NHS No. | Maternity Unit

CONFIDENTIAL

These notes should be carried by the expectant mother at all times during her pregnancy. If found, please return the notes immediately to the owner, or her midwife or maternity unit.

NHS

Pregnancy Notes

First name | Surname

Address

Postcode | ☎

Date of birth (D D M M Y Y) | Unit No.

These Pregnancy Notes are a guide to your options during pregnancy. They are intended to help you make informed choices and to assist you to develop and agree a personalised care plan with your healthcare providers. The explanations in these notes are a general guide only, and not everything will be relevant to you. If you are asked to make a choice, feel free to ask any questions. Talk about your options with family/friends, write down anything you want to discuss and take it to your appointment: there are spaces for you to write in the notes.
Key questions are:- What are my options? What are the advantages/disadvantages for each option for me? How do I get support to help me make a decision that is right for me?

EDD (D D M M Y Y)

Communication

Assistance required No☐ Yes☐ Details | Your preferred name

Do you speak English No☐ Yes☐ | What is your first language

Preferred language | Interpreter ☎

Plan of Care

Depending on your circumstances, you and your partner will have the choice between midwifery based care or maternity team based care during your pregnancy. Please discuss your choices/options with your midwife. This will be based on your individual medical and obstetric history.

Date recorded	Planned place of birth	Lead professional	Job title	Reason if changed
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				

Maternity Contacts

Named Midwife ☎

Maternity Unit ☎

Antenatal Clinic ☎ | Delivery Suite ☎

Community Office ☎ | Ambulance ☎

Primary Care Contacts

Centre ☎ | Other(s)

Initial | Surname

GP ☎

Postcode (GP) ☎

Health Visitor/ Family Nurse Practitioner ☎

Next of Kin

Name

Address

☎ | Relation

Emergency Contact

Name

Address

☎ ☎

Your Details

Single ☐ Married / CP ☐ Partner ☐ Separated ☐ Divorced ☐ Widowed ☐

Family name at birth

Country of birth | If not UK, year of entry (Y Y Y Y)

Have you had a full medical exam since coming to the UK? (if no refer to GP) No ☐ Yes ☐

Faith / Religion | Citizenship status

Sensory/physical Disability No ☐ Yes ☐ Details

Partner's Details

First name | Surname

Address if different

Postcode:

Date of birth (D D M M Y Y) ☎

Employed ☐ U/E ☐ Occupation

Citizenship status | If not born in UK, year of entry (Y Y Y Y)

Social Assessment - booking

record plan on page 15

	No	Yes	2nd Assessment No	2nd Assessment Yes	Referred
Has difficulty understanding English	☐	☐	☐	☐	☐
Any difficulties reading / writing English	☐	☐	☐	☐	☐
Needs help understanding Pregnancy Notes	☐	☐	☐	☐	☐
Needs help completing forms	☐	☐	☐	☐	☐

Employment status

Occupation | Age leaving full time education (Y Y)

F/T ☐ P/T ☐ Home ☐ Student ☐ Sick ☐ U/E ☐ Retired ☐ Voluntary ☐

Housing: Owns ☐ Rents ☐ With family/ friends ☐ UKBA ☐ NFA ☐

Care services ☐ Temporary accommodation ☐ Other

How long have you lived at your current address?

How many people live in your household?

Entitled to claim benefits (income support, child tax credits, job seeker etc.)	☐	☐	☐	☐	☐
Do you have support from partner / family / friend	☐	☐	☐	☐	☐
Any household member had/has social services support	☐	☐	☐	☐	☐

Name of social worker(s)/ Other multi-agency professionals

Does your partner have any other children. If yes, who looks after them? ☐ ☐

Tobacco use - booking

record plan on page15

	No	Yes
Are you a smoker?	☐	☐
Have you ever used tobacco?	☐	☐
Was this in the last 12 months?	☐	☐

When did you stop? (D D M M Y Y)

If in pregnancy, how many weeks? (W W KS)

Anyone else at home smoke? ☐ ☐

Do you:	1st No	1st Yes	1st No. per day	2nd No	2nd Yes	2nd No. per day
Smoke cigarettes	☐	☐		☐	☐	
Smoke roll ups	☐	☐		☐	☐	
Use e-cigarettes	☐	☐		☐	☐	
Use NRT	☐	☐		☐	☐	
Chew tobacco	☐	☐		☐	☐	
Smoking cessation referral	☐	☐	Declined ☐	☐	☐	Declined ☐
CO screening?	☐	☐	Result	☐	☐	Result

Drug use - booking

record plan on page 15

	1st No	1st Yes	2nd No	2nd Yes
Have you ever used street drugs, cannabis, or psychoactive substances (legal highs)?	☐	☐		
Have you ever injected drugs?	☐	☐		
Have you ever shared drugs paraphernalia?	☐	☐		
Do you currently use?	☐	☐	☐	☐
Details				
Are you receiving treatment?	☐	☐	☐	☐
Any drug or alcohol concerns in the home?	☐	☐		

Details

Alcohol - booking

record plan on page15

	No	Yes	2nd No	2nd Yes
Do you drink alcohol?	☐	☐	☐	☐

Alcohol units per week: Pre-pregnancy | Currently | 2nd

In the last 12 months. How often have you had a drink containing alcohol?

e.g. daily, weekly

How many units of alcohol do drink on a typical day when you are drinking?

Substance misuse referral — Declined ☐ ☐ | Declined ☐ ☐

Consider using an alcohol screening tool e.g. AUDIT-C

Ethnic Origin (If **mixed**, tick more than one box) - is to describe where your family originates from, as distinct from where you were born.

This information is needed to produce a customised growth chart for your baby (page 18).

Declined ☐ ☐

	You	Baby's father
British European (e.g. England, Wales)	☐	☐
East European (e.g. Poland, Romania)	☐	☐
Irish European (e.g. Northern Ireland, ROI)	☐	☐
North European (e.g. Sweden, Denmark)	☐	☐
South European (e.g. Greece, Spain)	☐	☐
West European (e.g. France, Germany)	☐	☐
North African (e.g. Egypt, Sudan)	☐	☐
East African (e.g. Ethiopia, Kenya)	☐	☐
Central African (e.g. Cameroon, Congo)	☐	☐
Southern African – Black (e.g. Botswana, S. Africa)	☐	☐
South African – Euro (South Africa)	☐	☐
West African (e.g. Gambia, Ghana)	☐	☐
Middle Eastern (e.g. Iraq, Turkey)	☐	☐
Indian (e.g. India, Sri Lanka)	☐	☐
Pakistani (i.e. Pakistan)	☐	☐
Bangladeshi (i.e. Bangladesh)	☐	☐
Chinese (i.e. China)	☐	☐
Other Far East (e.g. Japan, Korea)	☐	☐
South East Asian (e.g. Thailand, Philippines)	☐	☐
Caribbean (e.g. Barbados, Jamaica)	☐	☐
Other		

CP - Civil Partner, F/T- Full Time P/T-Part Time,
GP - General Practitioner
UKBA - United Kingdom Border Agency,
NFA - No Fixed Abode, NRT - Nicotine Replacement Therapy

Complete risk assessment page 14/ management plan page 15

Medical History Complete risk assessment page 14 and management plan page 15.

Do you have / have you had:	No	Yes
Admission to ITU / HDU	☐	☐
Admission to A & E in last 12 months	☐	☐
Anaesthetic problems	☐	☐
Allergies (inc. latex)	☐	☐
Autoimmune disease	☐	☐
Back problems	☐	☐
Blood / Clotting disorder	☐	☐
Blood transfusions	☐	☐
Cancer	☐	☐
Cardiac problems	☐	☐
Cervical smear	☐	☐
Chickenpox/Shingles	☐	☐
Diabetes	☐	☐
Epilepsy / Neurological problems	☐	☐
Exposure to toxic substances	☐	☐
Fertility problems (this pregnancy)	☐	☐
Female circumcision / cutting	☐	☐
Gastro-intestinal problems (eg Crohns)	☐	☐
Genital Infections (e.g. Chlamydia, Herpes)	☐	☐
Gynae history / operations (excl. caesarean)	☐	☐
Haematological (Haemaglobinopathies)	☐	☐
High blood pressure	☐	☐
Incontinence (urinary / faecal)	☐	☐
Infections (e.g. MRSA, GBS)	☐	☐
Inherited disorders	☐	☐
Liver disease inc. hepatitis	☐	☐
Migraine or severe headache	☐	☐
Musculo-skeletal problems	☐	☐
Operations	☐	☐
Pelvic injury	☐	☐
Renal disease	☐	☐
Respiratory diseases	☐	☐
TB exposure	☐	☐
Thrombosis	☐	☐
Thyroid / other endocrine problems	☐	☐
Medication in the last 6 months	☐	☐
Vaginal bleeding in this pregnancy	☐	☐
Other (provide details)	☐	☐
Folic acid tablets	☐	☐
Physical Examination performed	☐	☐

Details

Date D D M M Y Y Result

On epilepsy medication? ☐

Hepatitis B ☐ C ☐

Start date D D M M Y Y

0.4mg ☐
5mg ☐

Dose changed? No ☐ Yes ☐

Details

Family History The term 'family' here means blood relatives only - e.g. your children, your parents, grandparents, brothers and sisters, uncles and aunts and their children (i.e. first cousins). Update management plan (page 15) if indicated.

Has anyone in your family had:	No	Yes
- diabetes Type	☐	☐
- thrombosis (blood clots)	☐	☐
- high blood pressure / eclampsia	☐	☐
- hip problems from birth	☐	☐
Is your partner the baby's father	☐	☐
Is the baby's father a blood relation	☐	☐

First cousin ☐ Second cousin ☐ Other ☐

Age of baby's father

Has anyone had:	in your family No	in your family Yes	in family of baby's father No	in family of baby's father Yes
- a disease that runs in families	☐	☐	☐	☐
- need for genetic counselling	☐	☐	☐	☐
- stillbirths or multiple miscarriages	☐	☐	☐	☐
- a sudden infant death	☐	☐	☐	☐
- learning difficulties	☐	☐	☐	☐
- hearing loss from childhood	☐	☐	☐	☐
- heart problems from birth	☐	☐	☐	☐
- abnormalities present at birth	☐	☐	☐	☐
- MCADD	☐	☐	☐	☐

Details

MCADD - Medium Chain Acyl Dehydrogenase Deficiency

*** Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Previous Pregnancies

Details of previous pregnancies and births are relevant when making decisions about the care you will be offered. Your healthcare team will need to know important facts such as: where you gave birth, a summary of how your pregnancy went and if you developed any complications, the weight of your baby and how you and your baby were after the birth. Some of the main topics are outlined below and further information can be found on page 22 about pregnancy complications and page 28 about labour and types of birth. This information will help you and your healthcare team develop a personalised plan together which will support your choices/preferences. If there is anything else you think may be important, please tell your midwife or obstetrician.

Para. This is a term which describes how many babies you already have. Usually early pregnancy losses are also listed after a 'plus' sign. For example, the shorthand for two previous births and one miscarriage is '2 + 1'.

High blood pressure and/or pre-eclampsia. If you had this condition last time, you are more likely to have it again, although it is usually less severe and starts later in pregnancy. It is more likely to happen again if you have a new partner (page 22).

Intrahepatic Cholestasis in Pregnancy (ICP) (obstetric cholestasis) is a liver condition in pregnancy that causes itching especially at night (page 22). If you were diagnosed with ICP in a previous pregnancy, you are at an increased risk of developing it again.

Gestational Diabetes (GDM) can develop during pregnancy causing blood glucose (sugar) levels to become too high (page 22). You are at increased risk if you developed GDM in a previous pregnancy.

Premature birth. This means any birth before 37 weeks. The earlier the baby is born, the more likely that it will have problems and need special or intensive neonatal care. The chance of premature birth is increased because of smoking, infection, ruptured membranes, bleeding, or growth restriction with your baby. Having had baby prematurely increases the chances of it happening again.

Small babies (fetal growth restriction). If one of your previous babies was growth restricted, there is a chance of it happening again. Arrangements will be made to monitor this baby's growth more closely, offering ultrasound scans and other tests as necessary (page 16).

Big babies (macrosomia). A baby over 4.5 kg is usually considered big - but this also depends on your size and how many weeks pregnant you were when the baby was born. You may be offered a blood test to check for gestational diabetes, which can be linked to having bigger babies.

Baby Weight Conversion Chart

lb	oz	g	lb	oz	g	lb	oz	g	lb	oz	g	lb	oz	g
2	0	907	4	0	1814	6	0	2722	8	0	3629	10	0	4536
2	2	964	4	2	1871	6	2	2778	8	2	3685	10	2	4593
2	4	1021	4	4	1921	6	4	2835	8	4	3742	10	4	4649
2	6	1077	4	6	1984	6	6	2892	8	6	3799	10	6	4706
2	8	1134	4	8	2041	6	8	2948	8	8	3856	10	8	4763
2	10	1191	4	10	2098	6	10	3005	8	10	3912	10	10	4819
2	12	1247	4	12	2155	6	12	3062	8	12	3969	10	12	4876
2	14	1304	4	14	2211	6	14	3118	8	14	4026	10	14	4933
3	0	1361	5	0	2268	7	0	3175	9	0	4082	11	0	4990
3	2	1417	5	2	2325	7	2	3232	9	2	4139	11	2	5046
3	4	1474	5	4	2381	7	4	3289	9	4	4196	11	4	5103
3	6	1531	5	6	2438	7	6	3345	9	6	4252	11	6	5160
3	8	1588	5	8	2495	7	8	3402	9	8	4309	11	8	5216
3	10	1644	5	10	2551	7	10	3459	9	10	4366	11	10	5273
3	12	1701	5	12	2608	7	12	3515	9	12	4423	11	12	5330
3	14	1758	5	14	2665	7	14	3572	9	14	4479	11	14	5216

Congenital anomaly. These are also known as birth defects or deformities. Some congenital anomalies are detected during pregnancy, at birth or others as the baby grows older.

Placenta praevia describes the position of the placenta if it lies low in the womb. If you had this confirmed in the last months of any previous pregnancy, you are at an increased risk of this happening again.

Placenta acreta happens when the placenta embeds itself too deeply in the wall of the womb. This is more common with placenta praevia.

Bleeding after birth. Postpartum haemorrhage (PPH) means a significant loss of blood after birth (usually 500mls or more). Often this happens when the womb does not contract strongly and quickly enough. There is an increased risk of it happening again, so you will be advised to have a review with an obstetrician during pregnancy to discuss options for your place of birth.

Postnatal wellbeing. The postnatal period lasts up to 6 weeks after the birth and it is during this time your body recovers. However, for some women problems can occur e.g. slow perineal or wound healing, concerns with passing urine, wind and/or stools. Some women may also experience mental health problems (page 6).

Group B Streptococcus (GBS). If you've previously had a baby who was diagnosed with a GBS infection after birth, you will be offered intravenous (drip) antibiotics when labour begins. The aim of offering you antibiotics in labour is to reduce the risk of a GBS infection for this baby.

Miscarriages. A miscarriage (sometimes called spontaneous abortion) is when you lose a baby before 24 weeks of pregnancy. If this happens in the first 3 months of pregnancy, it is known as an early miscarriage. This is very common with 10-20% of pregnancies ending this way. Late miscarriages, after 3 months but before 24 weeks are less common, (only 1-2% of pregnancies). When a miscarriage happens 3 or more times in a row, this is called recurrent miscarriage. Sometimes there is a reason found for recurrent or late miscarriage.

What if I've had a termination (abortion) but do not want anyone to know? This information can be kept confidential between yourself, your midwife and obstetrician and can be recorded elsewhere.

Feel free to ask your midwife or doctor – or look at NHS Choices: **www.nhs.uk**

Previous Births

Is current pregnancy with a new partner? **No** ☐ **Yes** ☐ **Para** +

Child's Name & Surname	Boy ☐ Girl ☐	Date of birth (D D M M Y Y)	Age	Birthweight (G m s)	Centile	Gestation (W ks + D)	Condition since	Where now

Place of booking / Place of birth	Antenatal summary	**Complications** ICP ☐ SGA or FGR ☐ GDM ☐ Congenital Anomaly ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐	**Anaesthetic** None ☐ Epidural/Spinal ☐ General ☐	**Delivery** Normal ☐ Assisted ☐ Caesarean ☐	**3rd stage** Normal ☐ Haemorrhage ☐ Retained placenta ☐	**Perineum** Intact ☐ Episiotomy ☐ Tear I° ☐ 2° ☐ 3°/4° ☐

Labour details	Breast ☐ Formula ☐ Mixed ☐	Postnatal summary	PND ☐ PP ☐ Baby GBS Infection ☐

Child's Name & Surname	Boy ☐ Girl ☐	Date of birth (D D M M Y Y)	Age	Birthweight (G m s)	Centile	Gestation (W ks + D)	Condition since	Where now

Place of booking / Place of birth	Antenatal summary	**Complications** ICP ☐ SGA or FGR ☐ GDM ☐ Congenital Anomaly ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐	**Anaesthetic** None ☐ Epidural/Spinal ☐ General ☐	**Delivery** Normal ☐ Assisted ☐ Caesarean ☐	**3rd stage** Normal ☐ Haemorrhage ☐ Retained placenta ☐	**Perineum** Intact ☐ Episiotomy ☐ Tear I° ☐ 2° ☐ 3°/4° ☐

Labour details	Breast ☐ Formula ☐ Mixed ☐	Postnatal summary	PND ☐ PP ☐ Baby GBS Infection ☐

Child's Name & Surname	Boy ☐ Girl ☐	Date of birth (D D M M Y Y)	Age	Birthweight (G m s)	Centile	Gestation (W ks + D)	Condition since	Where now

Place of booking / Place of birth	Antenatal summary	**Complications** ICP ☐ SGA or FGR ☐ GDM ☐ Congenital Anomaly ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐	**Anaesthetic** None ☐ Epidural/Spinal ☐ General ☐	**Delivery** Normal ☐ Assisted ☐ Caesarean ☐	**3rd stage** Normal ☐ Haemorrhage ☐ Retained placenta ☐	**Perineum** Intact ☐ Episiotomy ☐ Tear I° ☐ 2° ☐ 3°/4° ☐

Labour details	Breast ☐ Formula ☐ Mixed ☐	Postnatal summary	PND ☐ PP ☐ Baby GBS Infection ☐

Child's Name & Surname	Boy ☐ Girl ☐	Date of birth (D D M M Y Y)	Age	Birthweight (G m s)	Centile	Gestation (W ks + D)	Condition since	Where now

Place of booking / Place of birth	Antenatal summary	**Complications** ICP ☐ SGA or FGR ☐ GDM ☐ Congenital Anomaly ☐ Placenta praevia ☐ PIH ☐ PET ☐ HELLP ☐ Placenta accreta ☐

Labour onset Spontaneous ☐ Induced ☐ Planned Caesarean ☐	**Anaesthetic** None ☐ Epidural/Spinal ☐ General ☐	**Delivery** Normal ☐ Assisted ☐ Caesarean ☐	**3rd stage** Normal ☐ Haemorrhage ☐ Retained placenta ☐	**Perineum** Intact ☐ Episiotomy ☐ Tear I° ☐ 2° ☐ 3°/4° ☐

Labour details	Breast ☐ Formula ☐ Mixed ☐	Postnatal summary	PND ☐ PP ☐ Baby GBS Infection ☐

Insert additional sheets here, and number them 5.1, 5.2 etc

Early Pregnancy Losses

Year	Gestation	Nature of loss	Comments
Y Y Y Y	W ks		
Y Y Y Y	W ks		
Y Y Y Y	W ks		

SGA - Small for Gestational Age FGR - Fetal Growth Restriction
PIH - Pregnancy Induced Hypertension PET - Pre-eclampsia/eclampsia
HELLP - Haemolysis Elevated Liver Enzymes Low Platelets
GDM - Gestational Diabetes ICP - Intrahepatic Cholestasis in Pregnancy
PND - Postnatal Depression PP - Puerperal Psychosis
GBS - Group B Streptococcus

Complete risk assessment p14/management plan p15

Name

Unit No/
NHS No

Pregnancy and having a baby can be an exciting but also a demanding time. This can result in pre-existing symptoms getting worse. It's not uncommon for women to feel anxious, worried or 'down' at this time. The range of mental health problems women may experience or develop is the same during pregnancy and after birth as at other times in her life, but some illnesses/ treatments may be different. Some women who have a mental health problem stop taking their medication when they find out they are pregnant. This can result in symptoms worsening. **You should not alter your medication without specialist advice from your GP, mental health team or midwife.**

Women with a severe mental illness such as psychosis, schizophrenia, schizoaffective disorder or bipolar disorders are more likely to become unwell again than at other times. Severe mental illness may develop more quickly immediately after childbirth and can be more serious requiring urgent treatment.

At your 1st appointment you will be asked how you are feeling now and if you have or have had any problems with your mental health in the past. You will be asked about your emotional wellbeing at your appointments during pregnancy and after the birth of your baby. These questions are asked to every pregnant woman and new mother. The healthcare team supporting you during pregnancy and after birth may identify that you are at risk of developing a mental health problem. If this happens they will discuss with you options for support and treatment. You may be offered a referral to a mental health team/specialist midwife/obstetrician.

If you are concerned about your thoughts, feelings or behaviour, you should seek help and advice.

Further information can be found about mental health including medication in pregnancy and breastfeeding via:
www.medicinesinpregnancy.org
www.nice.org.uk/guidance/cg192/ifp/chapter/about-this-information

1st Assessment. Have you ever been diagnosed with any of the following:	No	Yes
Psychotic illness, bipolar disorders, schizophrenia, schizoaffective disorder, post-partum psychosis	☐	☐
Depression	☐	☐
Generalised anxiety disorder, OCD, panic disorder, social anxiety, PTSD	☐	☐
Eating disorder e.g. anorexia nervosa, bulimia nervosa or binge eating disorder	☐	☐
Personality disorder	☐	☐
Self-harm	☐	☐
Is there anything in your life (past/present) which might make the pregnancy/childbirth difficult? e.g. tokophobia, trauma, childhood sexual abuse, sexual assault	☐	☐
Help received (current or previous):		
GP/Midwife/Health visitor support	☐	☐
Counselling/cognitive behavioural therapy (CBT)	☐	☐
Specialist perinatal mental health team	☐	☐
Hospital or community based mental health team	☐	☐

Inpatient (hospital name) _____ Date(s) _____

Psychiatrist _____ Psychiatric nurse/care coordinator _____

Medication (list current or previous) drug name, dose and frequency

Partner	No	Yes
Does your partner have any history of mental health illness?	☐	☐
Family History	No	Yes
Has anyone in your family had a severe perinatal mental illness? (first degree relative e.g. mother, sister)	☐	☐

Depression identification questions	1st No	1st Yes	2nd No	2nd Yes
During the past month, have you often been bothered by feeling down, depressed or hopeless?	☐	☐	☐	☐
During the past month, have you often been bothered by having little interest or pleasure in doing things?	☐	☐	☐	☐

If yes to either of these questions, consider offering self-reporting tools e.g. PHQ 9

Anxiety identification questions	No	Yes	No	Yes
During the past 2 weeks, have you been bothered by feeling nervous, anxious or on edge?	☐	☐	☐	☐
During the past 2 weeks, have you been bothered by not being able to stop or control worrying?	☐	☐	☐	☐
Do you find yourself avoiding places or activities and does this cause you problems?	☐	☐	☐	☐

If yes to any of these questions, consider offering self-reporting tool e.g. GAD 7

GAD - General Anxiety Disorder GP - General Practitioner
OCD - Obsessive Compulsive Disorder PHQ - Patient Health Questionnaire
PTSD - Post Traumatic Stress Disorder
*** Signatures must be listed on page 30 for identification**

Name
Unit No/ NHS No

My Pregnancy Planner

During your pregnancy, you will be offered regular appointments with your healthcare team. The location of these appointments will depend on your individual circumstances and preferences. The purpose of these, are to check that you and your baby are well and provide support and information about your pregnancy to help you make informed choices. How often these are varies from woman to woman and the frequency may need to be adjusted if your circumstances change. As a minimum, you should be offered appointments at the following weeks of your pregnancy. You can write the date of these appointments in the space provided. After each of your appointments, it is important you know when your next one is, where it will take place and who it is with.

Date

First Contact

Booking Appointment
LMP D D M M Y Y
Estimated wks gestation W ks + D

Dating scan
Screening tests

16 weeks
Screening results

Anomaly scan at 18 to 20 weeks

25 weeks -
for women having their first baby/or women receiving increased surveillance

28 weeks

Health Visitor
Antenatal visit from 28 weeks

31 weeks -
for women having their first baby/or women receiving increased surveillance

34 weeks

36 weeks

38 weeks

40 weeks -
for women having their first baby/or women receiving increased surveillance

41 weeks

42 weeks

Prenatal Screening and Diagnosis

The first half of pregnancy is a time when various tests are offered to check for potential problems, by blood tests (pages 8-9) and ultrasound scans (pages 10-11). The tests listed here are the ones offered by the NHS. Further information is available in the leaflet, 'Screening tests for you and your baby' from your midwife or via www.gov.uk. ***Do not hesitate to ask what each test means.*** The choice is yours and you should have all the relevant information to help you make up your mind, before the visit when the test(s) are done.

Blood Tests and Investigations

Mid-stream urine - a sample of your urine is tested to look for asymptomatic bacteriuria (a bladder infection with no symptoms). Treating it with antibiotics can reduce the risk of developing a kidney infection.

Anaemia is caused by too little haemoglobin (Hb) in the blood. Hb carries oxygen and nutrients around the body and to the baby. Anaemia can make you feel very tired, faint/feel dizzy, and have a pale complexion. If you have any of these symptoms, speak to your midwife. If you are anaemic, you will be offered iron supplements and advice on your diet.

Blood group & antibodies. It is important to know whether you are rhesus positive (Rh+ve) or negative (Rh-ve), and whether you have any antibodies (foreign blood proteins). If you are Rh-ve, you will be offered further blood tests to check for antibodies. If your baby has inherited the Rh+ve gene from the father, antibodies to the baby's blood cells can develop in your blood. To prevent this, you will be advised to have an anti-D injection if there is a chance of blood cells from the baby spilling into your blood stream (e.g. due to vaginal bleeding, amniocentesis or CVS and after the birth). It is recommended that anti-D is given routinely to all Rh-ve mothers in later pregnancy.

Sickle Cell and Thalassaemia are inherited blood disorders which affect haemoglobin and can be passed from parent to child. All pregnant women in England are offered a blood test to find out if they carry a gene for thalassaemia, and those at high risk of being a sickle cell carrier are also offered a test for sickle cell. Genes are the codes in our bodies for things such as eye colour and blood group. Depending on your results, a test from the baby's father may be requested. If the **baby's father** is a carrier you will be offered diagnostic tests to find out if the baby is affected.

Hepatitis B is a virus which infects the liver and can cause immediate or long-term illness. Specialist care is needed for pregnant women with hepatitis B. If you are a carrier, or catch hepatitis B during pregnancy, you will be advised to have your baby vaccinated in the first year of life to reduce the risk of the baby developing hepatitis B. Your partner and any other children living with you should also be offered a test for infection, and vaccinations if needed.

Syphilis is a sexually transmitted disease which, if left untreated, can seriously damage your baby, or cause miscarriage or stillbirth. If detected, you will be referred to a specialist team and offered antibiotic treatment. Your baby will need an examination and blood tests after birth and may need to be treated with antibiotics.

HIV (Human Immunodeficiency Virus) affects the body's ability to fight infection. This test is important because any woman can be at risk. It can be passed to your baby during pregnancy, at birth or through breastfeeding. Treatment given in pregnancy can greatly reduce the risk of infection being passed from mother to child. If you decline testing for hepatitis B, syphilis or HIV, your midwife will refer you to a specialist screening team, who will discuss your decision in more detail. You can request retesting for hepatitis B, HIV or syphilis at any time if you change your sexual partner or think you are at risk. If any of these tests are positive e.g. hepatitis B, syphilis or HIV, you will be referred to a specialist screening team as soon as possible for an individualised plan or care. Your partner will be offered testing to see if they need any treatment.

Rubella (German measles). Testing is not routinely offered. Avoid being in contact with anyone who has a rash at any time during your pregnancy. If you come into contact with someone with a rash or you develop a rash, **contact your midwife/GP immediately for advice.** If you delay getting advice, it may not be possible to give you a diagnosis or the right treatment.

Additional tests are offered as necessary, such as to check for infections which can cause damage to your baby, but rarely cause problems for you. Contact your midwife /GP immediately for advice, if you develop any rashes or if you think you have been in contact with: **Chickenpox, Cytomegalovirus (CMV), Parvovirus (slapped cheek) or Toxoplasmosis** (page 24).

Chlamydia is a sexually transmitted infection which can result in problems for you and your baby e.g. pelvic inflammatory disease, miscarriage and premature birth. If you are under 25, you may be offered either a vaginal swab or urine test. If positive, you and your partner will be offered antibiotics.

Methicillin Resistant Staphylococcus Aureus (MRSA) is a bacterium which sometimes cause wound infections and can be difficult to treat as it is resistant to some antibiotics. Hospitals may offer testing if you are booked for an elective caesarean section, have any wounds or have previously tested positive for MRSA.

Oral Glucose Tolerance Test (OGTT) is to find out if you have gestational diabetes (page 22). A blood test is taken after fasting and you will be advised how long to not eat. You will then be asked to drink a glucose drink and a further blood test will be taken two hours later. You may be offered this test if you have a history of the following:

Gestational diabetes ☐ Family Origin ☐ Family history - first degree relative ☐ BMI 30> kg/m ☐
Antipsychotic medication ☐ Polycystic ovarian syndrome ☐ Previous baby's birth weight > 4.5kg or >90th centile ☐

Screening for Down's (T21), Edwards' (T18) and Patau's (T13) Syndromes

The screening tests are designed to find out how likely it is that the baby has Down's, Edwards' or Patau's syndrome. Inside the cells of our bodies there are tiny structures called chromosomes. There are 23 pairs of chromosomes in each cell. With each of the individual syndromes there is an extra copy of a particular chromosome in each cell. The tests available will depend on how many weeks pregnant you are. If you are too far on in your pregnancy to have the combined test for Down's syndrome, you can choose to have the quadruple test. If you are too far on in your pregnancy to have the combined test for Edwards' and Patau's syndrome, the only other screening test is a mid-pregnancy (anomaly) scan which will look for physical abnormalities. These tests are available for women with a singleton (1 baby) or twin pregnancy.

The combined test involves having a blood test and an ultrasound scan. A blood sample is taken from you, between 10 and 14 weeks to measure the levels of substances naturally found in the blood. The ultrasound scan is performed between 11 weeks and 2 days and 14 weeks and 1 day, to measure the fluid at the back of the baby's neck (nuchal translucency measurement, NT). A computer programme is used to work out a result for you. You will be given two separate results: - one for Down's syndrome and another for Edwards' and Patau's syndrome.

The quadruple test is available if you are too far on in your pregnancy to have the combined test. This test is for Down's syndrome only. A blood sample is taken from you, between 14 weeks and 20 weeks to measure the levels of substances naturally found in the blood. A computer program is used to work out a result for you. **The result:** your midwife or obstetrician will discuss your results with you. Higher-chance result: you will be offered a diagnostic test to find out for certain if your baby has Down's, Edwards' or Patau's syndrome. There are two tests: – CVS or amniocentesis. For more information about these tests see page 10. Lower-chance result: if your result is lower than the recommended national cut off, you will not be offered a diagnostic test. A lower-chance result does not mean that there is no chance at all of the baby having Down's, Edwards' or Patau's syndrome.

BMI - Body Mass Index
CVS - Chorionic Villus Sampling
MMR - Mumps, Measles and Rubella
T - Trisomy

Feel free to ask your midwife or doctor – or look at NHS Choices: **www.nhs.uk**

Investigations If additional blood tests / investigations are required update management plan page 15.

Booking	Explained	Accepted by mother No	Accepted by mother Yes	Date taken	Results	Action	Signed*	Date
Mid-stream urine	☐	☐	☐	D D M M Y Y				D D M M Y Y
Haemoglobin	☐	☐	☐					
Blood group	☐	☐	☐					
Antibodies	☐	☐	☐					
Sickle cell	☐	☐	☐					
Thalassaemia	☐	☐	☐					
Hepatitis B	☐	☐	☐					
Syphilis	☐	☐	☐					
HIV	☐	☐	☐					

Date D D M M Y Y | D D M M Y Y | Comments

Leaflet(s) given ☐ *Signed | Care provider | Care provider | Signed*

Tests from Father	Explained	Accepted No	Accepted Yes	Date taken	Results	Action	Signed*	Date
	☐	☐	☐	D D M M Y Y				D D M M Y Y
				D D M M Y Y				D D M M Y Y

Date D D M M Y Y | D D M M Y Y | Comments

Leaflet(s) given ☐ *Signed | Care provider | Care provider | Signed*

28-week check	Explained	Accepted No	Accepted Yes	Date taken	Results	Action	Signed*	Date
Haemoglobin	☐	☐	☐	D D M M Y Y				D D M M Y Y
Antibodies	☐	☐	☐	D D M M Y Y				D D M M Y Y
Re-offer tests for infections if previously declined	☐	☐	☐	D D M M Y Y	Results to be recorded above			

Date D D M M Y Y | D D M M Y Y | Comments

Signed | Care provider | Care provider | Signed

Additional tests (if indicated)	Explained	Accepted No	Accepted Yes	Date taken	Results	Action	Signed*	Date
MRSA	☐	☐	☐	D D M M Y Y				D D M M Y Y
OGTT	☐	☐	☐					
OGTT	☐	☐	☐					
	☐	☐	☐					

Date D D M M Y Y | D D M M Y Y | Comments

Leaflet(s) given ☐ *Signed | Care provider | Care provider | Signed*

Anti D prophylaxis	If Rh-ve	Accepted No	Accepted Yes	Date given	Site	Batch No.	Dose	Signed*
Gestation W ks	☐	☐	☐	D D M M Y Y				
Gestation W ks	☐	☐	☐	D D M M Y Y				

Leaflet(s) given ☐ Date D D M M Y Y | D D M M Y Y | Comments

Signed | Care provider | Care provider | Signed

Screening for Down's (T21), Edwards' (T18) and Patau's (T13) Syndromes

	No	Yes			
Screening explained	☐	☐	Screening offered	☐	☐	If no: why	Signed*
NHS Screening Programme leaflet given	☐	☐	Accepted by mother	☐	☐	Test type	Date taken D D M M Y Y
			Choice of screening	☐ T21, T18/T13 (All the conditions) ☐ T21 only ☐ T18/13 only			

Date D D M M Y Y

*Signed

Care provider

Results	Action	Signed*
T21 ☐		
T18 ☐		
T13 ☐		

* **Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Ultrasound Scans

You will be offered one or two routine ultrasound scans in the first half of pregnancy (i.e. usually by 20 weeks). There are no known risks to the baby or you from having a scan, but it is important to think carefully about whether to have a scan or not. The scan may provide information that means you may have to make some difficult decisions. For example, you may be offered further tests that have a risk of miscarriage. Some people want to find out if their baby has problems and some do not. Further information can be found in the leaflet "Screening Tests for You and Your Baby" available from your midwife or via www.gov.uk.

It is important to be aware of what the scans are intended for. Most scans fall into one of three categories:

	Explained	Accepted by mother No	Yes
■ Early scans to: date the pregnancy, check the number of babies, look for possible physical problems and take specific measurements of the baby if you have agreed to first trimester screening.	☐	☐	☐
■ Anomaly scan is recommended to be performed between 18 to 20+6 weeks of pregnancy to look for possible physical problems with the baby.	☐	☐	☐
■ Scans later in pregnancy are not for screening but are carried out to monitor the baby's wellbeing and development.	☐	☐	☐

D D M M Y Y Y Y — Date

Signed*: Care Provider

Reasons for Scans

Dating pregnancies. It is important to know the size of the baby in your womb so that we know how mature the fetus is. ***Scan dates are more accurate than menstrual dates*** if done before 22 wks. This is because it looks at the actual age of the fetus, whereas menstrual dates are based on the first day of the last period which assumes fertilisation occurred 14 days later, this is not always the case. Most babies are NOT born on their expected due date, but during a 4 week period around it. Usually babies come when they are ready.

First trimester (early pregnancy). All pregnant women are offered an ultrasound scan at between 8-14 weeks of pregnancy. This is called the dating scan. It is done to confirm the pregnancy and number of babies in the womb, calculate the expected date of delivery and to check for major problems with the baby that may be detected at this early stage. You may also be offered screening for Down's, Edwards' and Patau's syndromes (page 8) at this time. This will depend on whether you have agreed to have the screening test done and how many weeks pregnant you are at the time of scan.

Mid-pregnancy (anomaly). You will be offered a scan between 18 weeks and 20 weeks and 6 days. The purpose of this scan is to look for structural problems in the way the baby is developing (sometimes called anomalies). The scan will look in detail at the baby's head, spinal cord, limbs, abdomen, face, kidneys, brain, bones and heart. In most cases the baby will be developing well, but sometimes a problem is found. If a problem is suspected, you will be referred to a specialist team to discuss the options available to you. However, it is important to know that ultrasound may not identify all problems. Detection rates will vary depending on the type of anomaly, the position the baby is lying in, previous surgery to your abdomen and maternal size.

Later pregnancy. Scans can be performed in later pregnancy to check the baby's well-being. This may be required if there are concerns about how the baby is growing, or if you have any risk factors identified early in your pregnancy, that may affect the growth and wellbeing of the baby e.g. high blood pressure/diabetes. The main measurement for this is the abdominal circumference, which includes the size of the liver (the main nutritional store of the growing baby) and the abdominal wall thickness (related to fat reserves). An assessment of liquor (fluid around the baby) and Doppler flow can be done if there are any concerns with the baby's growth (Doppler flow indicates how well the placenta is managing the blood supply needed for the baby). If the scan suggests any concerns/problems, you will be referred to a specialist doctor to discuss the options available to you. Scans are sometimes also done to identify the position of the placenta, which may have been low in the womb at an earlier scan. A low placenta increases the risk of heavy bleeding later in pregnancy (page 22).

Sex of the Baby. Although we can sometimes tell the sex of the baby, they are NOT done for personal requests to find out what the sex of the baby is.

Diagnostic Tests for Chromosomal Abnormalities

Diagnostic tests (Amniocentesis or CVS) are usually offered to diagnose whether a baby has a chromosomal condition such as Down's, Edwards' and Patau's syndrome. They are not offered on a routine basis but in certain circumstances such as: a family history of an inherited problem, a result of a screening test reported as a higher-chance result (page 8), abnormal scan findings or you have had a previous pregnancy/or baby affected by a genetic condition. It is up to you whether you have further tests. The risk of miscarriage from either of these tests is about 1 or 2 in a 100 (0.5% to 1%). The health care professionals looking after you will discuss the options available.

Amniocentesis: involves removing a small amount of the fluid from around the baby using a fine needle. It is usually performed after 15 weeks of pregnancy.

CVS (Chorionic Villus Sampling): involves removing a tiny sample of tissue from the placenta, using a fine needle. It is usually performed from 11 weeks to 14 weeks of pregnancy. Occasionally results from a CVS are not clear and you will then be offered an amniocentesis. There are two types of laboratory test which can be used to look at the baby's chromosomes – a full karyotype and a rapid test (PCR). A full karyotype checks all the baby's chromosomes and takes 2 to 3 weeks for the results to be available. PCR checks for specific chromosomes and results take up to 3 to 4 working days.

PCR - Polymerase Chain Reaction

Feel free to ask your midwife or doctor – or look at NHS Choices: **www.nhs.uk**

Pregnancy Assessment

Dates LMP D D M M Y Y — This date is used to determine the best time for the dating scan

Method of dating

Agreed EDD D D M M Y Y — To be entered also on page 19, and in the customised growth chart programme

Special points for screening

Anomaly leaflet

Dating Scan

FH - Fetal Heart, CRL - Crown Rump Length, BPD - Biparietal Diameter, HC - Head Circumference, FL - Femur Length, NT - Nuchal Translucency

Date	Print out (Y/N)	No. of fetuses	FH	CRL	BPD	HC	FL	NT	Gestation	Comments	Signed *
									W ks D		

Anomaly Scan

Date D D M M Y Y Gestation W ks D Print out attached to notes Yes ☐ No ☐

Skull & Ventricles ☐ Cerebellum ☐ Face ☐ Spine - long ☐ Spine - Transverse ☐

Heart 4-chamber view ☐ Heart outflows ☐ Stomach / Diaphragm ☐ Cord insertion ☐ Kidneys & Bladder ☐

Arms - 3 bones left ☐ Arms - 3 bones right ☐ Legs - 3 bones left ☐ Legs - 3 bones right ☐ Placental site

Comments

Signed*

Ultrasound Scan Details

GA - Gestational Age, Pres - Presentation, AC - Abdominal Circumference, EFW - Estimated Fetal Weight, Plac - Placenta, AF - Amniotic Fluid.

Date	GA	Lie/ Pres	BPD	HC	AC	FL	EFW	Plac	AF	Doppler	Signed *
Comments											
Comments											
Comments											
Comments											
Comments											
Comments											

MRI Scan Details

Comments

Diagnostic Tests

Tests explained No ☐ Yes ☐

NHS Fetal Anomaly Screening leaflet given No ☐ Yes ☐

Date D D M M Y Y

*Signed

Care provider

Test type Indication

	No	Yes
Test offered	☐	☐
Test accepted	☐	☐
Anti D required	☐	☐

Needle/cannula gauge No. uterine insertions

Aspiration method Blood stained tap

Date performed D D M M Y Y *Signed

Results

Comments

Insert additional sheets here for multiples (eg twins or triplets)

MRI - Magnetic Resonance Imaging

*** Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Information Sharing

The information collected in this record will be shared with your healthcare team (midwives, doctors, health visitors, specialists) so that they can provide you and your baby(ies) with care. Some of this information, about you and your baby, will also be recorded electronically to help your healthcare team provide the best possible care.

The National Health Service (NHS) also wishes to collect some of this information about you and your baby, to help it to:

- monitor health trends
- strive towards the highest standards
- increase our understanding of adverse outcomes
- make recommendations for improving maternity care.

The NHS has very strict confidentiality and data security procedures in place to ensure that personal information is not given to unauthorised persons. The data is recorded and identified by NHS number, and your name and address are removed to safeguard confidentiality. Other information such as date of birth and postcode are included to help understand the influences of age and geography.

If there are concerns for you or your child's safety, the relevant information will be shared with other agencies such as safeguarding teams. In these cases information will be shared without your consent.

Data collection and record keeping discussed ☐ Date D D M M Y Y Signed* Care Provider

Seasonal Flu

Pregnant women are more at risk from serious complications of seasonal flu such as bronchitis, chest infection and pneumonia. Flu in pregnancy also increases the risk of miscarriage, prematurity, fetal growth restriction and stillbirth. It is recommended you should have the seasonal flu vaccine. It is safe to have at any stage in pregnancy and will pass on protection to your baby which will last for the first few months of their lives. The vaccine is available from September until March and is free to pregnant women. Ask your GP/pharmacist/ midwife where you can get vaccinated. If you develop flu like symptoms, you must seek medical advice **immediately.** There is treatment to reduce the risk of complications.

Seasonal flu discussed No ☐ Yes ☐ Agrees flu vaccine No ☐ Yes ☐ If no, reason declined

Flu vaccine given No ☐ Yes ☐ Date given D D M M Y Y Given by whom

Antiviral medication	Date commenced D D M M Y Y	Medication	Dose	Duration of course	Signed*

Whooping Cough (Pertussis)

Whooping cough is a serious disease that can lead to pneumonia and permanent brain damage, in some cases a risk of dying. If you have the whooping cough vaccination during pregnancy, it can help protect your baby from getting the disease in their first weeks of life. Babies are at an increased risk until they are vaccinated. If you have been vaccinated before or had whooping cough yourself, the vaccine is still recommended. You should be offered the vaccine from 16 weeks of your pregnancy. If you have not been offered the vaccine, please ask your midwife or GP where you can get it done. It can be given at the same time as the flu vaccine.

Pertussis discussed No ☐ Yes ☐ Agrees to vaccine No ☐ Yes ☐ If no, reason declined

Vaccination given No ☐ Yes ☐ Date given D D M M Y Y Given by whom

Blood Products

Blood or blood products are only ever prescribed in specific medical conditions or emergency situations. If you have any objections about receiving these, please discuss this with your midwife and obstetrician, so that a personalised plan of care can be made.

Treatment discussed No ☐ Yes ☐
Agrees to receiving blood or blood products No ☐ Yes ☐
Agrees to baby receiving blood or blood products No ☐ Yes ☐
Management plan initiated No ☐ Yes ☐

Date D D M M Y Y

Signed*

Important Symptoms

Care provider should sign, following discussion with mother

Most pregnancy symptoms are normal, however, it is important to be aware that certain symptoms might suggest the possibility of serious pregnancy complications. The ticked boxes indicate which topics have been explained to you. (For further details see pages 16, 19 & 22 or www.nhs.uk for more information). **Contact your midwife or maternity unit immediately if any of these occur:**

Symptom or complaint		Further advice / Comments	Date	Signature*
Abdominal (stomach) pains	☐		D D M M Y Y	
Vaginal bleeding	☐			
Membranes (waters) breaking early	☐			
Severe headaches	☐			
Blurred vision	☐			
Itching, especially at night	☐			
Changed or reduced fetal movements	☐	Leaflet given ☐		
Symptoms of infection/sepsis	☐			

Name
Unit No/ NHS No

Feel free to ask your midwife or doctor – look at NHS Choices: **www.nhs.uk**
www.saferpregnancy.org.uk **www.sepsistrust.org**

Antenatal venous thromboembolism (VTE) assessment - booking and repeat if admitted

	Yes
Any previous VTE except a single event related to major surgery	☐
Hospital Admission	☐
Single previous VTE related to major surgery	☐
High risk thrombophilia and no VTE	☐
Medical Co-morbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU	☐
Any surgical procedure e.g. appendicectomy	☐
OHSS (first trimester only)	☐
Age>35 years	☐
BMI 30-39	☐
BMI ≥ 40 (= 2 risk factors)	☐
Parity 3	☐
Smoker	☐
Gross varicose veins	☐
Immobility e.g. paraplegia, PGP	☐
Current pre-eclampsia	☐
Family history of unprovoked or oestrogen-provoked VTE in first degree relative	☐
Low risk thrombophilia	☐
Multiple pregnancy	☐
IVF/ART	☐
Transient risk factors:	
Dehydration / hyperemesis	☐
Current systemic infection	☐
Long distance travel	☐

High risk
Requires antenatal prophylaxis with LMWH
Refer to Trust-nominated thrombosis in pregnancy expert team

Intermediate risk
Consider antenatal prophylaxis with LMWH
Seek Trust-nominated thrombosis in pregnancy expert team for advice

Four or more risk factors: prophylaxis from first trimester

Three risk factors: prophylaxis from 28 weeks

fewer than three risk factors

Lower risk
Mobilisation and avoidance of dehydration

Complete risk assessment and update management plan as necessary **No risks identified** ☐

Signature* _____ **Date** D D M M Y Y

	Yes	Yes	Yes
Any previous VTE except a single event related to major surgery	☐	☐	☐
Hospital Admission	☐	☐	☐
Single previous VTE related to major surgery	☐	☐	☐
High risk thrombophilia and no VTE	☐	☐	☐
Medical Co-morbidities e.g. cancer, heart failure, active SLE, IBD or inflammatory polyarthropathy, nephrotic syndrome, type 1 DM with nephropathy, sickle cell disease, current IVDU	☐	☐	☐
Any surgical procedure e.g. appendicectomy	☐	☐	☐
OHSS (first trimester only)	☐	☐	☐
Age>35 years	☐	☐	☐
BMI 30-39	☐	☐	☐
BMI ≥ 40 (= 2 risk factors)	☐	☐	☐
Parity 3	☐	☐	☐
Smoker	☐	☐	☐
Gross varicose veins	☐	☐	☐
Immobility e.g. paraplegia, PGP	☐	☐	☐
Current pre-eclampsia	☐	☐	☐
Family history of unprovoked or oestrogen-provoked VTE in first degree relative	☐	☐	☐
Low risk thrombophilia	☐	☐	☐
Multiple pregnancy	☐	☐	☐
IVF/ART	☐	☐	☐
Transient risk factors:			
Dehydration / hyperemesis	☐	☐	☐
Current systemic infection	☐	☐	☐
Long distance travel	☐	☐	☐
No risks identified	☐	☐	☐
Update management plan as necessary			
Signature*			
Date	D D M M Y Y	D D M M Y Y	D D M M Y Y

ART - Assisted Reproductive Technology, BMI - Body Mass Index
DM - Diabetes Mellitus, IBD - Inflammatory Bowel Disease
IVDU - Intravenous Drug User, IVF - In Vitro Fertilisation
LMWH - Low Molecular Weight Heparin, OHSS - Ovarian Hyperstimulation Syndrome
SLE - Systemic Lupus Erythematosus, PGP - Pelvic Girdle Pain

*** Signatures must be listed on page 30 for identification**

Name
Unit No/ NHS No

Risk Assessment

It is important to reassess your individual circumstances throughout the pregnancy as it may mean a change to your plan of care. Your care providers can record these below.

	Booking assessment			Second assessment			Referral required		
	No	Yes	Comment	No	Yes	Comment	No	Yes	To
Gestation	W ks + D			W ks + D					
Review of primary care/GP records	☐	☐		☐	☐		☐	☐	
Medical factors	☐	☐		☐	☐		☐	☐	
Obstetric factors	☐	☐		☐	☐		☐	☐	
VTE assessment performed	☐	☐		☐	☐		☐	☐	
VTE pathway initiated	☐	☐	Low/Med/ High Risk	☐	☐	Low/Med/ High Risk	☐	☐	
Aspirin required	☐	☐		☐	☐		☐	☐	
OGTT booked	☐	☐		☐	☐		☐	☐	
Mental health factors	☐	☐		☐	☐		☐	☐	
Social factors	☐	☐		☐	☐		☐	☐	
Smoking	☐	☐		☐	☐		☐	☐	
Drug/alcohol use	☐	☐		☐	☐		☐	☐	
BMI pathway initiated	☐	☐		☐	☐		☐	☐	
Management Plan updated	☐	☐		☐	☐		☐	☐	
Signature*									
Date	D D M M Y Y			D D M M Y Y					

Maternity Payment Pathway System (Please tick which pathway is indicated)

Standard ☐ Intermediate ☐ Intensive ☐ Signature & date _____ D D M M Y Y

Manual Handling/Tissue Viability Risk Assessment

Yes ☐ No ☐ Referred: to: _____ Signature* _____ Date D D M M Y Y

Anaesthetic Assessment

Yes ☐ No ☐ Referred: to: _____ Signature* _____ Date D D M M Y Y

Seen by: _____ Signature* _____ Date D D M M Y Y

VTE - Venous Thromboembolism OGTT - Oral Glucose Tolerance Test GP - General Practitioner

Name
Unit No/ NHS No

*** Signatures must be listed on page 30 for identification**

Regular Medication

If you are taking any medicines or tablets, your midwife or doctor will write them here. If your care providers need to change how much you take as your pregnancy progresses, or you need other medicines, they can also be written here.

Date recorded	Drug	Dose	Frequency	Comments e.g. discontinued, dose changed
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				
D D M M Y Y				

Management Plan

Highlight key points in special features box (page 19). If necessary, update the lead professional box on page 1.

A personalised management plan will outline specific treatment for you, considering any special issues in pregnancy. This will be discussed and agreed between you and your healthcare team, including any specialists. The aim is to keep you and your baby safe, and to ensure that everyone involved in your care is aware of your individual circumstances. This plan will be documented below and amended to reflect your changing needs.

Place of birth discussed:

Maternity unit ☐ Freestanding birth centre ☐ Homebirth ☐ Alongside birth centre ☐

Signature* **Date** D D M M Y Y

Risk factor / special features	Management plan	Discussed with mother	Referred to	Date/Signed *
Booking				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y
				D D M M Y Y

Insert continuation sheets here, and number them.

*** Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Antenatal Checks

It is very important to attend antenatal and scan appointments that are made for you during your pregnancy. If you cannot attend any appointments, please contact your midwife or the hospital to re-arrange. Your midwife or doctor will check you and your baby's health and wellbeing at each of these appointments. Please discuss any worries or questions that you may have. If you have had any tests or investigations (pages 8 & 10), make sure that you ask for the results at your next appointment.

Blood pressure (BP) is checked to detect pregnancy induced hypertension or pre-eclampsia (page 22). High blood pressure may cause severe headaches or flashing lights. If this happens, tell your midwife or doctor **immediately**.

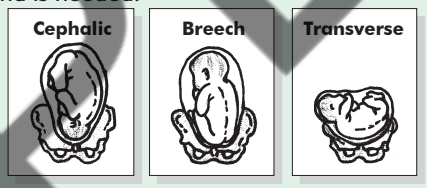
Urine tests You will also be asked to supply a sample of your urine at each visit to check for protein (recorded as + or ++ = presence of), which may be a sign of pre-eclampsia and glucose which may be a sign of gestational diabetes.

Fetal movements You will usually start feeling some movements between 16 and 24 weeks. A baby's movements can be described as anything from a kick, flutter, swish or roll. You will very quickly get to know the pattern of your baby's movements. At each antenatal contact your midwife will talk to you about this pattern of movements, which you should feel each day up to the time you go into labour and whilst you are in labour too. Become familiar with your baby's usual daily pattern of movements and contact your midwife or maternity unit **immediately if you feel that the movements have altered.** Do not put off calling until the next day. It is important for your doctors and midwives to know if your baby's movements have slowed down or stopped. A change, especially slowing down or stopping, can sometimes be an important warning sign that the baby is unwell and the baby needs checking by ultrasound and Doppler. If, after your check up, you are still not happy with your baby's movements, you must contact either your midwife or maternity unit straight away, even if everything was normal last time. **NEVER HESITATE** to contact your midwife or maternity unit for advice, no matter how many times this happens.

Fetal heart (FH or FHHR - fetal heart heard and regular). If you wish, your midwife or doctor can listen to the baby's heart with either a Pinard (stethoscope) or a fetal Doppler. With a Doppler, you can hear the heartbeat yourself. The use of home fetal doppler to listen to your baby's heart beat is not recommended. Even if you detect a heartbeat this does not mean your baby is well and you may be falsely reassured.

Liquor refers to the amniotic fluid, the water around the baby. A gentle examination of the abdomen can give an idea of whether the amount is about right (recorded as NAD - no abnormality detected, or just N), or whether there is suspicion of there being too much or too little, in which case an ultrasound is needed.

Lie and Presentation.
This describes the way the baby lies in the womb (e.g. L = longitudinal; O = oblique, T = transverse), and which part it presents towards the birth canal (e.g. head first or cephalic = C, also called vertex = Vx; bottom first or breech = B or Br).



Engagement is how deep the presenting part - e.g. the baby's head is below the brim of the pelvis. It is measured by how much can be still felt through the abdomen, in fifths: 5/5 = free; 4/5 = sitting on the pelvic brim; 3/5 = lower but most is still above the brim; 2/5 = engaged, as most is below the brim; and 1/5 or 0/5 = deeply engaged, as hardly still palpable from above. In first time mothers, engagement tends to happen in the last weeks of pregnancy; in subsequent pregnancies, it may occur later, or not until labour has commenced.

Assessing Fetal Growth

Accurate assessment of your baby's growth inside the womb is one of the key tasks of good antenatal care. Problems such as growth restriction can develop unexpectedly, and is linked with a significantly increased risk of adverse outcomes, including stillbirth, fetal distress during labour, neonatal problems, or cerebral palsy. Therefore it is essential that your baby's growth is monitored carefully.

Fundal height is measured every 2-3 weeks from 26-28 weeks onwards, ideally by the same midwife or doctor. The measurements are taken with a centimetre tape, from the fundus (top of the uterus) to the top of the symphysis (pubic bone), then plotted on the growth chart. The slope of the measurements should be similar to the slope of the three curves printed on the chart, which predict the optimal growth of your baby.

Customised Growth Charts. These notes have been developed to support the use of customised growth charts which are individually adjusted for you and your baby. The information required includes:

- Your height and weight in early pregnancy
- Your ethnic origin
- Number of previous babies, their name, sex, gestation at birth and birthweight
- The expected date of delivery (EDD) which is usually calculated from the 'dating ultrasound'

The chart is usually printed after your pregnancy dates have been determined by ultrasound (preferably) or by last menstrual period. If neither dates are available, regular ultrasound scans are recommended to check that your baby is growing as expected. For further information about customised growth charts see **www.perinatal.org.uk**

After the chart is printed, it is attached as **page 18**, using the stick-on tape on the right of this page. →

Growth restriction. Slow growth is one of the most common problems that can affect the baby in the womb. If the fundal height measurements suggest there is a problem, an ultrasound scan should be arranged and the estimated fetal weight (degree of error 10-15%) plotted on the customised chart to assess whether the baby is small for gestational age. If it does record as small, assessment of doppler flow is recommended, which indicates how well the placenta is managing the blood supply needed for the baby. If there is a serious problem, your obstetric team will need to discuss with you the best time to deliver your baby.

Large baby (macrosomia). Sometimes the growth curve is larger than expected. A fundal height measurement over the 90th centile is usually no cause for concern, but if the slope of subsequent measurements is too steep, your carers may refer you for an ultrasound scan to check the baby's size and amniotic fluid volume. They may also offer you a test to check for gestational diabetes (page 22). Big babies may occasionally cause problems either before or during birth (obstructed labour, shoulder dystocia etc). However, most often they are born normally without problems.

Insert customised growth chart here

PRINTER: Affix special tape here

Insert customised growth chart here

Feel free to ask your midwife or doctor – or look at NHS Choices: **www.nhs.uk**

Special Features

Height	Weight booking	BMI	BP booking	Age	Blood group	Weight 3rd trimester	Para	EDD
cms	kgs				+-	kgs	+	DDMMYY

Key points (from management plan, page 15)	Labour, delivery & postnatal — Paediatric alert form ☐
Flu vaccine given Yes ☐ Declined ☐	
SGA or FGR on scan Yes ☐	Paediatrician to be present ☐ Seniority Reason
Medications / Allergies	

Antenatal Visits

Gest - Gestation; BP - Blood Pressure; Pres - Presentation; Eng - Engagement; Hb - Haemoglobin. Mat pulse = maternal pulse

Care provider should reiterate discussion of important pregnancy symptoms including altered or reduced fetal movements (pages 12 & 16)

Date/Time	Gest	BP	Urine	CO level	Fetal Movements: Felt	Fetal Movements: Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
DDMMYY HHMM	Wks+D	/												

Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ______ Management plan: reviewed ☐ revised ☐ Signed*

Date/Time	Gest	BP	Urine	CO level	Felt	Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
DDMMYY HHMM	Wks+D	/												

Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ______ Management plan:reviewed ☐ revised ☐ Signed*

Date/Time	Gest	BP	Urine	CO level	Felt	Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
DDMMYY HHMM	Wks+D	/												

Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ______ Management plan:reviewed ☐ revised ☐ Signed*

Date/Time	Gest	BP	Urine	CO level	Felt	Discussed	Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
DDMMYY HHMM	Wks+D	/												

Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ______ Management plan:reviewed ☐ revised ☐ Signed*

SGA - Small for Gestational Age FGR - Fetal Growth Restriction

*** Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Antenatal Visits
Care provider should reiterate discussion of important pregnancy symptoms including altered or reduced fetal movements (pages 12 & 16)

Date/Time	Gest	BP	Urine	CO level	Fetal Movements		Pres	Lie	Eng	Liquor	Fetal heart	Mat pulse	Hb	Next contact
					Felt	Discussed								
D D M M Y Y Wks+D		/												

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

D D M M Y Y Wks+D		/												

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

D D M M Y Y Wks+D		/												

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

D D M M Y Y Wks+D		/												

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

D D M M Y Y Wks+D		/												

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

D D M M Y Y Wks+D		/												

H H M M Details and advice:(inc. infant feeding, smoking, lifestyle choices, pelvic floor exercises etc.)

Mental health and wellbeing discussed Yes ☐ Mother's page reviewed Yes ☐

Accompanied No ☐ Yes ☐ With ☐ Management plan:reviewed ☐ revised ☐ Signed*

Insert continuation sheets here, and number them.

*** Signatures must be listed on page 30 for identification**

Other Contacts / Visits e.g. day unit, delivery suite, inpatient summary or contacts with external agencies.

Date /time	Gest	Where seen	Details: reason for referral, investigations, plan of care, length of stay (if admitted)	Signed *	Follow up
D D M M Y Y H H M M	Wks + D				
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Insert continuation sheets here, and number them.

Name

Unit No/
NHS No

*** Signatures must be listed on page 30 for identification**

Common pregnancy symptoms. You may feel some tiredness, sickness, headaches or other mild aches and pains. Some women experience heartburn, constipation or haemorrhoids. There may also be some swelling of your face, hands or ankles or you may develop varicose veins. Most symptoms are normal and will not harm you or your baby, but if they are severe or you are worried about them, speak to your midwife or doctor. Changes in mood and sex drive are also common. Sex is safe unless you are advised otherwise by your healthcare team. Complications in pregnancy require additional visits for extra surveillance of you and your baby's well-being. Many conditions will only improve after the birth; it may be necessary to induce your labour or undertake a planned (elective) caesarean section.

Pregnancy sickness is common and can generally be managed with changes to their diet and lifestyle. However, it is not uncommon for pregnancy sickness to be severe and have a serious negative impact on the quality of your life and your ability to eat and drink and function normally. If this happens, speak to your GP and request anti-sickness medication. These are safe to take at any stage of pregnancy. It is important to treat pregnancy sickness at an early stage to prevent it from developing into the more serious condition called hyperemesis gravidarum. If you are sick, wait at least 30 minutes before brushing your teeth or using a mouthwash. This helps to protect your teeth from tooth decay. For further information visit www.pregnancysicknesssupport.org.uk

Multiple pregnancies. Twins, triplets or other multiple pregnancies need closer monitoring which includes frequent tests and scans, under the care of a specialist healthcare team. You will be advised to have your babies in a consultant led maternity unit that has a neonatal unit. Your healthcare team will discuss your options on how best to deliver your babies. It will depend on how your pregnancy progresses, the position that your babies are lying and whether you have had a previous caesarean section.

Prematurity. Labour may start prematurely (before 37 weeks), for a variety of reasons. If you plan to give birth in a birth centre/midwifery unit or at home, you will be advised to transfer your care to a maternity unit with a neonatal unit/special care baby facility. If labour starts before 34 weeks, most maternity units have a policy of trying to stop labour for at least 1-2 days, whilst offering you steroid injections that help the baby's lungs to mature. However, once labour is well established it is difficult to stop. Babies born earlier than 34 weeks may need extra help with breathing, feeding and keeping warm.

Breech. If your baby is presenting bottom or feet first this is called a breech position (page 16). If your baby is breech at 36 weeks, your health care team will discuss the following options with you: trying to turn your baby (ECV = external cephalic version); planned (elective) caesarean section or a planned vaginal breech birth.

Abdominal pain. Mild pain in early pregnancy is not uncommon and you may have some discomfort due to your body stretching and changing shape. If you experience severe pain, or pain with vaginal bleeding or need to pass urine more frequently - contact your midwife or nearest maternity unit **immediately** for advice. Don't wait until your next appointment.

Vaginal bleeding may come from anywhere in the birth canal, including the placenta. Occasionally, there can be an 'abruption', where a part of the placenta separates from the uterus, which puts the baby at great risk. If the placenta is low lying, tightenings or contractions may also cause bleeding. Any vaginal blood loss should be reported **immediately** to your midwife or nearest maternity unit. You will be asked to go into hospital for tests and advised to stay until the bleeding has stopped or the baby is born. If you are Rh -ve, you will require an anti-D injection (page 8).

Spontaneous Rupture of Membranes (SROM). Your waters may break before labour starts at any time during your pregnancy. If you have watery loss from your vagina, which you can't control, you need to contact your midwife or maternity unit.

Abnormal vaginal discharge. It is normal to have increased vaginal discharge when you are pregnant. It should be clear or white and not smell unpleasant. Seek medical advice if the discharge changes colour, smells offensive or you feel sore or itchy.

Infections. Your immune system changes when you are pregnant, and you are at a higher risk of infection. Wherever possible, keep away from people with an infection e.g. diarrhoea and sickness, cold/flu, any rash illness. Seek **urgent** medical advice: If you are unwell and are experiencing any of the following symptoms: • high temperature of 38°C or higher • fever and chills • pain or frequently passing urine • abdominal pain • rash • diarrhoea and vomiting • sore throat or respiratory infection • painful red blisters/sores around the vagina/bottom or thighs.

Avoid unprotected sexual contact if your partner has genital herpes and avoid oral sex from a partner with a cold sore. Wash your hands if you touch the sores.

Sepsis (also known as blood poisoning) is the immune system's overreaction to an infection or injury. This is a rare but serious condition which can initially look like flu, gastroenteritis or a chest infection. If not treated immediately, sepsis can result in organ failure and death. Yet with early diagnosis, it can be treated with antibiotics. Seek **urgent** medical help if you experience signs of sepsis: • Slurred speech or confusion • Extreme shivering or muscle pain • Passing no urine (in a day) • Severe breathlessness • It feels like you're going to die • Skin mottled or discoloured

Group B Streptococcus (GBS) is a common bacterium carried by some women and rarely causes symptoms or harm. It can be detected by testing a urine sample or a vaginal or rectal swab. In some pregnancies, it can be passed on to the baby around the time of birth, which can lead to serious illness in the baby. The national recommendation is to offer antibiotics to women as soon as labour starts if: • GBS has been detected during the current pregnancy • you have previously had a baby who developed a GBS infection • you have a high temperature (38°C or over) in labour • you go into labour prematurely • GBS was detected in a previous pregnancy and your baby was not affected, you should be offered antibiotics in labour or be offered a test to screen for GBS late in pregnancy. If the test is positive you will be offered antibiotics in labour.

Thrombosis (clotting in the blood). Your blood naturally has more clotting factors during pregnancy which helps prevent losing too much blood during labour and birth. However, this means that all pregnant women are at a slightly increased risk of developing blood clots during pregnancy and the first weeks after the birth. The risk is higher if you are over 35, have a BMI >30, smoke, or have a family history of thrombosis. Contact your midwife or nearest maternity unit **immediately** if you have any pain or swelling in your leg, pain in your chest or cough up blood.

High blood pressure. Your blood pressure will be checked frequently during pregnancy. A rise in blood pressure can be the first sign of a condition known as **pre-eclampsia** or pregnancy induced hypertension. Contact your midwife or nearest maternity unit **immediately** if you have: • severe headache/s • blurred vision or spots before your eyes • obvious swelling (oedema) especially affecting your hands and face • severe pain below your ribs and/or vomiting. These can be signs that your blood pressure has risen sharply. If there is protein in your urine, you may have **pre-eclampsia** which in its severe form can cause blood clotting problems and fits. It can be linked to problems for the baby such as growth restriction. Treatment may start with rest, but some women will need medication that lowers high blood pressure. Occasionally, this may be a reason to deliver your baby early.

Diabetes is a condition that causes a person's blood glucose (sugar) level to become too high. Some women can develop diabetes during their pregnancy (gestational diabetes). High levels of glucose can cross the placenta and cause the baby to grow large (macrosomia - page 16). If you have pre-existing diabetes or develop gestational diabetes, you will be looked after by a specialist team to monitor you and your baby's health and wellbeing closely. Keeping your blood glucose levels as near normal as possible can help prevent problems/complications for you and your baby. Gestational diabetes usually disappears after the birth but can occur in another pregnancy. To reduce your future risks of diabetes: - be the right weight for your height (normal BMI); eat healthily, cut down on sugar, fatty and fried foods and increase your physical activity (page 24).

Intrahepatic cholestasis in pregnancy (ICP) also known as obstetric cholestasis, is a liver condition in pregnancy that causes itching on the hands and feet but may occur anywhere on your body and is usually worse at night. It affects 1 in 140 women in the UK every year. Having this condition may increase your risk of having a stillbirth, so you will receive closer monitoring of you and your baby's health during your pregnancy. If you have itching, blood tests will be offered to check if you have ICP. Treatment includes medication, regular blood tests and delivering your baby around 37-38 weeks. After the birth, the itching should disappear quite quickly. A blood test to check your liver function will be carried out before you are discharged from hospital after the birth and repeated about 6-12 weeks later.

BMI - Body Mass Index

Feel free to ask your midwife or doctor – look at NHS Choices: **www.nhs.uk**
www.saferpregnancy.org.uk **www.sepsistrust.org**

Mother's Page

This space is for you to write any questions, concerns and expectations you may wish to discuss with your healthcare team. This may include your feelings around pregnancy, birth and becoming a mother, previous experiences of pregnancy and birth and any fears or concerns. Some questions you may want to ask are: • What things are important to you throughout your antenatal care? • What parts of birth and becoming a mother is most important to you? • What are your thoughts about where you want to give birth to your baby?

Date	

Work and benefits. The 'Parents Guide to Money' is available via www.moneyadviceservice.org.uk and provides information on financial aspects of having baby. You should discuss your options regarding maternity leave and pay with your employer early in pregnancy. An FW8 certificate will be issued in early pregnancy entitling you to free prescriptions / dental treatment. Your midwife will issue your maternity certificate from 20 weeks (Mat B1) to claim your entitlements. If you are under 18 or receive certain benefits, you may be entitled to Healthy Start vouchers for free milk, fruit, vegetables and vitamins.

Dentist. It is important that you are registered with a dentist and have regular check-ups. Changes in your hormone levels and diet may make your mouth more prone to disease which can lead to tooth decay. It is recommended that you brush your teeth twice a day for at least two minutes.

Health and Safety issues. If you are working, your employer has a responsibility to assess any health and safety risks to you. For further information contact your occupational health department or visit www.hse.gov.uk

Healthy eating. Make sure you eat a variety of different foods to get the right balance of nutrients for your growing baby and for your body to deal with the changes taking place. Although you may feel hungrier than usual, don't "eat for two". It is recommended that you should only increase your calorie intake by 200 calories per day during the last 3 months. Maintaining a healthy weight can reduce the risk of complications for pregnancy, labour and birth. Dieting is not recommended as it may harm the health of your baby. It is important to prepare and cook your food carefully to prevent food poisoning. Foods such as ready meals, meat, poultry, shellfish and eggs need to be thoroughly cooked. Avoid pâté and mould-ripened soft cheeses; liver and liver products and unpasteurised milk. Have no more than 2 portions of oily fish a week and avoid marlin, swordfish and shark. It is recommended that you take supplements of folic acid, which helps to prevent abnormalities in the baby, e.g. spina bifida. The recommended dose is 0.4mg per day while you are planning to get pregnant and up to 13 weeks of pregnancy. If you have:- diabetes, BMI >30, taking anti-epileptic drugs or have a family history of fetal anomalies, the recommended dose is 5mg per day. This is only available on prescription from your GP.

Vitamin D is needed for healthy bones, teeth and muscle development. To protect you and your baby from any problems caused by low levels, a 10mcgs Vitamin D supplement is recommended. (this is contained in the "Healthy Start" vitamins). Check with your midwife /GP/pharmacist if you are taking any other over the counter vitamins/supplements. **Vitamin A** can cause harm to your baby if you take too much, so don't take any supplements containing vitamin A (retinol). If you have any questions about the food you eat, discuss with your midwife who can refer you to a dietitian if needed.

Body Mass Index. There are increased risks if your BMI is less than 18 or more than 30.

Caffeine is a stimulant that is contained in tea, coffee, chocolate, energy and cola drinks. Its recommended that you limit your daily caffeine intake is 200mgs per day. Try decaffeinated versions of tea/coffee or cola drinks.

Alcohol increases the risk of miscarriage, stillbirth, fetal growth restriction, premature labour and may lead to fetal alcohol spectrum disorder (FASD) or fetal alcohol syndrome (FAS). Therefore, its recommended that pregnant women **AVOID** drinking alcohol during their pregnancy. Alcohol crosses the placenta into the blood stream of your baby and could affect how your baby grows and develops. Your midwife will ask you at your first appointment how many units of alcohol you drink. If you are finding it hard to stop drinking alcohol, ask for help from your midwife/GP. They can help you and refer you for specialist support.

Drugs. Taking street drugs, including cannabis and psychoactive substances e.g. spice, meow meow (MCAT) is **NOT** recommended; it may seriously harm you and your baby. If you take any prescription medication, you must discuss this with your GP to ensure they are safe to continue. Check with your pharmacist about taking over the counter medicines especially pain killer's containing codeine which can become addictive.

Carbon Monoxide (CO) is a poisonous gas produced when tobacco products are burnt. It is found in inhaled, exhaled and passive smoke. The CO replaces some of the oxygen in your bloodstream which means that both you and your baby have lower levels of oxygen overall. As part of routine antenatal care your midwife will test your CO levels. Environmental factors such as exhaust fumes or leaky gas appliances may also cause a high reading.

Smoking When you smoke, carbon monoxide, nicotine and other toxic chemicals cross the placenta directly into the baby's blood stream - so the baby smokes with you. This will reduce its oxygen and nourishment and put your baby at risk of low birth weight, stillbirth, premature birth and other problems. The sooner you stop smoking the better, to give your baby a healthy start in life. Your midwife can refer you to a stop smoking service for expert and friendly support to help you stop. If you need help to manage nicotine cravings the safest products to use are nicotine replacement therapies such as patches and gum. If using an e-cigarette helps you to quit smoking and stay smoke free, it is considered far safer for you and your baby than continuing to smoke. However, the potential risks to your baby from exposure to e-cigarettes are not fully understood. It is illegal to smoke in a car or any other vehicle with people who are under the age of 18. This is to protect babies, children and young adults from second hand smoke.

Home fire safety checks are available free of charge by your local fire service. All homes should have a working smoke alarm.

Hygiene. During pregnancy your immune system changes and you are more prone to infections. It is important that you try to reduce the risk of infections with good personal hygiene: washing your hands properly before and after preparing food, using the toilet or sneezing/blowing your nose. Always wear gloves when gardening or handling cat litter as toxoplasmosis can be found in cat faeces. If you feel unwell, have a sore throat or respiratory infection contact your midwife or GP **immediately**, you may need treatment.

Travel. If you are planning to travel abroad, you should discuss flying, vaccinations and travel insurance with your midwife or GP.

Car safety. To protect you and your unborn baby, always wear a seatbelt with the diagonal strap across your body between your breasts and the lap belt over your upper thighs. The straps then lie above and below your 'bump', not over it.

Relationships. Some women find pregnancy to be a time of increased stress and physical discomfort. It can greatly affect your emotional state, your body image and relationships. Discuss any problems or concerns you have with your midwife or GP.

Domestic abuse. 1 in 4 women experience domestic abuse at some point in their lives and can start during pregnancy. There are different kinds of abuse including physical, sexual, financial control, mental or emotional abuse. Where abuse already exists, it has been shown that it may worsen during pregnancy and after the birth. Domestic abuse can lead to serious complications which affect you and your baby. You can speak in confidence to your healthcare team who can offer help and support. You may prefer to contact a support agency such as The National Domestic Violence Helpline (listed on page 30).

Physical activity. Being active during pregnancy means you're likely to maintain a healthier weight and can cope better with the physical demands of pregnancy and labour. Physical activity is known to improve fitness, reduce high blood pressure and prevent diabetes in pregnancy. There is no evidence of harm and walking for 150 minutes each week can keep you and your baby healthy. It can also give you more energy, help you sleep better and reduce feelings of stress, anxiety and depression. Every activity counts in bouts of at least 10 minutes. If you are already active, keep going, if you are not active start gradually. Activity can include walking, dancing, yoga, swimming and walking up the stairs.

Sleeping/resting position in later pregnancy. The safest position for going to sleep/resting is on your side, either left or right. If you lie on your back, the weight of the baby and uterus can affect the blood flow to your major organs and also to your baby. Research has linked this with an increased risk of stillbirth. Don't worry if you wake up on your back – turn over onto your side again. You can find more information visit www.tommys.org.

Pelvic floor exercises. It is recommended that you do pelvic floor exercises during pregnancy to help strengthen this group of muscles. Your midwife will advise you how to do these.

Family and friends test. The survey has been designed for the NHS and your hospital to gain feedback on the services you have received. It is a quick and anonymous way to give your feedback. For further information discuss this with your midwife.

? Feel free to ask your midwife or doctor – or look at NHS Choices: **www.nhs.uk**

Your Plans for Pregnancy

Update management plan as required (page 15).

You may use the space below to write your comments to discuss with your healthcare team.

Topics	N/A	Discussed	Signature* and Date	Your wishes, intentions or preferences	Leaflets given
Employment rights	☐	☐			☐
Maternity benefits	☐	☐			
Health and safety issues	☐	☐			
Registered with a Dentist		☐			☐
Healthy eating		☐			
Vitamin D / Healthy Start Vitamins		☐		Start date: D D M M Y Y	
Caffeine		☐			
Alcohol consider using an alcohol screening tool (e.g. AUDIT-C)		☐			
Drugs		☐			
Hygiene		☐			
Smoking					
Effect on baby	☐	☐		First appointment with smoking cessation services D D M M Y Y	☐
Effect on mother	☐	☐			
Smoke free homes	☐	☐		Quit date set D D M M Y Y	
Working smoke alarm		☐			
Self referral - home fire safety check		☐			
Travel safety		☐			☐
Seat belts		☐			
Feelings about pregnancy		☐			
Stresses in pregnancy		☐			
Support at home		☐			
Sex in pregnancy		☐			
Sleeping/resting position		☐			
Physical activity		☐			☐
Pelvic floor exercises		☐			☐
Family and Friends test		☐			

Start4Life Information Service for Parents is a free NHS service for mums and dads offering regular emails or texts throughout your pregnancy and beyond. Get trusted NHS approved information, advice and tips including baby development, preparing for birth and what to expect as your baby grows, from breastfeeding to immunisations and development stages, as well as wider advice on healthy lifestyles and how to find local support. Search **Start4Life** online to sign up now. www.nhs.uk/start4life

Please supply your email address to receive regular information and advice throughout your pregnancy and afterwards.

Email:

Social & Health Assessment Completed

Signature* **Date** D D M M Y Y

Your Carers

Midwife. Your midwifery team are usually the main care providers throughout your pregnancy. They provide care and support for women and their families during pregnancy, childbirth and the early days after the birth. They will work in partnership with you and your family to ensure you can make informed decisions about your care. Your midwives will arrange to see you at clinics in the local community and will visit you at home after the birth of your baby. If you need to contact your midwife please refer to the telephone numbers on page 1 of this booklet.

Student Midwives. Will work under the supervision of a qualified midwife. Students will be undertaking a degree course at a university, but will spend time gaining experience in a clinical setting e.g. labour ward, antenatal clinic.

Maternity Support Workers. Support midwives as part of the midwifery team. They have had appropriate training and supervision to provide information, guidance, reassurance and support for example with antenatal classes, infant feeding, which improves the quality of care that the midwife is able to provide to you, your partner and your baby.

Obstetricians and Maternal-Fetal Medicine Specialists (MFM) are doctors who specialise in the care of women during pregnancy and childbirth. You may be referred to their care at the beginning of your pregnancy if you already have a medical problem, or during pregnancy if there are any concerns about your health or the health of the baby.

Health Visitors work within the NHS. All are qualified nurses/midwives who have done additional training in family and child health, health promotion and public health development work. They work as part of a team alongside your GP, other community nurses and your midwives. Your health visitor will visit you at home after you have had your baby, but will also see you during your pregnancy.

General Practitioner (GP). Doctors who work in the community, providing care for all aspects of health for you and your family throughout your lifetime.

Specialists. Some women with medical problems, such as diabetes, may need to be referred to a specialist for additional care during pregnancy. They may continue to provide care for you after you have had your baby.

Ultrasonographers are specially trained to carry out ultrasound scans. They will perform your dating, mid-pregnancy (anomaly) and any other scans you may need, based on your individual needs.

*** Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Antenatal classes are an opportunity for you and your partner to find out about pregnancy, labour, birth and becoming new parents. Ask your midwife/health visitor what is available in your area to suit you. There are often special classes for teenagers, parents expecting multiple babies and non-English speaking parents.

Safe sleeping. New babies have a strong desire to be close to you after birth as this will help them to feel secure and loved. Sudden Infant Death Syndrome (SIDS) is a sudden and unexpected death of a baby where no cause is found. While SIDS is rare, it can still happen and there are steps parents can take to reduce the risk of it happening. These include: • Place your baby on their back to sleep, in a cot or Moses basket in the same room as you for the first 6 months • Do not smoke in pregnancy or let anyone smoke in the same room as your baby • Do not share a bed with your baby if you have been drinking alcohol, taken drugs or if you are a smoker • Never sleep with your baby on a sofa or armchair • Do not let your baby get too hot or too cold, keep your baby's head uncovered • Place your baby in the "feet to foot" position. • Breastfeed your baby. • Infant immunisations reduce the risk of SIDS. • Seek medical help if your baby is ill. For further information: www.lullabytrust.org.uk

Pet Safety. Many pets are tolerant of small children and babies, but it's important to be aware of the potential dangers. Pets can be jealous of having to share you and not receiving the same level of attention. Getting prepared for when you bring your baby home, is something that you can do during pregnancy. Things to consider are: Where will your baby sleep and how can you keep your pet away from this area? How will you ensure that your pet is not left unsupervised with your baby? Good hygiene when handling your pet, especially when washing your hands e.g. reptiles carry a bacteria (germ) called salmonella that is very hard to kill. Ensure that your pets are up to date with vaccinations. For further information visit www.dogtrust.uk.org or www.rspca.org.uk

Equipment. Every new parent needs some essentials for their new baby. In the early days, you will need clothes and nappies. It may be advisable not to get too many until after your baby is born, so that you know what size to buy. You need something for your baby to sleep in such as a cot or Moses basket. If you have a car, you must have a car seat and your baby must travel in their seat. Think about other ways of carrying your baby when you are out, such as baby carriers/slings or prams/pushchairs.

Newborn screening. After birth, your baby will be offered some screening tests. The blood spot test is designed to identify those few babies who may be affected by PKU, cystic fibrosis, congenital hypothyroidism, MCADD, MSUD, HCU, IVA, GA1 and haemoglobinopathy disorders. Two detailed examinations of the baby will be performed, one within 72 hours of the birth and one is when your baby is 6-8 weeks old. These check your baby's eyes, heart and lungs, nervous system, abdomen, hips and testes (in boys). The hearing test is designed to find babies who have a hearing loss. Your midwife will give you a leaflet explaining these screening tests. For further information visit www.screening.nhs.uk/annbpublications

Vitamin K. We need vitamin K to make our blood clot properly so we do not bleed easily. To reduce the risk of a bleeding disorder, your baby should be offered vitamin K after birth. The most effective way of giving this is by an injection (oral doses may be an option).

BCG. This is a vaccine offered to all babies who may be at higher than average risk from contact with TB (tuberculosis). These include babies whose families come from countries with a high incidence of TB such as Asia, Africa, South and Central America and Eastern Europe or babies born in a town or city where there is a high rate of TB. It is also offered to babies who have a relative or close contact with TB, have a family history of TB in the past 5 years or who plan to travel to a high-risk country to stay for more than three months. TB is a potentially serious infection which usually affects the lungs but can also affect other parts of the body. Treatment is with antibiotics. The BCG vaccination is usually given to the baby early in the postnatal period, but in some circumstances, it may be delayed. Some maternal medical conditions or specific medications taken in pregnancy can affect the immune system of the baby. In these instances, the vaccination should be delayed for about 6 months after the baby is born. Please discuss this with your midwife if you think this may apply to your baby. Further information can be found in the leaflet "TB, BCG vaccine and your baby" or visit www.nhs.uk/vaccinations

Hepatitis B. Some people carry the hepatitis B virus in their blood without having the disease itself. If a pregnant mother has or carries hepatitis B, or catches it during pregnancy, she can pass it onto her unborn baby. Babies born to mothers who have hepatitis B are at risk of getting this infection and should receive a course of vaccine and a test at twelve months to exclude infection. The first immunisation will be offered soon after birth and then at 4, 8, 12 and 16 weeks with a final dose at twelve months.

Connecting with your baby. Taking time out to begin to develop a relationship with your unborn baby will have a positive impact on your baby's wellbeing and their brain to grow. You can begin to connect through talking or singing to your baby bump and noticing when your baby has a pattern of movements. It is lovely to include your partner and / or other children too.

Greeting your baby for the first time. Holding your baby in skin to skin contact soon after birth is the perfect way to say hello. Skin contact will help you both to feel calm, give you time to rest, keep warm and get to know each other. As your baby recognises your voice and smell, they will begin to feel safe and secure. Take time to notice the different stages your baby goes through to get ready their first feed.

Responding to your baby's needs. New babies have a strong desire to be close to their parents as this will help them to feel secure and loved. When babies feel secure they release a hormone called oxytocin which helps their brain to grow and develop. If you are breastfeeding you can offer your baby your breast when he/she shows signs of wanting to feed, when they just want a cuddle, if you need to fit in a quick feed or if you want to sit down and have a rest. If you choose to bottle feed, your baby will enjoy being held close, and fed by you and your partner rather than by lots of different people.

Feeding your baby. You may already have some thoughts about how you will feed your baby, based on previous experience or what others have told you. However, you don't have to decide until after your baby is born. Breastfeeding provides everything your baby needs to grow and develop. It also helps protect and comfort your baby. Your midwife will be happy to talk to you about this. Further information can be found via: www.bestbeginnings.org.uk. If you decide to use formula milk to feed your baby, your midwife will give you information about how to hold your baby for feeding and how to make up feeds safely.

Contraception. You need to start using contraception from 3 weeks after the birth. Don't wait for your periods to return or until you have had your postnatal check-up before you use contraception, you can get pregnant again before then. Longer lasting methods e.g. Depo injection, implant and IUD/IUS (coil) are effective because you don't have to remember to take pills or do any preparation before you have sex and they are safe to use if you are breastfeeding. A coil can be fitted at the time of a planned caesarean section, if this is something you are interested in having, speak to your midwife or obstetrician about it. For further information about contraception visit www.fpa.org.uk

PKU- Phenylketonuria MCADD- Medium-chain Acyl-CoA Dehydrogenase Deficiency MSUD- Maple Syrup Urine Disease
HCU- Homocystinuria (Pyridoxine Unresponsive) IVA- Isovaleric Acidaemia GA1- Glutatic Aciduria type 1
IUD - Intrauterine Device IUS - Intrauterine System

Feel free to ask your midwife or doctor – or look at NHS Choices: **www.nhs.uk**

Your Plans for Pregnancy and Parenthood

You may use the space below to write your comments to discuss with your healthcare team.

Topics	Discussed	Signature*& Date	Your wishes, intentions or preferences	Leaflets given
Preparing for your new baby Parent education Safe Sleeping Home environment Pet safety Equipment Newborn physical examination Newborn blood spot test Newborn hearing test Vitamin K	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	D D M M Y Y		☐ ☐
BCG discussed No ☐ Yes ☐ Baby BCG indicated No ☐ Yes ☐ Mother agrees to vaccine No ☐ Yes ☐		D D M M Y Y	Reason: If no, reason declined	☐
Connecting with your baby Talking to your baby Noticing/responding to baby's movements How this can help your baby's brain development	 ☐ ☐ ☐	D D M M Y Y		☐
Greeting your baby for the first time Skin to skin contact Keeping baby close Recognising feeding cues	 ☐ ☐ ☐	D D M M Y Y		☐
Responding to your baby's needs Importance of comfort and love to help baby's brain develop Responsive feeding	 ☐ ☐	D D M M Y Y		☐
Feeding your baby Value of breastfeeding as protection, comfort and food Getting off to a good start Understanding how a baby breastfeeds Where to get help including local support groups	 ☐ ☐ ☐ ☐	D D M M Y Y		☐

Confirmation that a conversation has taken place around the topics outlined above

Comments	*Signature & date
	D D M M Y Y
	D D M M Y Y
	D D M M Y Y

Contraception

What methods of contraception have you used in the past?

Postnatal contraceptive plan made? No ☐ Yes ☐

Contraception method of choice and who will provide this

*** Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Choosing where to have your baby. Depending upon your individual needs and what services are available locally, you and your partner will be able to choose where to have your baby. This may be at home, supported by a midwife, or in a midwifery unit or birth centre. These are either based in the community or in hospital and they promote natural labour and childbirth. Alternatively, you may choose to deliver in hospital supported by a maternity team. The team may include midwives, obstetricians, paediatricians and anaesthetists. When making your choice it is important to consider all your personal circumstances and any additional care needs you or your baby may need. You can discuss your wishes and options available with your midwife and/or obstetrician if there are any pregnancy concerns. It may be possible for you to visit the unit during your pregnancy. This will give you the opportunity to find out more about the facilities available. (Please note hospital sites are a smoke free environment.) You may be given a list of things to bring to the birth centre or hospital when you go into labour e.g. something comfortable for you to wear during labour, bras, pants, sanitary towels, toiletries, towels, dressing gown and slippers. For your baby: clothes and nappies, a shawl or blanket and outdoor clothing.

Signs of labour. Most labours start spontaneously with irregular contractions. They will become more often, last longer and feel stronger. It can take up to 24 hours for this to happen and you can stay at home until your contractions become stronger and more regular. You may also have backache. The contractions are widening and shortening the neck of the womb. Sometimes the waters break before labour starts, this is called spontaneous rupture of membranes (SROM). It can be a gush, leak or a trickle of amniotic fluid which you cannot control. If you think your waters have broken or you are having strong regular contractions you should contact staff in the delivery suite, who will advise you what you need to do. You may need an assessment, which could include a vaginal examination. If your waters have broken, but you are not in labour, swabs will be taken to check for infection. Labour often starts within a day of SROM. When you do go to hospital remember to take these notes and an overnight bag with you. If there have been any pregnancy complications e.g. you have developed diabetes in your pregnancy or scans have shown growth restriction with your baby, contact the delivery suite as soon as you start having regular contractions.

Inducing labour. It may be necessary to start your labour if there are problems in the pregnancy e.g. high blood pressure, concerns about the baby's growth or if you are 10-14 days overdue. If you are 'overdue' your midwife will offer you a membrane sweep at 41 weeks. This is a vaginal examination which stimulates the neck of the womb, which may trigger labour. Contractions can be started by inserting a pessary or gel into the vagina. It may take 24-48 hours to get you into labour, sometimes a hormone infusion (drip) is used to speed up the labour. You and your baby will be closely monitored.

Assessment of progress. Many factors play a part in the way your labour progresses – including the 'three Ps':

- POWERS (how strong and effective the contractions are)
- PASSAGE (the shape and size of your pelvis and birth canal)
- PASSENGER (the size of the baby, and which way it is lying)

Progress is assessed as necessary, and includes external and internal examinations to check whether the baby is moving down in the birth canal and whether the cervix is opening.

Monitoring the baby during labour. Your baby's heart beat will be monitored during labour. This is to detect any changes that could suggest your baby is becoming distressed. The midwife can use; a Pinard stethoscope or a fetal Doppler to listen intermittently, or continuously with a monitor. This will depend on your risk at the onset and during your labour.

Posture during labour and birth. You will be encouraged to move around during labour unless your chosen pain relief makes this difficult. During the active pushing phase, many mothers wish to remain upright; there is evidence that birth can be easier in a squatting or kneeling position. It is important that you find the position which is most comfortable for you.

Eating and drinking. If you feel like eating and drinking during labour, it is advisable you eat light meals and drink fluids, to keep your energy levels up. Sometimes it is recommended you do not eat and drink, the midwife caring for you during labour will advise you based on your individual circumstances.

Pain relief. Every woman experiences labour differently and most do not know how they will feel or what pain relief they may need until the day. It is important to be aware of the various options that are available to you. In early labour, you may find: a warm bath, 'TENS' machine, breathing exercises and massage helpful. Other methods include: Entonox (gas and air), intramuscular injections of pain relieving drugs, and epidurals. It is important to keep an open mind, choose what you feel you need.

Previous caesarean section. If you have had one caesarean section in the past you have a good chance (around 75%) of having a vaginal birth this time. This is known as VBAC (vaginal birth after caesarean section). Your midwife/obstetrician will discuss with you the reason for your last caesarean and options for childbirth this time. Labour after a previous caesarean section is monitored more closely, in hospital, to make sure the scar on your uterus (womb) does not tear. If you have had two or more caesarean sections in the past, your obstetrician will discuss with you the safest type of birth for this pregnancy.

Caesarean section. There are times when it is the safest option to have a caesarean section. A caesarean section involves major surgery and should only be carried out for good reasons. The operation involves delivering your baby through a cut in your abdomen. The cut is usually made just below the bikini line. It is usual for you to be awake during the operation, with an epidural or spinal anaesthetic. A caesarean section may be planned e.g. if your baby is breech and did not turn (page 22). It may be done as an emergency during labour, if your baby is distressed or the labour is unduly prolonged.

Instrumental delivery. Extra help may be needed if you have already progressed to pushing, but the delivery needs to be speeded up. This could be because you are tired or your baby is becoming distressed. The **ventouse** method uses a suction cup that fits on your baby's head, while **forceps** are a pair of spoon-shaped instruments that fit around the head. The obstetrician will decide which one to use at the time, based on the clinical situation.

Episiotomy and Tears. The perineum (area between the vagina and anus) stretches to allow the baby to be born. It usually stretches well, but sometimes may tear. An episiotomy is a cut to make the vaginal opening larger. It is not done routinely but may be necessary: to avoid a larger and more damaging tear, to speed up the birth if the baby is becoming distressed or at the time of an instrumental delivery. You will have a local anaesthetic to freeze the area, or if you've already had an epidural, the dose can be topped up before the cut is made. The same applies if stitches (sutures) are needed to repair the episiotomy or the tear. The stitches will dissolve and will not need to be removed.

The placenta (afterbirth). The placenta and membranes usually deliver soon your baby is born. You will be offered an oxytocin injection in your thigh which helps the uterus to contract more quickly and reduces the risk of heavy bleeding (postpartum haemorrhage, PPH). Putting the baby straight to the breast helps release natural oxytocin hormone. Your baby's umbilical cord will usually be clamped and cut within 1 and 5 minutes following birth. This delay allows your baby to carry on benefiting from blood from the placenta. This will depend on the way your baby responds immediately after birth.

TENS - Transcutaneous Electrical Nerve Stimulation

Feel free to ask your midwife or doctor – or look at NHS Choices: **www.nhs.uk**

Your Preferences for Birth and after your Baby is Born

The birth of your baby is a very exciting time. The healthcare team looking after you will discuss the different options for where you can give birth e.g. at home, at a midwifery unit or maternity unit. They also offer care to you and your baby after birth, the location of the appointments will be discussed with you and will depend on your individual circumstances or preferences. You may want to use the space below to record what you would like to happen e.g. what pain relief you would like or who you want to support you during labour and birth. A personalised plan can then be developed between you and your health care team, which outlines your choices, preferences. There are sources of additional information, including NHS Choices, listed on page 30 of this booklet, which you may find helpful.

Topics	Discussed	Signature* and Date	Your wishes, intentions or preferences	Leaflets given
Where to have your baby	☐	D D M M Y Y		☐
Hospital / birth centre visit	☐			
What to bring	☐			
Who will be present	☐			
Can students be present	☐			
Signs of labour		D D M M Y Y		
contractions	☐			☐
waters breaking	☐			
Inducing labour		D D M M Y Y		☐
methods used	☐			
reason	☐			
Assessment during labour		D D M M Y Y		☐
of progress	☐			
of mother	☐			
of baby - including	☐			
fetal heart monitoring				
Posture		D D M M Y Y		☐
during labour	☐			
during delivery	☐			
Eating and drinking	☐			
Pain relief		D D M M Y Y		☐
natural methods	☐			
entonox (gas and air)	☐			
injections	☐			
epidural/spinal	☐			
Vaginal birth	☐	D D M M Y Y		☐
Water birth	☐			
VBAC	☐			
Caesarean section	☐			
Ventouse	☐			
Forceps	☐			
Breech	☐			
Perineum		D D M M Y Y		☐
episiotomy	☐			
tear	☐			
Delivery of placenta				
Active management	☐			
Physiological	☐			
Delayed cord clamping	☐			
Postnatal care		D D M M Y Y		
Frequency/location of appointments	☐			

VBAC - Vaginal Birth after Caesarean section

*** Signatures must be listed on page 30 for identification**

Name

Unit No/ NHS No

Appointments

You will be offered appointments during your pregnancy to check you and your baby's well-being. The date and time of these can be recorded below.

Date	Day of week	Time	Where	With	Reason
D D M M Y Y					

Signatures

Anyone writing in these notes should record their name and signature here

Abbreviations: CMW - Community Midwife; MW - Midwife; StM - Student Midwife; HV - Health Visitor; HCA - Health Care Asst; MSW - Maternity support worker; PT- physiotherapist; PN - Practice Nurse GP - General Practitioner; Con - Consultant; STR - Speciality Training Registrar; Reg - Registrar; FY - Foundation Year Doctor; US - Ultrasonographer

Name (print clearly)	Post	Signature

Name (print clearly)	Post	Signature

Support Groups/Additional Information

Alcohol Concern	0300 123 1110	www.alcoholconcern.org.uk
Antenatal Results and Choices	0845 077 2290	www.arc-uk.org
Birth Rights		www.birthrights.org.uk
Childline	0800 1111	www.childline.org.uk
Citizens Advice Bureaux		www.citizensadvice.org.uk
Frank About Drugs	0300 123 6600	www.talktofrank.com
Group B Strep Support Group	01444 416176	www.gbss.org.uk
Mama Academy	07427 851670	www.mamaacademy.org.uk
MIND- for better mental health	0300 123 3393	www.mind.org.uk
National Breastfeeding Helpline	0300 100 0212	www.nationalbreastfeedinghelpline.org.uk
National Childbirth Trust (NCT)	0300 330 0700	www.nct.org.uk
National Domestic Violence Helpline	0808 200 0247	www.nationaldomesticviolencehelpline.org.uk
NHS Non-Emergencies	111	
NHS Smoking Helpline	0300 123 1044	www.nhs.uk/smokefree/why-quit/smoking-in-pregnancy
NSPCC's FGM Helpline	0800 028 3550	www.nspcc.org.uk
Royal College of Midwives	0300 303 0444	www.rcm.org.uk/your-pregnancy-resources-for-women
Samaritans	116 123	www.samaritans.org
Stillbirth & Neonatal Death Charity (SANDS)	0808 164 3332	www.sands.org.uk
Tommy's Pregnancy Line	0800 0147 800	www.tommys.org

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