



health

Department:
Health
REPUBLIC OF SOUTH AFRICA

Maternity Case Records

This record must always accompany the woman when transferred to another health facility.

This record must be filed at the facility discharging the woman after birth.

Failure to create and maintain a record or to remove a record is an offence in terms of section 17(2) of the National Health Act (61 of 2003)

This record book is valid for the duration of the pregnancy and puerperium and includes all patient encounters. The relevant ward/ clinic/ subsection must clearly print (stamp) the name of the section and the date the service was rendered

Level of care	
Antenatal clinic:	Delivery site:
Transport when in labour:	

Name of patient or place large patient sticker here

Name..... Surname

Address.....

Next to School/Shop.....

MomConnect

Date registered...../...../.....

Woman's name

ID Number

Religion

Institution file number

Record book number

Consent for blood products

Name of birth companion

Contact number of birth companion

Community health worker name

Contact detail of mandate
Name of person mandated to consent on behalf of woman when appropriate

Contact telephone number of mandate

Should I be unable to consent myself, I mandate the above in terms of the National Health Act to do so on my behalf.

Signed..... Date.....Witness.....

Danger signs in pregnancy

I have severe headache.
My hands feel stiff.
My rings are tight.
My feet are swollen.
PRE-ECLAMPSIA

I am unable to stop
worrying. I feel down,
depressed and hopeless. I
think about hurting myself.
DEPRESSION

I feel tired.
I feel weak.
I have no energy.
ANAEMIA

DECREASING
BABY KICKS OR
NO KICKS AT
ALL

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

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

I have a vaginal
discharge that itches or
smells foul.
VAGINAL INFECTION

I want to pass urine
all the time and it
burns.
URINARY TRACT
INFECTION

I have bleeding
from the vagina.
ANTEPARTUM
HAEMORRHAGE

Go to your nearest clinic or hospital
immediately if you have any of these
problems.

SBAR clinical report on maternity situation

Date:

R

A

B

S

S	<p>SITUATION</p> <p>I am calling about (name of woman) _____ Ward: _____</p> <p>Hospital number _____</p> <p>The problem I am calling about is _____</p> <p>I just made an assessment of the patient:</p> <p>Vital signs:- BP ____ / ____ Pulse ____ resp rate / ____ Oxygen saturation / ____ % Oxygen at ____ l/min</p> <p>Temperature ____ C</p> <p>I am concerned about:</p> <p>Blood pressure because:</p> <p style="margin-left: 20px;">Systolic pressure greater than 160 mm Hg</p> <p style="margin-left: 20px;">Diastolic pressure more than 100 mm Hg</p> <p style="margin-left: 20px;">Systolic pressure less than 90</p> <p>Pulse because:</p> <p style="margin-left: 20px;">Pulse rate more than 120</p> <p style="margin-left: 20px;">Pulse rate less than 40</p> <p style="margin-left: 20px;">Pulse rate greater than systolic BP</p> <p>Respiration rate because:</p> <p style="margin-left: 20px;">Rate less than 10/min</p> <p style="margin-left: 20px;">Rate more than 24/min</p> <p style="text-align: right;">Urine output:</p> <p style="margin-left: 20px;">Output less than 100 ml over last 4 hours</p> <p style="margin-left: 20px;">Significant proteinuria (++/+++)</p> <p>Haemorrhage</p> <p style="margin-left: 20px;">Antepartum</p> <p style="margin-left: 20px;">Postpartum</p> <p>Fetal well being</p> <p style="margin-left: 20px;">CTG pathology</p> <p style="text-align: right;">Early obstetric warning scores: _____</p>
B	<p>BACKGROUND (tick relevant sections)</p> <p><input type="checkbox"/> The woman is:-</p> <p style="margin-left: 20px;">Parity [primiparous / multiparous / grand multiparous] with gestation _____ weeks and a [singleton/ multiple] pregnancy</p> <p style="margin-left: 20px;">She had _____ previous caesarean sections or episodes of uterine surgery</p> <p><input type="checkbox"/> The present fetal assessment is:</p> <p style="margin-left: 20px;">Fundal height _____ cm Presentation _____ with _____ fifths head above brim: Fetal heart rate _____ bpm</p> <p style="margin-left: 20px;">CTG : Not done / normal/ suspicious / pathological</p> <p><input type="checkbox"/> Antenatal risks</p> <p style="margin-left: 20px;">Risks identified on antenatal card _____</p> <p><input type="checkbox"/> Labour</p> <p style="margin-left: 20px;">Not in labour / spontaneous onset of labour/ induced labour</p> <p style="margin-left: 20px;">IUGR / Pre-eclampsia/ reduced fetal movements/ Diabetes/ Antepartum haemorrhage</p> <p style="margin-left: 40px;">On oxytocin infusion (_____ IU/ _____ ml fluid given at _____ ml/hour)</p> <p style="margin-left: 40px;">Most recent vaginal examination done at _____ h Dilated _____ cm with _____ above brim and position</p> <p style="margin-left: 20px;">Membranes : Intact / ruptured at _____ h with currently clear / meconium stained liquor / Blood stained liquor</p> <p style="margin-left: 20px;">Delivered _____ at _____ with 3rd stage complete / retained placenta</p> <p><input type="checkbox"/> Post Natal</p> <p style="margin-left: 20px;">Delivery date _____ at _____ h _____ Type of delivery _____ With / without perineal trauma</p> <p style="margin-left: 20px;">Blood loss _____ ml Oxytocin infusion _____ IU / _____ ml at _____ ml / hour</p> <p style="margin-left: 20px;">Fundal height: High / Atonic/ Tender / Abdominal- / perineal wound oozing</p> <p><input type="checkbox"/> Treatment given/ in progress</p> <p style="margin-left: 20px;">Rx _____</p>
A	<p>ASSESSMENT</p> <p>I think the problem is _____</p> <p>The problem may be related to: Cardiac / infection / respiratory / haemorrhage / PET / HELLP / Embolism / Pulm edema / Fetal distress</p> <p>I am not sure what the problem is, but the woman is deteriorating and we need to do something</p>
R	<p>RECOMMENDATION</p> <p>Request</p> <p><input type="checkbox"/> Please come and see the woman immediately</p> <p><input type="checkbox"/> I think delivery need to be expedited</p> <p><input type="checkbox"/> I think the patient need to be transferred</p> <p><input type="checkbox"/> I would like advice on management of the patient</p> <p>Response</p> <p>_____</p>

Person completing form: (name) _____ Rank _____

Date _____ Time _____

Person reported to (Name) _____ Rank _____ Inst _____

Extra copy of SBAR if referral is needed during antenatal care

Blank page (back of SBAR)

Blank page (back of SBAR)

Patient Sticker

PMTCT Checklist

This is a checklist ONLY and does not replace official patient records.

HIV TESTING

HIV status unknown or previously negative

- | | | | | |
|--|----------------|------------------------------|------------------------------|--------------------------------|
| <input type="checkbox"/> Tested when pregnancy was confirmed | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 20 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 26 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 30 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 34 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 36 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 38 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 40 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |

ANTENATAL CARE

Known HIV not on ART / New HIV during pregnancy

- Started ART on the day of diagnosis Date: __/__/__ (integrated antenatal and ART services)
 Started AZT and referred for urgent ART Date: __/__/__ (antenatal and ART services not yet integrated)

Gestation at ART start: _____

Regimen: _____

CD4 at booking: _____

Creatinine _____

VL: _____	Date: __/__/__	Gestation: _____	_____
VL: _____	Date: __/__/__	Gestation: _____	_____
VL: _____	Date: __/__/__	Gestation: _____	_____
VL: _____	Date: __/__/__	Gestation: _____	_____

Known HIV on ART

Regimen: _____

Last ART visit: Date: __/__/__ Facility: _____

Site where ART will be accessed during pregnancy: _____

VL: _____ Date: __/__/__

VL: _____ Date: __/__/__ Gestation: _____

VL: _____ Date: __/__/__ Gestation: _____

VL: _____ Date: __/__/__ Gestation: _____

LABOUR & DELIVERY

VL: _____ Date: __/__/__ Gestation: _____

DATE

TIME

Client on ART

Continue ART Regimen: _____ Time taken: _____

Client not on ART [e.g. unbooked, on AZT prophylaxis, HIV diagnosis in labour, defaulted prior to delivery (≥ 1 week)]

Stat NVP Yes No

Stat TDF, 3TC and DTG Yes No

Mother's response to diagnosis:	
• Accepted and managing well	<input type="checkbox"/>
• Struggling with diagnosis	<input type="checkbox"/>
Help needed with disclosure issues:	yes/no
Support needed	yes/no
Referred to counsellor	yes/no

Back page of PMTCT

Patient Sticker

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HIV TESTING

HIV status unknown or previously negative

- | | | | | |
|--|----------------|------------------------------|------------------------------|--------------------------------|
| <input type="checkbox"/> Tested when pregnancy was confirmed | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 20 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 26 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 30 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 34 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 36 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 38 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |
| <input type="checkbox"/> Retested at 40 weeks | Date: __/__/__ | <input type="checkbox"/> Pos | <input type="checkbox"/> Neg | (if previous negative/unknown) |

ANTENATAL CARE

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Creatinine _____

VL: _____	Date: __/__/__	Gestation: _____	_____
VL: _____	Date: __/__/__	Gestation: _____	_____
VL: _____	Date: __/__/__	Gestation: _____	_____
VL: _____	Date: __/__/__	Gestation: _____	_____

Known HIV on ART

Regimen: _____

Last ART visit: Date: __/__/__ Facility: _____

Site where ART will be accessed during pregnancy: _____

VL: _____ Date: __/__/__

VL: _____ Date: __/__/__ Gestation: _____

VL: _____ Date: __/__/__ Gestation: _____

VL: _____ Date: __/__/__ Gestation: _____

LABOUR & DELIVERY

VL: _____ Date: __/__/__ Gestation: _____

DATE

TIME

Client on ART

Continue ART Regimen: _____ Time taken: _____

Client not on ART [e.g. unbooked, on AZT prophylaxis, HIV diagnosis in labour, defaulted prior to delivery (≥ 1 week)]

Stat NVP Yes No

Stat TDF, 3TC and DTG Yes No

Mother's response to diagnosis:	
• Accepted and managing well	<input type="checkbox"/>
• Struggling with diagnosis	<input type="checkbox"/>
Help needed with disclosure issues:	yes/no
Support needed	yes/no
Referred to counsellor	yes/no

Back page of PMTCT

MENTAL HEALTH SCREEN

Conduct a mental health screen for all pregnant women.
 Refer if needed to appropriate service, such as mental health nurse, social services, NGO, medical officer, counsellor, psychiatrists or other services.

Suggested words to use before screening.

“We would like to know about all the women who come here: how they are doing physically and emotionally. This helps us to understand the best sort of care we can offer. Please may I ask you three questions about how you are emotionally? Please answer ‘yes’ or ‘no’ to each question.”

In the last 2 weeks, have you on some or most days felt unable to stop worrying or thinking too much?	<input type="checkbox"/> Yes [1]	<input type="checkbox"/> No [0]
In the last 2 weeks, have you on some or most days felt down, depressed or hopeless?	<input type="checkbox"/> Yes [1]	<input type="checkbox"/> No [0]
In the last 2 weeks, have you on some or most days had thoughts and plans to harm yourself or commit suicide?*	<input type="checkbox"/> Yes Refer [1]	<input type="checkbox"/> No [0]
TOTAL SCORE	0 or 1 2 >>>>>>>>>> refer 3 >>>>>>>>>> refer	
Offered Counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Accepted counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**the self-harm question will require urgent referral if there are both thoughts AND plans. If there is a history of previous attempt, referral is required even if there are thoughts alone.*

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

Name _____
 Folder number _____
 Date of birth _____

Age: _____ (yrs) G _____ P _____ Misc _____

OBSTETRIC AND NEONATAL HISTORY						
Year	Gestation	Delivery	Weight	Sex	Outcome*	Complications

*A=Alive; ID= Infant Death, NND=Neonatal Death, IUD=Intra-uterine death

Descriptions of complications: _____

MEDICAL AND GENERAL HISTORY

Hypertension Diabetes Cardiac Asthma TB

Epilepsy Mental health HIV Other

If yes, give detail _____

Family history Twins Diabetes TB Congenital

Details _____
 Medication _____
 Operations _____
 Allergies _____

TB symptom screen pos neg Use of herbal medicine

Tobacco Alcohol Substances Use of OTC drugs

Psychosocial risk factors _____

CLINIC _____

d	d	m	m	y	y
---	---	---	---	---	---

EXAMINATION

BP _____ / _____ mmHg Urine _____

Height _____ cm Weight _____ kg

MUAC _____ cm BMI _____ kg/m²

Thyroid _____ Breasts _____

Heart _____

Lungs _____

Abdomen _____

SF Measurement at booking _____ cm

VAGINAL EXAMINATION

Examination explained and permission obtained

Vulva and vagina _____

Cervix _____

Uterus _____

Pap smear done Y N Date _____

Result _____

INVESTIGATIONS

Syphilis test Pos Neg Repeat syphilis test Pos Neg

Treatment: 1st Pos Neg 2nd 3rd

Rhesus Pos Neg Antibodies Yes No

Hb _____ g/dl Tetox 1st _____ 2nd _____ 3rd _____

Urine MCS: Date _____ Result _____

Screening for gestational diabetes _____ 28w

HIV status at booking Unknown Pos On ART Y N

HIV test at booking DD/MM/YY Pos Neg Declined

HIV re-test DD/MM/YY Pos Neg Declined

HIV re-test DD/MM/YY Pos Neg Declined

CD 4 _____ ART initiated on _____ DD/MM/YY

Viral load: Date _____ Result _____

Viral load: Date _____ Result _____

Viral load: Date _____ Result _____

Other: _____

GESTATIONAL AGE

LNMP _____ DD/MM/YYYY Certain? Y N

SONAR _____ DD/MM/YYYY

BPD _____ HC _____

AC _____ FL _____

Placenta _____ AFI _____

Average gestation _____ CRL _____

Singleton Multiple pregnancy Intra-uterine pregnancy

ESTIMATED DATE OF DELIVERY _____ DD/MM/YYYY

Method used to calculate EDD Sonar SF LNMP

MENTAL HEALTH

Mental health screening: Y N Score _____

Discussed and noted in case record Y

Where referred for mental health? _____

BIRTH COMPANION

Birth companion discussed and noted on MCR Y

COUNSELLING

Topic	Date 1	Date 2
Fetal movements		
Parental preparedness		
Nutrition		
Danger signs		
HIV		
Mental health		
Alcohol		
Tobacco		
Substances		
Domestic violence		
Labour and birth preparedness		
Breast care		
Infant feeding		

FUTURE CONTRACEPTION (PROVIDE DUAL PROTECTION)

Implant Intra-uterine device Tubal ligation Oral

All management plans discussed with patient

Educational material given on pregnancy and patient rights

If tubal ligation selected, adequate counselling was given

BOOKING VISIT AND ASSESSMENT OF RISK DONE BY _____

MENTAL HEALTH SCREEN

Conduct a mental health screen for all pregnant women.

Refer if needed to appropriate service, such as mental health nurse, social services, NGO, medical officer, counsellor, psychiatrists or other services.

Suggested words to use before screening.

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In the last 2 weeks, have you on some or most days felt down, depressed or hopeless?	<input type="checkbox"/> Yes [1]	<input type="checkbox"/> No [0]
In the last 2 weeks, have you on some or most days had thoughts and plans to harm yourself or commit suicide?*	<input type="checkbox"/> Yes [1] Refer	<input type="checkbox"/> No [0]
TOTAL SCORE	0 or 1 2 >>>>>>>>>> refer 3 >>>>>>>>>> refer	
Offered Counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Accepted counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**the self-harm question will require urgent referral if there are both thoughts AND plans. If there is a history of previous attempt, referral is required even if there are thoughts alone.*

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

Name _____

Folder number _____

Date of birth _____

Age: _____ (yrs) G _____ P _____ Misc _____

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Year	Gestation	Delivery	Weight	Sex	Outcome*	Complications

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Epilepsy Mental health HIV Other

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Operations _____

Allergies _____

TB symptom screen pos neg

Use of herbal medicine

Tobacco Alcohol Substances

Use of OTC drugs

Psychosocial risk factors _____

CLINIC _____

d d m m y y

EXAMINATION

BP _____ / _____ mmHg Urine _____

Height _____ cm Weight _____ kg

MUAC _____ cm BMI _____ kg/m²

Thyroid _____ Breasts _____

Heart _____

Lungs _____

Abdomen _____

SF Measurement at booking _____ cm

VAGINAL EXAMINATION

Examination explained and permission obtained

Vulva and vagina _____

Cervix _____

Uterus _____

Pap smear done Y N Date _____

Result _____

INVESTIGATIONS

Syphilis test Pos Neg Repeat syphilis test Pos Neg

Treatment: 1st Pos Neg 2nd Pos Neg 3rd Pos Neg

Rhesus Pos Neg Antibodies Yes No

Hb _____ g/dl Tetox 1st _____ 2nd _____ 3rd _____

Urine MCS: Date _____ Result _____

Screening for gestational diabetes _____ 28w

HIV status at booking Unknown Pos Neg On ART Y N

HIV test at booking DD/MM/YY Pos Neg Declined

HIV re-test DD/MM/YY Pos Neg Declined

HIV re-test DD/MM/YY Pos Neg Declined

CD 4 _____ ART initiated on _____ DD/MM/YY

Viral load: Date _____ Result _____

Viral load: Date _____ Result _____

Viral load: Date _____ Result _____

Other: _____

GESTATIONAL AGE

LNMP _____ DD/MM/YYYY Certain? Y N

SONAR _____ DD/MM/YYYY

BPD _____ HC _____

AC _____ FL _____

Placenta _____ AFI _____

Average gestation _____ CRL _____

Singleton Multiple pregnancy Intra-uterine pregnancy

ESTIMATED DATE OF DELIVERY

_____ DD/MM/YYYY

Method used to calculate EDD Sonar SF LNMP

MENTAL HEALTH

Mental health screening: Y N Score _____

Discussed and noted in case record Y

Where referred for mental health? _____

BIRTH COMPANION

Birth companion discussed and noted on MCR Y

COUNSELLING

Topic	Date 1	Date 2
Fetal movements		
Parental preparedness		
Nutrition		
Danger signs		
HIV		
Mental health		
Alcohol		
Tobacco		
Substances		
Domestic violence		
Labour and birth preparedness		
Breast care		
Infant feeding		

FUTURE CONTRACEPTION (PROVIDE DUAL PROTECTION)

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BOOKING VISIT AND ASSESSMENT OF RISK DONE BY _____

NOTES FOR ANTENATAL VISITS continued

Essential additional facts only (Do not duplicate data)		Name (print) and signature
I have introduced myself by name to this person <input type="checkbox"/> TB screen done <input type="checkbox"/>		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands <input type="checkbox"/>		
I have introduced myself by name to this person <input type="checkbox"/> TB screen done <input type="checkbox"/>		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands <input type="checkbox"/>		
I have introduced myself by name to this person <input type="checkbox"/> TB screen done <input type="checkbox"/>		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands <input type="checkbox"/>		
I have introduced myself by name to this person <input type="checkbox"/> TB screen done <input type="checkbox"/>		
Date and time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands <input type="checkbox"/>		

INITIAL ASSESSMENT

DD/MM/YYYY

HH/MM

Name of health care worker:

I have introduced myself by name to this person

[Large empty box with horizontal dotted lines for notes]

Assessment findings	Differential diagnosis

Working diagnosis

Proposed management plan

[Empty box with horizontal dotted lines for notes]

All procedures have been explained and verbally consented by the person

I have checked with the person regarding her birth companion

If problem/ diagnosis is prior to delivery- continue clinical notes on page 19

If problem/diagnosis is during established labour- continue clinical notes in labour section page 30

If problem/diagnosis is after delivery- continue clinical notes in post natal section page 50

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

DD/MM/YYYY

Performed by:

I have introduced myself by name to this person

Intrauterine	Yes	No	Number of fetuses		
Fetal movements	Yes	No	Heartbeat	Yes	No
Fetal lie	cephalic	breech	transverse		
Placenta	anterior	posterior	lateral		
	high	low	distance from os	mm	
Liquor	normal	reduced	increased	Deepest pool	cm

BIOMETRY- (attach hard copy if available)

Biparietal diameter (BPD)	mm	Weeks:	days:
Head circumference (HC)	mm	Weeks:	days:
Abdominal circumference (AC)	mm	Weeks:	days:
Femur length (FL)	mm	Weeks:	days:
Measurements concordant (8 days or less difference)	Measurements discordant (more than 8 days difference)		
Average gestation	WEEKS:	DAYS:	Estimated fetal weight (EFW):

DD/MM/YYYY

Performed by:

I have introduced myself by name to this person

Intrauterine	Yes	No	Number of fetuses		
Fetal movements	Yes	No	Heartbeat	Yes	No
Fetal lie	cephalic	breech	transverse		
Placenta	anterior	posterior	lateral		
	high	low	distance from os	mm	
Liquor	normal	reduced	increased	Deepest pool	cm

BIOMETRY- (attach hard copy if available)

Biparietal diameter (BPD)	mm	Weeks:	days:
Head circumference (HC)	mm	Weeks:	days:
Abdominal circumference (AC)	mm	Weeks:	days:
Femur length (FL)	mm	Weeks:	days:
Measurements concordant (8 days or less difference)	Measurements discordant (more than 8 days difference)		
Average gestation	WEEKS:	DAYS:	Estimated Fetal Weight:

OBSERVATION CHART when the diagnosis of labour is doubtful

Name:	Age:	G:	P:	Gestational age:	
Facility:	Hb:	Presentation:			
Companion:					
Risk factors:					
Assessment 1: Date and time					
Mother	Blood Pressure				
	Pulse				
	Temperature				
	Urine dipstick				
	Fetal movement felt	Yes	No	No	
	Emergency signs (bleeding, seizures, etc)	No	Yes	Yes	
	Contractions per 10 minutes				
	<20 sec 20-40 sec >40 sec				
	Maternal emotional state				
	FHR: normal baseline, no decelerations	Yes	No	No	
Fetus	Head above brim				
	Dilatation				
	Cervical length				
	Membranes intact	Yes	No	No	
	Is the maternal condition reassuring?	Yes	No	No	
	Is the fetal condition reassuring?	Yes	No	No	
	Plan:				
	Initials and signature:				
	Assessment 2: Date and time				
	Blood pressure				
Pulse					
Temperature					
Urine dipstick					
Fetal movement felt	Yes	No	Yes	No	
Emergency signs (bleeding, seizures, etc)	No	Yes	No	Yes	
Contractions per 10 minutes					
<20 sec 20-40 sec >40 sec					
Maternal emotional state					
FHR: normal baseline, no decelerations	Yes	Yes	Yes	No	
Head above brim					
Dilatation					
Cervical length					
Membranes intact	Yes	Yes	Yes	No	
Is the maternal condition reassuring?	Yes	No	Yes	No	
Is the fetal condition reassuring?	Yes	No	Yes	No	
Plan:					
Initials and signature:					
Plan (if not discharged):					
Reassuring maternal condition?	Yes	No	No	No	
Reassuring fetal condition?	Yes	No	No	No	
Intact membranes?	Yes	No	No	No	
No cervical changes since admission?	None	Changes	Changes	Changes	
Warning signs have been explained?	Yes	No	No	No	
The mother understands the danger signs?	Yes	No	No	No	
Follow-up date:					
Initials and signature:					
Discharge checklist					
Reassuring maternal condition?	Yes	No	No	No	
Reassuring fetal condition?	Yes	No	No	No	
Intact membranes?	Yes	No	No	No	
No cervical changes since admission?	None	Changes	Changes	Changes	
Warning signs have been explained?	Yes	No	No	No	
The mother understands the danger signs?	Yes	No	No	No	
Follow-up date:					
Initials and signature:					

EARLY WARNING OBSERVATION CHART FOR ANTENATAL ADMISSIONS

Date																				Date
Time																				Time
RESPIRATORY	>30																			>30
	21-30																			21-30
	11-20																			11-20
	0-10																			0-10
SATURATION	95-100%																			95-100%
	<95%																			<95%
TEMPERATURE	39°C																			39°C
	38°C																			38°C
	37°C																			37°C
	36°C																			36°C
	35°C																			35°C
Hb (plot actual value)	≥ 8 g/dl																			≥ 8 g/dl
	< 8 g/dl																			< 8 g/dl
MATERNAL HEART RATE	140																			140
	130																			130
	120																			120
	110																			110
	100																			100
	90																			90
	80																			80
	70																			70
	60																			60
	50																			50
	40																			40
SYSTOLIC BLOOD PRESSURE	170																			170
	160																			160
	150																			150
	140																			140
	130																			130
	120																			120
	110																			110
	100																			100
	90																			90
	80																			80
	70																			70
60																			60	
50																			50	
40																			40	
DIASTOLIC BLOOD PRESSURE	120																			120
	110																			110
	100																			100
	90																			90
	80																			80
	70																			70
	60																			60
	50																			50
40																			40	
Urine (VOLUME in ml/hour)																				ml/hour
Proteinuria	Clear (-)																			Clear (-)
	+																			+
	++ to +++																			++ to +++
Fetal heart rate (bpm)																				Fetal heart rate
Vaginal Bleeding	Spotting																			Spotting
	Clots																			Clots
	Bright red																			Bright red
Neuro response	Alert																			Alert
	Vocal																			Vocal
	Pain																			Pain
	Unresponsive																			Unresponsive
Pain	None-mild																			None-mild
	Severe																			Severe
Looks unwell	No (✓)																			No (✓)
	Yes (✓)																			Yes (✓)
TOTAL YELLOW SCORE																				TOTAL
TOTAL RED SCORE																				TOTAL
DOCTOR CALLED (Y/N)																				
Signature																				

EARLY WARNING OBSERVATION CHART FOR ANTENATAL ADMISSIONS

Date																				Date
Time																				Time
RESPIRATORY	>30																			>30
	21-30																			21-30
	11-20																			11-20
	0-10																			0-10
SATURATION	95-100%																			95-100%
	<95%																			<95%
TEMPERATURE	39°C																			39°C
	38°C																			38°C
	37°C																			37°C
	36°C																			36°C
	35°C																			35°C
Hb (plot actual value)	≥ 8 g/dl																			≥ 8 g/dl
	< 8 g/dl																			< 8 g/dl
MATERNAL HEART RATE	140																			140
	130																			130
	120																			120
	110																			110
	100																			100
	90																			90
	80																			80
	70																			70
	60																			60
	50																			50
	40																			40
SYSTOLIC BLOOD PRESSURE	170																			170
	160																			160
	150																			150
	140																			140
	130																			130
	120																			120
	110																			110
	100																			100
	90																			90
	80																			80
	70																			70
60																			60	
50																			50	
40																			40	
DIASTOLIC BLOOD PRESSURE	120																			120
	110																			110
	100																			100
	90																			90
	80																			80
	70																			70
	60																			60
	50																			50
40																			40	
Urine (VOLUME in ml/hour)																				ml/hour
Proteinuria	Clear (-)																			Clear (-)
	+																			+
	++ to +++																			++ to +++
Fetal heart rate (bpm)																				Fetal heart rate
Vaginal Bleeding	Spotting																			Spotting
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	Pain																			Pain
	Unresponsive																			Unresponsive
Pain	None-mild																			None-mild
	Severe																			Severe
Looks unwell	No (✓)																			No (✓)
	Yes (✓)																			Yes (✓)
TOTAL YELLOW SCORE																				TOTAL
TOTAL RED SCORE																				TOTAL
DOCTOR CALLED (Y/N)																				
Signature																				

LABOUR- INITIAL ASSESSMENT (use this chart when the diagnosis of labour is certain)

Date: Time assessed: Time of admission:
 Age: Gravidity: Parity: Assessed by:
 I have introduced myself by name to this person Gestational age: Nutritional status:
 If referred From: Time of referral:
 Reasons for referral:

Date and time: Onset of labour ROM: Bleeding:
Booked: Yes No If not booked, reason:
 Name of clinic: Gest. Age at 1st booking No of visits
 Gestational age: weeks and days based on: Ultrasound Booking SF LNMP
 Labour companion is present OR Offered to call a person she trusts to be with her in labour
 Hb: Rhesus: Pos Neg If Rh neg: antibodies Syphilis tests:
 HIV results: Pos Neg If HIV neg, retest during labour: Pos Neg
 ART: Yes No Regimen:

Main complaints

Convulsions	Bleeding	Severe abd pain	Looks very ill	Headache/visual disturbances	Severe difficulty breathing	Fever
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GENERAL EXAMINATION

General: Pulse: BP: Temp: Appearance:
 Chest: CVS:
 Other systems: MUAC:
 Urinary analysis:

ABDOMINAL EXAMINATION

Lie: Longitudinal Transverse Oblique **Scars:** Transverse Vertical Other:
Presentation: Cephalic Breech SF height
Liquor: Normal Decreased Increased **EFW:** gram
Level of head palpable above pelvic brim (in fifths) 5 4 3 2 1 0
Contractions mild moderate strong **Fetal heart rate:** Normal Abnormal Absent
Type of FHR abnormality:

VAGINAL EXAMINATION

Speculum: Liquor Blood Cervix
Digital exam: cervix

Thick	Thin	Edematous	Not felt	Application:	Good	Poor
Dilatation:		Length:		Position:		

Presenting part: Position: Moulding PP

0	+	++	+++
---	---	----	-----

 Caput:

0	+	++
---	---	----

Liquor: Clear Meconium stained liquor No Thin Thick

Blood stained	Offensive
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Pelvic assessment: Adequate Inadequate Unsure

RISK FACTORS

<u>Maternal</u>	<u>Fetal</u>	<u>Labour</u>
Check mental health screen at booking <input type="checkbox"/>		
Summary of diagnosis and management:		
I have explained any examinations/procedures to be done and obtained verbal consent <input type="checkbox"/>		
Person to be managed at	<input type="text"/> CLINIC/MOU <input type="text"/> District hospital <input type="text"/> Specialist hospital <input type="text"/> Tertiary hospital	

ASSESSMENTS DURING LABOUR

ASSESSMENT:	Date		Time		DOL		hrs	DORM		hrs	
I have introduced myself by name to this person: <input type="checkbox"/>											
Progress of labour:	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	None <input type="checkbox"/>	Birth companion/Doula present		Yes	No				
Maternal condition:	<div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div>										
Maternal mental and emotional condition:	What is her current pain management? What support is given?										
Fetal condition:	<div style="border-bottom: 1px dotted black; height: 15px;"></div>										
Overall assessment and management plan:	<div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div>										
I have explained management plans to this person and her birth companion and ensured that both understand <input type="checkbox"/>											
Name (print)					Signature and designation						

ASSESSMENT:	Date		Time		DOL		hrs	DORM		hrs	
I have introduced myself by name to this person: <input type="checkbox"/>											
Progress of labour:	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	None <input type="checkbox"/>	Birth companion/Doula present		Yes	No				
Maternal condition:	<div style="border-bottom: 1px dotted black; height: 15px;"></div> <div style="border-bottom: 1px dotted black; height: 15px;"></div>										
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I have introduced myself by name to this person: <input type="checkbox"/>											
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I have explained management plans to this person and her birth companion and ensured that both understand <input type="checkbox"/>											
Name (print)					Signature and designation						

Name:	Gravidity:	Parity:	Gestation:	Spontaneous I
Age:	Risk Factors:			Time of ROM:
Pelvis				Duration of labour (on arrival)

Date: ACTIVE PHASE

LATENT PHASE										ACTIVE PHASE									
Time																			
Duration in hours																			
Fetal heart rate (bpm)																			
Decelerations (Yes/No)	Y	N	Y	N	Y	N	Y	N	Y	Y	N	Y	N	Y	N	Y	N	Y	N
Type* (E/V/L)																			
Liquor* (I/C/B/M)																			

FETAL CONDITION		PROGRESS OF LABOUR	
Application*			
Presenting part*			
Caput (0 1+ 2+)			
Moulding (0 1+ 2+ 3+)			
Position e.g. LOA >			
	10		
	9		
	8		
	7		
	6		
	5		
	4		
	3		
	2		
	1		

CONTRACTIONS		OXYTOCIN	
CONTRACTIONS PER 10 MINUTES		Units	Rate
> 40 sec			
> 20 - 40 sec			
< 20 sec			

ASSESSMENTS DURING LABOUR

ASSESSMENT:	Date	Time	DOL	hrs	DORM	hrs
I have introduced myself by name to this person: <input type="checkbox"/>						
Progress of labour:	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	None <input type="checkbox"/>	Birth companion/Doula present Yes No		
Maternal condition:					
Maternal mental and emotional condition:	What is her current pain management? What support is given?					
Fetal condition:					
Overall assessment and management plan:					
I have explained management plans to this person and her birth companion and ensured that both understand <input type="checkbox"/>						
Name (print)				Signature and designation		

ASSESSMENT:	Date	Time	DOL	hrs	DORM	hrs
I have introduced myself by name to this person: <input type="checkbox"/>						
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Maternal mental and emotional condition:	What is her current pain management? What support is given?					
Fetal condition:					
Overall assessment and management plan:					
I have explained management plans to this person and her birth companion and ensured that both understand <input type="checkbox"/>						
Name (print)				Signature and designation		

ASSESSMENT:	Date	Time	DOL	hrs	DORM	hrs
I have introduced myself by name to this person: <input type="checkbox"/>						
Progress of labour:	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	None <input type="checkbox"/>	Birth companion/Doula present Yes No		
Maternal condition:					
Maternal mental and emotional condition:	What is her current pain management? What support is given?					
Fetal condition:					
Overall assessment and management plan:					
I have explained management plans to this person and her birth companion and ensured that both understand <input type="checkbox"/>						
Name (print)				Signature and designation		

CARDIOTOCOGRAPHY (CTG) (FIGO 2015) – CTG ONLY INDICATED FOR HIGH RISK PREGNANCIES

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:
Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm <input type="checkbox"/>	Lacking at least one characteristic of normality, but no pathological features <input type="checkbox"/>	<100 bpm <input type="checkbox"/> (make sure it is not maternal pulse)
Variability	5-25 bpm <input type="checkbox"/>		Reduced (<5 bpm) variability >50 minutes <input type="checkbox"/>
Decelerations	No repetitive* decelerations <input type="checkbox"/> <small>(*Decelerations are repetitive in nature when they are associated with more than 50% of uterine contractions)</small>		Repetitive* late decelerations <input type="checkbox"/> OR Prolonged (>3min) decelerations during >30 minutes <input type="checkbox"/> OR Prolonged (>3min) decelerations during >20 minutes with reduced variability <input type="checkbox"/> OR One prolonged deceleration >5 minutes <input type="checkbox"/>
Interpretation	Fetus with no hypoxia	low probability of hypoxia	Fetus with high probability of hypoxia/acidosis
Contractions	None <input type="checkbox"/> Irregular <input type="checkbox"/> Regular <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Strong <input type="checkbox"/> Expulsive <input type="checkbox"/>		
Clinical management:	No intervention necessary <input type="checkbox"/>	Action to correct reversible causes if identified <input type="checkbox"/> Alert doctor of findings <input type="checkbox"/>	Immediate action to correct reversible causes <input type="checkbox"/> If not possible, or no recovery; immediate delivery <input type="checkbox"/> Call doctor immediately <input type="checkbox"/>
I have explained the nature of the findings and planned action to the person and her birth companion <input type="checkbox"/>			
Evaluation done by:			

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:
Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm <input type="checkbox"/>	Lacking at least one characteristic of normality, but no pathological features <input type="checkbox"/>	<100 bpm <input type="checkbox"/> (make sure it is not maternal pulse)
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I have explained the nature of the findings and planned action to the person and her birth companion <input type="checkbox"/>							
Evaluation done by:							

SUMMARY OF LABOUR

From full dilatation to delivery

Method of delivery: NVD Breech Twins Caesarean section Instrumental Other: _____

Delivered by: _____ Assisted by: _____

Complications: _____

Maternal position during labour: _____

Fetal monitoring: normal abnormal if abnormal specify: _____

SUMMARY OF DURATION OF LABOUR

	Started at:		Duration:		Membranes:	
	Date	Time	Hours	Minutes	AROM <input type="checkbox"/>	SROM <input type="checkbox"/>
Latent phase					Time of ROM: _____	
Active phase (≥5cm)						
Full dilatation					Time of delivery: _____	
Bearing down					Duration of ROM: _____	
Third stage						
Total duration of labour:						

PAIN RELIEF

Entonox Opioid Local Pudendal Epidural Non-pharmacological pain relief used

Given by: _____ Detail: _____

NEONATAL DETAIL

Resuscitation done: Yes No Describe: _____

Birth injuries: Yes No Describe: _____

Neonate	Male	Female	Alive	FSB	MSB	NND	Weight	ID band on?	Cord clamp?
1.							g		
2.							g		

Konakion: Yes No Eye drops Yes No Type: _____ Given by: _____

THIRD STAGE- PLACENTA, MEMBRANES AND CORD

Oxytocin 10 units given intramuscularly: Yes No By _____ At _____

Method of delivery: Active Spontaneous Manual Cord around neck? Yes No

Placenta Normal Abnormal Complete Incomplete Membranes Complete Incomplete

No of vessels in cord: _____ Placental weight: _____ g Retroplacental clot Yes No Histology Yes No

Delayed cord clamping done If delayed cord clamping not done, explain why: _____

Result of cord blood gas (if indicated) _____

FOURTH STAGE (FIRST TWO HOURS AFTER DELIVERY- COMPLETE OBSERVATIONS ON SEPARATE PAGE)

Time of observation: _____ Observed by: _____

Temp: _____ Resp: _____ Pulse: _____ BP: _____ Urine passed: Yes No Catheter: Yes No

Uterus contracted: Yes No Uterus ruptured: Yes No Cord/maternal blood taken: Yes No

Cervical tears Yes No Details: _____

Perineum Intact 1st ° tear 2nd ° tear 3rd /4th ° tear Episiotomy Repaired by: _____

Detail of repair: _____ All swabs/tampons removed from vagina: Yes

Blood loss: Normal Excessive If excessive give details of management: _____

Feeding initiated Yes No Breast feeding initiated if method of choice: Yes No If no, give reasons: _____

Situation in labour ward at time of delivery: _____

TRANSFERRED TO WARD BY:

RECEIVED IN WARD BY:

TIME:

Condition satisfactory: Mother Yes No Baby Yes No

Further management, mother and/or baby _____

OBSERVATIONS IMMEDIATELY AFTER DELIVERY

Observations must be done every 15 min for 1 hour and then every 30 minutes for the next hour starting immediately after delivery. If the person is in a recovery area after Caesarean delivery, the recovery area staff must complete the observations.

Date and time of delivery: -----

Date	Time	BP	Pulse	Respiratory rate	Uterine contraction	Pad check	Oxytocin (rate)	Signature

Classification of shock

	Compensated shock (Class 1)	Mild shock (Class II)	Moderate shock (Class III)	Severe shock (Class IV)
Blood loss	500-1000ml (10-15%)	1000-1500 ml (15-25%)	1500-2000ml (25-35%)	2000-3000ml (35-45%)
Shock index*	0.6-0.9	1	1.5	2
Systolic Blood pressure	Normal	Some changes in blood pressure	Marked ↓	Severe ↓
Pulse	< 100/min	< 120/min	> 120/min	>140/min
Respiratory rate	Normal	Mild increase	Moderate increase	Marked increase
Mental status	Normal	Agitated	Confused	Depressed level of consciousness

*Shock index= heart rate/systolic BP (mmHg) (normal <0.5)

FORCEPS OR VACCUUM DELIVERY

Indication(s) _____

Date: _____ Time: _____ All healthcare workers have introduced themselves by name

Performed by _____ Assisted by: _____

The procedure was explained and verbal consent obtained from the person

CONDITIONS BEFORE DELIVERY

Fetal Heart Normal Abnormal Rate: _____ bpm Fetal distress Yes No

Type of FH abnormality: _____

Mat. Pulse BP Foleys catheter: Yes No

Level of head palpable above pelvic brim (in fifths)

5	4	3	2	1	0
---	---	---	---	---	---

PAIN RELIEF

Anaesthetic General Spinal Epidural Other Pudendal Local Saddle

Problems with pain relief: _____

ASSESSMENT

Cervical dilatation: _____ Application: Good Poor

Position _____ Flexion: _____ Moulding PP

0	+	++	+++
---	---	----	-----

Head above pelvic brim:

5/5	4/5	3/5	2/5	1/5
-----	-----	-----	-----	-----

 Caput:

0	+	++
---	---	----

Liquor: Clear Meconium stained liquor None Thin Thick Blood stained Offensive

Pelvic assessment: Adequate Inadequate Unsure

Pre-requisites for vacuum extraction met:	<input type="checkbox"/> Regular contractions	<input type="checkbox"/> 0/5 or 1/5 HAB	<input type="checkbox"/> Cervix fully dilated	<input type="checkbox"/> Bladder empty	<input type="checkbox"/> Cephalic presentation	<input type="checkbox"/> Fetus not premature
Pre-requisites for forceps delivery met:	<input type="checkbox"/> Normal contractions	<input type="checkbox"/> 0/5 HAB	<input type="checkbox"/> Cervix fully dilated	<input type="checkbox"/> Bladder empty	<input type="checkbox"/> Cephalic presentation	<input type="checkbox"/> Sagittal suture in AP diameter

Other findings: _____

Drugs (including dosage): _____

FORCEPS DELIVERY

Instrument type: _____ Application: Easy Difficult Abandoned attempt

Number of pulls: _____ Application-to-delivery time: _____

Comments: _____

VACUUM EXTRACTION

Cup type: Silicone Metal Disposable Application: Easy Difficult Abandoned attempt

Number of pulls: _____ Did cup slip? Yes No No of times cup slipped:

Site of application: _____ Application-to-delivery time: _____

Comments: _____

OUTCOME (FORCEPS OR VACUUM)

Time procedure commenced: _____ Time completed: _____

Condition of baby at birth: _____ APGAR: _____

Fetal injuries? (describe): _____

Maternal injuries? (describe): _____

In case of abandoned trial of instrumental delivery, state time decision was made to do caesarean section: _____

What was the period of time between decision to do Caesarean section and the actual time of operation? _____

REMARKS AND POST-PROCEDURAL INSTRUCTIONS

Signature

THEATRE NOTES: CAESAREAN SECTION

Indication _____

ROBSON (tick one) 1. Nullipara, singleton cephalic, term, spontaneous labour 2. Nullipara, singleton cephalic, term, induced/CS before labour
 3. Multipara, singleton cephalic, term, spontaneous labour 4. Multipara, singleton cephalic, term, induced/CS before labour
 5. Previous CS, singleton cephalic, term 6. Nulliparous breech 7. Multiparous breech
 8. Multiple pregnancy 9. Abnormal lie 10. All singleton cephalic, ≤ 36 weeks

Date: _____ Time surgery commenced _____ Time surgery completed _____

Surgeon _____ Assistant _____
 Anaesthetist _____ Midwife _____
 Operative procedure: _____

PRE-OPERATIVE DETAILS

Date of decision: _____ Time of decision: _____ By whom: _____

Mat. Pulse BP Temp Level of the head Foleys catheter Yes No

Pre-op drugs Antacid Metoclopramide Prophylactic antibiotics Thromboprophylaxis

Fetal Heart Present Absent Uncertain Fetal distress Yes No

Counselling for IUD insertion
 Information has been given regarding the procedure and informed consent obtained from the person Companion allowed to be present

OPERATION PROCEDURE AND FINDINGS

Anaesthetic General Spinal Epidural Other Maternal position: _____

Problems with anaesthetic: _____

Skin Incision: Transverse Midline Other Details: _____

Uterine Incision: Lower segment Classical DeLee Other: _____

Uterine Scar Intact Dehiscid Fetal Presentation _____ Fetal Position _____

Prolonged Incision-Delivery Time Yes No Reasons: _____

Difficulty with delivery of baby: Yes No Describe: _____

Liquor Increased Decreased Clear Meconium stained No Thin Thick Bloody Offensive

Placenta Fundal Central Anterior Posterior Praevia Retroplacental Clot: Yes No

Other Placental Abnormalities: _____ Delayed cord clamping done Time? _____

Uterine Abnormalities: _____

Uterine Tears: (give details) _____

Tubal ligation: Yes No Type: _____ Histology Yes No

Closure: _____
 Drains: _____
 Further description of operation: _____

IUD inserted Type: _____

Estimated Blood Loss _____ ml

Resuscitation of baby: Yes No Resuscitated by _____

Details of Neonatal Resuscitation: _____ Baby placed skin to skin

Result of cord blood gas (if indicated): _____

Advice for next pregnancy: VBAC Elective repeat CS Other _____

Post-operative Management: _____

Signature _____

FIRST EXAMINATION OF NEONATE (includes examination of stillborn babies)

Baby allowed to be placed skin to skin Time _____

General	Well	Sick			Comment*
Appearance	Well nourished	Obese	Wasted	Dysmorphic	
Behaviour	Responsive	Lethargic	Irritable	Jittery	
Cry	Normal	Hoarse	High-pitched	Absent	
Colour	Pink	Blue	Plethoric	Pale	
Skin	Intact	Jaundice	Rash / Purpura	Bruising	
Temperature	36-37°C	Hypothermic	Hyperthermic		
Odour	Normal	Offensive			
Head shape	Normal	Asymmetrical	Caput	Haematoma	
Fontanelles	Normal	Bulging	Large		
Sutures	Mobile	Overriding	Widened	Fused	
Face	Symmetrical	Asymmetrical	Abnormal		
Eyes	Normal	Infected	Small / Large	Slanting	
Ears	Normal	Abnormal	Low position		
Nose	Patent	Blocked			
Mouth	Normal	Smooth philtrum	Cleft lip		
Palate	Intact	Cleft soft	Cleft hard		
Tongue	Normal	Lip-tie, tongue tie	Large	Protruding	
Chin	Normal	Small			
Neck	Normal	Swellings	Webbed		
Apex beat	120-160/min	Tachycardia	Bradycardia		
Chest - nipples	Normal	Accessory			
Chest – clavicles	Intact	Swelling	Crepitus		
Chest movement	Symmetrical	Asymmetrical	Shallow		
Chest indrawing	Absent	Costal	Sternal		
Respiratory rate	40 – 60 pm	Fast	Slow		
Breath sounds	Quiet	Grunting	Noisy		
Arms	Normal	Not moving	Fracture L/R		
Palmar creases	Normal	Single			
Fingers	Normal	Polydactyly	Syndactyly		
Abdomen	Normal	Distended			
Umbilicus	Normal	Moist	Flare	Bleeding	
Hips	Normal	Dislocated	Dislocatable		
Legs	Normal	Not moving			
Toes	Normal	Polydactyly	Syndactyly		
Feet position	Normal	Position Deformity	Clubbed		
Back	Normal	Meningocele	Dimple / Hair tuft	Scoliosis	
Anus	Patent	Imperforate			
Femoral pulses	Present	Absent			
Genitalia: Male	Testes down	Undescended L/R	Hydrocoele	Inguinal hernia	
Genitalia: Female	Normal	Ambiguous			
Muscle tone	Normal	Hypotonic	Hypertonic		
Moro reflex	Present & equal	Asymmetrical	Weak	Absent	
Grasp reflex	Present	Weak	Absent		
Suck reflex	Present	Weak	Absent		
Urine	Passed	Not passed			
Meconium	Passed	Not passed			
Assessment:					
Examined by:			Date and time:		
Checked by:			Date and time:		

* If any birth defects noted, please complete the birth defects notification form.

ASSESSMENT OF THE NEWBORN

Infant's name: _____

Birth time: _____

Hospital number: _____

Birth date: _____

Gender: M F	Birth weight: g	HC: cm	Gest age score: weeks	Resuscitation: (circle)			
				None		Oxygen	Mask
APGAR Score	0	1	2	1 min	5 min	Details of resuscitation	
Appearance	Blue or pale	Body pink, limbs blue	Pink all over				
Pulse	Absent	<100/min	>100/min				
Grimacing (reflex)	No response	Grimace	Vigorous cry				
Activity	Limp	Slight flexion	Active, moves				
Respiration	Absent	Slow or irregular	Good crying				
TOTAL							
Routine care: Skin to skin <input type="checkbox"/> Delayed washing <input type="checkbox"/>							
Mode of delivery: NVD C/S Vac Forceps				Treatment given:		Date done:	
<u>Problems with delivery:</u>				Eye care:			
Placenta: _____ weight _____ g				Vitamin K 1mg IMI			
Risk factors to baby:			Examination of baby:		Normal	Abnormal	
Pregnancy:		Care required:		Care received:		Date done:	
RPR Positive	No Yes	Examine, Benzathine Pen if mother incompletely treated					
RPR unknown	No Yes	Examine, Benzathine penicillin to baby if no result					
Rhesus negative	No Yes	Check the TSB at 6 hours					
HIV Positive	No Yes	Follow current PMTCT protocol					
HIV Unknown	No Yes	Provide counselling and testing for mother, if positive start mother on ART and manage infant as high risk					
Maternal diabetes	No Yes	Refer to nursery for hourly blood sugars and 24 hours observation					
Labour:							
MSL	No Yes	Assess baby for respiratory distress					
Fetal distress	No Yes	Assess baby for Neonatal Encephalopathy					
Problems during newborn period:				Preventative care:			
Birth weight <2500g- observe for 24h in postnatal ward for low blood sugar and ability to suckle				Polio:		Hepatitis B	
1.				BCG:			
2.				RTHC filled in:			
3.				Birth PCR date:		result:	
Feeding: If mother is HIV positive:				Follow up plans:			
Mother counselled on infant feeding		No Yes	Before 3 days:		Date:	Place:	
Counsel on duration of NVP and where applicable AZT		No Yes	At 6 weeks:		Date:	Place:	
			For PCR:		Date:	Place:	
Feeding on discharge? EBF commenced within one hour Yes No				Reasons for failure of EBF:			
				Discharge weight:		Discharge date:	
Identification:							
At birth:	Date:	Midwife (print)		Mother (Print):		Witness:	
Postnatal ward:	Date:	Brought by:		Received by:		Mother:	
At discharge:	Date:	Midwife (print)		Mother (Print):		Witness:	

MATERNAL EARLY WARNING OBSERVATION CHART FOR POSTNATAL WARD CARE

Date																Date	
Time																Time	
RESPIRATORY RATE	>30															>30	
	21-30															21-30	
	11-20															11-20	
	0-10															0-10	
SATURATION	95-100%															95-100%	
	<95%															<95%	
TEMPERATURE	39°C															39°C	
	38°C															38°C	
	37°C															37°C	
	36°C															36°C	
	35°C															35°C	
Hb	≥ 8 g/dl															≥ 8 g/dl	
	< 8 g/dl															< 8 g/dl	
MATERNAL HEART RATE	140															140	
	130															130	
	120															120	
	110															110	
	100															100	
	90															90	
	80															80	
	70															70	
	60															60	
	50															50	
	40															40	
SYSTOLIC BLOOD PRESSURE	170															170	
	160															160	
	150															150	
	140															140	
	130															130	
	120															120	
	110															110	
	100															100	
	90															90	
	80															80	
	70															70	
DIASTOLIC BLOOD PRESSURE	120															120	
	110															110	
	100															100	
	90															90	
	80															80	
	70															70	
	60															60	
	40															40	
Urine volume in ml/hour																Urine volume in ml/hour	
Breasts																Breasts	
HEIGHT OF FIUNDUS	24 cm															24 cm	
	22 cm															22 cm	
	20 cm															20 cm	
	18 cm															18 cm	
	16 cm															16 cm	
	14 cm															14 cm	
	12 cm															12 cm	
	10 cm															10 cm	
Perineum																Perineum	
Lochia	Normal															Normal	
	Heavy (H) Fresh (F)															Heavy (H) Fresh (F)	
	Offensive (O)															Offensive (O)	
Neuro response	Alert															Alert	
	Vocal															Vocal	
	Pain															Pain	
	Unresponsive															Unresponsive	
Pain	None-mild															None-mild	
	Severe															Severe	
Looks unwell	No (✓)															No (✓)	
	Yes (✓)															Yes (✓)	
TOTAL YELLOW SCORE																TOTAL	
TOTAL RED SCORE																TOTAL	
DOCTOR CALLED (Y/N)																TOTAL	
Signature																	

Newborn Early Warning Observation Chart

Name of baby or place large baby sticker here

Date																			
Time																			

Temperature °C	38																		
	37.5																		
	37																		
	36.5																		
	36																		
	35.5																		
Value																			

Respiratory Rate	80																		
	70																		
	60																		
	50																		
	40																		
	30																		
	Value																		

Grunting																			
----------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Heart Rate	190																		
	180																		
	170																		
	160																		
	150																		
	140																		
	130																		
	120																		
	110																		
	100																		
	90																		
80																			
70																			
60																			
Value																			

SaO2	≥95																		
	92-94																		
	<92																		

Neuro	Alert																		
	Irritable																		
	Jittery																		
	Poor feed																		
	Floppy																		
	Seizures																		

Glucose 2.3-2.6																			
Glucose <2.6																			

All observations in green – Continue observations. Routine care.

1 Observation in amber – Inform Sr in charge. Repeat observations in 30 minutes. If glucose 2.3-2.6, give milk feed first. If sats 92-94, try on other hand first.

2 or more observations in amber – Immediately inform Dr for urgent medical review.

1 or more observation in red – Immediately inform Dr for urgent medical review.

PUERPERIUM NOTES

I have introduced myself by name to this person <input type="checkbox"/>			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands <input type="checkbox"/>			

I have introduced myself by name to this person <input type="checkbox"/>			Name (print) and signature
Date and time	Mother	Baby	
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I have introduced myself by name to this person <input type="checkbox"/>			Name (print) and signature
Date and time	Mother	Baby	
I have explained management plans to this person and checked that she understands <input type="checkbox"/>			

PRE-DISCHARGE CHECKLIST

Assess mother for problems	No	Yes	Recommended action
<p>The mother has a danger sign:</p> <ul style="list-style-type: none"> ○ heavy bleeding ○ severe abdominal pain ○ unexplained pain in chest or legs ○ visual disturbance or severe headache ○ breathing difficulty ○ fever, chills ○ vomiting 	<input type="checkbox"/>	<input type="checkbox"/>	<p>Assess the cause (s) and initiate care or refer.</p> <p>Delay discharge until all danger signs have been resolved for at least 24 hours and there is a follow-up plan in place.</p>
<p>The mother's bleeding is heavy or has increased since birth (e.g., bleeding soaks a pad in less than five minutes).</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Start IV fluid and keep mother warm</p> <p>Delay discharge. Treat or refer.</p> <p>Evaluate and treat possible causes of bleeding (e.g., uterine atony retained placenta, or vaginal/cervical tear).</p>
<p>The mother has an abnormal vital sign:</p> <ul style="list-style-type: none"> ○ high blood pressure (SBP > 140 mmHg or DBP >90 mmHg) ○ temperature > 37.5°C ○ heart rate > 100 beats per minute ○ respiratory rate >20 per minute 	<input type="checkbox"/>	<input type="checkbox"/>	<p>Give magnesium sulphate to mother if any of:</p> <ul style="list-style-type: none"> • SBP ≥160 mmHg or DBP ≥110 mmHg; and 2+ proteinuria • SBP ≥140 or DBP ≥90 mmHg, and 2+ proteinuria, and any: severe headache, visual disturbance, epigastric pain <p>Give antihypertensive medication to mother if SBP >160 mmHg or DBP >110mmHg</p> <p>Evaluate the cause of abnormal vital sign(s) and treat or refer.</p> <p>Defer discharge until vital signs have been normal for at least 48 hours and no danger signs remain.</p>
<p>The mother is not able to urinate easily</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Defer discharge; continue to monitor and evaluate the cause; treat or refer as needed</p>
<p>Mental state: The mother is agitated or very withdrawn</p> <p>Support person: The mother has a partner or support person to be with her at home</p> <p>The mother has a safe home to return to</p>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<p>Defer discharge; continue to monitor and evaluate, refer appropriately (social worker, mental health nurse, psychiatrist etc).</p>
Assess baby for problems	No	Yes	Recommended action
<p>The baby has any of these danger signs:</p> <ul style="list-style-type: none"> ○ fast breathing (> 60 breaths/ minute) ○ severe chest in-drawing ○ fever (temperature ≥ 37.5°C) ○ hypothermia (temperature < 35.5°C) ○ yellow palms (hands) or soles (feet) ○ convulsions ○ no movement or movement only on stimulation ○ feeding poorly or not feeding at all 	<input type="checkbox"/>	<input type="checkbox"/>	<p>Assess cause of danger signs and initiate care or refer</p> <p>Delay discharge until all danger signs have been resolved for at least 24 hours and there is a follow-up plan in place.</p>
<p>The baby is not breastfeeding at least every two to three hours (day and night).</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Establish good breastfeeding practices and delay discharge.</p>
<p>The baby has not passed urine and/or stool</p>	<input type="checkbox"/>	<input type="checkbox"/>	<p>Delay discharge and monitor; refer as needed</p>

Blank page (back of discharge
summary)

Blank page (back of discharge
summary)

Maternal and Infant PMTCT Discharge Letter

Complete on carbon copy, this page remain in folder

HPRN: _____

Mom Name & Surname: _____

Mom Date of Birth: _____

Dear Colleaau

Infant Name & Surname: _____

Gender: Male Female

Infant HPRN: _____

Infant Date of Birth: _____

Has been discharged from: _____ (facility name) on _____ (date)

Discharging nurse: _____ Date: ____/____/____

Follow-up Date: ____/____/____ Follow-up Site: _____

Sign: _____

Maternal Discharge Status and Postnatal Follow Up

LABORATORY BARCODE

ART

- Mother started on ART: less than 12 weeks prior to delivery
 at or after delivery

Viral Load

- VL done at delivery
Viral load: _____

- Mother on ART since before pregnancy or more than 12 weeks prior to delivery

Mother ART regime: _____

Feeding Method at Discharge (tick appropriate option)

- Exclusively breastfeeding Formula feeding Heat-treated own milk

Contraception at Discharge

- IUCD Implant Oral contraception Injectable hormones Sterilization

Infant Discharge Status and Postnatal Follow Up

HIV Test (Discharge)

- PCR test done
Date of PCR test: _____

LABORATORY BARCODE

- PCR test result received
 Positive Negative Awaited
 Mother informed of test result

Discharge Post Exposure Prophylaxis (PEP)

- Low risk** (moms VL at delivery < 1000c/ml)
 NVP for 6 weeks once daily

- High risk** (mom initiated after 28 weeks / has no VL / VL is > 1000c/ml)
 NVP once daily for 12 weeks if mom is **breastfeeding** and if needed until mom's VL <1000c/ml or until 1 week after cessation of all breastfeeding
 AZT twice daily for 6 weeks irrespective of feeding choice
 NVP once daily for 6 weeks if **formula fed**

Postnatal Follow-up and Baby Wellness Visits

		3-6 days	6 weeks	10 weeks	6 months	18 months	Any other test
Visit Date:		/ /	/ /	/ /	/ /	/ /	/ /
Mother	ART	<input type="checkbox"/> If using / willing to use reliable contraception TLD (TDF, 3TC and DTG) <input type="checkbox"/> If not, start TEE (TDF, FTC, and EFV)					
	VL	<input type="checkbox"/> Check ART adherence <input type="checkbox"/> If VL>50c/ml (manage as per VL non-suppression) <input type="checkbox"/> If VL>1000c/ml (manage infant as high risk)	<input type="checkbox"/> Check ART adherence <input type="checkbox"/> If VL>50c/ml (manage as per VL non-suppression) <input type="checkbox"/> If VL>1000c/ml (manage infant as high risk)	<input type="checkbox"/> Check ART adherence <input type="checkbox"/> If VL>50c/ml (manage as per VL non-suppression) <input type="checkbox"/> If VL>1000c/ml (manage infant as high risk)	<input type="checkbox"/> Check ART adherence <input type="checkbox"/> VL done @ 6mo (all HIV+ moms) Continue VL every 6 months until cessation of breastfeeding	<input type="checkbox"/> Check ART adherence <input type="checkbox"/> VL done @ 18mo (if mom is still breast-feeding)	<input type="checkbox"/> Check ART adherence <input type="checkbox"/> VL done @ 12/24mo (if mom is still breast-feeding)
Infant	HTS	<input type="checkbox"/> Birth PCR done <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Check mom's ART adherence and last VL value	<input type="checkbox"/> 10 weeks PCR test <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> 6 month PCR test <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Rapid/Elisa Test <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> HIV test <input type="checkbox"/> Positive <input type="checkbox"/> Negative
	Prophylaxis	<input type="checkbox"/> Check adherence and tolerance to NVP (and AZT)	<input type="checkbox"/> Start CPT <input type="checkbox"/> Stop NVP (low risk) <input type="checkbox"/> Stop AZT (high risk)	Stop NVP after 12 weeks if mothers VL < 1000c/ml If child tests positive for HIV stop NVP and initiate ART and do confirmatory PCR			
	Feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula fed	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula fed

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discharge summary)

DEPARTMENT OF HEALTH
CONGENITAL DISORDERS (CD) NOTIFICATION
Please mark applicable areas with an X

Case ID _____

GENERAL INFORMATION																	
Province:	District:	Name of Hospital/Facility:				Name of person notifying:			Date:								
		Facility Contact No.:				Signature:			y	y	y	/	m	m	/	d	d
PARTICULARS OF MOTHER																	
Surname:		Name:		Date of birth:				Age of mother:									
				y	y	y	/	m	m	/	d	d					
Maternal Conditions:																	
Pre-existing diabetes	Gestational diabetes	Epilepsy	Syphilis	TB	Cardiac Conditions	Hypertension	HIV										
Maternal medication (cover the counter):																	
Gravida & Parity:																	
PARTICULARS OF PATIENT																	
Surname:		Name:		Date of birth:				Gender:									
				y	y	y	/	m	m	/	d	d	Male	Female	Unspecified		
Population group:																	
African	White	Indian	Coloured	Other	Specify:												
Pregnancy outcome:																	
Live Birth	Still Birth	Termination of Pregnancy	Yes	No	If Yes:	Ultrasound	Chorionic Villus Sampling	Amniocentesis	Cordocentesis								
Birth weight:		Gestational age:		BANC 1st visit (weeks):		BANC total visits (number):											
<1000g	1000-1499g	1500-1999g	2000-2499g	>	≥2500g	<37 weeks	≥37 weeks										
INVESTIGATIONS REQUESTED																	
Chromosome/cytogenetic	Biochemical/metabolic	DNA/molecular	No investigation necessary	Other diagnostic or screening procedure													
Specify:																	
COUNSELLING GIVEN (BY)																	
Clinical geneticist	Medical Doctor	Registered Nurse	Genetic counselor	No counseling given	Genetic Training received:			Yes	No								
PATIENT STATUS/OUTCOME																	
Alive:	Inpatient	Outpatient	Discharged	Unit/Clinic/Ward name				Date of death if deceased:									
Referral:		Referred to another Hospital?		Yes	No	Referred from Hospital?		Yes	No	If yes, name of that Hospital:							
DIAGNOSIS																	
Skull	Face	Chest	Heart	Abdomen	Gastrointestinal Tract	Genitals	Arms	Legs	Hands	Feet	Skin						
Description:																	
Diagnosis:																	
Diagnosed by (if different than person notifying):																	
Name:		Doctor		Registered Nurse		Genetic Training received:		Yes	No								
								Contact No.:									

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Remove this page and give to patient as information leaflet on discharge after delivery

Some information about Family Planning after your baby is born

Why is it important?

Most couples start having sex again before six weeks after the baby is born. Pregnancy can occur by six weeks (before your periods start again) if you do not exclusively breastfeed; so it is important to make sure that you start using a method before your baby is four weeks old.

Best practice is for the chosen method of family planning to be started before you leave the place where your baby is born.

The most effective methods

Intrauterine contraception (IUD)

- Copper IUDs prevent pregnancy for up to 10 years
- Failure rates are less than one per 1000 women.
- IUDs can be inserted immediately after the afterbirth (placenta) has been delivered.
- IUD use does not interfere with breastfeeding.

Contraceptive implants

- Implants are effective for three years
- Failure rates are around one per 1000 women.
- Implants are not recommended for HIV positive patients on medication (ask your doctor).
- Implants can be inserted immediately after delivery of the baby and before you go home.
- Postpartum implant use does not interfere with breastfeeding.

Permanent contraception

Female sterilisation:

- Failure rates are around two per 1000 women but the method is considered permanent.
- Female sterilisation can be performed within the first week after delivery or at any time after your baby is six weeks old.
- It may be convenient to perform female sterilisation at the time of Caesarean section.

Male sterilisation (vasectomy):

- Failure rates are around one per 1000 men but the method is considered permanent.

Effective methods

Contraceptive injections (failure rate three per 100 women):

- Repeat injections must be given four or more times each year.
- Contraceptive injections can be started immediately after delivery and do not interfere with breastfeeding.

Hormonal contraceptive pills (failure rate nine per 100 women):

- Progestogen-only (POP, mini) pills:
 - Must be taken at the same time every day without a break.
 - They can be started immediately after delivery and do not interfere with breastfeeding.
- Combined oral contraceptive (COC) pills:
 - They can only be started six weeks after your baby is born
 - They should not be used by breastfeeding women until the baby is six months old

Less effective methods

Male or female condoms. These are not so effective in preventing pregnancy, but they must always be used with your other method to prevent HIV and other sexually transmitted infections.

Danger signs after delivery

I have severe
headaches.
I have blurry vision.
PRE-ECLAMPSIA

I cry all the time. I
have thoughts of
hurting myself or my
baby.
POST-PARTUM
DEPRESSION

I am short of breath.
I breathe very fast.
PULMONARY
EDEMA

I have a fever or
chills.
My stomach hurts
I have a foul
smelling vaginal
discharge.
POST-PARTUM
SEPSIS

My baby is unusually
cold
HYPOTHERMIA

My incision is not
healing.
WOUND INFECTION

I have severe pain
and swelling in my
calf. My calf is red.
DEEP VEIN
THROMBOSIS

I have vaginal
bleeding that is
soaking my pads.
POST-PARTUM
HAEMORRHAGE

