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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Guidelines for Completing Prenatal Record, 2023

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Introduction

The *Nunavut Prenatal Record* supports the assessment and documentation of information about a pregnant client's health and care in a structured and standardized manner. It also facilitates communication between health care providers and acts as a guide for evidence-based prenatal care. The *Prenatal Record* should be initiated soon after the confirmation of pregnancy.

The initial prenatal visit should take place between 6- and 12-weeks gestation, or as early as possible. Regular visits should be scheduled every 4 weeks until 28 weeks gestation, every two weeks until 34 weeks gestation and then weekly until client leaves community for intended birthplace. More frequent visits can be scheduled as required.

In conjunction with Parts 1 A and 2A of the Record, and a signature sheet for each patient chart, additional sheets are provided to assist with assessment.

These include:

- **Part 1A and 2A Supplementary** – provides space for charting additional pregnancies and prenatal visits.
- **Part 1B** – *Risk Assessment Guide*; *Estimate of BMI* and *Recommended Weight Gain*
- **Part 2B** –*Edinburgh Perinatal Depression Scale/Scoring Guide* and the *TWEAK Questionnaire/Scoring Guide*
- **Part 3** - Checklist by trimester for blood work, investigations, cultures and other recommendations for care.
- **Part 4** – Identification of risk factors for preeclampsia and gestational diabetes mellitus (GDM); as well as symptoms of preeclampsia.

The use of the *Prenatal Record* is supported by *Clinical Practices Guidelines* and reference texts available in each Health Centre including:

- First Nations and Inuit Health Branch (FNIHB) *Clinical Practice Guidelines* (Obstetrics). Username: Nursing; Password: National;
- *UpToDate* electronic clinical resources tool available on the GN Intranet site;
- *Anti-infective Guidelines for Community-acquired Infections*, 2019 Edition;
- Drug Information Resources in the Pharmacy channel in Teams;
- *Drugs in Pregnancy and Lactation: A Reference Guide to Fetal and Neonatal Risk*, published every 3 years;
- *Government of Nunavut Drug Formulary, 2021;*
- *Communicable Diseases Manual* of the Department of Health;
- *Immunization Manual* of the Department of Health;
- *Community Health Nursing Manual* of the Department of Health;
- Society of Obstetricians and Gynecologists' recommendations from *Guidelines* available at JOGC links provided in references and under relevant topics.

Circulation of Prenatal Record

After the initial prenatal visit, a copy of the *Prenatal Record* should be shared for review and case management with the community's assigned prenatal physician or Registered Midwife (RM). If a physician or RM has not been assigned to the community, Part 3 of the Record identifies risk factors which require a physician consult.

Page 1A should be **copied** and sent to the Labour and Delivery Suite of the hospital or birthing centre where the patient intends to give birth when the Estimated Date of Delivery (EDD) is identified and the initial investigations completed. It is expected that, in most cases, this will be done by twenty weeks of gestation.

Once the travel date to place of birth is known, usually between 30 to 34 gestational weeks, provide client with a copy of *Prenatal Record* to take with her when she travels to give birth and **fax** a copy to

intended birthplace. If a significant risk factor is identified then page 2A should be copied and sent whenever the risk factor is identified.

In addition, Page 2A should be **copied** and sent to the Labour and Delivery Suite of the hospital or birthing centre where the patient intends to give birth by thirty-six weeks when the bulk of subsequent visits and additional laboratory investigations are completed.

Nunavut Prenatal Record Part 1A

Section 1: Demographic and Background Information

Item	Description
Ethnic origin	Ethnic or cultural identity as provided by the client. This is used to identify specific racial or ethnic groups in so far as their genetic risks are concerned.
Language preferred	Language most readily understood by the client. This is important when English is the second language and may indicate the need for an interpreter.
Occupation	Occupational hazards may adversely impact a pregnancy and alternative duties or work cessation may become necessary.
Education	Maternal education may be relevant in terms of understanding written material.
# of children at home	Provides an indication of current parenting responsibilities; all children in the home should be included.
Partner's name - optional	Full name of partner – this is optional as the client may not wish to provide the name of her partner who may not be the baby's biological father.
Ethnic origin of baby's father	Ethnic or cultural identity of baby's father as provided by the client – optional as they may not wish to identify baby's biological father.
Partner's occupation	The partner's occupation may be relevant, for example if they frequently work out of town – optional.
Living arrangements	Indicate who the client is living with as they are likely to be their primary source of support throughout their pregnancy. Problems with living arrangements, including overcrowding, can be noted under Section 11 *Risk Factor Summary* while issues with housing can be noted under Section 8 *Lifestyle & Social*.
Intended Birthplace	The hospital or birthing centre where the client plans to give birth.

Section 2: Allergies/Current Medications/ OTC/ Vitamins At First Visit

Item	Description
Allergies	Indicate the medication or substance of the allergy and the response.
Medications, herbals, OTC, vitamins at first visit	Any prescription medications, over the counter medications, complementary medicines or herbal products the client is taking, at the first visit and the frequency and dosage of each. Any of these can potentially have deleterious effects on the pregnancy. Medications should be reviewed in *Drugs in Pregnancy and Lactation: A Reference Guide to Fetal and Neonatal Risk*. A copy of this reference manual is available at each Health Centre. Current medications may interact with those prescribed during the pregnancy. Consult with an MD/RM/NP if concerned about prescription medications, over the counter medications, complementary medicines or herbal products.

Section 3: Obstetrical History

Information on additional pregnancies can be recorded on ***Part 1A and 2A Supplementary***.

Given that it can be difficult for a client to remember details of a pregnancy from several years ago information on Obstetrical History must be confirmed by a chart review.

Item	Description
Gravida	The total number of pregnancies regardless of gestational age, type, time or method of termination/outcome (includes current pregnancy). Twins or multiples are counted as one pregnancy. An ectopic pregnancy, blighted ovum and hydatiform mole are classified as a pregnancy.
Term	The total number of previous pregnancies with birth occurring at greater than or equal to 37+0 weeks of gestation.
Preterm	The total number of previous pregnancies with birth occurring between 20+0 and 36+6 weeks gestation.
Abortion	The total number of previous spontaneous or induced terminations of pregnancies ending prior to 20+0 weeks gestation and weighing less than 500 grams. While ectopic pregnancies, miscarriages, blighted ova and hydatiform moles are classified as spontaneous abortions, the number of ectopic pregnancies should be noted **separately** from other spontaneous abortions.
Living	The total number of children the client has given birth to and who are currently alive. A previous multiple pregnancy should be counted per living child, i.e. twins = 2 living children. If adopted and unknown, use last known information.
Outcome of Previous Pregnancies	Document details of previous pregnancies and birth outcomes including date, place of birth/abortion, gestational age, hours in labour, type of birth (SVD, forceps, vacuum, VBAC or C/S), perinatal complications (including inductions, indications for vacuum, forceps & C/S as well as postpartum hemorrhage, stillbirth), sex of the baby, birth weight, if child was breastfed and present health status if known (as above).

Section 4: Menstrual History and EDD

This section focuses on information used to determine the EDD. Accurate dating is crucial as many decisions made in pregnancy depend on correct dating (i.e. timing of laboratory testing, ultrasounds (U/S) and postdates medical management). Referral for a dating U/S must be considered when dates are uncertain or if history of preterm birth.

Item	Description
LMP	Document the date of the **first day** of the client's last menstrual period (LMP).
Certain	Indicate whether the client is certain or not of her LMP date. They should be certain that it was the first day, that the bleeding came when it was expected and was normal in amount and duration. If unusual timing or only light bleeding consider referral for an early U/S.
Menses Cycle	Indicate the usual number of days from the beginning of one period to the beginning of the next (i.e. 21-35 days).
Contraceptives	Indicate both type of contraception being used and date stopped.
Expected Date of Delivery (EDD)	Calculate the EDD using the first day of the last menstrual period date (if known). This can be completed using a pregnancy wheel or Naegele's rule: count back 3 months from the LMP date and add 7 days (based on a 28-day cycle). If the client's normal cycle is shorter or longer than 28 days, appropriate adjustments

Item	Description
	need to be made (i.e. #of days less than 28 – subtract days from EDD, # of days greater than 28 – add days to EDD). EDD by dates is not as accurate as an EDD by U/S. LMP should be used to confirm the EDD **only if an U/S is not done ≤ 23 weeks and if LMP is certain.** Let pregnant client know that if an U/S is done, a revised and final EDD will be calculated and they will be informed of this date.
Confirmed EDD	If possible, the confirmed EDD should be based on the first available U/S at ≥ 7 weeks or ≤ 23 weeks. The first U/S is always considered the most accurate. With few exceptions, once the EDD is confirmed, it **should not be altered**. The only exceptions should be when a review reveals a miscalculation. **Pregnant client should be informed of confirmed EDD when it is available.** For more information see SOGC guideline *Determination of Gestational Age by Ultrasound*

Section 5: Present Pregnancy

Check the 'no' box if the condition/situation is not present. If 'yes' please document/explain.

Item	Description
Bleeding	Any vaginal bleeding that has occurred during the current pregnancy. Specify if bleeding occurred <20 weeks or ≥20 weeks and approximate amount.
Nausea	Presence of nausea and/or vomiting. Specify if nausea and vomiting are a concern for the client and how being treated. For more information see the SOGC guideline *Management of Nausea and Vomiting of Pregnancy, 2016*.
Infections or fever	Any fever, and issues related to infections such as Toxoplasmosis, Listeria, CMV, Parvovirus, Measles, etc.
Planned adoption	Indicate if an adoption is planned or being considered (uncertain) and if the adoption will be Custom or Other. A note should be made in Section 14, comments, regarding these plans and a tick under Section 16, Referrals to indicate that an adoption plan is in place, if required.
Other	Other health concerns in current pregnancy

Section 6: Family History

Check the 'no' box if the condition/situation is not present. If 'yes' please document/explain.

Item	Description
Family history of heart disease, hypertension, diabetes, depression, thromboembolic or coagulation issues.	Indicate any significant medical condition which has occurred among members of the immediate family of the pregnant client **that may be a concern for the client's health during pregnancy.** If yes indicate the type of condition, who experienced it, how it was managed and outcomes.
Family history of inherited	Indicate history of genetic/inherited disorders, including congenital anomalies which have occurred in the families of either biological parent. These can include

Item	Description
diseases/birth defects	congenital cardiac anomalies, cleft lip and/or palate, Down Syndrome, congenital hip dysplasia, spina bifida or open neural tube defects.
Twins	Indicate if twins or higher order multiples have occurred in the immediate families of either biological parent.
SIDS	Indicate if an infant has died of SIDS in the immediate families of either biological parent.
Other	Indicate any other information related to family history which may influence the pregnancy management or outcome. In general, family history of cancer or ischemic heart disease is **not** relevant to pregnancy.

Section 7: Medical History

Includes medical history of the client that may influence management or outcome of the current pregnancy or postpartum period. Check the 'no' box if the condition/situation is not present. If 'yes' please document/explain. If additional space required chart in *Part 1A and 2A Supplementary*.

Review client's chart to confirm medical history.

Item	Description
Surgery/ Anesthesia	If a caesarean section, surgical abortion or D&C following a spontaneous abortion has been mentioned under the Obstetrical History section there is no need to repeat it here. For all other surgical procedures, specify the procedure and outcome. Significant complications from anesthesia can include metabolic disorders such as malignant hyperthermia and pseudocholinesterase deficiency, difficult intubations and/or severe postoperative vomiting. If complications experienced indicate what the complication was, how it was managed and outcome.
Blood transfusion	Include any previous blood transfusions and outcome.
Asthma/Lung Disease	Asthma is a common respiratory disease and inadequate control during pregnancy increases the risk of preterm labour, intrauterine growth restriction and maternal complications. Indicate other lung diseases as reported. If yes, specify the disease, how it was managed and outcome.
Current TB	Include active or latent TB infection as well as known recent TB contacts. Clients can receive Tuberculin Skin Testing (TST) in pregnancy if needed for any reason (i.e. contact tracing). Consult Regional Communicable Disease Coordinator (RCDC) and *NU TB Manual* for additional information. If a client is undergoing a diagnostic workup for TB during pregnancy consult with a physician regarding CXR.
Uterine/Cervical Procedure	Indicate significant gynecological history or cervical procedures such as LEEP, fibroids, cone biopsy, endometriosis, as well as abnormal Pap tests which required treatment or further observation. Specify the procedure, when it took place and outcome.
STIs /Genital Herpes	A prior history of STIs may suggest a risk for re-infection requiring repeat testing in pregnancy, as well as the need to determine if a prior infection was adequately treated. Past history of Syphilis will need to be indicated on lab

Item	Description
	request for Syphilis in initial serology at first prenatal visit as it will influence interpretation of titre levels. Active genital herpes infection in labour is potentially transmissible to the newborn, particularly if it is a primary infection. Caesarean birth will be recommended if there are signs or symptoms of a genital herpes outbreak at the time of labour and delivery. The SOGC recommends that clients with known recurrent genital herpes infection should be offered acyclovir or valacyclovir suppression at 36 weeks' gestation to decrease the risk of clinical lesions and viral shedding at the time of delivery and therefore decrease the need for C/S (*Guidelines for the management of herpes simplex virus in pregnancy, 2017*). Consult with physician for drug and dose.
Susceptible to varicella	Serological testing for varicella is recommended only if a pregnant client has not been immunized, does not have record of immunity **and** does not report having chickenpox prior to 2002 (when vaccination started in Nunavut). Pregnant patients who may be **susceptible** to chickenpox/varicella should have serological testing with their initial pregnancy blood work and if required, postpartum vaccination. Consult with RCDC in the event of an outbreak. For additional information see the SOGC's *Management of Varicella Infection (Chickenpox) in Pregnancy, 2018.*
Susceptible to rubella	Serological testing for rubella is recommended only if a pregnant client has no record of rubella immunity (infection or testing) in the past **and** no proof of immunization against rubella. The two dose MMR vaccine was introduced in Canada in 1996/97 and many pregnant clients will have been fully immunized. If testing reveals client is **susceptible** to rubella, vaccination should be done in the postpartum period and indicated in Part 2A. Consult with RCDC in the event of an outbreak. For additional information see the SOGC's *Rubella in Pregnancy, 2018*.
Susceptible to toxoplasmosis	Toxoplasma is a parasite which causes an infection called toxoplasmosis. Immuno-competent pregnant clients who have had toxoplasmosis infection before their pregnancy are not at risk of primary infection during pregnancy. In rare cases, those who are immunocompromised may have a reactivation of a chronic toxoplasmosis infection during pregnancy. Primary toxoplasmosis infection that occurs during pregnancy can allow the transmission of toxoplasma to the fetus with very serious negative sequelae, including blindness in the infant. Ask if diet included raw country food prior to pregnancy as this reduces risk of primary infection with toxoplasmosis during pregnancy. All pregnant clients should be counselled to prevent exposure to toxoplasma during pregnancy.

Item	Description
	Toxoplasma can be found in raw country food, cat feces, undercooked or raw meat, fish or poultry (including eggs), and contaminated water. It is recommended that pregnant clients **cook** country food (and all store bought meats, fish and poultry, including eggs) before eating; **boil** untreated water before drinking; and **avoid** changing cat litter to prevent primary infection during pregnancy. There is a screening program for toxoplasmosis in Nunavut during pregnancy (insert guidelines when available). For additional information see SOGC guideline: *Toxoplasmosis in pregnancy: prevention, screening, and treatment*
Thromboembolic/ coag	History of previous problems with varicose veins, deep vein thrombosis, pulmonary embolism or coagulation disorder. If yes, specify the disease, how it was managed and outcome.
Hypertension/cardiac	History of significant heart disease, congenital or acquired. History of significant cardiac events (e.g. heart attacks, TIAs, strokes, symptomatic arrhythmias). History of chronic hypertension, hypertension requiring medications or hypertension with previous pregnancies. If yes, specify the disease, how it was managed and outcome.
GI	History of gastrointestinal disease (e.g. Crohn's disease, irritable bowel syndrome, chronic liver disease, chronic constipation). If yes, specify the disease, how it was managed and outcome.
Urinary/Renal	History of chronic renal disorders (e.g. recurrent UTIs, pyelonephritis or polycystic kidney disease). If yes, specify the disorder, how it was managed and outcome.
Endocrine/Diabetes	History of endocrine disorders (e.g. diabetes or adrenal conditions). Requires a referral to physician at first visit. If yes, specify the type of condition, management and outcome.
Thyroid	History of hyper- or hypothyroidism. If yes, specify the disease, how it was managed and outcome. TSH should be included on initial prenatal bloodwork **only if client has symptoms or a history of thyroid disease.**
Neurologic/Seizure	History of significant neurological disorder (e.g. epilepsy or multiple sclerosis). If yes, specify the disease, how it was managed and outcome.
Hx of Mental Illness	Past or current history of mental illness. Indicate if history of anxiety, depression/postpartum depression and/or other condition(s). If yes, specify the disease, how it was managed and outcomes. Includes eating disorders, substance abuse disorders as well as anxiety, depression and psychotic illnesses. All may be exacerbated in pregnancy and medication dosages may need to be altered. Particular attention should be paid to history of perinatal/postpartum depression in previous pregnancy(ies).
Other	**Other medical conditions** (i.e. blood dyscrasias, hepatitis B or C, HIV, rheumatoid arthritis, systemic lupus). If yes, specify the disease, complications, how it was managed and outcome.

Section 8: Lifestyle and Social

Check the 'Discussed' box of the item and document any concerns noted in the comments section of the Prenatal Record. If significant concerns are raised in relation to Lifestyle and Social issues which require additional documentation a Progress Note can be added to the prenatal chart.

Check the 'Referred' box if the client is referred for further follow-up and/or treatment. For any referral made, a corresponding note should be made in the Record, section 16.

To help facilitate effective engagement, begin your discussion with an introductory sentence (e.g. *I ask all my clients these questions because it is important to their health and the health of their newborns*).

Item	Description
Diet/Food Security	Determine if diet includes all four food groups as well as access to country foods (high in iron). (Food sources of **iron** include: country food, store bought meat/poultry/fish/seafood, eggs, soy products (tofu, soy milk), legumes (beans, peas, lentils), nuts/seeds, deep green leafy vegetables, dried fruit, and iron-enriched foods such as breakfast cereal and pasta (eating Vitamin C-rich foods like fruits and vegetables with plant-based sources of iron enhances iron absorption). Advise to cook country foods and store-bought meat, fish and poultry (including eggs). Document concerns about running out of food and refer to community resources such as CPNP and Social Services.
Folic acid/Vitamin D/Prenatal Vitamins	Assess if taking folic acid and stress importance of Vitamin D in a northern location. Provide (script or dispense) 1,000 IU Vitamin D and prenatal vitamins for duration of pregnancy It is recommended that pregnant clients take a prenatal vitamin every day. This ensures that the proper vitamins and minerals are available to the growing fetus. If client cannot tolerate the increased dose of iron in the prenatal vitamins, a regular vitamin supplement should be recommended. Taking folic acid supplements or a prenatal vitamin containing folic acid for three months before conceiving and in early pregnancy lowers the risk of some birth defects. For clients who are high risk for neural tube birth defects, a higher dosage of folic acid (4-5mg/d) may be recommended for 3 months preconception and until 12 weeks gestation followed by a lower dose of folic acid until completion of breastfeeding. Consult with physician if client had a previous pregnancy affected by a neural tube defect, have a neural tube defect themselves, or have a first-degree relative with a neural tube defect. In addition, consult a physician if the biological father has a neural tube defect, or has previously fathered a child with a neural tube defect.

Alcohol, Substance and Tobacco Use

- ***Alcohol Use***

Problematic use of alcohol during the child-bearing years can negatively affect both maternal and child health. Alcohol is a known teratogen and a safe level of alcohol consumption during pregnancy has not been established. Consumption of alcohol has been associated with harmful effects such as fetal growth restriction, fetal alcohol spectrum disorder and neonatal behavioural abnormalities.

For more information see SOGC guideline *Screening and Counselling for Alcohol Consumption During Pregnancy, 2020*

Each encounter is an opportunity to Assess, Advise and Assist. Refer to addiction services as appropriate.

Indicate if alcohol use is identified during the prenatal visit and the individual wishes to receive referrals for support – client can also self-refer. Any client who has a history of drinking during pregnancy should be counselled on the negative impact of drinking during pregnancy and encouraged to seek support.

One drink is defined as: beer (12 oz), wine (5 oz) or hard liquor (1.5 oz).

Item	Description
Alcohol use	It is recommended to assess and monitor alcohol use at least once per trimester. Has the client ever consumed alcohol? • If never, skip to next subsection. If quit, indicate date. • If yes, continue with the next question.
Drinks / wk: Before Pregnancy, Current	Document the average number of drinks/week consumed before conceiving and after conceiving. Sample questions: *Can you tell me a bit about your drinking patterns before you knew you were pregnant? In a typical week, on how many occasions did you usually have something to drink? On those days, would you have something like 3-4 drinks or about 8-10 drinks? Do you have any concerns about your drinking? Have you been able to cut down or stop since you found you were pregnant?* If client has experienced difficulty in cutting down or stopping drinking ask if they would consent to a referral to addiction services.
Binge Drinking	Binge drinking is defined as consumption of alcohol that brings blood alcohol concentration to about 0.08% or above. For an average-sized pregnant client a binge drinking episode is 4 or more drinks on one occasion. Sample question: *When was the last time you had 4 or more drinks on one occasion? How often does this happen?* If client is binge drinking they should be asked for a consent to be referred to addiction services.
TWEAK Score	Document the TWEAK score **for any client who is drinking**. Refer to Part 2B of the Prental Record for TWEAK questions and scoring. If TWEAK score indicates alcohol abuse they should be asked for a consent to be referred to addiction services.

- ***Cannabis and Other Substance Use***

Each encounter is an opportunity to Assess, Advise and Assist.

Just as with alcohol, there is no safe level for consumption of cannabis and other substances during pregnancy. Their use may result in spontaneous abortion, premature labour, low birth weight, placental abruption and stillbirth. In addition, recent data suggest cannabis use can lead to persistent neurocognitive and neurobehavioural effects throughout childhood and into adulthood.

Cannabis use has, in some populations, become normalized; therefore it is important to enquire specifically about the use of this drug. Request consent for referral to addiction services as appropriate.

For more information see SOGC guideline *Substance Use in Pregnancy, 2017* and *Cannabis Use Throughout Women's Lifespans - Part 2: Pregnancy, the Postnatal Period, and Breastfeeding, 2022*.

Practice Resource, BC Perinatal Services, *Cannabis During Pregnancy*.

Item	Description
Cannabis Use No/Yes	Indicate 'yes' or 'no' for cannabis use **in pregnancy**. This includes marijuana, and other cannabis products such as CBD oil. Cannabis may be smoked, vaped, eaten or applied as tinctures to the skin. If yes and experiencing difficulties in cutting down or quitting request consent to refer to addiction services.
Other Substance Use No / Yes Specify?	Indicate if there has been any other substance use during pregnancy (i.e. cocaine, heroin, methamphetamines, IV drugs, prescription drugs, other). Document specific type(s) of substances used and request consent for referral to addiction services as appropriate.

- ***Tobacco Use (Smoking and/or Chewing)***

NB in 2022 the SOGC recommended against vaping during pregnancy and have indicated that more information will be provided as evidence becomes available.

Each encounter is an opportunity to Assess, Advise and Assist.

Tobacco use during pregnancy can increase the risk of spontaneous abortion, preterm birth, placental abruption, IUGR, low birth weight, perinatal mortality and SIDS.

It is strongly advised that clients quit smoking or chewing tobacco for the duration of the pregnancy. If they can't quit then they should be encouraged to cut down. Helping a pregnant client to deal with the stressors in their life may help them quit/reduce smoking.

There is no known safe level of exposure to second hand smoke. Smoking in a closed-in space such as a home or car greatly increases the concentration of harmful chemicals produced by second-hand smoke.

The Nunavut Quitline (1-866-368-7848) is a toll-free confidential help line for people who want to quit smoking and the website has resources for professionals and smokers.

For those pregnant clients finding it difficult to quit on their own, nicotine replacement therapy (NRT), such as the patch, gum, lozenge, inhaler, may be used to reduce and eliminate tobacco consumption – consult with an MD/NP/RM.

Item	Description
Smoking Never/Quit	Indicate if the client is smoking, has never smoked or the date they quit if they are a former smoker.
Cig/day before pregnancy	Document the average number of cigarettes smoked per day before pregnancy. Sample question: *How many cigarettes did you smoke in a day before you were pregnant?*
Cig/day current	Document the average number of cigarettes smoked per day, during the current pregnancy. Sample questions: *Do you smoke now? If yes, how many cigarettes do you smoke in a day?* Could also ask about chewing tobacco and document by number of tins/week.
Exposure to 2nd hand smoke No/Yes	Indicate if client is currently exposed to second hand tobacco smoke and discuss strategies to create smoke free home for themselves and their newborn as well as their other children.

- ***Other concerns: Financial/Housing/Support/Safety/Intimate Partner Violence***

A client's responses to these questions indicate the support they have in their life and the stresses they are living with. These will impact on their adaptation to pregnancy and capacity to care for a newborn; this assessment provides the opportunity to ask for consent to refer to resources as required.

Item	Description
Financial	Enquire about financial concerns and provide referrals to social services if this is a concern to stabilize situation before baby is born.
Housing	Enquire about stability of housing, including overcrowding, and document response – provide referrals as appropriate. Sample questions: *Who do you live with? How long have you lived there? Is housing a problem for you?*
Safety	Ask if they feel safe living where they are. Sample questions: *Do you have any concerns about your current living situation? Has anything happened in the past month or so that worries you?*
Support System	Determine who will provide support during and after pregnancy. Sample Questions: *How do your partner and family feel about the pregnancy? Who'll be helping you with the baby after you give birth?*
Intimate Partner Violence	Intimate partner violence refers to a pattern or history of physical, sexual and/or emotional interpersonal violence. It is recommended that care providers ask all pregnant clients about intimate partner violence – care providers should be caring, non-judgemental and respectful when asking about IPV. Clients should be asked at the initial prenatal appointment and at various times over the course of the pregnancy because some clients do not disclose abuse the first time they are asked and abuse may begin later in pregnancy. If a client discloses abuse she should be referred to supports in her community. The following introductory script is helpful to begin the discussion: *Because violence is so common in many of our client's lives and because*

there is help available, I now ask every client about domestic violence – do you feel threatened, hurt or afraid of your partner?

Section 9: Initial Physical Examination

Completing a physical exam provides baseline information for subsequent assessments.

Item	Description
Exam Date	Document when the physical examination took place.
B.P.	Document the blood pressure taken during the exam (use automated cuff where possible).
HR	Document HR taken during the exam.
Height	Document the height of the client in cms.
Initial Wt	Document the weight of the client in kgs at the first prenatal visit. Given that it may not be reasonable to have a pre-pregnant weight, the weight at the first visit can serve as an approximate measure of pre-pregnancy weight.
Initial BMI	Calculate and document the initial BMI using the BMI calculator in Part 1B of the *Record*. Obesity, or a BMI 30 and over, has significant maternal and perinatal health risks. If the BMI is greater than or equal to 30, a referral needs to be made to a physician. The total amount of weight gain during pregnancy that is recommended by initial BMI is included in the table next to the BMI calculator.
Results of Physical Exam	If there are no abnormalities detected, place a tick in the box of each component of the initial physical examination. If abnormalities are present, indicate what the abnormality is, how it is managed and the resulting outcome. Comments can be written in the space provided or in the Progress Notes. **NB**: A Pap test only needs to be done if the client is < 10 weeks pregnant and 'due' for one under current guidelines**.** Consult with physician if client is ≥ 10 weeks and 'due' for a Pap. **If a Pap is not required the pelvic exam may not be necessary.**

Section 10: First Trimester Topics Discussed

Indicate with a check on Record if the topic was discussed and a note in the comments of Section 14 if follow-up required.

Item	Description
Prenatal Bloodwork	Provide client with an explanation of the tests which form part of routine prenatal bloodwork. Verbal consent should be given for all bloodwork including HIV and Hep C; a written consent for these tests is not required - document verbal consent for each of these. Blood tests give important information about the client's health, possible problems in pregnancy and support early interventions.
Comprehensive U/S	Discuss comprehensive (18-20 wk) U/S recommendations and identify how arrangements will be made.
Prenatal Genetic Screening	While prenatal genetic screening is optional, it should be discussed with all pregnant clients. Screening identifies clients who are at high risk of having a baby with Down syndrome (Trisomy 21), as well as other, less common, trisomy conditions. Screening early in pregnancy offers the client the opportunity to have further tests to determine if their baby has a problem. This means they can prepare for birth of an affected baby, or to decide to terminate the pregnancy.

Item	Description
	While non-Invasive Prenatal Testing (NIPT) is very accurate and can be done in the first trimester (as early as 10 weeks), it may not be accessible in every community. This means that, in some communities, clients will be offered Maternal Serum Screening (MSS) at between 14+0 and 20+6 weeks. While MSS is less accurate than NIPT, it will identify women at higher risk of having a baby affected by Down Syndrome or other trisomies - between 77% and 88% of infants affected by Down Syndrome are detected by MSS. Pregnant clients with specific risk factors may be offered the opportunity to travel to be screened with NIPT. These risk factors include history of a fetus with trisomy, maternal age ≥40 years or soft markers on ultrasound in the current pregnancy. Consult with physician if required. Prenatal screening is not diagnostic and simply indicates further testing is required. This means that some pregnant clients who screened positive will experience a false positive result – their baby has no problems. A false positive screen can lead to unnecessary stress and further testing. Let client know: • Prenatal genetic screening is done early in pregnancy to test for Down Syndrome, and some other problems with the baby, so that clients can have a therapeutic abortion if they choose to. • A positive screening result does not mean the baby has a problem – it does mean that further tests are recommended. • If screening results are positive, clients can choose between NIPT, invasive testing, or no further prenatal testing. NIPT and invasive testing are likely to involve travel outside the community. • Only an invasive test such as CVS or amniocentesis can provide a diagnosis of a problem. • A negative screening result is reassuring but does not guarantee the birth of a baby with no problems – it does indicate lower risk of a problem.
Physical Activity/ Rest	It is important that active pregnant clients stay active and non-active clients incorporate daily walks into their routines, gradually increasing length and intensity of exercise. For more information on physical activity in pregnancy see this SOGC guideline - *Canadian Guideline for Physical Activity throughout Pregnancy, 2019.*
Dental Care	Discuss the importance of taking care of teeth and gums during pregnancy. Encourage clients to brush their teeth twice a day with a fluoride toothpaste and floss gently once a day. Pregnant clients with periodontal disease may have a higher risk of delivering a premature or low birth weight infant. Encourage client to schedule appointments for a dental checkup and cleaning if they haven't had one in the last six months. If dental work is required, the best time to schedule it is in the second trimester. Dental X-rays should only be taken in an emergency. Clients with vomiting due to morning sickness should rinse their mouth with water or fluoride mouthwash immediately and delay tooth brushing for 30 – 60 minutes to prevent stomach acid from damaging teeth.

Item	Description
Prenatal Classes/ CPNP/CHR	Discuss opportunities for prenatal education available in the community. Refer to CPNP, if available, and to a CHR who can provide links to a range of community supports.
Food Safety	Foodborne illnesses can cause maternal disease as well as congenital disease, premature labor, spontaneous abortions and fetal death. To reduce the risk, it is important that pregnant clients: • Practice good personal hygiene (frequent hand washing). • Consume only country food and store-bought meats, fish, poultry (including eggs) that are fully cooked. • Thoroughly rinse fresh fruits and vegetables under running water before eating. • Wash hands, food surfaces, cutting boards, dishes and utensils that come into contact with raw meat, poultry or fish with hot soapy water. To prevent toxoplasmosis it is recommended that pregnant clients **cook** country food (and all store-bought meats, fish and poultry, including eggs) before eating; **boil** untreated water before drinking; and **avoid** changing cat litter.
Vaccines	All pregnant clients should receive Tdap at 21 to 32 gestational weeks. It is also highly recommended that they receive influenza vaccines in flu season and COVID-19 vaccines, according to the NU Immunization Schedule.
Sexual Relations	Discuss sexual relations/sexuality during pregnancy. Surveys show that up to half of all pregnant clients have concerns about their sexual health; however, many are too embarrassed or uneasy to bring the subject up with their health care providers. Asking a question on sexual relations provides an opportunity to discuss the topic. For more information see SOGC patient information at: *Sex and Pregnancy*.
Seat Belt Use	Discuss correct seat belt use during pregnancy – the seat belt should be worn snug and low over the hips and below the baby; the shoulder belt should be worn tightly against the chest – between the breasts and off the side of belly.
Child Care During Confinement	Raise issue of planning for child care for other children by a responsible adult when the client travels to another community for confinement. Ideally, an adult in the family or a close friend will assume responsibility for the other children. In some circumstances, resources may be sought from the Inuit Child First Initiative to assist in care for children. **Note plans for child care during confinement in Section 15 a.**
Plans to Breastfeed Yes / No / Undecided	Indicate the client's plans regarding breastfeeding. Address any questions they may have and review the booklet *Breastfeeding Your Baby* which outlines anticipatory guidance on breastfeeding. This booklet is available on the Department of Health website and in each Health Centre. Clients who have decided to breastfeed during pregnancy, and had the opportunity to ask questions, are more likely to breastfeed postpartum.

Section 11: Comments/Risk Factors

Item	Description
Risk factor summary	Summarize risk factors identified on the Risk Assessment Guide on Part 1B of the prenatal record. The purpose of risk assessment is to identify which pregnant clients need closer monitoring and additional supports. **Past obstetrical history is crucial because these complications may occur again in the current pregnancy.** Problems in the current pregnancy should also be identified in the Risk Factor Summary so they are not missed. Given that it may be difficult for the pregnant client to remember the details of each pregnancy, a thorough chart review is a crucial part of completing the risk factor summary.

Nunavut Prenatal Record Part 2A

A number of laboratory tests and investigations are universally recommended during pregnancy. Prenatal care providers have an important role to play in stressing the importance of testing in disease prevention, in emphasizing the standard of care for all clients and in helping to allay concerns about confidentiality and any perceived stigma associated with testing. Clients have the option to accept testing or to decline. Any testing declined should be noted in this section and in the comments in section 14 of the Record.

Section 12: Place of Birth and EDD

Item	Description
Intended Birthplace	The hospital or birthing centre where the client plans to give birth.
Age at EDD	Indicate the age the client will be at EDD.
Confirmed EDD	Transfer the **Confirmed EDD** from Part 1A of the Record. Indicate if based on dates of menses cycle or U/S results. The EDD is not normally changed once confirmed.

Section 13: Investigation/Results

When lab results return, results should be noted in Section 13 as they arrive.

Item	Description – Investigations/Results
ABO Rh Factor Antibody Screen Results	ABO, Rh Factor and red blood cell antibody screening is performed with the initial prenatal blood work for **all** pregnant clients and again at 24-28 weeks. Indicate the Blood Group and Rh Factor on the *Record*. Document results and consult with physician if client has a positive antibody screen. For more information see SOGC's guideline *Prevention of Rh Alloimmunization, 2018*.
RhIg Given	Document date Rh Immunoglobulin (RhIg) is given in the pregnancy, if indicated. Rh negative clients should receive Rh Immunoglobulin at 28 weeks gestation. **Prior to administration, a repeat antibody screen should be collected to exclude sensitization.** In addition to RhIg at 28 weeks, consult with a physician about giving RhIg to an Rh negative client at the following times:

Item	Description – Investigations/Results
	• Within 72 hours after birth of an Rh positive infant • After a spontaneous or induced abortion (includes miscarriage) • After an ectopic pregnancy • After a molar pregnancy • After an amniocentesis or chorionic villous sampling or cordocentesis • After an episode of antenatal bleeding including from placenta previa or abruption • After other invasive obstetrical procedures or trauma including external cephalic version or blunt trauma to the abdomen Document first RhIg given in Section 13 of the *Prenatal Record* and subsequent doses, if required, in Comments, Section 14, with indication. For more information see SOGC guideline *Prevention of Rh Alloimmunization, 2018*.
PP Immunization	Indicate if client will require immunization for Rubella and/or Varicella in the postpartum as this will need to be done when she returns to her home community. Note on Immunization Record. These vaccines should not be given during pregnancy.
MSS/NIPT	Prenatal genetic testing, while optional, should be discussed with all pregnant clients in the first trimester. MSS can be done anytime between 14+0 and 20+6 wks gestation. **Accurate dating is crucial for MSS – this may mean it is best to aim for the middle range of this timing.** If NIPT is available in client's community, the test can be done as early as 10-11 weeks. **NIPT is considered to be a more accurate test and should be used instead of MSS if available.** Review Regional guidelines to determine if NIPT is available and procedure to take sample and send for testing. NIPT would be the preferred initial test for pregnant patients with history of a fetus with trisomy, maternal age ≥40 years or soft markers on ultrasound in the current pregnancy. Consult with physician to determine if these clients should travel to access NIPT. **Indicate if screening was accepted**. If screening was not accepted indicate reason why screening was declined in comments, Section 14, (i.e. would not change management of pregnancy). Choosing to opt in to screening, or not, is the client's choice. **Indicate testing results**. Testing results are reported as positive or negative. All clients with positive screening results require a physician referral. Indicate if amniocentesis, or other testing, was performed and outcome in comments, Section 14 of the Record. For more information see the SOGC guideline: *Joint SOGC-CCMG guideline: update on prenatal screening for fetal aneuploidy, fetal anomalies, and adverse pregnancy outcomes, 2017.*
GBS Positive Urine or Swab (35-37 wks)	If the C & S urine culture grows Group B Strep bacteria, at any time during pregnancy, the client is considered **GBS positive** and prophylactic antibiotics offered in labour. While a pregnant client is usually screened with a vaginal/rectal swab at 36-37 weeks at her place of birth, this is **not** required when they were identified as GBS positive earlier in pregnancy through urine testing. For more information see SOGC guideline: *The Prevention of Early-Onset Neonatal Group B Streptococcal Disease, 2018*

Item	Description – Investigations/Results
Pap (if due)	Document date of any Pap testing done in the pregnancy with results documented in Comments Section 14. Opportunistic screening is not recommended. Instead follow the *Nunavut Cervical Cancer Screening Guidelines* on the Department of Health website and only test a pregnant client if they are due for a Pap **and** <10 weeks gestation. Consult with a physician If the client is ≥10 weeks gestation and due for a Pap.
Pertussis (Tdap)	In order to reduce susceptibility of the infant to pertussis, one dose of combined diphtheria, tetanus, acellular pertussis containing vaccine (Tdap) can be offered to pregnant clients at **21 to 32 weeks of gestation** unless already given previously in the pregnancy. • Immunization with Tdap has been shown to be safe in pregnant clients and allows high levels of antibody to be transferred to newborns during the first two months of life when the morbidity and mortality from pertussis infection is the highest. • Immunization should not be delayed until close to delivery since this may provide insufficient time for optimal transfer of antibodies and direct protection of the infant against pertussis. For more information on Tdap vaccine in pregnancy see SOGC guideline: *Immunization in Pregnancy, 2018*
Hep B Surface Ag Pos / Neg	All pregnant clients should be screened for Hep B Surface Ag (HBsAg) with the initial prenatal blood work. **Indicate results.** A positive HBsAg is a marker for both acute and chronic Hepatitis B infection, which carries a risk of perinatal transmission (passing Hepatitis B onto the newborn). Hepatitis B is a reportable communicable disease and positive results require the completion of an 'Enhanced Hepatitis B and C – Investigation' form and contact tracing – notify RCDC. Please refer to the *Communicable Disease Manual*. **Consult with physician as soon as positive HBsAg result is received as this will impact management during pregnancy.** Hepatitis B surface antigen-positive pregnant clients should receive counseling on prevention of hepatitis B virus transmission to sexual partners and household contacts. Screening for fetal aneuploidy with these clients should use non-invasive techniques. **NB**: A pregnant client who is HBsAg negative, and not previously immunized, but who is high risk for contracting Hepatitis B, should be offered a complete Hepatitis B vaccine series at the first opportunity during pregnancy and should be tested for antibody response. Hepatitis B vaccine can be used safely in pregnancy, and is indicated, because acute Hepatitis B infection in a pregnant client may result in severe disease for the mother and chronic infection for the infant – consult with RCDC. Infants of Hepatitis B positive mothers are at high risk of contracting Hepatitis B disease. These infants require Hepatitis B Immunoglobulin at birth and should be immunized at birth. Please see *Immunization Manual* Section 9 for the *Hepatitis B Protocol* and Section 10 for *Hepatitis B Immunoglobulin* – consult with RCDC. For more information see SOGC guideline: *Hepatitis B and pregnancy, 2017*

Item	Description – Investigations/Results
Syphilis	All pregnant clients should be screened for Syphilis with the initial prenatal blood work and again at 24-28 weeks and 35-37 weeks. If treated for Syphilis in the past, need to let lab know on the requisition form to aid in interpretation of lab results. **Indicate results - including titres, if required. Report test of cure following treatment, if required, in comments Section 14.** Syphilis is a reportable communicable disease and positive results require the completion of the *Syphilis Report Form* and notification of RCDC. A client with a positive Syphilis test should be referred for a physician consult. See *Syphilis Protocol* in the *Communicable Disease Manual.* Infectious Syphilis in pregnancy can lead to fetal infection with stillbirth, preterm birth, congenital abnormalities and active disease at delivery. Transmission occurs transplacentally (as early as 14 weeks and throughout pregnancy) or at the time of birth. Untreated primary and secondary Syphilis carry a transmission risk to the fetus of close to 100%. For more information SOGC *Statement on Syphilis*
HIV Testing	All clients should be screened with the initial prenatal blood work. The test can be explained along with other bloodwork; while a written consent is not required the client's verbal consent for HIV testing should be documented. Clients considered to be at high risk of HIV infection because of risky behaviours and/or an HIV positive partner should also be tested again at 24 to 28 weeks. Risky behaviours for HIV include engaging in unprotected sex, sharing needles or other injection equipment, or recurrent infections with other STIs. Refer to the *Communicable Disease Manual* for information for pregnant clients on HIV testing. HIV is a reportable communicable disease and positive results require completion of report form and the notification of the RCDC. Consult with physician if test result is positive as risk of transmission of HIV from mother to fetus is significant if the pregnant client is not treated. **Please note a negative HIV result from the birth mother is necessary before an infant can receive BCG vaccination.** For more information see SOGC guideline: *HIV Screening in Pregnancy, 2017*
Hep C Testing	The test for Hep C can be explained along with other bloodwork; while a written consent is not required the client's oral consent for Hep C testing should be documented. While all pregnant clients are screened for Hep C with the initial bloodwork – it is important to be aware that risk factors for Hep C include past or current injection drug use, incarceration history, unregulated tattoos/piercings, exposure to contaminated blood products, or exposure within Hep C endemic countries. If the HCV antibody test is negative, no further testing is required. If the HCV antibody test is positive, refer to physician for further testing recommendations.

Item	Description – Investigations/Results
	If the patient is already known to have a current or previous Hep C infection, send an HCV RNA level (viral load) test instead of HCV antibody. Hep C is a reportable communicable disease and positive results require the completion of an 'Enhanced Hepatitis B and C – Investigation' form and contact tracing – notify RCDC. Please refer to the *Communicable Disease Manual*. **Consult with physician as soon as positive HCV antibody result is received as this will impact management during pregnancy.** Pregnant patients with confirmed Hep C infection should receive counseling on prevention of Hep C virus transmission to sexual partners and household contacts. There is an increased risk of intrahepatic cholestasis of pregnancy and patients should be screened for symptoms of this at each antenatal visit.
Rubella Serological Testing	Clients are considered immune (protected) against Rubella if they have one of the following: • Documentation of two MMR vaccinations received after one year of age and given a minimum of 4 weeks apart (Nunavummiut have been routinely vaccinated with MMR since 1996/97). Or • A previous reactive rubella serology result in a client who has not been immunized. Clients who meet **one or both** of these criteria do not require serological testing during pregnancy. Clients who do not meet one or both of these criteria require serological testing with the initial prenatal blood work. A result of Non-reactive or Equivocal (Eq) means the client is susceptible to rubella – a result of Reactive means they are not. Clients who have received two documented MMR vaccinations, who are inadvertently tested during pregnancy, are still considered immune regardless of the result and no revaccination is necessary postpartum. All rubella-susceptible pregnant clients should be counselled to avoid exposures and should be immunized with MMR vaccine ASAP **after pregnancy** in accordance with the *Nunavut Immunization Guide*. Rubella-susceptible clients who receive Rh Immunoglobulin (RhIg) during their pregnancy or early postpartum period should be advised to wait 3 months prior to getting MMR vaccination. Rubella-susceptible clients who receive a blood transfusion during their pregnancy or early postpartum period should be advised to wait 5 months prior to getting MMR vaccination. Rubella infection in pregnancy may give rise to *Congenital Rubella Syndrome* (CRS). This condition can result in spontaneous abortion, stillbirth and fetal malformations, including congenital heart disease, cataracts, deafness and mental retardation. The rubella vaccine alone and in combination is a live vaccine and therefore is generally contraindicated during pregnancy. It may be considered during outbreaks of rubella and measles, where the benefit outweighs the risks for rubella-susceptible clients. Consult with RCDC during an outbreak situation.

Item	Description – Investigations/Results
	For more information see SOGC Guidelines: *Rubella in Pregnancy, 2018* and *Immunization in Pregnancy, 2018*
Varicella IgG	Clients are considered immune (protected) against Varicella if they have one of the following: • Documented two dose varicella vaccination; • Documented record of immunity from previous testing; • Reported having chickenpox prior to 2002 (when vaccination started in Nunavut). If a client is determined to be not immune by above criteria or if her history of chickenpox or immunization status is uncertain, a varicella titre (IgG) should be included with the initial prenatal blood work. All varicella-susceptible pregnant clients should be counselled to avoid exposures and to be immunized with Varicella vaccine ASAP after pregnancy in accordance with the *Nunavut Immunization Guide*. Varicella-susceptible clients who receive RhIg during their pregnancy or early postpartum period should be advised to wait 3 months prior to getting Varicella vaccination. In addition, varicella-susceptible clients who receive a blood transfusion during their pregnancy or early postpartum period should be advised to wait 5 months prior to getting Varicella vaccination. Varicella infection in pregnancy can cause *Congenital Varicella Syndrome* and possibly congenital malformations or deformations. Maternal infection just prior to or during labour and birth can seriously affect a newborn, who may develop fulminant (serious and fast developing) neonatal varicella infection. For more information see SOGC guidelines: *Management of Varicella Infection (Chickenpox) in Pregnancy, 2018.* and *Immunization in Pregnancy, 2018.* Varicella vaccine is a live- attenuated virus vaccine and should not be given during pregnancy. Consult with RCDC in the event of a possible exposure to varicella in a pregnant client with unknown immune status.
Hemoglobin	Screening is recommended in early pregnancy (at the first appointment) and at 24-28 & 36-37 weeks when other blood screening tests are performed. If Hgb is low (<110 g/L), follow with therapy (iron supplements), diet counselling and closer monitoring. Treatment should continue for at least 3 months after the hemoglobin level normalizes until 6 weeks postpartum. See the *Nunavut Food Guide* on the Department of Health website for diet recommendations. Consider a referral to a dietician.
Ferritin	Screening is recommended in early pregnancy (at the first appointment) and at 24-28 & 36-37 weeks when other blood screening tests are performed. Ferritin < 50 ug/L is diagnostic for iron deficiency while a ferritin <20 ug/L is considered to indicate severe iron deficiency. Follow with therapy (oral iron supplements), diet counselling and closer monitoring. See the *Nunavut Food Guide* on the Department of Health website for diet recommendations. Consider a referral to a dietician.
HbA1c	**At initial prenatal visit in first trimester screen for GDM only if high risk - defined as 1 or more of**:

Item	Description – Investigations/Results
(First Trimester Screening DM/GDM If HR)	• maternal age >35 years • obesity (pre-pregnancy body mass index >30 kg/m2), • ethnicity (First Nations, African, Asian, Hispanic, South Asian), • family history of diabetes, • polycystic ovary syndrome, • acanthosis nigricans, • systemic corticosteroid use, • previous pregnancy with GDM, or • previous macrosomic infant (>4,000 gms) • History of prediabetes (impaired glucose tolerance, impaired fasting glucose or HbA1c 6.0-6.4%) **Note 1:** HbA1c used to screen clients at HR of DM/GDM in first trimester in Kivalliq and Qikiqtaaluk Regions. **Note 2:** in Kitikmeot use 75 Gm oral glucose tolerance test (OGTT) during first trimester if HR of DM/GDM as per consultants at Stanton Hospital. **Results HbA1c in first trimester** HbA1c ≥6.5%– client has diabetes and a referral to a physician is required. Use this level for referral only in the first trimester of pregnancy – different results are used when HbA1c testing for GDM takes place at 24-28 weeks. For more information see *Diabetes and Pregnancy, 2018*.
Toxo IgG IgM	All pregnant clients are screened for toxoplasmosis at the initial visit and subsequently as indicated. Follow guidelines from Department of Health. To be inserted when available.
Urine C & S	Collect a Urine C&S at the first prenatal visit. Record date and result. This test screens for asymptomatic bacteriuria which is a risk factor for preterm birth and pyelonephritis and should be treated with 10-14 days of antibiotics. If the culture grows Group B Strep bacteria, consider the client **GBS positive**. **It is best to collect urine for C&S at end of visit and the sample for Gonorrhea and Chlamydia (G&C, see below) at the beginning of the visit.** **Instructions for pregnant client for clean-catch midstream urine collection for C&S (collect at end of prenatal visit):** ▪ Wash hands. ▪ Remove lid from container and set it down with the inner surface up. ▪ Clean the area around genitals (provide towelette). ▪ Urinate into toilet (holding labia apart) ▪ After the urine has flowed for several seconds, place collection container in the stream and collect about 60 mL (2 fl oz) of urine. ▪ Do not touch the rim of the container to genital area. ▪ Finish urinating into the toilet. ▪ Replace the lid on the container. ▪ Wash hands.

Item	Description – Investigations/Results
Gonorrhea / Chlamydia	Test for G&C with a urine sample at the first prenatal visit, and again at 24-28 & 36 – 37 weeks. **Indicate results.** If required, report when a test of cure is done in comments Section 14. A test of cure is recommended 3-4 weeks after the completion of treatment for G&C infections. **Instructions for pregnant client on obtaining urine sample for gonorrhea/chlamydia (collect at the beginning of the prenatal visit):** • Do not urinate for 2 hours before the test. • Wash hands • Remove lid of container and set it down with the inner surface up • Do not wipe the genital area clean before urinating. • Collect the first part of urine stream just as urination begins. • Collect about 60 mL (2 fl. oz) of urine. • Finish urinating into the toilet. • Replace the lid on the container. • Wash hands.
GDM Screen for all Clients	**At 24 to 28 weeks –** screen all pregnant clients with a 50 Gm 1 hr GCT Further management depends on the results of the 1 hr 50 Gm GCT: • 1hPG < 7.8 mmol/L – normal, no further testing. • 1hPG 7.8 - 11.0 mmol/L – perform a 2 Hr 75 Gm OGTT. • 1hPG ≥ 11.1 mmol/L – diagnose GDM – refer to physician – no need to do OGTT. **2 Hr 75 Gm OGTT at 24-28 weeks** Perform following an intermediate result from GCT screen. Clients should fast for 8 hours prior to testing, not smoke before the test and stay seated/rest during test. **Interpretation of 2 hr 75 Gm OGTT results:** If **one** or more of the following occur diagnose the client with GDM and refer to a physician: • Fasting plasma glucose ≥ 5.3mmol/L • 1 hour plasma glucose ≥ 10.6 mmol/L • 2 hour plasma glucose ≥ 9.0 mmol/L **All clients screened positive for GDM require a referral to a physician.** For more information see *Diabetes and Pregnancy, 2018*. NB: If the client is not able to, refuses, or avoids, the 50 Gm OCT (or 75 Gm OGTT if indicated), an HbA1c and random glucose can be sent instead. The client should be diagnosed with GDM if the HbA1c ≥5.7% or random glucose is ≥11.1 mmol/L. This alternative strategy is not as accurate as the recommended screening; however, it is preferable to having no screening for GDM at 24-28 weeks.
U/S Studies Date	A dating U/S is indicated as early as possible between >7 and ≤23 weeks estimated gestational age, particularly if client is uncertain of dates. In addition, if a client is

Item	Description – Investigations/Results
Gestational Age and Result	clinically larger than expected on abdominal and/or pelvic exam, or has a history of preterm birth, request a first or early second trimester U/S as soon as possible. A comprehensive U/S between 18-20 weeks should also be arranged. If the 18-20 week U/S results are satisfactory, there is no value to routinely performing additional U/S, and they should only be done for a specific indication. Indicate dates of U/S, the estimated gestational age, location of placenta and other results on the Record. For more information see SOGC guideline: *Determination of Gestational Age by Ultrasound, 2019.*

Section 14: Prenatal Visit Documentation

Space for documenting additional prenatal visits is provided on **Part 1A and 2A Supplementary**.

Item	Description
Date	Date of each prenatal visit.
Gestation (weeks/days)	Gestational age of the pregnancy in completed weeks/days
Fundus (cms)	The symphysis fundus height (SFH) is an abdominal measurement using a measurement tape, starting from the pubis to the top of the fundus. It is reported in centimeters. The measurement is extremely operator-dependent and, if possible, it should be performed by the same provider with consistency in the positioning of the client. The change in the fundal height from one visit to the next is the most important aspect. The fundus (top of the uterus) can be palpated just above the pubic bone around 12 wks gestation. By 16 weeks it is usually half way between the pubic bone and the umbilicus and by 20 weeks it is around the umbilicus. After 20 weeks the SFH, in cm, generally corresponds to the gestational age in weeks; if there is a difference > 3 cm between gestational age and the SFH, consult with a physician.
Weight	Weight in kilograms. Consistency should be attempted using the same scales and removing excessively heavy clothing and shoes. A healthy amount of weight gain during pregnancy depends upon pre-pregnancy BMI. Underweight clients should gain more weight than those who are overweight. Clients who are obese before pregnancy (BMI >30) have better obstetrical outcomes if they gain less weight during pregnancy. For more information see SOGC Guideline

<table>
<tr><th>Item</th><th>Description</th></tr>
<tr><td></td><td>Pregnancy and Maternal Obesity Part 1: Pre-conception and Prenatal Care, 2019.

Table 2: Weight gain in singleton pregnancies

The following table shows the rate and total weight gain recommended for singleton pregnancies based on a woman's pre-pregnancy BMI (adapted from: IOM, 2009).
<table><tr><th rowspan="2">Pre-pregnancy BMI</th><th colspan="2">Mean[a] rate of weight gain in the 2nd and 3rd trimester</th><th colspan="2">Recommended total weight gain[b]</th></tr><tr><td>kg/week</td><td>lb/week</td><td>kg</td><td>lbs</td></tr><tr><td>BMI < 18.5</td><td>0.5</td><td>1.0</td><td>12.5 - 18</td><td>28 - 40</td></tr><tr><td>BMI 18.5 - 24.9</td><td>0.4</td><td>1.0</td><td>11.5 - 16</td><td>25 - 35</td></tr><tr><td>BMI 25.0 - 29.9</td><td>0.3</td><td>0.6</td><td>7 - 11.5</td><td>15 - 25</td></tr><tr><td>BMI ≥ 30.0[c]</td><td>0.2</td><td>0.5</td><td>5 - 9</td><td>11 - 20</td></tr></table></td></tr>
<tr><td>Blood Pressure</td><td>Should be measured in a sitting position with the arm at the level of the heart. An appropriately sized cuff should be used and an automated BP machine is preferred, if available. The Korotkoff V sound should be used for the diastolic pressure. Blood pressure tends to fall in a normal pregnancy, reaching its lowest point around the 18th week, and slowly rising back to the prepregnant level in the third trimester.

Hypertension in pregnancy is defined as a measurement of at least two readings taken 15 minutes apart in the same arm of a systolic pressure > 140 mmHg or a diastolic pressure > 90 mmHg. This scenario requires additional evaluation and referral to a physician. In addition, an elevation of BP >20/>10 from baseline needs closer monitoring, symptom review and consultation with a physician even if it remains <140/<90.

Proteinuria testing by dipstick is essential when hypertension is diagnosed and at every subsequent visit. A finding of greater than or equal to 1+ for protein in a hypertensive client requires referral to physician.

For more information see SOGC guideline Hypertensive Disorders of Pregnancy: Diagnosis, Prediction, Prevention, and Management, 2022.</td></tr>
<tr><td>FHR</td><td>First attempt to auscultate for a fetal heart rate (FHR) around 11-12 weeks gestation; however reassure client if one is not heard at that time. Consult with a physician if unable to auscultate FHR by 14 weeks. Normal rate is 110-160 beats per minute.</td></tr>
<tr><td>FM</td><td>Indicate presence or absence of fetal movement (FM) with +/-.

Primiparous clients perceive fetal movements regularly after ~ 20 weeks gestation and multiparous clients after ~ 18 weeks. Once a client starts feeling fetal movements, they should continue to feel them. Normal counts are at least 6 movements in a 2 hour period. Advise to contact Health Centre if baby is moving less frequently.</td></tr>
<tr><td>Pres.</td><td>Presentation of the baby, if known. Fetal presentation can be palpable by 24-28 weeks. Indicate 'Ceph' for Cephalic (head down), 'Br' For Breech (bum down) and Tr for Transverse (shoulder or back down). By 34 weeks gestation the vast majority of fetuses are cephalic. If a presentation is not cephalic by 35-36 weeks, refer to a physician.</td></tr>
</table>

Item	Description
Comments	Note brief, relevant information only. If additional risk factors are identified at a visit add to Summary of Risk Factor section with date. If required, detailed notes should be completed on Progress Notes in chronological order. If Progress Notes are used to document assessment, plan and interventions during pregnancy **they should be included in the prenatal chart.**
Next Visit	Next planned prenatal visit in # of weeks/52 (i.e. 4/52 for one month).
Initial	Initials of Care provider.
Sign and initial the Signature Sheet on the patient's prenatal chart.	

Section 15: Second and Third Trimester Topics Discussed

Item	Description
Preterm Labour	Regular uterine contractions accompanied by progressive cervical dilation and/or effacement at less than 37+0 weeks gestation. Advise client to call Health Centre if they have the following symptoms of preterm labour: ▪ **Regular contractions for an hour.** This means about 6 or more within 1 hour, even after they have had a glass of water and are resting. ▪ **Leaking or gushing of fluid** from vagina. They may notice that it is pink or reddish. This is called a rupture of membranes, also known as water breaking. ▪ **Pain** that feels like menstrual cramps, with or without diarrhea. ▪ **A feeling of pressure** in their pelvis or lower belly. ▪ **A dull ache** in their lower back, pelvic area, lower belly, or thighs that doesn't go away. ▪ **Not feeling well,** including having a fever they can't explain and being overly tired. Their belly may hurt when they press on it.
Vitamin D	Stress the importance of continuing to take Vitamin D and Prenatal Vitamins during the second and third trimester.
Birth plan	Discuss and note client plan for childbirth. These plans must include identification of care for other children by a responsible adult. In some circumstances, resources may be sought from the Inuit Child First Initiative to assist in care for children. If using the Child First Initiative, it is beneficial to initiate the application as soon as possible to ensure no delay in transfer for delivery. Plans for care of other children during confinement, particularly OOT, should be noted in Section 15 a.
Symptoms of Preeclampsia	**Symptoms of preeclampsia, in addition to hypertension (plus or minus proteinuria):** • sudden swelling of the face, hands or feet • rapid weight gain - more than 1 kg (2 lb) a week or 3 kg (6 lb) a month. • severe headache not responding to usual treatment • vision problems, such as blurring or flashing • right upper quadrant or epigastric pain • chest pain • neurological deficits • reduced urination • problems breathing • vomiting.

Item	Description
Pain Management	Identify options for pain management at intended birthplace.
Contraception	Discuss and note client plans for family planning in the postpartum period. If a tubal ligation is requested arrangements can be made during pregnancy for tubal ligation in postpartum.
Caesarean/VBAC	Refer to provider at intended birthplace for discussion if required.
Fetal Movement	Advise client to be aware of fetal movements. If they are concerned by the lack of movement, they should have something to eat or drink and then sit down. They can then place they hands on their abdomen, pay close attention, and count how many times their baby moves in 2 hours. Their baby should have at least six movements (kicks, flutters, rolls) in 2 hours. **If they do not feel 6 movements during the 2-hour period**, they should call the Health Centre before going in to see why their baby is moving less than usual.
Newborn Hep B	The *Nunavut Immunization Schedule* recommends that Hepatitis B be offered to all newborns at birth.
Newborn Vit K	Discuss the administration of Vitamin K to newborns after birth. The *Canadian Pediatric Society* recommends a routine Vitamin K injection for all newborns shortly after birth. This is done prophylactically to prevent Hemorrhagic Disease of the Newborn (HDNB).
Edinburgh Perinatal Depression Scale	Edinburgh Perinatal Depression Scale is available on Part 2B to screen for depression. Provider can ask pregnant client the 10 questions on the EPDS and refer client who score is 14 or above to mental health services as appropriate. **If a client reports thoughts of self-harm they should be referred to mental health services immediately.**
PROM	Symptoms of Premature Rupture of Membranes (PROM) include both a sudden gush of fluid and a slow leak. Pregnant client should be advised to contact the Health Centre immediately if they feel their membranes have ruptured.
Newborn screening	Discuss newborn metabolic screening (for 22 rare but treatable disorders) tested by way of heel prick bloodspot card. Infants must be 24 hours old at the time of test; this means that infants who are discharged early may need to be tested in their home community.
Infant Safe Sleep	Discuss safe sleep practices for newborns. • Always put baby on their back to sleep. • Share a room but not a bed with baby. • Baby should have their own safe sleep surface – could be a drawer or a box with a thin folded blanket in the bottom. Tape blanket down so it can't cover baby's face. • Avoid loose bedding and other objects on safe sleep surface – baby should wear a sleep sack rather than use blankets. • Breastfeed. • Give baby a smoke-free environment during pregnancy and after birth – everyone should smoke outside the home.
Breastfeeding	Discuss client's knowledge and experience with breastfeeding. Three questions can be used to initiate discussion: • *What do you know about breastfeeding?*

Item	Description
	• *What have you heard about breastfeeding?* • *How do you feel about breastfeeding?* Breastfeeding is the normal and unequalled method of feeding infants. Health Canada recommends breastfeeding – exclusively for the first six months and sustained for up to two years or longer, with appropriate complementary feeding – for the nutrition, immunologic protection, growth, and development of infants and toddlers. *Breastfeeding Your Baby* is a booklet on the benefits of breastfeeding from the Dept. of Health and a copy may be obtained from the CHR. Reinforce practices which increase breastfeeding success (See "Breastfeeding Basics" booklet for further information): • Early initiation (breastfeed within the first hour after birth) • Skin to skin contact • Frequent cue-based feedings • No supplements or soothers given to babies, unless medically indicated • 24-hour rooming-in while in hospital • Access assistance with care of other children and household.
Car Seat	When placing newborn in a car, advise client to use a rear-facing car seat that reclines and faces the rear for an infant. It is safest for infants to remain in a rear-facing infant seat until they are at least one year of age and weigh 9 Kg (20 lbs). Place car seat in the back of the care and ideally in the centre seat position.
Plans for Child Care During Confinement	Document client's plans for child care during their confinement in this section; identify responsible adult and where child(ren) will stay during confinement, particularly OOT.

Section 16: Referrals, follow-up

Based on the result of the investigations above indicate who the client was referred to (other care provider, etc.) and the date of the referral. Additional comments on the referral can be noted in comments, Section 14. If client has decided on adoption, indicate if a plan is in place.

Section 17: Summary of Risk factors

Provides an overview of risk factors building on the ones identified at the initial prenatal visit from 1B; this section should provide an overview of the risk factors the client is dealing with as she comes into the third trimester which may impact on the remainder of the pregnancy and childbirth. Additional risk factors should be added as they are identified after the initial visit, with date.

Nunavut Prenatal Record Part 1A and 2A Supplementary

Provides space to chart additional pregnancies and prenatal visits. If additional space is required, use Progress Note and include in Prenatal Chart.

Nunavut Prenatal Record Part 3

Indicates the key blood, swabs/cultures and other tasks during pregnancy; health care provider who completes each task should initial in appropriate box and sign signature sheet on chart. This list is not complete as some clients may need additional tests/investigations based on their results. These investigations can be divided into routine for all pregnant clients and those which are for particular clients based on their risk factors. See summary table of investigations below.

Summary of Investigations by Trimester

<table>
<tr><th colspan="4">Initial Investigations at First Prenatal Visit</th></tr>
<tr><td colspan="2">All pregnant clients:</td><td colspan="2">Pregnant client with indications:</td></tr>
<tr><td>Initial serology:
• HBsAg
• Syphilis
• HIV
• Hep C
• CBC/Hgb
• Ferritin
• Antibody Screen
• Toxo screen</td><td>Initial cultures:
• Urine C&S
• Gonorrhea (urine PCR)
• Chlamydia (urine PCR)</td><td>Initial serology:
• TSH if indicated
• Screen for GDM with HbA1c if HR
• Varicella IgG if indicated
• Rubella testing if indicated</td><td>Initial other:
Pap if due and <10 weeks (if due and ≥10 weeks consult physician)
Initial culture:
• BV if Sx and/or Hx of PROM/PTL</td></tr>
<tr><th colspan="4">Investigations at 24 to 28 weeks</th></tr>
<tr><td colspan="2">All pregnant clients:</td><td colspan="2">Pregnant client with indications:</td></tr>
<tr><td>24-28 weeks serology:
• Antibody Screen
• Syphilis
• CBC/Hgb
• Ferritin
• GDM Screen
• Toxo screen</td><td>24-28 weeks culture:
• Gonorrhea (urine PCR)
• Chlamydia (urine PCR)</td><td>24-28 weeks serology:
HIV if HR</td><td></td></tr>
<tr><th colspan="4">Investigations at 36 to 37 weeks (may be done at place of birth)</th></tr>
<tr><td colspan="2">All pregnant clients:</td><td colspan="2">Pregnant client with indications:</td></tr>
<tr><td>35-37 weeks serology:
• Syphilis
• CBC/Hgb
• Ferritin</td><td>35-37 weeks culture:
• Gonorrhea (urine PCR)
• Chlamydia (urine PCR)</td><td></td><td>35-37 weeks culture:
Swab for GBS if not previously identified in urine</td></tr>
</table>

Nunavut Prenatal Record Part 4

Provides a description of risk factors for preeclampsia which can be identified early in pregnancy and symptoms of preeclampsia to be aware of. In addition, provides criteria for first trimester screening for DM/GDM.

Signature Sheet

Name, signature and initial of each health care provider charting on the Prenatal Record.

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