

MATERNITY CALL RECORD: Please complete clearly in black ink and BLOCK capitals for telephone contacts made within a 24hour period. (Refer to guidance and file in main record when complete.)

WOMAN'S DETAILS:

SURNAME:

FIRSTNAME.....

DOB (or age)...../...../..... AGE.....

HOSPITAL #.....

HOME ADDRESS.....

.....

.....POSTCODE.....

HOME Phone No.....

CURRENT LOCATION.....

.....

.....POSTCODE.....

RETURN Phone No.....

CALL DETAILS:

DATE...../...../..... TIME.....hrs

TIME CALL COMPLETEDhrs

Caller Name (if different).....

Relationship to woman.....

Type of Call

Antenatal Gestation

Pre Labour/

Intrapartum E.D.D.

Postnatal Parity

Obstetric History SVD Forceps/Ventouse CS

Additional Information.....

CALL REASON (record relevant details only)

Yes No N/A

Mild Mod Severe

Contractions Frequency 1 in Strength Duration secs.

S.R.O.M Describe..... Fetal Movements When felt

Group B strep Bleeding Describe.....

RhD-neg Meconium Describe.....

Headache PV Discharge Describe.....

Visual Disturb.

Abdominal Pain (not contractions) None Mild Mod Severe

Oedema

Woman's description.....

Urinary Prob. Anxiety/Distress

Other, please detail.....

POSTNATAL only: Delivery Date:...../...../.....	SVD <input type="checkbox"/>
Problem:	Forceps/Ventouse <input type="checkbox"/>
	CS <input type="checkbox"/>

Please continue and record clinical summary and advice given overleaf:

