

Last Name				First Name							
Planned Birth Attendant											
Newborn Care Provider In Hospital				In Community							
Family Physician/Primary Care Provider				Allergies or Sensitivities (include reaction)							
G   T   P   A   L   S   Final EDB YYYY/MM/DD				Medications (include Rx/OTC, complementary/alternative/vitamins, include dosage)							
<b>Issues (abnormal results, medical/social problems)</b>				<b>Plan of Management / Medication Change / Consultations</b>							
<b>Special Circumstances</b>						<b>GBS</b>					
Low dose ASA indicated <input type="checkbox"/> Progesterone indicated (PTB Prevention) <input type="checkbox"/> HSV supression indicated <input type="checkbox"/>						Rectovaginal swab <input type="checkbox"/> pos <input type="checkbox"/> neg					
Social (e.g. child protection, adoption, surrogacy)						Other indications for prophylaxis <input type="checkbox"/> Y <input type="checkbox"/> N					
<b>Recommended Immunoprophylaxis</b>											
Rh(D) neg <input type="checkbox"/>		Rh(D) IG given YYYY/MM/DD		Influenza Discussed <input type="checkbox"/>		Pertussis Discussed <input type="checkbox"/>					
Additional dose given YYYY/MM/DD		<input type="checkbox"/> Received <input type="checkbox"/> Declined		Up-to-date <input type="checkbox"/> Y <input type="checkbox"/> N Year _____		Post-partum vaccines discussed					
				<input type="checkbox"/> Received <input type="checkbox"/> Declined <input type="checkbox"/>		<input type="checkbox"/> Rubella <input type="checkbox"/> Other _____					
						Newborn needs <input type="checkbox"/> Hep B prophylaxis <input type="checkbox"/> HIV prophylaxis					
Pre-pregnancy Wt _____ kg BMI _____				<b>Subsequent Visits</b>							
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											
YYYY/MM/DD											
YYYY/MM/DD											
YYYY/MM/DD											
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YYYY/MM/DD											
YYYY/MM/DD											
YYYY/MM/DD											
<b>Discussion Topics</b>											
<b>1<sup>st</sup> Trimester</b>				<b>2<sup>nd</sup> Trimester</b>		<b>3<sup>rd</sup> Trimester</b>					
<input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Routine prenatal care /Emergency contact /On call providers <input type="checkbox"/> Safety: food, medication, environment, infections, pets <input type="checkbox"/> Healthy weight gain <input type="checkbox"/> Physical activity <input type="checkbox"/> Seatbelt use <input type="checkbox"/> Sexual activity				<input type="checkbox"/> Prenatal classes <input type="checkbox"/> Preterm labour <input type="checkbox"/> PROM <input type="checkbox"/> Bleeding <input type="checkbox"/> Fetal movement <input type="checkbox"/> Mental health <input type="checkbox"/> VBAC consent		<input type="checkbox"/> Fetal movement <input type="checkbox"/> Birth plan: pain management, labour support <input type="checkbox"/> Type of birth, potential interventions, VBAC plan <input type="checkbox"/> Admission timing <input type="checkbox"/> Breastfeeding and support <input type="checkbox"/> Newborn care / Screening tests / Circumcision / Follow-up appt. <input type="checkbox"/> Discharge planning / Car seat safety					
<input type="checkbox"/> Breastfeeding <input type="checkbox"/> Travel <input type="checkbox"/> Quality information sources <input type="checkbox"/> VBAC counseling						<input type="checkbox"/> Work plan / Maternity leave <input type="checkbox"/> Mental health <input type="checkbox"/> Contraception <input type="checkbox"/> Postpartum care					
Comments											
Approx 36 wks: Copy of OPR 2 (updated) & OPR 3 to hospital <input type="checkbox"/> and/or to pt/client <input type="checkbox"/>											
1. Name / Initials		2. Name / Initials		3. Name / Initials		4. Name / Initials		5. Name / Initials			