British Columbia Antenatal Record Part 2

DATE

SURNAME | GIVEN NAME

ADDRESS | PHONE NUMBER

PERSONAL HEALTH NUMBER | PHYSICIAN / MIDWIFE NAME

14. HOSPITAL | INTENDED PLACE OF BIRTH

15. LABORATORY

BLOOD GROUP | Rh FACTOR

RUBELLA TITRE | HBsAg.

HEMOGLOBIN (1st & 3 rd TM)
1st: 3 rd:

Rh ANTIBODY TITRE D M Y | Results

Rh Ig GIVEN D M Y

A.F.P./ TRIPLE SCREEN

S.T.S.

HIV TEST DONE ☐ NO ☐ YES

OTHER TESTS

GEST. DIABETES SCREEN WKS. D M Y | RESULT

GBS SCREEN (35-37 wks.) ☐ NO ☐ YES | RESULT

16. **AGE** | **PREPREGNANT WEIGHT** | **Ht.** | **BMI** | **LMP** D M Y | **EDD** D M Y

DATE D M Y	WT.	B.P.	URINE P G	GEST. AGE IN WEEKS	FUNDAL HEIGHT CMS.	FHR & ACTIVITY	PRESEN-TATION & POSITION

17. PROBLEM LIST *(specify):*

PREGNANCY:

LABOUR:

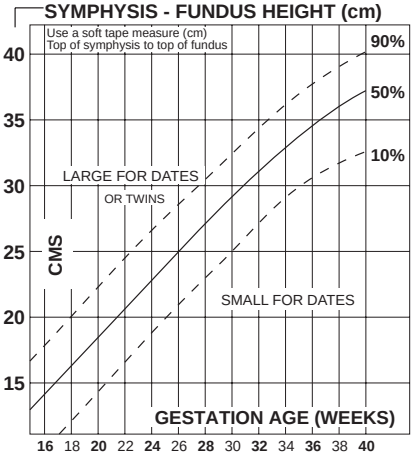
POSTPARTUM:

NEWBORN:

Return in

NOTE: SEND A PHOTOCOPY OF ANTENATAL PARTS 1&2 TO HOSPITAL AT 20 WEEKS ☐ SENT ☐ GIVEN TO PATIENT

NOTE: SEND HOSPITAL COPY AT 36 WEEKS



18. PROBLEMS, INVESTIGATIONS

1ST ULTRASOUND DATE	GEST. AGE BY US	COMMENTS

Doula: | Doula #:

CONSULTATION FOR MOTHER OR NEWBORN
Name:

SIGNATURE

MD/RM