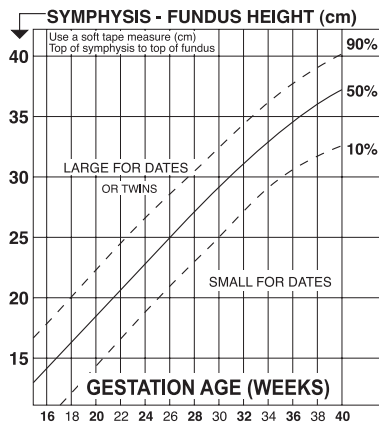


British Columbia Antenatal Record Part 1

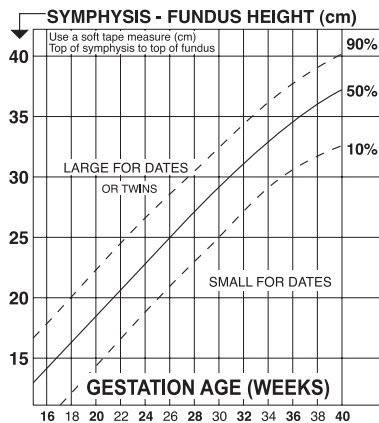
1. Hospital		Attending physician/midwife:		Referring physician/midwife:							
Mother's name			Date of birth (DD/MM/YYYY)	Age at EDD	Surname Given name						
Mother's maiden name			Ethnic origin	Language preferred	Address						
Occupation			Work hrs/day	No. of school yrs. completed							
Partner's name		Age	Ethnic origin of newborn's father	Partner's work	Phone number Personal health number						
2. Allergies <input type="checkbox"/> None known <input type="checkbox"/> Yes (reaction)			Medications/herbals		Beliefs & practices						
3. Obstetrical History		Gravida	Term	Preterm	Abortion (Induced _____ Spontaneous _____) Living						
Date	Place of birth/ abortion	Hrs. in labour	Gest. age	Type of birth	Perinatal complications	Sex	Birth Weight	Breastfed	Present health		
4. LMP (DD/MM/YYYY)		Menses cycle	Contraceptives	When stopped (DD/MM/YYYY)	EDD by dates (DD/MM/YYYY)	Confirmed EDD (DD/MM/YYYY)	1st US (DD/MM/YYYY)	GA by US (WEEKS + DAYS)			
5. Present Pregnancy				7. Medical History		8. Lifestyle & Social					
No		Yes (specify)		No		Yes (specify)		Discussed		Concerns	Referred
<input type="checkbox"/> IVF pregnancy				<input type="checkbox"/> Surgery				<input type="checkbox"/> Diet/Food Safety			<input type="checkbox"/>
<input type="checkbox"/> Bleeding				<input type="checkbox"/> Anesthesia				<input type="checkbox"/> Folic acid			
<input type="checkbox"/> Nausea				<input type="checkbox"/> Uterine/Cx procedure				<input type="checkbox"/> Physical Activity/rest/work			<input type="checkbox"/>
<input type="checkbox"/> Infections or fever				<input type="checkbox"/> STIs/infections				<input type="checkbox"/> OTC drugs/vitamins			<input type="checkbox"/>
<input type="checkbox"/> Other				<input type="checkbox"/> Susceptible to chicken pox				<input type="checkbox"/> Alcohol <input type="checkbox"/> never <input type="checkbox"/> quit (DD/MM/YYYY)			
				<input type="checkbox"/> Thromboembolic/coag.				Drinks/wk: before pregnancy _____ current _____			
				<input type="checkbox"/> Hypertension				Binge drinking <input type="checkbox"/> No <input type="checkbox"/> Yes			<input type="checkbox"/>
6. Family History		Yes (specify)		<input type="checkbox"/> GI				<input type="checkbox"/> TWEAK score _____ (see reverse)			
No				<input type="checkbox"/> Urinary				<input type="checkbox"/> Substance use <input type="checkbox"/> No <input type="checkbox"/> Yes			<input type="checkbox"/>
<input type="checkbox"/> Heart disease				<input type="checkbox"/> Endocrine/diabetes				<input type="checkbox"/> Heroin <input type="checkbox"/> Cocaine <input type="checkbox"/> Marijuana			
<input type="checkbox"/> Hypertension				<input type="checkbox"/> Neurologic				<input type="checkbox"/> Methadone <input type="checkbox"/> Solvents <input type="checkbox"/> Other			
<input type="checkbox"/> Diabetes				<input type="checkbox"/> Hx of mental illness				<input type="checkbox"/> Prescription <input type="checkbox"/> Unknown			
<input type="checkbox"/> Depression/psychiatric								<input type="checkbox"/> Smoking <input type="checkbox"/> never <input type="checkbox"/> quit (DD/MM/YYYY)			
<input type="checkbox"/> Alcohol/drug use								Cig/day: before pregnancy _____ current _____			<input type="checkbox"/>
<input type="checkbox"/> Thromboembolic/coag.		Maternal Newborn's Father						<input type="checkbox"/> Exposure 2nd hand smoke <input type="checkbox"/> No <input type="checkbox"/> Yes			
<input type="checkbox"/> Inherited disease/defect				<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar				<input type="checkbox"/> Financial & housing			<input type="checkbox"/>
<input type="checkbox"/> Ethnic (e.g. Tay Sachs, Sickle)				<input type="checkbox"/> PP depression <input type="checkbox"/> Unknown <input type="checkbox"/> Other				<input type="checkbox"/> Support system			<input type="checkbox"/>
<input type="checkbox"/> Other				<input type="checkbox"/> Other				<input type="checkbox"/> IPV			<input type="checkbox"/>
								<input type="checkbox"/> Public Health Nursing follow-up/assessment			<input type="checkbox"/>
9. Physical Examination					10. First Trimester Topics Discussed:						
Date (DD/MM/YYYY)	BP	Height (CM)	Pre-pregnant weight (KG)	Pre-pregnant BMI	Plans to breastfeed						
					<input type="checkbox"/> Prenatal Genetic Screening <input type="checkbox"/> Genetic counselling offered <input type="checkbox"/> HIV & other tests <input type="checkbox"/> Yes						
					<input type="checkbox"/> Baby's Best Chance <input type="checkbox"/> Prenatal education <input type="checkbox"/> Breastfeeding <input type="checkbox"/> No						
					<input type="checkbox"/> Seat belt use <input type="checkbox"/> Sexual relations <input type="checkbox"/> Maybe						
Head & neck					Musculoskeletal					11. Summary	
Breasts & nipples					Varicles & skin						
Heart & lungs					Pelvic exam						
Abdomen					Swabs/cervix cytology						
					SIGNATURE:					MD / MW	

12. Intended place of birth						Alternate place of birth (Hospital)									
13. Investigations / Result															
ABO group		Rh factor		Rubella titre			Prenatal Genetic Screening Type			Surname			Given name		
				<input type="checkbox"/> PP vaccination indicated						Address					
Antibody titre (DD/MM/YYYY) Results				S.T.S.			Gest. diabetes screen (24–28 wks) (DD/MM/YYYY) Result								
1				HIV test done <input type="checkbox"/> Yes <input type="checkbox"/> No											
2				HBsAg done (DD/MM/YYYY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Negative <input type="checkbox"/> Positive			GBS screen (35–37 wks) <input type="checkbox"/> Yes <input type="checkbox"/> No (DD/MM/YYYY) Result			Phone number			Personal health number		
Rhig given (DD/MM/YYYY)				<input type="checkbox"/> Partner/household contact <input type="checkbox"/> NB vaccination indicated			Edinburgh Postnatal Depression Scale (28–32 weeks) (DD/MM/YYYY) Score			15. Potential or Actual Concerns:			Lifestyle Pregnancy Labour Breastfeeding Postpartum Newborn		
1				Other tests (e.g. Hep C, TSH, Varicella)			Follow-up <input type="checkbox"/> Yes <input type="checkbox"/> No								
2															
Hemoglobin															
1st		3rd													
Urine C & S result															
14. Age		Pre-pregnant weight (kg)		Height (cm)		LMP (DD/MM/YYYY)			Confirmed EDD (DD/MM/YYYY)						
16. Date		B.P.	Urine	Wt. (KG)	Gest. wks.	Fundus (CM)	FHR	FM	Pres. and Pos.	Comments				Next visit	
												Give Pregnancy Passport			
												1 st tri serum 10–13 ⁺⁶ wks / NT 11–13 ⁺⁶ wks			
												2 nd tri serum 15–20 ⁺⁶ weeks			
												At 20 wks copy to patient / to hospital			
												Reassess diet, physical activity, smoking, alcohol & substance use			
												Discuss fetal movement 26–32 wks			
												At 36 wks copy to patient / to hospital			



16. Second & Third Trimester Topics Discussed <input type="checkbox"/> Call schedule <input type="checkbox"/> Preterm labour <input type="checkbox"/> Hospital admission <input type="checkbox"/> Doula <input type="checkbox"/> Risks/benefits of planned or use of blood/blood products <input type="checkbox"/> Birth plan <input type="checkbox"/> VBAC <input type="checkbox"/> Newborn screening: bloodspot/hearing <input type="checkbox"/> Pain management <input type="checkbox"/> Cesarean <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Infant safe sleep <input type="checkbox"/> Infant car seats		
17. Other Investigations & Comments 1st US (DD/MM/YYYY) GA by US (WEEKS + DAYS)		If maternal prenatal screen above cut-off, amnio: <input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE:		MD/MW

12. Intended place of birth						Alternate place of birth (Hospital)									
13. Investigations / Result															
ABO group		Rh factor		Rubella titre			Prenatal Genetic Screening Type			Surname			Given name		
				<input type="checkbox"/> PP vaccination indicated						Address					
Antibody titre (DD/MM/YYYY) Results				S.T.S.			Gest. diabetes screen (24–28 wks) (DD/MM/YYYY) Result								
1				HIV test done <input type="checkbox"/> Yes <input type="checkbox"/> No											
2				HBsAg done (DD/MM/YYYY) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Negative <input type="checkbox"/> Positive			GBS screen (35–37 wks) <input type="checkbox"/> Yes <input type="checkbox"/> No (DD/MM/YYYY) Result			Phone number			Personal health number		
Rhig given (DD/MM/YYYY)				<input type="checkbox"/> Partner/household contact <input type="checkbox"/> NB vaccination indicated			Edinburgh Postnatal Depression Scale (28–32 weeks) (DD/MM/YYYY) Score			15. Potential or Actual Concerns:			Lifestyle Pregnancy Labour Breastfeeding Postpartum Newborn		
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2															
Hemoglobin															
1st		3rd													
Urine C & S result															
14. Age		Pre-pregnant weight (kg)		Height (cm)		LMP (DD/MM/YYYY)			Confirmed EDD (DD/MM/YYYY)						
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17. Other Investigations & Comments 1st US (DD/MM/YYYY) GA by US (WEEKS + DAYS)		If maternal prenatal screen above cut-off, amnio: <input type="checkbox"/> Yes <input type="checkbox"/> No
SIGNATURE:		MD/MW