

# SUMMARY of BIRTH

To be completed by midwife present at birth

<b>Name</b> ..... <b>Address</b> ..... ..... <b>Postcode</b> ..... <b>Date of birth</b> /    / ..... <b>Unit No.</b> ..... <b>NHS No.</b> .....		Health visitor ..... GP ..... Specialist .....																														
<b>Place of birth</b> .....	<b>Unit</b> .....																															
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th style="text-align: center;">Baby 1</th> <th style="text-align: center;">Baby 2</th> </tr> </thead> <tbody> <tr><td>Name</td><td></td><td></td></tr> <tr><td>Unit no.</td><td></td><td></td></tr> <tr><td>NHS no.</td><td></td><td></td></tr> <tr><td>DOB</td><td></td><td></td></tr> <tr><td>Time</td><td></td><td></td></tr> <tr><td>Gestation</td><td></td><td></td></tr> <tr><td>Birth weight</td><td></td><td></td></tr> <tr><td>Mode of delivery</td><td></td><td></td></tr> <tr><td>Outcome</td><td></td><td></td></tr> </tbody> </table>		Baby 1	Baby 2	Name			Unit no.			NHS no.			DOB			Time			Gestation			Birth weight			Mode of delivery			Outcome			<b>Para</b> ..... + ..... <b>Duration of labour</b> ..... h ..... m <b>Third stage management</b> ..... EBL <b>Comments</b> .....	
	Baby 1	Baby 2																														
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<b>Date</b> /    / <b>Signature*</b> ..... <b>Title</b> .....																																

# MATERNAL DISCHARGE SUMMARY from Midwifery Care

To be completed by community midwife at final contact

<b>Perineum</b> ..... <b>Contraception</b> Not discussed <input type="checkbox"/> Leaflet given <input type="checkbox"/> Chosen method ..... Appointment date/time .....    Where .....	<b>Blood test results</b> Blood group .....    Last Hb ..... <b>Investigations / immunisations</b> Date .....    BN .....    Site .....    Signed* ..... Anti D <input type="checkbox"/> MMR <input type="checkbox"/>									
<b>Mental health</b> During the last month have you often been bothered by:    No    Yes Feeling down, depressed or hopeless? <input type="checkbox"/> <input type="checkbox"/> Having little interest or pleasure in doing things? <input type="checkbox"/> <input type="checkbox"/> Are these something you feel you need or want help with? <input type="checkbox"/> <input type="checkbox"/>	<b>Details of any postnatal problems</b> ..... 6-8 week postnatal check arranged <input type="checkbox"/> Yes <input type="checkbox"/> No									
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Method of feeding at discharge	.....	.....								
Discharge weight (g)	.....	.....								
<b>Date</b> /    / <b>Signature*</b> ..... <b>Title</b> .....										