

Midwives Regulations (Health Act) Form 2  
**NOTIFICATION OF CASE ATTENDED**

Hospital .....

For Adoption ( ) yes  
 ( ) no

PARTICULARS RELATING TO MOTHER

PRINT  
 IN  
 BLOCK  
 LETTERS

SURNAME		UNIT NO			
FORENAMES		BIRTH DATE			
ADDRESS OF USUAL RESIDENCE		POSTCODE			
MAIDEN SURNAME					

Current Conjugal State:

single ( )  
 married (incl. de facto) ( )  
 other .....

Race:

White ( )  
 Aboriginal (full or part) ( )  
 Other .....

Height (cms) 

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**PREGNANCY**

**PREVIOUS PREGNANCIES** (excluding this pregnancy)

Total number of: 

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Previous Pregnancies 

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Previous children now living 

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born alive, now dead 

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stillborn 

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**THIS PREGNANCY**

Date of LMP 

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This date — certain ( )  
 — not certain ( )

Expected due date 

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**Complications of Pregnancy:**

Threatened abortion (under 20 weeks) [ ]

urinary tract infection [ ]  
 pre eclampsia [ ]  
 APH — placenta praevia [ ]  
     — abruptio [ ]  
     — other [ ]  
 prem. rupture of membranes [ ]  
 other .....

**Medical Conditions:** (Eg. diabetes)

.....  
 .....

**LABOUR AND DELIVERY**

**Onset of Labour:**

spontaneous [ ]  
 induced [ ]  
 augmented [ ]  
 no labour [ ]

**Presentation:**

vertex ( )  
 breech ( )  
 other ( )

**Type of Delivery:**

normal [ ]  
 vacuum — successful [ ]  
           — failed [ ]  
 forceps — successful [ ]  
           — failed [ ]  
 breech manoeuvre [ ]  
 caesarean — elective [ ]  
                   — emergency [ ]

**Hours of established labour:**

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**Complications of Labour, Delivery or Puerperium:**

precipitate delivery [ ]  
 foetal distress [ ]  
 prolapsed cord [ ]  
 cord tight around neck [ ]  
 cephalopelvic disproportion [ ]  
 other .....

**BABY**

(Complete a separate form in full for each baby of a multiple birth)

Birth Date: 

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Time (24 hr. clock) 

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**Plurality:**

single birth ( )  
 first twin ( )  
 second twin ( )  
 other multiple birth: ( )  
 (specify baby number \_\_\_\_\_ of \_\_\_\_\_)

Sex: male ( )  
       female ( )

Condition: liveborn ( )  
               stillborn ( )

Birthweight (grams) 

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Length (cms) 

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Time to Spontaneous Respiration (mins) 

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**Resuscitation:**

none ( )  
 intubation ( )  
 other .....

Apgar Score (5 mins) 

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**Congenital Anomalies**

.....  
 .....

**Birth Trauma** (Eg. cephalhaematoma)

.....  
 .....

**MIDWIFE**

Please complete below, then forward this copy WITHIN 48 HOURS OF BIRTH TO

Commissioner,  
 Public Health and Medical Services  
 Box C134 G.P.O.  
 PERTH, W.A. 6001

Name .....

Signature .....

Reg. No. .... Date .....

The mother is not obliged to supply any information for the purposes of this form.