health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Maternity Case Records

This record must always accompany the woman when transferred to another health facility.
This record must be filed at the facility discharging the woman after birth.
Failure to create and maintain a record or to remove a record is an offence in terms of section 17(2) of the National Health Act (61 of 2003)
This record book is valid for the duration of the pregnancy and puerperium and includes all patient encounters. The relevant ward/ clinic/ subsection must clearly print (stamp) the name of the section and the date the service was rendered

Level of care	
Antenatal clinic:	**Delivery site:**
Transport when in labour:	

Name of patient or place large patient sticker here

Name.. Surname ....

Address...

Next to School/Shop..

MomConnect Yes No

Date registered......./........./............

Woman's name ______ Employed Unemployed

ID Number ______ Religion ______

Institution file number ______ Record book number Original Duplicate

Consent for blood products: Agrees to the use of blood products if needed / Disagrees to the use of blood products

Name of birth companion ______ Contact number of birth companion ______

Community health worker name ______

Contact detail of mandate
Name of person mandated to consent on behalf of woman when appropriate ______

Contact telephone number of mandate ______

Should I be unable to consent myself, I mandate the above in terms of the National Health Act to do so on my behalf.

Signed... Date.......................... Witness................................

Danger signs in pregnancy

I have severe headache.
My hands feel stiff.
My rings are tight.
My feet are swollen.
PRE-ECLAMPSIA

I am unable to stop worrying. I feel down, depressed and hopeless. I think about hurting myself.
DEPRESSION

I feel tired.
I feel weak.
I have no energy.
ANAEMIA

DECREASING BABY KICKS OR NO KICKS AT ALL

My water has broken and my baby is not due yet.
PREMATURE RUPTURE OF MEMBRANES

I have pains in my stomach and back but my baby is not due yet.
PREMATURE LABOUR

I want to pass urine all the time and it burns.
URINARY TRACT INFECTION

I have a vaginal discharge that itches or smells foul.
VAGINAL INFECTION

I have bleeding from the vagina.
ANTEPARTUM HAEMORRHAGE

Go to your nearest clinic or hospital immediately if you have any of these problems.

SBAR clinical report on maternity situation

S

SITUATION

I am calling about (name of woman) ___________________________Ward:____________Hospital number ___________________

The problem I am calling about is ____

I just made an assessment of the patient:

Vital signs:- BP _____/_____ Pulse ______ resp rate _______ Oxygen saturation _____% Oxygen at ____l/min Temperature _____ C

I am concerned about:

Blood pressure because:

Systolic pressure greater than 160 mm Hg
Diastolic pressure more than 100 mm Hg
Systolic pressure less than 90

Pulse because:

Pulse rate more than 120
Pulse rate less than 40
Pulse rate greater than systolic BP

Respiration rate because:

Rate less than 10/min
Rate more than 24/min

Urine output:

Output less than 100 ml over last 4 hours
Significant proteinuria (++/+++)

Haemorrhage

Antepartum
Postpartum

Fetal well being

CTG pathology

Early obstetric warning scores:

B

BACKGROUND (tick relevant sections)

☐ **The woman is:-**

Parity [primiparous / multiparous/ grand multiparous] with gestation _______weeks and a [singleton/ multiple] pregnancy

She had _____ previous caesarean sections or episodes of uterine surgery

☐ **The present fetal assessment is :**

Fundal height ________cm Presentation ________ with _____fifths head above brim: Fetal heart rate __________bpm

CTG : Not done / normal/ suspicious/ pathological

☐ **Antenatal risks**

Risks identified on antenatal card ____

☐ **Labour**

Not in labour / spontaneous onset of labour/ induced labour

IUGR / Pre-eclampsia/ reduced fetal movements/ Diabetes/ Antepartum haemorrhage

On oxytocin infusion (_____IU/_______ml fluid given at ______ml/hour)

Most recent vaginal examination done at _______h Dilated ______cm with ______above brim and position ___________

Membranes : Intact/ ruptured at _______h with currently clear / meconium stained liquor/ Blood stained liquor

Delivered ________________at _____h with 3rd stage complete/ retained placenta

☐ **Post Natal**

Delivery date __________at ___________h____ Type of delivery ______________ With/ without perineal trauma

Blood loss ___________ ml Oxytocin infusion ______IU/ _________ml at ________ml/hour

Fundal height: High / Atonic/ Tender/ Abdominal-/ perineal wound oozing

☐ **Treatment given/ in progress**

Rx ____

A

ASSESSMENT

I think the problem is ____

The problem may be related to: Cardiac/infection/ respiratory/haemorrhage/PET/HELLP/Embolism/ Pulm edema/Fetal distress

I am not sure what the problem is, but the woman is deteriorating and we need to do something

R

RECOMMENDATION

Request

☐ Please come and see the woman immediately
☐ I think delivery need to be expedited
☐ I think the patient need to be transferred
☐ I would like advice on management of the patient

Response

____

Person completing form: (name) _______________________________________Rank__________________Date_______ Time_______

Person reported to (Name) ________________________________(Rank)___________________Inst______________________

Extra copy of SBAR if referral is needed during antenatal care

Blank page (back of SBAR)

SBAR clinical report on maternity situation

Complete in duplicate (use carbon paper)

S

SITUATION

I am calling about (name of woman) ___________________________Ward:____________Hospital number ___________________

The problem I am calling about is ____

I just made an assessment of the patient:

Vital signs:- BP _____/_____ Pulse ______ resp rate _______ Oxygen saturation _____% Oxygen at ____l/min Temperature _____ C

I am concerned about:

Blood pressure because:

Systolic pressure greater than 160 mm Hg

Diastolic pressure more than 100 mm Hg

Systolic pressure less than 90

Pulse because:

Pulse rate more than 120

Pulse rate less than 40

Pulse rate greater than systolic BP

Respiration rate because:

Rate less than 10/min

Rate more than 24/min

Urine output:

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Response

____

Person completing form: (name) ______________________________________Rank__________________Date_______ Time_______

Person reported to (Name) _______________________________(Rank)___________________Inst_______________________

Tear this copy out and keep in the facility folder as a record of referral and advice.

Blank page (back of SBAR)

SBAR clinical report on maternity situation

Complete in duplicate (use carbon paper)

S

SITUATION

I am calling about (name of woman) ___________________________Ward:____________Hosp. No ___________________

The problem I am calling about is ____

I just made an assessment of the patient:

Vital signs:- BP _____/_____ Pulse ______ resp rate _______ Oxygen saturation _____% Oxygen at ____l/min Temperature _____ C

I am concerned about:

Blood pressure because:
- Systolic pressure greater than 160 mm Hg
- Diastolic pressure more than 100 mm Hg
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Response

____

Person completing form: (name) ____________________________________Rank__________________Date_______ Time_______

Person reported to (Name) ______________________________(Rank)___________________Inst______________________

This copy remains in case record and accompanies the patient.

Patient Sticker	**PMCTC Checklist**

PMTCT Checklist

This is a checklist ONLY and does not replace official patient records.

Patient Sticker

HIV TESTING

HIV status unknown or previously negative

- ☐ Tested when pregnancy was confirmed Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
- ☐ Retested at 20 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
- ☐ Retested at 26 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
- ☐ Retested at 30 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
- ☐ Retested at 34 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
- ☐ Retested at 36 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
- ☐ Retested at 38 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
- ☐ Retested at 40 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)

ANTENATAL CARE

Known HIV not on ART / New HIV during pregnancy

- ☐ Started ART on the day of diagnosis Date: ___/___/___ (integrated antenatal and ART services)
- ☐ Started AZT and referred for urgent ART Date: ___/___/___ (antenatal and ART services not yet integrated)

Gestation at ART start: ____________

Regimen: ____________

CD4 at booking: ____________ Creatinine ____________

VL: ______ Date: ___/___/___ Gestation: ____________ ____________

VL: ______ Date: ___/___/___ Gestation: ____________ ____________

VL: ______ Date: ___/___/___ Gestation: ____________ ____________

VL: ______ Date: ___/___/___ Gestation: ____________ ____________

Known HIV on ART

Regimen: ____________

Last ART visit: Date: ___/___/___ Facility: ____________

Site where ART will be accessed during pregnancy: ____________

VL: _____ Date: ___/___/___

VL: ______ Date: ___/___/___ Gestation: ______________

VL: ______ Date: ___/___/___ Gestation: ______________

VL: ______ Date: ___/___/___ Gestation: ______________

LABOUR & DELIVERY

VL: ______ Date: ___/___/___ Gestation: ______________

DATE TIME

Client on ART

☐ Continue ART Regimen: ____________ Time taken: ____________

Client not on ART [*e.g. unbooked,on AZT prophylaxis, HIV diagnosis in labour, defaulted prior to delivery (≥1 week)*]

Stat NVP ☐ Yes ☐ No

Stat TDF, 3TC and DTG ☐ Yes ☐ No

Mother's response to diagnosis:
- ♦Accepted and managing well ☐
- ♦Struggling with diagnosis ☐

Help needed with disclosure issues: yes/no

Support needed yes/no

Referred to counsellor yes/no

Back page of PMTCT

Patient Sticker	**PMTCT Checklist** **This is a checklist ONLY and does not replace official patient records.**

HIV TESTING

HIV status unknown or previously negative

- ☐ Tested when pregnancy was confirmed Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
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- ☐ Retested at 38 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)
- ☐ Retested at 40 weeks Date: ___/___/___ ☐ Pos ☐ Neg (if previous negative/unknown)

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- ☐ Started AZT and referred for urgent ART Date: ___/___/___ (antenatal and ART services not yet integrated)

Gestation at ART start: ______________

Regimen: ______________

CD4 at booking: ______________ Creatinine ______________

VL: ______ Date: ___/___/___ Gestation: ______________ ______________

VL: ______ Date: ___/___/___ Gestation: ______________ ______________

VL: ______ Date: ___/___/___ Gestation: ______________ ______________

VL: ______ Date: ___/___/___ Gestation: ______________ ______________

Known HIV on ART

Regimen: ____

Last ART visit: Date: ___/___/___ Facility: ______________________________

Site where ART will be accessed during pregnancy: ______________________________

VL: _____ Date: ___/___/___

VL: ______ Date: ___/___/___ Gestation: ______________

VL: ______ Date: ___/___/___ Gestation: ______________

VL: ______ Date: ___/___/___ Gestation: ______________

LABOUR & DELIVERY

VL: ______ Date: ___/___/___ Gestation: ______________

DATE	TIME

Client on ART

☐ Continue ART Regimen: ______________ Time taken: ______________

Client not on ART [*e.g. unbooked,on AZT prophylaxis, HIV diagnosis in labour, defaulted prior to delivery (≥1 week)*]

Stat NVP ☐ Yes ☐ No

Stat TDF, 3TC and DTG ☐ Yes ☐ No

Mother's response to diagnosis:	
•Accepted and managing well	☐
•Struggling with diagnosis	☐
Help needed with disclosure issues:	yes/no
Support needed	yes/no
Referred to counsellor	yes/no

Perforated

MENTAL HEALTH SCREEN

Conduct a mental health screen for all pregnant women.
Refer if needed to appropriate service, such as mental health nurse, social services, NGO, medical officer, counsellor, psychiatrists or other services.

Suggested words to use before screening.

"We would like to know about all the women who come here: how they are doing physically and emotionally. This helps us to understand the best sort of care we can offer. Please may I ask you three questions about how you are emotionally? Please answer 'yes' or 'no' to each question."

In the last 2 weeks, have you on some or most days felt unable to stop worrying or thinking too much?	☐ Yes [1]	☐ No [0]
In the last 2 weeks, have you on some or most days felt down, depressed or hopeless?	☐ Yes [1]	☐ No [0]
In the last 2 weeks, have you on some or most days had thoughts **<u>and</u>** plans to harm yourself or commit suicide?*	☐ Yes [1] **Refer**	☐ No [0]
TOTAL SCORE	0 or 1 2 >>>>>>>>>>> refer 3 >>>>>>>>>>> refer	
Offered Counselling	☐ Yes	☐ No
Accepted counselling	☐ Yes	☐ No

**the self-harm question will require urgent referral if there are both thoughts AND plans. If there is a history of previous attempt, referral is required even if there are thoughts alone.*

COMPLETE USING CARBON PAPER. TEAR OUT THIS COPY AND RETAIN IN CLINIC/BANC+ FOLDER

I, ________________________(healthcare worker) have introduced myself by name to:

Name______________________________
Folder number______________________
Date of birth_______________________

Age:__________(yrs) G______ P______ Misc_______

OBSTETRIC AND NEONATAL HISTORY					*A=Alive; ID= Infant Death, NND=Neonatal Death, IUD=Intra-uterine death	
Year	Gestation	Delivery	Weight	Sex	Outcome*	Complications
Descriptions of complications:						

MEDICAL AND GENERAL HISTORY

Hypertension | Diabetes | Cardiac | Asthma | TB
Epilepsy | Mental health | HIV | Other

If yes, give detail______________________________
____

Family history | Twins | Diabetes | TB | Congenital

Details__________________________________
Medication_______________________________
Operations_______________________________
Allergies_________________________________
TB symptom screen | pos | neg | Use of herbal medicine
Tobacco | Alcohol | Substances | Use of OTC drugs
Psychosocial risk factors___________________________
____

CLINIC__________________ | d | d | m | m | y | y |

EXAMINATION

BP________/________ mmHg Urine____________________
Height_____________cm Weight ______________kg
MUAC _____________cm BMI ____________________kg/m²
Thyroid________________ Breasts__________________
Heart____
Lungs____
Abdomen____
SF Measurement at booking___________________________cm

VAGINAL EXAMINATION

Examination explained and permission obtained ☐
Vulva and vagina__________________________________
Cervix____
Uterus____
Pap smear done | Y | N | Date______________________

Result____

INVESTIGATIONS

Syphilis test | Pos | Neg | Repeat syphilis test | Pos | Neg
Treatment: 1st __________2nd ____________3rd ____________
Rhesus | Pos | Neg | Antibodies | Yes | No

Hb________g/dl Tetox 1st ________2nd _________3rd ________
Urine MCS: Date________________ Result________________
Screening for gestational diabetes__________28w____________
HIV status at booking | Unknown | Pos | On ART Y N
HIV test at booking | DD/MM/YY | Pos | Neg | Declined
HIV re-test | DD/MM/YY | Pos | Neg | Declined
HIV re-test | DD/MM/YY | Pos | Neg | Declined
CD 4 __________ ART initiated on | DD/MM/YY

Viral load: Date_______________ Result_________________
Viral load: Date_______________ Result_________________
Viral load: Date_______________ Result_________________
Other: ____

GESTATIONAL AGE

LNMP | DD/MM/YYYY | Certain? | Y | N
SONAR | DD/MM/YYYY
BPD_______________________ HC ___________________
AC_______________________ FL ___________________
Placenta___________________ AFI ___________________
Average gestation______________CRL __________________
Singleton ☐ Multiple pregnancy ☐ Intra-uterine pregnancy ☐
ESTIMATED DATE OF DELIVERY | DD/MM/YYYY
Method used to calculate EDD | Sonar | SF | LNMP

MENTAL HEALTH

Mental health screening: | Y | N | Score ☐
Discussed and noted in case record | Y
Where referred for mental health?_______________________

BIRTH COMPANION

Birth companion discussed and noted on MCR | Y

COUNSELLING

Topic	Date 1	Date 2
Fetal movements		
Parental preparedness		
Nutrition		
Danger signs		
HIV		
Mental health		
Alcohol		
Tobacco		
Substances		
Domestic violence		
Labour and birth preparedness		
Breast care		
Infant feeding		

FUTURE CONTRACEPTION (PROVIDE DUAL PROTECTION)

Implant | Inject | Intra-uterine device | Tubal ligation | Oral

All management plans discussed with patient ☐
Educational material given on pregnancy and patient rights ☐
If tubal ligation selected, adequate counselling was given ☐

BOOKING VISIT AND ASSESSMENT OF RISK DONE BY

____

MENTAL HEALTH SCREEN

Conduct a mental health screen for all pregnant women.
Refer if needed to appropriate service, such as mental health nurse, social services, NGO, medical officer, counsellor, psychiatrists or other services.

Suggested words to use before screening.
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TOTAL SCORE	0 or 1 2 >>>>>>>>>>> refer 3 >>>>>>>>>>> refer	
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Accepted counselling	☐ Yes	☐ No

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Folder number________________________________
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Age:___________(yrs) G______ P______ Misc_______

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*A=Alive; ID= Infant Death, NND=Neonatal Death, IUD=Intra-uterine death

Year	Gestation	Delivery	Weight	Sex	Outcome*	Complications

Descriptions of complications:

MEDICAL AND GENERAL HISTORY

Hypertension | Diabetes | Cardiac | Asthma | TB
Epilepsy | Mental health | HIV | Other

If yes, give detail____

Family history: Twins | Diabetes | TB | Congenital

Details____
Medication_______________________________________
Operations_______________________________________
Allergies____
TB symptom screen: pos | neg | Use of herbal medicine
Tobacco | Alcohol | Substances | Use of OTC drugs
Psychosocial risk factors___________________________________

CLINIC__________________ d | d | m | m | y | y

EXAMINATION

BP_________/________ mmHg Urine____________________
Height_____________cm Weight ______________kg
MUAC _____________cm BMI ______________________kg/m²
Thyroid__________________ Breasts___________________
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Lungs____
Abdomen____
SF Measurement at booking_____________________________cm

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Examination explained and permission obtained ☐
Vulva and vagina___________________________________
Cervix____
Uterus____
Pap smear done Y | N Date__________________________

Result____

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Treatment: 1st __________2nd_____________3rd___________
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LNMP DD/MM/YYYY Certain? Y | N
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BPD_______________________ HC ____________________
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Placenta___________________ AFI ___________________
Average gestation_______________CRL ___________________
Singleton ☐ Multiple pregnancy ☐ Intra-uterine pregnancy ☐

ESTIMATED DATE OF DELIVERY DD/MM/YYYY

Method used to calculate EDD Sonar | SF | LNMP

MENTAL HEALTH

Mental health screening: Y | N Score ☐
Discussed and noted in case record Y
Where referred for mental health?_________________________

BIRTH COMPANION

Birth companion discussed and noted on MCR Y

COUNSELLING

Topic	Date 1	Date 2
Fetal movements		
Parental preparedness		
Nutrition		
Danger signs		
HIV		
Mental health		
Alcohol		
Tobacco		
Substances		
Domestic violence		
Labour and birth preparedness		
Breast care		
Infant feeding		

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BOOKING VISIT AND ASSESSMENT OF RISK DONE BY

____

EXAMINED BY:
(PRINT)

DATE :

GESTATION 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 37 38 39 40 < weeks

GESTATION ESTABLISHED BY:

- Dates
- Sonar
- Both
- SF measurement

PRESENTATION

HEAD ABOVE BRIM (fifths)

TB screen																													
GESTATION	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	37	38	39	40	
Blood-pressure																														Syst. / Diast.
Urine P																														P
Urine S																														S
Supplements																														Suppl.
Fetal movements																														
Haemoglobin (g/dl)																														

Iron (I)
Folate (F)
Calcium (C)

DOH Antenatal 2020 GSG

Date	PROBLEM LIST
1	
2	
3	
4	
5	
6	
7	

Date	NOTES (essential facts only)

NOTES FOR ANTENATAL VISITS continued

Essential additional facts only (Do not duplicate data from p4 or p5)		Name (print) and signature
I have introduced myself by name to this person ☐ TB screen done ☐		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands ☐		
I have introduced myself by name to this person ☐ TB screen done ☐		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands ☐		
I have introduced myself by name to this person ☐ TB screen done ☐		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands ☐		
I have introduced myself by name to this person ☐ TB screen done ☐		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands ☐		

NOTES FOR ANTENATAL VISITS continued

Essential additional facts only (Do not duplicate data		Name (print) and signature
I have introduced myself by name to this person ☐ TB screen done ☐		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands ☐		
I have introduced myself by name to this person ☐ TB screen done ☐		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands ☐		
I have introduced myself by name to this person ☐ TB screen done ☐		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands ☐		
I have introduced myself by name to this person ☐ TB screen done ☐		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands ☐		

Fetal Movement Chart (use only when indicated)

Date: ⇩	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Example *Week of 8 June*	✓✓✓✓✓✓✓✓✓✓✓ ✓ *12*	✓✓✓✓✓✓✓✓✓✓ *10*	✓✓✓✓✓✓✓✓✓✓ ✓✓ *12*	✓✓✓✓✓✓✓✓✓✓✓ ✓✓✓ *14*	✓✓✓✓✓✓✓✓✓ ✓✓✓ *12*	✓✓✓✓✓✓✓✓✓ ✓✓ *11*	✓✓✓✓✓✓✓✓✓ ✓✓✓ *12*

Fetal movements should be counted and recorded on the chart over a period of an hour per day after breakfast. The person should preferably rest on her side for this period.

INITIAL ASSESSMENT

DD/MM/YYYY | HH/MM | Name of health care worker:

I have introduced myself by name to this person ☐

Assessment findings	Differential diagnosis

Working diagnosis

Proposed management plan

All procedures have been explained and verbally consented by the person ☐

I have checked with the person regarding her birth companion ☐

If problem/ diagnosis is prior to delivery- continue clinical notes on page 19
If problem/diagnosis is during established labour- continue clinical notes in labour section page 30
If problem/diagnosis is after delivery- continue clinical notes in post natal section page 50

BASIC ULTRASOUND REPORT (attach copies of detailed reports or photos to this page)

DD/MM/YYYY	Performed by:

I have introduced myself by name to this person ☐

Intrauterine	Yes	No	**Number of fetuses**		
Fetal movements	Yes	No	**Heartbeat**	Yes	No
Fetal lie	cephalic	breech	transverse		
Placenta	anterior	posterior	lateral		
	high	low	distance from os	mm	
Liquor	normal	reduced	increased	**Deepest pool**	cm

BIOMETRY- (attach hard copy if available)

Biparietal diameter (BPD)	**mm**	**Weeks:**	**days:**
Head circumference (HC)	**mm**	**Weeks:**	**days:**
Abdominal circumference (AC)	**mm**	**Weeks:**	**days:**
Femur length (FL)	**mm**	**Weeks:**	**days:**
Measurements concordant (8 days or less difference)		**Measurements discordant (more than 8 days difference)**	
Average gestation WEEKS: DAYS:		**Estimated fetal weight (EFW):**	

DD/MM/YYYY	Performed by:

I have introduced myself by name to this person ☐

Intrauterine	Yes	No	**Number of fetuses**		
Fetal movements	Yes	No	**Heartbeat**	Yes	No
Fetal lie	cephalic	breech	transverse		
Placenta	anterior	posterior	lateral		
	high	low	distance from os	mm	
Liquor	normal	reduced	increased	**Deepest pool**	cm

BIOMETRY- (attach hard copy if available)

Biparietal diameter (BPD)	**mm**	**Weeks:**	**days:**
Head circumference (HC)	**mm**	**Weeks:**	**days:**
Abdominal circumference (AC)	**mm**	**Weeks:**	**days:**
Femur length (FL)	**mm**	**Weeks:**	**days:**
Measurements concordant (8 days or less difference)		**Measurements discordant (more than 8 days difference)**	
Average gestation WEEKS: DAYS:		**Estimated Fetal Weight:**	

CLINICAL NOTES: EXAMINATION AND FINDINGS IF NOT IN LABOUR

I have introduced myself by name to this person ☐
I have checked with this person regarding her birth companion ☐
I have discussed all management plans with this person and checked that she understands ☐

Date and time		Name (print) and signature

CLINICAL NOTES: EXAMINATION AND FINDINGS IF NOT IN LABOUR

I have introduced myself by name to this person ☐
I have checked with this person regarding her birth companion ☐
I have discussed all management plans with this person and checked that she understands ☐

Date and time		Name (print) and signature

CLINICAL NOTES: EXAMINATION AND FINDINGS IF NOT IN LABOUR

I have introduced myself by name to this person ☐
I have checked with this person regarding her birth companion ☐
I have discussed all management plans with this person and checked that she understands ☐

Date and time		Name (print) and signature

CLINICAL NOTES: EXAMINATION AND FINDINGS IF NOT IN LABOUR

I have introduced myself by name to this person ☐
I have checked with this person regarding her birth companion ☐
I have discussed all management plans with this person and checked that she understands ☐

Date and time		Name (print) and signature

CLINICAL NOTES: EXAMINATION AND FINDINGS IF NOT IN LABOUR

I have introduced myself by name to this person ☐
I have checked with this person regarding her birth companion ☐
I have discussed all management plans with this person and checked that she understands ☐

Date and time		Name (print) and signature

CLINICAL NOTES: EXAMINATION AND FINDINGS IF NOT IN LABOUR

I have introduced myself by name to this person ☐
I have checked with this person regarding her birth companion ☐
I have discussed all management plans with this person and checked that she understands ☐

Date and time		Name (print) and signature

CLINICAL NOTES: EXAMINATION AND FINDINGS IF NOT IN LABOUR

I have introduced myself by name to this person ☐
I have checked with this person regarding her birth companion ☐
I have discussed all management plans with this person and checked that she understands ☐

Date and time		Name (print) and signature

OBSERVATION CHART when the diagnosis of labour is doubtful

Name:	Age:	G:	P:	Gestational age:
Facility:	Hb:	Presentation:		
Companion:	Risk factors:			

	Assessment 1: Date and time				Assessment 2: Date and time		
Mother	Blood Pressure				Blood pressure		
	Pulse				Pulse		
	Temperature				Temperature		
	Urine dipstick				Urine dipstick		
	Fetal movement felt	Yes	No		Fetal movement felt	Yes	No
	Emergency signs (bleeding, seizures, etc)	No	Yes		Emergency signs (bleeding, seizures, etc)	No	Yes
	Contractions per 10 minutes				Contractions per 10 minutes		
	<20 sec ▩ 20-40 sec ▥ >40 sec ■				<20 sec ▩ 20-40 sec ▥ >40 sec ■		
	Maternal emotional state				Maternal emotional state		
Fetus	FHR: normal baseline, no decelerations	Yes	No		FHR: normal baseline, no decelerations	Yes	No
PV	Head above brim				Head above brim		
	Dilatation				Dilatation		
	Cervical length				Cervical length		
	Membranes intact	Yes	No		Membranes intact	Yes	No
Checklist	Is the maternal condition reassuring?	Yes	No		Is the maternal condition reassuring?	Yes	No
	Is the fetal condition reassuring?	Yes	No		Is the fetal condition reassuring?	Yes	No
	Plan:				Plan:		
	Initials and signature:				Initials and signature:		

Discharge checklist	Reassuring maternal condition?	Yes	No	**Plan (if not discharged):**
	Reassuring fetal condition?	Yes	No	
	Intact membranes?	Yes	No	
	No cervical changes since admission?	None	Changes	
	Warning signs have been explained?	Yes	No	
	The mother understands the danger signs?	Yes	No	
	Follow-up date:			
	Initials and signature:			

Hourly observation chart for patients on Magnesium Sulphate ($MgSO_4$)

Date	Time	BP	Pulse	Respiratory rate	Reflexes		$MgSO_4$ dose	Urine: vol/h	Urine protein	Signature
					L	R				

EARLY WARNING OBSERVATION CHART FOR ANTENATAL ADMISSIONS

Date																		Date
Time																		Time
RESPIRATORY	>30																	>30
	21-30																	21-30
	11-20																	11-20
	0-10																	0-10
SATURATION	95-100%																	95-100%
	<95%																	<95%
TEMPERATURE	39°C																	39°C
	38°C																	38°C
	37°C																	37°C
	36°C																	36°C
	35°C																	35°C
Hb (plot actual value)	≥ 8 g/dl																	≥ 8 g/dl
	< 8 g/dl																	< 8 g/dl
MATERNAL HEART RATE	140																	140
	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
	40																	40
SYSTOLIC BLOOD PRESSURE	170																	170
	160																	160
	150																	150
	140																	140
	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
DIASTOLIC BLOOD PRESSURE	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
	40																	40
Urine (VOLUME in ml/hour)																		ml/hour
Proteinuria	Clear (-)																	Clear (-)
	+																	+
	++ to +++																	++ to +++
Feat heart rate (bpm)																		Fetal heart rate
Vaginal Bleeding	Spotting																	Spotting
	Clots																	Clots
	Bright red																	Bright red
Neuro response	Alert																	Alert
	Vocal																	Vocal
	Pain																	Pain
	Unresponsive																	Unresponsive
Pain	None-mild																	None-mild
	Severe																	Severe
Looks unwell	No (✓)																	No (✓)
	Yes (✓)																	Yes (✓)
TOTAL YELLOW SCORE																		TOTAL
TOTAL RED SCORE																		TOTAL
DOCTOR CALLED (Y/N)																		
Signature																		

EARLY WARNING OBSERVATION CHART FOR ANTENATAL ADMISSIONS

Date																		Date
Time																		Time
RESPIRATORY	>30																	>30
	21-30																	21-30
	11-20																	11-20
	0-10																	0-10
SATURATION	95-100%																	95-100%
	<95%																	<95%
TEMPERATURE	39°C																	39°C
	38°C																	38°C
	37°C																	37°C
	36°C																	36°C
	35°C																	35°C
Hb (plot actual value)	≥ 8 g/dl																	≥ 8 g/dl
	< 8 g/dl																	< 8 g/dl
MATERNAL HEART RATE	140																	140
	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
	40																	40
SYSTOLIC BLOOD PRESSURE	170																	170
	160																	160
	150																	150
	140																	140
	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
DIASTOLIC BLOOD PRESSURE	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
	40																	40
Urine (VOLUME in ml/hour)																		ml/hour
Proteinuria	Clear (-)																	Clear (-)
	+																	+
	++ to +++																	++ to +++
Feat heart rate (bpm)																		Fetal heart rate
Vaginal Bleeding	Spotting																	Spotting
	Clots																	Clots
	Bright red																	Bright red
Neuro response	Alert																	Alert
	Vocal																	Vocal
	Pain																	Pain
	Unresponsive																	Unresponsive
Pain	None-mild																	None-mild
	Severe																	Severe
Looks unwell	No (✓)																	No (✓)
	Yes (✓)																	Yes (✓)
TOTAL YELLOW SCORE																		TOTAL
TOTAL RED SCORE																		TOTAL
DOCTOR CALLED (Y/N)																		
Signature																		

LABOUR- INITIAL ASSESSMENT (use this chart when the diagnosis of labour is certain)

Date: .... Time assessed: .... Time of admission: ....
Age: .... Gravidity: .... Parity: .... Assessed by: ....
I have introduced myself by name to this person ☐ Gestational age: .... Nutritional status: ....

If referred	From:	Time of referral: ....

Reasons for referral: ....

Date and time: Onset of labour [ ] ROM: [ ] Bleeding: [ ]

Booked: Yes | No If not booked, reason: ....

Name of clinic: .... Gest. Age at 1st booking .... No of visits ....

Gestational age:_________________weeks and _____________days based on: Ultrasound ☐ Booking SF ☐ LNMP ☐

Labour companion is present ☐ OR Offered to call a person she trusts to be with her in labour ☐

Hb: Rhesus: Pos | Neg If Rh neg: antibodies Syphilis tests:

HIV results: Pos | Neg If HIV neg, retest during labour: Pos | Neg

ART: Yes | No Regimen: ....

Problems at ANC ....

Main complaints

Convulsions	Bleeding	Severe abd pain	Looks very ill	Headache/visual disturbances	Severe difficulty breathing	Fever

GENERAL EXAMINATION

General: Pulse: .... BP: .... Temp: .... Appearance: ....
Chest: .... CVS: ....
Other systems: .... MUAC: ....
Urinary analysis: ....

ABDOMINAL EXAMINATION

Lie: Longitudinal | Transverse | Oblique **Scars:** Transverse | Vertical Other: ....

Presentation: Cephalic | Breech SF height ....

Liquor: Normal | Decreased | Increased **EFW:** .... gram

Level of head palpable above pelvic brim (in fifths)	5	4	3	2	1	0

Contractions mild | moderate | strong **Fetal heart rate:** Normal | Abnormal | Absent

Type of FHR abnormality: ....

VAGINAL EXAMINATION

Speculum: Liquor .... Blood .... Cervix ....

Digital exam: cervix

Thick	Thin	Edematous	Not felt	Application:	Good	Poor

Dilatation: | Length: | Position:

Presenting part: .... Position: ....

Moulding PP	0	+	++	+++
Caput:	0	+	++	

Liquor: Clear Meconium stained liquor No | Thin | Thick Blood stained | Offensive

Pelvic assessment: Adequate | Inadequate | Unsure

RISK FACTORS

Maternal	**Fetal**	**Labour**
Check mental health screen at booking ☐		

Summary of diagnosis and management: ....

I have explained any examinations/procedures to be done and obtained verbal consent ☐

Person to be managed at CLINIC/MOU | District hospital | Specialist hospital | Tertiary hospital

ASSESSMENTS DURING LABOUR

ASSESSMENT:	Date		Time		DOL		hrs	DORM		hrs
I have introduced myself by name to this person: ☐										
Progress of labour:	Good ☐	Poor ☐	None ☐	Birth companion/Doula present Yes No						
Maternal condition:										
Maternal mental and emotional condition:	What is her current pain management? What support is given?									
Fetal condition:										
Overall assessment and management plan:										
I have explained management plans to this person and her birth companion and ensured that both understand ☐										
Name (print)		Signature and designation								

ASSESSMENT:	Date		Time		DOL		hrs	DORM		hrs
I have introduced myself by name to this person: ☐										
Progress of labour:	Good ☐	Poor ☐	None ☐	Birth companion/Doula present Yes No						
Maternal condition:										
Maternal mental and emotional condition:	What is her current pain management? What support is given?									
Fetal condition:										
Overall assessment and management plan:										
I have explained management plans to this person and her birth companion and ensured that both understand ☐										
Name (print)		Signature and designation								

ASSESSMENT:	Date		Time		DOL		hrs	DORM		hrs
I have introduced myself by name to this person: ☐										
Progress of labour:	Good ☐	Poor ☐	None ☐	Birth companion/Doula present Yes No						
Maternal condition:										
Maternal mental and emotional condition:	What is her current pain management? What support is given?									
Fetal condition:										
Overall assessment and management plan:										
I have explained management plans to this person and her birth companion and ensured that both understand ☐										
Name (print)		Signature and designation								

Name:	Gravidity:	Parity:	Gestation:	Spontaneous l
Age:	Risk Factors:			Time of ROM:
Pelvis				Duration of labour (on arrival)

Date: LATENT PHASE | ACTIVE PHASE

Time	
Duration in hours	

FETAL CONDITION

	Latent phase	Active phase
Fetal heart rate (bpm)		
Decelerations (Yes/No)	Y N (×12)	Y N (×20)
Type* (E/V/L)		
Liquor* (I/C/B/M)		

PROGRESS OF LABOUR

Application*
Presenting part*
Caput (0 1+ 2+)
Moulding (0 1+ 2+ 3+)
Position e.g. LOA >

X Cervical dilitation
I Cervical length

Head above pelvis

10
9
8
7
6
5
4
3
2
1

CONTRACTIONS

CONTRACTIONS PER 10 MINUTES

> 40 sec
> 20 - 40 sec
< 20 sec

5
4
3
2
1

OXYTOCIN: Units, Rate

MATERNAL CONDITION

BLOOD PRESSURE & PULSE

200
190
180
170
160
150
140
130
120
110
100
90
80
70
60

URINE: Volume, Protein, Ketones, Blood, Glucose

TEMPERATURE ºC (TEMP)

TIME	
MANAGEMENT/ MEDICATION/ I.V. FLUID	
PAIN RELIEF	
SIGNATURE & RANK	

* Liquor: I = intact, B = blood stained, C = clear, M = meconium stained
* Presenting part: Breech = Br, Face = F, Vertex = Vx, Brow = Bw
* Application: good = G, poor = P
*early = E, late = L, variable = V

ASSESSMENTS DURING LABOUR

ASSESSMENT:	Date		Time		DOL		hrs	DORM		hrs
I have introduced myself by name to this person: ☐										
Progress of labour:	Good ☐	Poor ☐	None ☐	Birth companion/Doula present Yes No						
Maternal condition:										
Maternal mental and emotional condition:	What is her current pain management? What support is given?									
Fetal condition:										
Overall assessment and management plan:										
I have explained management plans to this person and her birth companion and ensured that both understand ☐										
Name (print)		Signature and designation								

ASSESSMENT:	Date		Time		DOL		hrs	DORM		hrs
I have introduced myself by name to this person: ☐										
Progress of labour:	Good ☐	Poor ☐	None ☐	Birth companion/Doula present Yes No						
Maternal condition:										
Maternal mental and emotional condition:	What is her current pain management? What support is given?									
Fetal condition:										
Overall assessment and management plan:										
I have explained management plans to this person and her birth companion and ensured that both understand ☐										
Name (print)		Signature and designation								

ASSESSMENT:	Date		Time		DOL		hrs	DORM		hrs
I have introduced myself by name to this person: ☐										
Progress of labour:	Good ☐	Poor ☐	None ☐	Birth companion/Doula present Yes No						
Maternal condition:										
Maternal mental and emotional condition:	What is her current pain management? What support is given?									
Fetal condition:										
Overall assessment and management plan:										
I have explained management plans to this person and her birth companion and ensured that both understand ☐										
Name (print)		Signature and designation								

CARDIOTOCOGRAPHY (CTG) (FIGO 2015) – CTG ONLY INDICATED FOR HIGH RISK PREGNANCIES

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:
Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm ☐	Lacking at least one characteristic of normality, but no pathological features ☐	<100 bpm ☐ (make sure it is not maternal pulse)
Variability	5-25 bpm ☐		Reduced (<5 bpm) variability >50 minutes ☐
Decelerations	No repetitive* decelerations ☐ (*Decelerations are repetitive in nature when they are associated with more than 50% of uterine contractions)		Repetitive* late decelerations ☐ OR Prolonged (>3min) decelerations during >30 minutes ☐ OR Prolonged (>3min) decelerations during >20 minutes with reduced variability ☐ OR One prolonged deceleration >5 minutes ☐
Interpretation	Fetus with no hypoxia	low probability of hypoxia	Fetus with high probability of hypoxia/acidosis
Contractions	None ☐ Irregular ☐ Regular ☐ Mild ☐ Moderate ☐ Strong ☐ Expulsive ☐		
Clinical management:	No intervention necessary ☐	Action to correct reversible causes if identified ☐ Alert doctor of findings ☐	Immediate action to correct reversible causes ☐ If not possible, or no recovery; immediate delivery ☐ Call doctor immediately ☐
I have explained the nature of the findings and planned action to the person and her birth companion ☐			
Evaluation done by:			

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:
Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm ☐	Lacking at least one characteristic of normality, but no pathological features ☐	<100 bpm ☐ (make sure it is not maternal pulse)
Variability	5-25 bpm ☐		Reduced (<5 bpm) variability >50 minutes ☐
Decelerations	No repetitive* decelerations ☐ (*Decelerations are repetitive in nature when they are associated with more than 50% of uterine contractions)		Repetitive* late decelerations ☐ OR Prolonged (>3min) decelerations during >30 minutes ☐ OR Prolonged (>3min) decelerations during >20 minutes with reduced variability ☐ OR One prolonged deceleration >5 minutes ☐
Interpretation	Fetus with no hypoxia	low probability of hypoxia	Fetus with high probability of hypoxia/acidosis
Contractions	None ☐ Irregular ☐ Regular ☐ Mild ☐ Moderate ☐ Strong ☐ Expulsive ☐		
Clinical management:	No intervention necessary ☐	Action to correct reversible causes if identified ☐ Alert doctor of findings ☐	Immediate action to correct reversible causes ☐ If not possible, or no recovery; immediate delivery ☐ Call doctor immediately ☐
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Evaluation done by:			

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:
Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm ☐	Lacking at least one characteristic of normality, but no pathological features ☐	<100 bpm ☐ (make sure it is not maternal pulse)
Variability	5-25 bpm ☐		Reduced (<5 bpm) variability >50 minutes ☐
Decelerations	No repetitive* decelerations ☐ (*Decelerations are repetitive in nature when they are associated with more than 50% of uterine contractions)		Repetitive* late decelerations ☐ OR Prolonged (>3min) decelerations during >30 minutes ☐ OR Prolonged (>3min) decelerations during >20 minutes with reduced variability ☐ OR One prolonged deceleration >5 minutes ☐
Interpretation	Fetus with no hypoxia	low probability of hypoxia	Fetus with high probability of hypoxia/acidosis
Contractions	None ☐ Irregular ☐ Regular ☐ Mild ☐ Moderate ☐ Strong ☐ Expulsive ☐		
Clinical management:	No intervention necessary ☐	Action to correct reversible causes if identified ☐ Alert doctor of findings ☐	Immediate action to correct reversible causes ☐ If not possible, or no recovery; immediate delivery ☐ Call doctor immediately ☐
I have explained the nature of the findings and planned action to the person and her birth companion ☐			
Evaluation done by:			

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:

Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm ☐	Lacking at least one characteristic of normality, but no pathological features ☐	<100 bpm ☐ (make sure it is not maternal pulse)
Variability	5-25 bpm ☐		Reduced (<5 bpm) variability >50 minutes ☐
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Interpretation	Fetus with no hypoxia	low probability of hypoxia	Fetus with high probability of hypoxia/acidosis
Contractions	None ☐ Irregular ☐ Regular ☐ Mild ☐ Moderate ☐ Strong ☐ Expulsive ☐		
Clinical management:	**No intervention necessary ☐**	**Action to correct reversible causes if identified ☐ Alert doctor of findings ☐**	**Immediate action to correct reversible causes ☐ If not possible, or no recovery; immediate delivery ☐ Call doctor immediately ☐**
I have explained the nature of the findings and planned action to the person and her birth companion ☐			
Evaluation done by:			

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:

Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm ☐	Lacking at least one characteristic of normality, but no pathological features ☐	<100 bpm ☐ (make sure it is not maternal pulse)
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Clinical management:	**No intervention necessary ☐**	**Action to correct reversible causes if identified ☐ Alert doctor of findings ☐**	**Immediate action to correct reversible causes ☐ If not possible, or no recovery; immediate delivery ☐ Call doctor immediately ☐**
I have explained the nature of the findings and planned action to the person and her birth companion ☐			
Evaluation done by:			

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:

Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm ☐	Lacking at least one characteristic of normality, but no pathological features ☐	<100 bpm ☐ (make sure it is not maternal pulse)
Variability	5-25 bpm ☐		Reduced (<5 bpm) variability >50 minutes ☐
Decelerations	No repetitive* decelerations ☐ (*Decelerations are repetitive in nature when they are associated with more than 50% of uterine contractions)		Repetitive* late decelerations ☐ OR Prolonged (>3min) decelerations during >30 minutes ☐ OR Prolonged (>3min) decelerations during >20 minutes with reduced variability ☐ OR One prolonged deceleration >5 minutes ☐
Interpretation	Fetus with no hypoxia	low probability of hypoxia	Fetus with high probability of hypoxia/acidosis
Contractions	None ☐ Irregular ☐ Regular ☐ Mild ☐ Moderate ☐ Strong ☐ Expulsive ☐		
Clinical management:	**No intervention necessary ☐**	**Action to correct reversible causes if identified ☐ Alert doctor of findings ☐**	**Immediate action to correct reversible causes ☐ If not possible, or no recovery; immediate delivery ☐ Call doctor immediately ☐**
I have explained the nature of the findings and planned action to the person and her birth companion ☐			
Evaluation done by:			

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ADDITIONAL CLINICAL NOTES DURING LABOUR AND DELIVERY

Date and time	Remarks	Name (print) and signature

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SUMMARY OF LABOUR

From full dilatation to delivery

Method of delivery: NVD | Breech | Twins | Caesarean section | Instrumental | Other: ....

Delivered by: .... Assisted by: ....

Complications: ....

Maternal position during labour: ....

Fetal monitoring: normal ☐ abnormal ☐ if abnormal specify:

SUMMARY OF DURATION OF LABOUR

	Started at:		Duration:		Membranes:	
	Date	Time	Hours	Minutes	AROM	SROM
Latent phase					Time of ROM:	
Active phase (≥5cm)						
Full dilatation					Time of delivery:	
Bearing down					Duration of ROM:	
Third stage						
Total duration of labour:						

PAIN RELIEF

Entonox | Opioid | Local | Pudendal | Epidural | Non-pharmacological pain relief used

Given by: .... Detail: ....

NEONATAL DETAIL

Resuscitation done: Yes | No Describe: ....

Birth injuries: Yes | No Describe: ....

Neonate	Male	Female	Alive	FSB	MSB	NND	Weight	ID band on?	Cord clamp?
1.							g		
2.							g		

Konakion: Yes | No Eye drops Yes | No Type: .... Given by: ....

THIRD STAGE- PLACENTA, MEMBRANES AND CORD

Oxytocin 10 units given intramuscularly: Yes | No By .... At ....

Method of delivery: Active | Spontaneous | Manual Cord around neck? Yes | No

Placenta Normal | Abnormal Complete | Incomplete Membranes Complete | Incomplete

No of vessels in cord: .... Placental weight: .... g Retroplacental clot Yes | No Histology Yes | No

Delayed cord clamping done ☐ If delayed cord clamping not done, explain why:__________

Result of cord blood gas (if indicated)

FOURTH STAGE (FIRST TWO HOURS AFTER DELIVERY- COMPLETE OBSERVATIONS ON SEPARATE PAGE)

Time of observation: .... Observed by: ....

Temp: .... Resp: .... Pulse: .... BP: .... Urine passed: Yes | No Catheter: Yes | No

Uterus contracted: Yes | No Uterus ruptured: Yes | No Cord/maternal blood taken: Yes | No

Cervical tears Yes | No Details: ....

Perineum Intact | 1st ° tear | 2nd ° tear | 3rd /4th ° tear | Episiotomy Repaired by: ....

Detail of repair: .... All swabs/tampons removed from vagina: Yes

Blood loss: Normal ☐ Excessive ☐ If excessive give details of management:__________

Feeding initiated Yes | No Breast feeding initiated if method of choice: Yes | No If no, give reasons: ....

Situation in labour ward at time of delivery:

TRANSFERRED TO WARD BY: **RECEIVED IN WARD BY:** **TIME:**

Condition satisfactory: Mother Yes | No Baby Yes | No

Further management, mother and/or baby ....

....

OBSERVATIONS IMMEDIATELY AFTER DELIVERY

Observations must be done <u>every 15 min for 1 hour and then every 30 minutes for the next hour</u> starting immediately after delivery. If the person is in a recovery area after Caesarean delivery, the recovery area staff must complete the observations.

Date and time of delivery: ---

Date	Time	BP	Pulse	Respiratory rate	Uterine contraction	Pad check	Oxytocin (rate)	Signature

Classification of shock

	Compensated shock (Class 1)	Mild shock (Class II)	Moderate shock (Class III)	Severe shock (Class IV)
Blood loss	500-1000ml (10-15%)	1000-1500 ml (15-25%)	1500-2000ml (25-35%)	2000-3000ml (35-45%)
Shock index*	0.6-0.9	1	1.5	2
Systolic Blood pressure	Normal	Some changes in blood pressure	Marked ⇩	Severe ⇩
Pulse	< 100/min	< 120/min	> 120/min	>140/min
Respiratory rate	Normal	Mild increase	Moderate increase	Marked increase
Mental status	Normal	Agitated	Confused	Depressed level of consciousness

***Shock index= heart rate/systolic BP (mmHg) (normal <0.5)**

FORCEPS OR VACCUUM DELIVERY

Indication(s) ....

Date: .... Time: .... All healthcare workers have introduced themselves by name ☐

Performed by .... Assisted by: ....

The procedure was explained and verbal consent obtained from the person ☐

CONDITIONS BEFORE DELIVERY

Fetal Heart | Normal | Abnormal | Rate: bpm | Fetal distress | Yes | No

Type of FH abnormality: ....

Mat. Pulse [ ] BP [ ] Foleys catheter: | Yes | No |

Level of head palpable above pelvic brim (in fifths) | 5 | 4 | 3 | 2 | 1 | 0 |

PAIN RELIEF

Anaesthetic | General | Spinal | Epidural | Other | Pudendal | Local | Saddle |

Problems with pain relief: ....

ASSESSMENT

Cervical dilatation: .... Application: | Good | Poor |

Position .... Flexion: .... Moulding PP | 0 | + | ++ | +++ |

Head above pelvic brim: | 5/5 | 4/5 | 3/5 | 2/5 | 1/5 | Caput: | 0 | + | ++ |

Liquor: | Clear | Meconium stained liquor | None | Thin | Thick | | Blood stained | Offensive |

Pelvic assessment: | Adequate | Inadequate | Unsure |

Pre-requisites for vacuum extraction met:	Regular contractions ☐	0/5 or 1/5 HAB ☐	Cervix fully dilated ☐	Bladder empty ☐	Cephalic presentation ☐	Fetus not premature ☐
Pre-requisites for forceps delivery met:	Normal contractions ☐	0/5 HAB ☐	Cervix fully dilated ☐	Bladder empty ☐	Cephalic presentation ☐	Sagittal suture in AP diameter ☐

Other findings: ....

Drugs (including dosage): ....

FORCEPS DELIVERY

Instrument type: .... Application: | Easy | Difficult | Abandoned attempt |

Number of pulls: .... Application-to-delivery time: ....

Comments: ....

VACUUM EXCTRACTION

Cup type: | Silicone ☐ | Metal ☐ | Disposable ☐ | Application: | Easy | Difficult | Abandoned attempt |

Number of pulls: .... Did cup slip? | Yes | No | No of times cup slipped: [ ]

Site of application: .... Application-to-delivery time: ....

Comments: ....

OUTCOME (FORCEPS OR VACUUM)

Time procedure commenced: .... Time completed: ....

Condition of baby at birth: .... APGAR: ....

Fetal injuries? (describe): ....

Maternal injuries? (describe): ....

In case of abandoned trial of instrumental delivery, state time decision was made to do caesarean section: ....

What was the period of time between decision to do Caesarean section and the actual time of operation? ....

REMARKS AND POST-PROCEDURAL INSTRUCTIONS

....

Signature

THEATRE NOTES: CAESAREAN SECTION

Indication ....

ROBSON (tick one)

1. Nullipara, singleton cephalic, term, spontaneous labour ☐
2. Nullipara, singleton cephalic, term, induced/CS before labour ☐
3. Multipara, singleton cephalic, term, spontaneous labour ☐
4. Multipara, singleton cephalic, term, induced/CS before labour ☐
5. Previous CS, singleton cephalic, term ☐
6. Nulliparous breech ☐
7 . Multiparous breech ☐
8. Multiple pregnancy ☐
9. Abnormal lie ☐
10. All singleton cephalic, ≤ 36 weeks ☐

Date: .... Time surgery commenced .... Time surgery completed ....

Surgeon .... Assistant ....

Anaesthetist .... Midwife ....

Operative procedure: ....

PRE-OPERATIVE DETAILS

Date of decision: .... Time of decision: .... By whom: ....

Mat. Pulse [ ] BP [ ] Temp [ ] Level of the head [ ] Foleys catheter | Yes | No |

Pre-op drugs: Antacid | Metoclopramide | Prophylactic antibiotics | Thromboprophylaxis

Fetal Heart: Present | Absent | Uncertain — Fetal distress: Yes | No

☐ Counselled for IUD insertion

☐ Information has been given regarding the procedure and informed consent obtained from the person ☐ Companion allowed to be present

OPERATION PROCEDURE AND FINDINGS

Anaesthetic: General | Spinal | Epidural | Other — Maternal position: ____________________

Problems with anaesthetic: ....

Skin Incision: Transverse | Midline | Other — Details: ....

Uterine Incision: Lower segment | Classical | DeLee — Other: ....

Uterine Scar: Intact | Dehisced — Fetal Presentation .... Fetal Position ....

Prolonged Incision-Delivery Time: Yes | No — Reasons: ....

Difficulty with delivery of baby: Yes | No — Describe: ....

Liquor: Increased | Decreased | Clear — Meconium stained: No | Thin | Thick — Bloody | Offensive

Placenta: Fundal | Central | Anterior | Posterior | Praevia — Retroplacental Clot: Yes | No

Other Placental Abnormalities: .... ☐ Delayed cord clamping done | Time? ....

Uterine Abnormalities: ....

Uterine Tears: (give details) ....

Tubal ligation: Yes | No — Type: .... Histology: Yes | No

Closure: ....

Drains: ....

Further description of operation: ....

....

....

☐ IUD inserted Type: ....

Estimated Blood Loss .... ml

Resuscitation of baby: Yes | No — Resuscitated by ....

Details of Neonatal Resuscitation: ....

Baby placed skin to skin ☐

Result of cord blood gas (if indicated):

Advice for next pregnancy: VBAC | Elective repeat CS — Other ....

Post-operative Management: ....

....

.... Signature

FIRST EXAMINATION OF NEONATE (includes examination of stillborn babies)

Baby allowed to be placed skin to skin ☐ Time ___________________________

General	Well	Sick			Comment*
Appearance	Well nourished	Obese	Wasted	Dysmorphic	
Behaviour	Responsive	Lethargic	Irritable	Jittery	
Cry	Normal	Hoarse	High-pitched	Absent	
Colour	Pink	Blue	Plethoric	Pale	
Skin	Intact	Jaundice	Rash / Purpura	Bruising	
Temperature	36-37°C	Hypothermic	Hyperthemic		
Odour	Normal	Offensive			
Head shape	Normal	Asymmetrical	Caput	Haematoma	
Fontanelles	Normal	Bulging	Large		
Sutures	Mobile	Overriding	Widened	Fused	
Face	Symmetrical	Asymmetrical	Abnormal		
Eyes	Normal	Infected	Small / Large	Slanting	
Ears	Normal	Abnormal	Low position		
Nose	Patent	Blocked			
Mouth	Normal	Smooth philtrum	Cleft lip		
Palate	Intact	Cleft soft	Cleft hard		
Tongue	Normal	Lip-tie, tongue tie	Large	Protruding	
Chin	Normal	Small			
Neck	Normal	Swellings	Webbed		
Apex beat	120-160/min	Tachycardia	Bradycardia		
Chest - nipples	Normal	Accessory			
Chest – clavicles	Intact	Swelling	Crepitus		
Chest movement	Symmetrical	Asymmetrical	Shallow		
Chest indrawing	Absent	Costal	Sternal		
Respiratory rate	40 – 60 pm	Fast	Slow		
Breath sounds	Quiet	Grunting	Noisy		
Arms	Normal	Not moving	Fracture L/R		
Palmar creases	Normal	Single			
Fingers	Normal	Polydactyly	Syndactyly		
Abdomen	Normal	Distended			
Umbilicus	Normal	Moist	Flare	Bleeding	
Hips	Normal	Dislocated	Dislocatable		
Legs	Normal	Not moving			
Toes	Normal	Polydactyly	Syndactyly		
Feet position	Normal	Position Deformity	Clubbed		
Back	Normal	Meningocoele	Dimple / Hair tuft	Scoliosis	
Anus	Patent	Imperforate			
Femoral pulses	Present	Absent			
Genitalia: Male	Testes down	Undescended L/R	Hydrocoele	Inguinal hernia	
Genitalia: Female	Normal	Ambiguous			
Muscle tone	Normal	Hypotonic	Hypertonic		
Moro reflex	Present & equal	Asymmetrical	Weak	Absent	
Grasp reflex	Present	Weak	Absent		
Suck reflex	Present	Weak	Absent		
Urine	Passed	Not passed			
Meconium	Passed	Not passed			

Assessment:	
Examined by:	**Date and time:**
Checked by:	**Date and time:**

* **If any birth defects noted, please complete the birth defects notification form.**

ASSESSMENT OF THE NEWBORN

Infant's name: ____________________________ **Birth time:** ____________________________

Hospital number: ___________________________ **Birth date:** ____________________________

Gender: M F	Birth weight: g	HC: cm	Gest age score: weeks	Resuscitation: (circle)			
				None	Oxygen	Mask	Intubation

APGAR Score	0	1	2	1 min	5 min	Details of resuscitation
Appearance	Blue or pale	Body pink, limbs blue	Pink all over			
Pulse	Absent	<100/min	>100/min			
Grimacing (reflex)	No response	Grimace	Vigorous cry			
Activity	Limp	Slight flexion	Active, moves			
Respiration	Absent	Slow or irregular	Good crying			
			TOTAL			

Routine care: Skin to skin ☐ Delayed washing ☐

Mode of delivery: NVD C/S Vac Forceps	Treatment given:		Date done:
Problems with delivery: Placenta: weight g	Eye care:		
	Vitamin K 1mg IMI		

Risk factors to baby:		Examination of baby:	Normal	Abnormal	

Pregnancy:		Care required:	Care received:	Date done:
RPR Positive	No Yes	Examine, Benzathine Pen if mother incompletely treated		
RPR unknown	No Yes	Examine, Benzathine penicillin to baby if no result		
Rhesus negative	No Yes	Check the TSB at 6 hours		
HIV Positive	No Yes	Follow current PMTCT protocol		
HIV Unknown	No Yes	Provide counselling and testing for mother, if positive start mother on ART and manage infant as high risk		
Maternal diabetes	No Yes	Refer to nursery for hourly blood sugars and 24 hours observation		
Labour:				
MSL	No Yes	Assess baby for respiratory distress		
Fetal distress	No Yes	Assess baby for Neonatal Encephalopathy		

Problems during newborn period:	Preventative care:
Birth weight <2500g- observe for 24h in postnatal ward for low blood sugar and ability to suckle	Polio: Hepatitis B
1.	BCG:
2.	RTHC filled in:
3.	Birth PCR date: result:

Feeding: If mother is HIV positive:			**Follow up plans:**		
Mother counselled on infant feeding	No	Yes	Before 3 days:	Date:	Place:
Counsel on duration of NVP and where applicable AZT	No	Yes	At 6 weeks:	Date:	Place:
			For PCR:	Date:	Place:

Feeding on discharge? EBF commenced within one hour Yes No Reasons for failure of EBF:

	Discharge weight:	Discharge date:

Identification:				
At birth:	Date:	Midwife (print)	Mother (Print):	Witness:
Postnatal ward:	Date:	Brought by:	Received by:	Mother:
At discharge:	Date:	Midwife (print)	Mother (Print):	Witness

MATERNAL EARLY WARNING OBSERVATION CHART FOR POSTNATAL WARD CARE

	Date																	Date
	Time																	Time
RESPIRATORY RATE	>30																	>30
	21-30																	21-30
	11-20																	11-20
	0-10																	0-10
SATURATION	95-100%																	95-100%
	<95%																	<95%
TEMPERATURE	39°C																	39°C
	38°C																	38°C
	37°C																	37°C
	36°C																	36°C
	35°C																	35°C
Hb	≥ 8 g/dl																	≥ 8 g/dl
	< 8 g/dl																	< 8 g/dl
MATERNAL HEART RATE	140																	140
	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
	40																	40
SYSTOLIC BLOOD PRESSURE	170																	170
	160																	160
	150																	150
	140																	140
	130																	130
	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
DIASTOLIC BLOOD PRESSURE	120																	120
	110																	110
	100																	100
	90																	90
	80																	80
	70																	70
	60																	60
	50																	50
	40																	40
Urine volume in ml/hour																		Urine volume in ml/hour
Breasts																		Breasts
HEIGHT OF FIUNDUS	24 cm																	24 cm
	22 cm																	22 cm
	20 cm																	20 cm
	18 cm																	18 cm
	16 cm																	16 cm
	14 cm																	14 cm
	12 cm																	12 cm
	10 cm																	10 cm
	8 cm																	8 cm
Perineum																		Perineum
Lochia	Normal																	Normal
	Heavy (H) Fresh (F)																	Heavy (H) Fresh (F)
	Offensive (O)																	Offensive (O)
Neuro response	Alert																	Alert
	Vocal																	Vocal
	Pain																	Pain
	Unresponsive																	Unresponsive
Pain	None-mild																	None-mild
	Severe																	Severe
Looks unwell	No (✓)																	No (✓)
	Yes (✓)																	Yes (✓)
	TOTAL YELLOW SCORE																	TOTAL
	TOTAL RED SCORE																	TOTAL
	DOCTOR CALLED (Y/N)																	
	Signature																	

Newborn Early Warning Observation Chart

Name of baby or place large baby sticker here

Date																		
Time																		

Temperature °C																			
	38																		
	37.5																		
	37																		
	36.5																		
	36																		
	35.5																		
	Value																		

Respiratory Rate																			
	80																		
	70																		
	60																		
	50																		
	40																		
	30																		
	Value																		

Grunting																		

Heart Rate																			
	190																		
	180																		
	170																		
	160																		
	150																		
	140																		
	130																		
	120																		
	110																		
	100																		
	90																		
	80																		
	70																		
	60																		
	Value																		

SaO2																			
	≥95																		
	92-94																		
	<92																		

Neuro																			
	Alert																		
	Irritable																		
	Jittery																		
	Poor feed																		
	Floppy																		
	Seizures																		

Glucose 2.3-2.6																		
Glucose <2.6																		

All observations in green – Continue observations. Routine care.

1 Observation in amber – Inform Sr in charge. Repeat observations in 30 minutes. If glucose 2.3-2.6, give milk feed first. If sats 92-94, try on other hand first.

2 or more observations in amber – Immediately inform Dr for urgent medical review.

1 or more observation in red – Immediately inform Dr for urgent medical review.

I have introduced myself by name to this person ☐

Date and time	Mother	Baby	Name (print) and signature

I have explained management plans to this person and checked that she understands ☐

I have introduced myself by name to this person ☐

Date and time	Mother	Baby	Name (print) and signature

I have explained management plans to this person and checked that she understands ☐

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Date and time	Mother	Baby	
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Date and time	Mother	Baby	
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Date and time	Mother	Baby	
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I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
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Date and time	Mother	Baby	Name (print) and signature

I have explained management plans to this person and checked that she understands ☐

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Date and time	Mother	Baby	Name (print) and signature

I have explained management plans to this person and checked that she understands ☐

PRE-DISCHARGE CHECKLIST

Assess mother for problems	No	Yes	Recommended action
The mother has a **danger sign**: o heavy bleeding o severe abdominal pain o unexplained pain in chest or legs o visual disturbance or severe headache o breathing difficulty o fever, chills o vomiting	☐	☐	Assess the cause (s) and initiate care or refer. Delay discharge until all danger signs have been resolved for at least 24 hours and there is a follow-up plan in place.
The mother's **bleeding is heavy** or has increased since birth (e.g., bleeding soaks a pad in less than five minutes).	☐	☐	Start IV fluid and keep mother warm Delay discharge. Treat or refer. Evaluate and treat possible causes of bleeding (e.g., uterine atony retained placenta, or vaginal/cervical tear).
The mother has an **abnormal vital sign**: o high blood pressure (SBP > 140 mmHg or DBP >90 mmHg) o temperature > 37.5°C o heart rate > 100 beats per minute o respiratory rate >20 per minute	☐	☐	Give magnesium sulphate to mother if any of: • SBP ≥160 mmHg or DBP≥110 mmHg; and 2+ proteinuria • SBP ≥140 or DBP ≥90 mmHg, and 2+ proteinuria, and any: severe headache, visual disturbance, epigastric pain Give antihypertensive medication to mother if SBP >160 mmHg or DBP >110mmHg Evaluate the cause of abnormal vital sign(s) and treat or refer. Defer discharge until vital signs have been normal for at least 48 hours and no danger signs remain.
The mother is not able to urinate easily	☐	☐	Defer discharge; continue to monitor and evaluate the cause; treat or refer as needed
Mental state: The mother is agitated or very withdrawn **Support person**: The mother has a partner or support person to be with her at home The mother has a **safe home** to return to	☐ ☐ ☐	☐ ☐ ☐	Defer discharge; continue to monitor and evaluate, refer appropriately (social worker, mental health nurse, psychiatrist etc).
Assess baby for problems	**No**	**Yes**	**Recommended action**
The baby has any of these danger signs: o fast breathing (> 60 breaths/ minute) o severe chest in-drawing o fever (temperature ≥ 37.5°C) o hypothermia (temperature < 35.5°C) o yellow palms (hands) or soles (feet) o convulsions o no movement or movement only on stimulation o feeding poorly or not feeding at all	☐	☐	Assess cause of danger signs and initiate care or refer Delay discharge until all danger signs have been resolved for at least 24 hours and there is a follow-up plan in place.
The baby is not breastfeeding at least every two to three hours (day and night).	☐	☐	Establish good breastfeeding practices and delay discharge.
The baby has not passed urine and/or stool	☐	☐	Delay discharge and monitor; refer as needed

Obstetric Discharge Summary (complete in duplicate). This copy accompanies the person.

Date and time delivered:

☐ Alive ☐ Stillbirth ☐ Perinatal death

Age: G P

Name…………………………………………………………………………………………………
Clinic/hospital number……………………………………………………………………………
Date of birth………………………………………………………………………………………
Use patient label if available

Type of delivery
☐ **Normal vaginal delivery (NVD)**
☐ Caesarean delivery ☐ primary ☐ repeat
☐ Breech delivery
☐ Forceps delivery
☐ Vacuum delivery
☐ Born before arrival (BBA)

HIV
☐ **Negative**
☐ Positive
☐ Declined testing
☐ CD 4: date:
☐ Viral load date:
☐ IPT
☐ Co-trimoxazole
WHO stage: I ☐ II ☐ III ☐ IV ☐
Current ART:

Syphilis status
☐ **Negative**
☐ Positive
Treatment dates:

Rhesus status
☐ **Negative**
☐ Positive
Anti-D given ☐ **Yes** ☐ **No**

Medical or surgical problems during pregnancy or delivery
☐ **None**
☐ Chronic hypertension
☐ Pre-eclampsia
☐ Eclampsia
☐ Diabetes ☐ GDM ☐ Type I ☐ Type II
☐ Other:

Obstetrical problems in pregnancy and delivery
☐ **None**
☐ Antepartum haemorrhage
☐ Postpartum haemorrhage
☐ ROM ☐ preterm ☐ prolonged
☐ Multiple pregnancy
☐ Other:

Intrapartum procedures
☐ **None**
☐ Repair of tears ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
☐ Episiotomy
☐ CD ☐ lower segment transverse
☐ lower segment vertical
☐ Classical

Post-partum procedures
☐ **None**
☐ Tubal ligation
☐ Manual removal of placenta
☐ Cervical tears repaired
☐ Evacuation/curettage
☐ Hysterectomy

Discharge medication
1
2
3
4
5

Family Planning
☐ All methods and options discussed
Method given
☐ Oral contraceptives
☐ Injectable
☐ Intra-uterine device
☐ Implant
☐ Tubal ligation
☐ Vasectomy
Given by:

Additional comments:

ICD 10:

Next Pap smear due on:

☐ Condoms and advice on dual protection provided
☐ Appointment given for sterilisation or follow up at family planning clinic:
Date: Clinic:

Examination on discharge
☐ Pre-discharge checklist completed ☐ looks well ☐ looks ill
Pulse: BP: Temp: HOF:
Hb: Breasts:
Perineum: ☐ intact ☐ clean ☐ septic
Urine output: ☐ good ☐ poor ☐ none

Baby 1 ☐ Male ☐ Female ☐ BCG ☐ Polio ☐ Birth PCR
Weight………………………g Head………………..cm Length ……………………cm

Baby 2 ☐ Male ☐ Female ☐ BCG ☐ Polio ☐ Birth PCR
Weight………………………g Head………………..cm Length ……………………cm

ART provided to baby:

Feeding options ☐ Discussed ☐ Initiated successfully
Method of feeding:
Remarks:

Advice on discharge Next pregnancy: BANC ☐ High Risk Clinic ☐
Future mode of delivery ☐ NVD ☐ VBAC ☐ Elective CS
Next viral load due: Next tetanus dose due:
Postnatal visit: Date: at clinic/hospital:
☐ Notification of birth Immunisations:
☐ Mental health matters discussed ☐ Child Support Grant discussed
☐ Postnatal care and breastfeeding support locations discussed
☐ Self-care discussed ☐ Baby care discussed

Name **Rank** **Signature**

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Obstetric Discharge Summary (complete in duplicate). This copy remains in case record.

Date and time delivered:

☐ Alive ☐ Stillbirth ☐ Perinatal death

Age: G P

Name……………………………………………………………………………………………………
Clinic/hospital number………………………………………………………………………………
Date of birth…………………………………………………………………………………………
Use patient label if available

Type of delivery
☐ **Normal vaginal delivery (NVD)**
☐ Caesarean delivery ☐ primary ☐ repeat
☐ Breech delivery
☐ Forceps delivery
☐ Vacuum delivery
☐ Born before arrival (BBA)

Post-partum procedures
☐ **None**
☐ Tubal ligation
☐ Manual removal of placenta
☐ Cervical tears repaired
☐ Evacuation/curettage
☐ Hysterectomy

Additional comments:

HIV
☐ **Negative**
☐ Positive
☐ Declined testing
☐ CD 4: date:
☐ Viral Load date:
☐ IPT
☐ Co-trimoxazole
WHO stage: I ☐ II ☐ III ☐ IV ☐
Current ART:

Discharge medication
1
2
3
4
5

Family Planning
☐ All methods and options discussed
Method given
☐ Oral contraceptives
☐ Injectable
☐ Intra-uterine device
☐ Implant
☐ Tubal ligation
☐ Vasectomy
Given by:

Syphilis status
☐ **Negative**
☐ Positive
Treatment dates:

ICD 10:

Next Pap Smear due on:

Rhesus status
☐ **Negative**
☐ Positive
Anti-D given ☐ **Yes** ☐ **No**

☐ Condoms and advice on dual protection provided
☐ Appointment given for sterilisation or follow up at family planning clinic:
Date: Clinic:

Medical or Surgical problems during pregnancy or delivery
☐ **None**
☐ Chronic hypertension
☐ Pre-eclampsia
☐ Eclampsia
☐ Diabetes ☐ GDM ☐ Type I ☐ Type II
☐ Other:

Examination on discharge
☐ Pre-discharge checklist completed ☐ looks well ☐ looks ill
Pulse: BP: Temp: HOF:
Hb: Breasts:
Perineum: ☐ intact ☐ clean ☐ septic
Urine output: ☐ good ☐ poor ☐ none

Baby 1 ☐ Male ☐ Female ☐ BCG ☐ Polio ☐ Birth PCR
Weight………………………g Head……………….cm Length …………………….cm

Baby 2 ☐ Male ☐ Female ☐ BCG ☐ Polio ☐ Birth PCR
Weight………………………g Head……………….cm Length …………………….cm

Obstetrical problems in pregnancy and delivery
☐ **None**
☐ Antepartum haemorrhage
☐ Postpartum haemorrhage
☐ ROM ☐ preterm ☐ prolonged
☐ Multiple pregnancy
☐ Other:

ART provided to baby:

Feeding options ☐ Discussed ☐ Initiated successfully
Method of feeding:
Remarks:

Advice on discharge Next pregnancy: BANC ☐ High Risk Clinic ☐
Future mode of delivery ☐ NVD ☐ VBAC ☐ Elective CS
Next viral load due: Next tetanus dose due:
Postnatal visit: Date: at clinic/hospital:
☐ Notification of birth Immunisations:
☐ Mental health matters discussed ☐ Child Support Grant discussed
☐ Postnatal care and breastfeeding support locations discussed
☐ Self-care discussed ☐ Baby care discussed

Intrapartum procedures
☐ **None**

☐ Repair of tears ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
☐ Episiotomy
☐ CD ☐ lower segment transverse
☐ lower segment vertical
☐ Classical

Name **Rank** **Signature**

Maternal and Infant PMTCT Discharge Letter

Complete on carbon copy, this page remain in folder

HPRN: ______________________
Mom Name & Surname: ______________________
Mom Date of Birth: ______________

Dear Colleague

Infant Name & Surname: ______________________________ Gender: ☐ Male ☐ Female

Infant HPRN: ______________________ Infant Date of Birth: ______________________

Has been discharged from: ____________________ (facility name) on ____________________ (date)

Discharging nurse: ______________________ Date: _____/_____/_____

Follow-up Date: _____/____/_____ Follow-up Site: ______________________ Sign: ____________________

Maternal Discharge Status and Postnatal Follow Up

LABORATORY BARCODE

ART

☐ Mother started on ART: ☐ less than 12 weeks prior to delivery
☐ at or after delivery

☐ Mother on ART since before pregnancy or more than 12 weeks prior to delivery

Mother ART regime: ____

Viral Load

☐ VL done at delivery

Viral load: ______________________

Feeding Method at Discharge (tick appropriate option)

☐ Exclusively breastfeeding ☐ Formula feeding ☐ Heat-treated own milk

Contraception at Discharge

☐ IUCD ☐ Implant ☐ Oral contraception ☐ Injectible hormones ☐ Sterilization

Infant Discharge Status and Postnatal Follow Up

HIV Test (Discharge)

☐ PCR test done Date of PCR test: ______________	LABORATORY BARCODE	PCR test result received ☐ Positive ☐ Negative ☐ Awaited ☐ Mother informed of test result

Discharge Post Exposure Prophylaxis (PEP)

Low risk (moms VL at delivery < 1000c/ml)	**High risk** (mom initiated after 28 weeks / has no VL / VL is > 1000c/ml)	
☐ NVP for 6 weeks once daily	☐ NVP once daily for 12 weeks if mom is **breastfeeding** and if needed until mom's VL <1000c/ml or until 1 week after cessation of all breastfeeding ☐ NVP once daily for 6 weeks if **formula fed**	☐ AZT twice daily for 6 weeks irrespective of feeding choice

Postnatal Follow-up and Baby Wellness Visits

		3-6 days	*6 weeks*	*10 weeks*	*6 months*	*18 months*	*Any other test*
Visit Date:		/ /	/ /	/ /	/ /	/ /	/ /
Mother	ART	☐ If using / willing to use r	☐ If using / willing to use reliable contraception TLD (TDF, 3TC and DTG)				
		☐ If not, start TEE (TDF, FTC	☐ If not, start TEE (TDF, FTC, and EFV)				
		☐ Check ART adherence	☐ Check ART adherence	☐ Check ART adherence	☐ Check ART adherence	☐ Check ART adherence	☐ Check ART adherence
	VL	☐ If VL>50c/ml (manage as per VL non-suppression)	☐ If VL>50c/ml (manage as per VL non-suppression)	☐ If VL>50c/ml (manage as per VL non-suppression)	☐ **VL done @ 6mo** (all HIV+ moms) Continue VL every 6 months until cessation of breastfeeding	☐ **VL done @ 18mo** (if mom is still breast-feeding)	☐ **VL done @ 12/24mo** (if mom is still breast-feeding)
		☐ If VL>1000c/ml (manage infant as high risk)	☐ If VL>1000c/ml (manage infant as high risk)	☐ If VL>1000c/ml (manage infant as high risk)			
Infant	HTS	☐ Birth PCR done ☐ Positive ☐ Negative	☐ Check mom's ART adherence and last VL value	☐ 10 weeks PCR test ☐ Positive ☐ Negative	☐ 6 month PCR test ☐ Positive ☐ Negative	☐ Rapid/Elisa Test ☐ Positive ☐ Negative	☐ HIV test ☐ Positive ☐ Negative
	Prophy-laxis	☐ Check adherence and tolerance to NVP (and AZT)	☐ Start CPT ☐ Stop NVP (low risk) ☐ Stop AZT (high risk)	Stop NVP after 12 weeks if mothers VL < 1000c/ml If child tests positive for HIV stop NVP and initiate ART and do confirmatory PCR			
	Feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula fed	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula fed

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Maternal and Infant PMTCT Discharge Letter

Complete on carbon copy, this page should be torn out at discharge and sent back to the clinic for postnatal and baby follow up visits.

HPRN: ____________________
Mom Name & Surname: ____________________
Mom Date of Birth: ________________

Dear Colleague

Infant Name & Surname: ________________________________ Gender: ☐ Male ☐ Female

Infant HPRN: ____________________________ Infant Date of Birth: ____________________________

Has been discharged from: ______________________ (facility name) on ______________________ (date)

Discharging nurse: __________________________ Date: _____/_____/_____

Follow-up Date: _____/____/_____ Follow-up Site: ________________________ Sign: ____________________

Maternal Discharge Status and Postnatal Follow Up

LABORATORY BARCODE

ART

☐ Mother started on ART: ☐ less than 12 weeks prior to delivery
☐ at or after delivery

☐ Mother on ART since before pregnancy or more than 12 weeks prior to delivery

Mother ART regime: ____

Viral Load

☐ VL done at delivery

Viral load: ____________________________

Feeding Method at Discharge (tick appropriate option)

☐ Exclusively breastfeeding ☐ Formula feeding ☐ Heat-treated own milk

Contraception at Discharge

☐ IUCD ☐ Implant ☐ Oral contraception ☐ Injectible hormones ☐ Sterilization

Infant Discharge Status and Postnatal Follow Up

HIV Test (Discharge)

☐ PCR test done Date of PCR test: ________________	LABORATORY BARCODE	PCR test result received ☐ Positive ☐ Negative ☐ Awaited ☐ Mother informed of test result

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☐ NVP for 6 weeks once daily	☐ NVP once daily for 12 weeks if mom is **breastfeeding** and if needed until mom's VL <1000c/ml or until 1 week after cessation of all breastfeeding ☐ NVP once daily for 6 weeks if **formula fed**	☐ AZT twice daily for 6 weeks irrespective of feeding choice

Postnatal Follow-up and Baby Wellness Visits

		3-6 days	***6 weeks***	***10 weeks***	***6 months***	***18 months***	***Any other test***
Visit Date:		/ /	/ /	/ /	/ /	/ /	/ /
Mother	ART	☐ If using / willing to use r	☐ If using / willing to use reliable contraception TLD (TDF, 3TC and DTG)				
		☐ If not, start TEE (TDF, FTC	☐ If not, start TEE (TDF, FTC, and EFV)				
		☐ Check ART adherence	☐ Check ART adherence	☐ Check ART adherence	☐ Check ART adherence	☐ Check ART adherence	☐ Check ART adherence
	VL	☐ If VL>50c/ml (manage as per VL non-suppression)	☐ If VL>50c/ml (manage as per VL non-suppression)	☐ If VL>50c/ml (manage as per VL non-suppression)	☐ **VL done @ 6mo** (all HIV+ moms) Continue VL every 6 months until cessation of breastfeeding	☐ **VL done @ 18mo** (if mom is still breast-feeding)	☐ **VL done @ 12/24mo** (if mom is still breast-feeding)
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Infant	HTS	☐ Birth PCR done ☐ Positive ☐ Negative	☐ Check mom's ART adherence and last VL value	☐ 10 weeks PCR test ☐ Positive ☐ Negative	☐ 6 month PCR test ☐ Positive ☐ Negative	☐ Rapid/Elisa Test ☐ Positive ☐ Negative	☐ HIV test ☐ Positive ☐ Negative
	Prophy-laxis	☐ Check adherence and tolerance to NVP (and AZT)	☐ Start CPT ☐ Stop NVP (low risk) ☐ Stop AZT (high risk)	Stop NVP after 12 weeks if mothers VL < 1000c/ml If child tests positive for HIV stop NVP and initiate ART and do confirmatory PCR			
	Feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula feeding	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula fed	☐ Breastfeeding ☐ Stopped breastfeeding ☐ Formula fed

health
Department: Health
REPUBLIC OF SOUTH AFRICA

Case ID ____________________

DEPARTMENT OF HEALTH
CONGENITAL DISORDERS (CD) NOTIFICATION
Please mark applicable areas with an X

GENERAL INFORMATION

Province:	District:	Name of Hospital/Facility:	Name of person notifying:	Date:
		Facility Contact No.:	Signature:	y y y y / m m / d d

PARTICULARS OF MOTHER

Surname:	Name:	Date of birth:	Age of mother:
		y y y y / m m / d d	

Maternal Conditions:

Pre-existing diabetes	Gestational diabetes	Epilepsy	Syphilis	TB	Cardiac Conditions	Hypertension	HIV

Maternal medication (cover the counter):

Gravida & Parity:

PARTICULARS OF PATIENT

Surname:	Name:	Date of birth:	Gender:		
		y y y y / m m / d d	Male	Female	Unspecified

Population group:

African	White	Indian	Coloured	Other	Specify:

Pregnancy outcome:			Diagnosed prenatally:						
Live Birth	Still Birth	Termination of Pregnancy	Yes	No	If Yes:	Ultrasound	Chorionic Villus Sampling	Amniocentesis	Cordocentesis

Birth weight:					Gestational age:		BANC 1st visit (weeks):	BANC total visits (number):
<1000g	1000-1499g	1500-1999g	2000-2499g>	≥2500g	<37 weeks	≥37 weeks		

INVESTIGATIONS REQUESTED

Chromosome/cytogenetic	Biochemical/metabolic	DNA/molecular	No investigation necessary	Other diagnostic or screening procedure

Specify:

COUNSELLING GIVEN (BY)

Clinical geneticist	Medical Doctor	Registered Nurse	Genetic counselor	No counseling given	Genetic Training received:	Yes	No

PATIENT STATUS/OUTCOME

Alive:	Inpatient	Outpatient	Discharged	*Unit/Clinic/Ward name*	Dead:	Date of death if deceased:	y y y y / m m / d d

Referral:

Referred to another Hospital?	Yes	No	Referred from Hospital?	Yes	No	If yes, name of that Hospital:	

DIAGNOSIS

Skull	Face	Chest	Heart	Abdomen	Gastrointestinal Tract	Genitals	Arms	Legs	Hands	Feet	Skin

Description:

Diagnosis: **ICD 10 code:**

Diagnosed by (If different than person notifying):	Doctor	Registered Nurse	Genetic Training received:	Yes	No

Name: **Contact No.:**

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Remove this page and give to patient as information leaflet on discharge after delivery

Some information about Family Planning after your baby is born

Why is it important?

Most couples start having sex again before six weeks after the baby is born. Pregnancy can occur by six weeks (before your periods start again) if you do not exclusively breastfeed; so it is important to make sure that you start using a method before your baby is four weeks old.

Best practice is for the chosen method of family planning to be started before you leave the place where your baby is born.

The most effective methods

Intrauterine contraception (IUD)

- Copper IUDs prevent pregnancy for up to 10 years
- Failure rates are less than one per 1000 women.
- IUDs can be inserted immediately after the afterbirth (placenta) has been delivered.
- IUD use does not interfere with breastfeeding.

Contraceptive implants

- Implants are effective for three years
- Failure rates are around one per 1000 women.
- Implants are not recommended for HIV positive patients on medication (ask your doctor).
- Implants can be inserted immediately after delivery of the baby and before you go home.
- Postpartum implant use does not interfere with breastfeeding.

Permanent contraception

Female sterilisation:

- Failure rates are around two per 1000 women but the method is considered permanent.
- Female sterilisation can be performed within the first week after delivery or at any time after your baby is six weeks old.
- It may be convenient to perform female sterilisation at the time of Caesarean section.

Male sterilisation (vasectomy):

- Failure rates are around one per 1000 men but the method is considered permanent.

Effective methods

Contraceptive injections (failure rate three per 100 women):

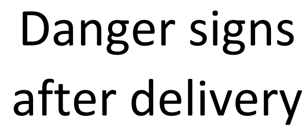
- Repeat injections must be given four or more times each year.
- Contraceptive injections can be started immediately after delivery and do not interfere with breastfeeding.

Hormonal contraceptive pills (failure rate nine per 100 women):

- Progestogen-only (POP, mini) pills:
  - Must be taken at the same time every day without a break.
  - They can be started immediately after delivery and do not interfere with breastfeeding.
- Combined oral contraceptive (COC) pills:
  - They can only be started six weeks after your baby is born
  - They should not be used by breastfeeding women until the baby is six months old

Less effective methods

Male or female condoms. These are not so effective in preventing pregnancy, but they must always be used with your other method to prevent HIV and other sexually transmitted infections.



I have severe headaches.
I have blurry vision.
PRE-ECLAMPSIA

I cry all the time. I have thoughts of hurting myself or my baby.
POST-PARTUM DEPRESSION

I am short of breath.
I breathe very fast.
PULMONARY EDEMA

I have a fever or chills.
My stomach hurts
I have a foul smelling vaginal discharge.
POST-PARTUM SEPSIS

My baby is unusually cold
HYPOTHERMIA

My incision is not healing.
WOUND INFECTION

I have severe pain and swelling in my calf. My calf is red.
DEEP VEIN THROMBOSIS

I have vaginal bleeding that is soaking my pads.
POST-PARTUM HAEMORRHAGE