Perinatal Personal Operational Plan (D4.3.)

Oramma

Operational Refugee And Migrant Maternal Approach

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''Birth is not about making babies. It's about making mothers, strong, competent, healthy mothers who trust in themselves and believe in the inner strength''

Barbara Katz Rothman

Introduction

What is this document?

This document presents a medical history record and a maternity plan, that is intended to be used for the provision of health and social care to migrant, asylum seeking and refugee mothers.

It is intended that this document be understood in the context of two other documents: the ORAMMA Approach and the ORAMMA Practice Guide.

Who is this document for?

This document is divided in two parts:

- Part I: Handheld notes for the Health Care Professionals
- Part II: Handheld notes for the Mothers - My Maternity Plan

Part I is intended to be used by health and social care providers as medical health record and social history, when providing care to migrant, asylum seeking and refugee mothers.

Part II is intended to be used by migrant, asylum seeking and refugee mothers, as a maternity plan.

How should this document be used?

Part I: Handheld notes for the Health Care Professionals

This part has been developed to provide health and social care providers with a tool which will be used for the assessment of the perinatal health and social needs of migrant, asylum seeking and refugee mothers. It includes:

- collection of medical history, including vaccination status
- collection of obstetric history
- substance use habits
- physical examination findings, including vital signs
- pregnancy examination findings, including ultrasound scan findings
- basic mental health evaluation
- indication of follow-up or treatment needs

This part is not intended to replace already existing medical records, but to complement them. In case there are not available health records, Part I can meet this need.

Part II: Handheld notes for the Mothers - My Maternity Plan

This part has been developed as a tool which will be used by migrant, asylum seeking and refugee mothers, in collaboration with health and social care providers, in order to identify their perinatal needs and be empowered in the decision-making process regarding their care. With the assistance of the multidisciplinary team of experts and the maternity peer supporters, mothers complete the sections of this document.

Mothers are intended to bring ‘My Maternity Plan’ to every appointment, so that every professional who provides care could see important information about their perinatal care

How sensitive personal information are protected?

This document contains sensitive personal information and medical data, so it should be used considering medical confidentiality.

Prior to processing personal data, health and social care providers must inform migrant, asylum seeking and refugee mothers about the processing, such as its purposes, the types of data collected, the recipients, and their data protection rights.

Completed documents shall be kept in a suitable form, so as to permit any consultation at a later date, taking into account any confidentiality.

In case migrant, asylum seeking, and refugee mothers prefer not to carry “My Maternity Plan” with them, providers should discuss an alternative solution (e.g. keeping “My Maternity Plan” together with mothers’ medical records).

Part I: Handheld notes for the Health Care Professionals

Mother ID:		**Father/Partner Details**
First Name:		**First Name:**
Surname: **Previous Surname:**		**Surname:**
Language can speak and/or write:		**Language can speak and/or write:**
Interpreter Service: Yes ☐ No ☐		
Age:	**Date of birth: ……./……./…….**	**Country of birth/countries lived in/transited:**
Ethnicity:	**Faith/religion:**	**Educational level:**
Parity:		**Occupation:**
Country of birth/countries lived in/transited:		**Telephone or mobile number:**
Marital status (married/separated/single/ widow):		**Email address:**
Educational level:		**Social circumstances (eg. Other children, existing family network, financial resources, etc):**
Occupation:		
Telephone or mobile number:		**Is the baby's father a blood relation?** **Yes ☐ No ☐**
Email address:		**Housing:**
Number of family members travelling and ages:		**Benefits claimed:** **Yes ☐ No ☐**
		Disability **Yes ☐ No ☐**
		Dietary Needs, if any:
Maternity Peer Supporter:		
Emergency contact details		**2nd Emergency contact:**
In case of emergency, contact:		**Name and contact number:**
Relationship:		**Relationship:**

When is my baby due?

Agreed estimated date of delivery	**By LMP:** **By Scan:**
LMP First day of your last period: ……./……./…….	How sure are you of this date? Sure ☐, fairly sure ☐, not sure ☐
Agreed by whom? (Signature of Midwife/Doctor)	
Height (m):	
Weight (kg) at first appointment:	
BMI (to be calculated):	

HEALTH HISTORY (please tick as appropriate and give details when necessary)			
Blood type:		Rhesus:	
HBsAg:	HCV:		HIV:
Do you have or have had:	**No**	**Yes**	If YES, Details
Allergies:	☐	☐	
Liver diseases or hepatitis:	☐	☐	
Sickle cell or thalassaemia:	☐	☐	
Asthma or chest problems:	☐	☐	
Bladder/ bowel problems:	☐	☐	
Diabetes or other endocrine disorder:	☐	☐	
Disabilities:	☐	☐	
Epilepsy:	☐	☐	
Tuberculosis, pneumonia or other lung disease:	☐	☐	
Fertility problems:	☐	☐	
Female Genital Mutilation:	☐	☐	
Gynaecological history/operations:	☐	☐	
Illness or injury requiring hospitalization:	☐	☐	
Heart disease or high blood pressure/ Preeclampsia:	☐	☐	
Kidney or Urogenital problems/conditions:	☐	☐	
Migraine or severe headache:	☐	☐	
Thrombosis (blood clots):	☐	☐	
Vaginal bleeding in pregnancy:	☐	☐	
Blood transfusion/ objections to receiving blood products:	☐	☐	
History of torture, violence:	☐	☐	
Others (specify):			
Date of last cervical smear: ___ /___ / ___	Result:		
Medications before pregnancy (please note the dose, frequency, route, duration):			
Herbs before pregnancy:			

FAMILY MEDICAL HISTORY

The term family here means blood relatives only – e.g. your children, your parents, grandparents, brothers, sisters, uncles and aunts and their children.

Has anyone in your family had:	No	Yes	If YES, Details
Diabetes:	☐	☐	
Heart Disease:	☐	☐	
High blood pressure:	☐	☐	
Blood disorders (e.g. sickle cell or thalassaemia disorder):	☐	☐	
Multifetal gestation:	☐	☐	
Abnormalities present at birth:	☐	☐	
Hearing loss from childhood:	☐	☐	
Tuberculosis	☐	☐	
A disease that runs in the family:	☐	☐	
Others (specify)			

OBSTETRIC HISTORY

Number of pregnancies:	**Numbers of deliveries:**
Number of Miscarriages (if yes note the gestational age and the reason):	
Number of Abortions (if yes note the gestational age and the reason):	

	Year	G.A.	Type of delivery	Sex	Weight	Severe Maternal Morbidity or Neonatal Morbidity?

If you have been pregnant before, have you experienced any of the following in previous pregnancies? Please mark all that apply.	☐ This is my first pregnancy
	☐ A baby born early, more than 3 weeks before his or her due date
	☐ Bleeding so much during pregnancy, birth, or after giving birth that you needed to be given blood
	☐ A caesarean section (operation to remove your baby through your abdomen)
	☐ Loss of a pregnancy after 20 weeks (5 months) of pregnancy

IMMUNIZATION RECORD

Immunization record presented/available: No ☐ , Yes ☐	
Tetanus, diphtheria and acellular pertussis (e.g. Tdap,Td):	Measles, mumps, rubella (MMR):
Polio vaccine (Oral PV- Inactive PV):	
Hepatitis A:	Hepatitis B:
Haemophilus influenza type B (Hib):	Varicella (chicken pox):
Meningococcal:	Pneumococcal:
Influenza:	
VACCINATION PLANNING (please note the exact vaccine and the time of vaccination)	

SUBSTANCE USE

Smoking			**Alcohol**			**Non- prescription drugs**		
Smoking	No ☐	Yes ☐	Drinking	No ☐	Yes ☐	Painkillers:	No ☐	Yes ☐
Number of cigarettes per day			Current drinking day/week			Cannabis:	No ☐	Yes ☐
If no, smoked during the last 12 months?	No ☐	Yes ☐	Max drinks/drinking day (during pregnancy)			Heroin:	No ☐	Yes ☐
Quit date	…../…../……		Pre-pregnancy drinking day/week			Herbal remedies:	No ☐	Yes ☐
Family member currently smoke?	No ☐	Yes ☐	Max drinks/drinking day (pre-pregnancy)			Other drugs (give details):	No ☐	Yes ☐
Do you or your partner like to be referred to a smoking cessation program?	No ☐	Yes ☐	Does your partner drinks alcohol?	No ☐	Yes ☐	Are you receiving treatment for addiction?	No ☐	Yes ☐

MENTAL HEALTH

Do you have a close family member (parent or sibling) with a history of mental health problems including bipolar disorder or any other serious mental illness? Details:	No ☐	Yes ☐
Do you have a history of any mental health problems including depression, anxiety, bipolar disorder, puerperal psychosis, schizophrenia or other serious mental illness? Details:	No ☐	Yes ☐
Are you feeling down, depressed or hopeless or do you have little pleasure or interest in doing things? Is this something you would like help with?	No ☐	Yes ☐

Pregnancy

RhD NEGATIVE BLOOD

If your blood is RhD Negative, you will be offered 'Anti-D' to prevent any problems developing. If you are RhD Negative and have any vaginal bleeding you must go to the hospital as soon as possible as you may need to have Anti D.

Prophylactic "Anti-D" given 28 weeks	**Dose:**
	Date given: (Signature of Midwife)

TESTS DURING PREGNANCY

Test		Gestation when test(s) taken	Date taken indicate if declined	Results/Action
Blood Group				
Antibodies screen	Booking			
	28 weeks			
Full Blood Count	Booking			
	28 weeks			
	36 weeks			
Rubella IgM: IgG:				☐ Immune. Woman advised that she is protected against rubella ☐ Non- immune. Woman advised to have postnatal MMR vaccination
Syphillis (VDRL- RPR)				☐ Negative. Woman advised that she does not have syphilis at this time ☐ Positive. Offered treatment and pregnancy management. See further documentation.
CMV IgM: IgG:				☐ Negative. Woman advised that she does not have CMV at this time ☐ Positive. Offered treatment and pregnancy management. See further documentation.
Hepatitis B				☐ Negative. Women advised that she does not have hepatitis B at this time ☐ Positive. Offered postnatal neonatal vaccinations for her baby to reduce the chance of the baby being affected by the virus.
HIV				☐ Negative. Women advised that she does not have HIV at this time ☐ Positive. Offered treatment and pregnancy management. See further documentation.
Haemoglobinopathy - sickle cell and thalassaemia				
Partner's Haemoglobinopathy screening result if applicable				
Mid-stream urine specimen for bacteriology				
Screening for Down's Syndrome				
Amniocentesis (please include indication for procedure)				
CVS (please include indication for procedure)				

ULTRASOUND SCANS

Dating Scan +/- NT measurement

Date	Gestation	EDD by scan	Number of fetus	Fetal heart		NT	CRL	BPD	Signature
				No ☐	Yes ☐				
				No ☐	Yes ☐				
Details:									
Details:									

Detailed Scan/ Fetal Anomaly

Date	Summary of findings	Signature

Other Scans

Date	Gestation	Amniotic Fluid Index (AFI) Oligo/normal/ polyhydramnios	Growth Within Normal Limits/95th Centile	Fetal presentation (Cephalic, breech, transverse)	Fetal movement/ heart activity	Placental position	Doppler	Signature
Details:								
Details:								
Details:								

SPECIAL FEATURES DURING PREGNANCY

Special features	Plans for care	Signature

MEDICATIONS DURING PREGNANCY

Are you taking any medication prescribed to you by a doctor?	No ☐	Yes ☐
Are you taking any 'over the counter' preparations or medications not prescribed to you? (If yes, include indications)	No ☐	Yes ☐

Details:

Prescribed medication	Dose	Frequency	Route	Duration

Herbs:

ANTENATAL APPOINTMENTS

	Date/ venue	Gestational Age	General appearance/ Nutrition	Blood pressure/ pulse/ temperature	Weight	Urinalysis	Oedema/ Swelling	Height of uterus	Presenting part	Fetal Position	Fetal mov.	Fetal heart	Blood tests taken and results
1st													
	Gest. diabetes: No □, Yes □ Treatment: Gest. hypertension: No □, Yes □ Thrombophilia: No □, Yes □ Smoking: No □, Yes □ Number of cig./per day:					**Other information/plans/referrals etc:**							**Signature**
2nd													
	Gest. diabetes: No □, Yes □ Treatment: Gest. hypertension: No □, Yes □ Thrombophilia: No □, Yes □ Smoking: No □, Yes □ Number of cig./per day:					**Other information/plans/referrals etc:**							**Signature**
3rd													
	Gest. diabetes: No □, Yes □ Treatment: Gest. hypertension: No □, Yes □ Thrombophilia: No □, Yes □ Smoking: No □, Yes □ Number of cig./per day:					**Other information/plans/referrals etc:**							**Signature**
4th													
	Gest. diabetes: No □, Yes □ Treatment: Gest. hypertension: No □, Yes □ Thrombophilia: No □, Yes □ Smoking: No □, Yes □ Number of cig./per day:					**Other information/plans/referrals etc:**							**Signature**
5th													
	Gest. diabetes: No □, Yes □ Treatment: Gest. hypertension: No □, Yes □ Thrombophilia: No □, Yes □ Smoking: No □, Yes □ Number of cig./per day:					**Other information/plans/referrals etc:**							**Signature**
6th													
	Gest. diabetes: No □, Yes □ Treatment: Gest. hypertension: No □, Yes □ Thrombophilia: No □, Yes □ Smoking: No □, Yes □ Number of cig./per day:					**Other information/plans/referrals etc:**							**Signature**

ANTENATAL ASSESSMENTS/ADMISSIONS/MULTI-PROFESSIONAL ASSESSMENT		
Date	**Time**	**Details**

SPECIAL FEATURES LABOUR, BIRTH & AFTER YOUR BABY IS BORN		
Special features	**Plans for care**	**Notes for Midwifes/Paediatrician**

Postpartum Period

POSTNATAL DISCHARGE SUMMARY		
Discharged from: Date :…../…../…..		Days postnatal:
To (address):		Teleph. numb.:
Place of delivery: ☐ Birth at hospital ☐ Birth at a hospital with a level 1 or 2 NICU ☐ Birth at a hospital with a level 3 NICU or higher		**Mode of delivery:** ☐ Vaginal birth ☐ Forceps or vacuum vaginal delivery ☐ Delivery by caesarean section
Onset of labour: ☐ Spontaneous ☐ Induced ☐ Did not labour	**Outcome:** ☐ Livebirth ☐Still birth (after 24 weeks)	**1st stage:** **2nd statge:** **3rd stage:** **Time of rupture of membranes:**
Date of birth: ___ / ___ / ___	**Time of Birth:**	**Sex:** Boy ☐ , Girl ☐
Live Birth/Stillbirth Gestation:	**Birth weight (g):**	**Breastfeeding 1h after birth:** No ☐ Yes ☐
Perineal/Vaginal/abdominal wound:		
Epidural/ general anesthesia:		
Blood group:	Anti-D needed: No ☐ Yes ☐	Anti-D given on: ___ / ___ / ___
Blood transfusion: No ☐ Yes ☐		
Rubella: No ☐ Yes ☐	Vaccination needed: No ☐ Yes ☐	Vaccinated on: ___ / ___ / ___
HBsAg positive: No ☐ Yes ☐	Vaccination baby needed: No ☐ Yes ☐	Vaccinated on: ___ / ___ / ___
Contraception/sexual health needs discussed: No ☐, Yes ☐		Details:
Cervical smear due: No ☐ Yes ☐		Due in _____ (month) 20___
Discharge medication:		
Problems identified during pregnancy, labour/birth:		
Problems in the postnatal period/referrals, investigations or results pending including recommendation to seek pre-pregnancy counselling prior to planning any subsequent pregnancies:		

POSTNATAL DISCHARGE SUMMARY

General wellbeing and mental health:

Current smoker? No ☐ Yes ☐ Number of cig./day: _____	Has risk of passive smoking to baby been explained? No ☐ Yes ☐

	Any problems		**Details**
Urination	No ☐	Yes ☐	
Pelvic floor	No ☐	Yes ☐	
Bowel function	No ☐	Yes ☐	
Breasts	No ☐	Yes ☐	
Perineal/abdominal wound	No ☐	Yes ☐	
Lochia	No ☐	Yes ☐	

POSTNATAL CARE

Date	**Time**	**Further multi-professional information/planning, delivering and evaluating postnatal care**

At discharge from birth unit within first days postpartum…

We know that just you get went through a life changing event, so we'll keep this short.
This survey will provide your healthcare providers with important information about how you and your new baby are doing so they can help you better.

Please answer every question. If you are unsure about how to answer a question, please give the best answer you can.

DATE: ___ / ___ / ___

Please indicate how you are feeding your baby:

☐ My baby has received a combination of breast milk, formula, or water in the past 7 days.

☐ My baby has received only breast milk in the past 7 days.

☐ My baby has received only formula, water, or other liquids but not breast milk in the past 7 days

How confident do you feel about looking after your baby?

Not at all confident	Not very confident	Somewhat confident	Confident	Very confident
☐	☐	☐	☐	☐

As you have recently had a baby we would like to know more about how you are feeling. Please check the answer that comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

Here is an example, already completed.

I have felt happy:
☐Yes, all the time
☑Yes, most of the time
☐No, not very often
☐No, not at all

This would mean: "I have felt happy most of the time" during the past week

Please complete the other questions in the same way.

1. I have been able to see the funny side of things ☐ As much as I always could ☐ Not quite so much now ☐ Definitely not so much now ☐ Not at all	**6. Things have been getting on top of me** ☐ Yes, most of the time I haven't been able to cope at all ☐ Yes, sometimes I haven't been coping as well as usual ☐ No, most of the time I have coped quite well ☐ No, I have been coping as well as ever
2. I have looked forward with enjoyment to things ☐ As much as I ever did ☐ Rather less than I used to ☐ Definitely less than I used to ☐ Hardly at all	**7. I have been so unhappy that I have difficulty sleeping** ☐ Yes, most of the time ☐ Yes, quite often ☐ Not very often ☐ No, not at all
3. I have blamed myself unnecessarily when things when wrong ☐ Yes, most of the time ☐ Yes, some of the time ☐ Not very often ☐ No, never	**8. I have felt sad or miserable** ☐ Yes, most of the time ☐ Yes, quite often ☐ Not very often ☐ No, not at all
4. I have been anxious or worried for no good reason ☐ No, not at all ☐ Hardly ever ☐ Yes, sometimes ☐ Yes, very often	**9. I have been so unhappy that I have been crying** ☐ Yes, most of the time ☐ Yes, quite often ☐ Only occasionally ☐ No, never
5. I have felt scared or panicky for no very good reason ☐ Yes, quite a lot ☐ Yes, sometimes ☐ No, not much ☐ No, not at all	**10. The thought of harming myself has occurred to me** ☐ Yes, quite often ☐ Sometimes ☐ Hardly ever ☐ Never

Maternal & Infant Outcomes

LONG TERM OUTCOMES		
Maternal		
Death from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of pregnancy termination, irrespective of site or duration of the pregnancy	No ☐ Yes ☐	Details:
Admission to an ICU or a unit that provides 24-hour medical supervision and is able to provide mechanical ventilation or continuous vasoactive drug support at any point during pregnancy through 42 days postpartum for pregnancy or childbirth related complications	No ☐ Yes ☐	Details:
Admission to a hospital within the first 42 days postpartum for childbirth related complications. (Excludes initial hospitalization for childbirth.)	No ☐ Yes ☐	Details:
Infant		
Death of a live born neonate up to 28 days of life	No ☐ Yes ☐	Details:
Subdural and cerebral hemorrhage, massive epicranial subaponeurotic hemorrhage, other injuries to skeleton due to birth trauma, injury to spine and spinal cord due to birth trauma, injury to brachial plexus due to birth trauma, other cranial and peripheral nerve injuries due to birth trauma in single liveborn neonates	No ☐ Yes ☐	Details:

Part II: Handheld notes for the Mothers

My Maternity Plan

''Birth is not about making babies. Birth is about making mothers, strong, competent, capable mothers who trust themselves and know their inner strength''

Barbara Katz Rothman

Your name:

Contact details:

	Name	Phone number
Midwife		
GP / MD		
Maternity peer supporter		
Other		

PLEASE BRING YOUR RECORD TO **ALL** HEALTHCARE APPOINTMENTS AND HOSPITAL ADMISSIONS.

The benefits of Maternity plan

This is your Maternity Plan. It will help you manage your pregnancy. Every health professional and your maternity peer supporter will help you complete sections in this document. You will usually be asked to carry your Maternity Plan with you so that everyone you meet can see important information about your pregnancy and your care. If you would prefer not to carry this Maternity Plan, please talk to your midwife and your maternity peer supporter who will help you arrange an alternative. Please keep your Maternity Plan safe and take it with you to every appointment during your pregnancy.

As a pregnant woman, Maternity Plan can help you to:

- Understand your pregnancy better
- Get you the care and support you need to manage your pregnancy
- Give you the confidence to take control of your pregnancy
- Be as independent as possible

For your family, Maternity Plan can:

- Help them to become recognized as partners in your care
- Give them access to information about your pregnancy and treatment
- Help them co-ordinate the support and care you need
- Help them get support in their caring role from appropriate professionals and agencies

How to get started

This depends on your personal situation. This may be:

- The midwife
- The General Practitioner or the Obstetrician
- The social care provider

Sharing your plan

You might like to share your plan with the health professionals above, and also:

- Your 'Maternity Peer Supporter'
- Your family and friends
- Anyone else you feel needs to know

My Maternity Plan can be shared with anyone who needs to be aware of what care and support you need. My Maternity Plan can be used by different health professionals. As it is a record of your care and treatment, it can help when you leave hospital, see different health professionals or move to a different place.

What I expect in my pregnancy….

You can record here things you wish to achieve, and discuss and explore them with your healthcare professionals and your maternity peer supporter.

Date: ___ / ___ / ___

Goals:

These are the steps I will take to achieve my goals:

This is the support I will need and who I will need it from:

Signed: _____ Review date: _____

PLAN OF CARE FOR YOUR PREGNANCY

My appointments

Date	Time	Where & Who with	Things to discuss

My personal details

Height (cm):	**BMI (to be calculated):**
Weight (kg): * at first appointment	
Religion:	
Countries lived in:	

When is my baby due?

Estimated date of delivery:	**Partner / supporter details:**
Planned place of birth:	**Midwife's details:**
Babies are often born 3 weeks before or up to 2 weeks after the agreed estimated date of delivery	

CLINICAL SUMMARY

RISK ASSESSMENT	Y / N	OUTCOME	INVESTIGATIONS	DATE	OUTCOME
Medical conditions			MSU		
Obstetric issues			Hb		
Venous thromboembolism			Blood group		
Aspirin required?			Antibodies		
BMI			HBV		
Bedsores risk			HCV		
Diabetes			Syphilis		
Mental Health			HIV		
Social factors			Sickle cell / Thalassaemia		
Anaesthetic assessment			MRSA		
Smoking			OGTT		
Drug / alcohol use					
Allergies					
Female circumcision					
Special diet					

MEDICAL COMPICATIONS DURING PREGANCY

Medical complication needs identified:	
1st trimester	3rd trimester

Plan to address medical complication needs:	
1st trimester	3rd trimester

*Call the midwife **immediate**, if you experience any of the following:*

- *Bleeding from the vagina*
- *Constant vomiting*
- *High temperature*
- *Painful urination*
- *Sudden, sharp or continuing abdominal pain*
- *Contractions*
- *Pelvic pain*
- *Persistent severe headache*
- *Loss of fluid from the vagina*
- *Swelling in face, hands or legs*
- *Blurred vision or changes in your vision*
- *Itching*
- *A change in the pattern of your baby's movements*

Your midwife will:

- *Be attentive and share information that is clear, accurate and meaningful.*
- *Provide care that is delivered in a warm, sensitive and compassionate way.*
- *Treat you with dignity and respect you as an individual.*

DISCUSSION TOPICS - CHECKLIST

Topics	Discussed-information provided/ Date	Comments
Health in pregnancy		
Maternity Benefits		
Place of birth		
Common symptoms		
Healthy eating *Folic acid* *Vitamin D* *Alcohol* *Drugs*		
Smoking *Effects in baby* *Effects in mother* *Smoking cessation*		
Travel safety		
Emotion wellbeing in pregnancy		
Support in camp or community		
Sex in pregnancy		
Preparation for birth		
Skin to skin contact		
Breastfeeding *Health benefits for baby by breastfeeding* *Health benefits for mother by breastfeeding* *Help will be available with feeds* *No other food or drink needed by baby until 6 moths*		

MENTAL, SOCIAL AND PHYSICAL HEALTH PLAN

How am I feeling?

Pregnancy comes with a lot of changes, all of which can impact upon your emotional wellbeing. It is good to take a moment to think about how you feel now, your thoughts about the pregnancy and birth. This helps you to prepare the support you might need to look after your emotional health.

Date: ___ / ___ / ___

How stressed do you feel?

How healthy do you feel?

How well do you sleep?

Are you often angry or irritated?

Do you worry a lot?

Mental health needs identified:	
1st trimester	3rd trimester

Plan to address mental health needs:	
1st trimester	3rd trimester

What are my social needs?

A social needs assessment will help you to have as much control over your quality of life as possible. If you are experiencing problems with your: clothing, home safety and security, family and social relationships, work, accessing community services or benefits, or carrying out any caring responsibilities, such as for children or the elderly or ill, please feel free to discuss these problems with your midwife, maternity peer supporter, or social care provider who will help find out what support you may need.

Social needs identified:	
1st trimester	3rd trimester

Plan to address social needs:	
1st trimester	3rd trimester

Am I physical active?

Physical activity in pregnancy is safe and healthy. Being active benefits you and your baby.

Physical activity needs identified:	
1st trimester	3rd trimester

Plan to address physical activity needs:	
1st trimester	3rd trimester

NUTRITION HEALTH PLAN

Nutrition needs identified:	
1st trimester	3rd trimester

Plan to address nutrition needs:	
1st trimester	3rd trimester

SUBSTANCE USE ASSESSMENT PLAN

Substance use needs identified:	
1st trimester	3rd trimester

Plan to address substance use needs:	
1st trimester	3rd trimester

SCREENING TESTS

You will be offered screening tests during your pregnancy. These will include urine and blood pressure checks, blood tests and scans. Your healthcare professionals will talk to you about the purpose of these tests and your choices.

TEST	Results
Urine tests:	
Blood pressure checks:	
Blood tests:	
Scans:	
Down's syndrome serum screening: If you miss the 12 to 14 weeks scan, you will be offered a blood test between 14 weeks, 0 days, and 22 weeks, 6 days.	

What I expect in my labour…

(should be discussed with each pregnant woman by 34 weeks of pregnancy)

You can record here things you wish to accomplish, discuss and explore them with your healthcare professionals and your maternity peer supporter.

Date: ___ / ___ / ___

GOALS:

These are the steps I will take to achieve these:

This is the support I will need and who I will need it from:

Signed: _____ Review date: _____

BREASTFEEDING - ANTENATAL CHECKLIST

(should be discussed with each pregnant woman by 34 weeks of pregnancy)

Topics	Discussed/Date	Comments
Getting your baby off to a good start ***Importance of early skin-to-skin contact*** *(keeps baby warm and calm, promotes bonding, helps with breastfeeding)* ***Baby-led feeding and feeding cues*** *(to ensure adequate milk intake and supply)* ***Rooming in / keeping baby near*** *(for baby-led feeding and reduction of risk of SIDS)*		
Why breastfeeding is important ***Benefits for the baby****:* *- Reduced risk of gastro-enteritis, diarrhoea, urinary tract,* *- Chest and ear infections, obesity and diabetes.* *- Latest evidence suggests reduced risk of asthma or allergies* *- Reduces risk of sudden Infant Death Syndrome and childhood leukaemia.* ***Benefits for the mother*** *Reduced risk of breast cancer, ovarian cancer and osteoporosis*		
Making breastfeeding work ***Effective positioning and attachment*** *(to ensure adequate milk intake and pain-free feeding)* ***Effect of teats, dummies, nipple shields*** *(may interfere with breastfeeding)* ***No other food or drink needed for 6 months*** *(for maximum health benefits)* ***Where to find support for breastfeeding*:**		

PREPARING FOR BIRTH - WHAT TO PACK IN YOUR BAG

(should be discussed with each pregnant woman by 34 weeks of pregnancy)

Here are some suggestions for what you should prepare ahead of birth. ***Please remember to take your Maternity Plan with you.***

For the birth:	After the birth:

YOUR POSTNATAL CARE

The chart below is used to plan your postnatal care. Your midwife (and sometimes other members of your maternity team) will discuss and arrange your care with you, according to your needs and your baby's needs. Maternity staff will explain the reasons for each appointment or visit, as well as where it will take place, who with and when.

My appointments

Date	Time	Where & Who with	Things to discuss

My postnatal discharge summary

Day: ___ / ___ / ___ **At:** _____		**Sex:** Boy ☐ , Girl ☐
Live Birth/Stillbirth Gestation:		**Birth weight (g):**
Any problems		**Details**
Passing urine	No ☐ Yes ☐	
Pelvic floor	No ☐ Yes ☐	
Bowel function	No ☐ Yes ☐	
Breasts	No ☐ Yes ☐	
Perineum/abdomen	No ☐ Yes ☐	
Lochia/menstruation	No ☐ Yes ☐	

*Hand hygiene is particularly important after childbirth. Please wash your hands in warm soapy water before and **after changing your sanitary towel and after every trip to the toilet.***

*You should be alert to signs of infection after childbirth. You should seek **immediate** advice from your midwife, general practitioner or maternity hospital if you have any of the following:*

1. *High temperature/feeling feverish/flu like symptoms*
2. *Sore throat – especially if other members of the family also have sore throats*
3. *Breathlessness*
4. *Abdominal or chest pain*

What I expect in my postnatal care….

You can record here things you wish to accomplish, discuss and explore them with your healthcare professionals and your maternity peer supporter.

Date: ___ / ___ / ___

GOALS:

These are the steps I will take to achieve these:

This is the support I will need and who I will need it from:

Signed: _____ Review date: _____

FORMULA FEEDING YOUR BABY

If you choose to formula feed your baby or are advised to do so by a healthcare professional, you will need to make sure you are preparing formula safely to protect the health of your baby. As with general baby care, you may already be skilled in making up formula feeds and formula feeding your new born baby, or it may be a new challenge. Your midwife and maternity care team will support you. The list below can be used to check that you feel confident formula feeding your baby.

Topics	Discussed-information provided/ Date	I feel confident / Date
Using bottled milk/disposable teats in the maternity unit		
The importance of good hand hygiene		
Sterilising equipment		
Making up a formula feed correctly and safely (always following the manufacturer's instructions)		
Giving a formula feed correctly and safely		
Winding my baby		
Choosing the right type of milk for my new baby (whey based / lactose free)		
Signs that my baby is feeding well and thriving		