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 | Language

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

Health Care Provider / 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...............................

Updated 27 August 2025

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

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

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

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

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:
- 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______________________

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

Back page 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
- 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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Haemorrhage
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Fetal well being
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CTG : Not done / normal/ suspicious/ pathological

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Risks identified on antenatal card ____

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☐ **Treatment given/ in progress**

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☐ 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______________________

This copy remains in case record and accompanies the patient.

Vertical Transmission Prevention of Communicable Infections

Patient name and folder number____

Use carbon paper to complete; this page remains in the Maternity Case Record

HIV Testing (at booking and every four weeks- align with BANC+ visits)

HIV test at **1st ANC visit**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **20 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **26 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **30 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **34 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **38 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested during **delivery admission**	Date: ________/_________/______	Positive ☐	Negative ☐

PreP offered Yes ☐ Accepted Yes ☐ No ☐ Date initiated: ________/_________/______

Woman living with HIV

ARV regimen TLD1 ☐ TLD2 ☐ Other: Date started ________/_________/______

Viral load at first visit- if already on ARVs *(C#Antenatal)*	Date _______/________/_______	Result_____________________c/mL
VL at 3 months after ARV start - if new HIV diagnosis *(C#Antenatal)*	Date _______/________/_______	Result_____________________c/mL
Repeat VL - if any VL> 50c/mL *(C#Antenatal)*	Date _______/________/_______	Result_____________________c/mL
VL at delivery - all women LHIV *(C#Delivery)*	Date _______/________/_______	Result_____________________c/mL

CD4 Date: ________/_________/______ CD4 result____________Cells/ul CrAg:______________________

Tuberculosis: screen for TB symptoms at every antenatal visit, regardless of HIV status

1st visit ☐Pos ☐Neg	**20 weeks** ☐Pos ☐Neg	**26 weeks** ☐Pos ☐Neg	**30 weeks** ☐Pos ☐Neg
34 weeks ☐Pos ☐Neg	**36 weeks** ☐Pos ☐Neg	**38 weeks** ☐Pos ☐Neg	**40 weeks** ☐Pos ☐Neg
Labour ☐Pos ☐Neg	**TB NAAT test** ☐Pos ☐Neg Date		**Urine LAM** ☐Pos ☐Neg Date

Treatment DS-TB ☐ Date started___________ DR-TB ☐ Date started____________ TPT offered ☐ TPT deferred ☐

Syphilis (test at booking and every four weeks- align with BANC+ visits)

Syphilis test at **1st ANC visit**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **20 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **26 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **30 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **34 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **38 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested during **delivery admission**	Date: ________/_________/______	Positive ☐	Negative ☐
Laboratory syphilis confirmation:	Date: ________/_________/______	Positive ☐	Negative ☐

Syphilis titre: ____

1st dose Bicillin IMI administered on	Date: ________/_________/______	Allergic to penicillin- refered for desensitisation
2nd dose Bicillin IMI administered on	Date: ________/_________/______	to ________________________________hospital
3rd dose Bicillin IMI administered on	Date: ________/_________/______	
Repeat laboratory syphilis test three months after treatment	Date: ________/_________/______	Titre______________________________

Hepatitis B (HBsAg)

HepBsAg at first ANC visit Date: ________/_________/______ Positive ☐ Negative ☐

HBsAg positive and not on ARVs or PreP: Counselled on Tenofovir prophylaxis for VTC and referred to specialist for initiation ☐

HBsAg positive and on ARVs Refer to a High Risk clinic and inform them of HBsAg status ☐

Vaccines

Influenza counselling:	Yes ☐	Accepted Yes ☐	No ☐	Date given: ________/_________/______
Tdap (26-34 weeks) counselling :	Yes ☐	Accepted Yes ☐	No ☐	Date given: ________/_________/______
RSVpreF (26-34 weeks) counselling	Yes ☐	Accepted Yes ☐	No ☐	Date given: ________/_________/______

Back page of VTP

Vertical Transmission Prevention of Communicable Infections

Patient name and folder number____

Use carbon paper to complete; this page can be torn out after delivery and attached to the discharge summary

HIV Testing (at booking and every four weeks- align with BANC+ visits)			
HIV test at **1st ANC visit**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **20 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **26 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **30 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **34 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **38 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested during **delivery admission**	Date: ________/_________/______	Positive ☐	Negative ☐
PreP offered Yes ☐	Accepted Yes ☐ No ☐	Date initiated: ________/_________/______	

Woman living with HIV		
ARV regimen TLD1 ☐ TLD2 ☐ Other:		Date started ________/_________/______
Viral load at first visit- if already on ARVs *(C#Antenatal)*	Date _______/________/_______	Result_____________________c/mL
VL at 3 months after ARV start - if new HIV diagnosis *(C#Antenatal)*	Date _______/________/_______	Result_____________________c/mL
Repeat VL - if any VL> 50c/mL *(C#Antenatal)*	Date _______/________/_______	Result_____________________c/mL
VL at delivery - all women LHIV *(C#Delivery)*	Date _______/________/_______	Result_____________________c/mL
CD4 Date: ________/_________/______	CD4 result____________Cells/ul	CrAg:______________________

Tuberculosis: screen for TB symptoms at every antenatal visit, regardless of HIV status											
1st visit	☐Pos	☐Neg	**20 weeks**	☐Pos	☐Neg	**26 weeks**	☐Pos	☐Neg	**30 weeks**	☐Pos	☐Neg
34 weeks	☐Pos	☐Neg	**36 weeks**	☐Pos	☐Neg	**38 weeks**	☐Pos	☐Neg	**40 weeks**	☐Pos	☐Neg
Labour	☐Pos	☐Neg	**TB NAAT test**	☐Pos	☐Neg	Date			**Urine LAM**	☐Pos	☐Neg Date
Treatment	DS-TB ☐ Date started___________		DR-TB ☐ Date started___________						TPT offered ☐		TPT deferred ☐

Syphilis (test at booking and every four weeks- align with BANC+ visits)			
Syphilis test at **1st ANC visit**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **20 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **26 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **30 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **34 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested at **38 weeks**	Date: ________/_________/______	Positive ☐	Negative ☐
Retested during **delivery admission**	Date: ________/_________/______	Positive ☐	Negative ☐
Laboratory syphilis confirmation:	Date: ________/_________/______	Positive ☐	Negative ☐
Syphilis titre:	____		
1st dose Bicillin IMI administered on	Date: ________/_________/______	Allergic to penicillin- refered for desensitisation	
2nd dose Bicillin IMI administered on	Date: ________/_________/______	to _______________________________hospital	
3rd dose Bicillin IMI administered on	Date: ________/_________/______		
Repeat laboratory syphilis test three months after treatment	Date: ________/_________/______	Titre_____________________________	

Hepatitis B (HBsAg)			
HepBsAg at first ANC visit	Date: ________/_________/______	Positive ☐	Negative ☐
HBsAg positive and not on ARVs or PreP:	Counselled on Tenofovir prophylaxis for VTC and referred to specialist for initiation ☐		
HBsAg positive and on ARVs	Refer to a High Risk clinic and inform them of HBsAg status ☐		

Vaccines				
Influenza counselling:	Yes ☐	Accepted Yes ☐	No ☐	Date given: ________/_________/______
Tdap (26-34 weeks) counselling :	Yes ☐	Accepted Yes ☐	No ☐	Date given: ________/_________/______
RSVpreF (26-34 weeks) counselling	Yes ☐	Accepted Yes ☐	No ☐	Date given: ________/_________/______

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?		
2. History of 3 or more consecutive spontaneous abortions?		
3. Birth weight of last baby < 2500g?		
4. Birth weight of last baby >4500g?		
5. Last pregnancy: hospital admission for hypertension or pre-eclampsia/eclampsia?		
6. Previous surgery on reproductive tract (e.g. Caesarean section, myomectomy, cone biopsy, cervical cerclage)		
Current pregnancy		
7. Diagnosed or suspected multiple pregnancy		
8. Age < 16 years		
9. Age > 37 years		
10. Isoimmunisation [Rh (-) WITH ANTIBODIES] in current or previous pregnancy		
11. Vaginal bleeding		
12. Pelvic mass		
13. Systolic BP ≥140mmHg and/or diastolic BP ≥90 mmHg at booking, or known chronic hypertension		
General medical		
14. Diabetes mellitus on insulin or oral hypoglycaemic treatment		
15. Cardiac disease		
16. Renal disease		
17. Epilepsy		
18. Asthmatic on medication		
19. Tuberculosis (currently on treatment)		
20. Known 'substance' abuse (including heavy alcohol drinking)		
21. Any other severe medical disease or condition		
22. Mental health screen positive		
23. Any severe mental health condition: bipolar affective disorder, schizophrenia, severe depression		

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)

Banc+ Checklist for Subsequent Antenatal Visits

First visit for all women at first contact with clinics, regardless of gestational age. If first visit later than recommended, carry out activities up to that time	VISITS							
	1st	**2nd**	**3rd**	**4th**	**5th**	**6th**	**7th**	**8th**
DATE:								
Approximate gestational age (weeks)	**<14**	**20**	**26**	**30**	**34**	**36**	**38**	**40**
Classifying form indicating eligibility for BANC								
History taken								
Full clinical examination								
Estimated date of delivery calculated								
Blood pressure taken								
Maternal height/weight/MUAC/BMI								
Haemoglobin test								
Rapid syphilis test performed		Retest monthly if syphilis negative						
Urine tested for protein, sugar								
Rapid Rh performed								
Screening for gestational diabetes (if indicated)								
Mental Health Screen		Screen in each trimester						
HIV counselling and testing		Retest monthly if HIV negative						
ART for HIV-infected women	Viral load monitoring as per guidelines							
Tdap given			Give a single dose of Tdap at any one of these visits					
Iron and folate supplementation provided								
Calcium supplementation provided								
Information for emergencies given								
Antenatal record completed and given to woman								
Prepare person for what to bring for labour and delivery (KMC wrap, woollen hat and booties)								
Link and arrange Ward Based Community Outreach Teams home visits								
Asked if fetal movements felt and normal	Do if 1st visit was >20 weeks							
TB symptom screen								
Clinical examination for anaemia								
Urine tested for protein and sugar								
Uterus measured for growth - twins, IUGR	Do if 1st visit was >20 weeks							
Instructions for delivery/transport to institution								
Recommendations for lactation and contraception								
Detection of breech presentation and referral								
Remind woman to bring MCR in labour								
Doctor or senior midwife to review gestational age								
Give hospital visit date at 41 weeks for induction								
Initials staff member responsible								

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."

	Booking visit		Second trimester		Third trimester	
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]	☐ Yes [1]	☐ No [0]	☐ 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]	☐ Yes [1]	☐ No [0]	☐ Yes [1]	☐ No [0]
In the last 2 weeks, have you on some or most days had thoughts **and** plans to harm yourself or commit suicide?*	☐ Yes [1] **Refer**	☐ No [0]	☐ Yes [1] **Refer**	☐ No [0]	☐ Yes [1] **Refer**	☐ No [0]
TOTAL SCORE	☐ 0 or 1 ☐ 2 >>refer ☐ 3 >>> refer		☐ 0 or 1 ☐ 2 >> refer ☐ 3 >>> refer		☐ 0 or 1 ☐ 2 >> refer ☐ 3 >>> refer	
Offered Counselling	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Accepted counselling	☐ Yes	☐ No	☐ Yes	☐ No	☐ 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. THIS IS THE ORIGINAL COPY AND STAYS IN THE MATERNITY CASE RECORD

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

Name________________________________
Folder number_______________________
Date of birth_______________________

Age:__________(yrs) G___P___ M____E____ToP___

PREVIOUS OBSTETRIC AND NEWBORN OUTCOME

*A=Alive; ID=Infant Death, NND=Neonatal Death, IUD=Intra-uterine death, FSB=Fresh Stillbirth MSB=Macerated Stillbirth M=Miscarriage E=ectopic

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____
Use of herbal medicine: Detail___________________
Tobacco | Alcohol | Substances | Use of OTC drugs
Psychosocial risk factors________________________

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

EXAMINATION

BP________/________ mmHg Urine____________________
Pulse _________________bpm
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 other than VTP

Hb at booking______g/dl **FBC** result ________________

Rhesus Pos Neg Antibodies Yes No
Rh Antibody Titer____________ Referred to ______________

Urine MCS: Date________________
Result:____
Treatment:_______________________________________

Screening for diabetes (when indicated): At Booking (date)______
Fasting:________mmol/L 2 Hours ______________mmol/L
Screening for diabetes (when indicated): At 26 weeks (date)______
Fasting:________mmol/L 2 Hours ______________mmol/L

BOOKING VISIT AND ASSESSMENT OF RISK DONE BY
____

GESTATIONAL AGE

LNMP DD/MM/YYYY Certain? Y N
SONAR DD/MM/YYYY
BPD_____________________ HC ___________________
AC______________________ FL ___________________
Placenta________________ AFI __________________
Average gestation________________________________
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 ☐

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.”

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TOTAL SCORE	☐ 0 or 1 ☐ 2 >>refer ☐ 3 >>> refer		☐ 0 or 1 ☐ 2 >> refer ☐ 3 >>> refer		☐ 0 or 1 ☐ 2 >> refer ☐ 3 >>> refer	
Offered Counselling	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Accepted counselling	☐ Yes	☐ No	☐ Yes	☐ No	☐ 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.*

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Name______________________________
Folder number______________________
Date of birth_______________________

Age:__________(yrs) G___P___ M____E____ToP___

PREVIOUS OBSTETRIC AND NEWBORN OUTCOME

*A=Alive; ID=Infant Death, NND=Neonatal Death, IUD=Intra-uterine death, FSB=Fresh Stillbirth MSB=Macerated Stillbirth M=Miscarriage E=ectopic

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______________________________
Use of herbal medicine | Detail______________________
Tobacco | Alcohol | Substances | Use of OTC drugs
Psychosocial risk factors______________________________

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

EXAMINATION

BP________/________ mmHg Urine____________________
Pulse ________________bpm
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 other than VTP

Hb at booking______g/dl **FBC** result ____________________

Rhesus Pos Neg Antibodies Yes No
Rh Antibody Titre____________ Referred to ______________

Urine MCS: Date________________
Result:______________________________
Treatment:______________________________

Screening for diabetes (when indicated): At Booking (date)______
Fasting:________mmol/L 2 Hours _______________mmol/L
Screening for diabetes (when indicated): At 26 weeks (date)______
Fasting:________mmol/L 2 Hours _______________mmol/L

BOOKING VISIT AND ASSESSMENT OF RISK DONE BY
____

GESTATIONAL AGE

LNMP DD/MM/YYYY Certain? Y N
SONAR DD/MM/YYYY
BPD______________________ HC __________________
AC______________________ FL __________________
Placenta__________________ AFI _________________
Average gestation______________________________
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)

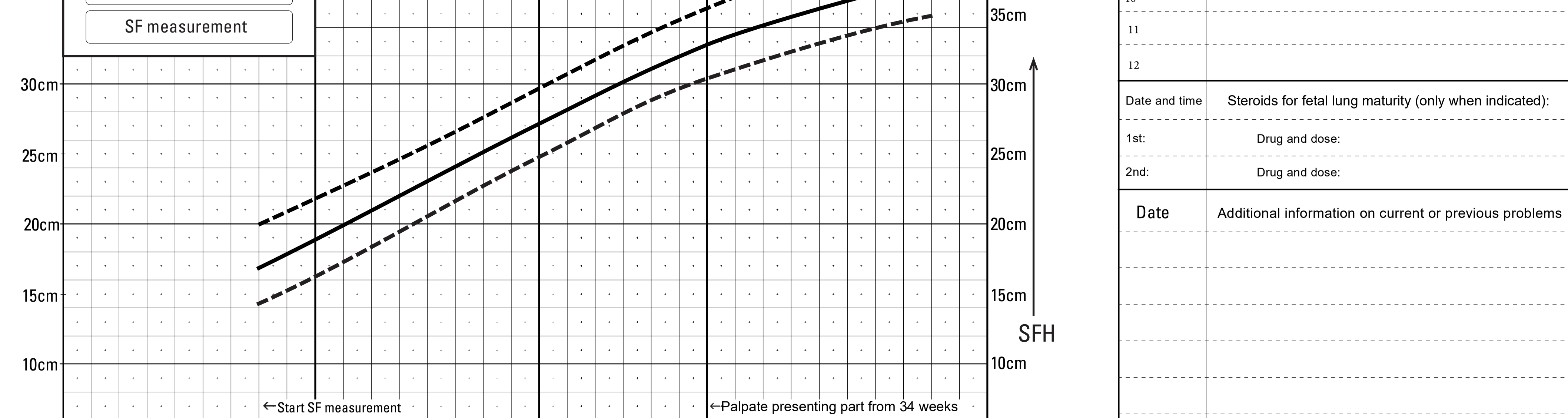
Implant | Inject | Intra-uterine device | Tubal ligation | Oral

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

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



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.

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

Fetal movements	
Haemoglobin (g/dl)	

DOH Antenatal 2025 GSG

Date	PROBLEM LIST
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

Date and time	Steroids for fetal lung maturity (only when indicated):
1st:	Drug and dose:
2nd:	Drug and dose:

Date	Additional information on current or previous problems

NOTES FOR ANTENATAL VISITS continued

Essential additional facts only (Do not duplicate data from p12 or p13)		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 from p12 or p13)		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 52

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

Date	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):**	

EDD according to LNM______________________ **EDD according to ultrasound**____________________________

Date	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:**	

EDD according to LNM______________________ **EDD according to ultrasound**____________________________

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

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

Discharge checklist				Plan (if not discharged):
	Reassuring maternal condition?	Yes	No	
	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

Parameter	Range																	Parameter
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 results (if neg retest during labour): Pos Neg
HIV results: Pos | Neg If HIV neg, retest during labour: Pos | Neg HBsAg: Pos Neg Treatment________
ART: Yes | No Regimen: .... TB: Pos Neg Treatment________
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 latest mental health screen ☐		

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		DORM since ROM	hrs
I have introduced myself by name to this person: ☐					DOL since labour started	hrs
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 IOL
Age:	Risk Factors:			Time of ROM:
Pelvis				Duration of labour (on arrival)

Date:

LATENT PHASE (Each block represents two hours) | ACTIVE PHASE (Each block represents one hour

Time

Duration in hours

FETAL CONDITION

- Fetal heart rate (bpm)
- Decelerations (Yes/No) — Y N (×12 latent) | Y N (×20 active)
- 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 X

I Cervical length I

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, C = clear, B = blood stained, M = meconium stained

* Presenting part: Breech = Br, Vertex = Vx, Face = F, 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 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 ☐
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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)
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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 condition during labour: 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 | Other, including non-pharmacological

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

Was cord clamping delayed for at least one minute? Yes ☐ If not done, explain____________________

Was cord blood gas taken? If yes, results:____________________

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 ☐ Total blood loss__________ml. Management of PPH:__________

Feeding initiated Yes | No Skin-to-skin care initiated: Yes | No If no, give reasons: ....

Workload/staffing 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 VAGINAL BIRTH

These observations must be commenced immediately after vaginal birth, and be done every 15 minutes for one hour, or longer if there is ongoing bleeding or any other complications.
(For Caesarean delivery, observations are made in the recovery room)

Date	Time	BP	Pulse	Respiratory rate	Uterine Tone	Vaginal blood loss observed *heavy flow or large blood clots or trickle or normal*	Cumulative vaginal blood loss measured in drape or tray (mL) (drape or tray remains in place)	Oxytocin infusion rate (if given)	Signature

THE WHO FIRST RESPONSE PPH BUNDLE MUST BE TRIGGERED WHEN:

EITHER

A. Blood loss ≥ 500 mL observed in drape or tray regardless of other observations or vital signs ☐

OR

B. Clinical judgement – heavy vaginal blood loss, large blood clots, constant trickle, OR other clinical signs of excessive blood loss ☐

Was PPH diagnosed NO ☐ | YES ☐ .

If yes, **HOW:** Tick A or B or Both in above box **What Time:**____________________

What treatment was given as part of first response?

✓ONLY tick actions which occurred during first response to PPH

Massage ☐ | Oxytocin ☐ | TXA ☐ | IV Fluids** ☐ | Examination (genital tract) ☐

Misoprostol ☐ | Syntometrine ☐ | Ergometrine ☐ | Second dose TXA ☐

Was treatment Escalated due to refractory PPH ☐

Name: **Date:** **Sign:**

***** Tick 'IV fluids' if at least a total of 200 mL volume of IV fluids have been given as part of an oxytocin and/or TXA infusion OR given alone***

	Compensated shock	Mild shock	Moderate shock	Severe shock
Blood loss	500-1000ml (10-15%)	1000-1500 ml (15-25%)	1500-2000ml (25-35%)	2000-3000ml (35-45%)
Systolic Blood pressure	Normal	Orthostatic changes in blood pressure	Marked fall (70-80)	Severe fall (50-70)
Pulse	< 100/min	< 120/min	> 120/min	>140/min
Respiratory rate	Normal	Mild increase	Moderate increase > 30/min	Marked increased > 40/min
Mental status	Normal or Agitated	Agitated	Confused Capillary refill >4 seconds	Depressed level of consciousness Cold & clammy

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 | Specify:____________________

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: .... Was cord clamping done for 1 min? Yes No____________________

Uterine Abnormalities: .... Cord around the neck? Yes No

Uterine Tears: (give details) ....

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

Further description of operation:

....

....

....

....

Continue on next page if needed

☐ IUD inserted Type: Closure:

Estimated Blood Loss .... ml

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

Details of Neonatal Resuscitation: ....

Baby placed skin to skin ☐

Was cord blood gas taken? Yes No Results:

Advice for next pregnancy: | VBAC not contra-indicated | Elective repeat CS | Other ....

Post-operative Management: ....

....

.... Signature

Date and Time	ADDITIONAL THEATRE NOTES	Name (print) and signature

Date and Time	ADDITIONAL DELIVERY NOTES	Name (print) and signature

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:	Eye care:		
Placenta: weight g	Vitamin K 1mg IMI		

Risk factors to baby:	Examination of baby:	Normal	Abnormal	

Pregnancy:		**Care required:**	**Care received:**	**Date done:**
Syphilis Positive	No Yes	Examine and treat according to protocol		
Rhesus negative	No Yes	Check Rh status of baby and antibody titre of mother		
HBsAgPositive	No Yes	Follow HB protocol (birth vaccine)		
HIV Positive	No Yes	Examine and treat according to VTP protocol		
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	Was cord gas done?		

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 6 days:	Date:	Place:
Counsel on duration of NVP and where applicable AZT	No Yes	At 6 weeks:	Date:	Place:
		Birth PCR:	Date:	Place:

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

Viral load at delivery done? No Yes Not indicated	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

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.**

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 FUNDUS (measure daily)	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 ☐

I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

PUERPERIUM NOTES

I have introduced myself by name to this person ☐			**Name (print) and signature**
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

I have introduced myself by name to this person ☐			**Name (print) and signature**
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands ☐			

I have introduced myself by name to this person ☐			Name (print) and signature
Date and time	Mother	Baby	
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 o Haemoglobin <8g/dl o A red, swollen limb suggestive of DVT	☐	☐	Give rapid acting anti-hypertensive medication to mother if SBP >160 mmHg and/or DBP >110mmHg and call a doctor Evaluate the cause of abnormal vital sign(s) or symptoms 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 is handed to the patient.

Date and time delivered:

Date and time discharged:

☐ Alive Z37.0 ☐ Stillbirth Z37.1 ☐ Perinatal death

Age_____ G____P____M____E____

Name……………………………………………………………………………………………

Clinic/Hospital number………………………………………………………………………

Date of Birth……………………………………………………………………………………

Use patient label if available

Type of delivery

☐ **Normal Vaginal Delivery (NVD)** O80.0

☐Caesarean O82.0 (Elect) O82.1 (Emerg)

☐ Breech Delivery O80.1

☐ Forceps Delivery 081.3

☐ Vacuum Delivery 081.4

☐ Born Before arrival (BBA) Z38.1

HIV

☐ **Negative**

☐ Positive O98.7

☐ Declined testing

☐ CD 4: date:

☐ Delivery Viral Load *C#Delivery*

☐ TPT

☐ Co-trimoxazole

WHO stage:

Current ART:

Syphilis status

☐ **Negative**

☐ Positive O98.1

Treatment dates:

Rhesus status

☐ **Positive**

☐ Negative Z29.13

Anti-D given ☐ **Yes** ☐ **No**

Medical or Surgical problems during pregnancy or delivery

☐ **None**

☐ Chronic hypertension O10.9

☐ Pre-eclampsia O14.9

☐ Eclampsia O15.9

☐ Diabetes GDM O24.4 Type I O24.0 Type II O24.1

☐ TB Treatment A15

☐ Other:

Obstetrical problems in pregnancy and delivery

☐ **None**

☐ Antepartum haemorrhage O46.9

☐ Postpartum haemorrhage O72.2

☐ PPROM O42.9

☐ Prolonged ROM O75.6

☐ Multiple pregnancy O30.9

☐ Other:

Intrapartum procedures

☐ **None**

☐ Repair of tears ☐ 1st ☐ 2nd ☐3rd

☐ Episiotomy 73.6

☐ CS ☐ Lower seg. transverse 74.1

☐ Classical 74.0

☐ Lower segment vertical

Post-partum procedures

☐ **None**

☐ Tubal ligation 66.39

☐ Manual rem. of placenta 75.4

☐ Cervical tears repaired 75.51

☐ Evacuation/curettage 69.02

☐ Hysterectomy

total 68.4 subtotal 68.3

Discharge medication

1
2
3
4
5

Family Planning

☐ All options discussed Z30.0

Method given

☐ Oral contraceptives Z30.011

☐ Injectable Z30.013

☐ Intra-uterine device Z30.1

☐ Implant Z30.017

☐ Tubal ligation Z30.2

☐ Vasectomy Z30.2

Given by_________________

☐ Condoms and advice on dual protection provided

Summary of complications, follow-up and advice for next pregnancy:

ICD 10 codes (all):

Postnatal viral load (6 months) date: *C#Postnatal*

Next pregnancy: ☐ BANC ☐ High Risk Clinic

Future mode of delivery: ☐ NVD ☐ VBAC ☐ Elective CS

☐ Appointment given for sterilisation or follow up at family planning clinic:

Date: Clinic:

Next Pap Smear due on:

Examination on discharge

☐ Pre-discharge checklist completed ☐ looks well ☐ looks ill

Pulse_______bpm BP____/_____mmHg Temp_______°C HOF__________cm

Hb_________g/dl 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 prophylaxis provided to baby:

Hepatitis B vaccine given to baby (only when indicated):

Feeding options ☐ Discussed ☐ Initiated successfully

Method of feeding:

Remarks:

Postnatal visit: Date_________________ ☐ Notification of birth

Clinic_______________________________

☐ Mental health matters discussed ☐ Child Support Grant discussed

☐ Postnatal care and breastfeeding support locations discussed

☐ Self-care discussed ☐ Baby care discussed

Name **Rank** **Signature**

Blank page (back of discharge summary)

Obstetric Discharge Summary (complete in duplicate). This copy remains in the folder

Date and time delivered:

Date and time discharged:

☐ Alive Z37.0 ☐ Stillbirth Z37.1 ☐ Perinatal death

Age_____ G____P____M____E____

Name...

Clinic/Hospital number...

Date of Birth..

Use patient label if available

Type of delivery

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☐ Declined testing

☐ CD 4: date:

☐ Delivery Viral Load *C#Delivery*

☐ TPT

☐ Co-trimoxazole

WHO stage:

Current ART:

Syphilis status

☐ **Negative**

☐ Positive O98.1

Treatment dates:

Rhesus status

☐ **Positive**

☐ Negative Z29.13

Anti-D given ☐ **Yes** ☐ **No**

Medical or Surgical problems during pregnancy or delivery

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☐ Diabetes GDM O24.4 Type I O24.0 Type II O24.1

☐ TB Treatment A15

☐ Other:

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☐ **None**

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☐ Implant Z30.017

☐ Tubal ligation Z30.2

☐ Vasectomy Z30.2

Given by_________________

☐ Condoms and advice on dual protection provided

Summary of complications, follow-up and advice for next pregnancy:

ICD 10 codes (all):

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Next pregnancy: ☐ BANC ☐ High Risk Clinic

Future mode of delivery: ☐ NVD ☐ VBAC ☐ Elective CS

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Date: Clinic:

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Pulse_______bpm BP____/_____mmHg Temp_______°C HOF__________cm

Hb_________g/dl 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 prophylaxis provided to baby:

Hepatitis B vaccine given to baby (only when indicated):

Feeding options ☐ Discussed ☐ Initiated successfully

Method of feeding:

Remarks:

Postnatal visit: Date_________________ ☐ Notification of birth

Clinic______________________________

☐ 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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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: y y y y / m m / d d
		Facility Contact No.:	Signature:	

PARTICULARS OF MOTHER

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

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: y y y y / m m / d d	Gender: 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.:**

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 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.
- For long term use (more than two years) discuss with a sister or doctor regarding possible risks involved.

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.

Danger signs after delivery

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