The Royal New Zealand College of General Practitioners

New Zealand College of Midwives
TE KĀRETI O NGA KAIWHAKAWHANAU KI AOTEAROA

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 _____

_____