

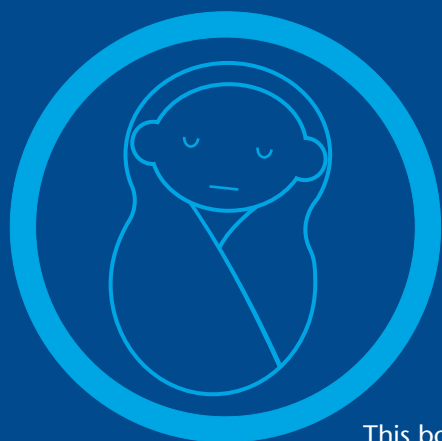
Baby Record - Midwifery Care

Confidential

PLEASE USE BLACK INK

BABY'S LABEL HERE

MOTHER'S LABEL HERE



**If you find this record,
please return it to the
nearest Maternity Unit or
General Practitioner surgery
as soon as possible.**

This booklet will document the care given to your baby in the first days in hospital and at home. When you and your baby are discharged from community midwifery care, the booklet will be returned to the baby's hospital medical record.

Complete this page by hand or affix hospital computer discharge summary here.

Postnatal discharge summary

Discharged from

To (address) 

GP at 

Obstetrician Midwife Paediatrician

Labour, birth and postnatal period

Onset of labour Spontaneous Induced: indication

Mode of delivery on day/...../..... at:..... Sex

Indication Presentation Location

Gestation Birthweight g Blood loss mls

APGARs 1 minute 5 minutes 10 minutes Placenta/membranes

Maternal blood group Anti-D needed No Yes Anti-D given on/...../.....

Rubella status Vaccination needed No Yes Vaccinated on/...../.....

Further details, including problems identified during pregnancy, labour, birth and the postnatal period/referrals, investigations or results pending:

.....

Baby CHI Discharged home with mum No Yes Feeding: type/comments

Length cm OFC cm Discharge Weight g

BCG vaccination needed No Yes: given on/...../.....

Newborn blood spot screening done No: due on/...../..... Yes: on/...../..... Declined

Newborn hearing screening done No: due on/...../..... Yes: on/...../..... Declined

Vitamin K administered No Yes: details

Admitted to neonatal unit No Yes: details

Discharge medication No Yes: details

Further details, including problems identified/referrals, investigations or results pending:

.....

.....

Summary completed by (print name) Date / /

Signature: Designation

Consent for Newborn Blood Spot Screening for Phenylketonuria, Congenital Hypothyroidism & Cystic Fibrosis

I have received and read the information leaflet "A Parent's Guide to Newborn Blood Spot Screening for Phenylketonuria, Congenital Hypothyroidism and Cystic Fibrosis" and have had an opportunity to discuss the tests I am being offered with a health professional. I understand the reasons for the tests and the consequences of the results. I also understand the significance of not having these tests performed. I am aware that my decision whether or not to have these tests will not affect the quality of care delivered by healthcare professionals.

Baby's Name Date of birth ____ / ____ / ____

CHI Number

- I wish I do not wish my baby to be tested for Phenylketonuria
- I wish I do not wish my baby to be tested for Congenital Hypothyroidism
- I wish I do not wish my baby to be tested for Cystic Fibrosis

We also need to obtain your permission to store the blood spot card beyond the 12 month testing period and to use any of the blood spots left over after testing is complete for anonymised research, such as the development of new screening tests. If any research was proposed in which the researcher would be able to identify you or your baby, we would always contact you again to seek your approval.

- I agree I do not agree for the storage of my baby's blood spot specimen beyond the 12 month testing period
- I agree I do not agree to the use of any left over blood spots for anonymised research

Signature: (Parent) Date ____ / ____ / ____

Witness: (Health professional)

(Please sign and print name)

Designation: Date ____ / ____ / ____

Discharge of baby from midwifery care

Date/...../..... Baby's age days Assessed by

Weight chart

Postnatal day	Date	Time	Weight g	Details:- including percentage of birth weight lost

Vitamin K

Vitamin K Im Oral Declined

Repeat oral doses given on/...../..... By Declined

...../...../..... By Declined

Feeding

Breast Bottle Mixed Supplementary feeds given

Details

Vaccinations

BCG vaccination needed No Yes BCG given as prescribed on/...../.....

Hepatitis B vaccination needed No Yes Hepatitis B vaccination given on/...../.....

Screening

Newborn bloodspot screening done on/...../..... By Declined

Newborn hearing screening done on/...../..... By Declined

Any problems identified

Jaundice No Yes SBR taken Highest SBR

Other

Hand over to health visitor complete No Yes

Follow-up appointments required No Yes

Other

Signed: Print name Date / /

