(ATC Reviewed 12-2016)

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Physician Guidelines for Routine Antepartum Care

PRECONCEPTION CARE: consists of the identification of conditions that could affect a future pregnancy or fetus and that may be amendable to intervention PRECONCEPTION IMMUNIZATIONS: • Influenza • Tdap • Varicella (if indicated) • Rubella (if indicated)	**Assessment and Counseling:** • General physical exam including vital signs, height and weight • Counseling regarding family planning and pregnancy spacing • Family history • Genetic history (both maternal and paternal) • Medical, surgical, psychiatric, and neurologic history • Current medications (prescription and non-prescription) • Substance use including tobacco, alcohol and illicit drugs • Exposure to violence and intimate partner violence • Nutrition • Teratogens, environmental and occupational • Risk factors for sexually transmitted diseases • Obstetric and Gynecologic history • Assessment of socioeconomic, educational, and cultural context	**Potential Screening Tests:** • Screening for sexually transmitted diseases, including HIV • Testing for maternal diseases based on medical or reproductive history • Mantoux skin test with purified protein derivative for tuberculosis • Screening for genetic disorders based on racial and ethnic background: -Sickle hemoglobinopathies (African Americans) -β-thalassemia (Mediterraneans, Southeast Asians, and African Americans) -α-thalassemia (Southeast Asians, Mediterraneans, and African Americans) -Tay-Sachs disease (Ashkenazi Jews, French Canadians, and Cajuns) - Canavan, and familial dysautonomia (Ashkenazi Jews) -Cystic fibrosis (CF) • Screening for other genetic disorders on the basis of family history (eg, fragile X syndrome for family history of nonspecific predominantly male-affected, mental retardation; Duchenne muscular dystrophy)	**Additional Counseling:** • Exercising • Reducing weight before pregnancy, if obese • Increasing weight before pregnancy, if underweight • Avoiding food faddism • Preventing HIV infection • Determining the time of conception by an accurate menstrual history • Abstaining from tobacco, alcohol, and illicit drug use before and during pregnancy • Consuming folic acid, 0.4 mg per day, while attempting pregnancy and during the first trimester of pregnancy for prevention of neural tube defects (NTDs) • Maintaining good control on any preexisting medical conditions (eg, diabetes, hypertension, systemic lupus erythematosus, asthma, seizures, thyroid disorders, inflammatory bowel disease • Avoiding pregnancy within one month of receiving a live attenuated viral vaccine (e.g., rubella)
ROUTINE PRENATAL CARE VISITS: should take into consideration the medical, nutritional, psychosocial, and educational needs of the patient and her family, and it should be periodically reevaluated and revised in accordance with the progress of the pregnancy.	**Initial Prenatal Care Visit:** During the gestational time period the **initial patient visit should include all content covered in the preconception visit as stated above**. Additional evaluation should include: • A patient questionnaire with personal health history, exposures affecting health, family history, psychosocial screening. • Pelvic examination; • Assessment of the cervix, uterus size, adnexa and clinical impression of the adequacy of the pelvis; • Assessment of gestational age by LMP, clinical exam and/or ultrasound prior to 18-20 weeks. • Papanicolaou smear and culture for gonorrhea and chlamydial infection; • Blood studies listed under first trimester initial lab testing • Urine for protein, glucose and culture for asymptomatic bacteriuria. • Repeat risk assessment for obstetrical outcomes as pre-term birth, low birth weight and pre-eclampsia. • Review medication use and concurrent medical conditions.		**Follow Up Prenatal Care Visits:** The purpose of each visit is to assess maternal and fetal well-being. Recommended time periods, laboratory evaluations, and nutritional assessments are: • Prenatal visits every 4 weeks until 28 weeks of pregnancy, then every 2 to 3 weeks until 36 weeks, then weekly until delivery (Note: this should be individualized and visit frequency is determined by the nature and severity of problems encountered); • Patient weight, blood pressure, presence or absence of edema, urine dipstick to check protein and glucose levels, uterine size and fetal heart rate should be done each visit; • After the patient reports quickening, she should be asked about fetal movement, contractions, leakage of fluid, or vaginal bleeding; • At 15 weeks patients should be offered biochemical marker screening for risk assessment for trisomies and open neural tube defects. • At 28 weeks a glucose screen for gestational diabetes, assays for hemoglobin and hematocrit and blood antibody screening and repeat testing for syphilis are done if indicated. If the patient is Rh negative and unsensitized, she should receive Rh immunoglobulin (RhoGAM) at this time; • At 35 to 37 weeks a vaginal and rectal culture can be obtained for group B Streptococcus; when using risk strategy, (and should be obtained for GC and Chlamydia when patients continue to be at risk. • At 36 weeks VDRL should be repeated for patients at risk. • Iron supplements and folic acid supplementation is advised.

References: Guidelines for Perinatal Care. Seventh Edition. 2012. American Academy of Pediatrics. The American College of Obstetricians and Gynecologists.

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PRENATAL LABS AND TESTING	FIRST TRIMESTER/INITIAL LAB TESTING:	SECOND TRIMESTER TESTING:	THIRD TRIMESTER TESTING:
	• Blood group and CDE (Rh) type • Antibody Screening • CBC • Rubella immunity • VDRL • Urine culture/screen • Urinalysis, including microscopic examination • Cervical cytology as needed • HBsAg • HIV Counseling/Testing • Hgb Electrophoresis (optional) • PPD (if high risk for TB) • Chlamydia (optional) • Gonorrhea (optional) • Genetic Screening Tests (optional) • First look at 10-11 weeks (NT, PAPP-A, free B-HCG) • Cell free DNA testing if indicated	• Ultrasound • MSAFP/Multiple Markers (ideally at 16-18 wks) • Amniocentesis (about 16 weeks) • Anti-D Immune Globulin (RhIG) if D negative and with invasive procedure (either amniocentesis or CVS) • Karotype • Amniotic Fluid (AFP) • MSAFP/Multiple Markers (Triple or Quad Test) ideally at 15-18 weeks	**24 – 28 weeks (when indicated)** • Hct/Hgb • Diabetes Screening (1-hr GTT) • 3 hr GTT if screening abnormal • D (Rh) Antibody Screen, as indicated • Anti-D Immune Globulin (RhIG) Given (28 wks), as indicated • D(Rh) Antibody screen if Rh negative and un sensitized at 28-29 weeks • HIV testing in high HIV prevalence areas **32 – 36 weeks (when indicated)** • Hct/Hgb (recommended) • Ultrasound • VDRL • Gonorrhea • Chlamydia • Non-stress tests • Biophysical Profile • Contraction Stress Test **35-37 Weeks** • Group B Strep

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PRENATAL PLANS/ EDUCATION	**FIRST TRIMESTER:** • HIV and other routine prenatal tests • Risk factors based on prenatal history • Anticipated course of prenatal care • Signs & symptoms to report to the physician • Nutritional weight counseling • Toxoplasmosis precautions • Sexual activity • Exercise • Environmental work hazards • Travel • Tobacco (ask, advise, assess, assist, and arrange) • Alcohol and illicit drugs • Use of any over the counter medication (including supplements, vitamins, and herbs) • Indications for ultrasound • Domestic violence • Seat belt use • Child birth classes/hospital facilities • Dental care • Psychosocial factors	**SECOND TRIMESTER:** • Signs and symptoms of pre-term labor • Abnormal laboratory values • Selecting a pediatrician • Postpartum family planning / sterilization	**THIRD TRIMESTER:** • Anesthesia/analgesia in labor • Fetal movement monitoring (“kick” counts) • Labor signs • VBAC counseling • Signs and symptoms pre-eclampsia • Circumcision • Post term counseling • Breast or bottle feeding • Postpartum depression • Car seats for newborn • Family Medical Leave Act/Disability • Tubal Sterilization Consent • Breech presentation at term, external cephalic repositioning • Umbilical cord blood banking • Newborn screening • Preparation for discharge
PRENATAL RECORD AND DOCUMENTATION	The content of the preconceptional assessment, prenatal care assessments and follow-up assessments must be documented in a well organized prenatal record. The Antepartum Record of the American Congress of Obstetrics and Gynecologists provides the template for documentation and the patients’ medical history questionnaire. All above described content can be documented in an appropriate format. Utilization of this nationally recognized record or an equivalent version is required unless the obstetrical provider can provide evidence of an alternative record that captures all required information and education content.		

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