MonashHealth

Hospital of booking ..... TEAM: .....

Type of care (Tick): ☐ Shared care ☐ Obstetric non-hospital

Care provider name: .....

Care provider contact number: .....

Affix Patient Identification Label

Unit Record Number: .....

Surname: .....

Given Name: .....

D.O.B: ..... Age: ..... Sex: .....

Address: .....

SHF028402

E.D.D

Dates .....

U/S .....

Agreed .....

Group B Streptococcus (GBS)

Intrapartum antibiotic prophylaxis indicated

Yes / No

VACCINATIONS IN PREGNANCY

PERTUSSIS (in third trimester Pref 28-32)

Vaccination given Yes / No / Declined

Date of vaccination ...../ ...../ .....

INFLUENZA (When available)

Vaccination given Yes / No / Declined

Date of vaccination ...../ ...../ .....

ANTI D

Anti D indicated Yes / No

HEPATITIS B

Neonatal Immunoglobulin indicated Yes / No

RUBELLA

Post birth vaccination indicated Yes / No

INVESTIGATIONS

Date collected: .....

Bl. Gp. .....

Rh. .....

Antibodies .....

Hb. .....

Platelets .....

MCV .....

Ferritin .....

HbEPG .....

Syphilis .....

Hep. B .....

Rubella .....

Hep. C .....

HIV .....

MSU .....

RBG .....

If indicated

Vit D .....

Chlamydia .....

Other .....

MANAGEMENT PLANS

Issues identified	Intended management
Increased risk of preeclampsia ☐	
Ethnicity /early postdates monitoring ☐	
Other :	

Psychosocial factors identified ☐ Yes Smoking N/A ..... per day

Height (cm) ..... Booking weight (kg) ..... Booking BMI ..... Recommended weight gain (kg) .....

Date	Gestation	Fundal Height	Present ation	F.H. F.M.	B.P.	Urinalysis	Weight (each visit)	Comments	WKS Return
								Sign	
								Sign	
								Sign	

GENETIC

Aneuploidy Screening Information given and options discussed? ☐

Date: .....

Results:.....

.....

ULTRASOUND (U/S)

Date Gestation

....

....

....

Placenta (low/not low)

.....

.....

26-32 WEEKS

Hb. .....

Rh. Antibodies. .....

OGTT .....

Anti D given Yes / No / NA

34-36 WEEKS

Hb. .....

Anti D given Yes / No / NA

35-37 WEEKS

GBS low vaginal/ anorectal swab taken

Yes / No / NA

ALL ENTRIES MUST BE CLEARLY SIGNED

MRF03
01/19

PREGNANCY HAND HELD RECORD

MRF03

MonashHealth

☐ Dandenong Hospital ☐ Monash Medical Centre Clayton

☐ Casey Hospital

Affix Patient Identification Label

Unit Record Number: .....

Surname: .....

Given Name: .....

D.O.B: ..... Age: ..... Sex: .....

Address: .....

.....

Date	Gestation	Fundal Height	Present ation	F.H. F.M.	B.P.	Urinalysis	Weight	Comments	WKS Return
								Sign	
								Sign	
								Sign	
								Sign	
								Sign	
								Sign	
								Sign	

ALL ENTRIES MUST BE CLEARLY SIGNED

PREGNANCY HAND HELD RECORD

MRF03