Ontario

Ministry of Health and Long-Term Care

Ontario Perinatal Record 1

Last Name	First Name		
Address - street number, street name	Apt/Suite/Unit	Buzzer No	
City/Town	Province	Postal Code	
Contact - Preferred	Leave Message ☐Y ☐N	Contact - Alternate/E-mail	
Date of Birth YYYY/MM/DD	Age at EDB	Language	Interpreter Required ☐Y ☐N
OHIP Number	Patient File Number	Disability Requiring Accommodation ☐Y ☐N	
Newborn Care Provider In Hospital	In Community		
Allergies or Sensitivities (include reaction)			

Partner's First Name	Partner's Last Name	
Partner's Occupation	Partner's Education Level	Age

Occupation	Education Level	Relationship Status	Sexual Orientation
Planned Place of Birth		Planned Birth Attendant	
Family Physician/Primary Care Provider			
Medications (include Rx/OTC, complementary/alternative/vitamins and dosage)			

Pregnancy Summary

LMP YYYY/MM/DD Cycle q ______ Certain ☐Y ☐N Regular ☐Y ☐N

Planned Preg ☐Y ☐N Contraceptive Type Last Used YYYY/MM

Conception: Assisted ☐Y ☐N Details

EDB By LMP YYYY/MM/DD

Final EDB YYYY/MM/DD

Dating Method ☐T_1US ☐T_2US ☐LMP ☐IUI YYYY/MM/DD ☐Embryo Transfer YYYY/MM/DD ☐Other

Gravida	Term	Preterm	Abortus	Living Children	Stillbirth(s)	Neonatal / Child Death

Obstetrical History

Year/ Month	Place of Birth	Gest. (wks)	Labour Length	Type of Birth	Comments regarding abortus, pregnancy, birth, and newborn (e.g. GDM, HTN, IUGR, shoulder dystocia, PPH, OASIS, neonatal jaundice)	Sex M/F	Birth Weight	Breastfed / Duration	Child's Current Health

Medical History (provide details in comments)

Current Pregnancy

1 Bleeding ☐Y ☐N
2 Nausea/vomiting ☐Y ☐N
3 Rash/fever/illness ☐Y ☐N

Nutrition

4 Calcium adequate ☐Y ☐N
5 Vitamin D adequate ☐Y ☐N
6 Folic acid preconception ☐Y ☐N
7 Prenatal vitamin ☐Y ☐N
8 Food access/quality adequate ☐Y ☐N
9 Dietary restrictions ☐Y ☐N

Surgical History

10 Surgery ☐Y ☐N
11 Anaesthetic complications ☐Y ☐N

Medical History

12 Hypertension ☐Y ☐N
13 Cardiac / Pulmonary ☐Y ☐N
14 Endocrine ☐Y ☐N
15 GI / Liver ☐Y ☐N
16 Breast (incl. surgery) ☐Y ☐N
17 Gynecological (incl. surgery) ☐Y ☐N
18 Urinary tract ☐Y ☐N
19 MSK/Rheumatology ☐Y ☐N
20 Hematological ☐Y ☐N
21 Thromboembolic/coag ☐Y ☐N
22 Blood transfusion ☐Y ☐N
23 Neurological ☐Y ☐N
24 Other ☐Y ☐N

Family History

25 Medical Conditions ☐Y ☐N
(e.g. diabetes, thyroid, hypertension, thromboembolic, anaesthetic, mental health).

Genetic History of Gametes

26 Ethnic/racial background:
Egg ____________________ Age _________Yrs
Sperm ____________________
27 Carrier screening: at risk? ☐Y ☐N
- Hemoglobinopathy screening (Asian, African, Middle Eastern, Mediterranean, Hispanic, Caribbean) ☐Y ☐N
- Tay-Sachs disease screening (Ashkenazi Jewish, French Canadian, Acadian, Cajun) ☐Y ☐N
- Ashkenazi Jewish screening panel ☐Y ☐N

28 Genetic Family History
- Genetic conditions (e.g. CF, muscular dystrophy, chromosomal disorder) ☐Y ☐N
- Other (e.g. intellectual, birth defect, congenital heart, developmental delay, recurrent pregnancy loss, stillbirth) ☐Y ☐N
- Consanguinity ☐Y ☐N

Infectious Disease

29 Varicella disease ☐Y ☐N
30 Varicella vaccine ☐Y ☐N
31 HIV ☐Y ☐N
32 HSV Self ☐Y ☐N Partner ☐Y ☐N
33 STIs ☐Y ☐N
34 At risk population (Hep C, TB, Parvo, Toxo) ☐Y ☐N
35 Other ☐Y ☐N

Mental Health / Substance Use

36 Anxiety Past ☐Y ☐N Present ☐Y ☐N
GAD-2 Score ____________
37 Depression Past ☐Y ☐N Present ☐Y ☐N
PHQ-2 Score ____________
38 Eating disorder ☐Y ☐N
39 Bipolar ☐Y ☐N
40 Schizophrenia ☐Y ☐N
41 Other ☐Y ☐N
(e.g. PTSD, ADD, personality disorders)
42 Smoked cig within past 6 months ☐Y ☐N
Current smoking ______ cig/day
43 Alcohol: Ever drink alcohol? ☐Y ☐N
If Yes: Last drink: (when) ____________
Current drinking ______ drinks/wk
T-ACE Score ____________
44 Marijuana ☐Y ☐N
45 Non-prescribed substances/drugs ☐Y ☐N

Lifestyle/Social

46 Occupational risks ☐Y ☐N
47 Financial/housing issues ☐Y ☐N
48 Poor social support ☐Y ☐N
49 Beliefs/practices affecting care ☐Y ☐N
50 Relationship problems ☐Y ☐N
51 Intimate partner/family violence ☐Y ☐N
52 Parenting concerns ☐Y ☐N
(e.g. developmental disability, family trauma)
53 Other ☐Y ☐N

Comments

Completed By		Reviewed By	
Signature	Date	MRP Signature	Date

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Ontario Perinatal Record 2

Last Name	First Name

Planned Birth Attendant

Newborn Care Provider
In Hospital | In Community

G	T	P	A	L	S	Final EDB YYYY/MM/DD	Family Physician/Primary Care Provider

Physical Exam

Ht ______ cm   Pre-pregnancy Wt ____ kg

BP ______   Pre-pregnancy BMI ____

Exam As Indicated

Head and neck	N/Abn	MSK	N/Abn
Breast/nipples	N/Abn	Pelvic	N/Abn
Heart/lungs	N/Abn	Other	N/Abn
Abdomen	N/Abn		

Exam Comments

Last Pap YYYY/MM/DD	Result

Initial Laboratory Investigations / Second and Third Trimester Lab Investigations

Initial Laboratory Investigations: Test	Result	Second and Third Trimester Lab Investigations: Test	Result
Hb		Hb	
ABO/Rh(D)		Platelets	
MCV		ABO/Rh(D)	
Antibody screen		Repeat Antibodies	
Platelets		1hr GCT	
Rubella immune		2 hr GTT	
HBsAg			
Syphilis			
HIV			
GC			
Chlamydia			
Urine C&S			

Additional investigations as indicated

TSH, Diabetes screen, Hb Electrophoresis/ HPLC, Ferritin, B12, Infectious diseases (e.g. Hep C, Parvo B19, Varicella, Toxo, CMV), Drug screen, repeat STI screen.

Test	Result	Test	Result

Prenatal Genetic Investigations

Screening Offered ☐Yes ☐No	Result		Result
☐FTS (between 11-13+6wks)		CVS/Amnio Offered ☐Y ☐N	
☐IPS Part 1(between 11-13+6wks) ☐Part 2(between 15-20+6wks)		Other genetic testing Offered ☐Y ☐N	
☐MSS (between 15-20+6wks) ☐AFP (between 15-20+6wks)		NT Risk Assessment 11-13+6wk (multiples)	
Cell-free fetal DNA (NIPT) Offered ☐Y ☐N		Abnormal Placental Biomarkers	

No Screening Tests

☐Counseled and declined	Date YYYY/MM/DD	☐Presentation > 20+6wk NIPT offered ☐Y ☐N	Date YYYY/MM/DD

Ultrasound

Date	GA	Result		
YYYY/MM/DD				
YYYY/MM/DD		NT Ultrasound (between 11-13+6 weeks)		
YYYY/MM/DD		Anatomy scan (between 18-22wks)	Placental Location	Soft Markers
YYYY/MM/DD				
YYYY/MM/DD				
YYYY/MM/DD				
YYYY/MM/DD				
YYYY/MM/DD				
YYYY/MM/DD				
YYYY/MM/DD				
YYYY/MM/DD				
YYYY/MM/DD				
YYYY/MM/DD				

Genetic screening result reviewed with pt/client ☐
Approx 22 wks: Copy of OPR 1 & 2 to hospital ☐ and/or to pt/client ☐

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Ministry of Health and Long-Term Care

Ontario Perinatal Record 3

Last Name	First Name
Planned Birth Attendant	

Newborn Care Provider In Hospital In Community	Allergies or Sensitivities (include reaction)
Family Physician/Primary Care Provider	Medications (include Rx/OTC, complementary/alternative/vitamins, include dosage)

G	T	P	A	L	S	Final EDB YYYY/MM/DD

Issues (abnormal results, medical/social problems)	Plan of Management / Medication Change / Consultations

Special Circumstances	GBS
Low dose ASA indicated ☐ Progesterone indicated (PTB Prevention) ☐ HSV supression indicated ☐	Rectovaginal swab ☐pos ☐neg
Social (e.g. child protection, adoption, surrogacy)	Other indications for prophylaxis ☐Y ☐N

Recommended Immunoprophylaxis

Rh(D) neg ☐ Rh(D) IG given YYYY/MM/DD Additional dose given YYYY/MM/DD	Influenza Discussed ☐ ☐Received ☐Declined	Pertussis Discussed ☐ Up-to-date ☐Y ☐N Year _______ Received ☐ Declined ☐	Post-partum vaccines discussed ☐Rubella ☐Other __________________	Newborn needs ☐Hep B prophylaxis ☐HIV prophylaxis

Pre-pregnancy Wt __________ kg BMI ________

Subsequent Visits

Date	GA (wks/days)	Weight (kg)	BP	Urine Prot.	SFH	Pres.	FHR	FM	Comments	Next Visit	Initial(s)
YYYY/MM/DD											
YYYY/MM/DD											
YYYY/MM/DD											
YYYY/MM/DD											
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YYYY/MM/DD											
YYYY/MM/DD											

Discussion Topics

1st Trimester	2nd Trimester	3rd Trimester
☐Nausea / Vomiting ☐Routine prenatal care /Emergency contact /On call providers ☐Safety: food, medication, environment, infections, pets ☐Healthy weight gain ☐Physical activity ☐Seatbelt use ☐Sexual activity ☐Breastfeeding ☐Travel ☐Quality information sources ☐VBAC counseling	☐Prenatal classes ☐Preterm labour ☐PROM ☐Bleeding ☐Fetal movement ☐Mental health ☐VBAC consent	☐Fetal movement ☐Birth plan: pain management, labour support ☐Type of birth, potential interventions, VBAC plan ☐Admission timing ☐Breastfeeding and support ☐Newborn care / Screening tests / Circumcision / Follow-up appt. ☐Discharge planning / Car seat safety ☐Work plan / Maternity leave ☐Mental health ☐Contraception ☐Postpartum care

Comments

Approx 36 wks: Copy of OPR 2 (updated) & OPR 3 to hospital ☐ and/or to pt/client ☐

1. Name / Initials	2. Name / Initials	3. Name / Initials	4. Name / Initials	5. Name / Initials

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Resources

Last Name	First Name

Anxiety Screening

Generalized Anxiety Disorder scale (GAD-2) Date YYYY/MM/DD

Over the last 2 weeks, how often have you been bothered by the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	**0**	**1**	**2**	**3**
2. Not been able to stop or control worrying	**0**	**1**	**2**	**3**
A total score of 3 or more warrants consideration of: Using the GAD-7 for further assessment or additional mental health follow-up.			**Total Score ____**	

Depression Screening

The Patient Health Questionnaire-2 (PHQ-2) Date YYYY/MM/DD

Over the last 2 weeks, how often have you been bothered by the following problems:	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2. Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
A total score of 3 or more warrants consideration of: Using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ) 9 for further assessment or additional mental health follow-up.			**Total Score ____**	

T-ACE Screening Tool (Alcohol)

Response Key

1 Drink is equivalent to:

• 12 oz of beer • 12 oz of cooler • 5 oz of wine • 1.5 oz of hard liquor (mixed drink)

Date YYYY/MM/DD

	Response	
1. How many drinks does it take to make you feel high?	≤ 2 drinks = **0**	> 2 drinks = **1**
2. Have people annoyed you by criticizing your drinking?	No = **0**	Yes = **1**
3. Have you felt you ought to cut down on your drinking?	No = **0**	Yes = **1**
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	No = **0**	Yes = **1**
A total score of 2 or greater indicates potential prenatal risk and need for follow-up.	**Total Score ____**	

Edinburgh Perinatal / Postnatal Depression Scale (EPDS) Cox, Holden, Sagovsky, (1987).

In the past 7 days: Date YYYY/MM/DD

Item		
1. I have been able to laugh and see the funny side of things	☐ As much as I always could = **0** ☐ Not quite so much now = **1**	☐ Definitely not so much now = **2** ☐ Not at all = **3**
2. I have looked forward with enjoyment to things	☐ As much as I ever did = **0** ☐ Rather less than I used to = **1**	☐ Definitely less than I used to = **2** ☐ Hardly at all = **3**
3. I have blamed myself unnecessarily when things went wrong	☐ No, never = **0** ☐ No, not very often = **1**	☐ Yes, some of the time = **2** ☐ Yes, most of the time = **3**
4. I have been anxious or worried for no good reason	☐ No, not at all = **0** ☐ Hardly ever = **1**	☐ Yes, sometimes = **2** ☐ Yes, very often = **3**
5. I have felt scared or panicky for no very good reason	☐ No, not at all = **0** ☐ No, not much = **1**	☐ Yes, sometimes = **2** ☐ Yes, quite a lot = **3**
6. Things have been getting on top of me	☐ No, I have been coping as well as ever = **0** ☐ No, most of the time I have coped well = **1**	☐ Yes, sometimes I haven't been coping as well as usual = **2** ☐ Yes, most of the time I haven't been able to cope = **3**
7. I have been so unhappy that I have had difficulty sleeping	☐ No, not much = **0** ☐ Not very often = **1**	☐ Yes, sometimes = **2** ☐ Yes, most of the time = **3**
8. I have felt sad or miserable	☐ No, not much = **0** ☐ Not very often = **1**	☐ Yes, quite often = **2** ☐ Yes, most of the time = **3**
9. I have been so unhappy that I have been crying	☐ No, never = **0** ☐ Only occasionally = **1**	☐ Yes, quite often = **2** ☐ Yes, most of the time = **3**
10. The thought of harming myself has occurred to me	☐ No, never = **0** ☐ Only occasionally = **1**	☐ Yes, quite often = **2** ☐ Yes, most of the time = **3**

Total Score ____

Score of 1-3 on item 10 indicates a risk of self-harm. Patient requires immediate mental health assessment and intervention as appropriate.

Score > 9 Monitor, support, and offer education

Score > 12 Follow up with comprehensive bio-psychosocial diagnostic assessment for depression.

Institute of Medicine Weight Gain Recommendations for Pregnancy (2009)

Prepregnancy Weight Category	Body Mass Index	Recommended range of Total Weight in kg (lb)	Rates of Weight Gain in Second and Third Trimesters	
			kg/wk	lb/wk (mean range)
Underweight	Less than 18.5	12.5-18 kg (28-40)	0.5	1 (1-1.3)
Normal Weight	18.5-24.9	11.5-16 kg (25-35)	0.4	1 (0.8-1)
Overweight	25-29.9	7-11.5 kg (15-25)	0.3	0.6 (0.5-0.7)
Obese (includes all classes)	30 and greater	5-9 kg (11-20)	0.2	0.5 (0.4-0.6)

†Calculations assume a 0.5 to 2 kg (1.1-4.4 lb) weight gain in the first trimester.

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Ontario Perinatal Record
Postnatal Visit

Last Name	First Name			
Date of visit YYYY/MM/DD	Date of Delivery YYYY/MM/DD	Number of weeks postpartum	GA at Birth	Primary Care Provider

History

Review of birth — Vaginal: ☐ Spontaneous ☐ Vacuum ☐ Forceps ☐ VBAC ☐ Episiotomy / Lacerations ☐ OASIS

Caesarean: ☐ Planned ☐ Unplanned

Details	Birth Attendant

Pregnancy/birth issues requiring follow-up (e.g. diabetes, hypertension, thyroid)

Baby's Name	Baby's Care Provider
Birth Weight (g)	Baby's Health/Concerns

Infant feeding ☐ Breast milk only ☐ Combination of breast milk and breast milk substitute ☐ Breast milk substitute only

Feeding concerns

Current Medications

Bladder function	Emotional wellbeing
Bowel function	Relationship
Sexual function	Postpartum Depression Screen (EPDS or other)
Lochia / Menses	Family Support / Community Resources
Perineum / Incision	
Smoking ☐ No ☐ Yes_____ cig/day	Alcohol ☐ No ☐ Yes If yes: Drinks/wk _____ and If yes: T-ACE score _____

Non-prescribed substances / drugs (e.g. opioids, cocaine, marijuana, party drugs, other) ☐ No ☐ Yes

Rubella Immune ☐ Yes ☐ No ☐ Discussed ☐ Declined ☐ Received	Influenza ☐ Discussed ☐ Declined ☐ Received YYYY/MM/DD
Pertussis (TdAP) Up-to-date ☐ Yes ☐ No ☐ Discussed ☐ Declined ☐ Received	Other Immunizations

Last Pap YYYY/MM/DD Result

Physical Exam As Indicated

Weight Today kg	Pre-Delivery Weight kg	Pre-Pregnancy Weight kg	BP mm Hg

Affect	N/Abn	Abdomen	N/Abn	Comments
Thyroid	N/Abn	Perineum	N/Abn	
Breasts	N/Abn	Pelvic	N/Abn	

Discussion Topics	Comments
☐ Transition to parenthood/partner's adjustment	
☐ Family violence and safety	
☐ Nutrition/physical activity/healthy weight	
☐ Plan for management of alcohol / tobacco / substance use	
☐ Contraception	
☐ Pelvic floor exercises	
☐ Community resources (e.g. Healthy Babies Healthy Children)	
☐ Advice regarding future pregnancies and risks	
☐ Preconception planning (e.g. folic acid,medications)	
☐ If CS, future mode of birth and pregnancy spacing	
☐ Other comments / concerns	

Signature of healthcare provider

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