

NHS No.

Maternity Unit



First Name Surname
 Address
 Postcode
 Date of birth Unit No.

Date Time Where seen Days post natal

Delivery summary Place of birth

	Baby 1	Baby 2
Name	<input type="text"/>	<input type="text"/>
Unit no.	<input type="text"/>	<input type="text"/>
NHS no.	<input type="text"/>	<input type="text"/>
DOB	<input type="text"/>	<input type="text"/>
Time	<input type="text"/>	<input type="text"/>
Sex	<input type="text"/>	<input type="text"/>
Gestation	<input type="text"/>	<input type="text"/>
Birth weight	<input type="text"/>	<input type="text"/>
Birth weight centile	<input type="text"/>	<input type="text"/>
Mode of delivery	<input type="text"/>	<input type="text"/>
Outcome	<input type="text"/>	<input type="text"/>
Apgars	<input type="text"/>	<input type="text"/>
Duration of labour	<input type="text"/> h	<input type="text"/> m

Referral made by
 Community Midwife GP Self Other

Maternal Observations

Pulse (bpm) <input type="text"/>	Currently receiving anti coagulation therapy <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Blood pressure <input type="text"/> / <input type="text"/>	VTE assessment performed (see back page) <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Temp <input type="text"/>	VTE pathway initiated <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Resps <input type="text"/>	Tissue viability assessment <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
MEOWS score <input type="text"/>	Manual handling assessment <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Urine <input type="text"/>	Oedema <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
Last Hb <input type="text"/>	Sepsis pathway initiated <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>
	Date <input type="text"/>		

EBL 3rd stage Perineum Wound

Presenting History

Pain <input type="checkbox"/> No <input type="checkbox"/> Yes	Symptomatic of infection/sepsis <input type="checkbox"/> No <input type="checkbox"/> Yes	PV bleeding <input type="checkbox"/> No <input type="checkbox"/> Yes	Mastitis <input type="checkbox"/> No <input type="checkbox"/> Yes	Dysuria/retention <input type="checkbox"/> No <input type="checkbox"/> Yes
Raised BP <input type="checkbox"/> No <input type="checkbox"/> Yes	Mental health & wellbeing discussed <input type="checkbox"/> No <input type="checkbox"/> Yes	CPE Screening <input type="checkbox"/> No <input type="checkbox"/> Yes	Severe chest pain/breathlessness <input type="checkbox"/> No <input type="checkbox"/> Yes	

Special features (medical history, medication, allergies etc)

Transferred to ward No Yes
 Baby admitted with mother No Yes
 Transfer of care tool completed Discharged home
 Prescription issued Follow up required

Signature* Date/Time



CPE = Carbapenemase Producing Enterobacteriaceae

