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NHS SCOTLAND

Pregnant Women with Red Cell Antibodies: Record of Care

PLEASE USE BLACK INK

MOTHER'S LABEL
Insert Name and CHI

Hospital / Unit (of booking):

Consultant:

Confidential: If you find this record, please return it to the nearest maternity unit or General Practitioner surgery as soon as possible.

This record is used by your doctors and midwives to ensure that you and your baby receive the best possible care, please remember to carry it with your main maternity record at all times.

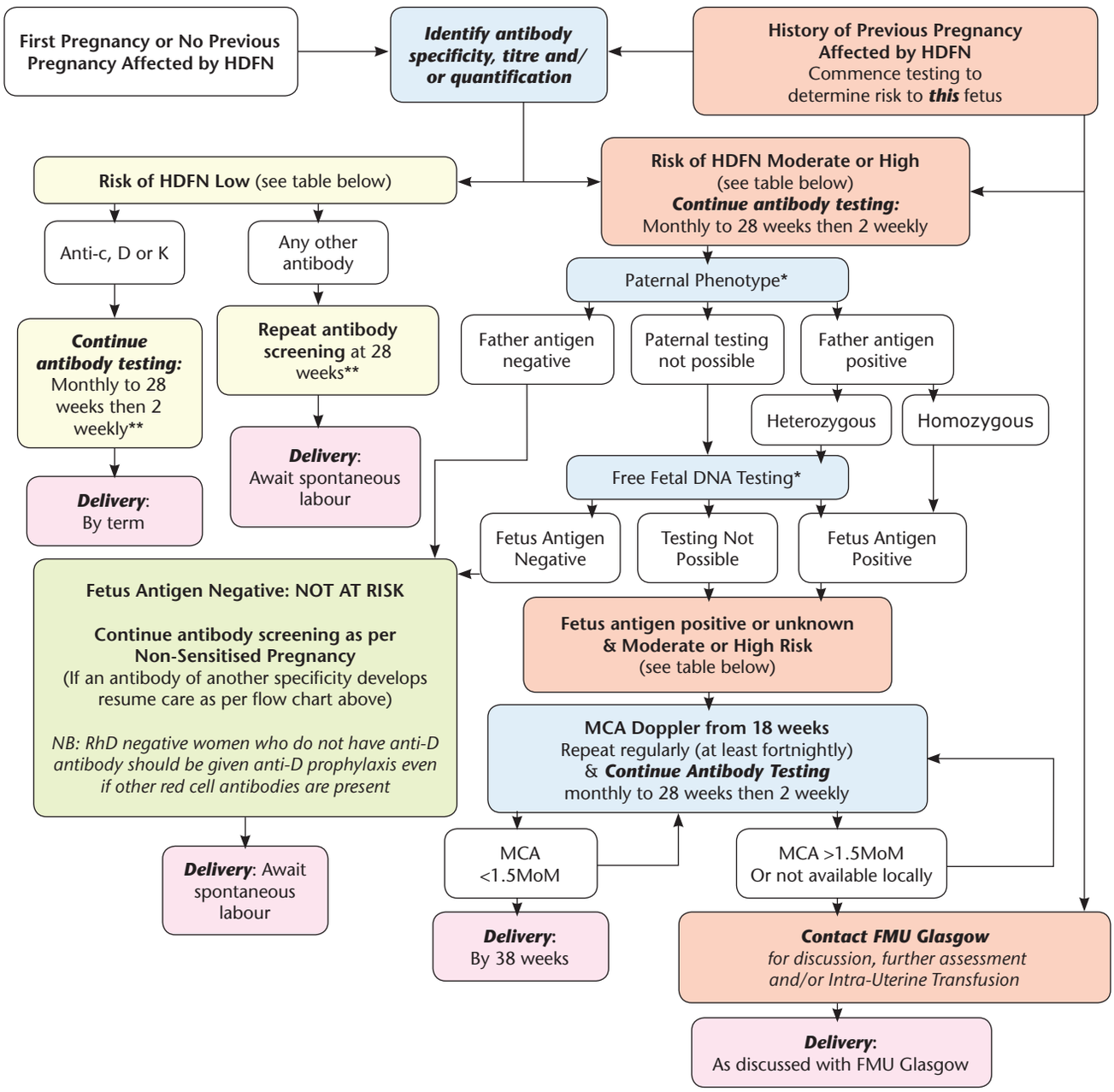
Your doctor and midwife will be happy to answer any questions you have.

Distribution List (List of people who should be copied into correspondence/results)

	Obstetrician	
	Midwife	
	Fetal Medicine Unit (Glasgow) Contact	
	Blood Bank Contact	
	Neonatologist	
	GP	

Summary of Clinical Care for Pregnant Women with Red Cell Antibodies

To be used in conjunction with Scottish National Guidance for Pregnant Women with Red Cell Antibodies.



Risk for Fetal Anaemia	Antibody Specificity & Level			
	Anti-D (iu/ml)	Anti-c (iu/ml)	Anti-K (Titre)	Other antibody(ies) (Titre)
Low	0-4	0-7.5	Less than 1in8	Less than 1in32
Moderate	4-15	7.5-20	-	-
High	15 or above	20 or above	1in8 or above	>1in32

NB: The presence of any red cell antibody impacts significantly on provision of suitable blood for maternal transfusion. The hospital blood bank should always be made aware, as far in advance as possible, of planned delivery and/or admission in labour. Blood bank should also be informed if there is increased risk of maternal haemorrhage eg. placenta praevia.

* Fetal & Paternal DNA testing will not be possible for some antibodies, the fetus should be considered 'at risk' in those cases.

** If antibody testing at any stage indicates a moderate or high risk of HDFN, then the care pathway for higher risk pregnancy should be followed thereafter.

If in doubt please call FMU Glasgow for advice: 0141 232 4339

Relevant History & Previous Pregnancies

Agreed EDD: ____________________ Blood Group: ____________________ Antibody Specificity: ____________________

Was antibody(ies) first detected during this pregnancy? Yes No

If No, please give approximate date when antibody first detected: ____________________

Previous Maternal Blood Transfusion? Yes No

'If Yes, please give details including dates: ____

Early Pregnancy Losses (please give number and type):

All Other Pregnancies

Date of delivery: ____ / ____ / ____ Outcome & Gender: __________ Mode of Delivery: __________ Birthweight: __________ kg

Place: __________________________ Baby Hb at Delivery: __________ Phototherapy: Yes No Exchange Transfusion: Yes No

IUT: Yes No If yes, gestation (s) ________________________________ Is Current pregnancy with the same partner? Yes No

Other information: ____

Date of delivery: ____ / ____ / ____ Outcome & Gender: __________ Mode of Delivery: __________ Birthweight: __________ kg

Place: __________________________ Baby Hb at Delivery: __________ Phototherapy: Yes No Exchange Transfusion: Yes No

IUT: Yes No If yes, gestation (s) ________________________________ Is Current pregnancy with the same partner? Yes No

Other information: ____

Date of delivery: ____ / ____ / ____ Outcome & Gender: __________ Mode of Delivery: __________ Birthweight: __________ kg

Place: __________________________ Baby Hb at Delivery: __________ Phototherapy: Yes No Exchange Transfusion: Yes No

IUT: Yes No If yes, gestation (s) ________________________________ Is Current pregnancy with the same partner? Yes No

Other information: ____

Date of delivery: ____ / ____ / ____ Outcome & Gender: __________ Mode of Delivery: __________ Birthweight: __________ kg

Place: __________________________ Baby Hb at Delivery: __________ Phototherapy: Yes No Exchange Transfusion: Yes No

IUT: Yes No If yes, gestation (s) ________________________________ Is Current pregnancy with the same partner? Yes No

Other information: ____

Other relevant history and/or previous pregnancies

Investigations: Blood Testing

Paternal Testing					
	Date sample taken	Date result received	Result	Action	Signature
ABO RhD Group					
Genotype					
Phenotype					

Fetal DNA Testing					
	Date sample taken	Date result received	Result	Action	Signature
Free Fetal DNA					
Amniocentesis (DNA)					

	Maternal Antibody Testing				
Date sample taken	Date result received	Antibody Specificity	Titre &/or Quantification	Action	Signature

Other relevant information / test results:

Investigations: Ultrasound Scanning

Date & Gestation	Result	Action	Signature
	PSV: MoM:		
	PSV: MoM:		
	PSV: MoM:		
	PSV: MoM:		
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	PSV: MoM:		
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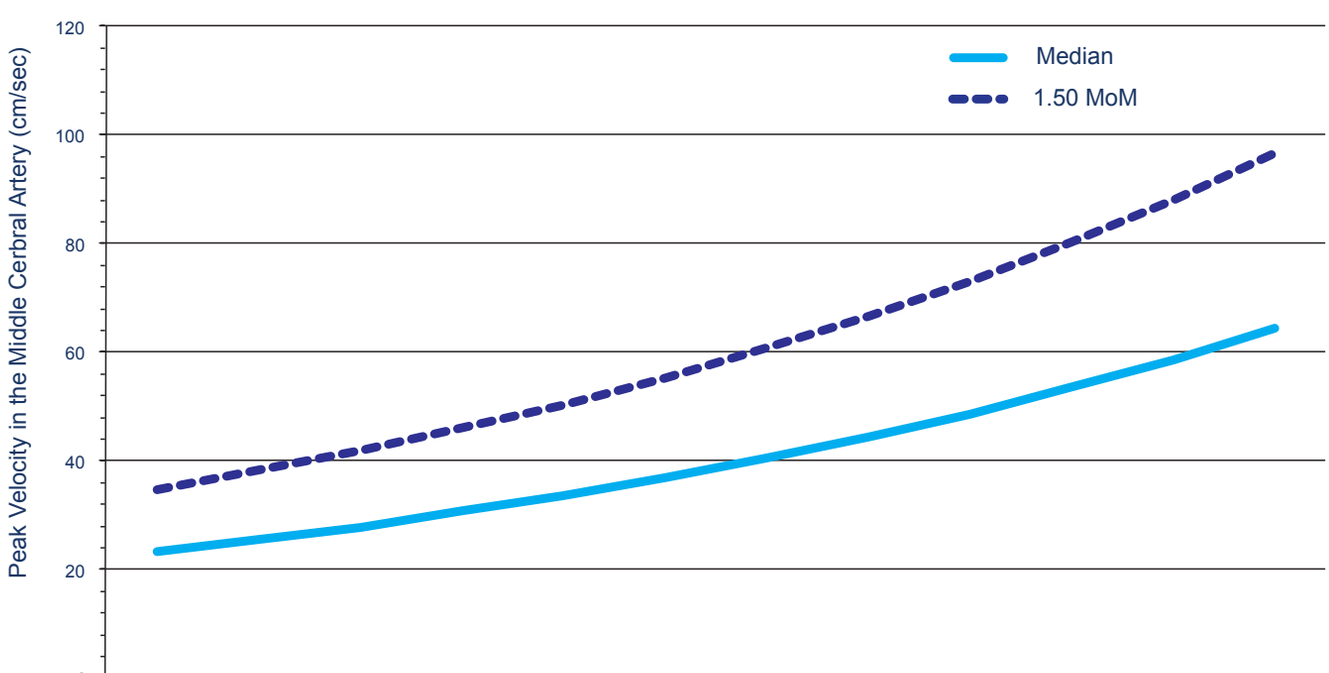

	18wk	20wk	22wk	24wk	26wk	28wk	30wk	32wk	34wk	36wk	38wk	40wk
Median	23.2	25.5	27.9	30.7	33.6	36.9	40.5	44.4	48.7	53.5	58.7	64.4
1.50 MoM	34.8	38.2	41.9	46	50.4	55.4	60.7	66.6	73.1	80.2	88	96.6

Gestational Age (weeks)

Treatment

Intra-Uterine Transfusions

Date: ____ / ____ / ____ Gestation: __________ Pre-IUT Haematocrit / Hb: __________ Volume Transfused: __________ mls

Action Plan & Post IUT Monitoring
(Include investigations, frequency & Planned future action): ______________________________

Date: ____ / ____ / ____ Gestation: __________ Pre-IUT Haematocrit / Hb: __________ Volume Transfused: __________ mls

Action Plan & Post IUT Monitoring
(Include investigations, frequency & Planned future action): ______________________________

Date: ____ / ____ / ____ Gestation: __________ Pre-IUT Haematocrit / Hb: __________ Volume Transfused: __________ mls

Action Plan & Post IUT Monitoring
(Include investigations, frequency & Planned future action): ______________________________

Date: ____ / ____ / ____ Gestation: __________ Pre-IUT Haematocrit / Hb: __________ Volume Transfused: __________ mls

Action Plan & Post IUT Monitoring
(Include investigations, frequency & Planned future action): ______________________________

Date: ____ / ____ / ____ Gestation: __________ Pre-IUT Haematocrit / Hb: __________ Volume Transfused: __________ mls

Action Plan & Post IUT Monitoring
(Include investigations, frequency & Planned future action): ______________________________

Date: ____ / ____ / ____ Gestation: __________ Pre-IUT Haematocrit / Hb: __________ Volume Transfused: __________ mls

Action Plan & Post IUT Monitoring
(Include investigations, frequency & Planned future action): ______________________________

Delivery Plan

Planned Mode, Date & Place of Delivery: (Remember to inform your BTS blood bank when a decision is made)	
Compatible blood requested for maternal and/or neonatal transfusion? Yes No NB: Please request irradiated blood for intrauterine or neonatal transfusion. Comments: _____	Is there an increased risk of maternal Blood transfusion eg. placenta praevia? Yes No Has any increased risk/transfusion Requirement been discussed with BTS? Yes No Comments: _____

On Admission in Labour or for Delivery	
Please inform:	
Obstetric Team	Signature: _____
Neonatal Team/Unit	Signature: _____
Blood Transfusion Service (your laboratory)	Signature: _____
Please send a Maternal Group and Screen	Signature: _____
Any other instructions on admission: _____	

Special Instructions at Delivery	
Cord bloods (please circle those required) FBC DAT ABO RhD Grouping Serum Bilirubin Other: _____	Signature: _____
Maternal Bloods Group & Screen Other: _____	Signature: _____

Paediatrician to be present? Yes No
If not present at delivery, a paediatrician should assess the newborn as soon as is practical

Any other special instructions at delivery: _____

Special Instructions for Neonatal Period (to be completed by paediatrician at delivery)				
Repeat serum bilirubin in	_____ hours	Yes	No	Review (please circle)
Phototherapy to commence within	_____ hours	Yes	No	Review (please circle)
Folic Acid before discharge	_____ hours	Yes	No	Review (please circle)

Other instructions for the neonatal period: _____

Pregnancy Outcome

It is vital that we are able to audit the outcome of sensitised pregnancies in order to provide the best possible care in the future. Please complete this information as soon as is practical.

Date of delivery: ____ / ____ / ____ **Gestation**: _____ **Place of Delivery**: _____

Mode of Delivery: Planned C/S Emergency C/S SVD Forceps/Ventouse Spontaneous Breech
(please circle one)

Maternal Blood Transfusion: (during this pregnancy, delivery or postnatal period) Yes No

Outcome: Live birth Stillbirth / IUD NND

Gender: Male Female **Birthweight**: _____ Kg

Hb taken at at delivery? Yes No **Result**: _____ **Sample source**: Cord Venous

HDN / Treatment required: No HDN apparent Clinical signs of HDN but no treatment
(please circle all that apply) Phototherapy Admission to Neonatal Unit
Top – Up Transfusion Exchange Transfusion

Neonatal Unit where treated: _____

Any other comments or relevant information: _____