

# The SA Maternity Case Record

## A quick guide to using the new MCR



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA





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REPUBLIC OF SOUTH AFRICA

## Maternity Case Records

This record must always accompany the woman when transferred to another health facility.  
This record must be filed at the facility discharging the woman after birth.  
Failure to create and maintain a record or to remove a record in an office in terms of section 11(2) of the National Health Act (96) of 2003.  
This record book is valid for the duration of the pregnancy and puerperium and includes all patient encounters. The relevant ward/ clinic sub-section must clearly print (stamp) the name of the section and the date the service was rendered.

Level of care	
Antenatal clinic:	Delivery site:
Transport when in labour:	

Name of patient or place large patient sticker here

Name: \_\_\_\_\_ Surname: \_\_\_\_\_ MomConnect  Yes  No

Address: \_\_\_\_\_ Date registered: \_\_\_\_\_

Next to School/Shop: \_\_\_\_\_

Woman's name: \_\_\_\_\_  Employed  Unemployed

ID Number: \_\_\_\_\_ Religion: \_\_\_\_\_

Institution file number: \_\_\_\_\_ Record book number:  Original  Duplicate

Consent for blood products:  Agree to the use of blood products if needed  Disagree to the use of blood products

Name of birth companion: \_\_\_\_\_ Contact number of birth companion: \_\_\_\_\_

Community health worker name: \_\_\_\_\_

Contact detail of mandate  
Name of person mandated to consent on behalf of woman when appropriate

\_\_\_\_\_

Contact telephone number of mandate: \_\_\_\_\_

Should I be unable to consent myself, I mandate the above in terms of the National Health Act to do so on my behalf.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_ Witness: \_\_\_\_\_



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## Maternity Care Peri-operative record

This record must be completed for all person's requiring surgery during pregnancy or the puerperium. Once completed, it must be placed within the Maternity Case Record to be filed at the hospital where the delivery took place. Procedures done at a facility where delivery did not occur must be filed in the patient records. Use a new record for every operation.

Name and ID number of patient or place large patient sticker here

Name of medical practitioner booking the procedure: \_\_\_\_\_

Procedure:  Caesarean section  Tubal ligation  Laparotomy  Emergency hysterectomy  
 Other \_\_\_\_\_

### URGENCY OF PROCEDURE (select only 1)

- RED: Immediate delivery (life threatening to mother and/or fetus)
- YELLOW: Urgent delivery (Maternal/fetal compromise not immediate life threatening)
- GREEN: Scheduled urgent delivery (need early delivery but no maternal/fetal compromise)
- ELECTIVE: Scheduled at a time to suit mother/staff

Best describe the reason/indication for the caesarean section/ procedure:

\_\_\_\_\_

Booking arrangements
Discussed case with senior colleague/consultant (name and time):
Discussed with anaesthetic doctor (name and time):
Discussed with neonatal staff (name and time):
Date and time procedure scheduled:

MCR 2018 Surgery Insert Page 1



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# *Intrapartum Care in South Africa*

Updated Guideline  
March 2019



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA  
Faculty of Health Sciences

# NATIONAL INTEGRATED MATERNAL AND PERINATAL CARE GUIDELINES FOR SOUTH AFRICA

A MANUAL FOR CLINICS, COMMUNITY HEALTH CENTRES, DISTRICT AND REGIONAL HOSPITALS

Fifth edition 2024

# 1. SA Maternity Case Records: what is new?

# Handheld case notes

- **Cochrane 2015: Giving women their own case notes to carry during pregnancy**



- Women carrying their own notes were more likely to feel in control
- Wanted to carry their own notes in a subsequent pregnancy
- The risk of notes lost or left at home was not significant
- No evidence of difference for health-related behaviours, depression, miscarriage, stillbirth or neonatal death

# Who developed the MCR?

- **National process of update, with multiple inputs from various organisations, committees and individuals including:**
  - *Ministerial advisory committees (NCCEDM and NaPeMMCo)*
  - *MRC Unit for Maternal and Infant Health Care Strategies*
  - *SOMSA*
  - *SASOG*
  - *Doctors, midwives, MCWH coordinators from every province*
  - *Expert input from WHO collaborators*
  - *Anaesthesiologists*
  - *PMTCT*
  - *Nutritionists*
  - *Primary care stationery (WC and national)*
  - *Maternal mental health group*
  - *Edited by the national DoH Communications Directorate*

# So what has changed?

- **Cover page**
- **More information for patients**
- **Screening for mental health care**
- **More space for notes (8 BANC+ visits)**
- **Updated HIV information**
- **Antenatal card updated**
- **Duplicate antenatal card (copy can be removed for primary care stationery)**
- **Early warning charts updated (separate antenatal, postnatal and newborn charts)**
- **Mental health and respectful care prompts**

# So what has changed?

- **Fetal kick chart added**
- **Basic ultrasound reports and report page**
- **New observation chart for doubtful labour**
- **New interim partogram**
- **Cardiotocography evaluation tick boxes**
- **Summary of labour (new definition of second stage)**
- **Shock index added**
- **Robson classification for CS**
- **More space for puerperium notes**
- **Pre-discharge safety checklist**
- **New discharge summary**
- **Separate booklet for anaesthetic charts and notes and consent forms**





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# Maternity Case Records

This record must always accompany the woman when transferred to another health facility.

This record must be filed at the facility discharging the woman after birth.

Failure to create and maintain a record or to remove a record in an office in terms of section 17(2) of the National Health Act (61 of 2003)

This record book is valid for the duration of the pregnancy and puerperium and includes all patient encounters. The relevant ward/clinic/subsection must clearly print (stamp) the name of the section and the date the service was rendered

Level of care	
Antenatal clinic:	Delivery site:
Transport when in labour:	

Name of patient or place large patient sticker here

Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address: \_\_\_\_\_

Next to School/Shop: \_\_\_\_\_

MomConnect  Yes  No

Date registered: \_\_\_\_/\_\_\_\_/\_\_\_\_

Woman's name

ID Number  Religion

Institution file number  Record book number

Consent for blood products

Name of birth companion  Contact number of birth companion

Community health worker name

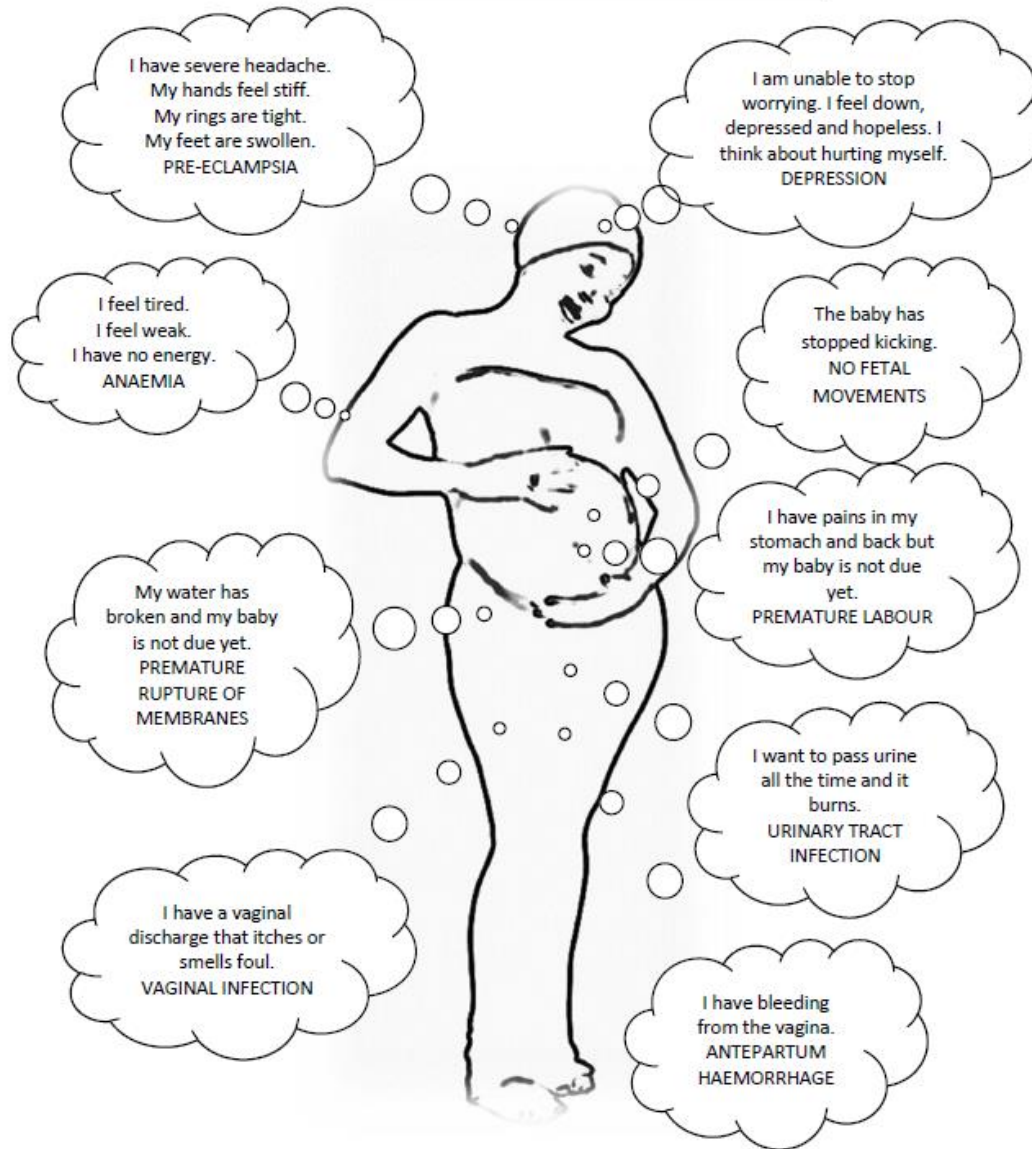
Contact detail of mandate   
Name of person mandated to consent on behalf of woman when appropriate

Contact telephone number of mandate

Should I be unable to consent myself, I mandate the above in terms of the National Health Act to do so on my behalf.

Signed: ..... Date: ..... Witness: .....

## DANGER SIGNS IN PREGNANCY



GO TO YOUR NEAREST CLINIC OR HOSPITAL IF YOU HAVE ANY OF THESE PROBLEMS

## DANGER SIGNS AFTER DELIVERY

I have severe  
headaches.  
I have blurry vision.  
PRE-ECLAMPSIA

I cry all the time. I  
have thoughts of  
hurting myself or my  
baby.  
POST-PARTUM  
DEPRESSION

I am short of breath.  
I breathe very fast.  
PULMONARY  
EDEMA

I have a fever or  
chills.  
My stomach hurts  
I have a foul  
smelling vaginal  
discharge.  
POST-PARTUM  
SEPSIS

My baby is unusually  
cold  
HYPOTHERMIA

My incision is not  
healing.  
WOUND INFECTION

I have severe pain  
and swelling in my  
calf. My calf is red.  
DEEP VEIN  
THROMBOSIS

I have vaginal  
bleeding that is  
soaking my pads.  
POST-PARTUM  
HAEMORRHAGE

## Some information about Family Planning after your baby is born

### Why is it important?

Most couples start having sex again before six weeks after the baby is born. Pregnancy can occur by six weeks (before your periods start again) if you do not exclusively breastfeed; so it is important to make sure that you start using a method before your baby is 4 weeks old.

Best practice is for the chosen method of family planning to be started before you leave the place where your baby is born.

### THE MOST EFFECTIVE METHODS

#### Intrauterine contraception (IUD)

- Copper IUDs prevent pregnancy for up to 10 years
- Failure rates are less than 1 per 1000 women.
- IUDs can be inserted immediately after the afterbirth (placenta) has been delivered.
- IUD use does not interfere with breastfeeding.

#### Contraceptive implants

- Implants are effective for 3 years
- Failure rates are around 1 per 1000 women.
- Implants are not recommended for HIV positive patients on medication (ask your doctor).
- Implants can be inserted immediately after delivery of the baby and before you go home.
- Postpartum implant use does not interfere with breastfeeding.

#### Permanent contraception

##### Female sterilization:

- Failure rates are around 2 per 1000 women but the method is considered permanent.
- Female sterilization can be performed within the first week after delivery or at any time after your baby is 6 weeks old.
- It may be convenient to perform female sterilization at the time of caesarean section.

##### Male sterilization (vasectomy):

- Failure rates are around 1 per 1000 men but the method is considered permanent.



# Mental Health Screen

## MENTAL HEALTH SCREEN

Conduct a mental health screen for all pregnant women.  
Refer if needed to appropriate service, such as mental health nurse, social services, NGO, medical officer, counsellor, psychiatrists or other services.

Suggested words to use before screening.

“We would like to know about all the women who come here: how they are doing physically and emotionally. This helps us to understand the best sort of care we can offer. Please may I ask you three questions about how you are emotionally? Please answer ‘yes’ or ‘no’ to each question.”

In the last 2 weeks, have you on some or most days felt unable to stop worrying or thinking too much?	<input type="checkbox"/> Yes [1]	<input type="checkbox"/> No [0]
In the last 2 weeks, have you on some or most days felt down, depressed or hopeless?	<input type="checkbox"/> Yes [1]	<input type="checkbox"/> No [0]
In the last 2 weeks, have you on some or most days had thoughts <b>and</b> plans to harm yourself or commit suicide?*	<input type="checkbox"/> Yes Refer [1]	<input type="checkbox"/> No [0]
<b>TOTAL SCORE</b>	0 or 1 2 >>>>>>>>>> refer 3 >>>>>>>>>> refer	
Offered Counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Accepted counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*\*the self-harm question will require urgent referral if there are both thoughts AND plans. If there is a history of previous attempt, referral is required even if there are thoughts alone.*













# Respectful care prompts and TB screen

ESSENTIAL ADDITIONAL FACTS ONLY (Do not duplicate data from p4 or p5)		Name (print) & signature
I have introduced myself by name to this person <input type="checkbox"/> TB screen done <input type="checkbox"/>		
Date and Time		
	Date for next visit:	
I have explained management plans to this person and checked that she understands <input type="checkbox"/>		



# Initial assessment

ASSESSMENT FINDINGS	DIFFERENTIAL DIAGNOSIS

WORKING DIAGNOSIS

PROPOSED MANAGEMENT PLAN


All procedures have been explained and verbally consented by the person

I have checked with the person regarding her birth companion

*If problem/ diagnosis is prior to delivery- continue clinical notes on page 17*

*If problem/diagnosis is during established labour- continue clinical notes in labour section page 28*

*If problem/diagnosis is after delivery- continue clinical notes in post natal section page 49*

Maternity Case Record Page 15

# Basic ultrasound report

**BASIC ULTRASOUND REPORT** (attach copies of detailed reports or photos to this page)

DD/MM/YYYY

Performed by:

I have introduced myself by name to this person

Intrauterine	Yes	No	Number of fetuses		
Fetal movements	Yes	No	Heartbeat	Yes	No
Fetal lie	cephalic	breech	transverse		
Placenta	anterior	posterior	lateral		
	high	low	distance from os	mm	
Liquor	normal	reduced	increased	Deepest pool	cm

**BIOMETRY - (attach hard copy if available)**

Biparietal diameter (BPD)	mm	Weeks:	days:
Head circumference (HC)	mm	Weeks:	days:
Abdominal circumference (AC)	mm	Weeks:	days:
Femur length (FL)	mm	Weeks:	days:
Measurements concordant (8 days or less difference)	Measurements discordant (more than 8 days difference)		
Average gestation	WEEKS:	DAYS:	Estimated Fetal Weight:

# Doubtful labour

<b>NAME:</b>		<b>AGE:</b>	<b>G:</b>	<b>P:</b>	<b>GESTATIONAL AGE:</b>	
<b>FACILITY:</b>		<b>Hb:</b>	<b>PRESENTATION:</b>			
<b>COMPANION:</b>		<b>RISK FACTORS:</b>				
<b>Assessment 1: date &amp; time</b>				<b>Assessment 2: date &amp; time</b>		
<b>Mother</b>	Blood Pressure					
	Pulse					
	Temperature					
	Urine dipstick					
	Fetal movement felt	Yes	No			
	Emergency signs (bleeding, seizures, etc)	No	Yes			
	Contractions per 10 minutes					
<20 sec <input type="checkbox"/> 20-40 sec <input type="checkbox"/> >40 sec <input type="checkbox"/>						
Maternal emotional state						
<b>Fetus</b>	FHR: normal baseline, no decelerations		Yes	No		
<b>PV</b>	Head above brim					
	Dilatation					
	Cervical length					
	Membranes intact	Yes	No			
<b>Checklist</b>	Is the maternal condition reassuring?		Yes	No		
	Is the fetal condition reassuring?		Yes	No		
	Plan:					
	Initials and signature:					
<b>Discharge checklist</b>	Reassuring maternal condition?		Yes	No	<b>Plan (if not discharged):</b>	
	Reassuring fetal condition?		Yes	No		
	Intact membranes?		Yes	No		
	No cervical changes since admission?		None	Changes		
	Warning signs have been explained?		Yes	No		
	The mother understands the danger signs?		Yes	No		
	Follow-up date:					
Initials & signature:						





# Assessment during labour

ASSESSMENT:	Date	Time	DOL	hrs	DORM	hrs
I have introduced myself by name to this person: <input type="checkbox"/>						
Progress of labour:	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	None <input type="checkbox"/>			
Maternal condition:	..... .....					
Maternal mental & emotional condition:	What is her current pain management? What support is given?					
Fetal condition:	..... .....					
Overall assessment & management plan:	..... .....					
I have explained management plans to this person and ensured that she understands <input type="checkbox"/>						
Name (PRINT)				Signature & designation		

### CARDIOTOCOGRAPHY (CTG) (FIGO 2015) – CTG ONLY INDICATED FOR HIGH RISK PREGNANCIES

DD/MM/YYYY	HH/MM	Indication:	Mat pulse:
Refer to page:	Normal	Suspicious	Pathological (any one feature)
Baseline	110-160 bpm <input type="checkbox"/>	Lacking at least one characteristic of normality, but no pathological features <input type="checkbox"/>	<100 bpm <input type="checkbox"/> (make sure it is not maternal pulse)
Variability	5-25 bpm <input type="checkbox"/>		Reduced (<5 bpm) variability >50 minutes <input type="checkbox"/>
Decelerations	No repetitive* decelerations <input type="checkbox"/> (*Decelerations are repetitive in nature when they are associated with more than 50% of uterine contractions)		Repetitive* late decelerations <input type="checkbox"/> OR Prolonged (>3min) decelerations during >30 minutes <input type="checkbox"/> OR Prolonged (>3min) decelerations during >20 minutes with reduced variability <input type="checkbox"/> OR One prolonged deceleration >5 minutes <input type="checkbox"/>
Interpretation	Fetus with no hypoxia	low probability of hypoxia	Fetus with high probability of hypoxia/acidosis
Contractions	None <input type="checkbox"/> Irregular <input type="checkbox"/> Regular <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Strong <input type="checkbox"/> Expulsive <input type="checkbox"/>		
Clinical management:	No intervention necessary <input type="checkbox"/>	Action to correct reversible causes if identified <input type="checkbox"/> Alert doctor of findings <input type="checkbox"/>	Immediate action to correct reversible causes <input type="checkbox"/> If not possible, or no recovery; immediate delivery <input type="checkbox"/> Call doctor immediately <input type="checkbox"/>
I have explained the nature of the findings and planned action to the person and her birth companion <input type="checkbox"/>			
Evaluation done by:			



# Summary of labour (second stage definition)

## SUMMARY OF LABOUR FROM FULL DILATATION TO DELIVERY

Method of delivery:  NVD  Breech  Twins  Caesarean section  Instrumental Other: \_\_\_\_\_

Delivered by: \_\_\_\_\_ Assisted by: \_\_\_\_\_

Complications: \_\_\_\_\_

Maternal position during labour: \_\_\_\_\_

Fetal monitoring: normal  abnormal  if abnormal specify: \_\_\_\_\_

## SUMMARY OF DURATION OF LABOUR

	STARTED AT:		DURATION:		MEMBRANES	
	Date	Time	Hours	Minutes	AROM	SROM
Latent phase					Time of ROM:	
Active phase (≥5cm)						
Full dilatation					Time of delivery:	
Bearing down					Duration of ROM:	
Third stage						
Total duration of labour:						

# Summary of labour (second stage definition)

## FOURTH STAGE (FIRST TWO HOURS AFTER DELIVERY- COMPLETE OBSERVATIONS ON SEPARATE PAGE)

Time of observation: _____	Observed by: _____
Temp: _____ Resp: _____ Pulse: _____ BP: _____	Urine passed: <input type="checkbox"/> Yes <input type="checkbox"/> No Catheter: <input type="checkbox"/> Yes <input type="checkbox"/> No
Uterus contracted: <input type="checkbox"/> Yes <input type="checkbox"/> No	Uterus ruptured: <input type="checkbox"/> Yes <input type="checkbox"/> No Cord/maternal blood taken: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cervical tears <input type="checkbox"/> Yes <input type="checkbox"/> No	Details: _____
Perineum <input type="checkbox"/> Intact <input type="checkbox"/> 1 <sup>st</sup> ° tear <input type="checkbox"/> 2 <sup>nd</sup> ° tear <input type="checkbox"/> 3 <sup>rd</sup> /4 <sup>th</sup> ° tear <input type="checkbox"/> Episiotomy	Repaired by: _____
Detail of repair: _____	All swabs/tampons removed from vagina: <input type="checkbox"/> Yes
Blood loss: Normal <input type="checkbox"/> Excessive <input type="checkbox"/>	If excessive give details of management: _____
Feeding initiated <input type="checkbox"/> Yes <input type="checkbox"/> No	Breast feeding initiated if method of choice: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, give reasons: _____
Situation in labour ward at time of delivery: _____	

# Classification of shock

## Classification of shock

	Compensated shock (Class I)	Mild shock (Class II)	Moderate shock (Class III)	Severe shock (Class IV)
Blood loss	500-1000ml (10-15%)	1000-1500 ml (15-25%)	1500-2000ml (25-35%)	2000-3000ml (35-45%)
Shock index*	0.6-0.9	1	1.5	2
Systolic Blood pressure	Normal	Some changes in blood pressure	Marked ↓	Severe ↓
Pulse	< 100/min	< 120/min	> 120/min	>140/min
Respiratory rate	Normal	Mild increase	Moderate increase	Marked increase
Mental status	Normal	Agitated	Confused	Depressed level of consciousness

\*Shock index= heart rate/systolic BP (mmHg) (normal <0.5)





## THEATRE NOTES: CAESAREAN SECTION

Indication	_____
ROBSON (tick one)	1. Nullipara, singleton cephalic, term, spontaneous labour <input type="checkbox"/> 2. Nullipara, singleton cephalic, term, induced/CS before labour <input type="checkbox"/> 3. Multipara, singleton cephalic, term, spontaneous labour <input type="checkbox"/> 4. Multipara, singleton cephalic, term, induced/CS before labour <input type="checkbox"/> 5. Previous CS, singleton cephalic, term <input type="checkbox"/> 6. Nulliparous breech <input type="checkbox"/> 7. Multiparous breech <input type="checkbox"/> 8. Multiple pregnancy <input type="checkbox"/> 9. Abnormal lie <input type="checkbox"/> 10. All singleton cephalic, $\leq$ 36 weeks <input type="checkbox"/>

Date: _____	Time surgery commenced _____	Time surgery completed _____
Surgeon _____	Assistant _____	
Anaesthetist _____	Midwife _____	
Operative procedure: _____		

### PRE-OPERATIVE DETAILS

Date of decision: _____	Time of decision: _____	By whom: _____
Mat. Pulse <input type="text"/>	BP <input type="text"/>	Temp <input type="text"/>
Level of the head <input type="text"/>	Foleys catheter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pre-op drugs	<input type="checkbox"/> Antacid <input type="checkbox"/> Metoclopramide <input type="checkbox"/> Prophylactic antibiotics <input type="checkbox"/> Thromboprophylaxis	
Fetal Heart	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Uncertain	Fetal distress <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Counselling for IUD insertion <input type="checkbox"/> Information has been given regarding the procedure and informed consent obtained from the person <input type="checkbox"/> Companion allowed to be present		

### OPERATION PROCEDURE AND FINDINGS

Anaesthetic	<input type="checkbox"/> General <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural <input type="checkbox"/> Other	Maternal position: _____
Problems with anaesthetic: _____		
Skin Incision:	<input type="checkbox"/> Transverse <input type="checkbox"/> Midline <input type="checkbox"/> Other	Details: _____
Uterine Incision:	<input type="checkbox"/> Lower segment <input type="checkbox"/> Classical <input type="checkbox"/> DeLee	Other: _____
Uterine Scar	<input type="checkbox"/> Intact <input type="checkbox"/> Dehisced	Fetal Presentation _____ Fetal Position _____
Prolonged Incision-Delivery Time	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reasons: _____
Difficulty with delivery of baby:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe: _____
Liquor	<input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Clear	Meconium stained <input type="checkbox"/> No <input type="checkbox"/> Thin <input type="checkbox"/> Thick <input type="checkbox"/> Bloody <input type="checkbox"/> Offensive
Placenta	<input type="checkbox"/> Fundal <input type="checkbox"/> Central <input type="checkbox"/> Anterior <input type="checkbox"/> Posterior <input type="checkbox"/> Praevia	Retroplacental Clot: <input type="checkbox"/> Yes <input type="checkbox"/> No
Other Placental Abnormalities: _____ <input type="checkbox"/> Delayed cord clamping done    Time? _____		
Uterine Abnormalities: _____		
Uterine Tears: (give details) _____		
Tubal ligation:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type: _____    Histology <input type="checkbox"/> Yes <input type="checkbox"/> No



# Early warning chart- new born

Date																					
Time																					
Temperature °C	38																				
	37.5																				
	37																				
	36.5																				
	36																				
	35.5																				
Value																					
Respiratory Rate	80																				
	70																				
	60																				
	50																				
	40																				
	30																				
Value																					
Grunting																					
Heart Rate	190																				
	180																				
	170																				
	160																				
	150																				
	140																				
130																					
120																					
110																					
100																					
90																					
80																					
70																					
60																					
Value																					
SaO <sub>2</sub>	≥94																				
	92-94																				
	<92																				
Neuro	Alert																				
	Irritable																				
	Jittery																				
	Poor feed																				
	Floppy																				
Seizures																					
Glucose 2.3-2.6																					
Glucose <2.5																					
All observations in green – Continue observations. Routine care.																					
1 Observation in amber – Inform Sr in charge. Repeat observations in 30 minutes. If glucose 2.3-2.6, give milk feed first. If sats 92-94, try on other hand first.																					
2 or more observations in amber – Immediately inform Dr for urgent medical review.																					
1 or more observation in red – Immediately inform Dr for urgent medical review.																					

## PRE-DISCHARGE CHECKLIST

Assess mother for problems	No	Yes	Recommended action
The mother has a danger sign: <ul style="list-style-type: none"> <li>○ Heavy bleeding</li> <li>○ Severe abdominal pain</li> <li>○ Unexplained pain in chest or legs</li> <li>○ Visual disturbance or severe headache</li> <li>○ Breathing difficulty</li> <li>○ Fever, chills</li> <li>○ Vomiting</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	Assess the cause (s) and initiate care or refer. Delay discharge until all danger signs have been resolved for at least 24 hours and there is a follow-up plan in place.
The mother's bleeding is heavy or has increased since birth (e.g., bleeding soaks a pad in less than 5 minutes).	<input type="checkbox"/>	<input type="checkbox"/>	Start IV fluid and keep mother warm Delay discharge. Treat or refer. Evaluate and treat possible causes of bleeding (e.g., uterine atony retained placenta, or vaginal/cervical tear).
The mother has an abnormal vital sign: <ul style="list-style-type: none"> <li>○ High blood pressure (SBP &gt; 140 mmHg or DBP &gt;90 mmHg)</li> <li>○ Temperature &gt; 37.5°C</li> <li>○ Heart rate &gt; 100 beats per minute</li> <li>○ Respiratory rate &gt;20 per minute</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	Give magnesium sulphate to mother if any of: <ul style="list-style-type: none"> <li>• SBP ≥160 mmHg or DBP ≥110 mmHg; and 2+ proteinuria</li> <li>• SBP ≥140 or DBP ≥90 mmHg, and 2+ proteinuria, and any: severe headache, visual disturbance, epigastric pain</li> </ul> Give antihypertensive medication to mother if SBP >160 mmHg or DBP >110mmHg Evaluate the cause of abnormal vital sign(s) and treat or refer. Defer discharge until vital signs have been normal for at least 48 hours and no danger signs remain.
The mother is not able to urinate easily	<input type="checkbox"/>	<input type="checkbox"/>	Defer discharge; continue to monitor and evaluate the cause; treat or refer as needed
<b>Mental state:</b> the mother is agitated or very withdrawn <b>Support person:</b> the mother has a partner or support person to be with her at home The mother has a safe home to return to	<input type="checkbox"/>	<input type="checkbox"/>	Defer discharge; continue to monitor and evaluate, refer appropriately (social worker, mental health nurse, psychiatrist etc).
	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
Assess baby for problems	No	Yes	Recommended action
The baby has any of these danger signs: <ul style="list-style-type: none"> <li>○ Fast breathing (&gt; 60 breaths/ minute)</li> <li>○ Severe chest in-drawing</li> <li>○ Fever (temperature ≥ 37.5°C)</li> <li>○ Hypothermia (temperature &lt; 35.5°C)</li> <li>○ Yellow palms (hands) or soles (feet)</li> <li>○ Convulsions</li> <li>○ No movement or movement only on stimulation</li> <li>○ Feeding poorly or not feeding at all</li> </ul>	<input type="checkbox"/>	<input type="checkbox"/>	Assess cause of danger signs and initiate care or refer Delay discharge until all danger signs have been resolved for at least 24 hours and there is a follow-up plan in place.
The baby is not breastfeeding at least every 2–3 hours (day and night).	<input type="checkbox"/>	<input type="checkbox"/>	Establish good breastfeeding practices and delay discharge
The baby has not passed urine and/or stool	<input type="checkbox"/>	<input type="checkbox"/>	Delay discharge and monitor; refer as needed

Date and time delivered:		Name.....	
<input type="checkbox"/> Alive <input type="checkbox"/> Stillbirth <input type="checkbox"/> Perinatal death		Clinic/Hospital number.....	
Age:                      G                      P		Date of Birth.....	
		Use patient label if available	
<b>Type of delivery</b> <input type="checkbox"/> Normal Vaginal Delivery (NVD) <input type="checkbox"/> Caesarean Delivery <input type="checkbox"/> primary <input type="checkbox"/> repeat <input type="checkbox"/> Breech Delivery <input type="checkbox"/> Forceps Delivery <input type="checkbox"/> Vacuum Delivery <input type="checkbox"/> Born Before arrival (BBA)		<b>Post-partum procedures</b> <input type="checkbox"/> None <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Manual removal of placenta <input type="checkbox"/> Cervical tears repaired <input type="checkbox"/> Evacuation/curettage <input type="checkbox"/> Hysterectomy	
<b>HIV</b> <input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive <input type="checkbox"/> Declined testing <input type="checkbox"/> CD 4:                      date: <input type="checkbox"/> Viral Load                      date: <input type="checkbox"/> IPT <input type="checkbox"/> Co-trimoxazole WHO stage: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Current ART:		<b>Discharge medication</b> 1 2 3 4 5	
<b>Syphilis status</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive Treatment dates:		<b>Family Planning</b> <input type="checkbox"/> All methods and options discussed <b>Method given</b> <input type="checkbox"/> Oral contraceptives <input type="checkbox"/> Injectable <input type="checkbox"/> Intra-uterine device <input type="checkbox"/> Implant <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vasectomy Given by:	
<b>Rhesus status</b> <input type="checkbox"/> Negative <input type="checkbox"/> Positive Anti-D given <input type="checkbox"/> Yes <input type="checkbox"/> No		<b>ICD 10:</b> _____ <b>Next Pap Smear due on:</b> _____	
<b>Medical or Surgical problems during pregnancy or delivery</b> <input type="checkbox"/> None <input type="checkbox"/> Chronic hypertension <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Diabetes <input type="checkbox"/> GDM <input type="checkbox"/> Type I <input type="checkbox"/> Type II <input type="checkbox"/> Other:		<input type="checkbox"/> Condoms and advice on dual protection provided <input type="checkbox"/> Appointment given for sterilization or follow up at family planning clinic. Date: _____ Clinic: _____	
<b>Obstetrical problems in pregnancy and delivery</b> <input type="checkbox"/> None <input type="checkbox"/> Antepartum haemorrhage <input type="checkbox"/> Postpartum haemorrhage <input type="checkbox"/> ROM <input type="checkbox"/> preterm <input type="checkbox"/> prolonged <input type="checkbox"/> Multiple pregnancy <input type="checkbox"/> Other:		<b>Examination on discharge</b> <input type="checkbox"/> Pre-discharge checklist completed <input type="checkbox"/> looks well <input type="checkbox"/> looks ill Pulse:                      BP:                      Temp:                      HOF: Hb:                      Breasts: Perineum: <input type="checkbox"/> intact <input type="checkbox"/> clean <input type="checkbox"/> septic Urine output: <input type="checkbox"/> good <input type="checkbox"/> poor <input type="checkbox"/> none	
		<b>Baby 1</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> BCG <input type="checkbox"/> Polio <input type="checkbox"/> Birth PCR Weight: _____g   Head: _____cm   Length: _____cm	
		<b>Baby 2</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> BCG <input type="checkbox"/> Polio <input type="checkbox"/> Birth PCR Weight: _____g   Head: _____cm   Length: _____cm	
		<b>ART provided to baby:</b>	
		<b>Feeding options</b> <input type="checkbox"/> Discussed <input type="checkbox"/> Initiated successfully <b>Method of feeding:</b> <b>Remarks:</b>	
<b>Intrapartum procedures</b> <input type="checkbox"/> None <input type="checkbox"/> Repair of tears <input type="checkbox"/> 1 <sup>st</sup> <input type="checkbox"/> 2 <sup>nd</sup> <input type="checkbox"/> 3 <sup>rd</sup> <input type="checkbox"/> 4 <sup>th</sup> <input type="checkbox"/> Episiotomy <input type="checkbox"/> CD <input type="checkbox"/> lower segment transverse <input type="checkbox"/> lower segment vertical <input type="checkbox"/> Classical		<b>Advice on discharge</b> Next pregnancy: BANC <input type="checkbox"/> High Risk Clinic <input type="checkbox"/> Future mode of delivery <input type="checkbox"/> NVD <input type="checkbox"/> VBAC <input type="checkbox"/> Elective CS Next viral load due:                      Next tetanus dose due: Postnatal visit: Date:                      at clinic/hospital: <input type="checkbox"/> Notification of birth                      Immunisations:	
		<input type="checkbox"/> Mental health matters discussed <input type="checkbox"/> Child Support Grant discussed <input type="checkbox"/> Postnatal care and breastfeeding support locations discussed <input type="checkbox"/> Self-care discussed <input type="checkbox"/> Baby care discussed	
		<b>Name</b> <b>Rank</b> <b>Signature</b>	

## Maternal and Infant PMTCT Discharge Letter

Complete on carbon copy, this page remain in folder

HPRN: \_\_\_\_\_

Mom Name & Surname: \_\_\_\_\_

Mom Date of Birth: \_\_\_\_\_

Dear Colleague

Infant Name & Surname: \_\_\_\_\_

Gender:  Male  Female

Infant HPRN: \_\_\_\_\_ Infant Date of Birth: \_\_\_\_\_

Has been discharged from: \_\_\_\_\_ (facility name) on \_\_\_\_\_ (date)

Discharging nurse: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Follow-up Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Follow-up Site: \_\_\_\_\_ Sign: \_\_\_\_\_

### Maternal Discharge Status and Postnatal Follow Up

#### ART

Mother started on ART:  less than 12 weeks prior to delivery  
 at or after delivery

#### Viral Load

VL done at delivery

Viral load: \_\_\_\_\_

Mother on ART since before pregnancy or more than 12 weeks prior to delivery

Mother ART regime: \_\_\_\_\_

#### Feeding Method at Discharge (tick appropriate option)

Exclusively breastfeeding  Formula feeding  Heat-treated own milk

#### Contraception at Discharge

IUCD  Implant  Oral contraception  Injectable hormones  Sterilization

LABORATORY BARCODE

### Infant Discharge Status and Postnatal Follow Up

#### HIV Test (Discharge)

PCR test done

Date of PCR test: \_\_\_\_\_

LABORATORY BARCODE

PCR test result received

Positive  Negative  Awaited

Mother informed of test result

#### Discharge Post Exposure Prophylaxis (PEP)

**Low risk** (moms VL at delivery < 1000c/ml)

NVP for 6 weeks once daily

**High risk** (mom initiated after 28 weeks / has no VL / VL is > 1000c/ml)

NVP once daily for 12 weeks if mom is **breastfeeding** and if needed until mom's VL < 1000c/ml or until 1 week after cessation of all breastfeeding  
 AZT twice daily for 6 weeks irrespective of feeding choice  
 NVP once daily for 6 weeks if **formula fed**

#### Postnatal Follow-up and Baby Wellness Visits

Visit Date:	3-6 days	6 weeks	10 weeks	6 months	18 months	Any other test
	/ /	/ /	/ /	/ /	/ /	/ /
Mother	<input type="checkbox"/> If using / willing to use reliable contraception TLD (TDF, FTC and DTG)					
	<input type="checkbox"/> If not, start TEE (TDF, FTC and DTG)					
ART	<input type="checkbox"/> Check ART adherence					
	<input type="checkbox"/> Check ART adherence					
VL	<input type="checkbox"/> If VL > 50c/ml (manage as per VL non-suppression)	<input type="checkbox"/> If VL > 50c/ml (manage as per VL non-suppression)	<input type="checkbox"/> If VL > 50c/ml (manage as per VL non-suppression)	<input type="checkbox"/> VL done @ 6 mo (all HIV+ moms) Continue VL every 6 months until cessation of breastfeeding	<input type="checkbox"/> VL done @ 18 mo (if mom is still breast-feeding)	<input type="checkbox"/> VL done @ 12/24 mo (if mom is still breast-feeding)
	<input type="checkbox"/> If VL > 1000c/ml (manage infant as high risk)	<input type="checkbox"/> If VL > 1000c/ml (manage infant as high risk)	<input type="checkbox"/> If VL > 1000c/ml (manage infant as high risk)			
HTS	<input type="checkbox"/> Birth PCR done					
	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Check mom's ART adherence and last VL value		<input type="checkbox"/> 6 month PCR test <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> Rapid/Elisa Test <input type="checkbox"/> Positive <input type="checkbox"/> Negative	<input type="checkbox"/> HIV test <input type="checkbox"/> Positive <input type="checkbox"/> Negative
Infant Prophylaxis	<input type="checkbox"/> Check adherence and tolerance to NVP (and AZT)					
	<input type="checkbox"/> Start CPT <input type="checkbox"/> Stop NVP (low risk) <input type="checkbox"/> Stop AZT (high risk)	Stop NVP after 12 weeks if mothers VL < 1000c/ml if child tests positive for HIV stop NVP and initiate ART and do confirmatory PCR				
Feeding	<input type="checkbox"/> Breastfeeding					
	<input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula feeding	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula fed	<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Stopped breastfeeding <input type="checkbox"/> Formula fed

## 2. SA Maternity Case Records: the surgical insert



health

Department:  
Health  
REPUBLIC OF SOUTH AFRICA

## Maternity Care Peri-operative record

This record must be completed for all person's requiring surgery during pregnancy or the puerperium. Once completed, it must be placed within the Maternity Case Record to be filed at the hospital where the delivery took place. Procedures done at a facility where delivery did not occur must be filed in the patient records. Use a new record for every operation.

Name and ID number of patient or place large patient sticker here

Name of medical practitioner booking the procedure

Procedure:  Caesarean section     Tubal ligation     Laparotomy     Emergency hysterectomy  
 Other \_\_\_\_\_

URGENCY OF PROCEDURE (select only 1)

- RED: Immediate delivery (life threatening to mother and/or fetus)  
 YELLOW: Urgent delivery (Maternal/fetal compromise not immediate life threatening)  
 GREEN: Scheduled urgent delivery (need early delivery but no maternal/fetal compromise)  
 ELECTIVE: Scheduled at a time to suit mother/staff

Best describe the reason/indication for the caesarean section/ procedure:

### Booking arrangements

Discussed case with senior colleague/consultant (name and time):

Discussed with anaesthetic doctor (name and time):

Discussed with neonatal staff (name and time):

Date and time procedure scheduled:



URGENCY OF CAESAREAN DELIVERY (examples)			
	RED Emergency- Immediate threat to life of person or her fetus	YELLOW Maternal or fetal compromise which is not immediately life threatening	GREEN Needing early delivery, but no maternal or fetal compromise)
Target time (decision to incision)	Ideally within 30 minutes	Ideally within 60 minutes	Ideally within 3 hours
Fetal condition (examples)	Fetal distress (pathological CTG)	Suspicious CTG	Fetal anomaly or compromise that need daytime delivery for paediatric management (arrange necessary skilled team as needed)
	Cord prolapse	Cord presentation; patient in labour	
	Footling breech- with ruptured membranes	Footling breech, membranes still intact, patient in labour	
Clinical presentation (examples)	Abruptio placentae; baby alive and viable	Poor progress in labour	Eclampsia, failed induction of labour or vaginal delivery not possible
	Placenta praevia- massive bleeding	Unsuccessful attempt at VBAC	Failed induction of labour: urgent indication for delivery
	Uterine rupture/dehiscence	Cephalo-pelvic disproportion	2 or more previous CS/previous classical CS in early labour
	Transverse lie, in labour	Prolonged second stage	One previous CS, patient not for VBAC, in early labour
	Abandoned instrumental delivery	Twin pregnancy; delivery of second twin	Any GREEN indication presenting in active labour
Maternal condition	Severe maternal disease		

**IMPORTANT INFORMATION FOR ANAESTHETIC TEAM:**

Haemoglobin:	NPO since:	Latest platelet count if pre-eclampsia:
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Maternal medical condition (select all that is applicable)

- Healthy  
 Severe pre-operative blood loss (antepartum haemorrhage)  
 Abruptio placentae  
 Placenta praevia  
 Morbidly adherent placenta  
 Pre-eclampsia  
 Decreased level of consciousness  
 Acute severe hypertension  
 Maternal diabetes  
 BMI 40-50  
 BMI >50  
 Cardiac disease  
 Active respiratory disease  
 Currently on MgSO<sub>4</sub>  
 Currently on anti-coagulative drugs  
 Allergies: \_\_\_\_\_  
 Medical history \_\_\_\_\_  
 Surgical history \_\_\_\_\_  
 Other \_\_\_\_\_

## WARD PREPARATION FOR THEATRE AND TRANSFER

Planned procedure

Procedure date/time  Pickup date/time

Known allergies

	WARD			Theatre		
	Yes	No	N/A	Yes	No	N/A
Informed consent signed						
Medical alert band/ chain in situ						
Make-up/varnish removed						
Artificial nails removed						
Jewelry removed						
Dentures removed						
Contact lenses removed						
Patient is nil per mouth since ___h__						
Dressed in theatre garment						
Urine catheter in-situ						
List pre-medication drugs:						
Premed administered by						
Signature						
Patient prepared by						
Signature						
Date /time	Left ward			Arrive OT		
Received in theatre by						
Signature						
Vital signs on arrival OT		Documents received OT				
Blood pressure			Maternity case record book			
Pulse			Prescription chart			
Respiration rate			Laboratory results			
Urine disptix			X-Rays			
Catheter						
Fetal heart						

### CONSENT TO MEDICAL OR SURGICAL PROCEDURE

I, Dr \_\_\_\_\_ have explained the nature, risks & possible consequences of the medical /surgical procedure to the undersigned patient or her legal guardian.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Circle whichever is applicable

Procedure explained:	Personally	Via Interpreter
----------------------	------------	-----------------

NATURE OF PROCEDURE:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Where applicable Indicate side of procedure (Right or Left)

Circle whichever is applicable

Type of anaesthetic:	Local	Spinal	General	Procedural Sedation
----------------------	-------	--------	---------	---------------------

CONSENT TO USE OF BLOOD and/or blood products if necessary during the course of the procedure

Consent granted by Patient/Guardian : \_\_\_\_\_ Consent withheld by Patient/Guardian: \_\_\_\_\_

Signature \_\_\_\_\_ Signature \_\_\_\_\_

I consent to a sample of my blood being taken and tested for Hepatitis B and the Human Immunodeficiency Virus (HIV) should contamination of a health care worker by my bodily fluids occur during the procedure.

Patient's / Guardian's Signature \_\_\_\_\_

Full Name of Patient	I, the undersigned, hereby consent to the performance of, and understand the nature, risks and possible outcomes of the above procedure. The doctors who perform the above may carry out additional or alternative measures (including general anaesthesia) if considered necessary. In the case of a sterilisation procedure, I understand that pregnancy may occur in exceptional cases, in which case I shall not hold the Department of Health and/or its personnel responsible. I also accept that alternative methods of birth control are still available to me.
Signature/Thumb Print of patient	
Date	

COMPLETE THIS SECTION IF CONSENT IS GIVEN BY A PERSON ON BEHALF OF THE PATIENT

Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to patient \_\_\_\_\_

Means by which consent was given: \_\_\_\_\_ Personally \_\_\_\_\_ Telephonically \_\_\_\_\_

NAMES AND SIGNATURES OF WITNESSES TO THE PATIENT'S / GUARDIAN'S SIGNATURE ON THIS DOCUMENT

Witness 1	Witness 2
Print Name _____	Print Name _____
Signature _____	Signature _____

### CONSENT TO CAESAREAN DELIVERY

NATURE OF PROCEDURE: CAESAREAN SECTION\*

Contact details (if patient wishes to discuss options later) \_\_\_\_\_

I have introduced myself by name and explained the nature, risks and possible consequences of a caesarean delivery to the undersigned patient or person legally competent to give consent. In particular, I have explained the following:	Print name _____	NAME OF DOCTOR (To be filled in by a registered health professional with appropriate knowledge of the proposed procedure)
	Signature _____	

**Intended benefit:**  
Delivery of her baby (or babies) through a cut in the tummy and the uterus (womb) in a situation where the risks of the baby being born through the vagina is more than the risk of the delivery by Caesarean section.

**Frequent risks:**  
Bleeding during or after the operation, infection in the wound or in the womb (sepsis), persistent pain and discomfort over the scar, risk of repeat caesarean delivery in following pregnancies, re-admission to hospital, minor cuts to the baby during delivery.

**Serious risks (uncommon):**  
Emergency requiring removal of the womb (hysterectomy), increased risk of a tear in the womb in future pregnancies, development of a blood clot in the legs or lungs, injury to the bladder or bowel.

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

THE PROCEDURE WILL INVOLVE (one or more)	General anaesthesia <input type="checkbox"/>	Regional anaesthesia (epidural or spinal) <input type="checkbox"/>	Local anaesthesia <input type="checkbox"/>
--	--	--	--

CONSENT TO USE OF BLOOD and/or BLOOD PRODUCTS

I grant consent  I withhold consent  Signature \_\_\_\_\_

I have counselled the patient on the use and dangers of blood products and the undersigned patient hereby Grants or Withholds consent for the use of blood and/or blood products should it become necessary during the procedure. TICK the appropriate box.

I, the undersigned patient hereby agree that a sample of my blood can be taken and tested and tested for Hepatitis B and Human Immunodeficiency Virus (HIV) should an incident of contamination of a health care worker by bodily fluids occur during the procedure. TICK whichever is applicable.

I agree  I do not agree

FULL NAME OF PATIENT	I, the undersigned, hereby consent to the performance of, and understand the nature, risks and possible consequences of the above procedure. The doctors who perform the procedure may increase the reasonable scope thereof or carry out additional or alternative measures (including general anaesthesia) if considered necessary.
SIGNATURE or THUMB PRINT OF PATIENT	
Date	

PERSON LEGALLY COMPETENT TO GIVE CONSENT	Print name _____	This section to be filled in if a person other than the patient gives consent.	
	Signature _____		Date _____
	Capacity or relationship to patient _____		
Means by which consent was given: _____ Personally <input type="checkbox"/> Telephonically <input type="checkbox"/> Other: _____			

WITNESS 1	Print name _____	Names and signatures of witness to the signing of this document by the patient or a person legally competent to give consent on behalf of the patient.
	Signature _____	
WITNESS 2	Print name _____	
	Signature _____	

\*A separate consent form should be used for sterilisation procedures.

\*A separate consent form should be used if any additional procedures are planned during the time of the Caesarean section (e.g. hysterectomy).

## COUNSELLING CHECKLIST PRIOR TO POST PARTUM TUBAL LIGATION

For persons capable of signing their own consent

**I have discussed the following with this person:**

- Her reason for choosing sterilization.
- Alternative long acting effective contraceptive methods.
- Sterilisation is a permanent and irreversible method of contraception.
- Stability of relationship and possibility of regret due to change in circumstances, such as possible loss of child/children/partner or remarriage.
- Consider option of male or female sterilization. (Male procedure is smaller, safer and more effective).
- The sterilization procedure. Local or general anaesthetic, surgical approach, type of tubal closure.
- Risk of anaesthesia/surgery and possibility of additional surgery if complications occur.
- The risk of failure: 1 in 200 lifetime risk of pregnancy in a female
- If pregnancy occurs after sterilisation, there is a slight risk of ectopic pregnancy and the symptoms to report are lower abdominal pain, missed period and irregular bleeding.
- The menstrual cycle will revert to what it was before pregnancy.
- No effect on long term health.
- Sterilisation does not protect against STI/HIV transmission.
- I have answered the person's questions and given a pamphlet

Date \_\_\_\_\_ Counsellor by \_\_\_\_\_

I, (patient name) .....

with ID/Passport/other number.....

Hereby states that I have requested a sterilisation (permanent family planning).

This was my own choice and I was not forced to make this decision.

I understand that I will not be able to have any pregnancies in the future and that the operation is permanent.

Signed (patient).....

Witness 1.....

Witness 2



OPERATION		INTRA-OPERATIVE RECORD									
		NB: Complete or mark in space given					THEATRE NR:				
Operation Time:		From:		To:		Duration:					
Type of Anaesthesia:							Anaesthetist:				
Surgeon:										Assistant:	
SECTION B - SURGEON COMPLETES THIS SECTION											
Nature of Operation:											
Surgeon:		Name in Print:			Signature:			Qualification:			
Procedure code:											
SECTION C: PROFESSIONAL NURSE COMPLETES THIS SECTION											
PATIENT POSITION:		(MARK X)		Supine		Prone		Lithotomy			
Left Lateral		Right Lateral		Trendelenburg		Other					
BONY PROMINENCES		Checked:		YES:		NO:		Padded:		YES: NO:	
WARMING BLANKET		YES:		NO:							
ANY ABNORMALITIES OBSERVED (Describe shortly)											
DIATHERMY:		Diathermy used		YES:		NO:		Checked		YES: NO:	
Plate site:		ARM:		LEG:		OTHER:		LEFT:		RIGHT:	
WOUND CLASSIFICATION:											
INFECTED:		CONTAMINATED:		CLEAN CONTAMINATED:							
SKIN PREPARATION											
Chlorhexidine in Alcohol		Povidone-iodine		Chlorhexidine in Water		Other:					
INFILTRATION		YES: NO:		Type:							
X-RAYS USED:		YES: NO:		C-Arm used		YES: NO:		Contrast used		YES: NO:	
SWAB/INSTRUMENT/SHARP CONTROL											
We, the undersigned, hereby declare that the Instruments, needles and swabs in respect of the above-mentioned operation were counted before, during and after the operation and that the totals were found correct.											
		COMPLETE		TOTAL:		N.A.		PLUGS:		YES: NO:	
		YES NO						Type:			
Abdominal								Size:			
Ratyc								Tapes/Other		YES: NO:	
Dissecting								Type:			
Other								Clips		YES: NO:	
								SKIN SUTURE			
CATHETERS/ DRAINS		YES: NO:		SIZE:							
Urine											
Nasal tube											
Thoracic drain											
Femoral drain											
Other											

INTRAOPERATIVE PATIENT CARE

		INTRA-OPERATIVE RECORD CONTINUED										
		NB: Mark applicable given spaces										
Unplanned events	UNUSUAL INCIDENT REPORT WRITTEN?		YES:		NO:							
		Intraoperative bleeding										
		Source of bleeding					Blood Loss					
		ROUTE CHART COMPLETED:		YES		NO						
		SPECIMEN OBTAINED		YES:		NO:		NUMBER:				
		TYPE:										
INTRA-OPERATIVE	OPERATING TEAM MEMBERS:		NAME IN PRINT				SIGNATURE					
	REGISTERED SCRUB NURSE:											
	SUPERVISOR: (if theatre student/ new PN)											
	CO-CHECKER/CIRCULATING NURSE:											
		ANAESTHETIC NURSE:										
		POST OPERATIVE CHECKLIST										
		Post-operative skin/pressure areas check:		Intact		Skin Lesion:						
		Short description of skin lesion:										
POST-OPERATIVE	PATIENT TRANSFERRED TO: (Date/Time)		RECOVERY ROOM									
			Professional authorising release of patient from theatre									
			Date/Time		Name		Signature					
			Professional receiving patient from Theatre									
			Date/Time		Name		Signature					
		WARD:										
		CRITICAL CARE:										
		HIGH CARE:										

## CAESAREAN DELIVERY SAFETY CHECKLIST

SIGN IN (To be said out loud before induction of anaesthesia)	TIME OUT (To be said out loud before skin incision)	SIGN OUT (To be said out loud before patient leaves the operation room)
<p>Patient has confirmed</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Identity</li> <li><input type="checkbox"/> Procedure</li> <li><input type="checkbox"/> Consent</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Confirm all team members have introduced themselves by name and role</li> </ul>	<p>Practitioner verbally confirms with the team:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Name of the procedure and any additional procedure has been recorded?</li> <li><input type="checkbox"/> Instruments, swabs and sharp counts are correct?</li> <li><input type="checkbox"/> Specimens have been labelled?</li> <li><input type="checkbox"/> Blood loss has been recorded?</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Anaesthesia safety check completed (Equipment and medication)</li> <li><input type="checkbox"/> Neonatal safety check completed (Equipment and medication)</li> <li><input type="checkbox"/> Pulse oximeter on patient and functioning</li> </ul>	<p><b>To Surgeon</b></p> <p>Are there any potential problems the team should be aware of?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No                      <input type="checkbox"/> Yes</li> <li><input type="checkbox"/> Mothers rhesus status known</li> <li>Does cord blood need to be taken?</li> <li><input type="checkbox"/> No                      <input type="checkbox"/> Yes</li> </ul>	<p>Obstetrician, Anaesthetist and Scrub Nurse have discussed:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Concerns for recovery and further management?</li> <li><input type="checkbox"/> Need for post-operative VTE prophylaxis?</li> <li><input type="checkbox"/> Need for postoperative antibiotics?</li> <li><input type="checkbox"/> Equipment problems that have been identified?</li> <li><input type="checkbox"/> Oxytocin 20 IU in 1000mls IVI ready to be administered</li> </ul>
<p>Is a difficult airway anticipated?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No   <input type="checkbox"/> Yes and equipment and assistance is available</li> </ul>	<p><b>To Anaesthetist:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Wedge placed?</li> <li><input type="checkbox"/> Any patient specific concerns?</li> </ul>	<p>Midwife has confirmed that</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Baby/ies been correctly labelled?</li> <li><input type="checkbox"/> Relevant cord bloods have been taken?</li> </ul>
<p>Does patient have a known allergy</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No                      <input type="checkbox"/> Yes</li> </ul>	<p><b>To Scrub Sister</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Sterility of instruments confirmed</li> <li><input type="checkbox"/> Any equipment issues / concerns</li> <li><input type="checkbox"/> Diathermy and suction functional</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Assess bleeding risk (Pre op Hb .....g/dl)</p> <p>Risk factors for PPH.                      <input type="checkbox"/> No   <input type="checkbox"/> Yes (i.e. prolonged labour, multiple pregnancy, big baby, polyhydramnios, grand multiparity, clotting dysfunction, PPH in the past). If yes,</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> There is adequate IV access?</li> <li>Is emergency blood available?   <input type="checkbox"/> No   <input type="checkbox"/> Yes</li> <li>Are there any concerns about the placental site</li> <li><input type="checkbox"/> No                      <input type="checkbox"/> Yes</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Antibiotic prophylaxis give in the last hour?</li> <li><input type="checkbox"/> Appropriate / recent antacid prophylaxis given?</li> <li><input type="checkbox"/> Urinary catheter is draining</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Are any additional procedures planned?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> IUCD</li> <li><input type="checkbox"/> BTL</li> <li><input type="checkbox"/> N/A</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Is the foetal heart present?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No                      <input type="checkbox"/> Yes</li> </ul>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
NAME AND SIGNATURE OF HEALTHCARE WORKER	NAME AND SIGNATURE OF HEALTHCARE WORKER	NAME AND SIGNATURE OF HEALTHCARE WORKER