AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct visit patient label

Elective Caesarean Booking Form

Referring doctor to complete and email to scheduler: caesarean@adhb.govt.nz

Today's date:
Estimated due date (EDD):
Gestational age requested for CS: weeks
If <39 weeks, reason:
Proposed procedure:
☐ Lower segment caesarean
☐ Other:

G:
P:

☐ First request
☐ Second request

Double slot needed
☐ Yes ☐ No

LMC name:
Mobile:
Team:

☐ Self-employed midwife
☐ Hospital midwife
☐ Private obstetrician

SMO responsible for booking:

PRIMARY INDICATION FOR CAESAREAN

☐ Previous caesarean
- ☐ 1 previous; maternal request
- ☐ >1 previous
- ☐ Other:

☐ Breech presentation
ECV booked ☐ Yes ☐ No
If no, why not:

☐ Placenta accreta

☐ Placenta pracevia
- ☐ anterior ☐ posterior

☐ Maternal medical condition:

☐ Fetal condition:

☐ Multiple pregnancy
- ☐ MCDA ☐ DCDA
- ☐ first baby cephalic; maternal request
- ☐ first baby non-cephalic
- ☐ triplets

☐ Primary, maternal request

☐ Other:

MATERNAL MEDICAL CONDITIONS

☐ MMH (stay >2 days in PN ward)
☐ Diabetes
- ☐ Type 1
- ☐ Type 2
- ☐ GDM

☐ Anaemia:
☐ Research trial
- ☐ Collect cord blood

☐ Other
☐ Allergies:

Surgical, medical or anaesthetic risks?:
☐ Caesarean pamphlet provided

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

Form completed by:

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

Received:
☐ PAC:
☐ PIMS
☐ CMS

ELECTIVE CAESAREAN BOOKING FORM

SINGLE SIDED FORM – Reverse not scanned
DO NOT DOCUMENT CLINICAL NOTES ON BACK