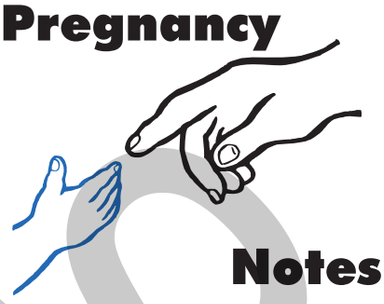
NHS No. | Maternity Unit

CONFIDENTIAL

These notes should be carried by the expectant mother at all times during her pregnancy. If found, please return the notes immediately to the owner, or her midwife or maternity unit.

NHS

Pregnancy Notes



First name | Surname

Address

Postcode | ☎

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

These Pregnancy Notes are a guide to your options during pregnancy, and are intended to help you 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, feel free to ask any questions. Talk about your options with family/friends, write down anything you want to discuss and take it to your appointment. 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 will also be available in leaflets which you will be given as needed.

EDD (D D M M Y Y)

Communication

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 ☎

Maternity Unit ☎

Antenatal Clinic ☎ | Delivery Suite ☎

Community Office ☎ | Ambulance ☎

Primary care contacts

Centre ☎ | Other(s)

Initial | Surname

GP ☎

Postcode (GP) ☎

Health Visitor ☎

Next of Kin

Name

Address

☎ | Relation

Emergency Contact

Name

Address

☎ | ☎

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)

Faith / Religion | Citizenship status

Disabilty 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

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

Social Assessment-booking

	No	Yes	2nd Assessment No	2nd Assessment Yes	Referred (Details: page 13)
Has difficulty understanding English	☐	☐	☐	☐	☐
Any difficulties reading / writing English	☐	☐	☐	☐	☐
Needs help understanding Pregnancy Notes	☐	☐	☐	☐	☐
Needs help completing forms	☐	☐	☐	☐	☐

Employment status

Occupation | Years in 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

	No	Yes	2nd No	2nd Yes	Referred
Entitled to claim benefits (income support, child tax credits, job seeker etc.)	☐	☐	☐	☐	☐
Do you have support from partner / family / friend	☐	☐	☐	☐	☐
Any household member had/has social services support	☐	☐	☐	☐	☐

Name of social worker(s)/ Other Professionals (CAF)

Does your partner have any other children ☐ ☐

Tobacco use - booking

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

When did you give up (D D M M Y Y)

If in pregnancy, how many weeks were you (W K S)

Anyone else at home smoke ☐ ☐

Do you:	No	Yes	No. per day	2nd No	2nd Yes	2nd No. per day
Smoke cigarettes	☐	☐	☐☐	☐	☐	☐☐
Smoke roll up's	☐	☐	☐☐	☐	☐	☐☐
Smoke cannabis	☐	☐	☐☐	☐	☐	☐☐
Chew tobacco	☐	☐	☐☐	☐	☐	☐☐
Use shisha	☐	☐	☐☐	☐	☐	☐☐
CO screening	☐	☐	Result ☐☐	☐	☐	Result ☐☐
Smoking cessation referral	☐	☐		☐	☐	

Drug use - booking

	No	Yes	2nd No	2nd Yes
Have you ever used street drugs, gas or glue	☐	☐		
Do you currently use	☐	☐	☐	☐
Details				
Are you receiving treatment	☐	☐	☐	☐

Alcohol - booking

	No	Yes	2nd No	2nd Yes
Do you drink alcohol	☐	☐	☐	☐
Units per week				
Pre-pregnancy ☐☐ Currently ☐☐			☐☐	
Substance misuse referral	☐	☐	☐	☐

Any drug or alcohol concerns in the home No ☐ Yes ☐ Details

Ethnic Origin (If **mixed**, tick more than one box)

The term Ethnic Origin is to describe where your family originates from, as distinct from where you were born. This information will help us to support which blood screening tests you should be offered (see p6) and to produce a customised growth chart for your baby.

	You	Baby's father
Africa		
North Africa (eg Morocco, Algeria)	☐	☐
Sub-Sahara (eg Somalia, Kenya, Nigeria)	☐	☐
Asia Bangladesh	☐	☐
India	☐	☐
Pakistan	☐	☐
Far East Asia (eg Japan, Korea, China)	☐	☐
South East Asia (eg Malaysia, Thailand, Philippines)	☐	☐
Caribbean (eg Barbados, Jamaica, Trinidad & Tobago)	☐	☐
European (eg Britain, Ireland, Greece, Poland)	☐	☐
Middle East (eg Egypt, Israel, Syria, Yemen)	☐	☐
Other		
Declined to give information	☐	☐

CP - Civil Partner, F/T- Full Time P/T-Part time, UKBA - United Kingdom Border Agency, NFA - No Fixed Abode, CAF- Common Assessment Framework.

Complete risk assessment page 11/ management plan page 13.

Medical History

Complete risk assessment page 11 and management 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	☐	☐
Cervical smear	☐	☐
Diabetes	☐	☐
Epilepsy / Neurological problems	☐	☐
Exposure to toxic substances	☐	☐
Fertility problems (this pregnancy)	☐	☐
Female circumcision	☐	☐
Gastro-intestinal problems (eg Crohns)	☐	☐
Genetic / Inherited disorder	☐	☐
Genital Infections (e.g. Chlamydia, Herpes)	☐	☐
Gynae history / operations (excl. caesarean)	☐	☐
Haemotological (Haemaglobinopathies)	☐	☐
High blood pressure	☐	☐
Incontinence (urinary / faecal)	☐	☐
Infections (e.g. MRSA, GBS)	☐	☐
Inherited disorders	☐	☐
Liver disease inc. hepatitis	☐	☐
Migraine or severe headache	☐	☐
Musculo-skeletal problems	☐	☐
Operations	☐	☐
Pelvic injury	☐	☐
Renal disease	☐	☐
Respiratory diseases	☐	☐
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

Mental Health

	No	Yes
Past or present mental illness	☐	☐
Previous treatment/In-patient care	☐	☐
Family history	☐	☐
Does your partner have any history	☐	☐

During the last month have you been bothered by:	1st No	1st Yes	2nd No	2nd Yes
Feeling down, depressed or hopeless	☐	☐	☐	☐
Having little interest or pleasure in doing things	☐	☐	☐	☐
Worrying or feeling very anxious about things	☐	☐	☐	☐
Is this something you feel you need or want help with	☐	☐	☐	☐
Referral required (record plan on page 13)	☐	☐	☐	☐

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 management 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	☐	☐	☐	☐
- MCADD	☐	☐	☐	☐

Details

MCADD - Medium Chain Acyl Dehydrogenase Deficiency

*** Signatures must be listed on page 26 for identification**

Name

Unit No/ NHS No

Previous Pregnancies ?

Details of previous pregnancies are relevant when making decisions about the care you receive. Some of the main topics are described below. If there is anything else you think may be important, please tell your midwife or doctor.

Para. This is a term which describes how many babies you already have. Usually early pregnancy losses are also listed after a 'plus' sign. For example, the shorthand for two previous births and one miscarriage is '2 + 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.

Premature birth. This means any birth before 37 weeks but the earlier the baby is born, the more likely that it will have problems and need special or intensive neonatal care. The chance of premature birth is increased because of smoking, infection, ruptured membranes, bleeding, or poor growth. Having had a 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 watch this baby's growth more closely, offering ultrasound scans and other tests as necessary.

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 high blood sugar (diabetes), which may be linked to having big babies.

Previous caesarean section. If you have had one caesarean section in the past you have a good chance (at least 2 in 3) of having a vaginal birth this time. This is known as VBAC - vaginal birth after caesarean section. Your midwife and doctor 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, to make sure the old scar does not tear, although in over 99% of cases this does not happen. If you have had two or more caesarean sections in the past, you may be advised to have your next baby(ies) also by caesarean section.

Baby Weight Conversion Chart

lb	oz	g	lb	oz	g	lb	oz	g	lb	oz	g
1	0	454	4	0	1814	7	0	3175	10	0	4536
1	2	510	4	2	1871	7	2	3232	10	2	4593
1	4	567	4	4	1928	7	4	3289	10	4	4649
1	6	624	4	6	1984	7	6	3345	10	6	4706
1	8	680	4	8	2041	7	8	3402	10	8	4763
1	10	737	4	10	2098	7	10	3459	10	10	4819
1	12	794	4	12	2155	7	12	3515	10	12	4876
1	14	850	4	14	2211	7	14	3572	10	14	4933
2	0	907	5	0	2268	8	0	3629	11	0	4990
2	2	964	5	2	2325	8	2	3685	11	2	5046
2	4	1021	5	4	2381	8	4	3742	11	4	5103
2	6	1077	5	6	2438	8	6	3799	11	6	5160
2	8	1134	5	8	2495	8	8	3856	11	8	5216
2	10	1191	5	10	2551	8	10	3912	11	10	5273
2	12	1247	5	12	2608	8	12	3969	11	12	5330
2	14	1304	5	14	2665	8	14	4026	11	14	5386
3	0	1361	6	0	2722	9	0	4082	12	0	5443
3	2	1417	6	2	2778	9	2	4139	12	2	5500
3	4	1474	6	4	2835	9	4	4196	12	4	5557
3	6	1531	6	6	2892	9	6	4252	12	6	5613
3	8	1588	6	8	2948	9	8	4309	12	8	5670
3	10	1644	6	10	3005	9	10	4366	12	10	5727
3	12	1701	6	12	3062	9	12	4423	12	12	5783
3	14	1758	6	14	3118	9	14	4479	12	14	5840

Bleeding after birth. Postpartum haemorrhage (PPH) means a significant loss of blood after birth (usually 500 ml or more). Often this happens when the womb does not contract strongly and quickly enough. There is a chance of it happening again, but your carers will make sure they are prepared.

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, including feeding difficulties, slow perineal healing, or concerns with passing urine, wind and/or stools. If you have experienced these or any other problems, talk to your doctor or midwife.

Depression. It is common to feel low for a little while after having a baby because of hormonal changes and tiredness. However, some mothers do become seriously depressed. This can carry on for months or even years and may require help, counselling and/or medication. Depression can happen again, so it is important that we know about it. We can then discuss any special worries or anxieties you may have and arrange care to suit your needs.

Miscarriages. A miscarriage (sometimes also called spontaneous abortion) is usually thought to happen because of a one-off problem with the baby's chromosomes, causing an abnormality. After one miscarriage, the chances of a successful next pregnancy are as good as before. If you have had three or more miscarriages, there is still a good chance that this pregnancy will go well, but special tests may be required.

What if I've had a termination (abortion) but do not want anyone to know? This information can be kept confidential between yourself, your midwife and doctor and can be recorded elsewhere.

? Feel free to ask your midwife or doctor – or look on the web: **www.preg.info**

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	Age	Birthweight	Centile	Gestation	Condition since	Where now
		D D M M Y Y		G m s		W ks+D		

Place of booking / Place of birth | Antenatal summary | **Complications** Cholestasis ☐ SGA or IUGR ☐ GDM ☐ Congenital Anomaly ☐ 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 1° ☐ 2° ☐ 3°/4° ☐

Labour details | Breast ☐ Bottle ☐ Mixed ☐ | Postnatal summary | PND ☐ PP ☐

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

Place of booking / Place of birth | Antenatal summary | **Complications** Cholestasis ☐ SGA or IUGR ☐ GDM ☐ Congenital Anomaly ☐ 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 1° ☐ 2° ☐ 3°/4° ☐

Labour details | Breast ☐ Bottle ☐ Mixed ☐ | Postnatal summary | PND ☐ PP ☐

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

Place of booking / Place of birth | Antenatal summary | **Complications** Cholestasis ☐ SGA or IUGR ☐ GDM ☐ Congenital Anomaly ☐ 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 1° ☐ 2° ☐ 3°/4° ☐

Labour details | Breast ☐ Bottle ☐ Mixed ☐ | Postnatal summary | PND ☐ PP ☐

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

Place of booking / Place of birth | Antenatal summary | **Complications** Cholestasis ☐ SGA or IUGR ☐ GDM ☐ Congenital Anomaly ☐ 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 1° ☐ 2° ☐ 3°/4° ☐

Labour details | Breast ☐ Bottle ☐ Mixed ☐ | Postnatal summary | PND ☐ PP ☐

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		

SGA - Small for gestational age IUGR- Intrauterine growth restriction
PIH - Pregnancy Induced Hypertension PET - Pre-eclampsia/eclampsia
HELLP - Haemolysis Elevated Liver Enzymes Low Platelets
GDM - Gestational diabetes PND - Postnatal Depression PP - Puerperal Psychosis

Complete risk assessment p11/ management plan pg 13

Name
Unit No/ NHS No

Prenatal Screening and Diagnosis

The first half of pregnancy is a time when various tests are offered to check for potential problems, by blood tests (pages 6-7) and ultrasound scans (pages 8-9). The tests listed here are the ones offered in the NHS. We can list only brief points here, but further information can be found on **www.screening.nhs.uk** and a leaflet, 'Screening tests for you and your baby' will be available from your midwife or doctor.

Do not hesitate to ask what each test means. The choice is yours and you should have all relevant information to help you make up your mind, before the visit when the test(s) are actually done.

Blood Tests and Investigations

Mid stream urine - a sample of your urine is tested to look for Asymptomatic bacteriuria a bladder infection with no symptoms. Treating it can reduce the risk of developing a kidney infection.

Anaemia is caused by too little haemoglobin (Hb) in the blood. The Hb is usually tested as part of the 'full blood count'. Hb carries oxygen and nutrients around the body and to the baby. Anaemia can make you feel very tired. If you are anaemic, you will be offered iron supplements and advice on 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 father, antibodies to the baby's blood cells can develop in your blood. To prevent this, you will be advised to have Anti-D injections if there is a chance of blood cells from the baby spilling into your blood stream (e.g. due to miscarriage, amniocentesis or CVS and after the birth). It is recommended that Anti-D is given routinely to all Rh-ve mothers in later pregnancy.

Rubella (German Measles) if caught early in pregnancy can damage your baby. A test is offered to check your immunity to rubella. Although most women will have had vaccinations they still may not be immune. If you are not immune, you will be advised to be immunised after the birth. Tell your midwife or doctor if you have a rash.

Hepatitis B is a virus which infects the liver. If you are a carrier, or have become infected during pregnancy, you will be advised to have your baby immunised at birth.

Syphilis is a sexually transmitted disease, left untreated can seriously damage your baby. If detected, you will be offered antibiotic treatment.

HIV (Human Immunodeficiency Virus) affects the body's ability to fight infection. This test is important because **any** woman can be at risk. It can be passed to your baby during pregnancy, at birth or through breastfeeding. Treatment given in pregnancy can *greatly* reduce the risk of infection being passed from mother to child.

Sickle Cell and Thalassaemia are blood disorders which affect haemoglobin and can be passed from parent to child. All women will be offered a test for thalassaemia.You will not always be offered a test for sickle cell. You may be asked to complete a questionnaire first to find out where your family and the family of your baby's father come from. If you are low risk you will not be offered the test. The results may require the **baby's father** to be tested.

Additional tests are offered as necessary, such as to check for infections which can cause damage to the developing baby, but rarely cause problems for you. Tell your midwife /Dr of any rashes or if you think you have been in contact with: **Chicken pox, Cytomegalovirus (CMV), Parvovirus (slapped cheek)** or **Toxoplasmosis**.

Chlamydia is a sexually transmitted infection which can result in pelvic inflammatory disease and infertility. If you are under 25, you may be offered a simple test, either a vaginal swab or urine test. If positive, you and your partner will be offered antibiotics.

Methicillin Resistant Staphylococcus Aureus (MRSA) is a bacterium which sometimes cause wound infections and can be difficult to treat as it is resistant to some antibiotics. Some areas may offer testing to pregnant women.

Oral Glucose Tolerance Test (OGTT) is to find out if you have gestational diabetes (see page 19). A blood test is taken after fasting, 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 maybe offered this test if you have a history of the following:

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

Screening for Down's syndrome

Down's syndrome is a condition caused by the presence of an extra chromosome in a baby's cells and usually occurs by chance. There is no such thing as a typical person with Down's syndrome, like all people they vary a lot in appearance and ability. They have learning difficulties and are at an increased risk of health problems. It is hard to tell in a baby how they will be affected when they grow up. The tests can show if there is an 'increased or higher risk or chance' of your baby having Down's syndrome. The tests offered will depend on how many weeks pregnant you are. If you have any questions ask your midwife or doctor.

-**The combined test** involves having a blood test and an ultrasound scan. A blood sample is taken from you, between 10 weeks and 14 weeks and 1 day to measure the levels of substances naturally found in the blood. The ultrasound scan is performed between 11 weeks and 2 days and 14 weeks and 1 day, to measure the amount of fluid lying under the skin at the back of the baby's neck (nuchal translucency measurement, NT). A computer program is used to work out a risk for you.

-**The quadruple test** is offered if you are not able to have the combined test in early pregnancy. A blood sample is taken between 14 weeks and 2 days and 20 weeks. A computer program is used to work out a risk for you.

The result: Your midwife or Dr will discuss your results with you.

High result: You will be offered a diagnostic test which can tell you definitely if your baby has Down's syndrome or not. There are two tests; CVS or Amniocentesis. For more information about these tests see page 8.

Low result: If your result is lower than the recommended national cut off, you will not be offered a diagnostic test. It is important to be aware that none of the tests are 100% accurate, they detect between 70-90% of all cases.

Feel free to ask your midwife or doctor – or look on the web: **www.preg.info**

Investigations If additional blood tests / investigations are required update management 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
Hb	☐	☐	☐					
Blood group	☐	☐	☐					
Antibodies	☐	☐	☐					
Sickle cell	☐	☐	☐					
Thalassaemia	☐	☐	☐					
Rubella	☐	☐	☐					
Hepatitis B	☐	☐	☐					
Syphilis	☐	☐	☐					
HIV	☐	☐	☐					

Date D D M M Y Y — D D M M Y Y

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

Comments — Signed*

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

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

Comments — Signed*

28-week check
Re-offer tests for infections if declined at booking

	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

Date D D M M Y Y — D D M M Y Y

*Signed — Care provider — Care provider

Comments — Signed*

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	☐	☐	☐					
	☐	☐	☐					

Date D D M M Y Y — D D M M Y Y

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

Comments — Signed*

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

*Signed — Care provider — Care provider

Comments — Signed*

Screening Tests for Down's syndrome

	No	Yes
Screening explained	☐	☐
NSC leaflet given	☐	☐

Date D D M M Y Y

*Signed — Care provider

	No	Yes		Date taken	Signed*
Screening offered	☐	☐	If no: why		
Accepted by mother	☐	☐	Test type	D D M M Y Y	

Results: High ☐ Low ☐ — Action — Signed*

*** Signatures must be listed on page 26 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 (i.e. usually by 20 weeks). As with blood tests, it is up to you to decide whether you want any scans to be performed in your pregnancy. The scientific evidence is that ultrasound scanning during pregnancy is safe for mother and baby.

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	Yes
■ early scans to check the number of babies and to date the pregnancy	☐	☐	☐
■ anomaly scans, recommended to be done at about 20 weeks	☐	☐	☐
■ scans later in pregnancy, not done routinely but when there are doubts about the baby's growth and wellbeing, or about the position of the placenta	☐	☐	☐

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. Usually babies come when they are ready.

Early pregnancy. You will be offered a scan, to be performed between 10 weeks and 14 weeks and 1 day to confirm the pregnancy and number of babies in the womb and also calculate the expected date of delivery. You may also be offered screening for Down's syndrome (see page 6) at this time.

Mid-pregnancy (anomaly). You will be offered another scan between 18 weeks and 20 weeks and 6 days. The purpose of this scan is to have a good look at your baby and check for abnormalities (anomaly) of the head, spine, limbs, abdomen and heart. We usually find the baby appears healthy and developing well, but sometimes a problem is found. If a problem is suspected, you will be referred to a specialist to discuss the options available to you. However it is important to know that ultrasound will not identify all problems. Detection rates will vary depending on the type of anomaly, the position the baby is lying in, previous surgery to your abdomen and maternal size.

Later pregnancy. Scans can be performed in later pregnancy to check the baby's well-being. This may be required if there are concerns about how the baby is growing, or if you have certain medical conditions, such as diabetes. The main measurement for this is the abdominal circumference, which includes the size of the liver (the main nutritional store of the growing baby) and the abdominal wall thickness (related to fat reserves). An assessment of the amount of amniotic fluid (liquor) around the baby is also important, as low liquor is linked to fetal growth restriction and can cause fetal distress. If the scan suggests that the baby may be small you will be referred to a specialist 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 (See 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 or not a baby has a chromosomal condition such as Down's syndrome. They are not offered on a routine basis but to: anyone with a family history of an inherited problem, a result of a screening test reported as higher risk (see page 6), or as a result of scan findings. It is important to remember that you have a choice of whether or not to undergo this procedure. Your health professionals will discuss the options available.

Amniocentesis: involves removing a small amount of the fluid from around the baby using a needle. It is normally performed after 15 weeks. The risk of miscarriage from amniocentesis is approximately 1 in 100.

CVS (Chorionic Villus Sampling): involves removing tiny amounts of the placenta (afterbirth), using a needle, it is usually performed between 11 and 13 weeks. The chance of miscarriage is similar or slightly higher than with amniocentesis. Occasionally results from CVS are not clear and you will then be offered an amniocentesis.

There are two types of laboratory test which can be used to look at the baby's chromosomes - a full karyotype and a rapid test (PCR). A full karyotype, checks all of the baby's chromosomes and takes 2 to 3 weeks. PCR checks for specific chromosomes, and results take up to 4 working days.

Feel free to ask your midwife or doctor – or look on the web: **www.preg.info**

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	☐	☐
NSC 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

MRI - Magnetic resonance imaging

*** Signatures must be listed on page 26 for identification**

Name

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

Information Sharing

Some of the information in these notes, about you and your baby will be recorded electronically, this is to help your health professionals provide the best possible care.
The National Health Service (NHS) also wishes to collect some of this information about you and your baby, 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 and 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 is removed to safeguard confidentiality. Other information such as date of birth and postcode are included to help understand the influences of age and geography. In some cases, details of the care are looked at by independent experts working for the NHS, as part of special investigations ('confidential enquiries'), but only after the records have been completely anonymised. While it is important to collect data to improve the standard and quality of the care of all mothers and babies, you can 'opt out' and have information about you or your baby excluded. This will not in any way affect the standard of care you receive. For further details, please ask your lead professional (see page 1).

However your information will be shared with other agencies such as safeguarding teams, where there are concerns for you or your child's safety. 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

Seasonal Flu

Pregnant women are more at risk from seasonal flu; it is recommended you should have the seasonal flu vaccine. It is safe to have at any stage in pregnancy. Your midwife will advise you where you can get the vaccine locally.
If you decline the vaccine and develop flu- like symptoms, you must seek medical advice urgently as you may need treatment.

Seasonal flu discussed No ☐ Yes ☐ Agrees flu vaccine No ☐ Yes ☐ If no, reason declined

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

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

Whooping cough

Whooping cough (pertussis) is a serious disease that can lead to pneumonia and permanent brain damage, in some cases a risk of dying. Young babies are at an increased risk, and they remain so until they can be vaccinated against it, the vaccine is offered to babies from two months of age.
To help protect your baby in the first few weeks of life, it is now recommended you should have a vaccination against whooping cough. Ideally this should be done between 28 and 38 weeks of your pregnancy. Your midwife/ GP will advise you where you can get the vaccine locally.

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

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

Blood products

Blood or blood products are only ever prescribed in specific medical conditions and a decision to decline them should only be made after you have considered all the issues involved. Your wishes will always be respected; it is important you discuss your wishes with your midwife and doctor so that an individualised plan of care can be made.

Treatment discussed	No ☐ Yes ☐		Date D D M M Y Y
Agrees to receiving blood or blood products	No ☐ Yes ☐		
Agrees to baby receiving blood or blood products	No ☐ Yes ☐		Signed*
Management plan initiated	No ☐ Yes ☐		

Important symptoms

Care provider should sign, following discussion with mother

Most pregnancy symptoms are normal, however, 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 12 and 14 or *www.preg.info* for more information). Contact your midwife 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 ☐			
Membranes (waters) breaking early ☐			
Severe headaches ☐			
Blurred vision ☐			
Persistent itching ☐			
Changed or reduced fetal movements ☐			

Name

Unit No/ NHS No

Risk assessment

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			Second assessment			Referral required		
	No	Yes	Comment	No	Yes	Comment	No	Yes	To
Gestation			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	☐	☐	
Asprin required	☐	☐		☐	☐		☐	☐	
OGTT booked	☐	☐		☐	☐		☐	☐	
Mental health factors	☐	☐		☐	☐		☐	☐	
Social factors	☐	☐		☐	☐		☐	☐	
CAF commenced	☐	☐		☐	☐		☐	☐	
BMI pathway initiated	☐	☐		☐	☐		☐	☐	
Management Plan updated	☐	☐		☐	☐		☐	☐	
Signature*									
Date	D D M M Y Y			D D M M Y Y					

Pregnancy Planner

During your pregnancy you will be offered regular appointments with a midwife, GP or Obstetrician. They check that you and your baby are well, give you support and information about 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 during the pregnancy. 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.

Up to 20 weeks

The aim of early visits is to record details about you and your pregnancy which are relevant for your care, give you information about your choices for antenatal screening, discuss healthy lifestyles and assess which additional services you might need to be offered. Your midwife should be able to give you information about how many appointments you are likely to have and when they will happen.

	Pregnancy week	With whom
Booking		
Dating scan		
Blood tests		
Anomaly scan		
Antenatal visits		

From 20 weeks

Visits in the second half of pregnancy aim to monitor your health and to check that your baby is well and growing as expected. Also, they provide continuing opportunities to discuss expectations and options for childbirth, and to prepare for motherhood. Your midwife works in partnership with the health visiting team, your health visitor will contact you during the later part of your pregnancy.

	Pregnancy week	With whom
Blood tests		
Antenatal visits		
Health Visitor		
Infant feeding		

VTE - Venous thromboembolism OGTT - Oral glucose tolerance test
CAF - Common assessment framework GP - General Practitioner

*** Signatures must be listed on page 26 for identification**

Name

Unit No/ NHS No

Pregnancy Complications

Common pregnancy symptoms. You may experience a number of symptoms during pregnancy. Most are normal and will not harm you or your baby, but if they are severe or you are worried about them, speak to your midwife or doctor. You may feel some tiredness, sickness, headaches or other mild aches and pains, or have heartburn, constipation or haemorrhoids. There may also be some swelling of your face, hands or ankles or you may develop varicose veins. Changes in mood and sex drive are also common. Sex is safe unless you are advised otherwise by your care provider. Problems in pregnancy require additional visits for tests and surveillance of you and your baby's well-being. Many conditions will only improve after delivery of the baby, therefore it may be necessary to induce your labour or undertake a planned (elective) caesarean section. Please discuss any worries with your midwife or doctor.

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

Vaginal bleeding. Bleeding may come from anywhere in the birth canal, including the placenta (afterbirth). 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, tightenings 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 advised to stay until the bleeding has stopped or the baby is born. If you are Rh -ve, you will require Anti-D injection (page 6).

Diabetes is when there is a higher than normal amount of glucose in the blood. It may be present before pregnancy, or develop during (gestational diabetes). High sugar levels cross the placenta and can cause the baby to grow large (macrosomic). If you have or develop diabetes, you will be looked after by a specialist team who will check you and your baby closely throughout the pregnancy. Keeping your blood glucose as near normal as possible can help prevent problems for you and your baby. Gestational diabetes usually disappears after pregnancy but can happen again in future pregnancies.

High blood pressure. A rise in blood pressure can be the first sign of a condition known as **pre-eclampsia** or pregnancy induced hypertension. Your blood pressure will be checked often during your pregnancy. You need to tell your midwife/doctor or nearest maternity unit if you get bad headaches; blurred vision or spots before your eyes; bad pain below your ribs and or vomiting as these can be signs that your blood pressure has risen sharply. If there is also protein in your urine, you may have pre-eclampsia which in its severe form can cause blood clotting problems and fits. It is also often linked to problems for the baby such as restricted growth. Treatment may start with rest, but some women will need medication that lowers blood pressure. Occasionally, this may be a reason to deliver the baby early.

Thrombosis (clotting in the blood). Your body naturally has more clotting factors during pregnancy, to stop the bleeding as quickly as possible once the placenta (afterbirth) is delivered. However, this also means that all pregnant women are at a slightly increased risk of developing blood clots during pregnancy and the first weeks thereafter. The risk is higher if you are over 35, overweight, smoke cigarettes, or have a family history of thrombosis. You are advised to see your doctor **immediately** if you have any pain or swelling in your leg, pain in your chest or cough up blood.

Obstetric Cholestasis, is severe **itching** especially on the hands and feet, caused by a liver condition. Cholestasis can affect the baby and may result in stillbirth. If you have severe itching a blood test is offered to check to see if you have the condition. If you do, you may require tablets and the baby will require careful monitoring. The timing of delivery should be discussed with you and your doctor according to your individual needs.

Prematurity. Labour may start prematurely (before 37 weeks), for a variety of reasons. If this happens before 34 weeks, most maternity units have a policy of trying to stop labour for at least a day or two, whilst giving steroid injections (betamethasone) to help the baby's lungs to mature. However once labour is well established it is difficult to stop. Babies born earlier than 34 weeks may need extra help with breathing, feeding and keeping warm.

Breech. If the baby's presentation (see page 14) is not head first, there is an increased chance that the labour will not be straightforward. If your baby is presenting bottom first (breech) it is now usually recommended to try and turn the baby before labour starts (ECV = External Cephalic Version). However, the procedure is not always successful. Your midwife/obstetrician will discuss with you the options on how best to deliver a baby that stays in the breech position; delivery by a planned (elective) caesarean section is now often recommended, but the alternative maybe to allow labour to start naturally, to watch and see how things go and to intervene only as necessary; as always the decision is yours.

Multiple pregnancy. Twins, triplets or other multiple pregnancies need close monitoring. More frequent tests and scans are recommended. Your midwife/obstetrician will discuss with you the 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 the babies share a placenta.

Body Mass Index is a test to see if you are a healthy weight for your height and is calculated by dividing your weight in kilograms by your height in metres squared. During pregnancy there are increased risks of certain complications if your BMI is less than 18 or more than 30.

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				

Management plan

Highlight key points in special features box (page 17). If necessary, update the lead professional box on page 1.

To deal with special issues during pregnancy, a management plan will outline specific treatment and care agreed between you and your care providers, including specialists. 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 updated and amended during pregnancy to reflect your needs.

Risk factor / special features	Management plan	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
			D D M M Y Y

Insert continuation sheets here, and number them 13.1, 13.2 etc

* **Signatures must be listed on page 26 for identification**

Name

Unit No/
NHS No

Antenatal Checks

At each antenatal visit, your midwife or doctor will check you and your baby's well being. Please discuss any worries or questions that you may have.

Blood pressure (BP) is checked to detect pregnancy induced hypertension or pre-eclampsia (see p12). High blood pressure may cause severe headaches or flashing lights. If this happens, tell your midwife or doctor immediately.

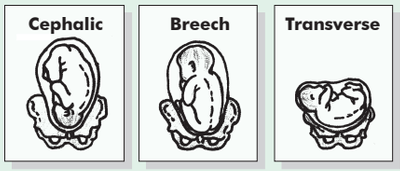
Urine tests You will also be asked to supply a sample of your urine at each visit to check for protein (recorded as + or ++ = presence of), which may be a sign of pre-eclampsia.

Fetal movements You will usually start feeling some movements between 16 and 22 weeks. Later in pregnancy your baby will develop its own pattern of movements. This will range from kicks and jerks to rolls and ripples. Sometimes your baby will hiccup. You will very quickly get to know the pattern of your baby's movements. At each antenatal contact your midwife will talk to you about this pattern of movements, which you should feel each day. A change, especially a reduction in movements, may be a warning sign that the baby needs checking by ultrasound and Doppler. 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.

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 (trumpet) or a fetal doppler (e.g. Sonicaid). With a doppler, you can hear the heartbeat yourself.

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. head first 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.

Internals / vaginal examinations are NOT usually done at antenatal visits unless there is a specific reason.

Assessing Fetal Growth

Accurate assessment of the 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 are 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 the 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 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.

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 the 'dating ultrasound'

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

Growth restriction. Slow growth is one of the most common problems that can affect the baby in the womb. If the fundal height measurements suggest there is a problem, an ultrasound scan should be arranged and the estimated fetal weight (degree of error 10-15%) plotted on the customised chart to assess whether the baby is small for gestational age. If it does record as small, assessment of Doppler flow is recommended, which indicates 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 the baby.

Large baby (macrosomia). Sometimes the growth curve is larger than expected. A large fundal height measurement 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 and the amniotic fluid volume. Big babies may cause problems either before or during birth (obstructed labour, shoulder dystocia etc.). However, most often they are born normally.

Insert customised growth chart here

Insert customised growth chart here

Feel free to ask your midwife or doctor – or look on the web: **www.preg.info**

Special features

Height	Weight booking	BMI	BP booking	Age	Blood group	Weight 3rd trimester	Para	EDD
c m s	k g s				+-	k g s	+	D D M M Y Y

Key points (from management plan, page 13)	**Labour, delivery & postnatal** Paediatric alert form ☐
SGA or IUGR on scan Yes ☐	Paediatrician to be present ☐ Seniority Reason
Medications Allergies	

Antenatal visits

Gest - Gestation; BP - Blood Pressure; Pres - Presentation; Eng - Engagement; Hb - Haemoglobin.

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

Date/Time	Gest	BP	Urine	Fetal Movements: Felt	Fetal Movements: Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Hb	Next contact
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With	Management plan: reviewed ☐ revised ☐	Signed*										

*** Signatures must be listed on page 26 for identification**

Name

Unit No/
NHS No

Antenatal visits

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

Date/Time	Gest	BP	Urine	Fetal Movements: Felt	Fetal Movements: Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Hb	Next contact
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With ☐	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With ☐	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With ☐	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With ☐	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With ☐	Management plan: reviewed ☐ revised ☐	Signed*										
D D M M Y Y	W ks+D	/										
H H M M	Details and advice:(inc. infant feeding, lifestyle choices, pelvic floor exercises etc.)											
Accompanied No ☐ Yes ☐ With ☐	Management plan: reviewed ☐ revised ☐	Signed*										

Insert continuation sheets here, and number them 18.1, 18.2 etc

*** Signatures must be listed on page 26 for identification**

Name

Unit No/ NHS No

Other contacts / visits e.g. day unit, inpatient summary or contacts with external agencies.

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 W ks D H H M M	+				
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Insert continuation sheets here, and number them 19.1, 19.2 etc

*** Signatures must be listed on page 26 for identification**

Name

Unit No/
NHS No

General information

Work and benefits. Having a baby does not come cheap, there may be a change in your household income. The 'Parents Guide to Money' is a pack giving you information on all financial aspects of the arrival of a new baby including budgeting, benefits and work options. Your midwife will be able to advise you where to get this pack. You should discuss your options regarding maternity leave and pay with your personnel officer or employer early in pregnancy; ensure everything is in writing. An FW8 certificate will be issued in early pregnancy entitling you to free prescriptions and dental treatment. Your midwife will also supply you with a maternity certificate at 20 weeks of pregnancy (Mat B1) to claim your entitlement. Families on certain benefits can get some support known as Healthy Start and will receive vouchers for free milk, fruit, vegetables and vitamins.

Healthy eating and drinking. 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. 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 and liver products; peanuts and unpasteurised milk. Have no more than two portions of oily fish a week and avoid marlin, swordfish and shark. It is advised that you take supplements of folic acid, which helps to prevent abnormalities in the baby, e.g. spina bifida. The recommended dose is 0.4mg per day for at least 8 weeks before pregnancy, and up to 12 weeks into the pregnancy. If you have diabetes, increased BMI over 30, are taking anti-epileptic drugs or have a family history of fetal anomalies, the recommended dose is 5mg per day.

Vitamin D is needed for healthy bone development. To protect your baby and yourself from the problems caused by low levels, a 10mcgs Vitamin D supplement is recommended as found in the Healthy Start Vitamins. Vitamin A supplements should NOT be taken in pregnancy and any other supplements should only be taken after checking with your midwife. If you require more advice about your diet your midwife can refer you to a dietitian.

Weight control. It is important to accept you are going to put weight on in your pregnancy. The normal changes in your body during pregnancy and the growing baby can add up to an average weight gain of around 11kg. The more weight you put on above the recommended amount in pregnancy, the more weight you will be left carrying after the birth of your baby. It is recommended you are weighed at the begining of your pregnancy and again near the end.

- **Caffeine** is a stimulant that is contained in tea, coffee and cola drinks. Too much caffeine should be avoided as it is passed through the placenta and may affect your baby.
- **Alcohol** increases the risk of miscarriage or may lead to Fetal Alcohol Syndrome, resulting in severe abnormalities. Pregnant women should avoid drinking alcohol. If you choose to drink during pregnancy, you should drink no more than 1-2 units, once or twice a week. A unit of alcohol = half a pint of beer/ lager, or a single measure of spirits or a small glass of wine. Getting drunk or binge drinking could harm your unborn baby.
- **Drugs.** Taking street drugs during pregnancy is not recommended as it may seriously harm you and your baby. Over-the-counter medicines should also be avoided.

Smoking. When you smoke tobacco, 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 it at risk of low birth weight, premature birth, and other problems. The sooner you stop smoking the better, to give your baby a healthy start in life. Your midwife can arrange referral to your local smoking cessation coordinator or group (see NHS Pregnancy Smoking Helpline). Cannabis smoking should also be avoided during pregnancy as it produces higher levels of carbon monoxide.

Hygiene. When you are pregnant your immune system changes and you are more prone to infections. It is really important you try to reduce the risk of infections by: good personal hygiene, washing your hands properly before and after preparing food, using the toilet or sneezing/blowing your nose. Always wear gloves when gardening or handling cat litter as toxoplasmosis can be found in cat faeces. If you feel unwell, have a sore throat or respiratory infection contact your midwife or GP for advice.

Travel. If you are planning to travel abroad, you should discuss flying, vaccinations and travel insurance with your midwife or doctor. Long-haul flights can increase the risk of deep vein thrombosis (DVT).

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. Also, make sure all baby/child seats are fitted correctly according to British Safety Standards.

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 with others. If you feel anxious or worried about anything, you can discuss your problems in confidence with your midwife or doctor.

Domestic violence. 1 in 4 women experience domestic abuse at some point in their lives, and many cases start during pregnancy. It can take many forms, including physical, sexual, financial control, mental or emotional abuse. Where abuse already exists, it has been shown that it may worsen during pregnancy and after the birth. Domestic abuse can lead to serious complications which affect you and your baby. You can speak in confidence to your healthcare team who can offer help and support. Or you may prefer to contact a support agency such as The National Domestic Violence Helpline .

Exercise. Regular exercise is important to keep you fit and supple. Make sure your instructor knows you are pregnant. Provided you are healthy and have discussed this with your midwife, exercise such as swimming or aquanatal classes are safe. Scuba diving and any vigorous exercise or contact sports should be avoided. It is recommended you do pelvic floor exercises daily during pregnancy. You should aim for eight contractions three times a day; your midwife will advise you on how to do these.

Plans for Pregnancy

Update management plan (page 13) as required

Topics	N/A	Discussed	Signature* and Date	Your intentions or preferences	Leaflets given
Parents Guide to Money pack		☐			☐
Employment rights	☐	☐			☐
Maternity benefits	☐	☐			
Healthy eating		☐			☐
Vitamin D / Healthy Start Vitamins		☐			
Caffeine		☐			
Alcohol		☐			
Drugs		☐			
				Start date: D D M M Y Y	
Hygiene		☐			
Smoking					
Effect on baby	☐	☐			
Effect on mother	☐	☐			
Smoking cessation	☐	☐		First appointment: D D M M Y Y	☐
Carbon Monoxide Testing (Record result on page 2)		☐			☐
Travel safety		☐			☐
Seat belts		☐			
Feelings about pregnancy		☐			☐
Stresses in pregnancy		☐			
Support at home		☐			
Sex in pregnancy		☐			
Exercise (Inc. pelvic floor)		☐			☐
Aquanatal		☐			☐

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

Email:

Alternatively, you can register on **www.nhs.uk/parents** to receive texts and emails.

Social & Health Assessment Completed Date D D M M Y Y Signed*

Your carers

Midwife. Your midwifery team are usually the main care providers throughout your pregnancy. They provide care and support for 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. Your midwives will arrange to see you at clinics in the local community and will visit you at home after the birth of your baby. If you need to contact your midwife please refer to the telephone numbers on page a of this booklet.

Supervisor of Midwives are experienced practising midwives who have had additional training to support, guide and supervise midwives. Every midwife has a named supervisor. As well as supporting midwives they also can support and advise you. If you have any concerns about your maternity care experience you can discuss this with a supervisor of midwives, if you feel unable to discuss it with your midwife. They can be contacted 24 hours a day by telephoning your local maternity unit- see page 1 of this booklet. For more information; see the 'Supervisor of Midwives - How they can help you' leaflet or ask your midwife.

Obstetrician. A doctor who specialises in the care of women during pregnancy and childbirth. You may be referred to an Obstetrician 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 the health of the baby. They will discuss with you a plan of care.

Health Visitors work within the NHS. All are qualified nurses 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 midwives. Your health visitor will visit you at home after you have had your baby, but will also see you during your pregnancy.

General Practitioner (GP). Doctors who work in the community, providing care for all aspects of health for you and your family throughout your lifetime.

Specialists. Some women with medical problems, such as diabetes, may need 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. They will perform your dating, mid-pregnancy (anomaly) and any other scans you may need, based on your individual needs.

*** Signatures must be listed on page 26 for identification**

Name

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Preparing for your new baby

Parent education. Expectant mothers who attend classes and prepare for birth and parenthood find that it helps them to cope better. The preparation also gives you the confidence to make your own, personal choices. Ask your midwife what is available in your area to suit you. There are often also special classes for teenagers, parents expecting twins and non-English speaking parents.

Hospital visit. If you choose to give birth in a hospital or birth centre, 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 within that unit and the opportunity to ask questions such as :- are there birthing pools; who can be present to support you during labour and the birth of your baby; how long will I be in hospital and what are the visiting hours?

Equipment. Every new parent needs some essentials for their new baby. It can be quite confusing to know what you really need. In the early days, you will need clothes and nappies. It may be advisable not to get too many until after your baby is born so that you know what size to buy. You also 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. You may want to think about other ways of carrying your baby when you are out and about, such as baby carriers/slings or prams/pushchairs.

If you are having your baby in hospital or in a birth centre, you may be given a list of things to bring in. This will include: 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. You should also pack things to help you to relax and pass time during labour such as magazines, playing cards and books. It maybe helpful to bring a sponge or water spray to keep you cool in labour and lip balm/salve to keep your lips moist. You might want to play some music during labour, check with your maternity unit what equipment they have for you to play music through.

Newborn screening. After birth, your baby will be offered some screening tests. The newborn hearing screen is a quick test to detect hearing loss and the blood spot test is a simple blood test to find those very few babies who may be affected by phenylketonuria, congenital hypothyroidism, MCADD (Medium Chain acyl-coA Dehydrogenase Deficiency) and haemoglobinopathy disorders. Two detailed examinations of your baby will be performed, one within 72 hours of the birth and one when your baby is 6 - 8 weeks old. These include examinations of the baby's eyes, heart and lungs sounds, nervous system, abdomen and hips, all findings will be discussed with you. Your midwife will give you a leaflet explaining all of these tests.

Vitamin K. We all need Vitamin K to make our blood clot properly so we do not bleed too easily. Some babies have too little Vitamin K. To reduce the risk of a bleeding disorder your baby should be offered Vitamin K. The most effective way of giving Vitamin K is by injection, oral doses can be an option. Speak to your midwife who will be able to advise you about this.

BCG. This is a vaccine offered to all babies who may be at risk from contact with TB (tuberculosis). Those at higher than average risk are travellers and the homeless, but also people that have arrived in the UK from Asia, Africa, South and Central America and Eastern Europe. TB is a potentially serious infection, which usually affects the lungs, but can also affect other parts of the body. Treatment is with antibiotics and the BCG vaccination is usually given to the baby early in the postnatal period. Please ask your midwife if you require more information about this.

Hepatitis B. Some people carry the Hepatitis B virus in their blood without actually having the disease itself. If a pregnant mother has Hepatitis B, or catches it during pregnancy, she can pass it onto her baby. Babies born to infected mothers should receive a course of vaccine. The first immunisation will be offered to your baby soon after birth and then at one, two and 12 months old.

Feeding your baby. It is never too early to start thinking about how you are going to feed your baby. Discuss your thoughts and the options with your partner, family, friends and your midwife.

Nature provides breast milk - the perfect milk to feed your baby, balanced to suit his/her needs. It protects against gastro-enteritis and diarrhoea, urinary tract infections, ear infections and chest infections; it may also protect against allergies and diabetes and reduce the risk of sudden infant death syndrome and childhood leukaemia. For you, breast feeding reduces the incidence of breast cancer, ovarian cancer and hip fractures in later life.

Almost all women can breastfeed, but it often needs practice and support to get it right. The more time you spend with your baby the quicker you will learn each others signs and signals. Holding your baby against your skin straight after birth will calm them, steady their breathing, keep them warm and encourage them to breast feed. It is advisable to do this until your baby has finished its first feed. Babies are often very awake in the first hour after birth and keen to feed. Your midwife will help you with this. When you feed your baby it is important you do so wherever you feel comfortable, relaxed and unhurried. Position yourself comfortably, remove your bra or any restrictive clothing to allow your breast to rest naturally.

When correctly attached to your breast your baby rhythmically takes long sucks and swallows until they have had enough, then they will come off the breast on their own. Breastfeeding should be pain free and your nipple should be the same shape after a feed as it was before the feed. The nipple should not be flat or pinched. Further information can be found on the DVD Bump to Breastfeeding which you can watch through the Best Beginnings website; www.bestbeginnings.org.uk.

It is possible to breastfeed even if you plan to return to work soon after the baby is born, your midwife /health visitor /breast feeding counsellor /support group will help you with this. If you did not feed your previous baby, consider it again for this pregnancy. If you decide not to breastfeed, your midwife can advise you on bottle feeding and sterilisation techniques to ensure safe feeding.

Plans for Pregnancy and Parenthood

Topics	Discussed	Signature* and Date	Your intentions or preferences	Leaflets given
Preparing for your new baby		D D M M Y Y		☐
Parent education	☐			
Hospital visit	☐			
Home environment	☐			
Equipment	☐			
Safe sleeping	☐			
Newborn screening and examination	☐			
Vitamin K	☐	D D M M Y Y		☐
BCG	☐			
Hepatitis B	☐			
Infant feeding		D D M M Y Y		☐
Why breastfeeding is important				
Benefits for baby	☐			
Reduce risk of gastro-enteritis, diarrhoea, urinary tract, ear & chest infections, obesity & diabetes				
Benefits for mother	☐			
Reduces risk of breast and ovarian cancer and oesteoporosis				
No other food or drink before 6 months	☐			
By 28 weeks		D D M M Y Y		☐
'Bump to Breast feeding' DVD	☐			
'Off to the Best Start' NHS leaflet	☐			
By 34 weeks - Getting off to a good start		D D M M Y Y		☐
Importance of early skin to skin, keeps baby warm, calm and promotes bonding	☐			
Keeping baby close	☐			
Baby-led feeding and cues	☐			
Importance of exclusive breastfeeding	☐			
Effective positioning	☐			
C - Close				
H - Head free				
I - In line				
N - Nose to nipple, facing breast				
Effective attachment	☐			
C - Chin touching breast				
O - Open mouth wide				
L - Lower lip curled back				
A - Areola visible above top lip				
R - Rounded full cheeks				
S - Sucking rhythmically, pain free				
Avoiding teats, dummies & nipple shields	☐			
Hand expressing	☐			
Support Groups	☐			

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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 led 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 of 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.

Signs of labour. Labour usually starts 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 can not control. If you think your waters have broken, or you have 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 may include a vaginal examination. If your waters have gone, 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.

Inducing labour. Most labours start by themselves. It maybe necessary to start your labour if there are problems in the pregnancy, such as 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. It 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 drip is used to speed up the labour. You and your baby will be closely monitored during this time.

Assessment of progress. Many factors play a part in the way your labour progresses – including the 'three Ps': The POWERS (how strong and effective the contractions are); the PASSAGE (the shape and size of your pelvis and birth canal) and the 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 it is becoming distressed. The midwife can use; a Pinard (trumpet) hand-held monitor to listen intermittently, or continuously with a monitor attached to your abdomen.

Posture during labour and birth. You will be encouraged to move around during labour unless your chosen pain relief makes this difficult. During the active pushing phase, many mothers wish to remain upright; there is evidence that birth can be easier in a squatting or kneeling position. It is important that you find the position which is most comfortable for you.

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. Labour is painful, it is important to learn about all the ways you can ease the pain. There are many options and most mothers do not know how they will feel or what they need until the day. In early labour, you may find; a warm bath, 'TENS' or approved complementary therapies helpful. Medical methods include: entonox (gas and air), intramuscular injections of pain relieving drugs, and epidurals. It is important to keep an open mind and choose what you feel you need at the time.

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 may be planned in advance - for example, if your baby is breech and did not turn. It may be done as an emergency during labour, if your baby is distressed or the labour is unduly prolonged.

Ventouse and Forceps. 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 doctor will decide which one to use at the time, based on the clinical situation. You will be asked to push while the doctor is gently pulling to guide the baby out.

Episiotomy and Tears. The 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, or to speed up the birth if the baby is becoming distressed at the end of labour. It may also be done at the time of a forceps delivery. Unless you already have an effective epidural or spinal anaesthetic, you will have a local anaesthetic to freeze the area. The same applies if stitches (sutures) are needed to repair the episiotomy or the tear. Usually the stitches will dissolve and will not need to be removed.

The placenta (afterbirth). The placenta and membranes usually deliver soon after the baby is born. You will be offered an injection in the thigh soon after the baby is born. This helps the uterus to contract more quickly and reduces the risk of heavy bleeding (post partum haemorrhage, PPH). Putting the baby straight to the breast also helps, as it helps to release natural oxytocin hormone.

Preferences for birth

The birth of your baby is a very exciting time, your midwives and doctors would like to make your birth experience special, while also making sure that it is safe. If you know what to expect during labour you will feel more in control. You may wish to make a record of what you would like to happen, such as what pain relief you would like or whether you would like to use a birthing pool. It allows the professionals caring for you to know your wishes and understand your individual needs. It is good to make plans but please remember that every birth is different as the course of labour is unpredictable. Lack of flexibility can lead to disappointment when things do not happen exactly as planned - the important thing is to keep an open mind.

Topics	Discussed	Signature* and Date	Your comments	Leaflets given
Where to have your baby	☐	D D M M Y Y		☐
Intended length of stay	☐			
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	☐			
Posture		D D M M Y Y		☐
during labour	☐			
during delivery	☐			
Eating and drinking	☐			
Pain relief		D D M M Y Y		☐
natural methods	☐			
entonox (gas and air)	☐			
injections	☐			
epidural/spinal	☐			
Vaginal birth	☐	D D M M Y Y		☐
Water birth	☐			
Caesarean section	☐			
Assisted vaginal birth	☐			
ventouse	☐			
forceps	☐			
breech	☐			
Perineum		D D M M Y Y		☐
episiotomy	☐			
tear	☐			
Delivery of placenta				
Active management	☐			
Physiological	☐			

*** Signatures must be listed on page 26 for identification**

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Appointments

You will be offered appointments 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				

Signatures

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

Abbreviations: CMW - Community Midwife; MW - Midwife; StM - Student Midwife; HV - Health Visitor; HCA - Health Care Asst; MSW - Maternity support worker, PT- physiotherapist; Ph - Phlebotomist GP - General Practitioner; Con - Consultant; SpR - Specialist Registrar; Reg - Registrar; FY - Foundation Year Doctor; US - Ultrasonographer

Name (print clearly)	Post	Signature

Name (print clearly)	Post	Signature

Support Groups

See also www.preg.info/groups

Antenatal Results & Choices (ARC)	0207 631 0285
Childline	0800 1111
Citizens Advice Bureaux (CAB)	0207 833 2181
Alcohol Concern	0800 917 8282
Frank About Drugs	0800 776 600
La Leche League National Breastfeeding	0845 120 2918
Maternity Action Advise Line	0845 600 8533
Miscarriage Association	07743 950 566
National Breastfeeding Helpline	0300 100 0212

National Childbirth Trust (NCT)	0300 330 0772
National Domestic Violence Helpline	0808 200 0247
NHS Direct	**111**
NHS Choices	www.nhs.uk
NHS Information Service for Parents	www.nhs.uk/parents
NHS Pregnancy Smoking Helpline	0800 169 9169
Sexual Health Information Helpline	0800 567 123
Stillbirth & Neonatal Death Charity (SANDS)	0207 436 5881
Working Families (Rights & benefits)	0800 013 0313

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Web: www.perinatal.org.uk E-mail: notes@perinatal.org.uk Tel: 0121 687 3456

perinatal institute
for maternal and child health