

Blood tests and other tests

During your pregnancy you will be offered several blood tests to check on your health and your baby's health. Your midwife will give you information leaflets on many of these tests. Maternity care staff will discuss all the blood tests with you. When you are sure that you understand about the tests, you will be asked if you want to have them done or not, and your wishes will be followed. For some of the blood tests you will be asked to sign a consent form.

Maternity care staff will tell you how to find out the results of any tests that you have. They will also organise any follow up care that may be needed.

Results should be filed between the 'your notes and questions pages' near the back of the notes so that they do not obscure the 'Special Features' boxes. Computer print outs can be hole punched and tagged into the record or the 'mount sheet' can be used for smaller results.

Test	Gestation when test due	Date taken indicate if declined	Results/Action
Blood Group			
Full Blood Count			
Rubella status			
Syphilis			
Hepatitis B			
HIV			
Screening for <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Down's Syndrome			
Antibody check			
Random blood glucose			
Haemoglobinopathy - sickle cell and thalassaemia			
Chlamydia (if under 25)			
Mid stream urine specimen for bacteriology			
Other			

If you have Rhesus Negative blood

This section does not apply to you applies to you

Your blood is Rhesus Negative. You will be offered 'Anti-D' to prevent any problems developing.

Discussions/plans Signed / /

Prophylactic 'Anti-D' given 28 weeks Dose Signed Date given / /

Prophylactic 'Anti-D' given 34 weeks Dose Signed Date given / /

Screening for fetal abnormalities

During your pregnancy you will be offered several tests to check on your baby's health. These include ultrasound scans and may include blood tests to screen for risk of fetal abnormalities including Down's Syndrome and Spina Bifida.

Your local maternity team will explain what ultrasound scans will be offered to you and you will be asked to complete the appropriate consent for these tests.

The ultrasound scans you are likely to be offered by your local maternity services are:

- Dating scan Nuchal translucency scan 11-13 weeks Detailed scan at weeks
 Growth scan as required Placental site scan as required Other

Consent for screening tests offered in pregnancy (Down's Syndrome and Neural tube defects)

I have received the information leaflet 'A Guide to the Screening Test for neural tube defects and Down's Syndrome' 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 health care professionals during my pregnancy.

I wish I do not wish to be screened for the risk of Neural tube defects

I wish I do not wish to be screened for the risk of Down's Syndrome

Signature: Date / /

Witness: (Health professional)

(Please sign and print name)

Designation: Date / /

Infant feeding - Antenatal Checklist

	Discussed (or note if mother declined discussion)	Signed	Date
Benefits of breastfeeding to the baby (protects against gastro-enteritis and diarrhoea, urinary tract infections, ear infections and chest infections; may also protect against allergies and diabetes)	<input type="checkbox"/> / /
Benefits of breastfeeding to the mother (protects against breast cancer, ovarian cancer and hip fractures in later life)	<input type="checkbox"/> / /
No other food or drink needed (for up to 6 months)	<input type="checkbox"/> / /
Importance of skin-to-skin contact after delivery (keeps baby warm and calm, promotes bonding, helps breastfeeding)	<input type="checkbox"/> / /
Importance of good positioning and attachment	<input type="checkbox"/> / /
Getting feeding off to a good start	<input type="checkbox"/> / /
<ul style="list-style-type: none"> • Baby-led feeding <input type="checkbox"/> • Problems with using teats, dummies, nipple shields <input type="checkbox"/> • Help will be available with feeds <input type="checkbox"/> • Importance of rooming-in/keeping baby nearby <input type="checkbox"/> • Baby's sleeping place <input type="checkbox"/> (To reduce risk of cot death, babies should sleep in parents' room until 6 months. It is safest to put your baby back in the cot before you go to sleep rather than letting them sleep with you)	 / /
Leaflets given and discussed	<input type="checkbox"/> / /
.....	<input type="checkbox"/> / /
.....	<input type="checkbox"/> / /
.....	<input type="checkbox"/> / /

Weight in late pregnancy kg

Date .. / .. / ..

Please remember to complete the 'Whose signature?' section on the back cover of the pregnancy record

Other information/plans/referrals etc	Return in (weeks)	Signature

Weight in late pregnancy kg

Date / /

Please remember to complete the 'Whose signature?' section on the back cover of the pregnancy record

Other information/plans/referrals etc	Return in (weeks)	Signature

Weight in late pregnancy kg

Date / /

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Other information/plans/referrals etc	Return in (weeks)	Signature

Breech Presentation at 36 weeks

Date _____ / _____ / _____

External Cephalic Version discussed and information given No Yes

External Cephalic Version offered No Yes

External Cephalic Version offer accepted No Yes

Details of ECV procedure

Record of cervical stretch and membrane sweep for postmaturity

Date _____ / _____ / _____ Time _____ : _____ Gestation _____

Record of discussion prior to the procedure

Abdominal examination

Fundal height _____ cm Lie _____

Presentation _____ Position _____

Presenting part - 5th palpable _____

Fetal heart rate _____ Maternal pulse _____

Comments _____

Signature: _____ Date _____ / _____ / _____ :

Cervical examination

Total score _____		Pelvic score			
		0	1	2	3
Cervical feature	Dilation (cm)	< 1	1-2	2-4	>4
	Length of cervix (cm)	>4	2-4	1-2	<1
	Station (cm)*	-3	-2	1/0	+1/+2
	Consistency	Firm	Average	Soft	-
	Position	Posterior	Mid/ anterior	-	-

* Relative to the ischial spines

Comments _____

Plans following procedure

