

NHS No.

Maternity Unit

# ANTENATAL SUMMARY



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

Midwife	<input type="text"/>	<input type="text"/>
GP	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>

First Name	<input type="text"/>	Surname	<input type="text"/>
Address		<input type="text"/>	
<input type="text"/>		<input type="text"/>	
Post code	<input type="text"/>	Date of birth	<input type="text"/>
<input type="text"/>			

Ethnic Origin	<input type="text"/>
Interpreter	<input type="text"/>

**Risk Assessment** EDD  Para  +  Age  BMI

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

**Maternity Payment Pathway System** Standard  Intermediate  Intensive

## Investigations

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

## Emergency Contact

Name	<input type="text"/>	Relationship	<input type="text"/>
	<input type="text"/>		<input type="text"/>

Completed by:  Date

