SCHEDULE 4 Regulation 43(5)

PART 1

Details to be Recorded in Respect of Patients Receiving Obstetric Services

1. The date and time of delivery of each patient, the number of children born to the patient, the sex of each child and whether the birth was a live birth or a stillbirth.

2. The name and qualifications of the person who delivered the patient.

3. The date and time of any miscarriage occurring in the hospital.

4. The date on which any child born to a patient left the hospital.

5. If any child born to a patient died in the hospital, the date and time of death.

PART II

Details to be Recorded in Respect of a Child Born in an Independent Hospital

6. Details of the weight and condition of the child at birth.

7. A daily statement of the child's health.

8. If any paediatric examination is carried out involving any of the following procedures—

(a) examination for congenital abnormalities including congenital dislocation of the hip;

(b) measurement of the circumference of the head of the child;

(c) measurement of the length of the child;

(d) screening for phenylketonuria;

(e) screening for congenital hypothyroidism;

(f) screening for cystic fibrosis;

(g) screening for sickle cell disease;

(h) screening for medium-chain acyl-CoA dehydrogenase deficiency;

details of such examination and the result.