AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

# Elective Caesarean Booking Form

**MUST ATTACH PATIENT LABEL HERE**

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

**Please ensure you attach the correct visit patient label**

**Referring doctor to complete, scan and email to Scheduler: caesarean@adhb.govt.nz**

**Today's Date** _____/_____/_____

**Estimated due date (EDD)** _____/_____/_____

**Gestational age for requested CS** _____ weeks

**If < 39 weeks, reason:** _____

**Proposed procedure**

- ☐ Lower segment caesarean
- ☐ Other _____

**LMC Name:**

Mobile:

- ☐ Self Employed Midwife
- ☐ Hospital Midwife; team _____
- ☐ Private obstetrician

**Specialist responsible for Caesarean decision:**

**Primary indication for Caesarean:**

- ☐ Primary, maternal request
- ☐ Breech, presentation
  - ECV offered? ☐ Yes ☐ No
  - If no, why not? _____
- ☐ Placenta accreta
- ☐ Placenta praevia
  - ☐ anterior ☐ posterior
- ☐ Maternal medical condition _____
- ☐ Fetal condition _____
- ☐ Previous caesarean
  - ☐ 1 previous; maternal request
  - ☐ > 1 previous
  - ☐ Other: _____
- ☐ Multiple pregnancy:
  - ☐ first baby cephalic; maternal request
  - ☐ first baby non-cephalic
- ☐ Other:

Surgical, medical or anaesthetic risks? _____

_____

Paediatrics needed at time of birth? ☐ Yes ☐ No Reason: _____

☐ Caesarean pamphlet provided Interpreter needed? ☐ Yes ☐ No

Language: _____

**Staff use only**

- ☐ Confirmed Booked CS Date _____ Time _____ Surgeon _____
- ☐ Scheduler to book date/time 6 weeks ahead and inform referring doctor or LMC
- ☐ Requires clinical review

ELECTIVE CAESAREAN BOOKING FORM

CR2952