NWT PRENATAL RECORD: USER GUIDE AND RESOURCES

2021

Government of
Northwest Territories

Table of Contents

Introduction 2

Section 1: **Demographics and Background Information** 4

Section 2: **Allergies** 4

Section 3: **Current Medications/OTC/Herbal** 4

Section 4: **Obstetrical History** 4

Section 5: **Menstrual History and EDD Confirmation** 5

Section 6: **Present Pregnancy** 6

Section 7: **Family History** 6

Section 8: **Beliefs and Practices** 7

Section 9: **Medical History** 7

Section 10: **Lifestyle and Social** 9

Section 11: **Initial Physical Examination** 13

Section 12: **First Trimester Topics Discussed** 13

Section 13: **Comments/Risk Factors** 16

Section 14: **Investigation/Results** 17

Section 15: **Confirmed EDD** 28

Section 16: **Prenatal Visit Documentation** 28

Section 17: **Referral Plan** 29

Section 18: **Second and Third Trimester Topics Discussed** 29

Appendix: **Prenatal Nutrition Discussion Questions, Part 4 Key Actions, Messages and Resources** 32

References 36

Introduction

The updated NWT Prenatal Record (PNR) is the assessment and documentation tool for health care professionals to facilitate health and pregnancy care for clients in a structured and standardized way. Prenatal care is part of core programming identified in the NWT Community Health Core Program Standards and Protocols and offered to all pregnant individuals. The purpose of the PNR tool is to provide screening assessments, risk assessments, health information, anticipatory guidance on safety, support systems, health promotion issues, and information on immunizations/vaccinations. Early identification of any risk factors or challenges in these areas should be followed up with additional screening, referrals, and interventions to improve the health and wellness of the client, their pregnancy, and their family's outcomes.

In conjunction with Parts 1-3, additional tools are provided to assist with assessment:

- Part 3 &4 – Work sheet, including Risk Assessment/Nutritional Assessment/TWEAK Questionnaire/SFH Chart/Safe Tool
- Part 5 – Flow sheet for the recommended NWT Blood Work and Investigations in Pregnancy
- Part 6 – Edinburgh Perinatal/Postnatal Depression Scale

The initial prenatal visit should take place between 6-12 weeks gestation. Regular visits should be scheduled every 4 weeks until 28 weeks, every 2 weeks until 36 weeks and every week until birth or client leaves community for planned birth services. More frequent visits can be scheduled as clinical situations arise.

It is recommended a copy of the Prenatal Record Parts 1-4 and all lab results be sent to the referral centre whenever the client has a scheduled appointment (i.e. Ultrasound) or at **20 weeks gestation**. This ensures important information is available when the client attends their appointment and/or if the client is transferred unexpectedly in pregnancy. Prior to any travel to referring centre for planned birth services or at **36 weeks gestation**, an up-to-date copy of the Prenatal Record Parts 1-4 and additional lab results should be sent to the intended hospital/health centre of birth as per organizational guidelines.

Overview

The NWT PNR is meant to encourage and guide dialogue between the health care provider and client on their prenatal care. The prenatal visit is an opportunity for a health care provider to engage one-on-one with the pregnant client and through the assessment recognize a client who might be at risk. This involves asking the client for any concerns about their pregnancy, assessing the client, identifying risk and protective factors (including determinants of health), and documenting the components of prenatal care.

The NWT PNR can help contextualize areas of concern from the client's lived experience and identify how determinants of health are impacting the client's health. The plan of care can promote a wide variety of positive behaviours that address determinants of health (such as nutrition, harm reduction, breastfeeding, injury prevention, and oral health), and use anticipatory guidance to promote these positive behaviours.

When a vulnerable infant or child is identified through questions on the NWT PNR, the client can be connected with supportive resources. These additional supports may help address a client's potential barriers in obtaining the interventions and treatment for the area of concern identified during the prenatal visit.

Programs Supporting NWT Prenatal Caregivers

Northern Women's Health Program – Stanton Territorial Hospital – (867) 669-4359

The Northern Women's Health Program (NWHP) is located in Stanton Territorial Hospital in Yellowknife. This program is run by a Nurse Practitioner, Registered Nurse and Program Assistant who coordinates the transition of pregnant clients from their community to Yellowknife. A toll-free line, **1-866-331-3376**, is answered Monday to Friday. The program can be contacted about questions regarding prenatal care, prenatal testing or for the coordination of referrals needed in Yellowknife. Monthly NWHP telehealth meetings are scheduled the last Friday of the month, excluding July and August and December. These meetings cover maternity care and women's health topics.

Obstetrics and Gynecology – Stanton Territorial Hospital – (867) 669-4151

The Department of Obstetrics and Gynecology is located in the Ambulatory Care Clinic (1st floor) at Stanton Territorial Hospital in Yellowknife. This department is the primary consultation and referral site for Obstetrical care in the NWT. Obstetrician/Gynecologists and Registered Nurses run the program and coordinate referrals. The program can be contacted about questions related to prenatal care, prenatal testing and medical referrals during pregnancy. STH Obstetrician/Gynecologists make regular trips to most Northern communities.

Physician on Obstetrical Call – Inuvik Regional Hospital – (867) 777-8000

Inuvik Regional Hospital (IRH) is the regional obstetrical consultation and referral centre for the Beaufort Delta Health region and parts of the Sahtu when appropriate and as per organizational guidelines. All inquiries and support related to pregnant clients from these regions, including advice on routine prenatal care or complications can be directed to the Physician on Obstetrical Call at the IRH.

This document provides instructions in completing the NWT Prenatal Record (2021).

Questions about the NWT Prenatal Record Form, Desktop Reference and User Guide should be directed to:
nursing@gov.nt.ca

Section 1: Demographics and Background Information

Item	Description
Intended Birthplace	The hospital or location the client plans to give birth.
Referring Community / Health Provider	The client's home community and/or primary care provider.
Education Level	Highest level of education completed (i.e. Grade 9, Grade 12, College Degree, University Degree). Relates to the ability to understand and carry out health recommendations and used in assessing the client's ability to comprehend oral and written information. This is an opportunity to assess for continuing education opportunity, or barriers to accessing education.
Ethnic Origin or Cultural Identity	Ethnic origin or cultural identity as provided by the client. This is used to identify specific racial or ethnic groups in so far as their genetic risks are concerned. Opportunity to ask about specific cultural preferences, including asking the client about their pronoun preference and record their response.
Occupation	The client's occupation, including homemaker. Occupational hazards may adversely impact a pregnancy and alternative duties or work cessation may become necessary.
Age at Delivery	Identify age of client at time of delivery.
Partner's Name and Age	Full name and age of the partner.
Partner's Occupation	The partner's occupation. The partner's occupation may be relevant; for example if they work frequently out of town. Ask how pregnant client perceives this impact.
Ethnic Origin of Newborn's Father	Ethnic origin or cultural identity of the fetus's father. This is used to identify specific racial or ethnic groups as far as their genetic risks are concerned. Opportunity to ask about specific cultural preferences, including asking the client about their pronoun preference and record.

Section 2: Allergies

Item	Description
Allergies	Document allergies and sensitivities and ensure that client's current strategies for mitigating symptoms or reactions is pregnancy safe.

Section 3: Current Medications/OTC/Herbal

Item	Description
Current medications, over the counter medications and herbal products	Any prescription medications, over the counter medications, traditional medicines, complementary medicines or herbal products the client is currently taking on a regular basis. Include the frequency and dosage of each. Any of these can potentially have harmful effects on the pregnancy.

Section 4: Obstetrical History

Item	Description
Gravida	The total number of pregnancies regardless of gestational age, type, time or method of termination/outcome (includes current pregnancy). Multiple fetuses are counted as one pregnancy. An empty sac and hydatidiform mole are classified as a pregnancy.
Term	The total number of previous pregnancies with birth occurring at greater than or equal to 37+0 weeks gestation.
Preterm	The total number of previous pregnancies with birth occurring between 20 and 36+6 weeks gestation.
Abortion – Induced	The total number of previous terminations of pregnancies.

Section 4: Obstetrical History, *cont.*

Item	Description
Abortion – Spontaneous	The total number of previous spontaneous terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 gms. Ectopic pregnancies, missed abortions, empty sac and hydatidiform moles are classified as spontaneous abortions.
Living	The total number of children the client has given birth to and who are presently living. If adopted and unknown, use last known information.
Previous Pregnancies, Details and Outcomes	Document the details of previous pregnancies and birth outcomes, including date, place of birth or pregnancy termination, hours in labour, gestational age, type of birth (SVD, forceps, vacuum, VBAC or C/S), perinatal complications (including inductions, indications for vacuum, forceps, Cesarean Section), sex of the baby, birth weight, if child was breastfed and present health status. Review past health record to consolidate history. If a client has a history of Cesarean section, preterm birth, stillbirth refer to/consult with the Northern Women's Health Program or OBS GYN Specialist.

Section 5: Menstrual History and EDD Confirmation

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

Item	Description
LMP	Document the first day of the client's last menstrual period.
Certain?	Indicate whether the client is certain of their LMP date. Ensure it was the first day (not the last day), that the bleeding came when it was expected and was normal in amount and duration. If unusual timing or light bleeding only, consider an early ultrasound.
Menses Frequency	Indicate the usual number of days from the beginning of one period to the beginning of the next (e.g. q28 days, q27-30d, or q23-40d).
Regular? Yes / No	Indicate whether menses frequency is regular - similar interval each month - or irregular.
Expected Date of Delivery (EDD) by dates	Calculate the EDD using the first day of the last menstrual period date (if known). This can be completed using a pregnancy wheel or Naegele's rule: count back 3 months from the LMP date and add 7 days (based on a 28 day cycle). If the client's normal cycle is shorter or longer than 28 days, appropriate adjustments need to be made (e.g. # of days less than 28 – subtract days from EDD, # of days greater than 28 – add days to EDD).
Expected Date of Delivery by 1st U/S	Calculate the EDD using biometry from the first available ultrasound (U/S) after 7 weeks gestation. The first ultrasound is always the most accurate. Later ultrasounds never adjust EDD based on an earlier ultrasound.

Section 5: Menstrual History and EDD Confirmation, *cont'd*

Item	Description
Confirmed EDD	Rules for assigning Confirmed EDD in order of accuracy (use only one): 1. If U/S available before 16 weeks gestation, use biometry for EDD. 2. If no U/S before 16 weeks and sure LMP, use sure LMP as long as 2nd trimester (TM) U/S is not discrepant from LMP: a) If 16-23 wk U/S differs from LMP by more than 7 days, use U/S. 3. If unsure LMP, use earliest available U/S. 4. If unsure LMP and no U/S, review with OBS. U/S performed after 23 weeks is highly inaccurate for determining EDD as the standard error is 3-4 weeks. If the only ultrasound available was performed after 23 weeks and it is discrepant from LMP, consult obstetrics. With few exceptions, the EDD should be finalized by 20 weeks and, once determined, it should not be altered. An exception is when a review of the dating criteria reveals a miscalculation. If any questions regarding dating, refer to the *NWT Obstetrical Dating Guidelines* available through the NWHP.

Section 6: Present Pregnancy

Check the 'no' box if the condition/situation is not present. If 'Yes', document/explain.

Item	Description
IVF/ART	Indicate here if In Vitro Fertilization (IVF) or other Assisted Reproductive Technology (ART) was used for conception. If IVF was used, indicate embryo transfer date. Pregnancies conceived by IVF or other ART are at elevated risk of twin gestation and sometimes other complications. A first trimester ultrasound is indicated.
Bleeding	Any vaginal bleeding that has occurred during the current pregnancy.Specify if bleeding occurred <20 weeks or ≥20 weeks.
Nausea / Vomiting	Presence of nausea and/or vomiting. Specify if nausea and vomiting are a concern for the client. Consult with the specialist for symptom management.
Infections or Fever	Any fever and issues related to infections such as Toxoplasmosis, Listeria, CMV, Parvovirus, Measles, etc.
Other	Other physical concerns in the current pregnancy.

Section 7: Family History

Check the 'no' box if the condition/situation is not present. If 'Yes' document/explain.

Item	Description
Family history of diabetes, anesthesia problems and thromboembolic or coagulation issues	Indicate any medical conditions which run in the client's extended family such as diabetes, anesthesia problems and thromboembolism or coagulation issues. Consider client risk factors and refer if necessary.

Section 7: Family History, *cont'd*

Item	Description
Family history of inherited diseases/defects or congenital anomalies	Indicate history of genetic/inherited disorders which occur in the families of either biological parent. These can include cystic fibrosis, tay-sachs disease, sickle cell anemia, hemophilia or Phenylketonuria (PKU). Indicate any history of congenital anomalies/birth defects which have occurred in the families of either the biological parent. These can include congenital heart disease, cleft lip and/or palate, Down Syndrome, congenital hip dysplasia or open neural tube defects. Consider client risk factors and refer if necessary.
Family History – Other	Indicate any other information related to family history which may influence the pregnancy management or outcome.

Section 8: Beliefs and Practices

Item	Description
Beliefs	Discuss any important beliefs or cultural practice related to pregnancy/birth/postpartum that may impact pregnancy, birth, or newborn care. Ensure these cultural/religious beliefs are communicated in advance, to support beliefs during care. Are blood products acceptable? Indicate Yes or No.
Planned Adoption Yes / No / Undecided	Indicate if an adoption is planned or being considered. Note this in the Ongoing Management Prenatal Comments section. • Adoption in the Northwest Territories

Section 9: Medical History

Includes medical history of the client that may influence management or outcome of the current pregnancy or postpartum period. Check the 'no' box if the condition/situation is not present. If 'Yes', document/explain. Take the opportunity to initiate conversation and build rapport with client, to facilitate discussion on personal safety and health and wellness. Each section has space for a comment, there is a limited number of characters available. If more space required, chart in the Ongoing Management Prenatal Comments section.

Item	Description
Surgery	All previous surgical procedures, including breast surgeries. Include any previous blood transfusions and outcomes. If a cesarean section, therapeutic abortion or D&C has been indicated under the Obstetrical history section there is no need to repeat it here.
Uterine/Cx	For any question regarding impact of clients gynecological or cervical procedure history on current pregnancy, contact the Northern Women's Health Program. Significant gynecological history or cervical procedures such as LEEP, fibroids, endometriosis, abnormal Pap tests which required treatment or further observation. If client is being followed by a Specialist, advise them of current pregnancy.
Anesthesia Problem	Significant complications from anesthetics. This can include metabolic disorders such as malignant hyperthermia and pseudocholinesterase deficiency, difficult intubations and/or severe postoperative vomiting.

Item	Description
STIs	STIs and Genital Herpes. A prior history of STIs may suggest a risk for re-infection requiring repeat testing in pregnancy, as well as the need to determine if a prior infection was adequately treated. Active genital herpes infection in labour is potentially transmissible to the newborn, particularly if it is a primary infection. A history of recurrent genital herpes should prompt inspection at the time of labour for asymptomatic lesions. Cesarean birth may be recommended if the risk of transmission is great. A pregnant client with a history of genital herpes infection should receive prophylactic antiviral treatment starting at 36 weeks gestation and continue until birth. This will reduce the likelihood of an outbreak at the time of birth. Consult with the appropriate maternity care provider for drug and dose of choice.
Susceptible to Chicken Pox	History of chicken pox (varicella) disease or varicella immunization. Clients considered immune/protected/non-susceptible to varicella disease include: • Self-reported history or diagnosis of varicella or herpes zoster by a health care provider, if the disease occurred before the year of a one-dose vaccine program (Sept, 2001) • Documented evidence of immunization with two doses of a varicella-containing vaccine. • Previous laboratory evidence of immunity (review chart for records). All other clients are considered susceptible to chickenpox/varicella and should have serological testing with their initial pregnancy bloodwork (see varicella section under Lab Work/Investigations).
Cardiovascular	History of significant heart disease, congenital or acquired. History of significant cardiac events (e.g. heart attacks, TIAs, strokes, symptomatic arrhythmias). History of chronic hypertension, hypertension requiring medications or hypertension with previous pregnancies (gestational hypertension). Clients with a history of gestational hypertension, pre-eclampsia or eclampsia, IUGR or abruption would likely benefit from pharmacological interventions during subsequent pregnancies to lower the risk of reoccurrence. Refer to/consult with the Northern Women's Health Program or OBS GYN Specialist.
Respiratory	History of respiratory illness and asthma. Asthma is a common respiratory disease and inadequate control during pregnancy increases the risk of preterm labour, IUGR and maternal complications. History of exposure to TB, concurrent treatment or screening for TB in pregnancy or past treatment of latent TB In the NWT, THINK TB! For any questions or concerns, refer to the NWT Tuberculosis Manual first and then consult with the TB specialist and the Office of the Chief Public Health Officer.

Section 9: Medical History, *cont.*

Item	Description
Thromboembolic	History of previous problems with varicose veins, deep vein thrombosis, pulmonary embolism or coagulation disorders (i.e. factor V leiden).
GI / GU	History of gastrointestinal disease (e.g. crohn's disease, irritable bowel syndrome, chronic liver disease). History of chronic renal disorders (e.g. recurrent UTIs, pyelonephritis or polycystic kidney disease).
Endocrine / Diabetes	History of endocrine disorders (e.g. diabetes, thyroid or adrenal conditions).
Neurologic	History of significant neurological disorder (e.g. epilepsy or multiple sclerosis).
Hx of Mental Illness	Mental Health History including anxiety, depression, postpartum depression and/or other mental health condition(s) and specify. A mental health assessment should be an ongoing process and the screening tools in Part 3 and Part 6 can be used at any time throughout pregnancy. Ask the client what their perception of mental health is in relation to their pregnancy, and what additional supports may benefit them during their pregnancy, and during the postnatal period.
Other	Other medical conditions

Section 10: Lifestyle and Social

Check the 'Discussed' box of the item and document any concerns noted in the Ongoing Management Prenatal Comments section Check the 'Referred' box if the client is referred for further follow-up and/or treatment. For any referral made, a corresponding note should be made in the Ongoing Management Prenatal Comments section.

To help facilitate effective engagement, begin your discussion with an introductory sentence (e.g. I ask all my clients these questions because it is important to their health and the health of their newborns).

ALCOHOL, SUBSTANCE AND TOBACCO USE

Use of alcohol by clients in their child-bearing years can negatively affect both maternal health and the health of the fetus. Alcohol is a known teratogen. A safe level of alcohol consumption during pregnancy has not been established. Consumption of alcohol has been associated with harmful effects such as growth restriction, fetal alcohol spectrum disorder and neonatal behavioural abnormalities.

Alcohol and substances are screened through supportive dialogue and interviewing, the use of questionnaires, and anticipatory guidance. Expectant clients are universally screened for alcohol and substances at their first prenatal visit, throughout their pregnancy per clinical judgement, and at 6 weeks post-partum on a case-by-case basis. Early screening allows for potential to improve early diagnoses, allow access to earlier intervention and resources that may mitigate the development of secondary impacts to newborns, and support the client as necessary throughout their pregnancy.

If a client is pregnant during the time of screening, and wishes to receive supports, they are identified as "high-risk" and made a priority for referral and treatment services. Available supports include counselling via the Community Counselling Program, 24/7 support via the NWT Help Line, voluntary supports and services via Child and Family Services. If a client decides to access facility based addictions treatment, a referral to the community counselling program is the most appropriate and the counsellor can help facilitate that process

- **Alcohol Use**

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

One drink is defined as: beer (12 oz), wine (5 oz) or hard liquor (1.5 oz).

Indicate if alcohol use is identified during the prenatal visit and the individual wishes to receive supports and services. The health care provider completing the screening can make those referrals or the client can also self-refer.

Item	Description
Alcohol Use in Pregnancy No / Yes	It is recommended to assess and monitor alcohol use in pregnancy at least EVERY TRIMESTER or more frequently if there are concerns. Has the client ever consumed alcohol? If no, skip to next subsection. If yes, continue with the next question.
Drinks / wk:	Document the number of drinks per week consumed, at any point, during pregnancy as one of the following: None, 1-6, or 7 or more. Sample questions: Can you tell me a bit about your drinking patterns before you knew you were pregnant? Is it possible that you may have been drinking before you found out you were pregnant? If so, do you recall having at least 7 drinks during any week in your pregnancy so far, even if it was before you found out? Do you have any concerns about your drinking? Have you been able to stop or cut back since you found out you were pregnant?
Binge Drinking (4 or more drinks on one occasion)	Document the presence of binge drinking, at any point, during pregnancy as one of the following: Once: No or Yes, or More than once No or Yes Binge drinking is defined as consumption of alcohol that brings blood alcohol concentration to about 0.08% or above. For an average-sized pregnant client a binge drinking episode is 4 or more drinks on one occasion. *Sample questions*: Can you tell me a bit about your drinking patterns before you knew you were pregnant? Is it possible that you may have been drinking before you found out you were pregnant? If so, do you recall having 4 or more drinks on one occasion (or being intoxicated if the exact number of drinks cannot be recalled)? More than once? Even if this was before you found out. Do you have any concerns about your drinking? Have you been able to stop or cut back since you found out you were pregnant?
TWEAK Score	Document the TWEAK score for all clients. Refer to Part 3 for TWEAK questions and scoring. Any client who has a history of drinking during pregnancy or a concerning TWEAK score should be counselled on the negative impact of alcohol on the developing fetus, and the abstinence from alcohol for the remainder of the pregnancy is advised.

Section 10: Lifestyle and Social, *cont.*

- **Substance Use**

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

As with alcohol, there is no safe level of substance use during pregnancy. Substance use during pregnancy may result in spontaneous abortion, premature labour, low birth weight infants, placental abruptions and fetal death. Indicate if there substance use is identified during the prenatal visit and the individual wishes to receive supports and services. The health care provider completing the screening can make those referrals or the client can also self-refer.

- **Cannabis Use**

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

There is still more research needed to know exactly how cannabis affects the developing fetus. Given what is currently known about the short-and-long term effects of cannabis on fetuses and newborns, it is safest for clients to avoid using cannabis while pregnant and breastfeeding. Until more is known it is best to support clients with finding other ways to relax and cope and seek alternatives to reduce nausea. For clients who use cannabis for medical reasons, it is advised to talk to their health care provider for alternatives.

What we do know is no matter how cannabis is used (smoked, vaped, or eaten), the developing fetus may be affected by all forms of cannabis taken by pregnant and breastfeeding clients. The use of cannabis during pregnancy may be associated with increased risk for low birth weight, preterm labour, and stillbirth. Cannabis compounds are stored in body fat and can be passed to the child through breastmilk. These chemicals are slowly released over time (up to 30 days), which means that "pumping and dumping" breastmilk does not work the same way it does with alcohol. Some research reports that children exposed to cannabis through breastmilk have slower motor development reduced muscular tone and poor sucking. There is also risk of exposure through second hand smoke.

Client Resources and Information on cannabis and pregnancy, and breastfeeding can be found at: Cannabis, Pregnancy & Breastfeeding.

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

- **Tobacco Use (Smoking)**

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

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

It is strongly advised that clients quit smoking for the duration of the pregnancy. Helping clients to deal with the stressors in their life may help them quit smoking.

There is no known safe level of exposure. Second hand smoke exposure includes vaping, and e-cigarettes. Smoking in a closed-in space such as a home or car greatly increases the concentration of harmful chemicals produced by second- hand smoke.

The NWT Quitline (1-866-286-5099) is a toll-free confidential help line for people who want to quit smoking and the website has resources for professionals and clients.

- **Pregnant Pause**

Some individuals might want to consider taking a "pause" from alcohol and other substance use as a way of showing support to their pregnant partner. Whether it is for a month, three months, or the entire pregnancy, having their partner be substance-free can be helpful and supportive for many clients.

Encourage pregnant clients and their partners to spend time thinking about the role of substance use in their life after giving birth. Some individuals may not be interested in changing their substance use and can plan to use responsibly. Others may see parenthood as a time of transition and will consider making long-term changes to their substance use. For those who continue to use substance, discuss safe usage around the newborn, safe breastfeeding, and safe storage of substances.

Item	Description
Smoking Never / Quit	Indicate if the client has never smoked or indicate the date they quit if they were a former smoker.
Cig / day before pregnancy	Document the average number of cigarettes smoked per day before pregnancy. *Sample question:* How many cigarettes did you smoke in a day before you were pregnant?
Cig / day current	Document the average number of cigarettes smoked per day, during the current pregnancy. *Sample questions:* Do you smoke now? If yes, how many cigarettes do you smoke in a day?
Exposure to 2nd hand smoke No / Yes	Indicate if client is currently exposed to second hand tobacco smoke.
Financial and Housing	Enquire about financial concerns and stability of housing. *Sample questions:* Who do you live with? How long have you lived there? Is housing a problem for you?
Support System	Discuss who will provide support during and after pregnancy. *Sample questions:* How do your partner and family feel about the pregnancy? Who'll be helping after you give birth?
Partner/Family Violence	It is recommended to assess and monitor partner/family violence at least EVERY TRIMESTER or more frequently if there are concerns. Intimate partner/family violence refers to a pattern or history of physical, sexual and/or emotional interpersonal violence. It is recommended that care providers screen all pregnant clients for intimate partner/family violence. This screening should occur at the initial prenatal appointment and at various times over the course of the pregnancy because some clients do not disclose abuse the first time they are asked and abuse may begin later in pregnancy. The following introductory script is helpful to begin the discussion. SAFE screening tool questions: 1. ***S****tress/Safety – Do you feel safe in your relationship?* 2. ***A****fraid/Abused – Have you ever been in relationship where you were threatened, hurt or afraid?* 3. ***F****riend/Family – Are your friends aware you have been hurt?* 4. ***E****mergency Plan – Do you have a safe place to go and the resources you need in an emergency?*

Section 11: Initial Physical Examination

Completing a full physical exam provides baseline information for subsequent assessments.

Item	Description
Exam Date	Document when the physical examination took place.
BP	Document the blood pressure taken during the exam. Refer to Section 16 (Prenatal visit documentation) for BP guidelines.
Height	Document the height of the client in cms.
Pre-pregnant Weight	Document the pre-pregnant weight of the client in kgs. Retrieve this from the record if a recent documented weight is available.
Pre-pregnant BMI	Calculate and document the pre-pregnant BMI using a BMI calculator. Obesity or a BMI 30 and over has significant maternal and perinatal health risks. Some of these include: gestational diabetes, hypertension, anesthetic risks, placental dysfunction and risk for cesarean section birth. If the BMI is greater than or equal to 40, a referral needs to be made to an Obstetrician, and a Registered Dietitian. See the Appendix for information on prenatal nutrition and recommended weight gain based on pre-pregnant BMI.
Results of Physical Examination	Document results of the initial physical examination under headings: head and neck including an oral examination of the dentition, gingiva and tongue, breasts and nipples, heart and musculoskeletal, lungs, varicosities and skin, pelvic exam. If there are no abnormalities detected, select NAD. Other comments can be written in the space provided or in the Ongoing Management Prenatal Comments section. In order to ensure all follow up discussions/investigations are managed and are easily highlighted for all healthcare professionals accessing the PNR, highlight topic in the Risk Factor Section (with the date) and chart the detail of the topic in the Ongoing Management tab under prenatal visits comments section.

Section 12: First Trimester Topics Discussed

Indicate with a check if the discussion topics were addressed.

Item	Description
Prenatal Vitamin	It is recommended that pregnant clients take a prenatal vitamin every day. This ensures that the proper vitamins and minerals are available to the growing fetus. If clients cannot tolerate the increased dose of iron in the prenatal vitamins, a regular women's supplement should be recommended. For clients who are high risk for birth defects a higher dosage of folic acid (5mg) may be recommended for 3 months preconception and until 12 weeks gestation. Clients that are considered high risk have risk factors such as: prior Neural Tube Defect (NTD), prior pregnancy affected with folate sensitive congenital anomaly, pre-existing diabetes, antiepileptic or folate inhibiting medication, 1st or 2nd degree relative of client or her partner with a history of NTD, GI malabsorptive conditions, (Eg. Celiac disease, inflammatory bowel disease, or gastric bypass surgery), advanced liver disease, kidney dialysis, or alcohol over-use.
Initial PN Blood Work, Investigations and U/S	Discuss initial blood work, investigations and anatomical (18-20 wk) U/S recommendations. Refer to the routine blood work and investigations in pregnancy flow sheet on Part 5.

Prenatal Genetic Screening	A discussion of genetic screening in early pregnancy is the standard of care. However, genetic screening may not be appropriate for all patients and should not be ordered as a routine test. Maternal Serum Screen (MSS) is an inferior test and should no longer be ordered. As of 2020, Non Invasive Prenatal Testing (NIPT) is the screening test of choice. Refer to Section 14 Prenatal Genetic Screening (Pg. 23) for more details on NIPT testing.
Physical Activity / Rest	All pregnancies without contraindication should be physically active throughout pregnancy. Pregnant clients should accumulate at least 150 minutes of moderate-intensity physical activity each week to achieve clinically meaningful health benefits and reductions in pregnancy complications Physical activity should be accumulated over a minimum of 3 days; however, being physically active every day is encouraged.
Oral Health	Pregnancy increases the risk of oral health problems (periodontal disease and tooth decay) due to physiological changes associated with pregnancy. In addition, many clients living in the NWT have other risk factors associated with oral disease: • History of caries and gingivitis; • Limited access to dental or oral health professionals; • No access to fluoridated drinking water; and • Lower socioeconomic status The initial prenatal visit is an opportunity to review the client's health, provide oral health education/advice, and provide oral health screening. Improving oral health of expectant and new caregiver's and providing oral health counseling to promote healthy behaviours may promote healthy behaviours for their future or existing children. The NWT Oral Health Screening Tool identifies patients at even greater risk of oral health problems and potential need of urgent or immediate dental interventions through referral to a dentist or oral health professional. However, as all pregnant clients are at elevated risk of oral health problems due to the hormonal changes of pregnancy, it is crucial that the following are provided: 1. REFERRAL to a dentist or oral health professional during the pregnancy; 2. ORAL EXAM, during which the teeth, gums, tongue and mucosa are visually inspected as part of the Head and Neck portion of the Physical Exam; 3. ORAL HEALTH EDUCATION, defined as: • Individualized, culturally safe client-centred oral health education and counselling; • Teaching of basic skills; • Provision of resources, including toothbrush, fluoridated toothpaste and dental floss given if necessary; and • Information on how to access oral health and/or dental resources available in the community. Discuss the importance of taking care of teeth and gums during pregnancy. Encourage clients to brush teeth twice daily with a fluoride toothpaste and floss gently once a day.

Section 12: First Trimester Topics Discussed, *cont.*

Oral Health *cont'd*	Clients with morning sickness should rinse the mouth with water after vomiting, and wait 30 minutes before brushing their teeth. Brushing the teeth sooner spreads stomach acid over the teeth and increases erosion of enamel. Instead, encourage a client to rinse her mouth with water or fluoride mouth rinse immediately after vomiting to prevent erosion of tooth enamel. Active dental decay in pregnant clients increases the risk of oral disease in the newborn, through the transmission of oral bacteria from mother to child after birth. Teaching the caregiver that keeping their teeth and mouth healthy will increase the baby's chances of also having healthy teeth. Additional oral health resources and reference tools will be provided to Prenatal Record users to provide individualized, culturally safe oral health education and counselling to expectant mothers on a yearly basis.
Prenatal Education	Discuss opportunities for prenatal education available in the community. Offer a copy of 'Healthy Pregnancy, Healthy Baby'. This booklet provides information on pregnancy changes, prenatal care and labour and birth. Hard copies are available from the Northern Women's Health Program. The Departments of Education, Culture and Employment and Health and Social Services have numerous programs focused on children and families across the NWT.
Food Safety	Foodborne illnesses can cause maternal disease as well as congenital disease, premature labor, spontaneous abortions and fetal death. To reduce the risk, it is important that pregnant clients: • Practice good personal hygiene (frequent hand washing). • Are aware they are at a higher risk for food poisoning and should follow careful food safety tips. • Are provided information on the risk of consuming meats that are not cooked and provided information on prenatal screening for toxoplasmosis • Avoid unpasteurized dairy products and fruit/vegetable juices. • Thoroughly rinse fresh fruits and vegetables under running water before eating. • Avoid eating raw sprouts (including alfalfa, clover, radish and mung bean). Bacteria can get into sprout seeds through cracks in the shell; these bacteria are nearly impossible to wash out. • Wash hands, food surfaces, cutting boards, dishes and utensils that come into contact with raw meat, poultry or fish with hot soapy water. 1/4 teaspoon liquid chlorine bleach per two cups of water and leaving to dry over 10 minutes. In regions such as the Arctic, the traditional diet may include large quantities of fish, traditional foods, and/or marine mammals. This traditional diet has many nutritional and socio-cultural benefits, which must be weighed against the potential risks. Discuss the risk of environmental contaminants like methyl mercury, toxoplasmosis, and cadmium. If there are concerns of exposure to contaminants, the reader should consult with the Office of the Chief Public Health Officer/or Contaminants Research Officer. Client Resources • HSS: Traditional Food Fact Sheets • HSS: Environmental Health Contaminants • Health Canada: Food Safety

Section 12: First Trimester Topics Discussed, *cont.*

Flu vaccine	Discuss the benefits of the flu vaccine during flu season. • Pregnant clients are considered at high risk for influenza related complications and hospitalization and should be offered the influenza vaccine during flu season. • Inactivated influenza vaccine is safe and effective to receive at any point in the pregnancy. • Evidence has shown that infants born during flu season to vaccinated clients are less likely to be premature, small for gestational age and low birth weight • Clients who do not receive influenza vaccination during pregnancy should receive the vaccine postpartum ASAP if the birth occurs during flu season. Vaccinating pregnant clients will help to protect their vulnerable babies, and infants less than six months of age, who are too young to receive vaccine. Follow guidance in these resources: • Seasonal Influenza Immunization Package • NWT Immunization Schedule • Canadian Immunization Guide
Sexual Relations	Discuss sexual relations/sexuality during pregnancy. Pregnant clients may have concerns about their sexual health. However, they may feel uneasy about initiating the topic up with their health care provider.
Seat Belt Use	Discuss correct seat belt use during pregnancy. When in a vehicle, pregnant clients should: • Ensure the lap belt and shoulder strap fit snugly. • Wear lap belt under their belly and over their hips. • Wear shoulder strap between breasts and off the side of belly. Never place shoulder strap under arm. • Ensure length of should strap is fits.
Plans to Breastfeed Yes / No / Undecided	Indicate the client's plans regarding breastfeeding.

Section 13: Comments/Risk Factors

Item	Description
Risk Factors (e.g. previous Preterm Birth, Genital Herpes, BMI > 35, Social, hypothyroid, depression)	Determination of risk factors is a crucial component of prenatal care. Check off the boxes for the known obstetrical, family and medical risk factors on the Risk Assessment Guide, page 4 of this Prenatal Record form. Indicate risk factors based on obstetrical, family, medical, lifestyle and social histories, and physical assessments in this box. Additional examples may be: previous C/S, essential hypertension, housing instability and addictions issues. Chart appropriately in the Ongoing Management Prenatal Comments section, and add to the list of risk factors as you become aware of them. Arrange for referrals or contact the NWHP if you have any questions.
Signature	Signature of the healthcare provider and designation.

Section 14: Investigation/Results

A number of laboratory tests and investigations are universally recommended during pregnancy. Discussions should be provided for all testing. Prenatal care providers have an important role to play in stressing the importance of testing in disease prevention, in emphasizing the standard of care for all clients and in helping to allay concerns about confidentiality and any perceived stigma associated with testing (i.e. HIV).

Clients have the option to accept testing or to opt out/decline. Any testing declined should be noted clearly in the Ongoing Management Prenatal Comments section. Refer to the flow sheet on Part 5.

Resources referred to in this section and their links:

- **NWT Communicable Disease Manual**
- **PHAC – Canadian Guidelines on Sexually Transmitted Infections**
- **NWT Sexually Transmitted Infections Report form (Gonorrhea, Chlamydia, Syphilis and HIV)**

Item	Description
ABO Rh Factor Antibody Titre Pos / Neg	Indicate the Blood Group and Rh Factor. Document the first Antibody screen results as well as second results if indicated. ABO, Rh Factor and red blood cell antibody screening is performed with the initial prenatal blood work. Repeat ABO, Rh and Antibody screening is indicated at 24-28 weeks if a client is a having their first baby, is Rh-negative, or has positive antibodies. A positive antibody screen requires an Obstetric referral.
RhIg Given Date:	Document date(s) Rh Immunoglobulin (RhIg) is given in the pregnancy, if indicated.RhIg is also known as Rhogam or WinRho. Rh negative clients should receive Rh Immunoglobulin at approx. 28 weeks gestation. Prior to administration, a repeat ABO/Rh/antibody screen should be collected to exclude sensitization. Rh Immunoglobulin should also be given to an Rh negative client: • Within 72 hours after birth of an Rh positive infant • After a spontaneous or induced abortion • After an ectopic pregnancy • After an amniocentesis • After an episode of antenatal bleeding • After other invasive obstetrical procedures or complications If a pregnant client is Rh negative and the child's paternal parent is Rh negative, the newborn will also be Rh negative and Rh Immunoglobulin will not be required. This only applies if paternity of the fetus is certain.
Hemoglobin	Document the 1st and 3rd trimester Hemoglobin results. A CBC should be performed with the initial prenatal blood work and repeated at 28 weeks.
Urine C&S Result	Collect a Urine C&S - clean mid-stream catch at the first prenatal visit. Record date and result. This test screens for asymptomatic bacteriuria. Asymptomatic bacteriuria is a risk factor for preterm birth and pyelonephritis and should be treated as suggested by the most up to date and approved pharmacological interventions. If the culture grows Group B Strep bacteria, also consider the client GBS positive and offer prophylactic antibiotics in labour. Further screening with vaginal/rectal C&S swab near term is not required.

Item	Description
Gonorrhea / Chlamydia Pos / Neg	All clients should be screened at the first Prenatal visit. Can be performed by cervical swab (via speculum exam) or by first catch urine test. Refer to the HSS NWT Communicable Disease Manual and PHAC – Canadian Guidelines on Sexually Transmitted Infections. Any client with ongoing risk factors for acquiring STIs during pregnancy should be rescreened each trimester. Refer to PHAC Canadian Guidelines on Sexually Transmitted Infections, Section 2, for a list of risk factors. Clients with positive results require adequate treatment with appropriate antibiotics. Refer to: • The NWT Clinical Practice Guidelines for the Treatment of Uncomplicated Gonorrhea • The NWT Clinical Practice Guidelines for the Treatment of Uncomplicated Chlamydia Gonorrhea and Chlamydia are reportable communicable diseases, under the *NWT Public Health Act*. Positive results for either disease require the completion of an NWT Case Investigation Report Form and contact tracing.
Test of Cure Done? Date	Indicate when a test of cure is done. Gonorrhea: Cultures from all positive sites and all positive partners should be done 3–7 days after the completion of therapy (checks for treatment resistance). If NAAT (Nucleic Acid Amplification Testing) is the only choice for test of cure, NAATs from all positive sites and all positive partners should be done 2–3 weeks after completion of therapy. Chlamydia: NAATs from all positive sites and all positive partners should be done 3-4 weeks after the completion of therapy. • NWT Communicable Diseases Manual: Gonorrhea • NWT Communicable Diseases Manual: Chlamydia • PHAC – Canadian Guidelines on Sexually Transmitted Infections
PAP Date: Normal / Abnormal	Document date and results of any PAP testing done in the pregnancy. Opportunistic screening is not recommended. Instead, follow the NWT Cervical Cancer Screening guidelines: NWT Cervical Cancer Screening Guidelines.
Other Tests	Document results of other tests completed (e.g. bacterial vaginosis, TORCH).
Edinburgh Perinatal/ Postnatal Depression Scale (EPDS) Score: Referred: Yes / No Date:	Indicate the score and date of Prenatal Depression Screening and if a referral is initiated. All clients are to be screened for antenatal depression between 28-32 weeks using the Edinburgh Perinatal Depression Screening (EPDS) tool, Part 6 of the Record. A copy can be given to the client to complete themselves during their appointment. Score the responses using the instructions on the bottom of the page. • Translated versions of the EPDS Tool *Note* Postnatal depression screening should also be completed at 6 weeks postpartum.
Healthy Family Program (HFP) Screening No / Yes / N/A	Complete Healthy Family Program Screening Tool as per the form in your region. If there is no Healthy Family Program in the community, indicate N/A (not applicable). Forward all completed screens (positive and negative) to your community Healthy Family Program.

Section 14: Investigation/Results, *cont.*

Item	Description
Referral Offered Yes / No	Indicate if a referral to the Healthy Family Program is offered. All clients with positive screens should be referred and encouraged to participate in the program. A home visit will be arranged by program staff. Participation is voluntary and clients can be invited to 'try it out'. A client can stop the program at any time
Accepted Yes / No	Indicate if a referral to the Healthy Family Program is accepted or not. Some clients with positive screens may not wish to take part in the program. It is important clients are aware of the program and that they may self-refer any time before their child is 5 years of age. Indicate if the client has verbally consented.
Information on HFP Provided? Yes / No / N/A	Many communities in each region of the NWT have a Healthy Family Program. This is a free home visitation program for families with children under 5 years of age. Home visitors help support and educate parents re: child development and positive parenting skills. The optimal time to screen families for the program is during pregnancy. Participation is voluntary and may self-refer at any time.
Hepatitis B Surface Ag Pos / Neg	All pregnant clients should be screened for hepatitis B Surface Ag (HBsAg) with the initial prenatal blood work. Indicate results. A positive HBsAg is a marker for chronic hepatitis B infection, which carries a risk of perinatal transmission (passing hepatitis B onto the newborn). Hepatitis B is a reportable communicable diseases, under the *NWT Public Health Act.* Positive results require the completion of: • Enhanced Hepatitis B & C – Case Investigation Form. Refer to the NWT Communicable Disease Manual or hepatitis B Clinical Desk Reference. A pregnant client who is HBsAg negative, but who is high risk for contracting hepatitis B, should be offered a complete hepatitis B vaccine series at the first opportunity during pregnancy and should be tested for antibody response. Hepatitis B vaccine can be used safely in pregnancy, and should be indicated, because acute hepatitis B infection in a pregnant client may result in severe disease for the caregiver mother and chronic infection for the infant. If the client has a low risk for acquiring hepatitis B during pregnancy, immunization with this vaccine can be deferred until after delivery. *Infants of hepatitis B positive clients are at high risk of contracting hepatitis B disease. • Infants born to mothers who are HBsAg positive require hepatitis B prophylaxis as per the Canadian Immunization Guide within 12 hours of birth. • Refer to the DHSS CPI #105 Hepatitis B Prenatal & Newborn Flow Chart for additional guidance • NWT Immunization Schedule • Canadian Immunization Guide: Part 4- Active Vaccines Hepatitis B Vaccine

Item	Description
Syphilis (EIA)	All pregnant clients should be screened for Syphilis with the initial prenatal blood work. Indicate results. Repeat screening should be offered at 28-32 weeks and again at birth for clients who are high-risk for contracting STI's. Refer to PHAC Canadian Guidelines on Sexually Transmitted Infections, Section 2, for a list of risk factors. Syphilis is a reportable communicable disease, under the NWT Public Health Act. Positive results require the completion of: • NWT Syphilis Investigation and Follow-Up Form and contact tracing A client with a positive Syphilis test should be referred for an Obstetrical consult. Infectious Syphilis in pregnancy can lead to fetal infection with stillbirth, preterm birth, congenital abnormalities and active disease at delivery. Transmission occurs transplacentally (as early as 14 weeks and throughout pregnancy) or at the time of birth. Untreated primary and secondary syphilis carries a transmission risk close to 100%. • NWT Communicable Disease Manual: Syphilis • Enhanced Congenital Syphilis Screening
HIV Test	All clients should be screened with the initial prenatal blood work. Indicate results. Refer to the PHAC – Canadian Guidelines on Sexually Transmitted Infections and the NWT Clinical Desk Reference. HIV is a reportable communicable disease under the *NWT Public Health Act*. Positive results require the completion of: • NWT HIV Investigation Form Clients with positive HIV results require an Obstetrical referral. A negative HIV result from the birth client is necessary before an infant can receive BCG vaccination. Client Resource: HIV Testing during pregnancy
Hep C Ab (if indicated) Pos / Neg	Screening should be done with clients who are at high risk of acquiring Hepatitis C. Refer to the NWT Clinical Desk Reference. Indicate results. Hepatitis C is a reportable communicable disease under the NWT Public Health Act. Positive results require the completion of: • Enhanced Hepatitis B and C – Case Investigation Form Refer to the NWT Communicable Disease Manual.
TSH	A TSH should be completed with initial prenatal blood work for all pregnant clients. Indicate the result. Untreated thyroid disease in pregnancy may lead to premature birth, preeclampsia, miscarriage and low birth weight infants, among other problems. TSH may be suppressed as a normal finding within the first trimester of pregnancy. If you have any questions, contact the Northern Women's Health Program.

Section 14: Investigation/Results, *cont.*

Item	Description
Rubella IgG Documented Immunity Otherwise Titre:	Clients are considered immune (protected) against Rubella if they have one of the following: • A documented protective rubella titre. • Documentation of two MMR vaccinations received after one year of age and given a minimum of 4 weeks apart. Clients who meet one or both of these criteria do not require serological testing during pregnancy. A Rubella IgG titre should be done with the initial prenatal blood work if there is no evidence of a protective rubella titre, or no documentation of the client having received two MMRs in the past. If assistance is required with interpreting titre results, consult with the laboratory. Indicate titre result. Clients who have received two appropriate doses of MMR vaccinations (given after 12 months of age and at least 4 weeks apart), who are inadvertently tested during pregnancy, and whose titre result is not protective are still considered immune; no revaccination is necessary postpartum. All rubella-susceptible pregnant clients should be counselled to avoid exposures and should be immunized with MMR vaccine ASAP after pregnancy in accordance with the NWT Immunization Schedule. Rubella-susceptible clients who receive Rh Immunoglobulin (RhIg) during their pregnancy or early postpartum period, should be advised to wait 3 months prior to getting MMR vaccination. Note in the section labelled '*Maternal PP vaccination indicated?*' that postpartum MMR immunization is indicated. **MMR is a live vaccine and should not be given during pregnancy.** Clients who have been appropriately immunized postpartum do not need to be serologically screened for rubella antibodies either post-immunization or in subsequent pregnancies. Clients who have been found to be serologically positive in one pregnancy do not need to be screened again in subsequent pregnancies. Rubella infection in pregnancy may give rise to Congenital Rubella Syndrome (CRS). This condition can result in spontaneous abortion, stillbirth and fetal malformations, including congenital heart disease, cataracts, deafness and mental retardation. Fetal infection can occur at any stage of pregnancy, but the risk of fetal damage following maternal infection is highest in the earliest months after conception (85% in the first trimester), with progressive decrease of risk thereafter, and it is very uncommon after the 20th week of pregnancy. Canadian Immunization Guide: Active Vaccines
Varicella IgG (if no history) Pos / Neg	Testing is based on the client's history of chicken pox/varicella disease. If a client is determined to be susceptible to varicella or if their history of chickenpox or immunization status is uncertain, a varicella titre should be included with the initial prenatal blood work. Indicate titre result. All varicella-susceptible pregnant clients should be counselled to avoid exposures to chicken pox and shingles and to be immunized with Varicella vaccine ASAP after the pregnancy in accordance with the NWT Immunization Guide. Varicella-susceptible clients who receive Rh Immunoglobulin (RhIg) during their pregnancy or early postpartum period should be advised to wait 3 months prior to getting the varicella vaccination. Note in the section labelled '*Maternal PP vaccination indicated?*' that postpartum Varicella immunization is indicated. **Varicella is a live vaccine and should not be given during pregnancy.**

Item	Description
Varicella IgG *cont'd*	Varicella infection in pregnancy can cause Congenital Varicella Syndrome and possibly congenital malformations or deformations. Maternal infection just prior to or during labour and birth can seriously affect a newborn, who may develop fulminant (serious and fast developing) neonatal varicella infection. • NWT Immunization Schedule • Canadian Immunization Guide: Active Vaccines
Vaccinations Tdap status: Yes / No Date	Practitioners should assess the immunization status of pregnant clients, as they are a vulnerable population. This applies to non-outbreak scenarios. The Tdap (Tetanus, Diphtheria, and acellular Pertussis) vaccine is safe to give during pregnancy. Tdap is a combination vaccine that protects against three potentially life-threatening bacterial diseases: Tetanus, Diphtheria, and acellular Pertussis (whooping cough). The goal of vaccinating pregnant clients allows high levels of antibody to be transferred to newborns during the first two months of life when the morbidity and mortality Offer the Tdap vaccine in each pregnancy, ideally between 27-32 weeks, UNLESS already given previously in the pregnancy. Immunization between 13 and 26 weeks of gestation may also be considered in some situations (e.g. pregnancies with an increased risk of preterm delivery) Immunization >32 weeks can also be considered (e.g. clients who present late to care) However, Immunization should not be delayed until close to delivery since this may provide insufficient time for optimal transfer of antibodies and direct protection of the infant against pertussis. • Canadian Immunization Guide: Active Vaccines • Canadian Immunization Guide: Immunization in Pregnancy with Tdap Vaccine • NWT Immunization Schedule
Influenza Status: Yes / No Date	Recommend the Influenza vaccine, which may be taken annually during flu season. Preferential immunization with inactivated influenza vaccine of all pregnant clients, at any stage of pregnancy, due to the risk of influenza-associated morbidity in pregnant clients, evidence of adverse neonatal outcomes associated with maternal respiratory hospitalization or influenza during pregnancy, evidence that vaccination of pregnant clients protects their newborns from influenza and influenza-related hospitalization, and evidence that infants born during influenza season to vaccinated clients are less likely to be premature, small for gestational age, and low birth weight. For further information: • Canadian Immunization Guide: Immunization in Pregnancy and Breastfeeding - Part 3 - Vaccination of Specific Populations • NWT Immunization Schedule • Seasonal Influenza Package
Maternal PP Vaccination indicated? Newborn Hep B. IgG indicated	Indicate the need for maternal postpartum MMR immunization if Rubella titre is unprotective. Indicate the need for maternal postpartum Varicella immunization if Varicella titre is negative. If Hepatitis B Surface Antigen results are positive, indicate the need for Newborn Hepatitis B immunoglobulin. Refer to: • NWT CPI Hepatitis B Prenatal & Newborn Flow Chart • NWT Immunization Schedule • Canadian Immunization Guide

Section 14: Investigation/Results, *cont.*

Item	Description
Prenatal Genetic Screening MSS Offered? Yes / No Date Offered: MSS Accepted? Yes / No Other Test(s): Date: Result: Pos / Neg / Ref'l	Prenatal Genetic Screening is an optional test which looks to detect a limited number of chromosome anomalies, the most common of which is Trisomy 21 or Down Syndrome. The risk of Trisomy 21 can occur in a pregnancy at any age, but the risk increases with maternal age. Trisomy 18 and Trisomy 13 cause more serious anomalies but are much more rare. Sex chromosome aneuploidy is an added optional screening component. **A discussion of genetic screening in early pregnancy is the standard of care. However, genetic screening may not be appropriate for all patients and should not be ordered as a routine test.** A decision to pursue screening must be made by the client only after a thorough informed choice discussion of potential risks and benefits. Please see the "NIPT Client Info Sheet". The main goal of detecting Trisomy 21, 18, or 13 is to give clients the option to end the pregnancy via an abortion. If a positive result would not change the client's management of the pregnancy, it is generally advisable to decline genetic screening. If a client is certain they would not want an amniocentesis to confirm a positive result or would not consider a termination, the test generally poses more risk than benefit due to the residual risk of a false positive. Similarly, if a client presents too late in pregnancy to be able to consider an abortion, the test has limited utility and should generally not be done. As of 2020, NIPT ("Harmony") is the screening test of choice to offer to any clients requiring this test, for both low-risk and high-risk clients. Non-invasive prenatal testing (NIPT) analyzes cell-free fetal DNA in maternal serum to assess the fetal chromosomes 21, 18, 13, X, and Y. NIPT is non-invasive, highly sensitive and more specific than older screening tests, detecting >99% of cases of Down syndrome. Negative tests avoid the need for amniocentesis. Positive tests may be strongly predictive of an abnormality; however, the diagnosis needs to be confirmed by amniocentesis. A positive NIPT result is more reliable and predictive as maternal age increases, but less reliable in a younger patient. Positive X/Y sex chromosome aneuploidy results are less reliable than positive trisomy results. NIPT is available after 10 weeks of pregnancy and should be offered once there has been confirmation of a viable fetus by either fetal heart auscultation or ultrasound. Results are available in 12-14 days. Amniocentesis is available after 16 weeks, via consultation with an Obstetrician. Results are available within 3-7 days. **Maternal Serum Screen (MSS) is an inferior test and should no longer be ordered.** The risks are higher than for NIPT of receiving either false negative or false positive results. Note: an exception remains for rare circumstances where NIPT has failed on multiple attempts, the patient remains in an appropriate time window of 15-20+6 weeks, and the patient wishes to pursue another non-invasive screening option. MSS can be ordered in this rare situation. Note: Open Neural Tube defects (spina bifida; anencephaly) are screened separately with spine views during the routine anatomy ultrasound, and do not require an additional AFP blood test.

Section 14: Investigation/Results, *cont.*

<table>
<tr><th>Item</th><th>Description</th></tr>
<tr><td>Prenatal Genetic Screening cont'd</td><td>Documentation should show:

When the genetic screening discussion occurred, and whether the client requested or declined the test. If declined, document the reason (e.g. "Client would not change management of the pregnancy").
The results of the screening test, and notification of the client.
Note: This is a high-stakes test which is highly time-sensitive. Results must be brought to the ordering provider immediately, and the client notified promptly. If results are missing or delayed, this can significantly impact the client's choices for next steps. All clients should be informed at the time of receiving the requisition, that they will be contacted within 14 days with their results, otherwise they must call their provider.

NIPT (Harmony) may be ordered by the following healthcare practitioners:

Obstetricians
Family physicians
Nurse Practitioners
Midwives

Other care providers (Community Health Nurses, etc.) should request consultation with one of the above categories of practitioner, through their usual pathways. A virtual encounter between the advanced practitioner and the patient may be advisable to ensure the informed consent process is appropriately completed.</td></tr>
<tr><td>GBS Screening (Group B Strep)</td><td>Indicate date of testing and results.

Screening is recommended between 35-37 weeks gestation. Approximately 10-30% of pregnant clients colonize GBS in their vagina and rectum. These bacteria can be transmitted to the newborn during the birthing process and can result in early-onset GBS infection that is manifested by sepsis, pneumonia or meningitis and can lead to death in rare instances.

All pregnant clients who are colonized with GBS (GBS positive) or who have a documented UTI caused by GBS during the pregnancy should be offered prophylactic IV antibiotics when in established labour. It is not necessary to screen clients with prior GBS bacteruria at 35-37 weeks as they are already considered GBS positive and will receive antibiotics in labour.</td></tr>
</table>

Section 14: Investigation/Results, *cont.*

Item	Description
Diabetic Screening	Resources available and their roles: **Yellowknife Diabetes Team (Dietitian Educator, Diabetes Educator, Nurse Practitioner):** offers diet and exercise advice, blood glucose monitoring education, initiation and adjustment of metformin and/or insulin for GDM and type 2 diabetes, and type 1 diabetes in coordination with Internal Medicine. The Diabetes Team is Yellowknife-based; however, their mandate includes providing care and support for pregnant clients with diabetes and their care providers, throughout the NWT and the Kitikmeot. Inform the team early about clients with any form of diabetes who are planning or likely to deliver in Yellowknife. The Yellowknife Diabetes Team can be reached via a WOLF message to 'YK Intake Diabetes' under Group recipients, or contact the Yellowknife Primary Care Clinic. **Community Diabetes Teams:** Hay River has a diabetes team that offers diet and exercise advice, blood glucose monitoring education, initiation and adjustment of metformin and/or insulin for GDM and type 2 diabetes. There are diabetes educators in Inuvik and Fort Smith who can see patients for diet and exercise advice, and blood glucose monitoring education. All community-based diabetes educators can liaise with the Yellowknife Diabetes Team for additional support as needed and to ensure a smooth transition for patients who come to Yellowknife to give birth. If patients have suboptimal glycemic control with complicated regimes, teams can also liaise with Internal Medicine. **Internal Medicine Specialist:** Insulin adjustment in all patients with type 1 diabetes, complicated type 2 diabetes or GDM patients on insulin with suboptimal control. **Obstetrics Specialist:** Review obstetrical implications and management with all pregnant clients with diabetes or GDM on one or more occasions during pregnancy. **Northern Women's Health Program (NWHP) Nurse Practitioner:** Helps coordinate ultrasounds & appointments for pregnant clients from outside of Yellowknife as well as antenatal monitoring near term for all clients delivering in Yellowknife **When to refer and to whom:** • **Pre-existing type 1 diabetes -** Refer to Diabetes Team, Internal Medicine, and Obstetrics pre-conceptually or as early in pregnancy as possible. • **Pre-existing type 2 diabetes -** Refer to Diabetes Team & Obstetrics pre-conceptually or as early in pregnancy as possible. The Diabetes Team will refer to Internal Medicine if control is poor and for insulin adjustment as necessary. • **GDM -** Refer to Diabetes Team & Obstetrics as soon as GDM is diagnosed. If control is poor despite initial management, the Diabetes Team will refer to Internal Medicine for insulin adjustment as necessary. **Considerations:** • Clients with pre-existing type 1 or type 2 diabetes of reproductive age should receive ongoing counselling regarding reliable birth control, the importance of glycemic control prior to pregnancy, the impact of BMI on pregnancy outcomes, the need for folic acid supplementation and the need to stop potentially embryopathic drugs prior to pregnancy.

Item	Description
Diabetic Screening *cont'd*	• Clients with pre-existing type 1 or type 2 diabetes are at increased risk of congenital malformations and should be referred to Obstetrics and the appropriate Diabetes Team pre-conceptually if possible, or as soon as pregnancy is diagnosed. The risk of malformation is proportional to HbA1C during the first trimester, therefore optimal blood sugar control BEFORE conception is extremely important. Optimal blood sugar control pre-conceptually (HbA1C ≤6.5%) can reduce the risk of spontaneous abortion, congenital anomalies, preeclampsia, progression of retinopathy and stillbirth. HbA1C measurements should be obtained prior to conception and monthly throughout pregnancy in all pregnant patients with diabetes. • Clients with pre-existing type 1 or type 2 diabetes: Consult with Obstetrics Specialists regarding medications and their management in the preconception and gestational periods as some may need to be adjusted. Folic Acid 1 mg daily should be started before or early in pregnancy to minimize the risk of facial, cardiac, and neural tube defects. An ophthalmology exam for retinopathy should be completed pre-conceptually or early in pregnancy and repeated during pregnancy and post-partum at the discretion of the eye specialist. A urine albumin-creatinine ratio and serum creatinine should be measured each trimester to screen for nephropathy and OB & Internal Medicine consulted if abnormal. • Clients with gestational diabetes should be referred to the appropriate Diabetes Team for advice on lifestyle modifications and initiation of home glucose monitoring as soon as they are diagnosed. Home glucose monitoring is required to assess control. If the resources for this are available in the community then monitoring can be started immediately. If not, a Diabetes Team will help arrange resources for them. Clients with gestational diabetes are to be referred to a specialist obstetrician. Referrals are to include the patient's diagnostic glucose testing results, EDC, current BMI, weight gain in pregnancy thus far, and whether or not they have been referred to the appropriate Diabetes Team. Appointments for out of town patients for Obstetrics and the Yellowknife Diabetes Team are to be coordinated through the Northern Women's Health Program (NWHP) nurse practitioner. **Ultrasound and Prenatal Diagnosis** • Clients with pre-existing diabetes are to have a detailed fetal ultrasound with attention to cardiac views (including 4-chamber, 3-vessel view, and outflow tracts) to rule out a cardiac anomaly. If ultrasound cardiac views are sub-optimal or the HbA1C was > 7.0% in the first trimester, fetal echocardiography should be performed. • Maternal Serum Screening for abnormal chromosomes can be performed in clients with diabetes; the client's diabetes diagnosis should be documented on the requisition. **Screening & Testing for diabetes (DM) & Gestational Diabetes (GDM)** All pregnant clients are to be screened or tested for diabetes in pregnancy. Ordering a screening HbA1C should be avoided unless a patient will simply not attend for an OGTT (oral glucose tolerance test). Clients with a history of prior GDM or with two or more risk factors from the following list should have a 2 hour 75 gram OGTT diagnostic test early in pregnancy (ideally in the first trimester) to detect early onset of gestational diabetes or possible type 2 diabetes: • obesity (BMI ≥ 30 kg/m2) • age ≥ 35 years • high-risk ancestry (African, Asian, Arab, Hispanic, Indigenous, South Asian) • history of PCOS or acanthosis nigricans

Section 14: Investigation/Results, *cont.*

Item	Description
Diabetic Screening *cont'd*	• history of prediabetes • previously given birth to infant weighing >4000 g • first-degree relative (parent or sibling) with type 2 diabetes If negative, it should be repeated at 26-28 weeks to detect GDM. Consider repeating OGTT again at 32 weeks in clients with two or more risk factors but negative tests thus far, particularly if a prior OGTT had borderline results or if clinically indicated (rapid weight gain, measuring large for dates, polyhydramnios). One abnormal OGTT value is a positive diagnosis of gestational diabetes: fasting ≥ 5.3; 1 hour ≥ 10.6; 2 hour ≥ 9.0. Clients with one or no risk factors should receive a screening 1 hour 50 g GCT (glucose challenge test) at 26-28 weeks. To reduce the risk of a false positive result, clients should have nothing to eat or drink except water for at least 3 hours before the test. If the 50g GCT is positive (≥7.8 mmol/L), then a 2 hour 75 gram OGTT should be done. If the result of the 50g GCT is ≥ 11.1 mmol/L, it is diagnostic of GDM; however, consider a 2 hour 75 gram OGTT if patient had a large carbohydrate intake within 3h of the GCT. Consults must occur with the Diabetes Program & Internal Medicine for patients at risk for diabetes or with an existing condition. Refer to the Diabetes & Obesity in Pregnancy –NWT Document by the NTHSSA-STH Deptartment of Obstetrics and Gynecology & NTHSSA-YK Region Diabetes Program for additional information. This document can be found in WOLF Links.
U/S Studies	If a client is uncertain about their LMP, a dating U/S is indicated as early as possible between 7 and 24 weeks *estimated* gestational age. If a client is clinically larger than expected on abdominal and/or pelvic exam, perform a first or early second trimester U/S as soon as possible. An Anatomical U/S between 18-20 weeks are to be arranged for all pregnant clients. If the 18-20 week U/S results are satisfactory, there is no value to performing additional ultrasounds routinely, and they should only be done for a specific indication, such as: • To follow up inadequately visualized fetal anatomy or possible abnormality. • To monitor growth, especially in conjunction with an abnormal SFH, multiple gestation, maternal obesity and a prior history of IUGR. • To monitor amniotic fluid level in high-risk pregnancies. • To reassess the position of the placenta to exclude placenta previa. • To confirm or exclude a malpresentation. • To determine fetal well-being during a biophysical profile where warranted by other maternal or fetal conditions. Indicate dates of ultrasounds, the estimated gestational age and any relevant comments. Indicate dates of ultrasounds, the estimated gestational age and any relevant comments especially abnormalities of the anatomy, placenta or fetus.

Section 15: Confirmed EDD

Item	Description
Confirmed EDD	Transfer the Confirmed EDD from Part 1.

Section 16: Prenatal Visit Documentation

The initial prenatal visit should take place between 6-12 weeks gestation. Regular visits should be scheduled every 4 weeks until 28 weeks, every 2 weeks until 36 weeks and every week until birth or client leaves community for planned birth services. More frequent visits can be scheduled as clinical situations arise.

Item	Description
Date	Date of each prenatal visit.
Gestation (wks)	Gestational age of the pregnancy in weeks.
Fundus (cms)	Fundal height in cms. The fundus (top of the uterus) can be palpated just above the pubic bone around 12 weeks gestation. By 16 weeks it is usually half way between the pubic bone and the umbilicus and by 20 weeks it is around the umbilicus. The Symphysis Fundus Height (SFH) is an abdominal measurement starting from the pubis to the top of the fundus. It is reported in centimeters using a measuring tape and is usually started at 20 weeks gestation. This measurement is extremely operator-dependent and, if possible, it should be performed by the same provider with consistency in the positioning of the client. The SFH can be quite variable depending upon factors such as racial and ethnic background, body habitus, parity, number of fetuses and the weights of previous infants. The change in the fundal height from one visit to the next is the most important aspect. Plotting the measurement on the SFH graph located on Part 4 is strongly recommended. If there is a difference > 3 cm between gestational age (in weeks) and the SFH, contact an Obstetrical Physician or the Northern Women's Health Program.
B/P	Blood pressure tends to fall in a normal pregnancy, reaching its lowest point around the 18th week, and slowly rising back to the pre- pregnancy level in the third trimester. Hypertension in pregnancy is defined as a measurement of at least two readings taken 15 minutes apart in the same arm of a systolic pressure > 140 mmHg or a diastolic pressure > 90 mmHg. This scenario requires additional evaluation and/or referral to an appropriate maternity care provider.
Urine Prot.	Urine testing for protein are to be performed at each prenatal visit. A finding of greater than or equal to 1+ (greater than 30 mg/l) for protein requires contact with an appropriate maternity care provider.
Weight (kgs)	Weight in kilograms. Consistency is to be attempted using the same scales and removing of outer and footwear.
FHR	Fetal heart rate. First attempt to auscultate for a FHR around 11-12 weeks gestation; however reassure client if one is not heard at that time. Consult with NWHP or refer to an appropriate maternity care provider if unable to auscultate.

Section 16: Prenatal Visit Documentation, *Con't*

Item	Description
FM	Presence or absence of fetal movement with **+/-.** Primiparous clients perceive fetal movements regularly after ~ 20 weeks gestation and multiparous clients after ~ 18 weeks. Once a client starts feeling fetal movements, they should continue to feel them. Normal counts are at least 6 movements in a 2 hour period. Suggest that high risk clients begin daily fetal movement counts starting at 28 weeks. A copy of a fetal movement count sheet can be obtained from the Northern Women's Health Program.
Pres.	Presentation of the fetus, if known. Fetal presentation can be palpable by 24-28 weeks. Indicate 'Ceph' for Cephalic (head down) and 'Br' For Breech (bum down). By 34 weeks gestation the vast majority of fetuses are cephalic. If a presentation is not cephalic by 35-36 weeks, refer to an appropriate maternity care provider.
Comments	Note brief, relevant information only. In order to ensure all follow up discussions/investigations are managed and not missed/are easily highlighted for all healthcare professionals accessing the PNR, highlight topic in the Risk Factor Section (with the date) and chart the detail of the topic in this Comments section.
Next Visit	Next planned prenatal visit in # of weeks/52 (i.e. 4/52 for one month).
ID	Initials of healthcare provider.

Section 17: Referral Plan

Item	Description
Referral Plan	Any referrals made during the pregnancy. A note should be made in the Ongoing Management Prenetal Comments Section re: indications for referral.

Section 18: Second and Third Trimester Topics Discussed

Indicate with a check if the discussion topics were addressed.

Item	Description
Preterm Labour	Discuss the signs and symptoms and risk factors for preterm labour.
Call Schedule	Discuss the call schedule of labour and birth caregivers. Information can be obtained from the NWHP for Yellowknife births and IRH Physician On Obstetrics call for Inuvik births.
Birth Plan	Inquire if client has a birth plan. If you are unfamiliar with what is an appropriate birth plan for the NWT, contact the NWHP.
Pain Management	Discuss pain management options with client.
Contraception	Discuss methods of contraception that can be used postpartum. Clients from outlying communities who give birth in Yellowknife are eligible for postpartum insertion of IUDs.
Caesarean	Discuss what would determine need for a Caesarean Section.
VBAC	Discuss what a VBAC is, if applicable.

Section 18: Second and Third Trimester Topics Discussed, *cont.*

Item	Description
Tdap Vaccine	Immunization with the Pertussis Vaccine (Tdap) to date has been shown to be safe in pregnant clients and allows high levels of antibody to be transferred to newborns during the first two months of life when the morbidity and mortality from pertussis infection is the highest. Tdap vaccination is recommended every pregnancy, regardless of last dose, preferably between 27-32 weeks gestation. Immunization should not be delayed until close to delivery since this may provide insufficient time for optimal transfer of antibodies and direct protection of the infant against pertussis. See section 14 for additional information. • NWT Immunization Schedule • Canadian Immunization Guide
Newborn BCG / Hepatitis B	BCG is recommended for high-risk infants, including infants from communities, infants from families in which there is a strong history of TB and infants born to immigrant families from countries with high rates of TB. Prior to giving a BCG vaccine to a newborn there **must** be a documented Negative HIV result for the birth mother. • NWT CPI: Bacilled Calmetted-Guerin (BCG) Vaccine The NWT Immunization Schedule recommends that Hepatitis B be offered to all newborns at birth. If a client is Hepatitis B Surface Ag negative, the newborn receives the standard dose of Hepatitis B vaccine. If the birth parent is Hepatitis B Surface Ag positive, the newborn requires Hepatitis B immunoglobulin in addition to the Hepatitis B vaccine within 12 hours of birth. For immunization of the newborn and post immunization serology testing for Hepatitis B Surface antibody and antigen: • NWT CPI: Hepatitis Prenatal & Newborn Flowchart • NWT Immunization Schedule • Canadian Immunization Guide: Bacille Calmette-Guerin (BCG) • Canadian Immunization Guide: Hepatitis B Vaccine
Newborn Vit K / Erthyro	Discuss the administration of Vitamin K and Erythromycin ointment to newborns after birth. The Canadian Pediatric Society recommends a routine Vitamin K injection for all newborns shortly after birth. This is done prophylactically to prevent Hemorrhagic Disease of the Newborn (HDNB). Erythromycin eye ointment is routinely applied shortly after birth for all newborns. This is done prophylactically to prevent ophthalmic neonatorum, a severe eye infection caused by contracting chlamydia and gonorrhea during birth.
Newborn Screening: Metabolic / Hearing	Discuss newborn metabolic screening and hearing screening testing. These tests are usually performed in the hospital prior to discharge.
Breastfeeding	Discuss client's knowledge and experience with infant feeding. Five questions can be used initiate discussion: • What is your plan for feeding your newborn? • What do you know about infant feeding? • What have you heard about breastfeeding? • How do you feel about breastfeeding? • How do you feel about other infant feeding options? If previous difficulties were experienced, offer referral to Public Health Nurse, Lactation Consultant or other maternity care provider with breastfeeding education in the community (i.e. Mom’s, Boobs and Babies support group). For further information regarding this community support, visit www.momsboobsandbabies.com.

Section 18: Second and Third Trimester Topics Discussed, *cont.*

<table>
<tr><th>Item</th><th>Description</th></tr>
<tr><td>Breastfeeding
cont'd</td><td>Breastfeeding is the unequalled method of feeding infants. Health Canada recommends breastfeeding – exclusively for the first six months and sustained for up to two years or longer, with appropriate complementary feeding –for the nutrition, immunologic protection, growth, and development of infants and toddlers. However, Parents should be supported with whatever decision they make on infant feeding.

Reinforce practices outlined below.
Important practices which increase breastfeeding success:
• Early initiation (breastfeed within the first hour after birth)
• Skin to skin contact
• Frequent cue based feedings
• No supplements or soothers given to babies, unless medically indicated
• 24 hour rooming-in while in hospital
Baby Friendly Initiative Infant Feeding Prenatal Checklist (See p. 22). Discuss with all pregnant clients by 32 weeks of pregnancy.

For additional information, see the NTHSSA Professionals website for the following resources:
The Infact Formula Series:
• Infant Formula: What You Need to Know (booklet)
• Companion Parent Resource: Safe Preparation of Infant Formula from Liquid Concentrate
• Companion Parent Resource: Safe Preparation of Infant Formula from Powder
• Companion Parent Resource: Safe Preparation of Ready-to-Feed Infant Formula
• Infant Formula: What You Need to Know, A practice support tool for healthcare professionals</td></tr>
<tr><td>Infant Car Seats</td><td>Discuss the safe use and installation of car seats.
• Transport Canada: Child and Car Safety
• Best Beginnings: Car Seat Safety</td></tr>
<tr><td>Infant Safe Sleep</td><td>Discuss safe sleep practices for newborns.
• CPS Position Statement on Safe Sleeping Environments
• Safer Infant Sleep practice support tool
• Honouring Our Babies: Safe Sleep Cards & Guide is interactive, evidence-informed, and incorporates cultural beliefs, practices, and issues specific to First Nations and Indigenous communities.</td></tr>
<tr><td>Other</td><td>Indicate other topics discussed. Repeat discussion of items from 1st trimester topics is based on perceived risk or need (e.g.: oral health, physical activity, rest and food safety, transportation safety).

See Appendix 1 Prenatal Nutrition Discussion Questions, and resources for more information on food security.</td></tr>
</table>

Appendix: Prenatal Nutrition Discussion Questions, Part 4 Key Actions, Messages and Resources.

QUESTION 1: FOOD SECURITY

• Ask permission to discuss food access issues. • Acknowledge that food insecure families without access to local or store foods can be difficult and assess challenges. • Assess barriers to food security (low incomes or less access to local food). • Assess root causes. Discuss reasons for going hungry, missing meals, not eating for days, worrying about food.	• Assist with identifying and developing goals and an action plan. • Assist by providing information on local collective kitchens or cooking programs, soup kitchens, food banks, social services or income support. • Assist and support through regular follow-up by phone, in person at health centre or home visits if service is available.	• Weight gain is inadequate for pre-pregnancy BMI category and stage of pregnancy. • Client expresses concern about access to healthy food, inadequate intake, or inability to afford healthy food. • Food intake is very limited.

Key Messages and Counselling Tips

- Be aware that healthy eating may not be a priority if there are other immediate issues.
- Focus on what can be improved within the current situation; accept small changes, such as eating one healthier choice daily.
- Explore opportunities that reduce barriers to participation, such as transportation subsidies, onsite childcare, discounts for low income families.

QUESTION 2: HEALTHY BEVERAGES

Key Actions

STEP 1: ASSESS and ADVISE	STEP 2: ASSIST	STEP 3: ARRANGE a referral to a registered dietitian when:
• Assess reasons for thirst and beverage choices. • Assess readiness for change and barriers to increasing intake of healthier beverages (water, broth and milk). • Ask if client is interested in using tracking tools to self-assess intake. • Discuss ways to reduce sugar-sweetened beverages and increase water, broth or milk intake.	• Assist by providing education resources. • Assist by providing food/ beverage tracking tools. • Assist and support through regular follow-up by phone, in person at health centre or home visits if service is available.	• Weight gain is inappropriate for pre-pregnancy BMI category and stage of pregnancy. • Client expresses concern about thirst or access to healthy foods. • Food intake is very limited and beverage intake is high.

Key Messages and Counselling Tips

- Soft drinks and other sugar-sweetened beverages are major sources of calories and sugar in the diets of many clients.
- Small changes make big differences. Start by substituting one healthy beverage (water, broth or milk) for one sugar sweetened beverage every day.

QUESTIONS 3-4: KEY NUTRIENT INTAKE IN PREGNANCY: CALCIUM, VITAMIN D AND IRON

Key Actions

STEP 1: ASSESS and ADVISE	STEP 2: ASSIST	STEP 3: ARRANGE a referral to a registered dietitian when:
• Assess intake: Adequate intake of calcium is 3-4 serving of calcium rich foods (dairy or non-dairy) daily. Adequate intake of iron is 3-4 servings of iron (heme) rich foods daily. • Assess readiness for change and barriers to increasing calcium, vitamin D and/or iron intake through healthier food choices. • Ask if client is interested in using food tracking tools to self-assess intake. • Discuss ways to increase calcium, vitamin D and iron intake where/when appropriate. Use visual aids when appropriate.	• Assist by providing education resources. • Assist by providing food/ beverage tracking tools. • Assist and support through regular follow-up by phone, in person at health centre or home visits if service is available.	• Client expresses concerns with food choices. • Iron deficiency anemia is confirmed or suspected. • Client has lactose intolerance or allergies to dairy or other calcium rich foods. • Client is vegetarian or vegan.

Key Nutrient Intake Recommendations and Food Sources*

Prenatal Age Group	Recommended Dietary Allowance per day		
	Calcium	VItamin D	Iron
14-18 years	1300 mg	800 IU*	27 mg
Over 19	1000 mg	800 IU*	27 mg
Breastfeeding	1000 mg	800 IU*	27 mg
	Food Sources	Food Sources	Food Sources

*NWT Clinical Practice Information: Vitamin D Supplementation Recommendations

Key Messages for Calcium, Vitamin D And Iron Intake

Calcium:
- Calcium is required for bone development in the fetus. Skeletal development requires about 30 grams of calcium, primarily in the last trimester.
- Drink at least 2 cups of milk or other calcium-fortified beverage like soy or rice beverage each day.
- Choose calcium rich foods like yogurt, cheese, canned fish, soft bones, tofu made with calcium.

Vitamin D:
- Vitamin D is needed to help the body use calcium (required for calcium absorption).
- Take Vitamin D pills every day, along with foods high in vitamin D.

Iron:
- Pregnant clients need more iron to support growth and normal brain development in the fetus.
- In the third trimester of pregnancy, the fetus builds iron stores for the first six months of life.
- Iron that comes from red meats (moose, caribou, beef) is better absorbed by the body.
- Iron that comes from plants is not so easily used by the body (usually bound by oxalates, reducing availability).

QUESTION 5: WEIGHT MANAGEMENT IN PREGNANCY

Key Actions

STEP 1: ASSESS and ADVISE	STEP 2: ASSIST	STEP 3: ARRANGE a referral to a registered dietitian when:
• Calculate pre-pregnant BMI at initial visit. • Measure and document weight change at every visit. • Assess root causes of weight gain or loss. • Assess readiness for change and barriers to change, including beliefs about weight gain. • Discuss appropriate rate and pattern for weight change. • Provide individual weight change plan based on pre-pregnancy BMI. Use chart 1 to decide on rate of weight change. • Advise on healthy eating by using key message guide for weight gain.	• Assist with identifying realistic goals and developing an action plan. • Assist by providing education resources. • Assist by connecting client with community healthy living/ pregnancy programs or other appropriate resources. • Assist and support through regular follow-up by phone, in person at health centre or home visits if service is available.	• Client expresses concerns around weight or body changes. • Pregnancy weight trend indicates inadequate or excessive weight change. • Weight gain is less than 5kg at 20 weeks gestation in clients with pre-pregnant BMI of 24.9 or less. • Client has had bariatric surgery.

Guidelines for Weight Gain by Pre-Pregnancy BMI*

Weight Category	Pre-Pregnant BMI	Recommended Weight Gain	Mean Weight Gain in 2nd and 3rd trimesters
Underweight	Less than 18.5	28-40 lbs or 12.5-18 kg.	1 lb/week or 0.5 kg/week.
Healthy Weight	18.5-24.9	25-35 lbs or 11.5-16 kg.	1 lb/week or 0.4 kg/week.
Overweight	25.0-29.9	15-25 lbs or 7-11.5 kg.	0.6 lb/week or 0.3 kg/week.
Obese	30-35 >35	11-20 lbs or 5-9 kg. Modest weight loss is acceptable.	Refer to Appendix 1: Diabetes section.

***Attention to maintaining adequate iron, calcium and protein intake.**

Key Messages for Pregnancy Weight Gain

- Weight gain may be a sensitive topic for many clients. Describe weight gain as a natural outcome of pregnancy. Indicate that some of the client's reserves will be used to support breastfeeding.
- The aim is not to intentionally lose weight by dieting or eliminating food groups but to focus on healthier portion size and food choices.

Messages for clients gaining BELOW weight gain guidelines:

- Eat larger portions at meals and snacks.
- Eat more often. Try eating 6 small meals each day.
- Eat meals and snacks that are high in nutrition.

Messages for clients gaining ABOVE weight gain guidelines:

- Use hand or plate method to measure portions.
- Eat 3 meals and 1-2 healthy snacks each day.
- Choose water, broth or 0% milk (skim milk). Stay away from sugar-sweetened drinks.
- Eat homemade food and stay away from take-out or fast foods.
- Deal with hunger in smart ways. Use tactics like eating more vegetables, eating slowly, drinking water or broth to feel full and not skipping meals.

Additional Resources

- HSS Professionals: Nutrition Resources
- Health Canada: Prenatal Nutrition
- Health Canada: Food Safety

Client Resources

- HSS: Healthy Eating & Healthy Weight Guide
- HSS: Traditional Food Fact Sheet
- HSS: Vegetable Fact Sheets
- HSS: Drop the Pop

References

- Best Start (2019) Risks of Cannabis on Fertility, Pregnancy, Breastfeeding and Parenting: https://resources.beststart.org/wp-content/uploads/2019/01/A30-E.pdf
- Breastfeeding Resources Ontario (2018) BFI 20-Hour Course: Clinical Practice Options: https://breastfeedingresourcesontario.ca/sites/default/files/pdf/Res_Strategy_Clinical_Practice_Options_EN.pdf
- Diabetes Canada Clinical Practice Guidelines Expert Committee (2018) Diabetes and Pregnancy: http://guidelines.diabetes.ca/browse/chapter36
- Canadian Diabetes Association (2018) Screening for Diabetes in Adults: http://guidelines.diabetes.ca/Browse/Chapter4
- Canadian Pediatric Society (2018) Guidelines for Vitamin K Prophylaxis in Newborns: https://www.cps.ca/en/documents/position/vitamin-k-prophylaxis-in-newborns
- Canadian Pediatric Society (2016) Safe Sleep for Babies: https://www.caringforkids.cps.ca/handouts/safe_sleep_for_babies
- Canadian Pediatric Society (2018) Testing HIV During Pregnancy: https://www.caringforkids.cps.ca/handouts/testing_for_hiv_during_pregnancy
- Cook, J.L., Green, C.R., Lilley, C.M. Anderson, S.M., Baldwin, M.E., Chudley, A.E., Conry, J.L., Leblanc, N., Loock, C.A., Lutke, J., Mallon, B.F., McFarlan, A.A., Temple, V.K., & Rosales, T. (2016). Fetal alcohol spectrum disorder: a guideline for diagnosis across the lifespan. CMAJ, 188(3) 191-197; DOI https://doi.org/10.1503/cmaj.141593
- Centre of Excellence for Women's Health (2018) 50 Brief Intervention Ideas for Dialogue, Skill Building, and Empowerment: http://bccewh.bc.ca/wp-content/uploads/2018/06/50-Brief-Intervention-Ideas_June-4-2018.pdf
- Cox, J.L., Holden, J.M., Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry 1987; 150:782-6
- Chudley, A. E., Conry, J., Cook, J. L., Loock, C., Rosales, T., & LeBlanc, N. (2005). Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis. CMAJ, 172(5 suppl), S1-S21; DOI: https://doi.org/10.1503/cmaj.1040302
- Endocrine Web (2014) Thyroid Disease in Pregnancy: http://www.endocrineweb.com/conditions/thyroid/thyroid-problems-pregnancy
- First Nations Health Authority (2017) New Safe Infant Sleep Toolkit: Honouring Our Babies Safe Sleep Cards and Guide: http://www.fnha.ca/what-we-do/maternal-child-and-family-health
- Government of Alberta (2017) Nutrition During Pregnancy: Care Instructions https://myhealth.alberta.ca/health/AfterCareInformation/pages/conditions.aspx?hwid=ud1664
- Government of Canada, National Advisory Committee on Immunization(2018) Update on immunization in pregnancy with tetnus toxoid, reduced diphtheria toxoid and reduced acellular pertussis (Tdap) vaccine: https://www.canada.ca/en/public-health/services/publications/healthy-living/update-immunization-pregnancy-tdap-vaccine.html
- Government of Canada (2019) First Nations and Inuit- Healthy Pregnancy: https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/family-health/healthy-pregnancy-babies.html
- Government of Canada, Health Canada (2016) Food Safety for Pregnant Women: https://www.canada.ca/en/health-canada/services/food-safety-vulnerable-populations/food-safety-pregnant-women.html

References, *cont'd*

- Government of Canada, Public Health Agency of Canada (2018) Canadian Guidelines on Sexually Transmitted Infections: https://www.canada.ca/en/public-health/services/infectious-diseases/sexual-health-sexually-transmitted-infections/canadian-guidelines/sexually-transmitted-infections.html
- Government of Canada , Public Health Agency of Canada(2019) Healthy Pregnancy: https://www.canada.ca/en/public-health/services/health-promotion/healthy-pregnancy/useful-links.html
- Government of Canada, Public Health Agency of Canada: Evergreen Canadian Immunization Guide: https://www.canada.ca/en/public-health/services/canadian-immunization-guide.html
- Government of Canada, Health Canada (2019) Oral Health and Pregnancy: https://www.canada.ca/en/public-health/services/pregnancy/oral-health-pregnancy.html
- Government of Canada, Health Canada (2019) Prenatal Nutrition: https://www.canada.ca/en/health-canada/services/canada-food-guide/resources/prenatal-nutrition.html
- Government of Canada, Health Canada (2019) Second-Hand Smoke: https://www.canada.ca/en/health-canada/services/smoking-tobacco/avoid-second-hand-smoke/second-hand-smoke.html
- Government of Canada, Transport and Infrastructure: Child Car Seat Safety: http://www.tc.gc.ca/en/services/road/child-car-seat-safety.html
- Government of the NWT, Department of Health and Social Services: Case Investigation Report Form: https://www.hss.gov.nt.ca/professionals/sites/default/files/nwt-case-investigation-report-form_0.pdf
- Government of the NWT, Department of Health and Social Services: Communicable Disease Manual: https://www.hss.gov.nt.ca/professionals/content/communicable-disease-manual-0
- Government of the NWT, Department of Health and Social Services (2011) Clinical Practice Guideline Notice: Bacille Calmette-Guerin (BCG) Vaccine: https://www.hss.gov.nt.ca/professionals/sites/default/files/page_103_bacille_calmette_guerin_bcg_vaccine.pdf
- Government of the NWT, Department of Health and Social Services (2013) Clinical Practice Guideline Notice: Release of Revised Chapter on Gonococcal Infections for the Canadian Guidelines on Sexually Transmitted Infections: https://www.hss.gov.nt.ca/professionals/sites/default/files/treatment_of_uncomplicated_gonorrhea.pdf
- Government of the NWT, Department of Health and Social Services (2011) Clinical Practice Guideline Notice: Hepatitis B Prenatal & Newborn Flow Chart: https://www.hss.gov.nt.ca/professionals/sites/default/files/page_105_hepatitis_b_prenatal_and_newborn_flow_chart.pdf
- Government of the NWT, Department of Health and Social Services (2010) Clinical Practice Guideline Notice: NWT Cervical Cancer Screening Guidelines: https://www.hss.gov.nt.ca/professionals/sites/default/files/page_95_nwt_cervical_cancer_screening_guidelines.pdf
- Government of the NWT, Department of Health and Social Services (2002) Clinical Practice Guideline Notice: Prenatal Screening for Varicella Immune Status: https://www.hss.gov.nt.ca/professionals/document/prenatal-screening-varicella-immune-status-revised-see-cpi-124
- Government of the NWT, Department of Health and Social Services (2014) Clinical Practice Guideline Notice: Standard for Maternal Serum Screening (MSS) in Pregnancy: https://www.hss.gov.nt.ca/professionals/sites/default/files/standard-maternal-serum-screening-pregnancy.pdf

References, *cont'd*

- Government of the NWT, Department of Health and Social Services (2014) Clinical Practice Guideline Notice: Vitamin D Supplementation Recommendations: https://www.hss.gov.nt.ca/professionals/sites/default/files/page-122-vitamin-d-supplementation-recommendations.pdf
- Government of the NWT, Department of Health and Social Services: Enhanced Hepatitis B and C –Case Investigation: https://www.hss.gov.nt.ca/professionals/sites/default/files/hepatitis_b_and_c_case_investigation_form.pdf
- Government of the NWT, Department of Health and Social Services (2016) General Fish Consumption Guidelines for the NWT: https://www.hss.gov.nt.ca/sites/hss/files/general-fish-consumption-guidelines-nwt.pdf
- Government of the NWT, Department of Health and Social Services: Healthy Eating Healthy Weight Guide: https://www.hss.gov.nt.ca/sites/hss/files/resources/healthy-eating-healthy-weight-guide.pdf
- Government of the NWT, Department of Health and Social Services: Health Effects of Cannabis: https://www.hss.gov.nt.ca/en/services/cannabis/pregnant-and-breastfeeding-mothers
- Government of the NWT, Department of Health and Social Services: NWT Syphilis Investigation and Follow-Up Form: https://www.hss.gov.nt.ca/professionals/sites/default/files/syphilis-investigation-form.pdf
- Government of the NWT, Department of Health and Social Services (2006) Northwest Territories HIV/Aids Manual for Health Professionals: https://www.hss.gov.nt.ca/professionals/sites/default/files/hiv_aids_manual_0.pdf
- Government of the NWT, Department of Health and Social Services: NWT HIV Case Investigation Form: https://www.hss.gov.nt.ca/professionals/sites/default/files/hiv_case_investigation_form.pdf
- Government of the NWT, Department of Health and Social Services (2018) Pot, Pregnancy & Breastfeeding: https://www.hss.gov.nt.ca/sites/hss/files/resources/pot-pregnancy-breastfeeding-brochure-min.pdf
- Government of the NWT, Department of Health and Social Services (2018) Immunization Schedule: https://www.hss.gov.nt.ca/professionals/sites/default/files/nwt_immunization_schedule.pdf
- Government of the NWT, Department of Health and Social Services (2018) Seasonal Influenza Immunization Package: https://www.hss.gov.nt.ca/professionals/content/seasonal-influenza-immunization-package
- Government of the NWT, Department of Health and Social Services (2013Healthy Family Program Collective Kitchen: Recipe Book for Northern Cooks: https://www.hss.gov.nt.ca/sites/hss/files/resources/northern-cookbook.pdf
- Greaves, L., Poole, N., Okoli, C. T. C., Hemsing, N., Qu, A., Bialystok, L., & O'Leary, R. (2011). Expecting to Quit: A best-practices review of smoking cessation interventions for pregnant and post-partum women (2nd ed.). Vancouver: British Columbia Centre of Excellence for Women's Health. http://bccewh.bc.ca/wp-content/uploads/2012/05/2011_Expecting-to-Quit-2nd-edition.pdf
- Koren, G. (2004) Is it all right to drink a little during pregnancy?: http://www.motherisk.org/women/updatesDetail.jsp?content_id=715
- Koreon, G. (2002) Drinking alcohol while breastfeeding: Will it harm my baby? : http://www.motherisk.org/women/updatesDetail.jsp?content_id=347
- March of Dimes (2014) Seatbelts During Pregnancy: https://www.marchofdimes.org/pregnancy/seatbelts-during-pregnancy.aspx

References, *cont'd*

- National Institute for Health and Care Excellence (2008) Diabetes in pregnancy: management of diabetes and its complications from preconception to the postnatal period: https://www.nice.org.uk/guidance/ng3

- Neufeld, B (1996) SAFE Questions: Overcoming barriers to the detections of domestic violence, Amer Fam Physician, Jun;53(8):2575-80, 2582.

- Northwest Territories Health and Social Services Association Stanton Dept. of Obstetrics and Gynecology & NTHSSA-YK Region Diabetes Program (2018) Diabetes & Obesity in Pregnancy – NWT

- Ontario Medical Association (2006) A guide to the 2005 revised Ontario Antenatal Record: http://ocfp.on.ca/docs/default-source/cme/new-antenatal-record-and-guidef9a835f1b72c.pdf?sfvrsn=0

- Perinatal Services BC (2012) A guide for completion of the Antenatal Record, Part 1 and 2: http://www.perinatalservicesbc.ca/Documents/Form/Form1582_Guide_AntenatalRecord1and2.pdf

- Perinatal Services BC: Edinburgh Postnatal Depression Scale (EPDS): http://www.perinatalservicesbc.ca/health-professionals/professional-resources/health-promo/edinburgh-postnatal-depression-scale-(epds)

- Perinatal Services BC (2017) Safer Infant Sleep: http://www.health.gov.bc.ca/library/publications/year/2017/safer-sleep-for-my-baby.pdf

- Public Agency of Canada (2018) Statement on Seasonal Influenza Vaccine for 2018- 2019: https://www.canada.ca/en/public-health/services/reports-publications/canada-communicable-disease-report-ccdr/monthly-issue/2018-44/issue-6-june-7-2018/article-1-summary-influenza-2018-2019.html

- Public Health Agency of Canada. (2015). An Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI): Varicella proof of immunity- 2015 update. CANADA: Author.

- Russell, M (1994). New assessment tools for risk drinking during pregnancy: T-Ace, TWEAK and others. Alcohol Health and Research World, 18, 1, 55-61

- Society of Obstetricians and Gynaecologists of Canada/ Canadian Society for Exercise Physiology (2018) No.367-2019 Canadian Guideline for Physical Activity throughout Pregnancy: https://els-jbs-prod-cdn.literatumonline.com/pb/assets/raw/Health%20Advance/journals/jogc/JOGC908_LR-1539864964137.pdf

- Society of Obstetricians and Gynaecologists of Canada (2012) Management of Group B Streptococcal Bacteriuria in Pregnancy: https://www.jogc.com/article/S1701-2163(16)35246-X/pdf

- Society of Obstetricians and Gynaecologists of Canada (2012) Management of Varicella Infection (Chickenpox) in Pregnancy: https://www.jogc.com/article/S1701-2163(16)35190-8/pdf

- Society of Obstetricians and Gynaecologists of Canada & Canadian Society for Exercise Physiology (2018) No. 367-2019 Canadian Guideline for Physical Activity throughout Pregnancy: https://els-jbs-prod-cdn.literatumonline.com/pb/assets/raw/Health%20Advance/journals/jogc/JOGC908_LR-1539864964137.pdf

- UpToDate (2019) Evaluation of proteinuria in pregnancy and management of nephrotic syndrome: https://www.uptodate.com/contents/evaluation-of-proteinuria-in-pregnancy-and-management-of-nephrotic syndrome?search=urine%20protein%20pregnancy&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

- UpToDate (2019) Neonatal group B streptococcal disease: Prevention: https://www.uptodate.com/contents/neonatal-group-b-streptococcal-disease-prevention?search=Group%20B%20Strep%20bacteria%20pregnancy&topicRef=3170&source=see_link

References, *cont'd*

- UpToDate (2018) Prevention of Rhesus (D) alloimmunization in pregnancy: https://www.uptodate.com/contents/prevention-of-rhesus-d-alloimmunization-in-pregnancy?search=when%20to%20give%20RH%20immunoglobulin&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

- UpToDate (2018) Spontaneous abortion: Risk factors, etiology, clinical manifestations, and diagnostic evaluation : https://www.uptodate.com/contents/spontaneous-abortion-risk-factors-etiology-clinical-manifestations-and-diagnostic-evaluation?search=Abortion%20%E2%80%93%20Spontaneous&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1