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/ Family Nurse Practitioner ☎

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)

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

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 15)
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

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	☐	☐	☐	☐	☐
Any household member had/has social services support	☐	☐	☐	☐	☐

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 p15

	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 KS)

Anyone else at home smoke ☐ ☐

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

Drug use - booking record plan on p15

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

Alcohol - booking record plan on p15

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

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

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 (see p18).

Declined ☐ ☐

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

CP - Civil Partner, F/T- Full Time P/T-Part Time,
UKBA - United Kingdom Border Agency,
NFA - No Fixed Abode,

Complete risk assessment page 14/ management plan page 15

Medical History Complete risk assessment page 14 and management plan page 15.

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	☐	☐
Chickenpox/Shingles	☐	☐
Diabetes	☐	☐
Epilepsy / Neurological problems	☐	☐
Exposure to toxic substances	☐	☐
Fertility problems (this pregnancy)	☐	☐
Female circumcision	☐	☐
Gastro-intestinal problems (eg Crohns)	☐	☐
Genital Infections (e.g. Chlamydia, Herpes)	☐	☐
Gynae history / operations (excl. caesarean)	☐	☐
Haematological (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 record plan on p15

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

During the last 4 weeks 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	☐	☐	☐	☐
Feeling worried, nervous or on edge	☐	☐	☐	☐
Not able to stop or control worrying	☐	☐	☐	☐
Is this something you feel you need or want help with	☐	☐	☐	☐
Referral required (record plan on page 15)	☐	☐	☐	☐

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 15) 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 30 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 obstetrician.

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 growth restriction with your baby. 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 monitor this baby's growth more closely, offering ultrasound scans and other tests as necessary (see p16).

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 (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. You may be given an information leaflet. Labour after a previous caesarean section is monitored more closely, in hospital, to make sure the scar on your uterus (womb) does not tear. Your baby's heart rate will be monitored continuously once your contractions have started. 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.

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 mls 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 your obstetrician during your pregnancy to discuss options for your place of birth.

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 midwife or obstetrician.

Mental health. It is common to feel low or anxious for a while after having a baby because of hormonal changes and lack of sleep. Postnatal depression is when you have those feelings that last for weeks or months. It can vary from mild to severe. It is not uncommon to feel depressed or anxious during pregnancy. If you have any concerns, please talk to your midwife or GP. They will tell you about your options for treatment if you need any to help you get better. If the problem is severe, they will refer you to a specialist mental health team. You can access more information via www.mind.org.uk

Miscarriages. A miscarriage (sometimes also 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've 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 elsewhere.

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

Previous Births

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

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** Cholestasis ☐ SGA or FGR ☐ GDM ☐ Congenital Anomaly ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

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

Labour details	Breast ☐ Formula ☐ Mixed ☐	Postnatal summary	PND ☐ PP ☐

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** Cholestasis ☐ SGA or FGR ☐ GDM ☐ Congenital Anomaly ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

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

Labour details	Breast ☐ Formula ☐ Mixed ☐	Postnatal summary	PND ☐ PP ☐

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** Cholestasis ☐ SGA or FGR ☐ GDM ☐ Congenital Anomaly ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

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

Labour details	Breast ☐ Formula ☐ Mixed ☐	Postnatal summary	PND ☐ PP ☐

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** Cholestasis ☐ SGA or FGR ☐ GDM ☐ Congenital Anomaly ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

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

Labour details	Breast ☐ Formula ☐ Mixed ☐	Postnatal summary	PND ☐ PP ☐

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

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 FGR- Fetal 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 p14/management plan p15

Name

Unit No/ NHS No

NHS

Women and their families should understand the purpose of all tests before they are taken

Pre-conception

Antenatal

Newborn

Blood for haemoglobin, group, rhesus and antibodies as early as possible, or as soon as a woman arrives for care, including labour

Blood for syphilis, hepatitis B and HIV as early as possible, or at any stage of the pregnancy, including labour

Hepatitis B vaccination +/- immunoglobulin within 24 hours

Commence folic acid

Blood for sickle cell and thalassaemia

Blood for T21, T18 and T13 (combined test)

Blood for T21 (quadruple test)

Reoffer screening for infectious diseases if initially declined

Repeat haemoglobin and antibodies

Newborn physical examination by 72 hours

Newborn hearing screen

Infant physical examination at 6-8 weeks

Week 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 BIRTH +1 +2 +3 +4 +5 +6

Women with type 1 or type 2 diabetes are offered diabetic eye (DE) screening annually. In pregnancy women with type 1 or type 2 diabetes are offered a DE screen when they first present for care

Early pregnancy scan to support T21, T18 and T13 screening

Detailed ultrasound scan for structural abnormalities, including T18 and T13

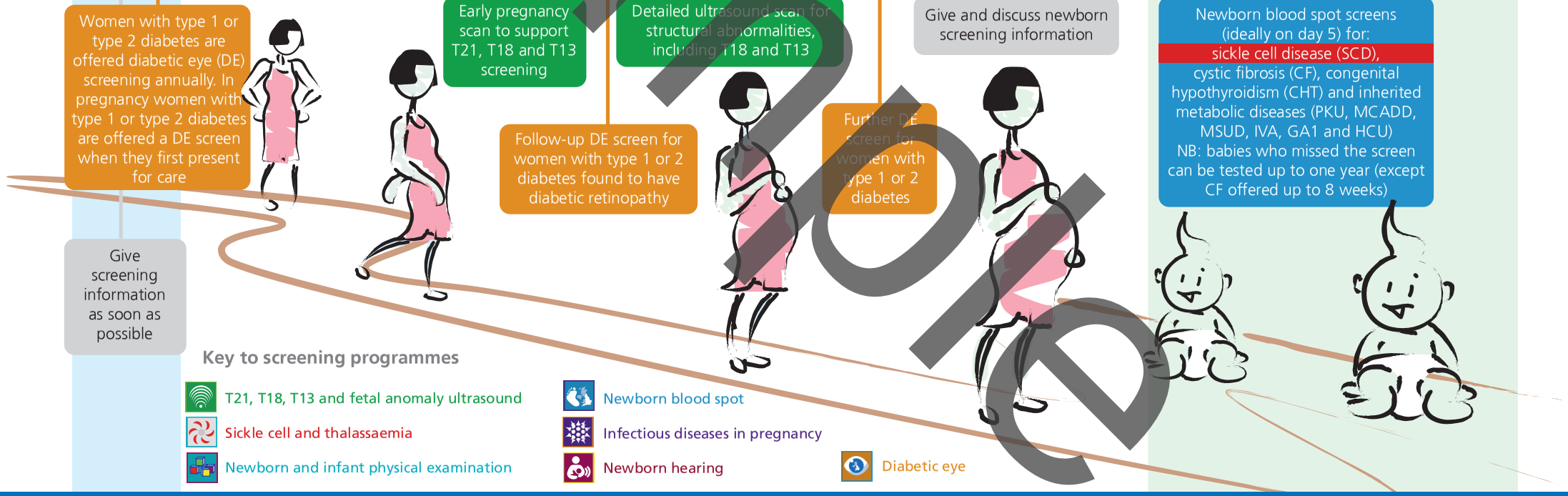
Give and discuss newborn screening information

Newborn blood spot screens (ideally on day 5) for:
sickle cell disease (SCD),
cystic fibrosis (CF), congenital hypothyroidism (CHT) and inherited metabolic diseases (PKU, MCADD, MSUD, IVA, GA1 and HCU)
NB: babies who missed the screen can be tested up to one year (except CF offered up to 8 weeks)

Follow-up DE screen for women with type 1 or 2 diabetes found to have diabetic retinopathy

Further DE screen for women with type 1 or 2 diabetes

Give screening information as soon as possible



Key to screening programmes

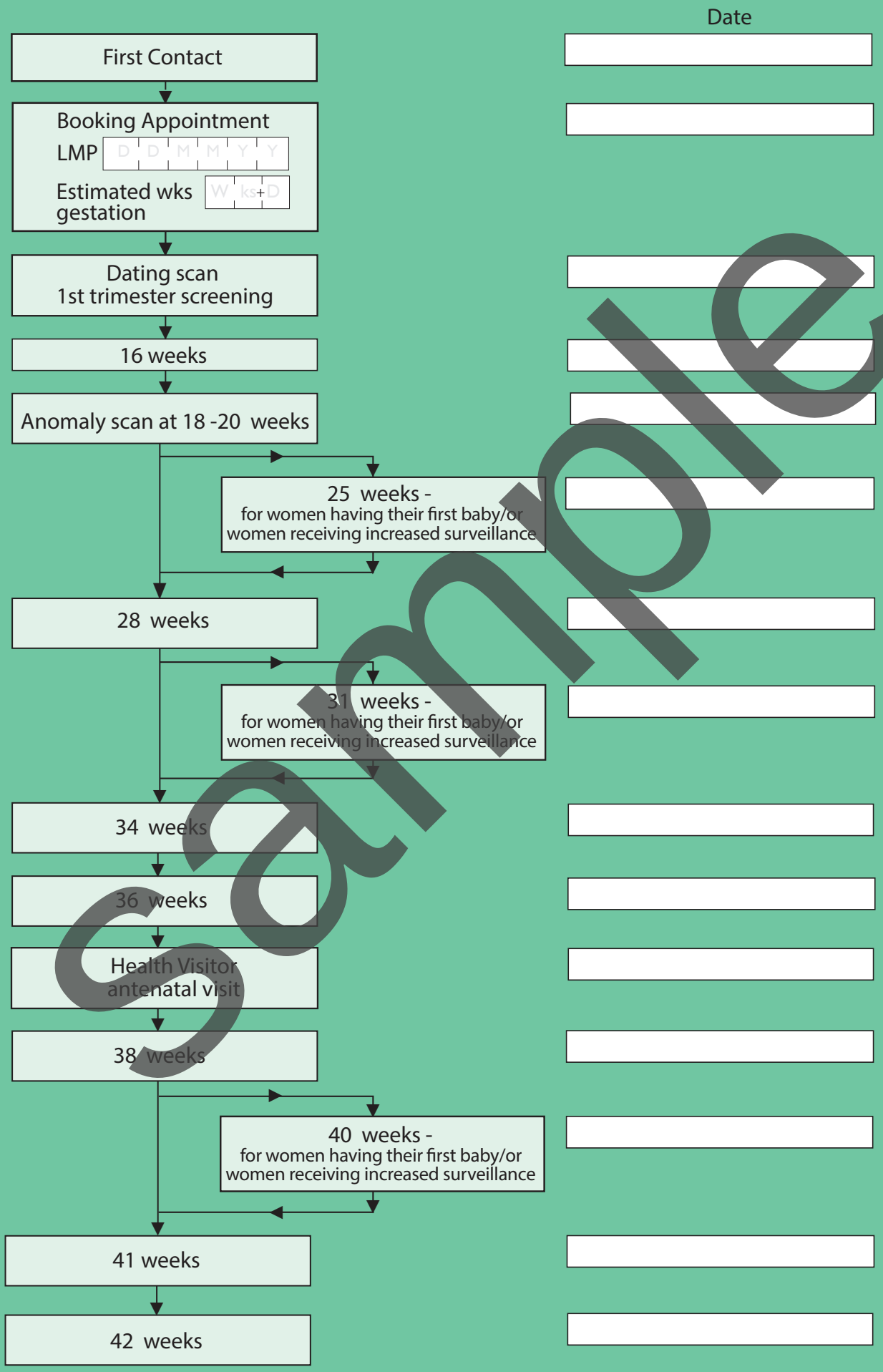
- T21, T18, T13 and fetal anomaly ultrasound
- Sickle cell and thalassaemia
- Newborn and infant physical examination
- Newborn blood spot
- Infectious diseases in pregnancy
- Newborn hearing
- Diabetic eye

Antenatal and Newborn Screening Timeline - optimum times for testing

Version 8.1, March 2016, Gateway ref: 2014696, Public Health England leads the NHS Screening Programmes

My 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 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 during the pregnancy. 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 spaces 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.



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 8-9) and ultrasound scans (pages 10-11). 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 an anti-D injection 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). From 1st April 2016, rubella testing in pregnancy will not be offered. This is because rubella is now very rare in the UK. The best way to protect you and your baby from rubella is to make sure you have had 2 MMR vaccinations before pregnancy. This will protect you and your baby in any future pregnancy and give you longer term protection against measles, mumps and rubella. The vaccinations can usually be given up to 1 month before pregnancy. You can't have the vaccinations while you are pregnant. Check with your GP surgery and if you have not been fully vaccinated, ask for this to be done at your 6 week postnatal check-up after your baby is born. Avoid being in contact with anyone who has a rash illness at any time during your pregnancy. **If you have a rash in pregnancy, tell your midwife or GP immediately.** They can arrange tests if necessary, to check if you have rubella.
Hepatitis B is a virus which infects the liver and can cause immediate or long term illness. Specialist care is needed for pregnant women with hepatitis B. If you are a carrier, or have become infected during pregnancy, you will be advised to have your baby vaccinated in the first year of life to reduce the risk of the baby developing hepatitis B.
Syphilis Syphilis is a sexually transmitted disease, left untreated can seriously damage your baby, or cause miscarriage or stillbirth. If detected, you will be offered antibiotic treatment. Your baby will need an examination and blood tests after birth and may need antibiotics.
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. You can request retesting for hepatitis B, HIV or syphilis at any time if you change your sexual partner or think you are at risk. If any of the infectious screening blood tests are positive e.g. hepatitis B, HIV or syphilis, your healthcare team will offer a test to your partner to see if they need any treatment.
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, but you can request a test if you are concerned. 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 /GP of any rashes or if you think you have been in contact with: **Chickenpox, Cytomegalovirus (CMV), Parvovirus (slapped cheek)** or **Toxoplasmosis** (see p24).
Chlamydia is a sexually transmitted infection which can result in problems for you and your baby e.g. pelvic inflammatory disease, miscarriage and 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.
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. Hospitals may offer testing if you are booked for an elective caesarean section; have any wounds or have previously tested positive for MRSA.
Oral Glucose Tolerance Test (OGTT) is to find out if you have gestational diabetes (see p22). 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 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 ☐

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

The screening tests are designed to find out how likely it is that the baby has Down's, Edwards' 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 particular 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 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' and Patau's syndrome, the only other screening test is a mid-pregnancy (anomaly) scan which will look for physical abnormalities.
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. The ultrasound scan is performed between 11weeks 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 risk for you. You will be given two separate risk results: - one for Down's syndrome and another for Edwards' and Patau's syndrome.
The quadruple test is available if you are to far on in your pregnancy to have the combined test. This test is for Down's syndrome only. A blood sample is taken between 14weeks and 20 weeks. A computer program is used to work out a risk for you.
The result: your midwife or obstetrician will discuss your results with you. Higher risk: you will be offered a diagnostic test which can definitely tell you if your baby has Down's, Edwards' or Patau's syndrome. There are two tests: – CVS or amniocentesis. For more information about these tests see page 10. Lower risk: if your result is lower than the recommended national cut off, you will not be offered a diagnostic test. A lower risk result does not mean that there is no risk at all.

CVS - Chorionic Villus Sampling
MMR - Mumps, Measles and Rubella
T - Trisomy

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

Investigations If additional blood tests / investigations are required update management plan p15.

Booking	Explained	Accepted by mother No 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	☐	☐ ☐					
Hepatitis B	☐	☐ ☐					
Syphilis	☐	☐ ☐					
HIV	☐	☐ ☐					

Date — Leaflet(s) given ☐ *Signed

D D M M Y Y — Care provider — D D M M Y Y — Care provider — Comments — Signed*

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

D D M M Y Y — Care provider — D D M M Y Y — Care provider — Comments — Signed*

28-week check	Explained	Accepted No 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 — *Signed

D D M M Y Y — Care provider — D D M M Y Y — Care provider — Comments — Signed*

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

Leaflet(s) given ☐ *Signed

D D M M Y Y — Care provider — D D M M Y Y — Care provider — Comments — Signed*

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

Leaflet(s) given ☐ Date *Signed

D D M M Y Y — Care provider — D D M M Y Y — Care provider — Comments — Signed*

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

	No	Yes
Screening explained	☐	☐
NSC leaflet given	☐	☐

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 30 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 between 18 - 20+6 weeks	☐	☐	☐
■ scans later in pregnancy are carried out to monitor the baby's growth and wellbeing, or to check 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.

First trimester (early pregnancy). All pregnant women are offered an ultrasound scan at between 8-14 weeks of pregnancy. This is called the dating scan. It is done to confirm the pregnancy and number of babies in the womb, calculate the expected date of delivery and to check for major problems with the baby that may be detected at this early stage. You may also be offered screening for Down's, Edwards' and Patau's syndromes (see page 8) at this time. 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 (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, face, kidneys, brain, bones 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 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 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 liquor (fluid around the baby) and Doppler flow can be done if there are any concerns with the baby's growth (Doppler flow indicates how well the placenta is managing the blood supply needed for the baby). If the scan suggests any concerns/problems, 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 (See page 22).

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, Edwards' and Patau's syndrome. They are not offered on a routine basis but in certain circumstances such as: a family history of an inherited problem; a result of a screening test reported as higher risk (see page 8), or as a result of scan findings. It is up to you whether you have further tests. The risk of miscarriage from either of these tests is about 1 in a 100 (1%). The health care professionals 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 normally performed after 15 weeks of pregnancy.

CVS (Chorionic Villus Sampling): involves removing a tiny sample of tissue from the placenta (afterbirth), using a fine needle. It is usually performed from 11 weeks to 14 weeks of pregnancy. Occasionally results from a 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 for the results to be available. PCR checks for specific chromosomes and results take up to 4 working days.

PCR - Polymerase Chain Reaction

Feel free to ask your midwife or doctor – or look at NHS Choices: **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 19, 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 30 for identification**

Name

Unit No/ NHS No

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 serious complications of seasonal flu such as bronchitis, chest infection and pneumonia. Flu in pregnancy also increases the risk of miscarriage, prematurity and fetal growth restriction. It is recommended you should have the seasonal flu vaccine. 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 January/February and is free when you are pregnant. Ask your GP, pharmacist or midwife where you can get vaccinated. If you develop flu like symptoms, you must seek medical advice **immediately**. There is prescribed treatment that is available to reduce the risk of complications. For further information please visit www.nhs.uk

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 until they are vaccinated against whooping cough from 2 months of age. You can help protect your unborn baby from getting this disease in its first weeks after birth by having the whooping cough vaccination while you are pregnant. You should have the vaccination even if you have been vaccinated before or have had whooping cough yourself. The best time to get vaccinated to protect your unborn baby is from 20 weeks of your pregnancy. If you are more than 20 weeks pregnant and have not been offered the vaccine, talk to your midwife or GP to make an appointment to get vaccinated. They will advise you where you can get the vaccine locally. Your baby will still need to be vaccinated as normal when he/she reaches 2 months of age.

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 obstetrician so that an individualised 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

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 14, 19 & 22 or www.nhs.uk 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 ☐	Leaflet given ☐		

Name

Unit No/ NHS No

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

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	☐
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

	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	☐	☐	☐
Current systemic infection	☐	☐	☐
Long distance travel	☐	☐	☐
No risks identified	☐	☐	☐
Update management plan as necessary			
Signature*			
Date	D D M M Y Y	D D M M Y Y	D D M M Y Y

ART - Assisted Reproductive Technology, BMI - Body Mass Index
DM - Diabetes Mellitus, IBD - Inflammatory Bowel Disease
IVDU - Intravenous Drug User, IVF - In Vitro Fertilisation
LMWH - Low Molecular Weight Heparin, OHSS - Ovarian Hyperstimulation Syndrome
SLE - Systemic Lupus Erythematosus, PGP - Pelvic Girdle Pain

*** Signatures must be listed on page 30 for identification**

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	☐	☐		☐	☐		☐	☐	
Smoking	☐	☐		☐	☐		☐	☐	
Drug/alcohol use	☐	☐		☐	☐		☐	☐	
BMI pathway initiated	☐	☐		☐	☐		☐	☐	
Management Plan updated	☐	☐		☐	☐		☐	☐	
Signature*									
Date	D D M M Y Y			D D M M Y Y					

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

Standard ☐ Intermediate ☐ Intensive ☐ Signature & date 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

Seen by: Signature* Date D D M M Y Y

VTE - Venous Thromboembolism OGTT - Oral Glucose Tolerance Test GP - General Practitioner

Name
Unit No/ NHS No

*** Signatures must be listed on page 30 for identification**

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				

Management plan

Highlight key points in special features box (page 19). 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
			D D M M Y Y

Insert continuation sheets here, and number them.

*** Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Antenatal Checks

It is very important to attend antenatal and scan appointments that are made for you during your pregnancy. If you cannot attend any appointments, please contact your midwife or the hospital to re-arrange. Your midwife or doctor will check you and your baby's health and wellbeing at each of these appointments. Please discuss any worries or questions that you may have.

Blood pressure (BP) is checked to detect pregnancy induced hypertension or pre-eclampsia (see p22). High blood pressure may cause severe headaches or flashing lights. If this happens, tell your midwife or doctor **immediately**.

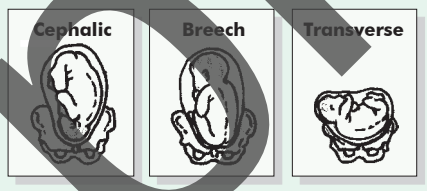
Urine tests You will also be asked to supply a sample of your urine at each visit to check for protein (recorded as + or ++ = presence of), which may be a sign of pre-eclampsia.

Fetal movements You will usually start feeling some movements between 16 and 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 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. 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 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 (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. The use of home fetal Doppler to listen to your baby's heart beat is not recommended. 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. 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.

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 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 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.perinatal.org.uk**

After the chart is printed, it is attached as **page 18**, 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 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

PRINTER: Affix special tape here

Insert customised growth chart here

Feel free to ask your midwife or doctor – or look at NHS Choices: **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 management plan, page 15)	Labour, delivery & postnatal — Paediatric alert form ☐
Flu vaccine given Yes ☐ Declined ☐	
SGA or FGR 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 12 & 16)

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

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

Accompanied No ☐ Yes ☐ With ___ Management plan:reviewed ☐ revised ☐ Signed*

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

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

Accompanied No ☐ Yes ☐ With ___ Management plan:reviewed ☐ revised ☐ Signed*

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

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

Accompanied No ☐ Yes ☐ With ___ Management plan:reviewed ☐ revised ☐ Signed*

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

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

Accompanied No ☐ Yes ☐ With ___ Management plan:reviewed ☐ revised ☐ Signed*

SGA - Small for Gestational Age FGR- Fetal Growth Restriction

*** Signatures must be listed on page 30 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 12 & 16)

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

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

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

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

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

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

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

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

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

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

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

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

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

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

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

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

HHMM 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.

* **Signatures must be listed on page 30 for identification**

Other contacts / visits e.g. day unit, delivery suite, 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 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 30 for identification**

Pregnancy symtoms/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 or nearest maternity unit **immediately** for advice. Don't wait until your next appointment.

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. Don't wait until your next appointment. 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 an anti-D injection (page 8).

Abnormal vaginal discharge. It is normal to have increased vaginal discharge when you are pregnant. This is due to the muscles of your vagina getting softer and to help prevent infections. It should be clear and white and not smell unpleasant. You need to seek medical advice if the discharge changes colour, smells unpleasant or you feel sore or itchy.

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. To reduce your future risks of diabetes: - be the right weight for your height (normal BMI); eat healthily and take regular exercise; cut down on sugar, fatty and fried food. You can get advice from your health care team.

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 contact your midwife or nearest maternity unit **immediately** if you get severe headaches; blurred vision or spots before your eyes; obvious swelling (oedema) especially affecting your hands and face; severe 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 high 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, raised BMI >30, smoke, or have a family history of thrombosis. You are advised to seek advice from 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.

Intrahepatic Cholestasis in Pregnancy (ICP) is also known as obstetric cholestasis. It is a liver condition in pregnancy that causes itching especially on the hands and feet, but may occur anywhere on your body. It affects 1 in 140 women in the UK every year. Having this condition can put you at a higher risk of having a stillbirth. This will involve closer monitoring of you and your baby during your pregnancy and may indicate delivering your baby at or around 37-38 weeks. If you have itching, a blood test is offered to check if you have the condition.
If the blood test confirms you have ICP, treatment will be discussed with you by your health care team. You will need to get your blood test checked after your baby is born. Your health care team will advise you on when and where to get this test done.

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. If you are planned to give birth in a 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.

Breech. If the baby's presentation (see page 16) 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 from 36 weeks (ECV = External Cephalic Version). However, the procedure is not always successful. Your midwife/obstetrician will discuss with you options on the best way 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 pregnancies. 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. Speak to your healthcare team if you have any questions or concerns about this.

Infections Your immune system changes when you are pregnant and you are at a higher risk of developing an infection. It is very important that if you are unwell and are experiencing any of the following symptoms, please seek **immediate** medical advice as treatment may be required:- high temperature of 38C or higher; fever and chills; foul smelling vaginal discharge; painful red blisters/sores around the vagina, bottom or thighs; pain or frequently passing urine; abdominal pain; rash; diarrhoea and vomiting; sore throat or respiratory infection. Avoid unprotected sexual contact if your partner has genital herpes and avoid oral sex from a partner with a cold sore. Wash your hands if you touch the sores. Wherever possible, keep away from people with an infection e.g. diarrhoea and sickness, cold/flu, any rash illness.

Group B streptococcus (GBS) is a bacterium carried by some women and rarely causes symptoms or harm. It can be diagnosed by testing a urine or vaginal swab sample. 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 treat women with GBS with antibiotics during labour. If you have any questions or concerns speak to your midwife or doctor.

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

Any questions or comments?

This space is for you to write any questions or concerns you wish to discuss with your midwife/obstetrician, including any concerns you might have about how you are feeling about your pregnancy, birth and looking after your baby.

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 available via www.moneyadviceservice.org.uk. This gives you information on all financial aspects of the arrival of a new baby including budgeting, benefits and work options. 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. Dental treatment is free throughout pregnancy and for 1 year following the birth. As a result of changes in hormone levels and changes to your diet your mouth is more prone to disease; this may lead to tooth decay. To prevent this, remember to brush twice a day for at least 2 minutes and wait at least 30 minutes before brushing or using a mouthwash if you are suffering with pregnancy sickness. It is also important that you ensure you are registered with a dentist. 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.

Health and Safety issues. If you are working, your employer has a responsibility to assess any health and safety risks to you. Your job might involve a lot of bending and stretching or travelling long distances - things that may be more difficult now you are pregnant. If any risks are identified, your employer should put measures to remove/reduce or control these. For further information contact your occupational health department or visit www.hse.gov.uk

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 and unpasteurised milk. Evidence shows that if you would like to eat peanuts or food containing peanuts (e.g. peanut butter) during pregnancy, you can choose to do so as part of a healthy balanced diet, unless you are allergic to peanuts or unless your health professional advices you not to. Have no more than 2 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 13 weeks into the pregnancy. If you have diabetes, BMI >30, or 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 should NOT be taken in pregnancy and any other supplements should only be taken after checking with your midwife/GP. 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 11-12kgs. 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 beginning of your pregnancy and again near the end. If you have any concerns, ask to be referred to a dietitian.

Caffeine is a stimulant that is contained in tea, coffee, energy and cola drinks. Limit your caffeine intake to 200mgs per day (e.g. 2 mugs coffee/ or 4 cups of tea/ or 5 cans of diet drinks. Try decaffeinated versions.

Alcohol increases the risk of miscarriage or may lead to Fetal Alcohol Syndrome. Alcohol crosses the placenta into the blood stream of your baby and could affect how your baby grows and develops. This could cause problems such as:- facial deformities, problems with physical and emotional development, poor memory. Pregnant women should **AVOID** drinking alcohol during their pregnancy. There is an increased risk of stillbirth in women who drink heavily. If you are finding it hard to stop drinking alcohol, ask for help from your midwife/GP. They will be able to refer you for specialist support.

Drugs. Taking street drugs during pregnancy is NOT recommended as it may seriously harm you and your baby. Discuss with your GP if you take any prescription medication to make sure that these are suitable for pregnancy. Check with your pharmacist about taking over-the-counter medicines.

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 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 arrange referral to your local smoking cessation coordinator or group. Cannabis smoking should also be avoided during pregnancy as it produces higher levels of carbon monoxide. The risks of using e-cigarettes to your unborn baby are still not understood. Please seek advice from your local smoking cessation coordinator. From October 2015 it is illegal to smoke in a car or any other vehicle with people who are under the age of 18. This is to protect babies, children and young adults from second hand smoke.

Carbon Monoxide is a poisonous gas produced by cigarettes that you breathe in every time you smoke a cigarette or every time you breathe in someone else's smoke. The carbon monoxide replaces some of the oxygen in your bloodstream which means that both you and your baby have lower levels of oxygen overall. As part of your routine antenatal care your midwife will test your level of carbon monoxide. This may be repeated throughout your pregnancy. Environmental factor such as traffic emissions or leaky gas appliances may also cause a high reading.

Home fire safety check. Your local fire service can visit your home to carry out an assessment free of charge. You may be eligible for free smoke alarms to be fitted. It is advisable for all households to have a working smoke alarm.

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 **immediately**, you may need treatment.

Travel. If you are planning to travel abroad, you should discuss flying, vaccinations and travel insurance with your midwife or doctor. Always carry your hand held notes with you in case of an emergency. Long-haul flights can increase the risk of deep vein thrombosis (DVT). To reduce the risk of DVT, drink plenty of water and move about regularly. You can buy compression stockings from a pharmacy – seek advice from the pharmacist. The airline you are travelling with, may ask for a letter from your doctor or midwife. For further information: www.nhs.uk

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. If you feel anxious or worried about anything, discuss this with your midwife or GP.

Domestic abuse. 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 (contact telephone number is listed on page 30 of these notes).

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 aqua natal classes are safe. Scuba diving and any 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.

Family and friends test. This is an important opportunity for you to provide feedback on the services that provide your care and treatment. Your feedback will help NHS England to improve services for everyone. You can ask a member of staff for more information about how this information is used. Completion is voluntary, but if you do answer, your feedback will provide valuable information for your hospital to celebrate good practice, and identify opportunities to make improvements. You will be asked to complete this survey at or around 36 weeks of your pregnancy. For more information about the programme visit NHS Choices.

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

Plans for Pregnancy Update management plan (page 15) as required

Topics	N/A	Discussed	Signature* and Date	Your intentions or preferences	Leaflets given
Employment rights Maternity benefits Health and safety issues	☐ ☐ ☐	☐ ☐ ☐			☐
Registered with a Dentist 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 Smoke free homes Carbon Monoxide Testing (Record result on page 2)	 ☐ ☐ ☐	 ☐ ☐ ☐ ☐		First appointment with smoking cessation services D D M M Y Y 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 Exercise (Inc. pelvic floor) Aquanatal Family and Friends test		☐ ☐ ☐ ☐ ☐ ☐ ☐			☐ ☐ ☐

Start4Life Information Service for Parents is a free NHS service for mums and dads offering regular emails or texts throughout your pregnancy and beyond. Get trusted NHS approved information, advice and tips including baby development, preparing for birth and what to expect as your baby grows, from breastfeeding to immunisations and development stages, as well as wider advice on healthy lifestyles and how to find local support. Search **Start4Life** online to sign up now. www.nhs.uk/start4life

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

Email:

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 1 of this booklet.

Student Midwives. Will 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 for example with antenatal classes; infant feeding; which improves the quality of care that the midwife is able to provide to you, to your partner and to your baby.

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 'SOM - How they can help you' leaflet or ask your midwife.

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 the health of the baby. They will discuss with you a plan of care.

Health Visitors work within the NHS. All 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 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 30 for identification**

Name

Unit No/ NHS No

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?

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. While cot death is rare, there are essential things that you and your partner can do to reduce the risk after your baby is born. These include:- • Place your baby on their back to sleep, in a cot in a room with you. • Do not smoke in pregnancy or let anyone smoke in the same room as your baby • Do not share a bed with your baby if you have been drinking alcohol, if you take drugs or if you are a smoker • Never sleep with your baby on a sofa or armchair • Do not let your baby get too hot or too cold, keep your baby's head uncovered • Place your baby in the "feet to foot" position. • Breastfeed your baby. • Infant immunisations reduce the risk of cot death. • Seek medical help if your baby is ill. For further information visit www.lullabytrust.org.uk

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 PKU, cystic fibrosis, congenital hypothyroidism, MCADD, MSUD, HCU, IVA, GA1 and heamoglobinopathy disorders. Two detailed examinations of the baby will be performed, one within 72hours of the birth and one is when your baby is 6-8 weeks old. These include examinations of the baby's eyes, heart and lung sounds, nervous system, abdomen and hips, all findings will be discussed with you. In many hospitals you will be offered a hearing screening test for your baby before you are transferred home or will be invited to attend a clinic. A small earpiece is placed in your baby's ear and soft clicking sounds are played. You will be given the baby's results as soon as the hearing test is done. Your midwife will give you a leaflet explaining all of these tests. www.screening.nhs.uk/annbpublications

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 for advice.

BCG. This is a vaccine offered to all babies who may be at higher than average risk from contact with TB (tuberculosis). These include babies whose families come from countries with a high incidence of TB such as Asia, Africa, South and Central America and Eastern Europe 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 5 years 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. 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, carries it her blood, or catches it during pregnancy, she can pass it onto her baby. Babies born to infected mothers are at risk of getting this infection and 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 and a booster before school.

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 help his/her brain to grow. You can begin to connect through talking or singing to your baby bump and noticing when your baby has a particular 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 as soon as possible 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 he/she recognises your voice and smell he/she will begin to feel safe and secure. Take time to notice the different stages he/she goes through as he/she gets ready for his/hers 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 he/she may just want a cuddle, if you need to fit in a quick feed or if you simply want to sit down and have a 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 on the Bump to Breastfeeding DVD which you can watch at www.bestbeginnings.org.uk

If you decide to bottle feed, your midwife will give you information about how to hold your baby for feeding and how to make up feeds as safely as possible.

PKU- Phenylketonuria MCADD- Medium-chain Acyl-CoA Dehydrogenase Deficiency MSUD- Maple Syrup Urine Disease
HCU- Homocystinuria (Pyridoxine Unresponsive) IVA- Isovaleric Acidaemia GA1- Glutatic Aciduria type 1

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

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	☐			
Safe sleeping	☐			
Home environment	☐			
Equipment	☐			
Newborn screening and examination	☐			
Newborn hearing test	☐			
Vitamin K	☐			☐
BCG (see p26)		D D M M Y Y		
Baby BCG indicated	No ☐ Yes ☐		Reason:	
Discussed with mother	No ☐ Yes ☐ N/A ☐			
Mother agrees to vaccine	No ☐ Yes ☐		If no, reason declined	
Leaflet: 'TB, BCG vaccine and your baby' given to mother	No ☐ Yes ☐ N/A ☐			
Connecting with your baby		D D M M Y Y		☐
Talking to your baby	☐			
Noticing and responding to baby's movements	☐			
How this can help your baby's brain development	☐			
Greeting your baby for the first time		D D M M Y Y		☐
Skin to skin contact	☐			
Keeping baby close	☐			
Recognising feeding cues	☐			
Responding to your baby's needs		D D M M Y Y		☐
Importance of comfort and love to help baby's brain develop	☐			
Responsive feeding	☐			
Feeding your baby		D D M M Y Y		☐
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	☐			

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

Comments

Signature & date

* **Signatures must be listed on page 30 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 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, supervisor of midwives and/or obstetrician if there are any pregnancy concerns. (Please note hospital sites are a smoke free environment)

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 or 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 may 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 has been any pregnancy complications e.g you have developed diabetes in your pregnancy or scans have shown growth restriction with your baby, you are advised to contact the labour ward as soon as you start having regular contractions.

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 your baby is becoming distressed. The midwife can use; a Pinard (trumpet), fetal Doppler to listen intermittently, or continuously with a monitor. This will depend on your risk at the onset of labour.

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' machine, breathing exercises and massage 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 obstetrician will decide which one to use at the time, based on the clinical situation.

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 instrumental 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. 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. The midwife looking after you in labour will discuss delaying clamping the umbilical cord after your baby is born. By delaying the cord being clamped, your baby can carry on benefiting from receiving blood from your placenta. This will depend on the way your baby responds immediately after birth.

TENS = Transcutaneous Electrical Nerve Stimulation

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

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	☐			
Delayed cord clamping	☐			

*** Signatures must be listed on page 30 for identification**

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					

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; PN - Practice Nurse GP - General Practitioner; Con - Consultant; STR - Speciality Training Registrar; Reg - Registrar; FY - Foundation Year Doctor; US - Ultrasonographer

Name (print clearly)	Post	Signature

Name (print clearly)	Post	Signature

Support Groups

Alcohol Concern	0300 123 1110
Antenatal Results & Choices (ARC)	0207 713 7486
Childline	0800 1111
Citizens Advice Bureaux (CAB)	03454 040506
Frank About Drugs	0300 123 6600
Group B Strep Support Group	www.gbss.org.uk
La Leche League National Breastfeeding	0845 120 2918
Maternity Action Advise Line	0845 600 8533
MIND- for better mental health	0300 123 3393
Miscarriage Association	01924 200 799
National Breastfeeding Helpline	0300 100 0212

National Childbirth Trust (NCT)	0300 330 0700
National Domestic Violence Helpline	0808 200 0247
NHS Choices	www.nhs.uk
NHS Non Emergencies	111
NHS Information Service for Parents	www.nhs.uk/start4life
NHS Smoking Helpline	0800 0224 332
NSPCC's FGM Helpline	0800 028 3550
Samaritans	08457 909090
Stillbirth & Neonatal Death Charity (SANDS)	0207 436 5881
Tommy's Pregnancy Line www.tommys.org	0800 0147 800
Working Families (Rights & benefits)	0300 012 0312

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