## Form M/B

# OBSTETRIC REPORT ON MOTHER/NEONATAL REPORT ON CHILD

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BAAF, Saffron House, 6-10 Kirby Street, London EC1N 8TS.

## Form M LOOKED AFTER CHILDREN **Obstetric report on mother**

#### CONFIDENTIAL



To be completed by a doctor or a midwife

Mother's consent to the sharing of health information
The Consent Form (or photocopy) signed by mother **must** be attached to this form

## Part A To be completed by the agency - write clearly in black ink

Parents		Child
Name of moth	ner	Name of child
Date of birth		Date of birth
Ethnicity of m	other	Time of birth
Ethnicity of fa Name of ager	ther (if known) ncy	Place of birth Social Worker
Address Telephone Fax Postcode		E-mail
Form to be	e returned to the	Agency Medical Adviser
Address Telephone		Fax
Postcode		E-mail
Part B	To be completed	by the doctor or midwife
Mother's pr	evious pregnancie	s
Mother's pr	evious pregnancie	Comments
Date	Outcome	
Date	Outcome	Comments
Date	Outcome	Comments  Comments  Comments
Date	Outcome  use in this pregnal	Comments  Comments  Comments

### Form M LOOKED AFTER CHILDREN

CONFIDENTIAL

Page 2

Obstetric report on mother Name of child DOB

#### Relevant factors in this pregnancy

		Comments
Gestation at booking visit	wks	
Was regular ante-natal care given	Y/N	
Evidence of foetal growth retardation	Y/N	
Abnormal ultrasound	Y/N	
Amniocentesis	Y/N	
Medical illness in pregnancy	Y/N	
Drug treatment in pregnancy	Y/N	
Mental illness/depression in pregnancy	Y/N	
Genetic illness in extended family	Y/N	

#### **Maternal blood tests**

	Result	Date
Blood group/rhesus factor		
Rubella status		
Haemoglobinopathy		
Hepatitis B		
Hepatitis C		
HIV		
Syphilis		

#### Labour: please give details of gestation, type of delivery, duration, any complications and drugs used

Gestation	al age	weeks		Induced Y/N	
Length of	labour			Drugs	
Type of d	elivery			Foetal distress	Y/N
Apgars	1 min	5 mins	10 mins		
Details of	complica	itions			

Signature of doctor/midwife	Date
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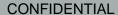
Qualifications

Name

Address Postcode

Telephone Fax

### Form B LOOKED AFTER CHILDREN Neonatal report on child





To be completed by a doctor or senior nurse

#### Parent's consent to the sharing of health information

The signed Consent Form (or photocopy) must be attached to this form

Part A To be completed by the	agency - write clearly in black in
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Part A To be completed by the agency –	write clearly in black ink
Name of agency	Social Worker
Address	
Telephone	Fax
Postcode	E-mail
Name of mother	Date of birth
Include all known names and underline surname	
Name of child Sex M/F	Date of birth
Form to be returned to the Agency Health Advise  Name	er
Telephone	Fax
Address	
Postcode	E-mail
Part B To be completed by a doctor or se	nior nurse
Hospital where born	Single or multiple birth
Type of delivery	Gestational age weeks
Time of birth Birth weight	OFC
What was the child's condition at delivery:	
Apgar 1 min 5 min 10 min spontaneous r	espiration established at min
Resuscitation	Y/N
Admitted to NICU/SCBU	Y/N

#### Post natal period

Condition	Yes / No	Details of condition and treatment
Breast feeding	Y/N	Breast or bottle, feeding difficulties
Jaundice	Y/N	Include maximum bilirubin and duration of treatment

Guidance note: This form will cover the essential information needed for most children. However if the child has had a very complicated neonatal course further information should be sought from the hospital records

Condition	Yes / No	Details of condition and treatment
Symptomatic hypoglycemia	Y/N	Include duration
Neonatal withdrawal syndrome	Y/N	Include maximum score and treatment details
Respiratory distress	Y/N	Include details of ventilation
Infection	Y/N	
Seizures	Y/N	
Others	Y/N	

Were there any abnormalities on **neonatal examination**? If yes, provide full details

Please describe the nature of the mother's relationship with the baby

### **Screening tests and investigations**

	Tested	Results	Date
PKU and Thyroid	Y/N		
Cystic Fibrosis	Y/N		
Haemoglobinopathy	Y/N		
Hearing screening	Y/N		
Hepatitis B, C and HIV	Y/N		
Ultra sound scan	Y/N		
Other	Y/N		

Immunisations	Yes/No	Date
BCG	Y/N	
Hepatitis B Immunoglobulin	Y/N	
Hepatitis B Vaccine first dose	Y/N	
Other	Y/N	

Discharge Details	Attach copy of discharge summary if available
Date of discharge from maternity unit	
Medications at discharge	
Referrals made	

Signature of doctor/senior nurse	Name	
Address		Qualifications
Postcode		Date
Telephone		Fax