GHANA HEALTH SERVICE

ANTENATAL CARE REGISTER

FACILITY/ZONE…… SUBDISTRICT……

S/No	DATE	REG No	NAME	ADDRESS (LOCATION/COMMUNITY/ HSE No)	AGE	PARITY	BP	HT (m)	WT (kg)	GEST	FHt*	EDD	HB AT REG	HB AT 36 WEEKS	BLOOD GROUP (ABO)	SICKLING		VDRL	PRE TEST COUNS
																*STATUS (P/N)	TYPE		
1																			
2																			
3																			
4																			
5																			
6																			
7																			

*STATUS: P = POSITIVE, N = NEGATIVE *TYPE: AS, SS or SC *FHt: FUNDAL HEIGHT

YEAR…………………

……………. DISTRICT………………………………………………………

PMTCT			SUBSEQUENT VISITS												TT				IPT			ITN USE	COMPLAINTS	REMARKS
TEST RESULTS	POST TEST COUNS	ARV		2	3	4	5	6	7	8	9	10	11	12	1	2	3	PROTECTED NOT DOSED	1	2	3			
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