The Royal New Zealand College of General Practitioners

NEW ZEALAND COLLEGE OF MIDWIVES (INC)

POSTNATAL

Please ensure that the completed form is sent to the GP (below) and the Well Child provider by four weeks postpartum, and that a copy is given to the woman.

Date _____ Planned date of discharge from LMC _____

Dear Dr _____

I am writing to update you on my client and her baby who have been in my care.

Name _____ DOB _____ NHI _____

Address _____ Home telephone _____

_____ Mobile number _____

_____ Alternative contact number _____

Partner/family/social support _____

Pregnancy summary _____

_____

_____

Birth summary (including mode of birth) and postnatal period _____

_____

_____

Parity _____ Contraception _____

Baby's name _____ DOB _____ NHI _____

Sex _____ Gestation _____ Apgar score _____

Birth weight _____ Last recorded weight _____ Date _____

Newborn baby summary _____

_____

_____

Newborn metabolic screening ❑ Yes ❑ No

Newborn hearing screening ❑ Yes ❑ No

Red eye reflex done ❑ Yes ❑ No

Vitamin K ❑ IM Oral ❑ 1st ❑ 2nd ❑ 3rd ❑ Declined

Baby's feeding ❑ Exclusive breastfeeding ❑ Fully breastfeeding ❑ Partially breastfeeding ❑ Artificial feeding

Well Child provider notified ❑ Yes ❑ No

Summary of ongoing maternal and baby needs and referrals made _____

_____

_____

_____

❑ I will follow up this summary with a phone call.

If you have any further questions please feel free to contact me.

Lead maternity carer _____

Contact details _____

_____