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Nova Scotia Prenatal Record Companion Document

2022 Edition

IWK Health

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Introduction

Purpose

The Reproductive Care Program of Nova Scotia (RCP) has produced and distributed a standardized form to guide prenatal care in Nova Scotia for more than twenty-five years. The Nova Scotia Prenatal Record (NS PNR) offers prenatal care providers a standardized approach and evidence-based tool to document assessment, investigation, and treatment interventions during pregnancy.
The prenatal record serves as a 'pregnancy pathway' that provides:

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

It is recommended that pregnant persons carry a copy of their prenatal record. Many prenatal care providers offer a copy of the prenatal record to pregnant persons after 36 weeks and some provide a copy for the entire pregnancy. RCP encourages care providers to do this.

Use of the NS PNR Companion Document

The NS PNR and Companion Document guide the provision and documentation of prenatal care by health care providers within NS. The Companion Document provides explanation for each page of the NS PNR, providing information and resources that will assist care providers in populating the record. The document provides a step-by-step approach and a 'how to' guide for health care professionals using the NS PNR and includes evidence that informed its development; however, it is not intended to provide a detailed overview of best practice.

The Companion Document and NS PNR are aligned with the principles of trauma informed care, cultural competence, and the World Health Organization (WHO) principles of prenatal care. The Companion Document was written using gender neutral language that is meant to be inclusive of all individuals regardless of gender identification. The RCP endeavors to be respectful of gender identity and the multiple ways in which individuals may identify themselves as a parent. While most people experiencing pregnancy identify as a woman, some do not. Thus, we have used the terms "pregnant person" and "nursing" to ensure that this document is inclusive.

At the time of development, the content of the NS PNR aligned with both national and local guidelines, and the links and references within the Companion Document were current and functional. Online sites may require membership or payment to retrieve full articles, guidelines, or detailed information, and in those cases the link provided will only access the information available. The Society of Obstetricians and Gynecologists of Canada

(SOGC) requires a membership to access the full Clinical Practice Guidelines (CPG), and therefore, the links within the document for SOGC CPG provide the abstract and summary of recommendations if access to a membership is not available.

Clinical care recommendations change rapidly; therefore, guidelines may change before the NS PNR can be updated to reflect them. Care providers are required to follow the existing standard of prenatal care and individualize care to each clinical situation. RCP has endeavored to capture all the elements required for high quality care and is committed to reviewing the NS PNR for revisions at least every 3-5 years. The Companion Document is accessible online on the RCP website for easy reference and to allow updates to be added as new information and recommendations that impact care become available.

The NS PNR will be used in both paper and electronic formats (where EMR systems are in place). If you are using the NS PNR in paper form it will arrive to your office/facility in 5 ***double-sided*** sheets. The NS PNR is no longer being printed in NCR format (duplicate). It is acknowledged that the NS PNR appears to be longer than the previous version. Not all the additional pages are for documentation; several pages at the back of the PNR are worksheets intended to serve solely as clinical resources to guide prenatal care. There is a bar code at the bottom of each page of the NS PNR. This bar code will be used for the provincial scanning and archiving system within health care facilities across the province. If demographic labels are applied to the paper version of the NS PNR, please be mindful not to cover information that has been documented as well as the preprinted record barcodes.

Note: In the future, the NS PNR will also be available electronically within the Access E-Forms Repository for care providers providing prenatal care within Regional Health Care Facilities across the province. It can be printed from this system as needed.

For additional NS PNR in paper format, please order them directly from RCP here.
Contact RCP via (902) 470-6798 or rcp@iwk.nshealth.ca with forms related inquiries.

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The Reproductive Care Program of Nova Scotia would like to acknowledge the contributions of prenatal care providers throughout Nova Scotia who provided feedback during recent revisions of the Nova Scotia Prenatal Record.

Nova Scotia Prenatal Record #1

Reproductive Care Program of Nova Scotia RCP | nova scotia health | IWK Health

Area for Patient Label.

NOVA SCOTIA PRENATAL RECORD

Part 1 - Date completed (YYYY/MON/DD) _____

Demographics

Last name	First name	Gender	Pronoun

Address	Contact phone # Alternate phone #	Leave message ❑ Yes ❑ No	Health card number

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

Language: ❑ English ❑ French ❑ Mi'kmaq ❑ Arabic ❑ Other _____ ❑ Interpreter required	Indigenous identity: ❑ Yes ❑ No ❑ First Nations ❑ Métis ❑ Inuit	Relationship status Partner involved ❑ Yes ❑ No

Partner's name	Gender	Age	Partner employed ❑ Yes ❑ No	Occupation	Support person ❑ Yes ❑ No Name

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

Pregnancy Dating

EDD (FINAL) YYYY/MON/DD

Last menstrual period (LMP) YYYY/MON/DD	EDD by LMP YYYY/MON/DD	Dating U/S YYYY/MON/DD Gestational age (GA)	EDD by U/S YYYY/MON/DD	Assisted Reproductive Technology (ART) ❑ Yes ❑ No Type	EDD by ART YYYY/MON/DD

Length of cycle _____ Regular ❑ Yes ❑ No Certain of dates ❑ Yes ❑ No Planned pregnancy ❑ Yes ❑ No	Multiple pregnancy ❑ Yes ❑ No	Chorionicity	Embryo Transfer YYYY/MON/DD

Obstetrical History

Gravida _____ Term _____ Preterm _____ Abortus _____ Living children _____ Stillbirth _____

Date YYYY/MON/DD	Place of birth	Gest. age	Type of birth	Complications/Comments e.g. PPH, GDM, IUGR, etc.	Birth weight	Sex	Current health	Nursing duration

Health History

Allergies (include reaction) ❑ Latex ❑ NKDA	Previous surgery ❑ Yes ❑ No	Past medications	Current medications

	Yes	No
Anesthesia comp.	❑	❑
Blood transfusion	❑	❑
Respiratory	❑	❑
Cardiovascular	❑	❑
❑ hypertension		
❑ previous GHTN		
Neurology	❑	❑
Hematology	❑	❑

	Yes	No
Infectious diseases ❑ HSV ❑ HIV ❑ Hep B ❑ Hep C ❑ Other	❑	❑
MSK/Rheumatology	❑	❑
Gynecology/Breast	❑	❑
Gastrointestinal/Liver	❑	❑
Renal/Genitourinary	❑	❑
Endocrine ❑ Thyroid ❑ previous GDM ❑ T1DM ❑ T2DM	❑	❑

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

Family History	Yes	No
	❑	❑
❑ Anesthesia comp.		
❑ Diabetes		
❑ Hypertension		
❑ Thromboembolic		
❑ Mental health		
❑ Genetic anomalies		
❑ Other _____		

Comments

For copies: Reproductive Care Program http://rcp.nshealth.ca/chart-prenatal-forms/nova-scotia-prenatal-record • Tel: 902-470-6798
REV 2022/MAR

Demographics

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

Item	Description
Part 1 Date completed	Document the date (YYYY/MON/DD) part 1 of the PNR is completed. This provides a timeline/date when prenatal care began.
Last Name	Document their last name as it appears on the health card. Note maiden name if applicable.
First Name	Record their given (first) name as it appears on the health card. Other names (preferred name, nickname, etc.) can be in quotations marks.
Gender	Gender identity is an important part of assessment and the pregnant person's history. Understanding their gender can help individualize care and identify needs and risk factors.
Pronoun	Ask and document the pregnant person's pronoun (e.g. she / her, he / him, they / them / their, ze, hir).
Address	Document their address, including apartment number, street number and name, city, and postal code. This information facilitates home visits (if applicable) and informs data collection.
Contact Phone	Preferred contact number. Indicate if it is a work, home, or cell phone.
Alternate Phone	An alternative work, home, or cell phone number.
Leave Message	Explicitly ask if it is appropriate to leave a message when contacting.
Health Card Number	Number recorded from the health card.
Date of Birth (DOB)	Pregnant person's date of birth in format of YYYY/MON/DD.
Age at Expected Date of Delivery (EDD)[12] SOGC Adolescent Pregnancy SOGC Delayed Childbearing	Record the pregnant person's age at EDD. Pregnancies during the adolescent period are noted to have higher maternal, obstetrical, and neonatal risks, with pregnant persons ≤ 15 having higher risks than even those aged ≥ 16. Pregnancies during adolescence should be managed as high risk to accommodate their unique concerns. Pregnancy in persons ≥ 35 years is associated with: □ hypertensive disorders of pregnancy and preeclampsia □ pre-existing diabetes and gestational diabetes □ increased risk of miscarriage, ectopic pregnancy, chromosomal aberrations and birth defects, multiple pregnancy, cesarean section, placenta previa, low birth weight (LBW) and preterm birth (PTB). The cumulative risk of stillbirth in pregnant persons 40 to 44 years of age at 39 weeks' gestation is nearly identical to the risk for those 25 to 29 years of age at 42

	weeks. Therefore, antenatal testing should begin at 36 to 38 weeks gestation with delivery by the completion of the 39th week for pregnant persons > 40 years of age.
Highest level of education completed	Document highest level of education completed by identifying the most appropriate option from the following list: □ Some High School □ Completion of High School □ Community College or working on a bachelor's degree □ Completion of a bachelor's degree □ Completion of a master's degree □ Completion of a Doctorate □ Professional Degree □ Unknown Informs data collection and assesses the pregnant person's comprehension.
Employed Y/N	Pregnant person's employment status.
Occupation	Document type of work and discuss any workplace hazards/risks that may affect the pregnancy. Note any physical and/or mental stress related to work or working conditions (e.g. shift work, long hours, excessive heat or cold, exposure to second-hand smoke or harsh chemicals, etc.).
Culture/beliefs/ practices	Document specific religious, cultural beliefs and/or practices that may impact pregnancy, birth, or newborn care, e.g. Jehovah's Witness.
Language	Language most readily understood and spoken by the pregnant person. Select from the list provided (i.e. English, French, Mi'kmaq, Arabic) or populate 'other' as appropriate.
Interpreter Required	Indicate whether assistance from an interpreter is required. IWK or Nova Scotia Health (central zone) call (902) 406-4600 or visit Access language services. Remote (phone) interpretation service is available to Nova Scotia Health employees through 'Language Services'. Interpretation and Language Services Coordinator (Nova Scotia Health) can be reached at (902) 473-1909.
Indigenous Identity	Ask every pregnant person this question, "Do you identify as an Indigenous or Aboriginal person?" The response to this question is voluntary. If they do identify as an Indigenous or Aboriginal person, select 'Yes,' and specify the identity by selecting all that apply from the following: □ First Nations □ Métis □ Inuk (Inuit)
Relationship Status	Note current relationship status and any recent changes (i.e. single, never legally married; legally married; separated, but still legally married; common-law; divorced; or widowed). May include any other partnership identified by the pregnant person.
Partner Involved Y/N	Partner is anyone the pregnant person identifies as their partner. This may also provide information on supports or possible safety issues.

	Regarding genetic screening, race/ethnic information is specific to the genetic contributor to the pregnancy.
Partner's Name	The given name of the current partner. Leave blank if no partner is reported. The named partner in this section may not be the genetic contributor to this pregnancy.
Partner's Gender	The current partner's identified gender.
Partner's Age	Age of the partner (or sperm contributor to the pregnancy) as advanced paternal age (≥ 40 years) increases risk of certain genetic disorders.
Partner Employed Y/N	The current partner's employment status.
Partner's Occupation	The current partner's occupation.
Support person	The name of a support person (if applicable). This person may be instead of or in addition to a partner.
Prenatal Care Provider(s)	Provide full name and profession (midwife, doctor, nurse practitioner) of the pregnant person's prenatal care provider(s).
Baby's Care Provider (in hospital)	Provide full name and profession (midwife, doctor, nurse practitioner) of baby's health care provider while still in hospital.
Community primary care provider	Provide full name and profession (nurse practitioner, doctor) of the pregnant person's primary care provider.
Baby's Care Provider (in community)	Provide full name and profession of baby's community health care provider in the community. **Note:** This may be different from the health care provider caring for the baby in the hospital or the care provider who cared for the pregnant person during pregnancy. If identified that the infant will be without a community care provider, complete the 'Unattached Newborn' form and send to the 'Need a Family Practice Registry' here. Document when an unattached newborn form has been sent and then update this section with the baby's community care provider when the information is available from the family.

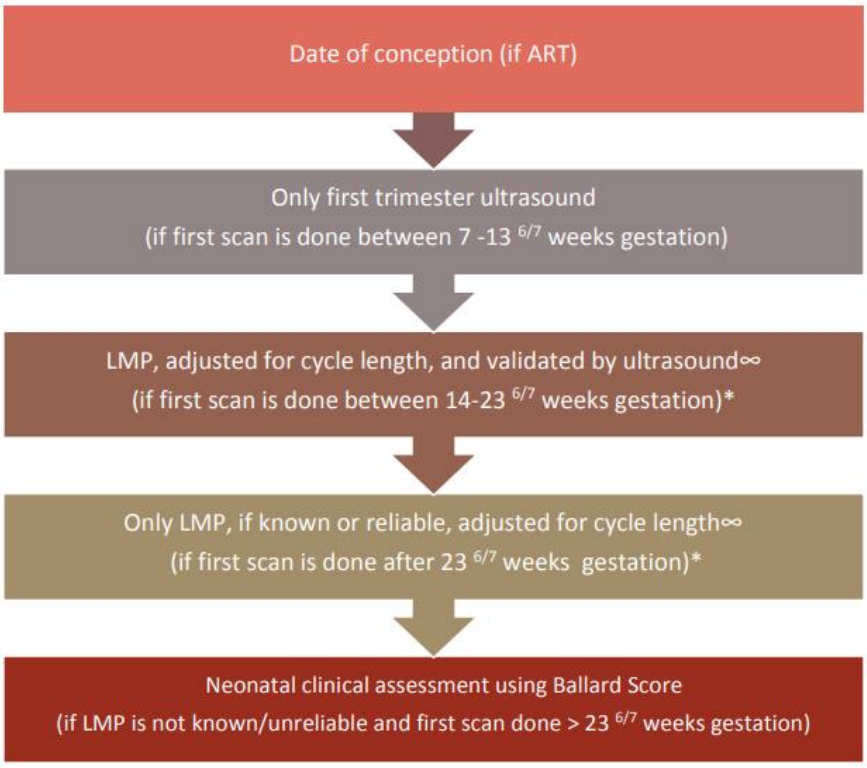
Pregnancy Dating

Item	Description
Last Menstrual Period	Note the first day of the Last Menstrual Period (LMP) in YYYY/MON/DD (if known).
EDD by LMP	Indicate the estimated date of delivery (EDD) based on the LMP in YYYY/MON/DD.
Dating Ultrasound (U/S)[34] SOGC CPG GA by U/S SOGC CPG 1st Trimester U/S	Record the date the dating U/S was performed in YYYY/MON/DD. A first trimester U/S is recommended to date a pregnancy (ideally at 7–12 weeks). If menstrual dating is reliable and an early comprehensive pregnancy ultrasound (11–14 weeks) is planned, dating should be confirmed concurrently with U/S.
GA at time of U/S	Document the gestational age (in weeks) at the time of the dating U/S.
EDD based on U/S	Indicate the EDD based on ultrasound in YYYY/MON/DD.
Assistive Reproductive Technology Type	Indicate if current pregnancy was conceived because of assistive reproductive technology (ART) such as fertility medication, in vitro fertilization (IVF), etc. Multiple gestation result in 30% of pregnancies conceived through IVF

Embryo Transfer	Record the date of embryo transfer. YYYY/MON/DD
EDD Based on ART	Document EDD based on ART. YYYY/MON/DD
Multiple Pregnancy	Indicate if multiple pregnancy.
Chorionicity	Indicate chorionicity of multiples.
Length of Cycle	Document the length of the pregnant person's menstrual cycle in days. EDD by LMP should be adjusted based on cycle length.
Regular	Indicate if the pregnant person's cycle is regular or not.
Certain of Dates?	Indicate if the pregnant person is certain or uncertain of their LMP dates.
Planned Pregnancy [5]	Indicate if the pregnancy was planned or unplanned. Unwanted pregnancies are a strong predictor of intimate partner violence (IPV), with utilizing contraceptive methods often being more difficult for persons who are experiencing IPV, leading to a higher incidence of unintended pregnancies.
EDD Final	Record the final EDD in YYYY/MON/DD according to the **RCP Guidelines.**

Algorithm for Determining the "Best Estimate" of Gestational Age

The best estimate for gestational age (GA) is calculated based on the estimated expected date of delivery (EDD) using the following hierarchy. Please confirm GA assessment using the algorithm provided, if the patient was not followed in FATC at the IWK Health Centre. If the patient was followed in FATC, please use the best Obstetric Estimate of GA which is the assigned GA on the fetal ultrasound report.



* Please use the best Obstetric Estimate of GA that is calculated based on EDD from the most reliable scan, as determined by the most responsible Obstetric provider, and documented in the patient's record

∞ If LMP is unknown/not reliable, and 1st scan was done at 14-23$^{6/7}$ weeks, the best estimate of GA is calculated based on EDD from the 2nd trimester scan. If LMP is unknown/not reliable, and 1st scan was done after 23$^{6/7}$ weeks, the best Obstetric Estimate of GA will be calculated based on the most reliable scan, as determined by the most responsible Obstetric provider, and documented in the patient's record

Obstetrical History

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

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

Item	Description
***Gravida**	The total number of pregnancies for the pregnant person, including this pregnancy, regardless of gestational age, type, or outcome. A pregnancy with twins/multiples is counted as one pregnancy. **Note:** An ectopic pregnancy, a missed abortion, a blighted ovum and a hydatidiform mole are classified as a gravida and should contribute to the total number of all pregnancies.
***Term**	The total number of previous pregnancies with birth at ≥ 37 completed weeks. **Note:** A previous multiple pregnancy delivered at term should be counted as 1 term. If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as 1 term and 1 preterm.
***Preterm**	The total number of previous pregnancies with birth occurring between 20^{+0} and 36^{+6} completed weeks. The absolute risk of recurrent spontaneous PTB is 30%. Late terminations should contribute to the total number of previous preterm pregnancies. **Note:** A previous multiple pregnancy delivered preterm should be counted as 1 preterm. If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as 1 term and 1 preterm.
***Abortus**	The total number of pregnancies that were spontaneous losses (before 20 weeks gestation or weighing < 500 grams) or planned terminations. Spontaneous abortions include miscarriage, ectopic pregnancy, missed abortion, blighted ovum and molar pregnancy.
***Living Children**	Number of children born to the pregnant person who are presently living.
***Stillbirth**	Number of fetal deaths born to the pregnant person ≥ 20 weeks pregnancy OR if gestational age is not known, with a birth weight of ≥ 500 grams.
Date	The date (YYYY/MON/DD) of each previous pregnancy.

	Each row corresponds with one child (i.e. for a multiple pregnancy, each row should correspond to one infant of that pregnancy). **Note:** All previous induced and spontaneous terminations should be recorded.
Place of Birth/Loss	The location of the previous birth/loss (e.g. Hospital, Home).
Gestational age	The gestational age (number of weeks and days) of previous birth/loss.
Type of Birth	The type of birth, i.e. vaginal, assisted, Cesarean section (emergency or elective).
Complications / Comments	Comment on important details and/or any complications related to previous pregnancies such as: □ postpartum pemorrhage (PPH) □ gestational diabetes mellitus (GDM) □ small/large for gestational age □ gestational hypertensive disorder (GHTN) □ preterm premature rupture of membranes (P-PROM) □ preterm birth (PTB) □ shoulder dystocia □ placental disorders □ perineal trauma (3rd or 4th degree tears, etc.) **Note:** This information is important as previous perinatal complications may have an impact on the current pregnancy /birth.
Birth - weight	The birth weight of infant (in grams).
Sex	The biological sex, male or female, or undifferentiated (sex could not be determine/defined) of the infant. For terminations (loss before 20 weeks) record, 'N/A'.
Current health	The current health status of the child and any relevant concerns.
Nursing duration	Indicate whether the child was nursed/breastfed, for how long (number of weeks or months), and if there were any issues or concerns.

Health History

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

Item	Description
Allergies (reaction)	Note any allergies (food, medication, environment, etc.) and indicate the type of reaction to the agent (anaphylaxis, rash, gastrointestinal distress, etc.) **Indicate if allergic to Penicillin.**
Latex Allergy	Note an allergy to natural rubber latex.
NKDA	Note no known drug allergies (NKDA)
Previous Surgery	Document any previous surgery, inpatient or outpatient. Comment on the type of surgery, date, and any complications.
Past Medications	List past medications (prescription, over the counter, vitamins, herbal, etc.) including dosage and reason for taking.

Current Medications	List all current medications (prescription, over the counter, vitamins, herbal, etc.) include specific name, dosage, and reason for taking. Medications that act systemically will most likely cross the placenta and reach the fetus. The advantages of taking medication during pregnancy should outweigh the risks to the fetus. Review all medication and consider discontinuing and/or safer alternatives when appropriate.
Anesthesia complications	Describe any complications from prior local, regional, or general anesthetics, including metabolic disorders, difficult intubations, and/or severe postoperative vomiting. Instances where an Anesthesia Consult should be considered:[6] □ Body Mass Index (BMI) over 40 □ History of significant pulmonary or heart disease □ Previous difficult anesthesia or traumatic delivery/surgery □ Harrington rods, previous laminectomy, or spinal fusion □ Symptomatic disc disease □ Lower back pain not yet diagnosed □ Intermittent "sciatica" □ Lumbar tattoo
Blood transfusions	Indicate any previous blood transfusions and comment on any reaction.
Respiratory	Indicate any significant respiratory disease such as asthma, chronic obstructive pulmonary disease, etc.
Cardiovascular	Specify any significant cardiovascular (CV) conditions or concerns such as congenital heart disease, arrhythmias, cardiomyopathy, etc. Indicate severity. Indicate whether the pregnant person has any history of: □ Hypertension □ Previous gestational hypertension (GHTN)
Neurology	Indicate any pre-existing condition, such as Multiple Sclerosis, epilepsy (include type of seizures and frequency), migraines, etc.
Hematology	Note any significant pre-existing disease such as iron deficiency, anemia, thalassemia, etc. Indicate any thromboembolic disorders or coagulopathies. Include previous thromboembolic events, deep vein thrombosis, pulmonary embolisms, etc.
Infectious diseases[789] NICE Hepatitis C SOGC CPG HSV SOGC CPG HIV SOCG CPG Hep B	Assess for infectious disease risk and indicate any history (past or current) of infrctious diseases including: □ Herpes Simplex Virus (HSV) and specify if primary outbreak occurred in pregnancy. □ HIV (with or without progression to AIDS. □ Hepatitis B □ Hepatitis C □ Other - Indicate any other past or current infectious diseases (e.g. Chlamydia, Gonorrhea, Human Papillomavirus, Syphilis, etc.), treatment, and test of cure. Consider repeat testing later in pregnancy for those with ongoing risks.
Musculoskeletal (MSK)/ Rheumatology	Indicate any musculoskeletal (MSK) disorders that may affect pregnancy/birth, as well as any rheumatic and autoimmune disorders (e.g. systemic lupus erythematosus (SLE), rheumatoid arthritis (RA), antiphospholipid syndrome).

Gynecological / Breast	Indicate any history of uterine fibroids, endometriosis, etc., and any uterine or cervical procedure such as cone biopsy or myomectomy. Note any history of breast surgeries, including biopsies, reduction, or augmentation.
Gastrointestinal / Liver	Indicate any significant pre-existing disease such as Crohn's, irritable bowel disease, chronic constipation, cirrhosis, etc.
Renal/ Genitourinary	Note any pre-existing urinary/renal condition. Include frequent urinary tract infections, kidney disease, etc.
Endocrine/Thyroid	Indicate any pre-existing endocrine conditions or any history of: □ Thyroid □ Type 1 Diabetes Mellitus (T1DM) □ Type 2 Diabetes Mellitus (T2DM) □ Previous Gestational Diabetes Mellitus (GDM)
Mental Health	Specify any significant mental health issues or concerns. Indicate a past or current diagnosis of: □ Anxiety □ Depression □ Previous Post-Partum Depression (PPD) □ Bipolar □ Eating Disorder □ Schizophrenia □ Other mental health issue or concerns
Family history concerns	Document any concerns with the family history **(<u>immediate</u> family members)**: □ Anesthesia complications □ Diabetes □ Hypertension □ Heart disease □ Thromboembolic or coagulation issues □ Mental Health - familial history of psychiatric disorders e.g. depression/anxiety □ Genetic anomalies - note any presence of hereditary anomalies/disorders (e.g. Tay-Sachs, Sickle Cell, Congenital Heart Defect, Cystic Fibrosis, Muscular Dystrophy, Neimann Pick C, Alstrom, etc.) to inform specific genetic screening. □ Other - Any disease that may negatively impact the pregnancy or birth such as history of substance use disorder.
Other	Indicate any other medical condition or illness that affects the pregnant person (past or present) and is relevant to pregnancy.

Nova Scotia Prenatal Record #2

Reproductive Care Program of Nova Scotia (RCP) · nova scotia health · IWK Health

Area for Patient Label.

NOVA SCOTIA PRENATAL RECORD

Part 2 - Date completed (YYYY/MON/DD) _____

Current Pregnancy

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

Infant feeding plan: ❑ nursing ❑ non nursing ❑ undecided

Clinical Exam

Height	Weight	Pre-pregnancy BMI	Recommended gestational weight gain see worksheet 1	Comments

BP	Lungs	Heart	Abdomen	Pelvic exam	Female genital cutting ❑ Yes ❑ No

Lifestyle/Risk Factors

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

Substance Use

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

Ethnicity

Acadian	❑	South Asian	❑
Black	❑	White	❑
East Asian	❑	Other	❑
Indigenous	❑	Unknown	❑
Latin American	❑	Prefer not to say	❑
Middle Eastern	❑		
Southeast Asian	❑		

Genetic Risk Assessment

	Yes	No
Donor gamete: Egg	❑	❑
Sperm	❑	❑
Egg age ≥ 35 at EDD	❑	❑

Ethnicity gamete

Hemoglobinopathy/Thalassemia screen (CBC, Hgb electrophoresis) ❑ Yes ❑ No ❑ NA

Consanguinity (blood relation) ❑ Yes ❑ No

Referral to Medical Genetics (see worksheet 2): ❑ Yes ❑ No ❑ NA

Specify

Genetic Screening/Investigations

No genetic screening ❑ Counseled and declined

MST 9-13+6 weeks	❑ Counseled	❑ Completed	❑ Declined	EPR	❑ Counseled ❑ Completed ❑ Declined ❑ NA
NT 11-13+6 weeks	❑ Counseled	❑ Completed	❑ Declined ❑ NA	NIPT	❑ Counseled ❑ Declined ❑ MSI ❑ Self pay
MST 15-20+6 weeks	❑ Counseled	❑ Completed	❑ Declined	CVS/Amniocentesis	❑ Yes ❑ No Other ❑ Yes ❑ No

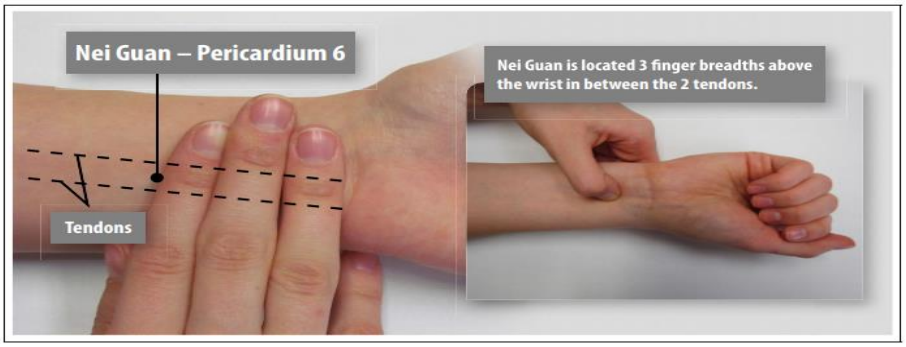
Comments

For copies: Reproductive Care Program http://rcp.nshealth.ca/chart-prenatal-forms/nova-scotia-prenatal-record • Tel: 902-470-6798
REV 2022/MAR

Current Pregnancy

Patient resource Your guide to a healthy-pregnancy-guide.pdf (canada.ca)

Indicate yes 'Y' or no 'N' with a √. Provide additional details in the comments section provided

Issue	Description
Nausea/Vomiting [10]	Note if the pregnant person is experiencing nausea and/or vomiting during pregnancy (NVP). If yes, indicate the severity and treatment, such as: □ Non-pharmacological therapies □ Dietary and lifestyle changes (e.g. eating small, frequent Meals) □ Discontinuing iron containing supplements □ Increasing rest □ Ginger □ Acupressure (stimulation of the P6 (Nei Guan) point) SOGC CPG Nausea and Vomiting  □ Mindfulness cognitive therapy □ Pharmacological modalities such as doxylamine and pyridoxine (Diclectin).
Illness/Rash/Fever [11] [12] [13] RCP Lyme Disease SOGC Toxoplasmosis SOGC Listeriosis SOGC CMV SOGC Parvovirus	Note whether the pregnant person has had any illness/rash or fever during current pregnancy and note the gestational age at the time. If 'Yes' is selected, specify the type of infection, rash, or fever that the pregnant person has had during the current pregnancy and treatment plan (if applicable). **Toxoplasmosis** Although rare, congenital toxoplasmosis can cause severe neurological or ocular disease (leading to blindness), as well as cardiac and cerebral anomalies. Routine screening is not recommended; however, pregnant persons should be informed of primary prevention measures to avoid toxoplasmosis infection, such as: □ washing hands before handling food □ thoroughly washing all fruit and vegetables, including ready-prepared salads, before eating □ thoroughly cooking raw meats and ready-prepared chilled meals □ wearing gloves and thoroughly washing hands after handling soil and gardening □ avoiding cat feces in cat litter or in soil

	Listeriosis A food-borne illness caused by consumption of unpasteurized dairy products, soft-ripened cheeses and deli meats that can lead to pregnancy loss, stillbirth, preterm birth, or life-threatening infection of the newborn. Prevention of listeriosis has been recognized as high priority by Health Canada as the risk of invasive listeriosis in pregnant persons is nearly 20 times greater than the general population. **Parvovirus B19 (Fifth disease)** In rare cases, parvo may cause a miscarriage, or the fetus could develop anemia. Proper hand hygiene is the best way to prevent the disease. **Cytomegalovirus infection (CMV)** CMV is transmitted in body fluids. Most people with CMV have no symptoms. The most common long-term health problem in babies born with congenital CMV infection is hearing loss. **Lyme Disease** Treatment for pregnant persons with Lyme disease is like treatment for the general adult population, with the exception that *treatment doses of doxycycline are contraindicated in pregnancy.*
Bleeding Rh section here	Indicate if any bleeding or spotting has occurred during current pregnancy. Specify gestation, duration, amount of bleeding, and whether an ultrasound was performed.
Travel (self/partner) RCP resource Zika	Indicate whether the pregnant person and/or their partner have travelled and/or are planning to travel during the current pregnancy. Note the travel destination and any precautions that may be recommended. **Note:** Advise against travel to high-risk areas to minimize the chances of becoming infected with malaria, yellow fever, Zika virus, etc.
Pre-conceptual Folic Acid [14] Health Canada: folate SOGC preconception folic acid	Indicate use of preconception folic acid and document the dosage taken. A diet of folate rich food (i.e. broccoli, spinach, lentils, peas, beans, dark leafy greens, and citrus) is recommended. Advise about the benefits of folic aid supplementation including, prevention of neural tube defects and other congenital anomalies (i.e. heart defects, uterine tract anomalies, oral facial clefts, limb defects, and pyloric stenosis). Supplementation with folic acid should begin 2-3 months preconception. **Low risk:** pregnant person and the male biological contributor have no personal or family history of folic acid–sensitive birth defects. Recommend daily oral multivitamin supplement of **0.4 mg folic acid** and vitamin B_{12} for at least 2 to 3 months before conception until 12 weeks gestation. **Moderate risk**: pregnant person with the following personal or co-morbidity scenarios (a to e) or the male biological contributor with a personal scenario (a and b): a) Personal or family history of other folic acid–sensitive anomalies b) Family history of NTD in first or second degree relative c) Diabetes (type 1 or 2) d) Use of teratogenic medications such as antiepileptic and cholestyramine medications

	e) Gastrointestinal malabsorption conditions (i.e. Crohn's disease, gastric bypass surgery, liver disease, kidney dialysis, alcohol overuse). Recommend daily oral supplementation with a multivitamin containing **1.0 mg folic acid** until 12 weeks' gestational age. **High risk**: if pregnant woman/individual or the male biological contributor have a personal NTD history or a previous NTD pregnancy. Recommend daily oral supplement with **4.0 mg folic acid** until 12 weeks' gestational age. **Risks of folic acid** supplementation are minimal, but include: □ Allergic reaction (rare) – erythema, rash, pruritus, general malaise, bronchospasm □ Seizure disorders – convulsions may occur in previously controlled patients □ Neoplasia – possible association with neoplasia or exacerbation of pre-existing colorectal cancer
Prenatal vitamins[15]	Specify if the pregnant person is taking prenatal multivitamins with folic acid, iron & vitamin D. Inform to **take only 1 daily dose** of their multivitamin. **Iron** - a supplement containing 16 to 20 mg of elemental iron is recommended. Therapeutic doses of iron may be required for iron deficiency (e.g. a low hemoglobin and serum ferritin). Food sources include tofu, beef, chicken, and shrimp.
Calcium/Vitamin D [16]	Indicate if the pregnant person has adequate calcium and vitamin D intake. **Calcium** supplementation of at least 1 gram per day for those with low calcium intake is recommended to reduce the risk of preeclampsia. Sources include milk/milk alternatives (i.e. yogurt, cheese, fortified plant-based beverages), dark green vegetables such as broccoli, kale and spinach, and canned salmon or sardines. **Vitamin D** deficiency is common in pregnancy. A daily allowance of 600 international units (15 mcg) of vitamin D is recommende for pregnant and lactating persons. Additional vitamin D may be required for those who have limited sunlight exposure or live in the northern latitudes, have darker skin tones, choose to cover themselves for cultural or other reasons, have diets low in vitamin D, or are Indigenous.
Infant feeding plan RCP breastfeeding	Note the infant feeding plan : □ Nursing □ Non nursing □ Undecided Identify existing knowledge and prior nursing experience (if applicable). Provide education on the benefits of nursing, offer available support, and discuss any questions/concerns.

Clinical exam

Item	Description
Height	The pregnant person's height in centimetres.
Weight Health Canada pregnancy	The pre pregnancy weight of the pregnant person in kilograms, or if unknown, weight at the first prenatal visit.
Pre-pregnancy Body Mass Index (BMI)	Calculate the pre-pregnancy body mass index (BMI). The formula to calculate BMI is weight (kg) divided by height (M) squared. Health Canada BMI calculator.
Recommended range of weight gain Nutrition - Multiples IOM	Pregnant persons should be advised to eat a healthy, well-balanced diet and increase their caloric intake by a small amount (350–450 calories/day). The recommended range of total weight gain (for single pregnancy) per BMI category is outlined according to the Institute of Medicine (IOM) guidelines.
Clinical exam: [17] [18] [19] **BP** **Lungs** **Heart** **Abdomen** **Pelvic exam**	Complete and document the findings of a clinical exam. The content of the exam is not specified beyond baseline blood pressure (BP), pre-pregnancy weight and height to calculate BMI, and to identify pregnant persons with female genital cutting (FGC). Assessment of heart, lungs, abdomen, pelvis, and other areas should be completed as indicated based on clinical judgement. **SOGC suggests the following for** pregnant persons ≥ 35 years of age: □ *A comprehensive history and physical examination. □ *Prenatal bloodwork that includes baseline liver and kidney function. □ *Mammogram (> 40 years) and Cardiology consultation (> 45 years). □ Monitoring for hypertensive disorders of pregnancy and preeclampsia. □ Placental localization with U/S with the 2nd trimester scan, to be followed up at 28 weeks' gestation if low lying or previa. *Consideration should be given to the individual, clinical and local practice context.
Female genital cutting [20] [21] SOGC female genital cutting	Record if the pregnant person has experienced female genital cutting (FGC) and provide details in the comment section. Pregnant women and individuals with FGM are at higher risk of cesarean delivery, postpartum hemorrhage, and extended maternal hospital stay, and their infants are at higher risk of requiring resuscitation and of dying in the hospital. Pregnant women and individuals who have experienced genital cutting must be approached with sensitivity and understanding. It was not their choice to be cut and health care providers need to be nonjudgmental and provide culturally competent and sensitive care. It is important to pay special attention to concerns related to confidentiality and privacy.

Lifestyle/Risk Factors

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

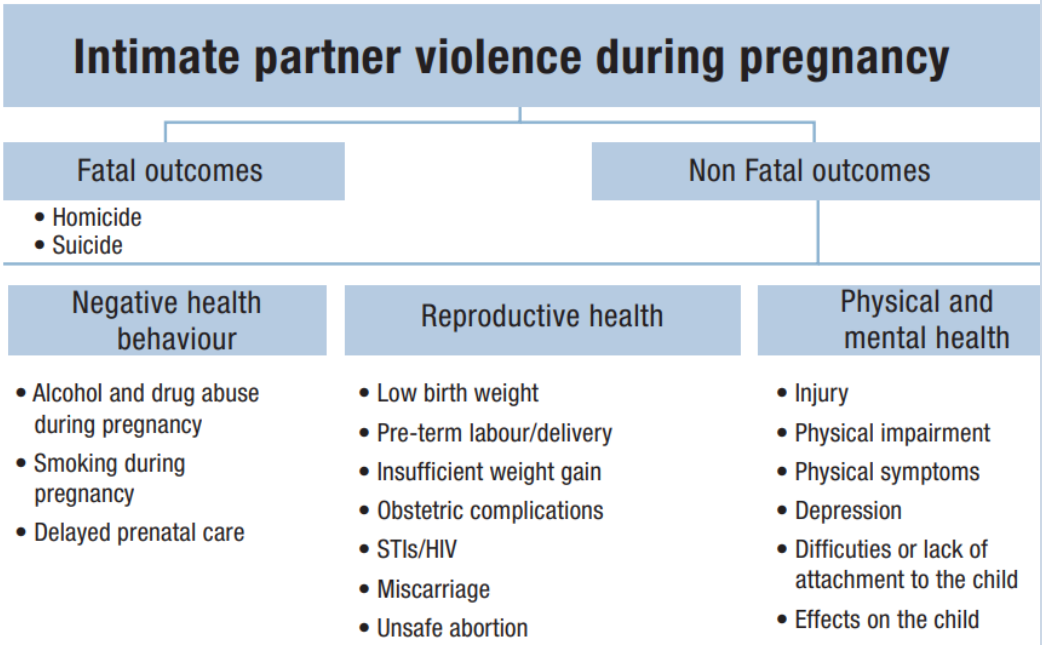
If lifestyle/risk factors are identified prenatally, consider available community resources and tools, such as:

- ❒ Public Health
- ❒ Nutrition
- ❒ Mental Health
- ❒ Social Work
- ❒ Poverty: A Clinical Tool for Primary Care Providers
- ❒ Housing, employment, and social assistance: NS Community Services

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

Provide additional details in the comments section provided.

Risk Factor	Description
Relationship issues	Ask questions such as: "How would you describe your relationship with your partner?" and "What do you think the relationship will be like after the baby arrives?" Relationship difficulties can be associated with increased dysfunction in pregnancy, postpartum depression, domestic abuse, and child abuse.
History of Trauma/Abuse [22]	Ask about previous trauma/abuse. Pregnant persons with a history of trauma and/or abuse have a higher likelihood of developing depressive symptoms during pregnancy and in the post partum period.
	All pregnant persons, regardless of socioeconomic status, race, sexual orientation, age, ethnicity, health status, and presence or absence of current partner, are at risk and should be screened for intimate partner violence (IPV). Intimate partner violence is abuse (pychological, physical, sexual, financial, or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality. Suggested ways to approach the topic: "I talk to all my patients about intimate partner violence because it is common in many patients' lives and there is help available." Ask questions such as: "Has your partner ever threatened to hurt you or physically harmed you in some way?' "Has your partner ever humiliated you, bullied you, or made you feel afraid?" or "Do you feel safe in your current relationship?" The VEGA (**V**iolence, **E**vidence, **G**uidance, and **A**ction) Project has created pan-Canadian, evidence-based guidance and education resources to assist healthcare providers in recognizing and responding safely to family violence. VEGA focuses on

	three main types of family violence: child maltreatment, intimate partner violence, and children's exposure to intimate partner violence. VEGA has developed an online platform of **free education resources** comprised of learning modules (e.g., care pathways, scripts, how-to videos), interactive educational scenarios and a Handbook. Intimate partner violence during pregnancy (who.int) 
Financial/housing concerns [23] NS Community Services	Financial and housing concerns can be screened by using the following question: "Do you ever have difficulty making ends meet, or paying your bills, at the end of the month?" Social determinants of health are interrelated and pregnant persons with low SES and social barriers have more difficulty accessing healthy food and adequate housing and have a higher incidence of anxiety and depression.
Barriers to accessing care [24]	Indicate if there are any barriers related to accessing care. Example of personal barriers include: □ Lack of transportation or childcare □ Low socioeconomic status/financial problems □ Lack of social support □ History of substance use disorder or addiction □ Intimate partner violence Examples of systemic barriers include: □ Negative experiences with the health care system □ Judgement from health care providers
Social support concerns	Social support can be screened for by asking the following questions: "Do you have someone you can depend on to help you if a problem comes up?" "How does your partner/family feel about your pregnancy?"

	"Who will be helping with the baby following birth?"
Parenting concerns	Indicate if there are any concerns related to the pregnant person's ability to parent and if additional resources and support are needed.
Occupational risks	Identify any occupational risks early in pregnancy to determine if adaptations need to be made. Strenuous extended work (lifting heavy objects, shiftwork, high stress environments) may be associated with low birth weight, prematurity, and miscarriage. Chemicals such as anesthetic and chemotherapeutic agents, and solvents and pesticides, can increase the risk of miscarriage, and other adverse pregnancy outcomes.
Oral hygiene concerns [25]	Ask about any concerns related to oral hygiene. Assessment of oral health should be part of prenatal care and general preventive dental care. The treatment of periodontal disease should continue during pregnancy. A cleaning and oral health assessment should be done in the 1st trimester, and any dental work (i.e. fillings) should be done during the 2nd trimester. Periodontal disease during pregnancy contributes importantly to the overall risks of preterm delivery, low birth weight, and preeclampsia.
Dietary restrictions/ concerns [26] SOGC CPG - Female Nutrition	Ask about any dietary concerns or restrictions that may impact nutritional status during pregnancy, such as lactose intolerance, a gluten free diet, veganism, etc. A vegetarian/vegan diet is healthy during pregnancy with careful attention to protein and adequate intake of nutrients such as zinc, iron, vitamin B12, and omega-3 fatty acids. Additional nutrients required during pregnancy include folate, choline, and iodine.
Food security concerns [27] [28] Poverty: A Clinical Tool for Primary Care Providers	Food security can be screened for using the following question: "In the past 12 months, were there times when the food for you and your family just did not last and there was no money to buy more?" Poverty is not always apparent, therefore screening for concerns is important. In Nova Scotia, 22.5% of families with children live in poverty. Food insufficiency and low levels of social support can impact the mental well-being among pregnant persons. Pregnant persons of lower socioeconomic status have an increase in food security/quality concern, financial/housing issues, and barriers to care, all of which can negatively impact pregnancy outcomes.

Substance Use

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

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

Provide additional details in the comments section provided

Substance	Description
Tobacco: past 6 months # cig/day Quit Women and Tobacco	Ask if tobacco was used in the last 6 months and if yes, document the # of cigs/day. If the pregnant person has quit using tobacco, note the date (YYYY/MON/DD) last used.
Tobacco: current use Cigs/per day [29]	Ask if tobacco is currently being used during pregnancy, and if yes, document the # of cigs/day.
Ceremonial	Indicate if tobacco use is ceremonial. While traditional tobacco plays an important medicinal and ceremonial role in many Indigenous communities, the spiritual use of traditional tobacco has no connection to the recreational use of commercial tobacco. This screening seeks to understand non-traditional use of tobacco (i.e. cigarette smoking) during pregnancy.
Nicotine replacement	Ask about nicotine replacement therapy and indicate frequency. Although no amount of nicotine is known to be safe during pregnancy, nicotine replacement therapy is an evidenced based method to support smoking cessation or to reduce the number of cigarettes smoked during pregnancy.
Vaping during pregnancy [30]	Ask if vaping during pregnancy. Many electronic cigarettes (e-cigarettes) contain nicotine, which has been shown to have harmful effects on fetal brain development and many other organs. E-cigarettes also contain ingredients (used to create vapor) and other harmful additives that are not known to be safe in pregnancy. Pregnant persons should be cautioned about using e-cigarettes due to the lack of evidence on their safety and efficacy during pregnancy.
Cannabis use in past 6 months	Ask about cannabis use (inhalation, topical, edibles, and the amount and strength, if known) during the past 6 months.
Current cannabis use #/times used/day/week Method and strength [31] [32] Cannabis Use Women and Cannabis SOGC Cannabis Resources	Ask about cannabis use (inhalation, topical, edibles, and the amount and strength, if known) during current pregnancy. Indicate the number of times used/day or week. Research indicates pregnant persons are turning to cannabis more frequently to treat nausea and vomiting of pregnancy. Advise pregnant persons to abstain from or reduce their cannabis use during pregnancy to prevent negative long-term cognitive and behavior outcomes for exposed babies. The risks of cannabis

	use include preterm labour, low birthweight, lower Intelligence Quotient (IQ) scores, and attention-deficit/hyperactive disorder (ADHD).
Alcohol use past 6 months. #/week **Last drink**	Ask about alcohol use in the past 6 months. If yes, indicate number of drinks per week. If the pregnant person is not currently using alcohol, note the date (YYYY/MON/DD) of last drink.
Current alcohol use #drinks/day or week[33]	Ask about any current use of alcohol. If yes, indicate the number of drinks per day or per week.
≥ 4 drinks at one time [34] Alcohol and pregnancy Women and Alcohol Alcohol and Pregnancy SOGC Alcohol Consumption	Indicate if ≥ 4 drinks are consumed at one time (binge drinking). Binge drinking is a common pattern of alcohol use in indivduals of reproductive age and is associated with adverse fetal effects. Adverse neurodevelopmental effects on the fetus have been associated with binge drinking during pregnancy.
Other substance use in pregnancy Mothering and Opioid toolkit Maternal health and substance use Talking about substance use during pregnancy Brief intervention on substance use Women and Opioids Methamphetamine Use in Pregnancy: A Call for Action (jogc.com)	Indicate if the pregnant person is using other substances in pregnancy. If yes, indicate what substance or substances are being used and the route of administration. □ **Cocaine** increases the risk of preterm birth, placenta-associated syndromes (e.g. placental abruption, preeclampsia, etc.), and impaired fetal growth. Cocaine is short-acting and can be safely stopped during pregnancy. □ **Methamphetamines** are associated with premature delivery, a decrease in the pregnant person's appetite, and slow fetal growth, leading to low birth weight. Treatment options for pregnant persons with methamphetamine dependence include cognitive behavioural therapy, parenting support, and a 12-step program with regular drug testing. □ **Opioids** should not be stopped suddenly during pregnancy as this poses a risk of spontaneous abortion and preterm labour. Opioid agonist treatment, with methadone or buprenorphine, are standard of care for opioid use disorder during pregnancy. □ **Other** – note any other substances used during the pregnancy. **Route**: Note the route of administration of substances used during pregnancy.

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

Ethnicity / Genetic Risk Assessment

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

Ethnicity	The terms "race" and "ethnicity" are often used interchangeably or as a single, conflated construct — "race/ethnicity." However, race and ethnicity are distinct social constructs, and the measurement and reporting of racial and ethnic health inequalities should reflect these differences. Race is a social construct used to judge and categorize people based on perceived differences in physical appearance in ways that create and maintain power differentials within social hierarchies. There is no scientifically supported biological basis for discrete racial groups. Racialization is the process by which people are judged and categorized into races primarily using differences in physical appearance. In this process, societies construct races as "real," different and unequal in ways that pertain to economic, political and social life. Ethnicity is a multi-dimensional concept referring to community belonging and a shared cultural group membership. It is related to socio-demographic characteristics, including language, religion, geographic origin, nationality, cultural traditions, ancestry and migration history, among others. Because race and ethnicity may affect how we are treated by individuals and instistuition and ultimately affect our health we recommend determining the ethnicity of the pregnant person by identifying with a √ all that apply from the following list: □ Acadian □ Black - African, African Canadian, Afro-Caribbean descent □ Southeast Asian - Cambodian, Filipino, Indonesian, Thai, Vietnamese, or other Southeast Asian descent □ Latin American - Hispanic or Latin American descent □ Indigenous - (First Nations, Inuk/Inuit, Métis) □ East Asian - Chinese, Japanese, Korean, Taiwanese descent □ Middle Eastern - Arab, Persian, West Asian descent (e.g., Afghan, Egyptian, Iranian, Kurdish, Lebanese, Turkish) □ South Asian - South Asian descent (e.g., Bangladeshi, Indian, Indo-Caribbean, Pakistani, Sri Lankan) □ White – European descent (Eastern – e.g. Russian, Polish; Western – e.g. English, Italian) □ Other - pregnant person identifies with an ethnicity that is not listed, specify the ethnicity in the space provided. □ Prefer not to answer - the pregnant person prefers not to answer. If the pregnant person does not know their ethnicity, record 'Do not know' in the space provided.

	Note: Ethnic or cultural identity is self reported and should not be assumed. It is often an indication of cultural beliefs/practices and the pregnant person may identify with more than one ethnic group.
Donor gamete	Indicate if a donor gamate contributed to the pregnancy.
Egg age greater than or equal to 35 at estimated date of delivery	Indicate if the pregnant person (or in the case of gamete donation, the age of the egg donor) will be ≥ 35 years of age at the EDD. In the use of frozen gametes, the age of the person at the time the gametes were frozen would be used for calculation. **Pregnant persons > 35 years at the EDD and those with specific risk factors should be offered an Early Pregnancy Review (EPR)**. An EPR is an ultrasound that reviews viability, dates, early development and assesses for fetal abnormalities through specific markers, particularly nuchal translucency. In Nova Scotia this is done at the Fetal Assessment and Treatment Center (FATC) at the IWK hospital.
Ethnicity gamete	Indicate the ethnicity of the male gamete contributor to the pregnancy. If the female gamete is from a donor egg, indicate the ethnicity of the female gamete.
Hemoglobinopathy/ Thalassemia screening	Indicate if screening was completed or if not applicable. Carrier screening for thalassemia/hemoglobinopathies should be offered to pregnant persons/families from ethnic backgrounds of African, Asian, Hispanic, Mediterranean, or Middle Eastern descent, when red blood cell indices reveal a mean cellular volume < 80 fl, or electrophoresis reveals an abnormal hemoglobin type. If the female thalassemia or sickle cell screening results are abnormal, a hemoglobinopathy screening protocol should be undertaken for the male gamete provider. If both reproductive partners are found to be carriers of thalassemia, sickle cell or a combination of thalassemia and hemoglobin variants, they should be referred for formal genetic counselling. **Screening should be done in the pre-conception period or as early into the pregnancy as possible.**
Consanguinity (blood relation)	Indicate if there is a consanguinity relation. Defined as a relationship between two people who are related to each other because they share a common ancestor: a 'shared blood' relationship. For example: a relationship between two cousins. This should be investigated if there is history of an autosomal disorder. For further information, contact Maritime Medical Genetics Service at (902) 470-8754. Referrals can be faxed to (902) 470-8709.
Referral to Medical Genetics	Consider referral to Medical Genetics for pregnant persons from higher risks populations and those with a personal or family history of: □ Congential anomaly (e.g. congential heart defect, neural tube defect) □ Intellectual disability or developmental delay

	□ Genetic syndrome (e.g. neurofibromatosis, Noonan syndrome) □ Chromosomal disorder (e.g. trisomy 21, familiar translocation) □ Muscular disorder (e.g. X-linked Duchenne and Becker muscular dystrophies) □ Bleeding disorder (e.g. X-linked hemophilia A or B) □ Stillbirth □ Sudden unexplained death □ Other major health concerns such as cardiomyopathy, neurologiacal disease, epilespsy, hearing loss, autism, and psychiatric diorders. □ Consanguinuity (blood relation) - a relationship between two people who are related to each other because they share a common ancestor: a 'shared blood' relationship (i.e. a relationship between two cousins). This should be investigated if there is history of an autosomal disorder.

Genetic Screening/investigations

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

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

All pregnant persons should be offered a fetal ultrasound between 7~~11~~ and 14 weeks for pregnancy dating (where available). For those with identified risks factors, include a nuchal translucency (NT) evaluation and early anatomic assessment (EPR) (11-14 weeks).

Select the appropriate boxes with a 'V'.

Screening	Description
No Genetic Screening	Indicate if the pregnant person was counseled and declined genetic screening.
Maternal Serum Testing[35 36 37] (9 -13^{+6} weeks gestation) SOGC Prenatal Screening SOGC CCMG Prenatal Screening	Indicate if counseled re MST and if screening was completed or declined. **Early Maternal Serum Testing (MST):** 1st trimester MST should be offered to all pregnant persons regardless of age. MST measures naturally occurring substances in the blood that are produced in all pregnancies. The first MST should be completed between 9 and 13^{+6} weeks gestation.
Nuchal Translucency (NT) (11 - 13^{+6} weeks gestation)	Indicate if N/A, or if counseled re NT and if completed or declined. **Nuchal translucency is part of the early pregnancy review (EPR), which should be offer to all pregnant persons > 35 years at the EDD and those with specific risk factors.**

Maternal Serum Testing (15 - 20^{+6} weeks gestation)	Indicate if counseled re second MST, and if completed or declined. The second MST is completed between 15^{+0} - 20^{+6} weeks gestation. It can be completed even if the first trimester maternal serum testing was not completed. **Integrated Maternal Serum Testing:** incorporates maternal age at EDD, 1st trimester MST and 2nd trimester MST into a combined or integrated assessment of risk for fetal chromosomal abnormalities, open neuro tube defects, and placental abnormalities. **Note:** for the integrated screen both 1st trimester and 2nd trimester testing must be offered and completed. **Integrated Prenatal Test:** the same as above with the nuchal translucency~~EPR~~ in the integration.
EPR (early pregnancy review)	Indicate if N/A, or counselled re EPR, and if completed or declined. An EPR is best completed between 11^{+0} - 13^{+6} weeks gestation and used in conjunction with the maternal serum test for assessment of risk for Trisomy 21.
NIPT (cell free DNA) (11-14 weeks) [38] [39] NIPT/Cell Free DNA Screening Predictive Value Calculator Clinical Genomics - NIPT Information for Care Providers (nshealth.ca)	Indicate if counseled about NIPT and if completed or declined. If completed, indicate if paid for by MSI or self pay. Non-Invasive Prenatal Testing (NIPT) is currently used in Nova Scotia as a second-tier screen for common aneuploidy, including Trisomy 13, 18, or 21 and sex chromosome aneuploidy (SCA). Patients should be made aware of the option to have NIPT, understanding that it may not be provincially funded. Care providers should discuss NIPT and other available prenatal screening options with pregnant persons. Patients in Nova Scotia will be offered funded NIPT under the following circumstances: • Pregnant persons with a previous pregnancy affected with Trisomy 13, 18 or 21 are eligible for funded NIPT in the first trimester, as early as 10 weeks gestation. This is in lieu of standard screening using the MST and nuchal translucency assessments. In order to access funded NIPT, these patients must be referred to Medical Genetics or a Maternal-Fetal Medicine Specialist. • Pregnant persons who have undertaken standard screening, and are found to be at **increased risk** of Trisomy 21 based on the results of standard screening, will be seen by either Medical Genetics or Maternal-Fetal Medicine Specialists and offered the option of funded NIPT in lieu of diagnostic testing (CVS or amniocentesis). A referral is not necessary.

	Patients meeting specific eligibility criteria as noted above will be provided pre-test counselling, test co-ordination, result reporting, and additional counselling as needed. NIPT is not offered to patients who are **not at increased risk** of Down syndrome either before or after standard screening tests. If a pregnant person wishes to have NIPT in lieu of standard screening, or after receiving a low-risk screening result after standard screening, they have the option to pay for this test through an independent referral laboratory. For more detailed information and a Care Provider FAQ resource click here. **If a pregnant person proceeds with NIPT, completing the MST is not necessary.**
Chorionic Villus Sampling (CVS) / Amniocentesis	Specify if CVS or amniocentesis was completed. CVS is a U/S guided procedure in which a sample of chorionic villi is obtained either transvaginal using biopsy forceps or transabdominal using a needle. CVS has an additional 1% (1/100) risk of miscarriage. Amniocentesis is a U/S guided procedure in which a needle is directed into the gestational sac and a sample of amniotic fluid is withdrawn. Amniocentesis has an additional 1/200 to 1/400 risk of miscarriage.
Other	Indicate if other testing was done and add comments in the space provided.

Nova Scotia Prenatal Record #3

Reproductive Care Program of Nova Scotia (RCP) · nova scotia health · IWK Health

Area for Patient Label.

NOVA SCOTIA PRENATAL RECORD

Part 3 For additional information referr to the "Guidelines for Antenatal Laboratory Screening and Testing" resource.

Ultrasound/Biophysical Profile

Date YYYY/MON/DD	GA	Results	Date YYYY/MON/DD	GA	Results

Initial Lab Investigations

Test	Results	Date YYYY/MON/DD
Hemoglobin		
Platelets		
ABO/Rh (D)		
Antibody screen	❑ Negative ❑ Positive	
Hemoglobin A1c		
Fasting Plasma Glucose	❑ NA	
Syphilis	❑ Non-reactive ❑ Reactive	
HbsAG	❑ Non-reactive ❑ Reactive	
HIV	❑ Non-reactive ❑ Reactive	
Urine C&S		
Varicella*	❑ Immune ❑ Non-immune	
Rubella*	❑ Immune ❑ Non-immune	
Pap due	❑ Yes ❑ No	
Last pap results	❑ Normal ❑ Abnormal	

24-28 Weeks Lab Investigations

Test	Results	Date YYYY/MON/DD
Hemoglobin		
Platelets		
ABO/Rh (D)		
Repeat Antibodies	❑ Negative ❑ Positive	
GCT 50 g	1 hour _____ ❑ **GDM**	
OGTT 75 g	❑ NA Fasting _____ 1 hour _____ 2 hour _____ ❑ **GDM**	
Syphilis	❑ Non-reactive ❑ Reactive	
Group B strep (35-37 weeks)	❑ Negative ❑ Positive	
GC/Chlamydia (35-37 weeks)	❑ Negative ❑ Positive	

Additional Tests (as indicated)

Ferritin	❑ NA		
TSH	❑ NA		
GC/Chlamydia**	❑ Negative ❑ Positive		

Screening Tool Results (see worksheets 3 and 4)

WAST ❑ Negative ❑ Positive	EPDS score	EPDS score	EPDS score	T-ACE score ❑ NA as no alcohol consumed
Date YYYY/MON/DD	Date YYYY/MON/DD	Date YYYY/MON/DD	Date YYYY/MON/DD	Date YYYY/MON/DD

Rh CARE ❑ NA

❑ Rh (D) Neg Paternal/Donor blood type _____

Rh (D) Alloimmunization ❑ Yes ❑ No

❑ Rho(D) IG (28-29+6 weeks) Date YYYY/MON/DD _____

❑ Additional Rho(D) given Date YYYY/MON/DD _____

Bleeding/other event in pregnancy ❑ Yes ❑ No

_____ weeks

Recommended Vaccines

Influenza vaccine ❑ NA Lot Number _____
Date YYYY/MON/DD

Hepatitis B vaccine ❑ NA Lot Number _____
Date YYYY/MON/DD

Tdap vaccine at 27-32 weeks Lot Number _____
Date YYYY/MON/DD

Other _____ Lot Number _____
Date YYYY/MON/DD

*Perform serology if immunity unknown ** Perform GC/Chlamydia screening early in pregnancy for those at risk.

For copies: Reproductive Care Program http://rcp.nshealth.ca/chart-prenatal-forms/nova-scotia-prenatal-record • Tel: 902-470-6798
REV 2022/MAR

Ultrasound/Biophysical Profile

Item	Description
Ultrasound/ Biophysical profile (BPP) [40] Fetal Surveillance	Indicate date (YYYY/MON/DD) of U/S or BPP, gestational age, and results. Pregnant persons at increased risk for adverse perinatal outcome, and where facilities exist, should have a biophysical profile to evaluate fetal well-being. The BPP is a sonographic evaluation performed over a 30-minute period, to assess and observe fetal breathing movement, body movement, tone, and amniotic fluid volume.

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

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

Maternal indications for increased fetal Surveillance in pregnancy may include:

Indication	Initiation	Frequency
Pregestational Diabetes	32 wks – poor glycemic control, any complications 36 wks – good glycemic control, no complications	weekly
GDM on insulin	36 wks	weekly
SLE, antiphosholipid antibody syndrome, high risk thrombophilia (antithrombin deficiency, compound heterozygote, homozygote for Factor V Leiden or Prothrombin)	32 wks	weekly
Low risk thrombophilias (heterozygote for Factor V Leiden or Prothrombin, Proteins S or C deficiency)	36 wks	weekly
Maternal renal/cardiac disease	32 wks – worsening function, any complications 36 wks – stable, no complications	weekly
AMA (≥ 40 years)	36 wks	weekly
Postdates	> 41 wks	1-2 x/wk
Previous third trimester IUFD	32 wks or 2 wks before gestational age of previous IUFD	weekly
IVF pregnancy	36 wks	weekly
Gestational HTN	At dx	weekly
Chronic abruption	At dx	weekly
Morbid obesity (BMI ≥ 40)	36 wks	weekly
Cholestasis	At dx	weekly

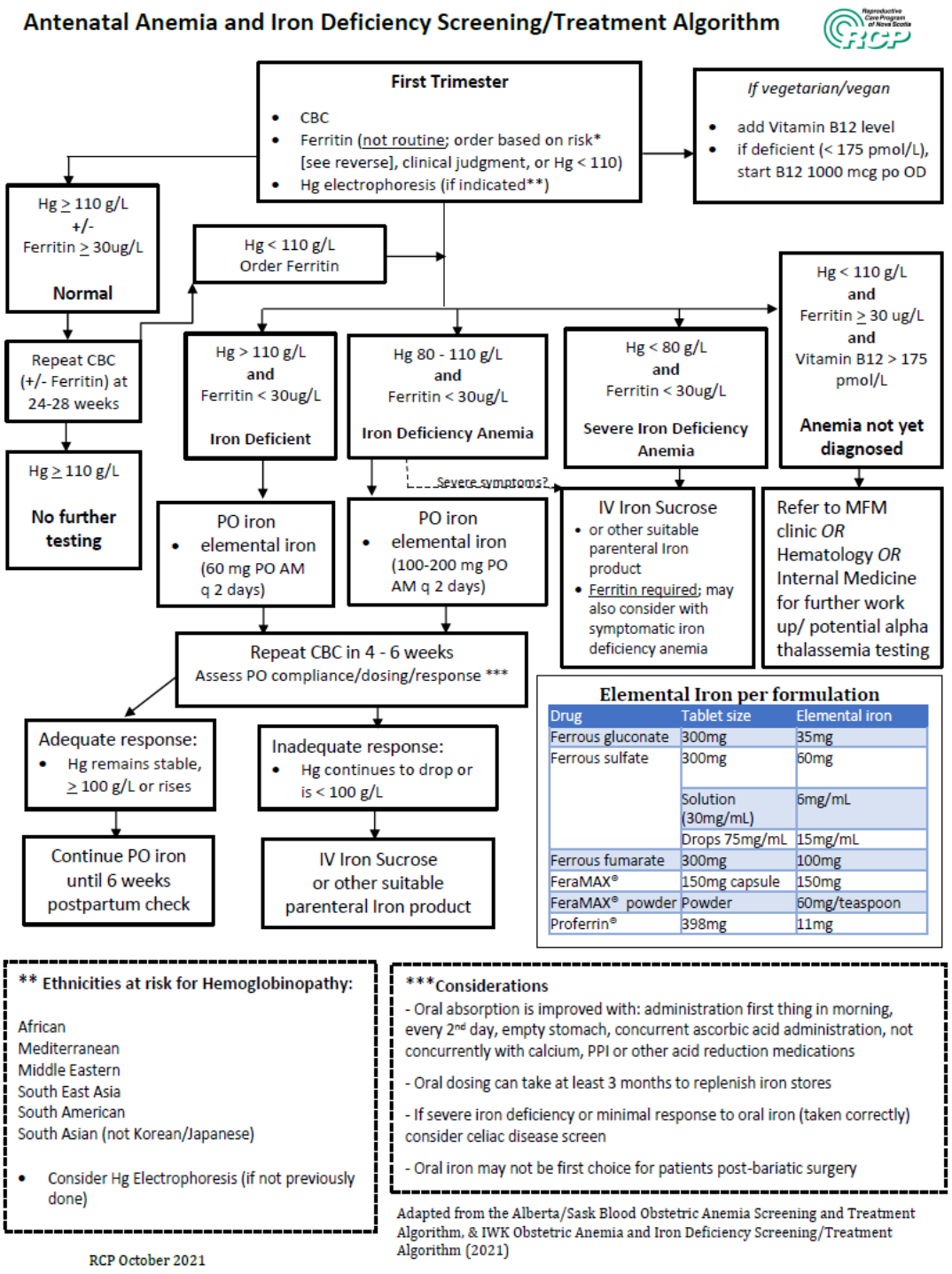
Fetal indications for increased ultrasound surveillance in pregnancy may include:

Indication	Initiation	Frequency
Decreased fetal movement	ASAP	prn
PPROM	At dx / viability	weekly
IUGR (<5th % ile)	At dx / viability	1-2 x/wk + Dopplers
MCDA Twins	32 wks	weekly
DCDA Twins	36 wks if appropriately grown	weekly
Polyhydramnios	At dx	weekly
Oligohydramnios	At dx / viability	weekly
Rh isoimmunization	32 wks	weekly

Initial Lab Investigations

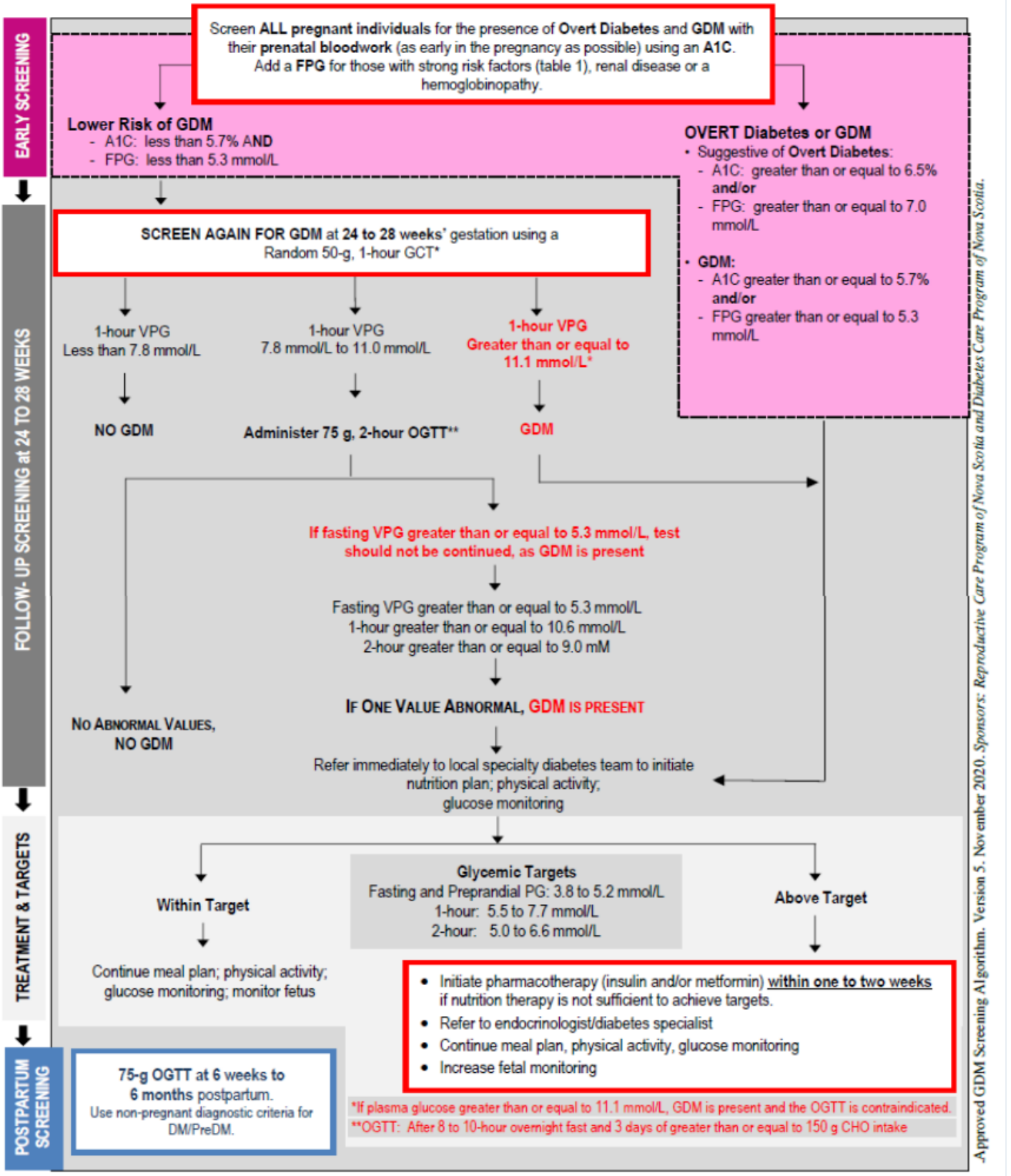
Test	Result Indicate the date (YYYY/MON/DD) of the lab investigations
Hemoglobin	Hemoglobin (HGB) will indicate anemia and any HGB abnormalities. Low MCV (<85) may indicate iron deficiency or thalassemia. High MCV may indicate folate or B12 deficiency, liver disease, hypothyroidism, or alcohol use.

Antenatal Anemia / Iron Deficiency Screening/Treatment Algorithm



Platelets	Platelets will screen for thrombocytopenia.
AB0/Rh (D) [41] SOGC Rh Alloimmunization	**ABO/Rh** - All pregnant persons should have a blood type and antibody screen with an indirect antiglobulin test (IAT) at their first prenatal visit. Indicate the blood group and Rh status.
Antibody Screen	**Red cell antibodies** – indicate test result as negative or positive. Any circulating antibody as measured by an indirect antiglobulin test. A positive screen warrants additional testing and follow up.
Hemoglobin A1c Recommendations for Gestational Diabetes Mellitus (GDM) Screening in NS	The DCPNS and RCP recommend that GDM screening in NS be as follows: □ Universal collection of HbA1c with initial prenatal bloodwork performed early in the antenatal period (before 20 weeks gestation). □ A fasting glucose be added to this initial bloodwork for pregnant persons with strong risk factors for developing GDM or risk of inaccurate HbA1c results (ex: hemoglobinopathies, chronic kidney disease). **Strong Risk Factors** • Prediabetes • Previous diagnosis of GDM • Multiple Gestation • BMI greater than or equal to 40 • Polycystic Ovary Syndrome (PCOS) • Corticosteroid use • Member of a high-risk population (Indigenous, Hispanic, South Asian, Asian, African Canadian) • Glycosuria The new approach to GDM screening will be help identify persons with overt diabetes and those at increased risk of developing GDM at a much earlier gestation. **Initial GDM Screen:** □ A1c plus or minus FPG □ A1c ≥ 6.5% and/or FPG ≥ 7 mmol/L = overt diabetes or GDM* □ A1c ≥ 5.7% and/or FPG ≥ 5.3mmol/L = GDM* □ A1c < 5.7% (and if applicable FPG < 5.3 mmol/L) = low risk for GDM, screen again at 24-28 weeks for GDM ***GDM diagnosis** - Refer immediately to local specialty diabetes team to initiate nutrition plan; physical activity; self-monitoring of blood glucose.
Fasting Plasma Glucose (FPG)	A fasting plasma glucose should be added to initial bloodwork for pregnant persons with renal disease, a hemoglobinopathy, or strong risk factors for developing GDM, including: □ Prediabetes □ Previous GDM □ Multiple gestation □ BMI > 40 kg/m2 □ Polycystic ovary syndrome (PCOS) □ Corticosteroid use □ Members of high-risk population (Indigenous/First Nations, Hispanic, South Asia, Asian, African Canadian) □ Glycosuria

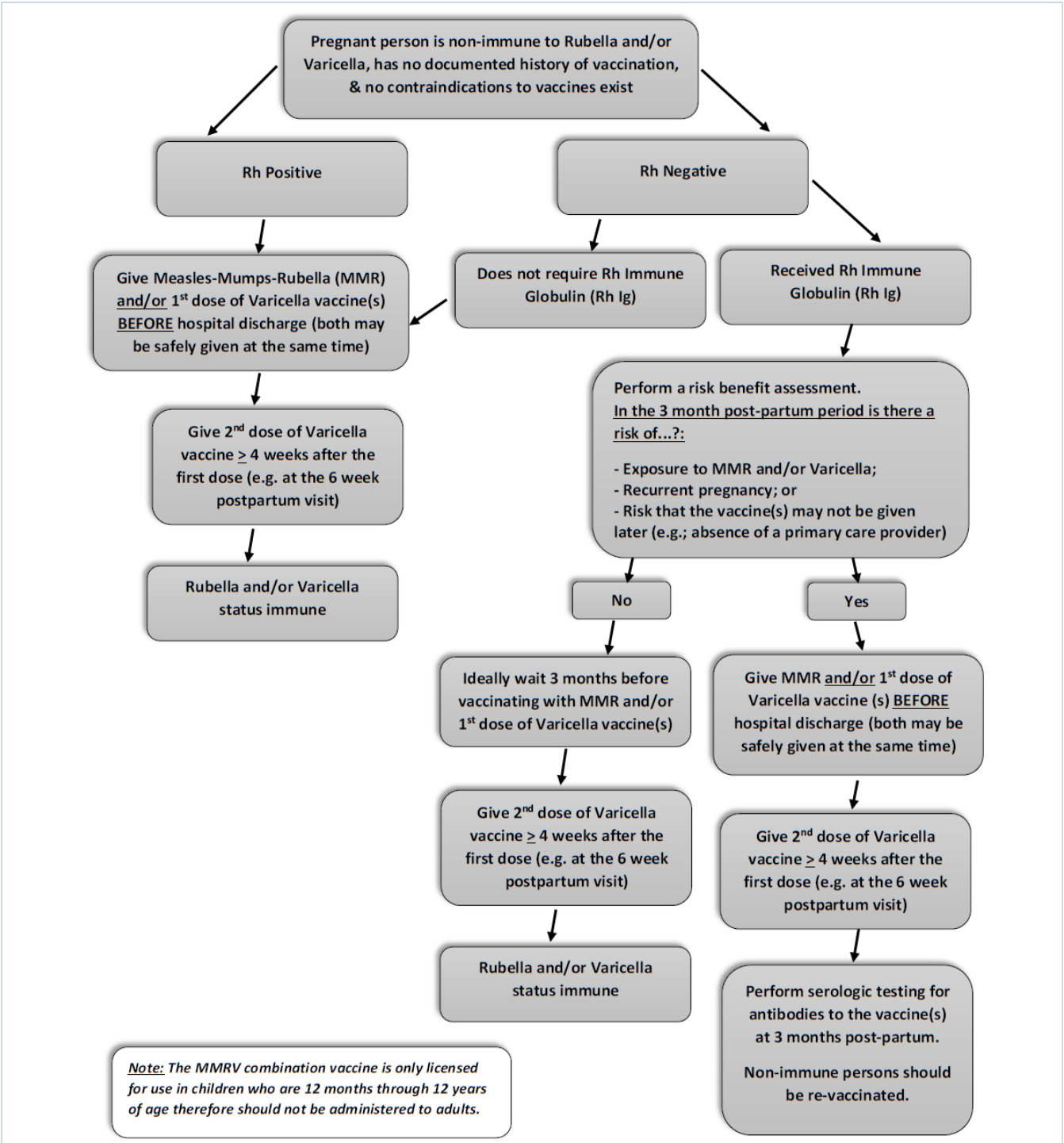
Recommendations for Gestational Diabetes Mellitus (GDM) Screening in NS



**** If 50-g GCT is not available (i.e., COVID-19 pandemic) or for those individuals who cannot tolerate the 50-g GCT or 75-g OGTT (e.g., allergy to orange dye, hyperemesis gravidarum), an A1C and a FPG can be done at 24-28 weeks using the same cutoffs used in early screening.**
Key: GCT = oral glucose challenge test; OGTT = oral glucose tolerance test

Syphilis RCP Syphilis Guidelines	Offer screening early in pregnancy. Indicate results as non-reactive or reactive. **Given the rise nationally in syphilis, and the provincial outbreak, screening is increasingly important.** Public Health and the RCP recommend: □ Repeat syphilis serology in all pregnant persons at 24 - 28 weeks gestation and for pregnant persons considered at high risk of syphilis, repeat syphilis serology at delivery. □ For pregnant persons who deliver a stillbirth from 20 weeks gestation onward, screen for syphilis. □ Syphilis serology should be completed prior to discharge after delivery if a pregnant person has NOT had the recommended syphilis screening during pregnancy.
Hepatitis B Surface Antigen (HbsAg) Canadian Guidelines on STIs	Indicate test results as reactive or non-reactive. Offer screening early inpregnancy to determine Hep B surface antigen. The presence of Hep B surface antigen indicates prior Hep B infection and carrier status. This information is required to assess maternal liver function and to identify newborns that require Hep B Immunoprophylaxis after birth. Those identified as high risk should be rescreened later in pregnancy. (e.g., illicit drug use, multiple sexual partners, multiple transfusions, immunosuppression, hepatitis B positive partner, incarceration, etc.) **Note: Hepatitis C (HCV)** is more prevalent than Hepatitis B in Nova Scotia. However, routine screening for HCV is not recommended as there is no known therapy that prevents vertical transmission nor is there an intervention for the neonate. Pregnant persons who identify risk factors for blood borne pathogens during prenatal health screening should be screened for HCV.
HIV screening [42] [43] SOGC HIV	Human Immunodeficiency Virus (HIV) screening should be considered a standard of care and offered on the first prenatal visit. Pregnant persons must be informed of the policy, its risks and benefits, the right of refusal, and should not be tested without their knowledge.
Urine culture and sensitivity	Document date (YYYY/MON/DD) of sample and indicate results. Screen for asymptomatic bacteriuria (ABU) in the 1st trimester of pregnancy, or at the 1st prenatal visit if it occurs later and treat if positive. ABU is defined as a urine sample containing bacteria with colony counts ≥100 000 CFU/mL, without specific symptoms of a urinary tract infection. Treatment with appropriate antibiotics is an accepted and recommended strategy for ASB. Consider rescreening if the first screen is positive or there is a history of recurrent urinary tract infections.
Varicella (serology/adult vaccine) [44] SOGC CPG Varicella in Pregnancy	Pregnant persons without a known history of varicella infections and without documented laboratory evidence of varicella immunity or prior immunization with 2 doses of varicella vaccine should be serologically screened for varicella antibodies. Serologically screen for rubella antibodies in pregnant persons without prior adult immunization with a rubella-containing vaccine or evidence of positive rubella serology.

Rubella (serology/vaccine) [45] SOGC CPG - Rubella Canadian Immunization Guide	**If non-immune, administer the MMR and/or Varicella vaccine in the immediate post-partum period** unless they have received Rh(D) immunoglobulin (RhIG). Patients receiving RhIG: To optimize response to vaccine, **pregnant persons who are susceptible to rubella, measles, or varicella and received RhIG in the peri-partum period should generally wait 3 months before being vaccinated with MMR or varicella vaccine.** However, if there is a risk of: exposure to rubella, measles, or varicella; recurrent pregnancy in the 3 months post-partum period; or a risk that vaccines may not be received later, either MMR or monovalent varicella vaccine or both may be given prior to discharge. In this context, serologic testing for antibodies to the vaccine antigens should be done 3 months after vaccination and non-immune women should be revaccinated. □ Consideration should be given to administering the MMR or monovalent varicella vaccine immediately postpartum for those persons without a primary care provider in the community. □ Follow-up serology for immunity should also be arranged prior to discharge for those persons without a primary care provider. **Note:** If both MMR and Varicella vaccines are indicated, they can be administered on the same day. The MMRV combination vaccine is only licensed for use in children who are 12 months through 12 years of age therefore should not be administered to adults.

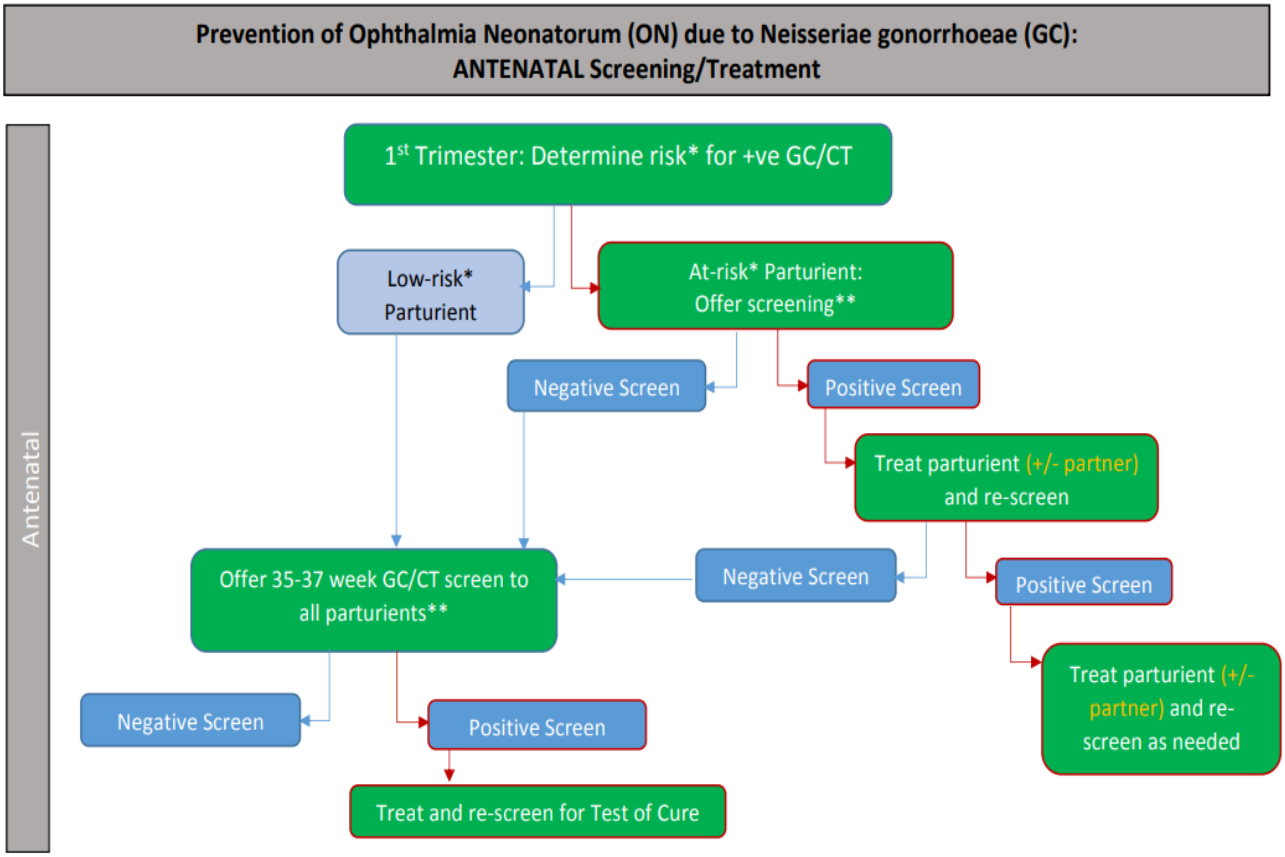


Pap Due Cancer Care Nova Scotia Guidelines	Indicate if pregnant person is due for a pap smear. The screening frequency for pregnant persons should be the same as for persons who are not pregnant, every three years. Anyone who have been treated for cervical dysplasia or has a history of cancer of the cervix, and those who are immunocompromised, or HIV positive should receive annual screening for life.
Last pap results	Document the date (YYYY/MON/DD) and the results ~~as normal or abnormal~~.

24-28 Week Lab Investigations

Test	Result Indicate the date (YYYY/MON/DD) of the lab investigations
Hemoglobin RCP Anemia / Iron Deficiency Screening/Treatment	Hemoglobin (HGB) will indicate anemia and any HGB abnormalities. Low MCV (<85) may indicate iron deficiency or thalassemia. High MCV may indicate folate or B12 deficiency, liver disease, hypothyroidism, or alcohol use.
Platelets	Platelets will screen for thrombocytopenia.
AB0/Rh (D)	Document date (YYYY/MON/DD) and indicate blood group and Rh status.
Antibody Screen	Document date (YYYY/MON/DD) and indicate test results as positive or negative.
Glucose Challenge Test (GCT) **50 grams**	Pregnant persons with an A1C < 5.7, and if applicable a FPG < 5.3mmol/L at the time of the early screen, should be offered additional screening for GDM between 24-28 weeks. A non-fasting 50-g GCT with plasma glucose (PG) measured 1 hour later is the preferred approach. □ A PG value of <7.8 mmol/L indicates no GDM. □ A PG value of 7.8 -11.0 mmol/L is a positive screen and an indication to administer the 75g OGTT. □ A PG over ≥11.1 mmol/L is diagnostic of GDM and an OGTT is not required.
OGTT 75 grams (If required) [46]	If the value of the GCT is ≥7.8 – 11.0mmol/L a two-hour fasting oral glucose tolerance test (OGTT) should be performed. GDM is confirmed with 1 of the following: □ Fasting PG ≥5.3 mmol/L OR □ 1-hour PG ≥10.6 mmol/L OR □ 2 hours PG ≥9.0 mmol/L
Syphilis RCP Syphilis 2020	Document date of sample (YYYY/MON/DD) and indicate results as Positive or Negative. Repeat syphilis serology in all pregnant persons at 24 -28 weeks gestation, and for pregnant persons considered at high risk of syphilis, repeat syphilis serology at delivery.
Group B Streptococcal (GBS) 35-37 weeks [47] ACOG GBS SOGC GBS	Document date (YYYY/MON/DD) and indicate results as positive or negative. GBS is bacteria that normally lives in the intestinal, vaginal, and rectal areas. Approximately 15-40% of all healthy persons carry GBS and are asymptomatic. GBS can be passed on to baby during delivery; therefore, universal screening with a recto-vaginal swab between 35-37 weeks gestation is recommended. The culture should be taken from one swab first in the vagina and then from the rectum (through the anal sphincter). The **swab provides a 5-week window for valid culture results** and the ACOG recommends obtaining the GBS swab between $36^{+0/7}$ and $37^{+6/7}$ to ensure results are valid with births occurring up to the gestational age of $41^{+0/7}$ weeks.[48]
Gonorrhea (GC) / Chlamydia **35-37 weeks**	Document date of sample (YYYY/MON/DD) and indicate results as Negative or Positive N. gonorrhea in pregnancy is associated with endometritis, pelvis sepsis, ophthalmia neonatorum and systemic neonatal infections. All pregnant persons should be screened for *N gonorrhoeae* and *C trachomatis* infections between 35-37 weeks gestation. Those

RCP ON Prevention in Nova Scotia	who are infected should be treated, tested after treatment to ensure therapeutic success, and tested again prior to delivery.



** The optimal timing and frequency of antenatal screening for gonorrhea/chlamydia (GC/CT) will be directed by clinical judgment in consideration of the risk factors associated with individual patients. Screening and treatment requires informed consent. Parturients may choose to decline – ensure discussion of risk factors and potential health outcomes is clearly documented.

*According to Public Health Agency of Canada, risk factors include age < 25 years, previous STI diagnosis, new sexual partner, multiple or anonymous sexual partners, sexual partner(s) having a STI, condomless sex, and sex while under the influence of alcohol or drugs. **Discussion of/screening for risk factors can occur any time in the perinatal continuum. If a "low-risk" parturient discloses risk factors after initial screening, follow algorithm for "at-risk" parturient.**

Additional Test

Additional test as indicated	Additional test should be completed when clinically indicated. B12, infectious diseases (Hep C, Parvo, CMV, Toxoplasmosis, etc.), rescreen STIs, drug screen, Pap, hemoglobin electrophoreses, Hemoglobin A1C, etc. Document date completed (YYYY/MON/DD) and results as applicable.
Ferritin [49] RCP Anemia / Iron Deficiency Screening/Treatment	Indications for ordering serum Ferritin Adapted from Alberta/Saskatchewan Blood Obstetric Anemia Screening and Treatment Algorithm, & IWK Obstetric Anemia and Iron Deficiency Screening/Treatment Algorithm

	Anemic pregnant persons where testing serum ferritin is necessary prior to iron supplementation: □ Known haemoglobinopathy □ Prior to parenteral (IV) iron replacement Non-anemic pregnant persons with high risk of iron depletion for empirical iron treatment with/without serum ferritin testing: □ Previous anaemia □ Multiparity ≥P3 □ Twin or higher order multiple pregnancy □ Interpregnancy interval <1 year □ Those who have poor dietary habits (or who are experiencing food insecurity) □ Those following a vegetarian/vegan diet □ Age < 20 years □ Recent history of clinically significant bleeding Non-anemic pregnant persons where serum ferritin may be necessary: □ High risk of bleeding during pregnancy or at birth □ Those declining blood products, such as Jehovah's Witnesses □ Those for whom providing compatible blood is challenging
TSH [50] [51] [52]	A Thyroid Stimulating Hormone (TSH) level should be part of the initial bloodwork for pregnant persons with one or more of the following: □ Age greater than 30 years □ Goiter □ History of thyroid dysfunction □ Body mass index greater than or equal to 40 □ Type 1 Diabetes/other autoimmune disorder □ Infertility □ Head or neck radiation □ Family history of thyroid disease □ Thyroid surgery □ Signs and symptoms of thyroid dysfunction □ History of recurrent miscarriage or preterm delivery □ Positive Thyroid peroxidase Antibody □ Residing in an area of moderate to severe iodine insufficiency □ Use of amiodarone, lithium, or radiologic contrast. TSH reference intervals during pregnancy 1st Trimester — 0.1 - 2.5 mU/L 2nd Trimester — 0.2 - 3.0 mU/L 3rd Trimester — 0.3 - 3.0 mU/L

Gonococcal / Chlamydia RCP ON Prevention in Nova Scotia	Screen for Gonorrhea and Chlamydia in pregnancy in the 1st trimester for those at hish risk. Risk factors include but are not limited to age <25 years and behavioural risk factors such as: □ previous STI diagnosis □ new sexual partner □ multiple or anonymous sexual partners □ sexual partner(s) having a STI, Document date of sample (YYYY/MON/DD) and indicate results as Positive or Negative

Screening Tool Results

Item	Description		
WAST	Indicate date (YYYY/MON/DD) and if the screen was positive or negative The Woman Abuse Screening Tool (WAST) is used by care providers to screen for intimate partner violence during pregnancy and should be completed in each trimester of pregnancy. If the answers to the first 2 questions of the WAST (below) are 'a lot of tension' and 'great difficulty' the screen is considered positive, and the remaining questions should be asked to elicit more information about the abuse and the need for additional support and resources.		
	1. In general how would you describe your relationship? □ A lot of tension □ Some tension □ No tension	2. Do you and your partner work out your arguments with: □ Great difficulty □ Some difficulty □ No tension	
EPDS score EPDS-3A	Indicate date (YYYY/MON/DD) and the score. The Edinburgh postnatal depression scale (EPDS) tool can be completed by the care provider, but it is ideal to have the pregnant person complete it independently. The EPDS can help identify anxiety if the answers to questions 3, 4, and 5 (below) have a score ≥ 5.		
	3. I have blamed myself unnecessarily when things went wrong 3 ☐ Yes, most of the time 2 ☐ Yes, some of the time 1 ☐ Not very often 0 ☐ No, never	4. I have been anxious or worried for no good reason 0 ☐ No, not at all 1 ☐ Hardly ever 2 ☐ Yes, sometimes 3 ☐ Yes, very often	5. I have felt scared or panicky for no very good reason 3 ☐ Yes, quite a lot 2 ☐ Yes, sometimes 1 ☐ No, not much 0 ☐ No, not at all
T-ACE score	Indicate date (YYYY/MON/DD) and the score. Check N/A if no alcohol consumed. The T-ACE (Tolerance Annoyed Cut down Eye opener) screening is **not** required if no alcohol is consumed.		

	A pregnant person who answers, “more than two drinks” on the tolerance question, “How many drinks does it take to make you feel high?” is scored 2 points. Each “yes” to the additional 3 questions scores 1 point. A score of 2 or more out of 5 indicates risk of a drinking problem, and further assessment and/or referral may be required.

Rh CARE / Recommended Immunizations

Item	Description
Rh (D) Neg	Indicate with a ‘✓’ pregnant person is Rh Neg
Paternal / donor blood type	Indicate partner’s / sperm blood type if known **Paternal Blood Type Testing in Pregnancy** – Paternal Rh testing can be done to confirm that an Rh (D) negative pregnant person truly requires administration of Rh immune globulin (WinRho®). When the paternal blood is tested and found to be Rh negative, the laboratory will do an additional more sensitive “weak D” test to determine if administration of WinRho® can be safely omitted. **Please note:** that if paternity is unknown or uncertain none of this applies and testing is unnecessary. Laboratories need to know when paternal testing is being requested to determine the need for Rho(D) IG (WinRho®). **When doing paternal testing:** □ Check off **ABO & Rh type (blood type).** The antibody screen is **not** required. □ Add comment: **Paternal testing. Partner Rh negative.**
Rh (D) alloimmunization	Indicate Y or N with a ‘✓’ if pregnant person has Rh (D) alloimmunization.
Rho (D) IG (28- 29^{+6}) Rh Program NS	Indicate with a ‘✓’ if given and document the date given (YYYY/MON/DD) Non-sensitized Rh (D) negative pregnant persons should receive Rho(D) IG at 28-29 weeks’ gestation. Rho(D) IG is a blood product and normal procedure for discussion and consent should be followed.
Additional dose given	Indicate with a ‘✓’ if an additional dose was given and document the date (YYYY/MON/DD) Rho(D) IG should also be given after in some cases of spontaneous or induced abortion ~~(after 8 weeks or 56 days)~~, ectopic pregnancy, or obstetrical complications (e.g. any bleeding, abdominal trauma) or procedures such as amniocentesis and external cephalic version; and within 72 hours after delivery of a Rh(D) positive infant.
Bleeding / other event in pregnancy	Indicate Y or N with a ‘✓’. Document weeks and if an U/S was done. Document the date Rho(D) IG given (YYYY/MON/DD), if applicable.

	Rh immune globulin (WinRho®SDF) may be safely withheld prior to 8 weeks (56 days) gestation for pregnancy complications or medical abortions when there is confident and reliable pregnancy dating, including one of the following: Ultrasound dating; certain conception dating; or known first day of LMP for individual having regular (28 day) cycles and in the three months prior to conception absence of lactation, hormonal contraception or IUD use.

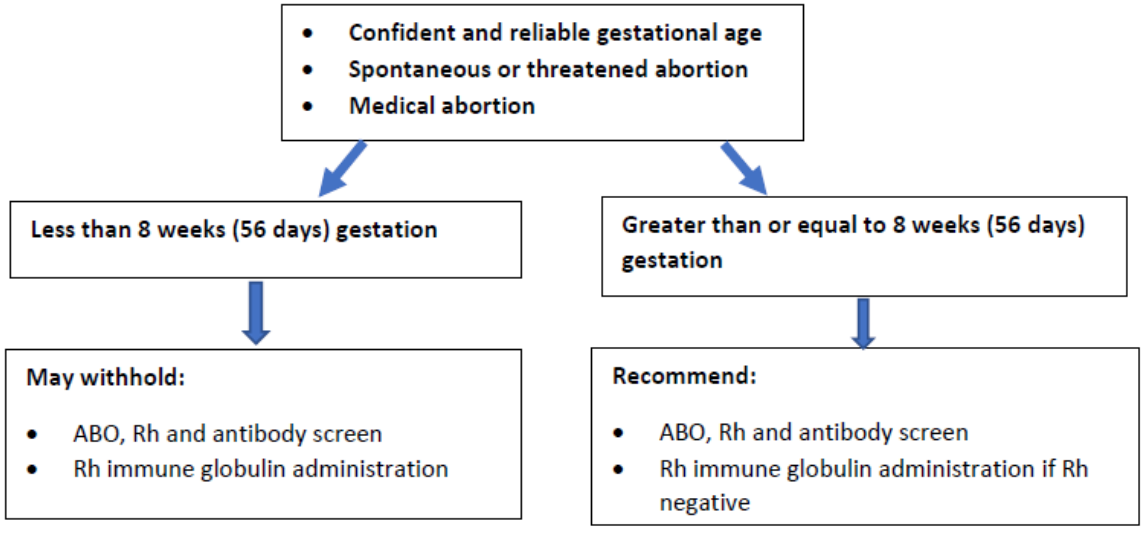
Rh prophylaxis before 8 weeks (56 days) gestation for Early Pregnancy Complications and Medical Abortions

Standard of Care

Rh immune globulin (WinRho®SDF) may be safely withheld prior to 8 weeks (56 days) gestation for pregnancy complications or medical abortions when there is confident and reliable pregnancy dating. Reliable dating includes any of the following:

- Ultrasound dating
- Certain conception dating
- Known first day of LMP for individual having regular (28 day) cycles and in the three months prior to conception absence of lactation, hormonal contraception or IUD use.[1]

The risk of anti-D alloimmunization before 8 weeks gestation is negligible [2,3]. The benefits of offering the choice to omit prophylaxis include reducing resource utilization as well as removing barriers to timely medical abortions. Surgical management of early pregnancy complications and surgical abortions may be associated with a higher risk of alloimmunization and Rh prophylaxis is still recommended for these individuals at any gestational age.



[1] Bracken H, Clark W, Lichtenberg E, Schweikert S, Tanenhaus J, Barajas A, Alpert L, Winikoff B. Alternatives to routine ultrasound for eligibility assessment prior to early termination of pregnancy with mifepristone-misoprostol. BJOG, 2011;118:17-23.
[2] Wiebe E, Campbell M, Aiken A, Albert A. Can we safely stop testing for Rh status and immunizing Rh-negative women having early abortions? A comparison of Rh alloimmunization in Canada and the Netherlands. Contraception: X 1 (2019) 100001
[3] Horvath S, Tsao P, Huang Z, Zhao L, Du Y, Sammel M, et al. The concentration of fetal red blood cells in first-trimester pregnant women undergoing uterine aspiration is below the calculated threshold for Rh sensitization. Contraception 102 (2020) 1-6.

Recommended Vaccines

Indicate Date and lot number of administration or with a '✓' if not applicable.	
Influenza Vaccine (consider October-May) [53] [54] SOGC CPG Immunization in Pregnancy	Document lot number and date given (YYYY/MON/DD). Recommended for all pregnant persons. The influenza vaccine can be safely administered any time during pregnancy. Pregnant persons are at an increased risk of influenza-associated morbidity and there is evidence of adverse neonatal outcomes associated with maternal influenza, including stillbirth, prematurity, SGA, or low birth weight infants
Hepatitis B Vaccine	Document lot number and date given (YYYY/MON/DD). The Hep B vaccine can be safely administered during pregnancy. A pregnant person who has no markers of Hep B infection (Hep B antibody and HbsAg negative) but is at high risk of Hep B acquisition should be offered the complete Hep B vaccine series at the first opportunity and should be tested for antibody response.
Tdap vaccine (between 27 and 32 weeks) PHAC Tdap in pregnancy	Document lot number and date given (YYYY/MON/DD). **NACI recommends that immunization with the diphtheria and tetanus toxoids and acellular pertussis (Tdap) vaccine should ideally be provided between 27 and 32 weeks of gestation during every pregnancy, irrespective of their immunization history.** Immunization with Tdap in pregnancy has been shown to be safe and effective in preventing neonatal and infant pertussis infection. When Tdap is given in pregnancy, the pregnant person produces antibodies that are transferred to the fetus and protect the newborn during the first months of life. Pertussis is particularly dangerous for infants who are too young to receive their first dose of vaccine, which is given at 2 months.
Other Vaccine	Document the date and lot number for an additional vaccine (i.e. COVID, etc.)

Nova Scotia Prenatal Record #4

Reproductive Care Program of Nova Scotia RCP | nova scotia health | IWK Health

Area for Patient Label.

NOVA SCOTIA PRENATAL RECORD

Part 4 Use 'Additional Prenatal Visit' page when additional space is required.

Refer to the "Nova Scotia Prenatal Record Companion Document".

Issues/Management Plan

EDD (FINAL) YYYY/MON/DD

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

Referral follow up:
❑ Obstetrics ❑ Medical Genetics ❑ Anesthesia ❑ Diabetes Centre ❑ Dietician
❑ Neonatology ❑ Pediatrics ❑ Mental Health ❑ Social Work ❑ Other

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

Prenatal Visits Gravida _____ Term _____ Preterm _____ Abortus _____ Living children _____ Stillbirth _____

Date YYYY/MON/DD	Wt. (kg)	BP	GA	Fundal height	Fetal HR	FM	Pres/ Pos.	Cig/ day	Comments: e.g. IPV, mental health, sub. use	Next visit	Initials

Care Provider Signature

Print name	Signature	Initials

Print name	Signature	Initials

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Issues / Management Plan

Issues / Management Plan	Document the plan of care including medications and required consultations.
EDD Final	Transcribe estimated date of delivery FINAL (YYYY/MON/DD) from Part 1 of the NS PNR.
Herpes Simplex Virus Treatment indicated	Indicate with a ✓ if HSV treatment is indicated. To decrease the risk of clinical lesions and viral shedding at the time of delivery and therefore decrease the need for cesarean section, pregnant persons with known recurrent genital HSV infection should be offered suppressive therapy. This should be started at 36 weeks in low risk pregnancy or earlier if there are risk factors or concerns for preterm birth. Options for prophylaxis include: □ Acyclovir (400 mg, taken orally three times a day, or 200 mg, taken four times a day) or □ Valacyclovir (500 mg taken orally twice daily) from 36 weeks gestation until delivery. Pregnant persons with **primary genital herpes** in the third trimester of pregnancy have a high risk of transmitting HSV to their neonates and should be counselled accordingly and offered a cesarean section to decrease this risk.
Low-dose aspirin indicated Low dose aspirin| ACOG SOGC Hypertensive Disorders of Pregnancy NSAID (SOGC) Planning-care-for-women-at-moderate-and-high-risk-of-preeclampsia-pdf (nice.org.uk)	Indicate with a ✓ if low dose aspirin is indicated. Consult OBS if history of previous preeclampsia or strong clinical markers for increased risk of hypertension. SOGC recommends that low-dose aspirin (81-162 mg) prophylaxis should be **initiated before 16 weeks and continued daily until 36 weeks** for the prevention of pre-eclampsia and pre-term birth for those individuals with 1 **high risk factor** or more than 1 **moderate risk factor** (see list of risk factors below). Low-dose ASA may be given orally in the form of two baby aspirin (162 mg total) at bedtime (SOGC). **RCP, in collaboration with maternal fetal medicine specialists in NS, has opted to adopt the following risk factors developed by NICE.** **Low-dose ASA is recommended for** pregnant persons with **one or more** of the following **high-risk factors**: □ Hypertensive disease in previous pregnancy □ Chronic kidney disease □ Systemic lupus erythematosus (SLE) □ Antiphospholipid antibody syndrome (APS) □ Type 1/2 diabetes □ Chronic hypertension

	Initiate low dose aspirin if the pregnant person has **more than one** of the following **moderate risk factors**: □ First pregnancy □ Age ≥ 40 years □ Pregnancy interval > 10 years □ BMI ≥ 35 kg/m2 □ Family history of preeclampsia □ Multifetal pregnancy
Progesterone (preterm birth prevention) indicated [555657]	Indicate with a ✓ if progesterone is indicated for the prevention of preterm birth. Risk Factors for preterm birth include: □ Previous preterm birth □ Cervical surgery □ Cervical insufficiency □ Uterine anomaly / surgery □ ART □ Poor nutrition □ Low socioeconomic status □ Abuse (IPV) □ Age < 17 or > 40 □ Physical labor □ + fFN 22 - 34 weeks □ Interpregnancy interval < 6 months □ Poly/Oligohydramnios □ BMI < 18 kg/m2 □ Diabetes □ Hypo/hyper thyroid □ Black or Indigenous □ Mental illness □ < grade 12 education □ Substance use □ Poor prenatal care □ Infections □ Fetal anomaly □ Vaginal bleeding □ Multiple gestation □ Short cervical length □ P-PROM □ Periodontal disease **Consult OBS** **Vaginal progesterone therapy** (VPT) for those with a short cervical length in current pregnancy (≤ 25 mm by transvaginal U/S between 16 – 24 weeks) or with a previous PTB. **Daily dose**: 200 mg for single pregnancy / 400 mg for multiple pregnancy, initiated between 16−24 weeks gestation (whenever risk is identified), VPT can be **continued up to 34–36 weeks** gestation (considering individual risk factors).
Social concerns (adoption, child protection, etc.)	Indicate if there are any social concerns by placing a √ in the □. and document the specifics, including referrals and follow up.
Referrals follow up	Indicate with a '✓' any referral that has been followed up.
At approximately 36 weeks: copy of prenatal record to hospital and / or with patient	Indicate with a ✓ if a copy of the prenatal record has been sent to hospital and/or with patient.

Prenatal Visits

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

- ❒ weight
- ❒ blood pressure monitoring
- ❒ gestational age in weeks
- ❒ measurement of symphis fundal height
- ❒ auscultation of fetal heart sounds
- ❒ query about fetal movement
- ❒ fetal presentation (using Leopold's maneuvers)
- ❒ lifestyle/risk factors (i.e cigs/day, IPV, mental health, substance use etc.)
- ❒ the date of the next prenatal visit

The initial prenatal visit should occur as soon as pregnancy is suspected to offer comprehensive antenatal screening. Refer to RCP's Guidelines for Antenatal Screening & Testing.

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

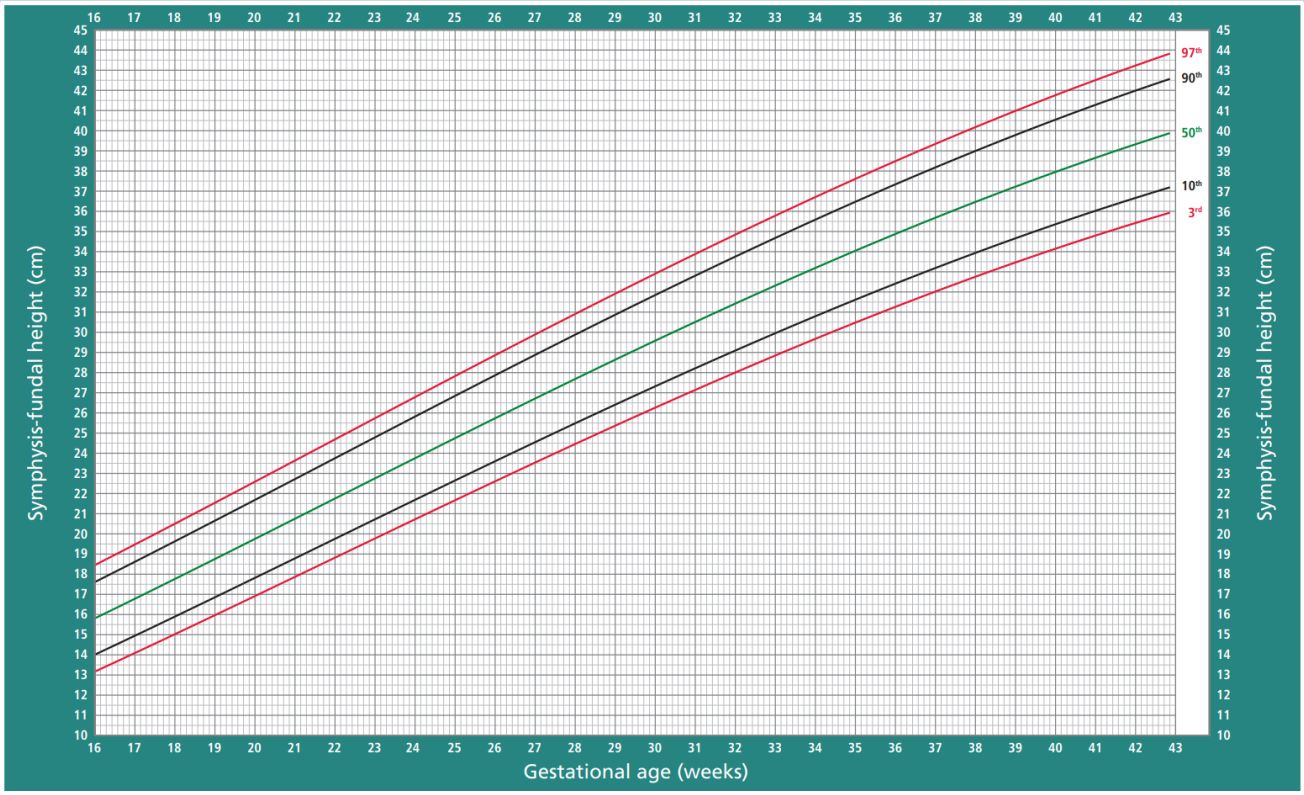
Populate each column on the PNR with the applicable information pertaining to each of the specific headings. If more space for documentation is required at prenatal visits, it is appropriate to take additional lines. When visits / documentation exceeds the allotted rows, additional pages of the NS PNR 4 can be used.

Additional resources:

- ❒ Sensible guide to a healthy pregnancy
- ❒ Dos and Don'ts in Pregnancy
- ❒ Is it safe during pregnancy?
- ❒ Smoking
- ❒ Alcohol
- ❒ Cannabis
- ❒ Opioids
- ❒ Nutrition
- ❒ Mental Health
- ❒ Depression
- ❒ Intimate Partner Violence
- ❒ Social support

GTPALS	Transcribe GTPALS from page 1 of the NS PNR.
Date	Document the date of each visit YYYY/MON/DD

Weight Assessment	Document weight in kilograms (preferably). Plot weight on the GWG graph.
Blood Pressure	Record the BP taken during the prenatal visit
Gestational Age	Document GA in weeks/days based on final EDD.
Fundal Height	Symphsis fundal height measurement in centimetres should correspond to the number of weeks of gestation, with an allowance of a 2-cm difference either way. Symphysis-Fundal Height



Fetal Heart Rate	Record the rate of the fetal heart. Normal FHR range is 110-160 bpm.
Fetal Movement	Note fetal movement as reported by pregnant person or palpated/observed by care provider. Perception of fetal movement by the pregnant person typically begins in the second trimester at around 16 to 20 weeks of gestation. In all pregnancies ***with risk factors for adverse outcome,*** the SOCG recommends daily monitoring of fetal movements starting at 26 to 32 weeks. Pregnant persons who do not perceive 6 movements in a 2-hour period require further antenatal testing and should contact their HCP immediately.
Fetal Presentation / Position	Fetal presentation refers to the fetal anatomical part closest to the pelvic inlet. Record as cephalic, breech or unstable (e.g. transverse or oblique). Assess presentation using Leopold's Maneuvers during the 3rd trimester prenatal visits.
Cigarettes Per Day	As applicable

Comments Guidelines Antenatal Screening and Testing	Discuss relevant information and lifestyle/risk factors and document in the comment section. A list of recommended discussion topics is available on the Guidelines for Antenatal Screening and Testing.
Next Visit	Document the interval of time for the next prenatal visit
Initials	Document the initials of the health care provider who completed the visit. If a learner is involved, document the initials of both the learner and health care provider. The full name of the health care provider (and any learners) should be entered on the Care Provider Signature section.

Care Provider Signature

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

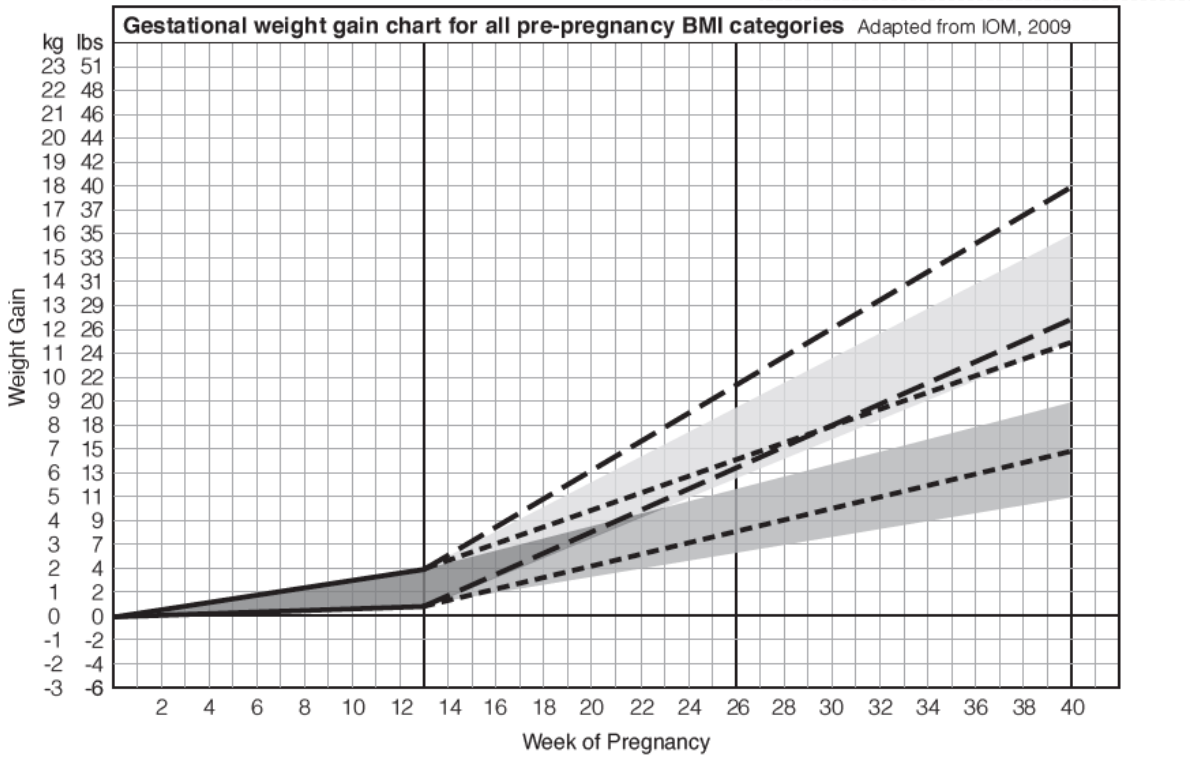
Nova Scotia Prenatal Record Worksheet 1

NOVA SCOTIA PRENATAL RECORD

Patient Label.

Worksheet 1 Height _____ Weight _____ Pre-Pregnancy BMI _____

Recommended total weight gain _____



Legend	Prepregnancy BMI	Recommend total weight gain	GWG/week in 2nd 3rd trimester
— —	< 18.5 kg/m²	12.5-18 kg (28-40 lbs)	0.5 kg (1-1.3 lbs)
	18.5-24.9 kg/m²	11.5-16 kg (25-35 lbs)	0.4kg (0.8-1 lbs)
- - - - -	25-29.9 kg/m²	7.5-11.5 (15-25 lbs)	0.3 kg (0.5-0.7 lbs)
	>30 kg/m²	5-9 kg (11-20 lbs)	0.2 kg (0.4-0.6 lbs)

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

Care Considerations for Increased Pre-Pregnancy BMI

Pre-pregnancy BMI ≥ 30 kg/m²

- Fasting plasma glucose with initial bloodwork
- Dating U/S – transvaginal for optimal accuracy
- 3rd Trimester U/S for fetal growth (serial)

Pre-pregnancy BMI ≥ 40 kg/m²

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

5A's of Healthy Pregnancy weight gain

Ask – for permission to talk about weight

Assess – potential root cause

Advise – pregnancy weight gain risk and options

Agree – on a realistic SMART plan to achieve healthy behaviour outcomes

Assist – in identifying barriers and facilitators

If weight gain is below or above recommendations:

Assess for clinical issues (such as edema) and explore the root causes of inappropriate weight gain, including

- **Mental** (e.g. insomnia)
- **Metabolic** (e.g. medications)
- **Mechanical** (e.g. reduced mobility)
- **Milieu** (e.g. employment)

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Gestational Weight Gain

The resources on this page of the NS PNR are intended to provide care providers with several tools to inform and guide prenatal care related to GWG. [1] [2]

Care providers have a responsibility to be knowledgeable that scientific evidence demonstrates that obesity is an illness not a product of inadequate lifestyle. It is important that care providers address negative attitudes about obesity and work to adopt care approaches that eliminate shame or stigma.

Discuss the risk of excessive weight gain and obesity in pregnancy (increased risk of gestational diabetes, gestational hypertension and preecclampsia, as well as cesarean delivery and macrosomia), and counsel the pregnant person about diet, exercise and appropriate weight gain during pregnancy based on their BMI category. GWG greater than or less than the IOM guidelines may be associated with higher risk of some adverse maternal and newborn outcomes.
Refer to SOGC CPG - Maternal Obesity Part 1 SOGC CPG - Maternal Obesity Part 2 for further information and Obesity Canada's guidelines for weight management over the reproductive years for adult persons living with obesity.

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

Height, Weight, BMI, Recommended GWG
Transcribe pre-pregnancy weight, height, pre pregnancy body mass index, and recommended gestational weight gain from page 2 of the NS PNR.

Care Considerations for Increased Pre-Pregnancy BMI
This section serves as a prompt/guide that will inform care interventions for those pregnant persons with a BMI ≥ 30 and those with a BMI ≥40.
Examples include prenatal discussions related to delivery planning, potential alterations to care, method of fetal health surveillance (FHS), expectations for the progress of labour, etc.

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

[1] Health Canada (2010). Prenatal nutrition guidelines for health professional: gestational weight gain. Retrieved from: http://www.hc-sc.gc.ca/fn-an/alt_formats/pdf/nutrition/prenatal/ewba-mbsa-eng.pdf
[2] Institute of Medicine (2009). Weight gain in pregnancy. Reexamining the guidelines. Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK32813/pdf/Bookshelf_NBK32813.pdf

The 5 A's is an acronym for:[3]

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

Ensure that follow-up takes place to facilitate the success of making action plans.
If weight gain is above or below recommendations, assess for clinical issues (such as edema) and explore the root causes of inappropriate weight gain.

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



[3] Canadian Obesity Network (2014). *5As of Health Pregnancy Weight Gain TM*. Retrieved from: https://obesitycanada.ca/5as-pregnancy/'

Nova Scotia Prenatal Record Worksheet 2

NOVA SCOTIA PRENATAL RECORD

Worksheet 2

Patient Label.

Genetic Screening and Assessment[1]

One's ethnicity is an important piece of risk assessment as some populations are known to have a higher incidence of certain genetic conditions, such as:

- ❑ Ashkenazi Jewish (Tay Sachs, Canavan, Familial dysautonomia)
- ❑ French Canadian from Saguenay Lac-St Jean, Charlevoix, Bas-St-Laurent (Tay Sachs, CF)

All pregnant persons and their partners should have a three-generation family history taken.

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

- congenital anomaly e.g. congenital heart defect, neural tube defect
- intellectual disability or developmental delay
- genetic syndrome e.g. neurofibromatosis, Noonan syndrome
- chromosomal disorder e.g. Down syndrome (trisomy 21), familial translocation
- muscular disorder e.g. X-linked Duchenne and Becker muscular dystrophies
- bleeding disorder e.g. X-linked hemophilia A or B
- stillbirth
- sudden unexplained death
- other major health concerns such as cardiomyopathy, neurological disease, epilepsy, hearing loss, autism, and psychiatric disorders
- consanguinity

Hemoglobinopathies

- α thalassemia
- β thalassemia
- Sickle cell disease

Screening recommendations

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

- African
- Mediterranean
- Middle East
- South East Asian
- Western Pacific
- Caribbean
- South American

Method of carrier screening:

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

Refer for genetic consultation if both members of a couple are carries of thalassemia OR a combination of thalassemia and hemoglobin variant.

[1] Wilson, R. and De Bei, I. (2016) Joint SOGC–CCMG Opinion for Reproductive Genetic Carrier Screening: An Update for All Canadian Providers of Maternity and Reproductive Healthcare in the Era of Direct-to-Consumer Testing. Retrieved from: https://www.jogc.com/article/S1701-2163(16)39347-1/pdf

Nova Scotia Prenatal Record Worksheet 3

NOVA SCOTIA PRENATAL RECORD

Worksheet 3

Patient Label.

T-ACE Alcohol Screening Tool[1]

The T-ACE screening tool is a measurement tool of four questions that are significant identifiers of pregnancy risk drinking (i.e., alcohol intake sufficient to potentially damage the embryo/fetus).

The T-ACE score has a range of 0-5. The value of each answer to the four questions is totaled to determine the final T-ACE score.

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

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

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

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

Total Score: _____

Women Abuse Screening Tool (WAST)[2]

The WAST specifically screens for verbal, emotional, physical, and sexual abuse and is used to help determine if the pregnant person is experiencing domestic violence. If the answers to questions 1 and 2 are "a lot of tension" and "great difficulty" the screen is considered positive and the remaining 6 questions should be answered.

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

1 Sokol, J., Martier, S., Ager, J. (1989). The T-ACE questions: practical prenatal detection of risk-drinking. American Journal of Obstetrics and Gynecology, 160(4):863-870.

2 Brown, J., Lent, B., Brett, P, Sas, G. and Pedersen, L. (1996). Development of the Woman Abuse Screening Tool for use in family practice. Family Medicine, 28, 422 -28.

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

The T-ACE is a validated screening questionnaire for risky drinking in pregnancy (defined as alcohol consumption of 1 ounce or more per day) and should be completed in each trimester of pregnancy unless initial screening reveals no alcohol is being consumed.

Scoring the T-ACE:

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

A score of 2 or more out of 5 indicates risk of a drinking problem, and further assessment and/or referral may be required.[4]

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

Woman Abuse Screening Tool (WAST)

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

[4] Hicks, M., Tough, S., Johnston, D., Siever, J., Clarke, M, Sauve, R., Brant, R. & Lyon, A. (2014). T-ACE and predictors of self-reported alcohol use during pregnancy in a large, population-based urban cohort. International Journal of Alcohol and Drug Research, 3(1), 51 – 61.

Nova Scotia Prenatal Record Worksheet 4

NOVA SCOTIA PRENATAL RECORD

Worksheet 4

Patient Label.

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

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

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

0 to 10	Monitor
11-13	Monitor, support, and provide education. Repeat EPDS in 2 weeks time. If still elevated, refer for further assessment.
≥ 14	Requires further assessment, diagnosis, and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/ psychologist may be necessary.
Item #10	Any individual who scores 1, 2, or 3 on item 10 requires further evaluation before leaving the care provider's office to ensure their own safety and that of their baby.

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

In the past 7 days

1. I have been able to laugh and see the funny side of things
   - 0 ❑ As much as I always could
   - 1 ❑ Not quite so much now
   - 2 ❑ Definitely not so much now
   - 3 ❑ Not at all
2. I have looked forward with enjoyment to things
   - 0 ❑ As much as I ever did
   - 1 ❑ Rather less than I used to
   - 2 ❑ Definitely less than I used to
   - 3 ❑ Hardly at all
3. I have blamed myself unnecessarily when things went wrong
   - 3 ❑ Yes, most of the time
   - 2 ❑ Yes, some of the time
   - 1 ❑ Not very often
   - 0 ❑ No, never
4. I have been anxious or worried for no good reason
   - 0 ❑ No, not at all
   - 1 ❑ Hardly ever
   - 2 ❑ Yes, sometimes
   - 3 ❑ Yes, very often
5. I have felt scared or panicky for no very good reason
   - 3 ❑ Yes, quite a lot
   - 2 ❑ Yes, sometimes
   - 1 ❑ No, not much
   - 0 ❑ No, not at all
6. Things have been getting on top of me
   - 3 ❑ Yes, most of the time I haven't been able to cope
   - 2 ❑ Yes, sometimes I haven't been coping as well as usual
   - 1 ❑ No, most of the time I have coped quite well
   - 0 ❑ No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
   - 3 ❑ Yes, most of the time
   - 2 ❑ Yes, sometimes
   - 1 ❑ Not very often
   - 0 ❑ No, not at all
8. I have felt sad or miserable
   - 3 ❑ Yes, most of the time
   - 2 ❑ Yes, quite often
   - 1 ❑ Not very often
   - 0 ❑ No, not at all
9. I have been so unhappy that I have been crying
   - 3 ❑ Yes, most of the time
   - 2 ❑ Yes, quite often
   - 1 ❑ Only occasionally
   - 0 ❑ No, never
10. The thought of harming myself has occurred to me
    - 3 ❑ Yes, quite often
    - 2 ❑ Sometimes
    - 1 ❑ Hardly ever
    - 0 ❑ Never

Total Score _____

1 Cox, J.L., Holden, J.M., and Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786

Edinburgh Perinatal/Postnatal Depression Scale

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

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

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

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

It is ideal for the pregnant person to complete the EPDS unless there is limited English proficiency or difficulty with reading. Ideally, a trained medical interpreter serves as the translator, not a family member.

Appendix A - Acronyms

ABU	Asymptomatic Bacteriuria
ART	Assisted Reproductive Technology
BP	Blood Pressure
BMI	Body Mass Index
BPP	Biophysical Profile
Cigs	Cigarettes
CMV	Cytomegalovirus
CPG	Clinical Practice Guideline
C/S	Cesarean Section
C&S	Culture & Sensitivity
CV	Cardiovascular
CVS	Chorionic Villus Sampling
DOB	Date of Birth
EDD	Estimated Date of Delivery
EPDS	Edinburgh Perinatal/ Postpartum Depression Scale
EPR	Early Pregnancy Review
FGC	Female Genital Cutting
FGP	Fasting Plasma Glucose
FHR	Fetal Heart Rate
FM	Fetal Movement
GA	Gestational Age
GBS	Group B Streptococcus
GC	Gonorrhea
GCT	Glucose Challenge Test
GDM	Gestational Diabetes Mellitus
GI	Gastrointestinal
GHTN	Gestational hypertension
GP	Gravida Parity
GTPALS	Gravida, Term, Preterm, Abortus, Living Children, Stillbirth
GWG	Gestational Weight Gain
OGTT	Oral Glucose Tolerance Test
HCP	Health Care Provider
HGB	Hemoglobin
HBsAG	Hepatitis B Surface Antigen
Hep B	Hepatitis B
HCV	Hepatitis C
HIV	Human Immunodeficiency Virus
HSV	Herpes Simplex Virus
IAT	Indirect Antigen Test
ICSI	Intracytoplasmic sperm injection
IOM	Institute of Medicine
IPV	Intimate Partner Violence
IV	Intravenous
IVF	In Vitro Fertilization
KG	Kilograms
LGA	Large for Gestational Age
LMP	Last Menstrual Period
LBW	Low Birth Weight
MCV	Mean Corpuscular Volume
MMR	Measles Mumps Rubella
MSK	Musculoskeletal
MST	Maternal Serum Testing
N/A	Not Applicable
Neg	Negative
NIPT	Non-Invasive Prenatal Testing (cell free DNA)
NKDA	No Known Drug Allergies
NST	Non-Stress Test
NT	Nuchal Translucency
NTD	Neural Tube Defect
ON	Ophthalmia Neonatorum
Pap	Papanicolaou Test
Parvo	Parvovirus B19
PCOS	Polycystic Ovarian Syndrome
PG	Plasma Glucose
PPD	Post-partum Depression
PPH	Post-partum Hemorrhage
PROM	Preterm Rupture of Membranes
Pres. / Pos	Presentation / Position
PTB	Preterm Birth
Rh(D)	Rhesus
RhIG	Rh Immune Globulin
SES	Socio-Economic Status
SFH	Symphysis Fundal Height
SGA	Small For Gestational Age
SLE	Systemic Lupus Erythematosus
SDOH	Social Determinants Of Health

SOGC	The Society of Obstetricians and Gynaecologists Of Canada
STI	Sexually Transmitted Infection
Sub. Use	Substance Use
T1DM	Type One Diabetes Mellitus
T2DM	Type Two Diabetes Mellitus
T-ACE	Tolerance, Annoyed, Cut Down, Eye Opener
Tdap	Tetanus, Diphtheria, Pertussis
TSH	Thyroid-Stimulating Hormone
U/S	Ultrasound
VBAC	Vaginal Birth After Cesarean
VPT	Vaginal Progesterone Therapy
WAST	Woman Abuse Screening Tool
WHO	World Health Organization
Wt.	Weight

Appendix B - SOGC Resources and Guidelines

2022

Cannabis Resources

2021

CMV Infection in Pregnancy

2020

Female Genital Cutting

Screening for alcohol use in pregnancy

Progesterone for the prevention of PTB

Preventing NTD

Your pregnancy – Pregnancy Info

2019

Determination of GA by U/S

Use of 1st Trimester U/S

Pregnancy and Maternal Obesity Part 1

Pregnancy and Maternal Obesity Part 2

Diabetes in Pregnancy

Statement on Planned Homebirth

Trial of Labour After Cesarean

2018

Prevention of Rh Alloimmunization

Immunization in Pregnancy

HIV in Pregnancy

Rubella in Pregnancy

Varicella Infection in Pregnancy

Toxoplasmosis in Pregnancy

Group B Streptococcal

Physical Activity Pregnancy

Pain Management

Fetal Health Surveillance

3rd Stage of Labour

2017

Delayed Childbearing

Management of HSV in Pregnancy

Prenatal Screening for Fetal Aneuploidy

Prenatal Screening – Adverse outcomes

Maternity Leave in Normal Pregnancy

Substance use in pregnancy

Pregnancy at 41^{+0} - 42^{+0} Weeks

Hepatitis B and Pregnancy

Management of Bacterial vaginosis

2016

Female Nutrition

Spontaneous Labour at Term

Nausea and Vomiting

Multidisciplinary Team in the care of pregnant people

2015

Adolescent Pregnancy

Preconception folic acid

Pregnant Trauma Patient

2014 or earlier

Parvovirus B19

Hypertensive Disorders of Pregnancy

IUGR

Intimate Partner Violence

Alcohol and pregnancy

References

[1] Fleming, N., O'Driscoll, T., Becker, G. & Spitze R. (2015). SOGC Clinical Practice Guideline: N0. 327-Adolescent Pregnancy Guidelines. Retrieved from: https://www.jogc.com/article/S1701-2163(15)30180-8/pdf

[2] Johnson, J. & Tough, S. (2017). SOGC Reaffirmed Guidelines: No. 271-Delayed Childbearing. Retrieved from: https://www.jogc.com/article/S1701-2163(17)30936-2/pdf

[3] Butt, K. & Lim, K. (2019), SOGC Clinical Practice Guideline: No. 388-Determination of Gestational Age by Ultrasound. Retrieved from: https://www.jogc.com/article/S1701-2163(19)30464-5/pdf

[4] Van den Hof, M., Smithies, M., Nevo, O. & Oullet, A. (2019). SOGC Clinical Practice Guideline: No. 375-Clinical Practice Guideline on the Use of First Trimester Ultrasound. Retrieved from: https://www.jogc.com/article/S1701-2163(18)30762-X/pdf

[5] Fletcher, T., Clements, A. and Bailey, B. (2016) Identifying Intimate Partner Violence during Pregnancy in Prenatal Care Settings," *International Journal of Health Sciences Education*, 3(1). Retrieved from: https://dc.etsu.edu/ijhse/vol3/iss1/3/

[6] Dr. Robert Nunn (May 2018) Personal communication. Anaesthesiologist IWK Health Centre.

[7] Money, D, and Steben, M. (2017). SOGC Clinical Practice Guideline No. 208: Guidelines for the Management of Herpes Simplex Virus in Pregnancy. Retrieved from: https://www.jogc.com/article/S1701-2163(17)30456-5/pdf

[8] Loutfy, M., Kennedy, V.L., et al (2018). SOGC Clinical Practice Guideline: No. 354-Canadian HIV Pregnancy Planning Guidelines. Retrieved from: https://www.jogc.com/article/S1701-2163(17)30701-6/pdf

[9] Castillo, E., Murphy, K. & van Schalkwyk, J. (2017). SOGC Clinical Practice Guideline: No. 342. Hepatitis B and pregnancy. Retrieved from: https://www.jogc.com/article/S1701-2163(16)39793-6/pdf

[10] Campbell, K., Rowe, H., Azzam, H. & Lane, C. (2016). SOGC Clinical Practice Guideline: No. 339-The Management of Nausea and Vomiting of Pregnancy. Retrieved from: https://www.jogc.com/article/S1701-2163(16)39464-6/pdf

[11] Paquet, C & Yudin, MH. (2018). SOGC Clinical Practice Guideline: No. 285, Toxoplasmosis in Pregnancy: Prevention, Screening, and Treatment. Retrieved from: https://www.jogc.com/article/S1701-2163(18)30499-7/pdf

[12] Yinon, Y., Farine, D, & Yudin, M. (2018). Reaffirmed SOGC Clinical Practice Guideline: No.240-CytomegalovirusInfection in Pregnancy. Retrieved from: https://www.jogc.com/article/S1701-2163(17)31124-6/pdf

[13] Crane, J., Mundle, W. & Boucoiran, I. (2014). SOGC Clinical Practice Guideline: No. 316. Parvovirus B19 Infection in Pregnancy. Retrieved from: https://www.jogc.com/article/S1701-2163(15)30390-X/pdf

[14] Wilson, R., Van Mieghem, T., Langlois, S. and Church, P (2021), SOGC Clinical Practice Guideline No. 410: Prevention, Screening, Diagnosis, and Pregnancy Management for Fetal Neural Tube Defects. Retrieved from: https://www.jogc.com/article/S1701-2163(20)30901-4/pdf

[15] Public Health Agency of Canada (2020). Care During Pregnancy: Chapter 3. Retrieved from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/healthy-living/maternity-newborn-care-guidelines-chapter-3/64-03-19-2445-fcng-chapter-3-en-final.pdf

[16] Health Canada (2019). "Vitamin D and Calcium: Updated Dietary Reference Intakes." Retrieved from: http://www.hc-sc.gc.ca/fn-an/nutrition/vitamin/vita-d-eng.php.

[17] Lockwood, C. & Magriples, U. (2022). Prenatal care: Initial assessment. Post TW, ed. UpToDate. Waltham, MA: UpToDate Inc. Retrieved from: Prenatal care - UpToDate

[18] National Institute for Health Care Excellence (2021) Antenatal care for uncomplicated pregnancies. Retrieved from: Antenatal care (nice.org.uk)

[19] Akkerman, D., Cleland, L, Croft, G., Eskuchen, K., Heim, C., Levine, A., Setterlund, L, Stark, C., Vickers, J. and Westby, E. (2012). Institute for Clinical Systems Improvement. Routine antenatal care. Retrieved from: https://www.bmchp.org/~/media/23e81f82425240699b6a73c9582fc84c.pdf

[20] World Health Organization (2006). Female genital mutilation and obstetric outcome: WHO collaborative prospective study in six African countries. Retrieved from: https://www.who.int/reproductivehealth/publications/fgm/fgm-obstetric-study-en.pdf

[21] Perron, L., Senikas, V., Burnett, M. & Davis, V. (2020). SOGC Clinical Practice Guideline: No.395-Female Genital Cutting. Retrieved from: https://www.jogc.com/article/S1701-2163(19)30665-6/pdf

[22] Alvarez-Segura, M. Garcia-Esteve, L. et al (2014). Are women with a history of abuse more vulnerable to perinatal depressive symptoms? A systematic review. Retrieved from: s00737-014-0440-9.pdf (dal.ca)

[23] Heaman, M., Moffatt, M., Elliott, L., et al. (2014). Barriers, motivators, and facilitators related to prenatal care utilization among inner-city women in Winnipeg, Canada: a case–control study. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4223395/pdf/1471-2393-14-227.pdf

[24] Heaman, M., Sword, W., Elliott, L., et al. (2015). Barriers and facilitators related to use of prenatal care by inner-city women: perceptions of health care providers. BMC Pregnancy and Childbirth, 15(2). 1-13 Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4302607/pdf/12884_2015_Article_431.pdf

[25] Daalderop, L., Wieland, B., Tomsin K., Reyes, L., Kramer, B., Vanterpool, S. & Been, J. (2018). Periodontal Disease and Pregnancy Outcomes: Overview of Systematic Reviews. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6191679/pdf/10.1177_2380084417731097.pdf

[26] O'Connor, D., Blake, J., et al (2016). SOGC Clinical Practice Guideline: No. 333-Canadian Consensus on Female Nutrition: Adolescence, Reproduction, Menopause, and Beyond. Retrieved from: http://www.jogc.com/article/S1701-2163(16)00042-6/pdf

[27] Hager, E., Quigg, A., Black, M., Coleman, S., Heeren, T., Rose-Jacobs R, et al. (2010). Development and Validity of a 2-Item Screen to Identify Families at Risk for Food Insecurity. Retrieved from: https://childrenshealthwatch.org/wp-content/uploads/EH_Pediatrics_2010.pdf

[28] Frank L (2015). Canadian Centre for Policy Alternatives. End It Now: The 2015 Report Card on Child and Family Poverty in Nova Scotia. Retrieved from: The 2015 Report Card on Child and Family Poverty in NS

[29] Ordean, A., Wong, S. & Graves, L. (2017). SOGC Clinical Practice Guideline: No. 349. Substance use in pregnancy. Retrieved from: http://www.jogc.com/article/S1701-2163(17)30470-X/pdf

[30] Suter, M., Mastrobattista, J., Sachs, M. and Aagaard, K. (2015). Is There Evidence for Potential Harm of Electronic Cigarette Use in Pregnancy? Birth Defects Res A Clin Mol Teratol; 103(3): 186–195. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4830434/pdf/nihms775961.pdf

[31] Society of Obstetricians and Gyneacologists of Canada (2020). Are you pregnant, considering pregnancy, or breastfeeding? Do you know that the use of cannabis may not be safe for your baby? Retrieved from: https://www.pregnancyinfo.ca/learn-more/

[32] Canada's Lower-Risk Cannabis Use Guidelines (2017). Retrieved from: https://www.camh.ca/-/media/files/lrcug_professional-pdf

[33] Carson, G., Vitale, L, et al (2017). SOGC reaffirmed guideline: No. 245-Alcohol Use and Pregnancy Consensus Clinical Guidelines. Retrieved from: http://www.jogc.com/article/S1701-2163(17)30584-4/pdf

[34] Graves, L., Carson, G., Pool, N., et al (2020). SOGC Guideline No. 405: Screening and Counselling for Alcohol Consumption During Pregnancy. Retrieved from: https://www.jogc.com/action/showPdf?pii=S1701-2163%2820%2930223-1

[35] Chitayat, D., Langlois, S. & Wilson, D. (2017). SOGC Reaffirmed Guideline. No. 261-Prenatal Screening for Fetal Aneuploidy in Singleton Pregnancies. Retrieved from: https://www.jogc.com/article/S1701-2163(17)30606-0/pdf

[36] Audibert, F., De Bie, I., et al (2017). Joint SOGC-CCMG clinical practice guideline No. 348: Update on Prenatal Screening for Fetal Aneuploidy, Fetal Anomalies, and Adverse Pregnancy Outcomes. Retrieved from: https://www.jogc.com/article/S1701-2163(17)30070-1/pdf

[37] Wilson, R.D, & Bie, I. (2016). Joint SOGC CCMG Opinion for Reproductive Genetic Carrier Screening: An Update for All Canadian Providers of Maternity and Reproductive Healthcare in the Era of Direct-to-Consumer Testing. Retrieved from https://www.jogc.com/article/S1701-2163(16)39347-1/pdf

[38] Caulfield T, Murdoch B. (2020). Non-Invasive Prenatal Screening: Navigating the Relevant Legal Norms. J Obstet Gynaecol Can; Retrieved from: https://www.jogc.com/action/showPdf?pii=S1701-2163%2820%2930334-0

[39] American Congress of Obstetricians and Gynecologists (2015). Committee Opinion Society for Maternal Fetal Medicine, No 640: Cell-Free DNA Screening for Fetal Aneuploidy. September (Reaffirmed 2017) Retrieved from: https://www.smfm.org/publications/198-cell-free-dna-screening-for-fetal-aneuploidy

[40] Liston, R., Sawchuck, D. & Young, D. (2018). SOGC Clinical Practice Guideline: No. 197a-Fetal Health Surveillance: Antepartum Consensus Guideline. Retrieved from: https://www.jogc.com/article/S1701-2163(18)30059-8/pdf

[41] Fung Kee Fung, K. & Eason, E. (2018). SOGC Clinical Practice Guideline: No. 133-Prevention of Rh Alloimmunization. Retrieved from: https://www.jogc.com/article/S1701-2163(17)31111-8/pdf

[42] Keenan-Lindsay, L. & Yudin, M. (2017). SOGC Reaffirmed Clinical Practice Guideline: No.185-HIV Screening in Pregnancy. Retrieved from: https://www.jogc.com/article/S1701-2163(17)30449-8/pdf

[43] Moore, D. & Allen, U. (2019). Canadian Paediatric Society Position Statement: HIV in pregnancy: Identification of intrapartum and perinatal HIV exposures. Retrieved from: https://www.cps.ca/en/documents/position/hiv-in-pregnancy
[44] Shrim, A., Koren, G., Yudin, M. & Farine, D. (2018). REAFFIRMED SOGC Clinical Practice Guideline: No. 274-Management of Varicella Infection (Chickenpox) in Pregnancy. Retrieved from: https://www.jogc.com/article/S1701-2163(18)30497-3/pdf
[45] Boucoiran, I. & Castillo, E. (2018). SOGC Clinical Practice Guideline: No. 368-Rubella in Pregnancy. Retrieved from: https://www.jogc.com/article/S1701-2163(18)30569-3/pdf
[46] Maxwell, C., Gaudet, L., Cassir, G., Nowik, C., McLeod, L., Jacob, CL. & Walke, M. (2019). SOGC Clinical Practice Guideline: No 392-Pregnancy and Maternal Obesity Part 2: Team Planning for Delivery and Postpartum Care. Retrieved from: https://www.jogc.com/article/S1701-2163(19)30454-2/pdf
[47] Money, D. & Allen, V. (2018). Reaffirmed SOGC Clinical Practice Guideline: No. 298-The Prevention of Early-Onset Neonatal Group B Streptococcal Disease. Retrieved from: https://www.jogc.com/article/S1701-2163(18)30495-X/pdf
[48] ACOG Committee opinion (2020). No. 797. Prevention of Group B Streptococcal Early-Onset Disease in Newborns. Retrieved from: https://www.acog.org/-/media/project/acog/acogorg/clinical/files/committee-opinion/articles/2020/02/prevention-of-group-b-streptococcal-early-onset-disease-in-newborns.pdf
[49] Pavord, S., Daru, J., Prasannan, N., Robinson, S., Stanworth, S. and Girling, J. (2019). BJH Guideline: UK Guideline on the management of iron deficiency in pregnancy. Retrieved from: UK guidelines on the management of iron deficiency in pregnancy (wiley.com)
[50] Deshauer S, Wyne A. (2017). Subclinical hypothyroidism in pregnancy. Retrieved from: https://www.cmaj.ca/content/cmaj/189/28/E941.full.pdf
[51] Kilpatrick, S (2015). ACOG Guidelines at a Glance Thyroid Disease in Pregnancy. Committee on Practice Bulletins—Obstetrics (2015). ACOG Practice Bulletin Number 148: Thyroid disease in pregnancy, Obstetrics and Gynecology, 125: 996–1005
[52] Canadian Agency for Drug and Technologies in Health (2016). Routine Prenatal Thyroid-Stimulating Hormone Testing: Evidence-Based Guidelines. Retrieved from: https://www.cadth.ca/sites/default/files/pdf/htis/2016/RB1038%20Thyroid%20Screening%20Final.pdf
[53] Public Health Agency of Canada (2018). Immunization in pregnancy and breastfeeding: Canadian Immunization Guide. Retrieved from: https://www.canada.ca/en/public-health/services/publications/healthy-living/canadian-immunization-guide-part-3-vaccination-specific-populations/page-4-immunization-pregnancy-breastfeeding.html
[54] Castillo, E & Poliquin, V. (2018). SOGC Clinical Practice Guidelines: No. 357. Immunization in Pregnancy. Retrieved from: No. 357-Immunization in Pregnancy (jogc.com)
[55] National Institute for Health Care Excellence (2019). Preterm labour and birth: NICE guideline [NG25). Retrieved from: https://www.nice.org.uk/guidance/ng25/chapter/Recommendations
[56]Lim, K., Butt, K., and Crane, J. (2017). SOGC Clinical Practice Guidelines: Ultrasonographic Cervical Length Assessment in Predicting Preterm Birth in Singleton Pregnancies Assessment in Predicting Preterm Birth in Singleton Pregnancies. Retrieved from: https://www.jogc.com/article/S1701-2163(16)34884-8/pdf
[57] Jain, V., McDonald, S., Mundle, W. and Farine, D. (2020). Guideline No. 398: Progesterone for Prevention of Spontaneous Preterm Birth. Retrieved from: Guideline No. 398: Progesterone for Prevention of Spontaneous Preterm Birth - Journal of Obstetrics and Gynaecology Canada (jogc.com)
[58] Public Health Agency of Canada (2020). Family-Centred Maternity and Newborn Care: National Guidelines: Chapter 3 Care during pregnancy. Retrieved from: National Guidelines: Maternity and Newborn Care: Chapter 3