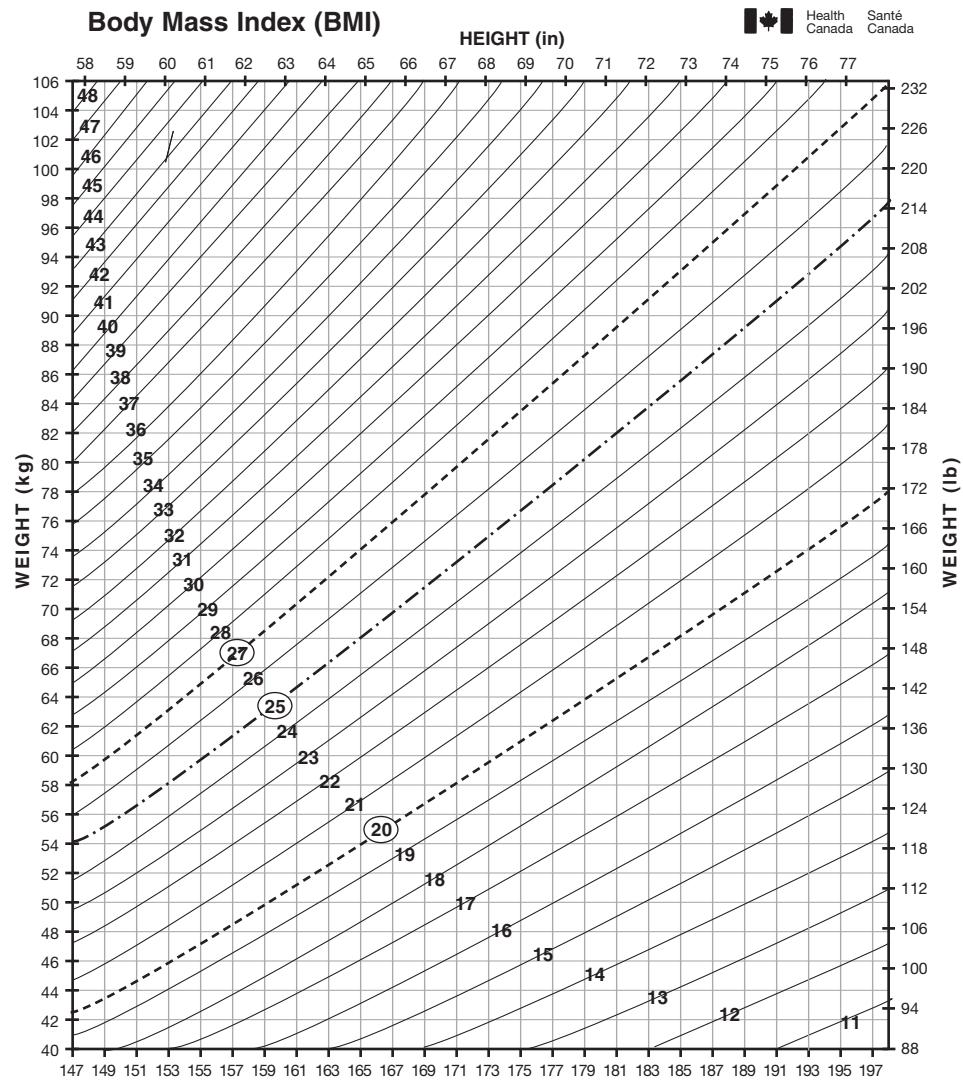


SUGGESTED REFERRALS	Family Doctor	Public Health Nurse	Community Dietitian	Diabetes Program	Lactation Consultant
ALL					
Psychosocial Assessment	X				
Prenatal Classes		X			
REPRODUCTIVE HISTORY					
- age 19 years and younger		X	X		
- previous baby < 5lbs.8 oz. (2500)			X		
- gestational diabetes	X	X	X	X	
- age ≥ 35 years	X				
- parity 0	X				
MEDICAL FACTORS & NUTRITIONAL INTAKE					
- pregravid weight BMI <20 or >25			X		
- diabetes mellitus			X	X	
- eating disorder			X		
- < 2 servings in any food group			X		
- special diet			X		
- insufficient money for food			X		
PRESENT PREGNANCY RISK					
- excessive weight gain			X		
- Wt. Gain "<" 4 kg @ 20 wks			X		
- IUGR /small for dates baby			X		
- HGB "<" 100 g/L			X		
- multiple pregnancy			X		
- gestational diabetes			X	X	
- alcohol use	X				
- smoker	X				
- street drug use	X				
- family at risk	X				
- stress	X				
BREASTFEEDING CONCERNS					
- plans to breastfeed	X				
- previous breast surgery					X
- problems with previous baby					X



Prenatal Record

P.E.I. Reproductive Care Program



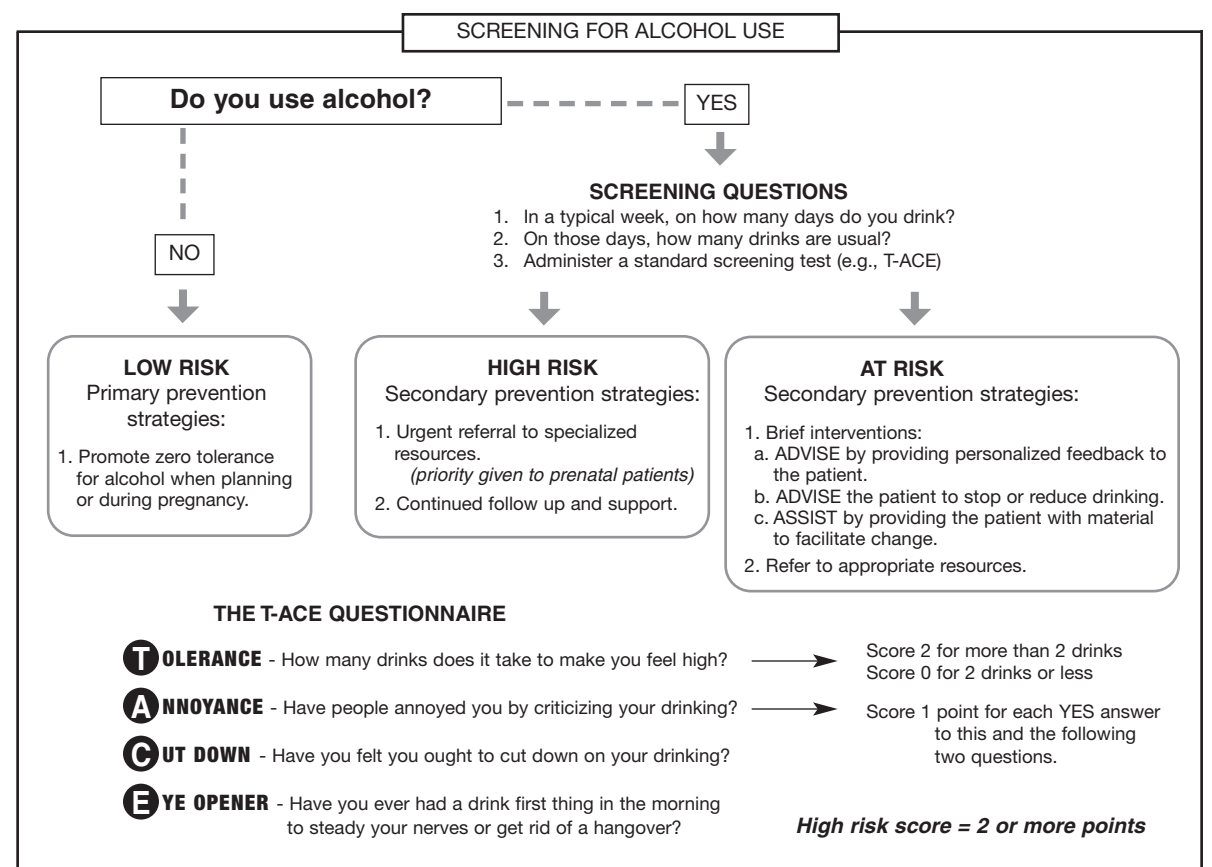
healthy mothers, healthy babies

The Prenatal Record is a clinical tool. The form is also used to gather statistics for research into improving reproductive health care in Prince Edward Island.

The Freedom of Information and Protection of Privacy (FOIPP) Act of Prince Edward Island governs the collection, use and disclosure of personal information contained in this form. If you have any questions about the collection of your personal information, please contact the Privacy and Information Access Coordinator, Health PEI at (902) 368-4942.

BABY'S BIRTH DATE		METHOD OF DELIVERY	
POSTPARTUM EXAMINATION			
Date	Weight	B / P	Hgb
Lochia	Menses	Bladder & Bowel Function	Kegels
BREAST EXAMINATION:		PELVIC EXAMINATION:	
		<ul style="list-style-type: none"> • Perineum • Cervix • Uterus • Pelvic Musculature <input type="checkbox"/> PAP taken	
METHOD OF FEEDING:		<input type="checkbox"/> Formula	
		<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Exclusive <input type="checkbox"/> Partial	
FAMILY PLANNING:			
MATERNAL / NEWBORN COMPLICATIONS:			
POSTPARTUM ADJUSTMENT:			

- DISCUSSION TOPICS**
- Nutrition / Vitamins
 - Weight Gain
 - Dental Care
 - Drugs (pres., OTC, street)
 - Alcohol
 - Activity
 - Work
 - Fetal Movement
 - Bowel / Bladder
 - Back Discomfort
 - Sexual Activity
 - Labour - Preterm / Term
 - Birth Plan
 - On-call Coverage
 - Circumcision
 - Postpartum Support
 - Parenting
 - Contraception
 - Cord blood banking
 - Newborn Screening



Today's Date
Day Month Year

Name _____ Personal Health No. _____ Tel. No. (H)/(W)/(Cell) _____
 Address _____ Postal Code _____
 Age _____ Date of Birth _____ Education - Highest level completed _____ Employed Yes No Type of work: _____
 Marital Status _____ Baby's Father OR Next of Kin _____ Age _____ Father's Employed Yes No Type of work: _____
 Contraception Type _____ Date Stopped _____ Pos. Pregnancy Test _____ Menstrual Cycle Length _____ LMP _____ Sure of LMP _____ EDB _____ Physician's Name _____
 Assisted conception Yes No Type: _____ Date: _____ Prenatal Education Previous This pregnancy None

OBSTETRICAL HISTORY INCLUDING ABORTIONS OR ECTOPIC PREGNANCIES

Grav.	Para.	Abort.	SB	NND	Prem.	IUGR	Congen. Abn.

PRESENT PREGNANCY	Y	N	PROBLEMS / COMMENTS / DETAILS / REFERRALS	MEDICAL HISTORY	Y	N
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Medications - Pre-concep Folic Acid				Allergies		
- Prescription				Operations		
- Non-prescription				Anesthetic problems		
- Herbal Supp.				Blood/Products (specify)		
Smoking pre-preg. (#/day)				Renal (including UTI)		
Smoking now (#/day)				Diabetes		
Exposed to second-hand smoke				Cardiac		
Alcohol pre-preg (drinks/week)				Thromboembolism		
Alcohol now (drinks/week)				Hypertension		
T-ACE score				CNS disorder/headaches		
Street drugs (details)				Psychiatric disorder/eating disorder Post-partum/other (specify)		
Bleeding (date)				STI- including Herpes		
Received Immune Globulin				Thyroid problems		
Pyrexia (date)				Asthma/Resp.disease		
Infections (e.g. UTI/STI date)				Bowel		
Benefits of breastfeeding discussed				Derm		
Plan to breastfeed				Varicella (CHICKEN POX)		
Breastfed previously				Gyne./Other		
Other (details)				GENETIC SCREENING:	Y	N
Flu vaccine (offer during flu season)				Age ≥ 35 at delivery		
LIFESTYLE/SPECIAL NEEDS	Y	N		Fam Hx congenital anomalies/birth defects		
Activity limitations				Fam Hx inherited disease/disorder		
Nutrition concern/Food security				Fam Hx Diabetes		
Concerns (e.g. financial, housing, violence, employment)				Ethnic Risk		
Support adequate				Genetic screening discussed		
Social assistance required				Genetic screening declined		
Anticipated Date of Mat. Leave				Consanguinity discussed		
				FAMILY HISTORY	Y	N
				Cardiac		
				Hypertension		
				Developmental disorders		
				Psychiatric disorder		
				Other		

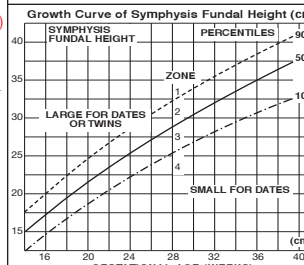
Revised EDB _____ D _____ M _____ Y _____ Based on: _____

PHYSICAL EXAMINATION
 Height _____ Pre-Preg. Wt _____ BMI _____ D _____ M _____ Y _____
 PAP SMEAR _____ D _____ M _____ Y _____
COMMENTS (Detail abnormal Findings) _____
CHECK (✓) IF NORMAL
 Heent Nipples Vulva
 Thyroid Breasts Vagina
 Teeth/gums Abdomen Cervix
 Chest Back / Ext. Uterus
 Heart Pelvic Adequacy Adnexae
 Uterine size: _____ Early U/S Date: _____ EGA: _____
 18-20 wk U/S Date: _____

LABORATORY (First Visit) RESULTS	RESULTS
Mother: ABO/Rh _____	PAP Smear _____
Antibodies _____	GC _____
Father Rh (if Mother Rh neg) _____	Chlamydia _____
HGB _____	Urine C&S _____
Syphilis Serology _____	Rubella <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Borderline
Hepatitis B Antigen _____	
TSH _____	
HIV <input type="checkbox"/> Discussed <input type="checkbox"/> Accepted <input type="checkbox"/> Declined	
Other (e.g. Hepatitis C, Toxo, Varicella, Early Diabetes Screen)	

GENETIC SCREENING

Integrated Maternal Serum Testing (IMST) (offer to all regardless of age)
 Both samples must be completed for IMST
 9-13^{6/7} wks discussed declined completed Date: _____
 15-20^{6/7} wks (Optimal 16 -18 wks) discussed declined completed
 Date: _____ Results: _____
Standard Second Trimester MST (offer only if patient missed the 1st Trimester MST)
 15-20^{6/7} wks (Optimal 16 -18 wks) discussed declined completed
 Date: _____ Results: _____
 11 - 13^{6/7} wks - **Early Pregnancy Review Ultrasound (EPR)**
 (women ≥35 yrs of age at EDB or with specific risk factors)
 Indication: _____
 discussed declined completed
 Date: _____ EGA: _____
 Results: _____



Date	Weight	Cum. Wt	BP	Hgb	Urine P S	Gest. (wks)	Fundal Height	Presentation	FHR	FM	# Cigs./day	Comments	Next Visit

NAME _____

Baby's Physician _____

Comments/Care Plan
 BPP to start @ _____ wks
 Indication: _____
 Previous C/S
 OR report reviewed
 candidate for VBAC
 C/S booked. Date: _____
 T/L: Yes No
 Prenatal Psychosocial Assessment Completed Declined

REFERRALS MADE TO: