Prenatal Audit Tool
Instruction Sheet

PRENATAL RECORD

Page 1

1) Identification
   - Client's surname entered
   - Client's given name entered
   - DOB entered correctly (i.e. D/M/Y)
   - Healthcare number entered
   - Client's address entered
   - Planned birthplace entered
   - Referring clinic/hosp/hc entered
   - Primary care giver name entered
   - Physician/Midwife's name entered
   - Client's Age entered at EDD
   - Client's ethnic origin entered
   - Contact number(s) entered
   - Father's name entered
   - Father's age entered
   - Ethnic origin of newborn's father entered
   - Support of father during pregnancy entered

2) Informed Consent
   - Client's signature entered
   - Witness's signature entered
   - Date entered

3) Allergies/Medications
   - Allergies entered
   - Medications entered

4) Previous Pregnancies, including Abortions
   - All preg./abor/ectopics entered COMPARE AGAINST MEDICAL RECORD
   - Year entered and correct
   - Community of birth, entered and correct
   - Weeks of gestation at birth
   - Length of labour entered and correct
   - Type of delivery entered and correct
   - Sex entered and correct
   - Birth wt. entered and correct
   - Infant's current health and correct
   - Complications entered and COMPREHENSIVE

5) Health History
   - CHECK the CHART. If any "yes" scores, comments are included.

6) Social History
   - If any yes scores, comments and referenced to page 4

7) Family/Genetic History
   - If any "yes" scores, comments are included

8) Present Pregnancy
   - If any "yes" scores, comments are included

9) Clinical Dating
   - Date of positive pregnancy test entered
   - LNMP entered
   - Certainty of LNMP checked off
   - Menses cycle entered
   - Contraception type entered
   - Date of discontinuance of contraception entered
   - EDD by LNMP entered
   - EDD by U/S entered

10) Revised/confirmed EDD entered

11) Initial Physical Examination
   - Date of initial examination (D/M/Y) entered
   - Height entered
   - Pre-pregnancy weight entered
   - BMI entered
   - Present weight entered
   - BP entered
   - Normal parameters entered
   - Details of abnormal findings entered
   - Name of initial assessor entered

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Page 2

12) Identification
- Client's surname entered
- Client's given name entered
- DOB entered correctly (i.e. D/M/Y)
- Healthcare number entered

13) Laboratory (Results and Dates)
- ABO & RH Type entered (should be performed at the first prenatal visit)
- Antibody screen results entered
- If, RH negative, this info is entered, with dates Rhogam given
- If indicated, maternal serum screen results entered
- If indicated Amnio/CVS results entered
- GDM –GCT results entered (to be done between 24-28 weeks)
- If indicated, GTT result(s) entered

Infection Screening
- Serology results entered for VDRL, HepB, HepC , Rubella, Varicella, and HIV (should be performed at the first prenatal visit). History of Chicken Pox is entered if serological evidence not required.
- Postpartum immunization(s) need entered
- Pap Smear (date and result) entered (should be performed at the first prenatal visit)
- Cervical results entered for Gonorrhea and Chlamydia (should be performed at the first prenatal visit)
- Vaginal results entered for Trichomonas, Bacterial Vaginosis and past Herpes/HSV
- MSU results entered
- Group B Strep results entered from 36 week visit
- Abnormal results, treatments and dates entered
-

14) Ultrasound Studies
- Ultrasound dates and results entered (one ultrasound is recommended between 16-20wks.
- F/u scans are not routine)

15) Confirmed Gestational Dating
- Confirmed gestational dating is entered (revised EDD should reflect LNMP, clinical exam and ultrasound results)

16) Clinical Visits
- Date entered for each visit using d/m/y
- Gest. age (wks) entered for each visit
- SFH entered (pg 2) and graphed (pg 3) for each visit (from 16wks onward)
- BP entered for each visit
- Wt entered
- Urine gluc/prot entered for each visit
- Hb dates and results entered (should be done minimum once each trimester)
- Fetal position entered for each visit (from 16wks onward)
- Movement (fetal activity) entered for each visit (from 16wks onward)
- FHR entered for each visit (from 16wks onward)
- Examiner's initials entered
- Comments entered as appropriate
- Return dates using d/m/y, as appropriate, entered for each visit

17) Risk Factors/Concerns to be Anticipated in Pregnancy (based on history, physical and scores of pg 3)
- Pregnancy scores entered. Is this assessment correct given the present pregnancy and family history.
- Delivery scores entered. Is this assessment correct given the history
- Newborn scores entered. Is this assessment correct given the history
- Total score entered at initial visit, at 36 wks and at L&D (pg 3)

18) Referral Plan
- Appropriate referral entered

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Page 3 & 4

19) Identification
- Client's surname entered
- Client's given name entered
- DOB entered correctly (i.e. D/M/Y)
- Healthcare number entered

20) Part A, B, and C (Risk Assessment)
- Risk assessment for Parts A, B, and C are entered, including subtotal and total score

21) SFH Graph
- SHF measurements (pg2) are entered for each visit as appropriate

22) 24 Hour Food Recall
- completed during initial visit. Used to identify women who are at risk for nutritional deficiencies.

23) T-ACE Questionnaire
- completed during initial visit. Used to identify women who are at risk for alcohol abuse in pregnancy.

24) Health Promotion Topics
- Completed APPROPRIATELY for the stage of pregnancy.

25) Information on extra pages of page 5 and page 6 are entered correctly.

Client's Chart

- Notation of pregnancy is on treatment record i.e. pt. profile and indication on clinic notes as prenatal record.
- Lab results filed by category and chronologically on client's chart.
- All prenatal correspondence i.e. specialist reports filed on client's chart.