Perinatal Program
Newfoundland Labrador

Newfoundland and Labrador Prenatal Record

Companion Guide

2025 Edition

NL Health Services

Perinatal Program Newfoundland and Labrador

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https://cwhp.easternhealth.ca/children-and-youth/ppnl/

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Introduction

Purpose

Perinatal Program Newfoundland and Labrador (PPNL) has produced and distributed a standardized form to guide prenatal care in Newfoundland and Labrador for more than more than thirty-five years. The Newfoundland and Labrador Prenatal Record (NL PNR) offers prenatal care providers a standardized approach and an evidence-based tool to document assessment, investigation, and treatment interventions during pregnancy.

The prenatal record serves as a 'pregnancy pathway' that provides:

- A systematic, evidence-informed, sequential approach to prenatal care.
- Information and tools to support assessment, screening, and testing at specific gestational ages.
- A framework to identify and manage modifiable risk factors.
- Documentation of care provided during the prenatal period.
- A means of communicating information to referring physicians and other care providers.
- A medico-legal document.
- A source of information to assess quality of care.
- A means of documenting pregnancy-related problems and the associated plan of care.

It is recommended that pregnant persons carry a copy of their prenatal record. Many prenatal care providers who choose to utilize the paper version provide the patient with their prenatal record (or a printed copy if using the EMR). PPNL encourages providers to do this. When doing so, counsel the pregnant person on the expectation to bring the prenatal record with them to all appointments and hospital/triage visits for the entire pregnancy.

Use of the NL PNR and Companion Guide

The NL PNR guides the provision and documentation of prenatal care by health care providers within NL. The Companion Guide explains each entry of the NL PNR, providing information and resources to assist care providers in populating the record. This document provides a step-by-step approach and a 'how to' guide for health care professionals using the NL PNR.

The NL PNR and Companion Guide are aligned with the principles of trauma informed care, cultural safety, and the World Health Organization (WHO) principles of prenatal care. The Companion Guide was written using gender neutral language that is meant to be inclusive of all individuals regardless of gender identification. PPNL endeavours to be respectful of gender identity and the multiple ways in which individuals may identify themselves as a parent. As not all those who experience pregnancy identify as a woman, we have used the terms "pregnant person" to increase this documents inclusivity.

At the time of development, the content of the NL PNR aligned with both national and local guidelines, and the links and references within the Companion Guide were current and functional. Online sites may require membership or payment to retrieve full articles, guidelines, or detailed information, and in those cases the link provided will only access the information available. The Society of Obstetricians and Gynecologists of Canada (SOGC) requires a membership to access the full Clinical Practice Guidelines (CPG), and therefore, the links within the document for SOGC CPG provide the abstract and summary of recommendations if access to a membership is not available.

Clinical care recommendations change rapidly; therefore, guidelines may change before the NL PNR can be updated to reflect them. Care providers are required to follow the existing standard of prenatal care and individualize care to each clinical situation. PPNL has endeavoured to capture all the elements required for high quality care and is committed to reviewing the NL PNR for revisions at least every 3–5 years. The Companion Guide is accessible on the Newfoundland and Labrador Health Services (NLHS) website, under "Resources for Staff and Physicians: NL Prenatal Record" for easy reference and to allow updates to be added as new information and recommendations that impact care become available.

The NL PNR will be used in both paper and electronic formats (via MedAccess, where EMR systems are in place). If you are using the NL PNR in paper form you may print it directly from the website. It is 5 double-sided 8.5 x 11 inch pages. The NL PNR is no longer being printed in NCR format (duplicate). It is acknowledged that the NL PNR appears to be longer than the previous version. Not all the additional pages are for documentation; several pages at the back of the PNR are worksheets intended to serve solely as clinical resources to guide prenatal care.

There is a bar code at the bottom of each page of the NL PNR. This bar code will be used for the provincial scanning and archiving system within health care facilities across the province. If demographic labels are applied to the paper version of the NL PNR, be mindful not to cover information that has been documented as well as the preprinted record barcodes.

Note: In the future, the NL PNR will also be available electronically within the EPIC Platform for care providers providing prenatal care within Health Care Facilities across the province. It can be printed from this system as needed.

For additional NL PNR in paper format, order them directly from the Office of the Kings Printer with the NL Government by calling 709-729-5265 or print them directly from the NLHS website.

Contact PPNL with any forms related inquiries and/or feedback.

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PPNL would like to acknowledge the contributions of prenatal care providers throughout Newfoundland and Labrador who provided feedback during recent revisions of the NL PNR.

PPNL would also like to acknowledge that this document has been adapted and reproduced with permission from the Reproductive Care Program of Nova Scotia, IWK Health © ™ 2022. The purpose of adapting the Nova Scotia Prenatal Record for use in Newfoundland and Labrador was to support standardized care across the Atlantic provinces while tailoring to the individualized needs and services of this province. PPNL stands alongside RCP in supporting access to standardized prenatal care guided by evidence-based practice across the country. PPNL thanks RCP for their support and collaboration throughout this project and for allowing the reproduction of this document.

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part I)

Date completed: _____ DD/MM/YYYY _____

Demographics

Last name	First name	Gender	Pronoun

Address	Contact Telephone: _____ Alternate Telephone: _____	Leave message ☐Yes ☐No	MCP

Date of birth DD/MM/YYYY	Age at EDD	Highest level of education completed	Employed ☐Yes ☐No	Occupation	Culture/beliefs/practices

Language: ☐English ☐French ☐Arabic ☐Other: _____ ☐Interpreter required	Indigenous identity: ☐Yes ☐No ☐ Innu ☐ Inuit ☐ Mi'kmaq ☐ _____	Relationship status: _____ Partner involved: ☐Yes ☐No

Partner's name	Gender	Age	Partner emplo ☐Yes ☐No	Occupation	Support person: ☐Yes ☐No Name: _____

Prenatal care provider(s)	Baby's care provider in hospital	Primary care provider	Baby's care provider in community

Pregnancy Dating

EDD (FINAL): DD/MM/YYYY

Last menstrual period (LMP) DD/MM/YYYY	DD/MM/YYYY	Dating U/S DD/MM/YYYY	Gestational Age (GA)	DD/MM/YYYY	Assisted Reproductive Technology (ART): ☐Yes ☐No Type: _____	EDD by ART DD/MM/YYYY

Length of cycle: _____ Regular: ☐Yes ☐No Certain of dates: ☐Yes ☐No Planned pregnancy: ☐Yes ☐No	Multiple pregnancy: ☐Yes ☐No	Chorionicity	Embryo Transfer DD/MM/YYYY

Obstetrical History

Gravida _____ **T**erm _____ **P**reterm _____ **A**bortus _____ **L**iving children _____ **S**tillbirth _____

Date	Place of birth	Gest. age	Type of birth	Complications/Comments e.g. PPH, GDM, IUGR, etc.	Birth Weight	Sex	Current Health	Breastf Duration
DD/MM/YYYY								
DD/MM/YYYY								
DD/MM/YYYY								
DD/MM/YYYY								
DD/MM/YYYY								
DD/MM/YYYY								

Health History

Allergies (include reaction) ☐ Latex ☐NKDA	Previous surgery ☐ Yes ☐No	Medications

	Yes	No
Anesthesia comp.	☐	☐
Blood transfusion	☐	☐
Respiratory	☐	☐
Cardiovascular	☐	☐
☐ Hypertension		
☐ Previous GHTN		
Neurology	☐	☐
Hematology	☐	☐

Infectious diseases	Yes	No
	☐	☐
☐ HSV ☐ HIV ☐ HBV ☐HCV		
☐ Syphilis ☐Gonorrhea ☐ Chlamydia ☐Other		
MSK/Rheumatology	☐	☐
Gynecology/Breast	☐	☐
Gastrointestinal/Liver	☐	☐
Renal/Genitourinary	☐	☐
Endocrine	☐	☐
☐ Thyroid ☐ Previous GDM ☐T1DM ☐T2DM		

Mental Health	Yes	No
	☐	☐
☐ Anxiety		
☐ Depression		
☐ Previous PPD		
☐ Bipolar		
☐ Eating disorder		
☐ Schizophrenia		
☐ Other: _____		

Family History	Yes	No
	☐	☐
☐ Anesthesia comp.		
☐ Diabetes		
☐ Hypertension		
☐ Thromboembolic		
☐ Mental health		
☐ Coagulopathies		
☐ Other: _____		

Comments

Demographics

Social Determinants of Health (SDOH), such as income, education, employment status, support networks, and socio-economic status, shape societal hierarchy and may influence health outcomes. The demographic section of the NL PNR is designed to capture the pregnant person's SDOH to help identify those needing additional resources and support, as well as those with an increased risk of adverse pregnancy outcomes (e.g. age < 18 or > 35 years, education level < grade 12, living in poverty or with a low socioeconomic status (SES), etc.).

Item	Description
Part 1 Date completed	Document the date (DD/MON/YYYY) part 1 of the PNR is completed. This provides a timeline/date when prenatal care began.
Last Name	Document their last name as it appears on the pregnant person's MCP card. If no MCP, as per insurance card or legal documentation. Note maiden name if applicable.
First Name	Record their given (first) name as it appears on the MCP card. If no MCP, as per insurance card or legal documentation. Other names (preferred name, nickname, etc.) can be in quotations marks.
Gender	Gender identity is an important part of assessment and the pregnant person's history. Understanding their gender can help individualize care, identify needs and risk factors.
Pronoun	Ask and document the pregnant person's pronoun (e.g. she/her, he/him, they/them/their, ze, hir).
Address	Document their address, including apartment number, street number and name, city, and postal code. This information facilitates home visits (if applicable) and informs data collection.
Contact Phone	Preferred contact number. Indicate if it is a work, home, or cell phone.
Alternate Phone	An alternative work, home, or cell phone number.
Leave Message	Explicitly ask if it is appropriate to leave a message when contacting.
MCP Number	Number recorded from the MCP Number or assigned hospital unit number..
Date of Birth (DOB)	Pregnant person's date of birth in format of DD/MON/YYYY.

Item	Description
Age at Expected Date of Delivery (EDD)[1 2] SOGC CPG: Adolescent Pregnancy SOGC CPG: Delayed Childbearing	Record the pregnant person's age at EDD. Pregnancies during the adolescent period are noted to have higher obstetrical and neonatal risks, with pregnant persons ≤ 15 having higher risks than even those aged ≥ 16. Pregnancies during adolescence should be managed as high risk to accommodate their unique concerns. Pregnancy in persons ≥ 35 years is associated with: • hypertensive disorders of pregnancy and pre-eclampsia • pre-existing diabetes and gestational diabetes • increased risk of miscarriage, ectopic pregnancy, chromosomal aberrations and birth defects, multiple pregnancy, cesarean section, placenta previa, low birth weight (LBW) and preterm birth (PTB). The cumulative risk of stillbirth in pregnant persons 40 to 44 years of age at 39 weeks' gestation is nearly identical to the risk for those 25 to 29 years of age at 42 weeks. Therefore, prenatal testing should begin at 36 to 38 weeks gestation with delivery by the completion of the 39th week for pregnant persons > 40 years of age.
Highest level of education completed	Document highest level of education completed by identifying the most appropriate option from the following list: • Some High School • Completion of High School • Community College or working on a bachelor's degree • Completion of a bachelor's degree • Completion of a master's degree • Completion of a Doctorate • Professional Degree • Unknown Informs data collection and assesses the pregnant person's comprehension.
Employed Y/N	Pregnant person's employment status.
Occupation	Document type of work and discuss any workplace hazards/risks that may affect the pregnancy. Note any physical and/or mental stress related to work or working conditions (e.g. shift work, long hours, excessive heat or cold, exposure to second-hand smoke or harsh chemicals, etc.).
Culture/beliefs practices	Document specific religious, cultural beliefs and/or practices that may impact pregnancy, birth, or newborn care, e.g. Jehovah's Witness.

Item	Description
Language	Language most readily understood and spoken by the pregnant person. Select from the list provided (i.e. English, French, Arabic) or populate 'other' as appropriate.
Interpreter Required	Indicate whether assistance from an interpreter is required and for what language. The Janeway Children's Health Centre/Health Sciences Centre has a French language interpreter on site and can be reached on weekdays from 0800h–1600h by calling (709) 800-6190 or (709) 777-6300 after hours. In addition, a remote interpretation service is available to Newfoundland and Labrador Health Services employees through RIO which can be accessed by telephone at 1-844-266-3120 and using the organizational client ID #256200. You will then need a secure access code, available from the manager of the department.
Indigenous Identity	Ask every pregnant person this question: "Do you identify as Indigenous?" The response to this question is voluntary. If they do identify as an Indigenous person, select 'Yes,' and specify the identity by selecting all that apply from the following: ❑ Innu ❑ Inuit ❑ Mik'maq ❑ Free text response
Relationship Status	Note current relationship status and any recent changes (i.e. single, never legally married; legally married; separated, but still legally married; common-law; divorced; or widowed). May include any other partnership identified by the pregnant person.
Partner Involved Y/N	Partner is anyone the pregnant person identifies as their partner. This may also provide information on supports or possible safety issues. Regarding genetic screening, race/ethnic information is specific to the genetic (sperm) contributor to the pregnancy. This may or may not be the involved partner.
Partner's Name	The given name of the current partner. Leave blank if no partner is reported. The named partner in this section may not be the genetic contributor to this pregnancy.
Partner's Gender	The current partner's identified gender.
Partner's Age	Age of the partner (or sperm contributor to the pregnancy) as advanced paternal age (≥ 40 years) increases risk of certain genetic disorders.
Partner Employed Y/N	The current partner's employment status.
Partner's Occupation	The current partner's occupation.

Item	Description
Support person	The name of a support person (if applicable). This person may be instead of or in addition to a partner.
Prenatal Care Provider(s)	Provide full name and profession (midwife, doctor, nurse practitioner) of the pregnant person's prenatal care provider(s).
Baby's Care Provider (in hospital)	Provide full name and profession (midwife, doctor, nurse practitioner) of baby's health care provider while still in hospital, if known or confirmed.
Community primary care provider	Provide full name and profession (nurse practitioner, doctor) of the pregnant person's primary care provider.
Baby's Care Provider (in community)	Provide full name and profession of baby's community health care provider/family physician in the community. Note: This may be different from the health care provider caring for the baby in the hospital or the care provider who cared for the pregnant person during pregnancy. If identified that the infant will be without a community care provider, encourage the patient to complete the requisition for a primary care provider through Patient Connect NL at www.patientconnect.nlchi.nl.ca and update this section with the baby's care provider when the information is available from the family. If still on wait list at time of delivery, providers should instruct the family to immediately update their Patient Connect NL information with the infant's date of birth (DOB).

Pregnancy Dating

Item	Description
Last Menstrual Period	Note the first day of the Last Menstrual Period (LMP) in DD/MON/YYYY (if known).
EDD by LMP	Indicate the estimated date of delivery (EDD) based on the LMP in DD/MON/YYYY.
Dating Ultrasound (U/S)[3,4] SOGC CPG: GA by U/S SOGC CPG: 1st Trimester U/S	Record the date the dating U/S was performed in DD/MON/YYYY. A first trimester U/S is recommended to date a pregnancy (ideally at 7–12 weeks). If menstrual dating is reliable and an early comprehensive pregnancy ultrasound (11–14 weeks) is planned, dating should be confirmed concurrently with U/S.
GA at time of U/S	Document the gestational age (in weeks) at the time of the dating U/S.
EDD based on U/S	Indicate the EDD based on ultrasound in DD/MON/YYYY.

Item	Description
Assistive Reproductive Technology **Type**	Indicate if current pregnancy was conceived using Assistive Reproductive Technology (ART) such as fertility medication, in vitro fertilization (IVF), etc. Note that 30% of pregnancies conceived through IVF result in multiple gestation.
Embryo Transfer	Record the date of embryo transfer. DD/MON/YYYY
EDD Based on ART	Document EDD based on ART. DD/MON/YYYY
Multiple Pregnancy	Indicate if multiple pregnancy.
Chorionicity	Indicate chorionicity of multiples.
Length of Cycle	Document the length of the pregnant person's menstrual cycle in days. EDD by LMP should be adjusted based on cycle length.
Regular	Indicate if the pregnant person's cycle is regularly the same number of days or not.
Certain of Dates?	Indicate if the pregnant person is certain or uncertain of their LMP dates.
Planned Pregnancy[5]	Indicate if the pregnancy was planned or unplanned. Unplanned pregnancies are a strong predictor of intimate partner violence (IPV), with utilizing contraceptive methods often being more difficult for persons who are experiencing IPV, leading to a higher incidence of unintended pregnancies.
EDD Final	Record the final EDD in DD/MON/YYYY according to the first trimester ultrasound. If first trimester ultrasound is not available or was not completed, document the method/clinical information used to determine the EDD Final.

Obstetrical History

The terms: 'gravida', 'term', 'preterm', 'abortus', 'living children', & 'stillbirth' (GTPALS) **are defined below** and have been adopted on the NL PNR to align documentation with terms used nationally. The GTPALS system provides more detail about the obstetrical history. For example, if a first-time pregnant person had twins at 35 weeks gestation, they would be G1T0P1A0L2S0.

The term "abortus" is widely accepted in literature and national guidelines to describe pregnancies that were not carried beyond 20 weeks gestation, however providers are encouraged to use discretion when using this term. Certain patient populations, particularly those struggling with infertility and/or recurrent pregnancy loss may have difficulty using this term.

In the Gravida Parity (GP) System, parity, or 'para', indicates the number of completed pregnancies reaching viable gestational age or beyond 20 weeks gestation (including live births and stillbirths). Parity does not reflect the number of children. If a first-time pregnant person had twins at 35 weeks, they would be a G1P1.

Item	Description
Gravida	The total number of pregnancies for the pregnant person, including this pregnancy, regardless of gestational age, type, or outcome. A pregnancy with twins/multiples is counted as one pregnancy. Note: An ectopic pregnancy, a missed abortion, a blighted ovum and a hydatidiform mole are classified as a gravida and should contribute to the total number of all pregnancies.
Term	The total number of previous pregnancies with birth at ≥ 37 completed weeks.
Preterm	The total number of previous pregnancies with birth occurring between 20+0 and 36+6 completed weeks. The absolute risk of recurrent spontaneous PTB is 30%. Late terminations should contribute to the total number of previous preterm pregnancies. Note: A previous multiple pregnancy delivered preterm should be counted as 1 preterm. If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as 1 term and 1 preterm.
Abortus	The total number of pregnancies that were spontaneous losses before 20 weeks gestation or weighing < 500 grams or planned terminations. Spontaneous abortions include miscarriage, ectopic pregnancy, missed abortion, blighted ovum and molar pregnancy.
Living Children	Number of children born to the pregnant person who are presently living.
Stillbirth	Number of fetal deaths born to the pregnant person ≥ 20 weeks pregnancy OR if gestational age is not known, with a birth weight of ≥ 500 grams.
Date	The date (DD/MON/YYYY) of each previous pregnancy, **from most recent.** Each row corresponds with one child (i.e. for a multiple pregnancy, each row should correspond to one infant of that pregnancy). If extra space is required, use the comment section below. Note: All previous induced and spontaneous terminations should be recorded.
Place of Birth/Loss	The location of the previous birth/loss (e.g. Hospital, Home).
Gestational age	The gestational age (number of weeks and days) of previous birth/loss.
Type of Birth	The type of birth, i.e. vaginal, assisted, Cesarean section (emergency or elective).

Item	Description
Complications/ Comments	Comment on important details and/or any complications related to previous pregnancies such as: • Postpartum Hemorrhage (PPH) • Gestational Diabetes Mellitus (GDM) • Small/Large for Gestational Age (SGA/LGA) • Gestational Hypertension Disorder (GHTN) • Preterm Premature Rupture of Membranes (PPROM) • Preterm Birth (PTB) • Shoulder Dystocia • Placental Disorders • Perineal Trauma (3rd or 4th degree tears, etc.) • Perinatal Mood and Anxiety Disorders (PMAD) Note: This information is important as previous perinatal complications may have an impact on the current pregnancy/birth.
Birth–weight	The birth weight of infant (in grams).
Sex	The biological sex, male or female, or undifferentiated (sex could not be determine/defined) of the infant. For terminations (loss before 20 weeks) record, 'N/A' if undetermined..
Current health	The current health status of the child and any relevant concerns.
Breastfeeding duration	Indicate breastfeeding duration (if applicable) and if there were any issues or concerns.

Health History

Indicate yes 'Y' or no 'N' with a √ in the appropriate box.

Item	Description
Allergies (reaction)	Note any allergies (food, medication, environment, etc.) and indicate the type of reaction to the agent (anaphylaxis, rash, gastrointestinal distress, etc.) **Ensure you clearly note any allergies to Penicillin in particular.**
Latex Allergy	Note an allergy to natural rubber latex.
NKDA	Note if there are any known drug allergies. If none, it may be recorded as No Known Drug Allergies (NKDA).
Previous Surgery	Document any previous surgery, inpatient or outpatient. Comment on the type of surgery, date, and any complications.
Current Medications	List all current medications (prescription, over the counter, vitamins, herbal, etc.). Include specific name, dosage, and reason for taking. Medications that act systemically will most likely cross the placenta and reach the fetus. The advantages of taking medication during pregnancy should outweigh the risks to the fetus. Review all medication and consider discontinuing and/or safer alternatives when appropriate. Also consider listing any relevant previous medications, such as any medications stopped for pregnancy that are to be re-started after delivery (i.e., certain SSRIs, anti-hypertensives for essential hypertension, etc) or any medications that were taken and then stopped throughout the pregnancy.
Anesthesia complications	Describe any complications from prior local, regional, or general anesthetics, including metabolic disorders, difficult intubations, and/or severe postoperative nausea/vomiting. Instances where an Anesthesia Consult should be considered:[6] • Body Mass Index (BMI) over 40 • History of significant pulmonary or heart disease • Previous difficult anesthesia or intubation • History of spinal instrumentation, including Harrington rods, previous laminectomy, or previous spinal fusion. • Known or suspected neurological disease (e.g. Multiple Sclerosis or Spina Bifida).
Blood transfusions	Indicate any previous blood transfusions and comment on any reaction.
Respiratory	Indicate any significant respiratory disease such as asthma, chronic obstructive pulmonary disease, etc.

Item	Description
Cardiovascular	Specify any significant cardiovascular (CV) conditions or concerns such as congenital heart disease, arrhythmias, cardiomyopathy, etc. Indicate severity. Indicate whether the pregnant person has any history of: ❑ Hypertension (Essential) ❑ Previous Gestational Hypertension (GHTN)
Neurology	Indicate any pre-existing conditions, such as Multiple Sclerosis, epilepsy (include type of seizures and frequency), migraines, etc.
Hematology	Note any significant pre-existing disease such as iron deficiency, anemia, thalassemia, etc. Indicate any thromboembolic disorders or coagulopathies. Include previous thromboembolic events, deep vein thrombosis, pulmonary embolisms, etc.
Infectious diseases[7 8 9] SOGC CPG: HSV SOGC CPG: HIV SOGC CPG: HBV SOGC CPG: HCV PHAC Gonorrhea/ Chlamydia	A supportive and person-centered approach is essential for assessing a history of sexually transmitted and blood-borne infections in pregnancy. Assess for past or current history of: ❑ Herpes Simplex Virus (HSV) and specify if primary outbreak occurred in pregnancy. ❑ Human Immunodeficiency Virus (HIV) ❑ Hepatitis B Virus (HBV) ❑ Hepatitis C Virus (HCV) ❑ Syphilis ❑ Gonorrhea ❑ Chlamydia ❑ Other–Indicate any other past or current infectious diseases, treatment, and test of cure. Consider additional or repeat testing later in pregnancy for those with ongoing risk.
Musculoskeletal (MSK)/ **Rheumatology**	Indicate any musculoskeletal (MSK) disorders that may affect pregnancy/birth, as well as any rheumatic and autoimmune disorders (e.g. systemic lupus erythematosus (SLE), rheumatoid arthritis (RA), antiphospholipid syndrome).
Gynecological/Breast	Indicate any history of uterine fibroids, endometriosis, etc., and any uterine or cervical procedure such as cone biopsy or myomectomy. Note any history of breast surgeries, including biopsies, reduction, or augmentation.
Gastrointestinal/Liver	Indicate any significant pre-existing disease such as Crohn's, irritable bowel syndrome, chronic constipation, cirrhosis, etc.

Item	Description
Renal/Genitourinary	Note any pre-existing urinary/renal condition. Include frequent urinary tract infections, kidney disease, etc.
Endocrine/Thyroid	Indicate any pre-existing endocrine conditions or any history of: ❑ Thyroid Disease ❑ Type 1 Diabetes Mellitus (T1DM) ❑ Type 2 Diabetes Mellitus (T2DM) ❑ Previous Gestational Diabetes Mellitus (GDM)
Mental Health SOGC CPG: Identification and Treatment of Perinatal Mood and Anxiety Disorders	Specify any significant mental health issues or concerns. Indicate a past or current diagnosis of: ❑ Anxiety ❑ Depression ❑ Previous Post-Partum Depression (PPD) ❑ Bipolar ❑ Eating Disorder ❑ Schizophrenia ❑ Other mental health issues or concerns
Family history concerns	Document any concerns with the family history (**immediate** family members): ❑ Anesthesia complications ❑ Diabetes ❑ Hypertension ❑ Heart disease ❑ Thromboembolic or coagulation issues ❑ Mental Health–familial history of psychiatric disorders e.g. depression/anxiety ❑ Other–Any disease that may negatively impact the pregnancy or birth such as history of substance use disorder.
Comments	Indicate any other medical condition or illness that affects the pregnant person (past or present) and is relevant to pregnancy.

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part II)

Date completed _____ DD/MM/YYYY

Current Pregnancy

	Yes	No		Yes	No		Yes	No	Comments
Nausea/vomiting	☐	☐	Travel (self/partner)	☐	☐	Calcium/vitamin D	☐	☐	
Illness/rash/fever	☐	☐	Preconception folic acid	☐	☐				
Bleeding	☐	☐	Prenatal vitamins	☐	☐				

Infant feeding plan: ☐Breastfeeding ☐Human Milk Substitute ☐Undecided

Clinical Exam

Height	Weight	Pre-pregnancy BMI	Recommended gestational weight management see worksheet 1		Comments
BP	Lungs	Heart	Abdomen	Pelvic exam	Female genital cutting ☐Yes ☐No

Lifestyle/Risk Factors

	Yes	No		Yes	No		Yes	No		Yes	No
Relationship issues	☐	☐	Financial/housing issues	☐	☐	Parenting concerns	☐	☐	Dietary restrictions/concerns	☐	☐
History of trauma/abuse	☐	☐	Barriers accessing care	☐	☐	Occupational risks	☐	☐	Food security concerns	☐	☐
Intimate partner violence	☐	☐	Social support concerns	☐	☐	Oral hygiene concerns	☐	☐	Other	☐	☐

Substance Use

	Yes	No		Yes	No	Comments/Follow-up
Tobacco - past 6 months Number of cigs/day _____ Quit DD/MM/YYYY	☐	☐	Alcohol - past 6 months Number per week _____ Last drink DD/MM/YYYY	☐	☐	
Tobacco - current use Number of cigs/day _____ ☐Ceremonial	☐	☐	Alcohol - current use Number of drinks/day _____ /week _____	☐	☐	
Nicotine replacement	☐	☐	≥4 drinks at one time	☐	☐	
Vaping during pregnancy	☐	☐	Other Substance use in pregnancy ☐Cocaine ☐Methamphetamines ☐Opioids ☐Other	☐	☐	
Cannabis - past 6 months	☐	☐				
Cannabis - current use	☐	☐	Route _____			
Number of times used/day _____ /week _____			Substance use disorder	☐	☐	
Method _____			☐Opioid agonist therapy			
Strength _____			_____			

Ethnicity

Black	☐	White	☐
East Asian	☐	Unknown	☐
Indigenous	☐	Prefer not to say	☐
Latin American	☐		
Middle Eastern	☐	Other (specify)	☐
Southeast Asian	☐		
South Asian	☐	_____	

Genetic Risk Assessment

	Yes	No	Hemoglobinopathy/Thalassemia screen (CBC, Hgb electrophoresis)	Consanguinity (blood relation)
Donor gamete: Egg	☐	☐	☐Yes ☐No ☐N/A	☐Yes ☐No
Sperm	☐	☐		
Egg age at EDD_____			**Referral to Medical Genetics** (see worksheet 2): ☐ Yes ☐ No ☐ N/A ☐ Declined	
_____ Ethnicity gamete			Specify	

Genetic Screening/Investigations (See worksheet 2)

No genetic screening ☐Counseled and declined

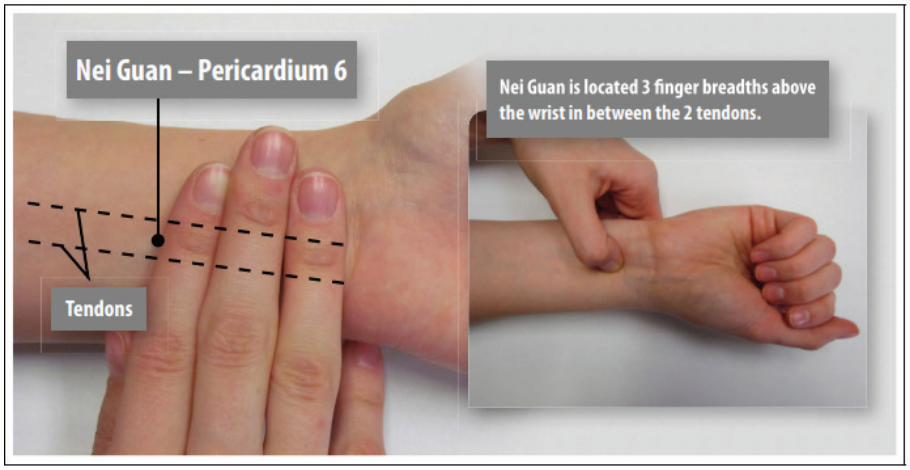
NT (11-13+6 weeks)	☐Counseled	☐Completed	☐Declined	☐N/A	NIPT	☐Counseled	☐MCP	☐Self pay ☐Declined
MSS (15-20+6 weeks)	☐Counseled	☐Completed	☐Declined		CVS/Amniocentesis		☐Yes	☐No
EPR	☐Counseled	☐Completed	☐Declined	☐N/A	Other		☐Yes	☐No

Comments

Current Pregnancy

Provide patients with the following link to the Government of Canada's patient educational resource: Your guide to a healthy-pregnancy-guide.pdf (canada.ca)

Use the next section to guide your assessment of the current pregnancy. Indicate yes 'Y' or no 'N' with a √. Provide additional details in the comments section provided.

Item	Description
Nausea/Vomiting[10]	Note if the pregnant person is experiencing nausea and/or vomiting during pregnancy (NVP). If yes, indicate the severity and treatment, such as: • Non-pharmacological therapies • Dietary and lifestyle changes (e.g. eating small, frequent meals) • Discontinuing iron containing supplements • Increasing rest • Ginger • Acupressure (stimulation of the P6 (Nei Guan) point) SOGC CPG: Nausea and Vomiting  • Mindfulness cognitive therapy • Pharmacological modalities such as doxylamine and pyridoxine (Diclectin).

Item	Description
Illness/Rash/Fever[11 12 13] Tick bites and lyme disease SOGC CPG: Toxoplasmosis SOGC CPG: Listeriosis SOGC CPG: CMV SOGC CPG: Parvovirus	Note whether the pregnant person has had any illness/rash or fever during current pregnancy and note the gestational age at the time. If 'Yes' is selected, specify the type of infection, rash, or fever that the pregnant person has had during the current pregnancy and treatment plan (if applicable). **Toxoplasmosis** Although rare, congenital toxoplasmosis can cause severe neurological or ocular disease (leading to blindness), as well as cardiac and cerebral anomalies. Routine screening is not recommended; however, pregnant persons should be informed of primary prevention measures to avoid toxoplasmosis infection, such as: • washing hands before handling food • thoroughly washing all fruit and vegetables, including ready-prepared salads, before eating • thoroughly cooking raw meats and ready-prepared chilled meals • wearing gloves and thoroughly washing hands after handling soil and gardening • avoiding cat feces in cat litter or in soil **Listeriosis** A food-borne illness caused by consumption of unpasteurized dairy products, soft-ripened cheeses and deli meats that can lead to pregnancy loss, stillbirth, preterm birth, or life-threatening infection of the newborn. Prevention of listeriosis has been recognized as high priority by Health Canada as the risk of invasive listeriosis in pregnant persons is nearly 20 times greater than the general population. **Parvovirus B19** (Fifth disease) In rare cases, parvo may cause a miscarriage, or the fetus could develop anemia. Proper hand hygiene is the best way to prevent the disease. **Cytomegalovirus infection** (CMV) CMV is transmitted in body fluids. Most people with CMV have no symptoms. The most common long-term health problem in babies born with congenital CMV infection is hearing loss. **Lyme Disease** Treatment for pregnant persons with Lyme disease is like treatment for the general adult population, with the exception that treatment doses of doxycycline are contraindicated in pregnancy.

Item	Description
Bleeding	Indicate if any bleeding or spotting has occurred during current pregnancy. Specify gestation, duration, amount of bleeding, and whether an ultrasound was performed.
Travel (self/partner)	Indicate whether the pregnant person and/or their partner have travelled and/or are planning to travel during the current pregnancy. Note the travel destination and any precautions that may be recommended. Note: Advise against travel to high-risk areas to minimize the chances of becoming infected with malaria, yellow fever, Zika virus, etc.
Pre-conceptual Folic Acid[14] Health Canada: folate SOGC CPG: Preconception Folic Acid	Indicate use of preconception folic acid and document the dosage taken. A diet of folate rich food (i.e. broccoli, spinach, lentils, peas, beans, dark leafy greens, and citrus) is recommended. Advise about the benefits of folic aid supplementation including, prevention of neural tube defects and other congenital anomalies (i.e. heart defects, uterine tract anomalies, oral facial clefts, limb defects, and pyloric stenosis). **Supplementation with folic acid should begin 2–3 months preconception.** **Low risk:** pregnant person and the male biological contributor have no personal or family history of folic acid–sensitive birth defects. Recommend daily oral multivitamin supplement containing **0.4 mg folic acid** and vitamin B12 for at least 2 to 3 months before conception until 4–6 weeks after delivery or as long as breastfeeding continues. **Moderate risk:** pregnant person with the following personal or co-morbidity scenarios (a to e) or the male biological contributor with a personal scenario (a and b): a) Personal or family history of other folic acid–sensitive anomalies b) Family history of neural tube defect (NTD) in first or second degree relative c) Diabetes (type 1 or 2) d) Use of teratogenic medications such as antiepileptic and cholestyramine medications e) Gastrointestinal malabsorption conditions (i.e. Crohn's disease, Celiac disease, gastric bypass surgery, liver disease, kidney dialysis, alcohol overuse).

Item	Description
Pre-conceptual Folic Acid continued	Recommend daily oral supplementation with a multivitamin containing 1.0 mg of folic acid, at least three months prior to conception and continuing through the first 12 weeks gestation. The multivitamin supplement should also contain vitamin B12. After 12 weeks gestation, it is recommended that pregnant persons continue daily oral multivitamin supplementation containing 0.4 mg of folic acid until at least 4–6 weeks after delivery, or as long as breastfeeding continues. The multivitamin should also contain vitamin B12. **High risk:** pregnant person or the male biological contributor have a personal NTD history or a previous NTD pregnancy. Recommend daily oral supplement with **4.0 mg folic acid** beginning at least 3 months prior to conception and continuing through the first 12 weeks gestation. The multivitamin should also contain vitamin B12. This can be achieved by consuming either one multivitamin containing 1.0 mg of folic acid plus three individual 1.0 mg folic acid tablets. After 12 weeks gestation, advise switching to a daily multivitamin containing 0.4mg to 1.0mg of folic acid until 4–6 weeks postpartum, or as long as breastfeeding continues. **Risks of folic acid** supplementation are minimal, but include: • Allergic reaction (rare)—erythema, rash, pruritus, general malaise, bronchospasm • Seizure disorders—convulsions may occur in previously controlled patients • Neoplasia—possible association with neoplasia or exacerbation of pre-existing colorectal cancer
Prenatal vitamins[15]	Specify if the pregnant person is taking prenatal multivitamins containing folic acid, iron and vitamin D. Inform to **take only 1 daily dose** of their multivitamin. **Iron**—a supplement containing 16 to 20 mg of elemental iron is recommended. Therapeutic doses of iron may be required for iron deficiency (e.g. a low hemoglobin and serum ferritin). Food sources include tofu, beef, chicken, shrimp, salmon, eggs, beans, lentils, spinach, nuts, and raisins. Providers should provide pregnant persons with information regarding the free Dial-A-Dietician service through the Newfoundland and Labrador healthline (811) to access support in improving iron status through diet.

Item	Description
Calcium/Vitamin D[16] Dieticians of Canada Nutrition in Pregnancy Summary CPS Position Statement: Preventing Vitamin D Deficiency and Ricketts amongst Indigenous infants and children in Canada Vitamin D Factsheet for Health Professionals	Indicate if the pregnant person has adequate calcium and vitamin D intake. Adequate calcium intake is recommended to reduce the risk of pre-eclampsia. Calcium-rich foods are the preferred source of calcium since these foods provide a variety of nutrients that are not present in calcium supplements. Recommend pregnant person contact the free Dial-a-Dietitian service for information on increasing intake of calcium through dietary sources such as milk, fortified plant-based beverages, yogurt, cheese and calcium-set tofu. **For those with low calcium intake** (< 900 mg/day), calcium supplementation of at least 500mg is recommended. Calcium supplements should be taken with meals and should not exceed a dose of 500 mg (elemental calcium) at one time, as this is the maximum amount that can be absorbed at once. Further, calcium supplements should not be taken at the same time as prenatal multivitamin supplements and/or iron supplements due to the potential interference with iron absorption. Separate taking calcium supplements from prenatal/iron supplements by several hours. **For those with low calcium intake and at high risk of pre-eclampsia,** a higher level of calcium supplementation may be recommended. In this case, referral to a Registered Dietitian is recommended. The recommended dietary allowance (RDA) of vitamin D during pregnancy is 600 IU/day, including intake from both food and supplemental sources. Food sources of vitamin D include egg yolks, soft margarine, fatty fish, cow's milk and fortified plant-based beverages. If dietary intake of vitamin D from food is low (e.g., consumes less than 2 cups/day of milk fortified soy beverage, and minimal intake of fatty fish or other food sources), a supplement containing 400 IU (10 mcg) of vitamin D is recommended. This requirement is typically met by most prenatal multivitamin supplements; however, individuals should be advised to check the label to confirm adequate amount of vitamin D. Additional vitamin D may be required for individuals who are at higher risk of vitamin D inadequacy, including those who: • have limited sun exposure • have their skin covered with clothing or sunscreen much of the time • live in northern latitudes • have darker skin pigmentation • have conditions that limit fat absorption (e.g. inflammatory bowel disease, liver disease, Celiac disease, intestinal failure)

Item	Description
Calcium/Vitamin D continued	• have health conditions that affect how vitamin D works (e.g. kidney disease) • use medications that impact vitamin D metabolism • are living with obesity or have previously undergone gastric bypass surgery
Infant feeding plan Baby Friendly NL Ten Valuable Tips for Successful Breastfeeding	Note the infant feeding plan: ❑ Breastfeeding ❑ Human milk substitute ❑ Undecided Identify existing knowledge and prior breastfeeding experience (if applicable). Provide education on the benefits of breastfeeding, offer available support, and discuss any questions/concerns. Included below are a few suggestions of points to include in the discussion with pregnant persons regarding breastfeeding: • Your body is designed make milk for your baby. Health Canada recommends that babies are exclusively breastfed for the first 6 months of life and should continue to breastfeeding with the appropriate introduction of complementary foods for up to 2 years and beyond. • Every drop counts! Any amount of breastmilk that you are able to feed your baby has significant benefits. You may wish to explore prenatal colostrum collection and decide if it would work for you. • Breastmilk changes as your baby grows. It adapts to meet your babies needs in every stage of development. When you latch your baby to the breast, your body is able to "read" your babies saliva and customize the milk for your baby. • Breastmilk contains antibodies that help protect your baby from infections and illnesses — especially colds, ear infections and diarrhea. • Breastfeeding offers more than just food — the closeness regulates temperature, heart rate and breathing of both parent and baby. • Breastfeeding Benefits YOU — it helps the uterus contract after birth, which can help reduce postpartum bleeding and lowers the risk of breast and ovarian cancers. Breastfeeding regularly helps you bond with your baby. • Having the right support helps you meet your breastfeeding goals. Support is available through your Public Health Nurse, Family Resource Centers, Community Breastfeeding Support groups and through Baby-Friendly NL.

Clinical Exam

Item	Description
Height	The pregnant person's height in centimetres.
Weight Health Canada pregnancy	The pre pregnancy weight of the pregnant person in kilograms, or if unknown, weight at the first prenatal visit.
Pre-pregnancy Body Mass Index (BMI)	Calculate the pre-pregnancy body mass index (BMI). The formula to calculate BMI is weight (kg) divided by height (M) squared. Health Canada BMI calculator
Gestational weight management Nutrition–Multiples Institute of Medicine (IOM)	Pregnant persons should be advised to eat a healthy, well-balanced diet and increase their caloric intake by a small amount (350–450 calories/day). The recommended range of total weight gain (for singleton pregnancy) per BMI category is outlined according to the Institute of Medicine (IOM) guidelines. See Worksheet #1 of the NL PNR for more information of Gestational weight management.
Clinical exam:[17 18 19] BP Lungs Heart Abdomen Pelvic exam	Complete and document the findings of a clinical exam. The content of the exam is not specified beyond baseline blood pressure (BP), pre-pregnancy weight and height to calculate BMI, and to identify pregnant persons with female genital cutting (FGC). Assessment of heart, lungs, abdomen, pelvis, and other areas should be completed as indicated based on clinical judgement. **SOGC suggests the following for** pregnant persons ≥ 35 years of age: • *A comprehensive history and physical examination. • *Prenatal bloodwork that includes baseline liver and kidney function. • *Mammogram (> 40 years) and Cardiology consultation (> 45 years). • Monitoring for hypertensive disorders of pregnancy and pre-eclampsia. • Placental localization with U/S with the 2nd trimester scan, to be followed up at 28 weeks' gestation if low lying or previa. *Consideration should be given to the individual, clinical and local practice context.

Item	Description
Female genital cutting[20 21] SOGC CPG: Female Genital Cutting	Record if the pregnant person has experienced female genital cutting (FGC) and provide details in the comment section. Pregnant women and individuals with FGM are at higher risk of cesarean delivery, postpartum hemorrhage, and extended maternal hospital stay, and their infants are at higher risk of requiring resuscitation and have an increased incidence of neonatal death. Pregnant women and individuals who have experienced genital cutting must be approached with sensitivity and understanding. It was not their choice to be cut and health care providers need to be nonjudgmental and provide culturally competent and sensitive care. It is important to pay special attention to concerns related to confidentiality and privacy.

Lifestyle Risk Factors

Lifestyle risk factors, lower socioeconomic status, social support concerns, history of trauma, and/or psychosocial risk factors can impact the health of the pregnant person, the in-utero environment for the fetus, and have a negative effect on pregnancy outcomes. This section of the NL PNR helps to identify pregnant persons with lifestyle and psychosocial risk factors as early interventions can improve perinatal outcomes.

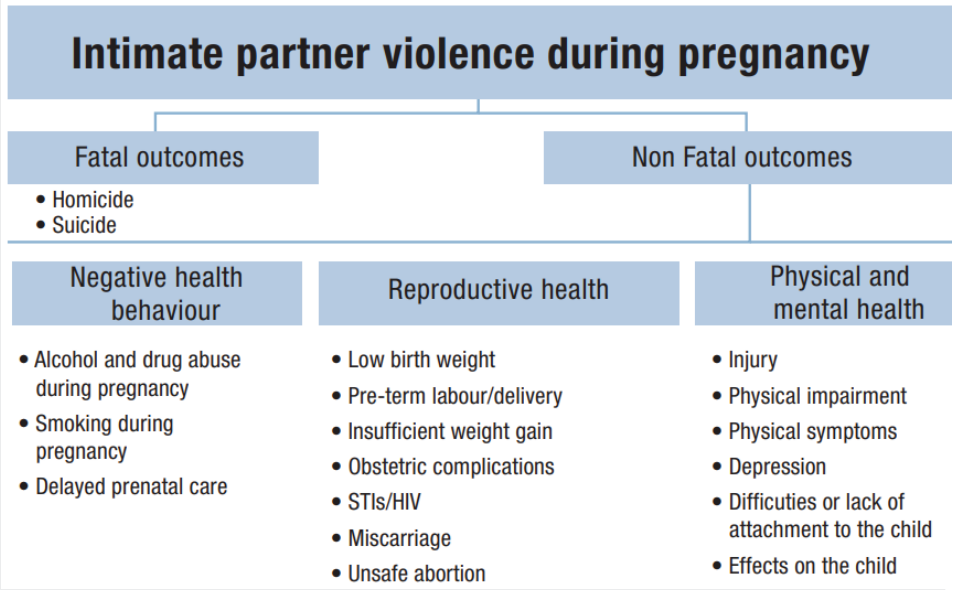
If lifestyle/risk factors are identified prenatally, consider available community resources and tools, such as:

- Public Health
- Nutrition
- Mental Health
- Social Work
- Poverty: A Clinical Tool for Primary Care Providers
- Income Support: Children, Seniors, Social Development
- Housing: NL Housing and Homelessness Network (NLHHN)

Indicate yes 'Y' or no 'N' with a √ in the appropriate box.

Provide additional details in the comments section provided.

Risk Factor	Description
Relationship issues	Ask questions such as: **"How would you describe your relationship with your partner?"** and **"What do you think the relationship will be like after the baby arrives?"** Relationship difficulties can be associated with increased dysfunction in pregnancy, postpartum depression, domestic abuse, and child abuse.
History of Trauma/ Abuse[22] WHO: Intimate Partner Violence during Pregnancy Intimate Partner Violence and Abuse	Ask about previous trauma/abuse. Pregnant persons with a history of trauma and/or abuse have a higher likelihood of developing depressive symptoms during pregnancy and in the post partum period. All pregnant persons, regardless of socioeconomic status, race, sexual orientation, age, ethnicity, health status, and presence or absence of current partner, are at risk and should be screened for intimate partner violence (IPV). Intimate partner violence is abuse (pychological, physical, sexual, financial, or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. Suggested ways to approach the topic: **"I talk to all my patients about intimate partner violence because it is common in many patients' lives and there is help available."** Ask questions such as: **"Has your partner ever threatened to hurt you or physically harmed you in some way?' "Has your partner ever humiliated you, bullied you, or made you feel afraid?"** or **"Do you feel safe in your current relationship?"** The VEGA (Violence, Evidence, Guidance, and Action) Project from McMaster University has created pan-Canadian, evidence-based guidance and education resources to assist healthcare providers in recognizing and responding safely to family violence. VEGA focuses on three main types of family violence: child maltreatment, intimate partner violence, and children's exposure to intimate partner violence. VEGA has developed an online platform of **free education resources** comprised of learning modules (e.g., care pathways, scripts, how-to videos), interactive educational scenarios and a Handbook.

Risk Factor	Description
History of Trauma/ Abuse continued	
Financial/housing concerns[23] Income Support - Children, Seniors, Social Development NL Housing Corporation (NLHC) NL Housing and Homelessness Network (NLHHN) Choices for Youth	Financial and housing concerns can be screened by using the following question: **"Do you ever have difficulty making ends meet, or paying your bills, at the end of the month?"** Social determinants of health are interrelated and pregnant persons with low socioeconomic status and social barriers have more difficulty accessing healthy food and adequate housing and have a higher incidence of anxiety and depression.
Barriers to accessing care[24]	Indicate if there are any barriers related to accessing care. Example of personal barriers include: • Lack of transportation or childcare • Low socioeconomic status/financial problems • Lack of social support • History of substance use disorder or addiction • Intimate partner violence Examples of systemic barriers include: • Negative experiences with the health care system • Judgement from health care providers

Risk Factor	Description
Social support concerns	Social support can be screened for by asking the following questions: **"Do you have someone you can depend on to help you if a problem comes up?"** **"How does your partner/family feel about your pregnancy?"** **"Who will be helping with the baby following birth?"**
Parenting concerns Family Resource Centres in NL CFY Momma Moments	Indicate if there are any concerns related to the pregnant person's ability to parent and if additional resources and support are needed. If a concern is identified, consider referring the patient and family to Family Resource Centres, Healthy Baby Clubs, Public Health clinics, or Children, Seniors, and Social Development (CSSD) Prenatal Supportive Care and Planning.
Occupational risks	Identify any occupational risks early in pregnancy to determine if adaptations need to be made. Strenuous extended work (lifting heavy objects, shiftwork, high stress environments) may be associated with low birth weight, prematurity, and miscarriage. Chemicals such as anesthetic and chemotherapeutic agents, and solvents and pesticides, can increase the risk of miscarriage, and other adverse pregnancy outcomes.
Oral hygiene concerns[25]	Ask about any concerns related to oral hygiene. Assessment of oral health should be part of prenatal care and general preventive dental care. The treatment of periodontal disease should continue during pregnancy. A cleaning and oral health assessment should be done in the 1st trimester, and any dental work (i.e. fillings) should be done during the 2nd trimester. Periodontal disease during pregnancy contributes importantly to the overall risks of preterm delivery, low birth weight, and pre-eclampsia.
Dietary restrictions/ concerns[26] SOGC CPG: Female Nutrition Prenatal Nutrition Guidelines for Health Professionals	Ask about any dietary concerns or restrictions that may impact nutritional status during pregnancy, such as lactose intolerance, a gluten free diet, veganism, etc. A vegetarian/vegan diet is healthy during pregnancy with careful attention to protein and adequate intake of nutrients such as zinc, iron, vitamin B12, and omega-3 fatty acids. Additional nutrients required during pregnancy include folate, choline, and iodine.

Risk Factor	Description
Food security concerns[27 28] Poverty: A Clinical Tool for Primary Care Providers Find a Canadian Food Bank Prenatal-Early Childhood Nutrition Supplement (PECNS)	Food security can be screened for using the following question: **"In the past 12 months, were there times when the food for you and your family just did not last and there was no money to buy more?"** Poverty is not always apparent, therefore screening for concerns is important. In Newfoundland and Labrador, 22.5% of families with children live in poverty. Food insufficiency and low levels of social support can impact the mental well-being among pregnant persons. Pregnant persons of lower socioeconomic status have an increase in food security/quality concern, financial/housing issues, and barriers to accessing care, all of which can negatively impact pregnancy outcomes.

Substance Use

Substance use (e.g. alcohol, tobacco, or recreational drug use), lower socioeconomic status, social support concerns, history of trauma, and/or psychosocial risk factors (e.g. anxiety or depression) can impact the health of the pregnant person, the in-utero environment for the fetus, and have a negative effect on pregnancy outcomes. This section of the NL PNR helps to identify pregnant persons with a history of substance use, as early interventions can improve perinatal outcomes.

Indicate yes 'Y' or no 'N' with a √ in the appropriate box.

Provide additional details in the comments section provided

Substance	Description
Tobacco: past 6 months **# cig/day Quit** Women and Tobacco	Ask if tobacco was used in the last 6 months and if yes, document the # of cigs/day. If the pregnant person has quit using tobacco, note the date (DD/MON/YYYY) last used. Offer to refer to the NL Smokers' Helpline to reduce or quit smoking and/or vaping. Phone: 1-800-363-5864 Website: https://www.smokershelp.net
Tobacco: current use **Cigs/per day**[29]	Ask if tobacco is currently being used during pregnancy, and if yes, document the # of cigs/day. Ask if the patient is open to reducing or trying to reduce the number of cigarettes used per day. Refer to NL Smokers' Helpline if appropriate.
Ceremonial	Indicate if tobacco use is ceremonial. While traditional tobacco plays an important medicinal and ceremonial role in many Indigenous communities, the spiritual use of traditional tobacco has no connection to the recreational use of commercial tobacco.

Substance	Description
Nicotine replacement	Ask about nicotine replacement therapy and indicate frequency. Although no amount of nicotine is known to be safe during pregnancy, nicotine replacement therapy is an evidenced based method to support smoking cessation or to reduce the number of cigarettes smoked during pregnancy.
Vaping during pregnancy[30] NL Smokers' Helpline	Ask if vaping during pregnancy. Many electronic cigarettes (e-cigarettes) contain nicotine, which has been shown to have harmful effects on fetal brain development and many other organs. E-cigarettes also contain ingredients (used to create vapor) and other harmful additives that are not known to be safe in pregnancy. Pregnant persons should be cautioned about using e-cigarettes due to the lack of evidence on their safety and efficacy during pregnancy.
Cannabis use in past 6 months	Ask about cannabis use (inhalation, topical, edibles, and the amount and strength, if known) during the past 6 months.
Current cannabis use #/times used/day/ week Method and strength[31,32] Cannabis Use Women and Cannabis SOGC CPG: Cannabis Resources SOGC CPG: Cannabis Use in Pregnancy, Postnatal and Breastfeeding	Ask about cannabis use (inhalation, topical, edibles, and the amount and strength, if known) during current pregnancy. Indicate the number of times used/day or week. Research indicates pregnant persons are turning to cannabis more frequently to treat nausea and vomiting in pregnancy. Advise pregnant persons to abstain from or reduce their cannabis use during pregnancy to prevent negative long-term cognitive and behaviour outcomes for exposed babies. The risks of cannabis use include preterm labour, low birthweight, lower Intelligence Quotient (IQ) scores, and attention-deficit/hyperactive disorder (ADHD).
Alcohol use past 6 months #/week **Last drink**	Ask about alcohol use in the past 6 months. If yes, indicate number of drinks per week. If the pregnant person is not currently using alcohol, note the date (DD/MON/YYYY) of last drink.
Current alcohol use #drinks/day or week[33]	Ask about any current use of alcohol. If yes, indicate the number of drinks per day or per week.
≥ 4 drinks at one time[34] Alcohol and pregnancy Women and Alcohol Alcohol and Pregnancy SOGC CPG: Alcohol Consumption	Indicate if ≥ 4 drinks are consumed at one time (binge drinking). Binge drinking is a common pattern of alcohol use in indivduals of reproductive age and is associated with adverse fetal effects. Adverse neurodevelopmental effects on the fetus have been associated with binge drinking during pregnancy.

Substance	Description
Other substance use in pregnancy Mothering and Opioid toolkit Maternal health and substance use Talking about substance use during pregnancy Brief intervention on substance use Women and Opioids Methamphetamine Use in Pregnancy: A Call for Action (jogc.com) SOGC CPG: Opioid Use Throughout Women's Lifespan: Opioid Use in Pregnancy and Breastfeeding	Indicate if the pregnant person is using other substances in pregnancy. If yes, indicate what substance or substances are being used and the route of administration. • **Cocaine** increases the risk of preterm birth, placenta-associated syndromes (e.g. placental abruption, pre-eclampsia, etc.), and impaired fetal growth. Cocaine is short-acting and can be safely stopped during pregnancy. • **Methamphetamines** are associated with premature delivery, a decrease in the pregnant person's appetite, and slow fetal growth, leading to low birth weight. • **Opioids** should not be stopped suddenly during pregnancy as this poses a risk of spontaneous abortion and preterm labour. Opioid agonist treatment, with methadone or buprenorphine, are standard of care for opioid use disorder during pregnancy. Patients can self-refer to Opioid Treatment Centres across the province and assistance should be provided by the practitioner to do so if required. Contact information for Opioid Treatment Centres across the province can be found here or by contacting the Provincial Opioid Dependence Treatment (ODT) phone line toll-free at 1-844-752-3588 from Monday to Friday, 8:30 a.m. to 4:30 p.m. • **Other** — note any other substances used during the pregnancy. **Route:** Note the route of administration of substances used during pregnancy. An accurate history of the type, amount, and route of substance use during pregnancy will directly inform care of the newborn. Supportive care of the substance-exposed newborns includes non-pharmacological interventions for all symptoms, and potentially additional pharmacological interventions to manage opioid withdrawal. Patients who wish to receive support in addiction management should be referred to the appropriate supports to do so. This can be facilitated by the prenatal care provider by referring to • The provincial Recovery Centre Phone: 709-752-4980 • Inpatient treatment (such as Humberwood or the Grace Centre) • Doorways program for same-day assistance and counselling Alternatively, patients and providers can reach out to one of the Mental Health and Addictions System Navigators for further assistance.

Substance	Description
Substance Use Disorder SOGC CPG: Substance Use in Pregnancy	Indicate if the pregnant person has a substance use disorder. Substance use disorder is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by **two or more** of the criteria within a 12-month period: • Taking substance in larger amounts or for longer than intended • Wanting to cut down or quit but not being able to decrease or discontinue use • Spending a great deal of time obtaining, using, or recovering from effects of substance • Craving or a strong desire to use • Repeatedly unable to fulfill major role obligations at work, school, or home • Continued use despite persistent or recurring social or interpersonal problems caused or made worse by substance • Stopping or reducing important social, occupational, or recreational activities • Recurrent use in physically hazardous situations • Continued use despite acknowledgment of persistent or recurrent physical or psychological problems related to substance use • Tolerance as defined by either a need for markedly increased amounts to achieve desired effect or markedly diminished effect with continued use of the same amount • Withdrawal manifesting as a characteristic syndrome with reduced concentration of substance after prolonged heavy use **Severity:** • Mild: 2–3 criteria • Moderate: 4–5 criteria • Severe: 6 criteria Note: if an Opioid Agonist Therapy is being used, document name, dosage, and the treatment plan. Opioid Agonist treatment with methadone or buprenorphine or other sustained-release opioid preparations are the standard of care for the management of opioid use disorders.

Ethnicity/Genetic Risk Assessment

Care providers should be sensitive to the various ways used to conceive, including the use of egg and sperm donors and gestational carriers.

Item	Description
Ethnicity	Ethnicity can affect health outcomes through factors such as genetic predispositions, environmental factors, language barriers, and access to health care. We recommend the pregnant person has the opportunity to self-report ethnic identity to collaborate with them in providing culturally competent care and achieve optimal health outcomes. Check all that apply by self report. ❑ **Black**–African, African Canadian, Afro-Caribbean descent ❑ Southeast Asian–Cambodian, Filipino, Indonesian, Thai, Vietnamese, or other Southeast Asian descent ❑ **Latin American**–Hispanic or Latin American descent ❑ **Indigenous**—(First Nations, Inuk/Inuit, Métis) ❑ **East Asian**—Chinese, Japanese, Korean, Taiwanese descent ❑ **Middle Eastern**—Arab, Persian, West Asian descent (e.g., Afghan, Egyptian, Iranian, Kurdish, Lebanese, Turkish) ❑ **South Asian**—South Asian descent (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan) ❑ **White** — European descent (Eastern—e.g. Russian, Polish; Western—e.g. English, Italian) ❑ **Other**—pregnant person identifies with an ethnicity that is not listed, specify the ethnicity in the space provided. ❑ **Prefer not to answer**–the pregnant person prefers not to answer. If the pregnant person does not know their ethnicity, record 'Do not know' in the space provided. Note: Ethnic or cultural identity is self reported and should not be assumed. It is often an indication of cultural beliefs/practices and the pregnant person may identify with more than one ethnic group.
Donor gamete	Indicate if a donor gamete contributed to the pregnancy.

Item	Description
Egg age at EDD	Indicate the egg age of the pregnant person (or in the case of gamete donation, the age of the egg donor) at the EDD. In the use of frozen gametes, the age of the person at the time the gametes were frozen would be used for calculation. **Pregnant persons > 35 years at the EDD and those with specific risk factors should be offered an Early Pregnancy Review** (EPR)**.** An EPR includes a consult with Maternal Fetal Medicine (MFM) and an ultrasound that reviews viability, dates, early development, and assesses for fetal abnormalities through specific markers, particularly nuchal translucency (NT).
Ethnicity gamete	Indicate the ethnicity of the male gamete contributor to the pregnancy. If the female gamete contributor to the pregnancy is from a donor egg, indicate the ethnicity of the female gamete.
Hemoglobinopathy/ Thalassemia screening	Indicate if screening was completed or if not applicable. Carrier screening for thalassemia/hemoglobinopathies should be offered to pregnant persons/families from ethnic backgrounds of African, Asian, Hispanic, Mediterranean, or Middle Eastern descent, when red blood cell indices reveal a mean cellular volume < 80 fl, or electrophoresis reveals an abnormal hemoglobin type. If the female thalassemia or sickle cell screening results are abnormal, a hemoglobinopathy screening protocol should be undertaken for the male gamete provider. If both reproductive partners are found to be carriers of thalassemia, sickle cell or a combination of thalassemia and hemoglobin variants, they should be referred for formal genetic counselling. **Screening should be done in the pre-conception period or as early into the pregnancy as possible.**
Consanguinity (blood relation)	Indicate if there is a consanguinity relation. Defined as a relationship between two people who are related to each other because they share a common ancestor: a 'shared blood' relationship. For example: a relationship between two cousins. This should be investigated if there is history of an autosomal recessive disorder.

Item	Description
Referral to Medical Genetics	Consider referral to Medical Genetics for pregnant persons from higher risks populations and those with a personal or family history of: • Congenital anomaly (e.g. congenital heart defect, neural tube defect) • Intellectual disability or developmental delay • Genetic syndrome (e.g. neurofibromatosis, Noonan syndrome) • Chromosomal disorder (e.g. trisomy 21, familiar translocation) • Muscular disorder (e.g. X-linked Duchenne and Becker muscular dystrophies) • Bleeding disorder (e.g. X-linked hemophilia A or B) • Recurrent miscarriage • Sudden unexplained infant death • Other major health concerns such as cardiomyopathy, neurological disease, epilepsy, hearing loss, autism, and psychiatric disorders. • Consanguinity (blood relation—a relationship between two people who are related to each other because they share a common ancestor: a 'shared blood' relationship (i.e. a relationship between two cousins). This should be investigated if there is history of an autosomal recessive disorder.

Genetic Screening/Investigations

A discussion should occur with all patients, regardless of age, of the risks, benefits, and alternatives of various methods of prenatal screening and diagnostic testing, including the option of no testing. Following discussion, pregnant persons should be offered:

- No aneuploidy screening
- Standard prenatal screening
- U/S guided invasive testing when appropriate, or
- Maternal plasma cell-free DNA (Non-Invasive Prenatal Testing, NIPT)

All pregnant persons should be offered a fetal ultrasound between 7 and 14 weeks for pregnancy dating (where available). For those with identified risk factors, include a nuchal translucency (NT) evaluation and early anatomic assessment (EPR) at 11–14 weeks gestation. SOGC Clinical Practice Guideline: No. 375 - Use of the First Trimester Ultrasound

Select the appropriate boxes with a checkmark.

Screening	Description
No Genetic Screening	Indicate if the pregnant person was counselled and declined genetic screening.
Nuchal Translucency (NT) **11^{+0}–13^{+6} weeks gestation**	Indicate if N/A, or if counselled re: NT and if completed or declined. Nuchal translucency is part of the early pregnancy review (EPR), which should be offered to those with specific risk factors.
Maternal Serum Screening (MSS)[35 36 37] 15–20+6 weeks gestation.	Indicate if counselled re: MSS, and if completed or declined. MSS is completed between 15^{+0}–20^{+6} weeks gestation. MSS screens for fetal chromosomal abnormalities (trisomy 21 and trisomy 18), neural tube defects, and placental abnormalities. MSS is a screening test that yields a high or low risk result for each condition screened for. It is not a diagnostic test.
Early Pregnancy Review (EPR)	An EPR is an ultrasound to review viability, dates, early development and assess for fetal abnormalities. It uses specific markers, such as a nuchal translucency (NT) and is offered to pregnant persons with specific risk factors. Indicate if N/A, or counselled re: EPR, and if completed or declined. An EPR is best completed between 11^{+0} and 13^{+6} weeks gestation.
Cell Free DNA/Non Invasive Prenatal Screening (NIPT) – **10 weeks – term**[38 39] PPV Calculator Dynacare NIPT Requisition and Funding Criteria SOGC CPG: Prenatal Screening for Fetal Chromosomal Anomalies	Indicate if counselled about NIPT and if completed or declined. If completed, indicate if paid for by MCP or self-pay. Cell-free DNA/Non-Invasive Prenatal screening or testing (NIPT) is currently used in Newfoundland and Labrador as a second-tier screen for common aneuploidy, including Trisomy 13, 18, or 21 and sex chromosome aneuploidy (SCA). Patients should be made aware of the option to have NIPT, understanding that it may not be provincially funded. Care providers should discuss NIPT and other available prenatal screening options with all pregnant persons. Funded NIPT can be arranged by any healthcare provider for patients meeting certain high-risk criteria. This is in lieu of using the MSS and nuchal translucency assessments. These criteria include: • Pregnant persons whose MSS is screen-positive for Trisomy 21 or Trisomy 18. • Pregnant persons 37 years old or older at EDD • Pregnant persons with a history of aneuploidy in a previous pregnancy or child • Twin pregnancies

Screening	Description
Cell Free DNA/Non Invasive Prenatal Screening (NIPT) – **10 weeks – term** continued	If a pregnant person wishes to have NIPT and is not eligible for funded NIPT, they have the option to pay for this test. Blood collection for patient-pay NIPT can be arranged at certain NLHS blood collection sites, where collection kits are also available. Collection kits will be stored at a blood collection and not individual provider offices. Contact your local blood collection clinic to confirm nearest availability. **If a pregnant person proceeds with NIPT, MSS is not necessary.** Additional indications for funded NIPT are restricted to Medical Genetics and Maternal Fetal Medicine (e.g.: certain soft markers, fetal anomalies, family history of an X-linked condition, etc.) If you are ordering funded NIPT, it is the provider's responsibility to complete the "Criteria for Eligibility Form" to ensure the patient does not receive the bill.
Chorionic Villus Sampling (CVS)/ **Amniocentesis**	Specify if CVS or amniocentesis was completed. CVS is a U/S guided procedure in which a sample of chorionic villi is obtained either transvaginally used biopsy forceps or transabdominally using a needle. CVS has an additional 1% (1/100) risk of miscarriage. Amniocentesis is a U/S guided procedure in which a needle is directed into the gestational sac and a sample of amniotic fluid is withdrawn. Amniocentesis has an additional 1/200 to 1/400 risk of miscarriage.
Other	Indicate if other testing was done and add comments in the space provided. If a pregnant person wishes to discuss CVS or Amniocentesis, refer them to the Provincial Medical Genetics program by faxing a referral to (709) 777 – 4190.

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part III)

For additional information refer to the "Guidelines for Prenatal Screening and Testing in Newfoundland and Labrador"

Ultrasound/Biophysical Profile

Date	GA	Results	Date	GA	Results
DD/MM/YYYY			DD/MM/YYYY		
DD/MM/YYYY			DD/MM/YYYY		
DD/MM/YYYY			DD/MM/YYYY		
DD/MM/YYYY			DD/MM/YYYY		

Initial Lab Investigations

Test	Results	Date DD/MMM/YYYY
Hemoglobin		DD/MM/YYYY
Platelets		DD/MM/YYYY
ABO/Rh (D)		DD/MM/YYYY
Antibody Screen	☐Negative ☐ Positive	DD/MM/YYYY
Hemoglobin A1c		DD/MM/YYYY
Fasting Plasma Glucose	☐NA	DD/MM/YYYY
Syphilis**	☐Non-reactive ☐Reactive	DD/MM/YYYY
Gonorrhea **	☐Negative ☐Positive	DD/MM/YYYY
Chlamydia**	☐Negative ☐Positive	DD/MM/YYYY
HBsAg**	☐Non-reactive ☐Reactive	DD/MM/YYYY
HCV Ab	☐Non-reactive ☐Reactive	DD/MM/YYYY
HIV**	☐Non-reactive ☐Reactive	DD/MM/YYYY
Urine C&S		DD/MM/YYYY
Varicella*	☐Immune ☐Non-immune	DD/MM/YYYY
Rubella*	☐Immune ☐Non-immune	DD/MM/YYYY
Pap Due	☐Yes ☐No	DD/MM/YYYY
Last pap results	☐Normal ☐Abnormal	DD/MM/YYYY

24-28 Week Lab Investigations

Test	Results	Date (DD/MMM/YYYY)
Hemoglobin		DD/MM/YYYY
Platelets		DD/MM/YYYY
ABO/Rh (D)		DD/MM/YYYY
Repeat Antibodies	☐ Negative ☐ Positive	DD/MM/YYYY
GCT 50 g	1 hour_____ ☐ **GDM**	DD/MM/YYYY
OGTT 75 g	☐ NA Fasting_____ 1 hour_____ 2 hour_____ ☐ **GDM**	DD/MM/YYYY
Third Trimester Lab Investigations		
Syphilis** (28-32 weeks***)	☐ Non-reactive ☐ Reactive	DD/MM/YYYY
Gonorrhea**	☐ Negative ☐ Positive	DD/MM/YYYY
Chlamydia**	☐ Negative ☐ Positive	DD/MM/YYYY
Group B Strep (35-37 weeks)	☐ Negative ☐ Positive	DD/MM/YYYY

* Perform serology if immunity unknown
** Consider additional screening for those at ongoing risk of infection
*** Or as close to this interval as possible

Additional Tests (as indicated)

Ferritin	☐ NA	
TSH	☐ NA	

Screening Tool Results (see worksheets 3 and 4)

WAST ☐Negative ☐Positive	EPDS score	EPDS score	EPDS score	T-ACE score ☐N/A as no alcohol consumed
Date DD/MM/YYYY	Date DD/MM/YYYY	Date DD/MM/YYYY	Date DD/MM/YYYY	Date DD/MM/YYYY

Rh CARE ☐NA

☐ Rh (D) Neg
Rh (D) Alloimmunization ☐Yes ☐ No

☐ Rho(D) IG (28-29+6 weeks) Date DD/MM/YYYY

☐ Additional Rho(D) given Date DD/MM/YYYY

Bleeding/other event in pregnancy ☐Yes ☐ No
_____weeks

Public Health Referral and Recommended Vaccines

☐ Refer all pregnant people to Public Health for immunization, prenatal education and support.

Influenza vaccine ☐N/A Date DD/MM/YYYY
Covid vaccine ☐N/A Date DD/MM/YYYY
Tdap vaccine at 27-32 weeks Date DD/MM/YYYY
Hepatitis B vaccine (if at risk) ☐N/A Date DD/MM/YYYY
Other _____ Date DD/MM/YYYY

Ultrasound/Biophysical Profile

Item	Description
Ultrasound/ Biophysical profile (BPP)[40] SOGC CPG: No. 441 - Antenatal Fetal Health Surveillance	Indicate date (DD/MON/YYYY) of U/S or BPP, gestational age, and results. Pregnant persons at increased risk for adverse perinatal outcomes, and where facilities exist, should have a biophysical profile (BPP) to evaluate fetal well-being. The BPP is a ultrasound evaluation performed over a 30-minute period, to assess and observe fetal breathing movement, body movement, tone, and amniotic fluid volume.

Component	Criteria
Breathing movements	At least one episode continuing more than 30 seconds.
Movements	At least three body or limb movements.
Tone	An episode of active extension with return to flexion of a limb or trunk.
Amniotic fluid volume	At least one cord and limb-free fluid pocket which is 2 cm by 2 cm in two measurements at right angles.

If a BPP is not available, U/S examination to determine amniotic fluid volume and a non-stress test (NST) is an acceptable alternative.

Maternal-Fetal Assessment Unit (MFAU) Surveillance

This list was created by Maternal Fetal Medicine Specialists in Newfoundland and Labrador. It is not an all-inclusive list. MFAU will triage consults based on the guidance below.

Patients will be booked within the clinical week of the recommended Gestational Age (GA) as measured in weeks and days (i.e. anywhere between 28^{0}–28^{6}).

Fetal Indications

Clinical Indication	Frequency
Fetal growth restriction or SGA fetus 1) EFW +/- AC < 10% 2) EFW > 3% but < 10% with umbilical artery PI > 95% and/or CPR < 5% 3) EFW +/- AC < 3%	1) Weekly BPP + umbilical artery Doppler. Growth q 2 wks. 2) Twice weekly BPP + umbilical artery Doppler. Growth q2 wks MCA +/- DV (GA dependent) 3) Twice weekly BPP + umbilical artery Doppler. Growth q2 wks MCA +/- DV (GA dependent)

Fetal Indications continued

Clinical Indication	Frequency
Chronic Abruption/ Antepartum hemorrhage	• Start weekly BPP and umbilical Doppler from diagnosis • Growth every 2 weeks
Preterm premature rupture of membranes (PPROM)	• Start weekly BPP and umbilical Doppler from diagnosis • Growth every 2 weeks
Polyhydramnios (persistent AFI > 300)	• Start weekly BPP and umbilical Doppler from diagnosis • Growth every 4 weeks
Postdates (> 41 completed weeks)	• Twice weekly BPP • Growth to be completed in MFAU if not completed within the last 2 weeks
Diamniotic dichorionic twins	• OBS to arrange 18-20 anatomy and TVS in DI • OBS to arrange growth and TVS at 23 weeks in DI • Referral to MFAU for 26–27 GA • Growth scans every 4 weeks in MFAU • Weekly BPP and umbilical artery Doppler starting at 34 weeks
Monoamniotic dichorionic twins	• Referral to MFAU ~ 12–13+6 GA • MFAU at 16 weeks then visits every two weeks • Weekly BPP, umbilical artery and MCA Dopplers starting at 32 weeks
Monoamniotic Monochorionic twins Higher order multiple gestation	• Referral to MFAU at 12–13+6 GA • Care plan to be determined based on clinical presentation • Weekly BPP at 28 GA
Fetal congenital anomaly and/or fetal genetic diagnosis	• Consult MFM at diagnosis • Intervention upon the clinical finding
Reduced fetal movements	• As per SOGC CPG: No. 441 - Antenatal Fetal Health Surveillance • BPP to be completed within 24 hours of presentation (if additional risk factors identified for stillbirth) or if patient presents with recurrent decreased fetal movement

Maternal Indications

Clinical Indication	Frequency
Maternal age >/= 40 at time of delivery **BMI > 40** **IVF pregnancy**	• Referral to MFAU at 28 GA • Growth at 28, 32 and 36 GA • Weekly BPP and umbilical artery Doppler starting 36 weeks
Hyperthyroidism 1) Well Controlled 2) Suboptimal control or positive thyroid receptor antibodies	1) Referral to MFAU at 28 GA » Growth and umbilical Doppler at 28, 32 and 36 GA. No BPP unless new concerns arise. 2) Referral to MFAU at 28 GA » Growth and umbilical Doppler at 28, 32 and 36 GA. » Weekly BPP at 28–32 GA (MFM to review) » NST only if evidence of fetal tachycardia
Gestational Diabetes (on Medications) **and Pre-gestational DM**	• Referral to MFAU at 28 GA • Growth at 28, 32 and 36 GA • Weekly BPP, umbilical artery Doppler at 32 weeks • NST to start in MFAU at 34 GA • Referral to ambulatory care for 2nd weekly NST at 34 GA
GDM diet controlled	• Growth scan in DI at 28, 32 and 36 GA • Referral to ambulatory care for weekly NST starting 36 GA
Gestational hypertension and Pre-eclampsia	• Referral to MFAU at diagnosis • Growth every 4 weeks in MFAU • Weekly BPP and umbilical artery Dopplers • +/- DV and MCA upon review
Past history of stillbirth	• Referral to MFAU at 24 GA • Growth and umbilical Doppler q 2-4 weeks depending on clinical situation • Weekly BPP, umbilical Doppler and NST at 28–32 GA
Pre-existing Hypertension	• Referral to MFAU at 28 GA • Growth and umbilical Doppler at 28, 32 and 36 GA • Weekly BPP starting 32 GA • If normal BPP (8/8) no NST required
Antiphospholipid Syndrome and/or Lupus	• Referral to MFAU at 24 GA • Growth and umbilical Doppler every 2 weeks • Weekly BPP and NST starting 28 GA

Maternal Indications continued

Clinical Indication	Frequency
Maternal serum screen analytes	• Abnormal uterine artery Dopplers (confirmed at 24–26 weeks in DI) order growth in DI every 4 weeks. • Normal uterine artery Doppler at 18-20 or 24–26 weeks do growth scan in DI at 32 weeks. • If AFP or HCG > 4.0 MoM or if Inhibin > 3.0 MoM growth every 4 weeks in DI. • No BPP unless FGR and/or abnormal umbilical Doppler
Poorly controlled asthma/ respiratory disease	• Referral to MFAU at time of diagnosis • Growth every 4 weeks • Weekly BPP and umbilical Doppler from time of diagnosis (if > 24 GA)
Methadone/Suboxone use	• Referral to MFAU at 28 GA • Growth and umbilical Doppler at 28, 32 and 36 GA • Weekly BPP starting 36 GA • No NST (if BPP 8/8)
Antepartum Hemorrhage	• Growth every 2 weeks • Weekly BPP, umbilical Doppler and NST at diagnosis (if > 24 GA)
Cholestasis	• Bile Acids (BA) to be ordered by OBS. Recommend repeat every 2 weeks. • Cholestasis is diagnosed if BA > 19 • Bile Acids < 40 – no fetal surveillance indicated • Bile Acids > or = to 40 - weekly BPP, umbilical and NST • Bile Acids > /=100 – twice weekly BPP and umbilical Doppler. • Growth every 4 weeks in MFAU if BA >/=40.
Post Dates	• Referral for 41+0 GA • Growth scan if not completed in the last 2 weeks. • Twice weekly BPP and umbilical Doppler
Placental Previa	• Stable/No active bleeding » Referral to MFAU after diagnosis at 28–32 weeks » Growth every 4 weeks » No BPP required if no active bleeding • Previa with bleeding » Growth every 2 weeks » Weekly BPP, umbilical Doppler and NST

Maternal Indications continued

Clinical Indication	Frequency
Chronic Abruption	• Weekly BPP and umbilical Doppler from the time of diagnosis • Growth every 2 weeks
Sickle Cell Disease (Not Sickle Cell Trait)	• Referral to MFAU at 28 GA • Weekly BPP and umbilical Doppler starting 28 GA • Growth at 28, 32 and 36 weeks

Guidance for Obstetricians/Gynecologists and other prenatal care providers

This list was created by Maternal Fetal Medicine Specialists in Newfoundland and Labrador to guide prenatal care providers in managing prenatal patients with co morbidities. It is not an all-inclusive list.

The conditions listed below do not require biophysical profiles or automatic MFM consults unless new clinical concerns arise. Consult MFM service if questions or concerns.

Maternal History	DI Investigation
Past history of SGA fetus or Fetal Growth Restriction, abruption or hypertensive disorder in pregnancy	• Uterine artery Doppler at 18-20 +/- 24–26 GA • If 24–26 GA uterine artery Doppler is abnormal arrange growth scan in DI every 4 weeks. • If 19–20 or 24–26 uterine artery Doppler is normal, arrange growth in DI at 32–34 weeks.
Inflammatory Bowel Disease	• Inactive disease or stable disease on medication—growth and umbilical artery Doppler at 28, 32 and 36 weeks. No BPP required. • Active disease—refer to MFAU
Ankylosing Spondylitis and arthritis **Epilepsy** **Multiple Sclerosis** **Bariatric Surgery**	Growth and umbilical artery Doppler at 28 and 34 weeks
Von Willebrand Disease or ITP **Previous or current VTE on therapy**	No growth or fetal surveillance required unless additional concerns arise

Maternal History	DI Investigation
Hepatitis C in pregnancy **Factor V Leiden**	Growth in DI at 32–34 weeks
Uterine Fibroids (>/= 6 cm) **and Uterine anomalies**	Cervical length surveillance in DI at 19–20 and 23–24 weeks Growth scan in DI every 4 weeks

Cervical Length Surveillance in Pregnancy

This list was created by Maternal Fetal Medicine Specialists in Newfoundland and Labrador. It is not an all-inclusive list.

- Patients with previous excisional procedures of the cervix and those with large fibroids ≥ 6 cm, should have their cervix checked with the anatomy scan. A follow up ultrasound between 23 to 24 weeks should also be arranged. If a measurement of less than 3 cm is obtained on either of these scans, a referral should be sent to Maternal Fetal Medicine.
- Patients with previous uterine anomalies should have cervical length assessments at 16, 20 and 24 weeks. Should a cervical length be measured less than 3 cm at ≤ 24 weeks, it is recommended that a referral be sent to Maternal Fetal Medicine.
- All twin gestations should have transvaginal ultrasound assessments at their anatomy scan and again at 23 to 24 weeks. If a cervical length is ≤ 2.5 cm under 24 weeks gestation, there is evidence of benefit to treat twins with Prometrium to lower the risk of preterm birth. Should a cervical length be obtained less than 3 cm at either of these scans, they should be referred to the Maternal Fetal Assessment Unit.

Initial Lab Investigations

Pregnant persons must be informed of the policy for prenatal serology testing, its risks and benefits, the right of refusal, and should not be tested without their knowledge and consent.

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Hemoglobin	Hemoglobin (HGB) will indicate anemia and any HGB abnormalities. Low MCV (<85) may indicate iron deficiency or thalassemia. High MCV may indicate folate or B12 deficiency, liver disease, hypothyroidism, or alcohol use.
Platelets	Platelets will screen for thrombocytopenia.
AB0/Rh(D)[41] SOGC CPG: Rh Alloimmunization	**ABO/Rh**—All pregnant persons should have a blood type and antibody screen with an indirect antiglobulin test (IAT) at their first prenatal visit. Indicate the blood group and Rh status.
Antibody Screen	**Red cell antibodies**—indicate test result as negative or positive. Any circulating antibody as measured by an indirect antiglobulin test. A positive screen warrants additional testing and follow up.
Hemoglobin A1c (HgbA1c)	Recommended GDM Screening in NL • Early GDM screening for pregnant people with risk factors (HgbA1c with first trimester bloodwork). • Add a fasting plasma glucose (FPG) for those with renal disease, a hemoglobinopathy, prediabetes, previous GDM, multiple gestation, BMI > 30km/m2, PCOS, corticosteroid use, glucosuria, or a high risk population (Indigenous, Hispanic, South Asian, Asian, African Canadian), or AMA >40. The new approach to GDM screening will be help identify persons with overt diabetes and those at increased risk of developing GDM at a much earlier gestation. Initial GDM Screen: • A1c plus or minus FPG • A1c ≥ 6.5% and/or FPG ≥ 7 mmol/L = overt diabetes or risk for GDM, screen again at 24–28 weeks. GDM diagnosis–Refer immediately to local specialty diabetes team to initiate nutrition plan; physical activity; self-monitoring of blood glucose.

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Fasting Plasma Glucose (FPG)	A fasting plasma glucose should be added to initial bloodwork for pregnant persons with renal disease, a hemoglobinopathy, or strong risk factors for developing GDM, including: • Prediabetes • Previous GDM • Multiple gestation • BMI > 40 kg/m2 • Polycystic ovary syndrome (PCOS) • Corticosteroid use • Members of high-risk population (Indigenous/First Nations, Hispanic, South Asia, Asian, African Canadian) • Glycosuria
Syphilis NLSTBBI Recommendations 2024 PHAC STBBI Guide for Health Professionals	With an ongoing rise in syphilis in NL and nationally, screening for syphilis in pregnancy is recommended as follows: Universal syphilis screening: In the first trimester or at the first prenatal visit **AND** • At 28–32 weeks gestation (or as close to this interval as possible) **AND** • For all people who deliver a stillborn infant after 20 weeks gestation. Indicate results as non-reactive or reactive. Syphilis serology should be done during labour or at delivery if: • No prenatal screening has occurred, or results are unavailable • The third trimester screening did not occur • Syphilis was diagnosed during pregnancy • The pregnant person or their partner had a new sexual partner after the third trimester syphilis screen or sexual contact with a known case of syphilis or other STBBI • There is ongoing risk of syphilis infection or re-infection of syphilis If there was inadequate prenatal care, testing for syphilis, HIV, hepatitis B surface antigen, and urine for gonorrhea and chlamydia PCR is recommended for the pregnant person. If their serum cannot be drawn, a syphilis serology screen should be performed on the newborn prior to discharge. Newborns should not be discharged from hospital until the birthing individual's and/or infant's serum is drawn, and follow up plans are ensured.

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Gonorrhea and Chlamydia PHAC Gonorrhea/ Chlamydia	Screening for gonorrhea and chlamydia is recommended for all pregnant persons: • During the first trimester or at the first prenatal visit, and again in the third trimester. • At the time of labour in any of the following situations: » No prenatal screening has occurred (no valid results available at the time of labour) » Third trimester screening has not occurred » A positive test result was obtained for gonorrhea or chlamydia during pregnancy without appropriate follow up, including treatment and a test-of-cure. Document date of sample (DD/MON/YYYY) and indicate results as Positive or Negative.
Hepatitis B Virus (HBV) SOGC CPG: HBV and Pregnancy	Indicate test results as reactive or non-reactive. Offer screening for Hepatitis B Virus (HBV) early in pregnancy with Hep B surface antigen. The presence of Hep B surface antigen indicates prior HBV infection and carrier status. This information is required to assess maternal liver function and to identify newborns that require HBV Immunoprophylaxis after birth. Pregnant persons at higher risk of acquiring HBV infection should be offered screening again late in pregnancy.
Hepatitis C Virus (HCV) Clinical Consensus Statement No. 458: Hepatitis C Virus in Pregnancy	Screening for Hepatits C Virus (HCV) infection in pregnancy is recommended: • In the first trimester of every pregnancy with HCV antibody testing. • If a pregnant person has a history of HCV virus infection, an HCV viral load should be requested instead of antibody because their HCV serology will remain positive for life regardless of treatment history. People diagnosed with HCV during pregnancy should be referred for assessment and treatment.
HIV screening[42 43] SOGC CPG: HIV Screening in Pregnancy HIV Screening and Testing Guide	Screening for Human Immunodeficiency Virus (HIV) infection in pregnancy is recommended: • In early pregnancy at the first prenatal visit as a standard of care with appropriate counselling • Pregnant persons who screen negative for HIV but who may be at higher risk of acquiring HIV during pregnancy can benefit from regular retesting and testing at point of delivery.

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Urine culture and sensitivity	Document date (DD/MON/YYYY) of sample and indicate results. Screen for asymptomatic bacteriuria (ABU) in the 1st trimester of pregnancy, or at the 1st prenatal visit if it occurs later and treat if positive. ABU is defined as a urine sample containing bacteria with colony counts ≥100 000 CFU/mL, without specific symptoms of a urinary tract infection. Treatment with appropriate antibiotics is an accepted and recommended strategy for ABU. Consider rescreening if the first screen is positive or there is a history of recurrent urinary tract infections.
Varicella (serology/ adult vaccine)[44] SOGC CPG: Varicella in Pregnancy Immunization in pregnancy and breastfeeding: Canadian Immunization Guide	Assessing varicella immunity is recommended for all pregnant persons. This should be documented by history of previous infection, prior Immunization with 2 doses of varicella-containing vaccine, or varicella zoster immunoglobulin G serology. Varicella immunization is recommended for all non-immune persons as part of pre-pregnancy and postpartum care. **Varicella vaccine is contraindicated in pregnancy.**
Rubella (serology/ vaccine)[45] SOGC CPG: Rubella Canadian Immunization Guide NL Immunization Manual	Screening for rubella immunity with rubella antibody is recommended for all pregnant persons early in pregnancy in NL. • A public health nurse will contact an individual with a negative/ non-immune rubella antibody to determine if the result is from a prenatal screen. • Rubella immunization as a component of MMR is offered by a public health nurse as soon as appropriate in the post-partum period • Timing of MMR administration in the post-partum period will take into consideration the receipt of Rh immunoglobulin and other blood products.
Pap Due Cervical Screening Guidelines for Newfoundland and Labrador	Indicate if pregnant person is due for a pap smear. The screening frequency for pregnant persons should be the same as for persons who are not pregnant, when results have been normal. Anyone who have been treated for cervical dysplasia or has a history of cancer of the cervix, and those who are immunocompromised, or HIV positive should receive annual screening for life.
Last pap results	Document the date (DD/MON/YYYY) and the results as normal or abnormal.

24–28 Week Lab Investigations

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Hemoglobin	Hemoglobin (HGB) will indicate anemia and any HGB abnormalities. Low MCV (<85) may indicate iron deficiency or thalassemia. High MCV may indicate folate or B12 deficiency, liver disease, hypothyroidism, or alcohol use.
Platelets	Platelets will screen for thrombocytopenia.
AB0/Rh(D)	This is a test for blood type. Document date (DD/MON/YYYY) and indicate blood group and Rh status.
Antibody Screen	This is a blood screening for antibodies. Document date (DD/MON/YYYY) and indicate test results as positive or negative.
Glucose Challenge Test (GCT) **50 grams**	Pregnant persons with an A1C < 5.7, and if applicable a FPG < 5.3 mmol/L at the time of the early screen, should be offered additional screening for GDM between 24–28 weeks. A non-fasting 50 g GCT with plasma glucose (PG) measured 1 hour later is the preferred approach. • A PG value of <7.8 mmol/L indicates no GDM. • A PG value of 7.8–11.0 mmol/L is a positive screen and an indication to administer the 75g OGTT. • A PG over ≥11.1 mmol/L is diagnostic of GDM and an OGTT is not required.
OGTT 75 grams (If required)[46]	If the value of the GCT is ≥7.8–11.0mmol/L a two-hour fasting oral glucose tolerance test (OGTT) should be performed. GDM is confirmed with 1 of the following: • Fasting PG ≥5.3 mmol/L OR • 1-hour PG ≥10.6 mmol/L OR • 2 hours PG ≥9.0 mmol/L

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Syphilis NL STBBI Recommendations 2024	With an ongoing rise in syphilis in NL and nationally, screening for syphilis in pregnancy is recommended as follows: Universal syphilis screening: • In the first trimester or at the first prenatal visit AND • At 28–32 weeks gestation (or as close to this interval as possible) AND • For all people who deliver a stillborn infant after 20 weeks gestation Indicate results as non-reactive or reactive. Syphilis serology should be done during labour or at delivery if: • No prenatal screening has occurred, or results are unavailable • The third trimester screening did not occur • Syphilis was diagnosed during pregnancy • The pregnant person or their partner had a new sexual partner after the third trimester syphilis screen or sexual contact with a known case of syphilis or other STBBI • There is ongoing risk of syphilis infection or re-infection of syphilis If there was inadequate prenatal care, testing for syphilis, HIV, HCV, or HBV, and urine for gonorrhea and chlamydia PCR is recommended for the pregnant person. If their serum cannot be drawn, a syphilis serology screen should be performed on the newborn prior to discharge. Newborns should not be discharged from hospital until the birthing individual's and/or infant's serum is drawn, and follow up plans are ensured.

Third Trimester Lab Investigations

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Group B Streptococcal (GBS)[47] ACOG GBS SOGC CPG: GBS	Document date (DD/MON/YYYY) and indicate results as positive or negative. GBS is bacteria that normally lives in the intestinal, vaginal, and rectal areas. Approximately 15–40% of all healthy persons carry GBS and are asymptomatic. GBS can be passed on to baby during delivery; therefore, universal screening with a recto-vaginal swab between 35–37 weeks gestation is recommended. The culture should be taken from one swab first in the vagina and then from the rectum (through the anal sphincter). The **swab provides a 5-week window for valid culture results** and ACOG recommends obtaining the GBS swab between $36^{+0/7}$ and $37^{+6/7}$ to ensure results are valid with births occurring up to the gestational age of $41^{+0/7}$ weeks.[48]

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Gonorrhea (GC)/ **Chlamydia** (third trimester) Prevention of Ophthalmia Neonatorum Recommendations on Screening for Chlamydia trachomatis and Neisseria gonorrhoeae in Pregnancy - Canada.ca	Screening for gonorrhea and chlamydia is recommended for all pregnant persons: • During the first trimester or at the first prenatal visit, and again in the third trimester. • At the time of labour in any of the following situations: » No prenatal screening has occurred or there are no valid results available at the time of labour » Third trimester screening has not occurred » A positive test result was obtained for gonorrhea or chlamydia during pregnancy without appropriate follow up, including treatment and a test-of-cure. Document date of sample (DD/MON/YYYY) and indicate results as Positive or Negative.

Additional Tests (as indicated)

Additional tests should be completed when clinically indicated.

Examples of additional tests include B12, infectious diseases (Parvo, CMV, Toxoplasmosis, etc.), rescreen STBBIs, drug screen, Pap, hemoglobin electrophoreses, Hemoglobin A1C, etc.

Document date completed (DD/MON/YYYY) and results as applicable.

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Ferritin[49]	Indications for ordering serum Ferritin Adapted from Alberta/Saskatchewan Blood Obstetric Anemia Screening and Treatment Algorithm, & IWK Obstetric Anemia and Iron Deficiency Screening/Treatment Algorithm **Anemic pregnant persons where testing serum ferritin is necessary prior to iron supplementation:** • Known haemoglobinopathy • Prior to parenteral (IV) iron replacement **Pregnant persons who are not anemic but taking empirical iron treatment due to high risk for iron depletion** (with or without serum ferritin testing)**:** • Previous anemia • Multiparity ≥P3 • Twin or higher order multiple pregnancy

Test	Result Indicate the date (DD/MON/YYYY) of the lab investigations
Ferritin continued	• Interpregnancy interval <1 year • Those who have poor dietary habits (or who are experiencing food insecurity) • Those following a vegetarian/vegan diet • Age < 20 years • Recent history of clinically significant bleeding Non-anemic pregnant persons where serum ferritin may be necessary: • High risk of bleeding during pregnancy or at birth • Those declining blood products, such as Jehovah's Witnesses • Those for whom providing compatible blood is challenging
TSH[50 51 52]	A Thyroid Stimulating Hormone (TSH) level should be part of the initial bloodwork for pregnant persons with one or more of the following: • Age greater than 30 years • Goiter • History of thyroid dysfunction • Body mass index greater than or equal to 40 • Type 1 Diabetes/other autoimmune disorder • Infertility x 1 year or more • Head or neck radiation • Family history of thyroid disease • Thyroid surgery • Signs and symptoms of thyroid dysfunction • History of recurrent miscarriage or preterm delivery • Positive thyroid peroxidase antibody • Use of amiodarone, lithium, or radiologic contrast.

Screening Tool Results

Item	Description
WAST	Indicate date (DD/MON/YYYY) and if the screen was positive or negative The Woman Abuse Screening Tool (WAST) is used by care providers to screen for intimate partner violence during pregnancy and should be completed at least once during pregnancy and as needed. Consider the WAST with an inclusive context. Despite the title stating "woman", this tool should be used to screen all pregnant people for risk of domestic violence regardless of gender dentity, using the appropriate pronouns and language. If the answers to the first 2 questions of the WAST (below) are 'a lot of tension' and 'great difficulty' the screen is considered positive, and the remaining questions should be asked to elicit more information about the abuse and the need for additional support and resources. **In general how would you describe your relationship?** • A lot of tension • Some tension • No tension **Do you and your partner work out your arguments with:** • Great difficulty • Some difficulty • No tension
EPDS score EPDS-3A	Indicate date (DD/MON/YYYY) and the score. The Edinburgh Postnatal Depression Scale (EPDS) tool can be completed by the care provider, but it is ideal to have the pregnant person complete it independently. It should be completed at least once during each trimester of pregnancy and more often as needed. The EPDS can help identify anxiety if the answers to questions 3, 4, and 5 (below) have a score ≥ 5. This is called the EPDS Anxiety Subscale. **I have blamed myself unnecessarily when things went wrong.** • **3** Yes, most of the time • **2** Yes, some of the time • **1** Not very often • **0** No, never

Item	Description
EPDS score continued	**I have been anxious or worried for no good reason.** • **0** No, not at all • **1** Hardly ever • **2** Yes, sometimes • **3** Yes, very often **I have felt scared or panicky for no very good reason.** • **3** Yes, quite a lot • **2** Yes, sometimes • **1** No, not much • **0** No, not at all For patients who are reporting signs and symptoms of perinatal mood and anxiety disorders or screening at risk, a plan to increase support is recommended. Prenatal care providers can support these patients by connecting them with the following resources: • Lifewise Phone: 855-753-2560 from 9 a.m. to 12 a.m. daily. • Doorways: Urgent counselling service • NL Health Line: 811 • Bridge the Gapp • Mental Health and Addictions System Navigator
T-ACE score	Indicate date (DD/MON/YYYY) and the score. Check N/A if no alcohol consumed. It should be performed at least once and as needed during pregnancy. The T-ACE (Tolerance Annoyed Cut down Eye opener) screening is **not** required if no alcohol is consumed. A pregnant person who answers, "more than two drinks" on the tolerance question, **"How many drinks does it take to make you feel high?"** is scored **2** points. Each **"yes"** to the additional 3 questions scores **1** point. A score of **2** or more out of **5** indicates risk of a drinking problem, and further assessment and/or referral may be required. Appropriate resources for referrals include: • AA Newfoundland and Labrador • Doorways urgent counselling program • UTurn Recovery • Mental Health and Addictions System Navigator

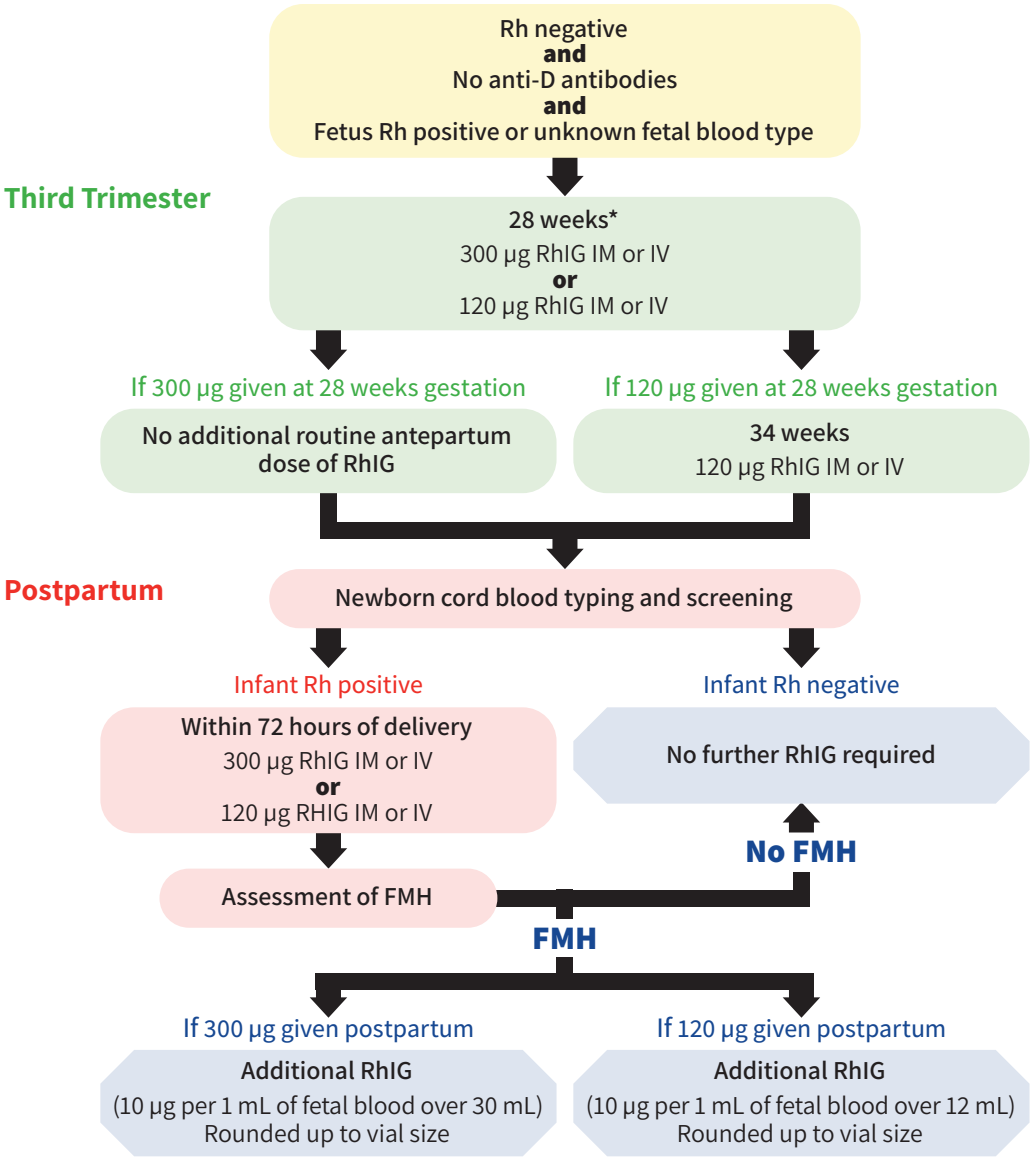
Rh Care

Item	Description
N/A	Indicate with a '√' if pregnant person is Rh Positive
Rh(D) Neg	Indicate with a '√' pregnant person is Rh Negative.
Rh(D) alloimmunization	Indicate Y or N with a '√' if pregnant person has Rh(D) alloimmunization.
Rho (D) **IG (28–29^{+6})** SOGC CPG: Prevention of Rh D Alloimmunization	Indicate with a '√' if given and document the date given (DD/MON/YYYY) Non-sensitized Rh(D) negative pregnant persons should receive Rho(D) IG at 28–29 weeks' gestation. Rho(D) IG is a blood product and normal procedure for discussion and consent should be followed.
Additional dose given	Indicate with a '√' if an additional dose was given and document the date (DD/MON/YYYY) Rho(D) IG should also be given after spontaneous or induced abortion (after 8 weeks or 56 days), ectopic pregnancy, or obstetrical complications (e.g. any bleeding, abdominal trauma) or procedures such as amniocentesis; and within 72 hours after delivery of a Rh(D) positive infant.
Bleeding/other event in pregnancy	Indicate Y or N with a '√'. Document weeks and if an U/S was done. Document the date Rho(D) IG given (DD/MON/YYYY), if applicable. Rh immune globulin (WinRho®SDF) may be safely withheld prior to 8 weeks (56 days) gestation for pregnancy complications or medical abortions when there is confident and reliable pregnancy dating, including one of the following: Ultrasound dating; certain conception dating; or known first day of LMP for individual having regular (28 day) cycles and in the three months prior to conception absence of lactation, hormonal contraception or IUD use.

Routine prophylaxis against RH D alloimmunization for pregnant individuals

(*non-sensitized) *Taken from the SOGC Clinical Practice Guideline: No. 448

First Trimester ≥ 8 weeks Assess Risk of Rh Alloimmunization



FMH: fetomaternal hemorrhage; IM: intramuscular; IV: intravenous; RhIG: Rho(D) immune globulin.

Recommended Vaccines and Public Health

Indicate the referral for Prenatal Education and Support has been sent for vaccine administration by Public Health.

Indicate the date of vaccine administration.

Vaccine	Description
Influenza vaccine (non-live)[53 54] SOGC CPG: Immunization in Pregnancy Immunization in pregnancy and breastfeeding	Document date given (DD/MON/YYYY). Recommended for all pregnant persons. All pregnant persons, at any stage of pregnancy, should receive a non-live influenza vaccine. Influenza vaccination during pregnancy has been shown to protect the pregnant person from Influenza and its complications. It also protects infants for the first few months of life from Influenza. Pregnant persons are at an increased risk of influenza-associated morbidity and there is evidence of adverse neonatal outcomes associated with maternal influenza, including stillbirth, prematurity, SGA, or low birth weight infants.
Tdap vaccine (between 27 and 32 weeks) Immunization in pregnancy and breastfeeding	Document date given (DD/MON/YYYY). **All pregnant persons should receive immunization with the diphtheria and tetanus toxoids and acellular pertussis** (Tdap) **vaccine between 27 and 32 weeks of gestation during every pregnancy, irrespective of their immunization history.** Immunization between 13 and 26 weeks of gestation may be considered in situations where there may be an increased risk of preterm delivery. Immunization with Tdap in pregnancy has been shown to be safe and effective in preventing neonatal and infant pertussis infection. When Tdap is given in pregnancy, the pregnant person produces antibodies that are transferred to the fetus and protect the newborn during the first two months of life. Pertussis is particularly dangerous for infants who are too young to receive their first dose of vaccine, which is given at 2 months,when morbidity and mortality from pertussis infection is highest for the newborn.
COVID-19 vaccine (mRNA) Immunization in pregnancy and breastfeeding	The COVID-19 vaccine can be safely administered in pregnancy and is particularly important as vaccination helps to protect the pregnant person and lowers risk of hospitalization for newborns. Document date given.
Hepatitis B vaccine (if no immunity or past infection and at risk) Immunization in pregnancy and breastfeeding	Document date given (DD/MON/YYYY). The HBV vaccine can be safely administered during pregnancy. A pregnant person who has no markers of HBV infection (HBV antibody and HbsAg negative) but is at high risk of Hep B acquisition should be offered the complete HBV vaccine series at the first opportunity and should be tested for antibody response.
Other Vaccine	Document the date and specify which vaccine.

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part IV)

Use 'Additional Prenatal Visits' page when additional space is required.
Refer to the "Newfoundland and Labrador Prenatal Record Companion Document".

Issues/Management Plan

EDD (FINAL) DD/MM/YYYY

☐ HSV treatment indicated ☐Low dose aspirin indicated ☐Progesterone (preterm birth prevention) indicated
☐ Social concerns (adoption, child protection, etc.)

Referral follow up:
☐ Obstetrics ☐ Medical Genetics ☐Anesthesia ☐Diabetic Educator ☐Dietician ☐Public Health Nurse
☐ Neonatology ☐ Pediatrics ☐ Mental Health ☐Social Work ☐Other _____

At approximately 36 weeks: Copy of prenatal record to ☐ hospital and/or with ☐ patient

Prenatal Visits **G**ravida_____ **T**erm_____ **P**reterm_____ **A**bortus_____ **L**iving children_____ **S**tillbirth_____

Date	Weight (kg)	BP	GA	Fundal height	Fetal HR	FM	Presentation/ Position	Cig/ day	**Comments**: e.g. IPV, mental health, substance use	Next visit	Initials
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											
DD/MM/YYYY											

Care Provider Signature

Print name	Signature	Initials

Print name	Signature	Initials

Issues/Management Plan

Document the plan of care at each prenatal visit, including medications and required consultations, using pages 4, 5, and 6 of the NL PNR.

Item	Description
EDD Final	Transcribe estimated date of delivery FINAL (DD/MON/YYYY) from Part 1 of the NL PNR.
Herpes Simplex Virus Treatment indicated SOGC CPG: Management of HSV in Pregnancy	Indicate with a √ if HSV treatment is indicated. To decrease the risk of clinical lesions and viral shedding at the time of delivery and therefore decrease the need for cesarean section, pregnant persons with known recurrent genital HSV infection should be offered: • Acyclovir (400 mg, taken orally three times a day, or 200 mg, taken four times a day) or • Valacyclovir (500 mg taken orally twice daily) from 36 weeks gestation until delivery. Pregnant persons with **primary genital herpes** in the third trimester of pregnancy have a high risk of transmitting HSV to their neonates and should be counselled accordingly and offered a cesarean section to decrease this risk.
Low-dose aspirin indicated Low dose aspirin| ACOG SOGC CPG: Hypertensive Disorders of Pregnancy NSAID (SOGC CPG)	Indicate with a √ if low dose aspirin is indicated. Consult OBS if history of previous pre-eclampsia or strong clinical markers for increased risk of hypertension. SOGC recommends that low-dose aspirin (81–162 mg) prophylaxis should be initiated between 12^0–16^0 weeks and continued daily until 36^0 weeks for the prevention of pre-eclampsia for those individuals with 1 high risk factor or more than 1 moderate risk factor (see list of risk factors below). Low-dose ASA may be given orally in the form of one to two baby aspirin (81–162 mg) at bedtime. Low-dose ASA is recommended for pregnant persons with one or more of the following high-risk factors: • Hypertensive disease in previous pregnancy • Chronic kidney disease • Systemic lupus erythematosus (SLE) • Antiphospholipid antibody syndrome (APS) • Type 1 or 2 diabetes • Chronic hypertension • BMI ≥ 30 • ART in pregnancy

Item	Description
Low-dose aspirin indicated continued	Initiate low dose aspirin if the pregnant person has more than one of the following moderate risk factors: • First pregnancy • Age ≥ 40 years • Previous stillbirth • Previous placental abruption • Prior history of fetal growth restriction • Multifetal pregnancy
Progesterone (preterm birth prevention) **indicated**[55 56 57]	Indicate with a √ if progesterone is indicated for the prevention of preterm birth. Risk factors for preterm birth (PTB) include: • Previous preterm birth • Cervical surgery • Cervical insufficiency • Uterine anomaly/surgery • ART • Poor nutrition • Low socioeconomic status • Abuse (IPV) • Age < 17 or > 40 • Physical labour • Interpregnancy interval < 6 months • Poly/Oligohydramnios • BMI < 18 kg/m2 • Diabetes • Hypo/hyper thyroid • Black or Indigenous • Mental illness • < grade 12 education • Substance use • Poor prenatal care • Infections • Fetal anomaly • Vaginal bleeding • Multiple gestation • Short cervical length on transvaginal ultrasound • PPROM • Periodontal disease • Fibroid ≥ 6cm **Consult OBS** **Vaginal progesterone therapy** (VPT) for those with a short cervical length in current pregnancy (≤ 25 mm by transvaginal U/S between 16^0–24^0 weeks) or with a previous PTB. **Daily dose:** 200 mg for single pregnancy/400 mg for multiple pregnancy, initiated between 16–24 weeks gestation (whenever risk is identified), VPT can be continued up to $34+^0$–$36+^0$ weeks gestation (considering individual risk factors).
Social concerns (adoption, child protection, etc.)	Indicate if there are any social concerns by placing a √ in the ❑ and document the specifics, including referrals and follow up.

Item	Description
Referrals follow up	Indicate with a '√' any referral that has been followed up.
At approximately 36 weeks: copy of prenatal record to hospital and/or with patient	Indicate with a √ if a copy of the prenatal record has been given to the patient. Note: Pregnant persons should always have a copy of the prenatal record. The indication for providing the patient and/or hospital with a copy of the prenatal record is intended for users of the EMR. Ensure the pregnant person has a printed copy of the most recent version of the prenatal record and knows to bring it with them to all appointments and prenatal visits.

Prenatal Visits

The basic prenatal visit, not including relevant discussion about prenatal screening and testing, is comprised of the following:

- Weight
- Blood pressure monitoring
- Gestational age in weeks
- Measurement of symphis fundal height
- Auscultation of fetal heart sounds
- Query about fetal movement
- Fetal presentation (using Leopold's maneuvers)
- Lifestyle/risk factors (i.e cigs/day, IPV, mental health, substance use etc.)
- The date of the next prenatal visit

The initial prenatal visit should occur as soon as pregnancy is suspected to offer comprehensive prenatal screening. Refer to PPNL's Guidelines for Prenatal Screening and Testing in Newfoundland and Labrador.

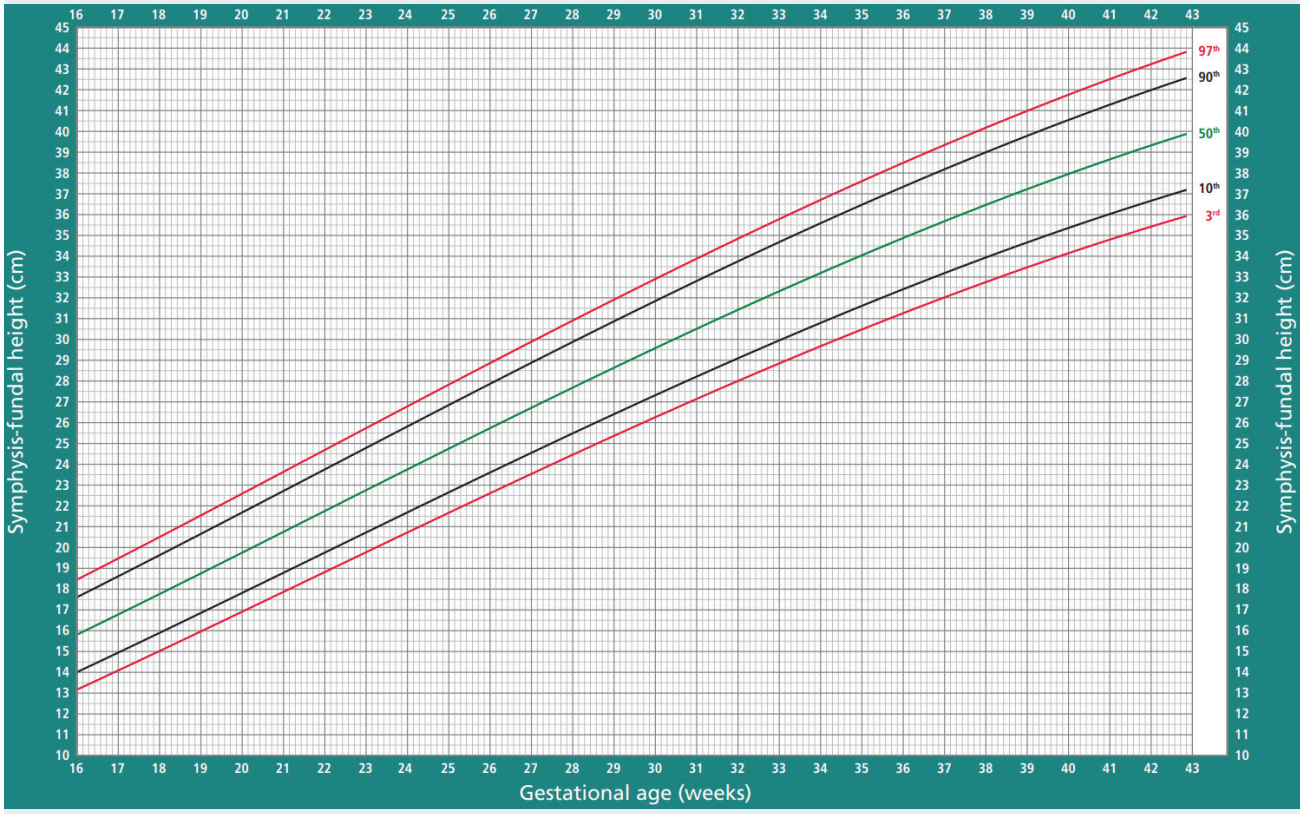
After the initial visit, pregnant persons with low-risk pregnancies should see their prenatal care provider every 4–6 weeks up to 30 weeks gestation, every 2–3 weeks after 30 weeks gestation, and every 1–2 weeks after 36 weeks gestation until labour occurs or up until 41 weeks when a post-dates assessment should be conducted (i.e. biophysical profile or induction of labour). The frequency of prenatal visits should be determined by the physical and psychosocial needs of the pregnant person, the family, and the unborn baby.[58]

Populate each column on the PNR with the applicable information pertaining to each of the specific headings. If more space for documentation is required at prenatal visits, it is appropriate to take additional lines. When visits/documentation exceeds the allotted rows, additional pages for issues and management plan are included on the NL PNR pages 5 and 6. Print extra page(s) as needed.

Additional resources:

- Sensible guide to a healthy pregnancy
- Smoking
- Alcohol
- Cannabis
- Opioids
- Nutrition
- Mental Health Supports
- Intimate Partner Violence
- Social support

Item	Description
GTPALS	Transcribe GTPALS from page 1 of the NL PNR.
Date	Document the date of each visit DD/MON/YYYY.
Weight Assessment	Document weight in kilograms (preferably). Plot weight on the graph.
Blood Pressure	Record the BP taken during the prenatal visit.
Gestational Age	Document GA in weeks/days based on final EDD.
Fundal Height	Symphysis fundal height measurement in centimetres should correspond to the number of weeks of gestation, with an allowance of a 2-cm difference either way. Symphysis-Fundal Height



Item	Description
Fetal Heart Rate	Record the rate of the fetal heart. Normal FHR range is 110–160 bpm.
Fetal Movement	Note fetal movement as reported by pregnant person or palpated/ observed by care provider. Perception of fetal movement by the pregnant person typically begins in the second trimester at around 16 to 20 weeks of gestation. In all pregnancies **with risk factors for adverse outcomes,** the SOCG recommends daily monitoring of fetal movements starting at 26 to 32 weeks. Pregnant persons who do not perceive 6 movements in a 2-hour period require further prenatal testing and should contact their HCP immediately and/or proceed to the nearest birthing hospital for assessment.
Fetal Presentation/ Position	Fetal presentation refers to the fetal anatomical part closest to the pelvic inlet. Record as cephalic, breech or unstable (e.g. transverse or oblique). Assess presentation using Leopold's Maneuvers during the 3rd trimester prenatal visits.
Cigarettes Per Day	As applicable
Comments	Discuss relevant information and lifestyle/risk factors and document in the comment section. A list of recommended discussion topics is available on the Guidelines for Prenatal Screening and Testing in Newfoundland and Labrador.
Next Visit	Document the interval of time for the next prenatal visit.
Initials	Document the initials of the health care provider who completed the visit. If a learner is involved, document the initials of both the learner and health care provider. The initials corresponding to the full name of the health care provider (and any learners) should be entered on the Care Provider Signature section below.

Care Provider Signature

Care Provider Signature	All care providers documenting on the NL PNR are required to legibly document their name printed, signature and initials in this section. Each care provider providing any prenatal care should specify their title/designation (i.e. Medical Doctor (MD), Registered Midwife (RM), or Nurse Practitioner (NP).

NL Health Services

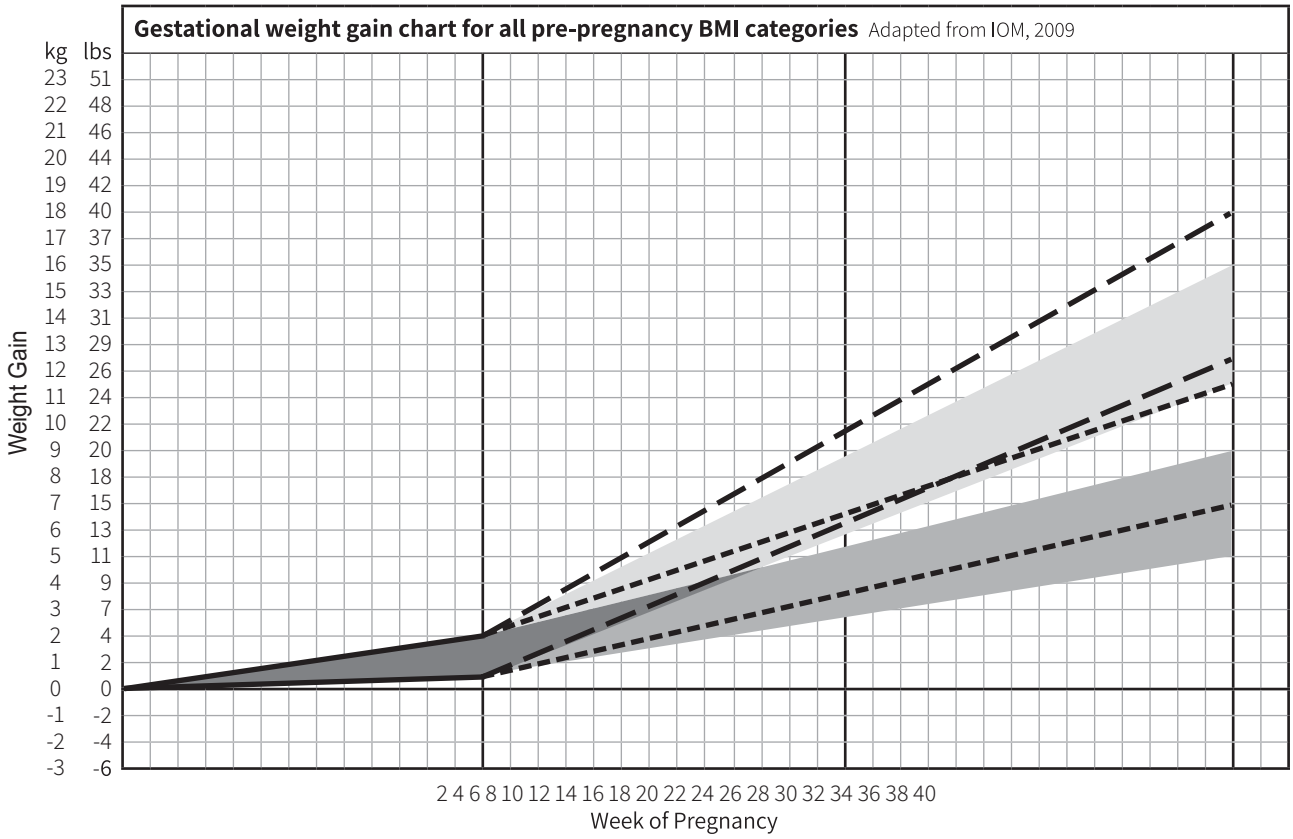
Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part VII)

Worksheet 1 Height _____ **Weight** _____ **Pre-Pregnancy BMI** _____ **Recommended total weight gain** _____



Legend	Prepregnancy BMI	Recommend total weight gain	GWG/week in 2nd 3rd trimester
— —	< 18.5 kg/m^2	12.5-18 kg (28-40 lbs)	0.5 kg (1-1.3 lbs)
	18.5-24.9 kg/m^2	11.5-16 kg (25-35 lbs)	0.4kg (0.8-1 lbs)
- - - - -	25-29.9 kg/m^2	7.5-11.5 (15-25 lbs)	0.3 kg (0.5-0.7 lbs)
	>30 kg/m^2	5-9 kg (11-20 lbs)	0.2 kg (0.4-0.6 lbs)

The y axis represents gestational weight gain (the 0 is the pre-pregnancy weight). The x axis represents weeks of pregnancy. Plot the accumulated weight gain on the along the y axis, above the weeks of pregnancy along the x axis.

Care Considerations for Increased Pre-Pregnancy BMI

Pre-pregnancy BMI ≥ 30 kg/m^2

- FPG and/or HgbA1C with initial bloodwork
- Dating U/S
- U/S for fetal growth at 28, 32, 36 weeks
- Start ASA 162 mg and 1000mg Calcium (dietary or supplemental)

If Pre-pregnancy BMI ≥ 40 kg/m^2, include the following:

- Consider anesthesia consult to assess risks/delivery planning
- Weekly biophysical at 36 weeks
- Thyroid screening with initial blood work
- Plan for delivery at 39-40 weeks.

5A's of Healthy Pregnancy weight gain

Ask – for permission to talk about weight
Assess – potential root cause
Advise – pregnancy weight gain risk and options
Agree – on a realistic SMART plan to achieve healthy behaviour outcomes
Assist – in identifying barriers and facilitators

If weight gain is below or above recommendations:

Assess for clinical issues (such as edema) and explore the root causes of inappropriate weight gain, including
- **Mental** (e.g. insomnia)
- **Metabolic** (e.g. medications)
- **Mechanical** (e.g. reduced mobility)
- **Milieu** (e.g. employment)

Worksheet 1: Gestational Weight Management

The resources on this page of the NL PNR are intended to provide care providers with several tools to inform and guide prenatal care related to gestational weight management.[59 60]

Scientific evidence demonstrates that obesity is an illness, not only a product of inadequate lifestyle. It is important that care providers address negative attitudes about obesity and work to adopt care approaches that eliminate shame or stigma.

Discuss the risk of excessive weight gain and obesity in pregnancy (increased risk of gestational diabetes, gestational hypertension and pre-eclampsia, as well as cesarean delivery and macrosomia), and counsel the pregnant person about diet, exercise and appropriate weight gain during pregnancy based on their BMI category. Gestational weight gain greater than or less than the IOM guidelines may be associated with higher risk of some adverse maternal and newborn outcomes.

Refer to SOGC CPG: Maternal Obesity Part 1 SOGC CPG: Maternal Obesity Part 2 for further information and Obesity Canada's guidelines for weight management over the reproductive years for adults living with obesity.

Gestational Weight Gain Chart

BMI and pregnancy weight gain calculator

This chart is provided for care providers to plot the weight gain at each prenatal visit. It will serve as a visual guide for gestational weight management. The 'y' axis on the chart represents the weight gain (the 0 is the pre-pregnancy weight). The 'x' axis represents the weeks of pregnancy. Plot the accumulated weight gain on the 'y' axis, above the weeks of pregnancy along the 'x' axis using a dot (·). Place the care provider's initials beside the (·).

Height, Weight, BMI, Recommended gestational weight management

Transcribe pre-pregnancy weight, height, pre pregnancy body mass index, and recommended gestational weight gain from page 2 of the NL PNR.

Care Considerations for Increased Pre-Pregnancy BMI

This section serves as a prompt/guide that will inform care interventions for those pregnant persons with a BMI ≥ 30 and those with a BMI ≥40.

Examples include prenatal discussions related to delivery planning, potential alterations to care, method of fetal health surveillance (FHS), expectations for the progress of labour, etc.

5A's for Healthy Pregnancy Weight Gain[61]

The '5 A's' Approach provides a model for care providers to have conversations with pregnant persons and their families/support persons regarding behavioural change. The goal of the 5 A's is to develop a personalized, collaborative action plan with specific behavioural goals and a specific plan for overcoming barriers and reaching those goals.

The 5 A's is an acronym for:

- **ASK** – Ask for permission to talk about the behaviour and health risk.
- **ASSESS** – Explore potential root cause and assess readiness for change. At each prenatal visit, try to determine drivers and complications of guideline-discordance weight gain as well as barriers to guideline-concordance weight gain using Obesity Canada's 4Ms of Gestational Weight Gain framework.
- **ADVISE** - Provide clear and specific advice on risks and options.
- **AGREE** – Collaboratively set **SMART** goals to achieve desired health outcomes and treatment goals.
  - » **S** = **Specific**—be as clear as possible with what is to be achieved.
  - » **M** = **Measurable**—what evidence proves progress toward the goal?
  - » **A** = **Achievable**—reasonably accomplished within a certain timeframe.
  - » **R** = **Relevant**—consider the relevance and whether the goal aligns.
  - » **T** = **Time-based**—provide a time frame to help with motivation and accountability.
- **ASSIST/ARRANGE** – Assist the pregnant person in accessing appropriate resources/providers to achieve the goal(s). Schedule follow up visits for on-going assistance/support. Adjust the treatment plan as needed, including referral to more intensive or specialized treatment.

Ensure that follow-up takes place to facilitate the success of making action plans.

If weight gain is above or below recommendations, assess for clinical issues (such as edema) and explore the root causes of inappropriate weight gain.

Refer to Obesity Canada's 4Ms of Gestational Weight Gain:

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part VIII)

Worksheet 2

Genetic Screening and Assessment[1]

All pregnant persons and their partners should have a three-generation family history taken family history taken by their primary care provider. One's ethnicity is an important piece of risk assessment as some populations are known to have a higher incidence of certain genetic conditions, such as:

☐ Ashkenazi Jewish (Tay Sachs, Canavan, Familial dysautonomia)

☐ French Canadian from Saguenay Lac-St Jean, Charlevoix, Bas-St-Laurent (Tay Sachs, CF)

Referral to Medical Genetics should be considered for those from higher risk populations and those with a personal or family history of:

- Congenital anomaly e.g. congenital heart defect, neural tube defect
- Intellectual disability or developmental delay
- Genetic syndrome e.g. neurofibromatosis, Noonan syndrome
- Chromosomal disorder e.g. Down syndrome (trisomy 21), familial translocation
- Muscular disorder e.g. X-linked Duchenne and Becker muscular dystrophies
- Bleeding disorder e.g. X-linked hemophilia A or B
- Recurrent miscarriage
- Sudden unexplained death
- Other major health concerns such as cardiomyopathy, neurological disease, epilepsy, hearing loss, autism, and psychiatric disorders
- Consanguinity

Hemoglobinopathies
- α thalassemia
- β thalassemia
- Sickle cell disease

Screening recommendations

Offer to individuals from the following at-risk populations/ethnic backgrounds when red blood cell indices reveal a mean cellular volume (MCV) < 80 fl OR electrophoresis reveals an abnormal hemoglobin type

- African
- Mediterranea
- Middle East
- South Eas Asian
- Western Pacific
- Caribbea
- South American

Method of carrier screening:

- Complete blood count
- Hemoglobin (Hb) electrophoresis (HE) or Hb high performance liquid chromatography (HHPLC)
- Quantification of Hb alpha 2 and fetal Hb
- Serum ferritin if microcytosis (MCV <80 fl) and/or hypochromia (mean cellular Hb <27 pg) in the presence of a normal HE or HHPLC assessment

Refer for genetic consultation if both members of a couple are carriers of the same type of thalassemia OR a combination of thalassemia and hemoglobin variant.

Hemoglobinopathy screening should be repeated for individuals previously screened with a point of care test (e.g. sickle cell disease) given an increased frequency of false negative results.

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part IX)

Worksheet 3

T-ACE Alcohol Screening Tool[1]

The T-ACE screening tool is a measurement tool of four questions that are significant identifiers of pregnancy risk drinking (i.e., there is no known safe amount of alcohol intake to consume during pregnancy.)

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.

A total score of 2 or more indicates a positive outcome for pregnancy risk drinking and the pregnant person should be referred for further assessment.

Screening is not required if initial assessment reveals no alcohol is consumed.

One drink is equivalent to:12 ounces of beer or cooler; 5 ounces of wine; 1.5 ounces of hard liquor

Tolerance	How many drinks does it take to make you feel high?	≤ 2 drinks = 0 > 2 drinks = 2	_____ score
Annoyed	Have people annoyed you by criticizing your drinking?	Yes = 1 No = 0	_____ score
Cut Down	Have you felt you ought to cut down on your drinking?	Yes = 1 No = 0	_____ score
Eye Opener	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?	Yes = 1 No = 0	_____ score
		Total Score:	_____

Women Abuse Screening Tool (WAST)[2]

The WAST specifically screens for verbal, emotional, physical, and sexual abuse and is used to help determine if the pregnant person is experiencing domestic violence. Consider the WAST with an inclusive context. Despite the title alluding to women, this tool should be used to screen all pregnant people for risk of domestic violence regardless of gender identity. If the answers to questions 1 and 2 are “a lot of tension” and “great difficulty” the screen is considered positive and the remaining 6 questions should be answered.

1. In general how would you describe your relationship?	☐ **A lot of tension**	☐ **Some tension**	☐ **No tension**
2. Do you and your partner work out your arguments with?	☐ **Great difficulty**	☐ **Some difficulty**	☐ **No tension**
3. Do arguments ever result in you feeling down or bad about yourself?	☐ Often	☐ Sometimes	☐ Never
4. Do arguments ever result in hitting, kicking, or pushing?	☐ Often	☐ Sometimes	☐ Never
5. Do you ever feel frightened by what your partner says or does?	☐ Often	☐ Sometimes	☐ Never
6. Has your partner ever abused you physically?	☐ Often	☐ Sometimes	☐ Never
7. Has your partner ever abused you emotionally?	☐ Often	☐ Sometimes	☐ Never
8. Has your partner ever abused you sexually?	☐ Often	☐ Sometimes	☐ Never

T-ACE (Tolerance, Annoyed, Cut down, Eye-opener) Alcohol Screening Tool

The T-ACE is a validated screening questionnaire for drinking risk in pregnancy (defined as alcohol consumption of 1 ounce or more per day) and should be completed in each trimester of pregnancy and as needed unless initial screening reveals no alcohol is being consumed. There is no known safe amount of alcohol to consume during pregnancy.

Scoring the T-ACE:

- A pregnant person who answers, “more than two drinks” on the tolerance question, “How many drinks does it take to make you feel high?” is scored 2 points.
- Each “yes” to the additional 3 questions scores 1 point.

A score of 2 or more out of 5 indicates risk of a drinking problem, and further assessment and/or referral may be required.[62]

The pregnant person can complete the screening tools independently in advance and then review the results with their care provider.

Woman Abuse Screening Tool (WAST)

The Woman Abuse Screening Tool (WAST) is used by care providers in screening for intimate partner violence (IPV) during pregnancy and should be completed at least once and as needed during pregnancy. The WAST short form (SF) screen is the first to questions. The WAST SF screen is considered positive If the answers to the first 2 questions are ‘a lot of tension’ and ‘great difficulty’. If the WAST SF is positive, the remaining questions of the tool should be asked to elicit more information about their experience of abuse and identify sources of support, need for legal assistance, and provide information about available community resources.

The WAST should be considered with an inclusive context. Despite the title stating “woman”, this tool should be used to screen all pregnant people for risk of domestic violence regardless of gender identity by using the appropriate pronouns and language.

NL Health Services

Name: _____

HCN: _____

Date of Birth: _____

Newfoundland and Labrador Prenatal Record (Part X)

Worksheet 4

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)[1]

Depression is the most common complication of childbearing. The 10-question EPDS is a valuable and efficient way of identifying patients at risk for perinatal depression. Pregnant persons who score above 13 are likely to be suffering from a depressive illness of varying severity. A careful clinical assessment should be carried out to confirm the diagnosis. Consider other causes for symptoms such as anemia, poor sleep, and lack of energy. Thyroid dysfunction, anemia, or bereavement should be excluded before diagnosing a depression.

Perform screening using the EPDS ideally once in each trimester of pregnancy.

0 t	Monitor
11-13	Monitor, support, and provide education. Repeat EPDS in 2 weeks time. If still elevated, refer for further assessment.
≥ 14	Requires further assessment, diagnosis, and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/ psychologist may be necessary.
Item #10	Any individual who scores 1, 2, or 3 on item 10 requires further evaluation before leaving the care provider's office to ensure their own safety and that of their baby.

In the presence of a negative EPDS screen, using a score of 5 or greater on the anxiety specific EPDS questions (4, 5, 6) may be helpful in identifying those who could benefit from further anxiety screening and treatment.

In the past 7 days

1. I have been able to laugh and see the funny side of things
   - 0 ☐ As much as I always could
   - 1 ☐ Not quite so much now
   - 2 ☐ Definitely not so much now
   - 3 ☐ Not at all

2. I have looked forward with enjoyment to things
   - 0 ☐ As much as I ever did
   - 1 ☐ Rather less than I used to
   - 2 ☐ Definitely less than I used to
   - 3 ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, some of the time
   - 1 ☐ Not very often
   - 0 ☐ No, never

4. I have been anxious or worried for no good reason
   - 0 ☐ No, not at all
   - 1 ☐ Hardly ever
   - 2 ☐ Yes, sometimes
   - 3 ☐ Yes, very often

5. I have felt scared or panicky for no very good reason
   - 3 ☐ Yes, quite a lot
   - 2 ☐ Yes, sometimes
   - 1 ☐ No, not much
   - 0 ☐ No, not at all

6. Things have been getting on top of me
   - 3 ☐ Yes, most of the time I haven't been able to cope
   - 2 ☐ Yes, sometimes I haven't been coping as well as usual
   - 1 ☐ No, most of the time I have coped quite well
   - 0 ☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, sometimes
   - 1 ☐ Not very often
   - 0 ☐ No, not at all

8. I have felt sad or miserable
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Not very often
   - 0 ☐ No, not at all

9. I have been so unhappy that I have been crying
   - 3 ☐ Yes, most of the time
   - 2 ☐ Yes, quite often
   - 1 ☐ Only occasionally
   - 0 ☐ No, never

10. The thought of harming myself has occurred to me
    - 3 ☐ Yes, quite often
    - 2 ☐ Sometimes
    - 1 ☐ Hardly ever
    - 0 ☐ Never

Total Score _____

Edinburgh Perinatal/Postnatal Depression Scale

The EPDS is a valuable and efficient way of identifying pregnant persons at risk for perinatal depression. The EPDS is a screening tool and should never override clinical judgment. A careful clinical assessment should be carried out to confirm concerns/a diagnosis.

Perform screening using the EPDS ideally once in each trimester of pregnancy and more often as needed.

Suggested strategy to introduce the EPDS: **'I'd like to check in with you about how you are feeling since you've become pregnant. Take a moment to fill out this short survey.'**

- Circle the response that comes closest to how the pregnant person has been feeling in the previous 7 days.
- All the items must be completed, and answers should come directly from the pregnant person.
- Once the tool is completed the results are scored using the guide provided.
- Care and interventions should be individualized based on the pregnant person's score.

It is ideal for the pregnant person to complete the EPDS unless there is limited English proficiency or difficulty with reading. Ideally, a trained medical interpreter serves as the translator, not a family member. The results should then be reviewed by a health care provider.

Appendix A–Abbreviations

ABU	Asymptomatic Bacteriuria
ART	Assisted Reproductive Technology
BA	Bile Acids
BP	Blood Pressure
BMI	Body Mass Index
BPP	Biophysical Profile
Cigs	Cigarettes
CMV	Cytomegalovirus
CPG	Clinical Practice Guideline
C/S	Cesarean Section
C&S	Culture & Sensitivity
CV	Cardiovascular
CVS	Chorionic Villus Sampling
DOB	Date of Birth
EDD	Estimated Date of Delivery
EPDS	Edinburgh Perinatal/Postnatal Depression Scale
EPR	Early Pregnancy Review
FGC	Female Genital Cutting
FGR	Fetal Growth Restriction
FHR	Fetal Heart Rate
FM	Fetal Movement
FPG	Fasting Plasma Glucose
GA	Gestational Age
GBS	Group B Streptococcus
GC	Gonorrhea
GCT	Glucose Challenge Test
GDM	Gestational Diabetes Mellitus
GI	Gastrointestinal
GHTN	Gestational hypertension
GP	Gravida Parity
GTPALS	Gravida, Term, Preterm, Abortus, Living Children, Stillbirth
GWG	Gestational Weight Gain
HCP	Health Care Provider
HGB	Hemoglobin
HBsAG	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HSV	Herpes Simplex Virus
IAT	Indirect Antigen Test
ICSI	Intracytoplasmic sperm injection
IOM	Institute of Medicine
IPV	Intimate Partner Violence
IUGR	Intrauterine Growth Restriction
IV	Intravenous
IVF	In Vitro Fertilization
KG	Kilograms
LGA	Large for Gestational Age
LMP	Last Menstrual Period
LBW	Low Birth Weight
MCV	Mean Corpuscular Volume
MFAU	Maternal Fetal Assessment Unit
MFM	Maternal Fetal Medicine
MMR	Measles Mumps Rubella
MSK	Musculoskeletal
MSS	Maternal Serum Screening
N/A	Not Applicable
Neg	Negative
NIPT	Non-Invasive Prenatal Testing (cell free DNA)

NKDA	No Known Drug Allergies
NST	Non-Stress Test
NT	Nuchal Translucency
NTD	Neural Tube Defect
OGTT	Oral Glucose Tolerance Test
ON	Ophthalmia Neonatorum
Pap	Papanicolaou Test
Parvo	Parvovirus B19
PCOS	Polycystic Ovarian Syndrome
PG	Plasma Glucose
PPD	Post-partum Depression
PPH	Post-partum Hemorrhage
PPROM	Premature Preterm Rupture of Membrane
Pres./Pos	Presentation/Position
PTB	Preterm Birth
Rh(D)	Rhesus
RhIG	Rh Immune Globulin
SES	Socio-Economic Status
SFH	Symphysis Fundal Height
SGA	Small For Gestational Age
SLE	Systemic Lupus Erythematosus
SDOH	Social Determinants Of Health
SOGC	The Society of Obstetricians and Gynaecologists of Canada
STBBI	Sexually Transmitted Blood Bourne Infection
Sub. Use	Substance Use
T1DM	Type One Diabetes Mellitus
T2DM	Type Two Diabetes Mellitus
T-ACE	Tolerance, Annoyed, Cut Down, Eye Opener
Tdap	Tetanus, Diphtheria, Pertussis
TSH	Thyroid-Stimulating Hormone
U/S	Ultrasound
VBAC	Vaginal Birth After Cesarean
VPT	Vaginal Progesterone Therapy
WAST	Woman Abuse Screening Tool
WHO	World Health Organization
Wt.	Weight

Appendix B–SOGC Resources and Guidelines

2025

Cannabis Resources

Hepatitis C in Pregnancy

2024

Fetal Chromosomal Abnormalities

Prevention, Recognition and Management of Obstetrical Anal Sphincter Injuries

HIV in Pregnancy

Prenatal Screening for Fetal Chromosomal Abnormalities

Identification and Treatment of Perinatal Mood and Anxiety Disorders

Diagnosis and Management of Intrahepatic Cholestasis of Pregnancy

Guideline No. 448: Prevention of Rh D Alloimmunization

2023

Fetal Growth Restriction in Singleton Pregnancies

Management of Monochorionic Twin Pregnancies

Diagnosis and Management of Vasa Previa

Antenatal Corticosteroids at Late Preterm Gestation

Cervical Ripening

Induction of Labour

2022

Postpartum Hemmorhage and Hemorrhagic shock

Diagnosis and management of PPROM

Management of Dichorionic Twin Pregnancies

Folic Acid and Multivitamin Supplementation

Hypertensive Disorders of Pregnancy

Cannabis Use in Pregnancy, the Postnatal Period, and Breastfeeding

Labour, Delivery, and Postpartum Care for People with Physical Disabilities

2021

CMV Infection in Pregnancy

Fetal Neural Tube Defects

2020

Diagnosis and Management of Placenta Previa

Female Genital Cutting

Screening for alcohol use in pregnancy

Progesterone for the prevention of PTB

Your pregnancy – Pregnancy Info

2019

Determination of GA by U/S

Use of 1st Trimester U/S

Pregnancy and Maternal Obesity Part 1

Pregnancy and Maternal Obesity Part 2

Diabetes in Pregnancy

Statement on Planned Homebirth

Trial of Labour After Cesarean

2018

Immunization in Pregnancy

Planning a pregnancy with HIV

Rubella in Pregnancy

Varicella Infection in Pregnancy

Toxoplasmosis in Pregnancy

Group B Streptococcal

Physical Activity Pregnancy

Pain Management

3rd Stage of Labour

2017

Delayed Childbearing

Management of HSV in Pregnancy

Maternity Leave in Normal Pregnancy

Substance use in pregnancy

Pregnancy at $41+^{0}$–$42+^{0}$ Weeks

Hepatitis B and Pregnancy

Management of Bacterial vaginosis

2016

Female Nutrition

Spontaneous Labour at Term

Nausea and Vomiting

Multidisciplinary Team in the care of pregnant people

2015

Adolescent Pregnancy

Preconception folic acid

Pregnant Trauma Patient

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