

Antenatal Record (Part 1)

Patient label (upper right hand side of form (pages 1-4) can place sticker here)	
Item	Description
Patient's last name	Last name of the mother
Patient's first name	First name of the mother
Address	Place of residence of woman (include postal code)
Phone number	Woman's phone number (include home/cell and work numbers)
Medicare number	Woman's medicare number with expiry date
Hospital chart number	Hospital chart number where she plans on giving birth (or home)

Demographic and Background information

Item	Description
Date of birth	Woman's date of birth
Age	Woman's age at estimated date of delivery
Occupation/Work Status	Woman's occupation. This can identify if her work exposes her to any environmental or occupational risks (e.g. chemicals, asbestos, radiation, hazardous waste, etc.) This data will help identify any factors linked to congenital anomalies, and is collected in our database for further investigation in provincial and national reporting. Also Indicate if she works full-time, part-time or doesn't work.
Ethnic/racial backgrounds of biological mother	Ethnic or cultural identity. Indicate whether she/he are: French Canadian, African-Decent, Asian, Caucasian, First Nations, Hispanic, Jewish, Mediterranean, Middle Eastern, Other (specify). Our goal in collecting this data is to be able to identify patients with increased risk of congenital anomalies linked to certain ethnicities, racial background. Please note that if the pregnancy results from artificial insemination or surrogacy - we would like to know the donor's ethnicity and not necessarily that of the partner who will be involved in the pregnancy.
Education level	The woman's level of education. Indicate: no high school diploma, high school diploma, current post-secondary education (includes working on college or university degree, college or trade diploma, university degree).
Marital status	Woman's marital status. Indicate single, married, divorced, separated, widowed, or common law.

Present Pregnancy

Item	Description
Pre-pregnancy folic Acid	Did they woman take folic acid prepregnancy 'Y' or 'N'
Folic acid dose	Indicate the folic acid dose in micrograms. (Milligrams multiply 100)

Partner/Father's information

Item	Description
Last name	Last name of the partner/father
First name	First name of the partner/father
Occupation	Partner/Father's occupation. This can identify if his work exposes him to any
Age	The age of the biological father

Healthcare Provider	
Item	Description
Family physician/Nurse Practitioner	Name of the family physician, nurse practitioner
Birth attendants	Indicate birth attendants, OBS, Family physician, midwife
Newborn care	Indicate Newborn care, Pediatrician, Family physician/NP, Midwife
Physical Examination	
Item	Description
Exam date	Indicate when the physical examination took place
BP	Document the blood pressure taken during the exam
Height	Document the height of the woman in centimeters
Pre-pregnancy weight	Document the pre-pregnant weight of the woman in kilograms
Pre-pregnancy BMI (Body Mass Index)	Document the pre-pregnant BMI. Refer to the BMI on the attached appendix A.
Breasts and Nipples	Document results of breasts and nipples exam
Pelvic Exam	Document results of pelvic exam
Normal	Document if normal
Abnormal	Document if abnormal, please describe abnormalities below
Lifestyle and Social History	
Item	Description
Occupation/Environmental Risks	Indicate whether discussed, if there are concerns, or if there was a referral
Support system	Indicate whether discussed, if there are concerns, or if there was a referral
Interpersonal Violence	Indicate whether discussed, if there are concerns, or if there was a referral
Sexual abuse	Indicate whether discussed, if there are concerns, or if there was a referral
Financial/Housing/Prenatal Benefits	Indicate whether discussed, if there are concerns, or if there was a referral
Prenatal classes	Indicate whether discussed, if there are concerns, or if there was a referral
Alcohol use	
The TWEAK tool is attached with the completion guide. The tool has been	
Item	Description
Alcohol	Indicate if the woman has used alcohol 'Yes' or 'No'
Before pregnancy	Document the maximum amount of drinks before pregnancy. Please refer to the attached appendix " Maternal drinking guide and how to ask the question"
Current	Document the maximum amount of drinks during the current pregnancy.
Tobacco use (smoking)	
Item	Description
Smoking	Indicate if the woman has never smoked. Or indicate a quit date if she is a former smoker
Cig/day before pregnancy	Document the average cigarettes per day before the pregnancy. (Please note 1/2 pack is 13 cigs, 1 pack is 25 cigs)
Cig/day current	Document the average number of cigarettes per day during the current pregnancy (Please note 1/2 pack is 13 cigs, 1 pack is 25 cigs)
Exposure to 2nd hand smoke	Check 'no' or 'yes' if exposed to tobacco use. (if the mother lives with a smoker or works in a environment with smokers)
Marijuana and substance use	
Item	Description
Marijuana Use	Indicate if the woman has never used cannabis. Or indicate a quit date if she is a former user.

Marijuana use before pregnancy	Document the average amount of usage per day, week or month before pregnancy
Marijuana use during current pregnancy	Document the average usage per day, week or month during the current pregnancy
Substances Use	Indicate 'Yes' or 'No' for substance use during pregnancy. Specify in the 'notes' section the type of substance. Can include methadone, solvents, opiates, vaping or other

Antenatal Record (Part 2)

(Reminder that to the upper right of the form the patients label should be placed)

Medical History, current pregnancy

Item	Description
Final EDD	Date of the final estimate of the delivery date. Please check corresponding box to determine dating method
Dating method	Indicate the EDD dating method: T1 ultrasound, T2 ultrasound, ART, or other
Method of conception	Please indicate the method of conception: Spontaneous, ART. If ART please specify: OI, IUI, IVF, ICSI
Pregnancy on contraceptive	Please indicate 'Yes' or 'No' if pregnancy occurred while on contraceptive
LMP	Date of last menstrual period

Obstetrical History

Item	Description
Gavida	The total number of prior plus present pregnancies regardless of gestational age, type, time or method of termination outcome. Twins or multiple are counted as one pregnancy
Term	The total number of previous pregnancies with birth occurring at greater than or equal to <u>37 completed weeks</u> gestation
Preterm	The total number of previous pregnancies with birth occurring between <u>20-36 completed weeks</u> gestation
Abortion - induced	The total number of previous induced terminations of pregnancies ending prior to 20 completed weeks gestation.
Abortion - Spontaneous	The total number of previous spontaneous terminations of pregnancies ending prior to 20 completed weeks gestation. This includes missed abortions, ectopic pregnancies, termination of a non-viable fetus
Living	The total number of children the women has given birth to, and are presently living. Does not include present pregnancy
Date of birth/abortion	Indicate the date of birth/abortion for each pregnancy
Place of Birth/abortion	Indicate the place of birth/abortion for each pregnancy
Hours in labour	Indicate the number of hours in labour for each pregnancy
Gestational age	Indicate the gestational age for each birth/abortion
Type of birth	Indicate the type of birth(vaginal or caesaran)
Perinatal complications	Indicate any perinatal complications for each birth/abortion
Sex	Indicate the babies sex for each birth/abortion
Birth weight	Indicate the birth weight for each birth/abortion
Breast fed	Indicate 'Yes' or 'No' for each baby
Present health of child	Document the present health of each child

Medical History and Family History

* Includes medical history/family history that may influence the management or outcome of the current pregnancy.

Medical History and Surgical History	
Item	Description
GI/Hepatic	History of Gastrointestinal or hepatic disease, please choose 'Yes' or 'No'.
Urinary/ Renal	Pre-existing disorders, history of recurrent UTI, pyelonephritis, ARF, CRF or those complicating a previous pregnancy. Please indicate 'Yes' or 'No'. Please specify in comments below
Anesthesia	Complications from previous anesthetics, please indicate 'Yes' or 'No'. Please specify in comments below
Hypertension/Preeclampsia/eclampsia	Previous chronic hypertension, hypertension currently on medication, hypertension with previous pregnancies. Please indicate 'Yes' or 'No'. Please specify in comments below
HSV/STI	History of herpes simplex virus or STI's. Indicate 'Yes' or 'No'. Please specify in comments below
Surgeries	History of any previous surgeries. Indicate 'Yes' or 'No'. Please specify in comments below
Varicella	History of varicella. Indicate 'Yes' or 'No'. Please specify in comments below
Blood transfusion	History of blood transfusions. Indicate 'Yes' or 'No'. Please specify in comments below
Mental Health Concerns	Past or present history of mental illness and treatments. Indicate 'Yes' or 'No'. Please specify in comments below
Diabetes/thyroid/endocrine	Endocrine disorders (diabetes, thyroid). Indicate 'Yes' or 'No'. Please specify in comments below
Uterine/ Cx procedure	History of uterine or Cx procedure (LEEP, cone, myomectomy). Indicate 'Yes' or 'No'. Please specify in comments below.
Neurological	History of neurological disorders. Indicate 'Yes' or 'No'. Please specify in the comments below.
Respiratory	History of any respiratory disorders. Indicate 'Yes' or 'No'. Please specify in the comments below.
Cardiovascular	History of cardiovascular disease. Indicate 'Yes' or 'No'. Please specify in the comments below.
Thromboembolic/Hematologic	History of thromboembolic or hematologic disorders. Indicate 'Yes' or 'No'. Please specify in comments below
Other	History of any other disorders or diseases not specified above. Indicate 'Yes' or 'No'. Please specify in the comments below
Comments	The comment section is a place to elaborate or specify on any of the above medical history questions.
Allergies/Sensitivities	Please specify any allergies or sensitivities in the space provided
Medications/Herbals/ OTC	Please specify any medications, herbals, and any over the counter medications in the space provided

Family History	
	*Includes medical history/family history that may influence the management or outcome of the current pregnancy. Check 'No' if the condition is not present. If 'Yes' please document.
Item	Description
Heart disease	Indicate 'Y' or 'N' for both Mother and Father
Hypertension	Indicate 'Y' or 'N' for both Mother and Father
Diabetes	Indicate 'Y' or 'N' for both Mother and Father
Thyroid disorders	Indicate 'Y' or 'N' for both Mother and Father
Thromboembolic (DVT/PE) Hematologic	Indicate 'Y' or 'N' for both Mother and Father
Multiple births	Indicate 'Y' or 'N' for both Mother and Father
Congenital anomalies	Indicate 'Y' or 'N' for both Mother and Father
Chromosome abnormalities	Indicate 'Y' or 'N' for both Mother and Father
At risk population (eg. Ashkenazi, consanguinity, CF, sicklecell, Tay Sach, Thalassemia)	Indicate 'Y' or 'N' for both Mother and Father
Other	Please specify other family history
Notes	Any notes you would like to document
Laboratory and Diagnostic Testing	
Item	Description
First Prenatal Visit	Date of the 1st prenatal visit, PAP date, and results. Other tests offered to all Indicate the results of the following test that is offered to some women : Varicella, Hepatitis C, Father's RH, TSH, early Diabetic screen, or other. If these
9 - 13 +6 WEEKS	Indicate if the maternal Serum Testing was 'discussed', 'declined' or 'accepted' with the date (Screen's for Down Syndrome, Trisomy 18). Nuchal Translucency and date.
15 - 20 +6 WEEKS	Indicate if the maternal Serum Testing was 'discussed', 'declined' or 'accepted' with the date (Screen's for Down Syndrome, Trisomy 18)
24 - 28 WEEKS	Indicate the results of the following tests offered to all women : CBC, GTT, Antibody Screen, Diabetic screen(1hr PC 50g glucose screen)
28 WEEKS	Indicate 'Yes' or 'No' if the Rho (D) Immuno Globulin is given, along with the date. Indicate VBAC eligibility 'Yes' or 'No'.
28 - 32 WEEKS	Indicate the score of Edingburg Postnatal depression scale, along with 'yes' or
35 - 37 WEEKS	Indicate the positive or negative result of the GBS (Group Strep B) if screening was done along with the date. Or Check 'declined' box if the patient refused
Other Lab/ DI results	Document if any other labs or diagnostic imaging results were done and the
Special Procedures/ Tests	Indicate whether the GTT was done 'yes' or 'no' along with the date and the results (Glucose tolerance test - gestational diabetes)
	Indicate if an Amniocentesis/ CVS was done along with the date and the results
	Indicate if NIPs was done along with the date and results
	Indicate if the seasonal flu Shot was 'discussed', 'declined' or 'given'. If it was
	Indicate if TDAP was done along with the date or if it was 'declined'.
	Indicate if the Covid-19 vaccine was 'discussed', 'declined' or 'given'. If it was administered, indicate the dates of the first and second dose as well as the manufacturer.

Antenatal Record(Part 3 & 4)

(Reminder that to the upper right of the form the patients label should be placed)

*Should you need more space for documentation please print subsequent assessments

Item	Description
Blood type	Please indicate blood type
GBS	Please indicate GBS status
Ultrasound T1	Please indicate the date and results of the T1 Ultrasound
Ultrasound T2	Please indicate the date and results of the T2 Ultrasound

Maternal/Fetal

Item	Description
Identified risk factors	Indicate any identified risk factors
Plan of management	Document the plan of management during current pregnancy
Consults	Indicate any consultations during current pregnancy
Hospitalizations	Document any hospitalizations during current pregnancy

Subsequent Assessments

Item	Description
EDD	Please indicate the estimated delivery date
Age	Document the age of the woman at delivery
G	Indicate the woman's gravida
P	Indicate the woman's parity
T	Indicate the woman's term pregnancies
A	Indicate if and how many abortions occurred
L	Indicate the number of living children the woman has
Pre-pregnancy BMI	Document the women's pre-pregnancy BMI. To determine BMI see appendix A

Please document, initial, date and sign for each visit the following

Item	Description
Date	Document the date of the visits
Gest. Age	Document the gest age at time of visits
SFH	Document the woman's symphysial fundal height at each visit
BP	Document the woman's blood pressure at every visit
Urine Prot.	Document the woman's urine protein for each visit
FHR/FM	Document the Fetal heart rate/fetal monitoring for each visit
Pres. Position	Document the presentation position for each visit
Comments	Space to document or specify in more detail
Next visit	Document the date for the next visit
Initials	Document your initials after each visit

Discussion topics

Below are some discussion topics to have with your patient that will help you complete the antenatal record

Nutrition	Sexual Activity
Travel	PROM/APH
Depression Scale	Newborn Screening
Weight Gain	Breastfeeding classes
Work Plan	On-call Providers
GBS Screen	Neonatal Care
Exercise	Prenatal Education
Fetal Movement	Birth Plan
Postpartum Care	Contraception

Acronym Legend

FT-Full Time
PT-Part Time
mcg-micrograms
EDD-expected due date
US-ultrasound
ART-assisted reproductive therapy
OI- Ovulation Induction
IUI- Intrauterine insemination
IVF- In vitro fertilization
ICSI- Intracytoplasmic sperm injection
GI-Gastrointestinal
HSV- Herpes Simplex Virus
STI- sexually transmitted infection
Hgb-hemoglobin
PLT-platelets
HgbAg-hemoglobin antigen
ABO- Landsteiner's blood grouping system
RH- rhesus factor
HIV- Human immunodeficiency virus
C&S-culture and sensitivity
TSH- Thyroid stimulating hormone
CBC- complete blood count
GTT-glucose tolerance test
rho-rhogam
VBAC-vaginal birth after caesarean
OTC-over the counter
CVS- chorionic villus sampling
TDAP- tetanus, diptheria, pertussis
DI-diagnostic imaging
G-gravida

P-parity
T-term
A-abortion
L-living
Gest age-gestational age
SFH- symphysial fundal height
BP-blood pressure
urine prot.-urine protein
FHR- fetal heart rate
FM-fetal monitoring
pres. Position-presentation position
T1-trimester 1
T2-trimester 2