

CAROBB NOTIFICATION FORM

Office use only - Case no

Congenital Anomaly Register for Oxfordshire, Berkshire and Buckinghamshire

Please register any actual OR prenatally suspected anomaly - structural, chromosomal or biochemical in fetus/baby. (See reverse of form for more information about the register and exclusion list)

Dup	Com	From
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MOTHER DETAILS

(Sticky label, if available)

Surname.....

Forename.....**Hosp No**.....

NHS Number.....

Postcode
(essential field)

Mother's DoB
(essential field)

Booking hosp.....

To deliver at.....
(if different from booking hospital)

EDD
(essential field)

Mother BMI..... **Smoker in 1st trim?** Y / N
(At booking. Or height & weight)

Assisted conception / IVF?.....
If yes, (please state method, if known)

No of previous pregnancies/births

.....Livebirth Miscarriage/TOP (<24 weeks) Stillbirth/TOP (>24 weeks)

Ethnic origin of mother *(pls circle or state)*.....

White	Pakistani	Black Caribbean	Chinese
Mixed	Bangladeshi	Black African	Other
Indian	Other Asian	Other Black	Not known

BABY DETAILS

(Sticky label, if available)

Surname.....

Forename.....**Hosp No**.....

NHS Number.....

Sex Male / Female / Ambiguous / Not known
(please circle)

Date of delivery / TOP
(and date of feticide if performed)

Place of delivery.....

Gest at delivery.....weeks

Weight g Not weighed

Multiple pregnancy?.....**Zygosity:**MCMA / MCDA / DCDA

Outcome *(when possible, please report date of delivery, gest, sex, weight and details of any anomalies, whatever the outcome)*

- Liveborn, no anomaly identified, no follow up requested
- Liveborn, anomaly present or req' further tests *(please give details)*
- Miscarriage/IUD (<24 weeks)
- Stillbirth/IUD (>24 weeks)
- Termination
- Neonatal death
 Date of neonatal death

Post mortem? Yes / No / Not known

PRENATAL INVESTIGATIONS

Screening and Diagnostic tests

Gest	Test <i>(please circle)</i>	Result
.....	Nuchal / Combined	NT measurementmm Down's risk 1 in
.....	Triple / Quad	Tri 13 / 18 risk 1 in
.....	Other	Not offered / Declined / Too late
.....	CVS / Amnio	Normal / Abnormal <i>(state karyotype if known)</i>
.....	FISH / PCR	Offered / Not offered / Declined
.....	Other <i>(please state)</i>	

Gest **Ultrasound scan findings** (& any other relevant details)

Anomaly scan undertaken? *(please circle)*
..... Yes / Declined / Not offered / Late booker.....

POSTNATAL DETAILS OF ANOMALY

Prenatally suspected? Yes No

Surgery? Performed / Expected in 1st year / Expected after 1st year

Additional details *(eg previous congenital anomalies, illness in mother, exposure to potentially harmful substances)*

Referred to:.....

Consanguinity? 1st cousins / other relation.....
(if applicable, please circle / state)

Notified by:.....Date:.....Hospital:.....Dept:.....Tel:.....