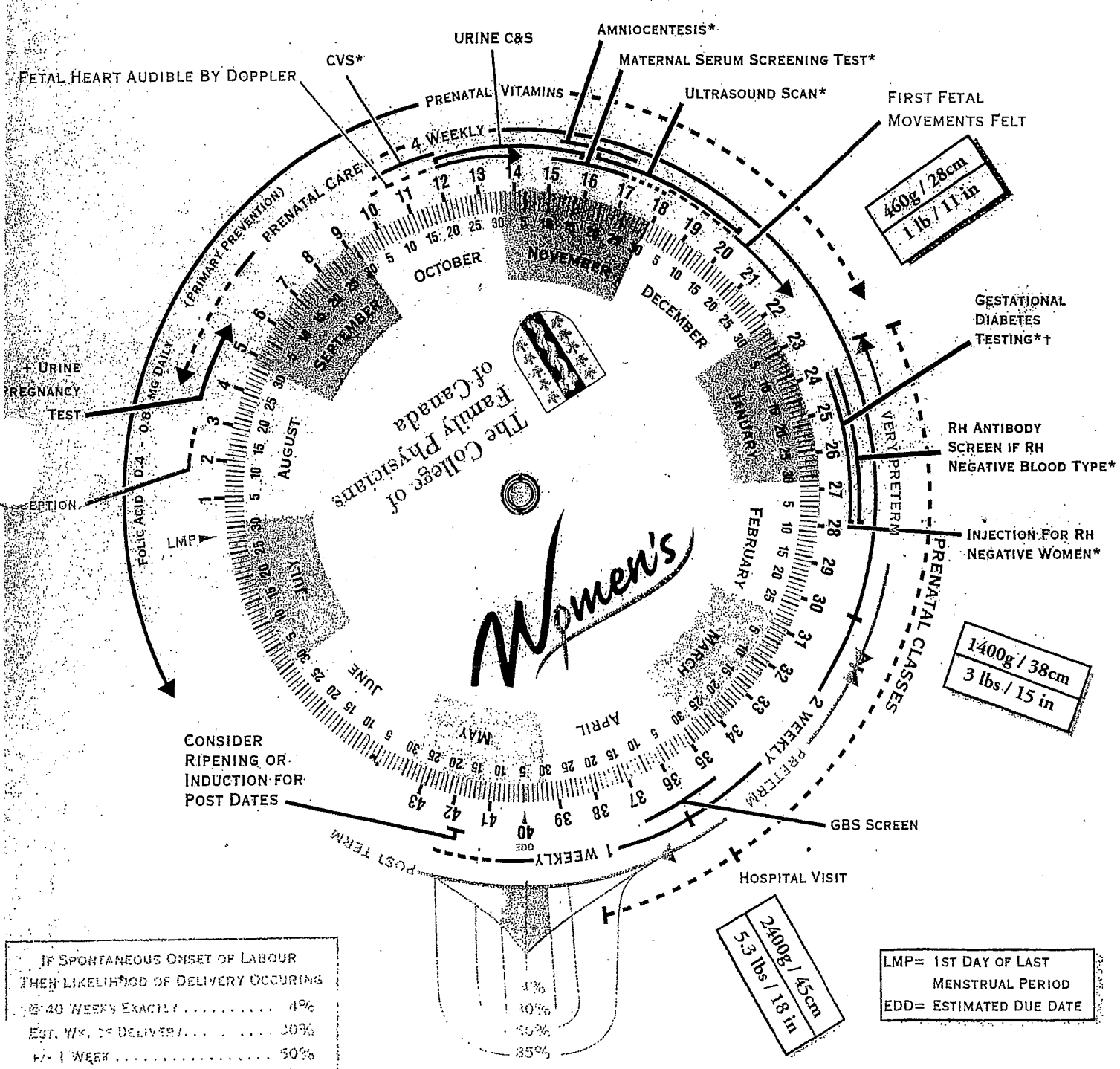
Maternity Care Calendar

IENT'S NAME: WEBBE, MIE
)ATING BY LMP ☐ NURSING STATION
ULTRASOUND ☐
BOTH ☐ (DATE WITHIN 7 DAYS)



IF SPONTANEOUS ONSET OF LABOUR THEN LIKELIHOOD OF DELIVERY OCCURING	
@ 40 WEEKS EXACTLY	4%
EST. WK. OF DELIVERY	30%
+/- 1 WEEK	50%
TERM (37 - 42 WKS)	85%

LIKELIHOOD OF DELIVERY

LMP= 1ST DAY OF LAST MENSTRUAL PERIOD
EDD= ESTIMATED DUE DATE

* Optimal Timing if Indicated
† Case Finding

Patient's _____

Maternity Care Guidelines (2003)

PRECONCEPTION | EARLY PREGNANCY | MID TRIMESTER | TERM | POST PARTUM

CLINICAL

PRECONCEPTION VISIT:

- ☐ recommend folic acid 0.4 mg-0.8 mg/day for primary prevention or 4 mg/day if previous pregnancy with a neural tube defect (ideally 1 month before conception through first trimester)
- ☐ ask about a history of genital-orolabial herpes in woman and partner *
  - women with no history of HSV should be counselled about avoiding exposure to active lesions if partner is HSV positive; advise abstinence, condom use and/or antiviral suppression of partner, avoidance of oral-vulva contact if partner has orolabial herpes
  - women with recurrent HSV should be counselled about the option of acyclovir at term, the role of C/S and avoiding transmission to the newborn postpartum
- ☐ ask about a prior infection with chickenpox (if no prior history, check immunity with varicella zoster IgG) *
  - if not immune and if not pregnant offer vaccine (delay conception 1 month after). If pregnant: counsel re avoiding exposure and reporting exposures immediately. Vaccinate postpartum

DIAGNOSIS:

- ☐ consider **early discussion/referral for prenatal diagnosis if ≥35 years at EDD or risk factors**
- ☐ consider early ultrasound (bleeding, uncertain dates, required for CVS)

FIRST ANTENATAL VISIT:

- ☐ complete history on prenatal form
- ☐ screen for domestic violence *
  - "Do you ever feel unsafe at home?"
  - "Have you been hit, kicked, punched or otherwise hurt by someone within the past year?"
- ☐ physical exam

EARLY FOLLOW-UP VISIT:

- ☐ regular prenatal visits every 4-6 weeks
- ☐ earliest auscultation of fetal heart with doppler (10-12 weeks)
- ☐ **unsensitized Rh negative women should receive a dose of D Ig within 72 hours after elective abortion, amniocentesis, CVS,** ectopic pregnancy termination, antepartum hemorrhage, miscarriage, abdominal trauma, external version procedures, stillbirth +/– threatened abortion before 12 weeks **(first trimester 50µg; after 12 weeks 300µg)** – informed consent needed
- ☐ offer influenza vaccine for women who will be in 2nd or 3rd trimester during flu season
- ☐ quickening (18-20 weeks)
- ☐ **Rh negative women: administer dose (300µg) of D Ig if antibody negative at 28 weeks** – informed consent needed **(U.K. 2 doses of 100µg at 28 and 34 weeks)**
- ☐ visits every 2-3 weeks after 30 weeks
- ☐ visits every 1-2 weeks after 36 weeks
- ☐ offer induction of labour between 41-42 weeks gestation (if declined recommend serial fetal surveillance)

DELIVERY/POST PARTUM:

- ☐ **Rh negative women: administer dose of D Ig 120µg (300µg if test for fetomaternal hemorrhage not done) within 72 hours of delivery if a D positive infant is delivered (U.K. 100µg)**
- ☐ **rubella and varicella vaccine(s) for all non-immune women**
- ☐ **infants born to HBsAg positive mothers should receive HBIG 0.5 ml IM within 12 hours of birth and Hepatitis B vaccine at birth, 1 and 6 months**
- ☐ **ocular prophylaxis for newborn**
- ☐ **newborn hip exam**
- ☐ **recommend rooming-in and early, frequent contact**

INVESTIGATIONS

- ☐ rubella serology
- ☐ offer **HIV testing** (with informed consent and pretest counselling including risk factors, risk of transmission to fetus and availability of therapy to reduce risk of transmission to fetus)
- ☐ offer hepatitis C antibody screening to women with risk factors (IDU, exposure to blood products - medical or occupational, HIV positive, elevated AST, prison inmates, multiple sex partners, tattoos) *
- ☐ **Tay Sachs disease testing in Ashkenazi Jews by hexosaminidase-A in serum (men, nonpregnant women) or WBCs (pregnant women) ***
- ☐ offer Canavan carrier screening for Ashkenazi Jews *
- ☐ **screen for hemoglobinopathies** (sickle cell disease, Beta thalassemia) **by MCV +/- hemoglobin electrophoresis in high risk populations** (Asian, African, Mediterranean, Hispanic, Middle Eastern, East Indian)
- ☐ consider cystic fibrosis carrier testing (recommended routinely in USA; not routinely available in Canada unless + family history)
- ☐ HBsAg
- ☐ syphilis serology
- ☐ **ABO and Rh blood type and antibody testing**
- ☐ **hemoglobin or hematocrit**
- ☐ test women at high risk for diabetes (50g GCT), if neg rpt 24-28 wks *
- ☐ **PAP (if not done in previous 6-12 months)**
- ☐ screen women age < 25 years or at high risk for chlamydia (consider screening all women) *
- ☐ screen women at high risk for gonorrhea *
- ☐ consider screening for bacterial vaginosis by gram stain or Amsel criteria in women at risk for preterm labour or **symptomatic women** *
- ☐ **screen for asymptomatic bacteriuria by urine culture (12-16 weeks)**

- ☐ **offer prenatal diagnosis to women with risk factors:**
  - **CVS** 10 1/2-12 weeks (f/u AFP & 18 week scan)
  - **Amniocentesis** 15 weeks (can be done later if necessary)
- ☐ **offer maternal serum triple screen to all women** (15-20 weeks, optimal time between 15-17 weeks) Note: first trimester screening using nuchal translucency measurement +/- serum markers may be available in some centers
- ☐ **detailed ultrasound at 16-20 weeks** (dates, anomalies, twins, placenta placement) - optimal time is 18 weeks
- ☐ consider glucose test between 24-28 weeks unless low risk with either 2 step: 1 hour, 50g load; not fasting - if >7.8 mmol do 3 hour GTT with 100g load (or 1 step: 2 hour, 75g OGTT, fasting) *
- ☐ **Rh negative women: repeat Rh antibody level at 24-28 weeks**
- ☐ consider repeat hemoglobin at 24-28 weeks
- ☐ if high risk: repeat syphilis serology, HBsAg, HIV serology, screening for chlamydia and gonorrhea (rpt syphilis serology again at delivery)
- ☐ +/- repeat urine culture
- ☐ f/u ultrasound if high risk (IUGR, placenta previa, bleeding)
- ☐ **screen for group B strep (GBS) with vaginal-rectal culture (35-37 weeks) and offer treatment to all colonized women with intrapartum IV antibiotics at the time of labour or rupture of membranes. Also offer treatment to all women with previously documented GBS bacteriuria or previous infant with GBS and women with risk factors (preterm labour <37 weeks, PROM >18 hours, maternal fever >38C) whose culture results are not available at time of delivery ***
- ☐ **newborn screening for PKU, congenital hypothyroidism** and galactosemia
- ☐ Rh negative women who deliver Rh positive infant: test (Kleihauer-Betke or rosette) for fetomaternal hemorrhage in excess of amount covered by standard dose of D Ig

ISSUES FOR DISCUSSION

- ☐ discuss prescription and over-the-counter medications
- ☐ discuss prenatal vitamins (including **folic acid**; vitamin A toxicity)
- ☐ **counsel re potentially harmful effects of smoking on fetus and recommend smoking cessation**
- ☐ **screen for evidence of risk-drinking** (2 drinks per day or binge drinking), **counsel re potentially harmful effects of alcohol on fetus, advise abstinence or limited drinking**
- ☐ **discuss potential risks to fetus of illicit drug use and encourage abstinence**
- ☐ recommend reading material and Pregnancy Planning Guide **(www.pregnancyplanningguide.com)**
- ☐ counsel re avoiding exposure to toxoplasmosis (1), listeria (2), CMV (3): *
  - avoid raw/undercooked meat (1,2), unpasteurized milk or milk products (1,2), soft cheeses (feta, Brie, Camembert, blue-veined, Mexican queso fresco) (2), deli foods (2), paté (2), refrigerated smoked seafood (2)
  - reheat leftovers, coldcuts and hotdogs until steaming hot (2)
  - frequent handwashing (1,2,3) especially after caring for child, changing diapers (3), wash fruits and vegetables (1,2)
  - avoid cat litter box (1), wear gloves for gardening (1)
- ☐ avoid eating shark, swordfish, king mackerel, tilefish, tuna steaks due to high levels of mercury (other fish, including canned tuna can be eaten in moderation: about 1-2 meals per week) *
- ☐ **discuss diet (including folate, calcium,** iron, calories and caffeine)
- ☐ discuss exercise (advantages, contraindications, maximum target heart rate)
- ☐ give hospital registration form if required
- ☐ give copy of Maternity Care Calendar, highlight relevant information
- ☐ discuss prenatal classes
- ☐ **counsel re prenatal diagnosis by CVS or amniocentesis with women with identified risk factors** (age > 35 years at EDD, previous affected pregnancy, known translocation)
- ☐ **discuss maternal serum triple screening with all pregnant women** (including limited sensitivity and specificity, psychological implications, risks associated with prenatal diagnosis and 2nd trimester abortion, delays inherent in process)
- ☐ **discuss and recommend breastfeeding**
- ☐ discuss circumcision
- ☐ discuss labour and delivery (pain relief, monitoring, episiotomy, labour support, when to call)
- ☐ discuss community resources for infants & parents
- ☐ **recommend infant car seat**
- ☐ discuss signs that your baby is breastfeeding well (by day 4: breastfeeding at least 8 times, has at least 6 wet diapers and 3-4 soft, yellow stools in 24 hours) *
- ☐ **breastfeeding information and support** (early frequent contact, positioning and latching, hand expression, support groups, collection, storage and freezing)
- ☐ recommend vitamin D supplementation (200 - 400 IU/day) *
- ☐ **recommend infants be placed on back to sleep, avoid exposure to second-hand smoke,** avoid overheating and soft, loose bedding, to decrease risk of SIDS *
- ☐ **anticipatory guidance for night-time crying** *
- ☐ watch for signs of postpartum depression

*** detailed reviews available on our website: www.maternitycarecalendar.com**

Note: ideally, interventions in green should be considered preconception