

BANC Plus Clinic checklist – classifying (first) visit

Name of patient _____	Clinic record number							
Address _____								
INSTRUCTIONS: Answer all the following questions by placing a cross mark in the corresponding box								
Obstetric History	No	Yes						
1. Previous stillbirth or neonatal loss?	<input type="checkbox"/>	<input type="checkbox"/>						
2. History of 3 or more consecutive spontaneous abortions?	<input type="checkbox"/>	<input type="checkbox"/>						
3. Birth weight of last baby < 2500g?	<input type="checkbox"/>	<input type="checkbox"/>						
4. Birth weight of last baby >4500g?	<input type="checkbox"/>	<input type="checkbox"/>						
5. Last pregnancy: hospital admission for hypertension or pre-eclampsia/eclampsia?	<input type="checkbox"/>	<input type="checkbox"/>						
6. Previous surgery on reproductive tract (e.g. Caesarean section, myomectomy, cone biopsy, cervical cerclage)	<input type="checkbox"/>	<input type="checkbox"/>						
Current pregnancy								
7. Diagnosed or suspected multiple pregnancy	<input type="checkbox"/>	<input type="checkbox"/>						
8. Age < 16 years	<input type="checkbox"/>	<input type="checkbox"/>						
9. Age > 37 years	<input type="checkbox"/>	<input type="checkbox"/>						
10. Isoimmunisation [Rh (-) WITH ANTIBODIES] in current or previous pregnancy	<input type="checkbox"/>	<input type="checkbox"/>						
11. Vaginal bleeding	<input type="checkbox"/>	<input type="checkbox"/>						
12. Pelvic mass	<input type="checkbox"/>	<input type="checkbox"/>						
13. Systolic BP ≥140mmHg and/or diastolic BP ≥90 mmHg at booking, or known chronic hypertension	<input type="checkbox"/>	<input type="checkbox"/>						
General medical								
14. Diabetes mellitus on insulin or oral hypoglycaemic treatment	<input type="checkbox"/>	<input type="checkbox"/>						
15. Cardiac disease	<input type="checkbox"/>	<input type="checkbox"/>						
16. Renal disease	<input type="checkbox"/>	<input type="checkbox"/>						
17. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>						
18. Asthmatic on medication	<input type="checkbox"/>	<input type="checkbox"/>						
19. Tuberculosis (currently on treatment)	<input type="checkbox"/>	<input type="checkbox"/>						
20. Known 'substance' abuse (including heavy alcohol drinking)	<input type="checkbox"/>	<input type="checkbox"/>						
21. Any other severe medical disease or condition	<input type="checkbox"/>	<input type="checkbox"/>						
22. Mental health screen positive	<input type="checkbox"/>	<input type="checkbox"/>						
23. Any severe mental health condition: bipolar affective disorder, schizophrenia, severe depression	<input type="checkbox"/>	<input type="checkbox"/>						
Please specify _____								
A yes to any ONE of the above questions (i.e. ONE shaded box marked with a cross) means that the woman is not eligible for the basic component of antenatal care and needs appropriate referral.								
Is the woman eligible (circle)								
				No				Yes
If NO, she is referred to _____								
Date _____	Name _____				Signature _____			
(Staff responsible for antenatal care)								