

MOTHER'S DETAILS

Surname
 Forename(s)
 Address
 Postcode [][][][][][][][][]
 GP Name
 GP Practice
 Mother's NHS Number

Hospital in which pregnancy
 BOOKED Hosp No
 ENDED Hosp No
 Mother's DoB [][][][][][][][][]
 Occupation
 Highest Educational Level (*circle number*)
 1. Secondary 2. Higher Secondary 3. Tertiary
 or
 Ethnic Origin (*circle number*)
 1. White 2. Mixed 3. Asian/Asian British
 4. Black/Black British 5. Other 6. Not Stated
 Immigrant in this pregnancy Yes / No
 Immigrant as an adult Yes / No
 Country of origin

OTHER FAMILY MEMBERS

Father's DoB [][][][][][][][][] or Age (yrs) [][][] Occupation
 Family History of Anomalies – Mother's side Yes / No / NK Father's side Yes / No / NK
 Details Consanguinity Yes / No / NK Details

RELEVANT MATERNAL FACTORS

Number of previous: Spontaneous Induced Body Mass
 Livebirths [][] Abortions [][] Stillbirths [][] Abortions [][] Index
 History of Anomalies in previous pregnancies: Yes / No / NK Details
 Alcohol abuse: Yes / No / NK Drug abuse: Yes / No / NK Epilepsy: Yes / No / NK Diabetes: Yes / No / NK
 If any, please give details including dates
 Folic acid taken: Yes / No / NK If Yes, please specify when, eg preconceptually etc
 Smoker: No Less than 10 10 or more NK
 Maternal illness before or during pregnancy: Yes / No / NK If Yes, details
 Other exposure or significant risk factor
 Prescribed drugs taken in **FIRST** trimester

DETAILS OF CURRENT PREGNANCY

Last Menstrual Period [][][][][][][][][] Estimated Date of Delivery* [][][][][][][][][] **use date calculated from booking scan*
 Assisted conception: Yes / No / NK If Yes, Details (drugs & method) No of Fetuses [][][]
 If twins please specify Chorionicity e.g. DADC, MAMC etc

FETUS / INFANT DETAILS

Outcome of Pregnancy
 1. Fetal Loss 2. Termination 3. Stillborn 4. Liveborn Date Ended [][][][][][][][][]
 If baby died, cause of death Date of Death [][][][][][][][][]
 Sex: 1. Male 2. Female 3. Indeterminate 4. NK Birthweight [][][][][][][][][] Birth Order [][][]
 Baby Surname NHS No
 Forename(s)
 Delivery Hospital
 Hospital No

Mother's Surname

DIAGNOSTIC TECHNIQUES USED TO DETECT ANOMALY

<input checked="" type="checkbox"/> any Test performed	Date of Test	Details of Results
Antenatal Ultrasound		
Serum Screening (triple test, combined test etc)		
Karyotype		

Technique used: 1. Amniocentesis 2. CVS 3. Cordocentesis 4. Infant Blood Lab No (if known)
Lab (if not Cardiff):

Examination of Newborn		
Heel Prick Test		
X-Ray / CT / MRI		
Cardiac Studies (incl Fetal ECGs)		
Postnatal Ultrasound		
Other Test / Procedures		

Surgery has been performed or is anticipated: Yes / No / NK Is surgery planned during first year of life: Yes / No / NK

Where has surgery been performed or anticipated to be done

Post Mortem? 1. Yes 2. Not requested 3. Not permitted 4. Requested but not done 5. NK

ANOMALIES FOUND IN INFANT / FETUS

Further describe Anomalies or use this space for Tests

Details of Anomaly diagnosis suspected (S) or confirmed (C) ▼

1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

Are any of the anomalies thought to be part of a syndrome? Y / N NK
If Yes, give details:

CONSULTANTS FROM WHOM FURTHER DETAILS MAY BE AVAILABLE

Obstetrician	Paediatrician	Surgeon or other Consultant
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Form completed by (PRINT NAME)	Position, Hospital & Contact Details (PRINT please)
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