



NWT PRENATAL RECORD - Part 1

PLANNED BIRTH PLACE		REFERRING CLINIC / HOSPITAL / HEALTH CENTRE	
PRIMARY CARE GIVER		PHYSICIAN / MIDWIFE	
CLIENT'S NAME		AGE AT EDD	LANGUAGE PREFERRED
ETHNIC ORIGIN	CONTACT NUMBERS:	RESIDENCE	ALTERNATE
BIOLOGICAL FATHER'S NAME:		AGE:	ETHNIC ORIGIN:
		INVOLVED IN PREGNANCY? <input type="checkbox"/> YES <input type="checkbox"/> NO	
<p>Informed Consent: I understand that this personal information is being collected to assist the lead health care provider in planning my care throughout pregnancy, childbirth, and postpartum. This information may be shared with other health care providers as necessary. The personal information on this form is collected under the authority of <i>Hospital Insurance and Health and Social Services Administration Act</i> and is protected by the <i>Access to Information and Protection of Privacy Act</i>. The information will only be used to provide me with health care services during my pregnancy, childbirth, and postpartum. If you have any questions about the collection ask your Health Care Provider.</p>			
Client's Signature: ✕		Witness: ✕	Date (d/m/y):

CLIENT'S SURNAME	GIVEN NAME
ADDRESS	
HEALTH CARE NUMBER	
DATE OF BIRTH (D/M/Y)	

Allergies

Medications

OBSTETRICAL HISTORY

Gravida		Term		Preterm		Abortions / Ectopic		Living		Multiple Pregnancies	
DATE (D/M/Y)	COMMUNITY OF BIRTH / ABORTION	WKS AT DELIVERY	LENGTH OF LABOUR	DELIVERY TYPE	PERINATAL COMPLICATIONS		SEX	BIRTH WEIGHT (Kg/g)	PRESENT HEALTH OF CHILDREN		

HEALTH HISTORY

None/No Concerns **Yes (SPECIFY)**

CARDIOVASCULAR _____

HYPERTENSION _____

GI _____

GENITAL/URINARY _____

RENAL _____

THROMBOSIS/PHLEBITIS _____

ASTHMA _____

DIABETES _____

EPILEPSY _____

THYROID DISEASE _____

BLEEDING DISORDER _____

TRANSFUSIONS _____

SURGERIES _____

PSYCHIATRIC/DEPRESSION _____

TB EXPOSURE _____

INFECTIONS _____

SOCIAL HISTORY (also see page 4)

None/No Concerns **Yes (SPECIFY)**

NUTRITION _____

SPECIAL DIET _____

ALCOHOL (COMPLETE T-ACE) _____

DRUGS _____

SUBSTANCE ABUSE _____

SMOKING _____

SECOND HAND SMOKE _____

DOMESTIC VIOLENCE _____

SUPPORT SYSTEMS _____

FAMILY / GENETIC HISTORY

None/No Concerns **Yes (SPECIFY Mat/Pat)**

CONGENITAL ANOMALY _____

NEURAL TUBE DEFECT _____

GENETIC DISEASE _____

DIABETES _____

HYPERTENSION _____

BLEEDING DISORDER _____

TWINS _____

ANAESTHESIA PROBLEM _____

PSYCHIATRIC PROBLEM _____

OTHER _____

PRESENT PREGNANCY

None/No Concerns **Date (D/M/Y)** **Yes (SPECIFY)**

BLEEDING _____

NAUSEA _____

VAGINAL DISCHARGE _____

INFECTIONS OR FEVER _____

DEPRESSION _____

OTHER _____

INITIAL PHYSICAL EXAMINATION

HEIGHT	PRE-PREGNANT WEIGHT	BMI	CURRENT WEIGHT	BP
No Concerns Yes (SPECIFY)		No Concerns Yes (SPECIFY)		
<input type="checkbox"/> HEAD/NECK/THYROID _____		<input type="checkbox"/> UTERINE SIZE _____		
<input type="checkbox"/> BREASTS/NIPPLES _____		<input type="checkbox"/> VAGINA _____		
<input type="checkbox"/> HEART/LUNG _____		<input type="checkbox"/> VARICIES/SKIN _____		
<input type="checkbox"/> ABDOMEN _____		<input type="checkbox"/> SPINE/BACK _____		
<input type="checkbox"/> PELVIS _____		<input type="checkbox"/> LIMBS _____		

CLINICAL DATING

PREGNANCY TEST POSITIVE DATE: _____

LNMP: _____

CERTAINTY OF DATE: YES NO (please check one)

MENSES CYCLE: _____

CONTRACEPTIVE: _____

LAST USE: _____

EDD BY LNMP: _____

EDD BY U/S < 20 WKS: _____

INITIAL ASSESSMENT DONE BY: _____ DATE (D/M/Y): _____

✕

REVISED/CONFIRMED EDD



NWT PRENATAL RECORD - Part 2

CLIENT'S SURNAME	GIVEN NAME
ADDRESS	
HEALTH CARE NUMBER	DATE OF BIRTH (D/M/Y)

LABORATORY - Send copy of prenatal sheets and lab results to hospital at 36 weeks or earlier if indicated.

ABO AND RH TYPE: DATE (D/M/Y):	GDM SCREEN: GCT 50 GM DATE (D/M/Y): RESULTS:	SEROLOGY SCREENING: DATE (D/M/Y): <input type="checkbox"/> SYPHILIS: RESULTS: <input type="checkbox"/> HEPATITIS B: RESULTS: <input type="checkbox"/> HEPATITIS C: RESULTS: <input type="checkbox"/> RUBELLA: RESULTS: <input type="checkbox"/> HIV: RESULTS: <input type="checkbox"/> VARICELLA: RESULTS:	INVESTIGATIONS: <input type="checkbox"/> PAP <input type="checkbox"/> GONORRHEA <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> TRICHOMONAS <input type="checkbox"/> BACTERIAL VAGINOSIS <input type="checkbox"/> HERPES IF INDICATED <input type="checkbox"/> GROUP B STREP <input type="checkbox"/> URINE MSU	ULTRASOUND STUDIES ATTACH RESULTS DATE (D/M/Y) GEST AGE _____ _____ _____
ANTIBODY SCREEN: REPEAT DATE:	IF ABNORMAL: GTT 75G DATE (D/M/Y): RESULTS:	POSTPARTUM IMMUNIZATION <input type="checkbox"/> NONE <input type="checkbox"/> RUBELLA <input type="checkbox"/> VARICELLA	TREATMENT FOR ANY OF THE ABOVE:	CONFIRMED EDD
IF RH NEGATIVE: RHOGAM GIVEN: DATE (D/M/Y): DATE (D/M/Y):	IF PREVIOUS INDICATORS AT FIRST SCREEN: GTT 75G DATE (D/M/Y): RESULTS:	MATERNAL SERUM SCREEN: OFFERED: <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPTED: <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS:	DATE (D/M/Y) RESULTS	
AMNIO / CVS RESULTS: INDICATED: <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPTED: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE (D/M/Y): RESULTS:	DATE (D/M/Y): RESULTS:			

CLINICAL VISITS - Please use page 5 if more entries are needed

DATE (D/M/Y)	WKS	SFH (cm)	B/P	WT. (Kg)	URINE (pro/glu)	CBC/Hb	POSITION	FETAL MVMNT	FHR	COMMENTS	INIT.	RTC D/M/Y

RISK FACTORS / CONCERNS TO BE ANTICIPATED IN PREGNANCY - RESULT OF HISTORY AND PHYSICAL PREGNANCY: _____ DELIVERY: _____ POSTPARTUM: _____ NEWBORN: _____	REFERRAL PLAN <input type="checkbox"/> OBSTETRICIAN <input type="checkbox"/> PUBLIC HEALTH NURSE <input type="checkbox"/> FAMILY PHYSICIAN <input type="checkbox"/> MIDWIFE <input type="checkbox"/> SOCIAL WORKER <input type="checkbox"/> OTHER <input type="checkbox"/> DIETICIAN/PRENATAL NUTRITION PROGRAM
--	--

