Ontario

# A User Guide to the Ontario Perinatal Record

Prepared by the Provincial Council for Maternal and Child Health (PCMCH) and
The Better Outcomes Registry & Network (BORN) Ontario
Perinatal Record Working Group

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Provincial Council for Maternal and Child Health
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# Contents

# Introduction

## Background

A standard form to guide and document pregnancy care in Ontario has been in place since 1979. This 2017 version is the 5th revision (1987, 1993, 2000 and 2005). Until 2005, the Ontario Medical Association (OMA) was primarily responsible for content and format. The 2017 update is a partnership between the Provincial Council for Maternal Child Health (PCMCH), The Better Outcomes Registry & Network (BORN) Ontario, the OMA and the Association of Ontario Midwives (AOM).

For the majority of women, pregnancy and birth is a normal physiological process. Nevertheless, it is a life-changing event for women and families, and the physical and psychosocial care provided during this period can have long-lasting effects. The 2017 version acts as a care map (pathway) for pregnancy, birth and the very early newborn period and should help support evidence-informed care and shared decision making. Clearly, care will differ depending on each woman's unique history and circumstances, but the basics of care applicable to most women are included.

## Method

A committee was formed by PCMCH and BORN Ontario inclusive of all practitioners using the current antenatal record to support clinical care in pregnancy (obstetricians, midwives, family physicians, nurses, nurse practitioners) as well as other stakeholders supporting high quality maternity care (Best Start, Public Health, BORN, PCMCH). We conducted a stakeholder survey of all maternity care practitioner groups as well as specialists in genetics, mental health, pediatrics, etc. to solicit their priorities for changes in content and functionality in the new record. We completed an environmental scan of other provincial antenatal records and looked to other countries for examples of similar forms. We reviewed each section of the form, reviewed the literature and clinical practice guidelines and consulted experts in the field to determine if care practices required change. We developed decision-making criteria to guide our work in determining whether a change/addition/deletion was required.

We went outside the committee for broad feedback three times during the process. The initial survey elicited over 350 responses which were all discussed. A "close to final" draft was distributed widely for feedback and over 150 individual and group responses were incorporated. The final draft was tested by committee members and reviewed by the whole committee. Changes based on the feedback were incorporated at each stage.

## Major changes since 2005

The first change is the name. The form is now called the ***Ontario Perinatal Record*** (OPR) as we have added a formal postnatal care tool. The second major change is that the form is one page

longer. The primary reason for this was care provider request – adding anything else to an already lengthy form with small font was not feasible. With changes to prenatal screening, the addition of mental health screening, and more discussion topics, a 2-page record was not possible.

Terminology, both medical and social, has also changed since 2005. In our choice of language, we have tried to be respectful of gender identity and the multiple ways in which individuals may identify themselves as a parent. While the vast majority of people experiencing pregnancy identify as women, some do not. Thus, we have used the terms "patient/client" to ensure that the form and the guide are inclusive. Similarly, genetic risk is documented in terms of the gametes rather that "father" and "mother".

## Use of the Form

The Ontario Perinatal Record was created to standardize the *documentation* of perinatal care, not to be the standard of clinical care. Care providers need to follow national and local guidelines and individualize care to each situation. Clinical care recommendations change rapidly (particularly in the domain of genetic screening) and thus, guidelines will change before the OPR can be updated. We hope that the form will standardize documentation and capture all of the elements required for high quality care.

The paper version of the Ontario Perinatal Record is not being issued in triplicate. The copies were often illegible, particularly when faxed to the hospital. Additionally, a large percentage of Ontario maternity care providers are using an electronic version of the record. We suggest that copies of Ontario Perinatal Record 1 and 2 are sent to the birthing unit of the hospital where the patient/client intends to give birth once the estimated date of birth is confirmed and the initial laboratory and ultrasound investigations are complete. This should occur by about 22 weeks' gestation. This ensures the record of essential information including position of the placenta is immediately available should there be early complications of pregnancy. A copy of the form can also be given to the patient/client to carry with them.

The fully completed OPR2 as well as the OPR3 is to be forwarded to the Birthing Unit by about thirty-six weeks when the bulk of the antenatal visits and laboratory investigations have been completed (including GBS status). A copy of these records can also be carried by the patient/client, if desired.

## Future plans for the OPR

Given the ever changing nature of medicine and perinatal care, it is important that the OPR reflect current practice. The form will be housed at the Provincial Council for Maternal and Child Health and be reviewed at least every 3 to 5 years with input from all of the major stakeholder organizations. We are also creating an electronic version of the form to assist care providers who work within an EMR environment. The ultimate goal is to be able to transmit data from the OPR to BORN Ontario to populate the maternal child registry data.

## Acknowledgements

The committee members and subject matter experts consulted for the 2017 version of the OPR are listed below. To say that this group was dedicated to the cause would be a vast understatement. People worked tirelessly to accomplish the goal. We would also like to acknowledge Perinatal Services British Columbia who generously shared and their prenatal care pathway and process.

## Ontario Perinatal Record Work Group Members

| Name | Role | Organization |
|---|---|---|
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| **Dr. Ann Sprague (Co-Chair)**<br>RN, PhD | Scientific Manager, BORN Ontario<br>Scientist Children's Hospital of Eastern Ontario Research Institute<br>Adjunct Professor, School of Nursing, University of Ottawa | |
| **Dr. Debra Boyce**<br>BSc, MD, CCFP, FCFP | Family Physician, Partners in Pregnancy Family Medicine Clinic, Peterborough<br>Assistant Professor, Queen's University | |
| **Dr. Doug Cochen**<br>MD FRCSC | Obstetrician, Queensway Carleton Hospital<br>Lecturer, Department of Obstetrics and Gynecology, University of Ottawa | |
| **Dr. Barbra de Vrijer**<br>MD, FRCSC | Obstetrician/MFM, London Health Sciences Centre<br>Associate Professor, Obstetrics and Gynecology, Western University | |
| **Dr. Jessica Dy**<br>MD, MPH, FRCSC | Obstetrician, The Ottawa Hospital<br>Head, Division of General Obstetrics and Gynecology, The Ottawa Hospital<br>Associate Professor, Department of Obstetrics and Gynecology, University of Ottawa | |
| **Ms. Dara Laxer** | Acting Director, Health Policy, Ontario Medical Association | |
| **Dr. Stan Lofsky**<br>MD | Family Physician, North York General Hospital<br>Assistant Professor, Department of Family and Community Medicine, University of Toronto (retired) | |
| **Ms. Matthuschka Sheedy**<br>RN, BNSc, ICCE | Health Promotion Consultant, Best Start Resource Centre (Health Nexus) | |
| **Dr. Bill Mundle**<br>MD, FRCSC | Obstetrician/MFM<br>Windsor Regional Hospital | |
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| **Ms. Julie Toole**<br>RM, MHSc | Midwife/ Quality and Risk Specialist<br>Risk Management Specialist, Association of Ontario Midwives | |
| **Ms. Doreen Day**<br>MHSc | Senior Program Manager, PCMCH | |
| **Ms. Anna Bucciarelli**<br>MBA | Senior Program Manager, PCMCH | |
| **Ms. Vanessa Abban**<br>MGA | Program Analyst, PCMCH | |

We would like to formally recognize the contribution of Dr. Stan Lofsky, a family physician from Toronto, to the ongoing development of the Ontario Perinatal Record. Having been formally involved since the 1992 revision, Stan brought his dedication to maternity care and a historical perspective to the committee which was missed when he had to withdraw from the project.

## *Subject Matter Experts Consulted*

| Name | Title / Role / Organization |
|---|---|
| **Dr. Cindy Lee Dennis**<br>RN, PhD | ***Women's Mental Health***<br>Professor in Nursing and Medicine, University of Toronto, Department of Psychiatry<br>Canada Research Chair in Perinatal Community Health<br>Women's Health Research Chair, Li Ka Shing Knowledge Institute, St. Michael's Hospital |
| **Dr. Dawn Kingston**<br>RN, PhD | ***Women's Mental Health***<br>Associate Professor, University of Calgary, Faculty of Nursing<br>Adjunct Associate Professor, University of Alberta, Department of Medicine<br>Lois Hole Hospital for Women Cross-Provincial Chair in Perinatal Mental Health |
| **Dr. Nan Okun**<br>MD, FRCSC, MHSc | ***MFM & Prenatal Screening***<br>Staff, Maternal-Fetal Medicine Division, Mount Sinai Hospital<br>Division Head, Maternal Fetal Medicine, University of Toronto<br>Professor, University of Toronto, Department of Obstetrics & Gynecology |
| **Dr. Anne McLeod**<br>MD, FRCPC | ***Medicine/Haematology***<br>Staff Cardiologist, Sunnybrook Hospital, Department of Hematology and Medical Oncology<br>Assistant Professor, University of Toronto |
| **Dr. Mark Yudin**<br>MD, MSc, FRCSC | ***Obstetrics, Gynecology and Reproductive Infectious Diseases***<br>Staff, St. Michael's Hospital, Department of Obstetrics and Gynecology<br>Associate Professor, University of Toronto |
| **Ms. Shelley Dougan**<br>**MPA, MSc, CGC** | ***Prenatal Screening***<br>Screening Specialist, BORN Ontario |
| **Dr. Lisa Graves**<br>MD, CCFP, FCFP | ***Family Medicine/Substance Abuse***<br>Associate Professor, University of Toronto, Department of Family and Community Medicine<br>Associate Professor, Northern Ontario School of Medicine |
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| **Dr. Peter Selby**<br>MBBS, CCFP, FCFP, MHSc, DipABAM, FASAM | ***Family medicine, Addictions/Nicotine dependence***<br>Director, Medical Education and Clinician Scientist, Addictions Division, Centre for Addiction and Mental Health<br>Professor, University of Toronto, Departments of Family and Community Medicine, Psychiatry and Dalla Lana School of Public Health |

## *Use of the Guide*

This companion document to the OPR is meant to be a guide for using the form and **NOT** an exhaustive treatise on perinatal care. Where the record has changed significantly, we have tried to include clinical details and resources. However, practitioners are advised to follow the most recent clinical guidelines in a field which changes constantly.

If using this updated OPR for the first time, it is useful to read the guide and learn about the new content and resources. If you have learners in your prenatal care setting, the guide will provide the step-by-step approach to completing the form. Resources for many parts of the guide are included at the back.

While this guide supports the paper version of the form, many of the same instructions/definitions/resources will be available as the EMR version of the form is developed.

# Ontario Perinatal Record 1

## *Demographics*

| Item | Description |
|---|---|
| **Last Name** | Last name as it appears on the health card. |
| **First Name** | Given (first) name as it appears on the health card. Other names (preferred name, nickname, etc.) can be in "quotations". |
| **Address – street number, street name** | |
| **Apt/Suite/Unit** | |
| **Buzzer No** | This information facilitates home visits. |
| **City/ Town** | |
| **Province** | |
| **Postal Code** | |
| **Contact – Preferred** | Preferred method of contact and information. Indicate if it is a work, home or cell phone number (specify if it is appropriate to text information) or email address. |
| **Leave Message Y/N** | This relates to the preferred contact. Explicitly ask if it is appropriate to leave a message when contacting. |
| **Contact – Alternate / E-mail** | An alternative work, home or cell phone number (specify if it is appropriate to text information) or email address. Informed consent to communicate by text or email should be obtained and recorded in the chart. |
| **Date of Birth** | Patient/Client's date of birth in format of YYYY/MM/DD |
| **Age at EDB** | Patient/Client's age at estimated date of birth. |
| **Language** | Language most readily understood. Important when English is the second language or is not spoken or understood. |
| **Interpreter Required Y/N** | Indicate whether or not assistance from an interpreter is required. |
| **Occupation** | Document type of work and discuss any workplace hazards/risks that might affect pregnancy |
| **Education Level** | Document level of education completed. Consider this when providing both written (handouts) and oral information.<br>• No certificate, diploma or degree<br>• High school certificate or equivalent<br>• Apprenticeship or trades certificate or diploma<br>• College, CEGEP or other non-university certificate or diploma<br>• University certificate or diploma below the bachelor level<br>• University certificate, diploma or degree at bachelor's level or above |

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| **Relationship Status** | Current relationship status to provide information on supports or safety issues:<br>• Single, Never legally married<br>• Legally married (and not separated)<br>• Separated, but still legally married<br>• Common-law<br>• Divorced<br>• Widowed |
| **Sexual Orientation** | Sexual orientation and gender identity are an important part of a medical history and as necessary as the medical and surgical history, travel history, or family history. A careful understanding of gender and sexuality can help tailor care to their individual risk factors. For assistance in asking about sexual orientation and gender identity, refer to the Rainbow Health Ontario website [1]. Seek guidance from patients/clients about the pronoun they expect you to use in referring to them (e.g. he/she/they or another word) and record this somewhere in the demographics or in the comments section. |
| **OHIP No.** | OHIP number and version code. |
| **Patient File No.** | Office file number/ MRN (medical record number). |
| **Disability Requiring Accommodation** | Note the disability and the required accommodation. This includes a physical, sensory or cognitive disability. In the case of cognitive or learning disabilities, information should be provided in a form that is easy to understand and accessible. |
| **Planned Place of Birth** | The place where the patient/client intends to give birth (hospital, home, birth centre, other-specify). |
| **Planned Birth Attendant** | Name of the most responsible provider (MRP) or on-call group planning to attend the labour and birth. |
| **Newborn Care Provider in Hospital** | Name of infant's health care provider while still in hospital. |
| **Newborn Care Provider in Community** | Name of infant's health care provider once discharged. |
| **Family Physician/ Primary Care Provider** | Name of family physician or primary care provider outside of pregnancy. |
| **Allergies or Sensitivities (include reaction)** | List allergies and sensitivities and the type of reaction to the agent (anaphylaxis, rash, GI distress, etc.) |
| **Medications (Rx/OTC, complimentary/alternative/vitamins, include dosage)** | List any medications currently used, including prescription, over-the-counter drugs, complementary, alternative therapies, herbals and vitamins and dosage. |
| **Partner's First Name** | The given (first) name of the current partner. |

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| **Partner's Last Name** | The surname (last name) of the current partner. This space may be left blank if no partner is reported. The named partner in this section may not be the genetic contributor to this pregnancy. |
| **Partner's Occupation** | The current partner's occupation. |
| **Partner's Education Level** | Document the partner's level of education. Consider this when providing both written (handouts) and oral information to the patient/client. |
| **Age** | Age of the partner. |

## Pregnancy Summary

| Item | Description |
|---|---|
| **LMP** | First day of the last menstrual cycle in YYYY/MM/DD. |
| **Cycle q** | Average length of cycle in days. |
| **Certain Y/ N** | Indicate if this date is certain or uncertain. |
| **Regular Y/ N** | Indicate if the cycle is regular or not. |
| **Planned Pregnancy Y/N** | Planned or unplanned pregnancy. |
| **Contraceptive Type Last Used** | Type of contraceptive and the month and year stopped. |
| **Conception: Assist Y/N Details:** | Indicate if assisted reproductive technologies were utilized in this pregnancy. Specify treatment. |
| **EDB by LMP** | Expected date of birth by using the last menstrual period date (if known) in YYYY/MM/DD. |
| **Final EDB** | Expected date of birth in YYYY/MM/DD confirmed by an ultrasound (US) at an appropriate gestational age according to the SOGC Guideline [2]. |
| **Dating Method** | Method used to determine the EDB. If assisted reproductive technology was used, indicate date of procedure (YYYY/MM/DD) and age of embryo at transfer (in the case of IVF) if known. |
| **Gravida** | Total number of prior plus present pregnancies regardless of gestational age, type, time or method of termination/outcome. A pregnancy with twins/multiples is counted as one pregnancy. |
| **Term** | Total number of previous pregnancies with birth occurring at greater than or equal to 37 completed weeks. |
| **Preterm** | Total number of previous pregnancies with birth occurring between 20 + 0 and 36+7 completed weeks. |
| **Abortus** | Total number of spontaneous or therapeutic abortions occurring prior to 20+0 weeks. Spontaneous abortions include miscarriage, ectopic pregnancy, missed abortion, and molar pregnancy. |
| **Living Children** | Total number of children the patient/client has given birth to that are presently living. Providers can include each child's name in the free text. |

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| **Stillbirth(s)** | Total number of previous pregnancies resulting in a stillbirth. A stillbirth is defined as a product of conception weighing 500 grams or more or of 20 or more weeks' gestation, which after being completely delivered shows no sign of life. Intentional terminations of pregnancy that meet either criterion are also classified as stillbirths in Ontario [3]. |
| **Neonatal/ Child Death** | Total number of deaths of an infant or child any time after live birth. |

## Obstetrical History

| Item | Description |
|---|---|
| **Year /Month** | Month and year of the birth or pregnancy loss. |
| **Place of Birth** | Place of birth or pregnancy loss (hospital name and/or city). |
| **Gest (wks)** | Number of weeks' of gestation at birth or loss. |
| **Labour Length** | Number of hours in active labour. |
| **Type of Birth** | Type of birth, including vaginal (spontaneous, forceps, vacuum) or caesarean section. Details can be included in "comments" section. |
| **Comments regarding abortus, pregnancy, birth and newborn (e.g. GDM, HTN, IUGR, shoulder dystocia, PPH, neonatal jaundice)** | Note any additional comments about the pregnancy or birth including any perinatal complications. Describe issues that are most relevant to current pregnancy. Include notes about neonatal/ child death. |
| **Sex M/F** | Male or female. |
| **Birth Weight** | Birth weight in grams. |
| **Breastfed/ Duration** | Number of months the baby was breastfed. |
| **Child's Current Health** | Relevant concerns, conditions or abnormalities. |

## Medical History and Physical Exam

Check Y or N next to each Item, and then use the Comments section at the bottom of the page to elaborate on the specific issue, noting the number of the Item the comment refers to.

| Item | Description |
|---|---|
| **Current Pregnancy** | |
| **1. Bleeding** | Any vaginal bleeding that has occurred during the current pregnancy. Specify gestation and duration. |
| **2. Nausea /vomiting** | Any nausea and/or vomiting that have been a concern in the pregnancy. Document any medications used. |
| **3. Rash/fever/illness** | Any fever in pregnancy and the gestational age of the fetus at the time of the fever. Consider infections such as Toxoplasmosis, Listeria, CMV, Parvo, TB, etc. |

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| **Nutrition** | |
| **4. Calcium adequate** | The adequacy of dairy products or other calcium sources in the normal diet. Eat Right Ontario [4] and Health Canada [5] recommend 1000 mg/day of calcium during pregnancy with a higher dose of 1300 mg/day of calcium for those under 19.<br>The SOGC Guideline recommends calcium supplementation of at least 1 g/day, orally, for women with low dietary intake of calcium (< 600 mg/day) who are at high risk of preeclampsia [6]. |
| **5. Vitamin D adequate** | Inform about of the importance of vitamin D stores while pregnant and breastfeeding. Patieints/clients at risk for low vitamin D stores include those who:<br>• Have darker skin tones<br>• Live in northern latitudes,<br>• Routinely cover their skin for cultural reasons<br>• Have diets low in vitamin D. The recommended total daily intake from diet and supplementation is 15 mcg (600 IU) [5].<br>• Are Indigenous |
| **6. Folic acid preconception** | Maternal use of folic acid prior to and during pregnancy. Document the dosage taken. Recommended dosage by Health Canada is 0.4 mg if at average risk [7] . Refer to the SOGC Guideline on risk factors requiring a higher dose [8]. |
| **7. Prenatal vitamin** | Indicate any prenatal vitamin use. Health Canada recommends a daily supplement with 16-20 mg iron. Any prenatal vitamin containing 0.4 mg folic acid is acceptable [7]. |
| **8. Food access/ quality adequate** | Indicate if poverty/other circumstances impact access to healthy food and make referrals as appropriate. |
| **9. Dietary restrictions** | Indicate any restrictions that may have an impact on nutritional status, e.g. vegan, lactose intolerance. |
| **Surgical History** | |
| **10. Surgery** | Any surgical procedures, particularly those that may affect pregnancy management or outcome. |
| **11. Anaesthetic complications** | Significant complications from prior local, regional or general anaesthetics. This includes metabolic disorders such as malignant hyperthermia and pseudocholinesterase deficiency, difficult intubations, as well as severe postoperative vomiting. |
| **Medical History** | |
| **12. Hypertension** | Previous chronic hypertension, hypertension currently managed by medication, hypertension with previous pregnancies. |
| **13. Cardiac/Pulmonary** | Significant cardiac or pulmonary disease, including congenital heart disease and chronic respiratory disease, including asthma. |

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| **14. Endocrine** | Endocrine disorders, of which diabetes and thyroid conditions are most commonly encountered. |
| **15. GI/Liver** | Significant pre-existing liver and gastrointestinal disease. |
| **16. Breast (incl. surgery)** | Breast surgery, including biopsies, augmentation or reduction, or other conditions which may affect pregnancy or breastfeeding. |
| **17. Gynecological (incl. surgery)** | Any uterine or cervical procedure, particularly those which may affect uterine or cervical integrity, such as cone biopsy or myomectomy. Include any vulvar alterations, such as female genital mutilation (FGM), which may affect delivery. |
| **18. Urinary tract** | Pre-existing urinary disorders and those complicating a prior pregnancy. |
| **19. MSK/Rheum** | Rheumatic and autoimmune disorders (e.g. SLE, rheumatoid arthritis, antiphospholipid syndrome). Also indicate musculoskeletal conditions that might affect pregnancy/birth such as scoliosis. |
| **20. Hematological** | Significant hematological disorders. |
| **21. Thromboembolic/coag** | Indicate existing thromboembolic disorders or coagulopathies. |
| **22. Blood transfusion** | Any prior transfusions of blood or blood products. |
| **23. Neurological** | Any existing neurological history including those that affect or can be affected by pregnancy (e.g. epilepsy, migraines, multiple sclerosis). |
| **24. Other** | |
| **Family History** | |
| **25. Medical Conditions (e.g. diabetes, thyroid, hypertension, thromboembolic, anaesthetic complications, mental health)** | Family history of heart disease, hypertension, diabetes, thromboembolic or coagulation issues. Include diseases in the immediate family that pose an increased risk for the pregnancy and birth. Screen for family history of depression/psychiatric issues, addiction to alcohol or drug abuse. |
| **Genetic History of Gametes** | |
| **26. Ethnic/racial background**<br>**Egg _____ Age___Yrs**<br>**Sperm_____** | For assessment of risk for genetic disorders, the genetic origin of each gamete needs to be considered. In cases of gamete donation, the age of the egg donor should be documented for assessment of age-related chromosomal risk. Care providers should be sensitive to the various ways employed to conceive, especially the use of egg and sperm donors and gestational carriers. |
| **27. Carrier Screening: at risk?**<br>• **Hemoglobinopathy screening** (Asian, | Screen for the diseases listed in the identified populations. As these conditions are autosomal recessive, consider testing carrier status of both gamete providers, if one tests positive. |

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| African, Middle Eastern, Mediterranean, Hispanic, Caribbean)<br>• **Tay-Sachs disease screening** (Ashkenazi Jewish, French Canadian, Acadian, Cajun)<br>• **Ashkenazi Jewish screening panel** | |
| **28. Genetic Family History**<br>• **Genetic conditions** (e.g. CF, muscular dystrophy, chromosomal disorders)<br>• **Other** (e.g. intellectual, birth defect, congenital heart, developmental delay, recurrent pregnancy loss, stillbirth)<br>• **Consanguinity** | Consider screening if available and refer to genetic counsellor if appropriate. [9]<br><br>Couples who are biological relatives are common in some cultures, and raise the risk of genetic disorders and pregnancy loss. If consanguinity is confirmed and there is a family history of recurrent pregnancy loss or infant morbidity/mortality, referral to a geneticist/genetic counselor may be appropriate. |
| **Infectious Disease** | |
| **29. Varicella disease** | History of varicella (chicken pox) disease negates the need for antibody testing. |
| **30. Varicella vaccine** | History of vaccination against varicella (two doses) negates the need for antibody testing. |
| **31. HIV** | In Ontario, universal HIV testing is recommended at the first antenatal visit regardless of risk factors as effective interventions are available to reduce the risk of mother-to-baby transmission. Recognised risk factors include having a history of intravenous drug use or sexual partners who have injected drugs or have HIV, and/or residence in a country where HIV is endemic. Consider repeat HIV testing later in pregnancy for those with ongoing risk. |
| **32. HSV Self Y/N**<br>**Partner Y/N** | Consider prophylaxis when there is a history of recurrent genital HSV, as per the SOGC Guideline for management of HSV in pregnancy [10]. Women who have no history of HSV but have a partner with genital HSV should have type-specific serology to determine their risk of acquiring primary HSV in pregnancy [10]. |
| **33. STIs** | Past or present history of a sexually transmitted infection(s)/ treatment and test of cure. Consider repeat testing later in pregnancy for those with ongoing risk. |

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| **34. At risk population (Hep C, TB, Parvo, Toxo)** | Prior history of active disease, whether treated or not, as well as exposure through high risk environment or behaviour. For more information on Hep C, refer to the resources provided by CDC [11], ACOG [12] and the Canadian Liver Foundation [13]. For more information on TB, please refer to the resources provided by CDC [14]. For more information on Parvo, refer to the SOGC Guideline [15] and the resources provided by CDC [16]. For more information on Toxo, refer to the SOGC Guideline [17] and resources provided by CDC [18]. |
| **35. Other** | Refers to other infectious diseases not noted above. This includes previous infections with, or potential exposures to other infectious agents including CMV, West Nile virus, malaria, Lyme disease and Zika virus. For more information, refer to the following resources (Appendix B): PHAC, CDC, and MotherRisk. |
| **Mental Health/ Substance Use** | |
| **36. Anxiety**<br>**Past Y/N**<br>**Present Y/N**<br>**GAD-2 Score** | Routine mental health screening in pregnancy is recommended by several organizations. Maternal anxiety or depression is associated with prenatal and postpartum depression and poor infant and child outcomes. Routine screening and intervention has the potential to improve mental health in pregnancy and decrease postpartum depression. Past history or current anxiety should be documented and include treatment/coping strategies. The GAD -2 score is a validated tool to screen for anxiety [19]. Its use is explained in OPR 4 and the score is recorded in this box. This tool can be used repeatedly throughout pregnancy; re-screen women at high risk of anxiety. |
| **37. Depression**<br>**Past Y/N**<br>**Present Y/N**<br>**PHQ-2 Score** | Past history or current depression should be documented and include treatment/coping strategies. The PHQ 2 score is a validated tool to screen for depression [20]. Its use is explained on the OPR 4 and the score is recorded in this box. This tool can be used repeatedly throughout pregnancy; re-screen women at high risk of depression. The Edinburgh Perinatal/Postnatal Depression Score (EPDS) has also been validated in pregnancy and can be used as further testing if the PHQ2 score indicates risk. Its use is also explained on the OPR 4. |
| **38. Eating Disorder** | Specify the disorder and how it is being managed. |
| **39. Bipolar** | Specify and document ongoing treatment. |
| **40. Schizophrenia** | Specify and document ongoing treatment. |
| **41. Other (PTSD, ADD, personality disorders, etc.)** | Specify the condition and document ongoing treatment. |
| **42. Smoked cig within past 6 months** | Document any cigarette use in the last six months, even prior to pregnancy or in early pregnancy. If still smoking, the estimated number of cigarettes smoked daily is entered. Quitting is best, |

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| **Current smoking ___ cig/day** | but even reducing smoking during pregnancy has an important impact on improving pregnancy outcomes. For more information, refer to the following resources (Appendix B): MotherRisk, Pregnets, and ACOG. |
| **43. Alcohol: Ever drink alcohol**<br>**If yes:**<br>**Last drink: (when) __**<br>**Current drinking ___ drinks/ wk**<br>**T-ACE Score ___** | Ask everyone a general screening question such as "Do you ever use alcohol?" or "Do you ever enjoy a drink or two?" If the answer is "no" there is no need to continue. If the answer is "yes", ask "When was the last time that you had a drink?" to identify if alcohol has been consumed during the pregnancy. The T-ACE score is a validated tool to assess problem drinking in pregnancy (see OPR 4) and the score is recorded in this box. Consider referral as appropriate. |
| **44. Non-prescribed substances / drugs** | Include all illicit drugs and pharmaceuticals being taken without a prescription. Specify the drug, quantity and frequency. |
| **45. Marijuana** | Marijuana is of particular concern given the prevalence of its use. Provide appropriate information or counsel regarding risk to pregnancy and the fetus, and consider referral as appropriate. |
| **Lifestyle/ Social** | |
| **46. Occupational risks** | Refers to work-related or other environmental situations, which are detrimental to pregnancy, examples include ionizing radiation, toxic chemicals, and infectious agents. |
| **47. Financial/housing issues** | Document any financial concerns, including housing stability. For more information, refer to the child poverty clinical tools from the Ontario College of Family Physicians (OCFP) provided in the resources (Appendix B). |
| | *A useful question regarding poverty is: "**Do you ever have difficulty making ends meet at the end of the month**?"* |
| **48. Poor social support** | Poor social support is associated with postpartum depression. Discuss who will provide support during and after pregnancy. Questions about how the partner/family feel about the pregnancy and who will be helping with the baby following birth are helpful in eliciting information. |
| **49. Beliefs/practices affecting care** | Refers to any religious or cultural practice that may impact pregnancy, birth, or newborn care. Ensure these cultural/religious are communicated in advance where changes to the usual clinical pathway in hospital are required. For more information, please refer to the SOGC Consensus Guideline for health professionals working with First Nations, Inuit, and Métis [21]. |

| | |
|---|---|
| **50. Relationship problems** | *Problematic relationships can be associated with increased dysfunction in pregnancy, the postpartum period, postpartum depression, domestic abuse, and child abuse.*<br><br>*Useful questions to ask include:* ***"How would you describe your relationship with your partner?"*** *and* ***"What do you think the relationship will be like after the baby arrives?"*** |
| **51. Intimate partner/ family violence** | Consider routine screening for risk of physical, emotional or sexual abuse. This also refers to a pattern or history of physical, sexual and/or emotional interpersonal violence. If appropriate, make a referral. There are many tools to screen for intimate partner abuse, for example the Woman Abuse Screening Tool (WAST) [22]. For more information, refer to the resources from ACOG [23] [24].<br><br>*Useful questions include:*<br>• ***Within the past year - or since you have been pregnant - have you been hit, slapped, kicked or otherwise physically hurt by someone?***<br>• ***Are you in a relationship with a person who threatens or physically hurts you?***<br>• ***Has anyone forced you to have sexual activities that made you feel uncomfortable?*** |
| **52. Parenting concerns (e.g. developmental disability, family trauma etc.)** | Parenting concerns may be related to the physical or emotional aspects of child care. If there are concerns about the prospective parents' ability to care for a baby, consider referral to the appropriate resources. Mandatory reporting guidelines should be discussed and followed as per the Child and Family Services Act (CFSA). The full text of the CFSA and its associated regulations can be found online at the Ontario government's e-laws website [25]. |

# Ontario Perinatal Record 2

## Demographics

Some of the information contained on the Ontario Perinatal Record 1 is repeated at the top of the Ontario Perinatal Record 2. These were chosen both for their importance, and for the convenience of easily referring to them.

## Physical Exam

| Item | Description |
|---|---|
| **Ht_____cm** | Height in centimetres. |
| **Pre-pregnancy Wt____kg** | Pre-pregnant weight in kilograms. |
| **BP_____** | Blood pressure at the initial exam. |
| **Pre-pregnancy BMI _____kg/m²** | Pre-pregnant body mass index in kg/m². |
| **Exam as indicated**<br>**Head and neck**<br>**Breast/nipples**<br>**Heart/lungs**<br>**Abdomen**<br>**MSK**<br>**Pelvic**<br>**Other** | Document results and comments for the physical examination findings in the space provided. |
| **Exam Comments** | |
| **Last Pap YYYY/MM/DD**<br>**Result** | In accordance with the Ontario Cervical Cancer Screening Clinical Practice Guidelines [26], initiate Pap tests at age 21 and, if normal, repeat every three years. Pap tests should only be conducted during the pre- or postnatal period if the woman is due for the routine screening. |

## Initial Lab Investigations

This section explains routinely ordered lab investigations. Results should be documented and discussed with the patient/client. Note any tests declined.

| Test | Description |
|---|---|
| **Hb** | The Hb screens for anemia which requires diagnosis and follow up. |
| **ABO/Rh(D)** | Refers to the major blood groups. This may or may not need to be repeated with the second/third trimester blood work. Rh(D) |

| | |
|---|---|
| | negative status is documented on OPR 3 as a reminder of the need for Rh(D) immune globulin administration. |
| **MCV** | Refers to any abnormality in red cell volume. Low MCV (<85) may indicate iron deficiency or thalassemia. High MCV may indicate folate or B12 deficiency, liver disease, hypothyroidism or alcohol use. |
| **Antibody screen** | Any circulating antibody measured by indirect Coomb's. A positive screen warrants additional testing in order to identify the specific antibody as some will have implications for the fetus. |
| **Platelets** | Thrombocytopenia is relatively common in pregnancy and may represent either benign or pathological conditions which require diagnosis and follow up. |
| **Rubella immune** | Record Rubella status as immune (positive titre) or nonimmune (negative or indeterminate). Check box in "Recommended Immunoprophylaxis" on the OPR 3 if rubella immunization is required postpartum. Inform patient/client of non-immune status. |
| **HBsAg** | The presence of Hepatitis B surface antigen indicates prior Hepatitis B infection and carrier status. The information is important for assessment of maternal liver function and identifying newborns that require Hep B immunoprophylaxis after birth. Check box in "Recommended Immunoprophylaxis" on the OPR 3 to ensure that the infant receives appropriate immunization. Hep B antibody screening indicates previous vaccination and immunity or previous exposure and is **NOT** the appropriate test for Hep B screening in pregnancy. [27] |
| **Syphilis** | Screen everyone for syphilis. Consider rescreening those at risk of acquiring syphilis during pregnancy in each trimester. |
| **HIV** | Screen everyone for HIV. Consider rescreening those at risk of acquiring HIV during pregnancy in each trimester. |
| **GC** | Screen everyone for gonorrhea. Consider rescreening those at risk of acquiring gonorrhoea during pregnancy in each trimester. |
| **Chlamydia** | Screen everyone for Chlamydia. Consider rescreening those at risk of acquiring chlamydia during pregnancy in each trimester. |
| **Urine C&S** | Screen everyone for asymptomatic bacteriuria (ABU) preferably at 12-16 weeks' gestation and treat if positive. Consider re-screening if the first screen is positive or there is a history of recurrent urinary tract infections. Treat GBS bacteriuria in pregnancy and treat as GBS positive when in labour (document GBS positivity in OPR 3). |

## Second and Third Trimester Lab Investigations

| Test | Description |
|---|---|
| **Hb** | Hb is routinely repeated at approximately 28 weeks' gestation. |
| **Platelets** | Same as above. |
| **ABO/Rh(D)** | Same as above. |
| **Repeat Antibodies** | Done for those who are Rh(D) negative prior to administering Rh(D)Ig. |
| **1 hr GCT** | As untreated gestational diabetes mellitus (GDM) can lead to increased perinatal morbidity and mortality and universal screening is recommended between 24 and 28 weeks' gestation, or at any stage in pregnancy with multiple risk factors. There are two approaches to screening outlined in the Canadian Diabetes Association (CDA) Clinical Practice Guideline [28]. The preferred approach is to start with a non-fasting, one-hour 50g glucose challenge test (GCT). A GCT between 7.8 and 11.2 mmol/L requires a two-hour fasting GTT for diagnosis. A GCT over 11.2 is diagnostic of gestational DM. [29] |
| **2 hr GTT** | Refers to the two-hour fasting glucose tolerance test (GTT). This can be used as a follow-up of an abnormal GCT or as a first line test in those presenting with risk factors. Diagnostic criteria for each of these algorithms can be found in the CDA Guideline [28]. |
| **Additional investigations as indicated:**<br>**TSH, Diabetes Screen**<br>**Hb Electrophoresis/ HPLC, Ferritin, B12,**<br>**ID (e.g. Hep C, Parvo B19, Varicella, Toxo, CMV)**<br>**Drug Screen, repeat STI screen** | These tests should be considered when clinically indicated. |

## Prenatal Genetic Investigations

| Item | Description |
|---|---|
| **Screening Offered Yes/No** | Everyone, regardless of age, should be offered prenatal screening for the common aneuploidies, major congenital anomalies and other chromosomal abnormalities after a discussion of the risks and benefits. The type of screening test offered will depend on gestational age at 1st prenatal visit, availability of nuchal translucency (NT) measurement, maternal (oocyte) age at delivery and personal risk factors for aneuploidy and other chromosomal |

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| | abnormalities. The availability of prenatal genetic investigation should be discussed early in the pregnancy, as the information is complex and the tests are time-specific. Document the test(s) selected, if testing was declined or if screening was not feasible due to being outside the appropriate gestational age. For all genetic tests, indicate the test performed (or offered) and the results. |
| **FTS (between 11-13+6wks)** | First Trimester Screening (FTS) combines a nuchal translucency scan and first trimester PAPP-A and hCG. Enhanced FTS is available in some locations and includes additional markers of placental growth factor (PlGF) and/or AFP. The performance characteristics of enhanced FTS are similar to IPS. |
| **IPS Part 1 (between 11-13+6wks)**<br>**Part 2(between 15-20+6wks)** | Integrated Prenatal Screening (IPS) combines a nuchal translucency scan and first trimester PAPP-A with second trimester AFP, uE3, hCG and inhibin-A at 15-20+6 weeks. Serum IPS (i.e. blood analytes alone in first and second trimester) can be used in circumstances where NT is not available or could not be obtained. |
| **MSS (between 15-20+6wks)**<br>**AFP (between 15-20+6wks)** | MSS (Quad screening) uses second trimester blood analytes alone and can be used when the gestational window for FTS or IPS has passed. AFP alone screens for neural tube defects but is not recommended when there is access to a high-quality second trimester anatomy ultrasound, with the exception of a BMI ≥35 $kg/m^2$. |
| **Cell-Free Fetal DNA (NIPT)**<br>**Offered Y/N** | Cell-free fetal DNA - often referred to as Non-invasive Prenatal Testing (NIPT) - screens for specific chromosome aneuploidies (trisomy 21, 18, 13) as well as sex chromosome disorders and microdeletion or microduplication syndromes, by analyzing circulating cell-free fetal DNA present in maternal blood. This test can be initiated as early as 10 weeks' gestational age and up to any gestation. Cell-free fetal DNA does not screen for open neural tube defects. Provincial OHIP coverage for this test is currently limited to specific clinical circumstances but several companies offer the test for private pay. Consider discussing this option with all patients/clients, even if the gestational window for standard testing has elapsed. |
| **CVS/Amino**<br>**Offered Y/N** | Chorionic villus sampling (CVS) (GA 10-12 weeks) and/or amniocentesis (GA >15 weeks) are considered diagnostic tests and may be used if a screening test is abnormal or in other high risk circumstances. |
| **Other genetic testing**<br>**Offered Y/N** | Indicate type of testing and results. |
| **NT Risk Assessment 11-13+6wk (multiples)** | Fetal nuchal translucency (NT) measurement combined with maternal age is an acceptable first trimester screening test for aneuploidies in twin pregnancies. Cell-free fetal DNA testing can also be used in twins. |

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| **Abnormal Placental Biomarkers** | Abnormal serum markers may reflect abnormalities of placentation and require further follow up. A thickened NT in the absence of genetic abnormalities may indicate cardiac defects or other fetal anomalies requiring further investigations. |
| **No Screening Tests** | |
| **Counseled and declined Date: YYYY/MM/DD** | Date testing was offered and declined. |
| **Presentation >20+6wks NIPT offered Y/N Date YYYY/MM/DD** | Document that patient/client presented outside the gestational window for standard genetic testing and whether NIPT was offered as an alternative (and the date). |

## *Ultrasound*

| Item | Description |
|---|---|
| **Date** | Date of the ultrasound(s) in YYYY/MM/DD. |
| **GA** | The gestational age in weeks and days for this ultrasound as calculated using the dating methods indicated on OPR 1. |
| **Result** | Document discrepancy between GA calculated based on dates with the GA calculated based on measurements in this ultrasound. Include other important findings (e.g. placenta location, completion of anatomy survey, estimated fetal weight, any anomalies). |
| **NT Ultrasound (between 11-13+6 weeks)** | In addition to assessment of nuchal thickness, the NT ultrasound may be used for dating if an earlier dating ultrasound was not done. |
| **Anatomy scan (between 18-22wks)** | The anatomy scan is also a genetic screening test which can detect major and minor malformations of the fetus. Note any cervical or placental abnormalities detected. |
| **Placental Location** | Document the location of the placenta as noted on the ultrasound |
| **Soft Markers** | Soft markers are obstetric ultrasound findings that are considered variants of normal but are associated with an increased risk for underlying fetal aneuploidy. These findings, for example choroid plexus cysts, left ventricular echogenic intracardiac focus (LVEIF) or single umbilical artery are not diagnostic but may change the likelihood ratio for aneuploidy with varying degrees of association. Adjustment of the background risk as determined by genetic screening tests is warranted especially in situations where multiple soft markers are present. Referral to genetics or MFM may be indicated as per the SOGC Guideline [30]. |
| **Genetic screening result reviewed with pt/client** | This is a prompt to remind care providers of the importance of reviewing the genetic screening results with the patient/client to ensure they understand results and potential next steps. |
| **Approx 22 wks: Copy of OPR 1 & 2 sent to hospital and/or given to pt/client** | This is a prompt to remind care providers to forward the information on OPR 1 and 2 to the hospital (even if intending an out of hospital birth). Copies may also be given to the patient/client to carry. |

# Ontario Perinatal Record 3

## Demographics

Some of the information contained on the Ontario Perinatal Record 1 is repeated at the top of the Ontario Perinatal Record 3. These were chosen both for their importance, and for the convenience of easily referring to them.

## Issues

| Item | Description |
|---|---|
| **Issues (abnormal results, medical/social problems)** | Use this section to list any problems (medical or social) identified in the completion of the OPR 1 or 2, review of lab results or subsequent visits. Keep this list current and review regularly. |
| **Plan of management/ Medication change/ Consultations** | For each issue identified, indicate follow up plans affecting antenatal, intrapartum, postpartum and newborn care. This may include consultations, investigations, results and medication changes. Keep this list current and review regularly. |

## Special Circumstances

| Item | Description |
|---|---|
| **Low Dose ASA Indicated** | Low dose ASA (81 mg) taken nightly has been shown to decrease preeclampsia and IUGR if started between 12 and 20 weeks' (preferably by 16 weeks') gestation in women at higher risk for these conditions. Major risk factors include, but are not limited to, prior preeclampsia, chronic hypertension, pre-gestational (type 1 or type 2) diabetes, pre-pregnancy BMI > 30 kg/m2 or assisted reproductive therapy. Other risk factors which may be important, especially in combination, include prior placental abruption, multifetal pregnancy, chronic kidney disease, prior stillbirth or IUGR, age > 40 years, nulliparity, or SLE [31] [32]. When ASA is used, it is generally discontinued at 36 weeks. |
| **Progesterone Indicated (PTB prevention)** | Consider vaginal (not intramuscular) progesterone for women at risk of preterm birth. Risk factors include, but are not limited to, a history of preterm birth or a shortened transvaginal cervical length < 2.5 cm prior to 22-24 weeks' gestation. |
| **HSV suppression indicated** | Offer those with known recurrent HSV acyclovir or valacyclovir suppression from 36 weeks' gestation to delivery. This decreases the risk of clinical lesions and viral shedding at the time of delivery |

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| | and therefore decreases the need for a caesarean section. For more information, refer to the SOGC Guideline for the management of HSV in pregnancy [10]. |
| **Social (e.g. child protection, adoption, surrogacy)** | Social issues or specific circumstances that require involvement of other agencies or referrals, social work or specific planning around delivery and postpartum care. |

## GBS

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| **Rectovaginal swab**<br>**Pos/ neg**<br>**Other indications for prophylaxis Y/N** | Rectovaginal GBS swab screening is routinely offered between 35 and 37 weeks. Include the date the swab was done, results and sensitivities if indicated. Document any history of GBS bacteriuria in this pregnancy or a previous GBS affected infant. These are indications for intrapartum antibiotic prophylaxis and negate the need for a rectovaginal swab. For more information, refer to the SOGC Guideline [33]. |

## Recommended Immunoprophylaxis

For more information on the recommended immunoprophylaxis, please refer to the SOGC Guideline for immunization in pregnancy [34].

| Item | Description |
|---|---|
| **Rh(D) neg [ ]**<br>**Rh(D) IG Given [ ]**<br>**YYYY / MM / DD** | Non-sensitized Rh(D) negative women should receive Rh(D) immunoglobulin at 28-29 weeks' gestation. Timing of immunoprophylaxis may be affected by prior administration of additional Rh(D) immunoglobulin doses and these should be documented in the section below. As Rh(D) immunoglobulin is a blood product, usual practice for discussion and consent should be followed. |
| **Additional dose given: YYYY/MM/DD** | Rh(D) Immune globulin should also be given:<br>• after spontaneous or induced abortion, ectopic pregnancy or obstetrical complications (e.g. any bleeding, abdominal trauma) or procedures such as amniocentesis.<br>• within 72 hours after delivery of a Rh(D)positive infant<br>Note the date(s) of additional doses of RhIG given. |
| **Influenza**<br>**• Discussed**<br>**• Received**<br>**• Declined** | During influenza season, discuss the benefits of influenza vaccine to the pregnant woman, fetus and newborn. The vaccine can be safely administered at any gestation. For more information, refer to the resources from the Public Health Agency of Canada (PHAC) [35], including the recommendations from the National Advisory Committee on Immunizations (NACI) [36]. |

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| **Pertussis:**<br>**• Discussed**<br>**Up-to-date Y/N Year___**<br>**• Received**<br>**• Declined** | Offer or refer for a booster of TdAP (tetanus, diphtheria, acellular pertussis) in the third trimester if they have not received a dose of acellular pertussis vaccine in adulthood. The approach may differ when there is a pertussis outbreak. For more information, refer to the following resources from PHAC: "Pertussis (whooping cough)" [37] and "NACI Statement: Update on Pertussis Vaccination in Pregnancy" [38]. |
| **Post-partum vaccine discussed**<br>**• Rubella**<br>**• Other** | Offer postpartum vaccination with MMR if not immune or rubella indeterminate. Document other vaccines which might be indicated such as varicella. |
| **Newborn needs**<br>**• Hep B prophylaxis**<br>**• HIV prophylaxis** | Refers to the needs of the newborn in a household where Hepatitis B exposure is possible. An infant born to a mother who is HbsAg positive and potentially chronically infected is at risk for acquiring Hepatitis B. Passive immunization with Hepatitis B immunoglobulin (HBIG) should be administered postpartum along with the first dose of active immunization with Hepatitis B vaccine. This is administered as a three-dose series and is available free of charge from the local Public Health Department. In households where close family members other than the mother are HBsAg positive, the newborn needs active immunization only. For more information, refer to the following resource from PHAC: "Primary Care Management of Hepatitis B – Quick Reference (HBV-QR)" [39]. |
| **Pre Preg Wt ___ kg**<br>**BMI ___** | These numbers are carried over from OPR 1 to remind care providers of the pregnancy, birth and postpartum risks associated with BMI over 30 and to facilitate calculation of weight gain. Those with high BMI may need referral or consultation for specialized services. For more information, refer to the SOGC Guideline [40] and the AOM Guideline [41]. |

## Subsequent Visits

| Item | Description |
|---|---|
| **Date** | YYYY/MM/DD |
| **GA (wks/days)** | Gestational age in weeks + days based on the EDB. In some cases the EDB based on dates may be modified. As soon as the final EDB is determined, the gestational age should be listed accordingly. As an option, the previously recorded dates could be circled or otherwise marked to indicate these referred to a preliminary EDB and are not synchronous with the final EDB. |
| **Weight (kg)** | Weight in kilograms. Assess trend in weight gain during pregnancy. For recommended weight gain in pregnancy by BMI see OPR 4. For more information, refer to the Institute of Medicine weight gain |

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|---|---|
| | recommendations for pregnancy, as per the ACOG Committee Opinion no. 548 [42]. |
| **BP** | Measure blood pressure in a sitting position with an appropriately-sized cuff on the arm resting comfortably at the level of the heart. |
| **Urine Prot.** | Measurement of urinary protein by dipstick (ranges from neg (-), trace (tr), 1+, 2+, 3+, 4+). There are conflicting guidelines about the utility of routine screening for urinary protein. However, it has been left on this form until up-to-date Canadian clinical practice guidelines are issued. |
| **SFH** | Symphysis to fundal height measured in centimetres from the pubis to the top of the fundus. This measurement is operator-dependent and if possible should be performed by the same provider with consistency in the positioning the patient. Fundal height in cm correlates approximately to gestational age in weeks but is affected by fetal position and habitus of the pregnant patient/client. |
| **Pres.** | Presentation refers to the fetal anatomical part closest to the pelvic inlet (usually the head or the buttocks). Document as cephalic or breech. Document the lie if not longitudinal (e.g. transverse, oblique) or unstable. This box may be left blank in early pregnancy visits until fetal parts are more easily palpated. |
| **FHR** | The fetal heart may be recorded as present or not, or the rate specified. Document rate when at risk for heart rate anomalies or when auscultation reveals a rate outside the normal range of 110-160 bpm. |
| **FM** | Fetal movements can be reported by the mother, palpated and/or observed by the clinician. Document as present, absent or decreased. Decreased or absent movements require further assessment. |
| **Comments** | Refers to any additional information relative to the condition of the patient/client and fetus. Any aspects of the antenatal care, specifics of discussions, etc. may be recorded. |
| **Next Visit** | Indicate the interval until the next visit and any upcoming tests or procedures. |
| **Initial(s)** | Enter the initials of the health care provider conducting the visit. If a learner is involved, provide initials of both the learner and the supervisor/preceptor. The full name corresponding to the initials of the health care provider should be entered at the bottom of the page. |

## *Discussion Topics*

Finding reputable online information sources can be challenging. Best Start and OMama provide Ontario-specific resources which address all of these discussion topics and more.
Indicate with a check if the discussion topics were addressed. For more information, including how to access these websites, refer to the resources provided in Appendix B.

| Item | Description |
|---|---|
| | **1st Trimester** |
| **Nausea/ Vomiting** | Suggestions to assist with this common issue and when to contact a health care provider. For more information, refer to the SOGC Guideline "The management of nausea and vomiting of pregnancy" [43]. |
| **Routine prenatal care/Emergency contact/ On call providers** | Individualized discussion regarding your practice, on call arrangements, appointment frequency, who to call with urgent or non-urgent questions. |
| **Safety: food, medication, environment, infections, pets** | Review:<br>• Food safety to reduce risk of food-acquired infection (e.g. listeriosis) [44].<br>• The use of prescription, non-prescription, homeopathic or herbal and common over-the-counter medications in pregnancy and where to find current information.<br>• Fever and other signs of infection that require contact with a health care provider.<br>• SOGC Guidelines on toxoplasmosis [17] and parvovirus [15], and when to contact a health care provider. |
| **Healthy weight gain** | Discussing weight management requires a positive and respectful approach. Provide support and information about healthy eating and physical activity and make a referral when necessary. |
| **Physical activity** | Exercise during pregnancy is associated with a range of benefits and is not associated with adverse outcomes. Discuss physiological changes in pregnancy and their effects on the safety of certain activities. |
| **Seatbelt use** | Recommend and review the routine and correct use of seatbelts. |
| **Sexual activity** | Reassure that sexual activity in pregnancy is safe but may require adaptations for comfort. Some complications of pregnancy are contraindications for vaginal intercourse (e.g. threatened preterm labour, P-PROM, placenta previa). |
| **Breastfeeding** | Discuss plans for infant feeding. Discuss the importance of breastfeeding and the risks associated with formula feeding, as well as postpartum supports for breastfeeding.<br>Populations with lower breastfeeding rates that benefit from additional prenatal breastfeeding support include:<br>• Body mass index >30 |

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|---|---|
| | • Breast reduction/surgery<br>• First baby<br>• Gestational diabetes or existing diabetes<br>• Lack of social/emotional support<br>• Low socio-economic circumstances<br>• Low thyroid hormone<br>• Polycystic Ovarian Syndrome<br>• Pregnant with multiples<br>• Previous breastfeeding difficulty<br>• Previous preterm birth<br>• Scheduled or high risk for Caesarean birth<br>• Under 25 years of age<br>• Use of assisted reproductive technologies |
| **Travel** | Discuss travel and the risk of deep vein thrombosis, vaccinations for international travel, insurance, high risk travel areas (including risk of infections), availability of health services and airline requirements. |
| **Quality information sources** | Recommend reliable sources of information about pregnancy and childbirth. Best Start and OMama provide Ontario-specific resources which address all of these discussion topics and more. For more information, including how to access these websites, refer to the resources provided in Appendix B. |
| **VBAC Counseling** | For those with a previous caesarean section and no contraindications to vaginal birth, discuss the benefits and risks associated with a planned trial of labour. For more information, refer to the following resources: Association of Ontario Midwives [45], BC Women's Hospital & Health Centre [46] and the SOGC VBAC Guideline [47]. |
| **2nd Trimester** | |
| **Prenatal classes** | Provide information about finding prenatal classes or on-line alternatives appropriate for their needs (e.g. language, level of literacy, financial situation, philosophy and values). Encourage registration in early second trimester. |
| **Preterm labour** | Review risk factors for preterm labour. Educate **EVERYONE** on symptoms of preterm labour and when to seek care. |
| **PROM** | Discuss symptoms of pre-labour rupture of membranes (PROM) at any gestation and when to seek care. |
| **Bleeding** | Discuss vaginal bleeding, possible causes and when to seek care. |
| **Fetal Movement** | Discuss normal patterns of fetal movement and when to seek care for concerns. For more information, refer to the SOGC Guideline [48]. |
| **Mental health** | Anxiety, depression or other conditions are common and may develop or worsen during pregnancy. Review signs and symptoms, resources and when to seek care with **EVERYONE**. Mental health assessment should be an **ongoing process** and the screening tools in the OPR 4 can be used at any time throughout pregnancy. |

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|---|---|
| **VBAC consent** | Vaginal birth after caesarean is appropriate for many women. Obtain informed consent for the patient/client's choice of trial of labour or repeat caesarean section. |
| **3rd Trimester** | |
| **Fetal movement** | Discuss the importance of awareness of fetal movement, normal patterns and when to seek care for concerns [48]. |
| **Work plan/Maternity leave** | Discuss work and any plans for pregnancy or parental leave. For more information, refer to the pregnancy and parental leave resources provided by the Ontario Ministry of Labour [49]. |
| **Birth plan: pain management, labour support** | Review birth preferences and discuss:<br>• Stages of labour<br>• Pain management options<br>• Labour support, including who will be present<br>• Specific wishes such as delayed cord clamping, skin-to-skin care, etc. |
| **Type of birth, potential interventions, VBAC plan** | Provide information about the risk and benefits of common interventions. Confirm intention for trial of labour or repeat CS in those with previous CS. |
| **Admission timing** | Discuss:<br>• Signs and symptoms of early labour and comfort measures<br>• Benefits of staying home until labour is established, if appropriate<br>• Important telephone numbers, such as after hours, labour triage, etc.<br>• Term PROM without labour<br>This information should be adapted to the family's specific circumstances and geography |
| **Mental health** | Review signs and symptoms, resources and when to seek care with **EVERYONE**. Mental health assessment should be an **ongoing process** and the screening tools in the OPR 4 page can be used at any time throughout pregnancy. |
| **Breastfeeding and support** | Reiterate the importance of breastfeeding from the first trimester discussion topics. Consider risks for lower breastfeeding initiation and success (e.g., first baby, breast reduction, gestational diabetes, previous breastfeeding difficulty) and refer to supports from prenatal breastfeeding classes or a skilled lactation professional. Review local postpartum breastfeeding supports. |
| **Contraception** | Discuss plans for contraception in the postpartum period including options specific to patient's circumstances (e.g. feeding method, medical risk factors, whether reversibility desired). |
| **Newborn care/ Screening tests/** | Discuss:<br>• Preparation for parenthood and answer questions regarding newborn care. |

| | |
|---|---|
| **Circumcision/ Follow-up appt.** | • Strategies for ensuring a health care provider is available for the newborn at the time of birth and after discharge.<br>• Newborn screening tests and follow-up appointments.<br>• Recommendations regarding routine circumcision of male infants. For more information, refer to the Canadian Paediatric Society Position Statement on newborn male circumcision [50]. |
| **Discharge planning/Car seat safety** | Discuss car seat legislation, use and installation and inform about any hospital regulations regarding discharge and car seats. |
| **Postpartum care** | Provide information on the physiological and psychological recovery from birth. Refer to issues such as perineal hygiene, rest, nutrition, emotional changes, and comfort measures. Include expectations for routine follow-up and indications for emergent care. |
| **Comments** | |
| **Approx 36 wks: Copy of OPR 2 (updated) & 3 to hospital and/or to pt/client** | This is a prompt to remind care providers to forward the information on updated OPR 2 and OPR 3 to the hospital. Copies may also be given to the patient/client to carry. |
| **Name/Initials** | Enter the name and initials of the health care provider or learner conducting the visit(s). |

# Ontario Perinatal Record 4 – Resources

These validated screening tools can be used to assess the need for further counselling/ treatment/ referrals.

| Item | Description |
|---|---|
| **Generalized Anxiety Disorder scale (GAD-2)** | The GAD-2 is a validated screening tool for generalized anxiety disorder as well as panic disorder, social anxiety and post-traumatic stress disorder. A score of 3 or more merits consideration of further assessment by the more comprehensive GAD-7 or a referral [19]. |
| **The Patient Health Questionnaire-2 (PHQ-2)** | The PHQ-2 is a commonly used validated screening tool for depression. A score of 3 or more merits consideration of further assessment by tools such as the PHQ-9 or the EPDS or a referral [20]. |
| **T-ACE Screening Tool** | The T-ACE is a validated screening tool developed specifically to assess problem drinking in pregnancy which may affect the fetus. A score of 2 indicates need for further assessment and follow-up. For more information, refer to the SOGC Guideline on alcohol use and pregnancy [51]. |
| **Edinburgh Perinatal/Postnatal Depression Scale (EPDS)** | The EPDS is a widely-used screening tool for perinatal depression. Initially developed for diagnosis of postpartum depression, it has been validated for use in pregnancy as well. It is available in multiple languages. A score of 13 or more merits more comprehensive assessment. Any positive response to question 10 (self-harm) requires immediate mental health assessment. |
| **Institute of Medicine Weight Gain Recommendations for Pregnancy** | The IOM Weight Gain recommendations have been widely adopted. Calculation of pre-pregnancy BMI is required to determine appropriate gestational weight gain. Both low and high BMI as well as inappropriate gestational weight gain are risk factors for poor pregnancy outcomes. |

# Ontario Perinatal Record 5 – Postnatal Visit

## *Demographics*

Some of the information contained on the Ontario Perinatal Record 1 is repeated at the top of the Ontario Perinatal Record 2. These were chosen both for their importance, and for the convenience of easily referring to them.

## *History*

| Item | Description |
|---|---|
| **Review of birth** | |
| **Vaginal:**<br>**• Spontaneous**<br>**• Vacuum**<br>**• Forceps**<br>**• VBAC**<br>**• Episiotomy/ Lacerations**<br>**• OASIS** | Debrief the birth experience and answer any questions about the event or outcomes.<br><br>Any *OASIS (Obstetrical Anal Sphincter Injuries) should be discussed with respect to risks of recurrence in subsequent pregnancies, and anal incontinence should be referred for pelvic floor physiotherapy. [52] |
| **Caesarean:**<br>**• Planned**<br>**• Unplanned** | |
| **Details** | |
| **Birth Attendant** | |
| **Pregnancy/ birth issues requiring follow-up (e.g. diabetes, hypertension, thyroid)** | Identify any opportunities for follow-up screening, treatment, referrals or longer term health counselling. Common issues include adjusting thyroid medications, ensuring appropriate glucose screening for those who had gestational diabetes, and adjusting antihypertensive medications. |
| **Baby's Name** | |
| **Baby's Care Provider** | Name of care provider who will complete the well-baby visits. |
| **Birth Weight (g)** | |
| **Baby's Health/Concerns** | |
| **Infant feeding:**<br>• **Breast milk only;**<br>• **Combination of breast milk and breast milk substitute** | Document how the baby is being fed. |

| | |
|---|---|
| • **Breast milk substitute only** | |
| **Feeding concerns** | Discuss infant feeding method and any need for referral/ support. |
| **Current medications** | Review medication and supplement use and any need for dosage adjustment. |
| **Bladder function** | Discuss bladder function and incontinence and treat/refer as needed. |
| **Emotional wellbeing** | Review adjustment to parenthood and emotional wellbeing. |
| **Bowel function** | Discuss bowel function, constipation and incontinence and treat/refer as needed. |
| **Relationship** | Review how the new baby has affected the parents' relationship. |
| **Sexual function** | Discuss sexual activity, changes and expectations. |
| **Postpartum Depression Screen (EPDS or other)** | Screen **ALL** clients/patients for postpartum depression. See screening tools on the Resource page 4 of the OPR. |
| **Lochia/Menses** | Discuss postpartum bleeding and return of menstrual cycle. |
| **Family support/ Community resources** | Review supports in place and refer as necessary. |
| **Perineum/Incision** | Discuss perineal or incisional healing and any ongoing discomfort if present. |
| **Smoking N/Y**<br>**_____ cig/day** | The postpartum period is a high-risk time for relapse among those who managed to reduce or quit during pregnancy. Discuss strategies for maintenance of smoking cessation. Discuss risks of smoking around infants and children. |
| **Alcohol N/Y**<br>**If yes: Drinks/wk_____**<br>**and If yes: T-ACE Score_____** | Ask about alcohol use and refer to Ontario Perinatal Record-Resources for T-ACE screening tool. |
| **Non-prescribed substances/drugs (e.g. opioids, cocaine, marijuana, party drugs, other) N/Y** | Discuss the health risks of using non-prescribed substances/ drugs as well as newborn implications. Refer as appropriate. |
| **Rubella immune**<br>**Y/ N**<br>**• Discussed**<br>**• Declined**<br>**• Received** | Inform about the benefits of postpartum immunization. For more information, refer to the resources from PHAC [35], including the recommendations from the NACI [36]. |

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|---|---|
| **Influenza**<br>**• Discussed**<br>**• Declined**<br>**• Received** | *Inform about the benefits of postpartum immunization. For more information, refer to the resources from PHAC [35], including the recommendations from the NACI [36].* |
| **Pertussis (TdAP)**<br>**Up-to-Date Y/N**<br>**• Discussed**<br>**• Declined**<br>**• Received** | Inform about the benefits of postpartum immunization. For more information, refer to the resources from the PHAC [35], including the recommendations from the NACI [36]. |
| **Other Immunizations** | |
| **Last Pap YYYY/MM/DD**<br>**Results** | Perform PAP test only if indicated as per provincial screening |

## Physical Exam As Indicated

| Item | Description |
|---|---|
| **Weight Today (kg)** | Examine as indicated. |
| **Pre-Delivery Weight (kg)** | |
| **Pre-Pregnancy Weight (kg)** | |
| **BP (mm Hg)** | |
| **Affect, Thyroid, Breasts, Abdomen, Perineum, Pelvic** | |

## Discussion Topics

| Item | Description |
|---|---|
| **Transition to parenthood/partner's adjustment** | Opportunity to discuss emotional health, coping strategies and changes in relationships. |
| **Family violence and safety** | Ask about any physical, emotional or verbal abuse and feelings about personal or newborn safety. Discuss safety plans and referrals as appropriate. |
| **Nutrition/physical activity/healthy weight** | Discuss postpartum physical activity, nutrition and the benefits of a healthy weight following and between pregnancies. Outline the longer term health risks associated with cumulative weight gain, including diabetes. |

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|---|---|
| **Plan for management of alcohol tobacco/ substance use** | Based on screening tools and answers to questions above, provide resources and/or referrals as appropriate. For more information, refer to the SOGC Guidelines on alcohol use [51] and substance use in pregnancy [53], as well as the following resources (Appendix B): Pregnets and MotherRisk. |
| **Contraception** | Discuss plans for future pregnancies/contraception. Discuss risks and benefits of different methods, including the effects on breastfeeding. Prescribe and arrange chosen method. |
| **Pelvic floor exercises** | Review pelvic floor exercises to help strengthen pelvic floor muscles. Provide resources and referrals as appropriate. |
| **Community resources (e.g. Healthy Babies Healthy Children)** | Outline postpartum and child resources available in the community and online. |
| **Advice regarding future pregnancies and risks** | Based on pregnancy history and outcomes, outline potential risk factors and important considerations for future pregnancies (e.g. preterm birth, severe jaundice, placental issues, and gestational diabetes). Considerations may include education, preconception planning and communication with other members of the health care team. |
| **Preconception planning: folic acid, medications, etc.** | Outline health promotion strategies for future pregnancies. For more information, refer to the SOGC Guideline [8]. |
| **If CS, future mode of birth and pregnancy spacing** | Discuss the recent caesarean section. Outline factors associated with successful vaginal birth after caesarean in a subsequent pregnancy, as well as any contraindications. |
| **Other comments / concerns** | |
| **Signature of healthcare provider** | |

# Appendix A: Acronyms and Abbreviations

| Acronym | Full Term |
|---|---|
| **A (in GTPALS)** | Abortions |
| **Abn** | Abnormal |
| **ADD** | Attention Deficit Disorder |
| **AFP** | Alpha-feto Protein |
| **ASA** | Acetylsalicylic Acid |
| **BP** | Blood Pressure |
| **BMI** | Body Mass Index |
| **Cig** | Cigarettes |
| **CF** | Cystic Fibrosis |
| **CMV** | Cytomegalovirus |
| **CS** | Caesarean Section |
| **C&S** | Culture & Sensitivity |
| **CVS** | Chorionic Villus Sampling |
| **EDB** | Estimated Date of Birth |
| **EPDS** | Edinburg Perinatal/Postpartum Depression Scale |
| **FGM** | Female Genital Mutilation |
| **FHR** | Fetal Heart Rate |
| **FM** | Fetal Movement |
| **FTS** | First Trimester Combined Screening |
| **G (in GTPALS)** | Gravida |
| **GA** | Gestational Age |
| **GBS** | Group B Streptococcus |
| **GC** | Gonorrhea |
| **GCT** | Glucose Challenge Test |
| **GDM** | Gestational Diabetes Mellitus |
| **GI** | Gastrointestinal |
| **GTT** | Glucose Tolerance Test |
| **Hb or Hgb** | Hemoglobin |
| **HBsAG** | Hepatitis B Surface Antigen |
| **Hep B** | Hepatitis B |
| **Hep C** | Hepatitis C |
| **HIV** | Human Immunodeficiency Virus |
| **HPLC** | High performance liquid chromatography |
| **HSV** | Herpes Simplex Virus |
| **Ht** | Height |
| **HTN** | Hypertension |
| **IPS** | Integrated Prenatal Screening |
| **IUGR** | Intrauterine Growth Restriction |
| **IUI** | Intrauterine Insemination |

| | |
|---|---|
| **KG** | Kilograms |
| **L (in GTPALS)** | Living Children |
| **LEEP** | Loop Electrosurgical Excision Procedure |
| **LMP** | Last Menstrual Period |
| **M** | Metres |
| **MCV** | Mean Corpuscular Volume |
| **MRN** | Medical Record Number |
| **MRP** | Most Responsible Provider |
| **MSK** | Musculoskeletal |
| **MSS** | Maternal Serum Screening |
| **Neg** | Negative |
| **NIPT** | Non-Invasive Prenatal Testing (cell free DNA) |
| **NT** | Nuchal Translucency |
| **OHIP** | Ontario Health Insurance Plan |
| **OTC** | Over the counter (i.e. medications) |
| **Pap** | Papanicolaou Test |
| **P (In GTPALS)** | Preterm |
| **Parvo** | Parvovirus |
| **PPH** | Postpartum Hemorrhage |
| **Pres.** | Presentation |
| **PROM** | Pre-Labour Rupture of Membranes |
| **P-PROM** | Preterm Pre-Labour Rupture of Membranes |
| **Rh(D)** | Rhesus |
| **Rx** | Prescription |
| **PTB** | Preterm Birth |
| **PTSD** | Post-Traumatic Stress Disorder |
| **S (in GTPALS)** | Stillbirth |
| **SFH** | Symphysis Fundal Height |
| **SOGC** | The Society of Obstetricians and Gynaecologists of Canada |
| **STI** | Sexually Transmitted Infection |
| **T (in GTPALS)** | Term |
| **T1 or T2** | Trimester 1 or Trimester 2 |
| **TB** | Tuberculosis |
| **TdAP** | Tetanus, Diphtheria, Pertussis |
| **Toxo** | Toxoplasmosis |
| **TSH** | Thyroid-Stimulating Hormone |
| **US** | Ultrasound |
| **VBAC** | Vaginal Birth After Caesarean |
| **Wt** | Weight |

# Appendix B: Additional Resources

| Resource | Resource Location |
|---|---|
| **OPR – Page 1** | |
| **Sexual Orientation – Rainbow Health**<br>• Offers training to health and social service providers across the province on a variety of LGBTQ related topics | www.rainbowhealthontario.ca |
| **Infectious Diseases**<br>• Public Health Agency of Canada - Canadian Guidelines on Sexually Transmitted Infections in Pregnancy<br>• Centers for Disease Control and Prevention | http://www.phac-aspc.gc.ca/std-mts/sti-its/cgsti-ldcits/section-6-4-eng.php<br><br>https://www.cdc.gov/zika/<br>https://www.cdc.gov/lyme/index.html<br>https://www.cdc.gov/westnile/index.html |
| **Smoking**<br>• Pregnets (Prevention of Gestational and Neonatal Exposure to Tobacco Smoke). They provide information, resources and support to pregnant and postpartum women and their health care providers.<br>• ACOG – A Clinician's Guide to Helping Pregnant Women Quit Smoking | www.pregnets.org<br><br>www.acog.org/~/media/Departments/Tobacco%20Alcohol%20and%20Substance%20Abuse/SCDP.pdf |
| **Poverty**<br>• Ontario College of Family Physicians Clinical Tools and Resources | http://ocfp.on.ca/tools/clinical-tools-and-resources#wh |
| **Intimate Partner Violence** | http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Intimate-Partner-Violence<br><br>http://rnao.ca/sites/rnao-ca/files/Woman_Abuse_Screening_Identification_and_Initial_Response.pdf<br><br>https://sogc.org/wp-content/uploads/2013/01/157E-CPG-April2005.pdf |
| **Nutrition in Pregnancy** | http://www.hc-sc.gc.ca/fn-an/nutrition/prenatal/index-eng.php |
| **OPR – Page 2** | |
| **Pap Tests – Cancer Care Ontario** | https://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=13104 |

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|---|---|
| **Lab tests in Pregnancy**<br>• ACOG describes routine testing in pregnancy | http://www.acog.org/~/media/For%20Patients/faq133.pdf |
| **Diab**<br>**etes Screening**<br>• Executive summary and algorithms | http://guidelines.diabetes.ca/executivesummary/ch36 |
| **Prenatal Screening**<br>• An overview of ON prenatal screening | http://prenatalscreeningontario.ca/ |
| **Ultrasound in Pregnancy**<br>• Determination of gestational age (SOGC)<br>• Ultrasound in twin pregnancy<br>• ACOG Guideline | https://sogc.org/wp-content/uploads/2014/02/gui303CPG1402E.pdf<br>https://sogc.org/wp-content/uploads/2013/01/gui260CPG1106E.pdf<br>http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Guidelines-for-Diagnostic-Imaging-During-Pregnancy-and-Lactation |
| **OPR – Page 3** | |
| **Immunization in Pregnancy**<br>• SOGC information<br>• CDC overview | https://sogc.org/wp-content/uploads/2013/01/gui220CPG0812.pdf<br>http://www.cdc.gov/vaccines/pregnancy/pregnant-women/<br>http://www.cdc.gov/vaccines/pregnancy/downloads/immunizations-preg-chart.pdf |
| **Best Start**<br>• Ontario specific fact Sheets for pregnancy | http://en.beststart.org |
| **OMama**<br>• Ontario specific website and mobile app | www.omama.com |
| **Travel and Pregnancy**<br>• Gov't of Canada<br>• ACOG information | https://travel.gc.ca/travelling/health-safety/travelling-pregnant<br>http://www.acog.org/Patients/FAQs/Travel-During-Pregnancy |
| **General Resources** | |
| **Society of Obstetricians & Gynaecologists of Canada** | www.sogc.org |
| **The Association of Ontario Midwives (AOM)** | www.aom.on.ca |
| **Public Health Agency of Canada** | www.phac-aspc.gc.ca |
| **National Institute of Health and Care Excellence** | www.nice.org.uk |

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|---|---|
| **Decision Aids for Pregnancy**<br>• Ottawa Hospital Research Institute Resources | https://decisionaid.ohri.ca/AZsearch.php?criteria=pregnancy |
| **Healthy Babies Healthy Children** | http://www.children.gov.on.ca/htdocs/English/earlychildhood/health/index.aspx |

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