



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:
Allergies:		Medications/Alternate Therapies:	

PATIENT'S SURNAME	GIVEN NAME
ADDRESS	
HEALTH CARE NUMBER	
DATE OF BIRTH (D/M/Y)	
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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS / FINDINGS FROM HISTORY / PHYSICAL

CLINICAL DATING

PREGNANCY TEST POSITIVE DATE:	_____
LNMP:	_____
CERTAINTY OF DATE: <input type="checkbox"/> YES <input type="checkbox"/> 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)

ABO AND RH TYPE: DATE (D/M/Y):	GDM SCREEN: GCT 50 G DATE (D/M/Y): RESULTS:	SEROLOGY SCREENING: 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:	INVESTIGATIONS: 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	ULTRASOUND STUDIES ATTACH RESULTS DATE (D/M/Y) GEST AGE _____ _____ _____
ANTIBODY SCREEN: INITIAL: REPEAT 26-28 WKS:	IF ABNORMAL: GTT 75 G DATE (D/M/Y): RESULTS:	POSTPARTUM IMMUNIZATION <input type="checkbox"/> NONE <input type="checkbox"/> RUBELLA <input type="checkbox"/> VARICELLA	TREATMENT FOR ANY OF THE ABOVE:	CONFIRMED EDD
IF RH NEGATIVE: RHOGAM GIVEN: DATE (D/M/Y): DATE (D/M/Y):	IF PREVIOUS INDICATORS AT FIRST SCREEN: GTT 75 G DATE (D/M/Y): RESULTS:	DATE (D/M/Y): RESULTS:	DATE (D/M/Y): RESULTS:	DATE (D/M/Y): RESULTS:
MATERNAL SERUM SCREEN: OFFERED: <input type="checkbox"/> YES <input type="checkbox"/> NO ACCEPTED: <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS:	AMNIO / CVS RESULTS: 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:	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

RISK FACTORS / CONCERNS TO BE ANTICIPATED IN PREGNANCY, DELIVERY, POSTPARTUM, NEWBORN - RESULTS OF HISTORY AND PHYSICAL PREGNANCY: DELIVERY: POSTPARTUM: NEWBORN:	REFERRAL PLAN <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
--	---



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"/>
OTHER MEDICAL DISORDERS:	
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?

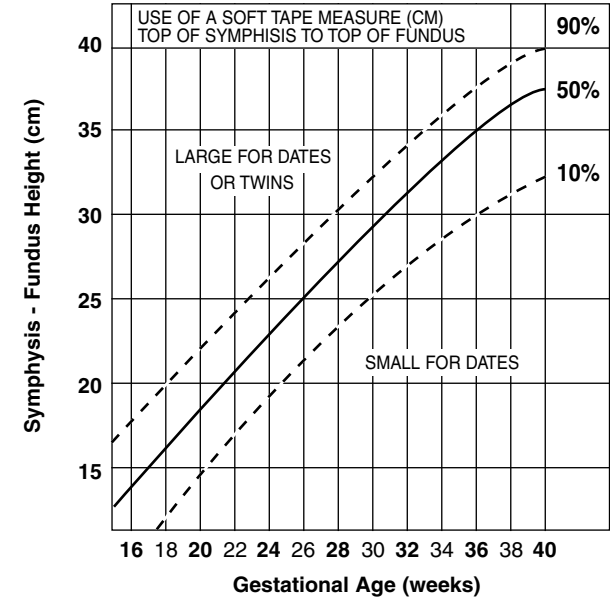
F: Do fights result in her being hit, shoved or hurt?

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		TOLERANCE	
2. HAVE PEOPLE ANNOYED YOU BY CRITICIZING YOUR DRINKING? 0 - NO 1 - YES		ANNOYANCE	
3. HAVE YOU FELT YOU OUGHT TO CUT DOWN ON YOUR DRINKING? 0 - NO 1 - YES		CUT DOWN	
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		EYE OPENER	
TOTAL:			



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.

