

|                           |                |              |
|---------------------------|----------------|--------------|
| Name of Health Service:   | Surname:       | Urn:         |
| <b>ANTENATAL RECORD</b>   | Given Names:   |              |
| G:..... P:..... EDD:..... | Date Of Birth: | Medicare No: |
|                           | Address:       |              |
|                           | Phone:         |              |

| Date | Weeks | Fundal Height | Weight (kg) | Urine | BP | Oedema | Presen-tation | Posltion | FHR | FM | Next Visit | Sign |
|------|-------|---------------|-------------|-------|----|--------|---------------|----------|-----|----|------------|------|
|      |       |               |             |       |    |        |               |          |     |    |            |      |

Client info - tick if discussed.  
 Smoking  Alcohol  Mood  Diet And Exercise  Social Assesment

|  |  |  |  |  |  |  |  |  |  |  |  |  |
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Smoking  Alcohol  Mood  Diet And Exercise  Social Assessment

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Smoking  Alcohol  Mood  Diet And Exercise  Social Assessment

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Smoking  Alcohol  Mood  Diet And Exercise  Social Assessment

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Smoking  Alcohol  Mood  Diet And Exercise  Social Assessment

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Smoking  Alcohol  Mood  Diet And Exercise  Social Assessment

| OUTCOMES                        | DOB | Gestation | Sex | Weight | Type of Birth | Apgars |
|---------------------------------|-----|-----------|-----|--------|---------------|--------|
|                                 |     |           |     |        |               |        |
| Complications, analgesia, other |     |           |     |        |               |        |
|                                 |     |           |     |        |               |        |
|                                 |     |           |     |        |               |        |
|                                 |     |           |     |        |               |        |

|  |                |          |
|--|----------------|----------|
| <b>NAME OF HEALTH SERVICE FOR ANTENATAL CARE</b> | Surname:       | Urn:     |
|  | Given Names:   |          |
| Hospital for Birth:                              | Date Of Birth: | Address: |
| Hospital Phone:                                  | Phone:         |          |
| Hospital Fax:                                    |                |          |

**PERSONAL DETAILS**

|   |                                  |
|---|----------------------------------|
| Alternate Address Whilst In Town Awaiting Birth | Partners Name:                   |
|   | Support Person:                  |
| Alternate Phone No:                             | Support Persons Contact Details: |
| Ethnicity:                                      |                                  |

Contraception/Date Ceased:

|      |         |     |    |         |     |    |               |
|------|---------|-----|----|---------|-----|----|---------------|
| LMP: | Certain | Yes | No | Regular | Yes | No | Cycle Length: |
|------|---------|-----|----|---------|-----|----|---------------|

|                   |              |
|-------------------|--------------|
| EDD Based on LMP: | Revised EDD: |
|-------------------|--------------|

|          |         |
|----------|---------|
| Gravida: | Parity: |
|----------|---------|

| OBSTETRIC HISTORY | Year: | Gest: | Alive SB & NND: | Sex: | Birth Weight: | Type Of Delivery: | Additional Information: Including Analgesia , Complications, Method of Feeding: |
|-------------------|-------|-------|-----------------|------|---------------|-------------------|---|
|                   |       |       |                 |      |               |                   |   |
|                   |       |       |                 |      |               |                   |   |
|                   |       |       |                 |      |               |                   |   |
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|                   |       |       |                 |      |               |                   |   |
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|                   |       |       |                 |      |               |                   |   |
|                   |       |       |                 |      |               |                   |   |
|                   |       |       |                 |      |               |                   |   |
|                   |       |       |                 |      |               |                   |   |

**ULTRASOUND SCANS:**

|       |         |
|-------|---------|
| Date: | Result: |
| Date: | Result: |
| Date: | Result: |

| HEALTH HISTORY | Yes | No | Details | Operations:             | Details |
|----------------|-----|----|---------|-------------------------|---------|
| Medications    |     |    |         |                         |         |
| Allergies:     |     |    |         |                         |         |
| Respiratory:   |     |    |         | Blood Transfusion:      |         |
| Cardiac/RHD:   |     |    |         | Date Of Last Pap Smear: |         |
| Diabetes:      |     |    |         | Result:                 |         |
| Epilepsy:      |     |    |         | <b>Family History:</b>  |         |
| Kidney:        |     |    |         | Diabetes:               |         |
| Thyroid:       |     |    |         | Heart Disease:          |         |
| Dental:        |     |    |         | Multiple Pregnancy:     |         |
| Other:         |     |    |         | Genetic Disorders:      |         |

**PROBLEM LIST**

**Risk Factors (Date/Gestation Identified):**

|  |
|--|
|  |
|  |
|  |

**Referrals:**

|  |
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|  |
|  |

**Delivery Plan:**

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|--|
|  |
|  |
|  |

| ADDITIONAL RISK FACTORS       | Have you used any of the following during the pregnancy?   |           |   |    |
|-------------------------------|--|-----------|---|----|
|                               |  | Yes       | If so, how much & how often? When ceased? | No |
|                               | Alcohol:   | 1st visit |   |    |
|                               |  | 36/40     |   |    |
|                               | Tobacco:   | 1st visit |   |    |
|                               |  | 36/40     |   |    |
|                               | Marijuana:   | 1st visit |   |    |
|                               |  | 36/40     |   |    |
|                               | Other recreational drugs?                                  |           |   |    |
|                               | History of depression, PND, or other mental health issues? |           |   |    |
| History of Domestic Violence? |  |           |   |    |

| SOCIAL HISTORY | How many people live in your house?                           |
|----------------|---|
|                | Do all your children live with you? If not, who is the carer? |
|                | Do you have a supportive partner / family?                    |
|                | Do you have access to food / fridge?                          |
|                | Was the pregnancy planned? How do you feel?                   |

| INVESTIGATIONS AND RESULTS         |      |         |  |      |         |
|------------------------------------|------|---------|--|------|---------|
| 1st Visit                          | Date | Results | 14 - 17 Weeks                              | Date | Results |
| FBC                                |      |         | Maternal Serum Screen if appropriate       |      |         |
| Blood group and antibodies         |      |         | Book anatomy scan                          |      |         |
| Rubella / Varicella                |      |         | Notes to referral hospital                 |      |         |
| Hep B                              |      |         | <b>28 Weeks</b>                            |      |         |
| Hep C                              |      |         | FBC  |      |         |
| HIV                                |      |         | Syphilis serology                          |      |         |
| Syphilis serology                  |      |         | Blood group and antibodies                 |      |         |
| Random / fasting glucose           |      |         | *Glucose challenge - 50 gms (non-fasting)  |      |         |
| Iron studies                       |      |         | *Glucose tolerance test - 75 gms (fasting) |      |         |
| SOLVS or ECS - PCR for STI screen  |      |         | Offer anti D if Rh neg                     |      |         |
| SOLVS or HVS - MC & S              |      |         | <b>34 Weeks</b>                            |      |         |
| Urine (MSU) - MC & S               |      |         | Offer anti D if Rh neg                     |      |         |
| Urine (FVU) - PCR for STI screen   |      |         | <b>36 Weeks</b>                            |      |         |
| Pap smear if required              |      |         | FBC  |      |         |
| Prescribe folic acid / FGF         |      |         | Blood group and antibodies                 |      |         |
| Dating scan                        |      |         | Syphilis serology                          |      |         |
| Consider early pregnancy screening |      |         | SOLVS or ECS - PCR for STI screen          |      |         |
| Is obstetric referral required?    |      |         | SOLVS - MC&S                               |      |         |
| Consider booking anatomy scan      |      |         | Urine (FVU) - PCR for STI screen           |      |         |
| Added to electronic database       |      |         | Ensure all notes to referral hospital      |      |         |
|                                    |      |         | Arrange PATS if required                   |      |         |

\* See diabetes in pregnancy protocol

|                          |          |                |
|--------------------------|----------|----------------|
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| <b>ANTENATAL RECORD</b>  |          |                |
| G:.....P:..... EDD:..... |          | Given Names:   |
|                          |          | Date Of Birth: |
|                          |          | Medicare No:   |
|                          |          | Address:       |
|                          |          | Phone:         |

| Antenatal Education   | Date Discussed | Date Discussed   |
|---|----------------|--|
| Frequency Of Antenatal Visits                                     |                | Interventions And Monitoring During Labour                 |
| Fetal Growth And Development                                      |                | Complications Of Labour - Instrumental Birth And C/section |
| Antenatal Classes Available - Dates                               |                | Syntocinon And Vitamin K                                   |
| Nutrition   |                | Hep B Vac & BCG  |
| Oral Health   |                | Breastfeeding  |
| Exercise And Back Care  |                | Newborn Screening Test                                     |
| Effects Of Smoking, Alcohol And Drugs                             |                | Postnatal Check At Home                                    |
| Antenatal And Postnatal Depression                                |                | Family Support Available?                                  |
| Ward, Birth Suite Tour  |                | 6 Week PN Check - Why It Is Important To Come              |
| When To Go To Hospital  |                | Contraception  |
| Support Person/s  |                | SIDS Information And Brochure                              |
| What To Take To Hospital  |                | PATS Arrangment  |
| Signs Of Labour / Stage Of Labour                                 |                | Other Information Provided                                 |
| Pain Relief Available, Including Non-pharmacological, Positioning |                |  |

| Date   | Weeks | Fundal Height | Weight (kg) | Urine | BP | Oedema | Presentation | Position | FHR | FM | Next Visit | Sign |
|--|-------|---------------|-------------|-------|----|--------|--------------|----------|-----|----|------------|------|
|  |       |               |             |       |    |        |              |          |     |    |            |      |
| Client Education (tick if discussed and add any comments): Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Mood <input type="checkbox"/> Diet And Exercise <input type="checkbox"/> Social Assessment <input type="checkbox"/> |       |               |             |       |    |        |              |          |     |    |            |      |
|  |       |               |             |       |    |        |              |          |     |    |            |      |
| Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Mood <input type="checkbox"/> Diet And Exercise <input type="checkbox"/> Social Assessment <input type="checkbox"/>  |       |               |             |       |    |        |              |          |     |    |            |      |
|  |       |               |             |       |    |        |              |          |     |    |            |      |
| Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Mood <input type="checkbox"/> Diet And Exercise <input type="checkbox"/> Social Assessment <input type="checkbox"/>  |       |               |             |       |    |        |              |          |     |    |            |      |
|  |       |               |             |       |    |        |              |          |     |    |            |      |
| Smoking <input type="checkbox"/> Alcohol <input type="checkbox"/> Mood <input type="checkbox"/> Diet And Exercise <input type="checkbox"/> Social Assessment <input type="checkbox"/>  |       |               |             |       |    |        |              |          |     |    |            |      |