

Form M/B

OBSTETRIC REPORT ON MOTHER/NEONATAL REPORT ON CHILD

This electronic edition : copyright BAAF 2013.

Based on a printed edition copyright BAAF 2004

Reproduced by permission of BAAF for the use by staff of(local authority/agency)
Council on in-house computer wordprocessing systems and in-house local
computer networks on’s premises.

Permission to copy, transmit or distribute further must be sought in writing from BAAF.

Permission to add to, amend, and adapt must be sought in writing from BAAF.

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

Name of mother

Date of birth

Ethnicity of mother

Ethnicity of father (if known)

Name of agency

Address

Telephone

Fax

Postcode

Child

Name of child

Date of birth

Time of birth

Place of birth

Social Worker

E-mail

Form to be returned to the Agency Medical Adviser

Name

Address

Telephone

Fax

Postcode

E-mail

Part B To be completed by the doctor or midwife

Mother's previous pregnancies

Date	Outcome	Comments

Substance use in this pregnancy (include duration and trimester when used if possible)

	Comments
Cigarettes number/day	
Alcohol units/day	
Drugs – prescribed and other	

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

Gestational age	weeks	Induced	Y/N
Length of labour		Drugs	
Type of delivery		Foetal distress	Y/N
Apgars	1 min	5 mins	10 mins
Details of complications			

Signature of doctor/midwife

Date

Qualifications

Name

Address

Postcode

Telephone

Fax

Form B LOOKED AFTER CHILDREN

Neonatal report on child

CONFIDENTIAL

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 ink

Name of agency	Social Worker	
Address		
Telephone	Fax	
Postcode	E-mail	
Name of mother	Date of birth	
<i>Include all known names and underline surname</i>		
Name of child	Sex M/F	Date of birth
<i>Include all known names and underline surname</i>		

Form to be returned to the Agency Health Adviser

Name	
Telephone	Fax
Address	
Postcode	E-mail

Part B To be completed by a doctor or senior 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 respiration 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