MANAGEMENT OF PAIN & BLEEDING IN EARLY PREGNANCY - CLINICAL GUIDELINE

1. Aim/Purpose of this Guideline
All clinical staff working in the Division of women, children & sexual health to provide evidence based guidance in the management of pain & bleeding in early pregnancy

2. The Guidance
The majority of women who experience pain & bleeding in early pregnancy can be managed on an outpatient basis and seen in the Early Pregnancy Unit (EPU) - see referral criteria and guideline below.
All women should be offered an appointment and scan within 24 hours of presentation.
If the woman is referred to the ward / seen in A&E as an emergency, a full assessment must be made.

All women have initial observations done:
- Pulse
- Blood pressure
- Urine pregnancy test (if unable to pass urine and haemodynamically unstable, obtain a catheter specimen of urine) see RCHT Pregnancy Testing Protocol

Haemodynamically unstable:
If a woman is haemodynamically unstable and you suspect a miscarriage (heavy bleeding with lower abdominal cramps):

- Basic resuscitation (ABC)
- IV access (18 Gauge cannula)
- FBC
- Group & Cross match
- Speculum examination to exclude products of conception stuck at the cervical os (causing a vagal response) that can be removed and sent to histology with relevant documentation completed
  1) Written consent for sensitive disposal filed in notes (Appendix 4)
  2) Specimen accompanied with signed cremation form (Appendix 5)

If a woman is haemodynamically unstable and you suspect an ectopic pregnancy (minimal bleeding and severe lower abdominal pain / acute abdomen):

- Basic resuscitation (ABC)
- IV access (18 Gauge cannula)
- FBC
- Group & Cross match
• IV fluids
• Inform consultant on call
• Arrange immediate transfer to theatre for laparoscopy +/- laparotomy.

Haemodynamically stable:

If the woman is haemodynamically stable, a full assessment must be made to calculate gestation and assess symptoms:

Minimum history taken:

• First day of last menstrual period
• Cycle length and regularity
• Certainty of dates
• Date of first +ve pregnancy test
• Symptoms this pregnancy (pain / bleeding) and quantify this
• Current / recent contraception methods
• Past obstetric history (especially history of previous miscarriages / ectopics and how they were managed)
• Past gynaecological history (history of infertility, PID, tubal / pelvic surgery)

Examination (document the name of chaperone):

• Abdominal examination
• Speculum (document presence or absence of blood or pregnancy tissue, appearance of cervix, any dilatation of cervix). Remove any pregnancy tissue if seen and send to histopathology with relevant documentation (see appendix 2)
• Bimanual examination *DO NOT do this if suspecting an ectopic pregnancy as you may cause rupture (document size of uterus, anteverted / retroverted, whether cervical os open or closed, presence or absence of adnexal masses, site of any tenderness)

Investigations

• Bloods  
  FBC  
  Group and antibody screen  
  Serum bHCG (ring the lab to ensure gets processed)

• USS – this should only be performed by those trained in USS and assessed locally to be competent. If USS performed, they should be reported as per the format described in the early pregnancy unit guideline below and the guideline followed according to the diagnosis made
Management

All women presenting as an emergency with pain and / or bleeding in early pregnancy should have an USS to confirm pregnancy location and viability. If the woman has any risk factors for ectopic pregnancy (eg infertility, history of Chlamydia, assisted reproduction, previous pelvic / tubal surgery), she should NOT be sent home before a scan.

Likely intrauterine pregnancy / miscarriage
If the woman is stable and your assessment is that she is likely to have an intrauterine pregnancy or a threatened or complete miscarriage, she can be managed as an outpatient. Discharge home with an appointment in the early pregnancy unit (EPU) or emergency gynaecology unit (EGU) within 48 hours (if this is not possible, inform consultant on call). On the discharge letter in the comments section state she has ‘open access’ to the ward should she have worsening symptoms before her scan appointment and write down the ward telephone numbers. Add to the ‘open access’ file on the gynaecology ward.

Possible ectopic pregnancy
If your assessment is that you suspect an ectopic pregnancy (pain / light bleeding / normal sized uterus / past history of ectopic pregnancy or other risk factors for ectopic) DO NOT send home until she’s had a scan. Admit to the ward and arrange an urgent USS (EPU / EGU / Main USS dept). If an USS is not available within 24 hours of admission, inform the consultant on call.
**Early Pregnancy Unit Guidelines**

Direct Booking by GP / CMW / other healthcare professional to EPU (diary held on the Gynaecology ward at all times)

- Criteria – ALL of the following:
  - Haemodynamically stable
  - +ve pregnancy test
  - <14/40 by LMP
  - history of pain and / or bleeding

Women who fulfil the following criteria can also been seen in EPU

- Previous ectopic pregnancy
- History of recurrent miscarriage
- Previous molar pregnancy

Women attending EPU are informed:

- To expect a transvaginal scan (no need to have a full bladder)
- To bring a sample of urine (pot given at reception if they haven’t brought a sample)

**Consultation in EPU**

Women receive the laminated card entitled ‘What is EPU’ upon arrival at Maternity Reception

Asked to have an empty bladder prior to their appointment and provide a urine sample

All women attending EPU are offered Chlamydia screening.

**Minimum history taken:**

- First day of last menstrual period
- Cycle length and regularity
- Certainty of dates
- Date of first +ve pregnancy
- Symptoms this pregnancy (pain / bleeding) and quantify this
- Current / recent contraception methods
- Past obstetric history (especially history of previous miscarriages / ectopics and how they were managed)
- Past gynaecological history (history of infertility, PID, tubal / pelvic surgery)

**USS**

- ALL women who attend EPU should be scanned if they have a positive pregnancy test regardless of their dates.
- If good history of a complete miscarriage or they’ve never actually had a positive pregnancy test or if in doubt, do a urine pregnancy test prior to scanning. No need to scan if pregnancy test negative. A discharge letter to the GP must still be generated explaining the pregnancy test is negative and suggesting referral to EGU if needs to be seen as an emergency. If there is any
doubt as to whether the urine pregnancy test is accurate, arrange a serum bHCG.

- TVS is the first line mode of scanning if they are <8/40 gestation. TAS can be performed if they are >8/40, have pelvic pathology like fibroids or an ovarian cyst or if a woman refuses a TVS (in this case inform her of the limitations of TAS)

**USS Report**

The USS should be reported on the viewpoint system and include the following

**Uterus:**
- Anteverted / retroverted / axial
- Endometrial thickness in the absence of a gestation sac (and a description of this eg thin and / or the presence of a midline echo (?ectopic pregnancy), homogenous and thickened (?early IUP), mixed echogenicity (?miscarriage and retained pregnancy tissue)
- Sac: number present, measured in 3 planes and the ‘mean sac diameter’ (MSD) calculated if no fetal pole
- Sac Site in the absence of yolk sac: eccentrically placed – likely gestation sac; midline – possible pseudosac
- Yolk sac: presence / absence
- Fetus: - presence / absence
- Fetal heart pulsations – presence / absence
- Areas of haemorrhage around the sac (with corresponding measurements)

**Adnexae**
- Both ovaries should be visualised and measured in 3 planes
- Comments made on whether they look normal and description of corpus luteum / cysts (with measurements) made
- Presence and description of any adnexal masses (particularly where there is an empty uterus)

**Pouch of Douglas**
- Comments made upon whether there is any free fluid or not
- If present, maximum depth measured and its consistency described (eg areas of mixed echogenicity – clot / blood or anechoic – eg cyst fluid)

**Pain**
- If the woman has presented with pain, please comment on whether or not (and if so where) the woman experiences any pain during the TVS

**Diagnosis**

Based on the scan findings and history, a diagnosis must be selected (from the dropdown menu on viewpoint):
• Viable intrauterine pregnancy
• Intrauterine pregnancy uncertain viability
  (CRL <7mm with no obvious cardiac pulsations)
• Early intrauterine pregnancy <6/40
  (gestation sac and yolk sac only)
• Non viable intrauterine pregnancy
  (fetal pole with crown rump length >/= 7mm and no cardiac pulsations * or no change on scans 7-10 days apart)
• Anembryonic pregnancy
  (gestation sac with MSD >/=25mm and no yolk sac * or no change on scans 7-10 days apart)
• Ectopic pregnancy
  (only select this diagnosis if a gestation sac and yolk sac +/- fetus are seen extrauterine, otherwise select ‘PUL possible ectopic’ whilst awaiting serum bHCG)
• Suspected Molar pregnancy
• Pregnancy unknown location (PUL) likely miscarriage
  (serial bHCGs have been commenced)
• Pregnancy unknown location (PUL) likely early intrauterine pregnancy
  (serial bHCGs have been commenced)
• Pregnancy unknown location (PUL) possible ectopic pregnancy
  (serial bHCGs have been commenced)
• Miscarriage of previously seen intrauterine pregnancy

* before making the diagnosis of non viable intrauterine pregnancy or anembryonic pregnancy on first scan, aim to seek a second opinion. Offer a repeat scan a minimum of 7 days later.

NB We do NOT make the diagnosis of ‘complete miscarriage’ or ‘Retained products of conception’ (incomplete miscarriage) on a scan alone if a gestation sac hasn’t been previously confirmed on USS or histological proof of chorionic villi on tissue removed from the cervix. These women must be managed according to the PUL guideline with serial bHCGs. In the Confidential Enquiry into Maternal and Child Health 2000-2002, 11 out of 17 deaths in early pregnancy were from ruptured ectopic pregnancy. One potentially avoidable death was a woman seen in a specialist centre with an empty uterus on USS. This was interpreted as a complete miscarriage. Death occurred 3 weeks later from a ruptured ectopic pregnancy. Serial hCG levels would have almost certainly established the diagnosis.

If and when a miscarriage is confirmed, ensure a clear description of the endometrium is given. If endometrial thickness is >15mm the diagnosis of ‘incomplete miscarriage’ can be assumed and the woman can be warned to expect heavy bleeding and / or offered medical or surgical management.

Management
Viable intrauterine pregnancy
Complete viewpoint report and discharge woman. Advise her to book with community midwife if hasn’t already done so in order for her dating scan to be arranged.

Intrauterine pregnancy uncertain viability (CRL < 7mm with no obvious cardiac pulsations)
Arrange a rescan in 7-10 days. Offer RCHT patient information leaflet Number 971 entitled ‘unclear pregnancy scan / possible miscarriage’ if your assessment is that this is likely a failed pregnancy (from history)

Early intrauterine pregnancy <6/40 (gestation sac and yolk sac only)
Complete viewpoint report and discharge woman. Advise her to book with community midwife if hasn’t already done so in order for her dating scan to be arranged.

Non viable intrauterine pregnancy (CRL >/=7mm and no cardiac pulsations, ideally checked by a second sonographer or no change on scans 7-10 days apart)
Inform the woman in a sensitive manner. Counsel her as to her options of management (surgical, medical & expectant). Offer RCHT patient information leaflet 968 entitled ‘Managing your miscarriage’. Make appointment in EGU if chooses surgical / medical management or is undecided. Offer follow up in 2 weeks in EPU if she chooses expectant management and give RCHT patient information leaflet 989 ‘Expectant management of your miscarriage’. Follow Management of Miscarriage Guideline.

Anembryonic pregnancy (gestation sac with MSD >/=25mm and no yolk sac or no change on scans 7-10 days apart)
Inform the woman in a sensitive manner. Counsel her as to her options of management (surgical, medical & expectant). Offer RCHT patient information leaflet 968 entitled ‘Managing your miscarriage’. Make appointment in EGU if chooses surgical / medical management or is undecided. Offer follow up in 2 weeks in EPU if she chooses expectant management and give RCHT patient information leaflet 989 ‘Expectant management of your miscarriage’. Follow Management of Miscarriage Guideline.

Ectopic pregnancy
Refer to EGU or gynaecology ward. Inform SHO and / or registrar on call. Follow Management of Ectopic Pregnancy Guideline.

Suspected Molar pregnancy
Refer to EGU or the gynaecology ward. Inform SHO and / or registrar on call. Serum bHCG, FBC, G&H to be taken. Follow surgical management of miscarriage guideline and arrange urgent histology.

Pregnancy site uncertain (PUL) likely miscarriage (serial bHCGs have been commenced)
Pregnancy site uncertain (PUL) likely early intrauterine pregnancy (serial bHCGs have been commenced)
Pregnancy site uncertain (PUL) possible ectopic pregnancy (serial bHCGs have been commenced)
Give RCHT patient information leaflet No 988 entitled ‘Pregnancy of unknown location: A guide for patients’
Follow PUL Guideline

**Miscarriage of previously seen intrauterine pregnancy**
Inform the woman in a sensitive manner. If endometrial thickness is >15mm the diagnosis of ‘incomplete miscarriage’ can be assumed and the woman can be warned to expect heavy bleeding and / or offered medical or surgical management. If chooses expectant management, give RCHT patient information leaflet entitled: ‘Miscarriage of a previously seen pregnancy’. Give urine pregnancy test (with instruction leaflet) and advice to perform one week after bleeding stops.

**General Principles of serum bHCG levels**
Serum bHCG normally rise >63% every 48 hours in an ongoing intrauterine pregnancy. However, this rise is seen in 15-20% of ectopic pregnancies.

We would expect to see an intrauterine gestation sac on transvaginal scans where bHCGs >1500 IU/L.

The diagnosis of miscarriage / failed intrauterine pregnancy is made on USS assessment, NOT on suboptimally rising bHCGs alone.

**Documentation to accompany any suspected pregnancy tissue sent to the laboratory**
Any tissue sent to the laboratory that is suspected pregnancy tissue, must be accompanied by written consent from the patient that they agree to collective cremation of the tissue, or that they have agreed to other options for disposal as detailed in the patient information leaflet explaining other options. The nurse / midwife / doctor can countersign these forms.

**Reference:** Ectopic pregnancy & miscarriage: Diagnosis and initial management. NICE clinical guideline 154. Dec 2012

### 3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Is the ‘Diagnosis on USS findings’ box completed on the viewpoint database</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Miss Lisa Verity, Consultant O&amp;G</td>
</tr>
<tr>
<td>Tool</td>
<td>Ad hoc monitoring of viewpoint database as part of routine activity</td>
</tr>
<tr>
<td>Frequency</td>
<td>At the monthly EGU &amp; EPU MDT</td>
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<tr>
<td>Reporting arrangements</td>
<td>Monthly EGU / EPU MDT</td>
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<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>EGU &amp; EPU MDT</td>
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</table>

Change in practice and lessons to be shared
Required changes to practice will be identified and actioned within 3 months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.
4. **Equality and Diversity**

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

4.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

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**Appendix 1. Governance Information**

<table>
<thead>
<tr>
<th>Document Title</th>
<th>MANAGEMENT OF PAIN &amp; BLEEDING IN EARLY PREGNANCY - CLINICAL GUIDELINE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>11/04/2017</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>08/06/2017</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>08/06/2020</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Miss Lisa Verity Consultant O&amp;G</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 252685</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>All clinical staff working in the Division of women, children &amp; sexual health to provide evidence based guidance in the management of pain &amp; bleeding in early pregnancy</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Early pregnancy miscarriage ectopic pain bleeding</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>11/04/2017</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>MANAGEMENT OF PAIN &amp; BLEEDING IN EARLY PREGNANCY - CLINICAL GUIDELINE</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Obstetric &amp; Gynaecology Directorate meeting</td>
</tr>
<tr>
<td>Divisional Manager confirming approval processes</td>
<td>Miss Karen Watkins</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Not Required</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Publication Location (refer to Policy on Policies – Approvals and Ratification):</td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td>Document Library Folder/Sub Folder</td>
<td>Clinical / Gynae</td>
</tr>
<tr>
<td>Links to key external standards</td>
<td>Ectopic pregnancy &amp; miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy &amp; miscarriage. NICE clinical guideline 154. Dec 2012</td>
</tr>
<tr>
<td>Related Documents:</td>
<td>List other guidelines &amp; hyperlink guidelines in document library</td>
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<tr>
<td>Training Need Identified?</td>
<td>No</td>
</tr>
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**Version Control Table**

<table>
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<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tr>
<td>11 Jun 14</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td>Lee Azancot Data Administrator</td>
</tr>
<tr>
<td>15 Mar 17</td>
<td>V1.1</td>
<td>Addition of Sensitive Disposal and Crematation documentation</td>
<td>Lee Azancot Divisional Administrator</td>
</tr>
</tbody>
</table>

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): MANAGEMENT OF PAIN &amp; BLEEDING IN EARLY PREGNANCY - CLINICAL GUIDELINE</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Directorate and service area: Gynaecology</td>
<td>Is this a new or existing Policy? Existing</td>
</tr>
<tr>
<td>Name of individual completing assessment: Miss Lisa Verity</td>
<td>Telephone: 01872 252685</td>
</tr>
<tr>
<td>1. Policy Aim* Who is the strategy / policy / proposal / service function aimed at?</td>
<td>All clinical staff working in the Division of women, children &amp; sexual health to provide evidence based guidance in the management of pain &amp; bleeding in early pregnancy</td>
</tr>
<tr>
<td>2. Policy Objectives*</td>
<td>As above</td>
</tr>
<tr>
<td>3. Policy – intended Outcomes*</td>
<td>As above</td>
</tr>
<tr>
<td>4. *How will you measure the outcome?</td>
<td>See section 3</td>
</tr>
<tr>
<td>5. Who is intended to benefit from the policy?</td>
<td>All obs &amp; gynae patients</td>
</tr>
<tr>
<td>6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?</td>
<td>No</td>
</tr>
<tr>
<td>b) If yes, have these *groups been consulted?</td>
<td></td>
</tr>
<tr>
<td>C). Please list any groups who have been consulted about this procedure.</td>
<td></td>
</tr>
</tbody>
</table>

7. The Impact
Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
<tr>
<td>Age</td>
<td>x</td>
<td></td>
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</table>
### Sex (male, female, transgender / gender reassignment)
- [ ]

### Race / Ethnic communities / groups
- [ ]

### Disability - learning disability, physical disability, sensory impairment and mental health problems
- [ ]

### Religion / other beliefs
- [ ]

### Marriage and civil partnership
- [ ]

### Pregnancy and maternity
- [ ]

### Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian
- [ ]

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

<table>
<thead>
<tr>
<th>8. Please indicate if a full equality analysis is recommended.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ]</td>
<td></td>
<td>[ ]</td>
</tr>
</tbody>
</table>

9. If you are not recommending a Full Impact assessment please explain why.

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
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</table>

<table>
<thead>
<tr>
<th>Names and signatures of members carrying out the Screening Assessment</th>
<th>1. Miss Lisa Verity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2.</td>
</tr>
</tbody>
</table>

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead, c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed _______________________

Date _______________________
Appendix 4. Consent form for funeral arrangements after pregnancy loss (for 14-24 weeks gestation)

Royal Cornwall Hospitals NHS Trust

What happens to our baby?
As explained in the leaflet you have been given, there are some options available to you. Please indicate which you would prefer

I would like the hospital to arrange cremation
I understand that the hospital will dispose of my baby sensitively by means of a monthly collective cremation at Penmount Crematorium together with other tissue of conception only. I understand there will be no ashes and that a non-denominational service is held in the Chapel. I understand that it will not be possible for me to attend the cremation.

I would like to make private arrangements for a funeral
I would like to make my own arrangements for a private funeral and I will instruct a Funeral Director at my own expense.

I would like to arrange a home burial
I would like to take my baby for burial at home.
I understand I am required to contact my County Council for advice.

I have not yet made a decision regarding these arrangements
I understand I have up to one month to make a decision and I will make contact with the Hospital Bereavement Office in that time.
I understand that if I don’t make contact within that time the hospital will arrange cremation on my behalf. This is a collective cremation with other pregnancy losses conducted monthly at Penmount Crematorium. I understand the hospital will NOT contact me with details.

I understand that I may contact the Hospital Bereavement Office to discuss the options available and/or any financial concerns I may have.

Patient Label

..........................................................
Print name

..........................................................
Signature

Options explained and consent from parent obtained by

..........................................................
Print name

Midwife/Nurse
(please state)

..........................................................
Signature

..........................................................
Date

Procedure for the sensitive disposal of pre-24 week fetal tissue

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Appendix 5. Certificate of Medical Practitioner or Midwife in Respect of Fetal Remains

<table>
<thead>
<tr>
<th>Histology Case Number</th>
<th>Collective Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crematorium Number</td>
<td></td>
</tr>
</tbody>
</table>

Cornwall Council  
PENMOUNT CREMATORIUM, TRURO  
Tel 01872 272871

CERTIFICATE OF MEDICAL PRACTITIONER OR MIDWIFE IN RESPECT OF FETAL REMAINS

(The products of conception expelled from the uterus before 24 weeks gestation which showed no visible signs of life)

I hereby certify that I have examined the fetal remains whose details are shown below:

Delivered on ..........................................................(Date) at ................................am/pm of ................................................ weeks gestation
and which at no time showed any visible signs of life. Place of delivery ..............................................................

I have no reason to suspect that the duration of pregnancy was shortened by violence, poison or any unlawful act and I know of no reason why any further examination or enquiry should be made.

Tick one box

I confirm that informed written consent for collective cremation has been obtained.  (Complete sections A & B)

☐

I confirm that informed written consent for a private funeral has been obtained.
The mother/parents understand that they may contact the Hospital Bereavement Office to discuss the options available and/or any financial concerns they may have.  (Complete sections A & C)

☐

A) Doctor/Midwife details

Print Name.............................................................. Signature..............................................

Registered qualifications.................................. Date......................................................

Workplace............................................................. Tel......................................................

(Mother’s details to be removed by bereavement office if remains are for collective cremation)

Funeral Arrangements

As explained these are the options available to you, please indicate your preference below:

B) The mother/parents would like the hospital to arrange collective cremation by means of a monthly collective cremation together with other tissue of conception only.

☐

C) The mother/parents would like to make private funeral arrangements. They will instruct a funeral director and advise the bereavement office accordingly within one month.

☐

Affix Patient Label

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Procedure for the sensitive disposal of pre-24 week fetal tissue

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Clinical Guideline Template

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