NHS
Manchester University
NHS Foundation Trust

Patient's Sticker

Date of Booking:...
Named Community Midwife:............................
Community Team:...

Booking Proforma

GP code and Practice Code need adding

G.P. Sticker

Home Tel. No:...
Mobile Tel. No:...
GP Tel. No:...

Housing

Owns	☐	Rents	☐	Traveller	☐
With Family/friends	☐	Homeless	☐	Prison	☐
		Temporary accommodation	☐	Other	☐

Any other previous names ....
Lone Family Yes ☐ No ☐
Occupation ....

Status

Married/Civil Partnership	☐	Single	☐
Divorced	☐	Separated	☐
Widowed	☐	Partner	☐

Main case notes reviewed: YES/NO .... If no reason why (ie. not available at time of booking)
....

Religion:.. Language spoken:...
Country of birth: ....
How long have you been a resident in the UK? ....Type of Visa...
Ethnic Origin: .... Interpreter Needed: Yes ☐ No ☐
Referral to Asylum
Seeker/Refugee Midwife: YES/NO................................ Date of Referral:...

Name of baby's biological father ....DOB...............................
Ethnic origin .... Country of Birth: ....
Address if different from woman's address...
....
Proposed contact with child Yes/No Present at booking Yes/No

Name of Partner if different from above ....DOB ....
Ethnic origin .... Country of Birth: ....
Address if different from woman's address...
....
Proposed contact with child Yes/No Present at booking Yes/No

Date of LMP.. Gestation at Booking:..
Confirmed EDD (by Scan)...
Fertility Treatment: YES/NO Confirmed EDD by embryo replacement ....
Obstetric History: Gravida: .... Para:...

Midwife Signature .... Date ....

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Patient's Sticker

POSITIVE PATIENT IDENTIFICATION ACHIEVED
Sign: ______________ Date: _______
Print: __________________
CM13634

Date of Delivery	Place	Gest	Mode of Delivery	Outcome	Sex	Wgt in Kg	Name of child including surname	Centile	Resides with?

<20 weeks gestation pregnancy losses			
Date	Gest	Nature of Loss	Comments/Investigations

Previous Obstetric history	**Yes**	**No**	**Comments**	**Clinic/NOA**
Pre-term delivery < 34 weeks			**NB.** only pre-term delivery ≤ 32 weeks needs referral to Pre-term clinic via ICE referral	Pre-term clinic via ICE referral
Mid trimester miscarriage				Pre-term clinic via ICE referral
Cervical cerclage			to be seen by 11/40 if possible	Pre-term clinic via ICE referral
Stillbirth				Rainbow clinic
Hypertension at booking: systolic >140 and or diastolic ≥ 90 Gestational hypertension onset 34 weeks or less Pre-eclampsia onset 34 weeks or less Pre-eclampsia requiring medication > 6/40 post delivery				Renal Hypertension clinic
Gestational hypertension onset > 34/40 with baby <10th centile Pre-eclampsia >34 weeks with baby <10th centile				MAVIS Clinic

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 Midwife Signature .... Date ....

Patient's Sticker

Previous Obstetric history	Yes	No	Comments	Clinic/NOA
Gestational hypertension >34 weeks with baby ≥ 10th centile Pre-eclampsia >34 weeks with baby ≥ 10th centile and medication for <6/40 post delivery			Please arrange weekly BP monitoring with CMW beginning 2 weeks before previous onset and continuing until delivery.	NOA not required
Caesarean section				General NOA
Previous surgeries			All laparotomies especially midlines; Laparoscopic/abdominal myomectomies; Moderate/Severe endometriosis +/- endometriomas that have had extensive excision; Radical trachelectomies; Previous cornual pregnancies; Endometrial ablation; Previous severe wound infections after C-sections. Previous bowel resection +/- stoma, Major pelvic surgery; Urinary diversion/ bladder surgery.	Notes for triage to Complex Caesarean Service Lead
Shoulder dystocia				General NOA
3rd or 4th degree tear				General NOA
PPH				Not required
Placental abruption				General NOA
Retained placenta				Not required
Other significant postnatal problems e.g. faecal incontinence, persistent perineal pain				General NOA

Previous Fetal Complications	Yes	No	Comments	Clinic/NOA
Previous congenital anomaly eg structural heart/brain abnormality				Discuss with Fetal Medicine Unit (66385)
Previous SGA:				
3rd - <10th Centile (no other risk factors)			Requires growth scans at 32 & 36 weeks (Request via ICE)	Midwife led SGA clinic
3rd - <10th Centile (plus additional factors risk factors)				General NOA
<3rd centile (no other risk factors)				Placenta Clinic via ICE referral form
<3rd centile (plus additional risk factors)				General NOA
Complication with baby (NICU, phototherapy, Group B Strep)				

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Midwife Signature .... Date ....

Patient's Sticker

Medical history	Yes	No	Comments	Clinic/NOA
Allergies (drugs/ anaesthetic)			Opiods or anaesthetic drugs	Anaesthetic referral
Anaesthetic problem (including spinal, epidural)				Anaesthetic referral
Medical history	**Yes**	**No**	**Comments**	**Clinic/NOA**
Admission to ITU/HDU				
Asthma (any other respiratory disease)			Asthma mild ☐ moderate ☐ severe/ brittle ☐ Other....................................	General NOA (only required if unstable, hospital admission, severe/ brittle)
Back problems			e.g scoliosis, metal rods	Anaesthetic referral
Cardiac or vascular disease				General NOA
Central nervous system disorders				Notes for triage to Neurology clinic
Cystic Fibrosis				General NOA
Chronic hypertension				refer to Renal Hypertension Team
Diabetes			Type 1 ☐ Type 2 ☐ previous gestational diabetes ☐	Diabetic clinic
Disability: Learning, physical, sensory (hearing, speech, visual)			Do you feel you will need any additional support due to this disability Yes/No	MIRF required
Endocrine disorders			Hypothyroidism ☐	General NOA
			Hyperthyroidism ☐ Pituitary related ☐ Adrenal related ☐	Endocrinology clinic
Epilepsy not requiring anti-convulsants			Approximate date of last seizure	General NOA
Epilepsy requiring anti-convulsants			Type of medication .... Approximate date of last seizure	Notes for triage to Neurology clinic
Female genital mutilation			Type of FGM................ When performed......... Would you agree to have FGM performed on a female child Yes/No	General NOA within two weeks
Genetic inherited disorders				Discuss with Fetal Medicine Unit (66385)
Haematology	**Yes**	**No**	**Comments**	**Clinic/NOA**
Autoimmune disease, on anti TNF or similar drug treatment			CHI ☐ Rheumatoid arthritis ☐ SLE ☐ Sjogren's syndrome ☐ Mixed connective tissue ☐ Antiphospholipid syndrome ☐ Other ☐ please specify	LIPs clinic
(Please specify if diagnostic results are required before a condition is confirmed)				

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 Midwife Signature .... Date ....

Patient's Sticker

Medical history	Yes	No	Comments	Clinic/NOA
Blood transfusions				
Clotting/bleeding disorder				Haematology clinic
Hepatitis C				Screening Midwives
Rhesus immunisation/other significant blood group disorders			Any red cell antibodies	MRCA clinic
			Any anti-platelet antibodies ☐ Previous (NAIT) ☐	General NOA
Thrombophilia				Haematology clinic
Venous thromboembolic disease				Haematology clinic
Infertility/IVF				Not required
Malignant disease			When occurred and treatment	General NOA
Medication in the last 6 months				
Previous Organ transplant				General NOA
Previous LLETZ (2 or more) Previous cone biopsy Known uterine malformation e.g bicornuate uterus				Pre-term clinic via ICE referral
Renal disease				Renal hypertension clinic
Serious gastro intestinal problems (e.g Crohns)				General NOA
Sexually transmitted infection including genital herpes			Please specify	
Smear tested (if appropriate) Yes/No/Never had Year of last smear .... Result	Advice given...			
Varicella - Had Chicken Pox Yes/No/Unknown	Advice given...			
YPG (19 or under at time of booking)				All teenagers are consultant-led through YPG consultant. NOA only required with risk factors

Midwife Signature .... Date ....

PROOF

Patient's Sticker

Family History: the term family means blood relatives only: e.g. your children, your parents, grandparents, brothers, sisters, uncles and aunts and their children i.e. first cousins

Has any 1st degree relative had:

Diabetes: Yes ☐ No ☐

Type...

- Venous thrombosis (blood clots) Yes ☐ No ☐
- High blood pressure/eclampsia Yes ☐ No ☐
- Hip problems from birth Yes ☐ No ☐
  eg: dislocation

Is the baby's father a blood relation Yes ☐ No ☐

First cousin ☐ Second cousin ☐ Other ☐

Has anyone had:	**In your family**	**In father of baby or father's family**
• A disease that runs in either family. Please specify	Yes ☐ No ☐	Yes ☐ No ☐
• Need for genetic counselling	Yes ☐ No ☐	Yes ☐ No ☐
• Stillbirths or consecutive miscarriages >3	Yes ☐ No ☐	Yes ☐ No ☐
• A sudden infant death	Yes ☐ No ☐	Yes ☐ No ☐
• Learning difficulties	Yes ☐ No ☐	Yes ☐ No ☐
• Hearing loss from childhood	Yes ☐ No ☐	Yes ☐ No ☐
• Heart problems from birth	Yes ☐ No ☐	Yes ☐ No ☐
• Abnormalities present at birth	Yes ☐ No ☐	Yes ☐ No ☐
• Any Metabolic disorder	Yes ☐ No ☐	Yes ☐ No ☐
• Sickle Cell anaemia	Yes ☐ No ☐	Yes ☐ No ☐
• Thalassaemia	Yes ☐ No ☐	Yes ☐ No ☐
• Muscular Dystrophy	Yes ☐ No ☐	Yes ☐ No ☐
• Cystic Fibrosis	Yes ☐ No ☐	Yes ☐ No ☐
• Tuberculosis	Yes ☐ No ☐	Yes ☐ No ☐

Comments

PROOF

 Midwife Signature .... Date ....

Patient's Sticker

Booking Investigations – must be completed fully

Height		ABO (Blood Group)	
Weight		Rhesus	
BMI .... 35-39.9 (no other risk factor) 35-39.9 (plus risk factor) 40 and above	☐ referred to Midwife BMI clinic ☐ referred for NOA ☐ referred to BMI clinic and anaesthetic referral	Antibodies	
BP		Hb	
Urinalysis – Proteinuria		Serum Ferritin	
MSSU/Antenatal screen taken		Other bloods	Please specify ....

Trisomy Screening
- ☐ Accepted
- ☐ Declined
- ☐ Undecided
- ☐ Appt arranged
- ☐ Result if tested already in pregnancy ....

HIV Testing
- ☐ Accepted
- ☐ Declined at booking
- ☐ Status known
- ☐ Result if tested already in pregnancy ....

TPHA (VDRL)
- ☐ Accepted
- ☐ Declined at booking
- ☐ Result if tested already in pregnancy ....

Hepatitis B
- ☐ Accepted
- ☐ Declined at booking
- ☐ Result if tested already in pregnancy ....

ANC use only bloods taken
- ☐ Blood Room
- ☐ ANC

N.B. If undecided then please document in management plan (Page 11 Handheld notes) and review at next appointment. If tested already please document results in Main Case Notes

Haemoglobinopathy (mother)..

Haemoglobinopathy (Partner) if applicable/known ....

All women to be offered screening irrespective of previous testing

Bloods
- ☐ Accepted
- ☐ Declined
- ☐ Undecided

If tested previously at MFT previous results:

Sickle cell ....

Thalassaemia ....

Date referred to sickle cell centre ....

Refer all women with known Haemoglobinopathy Trait/Disease to the Sickle Cell Centre.
Fax Copy of referral form to the Sickle Cell Centre. File referral form in notes with copy of Fax receipt

N.B. If undecided then please document in management plan (Page 11 Handheld notes) and review at next appointment. If tested already please document result seen.

Midwife Signature .... Date ....

PROOF

RISK ASSESSMENT / PATHWAY

Patient's Sticker

Alcohol Assessment

We ask everyone whether they drink alcohol as part of the routine health check for pregnant women. Your answers will help us provide the best possible advice and support for you and your baby.

PRE PREGNANCY

How often have you had 6 or more units on a single occasion in the last year? (one drink is rarely one unit of alcohol so use a unit calculator to add up drinks accurately).

DURING PREGNANCY	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
2. How many units of alcohol do you drink on a typical day when you are drinking?	1-2 units	3-4 units	5-6 units	7-9 units	10 units +	
3. How often have you had 6 or more units	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total score	

NO ALCOHOL = NO RISK

Staff use

AUDIT-C score	Risk level	Desired action	Midwife signature/date
0	No risk	No further action	
1-2	Explain risks	Brief advice given	
3-12	Explain health harm to mother and baby	Support referral to Specialist Midwives	

Drug Misuse/type of Drug: for example: prescribed/illicit/over the counter/internet

Yes ☐ No ☐ Details: ....

If Yes date of consent for specialist support: ....

Smoking

Currently smoking: Yes ☐ No ☐ No. of Cigarettes ☐

Or use of tobacco products (includes e cigarettes) Yes ☐ No ☐

Smoking before pregnancy but not now: Yes ☐ No ☐ Date Stopped: ....

Referral for specialist support: Accepted ☐ Declined ☐ Referral to: ....

Does your partner smoke: Yes ☐ No ☐ Risks of smoking discussed Yes ☐

 Midwife Signature .... Date ....

PROOF

Patient's Sticker

Mental health	Yes	No	Comments	Clinic/NOA
Depression (current ☐ Past ☐) Severe depression requiring treatment (including inpatient admission) ☐ Postpartum psychiatric illness (puerperal psychosis) ☐ Schizophrenia ☐ Other psychiatric ☐ Anxiety ☐ Eating disorder ☐ Other ☐				Specialist Midwives

During the past month have you often been bothered by feeling down, depressed or hopeless?
Yes/No

During the past month have you often been bothered by having little interest or pleasure in doing things?
Yes/No

During the past month have you been feeling nervous, anxious or on edge?
Not at all 0 Several Days 1 More than half the days 2 Nearly every day 3

During the past month have you not been able to stop or control worrying?
Not at all 0 Several Days 1 More than half the days 2 Nearly every day 3

Total Score = ...
Any cause for concern or score of 3 or above please refer to the woman's GP

Mental health medication	Yes	No	Specify
Mental health referral	Yes	No	When
			Seen by psychiatrist Yes ☐ No ☐
			Referred to specialist services Yes ☐ No ☐ Date referred..

Is there a family history of severe postpartum illness in a first degree relative?

PROOF

Midwife Signature .... Date ....

FW 8 issued Yes ☐ No ☐

Commenced Folic Acid? Yes ☐ No ☐

Pre-conception/post Conception. If post conception, gestational age when commenced: ....

Dose recommended 400mcg/5mg

Vitamin D advice

Informed at booking about the importance of maintaining adequate Vitamin D stores during pregnancy and breastfeeding ☐

All women advised to take a minimum dose of 10mcg/400IU of Vitamin D per day. ☐

Dose recommended 10mcg/400IU or 20mcg/800IU

MRSA Screen

An MRSA screen needs to be performed if the woman has a history of being MRSA positive or is a health care worker.

MRSA screen taken:
Yes ☐ No ☐ N/A ☐

Aspirin assessment

Women with any ONE of the following risk factors should be prescribed Aspirin 150mg once at night for the duration of the pregnancy	**Women with TWO of the following risk factors should be prescribed Aspirin 150mg once at night for the duration of the pregnancy**
Hypertensive disease during a previous pregnancy Chronic hypertension (BP > 135/85mmHg in the first trimester)	First pregnancy
	Age 40 years or older
Previous SGA <3rd Centile	Pregnancy interval of more than 10 years
Type 1 or type 2 diabetes	Body mass index (BMI) of 35 kg/m2 or more at first visit
Chronic kidney disease	Family history of pre-eclampsia
Autoimmune disease such as systemic lupus erythematosis (SLE) or antiphospholipid syndrome	Multiple pregnancy
Stillbirth due to placental problems	

Meets criteria: Yes ☐ No ☐

Aspirin prescribed or to purchase: Yes ☐ No ☐ declined ☐

Seasonal flu

Seasonal flu discussed Yes ☐ No ☐

Agree flu vaccine Yes ☐ No ☐

Whooping cough and pregnancy discussed Yes ☐ No ☐

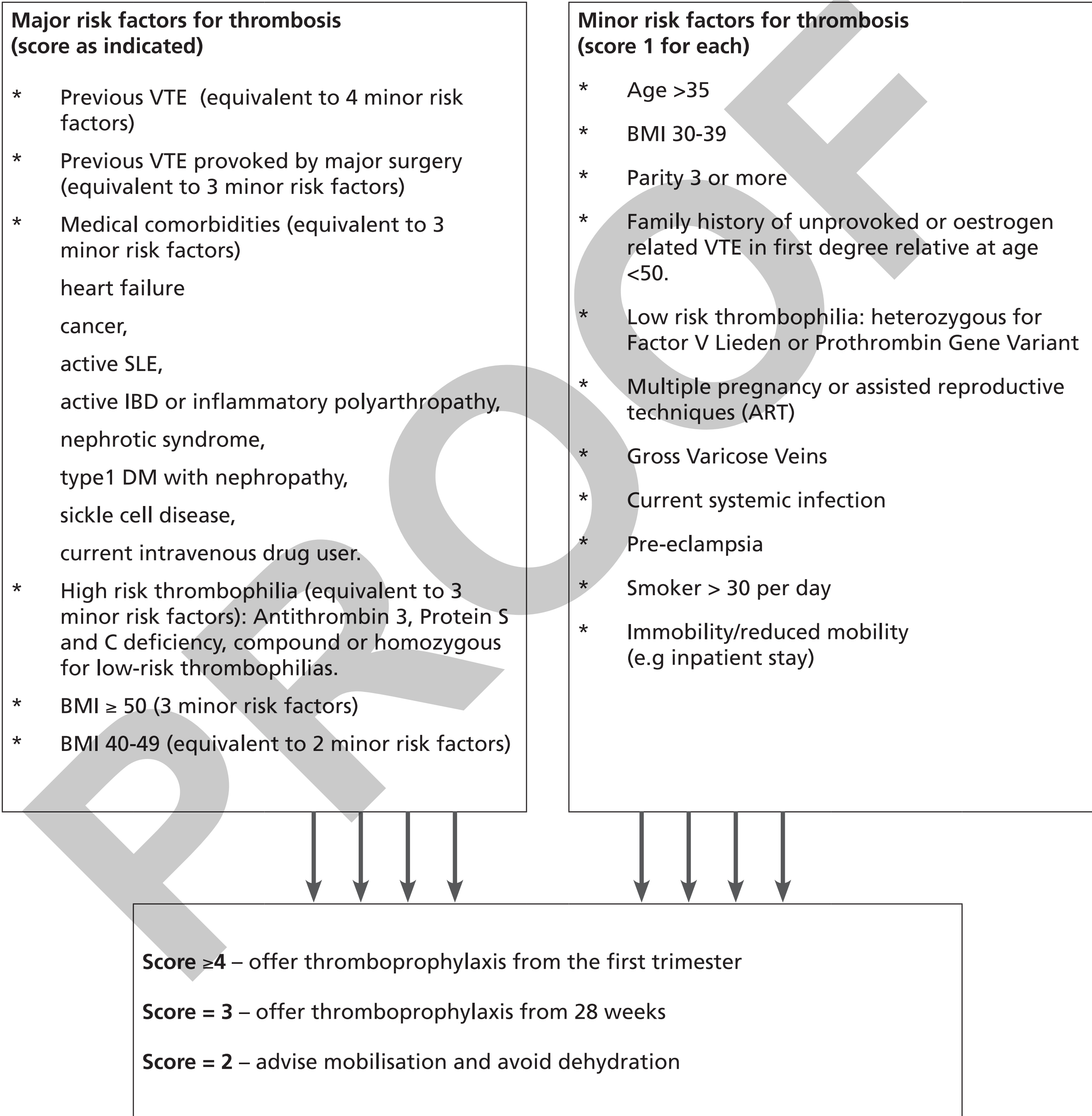
Advised about attending GP for vaccination after 16 weeks gestation Yes ☐ No ☐

Midwife Signature .... Date ....

PROOF

Patient's Sticker

Figure 1: **Antenatal risk assessment for venous thromboembolism**



Major risk factors for thrombosis (score as indicated)

- Previous VTE (equivalent to 4 minor risk factors)
- Previous VTE provoked by major surgery (equivalent to 3 minor risk factors)
- Medical comorbidities (equivalent to 3 minor risk factors)
  - heart failure
  - cancer,
  - active SLE,
  - active IBD or inflammatory polyarthropathy,
  - nephrotic syndrome,
  - type1 DM with nephropathy,
  - sickle cell disease,
  - current intravenous drug user.
- High risk thrombophilia (equivalent to 3 minor risk factors): Antithrombin 3, Protein S and C deficiency, compound or homozygous for low-risk thrombophilias.
- BMI ≥ 50 (3 minor risk factors)
- BMI 40-49 (equivalent to 2 minor risk factors)

Minor risk factors for thrombosis (score 1 for each)

- Age >35
- BMI 30-39
- Parity 3 or more
- Family history of unprovoked or oestrogen related VTE in first degree relative at age <50.
- Low risk thrombophilia: heterozygous for Factor V Lieden or Prothrombin Gene Variant
- Multiple pregnancy or assisted reproductive techniques (ART)
- Gross Varicose Veins
- Current systemic infection
- Pre-eclampsia
- Smoker > 30 per day
- Immobility/reduced mobility (e.g inpatient stay)

Score ≥4 – offer thromboprophylaxis from the first trimester

Score = 3 – offer thromboprophylaxis from 28 weeks

Score = 2 – advise mobilisation and avoid dehydration

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Midwife Signature .... Date ....

Patient's Sticker

Cardio/Respiratory Check: Required/Not required	If required refer to GP:

Do you give consent for the children's centre to receive your details? Yes ☐ No ☐
Consent for data sharing: Implied/Explicit/Refused

	Yes	No	Comments
T13 T18 T21 *(circle as appropriate)* Quad test			**Date of Appointment**
Anomaly Scan			**Date of Appointment**
GTT 26/40 **as per referral criteria guidance** **Reason:**			**Any ONE of the following:** • BMI 30kg/m2 or higher • Previous large baby (>4.5kg or >95th centile on customised chart) • Previous gestational diabetes • Parent, brother or sister with diabetes • Women with a family origin with a high prevalence of diabetes which includes South Asian (specifically from India, Pakistan and Bangladesh), Black Caribbean and Middle Eastern (specifically from Saudi Arabia, United Emirates, Jordon, Oman, Kuwait, Lebanon and Egypt).
Anaesthetic referral via ICE **Reason:**			
Blood Products Discussed:			**Accepts/Declines**
Internet Access			**If NO Hard Copies of Leaflets given** Yes/No
Signposted to			**http://www.mft.nhs.uk/saint-marys/our-services/maternity-services/patient-information-leaflets**

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 Midwife Signature .... Date ....

Patient's Sticker

Please do not put this page in the hand held notes

Domestic abuse discussed: ☐ (insert appropriate triangle near confirmed EDD in main notes and front cover of HHN). Date:________________________

RIC Assessment Indicated Yes ☐ No ☐ Date completed__________________________

Has IDVA support been offered Yes ☐ No ☐ If not why__________________________

Referral made to IDVA Yes ☐ No ☐

If domestic abuse not discussed please indicate why and document plan for future routine enquiry.

____

____

Any current/previous Social Services involvement?

You/Partner/Children Yes ☐ No ☐ Name of Social Worker______________________________

Details including year of involvement____

If patient informs that case is closed contact relevant Children's Social Care to confirm.

Closed ☐ Still Open ☐ N/A ☐ Date of contact ______________________________________

Details ____

Based on all booking information is a Safeguarding Referral Required: Yes ☐ No ☐

If yes please indicate: MIRF ☐ OR Multi Agency Referral Form (Social Care) completed ☐

Referral sent to:	**Yes**	**No**	**DATE**	**SIGNATURE**
Children's Social Care				
Adult Social Care				
Sp. M/w HIV				
Sp. M/w Substance Misuse (inc. alcohol)				
Sp. M/w Mental Health				
Sp. M/w Refugees/Asylum Seekers				
Sp. M/w YPG				
Vulnerable Babies Project				
CONI/ CONI Plus				
Other				

HAS A COPY BEEN SENT TO safeguarding.maternity@mft.nhs.uk and receipt obtained ☐

Midwife Signature .... Date ....

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Patient's Sticker

Type of Maternity Care at Booking

☐ Midwifery Led Care

☐ Independent Midwife

☐ Consultant led shared care (risk factors identified)

☐ Consultant led specialist care

☐ Transfer of care

Name of hospital: ______________________________

Assessment for place birth

☐ Suitable for home birth if wishes

☐ Suitable for birth in midwife led unit

☐ Advised to give birth in hospital under care of Maternity team (risk factors identified)

Proposed/Choice of place of Birth ____

Next Appointment

Date:.. Time: .... SMH: ....

Date:.. Time: .... Comm: ....

Name of Midwife (please print)...

Signature: ....

Name of Consultant (Please print)..

Signature: ....

PROOF

 Midwife Signature .... Date ....

Patient's Sticker

	PLEASE CLEARLY STATE THE REASON FOR A NEW OBSTETRIC APPOINTMENT (NOA) IF REQUESTED
	ANTENATAL SPECIAL INSTRUCTIONS
DATE	**ADDITIONAL ANTENATAL REMARKS**

Midwife Signature .... Date ....

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Continuation

DATE	ADDITIONAL ANTENATAL REMARKS

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