South African Nursing Council
Regulating nursing, advocating for the public

ANNEXURE E: RECORD OF MATERNITY CASES ATTENDED

Instructions:

- The annexure on the record of maternity cases attended must be read in conjunction with the relevant Regulation and Guidelines relating to education and training for the Advanced Diploma in Midwifery (NQF Level 7) and Midwifery component of Bachelor of Nursing (NQF level 8)
- The information provided in the annexure should guide in the completion of an approved Midwifery Register

First antenatal visit

Date of booking: ………………………………………………………….

Institution file Number: ……………………………………………….

Age: ……………………………………………………………………………

Marital Status: ……………………………………………………………

Occupation: ………………………………………………………………..

Religion: ……………………………………………………………………

Gravidity: ……………………………………………………………………

Parity: ……………………………………………………………………….

Last normal Menstrual Period (LNMP): ……………………….

Estimated date of delivery (EDD): ………………………………

Method used to calculate EDD (Tick where applicable): Sonar: ……… SFH: …………. LNMP: …………

Observations and investigations

General health/appearance (good/fair/poor): …………………………………………………

Vital signs: ……………………………………………………………………………….

Urine test: ………………………………………………………………………………..

HIV Test: …………………………………………………………………………………..

Blood tests (specify): ………………………………………………………………..

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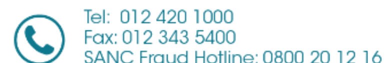
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Chairperson: Dr M Molepo, Vice Chairperson: Dr S Zuma, Registrar & CEO: Ms S Mchunu

Allergies: …………………………………………………………………………………..

Height: ………………………………………………………………………

Weight: ……………………………………………………………………

Thyroid: ……

Mid Upper Arm Circumference (MUAC): …………………………cm BMI: …………………………..Kgm^2

Medications: …………………………………………………………

Concerns about pregnancy:
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………

Life style counselling/health education, e.g., smoking, nutrition, alcohol, substance abuse:
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Information on/history of contraceptive use: ……………………………………………………………………………..

Planned/Future contraceptive method: ………………………………………………………………………………………

Feeding options: …….

Health Information shared: ……………………………………………………………………………………………………….

Parental preparedness: ……………………………………………………………………………………………………

Obstetric history

History of previous pregnancies:
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History of previous babies:
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Birth weight of previous babies:
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History of previous labour:

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History of previous puerperia:

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Observations and investigations done:

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Any other illness, complications or abnormalities:

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Any medication taken in the course of this pregnancy:

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General history

Medical history: ……
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Mental health screening and score if applicable:
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History of/information about domestic violence:
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Family History and genetic disorders:

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Previous surgery:
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Breast examination:

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Abdominal examination:

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Subsequent antenatal visits:

In accordance with the relevant sections of the Midwifery Register to include the following information:

Mother

- Date of visit: ……
- Height of fundus (HOF)/Symphysis pubis height (SFH): …………………………………………………..
  - by date: ………..
  - on palpation: ……………………………………………………………………………………………………..
- Urine: ……..
- Blood pressure: ……………………………………………………………………………………………………….
- Weight: ………..
- Oedema: ………
- Estimated date of delivery………………………………………………………………………………………

Baby

- The lie: ……
- Presentation: …….
- Position: ……….
- Engagement: ……….
- Fetal heart: ………..

Date of 1st booking: ………

Gestational age at booking: ……………………………………………………………………………………………………….

Date of Visit	Intervention/outcome

Abnormal findings including danger signs, if any:
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Referral to medical practitioner:
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If referred, name of medical practitioner:
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Medications or treatment prescribed:
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If not referred in case of illness, complications or abnormalities, reasons why not referred:
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Emergencies and action taken:
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Delivery Site:

……………………………………………………………………………………………………

Labour:

Institution file number: ………………………………………………………………………………………………

Date and time of arrival of the woman at the delivery site: ………………………………………………………

Date and time of commencement of labour: ………………………………………………………………………

Record on arrival:

(a) Maternal pulse rate, temperature and blood pressure:
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(b) Foetal heart rate:
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(c) Date and time of beginning of established labour, including contractions:
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Findings on abdominal palpations:
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Dates and times of findings of all internal/vaginal examinations should include:

- State of vagina: ……………………………………………………………………………………..
- Cervix dilatation: ……………………………………………………………………………………..
- Application: ……………………………………………………………………………………………..
- Caput: ……………………………………………………………………………………………………..
- Moulding: ……………………………………………………………………………………………….
- Presenting part, etc.: ………………………………………………………………………………
- Person who performed the examination (name and professional status):
  ……….
-

Name or signature of the person who did the internal examination:
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Date	Time	Findings, e.g. cervix dilation, application, caput, moulding, presenting part

Date and time of rupture of membranes, spontaneous or artificial:
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Liquor clear/blood stained/meconium stained:

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Foetal monitoring and contractions monitoring: decelerations yes or no:

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………

Foetal heart rate:

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………
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Date and time of beginning of second stage:

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Type of delivery:

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Date and time of birth of baby:

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Date and time of completion of third stage:

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………

Blood pressure, pulse rate and temperature on completion of third stage:

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Method of expulsion of the placenta:

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Check if the uterus is well contracted following the delivery of the placenta:..

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Condition of the placenta and membranes:

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Amount of blood loss during pad checks:

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Duration of labour:

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Any complications:

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Perineal and vaginal inspection in order to assess extent of the trauma whether (first, second, third or fourth degree prior to repair:

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Local anaesthetic administered:

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Episiotomy, suturing**:**

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Name of medical practitioner, if called in, with the date, time, and reason for calling him in:
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Details of and reasons for medication and treatment given to the mother and baby, including any emergency action taken:
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Interventions:

Any medication given (specify):
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Any fluids given (specify):
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The Neonatal Examination

Immediate intervention:

Sex: ………………………………………….

Whether full term or premature (if premature give approximate number of weeks):
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Alive or stillborn (if stillborn, state whether macerated or not:
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Mass/Weight at birth: ……

APGAR rating at one minute after birth: ……………………………………………………………………………………..

APGAR rating at five minutes after birth: ……………………………………………………………………………………

APGAR rating at 10 minutes if the initial score is abnormal……………………………………………………………..

Details of resuscitation performed (if applicable):
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Medication: eyes or other for the baby: ……………………………………………………………………………………….

Vitamin K: ……

Full Examination of the neonate:
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Physical assessment done by:
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Any physical abnormalities and any deviation from the normal at birth or during the puerperium:
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Name of medical practitioner, if called in, with the date, time and reason for calling him in:
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Discharge or last visit:

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Date: ……………………………………………………………………………………….

Temperature and respiration: ……………………………………………………………………………………………

Mass/weight and condition: ………………………………………………………………………………………………

Condition of the eyes: ……………………………………………………………………………………………………

Colour of the skin: ……

Condition of the cord: ……………………………………………………………………………………………………

Immunisations given: ……………………………………………………………………………………………………

Health information shared: ……………………………………………………………………………………………

Date of return: ……

Method of feeding: ………………………………………………………………………….

Emergencies and action taken: ……………………………………………………….

The mother

Vital signs:

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Physical assessment:

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Involution of the uterus:

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Lochia colour and smell:

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Haemoglobin:

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Urine analysis:
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………..
Passed tool:
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Condition of the breasts:
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………..

Psychological status of the woman:
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………
………
………

Condition of mother on discharge or last visit:
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Who accompanied the women home?
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Any available support person at home (Especially during the 1st six weeks of delivery):
………..
Concerns raised on discharged:
………
……….
Referral to clinic for follow-up and further support:
………..

Health Information provided (e.g. Breastfeeding, self-care, post-natal exercises, dander signs, etc.):
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………
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………
Signature of student midwife: ………………………………………………………………………………………………..

Signature of registered midwife: ……………………………………………………………………………………………