M	Signed		
Discussion with parents		Date seen D D M M Y Y	Time H H M M	Signed		
Tocolysis		Date given D D M M Y Y	Time H H M M	Signed		

Plan for delivery Monitoring, mode of birth, resuscitation plan

Comments / further medication

Mother's Page

This space is for you to write any questions, concerns and expectations you may wish to discuss with your healthcare team. This may include your feelings around pregnancy, birth and becoming a mother, previous experiences of pregnancy and birth and any fears or concerns. Some questions you may want to ask are: • What things are important to you throughout your antenatal care? • What parts of birth and becoming a mother is most important to you? • What are your thoughts about where you want to give birth to your baby?

Date	

Feel free to ask your midwife or doctor – or look at NHS website: **www.nhs.uk**

Abbreviations

AC	Abdominal circumference	IVF	In vitro fertilisation
AF	Amniotic fluid - fluid around your baby in the womb	LMP	Last menstrual period
ART	Assisted reproductive technology	LMWH	Low-molecular weight heparin
BCG	Bacillus Calmette–Guérin, vaccine against TB	MCADD	Medium chain acyl-coa dehydrogenase deficiency
BMI	Body mass index	MEOWS	Modified Obstetric Early Warning System
BN	Batch number	MFM	Maternal Fetal Medicine
BP	Blood pressure	Mls	Millilitres
BPD	Bi-parietal diameter	MMR	Measles Mumps Rubella
CCT	Controlled cord traction	MRI	Magnetic resonance imaging
CMW	Community midwife	MSUD	Maple syrup urine disease
CO	Carbon monoxide	MSW	Maternity support worker
Con	Consultant	MW / RM	Midwife / Registered Midwife
CP	Civil partner	NAD	No abnormalities detected
CPE	Carbapenemase Producing Enterobacteriaceae	NEWS	Newborn Early Warning System
CRL	Crown rump length	NFA	No fixed abode
CTG	Cardiotocograph	No.	Number
CVS	Chorionic villus sampling	NRT	Nicotine Replacement Therapy
DM	Diabetes mellitus	NT	Nuchal translucency
DVT	Deep vein thrombosis	NVD / SVD	Normal vaginal delivery / Spontaneous vaginal delivery
EBL	Estimated blood loss	O_2	Oxygen
ECV	External cephalic version	Obs.	Obstetrician
EDD	Expected date of delivery	OCD	Obsessive Compulsive Disorder
EFW	Estimated fetal weight	ODP	Operating department practitioner
ETT	Endotracheal tube	OHSS	Ovarian Hyperstimulation Syndrome
F/T	Full time	Palp	Palpation
FBS	Fetal blood sampling	PET	Pre-eclampsia/eclampsia
FGR	Fetal growth restriction	PGP	Pelvic girdle pain
FH / FHHR	Fetal heart / Fetal heart heard regular	PHQ	Patient Health Questionnaire
FL	Femur length	PIH	Pregnancy induced hypertension
FMF	Fetal Movements Felt	PKU	Phenylketonuria
FY	Foundation year doctor	PND	Postnatal depression
GA	Gestational age	PP	Peuperal Psychosis
GA1	Glutaric aciduria Type 1	PPH	Post-partum Haemorrhage
GAD	General Anxiety Disorder	PR	Per Rectum
GBS	Group B streptococcus	Pres	Presentation
GDM	Gestational diabetes	PTSD	Post Traumatic Stress Disorder
Gest	Gestation	P/T	Part time
Gms	Grams	Resp	Respirations
GP	General practitioner - family doctor	SGA	Small for gestational age
Hb	Haemoglobin	SLE	Systemic lupus erythematosus
HC	Head circumference	SROM	Spontaneous rupture of membranes
HCU	Homocystinuria (pyridoxine unresponsive)	StM	Student Midwife
HDU	High dependency unit	STR	Speciality training registrar (Doctor)
HELLP	Haemolysis Elevated Liver Enzymes Low Platelets	TB	Tuberculosis
HV	Health Visitor	Temp	Temperature
HVS	High Vaginal Swab	TENS	Transcutaneous electrical nerve stimulation
IBD	Inflammatory bowel disease	T	Trisomy
ICP	Intrahepatic Cholestasis in Pregnancy	U/E	Unemployed
IOL	Induction of labour	U/S	Ultrasound
IPPV	Intermittent Positive Pressure Ventilation	UKBA	United Kingdom Border Agency
ITU	Intensive therapy unit / intensive care unit	VBAC	Vaginal birth after Caesarean Section
IUD	Intrauterine Device	VE	Vaginal examination
IUS	Intrauterine System	VTE	Venous thrombo-embolism
IV	Intravenous	Wks	Weeks
IVA	Isovaleric acidaemia		
IVDU	Intravenous drug user		

Other contacts / visits

e.g. day unit, delivery suite, inpatient summary or contact with external agencies. *Document episodes of RFM on page 17.

Date /time	Gest	Where seen	Details: reason for referral, investigations, plan of care, length of stay (if admitted)	Signed *	Follow up
D D M M Y Y H H M M	W ks + D				
	+				
	+				
	+				
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	+				
	+				
	+				
	+				

Insert continuation sheets here, and number them.

Name

Unit No/ NHS No

*** Signatures must be listed on page b for identification**

Antenatal Admission

Are personal details on page a correct? ☐ Yes ☐ No

Date D D M M Y Y | Time H H M M | Where seen | Lead professional

Blood group	Previous pregnancies (>24 wks + <24 wks)	BP at booking	Current gestation (weeks + days)	VTE assessment performed	VTE pathway initiated	EDD
	+	/	+	☐ Yes	☐ No ☐ Yes	D D M M Y Y

No. of antenatal visits

Unbooked ☐ 5 or less ☐ 6-10 ☐ 11 or more ☐ Total number of reduced fetal movement visits

Smoking/tobacco use ☐ No ☐ Yes CO reading (if performed) Referral to smoking cessation services ☐ Yes ☐ Declined

Special features (i.e. A/N risk factors, mental health, allergies, GBS positive, previous baby affected by GBS etc.)

Presenting history

CPE screening Yes No	Signs of sepsis /infection Yes No	Fetal movements Yes No	Contractions Yes No	Pain Yes No	Vaginal loss Yes No	Membranes intact Yes No	Vaginal bleeding Yes No

Observations

Pulse (bpm)		Resps	
Blood pressure	/	Temp	
MEOWS score		***Weight on admission	
Oedema		Tissue viability assessment	
Urine		Manual handling assessment	

Palpation

Presentation	
Lie	
Position	
Engagement (5ths palpable)	
Fundal height (cm)	

Estimated liquor Normal ☐ Oligohydramnios ☐ Polyhydramnios ☐

Estimated growth status Normal ☐ Small (<10th customised centile) ☐ Large (>90th customised centile) ☐

Comments

Contractions Yes ☐ No ☐ No. / 10 min Strength Regularity

Fetal heart

Pinard ☐ Doptone ☐ CTG ☐

Rate (bpm) | Baseline | Variability

Maternal pulse (bpm) | Rate (Twin 2) (bpm) | Duration of assessment (mins) | Accelerations | Decelerations

**Normal ☐ **Suspicious ☐ **Pathological ☐

Signed*

Date/Time D D M M Y Y H H M M

DAY ASSESSMENT

Tissue viability risk assessment

Referred: Yes ☐ No ☐ to: Signature* Date D D M M Y Y

Manual handling risk assessment

Referred: Yes ☐ No ☐ to: Signature* Date D D M M Y Y

*** Re-weigh on admission if booking BMI >30

** **Definitions**

Normal CTG where all features are reassuring

Suspicious CTG where there is 1 non-reassuring feature **AND** 2 reassuring features

Pathological CTG where there is 1 abnormal feature **OR** 2 non-reassuring features

* **Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Antenatal Admission - Details

Medication prior to admission (e.g. pain relief, complimentary therapies)

Date/ Time	Notes	Signed*
D D M M Y Y H H M M		

Name

Unit No/ NHS No

*** Signatures must be listed on page b for identification**

Lead Professionals for antenatal care

Intended place of birth

Midwife	Consultant

Lead Professionals for intrapartum care

Midwife	Consultant

Care pathway for intrapartum care

High risk ☐ Low risk ☐ If changed reason:

Lead Carers in Labour

From Date/Time	To Date/Time	Name	Post	Reason for change

Intrapartum venous thromboembolism (VTE) assessment -on admission

BIRTH

	Yes
Any previous VTE except a single event related to major surgery	☐
Hospital Admission	☐
Single previous VTE related to major surgery	☐
High risk thrombophilia and no VTE	☐
Medical Co-morbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU	☐
Any surgical procedure e.g. appendicectomy	☐
OHSS (first trimester only)	☐
Age>35 years	☐
BMI 30-39	☐
BMI ≥ 40 (= 2 risk factors)	☐
Parity ≥3	☐
Smoker	☐
Gross varicose veins	☐
Immobility e.g. paraplegia, PGP	☐
Current pre-eclampsia	☐
Family history of unprovoked or oestrogen-provoked VTE in first degree relative	☐
Low risk thrombophilia	☐
Multiple pregnancy	☐
IVF/ART	☐
Transient risk factors:	
Dehydration / hyperemesis	☐
Current systemic infection	☐
Long distance travel	☐

High risk
Requires antenatal prophylaxis with LMWH
Refer to Trust-nominated thrombosis in pregnancy expert team

Intermediate risk
Consider antenatal prophylaxis with LMWH
Seek Trust-nominated thrombosis in pregnancy expert team for advice

↑

Four or more risk factors: prophylaxis from first trimester

Three risk factors: prophylaxis from 28 weeks

fewer than three risk factors

↓

Lower risk
Mobilisation and avoidance of dehydration

Complete risk assessment and update management plan as necessary **No risks identified** ☐

Signature* **Date** D D M M Y Y

*** Signatures must be listed on page b for identification**

Name
Unit No/ NHS No

Initial Assessment (to assist with a risk assessment at the onset of labour)

Induction of labour Yes ☐ No ☐ Augmentation of labour Yes ☐ No ☐

Date D D M M Y Y Time H H M M Where seen ☐ Current gestation W ks + D

Special Features Medical Factors Yes ☐ No ☐ Obstetric Factors Yes ☐ No ☐ Social Factors Yes ☐ No ☐

AN Visits: Unbooked ☐ 5 or less ☐ 6-10 ☐ 11 or more ☐

Total number of reduced fetal movement visits ☐

GBS screen No ☐ Yes ☐ Result ☐ **Previous baby affected by GBS** No ☐ Yes ☐

IV antibiotics in labour No ☐ Yes ☐ Comments

Presenting history Induction of labour Yes ☐ No ☐ Augmentation of labour Yes ☐ No ☐

CPE screening Yes ☐ No ☐	Signs of sepsis /infection Yes ☐ No ☐	Fetal movements Yes ☐ No ☐	Contractions Yes ☐ No ☐	Pain Yes ☐ No ☐	Vaginal loss Yes ☐ No ☐	Membranes intact Yes ☐ No ☐	Vaginal bleeding Yes ☐ No ☐

General examination

Pulse (bpm) ☐ Blood pressure / ☐ SATS ☐ Resps ☐ Temp ☐ MEOWS score ☐

Oedema ☐ Urine ☐ Manual handling assessment ☐ ***Weight on admission ☐ Tissue viability assessment ☐ Escalation required Yes ☐ No ☐

Presentation ☐ Lie ☐ Position ☐ Engagement (5ths palpable) ☐ Fundal height (cm) ☐

Estimated liquor Normal ☐ Oligohydramnios ☐ Polyhydramnios ☐

Estimated growth status Normal ☐ Small (<10th customised centile) ☐ Large (>90th customised centile) ☐

Comments

Contractions

Yes ☐ No ☐ No. / 10 min ☐ Strength ☐ Regularity ☐

Fetal heart

Pinard ☐ Doptone ☐ Rate (bpm) ☐ Maternal pulse (bpm) ☐ Rate (Twin 2)(bpm) ☐ Duration of assessment (mins) ☐

CTG ☐ Baseline ☐ Variability ☐ Accelerations ☐ Decelerations ☐

** Normal ☐ ** Suspicious ☐ ** Pathological ☐ Comments

Vaginal Examination

Consent ☐ Chaperone offered accepted ☐ declined ☐

Lie/Presentation ☐ Ext genitalia/Show ☐ 5ths palpable ☐ Position ☐ Maternal pulse prior to VE ☐

Cervix position ☐ length ☐ consistency ☐ dilatation ☐

anterior / right / left / posterior

Presenting part ☐ station ☐ caput ☐ moulding ☐ position ☐

Bladder care Void prior to procedure ☐ Catheter required Yes ☐ No ☐

Membranes intact ☐ hindwater leak ☐ Forewaters: already ruptured ☐ ruptured during VE ☐

Liquor none ☐ clear ☐ blood stained ☐ light meconium ☐ thick meconium ☐

Swab count (inc.number) ☐ Swabs correct Yes ☐ No ☐ Swab red string Yes ☐ No ☐ *Signatures ☐

Fetal heart rate after VE (bpm) ☐ Pinard ☐ Doptone ☐ Monitor ☐

Duration of assessment (mins) ☐ Maternal pulse after VE ☐

Escalation required Yes ☐ No ☐ Escalation required ☐

Signature* **Date/Time** D D M M Y Y H H M M

Insert additional sheets here and number 32.1, 32.2 etc

*** Re-weigh on admission if booking BMI >30

**** Definitions**

Normal CTG where all features are reassuring

Suspicious CTG where there is 1 non-reassuring feature **AND** 2 reassuring features

Pathological CTG where there is 1 abnormal feature **OR** 2 non-reassuring

Plans for labour

Birth plan completed Yes ☐ No ☐ Birth plan discussed Yes ☐ Call buzzer/emergency buzzer discussed Yes ☐ NA ☐

Transfer to obstetric unit discussed (if required) Yes ☐ NA ☐ Birth partners

Comments e.g. coping strategies, management of 3rd stage

Signature* **Date/Time** D D M M Y Y H H M M

Personalised Care Plan

To deal with special issues/risks during labour and birth, a personalised care plan should be initiated which outlines specific treatment and care agreed between care providers and the expectant mother and her birth partner/s. This should be altered/amended as labour progresses to ensure that everyone involved in her care is aware of her individual circumstances. The plan should be reviewed at each handover of care.

Risk assessment - at the onset of labour

Pathway of care for labour Low risk ☐ High risk ☐ Type of fetal heart monitoring Intermittent auscultation ☐ Continuous monitoring ☐

Date/time	Risk factor / Special features	Care plan	Discussed with mother	Obstetrician aware	Signed *
D D M M Y Y					
H H M M					

Affix additional sheets here, and number them

*** Signatures and initials must be listed on page b for identification**

Name

Unit No/
NHS No

Date/ Time	Notes	Signed*
D D M M Y Y H H M M		

Name

Unit No/ NHS No

*** Signatures must be listed on page b for identification**

Date/ Time	Notes	Signed*
D D M M Y Y H H M M		

*** Signatures must be listed on page b for identification**

Name

Unit No/
NHS No

Date/ Time	Notes	Signed*
D D M M Y Y H H M M		

Name

Unit No/ NHS No

*** Signatures must be listed on page b for identification**

Date/ Time	Notes	Signed*
D D M M Y Y H H M M		

*** Signatures must be listed on page b for identification**

Name

Unit No/
NHS No

Date/ Time	Notes	Signed*
D D M M Y Y H H M M		

Insert additional sheets here and number 38.1. 38.2 etc

Name

Unit No/ NHS No

* Signatures must be listed on page b for identification

Procedures (e.g. analgesia, epidural anaesthetic, fetal blood sampling, operative delivery, episiotomy, cannulation, delayed cord clamping, 3rd stage management)

Date/ Time	Procedure	Indication	Benefits and risks	Care provider should sign following discussion with mother
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *
D D M M Y Y H H M M				Discussed with mother ☐ Consent Yes ☐ No ☐ Signed *

* **Signatures must be listed on page b for identification**

Name

Unit No/
NHS No

Name	Unit no.
Maternal Preferences	

Significant risk factors

Antenatal risks present No ☐ Yes ☐ SGA or FGR on scan No ☐ Yes ☐

Personalised care plan initiated ☐

Medications Allergies

Age	Prev. pregnancies (>24 wks + <24 wks)	BP at booking	Current gestation (weeks + days)
	+	/	+

Booking BMI

Date	MEOWS score onset of labour	Urine P = protein G = glucose K = ketones B = blood	Maternal Pulse ● (bpm) / Fetal Heart Rate x (bpm)	Maternal activity-posture/ pressure area care	Liquor I = intact C = clear M = meconium B = blood	Fifths palpable per abdomen

Hrs	Time Hrs Mins	Temp (°c)	Resps	BP	P G K B	60 70 80 90 100 110 120 130 140 150 160 170 180
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

60 70 80 90 100 110 120 130 140 150 160 170 180

Affix additional sheets here

Onset date and times: Labour D D M M Y Y H H M M

Intrapartum Action plans

Blood group | Haemoglobin (g/L) | Date taken (D D M M Y Y)

Antibodies present | Group & save ☐ | Cross match | units

Name | Unit no.

Birth Action Plans

Paediatrician to be present ☐ Seniority :

Position Moulding Caput	Cervical dilatation **x** / Station ● (0 1 2 3 4 5 6 7 8 9 10 / +2 +1 0 -1 -2 -3 high)	Contractions No. / 10 min; W = weak, M = moderate, S = strong; R = regular, I = irregular	Oxytocin rate* or pool temp°	Drugs dosage	Fluids in	Fluids out	Signature (List on page 31 for identification)

Total fluids in/out

*If contractions exceed 4:10 min, stop or reduce oxytocin and reassess in line with local protocol

Rupture of membranes (D D M M Y Y H H M M) Active 2nd stage (D D M M Y Y H H M M)

Operative details

Procedure

Ventouse ☐ Caesarean ☐ _____ Classification **

Forceps ☐ Other _____

Indication

Suspected fetal compromise ☐ Failure to progress ☐ Breech ☐

Antepartum haemorrhage ☐ Maternal request ☐ Multiple pregnancy ☐

Other _____

Pre-delivery findings

Abdominal palpation

Presentation _____

Lie _____

Position _____

Engagement (5ths palpable) _____

Vaginal examination

Consent ☐

Chaperone offered ☐ accepted ☐ declined ☐

Not performed ☐

Cervix position _____ **Presenting** part _____

consistency _____ station _____

length _____ position _____

dilatation _____ caput _____

moulding _____

Liquor

None ☐

Clear ☐

Light meconium ☐

Thick meconium ☐

Bloodstained ☐

Fetal heart

CTG performed ☐ Normal ☐

Baseline _____ Suspicious ☐

Variability _____ Pathological ☐

Accelerations _____ Predelivery FBS ☐

Decelerations _____

FBS result _____

Pre-delivery bladder care Bladder emptied Yes ☐ No ☐ Indwelling catheter Yes ☐ No ☐ Time H H M M

Delivery decision made by _____ **Consultant aware** Yes ☐ No ☐ **Consultant present** Yes ☐ No ☐

Designation/ Grade _____ **Name of Consultant** _____

Informed consent obtained for assisted delivery Verbal ☐ Written ☐

Informed consent obtained for caesarean section Verbal ☐ Written ☐

Anaesthetic/Analgesia None ☐ Epidural ☐ Perineal infiltration ☐ Pudendal ☐ Spinal ☐ General anaesthetic ☐

Alerts/Comments (eg allergic reaction, difficult intubation, O_2 for 4hrs post op, dural tap observed)

Assisted delivery

Decision date and time	D D M M Y Y H H M M
Venue for procedure	
Type of instrument used	
Time instrument applied	H H M M
Duration of application	M M minutes
Rotation	
Number of pulls	
Change of instrument (Type)	
Time instrument applied	
Episiotomy performed	Yes ☐ No ☐
Liquor	
Time baby delivered	H H M M
Position at delivery	
Placenta delivered	
Cord pH	
Pre delivery swabs/ instruments correct (inc. no)	
Pre delivery swab red string/sharps (inc. no)	
Pre delivery sterility of instruments confirmed	Yes ☐ No ☐
Post delivery swabs/ instruments correct (inc. no)	
Post delivery swab red string/sharps (inc. no)	
Signatures*	

Caesarean section

Decision date and time	D D M M Y Y H H M M
Time arrived in theatre	H H M M
Prophylactic antibiotics given	Yes ☐ No ☐
Time of knife to skin	H H M M
Time of knife to uterus	H H M M
Type of uterine incision	
Liquor	
Time baby delivered	H H M M
Decision to delivery time	M M minutes
Placenta delivered	
Tubes and ovaries	
Skin closed	
Cord pH	
Time out of theatre	H H M M
Pre delivery swabs/ instruments correct (inc. no)	
Pre delivery swab red string/sharps (inc. no)	
Pre delivery sterility of instruments confirmed	Yes ☐ No ☐
Post delivery swabs/ instruments correct (inc. no)	
Post delivery swab red string/sharps (inc. no)	
Signatures*	

Name _____

Unit No/ NHS No _____

** **Caesarean section classification:**
1. Immediate threat to the life of the mother or fetus.
2. Maternal or fetal compromise, not immediately life-threatening.
3. No maternal or fetal compromise but needs early delivery. **4.** Delivery timed to suit woman or staff.

Details - including surgeon's name and signature

Closure and sutures

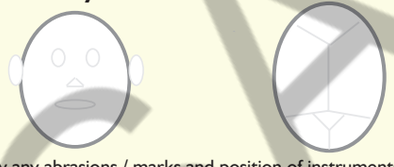
Blood loss (ml)

Measured

Estimated

Total

Post-delivery instructions



Draw any abrasions / marks and position of instruments

	Yes	No
Drains		
Urinary catheter		
Sutures for removal		
Suggest for VBAC next time		
Vaginal pack in situ		
Vaginal pack removed		
Anti-coagulation therapy		

	Yes	No
Anti-embolic stockings		
Antibiotics		
Analgesia		
Epidural catheter removed		
Follow up required		

Comments

Staff present

Surgeon

Assistant

Midwives

Anaesthetist

ODP

Paediatrician

Time called Time arrived

Others

Birth partner in theatre Yes No

Time in recovery M M M minutes

Signature* **Date/Time** D D M M Y Y H H M M

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Third Stage

Management
Physiological ☐ Active (CCT) ☐ Manual removal of placenta ☐

Delayed cord clamping-duration <5 mins ☐ >5 mins ☐

Comments

Drugs
Consent obtained Yes ☐
Dosage & time given
Syntometrine ☐ Ergometrine ☐ Oxytocin ☐
Haemobate ☐ Misoprostol ☐ Tranexamic acid ☐

Blood loss (ml)
Measured
Estimated
Total

Cord No. of vessels
Placenta
Apparently complete ☐
Incomplete ☐
Sent for histology ☐
Comments

Membranes
Apparently complete ☐
Ragged ☐
Incomplete ☐

Further action

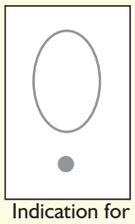
Vaginal delivery pack

Pre delivery swab count (inc. no)
Swab red string correct Yes ☐ No ☐
Signatures*

Post delivery swab count (inc. no)
Swab red string correct Yes ☐ No ☐
Signatures*

Perineum

No trauma identified ☐
PR performed ☐
If PR declined, reason



Trauma **
1° ☐ 3b° ☐
2° ☐ 3c° ☐
3a° ☐ 4° ☐
Labial ☐ Vaginal ☐
Cervical ☐ Episiotomy ☐
Indication for episiotomy

Pre-repair
Repair required No ☐ Yes ☐
Discussed with mother ☐ Consent obtained ☐
Catheterised ☐ Indwelling ☐
Tampon inserted ☐
Venue for repair (room/theatre)
Repair by
Start date and time
Sterility of instruments confirmed Yes ☐ No ☐
Swab count (inc. no)
Needle count
Swab red string correct Yes ☐ No ☐
Instruments correct Yes ☐ No ☐
Count by:
Signature*
Signature*

Details of repair

Anaesthetic
Epidural ☐ None ☐
Pudendal ☐ Spinal ☐ GA ☐
Local ☐ Lignocaine (mls)

Suture material

Technique (post vaginal wall, muscle, skin, labia)

Advice given
Post natal review ☐
Extent of trauma ☐ Hygiene ☐
Type of repair ☐ Diet, including fibre ☐
Pain relief ☐ Pelvic floor exercises ☐

Post repair
Finish date and time:
Haemostasis ☐ Analgesia ☐
Vaginal pack in situ ☐ Time of removal H H M M
PV examination ☐ PR examination ☐
If declined, reason
Tampon removed ☐
Laxatives ☐ Antibiotics ☐
Swab count (inc. no)
Needle count
Swab red string correct Yes ☐ No ☐
Instruments correct Yes ☐ No ☐
Count performed by:
Signature*
Signature*
For postnatal consultant review ☐

Comment

Immediate Postnatal Observations

If further observations required commence Trust MEOWS chart

Date/Time	Temp (°C)	Pulse (bpm)	Resps	O_2 Saturation	BP	Uterus	Lochia / Blood loss	Wound / Drains	Perineum	Urine	Pain	Signature *

Epidural catheter removed Yes ☐ No ☐ N/A ☐ D D M M Y Y H H M M

Comments / Actions

Name
Unit No/ NHS No

** **Descriptions:**
3a =Less than 50 % of external anal sphincter (EAS) thickness torn.
3b=More than 50 % of EAS thickness torn 3c= Internal anal sphincter (IAS) torn.
4th=Injury to perineum involving the EAS and IAS and anal epithelium

Birth Summary - Mother - to assist with handover of care

(complete page OR attach computer printout if available)

Labour onset

- ☐ None
- ☐ Spontaneous
- ☐ Induced
- ☐ Augmented

Indication

Delivery

	Baby 1	Baby 2
Normal	☐	☐
Vaginal breech	☐	☐
Ventouse	☐	☐
Forceps	☐	☐
Caesarean: 1.	☐	☐
2.	☐	☐
3.	☐	☐
4.	☐	☐

(See page 16 for classifications)

One to one care achieved Yes ☐ If no, reason why

Was continuity of carer achieved for labour and birth

Comments

Place of birth

Maternal position at delivery

Bloods

	No	Yes
Maternal blood taken	☐	☐
Cord blood taken	☐	☐

Comments

Pain relief

- ☐ None
- ☐ Entonox
- ☐ Spinal
- ☐ H_2O
- ☐ Narcotics
- ☐ Epidural
- ☐ TENS
- ☐ Pudendal
- ☐ Combined spinal/epidural

Complementary therapies:

Smoking/Tobacco use

	No	Yes	Number
At beginning of pregnancy	☐	☐	
At end of pregnancy	☐	☐	

Received antenatal smoking cessation services ☐ Yes ☐ Declined

Rupture of membranes

Spontaneous ☐ Artificial ☐ Indication

Colour

Date Time Duration hrs /mins /

Maternal complications

Length of labour

	Date	Time
Onset of est. labour		
Fully dilated		
Pushing commenced		
Head delivered		
Baby delivered		
End of third stage		

Twin 2 delivered

Length (hrs/mins)

1st stage /

2nd stage /

3rd stage /

Duration of labour /

Third Stage

Placenta Apparently complete ☐ Incomplete ☐

Total blood loss (ml)

Membranes Apparently complete ☐ Incomplete ☐ Ragged ☐

Comments

Proforma checklist

	Yes	N/A
Post-partum haemorrhage	☐	☐
Shoulder dystocia	☐	☐
Theatre (WHO checklist)	☐	☐
Third/ Fourth degree tear	☐	☐

	Yes	N/A
Meconium	☐	☐
Incident form	☐	☐

Number

Indication

Other:

Birth Attendants

	Baby 1	Baby 2
Delivered by		
Midwife at delivery		
Others present		

Signature* **Date/Time** D D M M Y Y H H M M

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Birth Summary - Baby

Complete page OR attach computer printout if available

Mother's Name	Unit number	NHS number

Baby Details Number of babies [ ] Time from birth to onset of regular respirations Baby 1 [ ] mins Baby 2 [ ] mins

Birth order	Date of Birth	Time	Sex	Birth weight (g)	Centile	Mode of Delivery	Outcome	Apgars 1	5	10	Congenital Anomaly	Unit Number	NHS Number
1													
2													

Apgar Score

	0	1	2	Baby 1: 1	5	10	Baby 2: 1	5	10
Heart rate (bpm)	absent	<100	>100						
Respiratory effort	absent	weak cry	good strong cry						
Muscle tone	limp	some flexion of extremities	well flexed						
Reflex irritability	no response	some motion	cry						
Colour	blue / pale	body pink, limbs blue	pink						
			Total						

Cord Gases

	Baby 1 Arterial	Baby 1 Venous	Baby 2 Arterial	Baby 2 Venous
pH				
Base excess /deficit				
Lactate				
Other				

Initial Examination

	Baby 1	Baby 2
Head circumference (HC, cm)		
Temperature (°C) / route		
Identification / security labels		
Physical examination at birth completed as per Trust guideline		
Signature*		

Resuscitation

	Baby 1	Baby 2
Level	None [ ] Basic [ ] Advanced [ ]	None [ ] Basic [ ] Advanced [ ]
IPPV : Face mask	Yes [ ] No [ ]	Yes [ ] No [ ]
ETT	Yes [ ] No [ ]	Yes [ ] No [ ]
T- Piece	Yes [ ] No [ ]	Yes [ ] No [ ]
Cardiac massage	Yes [ ] No [ ]	Yes [ ] No [ ]
Intubated	Yes [ ] No [ ]	Yes [ ] No [ ]
Age intubated (mins)		
Drugs		
Grade		
Resuscitation discussed with parents	Yes [ ] No [ ]	Yes [ ] No [ ]

Contact & Feeding

Skin-to-skin	Yes	No	Comments	Baby 1	Baby 2
Offered	[ ]	[ ]		Time	Time
Accepted	[ ]	[ ]		Duration (mins)	Duration (mins)
Declined	[ ]	[ ]			

		Baby 1	Baby 2
Type of feed	Breast	[ ]	[ ]
	Formula	[ ]	[ ]
Feed offered	Method		
	Time feed started		
	Duration of feed		

Vitamin K

	Baby 1	Baby 2
Consent obtained	[ ] Yes [ ] No	[ ] Yes [ ] No
Administered	[ ] Yes [ ] No	[ ] Yes [ ] No
Route		
Requires further dose	[ ] Yes [ ] No	[ ] Yes [ ] No

Neonatal Comments/Risks

Prolonged rupture of membranes	[ ] Yes	[ ] No
Meconium present at birth	[ ] Yes	[ ] No
Shoulder dystocia	[ ] Yes	[ ] No
Traumatic/difficult delivery	[ ] Yes	[ ] No
Risk of hypoglycaemia	[ ] Yes	[ ] No
Rhesus negative	[ ] Yes	[ ] No
Birth hypoxia	[ ] Yes	[ ] No
NEWS chart commenced	[ ] Yes	[ ] No

Plans for Transfer after Birth

	Transfer to:	Date and time of transfer	Signature *
Mother		D D M M Y Y H H M M	
Baby(ies)		D D M M Y Y H H M M	
		D D M M Y Y H H M M	

Handover of care tool (as per trust guideline) [ ] Yes [ ] N/A Handover to - (name)

Handover of care tool (as per trust guideline) [ ] Yes [ ] N/A Handover to - (name)

Comments

*** Signatures must be listed on page b for identification**

Name
Unit No/ NHS No

Postnatal venous thromboembolism (VTE) assessment - to be completed immediately after birth. Update personalised care plan as required.

	Yes
Any previous VTE	☐
Anyone requiring antenatal LMWH	☐
High-risk thrombophilia	☐
Low-risk thrombophilia + family history	☐
Caesarean section in labour	☐
BMI ≥ 40	☐
Readmission or prolonged admission (≥ 3 days) in the puerperium	☐
Any surgical procedure in the puerperium except immediate repair of the perineum	☐
Medical Co-morbidites e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy; nephrotic syndrome, type I DM with nephropathy, sickle cell disease, current IVDU	☐
Age>35 years	☐
BMI ≥30	☐
Parity ≥3	☐
Smoker	☐
Elective caesarean section	☐
Family hisory of VTE	☐
Low-risk thrombophilia	☐
Gross varicose veins	☐
Current systemic infection	☐
Immobility, e.g. paraplegia, PGP, long distance travel	☐
Current pre-eclampsia	☐
Multiple pregnancy	☐
Preterm delivery in this pregnancy (<37 weeks)	☐
Stillbirth in this pregnancy	☐
Mid cavity rotational or operative delivery	☐
Prolonged labour (>24 hours)	☐
PPH > 1 litre or blood transfusion	☐

High risk
At least 6 weeks postnatal prophylactic LMWH

Intermediate risk
At least 10 days' postnatal prophylactic LMWH
Note: if persisting or > 3 risk factors, consider extending thromboprophylaxis with LMWH

2 or more risk factors

Fewer than 2 risk factors

Lower risk
Early mobilisation and avoidance of dehydration

No risks identified ☐

Signature* _____ **Date** D D M M Y Y

Mother alerts

Part of the assessment at each postnatal contact is to identify any additional needs you may have. The alerts below can be used by your care team to help identify your risk of developing problems. The aim is to monitor your health and to check that you are well and progressing normally after the birth. The management of any problems or special features can be documented on page 48.

1	Age > 35
2	Para > 3
3	BMI > 30
4	Pregnancy induced hypertension / Pre-eclampsia
5	Prolonged rupture of membranes
6	Pushing > 1.5 hours
7	Ventouse or forceps
8	Caesarean section
9	Incomplete placenta or membranes
10	Baby weight > 90th centile
11	High temperature / unwell
12	Episiotomy / 2nd degree tear
13	3rd / 4th degree tear
14	No spontaneous urinary void > 3 hours
15	Single catheter drainage > 500 ml
16	Indwelling catheter > 24 hours
17	Lack of support
18	Current mental health problems
19	Previous mental heath problems
20	Family history of severe perinatal mental health
21	Excessive blood loss
22	Smoker
23	Antenatal anti-coagulation therapy
24	Thrombophilia
25	Difficult / Traumatic birth

☐ None identified at delivery

Key to risk

If you have one or more risk factors for any of the conditions below, it does not necessarily mean that you will develop a problem. These are merely prompts for your carers to initiate further investigations, treatment or referral.

Infection	**5** **8** **9** **11** **12** **13** **14** **15** **16** **21** **22**
Abnormal bleeding	**2** **4** **9** **11** **23** **24**
Hypertensive disorders	**1** **3** **4**
Urinary urgency or incontinence Faecal urgency or incontinence	**2** **6** **7** **10** **12** **13** **14** **15** **16**
Psychological well being	**17** **18** **19** **20** **25**

For more information on what to do if you start to feel unwell, see pages 6, 7, 13, 15 and 17.

Name _____
Unit No/ NHS No _____

*** Signatures must be listed on page b for identification**

Debrief

Prior to leaving the hospital, your healthcare team can discuss the type of birth you had and how this may affect future pregnancies/birth options. Please take the opportunity to ask any questions, discuss your experience and how you are feeling now.

Any operative delivery ☐	Unexpected or traumatic birth ☐	Referral required ☐
Adverse outcome/incident ☐	Future pregnancies/birth ☐	Support groups/leaflets ☐

Summary of discussion

Signature* ____ **Date** D D M M Y Y **Time** H H M M

Personalised care plan

To deal with special issues after your birth, a personalised care plan will outline specific treatment and care agreed with you and your healthcare team, including specialists. The aim is to keep you well, and to ensure that everyone involved in your care is aware of your individual circumstances. If any special issues/risks have been identified from the alerts on page 47, which require further consideration they will be documented below. This plan will be updated and amended to reflect your changing needs.

Date/Time	Risk factor / Special features	Personalised care plan	Referred to	Signed *
D D M M Y Y H H M M				

Name

Unit No/ NHS No

* Signatures must be listed on page b for identification

Special features

Booking B/P	Booking BMI	Age	Blood group	Para	Last Hb and Date
			+-	+	D D M M Y Y

Key points (i.e. specific antenatal/intrapartum/postnatal events)	**1st urinary void** Date	Time	Amount (ml)
Medications	Allergies		

First postnatal assessment

To be completed prior to: leaving a home birth, early transfer home, or on admission to postnatal ward.

Date D D M M Y Y Time H H M M

Where seen

Are there any concerns about the following:	No	Yes	Comments/Actions
A Temperature, pulse, respirations and blood pressure Infection, fever, chills, headache, visual disturbances, fast pulse, severe breathlessness	☐	☐	MEOWS chart commenced ☐ No ☐ Yes
B Breasts and nipples Redness, pain, cracked, sore, bruised nipples	☐	☐	
C Uterus Abdominal tenderness, subinvolution	☐	☐	
D Vaginal loss Clots, offensive smell, return to heavy loss	☐	☐	
E Legs DVT, redness, swelling, pain, varicose veins, cramps	☐	☐	
F Bladder Pain on passing urine, leakage, urgency	☐	☐	
G Bowels Constipation, haemorrhoids, leakage, urgency	☐	☐	
H Wound Suture removal, healing, infection	☐	☐	
I Perineum Soreness, bruising, swelling, sutures, infection	☐	☐	
J Pain Headache, backache, abdominal, severe chest pain spreading to your jaw, arm or back	☐	☐	
K Fatigue Unable to sleep, restless sleep, extreme tiredness	☐	☐	
L Mental health and wellbeing Feeling down, low in mood, worried or anxious	☐	☐	
M Postnatal exercises Pelvic floor, abdominal, legs, deep breathing, relaxation	☐	☐	
N Tissue viability assessment completed Risk of developing a pressure ulcer	☐	☐	

Infant feeding method

Key to risk reviewed (page 47) ☐ Yes

Personalised care plan initiated ☐ Yes

Signature* **Date/Time** D D M M Y Y H H M M

Orientation to ward

Explanation of ward routine and layout (if applicable)

Introductions ☐ Call system ☐ Security system ☐ Ward layout ☐ Visiting details ☐ Meals/ drinks ☐ Information leaflets ☐ Expected date of discharge ☐

Date D D M M Y Y Time H H M M Signature*

*** Signatures must be listed on page b for identification**

Name

Unit No/ NHS No

Date/ Time	Notes	Signed*
D D M M Y Y H H M M		

Name

Unit No/ NHS No

* Signatures must be listed on page b for identification

Date/ Time	Notes	Signed*
D D M M Y Y H H M M		

Reflections on birth experience (Completed during the postnatal period, at appropriate times)

You may find it helpful to discuss aspects of your pregnancy, birth and postnatal experience with your care givers. This can take place at any time and your midwife may wish to record the details below.

	Details	Signature*/Date/Time
Pregnancy		
Birth		
Postnatal		

Name

Unit No/ NHS No

*** Signatures must be listed on page b for identification**