Prenatal Care Timetable

Positive Pregnancy Test		
Task/Problem	**Background**	**Plan: Rx/Counseling/ Advance Planning/Testing**

All patients see a provider for a brief prenatal history. Physical exam is performed if indicated. Use EMR template diagnosis of pregnancy.
 	
• Identify:
  ○ patients who wish to continue pregnancy
  ○ patients at risk for ectopic
  ○ patients at high risk of genetic conditions
  ○ patients with uncertain dates
 	
• Perform a physical exam if
  ○ Uncertain dates
  ○ Risk factors for ectopic
 	
• Provide Options Counseling
 	
• Assess
  ○ EDD
  ○ Risk for ectopic
  ○ Patient's plan
	Rely on LMP for EDD only if "certain."
	• No hormonal contraceptives in the 3 mo before LMP
	• Regular menses for past 3 months
	• No vaginal bleeding since last LMP
	• Firm LMP recall (within 3-5 days)
	• LMP seemed like a "normal period"
	
	Risks for ectopic
	• Prior ectopic
	• Infertility treatment
	• Prior PID
	• Bleeding since LMP
	• Pelvic pain
	
	Higher Genetic Risk
	• Over age 35
	• History of infant with genetic disease
	
	Physical findings
	• Bluish color change for cervix may be present
	• Increased discharge may be present
	• Uterine size increased:
	  ○ Egg = 5wks
	  ○ Orange = 8wks
	  ○ Grapefruit = 12w
		Patients seeking termination
		• Site specific protocol
		• Planned parenthood
		• Rx Folic Acid 1mg daily
		• See rhedi.org for resources
		• F/U 4-6wks
		
		Patients who are uncertain
		• Rx Folic Acid 1mg daily
		• F/U 2wks
		
		Patients continuing pregnancy
		• Order prenatal vitamins
		• Order prenatal labs
		• Order sonogram if indicated
		• Schedule follow-up
		
		Site-specific protocols
		<u>WB</u>
		• Schedule initial prenatal visit
		• Front desk for PCAP
		• Health educator
		• Social work – all teens and prn
		
		<u>FHC</u>
		• Prenatal coordinator
		• Social work – all teens and prn
		• F/U 2-4wks (ideally before 10 wks)

When to do a sonogram:

1. Uncertain dates
2. Viability
    a. Confirm intrauterine pregnancy (risk of ectopic)
    b. Absence of fetal heart tones at 12 weeks
3. Genetic testing (First trimester screen at 10-14 wks)
4. Size-date discrepancy of 3 or more weeks (between 20-36 wks)
5. Anatomy scan (18-21 wks)
6. Decreased fetal movement (biophysical profile)
7. Accreta scan for prior section with anterior placenta (35-37 wks)
8. Presentation

All patients with ectopic risk factors should have a sonogram ordered at diagnosis of pregnancy. If the patient with ectopic risk has bleeding, pain or adnexal tenderness or fullness, send to ER for evaluation.

If patient does not yet have insurance, refer to Montefiore radiology for sonogram.

Prenatal Care Timetable

Each Appointment		
Task/Problem	**Background**	**Plan: Rx/Counseling/Advance Planning/Testing**
Vitals Blood pressure Weight Urine Dip Fundal height Fetal Heart Tones Risk assessment Follow-up Patient education	Pulse and respiratory rate are often elevated. BP check with manual cuff. If over 140/90 repeat, if still elevated evaluate further. Goal 25 - 35 lbs for BMI of 18.5 - 25, </=4lbs first trimester; then 1lb/wk [See IOM guidelines for over/underweight] No EBM reason to perform routinely FH should correlate w/ gestational age from 20 – 36 wks (***lie patient flat for accurate measurement)*** If no FHT at 12 wks, revisit in 2 wks or order sonogram for viability/dates ID and modify risks, treat disease Cover diet/exercise/work/anticipatory & anticipatory guidance **Site of delivery is Wakefield**	**Diet** "Not eating for two" • Folic acid supplement min 800ug ○ PNV or ○ Flintstone chewable vitamins 2qd (or 4 gummies daily) or ○ 1mg Folic Acid daily • Calcium 1200mg ○ Supplement if needed • Iron ○ Part of prenatal vitamin. Supplement as needed • Consider nutrition/health ed referrals **Exercise/Work/Sex**: generally good Encourage breastfeeding, smoking cessation. Check all meds for pregnancy class. Social work referral for teens and prn Next visit: schedule all visits in advance Q4wks until 28wks, Q2 wks until 36 wks, Weekly until delivered.

Prenatal Care Timetable

Initial Prenatal Visit		
Task/Problem	**Background**	**Plan: Rx/Counseling/Advance Planning/Testing**
<u>Before entering the room</u>: Check results of screening studies • Lab/Sono/TB screening • EDD information Whose patient is she? Review/complete ASOBGYN Past medical history Perform PE including pelvic Complete initial encounter Confirm dating Determine risk Pt education Bond with the patient	CBC, blood type and antibody screen, Hb electrophoresis, rubella, hepatitis, syphilis screens, PAP (if due), GC/Chlam, lead level, PPD. 1hr GCT currently required Also add A1C & Varicella Check that all labs were reported. Pelvic exam is necessary for pelvimetry and confirming dates. An accurate EDD is important for prenatal care as milestones and screenings are timed. See consult guidelines in fcmc.weebly.com N/V, wt gain, breastfeeding, genetic testing & warning signs Identify your role[resident family physician, providing prenatal care, delivery, and care for the whole family] and let the patient know how to contact you. **Site of delivery is Wakefield**	Determine primary and backup provider if rotation schedules are known. Offer cystic fibrosis screening & genetic testing if not done Refer for • Risk • WIC • Medicaid/PCAP • Sono Address each RISK in ASOBGYN • Refer as per consult guidelines WIC forms are on EMR Review plan for next visit Obtain a valid phone number.

*Special circumstances		
Genetics Counseling with option for testing Early testing options: chorionic villi sampling (10-12wks) amniocentesis (15-20wks) parental chromosomes	ACOG recommends that all patients be offered genetic counseling. Advise genetic counseling to all those who are at higher risk; i.e., advanced maternal age, family history of genetic disorder. Screening tests, like the QUAD and First Trimester screen are not adequate for patients at increased risk. Counselors will review options.	Patient education: early diagnosis provides options and better planning for care of affected fetus Offer cystic fibrosis screening
Diabetes Risk	Patients at increased risk: • Obese, BMI > • Hx macrosomic infant (4kg or 8lb13oz) • Family history of diabetes • Hispanic ethnicity	We screen all patients for pre-existing diabetes at initial visit. This is done by 1 hr GCT. Add HbA1C for data.
Prior cesarean section or any prior uterine surgery	With one prior section it may be possible for the patient to attempt VBAC. This decision is made by the obstetrician on review of the OP report.	Request op report & consult with Open Door before 30 weeks
High BMI	➢ 30	Consider referral to nutritionist or health educator for counseling Follow ASOBGYN recommendation for Sleep Apnea Screen and consultation with anesthesia
+PPD (at any time)	CXR after 13wks	See AECOM OB guidelines for PPD testing

Second visit	Follow up on labs and referrals Follow up on op reports if needed	Rh negative – Rhogam for any bleeding Sickle screen positive – test FOB	
12 - 20 wks	Urine Culture (12 – 16 wks) AFP (if patient had FTS) or Quad test (15 – 20wks) Structural survey (18 – 21 weeks)	Screen for asymptomatic bacteriuria is done by culture. Urine dip may be entirely negative. Treat UTI in pregnancy for 7-10 days & do TOC Elevated AFP (>2.5MOM) may be dating error, order ultrasound (if not done earlier) and refer to genetics Abnormal Quad offer prompt referral to genetics Also called the anatomical survey or 2T scan, this sonogram shows all the body parts.	Parents should start thinking about birth plan, child care . . . Diet/exercise
After 20 wks	Watch BP and wt gain	More than 2lb/wk is water weight beware of PIH	Preterm labor/preeclampsia counseling

24 - 28	if Rh negative - do type and screen) GDM screening 3T labs (RPR, CBC, & type and screen)	If antibody screen is positive, ask for identification & follow-up with faculty. 1hr glucose test with 50 grams Glucola. **If 1hr >130 <200, do 3hr GTT** **>/= 200 = GDM** 3 hr glucose test (Glucose Tolerance Test, GTT) is done with 100 gram Glucola. Must be fasting. Fasting 95 1hr 180 2hr 155 3hr 140 Two values at or above level = GDM One elevated = increased risk for macrosomia	Birth plan Circumcision preference Contraceptive method Discuss breastfeeding plan Nutrition consult for risk of macrosomia
28 - 33	Rhogam for Rh neg patients Check placenta	300ug Rhogam IM (50 ug dose for miscarriage before 13wks) Check type & screen same day or before Rhogam Low-lying and placenta previa should resolve by now	Kick counts, Preterm labor & PEC counseling Contraception/tubal ligation papers **Papers must be signed 30d in advance** Repeat sono Refer to on-site OB if persistent previa or low-lying placenta

33 - 35	3T HIV (33-35 wks) Follow-up cbc if anemic Accreta scan TdaP (34 wks)	Public health recommendation/local custom (Repeat consent not required for HIV). If <Hb less than 9, consider iron injection Performed for pts with prior c-section and anterior placenta CDC recommendation to protect infant from whooping cough. Administer if >1yr since last shot.	Review signs of labor & when & how to go to the hospital **411 method** (cx every 4 min, lasting 1min for 1hr) How will she feed the baby?
35 – 37	Beta strep screen (35-37 wks) Repeat GC/Chlam if prior positive Verify vertex (36 wks)	Screen is done from vagina and rectum to increase change of identifying beta strep colonization. Repeat beta strep screen q5wks until delivery. [Vaginal/rectal screen not needed if GBS bacteriuria] If presentation is uncertain by Leopold's maneuvers and vaginal exam, order sonogram	Review 411 labor signs and reasons to go to triage: • Decreased movement • Loss of fluid • Bleeding (more than a period) • 411 Describe early breastfeeding Recommend perineal massage
37 - 40	Breast exam Offer membrane stripping	Breast shell for flat nipples Membrane stripping decreased rates of post-date pregnancy	Review breastfeeding Document infant provider

>40	40.5 weeks 41 weeks	Check Bishop score Schedule post-date testing in MFAC Schedule induction after 41 weeks.	