

# NWT Clinical Practice Information Notice

UPON RECEIPT: (1) PLEASE FOLLOW THE DIRECTIONS BELOW  
 (2) FILE THIS NOTICE IN SECTION C, CLINICAL PRACTICE INFORMATION BINDER FOR FUTURE REFERENCE

The following clinical practice has been approved for use in the Northwest Territories Health and Social Services system, and has been distributed to:

Hospitals     
  Community Health Centers     
  Public Health Units     
  Doctors' Offices     
  Social Services Offices     
  Other: \_\_\_\_\_

The information contained in this document is a Departmental:

Policy     
  Standard     
  Protocol     
  Procedure     
  Guidelines

**Title: NWT Prenatal Record 2008**

**Effective Date: June 30, 2008**

**Statement of approved clinical practice:**

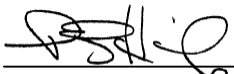
The NWT Maternal-Perinatal Committee recommends that the attached NWT Prenatal Record, dated June 2008, be used as the standard for use with all prenatal clients. Immediately replace the current Prenatal Record in use with the 2008 Prenatal Record attached.

- The revised guidelines to the NWT Prenatal Record were produced in consultation with Community Health Nurses, Nurse Practitioners, Advanced Nursing Practice Instructors, Midwives and Physicians.
- An electronic copy of this notice is also available on the Department of Health and Social Services Public Website at: <http://hlthss.gov.nt.ca> Once you have accessed the site, click on "Manuals". The Clinical Practice Information Notice can be found in the *NWT Clinical Practice Information* manual.

In addition, please replace the attached Maternal Health Program protocol, dated June 2008, in the Maternal Health section of the community Health Nursing Program standards and Protocols Manual.

**Attachments:**

- NWT Prenatal Record (June 2008)
- Maternal Health Programs Protocol

This clinical practice is approved.   
 \_\_\_\_\_  
 (signature & date)

Assistant Deputy Minister      
 Chief Medical Officer of Health      
 Director, Child & Family Services      
 Director, Adoptions

## Reference Guide for completion of the NWT Prenatal Record

The 2008 Prenatal Record was designed as a source of information for the maternal health care provider, as a source of communication amongst maternal health care providers, and as a mechanism for review of the quality of care provided to the client. The Maternal-Perinatal Committee recommends that the Prenatal Record and relevant laboratory results be faxed routinely to the hospital at 36 weeks gestation; and earlier if indicated and especially with any early ultrasound request.

1. Please fill out the standard historical information, ideally by the primary care giver at the first visit.
  - a. The support person could be spouse, newborn's father, friend, family member. Answer may indicate a referral.
  - b. The primary care giver may/may not be the same as the physician/midwife. It may be a community health nurse or several community health nurses or a nurse practitioner.
  - c. The space on the upper right side is for the addressogram.
  - d. Informed consent for sharing of the prenatal record is not needed if the information is being shared in the circle of health care providers who would normally be seen in a clinic or hospital setting, or if it is legislated to be shared. Informed consent is needed with the disclosure of specific personal information collected on the Prenatal Record to social workers, massage therapists, mental healthy workers, addictions workers.
  - e. Additional Obstetrical history can be added onto page 6).
  - f. In the health, social, current, and family/genetic histories sections, there are "Y" for yes and "N" for no. Marking the appropriate box with an "X" implies that the question was asked. The social history has an added "past" or "current" choice that will requires additional boxes to be marked with an "X". Family/genetic history has an additional "maternal" or "paternal" choice to be marked with an "X". Current pregnancy has an additional date to be filled in d/m/y.. Any identified concerns would be briefly noted in the empty box at the bottom of page 1. If none of the choices are marked with an "X", or there are no comments, it signifies that the question was not asked.
  - g. In the health history, the topic "Infections/STI, Herpes, HIV" includes asking about toxoplasmosis, rubella, cytomegalovirus, varicella.
  - h. The Social History Section, in recognition that these factors may influence the course of Perinatal care and Perinatal outcomes, works in conjunction with the health promotion section on page 4 where further detail can be charted with the discussed concerns. Note that drugs include marijuana use. If the smoking/chewing of tobacco is a concern, then the type,

amount per day, and quit date would be noted in the concerns box at the bottom of page 1 with further comments under the respective health promotion topic.

- i. Medications include traditional medications and alternate therapies.
2. The initial history should be aimed at LNMP and EDD determination. LNMP means the last normal menstrual period of length and flow of menses. The complementary physical examination should confirm this and establish uterine size. The Expected Date of Delivery (EDD) is calculated using Naegele's Rule: for a 28-day cycle, count back 3 months from the LNMP and add 7 days. For a 21 day cycle, count back 3 months from the LNMP and subtract 7 days. For a 35 day cycle, count back 3 months from the LNMP and add 7 days. The revised/confirmed EDD box is the same on pages 1 and 2, and reflects EDD determination from LNMP and U/S. If the last LNMP is not known, refer to the appropriate maternal care provider for possible ultrasound dating.
3. Any pertinent medical conditions should be treated early and/or consider consultation with referral to the appropriate consultant.
4. Physical includes BMI. Risks increase with increased BMI to both the fetus and to the mother. The NWT has chosen a BMI of 35 so that the women who most need this discussion around risks are seen and to make the best use of the resources in the NWT. A consultation with both an obstetrician and anaesthesiologist are recommended.
5. **Laboratory:**
  - a. Cervical Cancer Screen – is routinely taken at the first prenatal visit, unless the client is being followed in an abnormal pap schedule already.
  - b. Hb – CBC should be done at the first visit in the first trimester. If low, closer monitoring each trimester with appropriate therapy as indicated. If Hb falls below 10g/L and

not responding to therapy, consider physician/nurse practitioner consultation, and further monitoring.

- c. ABO+Rh – screening done at initial prenatal visit. Rh-positive clients should have a repeat antibody screen at 26-28 weeks only if it is the client's first pregnancy or it is recommended on the laboratory results by Blood Services. Rh-negative clients require appropriate monitoring and therapy for prevention of Rh disease. If Rh-negative, repeat antibody screen per Blood Services recommendation and administer Rhogam accordingly. Rhogam should be given to Rh-negative women at 28 weeks. If given earlier, another course should be given 12-13 weeks after the first course.
- d. Maternal Serum Screening (QUADRUPLE screen) is offered to all pregnant women in the NWT, through an informed consent process and regardless of maternal age (SCOGC Guidelines No. 187 *Prenatal Screening for Fetal Aneuploidy*, February 2007). It screens for Down Syndrome, Open Neural Tube Defects, and Trisomy 18. Timing of the screen can only be done between 15 and 20 weeks of pregnancy, optimally at 16 weeks. Accurate estimation of gestational age is extremely important.
- e. Amnio/CVS – patients who will be over the age of 35 (singleton) or 32 (twins) at the time of delivery, and/or patients with first degree relatives with neural tube defects/spina bifida should receive appropriate counselling for, and be offered genetic testing.

#### 6. Infection Screening:

- a. Serology for the demarcated infective agents should be done at the first prenatal visit. TSH is done if indicated.
- b. Appropriate cervical and vaginal cultures required on initial prenatal visit. Repeat swabs are commended at 36 weeks.
- c. If any cultures return positive, refer to STI and Vaginitis in pregnancy in the STI Treatment Guidelines. If still uncertain

about appropriate therapy, consult referral physician/Health Protection Unit DHSS. (ref *Canadian Guidelines on STIs* 2006)

- d. GBS – refer to current guidelines for GBS (Group B streptococcus) prevention strategies in the third trimester. Recto/vaginal swab is not taken at the initial prenatal visit, but at 35-37 weeks gestation. (Ref, *SOGC Guidelines*, 2004, Centres for Disease Control Guidelines on GBS, Aug. 2002)
  - e. Urine – midstream urine (MSU) using clean technique for C&S – ideally late in the first trimester or early in the second trimester and then as required from the results of the POCT routine urinalysis. Indicator of asymptomatic bacteria and GBS colonization
7. Postpartum Immunizations needs are indicated from the serology screening. The boxes flag that specific immunizations are/are not needed. “X” Marked boxes do not mean that the immunizations were given.
  8. **Gestational Diabetes/GDM** – routine Oral Glucose Challenge Test (OGCT) of 50G is done between 24-28 weeks of gestation. Abnormal values of greater than or equal to 7.8 mmol/L at 1 hour is considered positive and will need follow-up with Oral Glucose Tolerance Test (OGTT) of 75G for proper diagnosis and treatment. If the OGCT is greater than or equal to 10.3 mmol/L, then the patient is diagnosed with GDM and does not need further testing. If the patient has a history of GDM or is otherwise at high risk e.g. morbid obesity, strong family history, previous stillbirth, give the initial OGTT at 16-20 weeks, and if negative then followed by a second one at 24-28 weeks. Consider physician consultation. (ref SOGC CPG November 2002 *Screening for Gestational Diabetes Mellitus*)
  9. Confirmed EDD should reflect LNMP, clinical examination, +/- U/S confirmation preferably with an early (<20 weeks) ultrasound.
  10. One screening ultrasound recommended at 16-20 weeks, ideally at 18 weeks gestation. Follow-up scans are not routine and are at the discretion of the referral midwife, nurse practitioner or physician.  
  
If the dates are uncertain, then a first trimester ultrasound is recommended (SOGC CPG *The Use of First Trimester Ultrasound*, October 2003). In this case, a follow-up ultrasound is recommended at 18 weeks gestation.
  11. **Prenatal visits Part 2** (an additional sheet for visits has been added to prevent repetition of other information):
    - a. Clients should be seen routinely Q4 weeks to 28 weeks, Q 2 weeks from 29-36 weeks, and every week thereafter until delivery. If clinical situation requires it, schedule visits more frequently. Additional visits at 34 and 35 weeks are recommended in communities from where the patient will eventually need to be transported.
    - b. The prenatal record aids in determining fetal growth and documenting maternal well-being. It is important to follow trends and act upon abnormalities as soon as possible.
    - c. In particular, SFH (symphyseal-fundal height) and gestational weeks should correlate each week after 20 weeks. Suspicion should be raised if SFH does not exhibit the predicted growth +/- 2 cm or does not increase over a 3 week period. An appropriate referral for possible ultrasound should be considered. (Ref. Martin (2003) *Intrapartum Management Modules*).
    - d. Movement and SFH should be documented with each visit.
  12. Risk factors/Concerns, anticipated from the history and physical, would be documented in the Pregnancy/Delivery, Postpartum/Newborn box (found bottom of Part 2). It is expected that these factors would be addressed at a prenatal visit, delivery, or the neonatal period. e.g. VBAC, or infant requires Hepatitis B Vaccine. It should be an itemization of any conditions that may complicate this pregnancy. As a

result, a referral plan may be indicated and identification of the referrals identified in the Referral Plan box.

13. Part 3: the Pregnancy Risk Assessment have been revised and no longer includes a score. The lists do not replace the need for a comprehensive understanding of prenatal management. It is expected that identification of one or more of these risk factors would prompt appropriate consultation and flag the maternal health care provider that this client needs more diligent monitoring.
14. T-ACE questionnaire, included on the Risk Scoring sheet, is an effort to quickly identify women at risk for alcohol abuse in pregnancy. T-ACE is a measurement of four questions that are significant issues of risk drinking. The T-ACE questionnaire should be completed at intake on all clients. The T-ACE score has a range of 0-5. The value of each answer to the four questions is totalled to determine the final T-ACE score. Any positive results indicate exploration of women's drinking i.e. further questions.(ref National Institute on Alcohol Abuse & Alcoholism, Oct 2004). A client should be referred to an addictions worker if she has a score of greater than 2 or if the Tolerance question answer is greater than 2 drinks. Any plans to quit or to follow-up would be discussed and charted under the health promotion topics on page 4.
15. SAFE screening tool has been added. Healthy Relationships and domestic violence questions are intended to be asked throughout pregnancy. An "X" in the box signifies that the topic was discussed individually with the client to identify the nature of the relationship, the manner for resolving arguments, and the presence of physical, emotional or sexual abuse. This tool can be easily worked into a general conversation. If concerns arise, consider referral to appropriate resources. (Ref. *EpiNorth* 2007 Spousal Violence in the NWT: Implications for Health Care Providers).
16. The nutritional recall chart is similarly intended to identify women who are at risk for deficiencies. If any concerns in any area arise, consider referral to appropriate consultant.
17. Health Promotion Topics Part 4 for conversation listed are issues throughout pregnancy. An "X" on the box signifies that the topic was discussed. If any concerns in any area arise, document under the comments section and consider referral to appropriate consultant e.g. nutritionist, addictions worker.



# NWT PRENATAL RECORD - Part 1

PLANNED BIRTH PLACE		REFERRING CLINIC / HOSPITAL / HEALTH CENTRE	
PRIMARY CARE GIVER		PHYSICIAN / MIDWIFE	
MOTHER'S NAME		AGE AT EDD	LANGUAGE PREFERRED
ETHNIC ORIGIN	CONTACT NUMBERS: RESIDENCE		ALTERNATE
SPOUSE/PARTNER NAME:		AGE:	SUPPORT PERSON:

PATIENT'S SURNAME	GIVEN NAME
ADDRESS	
HEALTH CARE NUMBER	DATE OF BIRTH (D/M/Y)

<b>Allergies:</b>	<b>Medications/Alternate Therapies:</b>
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INITIAL ASSESSMENT DONE BY: \_\_\_\_\_ DATE (D/M/Y): \_\_\_\_\_

## OBSTETRICAL HISTORY

Gravida		Term			Preterm		Abortions / Ectopic		Living		Multiple Gestations	
DATE (D/M/Y)	COMMUNITY OF BIRTH / ABORTION	WKS AT DELIVERY	LENGTH OF LABOUR	DELIVERY TYPE	PERINATAL COMPLICATIONS		SEX	BIRTH WEIGHT (kg/g)	PRESENT HEALTH OF CHILDREN			

## HEALTH HISTORY

DATE - D/M/Y:	N	Y
CV/HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA/LUNG DISEASE/ TB EXPOSURE	<input type="checkbox"/>	<input type="checkbox"/>
GENITAL/URINARY/RENAL	<input type="checkbox"/>	<input type="checkbox"/>
DVT/CLOTTING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>
BLOOD/BLOOD PRODUCTS	<input type="checkbox"/>	<input type="checkbox"/>
HEMATOLOGY/ BLOOD DISORDERS	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES/ENDOCRINE/ THYROID	<input type="checkbox"/>	<input type="checkbox"/>
SEIZURE/NEUROLOGICAL	<input type="checkbox"/>	<input type="checkbox"/>
SURGERIES/ANESTHESIA	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC/DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>
INFECTIONS/STI/HERPES/HIV	<input type="checkbox"/>	<input type="checkbox"/>
HEM/IMMUNOLOGY	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>

## SOCIAL HISTORY

DATE - D/M/Y:	N	Y	PAST	CUR.
NUTRITION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPECIAL DIET	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALCOHOL (COMPL. TACE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DRUGS/SUBST. ABUSE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SMOKING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SECOND HAND SMOKE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DOMESTIC VIOLENCE (COMPLETE SAFE)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SUPPORT SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HOUSING/FINANCIAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
RELIGIOUS/CULTURAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENVIRONMENTAL/OCCUP.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## FAMILY/GENETIC HISTORY

DATE - D/M/Y:	N	Y	MAT	PAT
CONGENITAL ANOMALIES/ MALFORMATIONS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INHERITED DISEASE EFFECT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HYPERTENSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BLEEDING DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MULTIPLE GESTATION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ANESTHESIA PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSYCHIATRIC PROBLEMS/ DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SIDS/NEONATAL LOSS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## CURRENT PREGNANCY

	N	Y	DATE
BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	_____
NAUSEA/VOMITING	<input type="checkbox"/>	<input type="checkbox"/>	_____
VAGINAL DISCHARGE	<input type="checkbox"/>	<input type="checkbox"/>	_____
INFECTIONS OR FEVER	<input type="checkbox"/>	<input type="checkbox"/>	_____
DEPRESSION	<input type="checkbox"/>	<input type="checkbox"/>	_____
OTHER	<input type="checkbox"/>	<input type="checkbox"/>	_____

## INITIAL PHYSICAL EXAMINATION

HEIGHT	PRE-PREGNANT WEIGHT	BMI	CURRENT WEIGHT	BP

HEAD/NECK/THYROID   
 HEART/LUNG   
 PELVIS   
 VAGINA   
 SPINE/BACK  
 BREASTS/NIPPLES   
 ABDOMEN   
 UTERINE SIZE   
 VARICIES/SKIN   
 LIMBS

## COMMENTS / FINDINGS FROM HISTORY / PHYSICAL

## CLINICAL DATING

PREGNANCY TEST POSITIVE DATE: \_\_\_\_\_

LNMP: \_\_\_\_\_

CERTAINTY OF DATE:  YES  NO (please check one)

MENSES CYCLE: \_\_\_\_\_

CONTRACEPTIVE: \_\_\_\_\_

LAST USE: \_\_\_\_\_

EDD BY LNMP: \_\_\_\_\_

EDD BY U/S < 20 WKS: \_\_\_\_\_

**REVISED/CONFIRMED EDD**



# NWT PRENATAL RECORD - Part 2

**LABORATORY** - Send copy of prenatal sheets and lab results to hospital at 36 weeks or earlier if indicated.

PATIENT'S SURNAME	GIVEN NAME
ADDRESS	
HEALTH CARE NUMBER	DATE OF BIRTH (D/M/Y)

<b>ABO AND RH TYPE:</b> DATE (D/M/Y):	<b>GDM SCREEN:</b> GCT 50 G DATE (D/M/Y): RESULTS:	<b>SEROLOGY SCREENING:</b> DATE (D/M/Y): <input type="checkbox"/> SYPHILIS: <input type="checkbox"/> HEPATITIS B: <input type="checkbox"/> HEPATITIS C: <input type="checkbox"/> RUBELLA: <input type="checkbox"/> VARICELLA: <input type="checkbox"/> THS IF INDICATED: <input type="checkbox"/> OTHER:	<b>INVESTIGATIONS:</b> DATE (D/M/Y)      RESULTS <input type="checkbox"/> CERVICAL CANCER SCREENING <input type="checkbox"/> GONORRHEA <input type="checkbox"/> CHLAMYDIA <input type="checkbox"/> TRICHOMONAS <input type="checkbox"/> BACTERIAL VAGINOSIS <input type="checkbox"/> HERPES IF INDICATED <input type="checkbox"/> GROUP B STREP <input type="checkbox"/> URINE MSU	<b>ULTRASOUND STUDIES</b> ATTACH RESULTS DATE (D/M/Y)      GEST AGE    
<b>ANTIBODY SCREEN:</b> INITIAL: REPEAT 26-28 WKS:	IF ABNORMAL: GTT 75 G DATE (D/M/Y): RESULTS:	IF PREVIOUS INDICATORS AT FIRST SCREEN: GTT 75 G DATE (D/M/Y): RESULTS:	<b>TREATMENT FOR ANY OF THE ABOVE:</b>	<b>CONFIRMED EDD</b>
<b>IF RH NEGATIVE:</b> RHOGAM GIVEN: DATE (D/M/Y): DATE (D/M/Y):	IF PREVIOUS INDICATORS AT FIRST SCREEN: GTT 75 G DATE (D/M/Y): RESULTS:	<b>POSTPARTUM IMMUNIZATION</b> <input type="checkbox"/> NONE <input type="checkbox"/> RUBELLA <input type="checkbox"/> VARICELLA		
<b>MATERNAL SERUM SCREEN:</b> OFFERED: <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPTED: <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS:	DATE (D/M/Y): RESULTS:			
<b>AMNIO / CVS RESULTS:</b> INDICATED: <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPTED: <input type="checkbox"/> YES <input type="checkbox"/> NO DATE (D/M/Y): RESULTS:	DATE (D/M/Y): RESULTS:			

**CLINICAL VISITS** - Please use page 5 if more entries are needed

DATE (D/M/Y)	WKS	SFH (cm)	B/P	WT. (kg)	URINE (pro/glu)	CBC/Hb	POSITION	FETAL MVMNT	FHR	COMMENTS	INIT.	RTC D/M/Y

<b>RISK FACTORS / CONCERNS TO BE ANTICIPATED IN PREGNANCY, DELIVERY, POSTPARTUM, NEWBORN - RESULTS OF HISTORY AND PHYSICAL</b> PREGNANCY: _____ DELIVERY: _____ POSTPARTUM: _____ NEWBORN: _____	<b>REFERRAL PLAN</b> <input type="checkbox"/> OBSTETRICIAN <input type="checkbox"/> PUBLIC HEALTH NURSE <input type="checkbox"/> FAMILY PHYSICIAN <input type="checkbox"/> MIDWIFE <input type="checkbox"/> SOCIAL WORKER <input type="checkbox"/> CHR <input type="checkbox"/> DIETICIAN/CPNP <input type="checkbox"/> ADDICTIONS COUNSELLOR <input type="checkbox"/> OTHER
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# NWT PRENATAL RECORD - Part 3

## PREGNANCY RISK ASSESSMENT

Ideally, each pregnant woman should be assessed for the following risks before pregnancy, at the first prenatal visit, and throughout pregnancy. These lists do not replace the need for a comprehensive understanding of prenatal management. Identification of one or more of these risk factors should prompt discussion with, and consideration of referral to, a more knowledgeable maternal health care provider.

Pre-Pregnancy	X Box
AGE < 16 AT DELIVERY	<input type="checkbox"/>
AGE > 40 AT DELIVERY	<input type="checkbox"/>
BMI > 35 OR < 18	<input type="checkbox"/>
DIABETES MELLITUS	<input type="checkbox"/>
HEART DISEASE	<input type="checkbox"/>
PRE-EXISTING HYPERTENSION > 140/90	<input type="checkbox"/>
CHRONIC RENAL DISEASE	<input type="checkbox"/>
<b>OTHER MEDICAL DISORDERS:</b>	
EPILEPSY	<input type="checkbox"/>
LUPUS	<input type="checkbox"/>
CROHN'S	<input type="checkbox"/>
ULCERATIVE COLITIS	<input type="checkbox"/>
OTHER	<input type="checkbox"/>

Current Pregnancy	X Box
ABNORMAL GROWTH BY SFH MEASUREMENTS	<input type="checkbox"/>
MULTIPLE GESTATIONS	<input type="checkbox"/>
BLEEDING AFTER 10 WEEKS	<input type="checkbox"/>
PREGNANCY INDUCED HYPERTENSION	<input type="checkbox"/>
PROTEINURIA > 1+	<input type="checkbox"/>
GESTATIONAL DIABETES	<input type="checkbox"/>
ABNORMAL PRENATAL BLOOD GROUP AND SCREEN	<input type="checkbox"/>
ANEMIA - HGB < 100 G/L	<input type="checkbox"/>
SUBSTANCE / DRUG / ALCOHOL / TOBACCO USE	<input type="checkbox"/>

### NUTRITION RECALL

24 Hour Food Recall	
BREAKFAST:	<input type="checkbox"/> BREAD <input type="checkbox"/> MILK <input type="checkbox"/> FRUIT/VEG <input type="checkbox"/> MEAT <input type="checkbox"/> OTHER
SNACK:	<input type="checkbox"/> BREAD <input type="checkbox"/> MILK <input type="checkbox"/> FRUIT/VEG <input type="checkbox"/> MEAT <input type="checkbox"/> OTHER
LUNCH:	<input type="checkbox"/> BREAD <input type="checkbox"/> MILK <input type="checkbox"/> FRUIT/VEG <input type="checkbox"/> MEAT <input type="checkbox"/> OTHER
SNACK:	<input type="checkbox"/> BREAD <input type="checkbox"/> MILK <input type="checkbox"/> FRUIT/VEG <input type="checkbox"/> MEAT <input type="checkbox"/> OTHER
SUPPER:	<input type="checkbox"/> BREAD <input type="checkbox"/> MILK <input type="checkbox"/> FRUIT/VEG <input type="checkbox"/> MEAT <input type="checkbox"/> OTHER
COMMENTS: _____	
IS FOOD SECURITY AN ISSUE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

Past Obstetrical History	X Box
NEONATAL DEATH	<input type="checkbox"/>
STILLBIRTH	<input type="checkbox"/>
BIRTH < 36 WEEKS	<input type="checkbox"/>
ABORTION:	
> 3 SPONTANEOUS 1ST TRIMESTER ABORTIONS OR	<input type="checkbox"/>
≥ 1 SPONTANEOUS ABORTION > 12 WEEKS	<input type="checkbox"/>
CAESAREAN SECTION OR UTERINE SURGERY	<input type="checkbox"/>
SMALL / LARGE FOR DATES	<input type="checkbox"/>
RH ISOIMMUNIZATION	<input type="checkbox"/>
MAJOR CONGENITAL ANOMALY	<input type="checkbox"/>
PLACENTA ABRUPTION	<input type="checkbox"/>
PRE-ECLAMPSIA OR ECLAMPSIA	<input type="checkbox"/>
OTHER SIGNIFICANT PRIOR FETAL / MATERNAL COMPLICATION _____	<input type="checkbox"/>

**SAFE TOOL**      DATE- D/M/Y:

**S:** How would she describe her spousal/intimate relationship?

**A:** What happens when she and her partner argue?

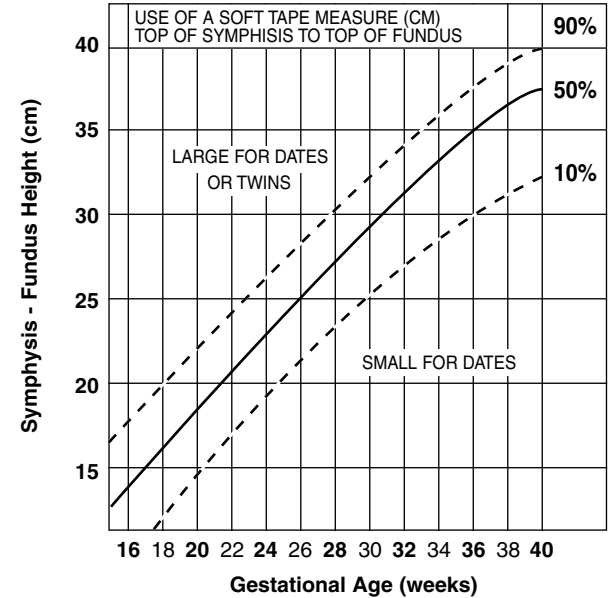
**F:** Do fights result in her being hit, shoved or hurt?

**E:** Does she have an emergency plan?

**Note:** A client is at risk for alcohol use if she has a positive T-ACE (a score of 2 or greater).

PATIENT'S SURNAME	GIVEN NAME
ADDRESS	
HEALTH CARE NUMBER	DATE OF BIRTH (D/M/Y)

## SYMPHYSIS - FUNDUS HEIGHT GROWTH CHART



T-ACE QUESTIONNAIRE	DATES - D/M/Y:	SCORE	SCORE
1. HOW MANY DRINKS DOES IT TAKE TO MAKE YOU FEEL HIGH? 0 - LESS THAN OR EQUAL TO 2 DRINKS 2 - MORE THAN 2 DRINKS		<b>TOLERANCE</b>	
2. HAVE PEOPLE ANNOYED YOU BY CRITICIZING YOUR DRINKING? 0 - NO 1 - YES		<b>ANNOYANCE</b>	
3. HAVE YOU FELT YOU OUGHT TO CUT DOWN ON YOUR DRINKING? 0 - NO 1 - YES		<b>CUT DOWN</b>	
4. HAVE YOU EVER HAD A DRINK FIRST THING IN THE MORNING TO STEADY YOUR NERVES OR TO GET RID OF A HANGOVER? 0 - NO 1 - YES		<b>EYE OPENER</b>	
<b>TOTAL:</b>			



# NWT PRENATAL RECORD - Part 4

PATIENT'S SURNAME	GIVEN NAME
ADDRESS	
HEALTH CARE NUMBER	DATE OF BIRTH (D/M/Y)

## HEALTH PROMOTION TOPICS

### 4 - 20 WEEKS:

<input type="checkbox"/> DRUGS:	<input type="checkbox"/> TOBACCO:
<input type="checkbox"/> RX	<input type="checkbox"/> SMOKING
<input type="checkbox"/> OTC	<input type="checkbox"/> SECOND HAND SMOKE
<input type="checkbox"/> STREET	<input type="checkbox"/> SMOKELESS TOBACCO
<input type="checkbox"/> NUTRITION/WEIGHT GAIN:	<input type="checkbox"/> SMOKE FREE ENVIRON.
<input type="checkbox"/> CALCIUM	
<input type="checkbox"/> FOLIC ACID	<input type="checkbox"/> ALCOHOL - T-ACE SCORE
<input type="checkbox"/> IRON	<input type="checkbox"/> HEALTHY RELATIONSHIPS
<input type="checkbox"/> VITAMINS	<input type="checkbox"/> GENETIC COUNSELLING
<input type="checkbox"/> PRENATAL NUTRITION PROGRAM	<input type="checkbox"/> ADOPTION
<input type="checkbox"/> HEALTHY BABY CLUB/OTHER	<input type="checkbox"/> SOCIAL RISK FACTORS
<input type="checkbox"/> PRENATAL CLASSES	<input type="checkbox"/> ULTRASOUND

### COMMENTS

DATE - D/M/Y		INIT.

### 20 - 30 WEEKS:

<input type="checkbox"/> FETAL MOVEMENT
<input type="checkbox"/> SEXUAL RELATIONS / SEXUALITY
<input type="checkbox"/> BIRTH PLAN:
<input type="checkbox"/> BIRTH PLACE/TRANSFER PLAN
<input type="checkbox"/> BIRTH SUPPORT / PERSONAL COACH
<input type="checkbox"/> LABOUR AND DELIVERY
<input type="checkbox"/> ADMISSION TIMING
<input type="checkbox"/> PAIN RELIEF / ANALGESIA
<input type="checkbox"/> POSTNATAL SUPPORT
<input type="checkbox"/> BREAST FEEDING PROMOTION

### COMMENTS

DATE - D/M/Y		INIT.

### 30 WEEKS TO POSTPARTUM:

<input type="checkbox"/> BIRTH PLANS	<input type="checkbox"/> SEXUAL RELATIONS
<input type="checkbox"/> BREAST FEEDING PROMOTION	<input type="checkbox"/> BIRTH CONTROL / FAMILY PLANNING
<input type="checkbox"/> SELF-CARE POSTNATAL:	<input type="checkbox"/> PARENTING RESOURCES
<input type="checkbox"/> HYGIENE	<input type="checkbox"/> INFANT CAR SEAT AND HOME SAFETY
<input type="checkbox"/> BOWELS / URINATION	<input type="checkbox"/> SUDDEN INFANT DEATH SYNDROME PREVENTION
<input type="checkbox"/> CLOTHING	<input type="checkbox"/> IMMUNIZATIONS
<input type="checkbox"/> DEPRESSION	<input type="checkbox"/> SHAKEN BABY SYNDROME

### COMMENTS

DATE - D/M/Y		INIT.



