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Contact: QldMaternityandNeonatalNetwork@health.qld.gov.au

Queensland Government

Antenatal Assessment

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

- Refer to the woman's *Handheld Pregnancy Health Record (SW071)* for all relevant antenatal information.
- Care outlined in this assessment **must be altered if it is not clinically appropriate** for the individual client.

Documentation Instructions

Initials – indicates action/care has been ordered/administered.
N/A – indicates preceding care/order is not applicable.
Crossing out – indicates that there is a change in the care outlined.
- For maternity and neonatal clinical guidelines go to Queensland Clinical Guidelines (QCG) at: www.health.qld.gov.au/qcg/publications
- Every person documenting in this assessment **must** supply a sample of their initials and signature in the Signature Log.

Signature Log

Print name	Designation	Signature	Initials	Print name	Designation	Signature	Initials

Arrival date: ... / ... / ... **Arrival time** (24hr): ... : ...

Reason for presentation:

Assessment	**Date:** ... / ... / ...	**Time** (24hr): ... : ...	Gravida:	Parity:	Estimated date of birth: ... / ... / ... ☐ Date ☐ Scan
	Gestation: weeks	Placental location:	Abdominal palpation:	Fundus: cm	
	Lie:	Position:	Presentation/attitude:		
	PV loss:	Contractions:	FHR: bpm	Foetal movements:	
	CTG indicated: ☐ Yes ☐ No ☐ N/A Reason: ...				
	☐ Vaginal examination:				
	☐ Speculum:				
	Urinalysis: ... MSU sent: ☐ Yes ☐ No				
Investigations and results	**Blood**	Test date: ... / ... / ...	Hb: g/L	Platelets: /L	Blood group: / Antibodies:
	Serology	☐ Hepatitis B: ◯ Positive ◯ Negative ◯ Not tested ☐ Hepatitis C: ◯ Positive ◯ Negative ◯ Not tested ☐ HIV: ◯ Positive ◯ Negative ◯ Not tested			
		Rubella: ☐ Immune ☐ Not immune ☐ Unknown			
	Syphilis screen	☐ Initial screen: ◯ Reactive ◯ Non-reactive ◯ Not tested Date: ... / ... / ... ☐ K26–28: ◯ Reactive ◯ Non-reactive ◯ Not tested Date: ... / ... / ... ☐ K34–36: ◯ Reactive ◯ Non-reactive ◯ Not tested Date: ... / ... / ...			
Vaccinations and alerts	Pertussis vaccine: ☐ Yes ☐ No If *YES*, gestation age given (weeks): ...				
	Influenza vaccine: ☐ Yes ☐ No If *YES*, gestation age given (weeks): ...				
	Respiratory Syncytial Virus (RSV) vaccine: ☐ Yes ☐ No If *YES*, gestation age given (weeks): ...				
	Alerts:				
Current medications					
Antenatal ACM* category on admission	☐ A ☐ B ☐ C **Australian College of Midwives (ACM) National Midwifery Guidelines for Consultation and Referral*				

DO NOT WRITE IN THIS BINDING MARGIN

ANTENATAL ASSESSMENT

v5.00 - 08/2025
WINC Code: 1NY31765
SW248

Queensland Government

Antenatal Assessment

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Risk Factors/Management Plan/Obstetric History	Initials

Current Presentation

Date	Time (24hr)	Document status on arrival, advice given, procedures/investigations undertaken and final assessment of maternal and fetal condition(s) *(include name, designation, signature, date and time with all entries)*	Initials

Discharge/ transfer	☐ Birth Suite ☐ Ward ☐ Home ☐ Other *(specify)*:	
	Discharge/transfer time (24hr): ..... :	
Follow-up appointment (if applicable)	Date: ..... / ..... /	Time (24hr): ..... : .....
	Clinic/GP:	
Medical consultation/ referral	☐ Not required ☐ Required → Referred to: ..... Date referred: ..... / ..... / ..... Time referred (24hr): ..... :	

DO NOT WRITE IN THIS BINDING MARGIN