Public Health England

OFFICIAL – SENSITIVE

# National Congenital Anomaly and Rare Disease Registration Service (NCARDRS)

## Data collection form – Delivery/Postnatal

Please notify any suspected or confirmed anomaly identified – structural, chromosomal or biochemical.

**DO NOT WAIT until final confirmation before sending this form.**

Authorised under Section 251 of the NHS Act 2006 to collect information without patient consent (CAG 10-02(d)2015)

For office use only

### MOTHER'S DETAILS

(Sticky label, if available)

Surname:

Forename:

Hosp. no:

NHS no:

Address at booking:

Postcode: Date of birth:

Ethnic category: ◯ White ◯ Mixed ◯ Indian ◯ Pakistani ◯ Bangladeshi ◯ Other Asian* ◯ Black Caribbean ◯ Black African ◯ Other Black* ◯ Chinese ◯ Other* ◯ Not known

*If other, please state:

Occupation:

### BABY'S DETAILS

(Sticky label, if available)

Surname:

Forename(s):

Hosp. no:

NHS no:

Address at birth:

Postcode:

Date of birth:

Sex: ◯ Male ◯ Female ◯ Indeterminate ◯ Not known

### BIRTH DETAILS

Place of delivery:

Type of delivery: ◯ Spont. vertex ◯ Spont. other ◯ Low forceps ◯ Other forceps ◯ Ventouse ◯ Breech ◯ Breech extraction ◯ Elective CS ◯ Emergency CS ◯ Other, specify ◯ Not known

Birth weight: g Birth order: of

### OUTCOME DETAILS

Outcome: ◯ Live birth ◯ Stillbirth (24+ weeks) ◯ Fetal loss (<24 weeks) ◯ Termination of preg. (<24 weeks) ◯ Not known

Termination of pregnancy: ◯ Medical TOP ◯ Surgical TOP ◯ Yes – unknown method ◯ No ◯ Not known

Feticide: ◯ Yes ◯ No ◯ Not known

If yes, date:

### DEATH DETAILS (if applicable)

Date of death:

Post mortem: ◯ Yes ◯ Not requested ◯ Not permitted ◯ Requested but not performed ◯ Not known

### NOTIFIER DETAILS

Name:

Hospital:

Department:

Email:

Tel: Date:

### ANOMALY DETAILS – LIST ALL

| Anomaly | Suspected prenatally | How confirmed? E.g. cytogenetics, x-ray, PM |
|---|---|---|
| | ◯ Yes ◯ No | Date confirmed |
| | ◯ Yes ◯ No | Date confirmed |
| | ◯ Yes ◯ No | Date confirmed |
| | ◯ Yes ◯ No | Date confirmed |
| | ◯ Yes ◯ No | Date confirmed |
| | ◯ Yes ◯ No | Date confirmed |
| | ◯ Yes ◯ No | Date confirmed |
| | ◯ Yes ◯ No | Date confirmed |

### PROCEDURE DETAILS (if applicable)

| Date/age performed/ expected | Department/ Doctor | Procedure |
|---|---|---|
| | | |

### BABY'S REFERRAL DETAILS

Department/Hospital:

Consultant:



*Form continues on next page*

## BOOKING DETAILS

Date of 1st booking appointment:

Booking hospital:

EDD:

Height: cm Weight: kg BMI:

Smoking status: ◯ Current ◯ Ex ◯ Non ◯ Never ◯ Not known

Weekly alcohol units at booking:

Substance use at booking: ◯ Yes ◯ No ◯ Not known

If yes, substance:

Prescription drugs (1st trimester) inc. dose:

Maternal illnesses:

Folic acid: ◯ Pre and post conception ◯ Post conception only ◯ Taken, timing unknown ◯ Not taken ◯ Not known

If taken, dose: ◯ Standard 400mcg ◯ High 5mg

Assisted conception: ◯ Yes ◯ No ◯ Not known

If yes, type: ◯ Ovulation induction ◯ IVF ◯ ICSI ◯ Not known

Number of previous live births:

Number of previous stillbirths (24+ weeks, incl. TOPs):

Number of previous losses (<24 weeks, incl. TOPs):

Number of previous neonatal deaths:

Previous congenital anomalies:

Father's age at booking: years

Family history of anomalies:

Maternal:

Paternal:

Consanguinity: ◯ No ◯ Yes, 1st cousin ◯ Yes, 2nd cousin ◯ Yes, other ◯ Yes, relation nk ◯ Not known

## PREGNANCY DETAILS

Number of fetuses:

Twin type/chorionicity:

## ADDITIONAL DETAILS

Use this box to extend answers or include any extra information you think is relevant

## ANEUPLOIDY SCREENING DETAILS

Date (specimen) Test | Result

◯ Combined | ◯ Accepted

T21 risk:1 in T13/18 risk: 1 in

◯ Quad | ◯ Declined ◯ Not offered Reason

◯ NIPT | ◯ Positive ◯ Negative ◯ Inconclusive

Risk: 1 in

## DIAGNOSTIC TEST DETAILS

Date (procedure) Sample | Result

◯ CVS | ◯ Normal ◯ Abnormal ◯ Declined

◯ Amnio | ◯ Offered ◯ Not offered Reason

◯ Fetal blood | ◯ Other, specify:

Karyotype/microarray:

## ANTENATAL SCAN DETAILS

1st trimester (dating) scan:

Date

USS findings *(attach report)*

◯ Normal ◯ Abnormal ◯ Incomplete

NT measurement mm

Fetal anomaly ($18^{+0}$ – $20^{+6}$) scan:

1st attempt

Date

USS findings *(attach report)*

◯ Normal ◯ Abnormal ◯ Incomplete ◯ Not known

◯ Not done, give details:

2nd attempt

Date

USS findings *(attach report)*

◯ Normal ◯ Abnormal ◯ Incomplete

◯ Not done, give details:

Echo/MRI/Other:

Date

Findings *(attach report)*

**Please attach copies of any relevant scans/clinic letters/laboratory or post mortem reports.**

Please send by secure electronic transfer to your regional NCARDRS office. Details of each regional NCARDRS office can be found at www.gov.uk/phe/ncardrs.

Click to lock all form fields and prevent future editing