MRFM

MANAGEMENT OF ALTERED FETAL MOVEMENTS UHDB August 2023

Insert patient sticker or complete:

Name:

Date of birth:

Hospital number:

Arrival: ……..
Referred from: ……..
Midwife: ……..
Consultant: ……..
Previous PAU admissions: …….....
Previous Altered movements episodes: ……...
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Date	Time	Grav/Par	EDD	Gestation	BloodGr/Rh	Allergies	BMI

Maternal Perception of movements: ☐ reduced ☐ changed ☐ absent
How long has there been RFM?
Is this the first episode in last 21 days (from 26 weeks)?
When were movements last felt:

Additional symptoms:

Vaginal loss:	Pain:

	Pre-existing risk factors	Risk factors identified in this pregnancy
Obstetric		
Medical		
Lifestyle		

Any risk factor related to altered fetal movements identified as listed in guideline: YES / NO

If yes state:
If yes: for senior doctors review (SpR 3-7 or higher)

Last Ultrasound scan:

Next scan appointment i/a:

BP	Pulse	Sats	RR	Temp	Urinalysis	Oedema	Pres/lie	PP/brim	SFH	FHR

Signs of infection: ☐ NO ☐ YES Amber or Red scores on Meows: ☐ NO ☐ YES:……..
Consider SEPSIS if signs of infection, fetal tachycardia or unwell

Name: …….. Designation: …….. Signature: ……

ANY abnormal findings in the presence of reduced fetal movements prompts immediate senior doctors review

Patient name: Hospital number:

A cCTG must be performed on any pregnancy, presenting with reduced fetal movements ≥26 weeks as per guideline

USS for fetal growth, liquor volume and umbilical Doppler should be offered (unless a growth scan has been carried out within the last 2 weeks) if:

- First episode of RFM in the presence of an additional indication such as a suspected fetal growth disorder (including static or reduced SFH); maternal perception of fetal movements not restored. (this is not an exhaustive list)
- Presenting with recurrent episode of RFM (second episode within 21 days from 26 weeks gestation)

See Induction of Labour framework for guidance on timing of delivery for pregnancies where RFM has been reported.

Has Fetal Growth been assessed: ☐ Yes, on SFH chart ☐ Yes, on USS chart ☐ NO

Midwifery notes and CTG review:

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Perception of fetal movements restored on discharge: ☐ Yes ☐ No

Advised to re-attend *promptly* when recurrent reduced/altered movement: ☐ Yes

Care on discharge: MLC / CLC Next appointment: Date: …….. Location: ……..

Ultrasound scan appointment: ☐ Yes: date: …… ☐ N/A

Medical review completed: ☐ Yes, level …… ☐ Not indicated

Discharged: Date:……... Time: ……..

Name: …… Designation: …….. Signature ……..