Strengthening Maternal and Child Health Services in Eastern Visayas

BEmONC ASSESSMENT TOOL FOR ANTENATAL CARE

Name of facility

FAMILY RECORD NO.: _____ PHILHEALTH NO.: _____

NAME: _____ DATE OF BIRTH: _____ AGE: _____ ADDRESS: _____

CIVIL STATUS: _____ NAME OF HUSBAND: _____

OBS. HISTORY: G ___ P ___ (F ___ P ___ A ___ L ___) LMP: _____ EDC: _____ BLOOD TYPE: _____

	ASSESS (Instructions: put (✓) if yes, (X) if No, N/A for not applicable)	CLASSIFY			
1	**QUICK CHECK: (B2) / RAM (B3 TO B7)**	1st Visit	2nd Visit	3rd Visit	4th Visit
	● ASK, LOOK, LISTEN AND FEEL Date:	/ /	/ /	/ /	/ /
	● Is the woman being wheeled, carried or has any of the following?	☐	☐	☐	☐
	Note down in the column on the right, if any				
	• bleeding vaginally • severe headache				
	• convulsing • blurred vision				
	• looking very ill • in severe abdominal pain / epigastric pain				
	• unconscious				
	• severe pallor				
	• very difficult breathing and/or central cyanosis				
	• cold moist skin and/ or weak and fast pulse				
	• ruptured membranes				
	• in labor				
	• delivery is imminent				
	● CHECK VITAL SIGNS:				
	• Respiratory Rate (per minute)	_____	_____	_____	_____
	• Blood Pressure * If diastolic BP is >=90 mmHg, re-evaluate (see 5)	_____	_____	_____	_____
	• Pulse Rate (per minute)	_____	_____	_____	_____
	• Temperature	_____	_____	_____	_____
2	ASK CHECK RECORD (C2)				
	FIRST VISIT - PAST OBSTRETICAL HISTORY				
	• Ask LMP and calculate EDC (write down in the ID part, above)				
	• Ask obstetrical history (write them down in the ID part above)				
	• Age of Menarche:	_____			
	• Date of last delivery:	_____			
	• Prior caesarian section, (check for the scar)	☐			
	• Prior instrumental delivery	☐			
	• Prior third degree tear	☐			
	• Heavy bleeding during or after delivery	☐			
	• Convulsions	☐			
	• Stillbirth or death in the first day specify _____	☐			
	PAST MEDICAL CONDITION				
	● Ask for medical conditions (Diabetes, Hypertension, TB, Asthma, Heart conditions) Specify. If none, write down NONE.	_____			
3	**ALL VISITS (C2)**				
	• Age of gestation in weeks	_____	_____	_____	_____
	• Where do you plan to deliver (check Birth/Em.plan)	_____	_____	_____	_____
	• Any vaginal bleeding since last visit?	☐	☐	☐	☐
	• Is baby moving? (after 16 weeks)	☐	☐	☐	☐
	• Fundic height (cm)	_____	_____	_____	_____
	• Weight (kg)	_____	_____	_____	_____
	• Edema (-/+/++)	_____	_____	_____	_____
	• Do you have any concerns? Specify: If none, write down NONE.	_____	_____	_____	_____
4	**THIRD TRIMESTER (C2)**				
	* Multiple pregnancy?	☐	☐	☐	☐
	* Check for presentation	_____	_____	_____	_____
	* Fetal Heart Rate (beats per minute)	_____	_____	_____	_____
	* Transverse lie/breech?	☐	☐	☐	☐
	* Has she been counseled on family planning?	☐	☐	☐	☐
	If yes, please specify what method: _____	_____	_____	_____	_____

	ANTENATAL CARE ASSESS	CLASSIFY			
		1st Visit	2nd Visit	3rd Visit	4th Visit
5	**CHECK FOR PRE-ECLAMPSIA （C3)** ● ASK, CHECK RECORD (Refer to page 1 for Blood Pressure) ● LOOK, LISTEN, FEEL * If diastolic BP is >=90 mmHg, repeat after 1 hour rest * If diastolic BP is still >=90 mmHg, ask the woman if she has; - Severe headache/blurred vision/Epigastric pain * Check protein in urine(-/+/++)				
6	**CHECK FOR ANEMIA （C4)** ● ASK, CHECK RECORD ・ Hgb measured? (If so, write down the value) ・ Do you get tired easily? ・ Are you breathless (short of breath) during routine household work? ● LOOK, LISTEN, FEEL * Look for conjunctival and palmar pallor. Are they pale? * Is the RR more than 30/min?				
7	**DOES THE PATIENT HAVE ONE OF THE FOLLOWING** OBSERVED SIGNS OR VOLUNTEERED PROBLEMS? ・ No fetal movement (C7) ・ Ruptured membranes and no labor (C7) ・ Fever and/or burning in urination (C8) ・ Vaginal discharge (C9) ・ Coughing or difficulty in breathing (C11) ・ Taking Anti-TB Drugs (C11) ・ Smoking, alcohol or drug abuse or history of violence (C10) ・ Signs suggesting HIV infection (C6/C10) or syphilis (C5) ・ Current medical condition (DM, HPN, TB, Asthma, Cardiac condition) Specify:				
8	**PHISICAL EXAMINATION FINDING** ● Check for Nutrition, Skin. Head and Neck, Heart and Lungs, Breasts/ Nipples, Extremities, and write down any abnormal findings				
9	**OTHER LABORATORY FINDINGS**				
10	**ASSESS FOR OTHER PROBLEMS:** ・ For women with special needs (H1-H4)				
11	**INFORM AND COUNSEL ON HIV (G2-G8)** ・ Provide information on HIV and counsel on VCT (G2/G3) ・ If HIV positive, counsel on infant feeding choice (G7,G8)				
12	**PREVENTIVE MEASURE (C12)** * Tetanus Toxoid given (TT1 - TT5) - pls specify * No. of Iron/Folate tabs given * Oral health (Examination and prophylaxis, at least once)				
13	**ADVICE/COUNSELLING** ・ Self-care （C13) (M2) ・ Nutrition （C13) ・ Routine and follow-up visits (C17)(M2) ・ Advice on labour and danger signs (C15)(M9)(M2) ・ Breastfeeding (K2-K8) ・ Newborn screening (J12)				
14	**DEVELOP AND ATTACH BIRTH AND EMERGENCY PLAN （C14) (M3)**				

15	OVERALL ASSESSMENT	Management (Treatment/Advice)
1st		
2nd		
3rd		
4th		

16	**DATE OF NEXT VISIT' (AGREED UPON WITH THE WOMAN)**	/ /	/ /	/ /	/ /
17	**ASSESSMENT DONE BY: (write your name)**				

* Record relevant findings/management to the Mother and Child Book.