Ontario

Ministry of Health and Long-Term Care

Ontario Perinatal Record 3

Last Name	First Name
Planned Birth Attendant	

Newborn Care Provider In Hospital In Community	Allergies or Sensitivities (include reaction)
Family Physician/Primary Care Provider	Medications (include Rx/OTC, complementary/alternative/vitamins, include dosage)

G	T	P	A	L	S	Final EDB YYYY/MM/DD

Issues (abnormal results, medical/social problems)	Plan of Management / Medication Change / Consultations

Special Circumstances	GBS
Low dose ASA indicated ☐ Progesterone indicated (PTB Prevention) ☐ HSV supression indicated ☐	Rectovaginal swab ☐pos ☐neg
Social (e.g. child protection, adoption, surrogacy)	Other indications for prophylaxis ☐Y ☐N

Recommended Immunoprophylaxis

Rh(D) neg ☐ Rh(D) IG given YYYY/MM/DD Additional dose given YYYY/MM/DD	Influenza Discussed ☐ ☐Received ☐Declined	Pertussis Discussed ☐ Up-to-date ☐Y ☐N Year _____ Received ☐ Declined ☐	Post-partum vaccines discussed ☐Rubella ☐Other _____	Newborn needs ☐Hep B prophylaxis ☐HIV prophylaxis

Pre-pregnancy Wt _____ kg BMI _____

Subsequent Visits

Date	GA (wks/days)	Weight (kg)	BP	Urine Prot.	SFH	Pres.	FHR	FM	Comments	Next Visit	Initial(s)
YYYY/MM/DD											
YYYY/MM/DD											
YYYY/MM/DD											
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Discussion Topics

1st Trimester	2nd Trimester	3rd Trimester
☐Nausea / Vomiting	☐Prenatal classes	☐Fetal movement ☐Work plan / Maternity leave
☐Routine prenatal care /Emergency contact /On call providers	☐Preterm labour	☐Birth plan: pain management, labour support
☐Safety: food, medication, environment, infections, pets	☐PROM	☐Type of birth, potential interventions, VBAC plan
☐Healthy weight gain ☐Breastfeeding	☐Bleeding	☐Admission timing ☐Mental health
☐Physical activity ☐Travel	☐Fetal movement	☐Breastfeeding and support ☐Contraception
☐Seatbelt use ☐Quality information sources	☐Mental health	☐Newborn care / Screening tests / Circumcision / Follow-up appt.
☐Sexual activity ☐VBAC counseling	☐VBAC consent	☐Discharge planning / Car seat safety ☐Postpartum care

Comments

Approx 36 wks: Copy of OPR 2 (updated) & OPR 3 to hospital ☐ and/or to pt/client ☐

1. Name / Initials	2. Name / Initials	3. Name / Initials	4. Name / Initials	5. Name / Initials

