OFFICIAL – SENSITIVE

Public Health England

National Congenital Anomaly and Rare Disease Registration Service (NCARDRS)

Data collection form – Antenatal

Please notify any suspected or confirmed anomaly identified antenatally – 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:

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:

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

ANEUPLOIDY SCREENING DETAILS

Date (specimen) Test: ◯ Combined ◯ Quad
Result: ◯ Accepted T21 risk:1 in T13/18 risk: 1 in ◯ Declined ◯ Not offered Reason

Date (specimen) Test: ◯ NIPT
Result: ◯ Positive ◯ Negative ◯ Inconclusive Risk: 1 in

DIAGNOSTIC TEST DETAILS

Date (procedure) Sample: ◯ CVS ◯ Amnio ◯ Fetal blood
Result: ◯ Normal ◯ Abnormal ◯ Declined ◯ Offered ◯ Not offered Reason ◯ 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)*

REFERRAL DETAILS

Department/Hospital:
Consultant:

ADDITIONAL DETAILS

Use this box/back of the form to extend answers or include any extra information you think is relevant

NOTIFIER DETAILS

Name:
Hospital:
Department:
Email:
Tel: Date: