

Prenatal Care Plan

Alberta Medical Association, October 2000



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Introduction

This document is intended as a guide to comprehensive prenatal care for the women of Alberta. It is suitable for use by obstetricians, family physicians and midwives.

This care plan is not meant to replace clinical judgment, especially for women with significant risk factors or unusual circumstances.

Certain investigations should only be performed if deemed appropriate by the attending physician/midwife. Note that separate guidelines may also be available for some of the items.

Please forward any comments or questions to the Committee on Reproductive Care, Alberta Medical Association.

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Prenatal Worksheet

This prenatal worksheet outlines the examinations, investigations and counseling the physician or midwife should consider conducting during a woman's pregnancy. ■ **Dark purple** indicates items to be considered in at-risk populations. ■ **Light purple** indicates items to investigate only if evidence warrants.

How to use this worksheet

The physician or midwife may use this worksheet as a reference tool when providing prenatal care. The form may also be completed and maintained in the patient's record. If used, this worksheet is a supplementary reference tool and cannot replace the *Alberta Prenatal Record*.

Two additional copies of this worksheet are provided at the end of this document. The worksheets are perforated so they can be easily removed and photocopied for use as a patient record if desired.

For detailed explanations about any items on the worksheet, refer to the corresponding text in this document.

Prenatal Worksheet			
Prenatal Care Plan, Alberta Medical Association, October 2000			
This prenatal worksheet outlines the examinations, investigations and counseling the physician or midwife should consider conducting during a woman's pregnancy. ■ Dark purple indicates items to be considered in at-risk populations. ■ Light purple indicates items to investigate only if evidence warrants.			
TIMING	HISTORY & PHYSICAL	INVESTIGATIONS TO CONSIDER	COUNSELING
Prior to conception	<input type="checkbox"/> Complete history & physical <input type="checkbox"/> Assess impact of current medical illness (diabetes, hypertension)	<input type="checkbox"/> CBC <input checked="" type="checkbox"/> Carrier Screening <input type="checkbox"/> Rubella titre <input type="checkbox"/> Pap smear <input type="checkbox"/> STD screening <input type="checkbox"/> HIV serology <input checked="" type="checkbox"/> Other viral serology <input checked="" type="checkbox"/> Glucose testing	Lifestyle issues <input type="checkbox"/> nutrition (including folic acid supplementation) <input type="checkbox"/> sleep patterns <input type="checkbox"/> exercise <input type="checkbox"/> work <input type="checkbox"/> smoking <input type="checkbox"/> alcohol and drug use
6 – 10 weeks	<input type="checkbox"/> Review history & physical	<input type="checkbox"/> CBC <input type="checkbox"/> Rubella titre <input type="checkbox"/> Syphilis serology (RPR) <input type="checkbox"/> HIV serology <input type="checkbox"/> ABO/Rh & antibodies <input type="checkbox"/> Hepatitis B antigen <input type="checkbox"/> Urinalysis ± C&S <input type="checkbox"/> Pap smear <input checked="" type="checkbox"/> Vaginal or cervical cultures <input checked="" type="checkbox"/> Other viral serology <input checked="" type="checkbox"/> Glucose testing	<input type="checkbox"/> Review lifestyle issues <input type="checkbox"/> Management of nausea if present <input type="checkbox"/> Normal symptoms of pregnancy <input type="checkbox"/> Genetic screening <input type="checkbox"/> Sexuality <input type="checkbox"/> Seatbelt use <input type="checkbox"/> Domestic violence <input type="checkbox"/> Prenatal classes <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Assign EDD (Estimated Due Date) <input type="checkbox"/> Review medication and herb usage
At each visit (Conduct visits q4weeks up to 28-30 weeks, q2weeks up to 36 weeks and q1week until delivery)	<input type="checkbox"/> Inquire as to general well-being <input type="checkbox"/> Assign gestational age <input type="checkbox"/> Weight <input type="checkbox"/> Blood pressure <input type="checkbox"/> Symphysis-fundal height in cm <input type="checkbox"/> Fetal heart sounds <input type="checkbox"/> Presence of fetal movements	<input type="checkbox"/> Urine for glucose <input type="checkbox"/> Urine for protein	<input type="checkbox"/> Counsel for common symptoms at this gestation
10 – 16 weeks		<input checked="" type="checkbox"/> Genetic Screening (Biochemical/Amniocentesis/CVS)	
17 – 19 weeks		<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Confirm EDD for entire pregnancy
18 – 22 weeks			<input type="checkbox"/> Preterm labour
24 – 28 weeks		<input type="checkbox"/> Hemoglobin <input type="checkbox"/> Diabetic screening <input checked="" type="checkbox"/> ABO/Rh & antibodies (if Rh negative)	<input checked="" type="checkbox"/> Obtain VBAC consultation/ documentation
28 – 32 weeks	<input type="checkbox"/> Add fetal position to routine visit	<input checked="" type="checkbox"/> Give Rh immune globulin (if Rh negative)	<input type="checkbox"/> Importance of fetal movement awareness
30 – 36 weeks			<input type="checkbox"/> Labour & delivery issues <input type="checkbox"/> Hospital admission procedures <input type="checkbox"/> Newborn issues and testing <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum planning <input checked="" type="checkbox"/> Commence fetal movement charting
36 weeks	<input type="checkbox"/> Confirm presentation of fetus	<input checked="" type="checkbox"/> GBS culture	<input type="checkbox"/> Ensure record available to L&D unit
41 – 42 weeks		<input type="checkbox"/> Fetal assessment	<input type="checkbox"/> Induction plans
Postpartum (6 weeks)	<input type="checkbox"/> Pelvic examination <input type="checkbox"/> Breastfeeding evaluation <input type="checkbox"/> Check for postpartum depression	<input type="checkbox"/> Pap smear <input checked="" type="checkbox"/> Hemoglobin	<input type="checkbox"/> Labour & delivery issues <input type="checkbox"/> Sexuality & contraception <input type="checkbox"/> Review Rubella status <input type="checkbox"/> Coping strategies

Preconception Visit

All women should be offered preconception care. A preconception visit is an ideal opportunity to discuss potential problems and provide appropriate interventions before a pregnancy even begins. Page one of the *Alberta Prenatal Record* may be a helpful framework from which to begin.

History and Physical

History

The obstetrical, medical and family history should all be reviewed. Anything that could adversely influence the future pregnancy should be documented, investigated and treated when possible. Certain conditions, such as diabetes and hypertension, can have a profound effect on pregnancy and its management.

Example 1:

If the obstetrical history includes recurrent pregnancy losses, some investigations can be completed prior to conception, with appropriate interventions initiated early in pregnancy.

Example 2:

If the family history shows an unusual syndrome, it can be investigated pre-conception to assess the couple's risk of conceiving a child with the syndrome. This allows the couple to make informed choices in a timely manner.

Example 3:

A medical history of a seizure disorder and use of antiepileptic therapy can increase the risk of neural tube defect. Risk may be significantly reduced by adjusting the medication and using folic acid supplementation.

Note: It is not within the scope of this document to address all the significant historical factors that can influence conception and pregnancy. Each accoucheur should familiarize him/herself with factors that can lead to complications of pregnancy and delivery.

Physical

The preconception physical examination provides an opportunity to identify factors that are best investigated and treated prior to pregnancy.

Example 1:

If a thyroid nodule is detected in pregnancy, it may be difficult to determine whether the patient is euthyroid due to an alteration of thyroid indices during pregnancy. Further, the thyroid cannot be investigated or treated with radioactive iodine during pregnancy.

Example 2:

If detected prior to conception, a suspicious breast nodule can be investigated and removed if necessary. If chemotherapy is indicated, this can occur immediately. In contrast, a malignant breast lesion discovered in early pregnancy may force a woman to choose between terminating the pregnancy and delaying appropriate therapy.

Investigations

CBC

A preconception CBC may identify an iron deficiency state that could be corrected prior to conception; it may also help identify any previously undiagnosed hemoglobinopathies. MCV \pm hemoglobin electrophoresis is the most reliable way to diagnose hemoglobinopathies.

Carrier Screening

Populations at risk for hemoglobinopathies should be screened with MCV \pm hemoglobin electrophoresis. Southeast Asians, East Indians, Blacks and Hispanics are at risk for α -thalassemia. Italians, Greeks and those of Mediterranean backgrounds are considered at risk for β -thalassemia.

All blacks are at risk for sickle cell disease and should be offered Sickledex screening. The Ashkenazi Jewish population is at risk for Tay Sachs Disease and should be offered the benefit of genetic counseling.

Rubella titre

Any non-immune woman can receive appropriate immunization prior to conception. Any positive titre within the preceding 10 years is sufficient to indicate current immunity.

Pap smear

Significant abnormalities should be treated prior to conception.

STD screening

It may be appropriate to perform STD (sexually transmitted disease) screening at the preconception visit. Some STDs can lead to infertility and should therefore be treated upon detection. Once a woman is pregnant, she or her physician may be reticent to use certain pharmaceutical agents due to their potential impact on the fetus. In many instances, treatment prior to pregnancy is preferable.

HIV serology

Patients who do not consider themselves at risk of being HIV (Human Immunodeficiency Virus) positive may still be infected. With appropriate counseling, determining HIV status may be an important factor in considering whether or not to conceive.

Other viral serology

Some patients may be at risk of exposure to certain viral agents and may benefit from determining their immune status prior to conception. Examples include the mother of a preschool infant who is uncertain if she has had chicken pox; the childcare worker who worries about CMV (cytomegalovirus); and the veterinarian who is concerned about toxoplasmosis.

Glucose Testing

Glucose testing may be indicated in women with a higher risk of diabetes. Since overt diabetes carries an increased risk of fetal anomaly, it is best to identify and treat the condition prior to conception.

Counseling

Nutrition and vitamins

Women should be encouraged to eat a well balanced diet with calories and food groups spread evenly throughout the day. The *Canada Food Guide* is a good reference and educational tool.

Encourage obese patients to eat well and to move closer to their ideal body weight by increasing exercise and avoiding excessive fat intake.

All women should be counseled to take folic acid supplementation of 0.4 – 0.8 mg/day for at least a month prior to conception and for the first 12 weeks of pregnancy. Women at increased risk of giving birth to a child with a neural tube defect should take 4 – 5 mg of folic acid supplementation daily.

All women should consider taking prenatal vitamins.

Sleep patterns

Increased sleep requirements are common in early pregnancy and women should be advised to expect this. Developing good sleep habits prior to conception is often helpful.

Nausea and vomiting in pregnancy

Although nausea and vomiting are considered normal symptoms of early pregnancy, treatment can often alleviate symptoms. Women should be advised to seek attention for these symptoms if they become problematic.

Exercise

Exercise is encouraged during pregnancy; however, the following activities should be avoided:

- exercise that could cause significant trauma
- activities resulting in significant changes in atmospheric pressure
- activities involving large acceleration and deceleration forces.

While pregnant, women should monitor their level of exercise by measuring heart rate (target 140 bpm) or using the talk test (if too winded to carry on a conversation while exercising, slow down).

Counseling

Work

Determine if the woman is exposed to any potential teratogens in the workplace or at home, and recommend adjusting employment to avoid teratogenic exposure prior to conception. Also discuss the impact of heavy labour and shift work on pregnancy, and talk about plans for work throughout the pregnancy.

Smoking

Pregnancy is an ideal opportunity to help a woman quit smoking. Encourage her to be realistic in her goals, and help her to achieve any reduction in cigarette consumption if she is unable to quit.

Consider discussing the association between smoking (including second-hand smoke) and:

- reduced fertility
- increased miscarriage
- fetal growth restriction
- fetal brain development
- antepartum hemorrhage (abruption)
- preterm labour
- fetal intolerance to labour
- sudden infant death syndrome (SIDS).

A helpful publication, *Approaching Smoking in Pregnancy: Handbook for Health Professionals*, is available through Health Canada.

Alcohol and drug use

Review current and past use of alcohol, prescription drugs and nonprescription drugs. Also obtain a clear history of herbal preparations, as they may also be considered medications.

If prescription drugs should be discontinued or modified for pregnancy, these changes should be made prior to conception.

Review the hazardous effects of illicit drugs and recommend appropriate contraception until drug use has ceased.

Since a safe level of alcohol consumption has not been determined, women wishing to conceive should be advised to avoid all alcohol consumption.

Conception

Some couples may need information about the physiology of conception. Consider discussing realistic expectations about conception, reinforcing that normal conception may take up to one year and that many healthy individuals can experience miscarriage. Discussing expectations early may help women who subsequently experience conception difficulties or miscarriage.

First Antenatal Visit

If no preconception visit took place, the first antenatal visit should include the areas of assessment covered in the section, "Preconception Visit."

If the preconception visit was more than six months ago, the full physical assessment should be repeated.

If a preconception visit took place within the preceding six months, it may be appropriate to limit the first antenatal visit to an assessment of previous abnormalities, areas of symptomatology and a pelvic assessment.

History and Physical

History

The obstetrical, medical and family history should all be reviewed and documented on the *Alberta Prenatal Record*.

The DLNMP (date of last normal menstrual period) should be determined and EDD (estimated date of delivery) assigned based on the normal menstrual cycle for the woman. To be considered accurate, the EDD must be determined and confirmed prior to 20 weeks gestation.

Example 1:

A woman who has a DLNMP of January 1 is known to have a regular, long cycle of 35 days. The EDD of September 8 by gestational wheel must be extended to September 15 to compensate for the menstrual cycle being seven days longer.

Physical

A good general physical assessment in pregnancy should include all factors that may be of significance in the pregnancy.

- Head and neck examination should include fundoscopic evaluation for evidence of systemic disorders such as hypertension.
- As the symptoms of thyroid disorders and early pregnancy are virtually identical at times, thyromegaly should be evaluated.
- Cardiovascular and respiratory assessment are important.
- Abdominal exam should rule out organomegaly and tenderness. Any scars should be consistent with the history taken.
- Pelvic assessment should include estimated gestational size and any adnexal findings.
- Evaluation of the musculoskeletal/central nervous system (MSK/CNS) should be conducted to ascertain if there are any gross anomalies.
- Baseline reflexes are important prior to encountering hypertensive disorders of pregnancy.

Investigations

Investigations such as pap smear, rubella serology and other serologies may not be necessary in early pregnancy if they were conducted recently.

CBC

The hemoglobin should be well within normal range at the beginning of pregnancy. The WBC may be moderately elevated and the platelets should be normal. A reduced MCV may be indicative of a hemoglobinopathy.

Rubella titre

Any non-immune woman should be aware of the risks of contracting rubella in early pregnancy and should report any possible contact immediately.

Syphilis screening (RPR)

Universal screening of pregnant women for syphilis remains the standard of care in Alberta. A positive non-treponemal test (RPR) in conjunction with a positive treponemal test (FTA-ABS, MHA-TP) is consistent with a diagnosis of syphilis, and the patient should be referred for evaluation and treatment. False positive serology may be indicative of systemic lupus erythematosus (SLE), which could have a profound effect on the pregnancy.

HIV serology

Patients who do not consider themselves at risk for HIV may still be infected. For this reason, it is considered routine prenatal care in Alberta to offer HIV screening to all pregnant women. Women should also be given the option to decline screening.

Treating an HIV positive woman in pregnancy, and her infant at birth, reduces the transmission rate from 24% to 8%. HIV positive women should not breastfeed their infants. Appropriate pre- and post-test counseling must occur in all cases.

HIV is a reportable disease.

ABO/Rh and antibodies

Maternal blood typing (ABO), including Rhesus (Rh) and antibody testing conducted through the Canadian Blood Services Perinatal Program, will also include screening for Hepatitis B Antigen and HIV. It is the preferred route of testing.

If the woman is Rh negative, some physicians choose to assess the partner's Rh status to determine if Rh immune globulin is needed in the pregnancy. Others prefer to assume the partner is Rh positive and thus avoid the potential problems associated with non-paternity.

Urinalysis +/- C&S

Urinalysis is a reasonable screen for renal disorders and infections. Since asymptomatic bacteriuria is also significant in pregnancy, it may be appropriate to perform a culture (C&S) as well. Women should be advised how to properly collect a midstream urine sample to avoid contamination.

Investigations

Pap smear

Significant abnormalities should be evaluated and treated.

Vaginal or cervical cultures

A high index of suspicion for STDs (sexually transmitted disease) should be maintained in pregnancy. Infection may be asymptomatic and untreated infection can have serious implications for pregnancy outcome, maternal health and fetal complications. All women with symptoms or signs of abnormal vaginal/cervical discharge should undergo appropriate microbiologic testing.

Cervical testing for *Chlamydia trachomatis* and *Neisseria gonorrhoeae* is indicated in asymptomatic women with current or past risk behaviours for STDs. Recent evidence indicates that screening of asymptomatic women for BV (bacterial vaginosis) is not beneficial. Antimicrobial agents used for the treatment of STDs should be appropriate for the gestational age.

Other viral serology

Perform as per preconception counseling.

Glucose testing

Glucose testing may be indicated in women with a higher risk of diabetes. Evaluation of glucose level early in pregnancy may allow early intervention for a previously unrecognized Type II diabetes.

Counseling

Lifestyle issues and normal symptoms in pregnancy

Review lifestyle issues and any normal pregnancy symptoms raised during preconception counseling. Encourage women to maintain realistic expectations about their abilities given the physiologic changes during pregnancy.

Nausea and vomiting during pregnancy

Women who experience nausea in early pregnancy, with or without vomiting, need not suffer with the symptoms. Significant weight loss or reduced coping ability may signal a need for medical intervention. Counseling should include simple advice (such as increased rest, time off work, dietary adjustments and avoiding trigger odours) and therapeutic modalities (such as accupressure [Sea Bands], medication and occasionally hospital admission).

Genetic counseling

Advise women of available genetic screening options, including the associated risks, benefits and timing constraints. It is also important to clarify the difference between screening and testing.

Counseling

Screening and testing options include:

- maternal serum AFP screening for neural tube defects
- ultrasound for structural anomalies
- biochemical screening (serum triple screening) for NTD (neural tube defect) and Down Syndrome
- amniocentesis and chorionic villous sampling (CVS) for chromosomal abnormalities.

Referral for genetic counseling may also be appropriate.

Sexuality

Although women may experience reduced sex drive in early pregnancy, it is important to assure women that normal sexual activity in pregnancy is not contraindicated. Exceptions may include placenta previa, APH (antepartum hemorrhage) and PROM (prelabour rupture of membranes).

Seat belt use

Some pregnant women mistakenly believe seat belts can be harmful during pregnancy in the event of a motor vehicle collision (MVC). Women should be advised that seat belts protect both mothers and babies, regardless of gestational age, and should be used faithfully.

Domestic violence

The subject of domestic violence should be raised when appropriate, and women should be assessed for their risk of violence. The woman's care provider(s) should be positioned as a source of trust and support if violence is a threat.

Women at risk of, or involved in, abusive relationships should be aware that pregnancy may escalate the violence, increasing the risk of trauma during pregnancy. It is important to reinforce that domestic violence is never acceptable.

Prenatal classes

Prenatal education has been shown to reduce childbirth anxiety for women and their partners. Encourage women to enroll in classes early in pregnancy so they are well informed and can make appropriate choices about labour and delivery.

Breastfeeding

All women should be encouraged to breastfeed their infants and should be supported in their decision. Consider initiating a discussion about the many misconceptions about breastfeeding (such as ability to produce milk or nurse properly). This is an excellent opportunity to dispel myths and discuss breastfeeding concerns.

Certified lactation consultants can also provide educational and support resources (see *AMA Breastfeeding Directory*).

First Antenatal Visit

Counseling

Women who choose to bottle feed should be supported in their decision and provided with appropriate information on formula feeding.

Medications

Women should be advised to report use of all prescription, non-prescription, topical and herbal preparations to their care provider. They should also be informed that although some medications are potentially harmful in pregnancy, there are many pharmaceuticals safe for use throughout pregnancy. Acetaminophen is considered the analgesic of choice throughout pregnancy.

Routine Antenatal Visit

When pregnancy is proceeding normally, routine visits are scheduled every four weeks until 28 – 30 weeks gestation, increasing to every two weeks from 30 – 36 weeks gestation, and then weekly until delivery. More frequent visits may be necessary.

History and Physical

History

Calculate and record the gestational age at each visit. Ensure all laboratory studies are recorded. Inquire about any concerns and raise issues pertinent to the gestational age and clinical situation. Ascertain if fetal movements are adequate.

Physical

Record the weight and blood pressure at each visit, thereby establishing the normal baseline in early pregnancy. Measure, record and plot the symphysis-fundal height in cm at each visit after 14 weeks gestation. Once fetal heart tones can be heard, listen and record their presence.

By 28 – 32 weeks gestation add the fetal lie and presentation to your physical assessment.

At 36 weeks gestation confirm vertex presentation and obtain a vaginal-anal swab for GBS if this is your GBS screening choice.

Investigations

Throughout pregnancy

Urine should be dipped for protein and glucose at each visit. Abnormal results should be followed appropriately.

Gestation-specific investigations

At 13 – 16 weeks gestation ensure that any desired genetic screening is arranged (earlier if CVS is an option).

Investigations

At 18 weeks gestation a detailed anatomical ultrasound with date confirmation should be offered.

At 24 – 28 weeks gestation laboratory testing for hemoglobin, gestational diabetic screening, and ABO/Rh and antibody testing is indicated. If the woman is Rh positive and has no unusual antibodies, repeat ABO/Rh testing is not necessary.

At 28 – 30 weeks gestation Rh immune globulin should be given to Rh negative women. Note that this antibody coverage is only effective for 12 weeks; it should be repeated after this time or if there is suspected fetal-maternal hemorrhage (in the event of trauma, overt bleeding or certain obstetrical procedures).

At 36 weeks gestation a vaginal-anal swab for GBS (group B Strep) screening may be indicated.

At 41 weeks gestation fetal assessment is indicated for post dates.

Counseling

Throughout pregnancy

If the woman cites common complaints of pregnancy, offer advice and coping strategies as appropriate.

Gestation-specific counseling

By 18 – 22 weeks gestation the signs and symptoms of preterm labour should be discussed, along with instructions regarding what to do if these occur.

At 24 – 28 weeks gestation ensure VBAC (vaginal birth after cesarean), if appropriate, is offered as an option for women with a previous uterine scar. This may involve reviewing previous records and/or obtaining a consultation.

At 28 – 32 weeks gestation ensure the woman is aware of appropriate fetal movement.

By 30 – 36 weeks gestation fetal movement charting should begin. Also plan to discuss:

- labour and delivery routines/expectations
- hospital admission procedures
- analgesia
- breastfeeding
- newborn care and metabolic screening
- postpartum planning.

At 36 weeks gestation ensure the *Alberta Prenatal Record* is available to the labour and delivery unit.

Post dates fetal assessment is required to ensure fetal well-being. Once 41 weeks gestation is passed, begin induction planning and ensure induction is arranged by 42 completed weeks.

Neonatal Care

Early hospital discharge means newborns are often discharged before they have adjusted to extrauterine life. Breast-feeding may not be well established, or the baby may not have returned to birth weight. Peak bilirubin levels may not have been reached, or other common neonatal problems may not be evident at the time of discharge.

For these reasons it is not acceptable to wait a full week before re-evaluating the infant. Apparently normal, healthy infants should be seen by their physician or midwife within three to five days of birth for evaluation of feeding, hydration, elimination, weight gain and general well being.

Postpartum Visit

At about six weeks postpartum, routine maternity care is usually completed.

History

Maternal symptoms and concerns should be addressed at this time. They may include:

- bleeding
- bladder function or incontinence
- bowel function
- breasts and breastfeeding
- perineal symptoms
- sexuality and contraception
- postpartum depression.

Physical

Pelvic and breast examination should be routinely conducted postpartum.

History and Physical

Investigations

Pap smear

It is routine to perform a pap smear at the postpartum visit. If the lochia is too heavy, a pap smear should be arranged for a later date.

Hemoglobin

If there was anemia in pregnancy or significant blood loss at delivery, a follow-up hemoglobin may be indicated to determine if ongoing iron supplementation is needed.

Counseling

Debriefing

During the postpartum visit, consider asking about concerns and misconceptions about pregnancy care and delivery. Discussion topics could also include Rubella immunity, VBAC or gestational diabetes in future pregnancies.

Sexuality

Women may need assistance in dealing with issues of sexuality and contraception postpartum. Offer advice, support and resources as necessary.

Sudden Infant Death Syndrome

Women should be advised about the appropriate infant sleeping position (on the back) to reduce the risk of SIDS. Also consider reminding women about the link between tobacco smoke and SIDS. Encourage the establishment of a smoke-free household for the health of the newborn and any other children in the family.

Coping strategies

Postpartum depression occurs frequently. Ask women about their ability to cope in the postpartum period so depression, if evident, can be diagnosed and treated. Lack of support increases the risk of postpartum depression, and identifying community support groups may be of benefit.

Additional Resources

For Health Care Providers

General

Family-Centred Maternity and Newborn Care National Guidelines

Health Canada
Phone: (613) 954-5995
Fax: (613) 941-5366
Website: www.hc-sc.gc.ca

Breastfeeding

National Breastfeeding Guidelines for Health Care Providers

Canadian Institute of Child Health
384 Bank Street
Suite 300
Ottawa ON K2P 1Y4
Phone: (613) 230-8838
Fax: (613) 230-6654
Email: cich@cich.ca
Website: www.cich.ca

Alberta Breastfeeding Support Services Directory

Alberta Medical Association
Available on the AMA web site:
<http://www.amda.ab.ca>
Or, contact the Alberta Medical Association at:
Phone: (780) 482-2626
Fax: (780) 482-5445
Toll-free: 1-800-272-9680

Folic Acid

Periconceptional use of folic acid for reduction of the risk of neural tube defects

This CPS statement is available on the CPS website at:
www.cps.ca/english/statements/DT/dt95-01/htm

Tobacco and Drug Use

Approaching Smoking in Pregnancy – A guide for health professionals by the College of Family Physicians of Canada

Dr. Cheryl Levitt, Department of Family Medicine
McMaster University
MUMC 2VC
1200 Main Street W
PO Box 2000
Hamilton ON L8N 3Z5
Phone: (905) 521-2100 ext. 75015

MotheRisk

Questions about safety of drugs, chemicals, radiation or infection in women who are pregnant or breastfeeding.
Fax: (416) 813-7562
Website: www.motherisk.org

Nutrition for a Healthy Pregnancy

National Guidelines for the Childbearing Years

Publications, Health Canada
Ottawa ON K1A 0K9
Phone: (613) 954-5995

Fetal Movement

Alberta Fetal Movement Count Chart

To order the Fetal Movement Chart, Form Number HS001-132, contact Alberta Health Supply and Services:
Phone: (780) 422-1693
Fax: (780) 427-3023

Abuse During Pregnancy

A handbook for health and social service professionals responding to abuse during pregnancy

National Clearinghouse on Family Violence, Health Canada
Phone: (613) 057-1291
Toll free: 1-800-267-1291
Fax: (613) 941-8930
Website: www.hc-sc.ca/nc-cn

Alberta Medical Association Clinical Practice Guidelines (CPGs)

- Ultrasound as Part of Routine Prenatal Care
 - Use of Prenatal Ultrasound First Trimester
 - Preface to the Prevention and Diagnosis of Fetal Alcohol Syndrome (FAS)
 - Recommendations Prevention of Fetal Alcohol Syndrome (FAS)
 - Diagnosis of Fetal Alcohol Syndrome (FAS)
 - Medical Induction of Labour
 - Screening for Cervical Cancer
- All CPGs available from:
The Alberta Clinical Practice Guidelines Program
12230 106 Avenue NW
Edmonton AB T5N 3Z1
Phone: (780) 482-2626
Toll free: 1-800-272-9680
Fax: (780) 482-5445
E-mail: ama_cpg@amda.ab.ca

Note: CPGs may include patient education pamphlets

Additional Resources

Patient Education Materials

Folic acid

March of Dimes, Birth Defects Foundation

Folic Acid Campaign

White Plains NY 10602-9987

Phone: (914) 428-7100

Fax: (914) 997-4763

Website: www.modimes.org

A patient handout, *Take folic acid during pregnancy*, is available on the Caring for Kids website at:

www.cps.ca/english/carekids/index.htm

Group B Streptococcus (GBS)

Group B Streptococcus (GBS) infection in pregnancy

The Society of Obstetricians and Gynaecologists of Canada

780 Echo Drive

Ottawa ON K1S 5N8

Phone: (613) 730-4192

Toll free: 1-800-561-2416

Fax: (613) 730-4314

Website: www.sogc.org

SIDS

Back to Sleep Posters and Pamphlets

Sudden Infant Death Syndrome Foundation

Phone: 1-800-363-7437

Forever Sleeping brochure

Childhood & Youth Division, Health Canada

Phone: (613) 957-3437

Newborn Metabolic Screening

Metabolic Screening Test – A healthy beginning for your baby (form HG27)

Alberta Health Supply and Services

Phone: (780) 422-1693

Fax: (780) 427-3023

Fetal Alcohol Syndrome (FAS)

Prevention of Fetal Alcohol Syndrome (FAS)

Alberta Children's Services

11th Floor, Seventh Street Plaza

10030 107 Street

Edmonton AB T5J 3E4

Phone: (780) 427-2039

Fax: (780) 422-5916

Fax: (613) 941-5366

Website: <http://www.hc-sc.gc.ca>

HIV

HIV in Pregnancy

Alberta Health & Wellness, Supply and Forms Services

Phone: (780) 422-1693

Fax: (780) 427-3023

Other Alberta Health Resources

For a comprehensive list and order form for print materials available through Alberta Health, call

427-7164

or visit the Alberta Health web site at

www.health.gov.ab.ca.

References

1. Society of Obstetricians and Gynecologists. *Healthy beginnings: Guidelines for care during pregnancy and childbirth*. SOGC Clinical Practice Guidelines, Policy Statement, 1998;71:122.
2. Singh A, STD Provincial Medical Consultant. *Personal communications*. 1999.
3. Alberta Medical Association Clinical Practice Guidelines. *The use of prenatal ultrasound first trimester*. 1998.
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Prenatal Worksheet

Prenatal Care Plan, Alberta Medical Association, October 2000

This prenatal worksheet outlines the examinations, investigations and counseling the physician or midwife should consider conducting during a woman's pregnancy.

■ **Dark purple** indicates items to be considered in at-risk populations. ■ **Light purple** indicates items to investigate only if evidence warrants.

TIMING	HISTORY & PHYSICAL	INVESTIGATIONS TO CONSIDER	COUNSELING
Prior to conception	<input type="checkbox"/> Complete history & physical <input type="checkbox"/> Assess impact of current medical illness (diabetes, hypertension)	<input type="checkbox"/> CBC <input checked="" type="checkbox"/> Carrier Screening <input type="checkbox"/> Rubella titre <input type="checkbox"/> Pap smear <input type="checkbox"/> STD screening <input type="checkbox"/> HIV serology <input checked="" type="checkbox"/> Other viral serology <input checked="" type="checkbox"/> Glucose testing	Lifestyle issues <input type="checkbox"/> nutrition (including folic acid supplementation) <input type="checkbox"/> sleep patterns <input type="checkbox"/> exercise <input type="checkbox"/> work <input type="checkbox"/> smoking <input type="checkbox"/> alcohol and drug use
6 – 10 weeks	<input type="checkbox"/> Review history & physical	<input type="checkbox"/> CBC <input type="checkbox"/> Rubella titre <input type="checkbox"/> Syphilis serology (RPR) <input type="checkbox"/> HIV serology <input type="checkbox"/> ABO/Rh & antibodies <input type="checkbox"/> Hepatitis B antigen <input type="checkbox"/> Urinalysis ± C&S <input type="checkbox"/> Pap smear <input checked="" type="checkbox"/> Vaginal or cervical cultures <input checked="" type="checkbox"/> Other viral serology <input checked="" type="checkbox"/> Glucose testing	<input type="checkbox"/> Review lifestyle issues <input type="checkbox"/> Management of nausea if present <input type="checkbox"/> Normal symptoms of pregnancy <input type="checkbox"/> Genetic screening <input type="checkbox"/> Sexuality <input type="checkbox"/> Seatbelt use <input type="checkbox"/> Domestic violence <input type="checkbox"/> Prenatal classes <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Assign EDD (Estimated Due Date) <input type="checkbox"/> Review medication and herb usage
At each visit (Conduct visits q4weeks up to 28-30 weeks, q2weeks up to 36 weeks and q1week until delivery)	<input type="checkbox"/> Inquire as to general well-being <input type="checkbox"/> Assign gestational age <input type="checkbox"/> Weight <input type="checkbox"/> Blood pressure <input type="checkbox"/> Symphysis-fundal height in cm <input type="checkbox"/> Fetal heart sounds <input type="checkbox"/> Presence of fetal movements	<input type="checkbox"/> Urine for glucose <input type="checkbox"/> Urine for protein	<input type="checkbox"/> Counsel for common symptoms at this gestation
10 – 16 weeks		<input checked="" type="checkbox"/> Genetic Screening (Biochemical/Amniocentesis/CVS)	
17 – 19 weeks		<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Confirm EDD for entire pregnancy
18 – 22 weeks			<input type="checkbox"/> Preterm labour
24 – 28 weeks		<input type="checkbox"/> Hemoglobin <input type="checkbox"/> Diabetic screening <input checked="" type="checkbox"/> ABO/Rh & antibodies (if Rh negative)	<input checked="" type="checkbox"/> Obtain VBAC consultation/ documentation
28 – 32 weeks	<input type="checkbox"/> Add fetal position to routine visit	<input checked="" type="checkbox"/> Give Rh immune globulin (if Rh negative)	<input type="checkbox"/> Importance of fetal movement awareness
30 – 36 weeks			<input type="checkbox"/> Labour & delivery issues <input type="checkbox"/> Hospital admission procedures <input type="checkbox"/> Newborn issues and testing <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Postpartum planning <input checked="" type="checkbox"/> Commence fetal movement charting
36 weeks	<input type="checkbox"/> Confirm presentation of fetus	<input checked="" type="checkbox"/> GBS culture	<input type="checkbox"/> Ensure record available to L&D unit
41 – 42 weeks		<input type="checkbox"/> Fetal assessment	<input type="checkbox"/> Induction plans
Postpartum (6 weeks)	<input type="checkbox"/> Pelvic examination <input type="checkbox"/> Breastfeeding evaluation <input type="checkbox"/> Check for postpartum depression	<input type="checkbox"/> Pap smear <input checked="" type="checkbox"/> Hemoglobin	<input type="checkbox"/> Labour & delivery issues <input type="checkbox"/> Sexuality & contraception <input type="checkbox"/> Review Rubella status <input type="checkbox"/> Coping strategies

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