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Department of Health
Munaqhiliqiyitkut
Ministère de la Santé

Guidelines for Completing Prenatal Record

Introduction

The Nunavut Prenatal Record supports the assessment and documentation of information about a pregnant woman'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 as soon as possible after confirmation of pregnancy.

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 and BMI table as well as *Health Risk Classification According to BMI*
Part 2B – Edinburgh Perinatal Depression Scale and TWEAK Questionnaire/Scoring Guide
Part 3 - Flow sheet for blood work, cultures and other recommendations for care.

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

- First Nations and Inuit Health Branch (FNIHB) Clinical Practice Guidelines (adult, Chapter 12 Obstetrics);
- *Anti-infective Guidelines for Community-acquired Infections*, 2013 Edition;
- Lexicomp on-line *Username:* nunavut15 *Password:* province;
- *Drugs in Pregnancy and Lactation: A Reference Guide to Fetal and Neonatal Risk*, published every 3 years;
- *Therapeutic Choices;*
- *Government of Nunavut Drug Formulary, 2015-2016;*
- *Communicable Diseases Manual* of the Department of Health;
- *Community Health Nursing Standards and Protocols* of the Department of Health;
- *Community Health Nursing Administration Manual* of the Department of Health.

Circulation of Prenatal Record

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 once the estimated date of birth is confirmed and the initial laboratory investigations are complete. It is expected that, in most cases, this will be done by **twenty weeks** gestation.

Page 2A should be **copied** and sent to the Labour and Delivery Suite of the Hospital or Birthing Centre where the patient intends to deliver by **thirty-six weeks** when the bulk of subsequent visits and additional laboratory investigations are completed. If a significant risk factor is identified then page 2A should be copied and sent whenever the significant risk factor is identified.

Nunavut Prenatal Record Part 1A

Section 1: Demographic and Background Information

Item	Description
Ethnic origin	Ethnic or cultural identity as provided by the woman. 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 woman. 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. If woman is unemployed or on welfare will have an impact on the resources available to care for herself and her family.
Education	Maternal education may be relevant in terms of understanding written material.
# of children at home	Provides an indication of current parenting responsibilities.
Partner's name - optional	Full name of partner – this is optional as the woman 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 woman – optional for reasons as above.
Partner's occupation	The partner's occupation may be relevant, for example when they frequently work out of town – optional as above
Living arrangements	Indicate who the woman is living with as they are likely to be her primary source of support throughout her pregnancy. Problems with living arrangement 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 woman 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 woman 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 the Health Centre. Current medications may also interact with those prescribed during the pregnancy. Consult with an MD/RM 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***.

Item	Description
Gravida	The total number of pregnancies regardless of gestational age, type, time or method of termination/outcome (includes current pregnancy). Multiple pregnancies are counted as one pregnancy. A 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 gestation.
Preterm	The total number of previous pregnancies with birth occurring between 20 and 36+6 weeks gestation.
Abortion	The total number of previous spontaneous terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 grams. Ectopic pregnancies, miscarriages, blighted ova and hydatiform moles are classified as spontaneous abortions. The total number of induced terminations of pregnancies is also captured in this section.
Living	The total number of children the woman has given birth to and who are currently alive.
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, postpartum hemorrhage), sex of the baby, birth weight, if child was breastfed and present health status. **Given that it can be difficult for a woman to remember details of a pregnancy from several years ago this information should be confirmed by a chart review.**

Section 4: Menstrual History and EDD

This section focuses on information used to determine the Estimated Date of Delivery (EDD). Accurate dating is crucial as many decisions made in pregnancy depend on correct dating (i.e. timing of laboratory testing, ultrasounds and postdates medical management).

Item	Description
LMP	Document the date of the **first day** of the woman's last menstrual period.
Certain	Indicate whether the woman is certain or not of her LMP date. She should be certain that it was the first day, that the bleeding came when it was expected and was normal in amount and duration.
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) by dates	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 woman's normal cycle is shorter or longer than 28 days, appropriate adjustments need to be made (i.e. #of days less than 28 – subtract days from EDD, # of days greater than 28 – add days to EDD).

Item	Description
Confirmed EDD based on U/S	The SOGC guidelines indicate that EDD should be based on the first available ultrasound after 7 weeks or before 23 weeks. Refer to the SOGC guidelines (Tab 1.) to clarify issues on dates. This means that LMP should be used to determine the EDD only if an ultrasound is not done before 23 weeks. Let mother know that once the 18-20 week ultrasound is done, a revised and final EDD will be calculated. Relevant statements from the SOGC on confirming EDD include: • When performed with quality and precision, ultrasound alone is more accurate than a "certain" menstrual date for determining gestational age in the first and second trimesters (≤ 23 weeks) in spontaneous conceptions, and it is the best method for estimating the delivery date. • In the absence of better assessment of gestational age, routine ultrasound in the first or second trimester reduces inductions for post-term pregnancies. With few exceptions, once the EDD is finalized, it **should not be altered**. The only exceptions should be when a review of the dating criteria reveals a miscalculation. **Mother should be informed of her confirmed EDD when it is available.**

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.
Nausea	Presence of nausea and/or vomiting. Specify if nausea and vomiting are a concern for the woman. For more information see the SOGC guideline on the management of nausea and vomiting in pregnancy (Tab 2.)
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 the Prenatal Record comments, Section 14, regarding these plans.
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 medical conditions which have occurred in the families of either the pregnant woman or the baby's father.
Family history of inherited diseases/defects	Indicate history of genetic/inherited disorders, including congenital anomalies which have occurred in the families of either the woman or the baby's father. These can include congenital heart disease, cleft lip and/or palate, Down Syndrome, congenital hip dysplasia or open neural tube defects.
Twins	Indicate if twins or higher order multiples have occurred in the families of either the woman or the baby's father.
SIDS	Indicate if an infant has died of SIDS in the immediate families of the woman or the baby's father.
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 woman 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.

Item	Description
Surgery/Anesthesia	All previous surgical procedures, including breast surgeries. If a caesarean section, therapeutic abortion or D&C has been mentioned under the Obstetrical History section there is no need to repeat it here. Significant complications from anesthetics can include metabolic disorders such as malignant hyperthermia and pseudocholinesterase deficiency, difficult intubations and/or severe postoperative vomiting.
Blood transfusion	Include any previous blood transfusions and outcomes.
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.
Current TB	Include active or latent TB infection as well as known recent TB contacts. Women can receive Tuberculin Skin Testing (TST) in pregnancy if needed for any reason (i.e. contact tracing). If a woman 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, abnormal Pap tests which required treatment or further observation.

Item	Description
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 request for Syphilis in initial serology 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. A history of recurrent genital herpes should prompt inspection at the time of labour for asymptomatic lesions. Caesarean birth may be recommended if the risk of transmission is great. A pregnant woman with a history of genital herpes infection should receive prophylactic antiviral treatment starting at 36 weeks gestation and continue until birth. This will reduce the likelihood of an outbreak at the time of birth. Consult with the physician for drug and dose of choice.
Susceptible to Chickenpox (varicella)	Women considered immune/protected/non-susceptible to varicella disease include: • Women with a history of chickenpox or herpes zoster. • Women who have received a healthcare practitioner diagnosis of chickenpox or herpes zoster. • Women who have been fully immunized with two doses of Varicella vaccine, 6 weeks apart. • Women who have documented serological testing indicating protection from varicella (Varicella IgG positive) All other women are considered **susceptible** to chickenpox/varicella and should have serological testing with their initial pregnancy blood work (see Varicella under Part 2A Investigations/results) and if required, postpartum immunization.
Susceptible to toxoplasmosis	Has a cat with a litterbox at home and has been cleaning litter since pregnancy. Beluga whale meat should be cooked during pregnancy to reduce the risk of transmission of toxoplasmosis. If susceptible should be tested with other bloodwork.
Thromboembolic/ coag	History of previous problems with varicose veins, deep vein thrombosis, pulmonary embolism or coagulation disorder.
Hypertension/cardiac disease	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. Important to check anti-hypertensive medication as some may be teratogenic.
GI	History of gastrointestinal disease (e.g. Crohn's disease, irritable bowel syndrome, chronic liver disease, chronic constipation).
Urinary/Renal	History of chronic renal disorders (e.g. recurrent UTIs, pyelonephritis or

Item	Description
	polycystic kidney disease).
Endocrine/Diabetes	History of endocrine disorders (e.g. diabetes or adrenal conditions). Requires a referral to physician at first visit.
Thyroid	History of hyper or hypothyroidism. Will need to include TSH on prenatal bloodwork and review frequency and results of further TSH testing during pregnancy with MD/RM.
Neurologic/Seizure	History of significant neurological disorder (e.g. epilepsy or multiple sclerosis).
Hx of Mental Illness	Past or current history of mental illness. Indicate if history of anxiety, depression/postpartum depression and/or other condition(s) and specify. These can include eating disorders, substance abuse disorders as well as psychotic illnesses. All may be exacerbated in pregnancy and medication dosages may need to be altered. Particular attention should be paid to history of postpartum depression.
Other	**Other medical conditions** (i.e. blood dyscrasias, hepatitis B or C, rheumatoid arthritis, systemic lupus).

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 woman 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 woman's diet includes all four food groups as well as her access to country foods (high in iron). 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 she is taking folic acid and provide prenatal vitamins. Stress importance of Vitamin D in a northern location. Provide Vitamin D for duration of pregnancy It is recommended that pregnant women take a prenatal vitamin every day. This ensures that the proper vitamins and minerals are available to the growing fetus. If women cannot tolerate the increased dose of iron in the prenatal vitamins, a regular women's supplement should be recommended. Taking folic acid supplements or a prenatal vitamin containing folic acid for three months before conceiving and/or in early pregnancy lowers the risk of some birth defects. For women who are high risk for birth defects a higher dosage of folic acid (5mg) may be recommended for 3 months preconception and until 12 weeks gestation. For more information on pre-conceptional Folic Acid see the SOGC Guideline (Tab 3.)

Alcohol, Substance and Tobacco Use

Problematic use of alcohol by women in their 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 growth restriction, fetal alcohol spectrum disorder and neonatal behavioural abnormalities.

Refer to the SOGC guideline *Alcohol Use and Pregnancy: Consensus Clinical Guidelines (2010).* (Tab 4).

- ***Alcohol Use***

Each encounter is an opportunity to Assess, Advise and Assist. Refer to addiction services as appropriate. One drink is defined as: beer (12 oz), wine (5 oz) or hard liquor (1.5 oz).

Item	Description
Alcohol use	Has the woman 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?*
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 woman a binge drinking episode is 4 or more drinks in about 2 hrs. Sample question: *When was the last time you had 4 or more drinks on one occasion?*
TWEAK Score	Document the TWEAK score **if woman is drinking**. Refer to Part 2B for TWEAK questions and scoring.

- ***Marijuana and Other Substance Use***

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

Just as with alcohol, there is no safe level of illegal drug consumption during pregnancy. Marijuana and other substance use during pregnancy may result in spontaneous abortion, premature labour, low birth weight infants, placental abruptions and fetal death. Marijuana use has, in some populations, become normalized; therefore it is important to enquire specifically about the use of this drug. Refer to addiction services as appropriate.

Item	Description
Marijuana Use No/Yes	Indicate 'yes' or 'no' for marijuana use **in pregnancy**.
Other Substance Use No / Yes Specify?	Indicate if there has been any other illegal substance use during pregnancy (i.e. cocaine, heroin). Document specific type(s) of substances used.

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

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

It is strongly advised that women quit smoking or chewing tobacco for the duration of the pregnancy. If she can't quit then she should be encouraged to cut down on her tobacco use. Helping mothers to deal with the stressors in her life may help her quit/reduce smoking. Refer to the SOGC Guideline for strategies to assist women to stop smoking and using other harmful substances in pregnancy (Tab 5.).

Second-hand smoke has been labelled carcinogenic and there is no known safe level of exposure. 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 women finding it difficult to quit on their own, nicotine replacement therapy (NRT), such as the patch, gum, lozenge, inhaler, should be used to reduce and eliminate tobacco consumption. While NRT use during pregnancy is considered off label, however it is considered best practice.

Item	Description
Smoking Never/Quit	Indicate if the woman has never smoked or indicate the date she quit if she is 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 woman is currently exposed to second hand tobacco smoke and discuss strategies to create smoke free home for herself and her newborn as well as her other children.

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

A woman's responses to these questions indicate the support she has in her life and the stresses she is living with. Both of these will impact on her adaptation to pregnancy and caring for a newborn; this assessment provides the opportunity to refer her to resources as required.

Item	Description
Financial	Enquire about financial concerns and refer to social services if this is a concern to stabilize situation before baby is born.
Housing	Enquire about stability of housing. Sample questions: *Who do you live with? How long have you lived there? Is housing a problem for you?*

Item	Description
Support System	Discuss 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 screen all pregnant women for intimate partner violence. This screening should occur at the initial prenatal appointment and at various times over the course of the pregnancy because some women do not disclose abuse the first time they are asked and abuse may begin later in pregnancy. The following introductory script is helpful to begin the discussion: *Because violence is so common in many women's lives and because there is help available for women, I now ask every client about domestic violence.* For more information see the SOGC Consensus Statement on Intimate Partner Violence (Tab 6.).

Section 9: Initial Physical Examination

Completing a full 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.
Height	Document the height of the woman in cms.
Pre-Pregnant Wt	Document the weight of the woman 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.
Pre-Pregnant BMI	Calculate and document the pre-pregnant BMI using the BMI calculator in Part 1B. Obesity or a BMI 30 and over has significant maternal and perinatal health risks which may influence place of birth. Some of these risks include: gestational diabetes, hypertension, anesthetic risks, placental dysfunction and risk for caesarean birth. If the BMI is greater than or equal to 30, a referral needs to be made to an MD or RM.
Results of Physical Exam	Document results of the initial physical examination under headings: head and neck, dental, breasts and nipples, heart and lungs, abdomen, musculoskeletal, varicosities and skin, pelvic exam (prn). A Pap test only needs to be done if the woman is 'due' for one under current guidelines; if a Pap is not required the pelvic exam may not be necessary. If there are no abnormalities detected, indicate NAD. Other comments can be written in the space provided or in the Progress Notes.

Section 10: First Trimester Topics Discussed

Indicate with a check if the topics were discussed.

Item	Description
Prenatal Bloodwork	Provide woman with an explanation of the tests which form part of routine prenatal bloodwork. Verbal consent should be given for all bloodwork including HIV; a separate consent for this test is not required. Blood tests give important

Item	Description
	information about the woman'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. For more information see the SOGC Guideline on comprehensive ultrasounds (Tab 7.).
Prenatal Genetic Screening	Discuss the role of Prenatal Genetic screening. Maternal Serum Screening (MSS) should be discussed with all pregnant women. For more information on Maternal Serum Screening for providers see the Ontario Guidelines (Tab 8.) Also see Maternal Serum Screening under Section 13 for more details on testing.
Physical Activity/ Rest	It is important that active pregnant women stay active and non-active women 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 (Tab 9).
Dental Care	Discuss the importance of taking care of teeth and gums during pregnancy. Encourage women to brush their teeth twice a day with a fluoride toothpaste and floss gently once a day. Pregnant women with periodontal disease may have a higher risk of delivering a premature or low birth weight baby. Encourage women 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. Women 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.
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 women: • Practice good personal hygiene (frequent hand washing). • Consume only store-bought meats, fish, poultry (including eggs) that are fully cooked. **NB: Country food can be safely eaten raw with the exception of beluga whale meat which may contain toxoplasmosis**. • 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.
Flu Vaccine	Discuss the benefits of the flu vaccine during flu season. The Canadian Immunization Guide recommends that all pregnant women receive inactivated influenza (flu) vaccine during flu season. The vaccine is safe to receive at any point in the pregnancy. Women who do not receive influenza vaccination during pregnancy should receive influenza vaccine postpartum ASAP if the birth occurs

Item	Description
	during influenza season.
Sexual Relations	Discuss sexual relations/sexuality during pregnancy. Surveys show that up to half of all women have concerns about their sexual health; however, many are too embarrassed or uneasy to bring the subject up with their health care providers.
Seat Belt Use	Discuss correct seat belt use during pregnancy.
Plans to Breastfeed Yes / No / Undecided	Indicate the woman's plans regarding breastfeeding. Address any questions she may have and review the booklet *Breastfeeding Your Baby* which is available on the Department of Health website and in each Health Centre.

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 women need closer monitoring and additional supports. Past obstetrical history is crucial because these risks may occur again in the current pregnancy. Problems in the current pregnancy should be identified in the Risk Factor Summary so they are not missed. Given that it may be difficult for the mother 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 women and in helping to allay concerns about confidentiality and any perceived stigma associated with testing. Women 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 woman plans to give birth.
Age at EDD	Indicate the age the woman will be at EDD.
Confirmed EDD	Transfer the **Confirmed EDD** from Part 1A of the Record. Indicate if based on dates or U/S results.

Section 13: Investigation/Results

Item	Description
ABO **Rh Factor** **Antibody Titre** **Results**	ABO, Rh Factor and red blood cell antibody screening is performed with the initial prenatal blood work for **all** pregnant women and again at 24-28 weeks. Indicate the Blood Group and Rh Factor on the Record. Document results and consult with physician if required. For more information see SOGC *Guidelines on Prevention of Rh Alloimmunization* (Tab 10.).

Item	Description
RhIg Given	Document date(s) Rh Immunoglobulin (RhIg) is given in the pregnancy, if indicated. Rh negative women should receive Rh Immunoglobulin at approximately 28 weeks gestation. Prior to administration, a repeat ABO/Rh/antibody screen should be collected to exclude sensitization. Consult with a physician about giving RhIg to an Rh negative woman: • Within 72 hours after birth of an Rh positive infant • After a spontaneous or induced abortion • After an ectopic pregnancy • After an amniocentesis • After an episode of antenatal bleeding • After other invasive obstetrical procedures or complications
PP Immunization	Indicate if woman requires immunization to Rubella or Varicella postpartum as this will need to be done when she returns to her home community. Note on Immunization Record.
Maternal Serum Screening	Maternal Serum Screening (MSS) should ideally be discussed with all pregnant women before 15 gestational weeks. The test itself can be done anytime between 15 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.** Review the information sheets available from the Children's Hospital of Eastern Ontario for more information on screening (Tab 11.). MSS determines a woman's risk of giving birth to a baby with Trisomy 21 (Down Syndrome), Trisomy 18 and/or neural tube defects (NTD) such as spina bifida and anencephaly. The chance of a woman having a baby with Down Syndrome or Trisomy 18 increases as she ages, with the greatest rise in risk occurring over the age of 35. The risk of having a baby with a NTD is not related to maternal age. **Indicate if screening was accepted**. If screening was not accepted indicate a reason why screening was declined in comments, Section 14 (i.e. would not change management of pregnancy). **Indicate testing results**. Testing results are reported as positive or negative. All women with positive screening results require a physician referral. Indicate if amniocentesis was performed and outcome in comments, Section 14 of the Record.
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 woman is considered **GBS positive** and prophylactic antibiotics offered in labour. While a pregnant woman is usually screened with a vaginal/rectal swab at 35-37 weeks at her place of birth, this is **not** required when a woman was identified as GBS positive earlier in pregnancy through urine testing.

Item	Description
Hep B Surface Ag Pos / Neg	All pregnant women 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. Please refer to the *Communicable Disease Manual*. A pregnant woman 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 woman may result in severe disease for the mother and chronic infection for the infant. *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.
Syphilis	All pregnant women 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 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*. A woman 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 carries a transmission risk close to 100%.
HIV Testing	All women should be screened with the initial prenatal blood work; explain test along with other bloodwork; a separate consent is not required. **Indicate results.** Refer to the *Communicable Disease Manual* for information for pregnant women on HIV testing. HIV is a reportable communicable disease and positive results require the notification of the Regional Communicable Disease Co-ordinator. For more information on HIV testing in pregnancy see the SOGC Guideline (Tab 12). **Please note a negative HIV result from the birth mother is necessary before an infant can receive BCG vaccination.**

Item	Description
Rubella	Women 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. Or • A documented rubella titre > 10 in a woman who has not been immunized. Women who meet **one or both** of these criteria do not require serological testing during pregnancy. Women who do not meet one or both of these criteria require serological testing with the initial prenatal blood work. Women who have received two document MMR vaccinations, who are inadvertently tested during pregnancy, are still considered immune and no revaccination is necessary postpartum. All rubella-susceptible pregnant women 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 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. For more information on rubella in pregnancy see the SOGC Guideline (Tab 13.).
Varicella IgG (if no history of chicken pox or previous vaccine)	Testing is based on the woman's history of chicken pox or previous vaccine. If a woman is determined to be susceptible to varicella or if her history of chickenpox or immunization status is uncertain, a varicella titre (IgG) should be included with the initial prenatal blood work. A result of Neg or Equivocal (Eq) means a woman is susceptible to varicella – a result of Pos means she is not. **Indicate titre result.** All varicella-susceptible pregnant women 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 Rh Immunoglobulin (RhIg) during their pregnancy or early postpartum period should be advised to wait 3 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.
Pertussis	In order to reduce susceptibility to pertussis, one dose of combined diphtheria, tetanus, acellular pertussis containing vaccine (Tdap) can be offered to pregnant

Item	Description
	women (≥26 weeks of gestation) who have not been previously vaccinated against pertussis in adulthood, i.e. after 18 years of age. • Immunization with Tdap to date has been shown to be safe in pregnant women 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.
Hemoglobin	Record Hgb results for the 1st and 3rd* trimesters. Screening is recommended in early pregnancy (at the first appointment) and at 24-28 weeks when other blood screening tests are performed. If low, follow with therapy (iron supplements) and closer monitoring. See the Nunavut Food Guide on the Department of Health website for diet recommendations.
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 woman **GBS positive** as above.
Gonorrhea / Chlamydia	Test for gonorrhea and chlamydia with a urine sample at the first prenatal visit, and again at 24-28 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 chlamydia and gonorrheal infections.
Pap (if due)	Document results of any Pap testing done in the pregnancy. Opportunistic screening is not recommended. Instead follow the *Nunavut Cervical Cancer Screening Guidelines* on the Department of Health website.
GDM Screening	*Gestational Diabetic Screening Recommendations for Nunavut* are as follows: 1. 50 Gm GCT in the first trimester, and if negative once per trimester, for women with **one or more risk factor** for GDM as outlined in FNIHB CPG: ○ Maternal BMI ≥ 30 kg/m^2 and/or overweight prior to pregnancy ○ Hypertension ○ Polyhydramnios ○ Repeated glycosuria (> +1) ○ Suspected fetal macrosomia ○ Maternal age ≥ 35 years ○ Women of Aboriginal, Hispanic, South Asian, Asian or African descent ○ Acanthosis nigricans ○ Corticosteroid use ○ History of GDM or glucose intolerance ○ Family history of diabetes ○ Unexplained stillbirth ○ Previous infant with congenital anomalies ○ Previous delivery of a macrosomic infant ○ Recurrent fetal loss ○ Polycystic ovarian syndrome.

Item	Description
	2. 50 Gm GCT at 24-28 weeks For all non-diabetic women. Can be performed at any time of day. Record the date and test result. **Results 50 Gm GCT**: • 1hPG=7.8-10.2 mmol/L – perform a 2 Hr 75 Gm GTT. • 1hPG ≥ 10.3 mmol/L – indicates GDM – refer to physician. • 1hPG < 7.8 mmol/L – normal – reassess every trimester if multiple risk factors present (list above). *Continued on next page.* 3. 2 Hr 75 Gm GTT – Following a positive GCT screen. Women should fast for 8 hours prior to testing, not smoke before the test and stay seated during test. **Results 75 Gm GTT** If **one** or more of the following occur the client has GDM and a referral to a physician is required: • Fasting plasma glucose ≥ 5.3mmol/L • 1 hour plasma glucose ≥ 10.6 mmol/L • 2 hour plasma glucose ≥ 8.9 mmol/L If **one** of the above criteria occurs the client has GDM. All women with GDM require a referral to a physician. Questions regarding who and when to test or the interpretation of test results should also be directed to a physician. For more information on diabetes and pregnancy see the Canadian Diabetes Association Guidelines (Tab 14.).
U/S Studies Date Gestational Age and Result	If a woman is very uncertain about her LMP, a dating U/S is indicated as early as possible between 7 and 24 weeks estimated gestational age. If a woman is clinically larger than expected on abdominal and/or pelvic exam, perform 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 ultrasounds, and they should only be done for a specific indication. Indicate dates of U/S, the estimated gestational age and results.

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)	Gestational age of the pregnancy in weeks
Fundus (cms)	The Symphysis fundus height (SFH) is an abdominal measurement starting from the pubis to the top of the fundus. It is reported in centimeters using a measuring tape. The measurement is extremely operator-dependent and, if possible, it should be performed by the same provider with consistency in the

Item	Description
	positioning of the woman. The change in the fundal height from one visit to the next is the most important aspect. Plot the measurement on the SFH graph from 20 weeks gestation. 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, contact an MD or RM.

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 women should gain more weight than overweight women. Women who are obese before pregnancy (BMI >30) have better obstetrical outcomes if they gain little or no weight during pregnancy.
Blood Pressure	Should be measured in a sitting position with the arm at the level of the heart. An appropriately sized cuff should be used. The Korotkoff V sound should be used for the diastolic pressure. Use of either a manual sphygmomanometer or calibrated automated BP machine is acceptable. Blood pressure tends to fall in a normal pregnancy, reaching its lowest point around the 18th week, and slowly rising back to the prepregnancy 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 an MD or RM.
Urine	Urine testing for glucose and protein should be performed at each prenatal visit. A finding of greater than or equal to 1+ (greater than 30 mg/dL) for protein requires referral to an MD or RM.
FHR	Fetal heart rate. First attempt to auscultate for a FHR around 11-12 weeks gestation; however reassure woman if one is not heard at that time. Consult with an MD or RM if unable to auscultate FHR by 14 weeks. Normal rate is 110-160 beats per minute.
FM	Indicate presence or absence of fetal movement with +/-. Primiparous women perceive fetal movements regularly after ~ 20 weeks gestation and multiparous women after ~ 18 weeks. Once a woman starts feeling fetal movements, she should continue to feel them. Normal counts are at least 6 movements in a 2 hour period.
Pres.	Presentation of the baby, if known. Fetal presentation can be palpable by 24-28 weeks. Indicate 'Ceph' for Cephalic (head down) and 'Br' For Breech (bum down). By 34 weeks gestation the vast majority of fetuses are cephalic. If a presentation is not cephalic by 35-36 weeks, refer to an MD or RM.
Comments	Note brief, relevant information only. 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 completed weeks gestation. Risk factors include: •History of previous preterm labour •Preterm pre-labour rupture of membranes (PPROM) •Low socioeconomic status •Multifetal pregnancy •Infection (systemic, vaginal, urinary tract, amnionitis) •Uterine anomalies •Antepartum hemorrhage •Fibroids •Retained intrauterine device •Over-distended uterus (polyhydramnios, multiple gestation) The SOGC page on preterm labour providers additional information (Tab 15.).
Vitamin D	Stress the importance of continuing to take Vitamin D during the second and third trimester.
Birth plan	Discuss and note client plan for childbirth
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.
Trial of Labour after Caesarean	Refer to provider at intended birthplace for discussion.
Newborn BCG and Hep B	The *Nunavut Immunization Schedule* recommends that BCG and Hepatitis B be offered to all newborns at birth. If the birth mother is Hepatitis B Surface Ag positive, refer to the *Nunavut Communicable Disease Manual* for more information.
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).
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. • Breastfeed. • Give baby a smoke-free environment during pregnancy and after birth. • Avoid loose bedding.
Edinburgh Perinatal Depression Scale	Edinburgh Perinatal Depression Scale is available on Part 2B to screen for depression. Provider can ask pregnant woman the 10 questions on the EPDS and refer women who score is 14 or above to mental health services as appropriate. If a woman reports thoughts of self-harm she should be referred to mental health

Item	Description
	services immediately.
Breastfeeding	Discuss woman's knowledge and experience with breastfeeding. Three questions can be used initiate discussion: • *What do you know about breastfeeding?* • *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. Offer copies of this resource and review it with her. Reinforce practices which increase breastfeeding success: • 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.
Car Seat	If she has a car, client can be advised 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 reach the maximum weight or height allowed by the car seat's manufacturer.

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 this section.

Section 17: 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 woman is dealing with as she comes into the third trimester which may impact on the remainder of the pregnancy and childbirth.

Nunavut Prenatal Record Part 1A and 2A Supplementary

Provides space to chart additional pregnancies and prenatal visits

Nunavut Prenatal Record Part 3

Indicates the key blood, swabs/cultures and other tasks during pregnancy; nurse who completes each task should initial in appropriate box and sign signature sheet on chart. This list is not complete as some women may need additional tests/investigations based on their results.