

South West Congenital Anomaly Register Notification Form

Please notify any suspected or confirmed anomaly – structural, chromosomal or biochemical – diagnosed antenatally, at birth or in childhood

Office Use

/

Mother's Details

Surname		Forename(s)		
Address in pregnancy				Postcode
Date of Birth	<i>dd/mm/yy</i>	NHS number		
Booking hospital				Hospital no.
Referred to hospital				Ref. Hospital no.
Ethnic Origin	White British	White Irish	White European	White Other
	Black African	Black Caribbean	Black Other	Chinese
	Indian	Pakistani	Bangladeshi	
	Mixed <i>please specify</i>		Other <i>please specify</i>	
	Occupation			

Details of Pregnancy

Last menstrual period	EDD by scan			No. of fetuses
Assisted conception	Yes	No	Not Known	Twin Type
<i>If yes give details</i>				<i>Other</i>

Outcome of Pregnancy

<i>Please tick all that apply</i>			Date end of Pregnancy		
Liveborn	Termination		Gestation at delivery		/40
Miscarriage / IUD (<24/40)	Feticide performed		Date of death <i>(if applicable)</i>		
Stillbirth / IUD (≥24/40)	<i>date of feticide</i>		Post Mortem	Yes	No
Continuing Pregnancy	TOP likely			Not known	Not requested

Fetus/Baby Details

Surname		Forename(s)				
Sex	F	M	Indeterminate	Not known	Birth order	Birth weight
Place of delivery	Hospital	Home	In transit	NHS no.		
Hospital of delivery				Hospital no.		
Mother's address at delivery				Postcode		

Skip to: [antenatal information \(p2\)](#) [antenatal tests \(p3\)](#) [anomaly details \(p4\)](#)

Father's Details

Occupation Age years

Family History

Anomalies Mother's side	Yes	No	N/K	<i>Details</i>
Anomalies Father's side	Yes	No	N/K	<i>Details</i>
Consanguinity	Yes	No	N/K	<i>Details</i>

Mother's Obstetric History

No. previous babies	Livebirths	Stillbirths ≥24/40	Miscarriages <24/40
	Terminations	Not Known	

How many of above were twins? Gravida, if no other details known

History of anomalies in previous pregnancies	Yes	No	N/K
<i>Details</i>			

Height	cm	Weight	kg	BMI
--------	----	--------	----	-----

Maternal Risk Factors

Alcohol	Yes	No	N/K	<i>If yes, details</i>			
Smoker	Yes	No	N/K	If yes, how many per day?	<11	11-20	
				If no, ex-smoker?	>20	N/K	
Drug Abuse	Yes	No	N/K	<i>If yes, details</i>			
Prescribed Drugs	Yes	No	N/K	<i>If yes, details</i>			
Folic Acid	Yes	No	N/K	<i>If yes, when started?</i>	Preconceptionally		
				1-4 wks	5-12 wks	>12 wks	N/K
Epilepsy	Yes	No	N/K	<i>If yes, details</i>			
Diabetes	Yes	No	N/K	<i>If yes, what type?</i>	Insulin-dependent	Non insulin-dependent	
				Gestational - insulin	Gestational - diet	Gestational – not known	
Other significant maternal illness	Yes	No	N/K	<i>If yes, details</i>			

Further details on any of the above / any other relevant details (e.g. exposures to potentially harmful substances)

Skip to: [patient details \(p1\)](#) [antenatal tests \(p3\)](#) [anomaly details \(p4\)](#)

Antenatal Investigations

Screening and diagnostic tests

Date	Test (please tick)	Results / outcome
	Nuchal only	Raised measurement mm
	Serum screening only	Down's Risk 1 in 1-99000
	Combined	Tri 13/18 risk 1 in 1-99000
	Cell-free fetal DNA	Normal result
	Yes – method not known	Not offered Declined
	<i>Further detail if known</i>	

Date	Sample	Technique	Results / outcome
	CVS	FISH/PCR	Normal Abnormal
	Amnio	MLPA	State karyotype if known
	FBS	Array - CGH	
		Genetic	Not offered Declined

Details of antenatal scans – please include early, 20/40, and later scans

Date	Test
	Early USS 20/40 USS FMU scan Echo MRI
	Early USS 20/40 USS FMU scan Echo MRI
	Early USS 20/40 USS FMU scan Echo MRI

Further antenatal investigation details, if relevant

Please state any other relevant information (e.g. further investigations / follow up needed / booked)

Skip to: [patient details \(p1\)](#) [antenatal information \(p2\)](#) [anomaly details \(p4\)](#)

Anomalies

Please include all suspected and confirmed anomalies. Attach additional sheets as required

Anomaly 1

Anomaly description	First Suspicion	Confirmation
	Date	Date
	If date not known, when?	How confirmed?
	Antenatal	Postnatal
	At birth	Childhood
		clinical exam USS xray surgery
		Post Mortem karyotype echo other
		<i>Details</i>

Anomaly 2

Anomaly description	First Suspicion	Confirmation
	Date	Date
	If date not known, when?	How confirmed?
	Antenatal	Postnatal
	At birth	Childhood
		clinical exam USS xray surgery
		Post Mortem karyotype echo other
		<i>Details</i>

Anomaly 3

Anomaly description	First Suspicion	Confirmation
	Date	Date
	If date not known, when?	How confirmed?
	Antenatal	Postnatal
	At birth	Childhood
		clinical exam USS xray surgery
		Post Mortem karyotype echo other
		<i>Details</i>

Anomaly 4

Anomaly description	First Suspicion	Confirmation
	Date	Date
	If date not known, when?	How confirmed?
	Antenatal	Postnatal
	At birth	Childhood
		clinical exam USS xray surgery
		Post Mortem karyotype echo other
		<i>Details</i>

Returning the form

Person completing the form

Job title

Hospital

Tel.

Date

NOTE: Completed forms returned via email will ONLY be accepted if sent to our NHS.NET email – phe.swcar@nhs.net

Please save the PDF to your computer and use your own NHS.NET email account to attach and send it. If sending by post, please return your printed copy to:

SWCAR, Public Health England, 3rd Floor, 2 Rivergate, Bristol BS1 6EH. Tel. 0117 906 9079