

Supplementary material

From maternity paper hand-held records to electronic health records: what do women tell us about their use?

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family name:
given name(s):
address:
medicare number:
date of birth:

Always carry this record with you

You must bring this record with you to your health care professional / hospital

Mater Mothers Hospital

Antenatal Clinic: 3163 8330
General Enquiries: 3163 8111
Pregnancy Assessment Unit: 3163 7000

In an emergency dial 000

Mother's information

Preferred name: <input type="text"/>	Country of birth: <input type="checkbox"/> Australia <input type="checkbox"/> Other <input type="text"/>
Are you of Aboriginal or Torres Strait Islander origin? (both may be ticked) <input type="checkbox"/> Yes, Aboriginal <input type="checkbox"/> Yes, Torres Strait Islander <input type="checkbox"/> No	Interpreter required? <input type="checkbox"/> Yes, language: <input type="text"/> <input type="checkbox"/> No

Shared Care Contact Information

Consultant:		Primary maternity carer name:	
General Practitioner (GP) / Midwife (stamp or print details):		Useful Phone Numbers	
Name:	Shared care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Discontinued		
Address:	Phone:		
	Fax:		
Email:	Pager:		
Name:	Shared care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Discontinued		
Address:	Phone:		
	Fax:	13 HEALTH 13 43 25 84 DVI Hotline 1800 811 811	
Email:	Pager:		

Anti D Prophylaxis (for Rh Negative women only)

☐ Yes → Week 28: Week 34-36:
☐ No (initial) (initial)

Disclaimer

This document is not nor should it be treated as a complete obstetric record for the mother. Copies of the complete obstetric record for the mother will be made available to the mother's treating health practitioner/s on request. Any notes in this document must be read in conjunction with the documents attached to it. This document will be updated at each visit.

Queensland Health does not warrant that this document is a comprehensive or up to date record. In no event shall Queensland Health be liable for any damages (including without limitation, direct, indirect, special or consequential) whatsoever including damages connected with or resulting from the information contained in this document or reliance on it.

This document does not replace the need to obtain a valid consent from the mother in relation to any procedure.

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Best Contact Person

Full name:			Relationship: <input type="checkbox"/> Partner <input type="checkbox"/> Other (specify):	
<input type="text"/>			<input type="text"/>	
Home phone:	Work phone:	Mobile phone:	Email address:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address				
<input type="text"/>				

Additional Contact Person

Full name:			Relationship: <input type="checkbox"/> Partner <input type="checkbox"/> Other (specify):	
<input type="text"/>			<input type="text"/>	
Home phone:	Work phone:	Mobile phone:	Email address:	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Address				
<input type="text"/>				

Important Information

It is very important that you tell your health care providers about any problems you or your baby had in previous pregnancy, labour and/or post-birth.

Call your GP / midwife / obstetrician or birth suite:

1. If you are unsure about what is happening to you or if you think you are in labour
2. If your 'waters' break (membranes rupture)
3. If you are experiencing any of these complications:
 - Any vaginal bleeding during pregnancy
 - Your baby is moving less than usual
 - Uncontrollable vomiting or diarrhoea
 - Abdominal or back pain
 - Unusual headaches and/or blurred vision
 - Fainting
 - Urinary problems

Please phone the following number prior to arriving at the hospital.

You may be in early labour and still be able to remain at home. A phone call to the hospital may reduce your anxiety and prepares staff for your arrival if necessary.

When to see your GP / midwife / obstetrician

Please refer to the Recommended Minimum Antenatal Schedule on page 8. If you have any concerns, please discuss this with your health care provider.

Types of pregnancy / antenatal care available

Shared care with hospital or hospital based midwife / doctor care / midwife in private practice or GP. Most hospitals offer 3 or 4 models of pregnancy / antenatal care. Please ask for details.

Referral for Booking In

Where was the referral sent?	Referral sent by:
	<input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Other: <input type="text"/>
	<input type="checkbox"/> Electronically

Date of birth:

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Birth Preferences

Please complete by 34 weeks after talking with your GP, midwife or obstetrician. You may tick more than one box. These plans are flexible and can be changed at any time, even through labour and birth.

Mobility and positions for labour

- ☐ Walking ☐ Standing ☐ Squatting
☐ Kneeling ☐ Lying (bed/floor mat)
☐ Other:

Relaxation and personal comfort

- ☐ Massage Oils ☐ Heat pack ☐ Music-relaxation CD/Tapes
☐ Shower/Bath ☐ Aromatherapy ☐ Relaxation techniques

Be aware

Circumstances can change due to a long and/or difficult labour or preterm baby. I may require:

- ☐ More pain relief than you anticipated
☐ Assisted birth [ie. forceps, ventouse (vacuum)]
☐ Caesarean section (operative birth)
☐ Episiotomy

Support / Cultural needs

Name of main support person: Name of second support person:

Comments:

Plans for home discussed

I have discussed with my health provider

- ☐ Vaginal birth, expected discharge 6–48 hours
☐ Caesarean birth, expected discharge within 4 days
☐ My preferred discharge time. May be within 24 hours, mother and baby condition permitting ⇒ Day 3–5 GP check.
☐ Community midwifery service – postnatal home visiting / phone contact
☐ Community Child Health Services
☐ Day 5–10 baby check with GP
☐ 6 weeks postnatal check with GP
☐ Postnatal depression information
☐ Postnatal follow up regarding pre-existing medical condition(s) – see page 13
☐ SAFE sleeping and SIDS information
☐ Recommended discharge time is by 10am
☐ How to register a compliment or complaint about the service

Birth aids

- ☐ Bean bag ☐ Bath ☐ Shower
☐ Mirror ☐ Birth stool ☐ Gym ball
☐ Other:

Pharmacological pain relief

- ☐ Entonox gas
☐ Narcotic intramuscular injection
☐ Epidural

Placenta – 3rd stage management

- ☐ Active – oxytocic injection given to mother following baby's birth to reduce the risk of bleeding as recommended by hospital guideline
☐ Modified active – discuss delayed cord clamping
☐ Physiological – as discussed with care givers (comments):

Screening and Vaccinations recommended for all babies following birth

I have received information and would like my baby to have:

- | | | |
|-------------------------------|------------------------------|-----------------------------|
| Vitamin K | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis B vaccination | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neonatal screening blood test | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Healthy Hearing screening | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Consent will be sought for the above when you have your baby

Whooping cough vaccination

- ☐ I have received information about whooping cough vaccination for my family and for me

Seasonal flu vaccination

- ☐ I have received information about seasonal flu vaccination

Meals

- ☐ I will require normal hospital food
☐ I will require a special diet:
☐ Vegetarian ☐ Vegan ☐ Diabetic
☐ Halal ☐ Gluten free
☐ Other:

Comments and questions

Awareness statement

Safety for you and your baby will be paramount in any decision making.

I understand that this is a guide to my preferences and acknowledge that circumstances can change, sometimes suddenly. I understand that if things do not happen as indicated then the primary maternity carer will discuss options with me in consultation with the specialist team on duty. I have information about and have indicated my choices for screening and vaccinations following birth.

Mother's signature:

Doctor's/Midwife's signature:

Doctor's/Midwife's name:

Date:

Date of birth:

Brown. Trauma in Pregnancy. Obstet Gynecol 2009.

DO NOT WRITE IN THIS BINDING MARGIN

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There is no handwriting or other markings on the paper.

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Feeding Your Baby

Have you breastfed before?

☐ Yes → Duration:
☐ No

Have you experienced difficulties with breastfeeding in the past?

☐ Yes → Give details:
☐ No

Sign and date each section as it is discussed		Date	Initial
Advantages of breastfeeding for your baby	<ul style="list-style-type: none"> - Breastmilk is a complete food for your baby. It is a living fluid constantly changing according to your baby's needs and packed full of minerals and antibodies to boost your baby's immune system. - A breast fed baby is less likely to develop allergies, diabetes, some childhood cancers, gastroenteritis and obesity 		
Advantages of breastfeeding for the mother	<ul style="list-style-type: none"> - Breastfeeding may assist the bonding and attachment between mothers and babies. - Breastfeeding promotes faster maternal recovery from childbirth and women who have breastfed have reduced risks of breast and ovarian cancers later in life. 		
Advantages of breastfeeding for the family	<ul style="list-style-type: none"> - Breastfeeding is free, safe, convenient and environmentally friendly - No preparation required; ready anytime, anywhere 		
Importance of skin-to-skin contact after birth	<ul style="list-style-type: none"> - Holding baby close after birth keeps them warm and calm, promotes bonding and helps breastfeeding. Bathing and weighing should wait until after the first feed. 		
Importance of good positioning and attachment	<ul style="list-style-type: none"> - Problems are most often caused by baby not being well attached; ask for help when you are starting out 		
Getting breastfeeding off to a good start	<ul style="list-style-type: none"> - Keep your baby with you while in hospital (getting to know each other) - Feed baby when shows signs of hunger (hands to mouth, searching) - Dummies and teats can sometimes cause problems when getting started 		
No other food or drink for the first 6 months	<ul style="list-style-type: none"> - Giving formula to breastfed babies in the first six months can reduce some of the health benefits of breastfeeding and decrease breastfeeding duration - Breastfeeding is still important for babies health after the introduction of solids at around six months of age, breastfeeding has ongoing health benefits for mum and baby for as long as it continues 		
Who can help support you to breastfeed?	<ul style="list-style-type: none"> - Your partner—partners can help in a lot of ways other than feeding (settling, bathing) - Your family and friends by giving practical support and help at home 		
Signs baby is getting enough breastmilk	<ul style="list-style-type: none"> - 6–12 feeds per day can be normal - 5–6 wet nappies each day - A breastfed baby may poo many times a day or none for a few days 		
Where to get help in the community	<ul style="list-style-type: none"> - Australian Breastfeeding Association www.breastfeeding.asn.au - 1800 mum 2 mum (1800 686 2 686) 24 hour helpline - Lactation consultants (see Yellow Pages) - General practitioners - Community Child Health (see Yellow Pages) - 13HEALTH (13 43 25 84) 		

Mothers who formula feed their baby will be shown how to safely prepare, store and transport feeds before discharge from hospital

I have had all the above information discussed with me and all my questions answered to my satisfaction.

Mother's signature:

Date:

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Glossary of Terms

A B O Rhesus human blood types; checks are done to see that there is no problem between the mother's and baby's blood.

Amniocentesis fluid (also called liquor) is taken by needle from the mother's uterus to do tests

Antenatal the period of pregnancy – before the birth

Antibodies proteins produced by blood (checks are done to see that there is no problem between the mother's and baby's blood)

BGL blood glucose level – to be watched for early signs of diabetes

BMI body mass index – A measure of weight and height

BP blood pressure

Br, Breech unborn baby is lying bottom-down in the uterus

C, Ceph unborn baby is lying head down in the uterus – cephalic presentation

CVS chorionic villus sampling, taking a small sample of placenta for testing for Down syndrome etc.

Cx (Pap) smear vaginal examination where a sample is collected to detect early warning of cancer of the cervix

E, Eng, Engaged unborn baby's head is positioned in the mother's pelvis, ready to be born

EDD estimated date of baby's birth – it is normal for the baby to be born up to 2 weeks before/after this date.

EDS, EPDS Edinburgh Depression Scale

Episiotomy surgical incision to enlarge the vaginal opening to help the birth

Fetal heart rate unborn baby's heartrate

Fetal movements unborn baby's movements

Fetus developing human baby

FH (H) fetal heart

Fifths above brim position of unborn baby's head in relation to mother's pelvis assessed by examining the abdomen

FMF; FMNF fetal (baby) movements felt; fetal movements not felt

Forceps instruments supporting baby's head to assist in childbirth

This list is an explanation of some of the terms or abbreviations you may see printed or added to this Pregnancy Health Record. Ask your GP, midwife or obstetrician if you don't understand any of the terms or words they use.

Fundal height size of the uterus – expected to increase 1cm per week from 20 – 36 weeks of pregnancy

GDM gestational diabetes mellitus – diabetes in pregnancy

Gestation number of weeks pregnant

Gestational hypertension a rise in blood pressure during pregnancy which will require close monitoring

Glucose challenge test (GCT) screening blood test for gestational diabetes which may develop during pregnancy

Glucose tolerance test (GTT) diagnostic blood test for gestational diabetes which may develop during pregnancy

GP, general practitioner family doctor

Gravida the number of times you have been pregnant, primigravida means first, multigravida means more than 1

Hb, haemoglobin the red cells in your blood, which carry oxygen and iron

Hepatitis A B or C inflammation or enlargement of the liver caused by various viruses. Baby may be immunised at birth against Hepatitis B.

HIV human immunodeficiency virus, the virus that may lead to AIDS

Hypertension high blood pressure

IOL induction of labour – labour that is initiated by medication or surgical rupture of membranes

Liquor fluid around baby

LNMP last normal menstrual period

MC miscarriage

Midwife professional healthcare worker who specialises in providing care for women and their families throughout pregnancy, labour and birth, and after the birth

MSU mid-stream specimen urine – tested to check for infection

NAD no abnormality detected

NE not engaged (see engaged)

Nuchal Translucency one of the special measurements taken of the unborn baby during an ultrasound scan

Obstetrician Medical specialist who specialises in providing care for women and their families throughout pregnancy, labour and birth, and after the birth

Oedema swelling generally of ankles, fingers or face

Parity the number of babies you already have had

PET pre-eclampsia or pre-eclampsic toxemia (elevated BP in pregnancy associated with protein in the urine)

Placenta the baby's lifeline to you, also known as after-birth

Posterior the unborn baby is lying with its spine alongside mother's spine. This can cause backache in labour

Postnatal period of time after the birth of the baby

Presentation the position of the baby in the uterus before the birth (referred to as vertex, breech, transverse)

Primary maternity carer the health care professional providing the majority of your maternity care

Primigravida mother pregnant for the first time

Rubella German measles, a disease that can cause major abnormalities in an unborn baby

Spontaneous labour labour that occurs naturally

STI sexually transmitted infections: includes syphilis, gonorrhoea, chlamydia and herpes.

T, FT, Term full-term, baby is due to be born (37–42 weeks)

Transverse unborn baby is lying crossways in the uterus

US, scan, Ultrasound sound waves passed across the mother's abdomen are used to make pictures of the unborn baby.

Uterine size size of the uterus relative to stage of pregnancy

Uterus, womb hollow muscle in which the baby grows

UTI urinary tract infection

VE vaginal examination (an internal check of the mother's cervix)

Venous Thrombus Embolism a blood clot in a vein

Ventouse/Vacuum Extraction suction cap to baby's head to assist birth

Vx, Vertex unborn baby is lying head down in the uterus – the most common position for birth

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Recommended Minimum Antenatal Schedule

First visit GP/Midwife visit preferably before 12 weeks	<ul style="list-style-type: none"> » Pregnancy confirmed- maternal counselling including tobacco/alcohol/other drug cessation » Pre-pregnancy weight, height and BMI » Urine dipstick/MSU » Antenatal blood tests ordered with consent and counselling » Blood group and antibodies (status checked/identified), full blood count, syphilis, rubella, hepatitis B, hepatitis C, HIV » Ultrasounds ordered » Antenatal screening bloods Free Beta-hCG and Papp A after 10 completed weeks and preferably 3–5 days prior to Nuchal USS Note: Request slip to include EDD and current maternal weight » Nuchal Translucency 11 weeks–13 weeks ^{+6 days} » Diagnostic Morphology 18–20 weeks » Booking in referral sent » Genetic Counselling and testing discussed as appropriate » Chorionic Villus Sampling 11–13 weeks/Amniocentesis 16–18 weeks
12–18 weeks Midwife booking in visit	<ul style="list-style-type: none"> » Booking in Visit – demographic, social, medical and obstetric history ± allied health referrals » SAFE Start or similar tool, tobacco/alcohol/other drug cessation and EDS (EPDS) completed » Maternal counselling including tobacco/alcohol/other drug cessation, and breastfeeding (see pages 6, 18 and 19) » Models of care discussed and preference identified
20 weeks Hospital staff visit	<ul style="list-style-type: none"> » Post diagnostic morphology ultrasound assessment and general health check » Appropriate model of care confirmed (after risk assessment completed) » Maternal counselling including tobacco/alcohol/other drug cessation and breastfeeding » Rh negative women – Consent for prophylactic Anti D stapled inside Pregnancy Health Record
24 weeks Standard antenatal visit with primary maternity carer	<ul style="list-style-type: none"> » Full assessment including abdominal palpation and fetal auscultation » Request slip given for blood tests to be performed between 26–28 weeks » Full blood count, Rhesus Antibody blood screen and Glucose Challenge for all women
28 weeks Standard antenatal visit with primary maternity carer	<ul style="list-style-type: none"> » Check pathology results » 1st dose of Anti D for Rhesus negative women
30–32 weeks Standard antenatal visit with primary maternity carer	<ul style="list-style-type: none"> » Standard antenatal visit including maternal counselling on tobacco/alcohol/other drug cessation and breastfeeding » Discuss birth preferences, length of hospital stay and postnatal community supports
34 weeks Standard antenatal visit with primary maternity carer	<ul style="list-style-type: none"> » 2nd dose of Anti D for Rhesus negative women » EDS (EPDS) completed
36 weeks Hospital staff visit	<ul style="list-style-type: none"> » Standard antenatal visit including maternal counselling on tobacco/alcohol/other drug cessation and breastfeeding » Perform Full blood count, Rhesus Antibody blood screen
38 weeks Standard antenatal visit with primary maternity carer	<ul style="list-style-type: none"> » Discuss signs of early labour and when to come to hospital » Review blood results
40 weeks Standard antenatal visit with primary maternity carer	<ul style="list-style-type: none"> » Standard antenatal visit including maternal concerns
41 weeks Hospital visit	<ul style="list-style-type: none"> » Assessment of maternal and baby wellbeing (arrange for CTG if indicated) » Uncomplicated pregnancy - offer IOL for T^{+10–14} i.e. 42 weeks

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URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Antenatal Care Checklist

Additional appointments may be required according to individual need. Please discuss any questions or concerns you have during your antenatal, labour or postnatal period with your care providers.

Visit	Activity	Notes
First Visit Preferably before 12 weeks	<input type="checkbox"/> Discuss/order/perform routine investigations and genetic counselling Bloods —group and antibodies, FBC, syphilis, hepatitis B&C, rubella, HIV and urine dipstick/MSU Antenatal screening —Nuchal Translucency + Bloods at week 11–13 ⁶ Diagnostic morphology 18–20 weeks <input type="checkbox"/> Offer pap smear if due <input type="checkbox"/> Discuss normal breast changes / examination <input type="checkbox"/> Send hospital referral. Note interest in birth centre care if applicable. <input type="checkbox"/> Discuss folate and iodine supplementation	
12–18 Week Midwife Booking in Visit	<input type="checkbox"/> Discuss preferred model of care <input type="checkbox"/> Commence smoking/alcohol cessation counselling <input type="checkbox"/> Complete SAFE Start or similar tool and EDS (EPDS) <input type="checkbox"/> Discuss recommended weight gain/nutrition <input type="checkbox"/> Discuss physiotherapy <input type="checkbox"/> Discuss reasons to breast feed <input type="checkbox"/> Offer antenatal classes: <input type="checkbox"/> Accepted <input type="checkbox"/> Declined	
20 Week Visit	<input type="checkbox"/> Obtain consent for Anti D prophylaxis <input type="checkbox"/> Confirm expected date of birth <input type="checkbox"/> Confirm model of care <input type="checkbox"/> Review blood/scan results <input type="checkbox"/> Discuss skin to skin contact <input type="checkbox"/> Discuss initiation of breast feeding/baby led feeding <input type="checkbox"/> Discuss positioning and attachment of baby	
Subsequent Visits A minimum of every 4 weeks until 28 weeks	<input type="checkbox"/> Discuss benefits of rooming-in (baby/mother staying together) <input type="checkbox"/> Discuss exercise and rest <input type="checkbox"/> Week 26–28: Obtain GCT/FBC/antibodies (GTT when indicated) <input type="checkbox"/> Review blood results <input type="checkbox"/> Week 28: Provide first dose Anti D if applicable <input type="checkbox"/> Discuss home safety and hazard identification for injury prevention	
30–32 Week Visit with Midwife	<input type="checkbox"/> Discuss birth preferences <input type="checkbox"/> Discuss discharge planning including post-natal supports <input type="checkbox"/> Discuss exclusive breast feeding for six months	
34 Week Visit	<input type="checkbox"/> Week 34: Provide second dose Anti D if applicable <input type="checkbox"/> Discuss expressing breast milk and safe storage <input type="checkbox"/> Review EDS (EPDS)	
36 Week Visit Then as clinically indicated every 1–2 weeks until 41 weeks	<input type="checkbox"/> Discuss signs of early labour, when to come to hospital <input type="checkbox"/> Book elective caesarean section (if applicable) <input type="checkbox"/> Review blood results <input type="checkbox"/> Review breastfeeding information	
41 Week Hospital Visit	<input type="checkbox"/> Discuss induction of labour for week 40 +10–14 days plus or minus membrane sweep <input type="checkbox"/> Monitoring if indicated as per current fetal surveillance guidelines	

DO NOT WRITE IN THIS BINDING MARGIN

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Details of Baby's Father

Full name:	Age:
<input type="text"/>	<input type="text"/> yrs
Aboriginal or Torres Strait Islander origin? (both may be ticked)	
<input type="checkbox"/> Yes, Aboriginal	<input type="checkbox"/> Yes, Torres Strait Islander
<input type="checkbox"/> No	
Country of birth:	Preferred language:
<input type="text"/>	<input type="text"/>
Reside together?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	

Details of smoking / alcohol use:

Health status:

Hereditary conditions:

Mother's Health History

Consult with your health care professional to complete this section

Health Directive in place? ☐ Yes → ☐ Copy in chart ☐ No (tick if yes and comment as appropriate)

<p><input checked="" type="checkbox"/> Gynaecological</p> <p>Pap smear (specify date/result):</p> <p>Previous abnormal pap smear: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fertility problems:</p> <p>STI:</p> <p>Gynaecological problems:</p> <p>Antenatal Diagnosis Counselling:</p> <p>Other:</p>	<p>Haematological (blood) conditions</p> <p><input type="checkbox"/> Autoimmune</p> <p><input type="checkbox"/> Other</p> <p>Venous thrombus embolism (VTE) risk assessment</p> <p>Assess if the mother has any of the following VTE risks:</p> <p><input type="checkbox"/> Major medical illness</p> <p><input type="checkbox"/> Personal history of DVT, PE</p> <p><input type="checkbox"/> Family history of DVT, PE</p> <p><input type="checkbox"/> Thrombophilia:</p> <p><input type="checkbox"/> Congenital or acquired</p> <p><input type="checkbox"/> Antiphospholipid syndrome</p> <p>Consider referral to obstetric or medical service if:</p> <p><input type="checkbox"/> Age over 35 years</p> <p><input type="checkbox"/> Weight over 80kg or BMI ≥ 30</p> <p><input type="checkbox"/> Parity 4 or more</p> <p><input type="checkbox"/> Gross varicose veins</p> <p><input type="checkbox"/> Current infection</p> <p><input type="checkbox"/> Preeclampsia</p> <p><input type="checkbox"/> Prolonged immobility</p>
<p><input checked="" type="checkbox"/> Medical</p> <p>Asthma / Chest diseases:</p> <p>Heart disease:</p> <p>High blood pressure:</p> <p>Kidney disease / UTI:</p> <p>Incontinence</p> <p><input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Dysuria</p> <p><input type="checkbox"/> Stress Incontinence <input type="checkbox"/> Bowel <input type="checkbox"/> Referral</p> <p>Diabetes (specify treatment):</p> <p>Thyroid disorder:</p> <p>Neurological:</p> <p>Gastrointestinal:</p> <p>Liver disorders:</p> <p>Epilepsy:</p> <p>Musculoskeletal disorder:</p> <p>Mental health issues / Eating disorders:</p> <p>Postnatal depression:</p> <p>Childhood illness / Vaccinations:</p>	<p>Surgical history:</p> <p><input type="checkbox"/> Blood transfusions</p> <p><input type="checkbox"/> Previous anaesthetic</p> <p>Medications (including over the counter, natural remedies, vitamins etc.)</p> <p>Maternal family history</p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Mental health issues</p> <p><input type="checkbox"/> Heart disease <input type="checkbox"/> Hearing</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Multiple pregnancies</p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Genetic disorders / congenital abnormalities</p> <p><input type="checkbox"/> Postnatal depression</p> <p><input type="checkbox"/> Thyroid disorder</p> <p>Other / Comments:</p>

Signature:

Date:

DO NOT WRITE IN THIS BINDING MARGIN

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Previous Pregnancies

Gravida: Parity: Pregnancy loss:

Date of birth	Ges- tation	Place of birth	Type of labour	Duration of labour	Type of birth	Sex	Birth weight	Duration of B/F	Comments / Name
/ /			<input type="checkbox"/> Spont <input type="checkbox"/> Ind				g		
/ /			<input type="checkbox"/> Spont <input type="checkbox"/> Ind				g		
/ /			<input type="checkbox"/> Spont <input type="checkbox"/> Ind				g		
/ /			<input type="checkbox"/> Spont <input type="checkbox"/> Ind				g		
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/ /			<input type="checkbox"/> Spont <input type="checkbox"/> Ind				g		
/ /			<input type="checkbox"/> Spont <input type="checkbox"/> Ind				g		

Guidelines for Calculation of Estimated Due Date

1. First day of LNMP

Date / /

Certain?

☐ Yes ☐ No

Assisted conception?

☐ Yes ☐ No☐ Pill or other contraception

Comments:

2. Menstrual cycle

☐ Regular ☐ IrregularNumber of bleeding
days:

Usual length of cycle:

3. Due date based on period and cycle:

/ /

4. Due date by ultrasound:

/ /

Gestation at ultrasound:

/ 40

LNMP consistent with early
ultrasound scan (within seven days)?☐ Yes ☐ No

5. Estimated Due Date

/ /

Person who calculated (print name):

Date:

/ /

Position:

Physical Examination at First Booking Visit

Date: / /	Pre-pregnancy weight: kg	Height: cm	Pre-pregnancy BMI:	To be completed by a medical officer:	
Booking weight: kg	Comments:			Breast / Nipples:	
Cx (Pap) smear: <input type="checkbox"/> Up to date <input type="checkbox"/> Offered <input type="checkbox"/> Performed <input type="checkbox"/> Declined <input type="checkbox"/> Deferred postpartum <input type="checkbox"/> Referral arranged				Cardiovascular:	
Dental:				Respiratory:	
				Abdominal:	
				Skeletal:	
				Thyroid:	

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Medical information

Laboratory Results

	5-12 weeks	26-28 weeks	36 weeks			
Date	/ /	/ /	/ /	/ /	/ /	/ /
Blood group						
Antibody screen						
Antibody screen 28/34 weeks for Rh negative						
Hb g/L						
GCT						
RPR / TPHA						
Hep B						
Hep C						
Rubella titre						
HIV						
Urine dipstick/MSU						
Optional (if indicated)	GTT					
	Group B Strep Status (GBS)					
	Varicella Consider if history uncertain					
	Chlamydia screening (first catch urine)					

Ultrasound Results

Date of US	Gestation	Findings	Follow up (only if required)
		Estimated due date by dating scan	
		Combined first trimester screen: • PaPP-A and free bhCG after 10 completed weeks • Nuchal translucency 11-13 weeks + 6 days	<input type="checkbox"/> Low risk <input type="checkbox"/> High risk <input type="checkbox"/> Counselling <input type="checkbox"/> Amnio/CVS considered <input type="checkbox"/> Tertiary referral offered
		Morphology Scan Placenta: <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Fundal <input type="checkbox"/> Low lying Fetal morphology: <input type="checkbox"/> No abnormalities detected <input type="checkbox"/> Review result	<input type="checkbox"/> Rescan 34 weeks

Model of care

Is the mother eligible for low risk care?

☐ Yes → ☐ GP Shared Care ☐ Hospital midwife ☐ Community midwife ☐ Birth Centre ☐ Midwifery Group Practice
☐ Other:

☐ No, state reason: Print name: Doctor's signature: Date: / /

Additional Notes

EDS (EPDS) completed (initial):	Score:	Gestation:	Comments:
Mental health referral completed (initial):		Comments:	
Safe Start completed (initial):		Comments:	

Best estimate due date:

/	/
---	---

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Medical information

Adverse Reactions

Document below or ☐ Nil known

Allergy	Date of reaction	Type of reaction	Severity of reaction	Intervention required

Medical and Obstetric Issues and Management Plan

Diagnosis:

Antenatal management

☐

Anaesthetic review—date:

/	/
---	---

☐

Neonatology review—date:

/	/
---	---

Peripartum management

Postpartum management

Postpartum follow-up

Pap smear

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Contraception

--

Signature:

--

Date:

--

DO NOT WRITE IN THIS BINDING MARGIN

Best estimate due date:

/ /

(affix identification label here)

URN:

Family name:

Given name(s):

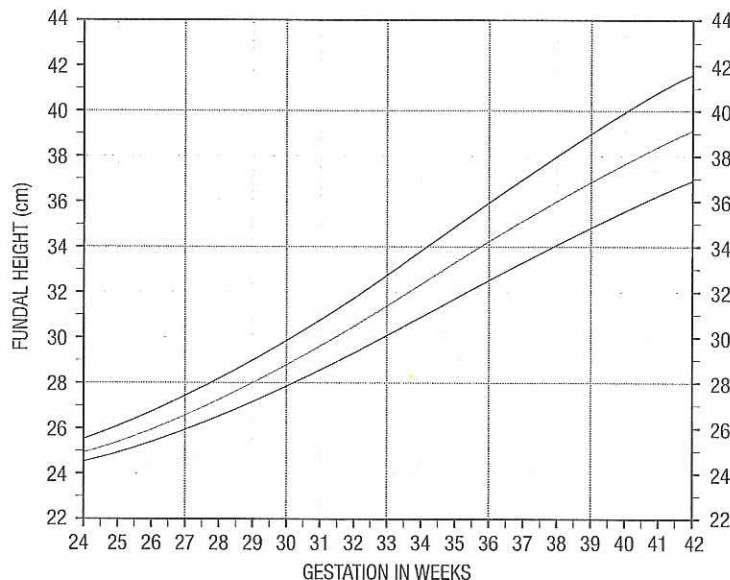
Address:

Medicare number:

Date of birth:

Fundal Height Chart

Plot at each visit



Visit Notes

1 of 4

All hospital staff document any variances in progress notes

Date	Blood pressure (seated)	Weeks/gestation calc	Gestation clinical (cm)	Presentation	Descent/Fifths above brim	Fetal heart rate	Fetal movements	Liquor	Weight (if required)	Urinalysis (if required)	Smoking (yes / no)
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		

DO NOT WRITE IN THIS BINDING MARGIN

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Best estimate due date:

/ /

Visit Notes 2 of 4

2 of 4

All hospital staff document any variances in progress notes

[illegible]

Notes:

Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N	Name:	Position:	Signature:
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[illegible]

Notes:

Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N	Name:	Position:	Signature:
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[illegible]

Notes:

Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N	Name:	Position:	Signature:
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[illegible]

Notes:

Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N	Name:	Position:	Signature:
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[illegible]

Notes:

Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N	Name:	Position:	Signature:
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DO NOT WRITE IN THIS BINDING MARGIN

Clinic notes

URN:
Family name:
Given name(s):
Address:
Medicare number:
Date of birth:

/ /

All hospital staff document any variances in progress notes

Date	Blood pressure (seated)	Weeks/ gestation calc	Gestation clinical (cm)	Presentation	Descent/ Fifths above brim	Fetal heart rate	Fetal movements	Liquor	Weight (if required)	Urinalysis (if required)	Smoking (yes / no)
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											

DO NOT WRITE IN THIS BINDING MARGIN

Best estimate due date:

/ /

Date of birth:

4 of 4

All hospital staff document any variances in progress notes

Date	Blood pressure (seated)	Weeks/ gestation calc	Gestation clinical (cm)	Presentation	Descent/ Fifths above brim	Fetal heart rate	Fetal movements	Liquor	Weight (if required)	Urinalysis (if required)	Smoking (yes / no)
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											
Registered interpreter present? <input type="checkbox"/> Y <input type="checkbox"/> N			Name:			Position:			Signature:		
Notes:											

Clinic notes

DO NOT WRITE IN THIS BINDING MARGIN

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Tobacco Screening Tool

Smoking is proven harmful to mothers and their unborn children. To help smokers there is smoking cessation support available.

Date: Gestation: ☐ Clinician has advised that smoking is harmful to mothers and unborn children

1. Ask

Which of these statements best describes your current smoking?

- ☐ I have never smoked
☐ I smoke daily now, about the same as before finding out I was pregnant
☐ I smoke daily now, but I've cut down since finding out I was pregnant
☐ I smoke every once in awhile
☐ I quit smoking since finding out I was pregnant
☐ I wasn't smoking around the time I found out I was pregnant – I had smoked within the last 12 months

If currently smoking, number of cigarettes per day:

Does your partner smoke?

☐ Yes ☐ No ☐ N/A

Does anyone residing in or regularly visiting your household smoke?

☐ Yes ☐ No ☐ N/A

2. Assess

Quitting stage

- ☐ 1. Not ready ☐ 3. Ready ☐ 5. Relapse
☐ 2. Unsure ☐ 4. Staying a non-smoker

Barriers to quitting

- ☐ Withdrawal/cravings ☐ Partner smoking ☐ Weight gain ☐ Stress ☐ Other

Notes

3. Advise

Benefits of quitting

- ☐ **Pregnancy**
 ↑ Oxygen and nutrients to baby
 Normal birth weight
 ↓ Risk of complicated birth
 ↓ Risk of pre-term birth
☐ **Baby**
 More settled
 ↓ Risk of SIDS, asthma
 Baby more likely to be discharged with mother
 Fewer colds, ear, respiratory infections
☐ **Breastfeeding**
 ↑ Intention to breastfeed / duration of feeding
 No chemicals in milk to baby
☐ **Families**
 ↓ Risks of passive smoking
 Healthy environment
☐ **Mother / partner**
 ↑ Self esteem
 ↓ Cancers
 ↓ Cardiac / respiratory disease
 ↑ Energy, breath easier
 Save money

4. Assist/arrange

Education

- ☐ Affirm positive change
☐ Give encouragement
☐ Discuss supports: GP, Quitline
☐ Discuss nicotine replacement therapy (NRT)

Written resources given (for mother)

☐ Yes ☐ Declined

Written resources given (for partner)

☐ Yes ☐ Declined

☐ Quitline number offered 13 QUIT (13 7848)

☐ Quitline declined

Referral to Indigenous Health Clinic

☐ Faxed ☐ Declined ☐ N/A

5. Ask again

Please complete the following at every opportune visit for smokers and recent quitters

Visit date	Weeks gestation	1. Cigarettes per day	2. Quitting stage	3. Advice offered Benefits of quitting	4. Support / Assistance given
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		

URN:

Family name:

Given name(s):

Address:

Medicare number:

Date of birth:

Alcohol and Drug Screening Tool

No alcohol in pregnancy is the safest option – please ask – you can make a difference

1. Ask

DURING THIS PREGNANCY:

How often have you had a drink containing alcohol in it? ☐ Never (0) ☐ 2 to 3 times a week (3) ☐ 4 or more times a week (4)

How many standard drinks have you had on a typical day when drinking? ☐ Monthly or less (1) ☐ 2 to 4 times a month (2) ☐ 7 to 9 (3) ☐ 10 or more (4)

How often have you had six (6) or more standard drinks on one occasion? ☐ 1 or 2 (1) ☐ 3 or 4 (1) ☐ 5 or 6 (2) ☐ Less than monthly (1) ☐ Monthly (2) ☐ Weekly (3) ☐ Daily or almost daily (4)

Scoring
Add the scores (shown in brackets) for each of the three questions for a total score out of 12
Score:/12
0 No risk drinking
1-3 Some risk drinking
4-5 Risky drinking
≥ 6 High-risk drinking

2. Assess

Readiness to stop drinking (Ask: 'how ready are you to stop drinking now you are pregnant?') ☐ 1. Not ready ☐ 3. Ready ☐ 5. Relapse
☐ 2. Unsure ☐ 4. Staying a non-drinker

Barriers to stopping drinking ☐ Withdrawal/cravings ☐ Partner drinking ☐ Stress ☐ Other

Notes

3. Advise

0 No risk drinking ☐ Congratulate and reinforce no safe level of drinking whilst pregnant

1-3 Some risk drinking ☐ Reinforce there is no safe level of drinking whilst pregnant
☐ May indicate harm for baby

4-5 Risky drinking ☐ Reinforce there is no safe level of drinking whilst pregnant
☐ May indicate harm for baby
☐ Reinforce benefits of stopping at any time
☐ Discuss potential effects of current drinking levels, including health concerns for both mother and baby
☐ Fetal Alcohol Spectrum Disorder (FASD)
☐ If unsure or ready to cut down or stop:

- ask how confident she is about succeeding
- ask if she would like some assistance
- offer referral to local support service

≥ 6 High-risk drinking ☐ Advise same as 'risky drinking' section above
☐ Refer to local support service for assessment and support
☐ Discuss concerns with treating team

4. Assist/arrange

Education ☐ Affirm positive change ☐ Give encouragement ☐ Discuss supports – family, GP, ATODS

Written resources given (for mother) ☐ Yes ☐ Declined

Written resources given (for partner) ☐ Yes ☐ Declined

Referral to local support service ☐ Faxed ☐ Declined (midwife to follow up at next visit)

Referral to Indigenous Health Clinic ☐ Faxed ☐ Declined (midwife to follow up at next visit) ☐ N/A

5. Ask again

Please complete the following at every opportune visit

Visit date	Weeks gestation	1. Drinks per day	2. Stage of readiness (As above, in ASSESS)	3. Advice offered Risks of drinking	4. Support / Assistance given / Referral
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		
			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5		

Drug Screening ☐ Check medical record

In the past 3–6 months have you used any prescribed, non-prescribed or herbal drugs? ☐ Yes ☐ No

If Yes, - specify:
- refer to local support service for assessment and ongoing support.

Ask again:

Visit date 1	Weeks gestation	Support / Assistance given	Visit date 2	Weeks gestation	Support / Assistance given

Appointments

[illegible]

DO NOT WRITE IN THIS BINDING MARGIN

Antenatal Education Classes

[illegible]

Acknowledgements

This document has been an initiative of the Queensland Health Statewide Maternity and Neonatal Clinical Network including the Queensland Health Antenatal Hand Held Steering Committee and Working Group.

We wish to thank the South Australian Department of Health, Townsville Health Service, Royal Brisbane and Woman's Health and the Southern Area Health Service Maternity Network for providing their pregnancy health records to aid in the design of this document.

Fig. S2. MSEHR home page.

