Name

Health Care Number

Signature of woman_____

This is the minimum number of antenatal appointments you should expect, others will be added as required and the reasons why discussed with you.

Routine Antenatal Appointments		Appointment Date/Time/Location
8-14 weeks	At your Booking appointment the following will be discussed : • Full medical and family history to determine the type of care you are suitable for • Early pregnancy advice on public health issues such as smoking, alcohol and diet including receiving your pregnancy book and hand held record • Ultrasound scan to determine more accurately when your baby is due • A customised growth chart for your baby will be generated	
16 weeks	You arrange this contact with your midwife who may review any screening tests carried out at booking and carry out an antenatal examination	
18-20 weeks	An appointment with an Obstetric Ultrasonographer if you choose to have an ultrasound scan to detect structural anomalies. If your afterbirth is found to be covering the neck of your womb (cervix), you will be offered another scan at 32-34 weeks.	
25 weeks	At this appointment the following will happen: • Full antenatal check including blood pressure, urine check and assessing the health of your baby • Continue to build a relationship with your midwife • Further advice on public health issues such as smoking, alcohol and diet **You will have this appointment with your first baby only**	

Routine Antenatal Appointments		Appointment Date/Time/Location
28 weeks	This appointment will be as above but also include a blood test to check for anaemia. At this stage you will also begin to have your baby's growth measured and plotted on your customised growth chart to ensure your baby is growing appropriately. You should discuss your birth plan at this stage You will have your blood results reviewed and if blood group is rhesus negative you will also be offered Anti D	
31 weeks	This appointment will be as for 25 weeks and additionally your baby's growth will be measured	
34 weeks	This appointment will be as for 25 weeks and additionally your baby's growth will be measured	
36 weeks	This appointment will be as for 25 weeks Additionally your baby's growth will be measured and information on recognition of labour	
38 weeks	This appointment will be as for 25 weeks Additionally your baby's growth will be measured and information regarding a membrane sweep will be given	
40 weeks	This appointment will be as for 25 weeks and additionally your baby's growth will be measured You will be offered a membrane sweep (where the midwife or doctor will aim to separate the membranes around your baby from the neck of your womb (cervix). This releases hormones called prostaglandins, which may help start your labour)	
41 weeks	This appointment will be as for 25 weeks and additionally you will be offered a date for induction of labour and a membrane sweep	

Feeling your baby move is a sign they are well.

MOVEMENT

Most women usually begin to feel their baby move between 18 and 24 weeks of pregnancy.

A baby's movements can be described as anything from a kick, flutter, swish or roll. The type of movement may change as your pregnancy progresses. If by 24 weeks you have never felt your baby move, you should contact your midwife, who will check your baby's heartbeat and, if needed, arrange an ultrasound scan.

How often should my baby move?

There is no set number of normal movements. Your baby will have *their own pattern of movements* that you should get to know. The pattern may be different at different stages, especially towards the end of pregnancy.

It is ***not true*** that babies move less towards the end of pregnancy.

Why are my baby's movements important?

A reduction in baby's movements can sometimes be an important warning sign that a baby is unwell. Around half of women who had a stillbirth noticed their baby's movement had slowed down or stopped.

Do not use any hand-held monitors, dopplers or phone apps to check your baby's heartbeat. Even if you detected a heartbeat, this does not mean your baby is well.

Do not wait until the next day to seek advice if you are worried about your baby's movements.

What if my baby's movements are reduced again?

If, after your check up, you are still not happy with your baby's movements, you must contact either your midwife or maternity unit straight away, even if everything was normal last time. If you think your baby's movements have slowed down or stopped, contact your midwife or maternity unit immediately (it is staffed 24hrs, 7 days a week). Do not worry about phoning, no matter how many times this happens.

NEVER HESITATE TO CONTACT

BIRTH PREFERENCES

You can use this Birth Preferences form if you wish or write your own.

A summary of your birth preferences is a simple and clear way to let your midwife or doctor know what you would like during labour, birth and immediately afterwards. Below are some areas you may wish to consider. We want you to feel confident and informed about all the options available, so the information included is supported by the latest research to help you decide. You have the right to choose, accept or decline any treatment and your informed decisions will be discussed, respected and supported.

This summary is an outline of my wishes and assumes all will go well with my pregnancy, labour and birth. I understand that if problems develop, then some of my preferences may not be recommended and my alternatives will be discussed.

BIRTHPLACE CHOICES

I understand that choosing the right place of birth will help me have a better, safer birth.
I will be given information about the best options for me.

If my pregnancy is straightforward, evidence shows that the following options may be particularly suitable for me and my baby:

- freestanding midwife-led units (birth centres);
- alongside midwife led units (on the same site as consultant units);
- my own home (I can discuss this with my midwife); and
- DOMINO (a community midwife will care for me in a maternity unit).

If my pregnancy is not straightforward, the best place is likely to be a Consultant unit under the care of an obstetrician. A multidisciplinary team including midwives will be available to provide care for all women who need specialised services.

The Which? Birth Choices website can give me information about local units (www.which.co.uk/birth-choice) and I can ask my midwife to explain the benefits and risks of each birth place using information from the Birthplace research study.*

** The Birthplace tables are included elsewhere in these notes.*

My preferences/thoughts about where I would like to have my baby...

MY BIRTH COMPANION(S)

I understand that:

- having the right birth companion (someone who is calm and supportive) may help me have a more straightforward birth and a calmer experience;
- I can have 1 - 2 people with me during my labour (the same people throughout). For home births, the choice and number of birth companions can be more flexible; and
- I don't have to have the baby's father as my birth companion: I might choose my partner, a female friend/relative, or a Doula.

My preferences/thoughts about who I might like with me...

THE START OF LABOUR

I understand that:

- it is generally better for women to go into labour naturally. Normally babies are born between 37 and 42 weeks;
- I will be offered induction of labour after 42 weeks. I have the option of increased monitoring of my and my baby's wellbeing as an alternative to induction; and
- if my doctor or midwife recommends induction, they will explain the reasons for this, as well as the risks and benefits, and they will give me the Induction of Labour leaflet.

My preferences/thoughts about the start of labour...

FIRST STAGE OF LABOUR

(when my contractions are regular and my baby moves into the birth canal)

I understand that:

- in early labour, it is helpful to relax, get some rest, perhaps take a bath/shower and not forget to eat and drink;
- it is generally better to labour at home for as long as possible (this way I can be comfortable but I will remember to keep in touch with my midwife to ensure I go to my birth unit when needed);
- if my waters break, I should contact my midwife, who may advise me to come in to the birth unit/ hospital, particularly if the waters around the baby are green coloured or have a bad smell;
- vaginal examinations to assess cervix dilation are not routinely needed and are optional, however sometimes my midwife or doctor will ask if they can carry out an examination to determine the progress of my labour; and
- it is generally better for the waters to break by themselves, although in some circumstances it may be recommended that they are broken by a midwife or doctor.

My preferences/thoughts for this stage of labour...

WORKING WITH PAIN IN LABOUR

I understand that:

- emotional support, encouragement and reassurance from someone I trust can boost my confidence and ability to cope with pain when I need it most;
- some forms of pain relief can affect my baby and how s/he will feed after birth; and
- I can change my mind about my pain relief preferences when in labour.

Pain relief options are described at the end of this birth plan.

1. I would like to try the following if possible:

2. I would like to avoid the following if possible:

3. Some women like staff to remind them of their pain relief options in labour, while others prefer to ask if they feel they need something. My preferences/thoughts...

SECOND STAGE OF LABOUR

(when the baby is being born)

I understand that:

- I might feel overwhelmed, frightened or discouraged just before the second stage, but my midwife will be with me throughout to support me and explain everything that is happening;
- my midwife will guide me with what to do when I feel the urge to push and encourage me to push at the right time;
- upright positions (kneeling, sitting, all fours) may help the delivery of my baby; and
- I can birth my baby in a pool if I wish, although in certain circumstances this may not be possible.

If I have a caesarean birth, I understand that:

- my partner can be present, unless I have a general anaesthetic;
- I can request a caesarean which includes a calm atmosphere for my baby's birth; and
- I can decide whether I want a screen to prevent me seeing the caesarean taking place.

My preferences/thoughts for this stage of labour...

IMMEDIATELY AFTER MY BABY'S BIRTH

I understand that I can request:

- my baby be placed directly onto my tummy or into my arms;
- low lighting and minimal noise as my baby is born;
- my religious practices be respected; and
- to find out for myself if my baby is a boy or a girl.

Skin-to-skin contact has great benefits for Mums (and Dads) and babies. If immediate skin to skin is not possible it can be done as soon as I and my baby are both well. Uninterrupted skin-to-skin contact, including baby's first feed, is recommended for an hour after my baby is born, where possible.

My preferences/thoughts about the time immediately after my baby's birth...

THIRD STAGE OF LABOUR

(when the placenta, or afterbirth comes away)

I understand that:

- I can request that my birth companion cuts the cord;
- I can request that the cord is left for a specific length of time, until it has stopped pulsating or until it has turned white (my midwife or doctor can explain the benefits of this for my baby);
- if there is a risk of bleeding after the birth, or if my baby needs immediate treatment/assistance, I may be offered an injection in my thigh to help the placenta come out more quickly. The cord may also be cut quickly.

My preferences/thoughts about this stage...

AFTER THE BIRTH

I understand that:

- it is best to feed the baby within an hour of birth;
- breastfeeding, even for one day, gives my baby a good start in life;
- it is better for my baby to be handled by as few people as possible and to be held mostly by his/her Mum/Dad (unless there is a problem); and
- I can have some time alone with my baby and my birth companion(s), unless there is a problem.

My preferences/thoughts about the time after my baby is born...

ADDITIONAL THOUGHTS AND COMMENTS

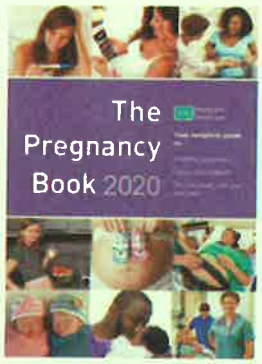
What are my biggest concerns or fears for my labour and birth? What else should my midwives/doctors know about me? (Discussing anything that may be worrying me before my baby is born may help me to feel more confident and comfortable when going into labour. I know that I can ask questions at any time and that my voice will be heard).

A request to my midwife, if things don't go to plan...

I know that there can be emergencies. If there is an emergency I may be too afraid or tired to take in all you say. Please let me know what has happened and why, then please just double check I understood.

Pregnancy and new parent information

The Public Health Agency produces the following books and leaflets which you may find useful to download to your smart phone by scanning the QR codes below. These resources can also be viewed online at www.publichealth.hscni.net/publications



This book provides information on many aspects of pregnancy and a list of useful organisations.

This book provides information on caring for children up to five years old and contact details for useful organisations.

This book presents the reasons why mothers and babies benefit from breastfeeding and explains how to breastfeed successfully.

This booklet provides safety information on the preparation and storage of infant formula milk.

Name:
ID No:

INFORMATION FOR FETAL ABNORMALITY SCAN

INFORMATION

This scan is usually offered to women close to the 18th - 20th week of their pregnancy. The purpose of the scan is to identify any physical problems with the development of the baby in order to:

- help parent(s) prepare for the birth
- enable plans to be made for delivery (which may be in a specialist unit or with specialist doctors present)
- in some instances allow for further pregnancy investigations and or treatment to improve the outcome chances for the baby

Before you decide to have the scan you need to consider the following:

For most women the scan will not pick up any problems as the baby will be developing normally. However, for some women a problem may be found that will require further ultrasound scans. Some of these problems may be quite common while others may be very rare. The problems may be minor or may in some cases have serious health implications for the baby.

It is important to consider that scans do have their limitations and in a small number of cases babies are born with abnormalities that have not been detected at the scan. It is also possible for the scan to show a potential problem that may require further tests before we can be certain.

The ability of the scanner to obtain clear images of the baby can be affected by the mother's weight, the position of the baby in the womb or previous operations on the lower abdomen. On such occasions a second or repeat scan is arranged usually within 2 weeks. This can happen in about 1 in 10 scans.

The choice to decline or have a fetal abnormality scan and/or subsequent scans/tests is up to you and you can decline or stop the process at any stage

Conversations in pregnancy: Key points

Remember: explore what parents already know → accept → offer relevant information*

Encouraging parents to connect with their baby	Taking time out to connect: talking to baby, noticing and responding to movements
Skin contact	The value of skin contact What this means for mother and baby
Responding to baby's needs	How closeness, comfort and love can help baby's brain develop Responsive feeding
Feeding	Value of breastfeeding as protection, comfort and food How to get off to a good start

Confirmation that a conversation has taken place to cover relationship building, responsiveness and feeding, as per mother's needs

	Signature:	Date:	Comments:
1			
2			
3			

*refer to the health professionals' guide for more information

PLACE OF BIRTH – what the evidence says

1. First time mothers having a straightforward pregnancy

These tables contain information that may help you make your decisions. Please ask your doctor or midwife to discuss them with you.

Table 1 **Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: low-risk nulliparous women (sources: Birthplace 2011; Blix et al. 2012)**

	Number of incidences per 1000 nulliparous women giving birth							
	Home		**Freestanding midwifery unit**		**Alongside midwifery unit**		**Obstetric unit**	
Spontaneous vaginal birth	794*	79.4%	813	81.3%	765	76.5%	688*	68.8%
Transfer to an obstetric unit	450*	45%	363	36.3%	402	40.2%	10**	1%
Regional analgesia (epidural and/or spinal)* **	218*	21.8%	200	20%	240	24%	349*	34.9%
Episiotomy	165*	16.5%	165	16.5%	216	21.6%	242*	24.2%
Caesarean birth	80*	8%	69	6.9%	76	7.6%	121*	12.1%
Instrumental birth (forceps or ventouse)	126*	12.6%	118	11.8%	159	15.9%	191*	19.1%
Blood transfusion	12	1.2%	8	0.8%	11	1.1%	16	1.6%

* Figures from Birthplace 2011 and Blix et al. 2012 (all other figures from Birthplace 2011).
** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.
*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.

Table 2 Outcomes for the baby for each planned place of birth: low-risk nulliparous women (source: Birthplace 2011)

	Number of babies per 1000 births							
	Home		**Freestanding midwifery unit**		**Alongside midwifery unit**		**Obstetric unit**	
Babies without serious medical problems	991	99.1%	995	99.5%	995	99.5%	995	99.5%
Babies with serious medical problems*	9	0.9%	5	0.5%	5	0.5%	5	0.5%

* Serious medical problems were combined in the study: neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes less than 4% of adverse events

2. Women who have had a baby before and who are having a straightforward pregnancy

These tables contain information that may help you make your decisions. Please ask your doctor or midwife to discuss them with you.

Table 3 **Rates of spontaneous vaginal birth, transfer to an obstetric unit and obstetric interventions for each planned place of birth: low-risk multiparous women (sources: Birthplace 2011;Blix et al. 2012)**

	Number of incidences per 1000 multiparous women giving birth							
	Home		**Freestanding midwifery unit**		**Alongside midwifery unit**		**Obstetric unit**	
Spontaneous vaginal birth	984*	98.4%	980	98%	967	96.7%	927*	92.7%
Transfer to an obstetric unit	115*	11.5%	94	9.4%	125	12.5%	10***	1%
Regional analgesia (epidural and/or spinal)* **	28*	2.8%	40	4%	60	6%	121***	12.1%
Episiotomy	15*	1.5%	23	2.3%	35	3.5%	56*	5.6%
Caesarean birth	7*	0.7%	8	0.8%	10	1%	35*	3.5%
Instrumental birth (forceps or ventouse)	9*	0.9%	12	1.2%	23	2.3%	38*	3.8%
Blood transfusion	4	0.4%	4	0.4%	5	0.5%	8	0.8%

* Figures from Birthplace 2011 and Blix et al. 2012 (all other figures from Birthplace 2011).
** Estimated transfer rate from an obstetric unit to a different obstetric unit owing to lack of capacity or expertise.
*** Blix reported epidural analgesia and Birthplace reported spinal or epidural analgesia.

Table 4 **Outcomes for the baby for each planned place of birth: low-risk nulliparous women (source: Birthplace 2011)**

	Number of babies per 1000 births							
	Home		**Freestanding midwifery unit**		**Alongside midwifery unit**		**Obstetric unit**	
Babies without serious medical problems	997	99.7%	997	99.7%	998	99.8%	997	99.7%
Babies with serious medical problems*	3	0.3%	3	0.3%	2	0.2%	3	0.3%

* Serious medical problems were combined in the study: neonatal encephalopathy and meconium aspiration syndrome were the most common adverse events, together accounting for 75% of the total. Stillbirths after the start of care in labour and death of the baby in the first week of life accounted for 13% of the events. Fractured humerus and clavicle were uncommon outcomes less than 4% of adverse events

Signature and Profession	Date	Time