SASKATCHEWAN PRENATAL RECORD

** (DATE FORMAT EXAMPLE: 04 JAN 2018)

Last Name, First Name	Facility/Clinic Code

Date of Birth: dd/mmm/yyyy **	Age yrs	MRN	HSN

Address:

City, Province, Postal Code	Primary Phone Number

Family Physician

Referring Physician

Attending Physician

☐ Leave Message	Alternate Phone/Email
Preferred Language	☐ Interpreter Required

Occupation

Education Level

LMP dd/mmm/yyyy **	Cycle q	Certain ☐ Y ☐ N	Regular ☐ Y ☐ N	EDB by LMP dd/mmm/yyyy**
Dating by	☐ Ultrasound (preferred) (7-22 weeks)	☐ LMP	☐ ART	**Definitive EDB** dd/mmm/yyyy**

Wanted Pregnancy ☐ Y ☐ N	Contraceptive Type	Last Used dd/mmm/yyyy**

Partner's Last Name, First Name

Partner's Age	Partner's Occupation	Partner's Education Level

Current Medications and Alternate/Complementary Therapies

☐ Folic Acid at Conception ________ mg	☐ Prenatal Vitamins

Non-Prescription/Herbal/Alternate Medicine/Prescriptions

Drug Allergies

Relationship Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Common Law ☐ Other

Allowance(s) for Care/Special Needs

Past Obstetrical History

Date **	Place of Birth	Gest. Age	Labour Length	Type of Birth	Comments Regarding Fetus, Pregnancy, Birth, and Newborn	Infant Sex	Birth Weight	Breastfed/ Duration	Baby Living With
dd/mmm/yyyy		Weeks							
dd/mmm/yyyy		Weeks							
dd/mmm/yyyy		Weeks							
dd/mmm/yyyy		Weeks							
dd/mmm/yyyy		Weeks							

Health Status

(Check box[es] only if positive. If so, describe. Provide details and any referrals in the comments section).

Current Pregnancy

☐ Bleeding
☐ Nausea/Vomiting
☐ Rash/Fever/Illness

Health History

☐ Hypertension
☐ Cardiac/Pulmonary
☐ Endocrine
☐ GI/Liver
☐ Gynecology
☐ Renal/Urinary Tract
☐ MSK/Rheumatology
☐ Respiratory Diseases
☐ Tuberculosis
☐ Thromboembolic/Coag
☐ Blood Transfusion
☐ Neurological
☐ Surgery:
____
☐ Anesthetic Complications

Health History (Continued)

☐ Dental Cleaning in the Last Year
☐ Unmet Dental Needs
☐ Dental Pain/Infection
☐ Anxiety/Depression
EPDS Score*______________
☐ Bipolar Disorder
☐ Other Problems __________________

Infectious Disease

☐ Hep B
☐ Hep C
☐ HIV
☐ HSV
☐ STIs ______________________
☐ At risk for Parvo, Toxo, TB
☐ History of Varicella
☐ Other ____________________________

Family History

☐ Medical Conditions
____
☐ Carrier for Genetic Condition: at risk?
☐ Birth Defects/Disabilities
☐ Other ________________________
____

Nutrition

☐ Adequate
☐ Special Diet
☐ Food Security Issues

Lifestyle/Social/Substance Use

☐ Financial Issues
☐ Housing Issues
☐ Beliefs/Practices Affecting Care
☐ Social Support (family, friends)

Lifestyle/Social/Substance Use (Continued)

Relationship Concerns ☐ Y ☐ N
Lives With? __________________________
Are you safe where you are living?
☐ Y ☐ N
WAST II Results* ________
Parenting Concerns ☐ Y ☐ N

Alcohol: Have you consumed alcohol during pregnancy? ☐ Y ☐ N
Currently Drinking______________per day
T-ACE Score*____________

Cigarettes: Have you ever smoked?
☐ Y ☐ N
Currently Smoking per day

Cannabis: Have you ever used? ☐ Y ☐ N
Currently Using _____________ per day
Used How?

Use of Other Drugs? ☐ Y ☐ N
What Drug? ______________________
Currently Using ______________ per day
Used How?

Additional Comments

Practitioner Signature	**Date** dd/mmm/yyyy **

See Care Guide for details **Date: See example top of page 1

H19-42 (03/19) PRF Form available at:
https://www.ehealthsask.ca/services/resources/Resources/Prenatal-Record-Form-2019.pdf

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Last Name, First Name	**Date of Birth** dd/mmm/yyyy ** **Age**	**PHN**	**EDB** dd/mmm/yyyy

Physical Examination (checked means completed and normal)

Height _______cm Current Weight _______kg Recommended Weight Gain ____kg	Pre-pregnancy Weight _____kg Pre-pregnancy BMI _________	☐ Head & Neck ☐ Teeth/Mouth ☐ Breast/Nipples	☐ Heart ☐ Lungs ☐ MSK	☐ Pap Smear ☐ Pelvic	☐ Other

Blood Group and Antibody Screening

Test	Date **	Result
ABO/Rh(D)	dd/mmm/yyyy	
	dd/mmm/yyyy	
Antibody Screen	dd/mmm/yyyy	
	dd/mmm/yyyy	

Rh Status	Date **	Results
Positive Repeat Screen (36 weeks)	dd/mmm/yyyy	
Negative Repeat Screen (28 weeks)	dd/mmm/yyyy	
Repeat Screen (36 weeks)	dd/mmm/yyyy	
Rh Globulin Given	dd/mmm/yyyy	

Group B Streptococcus Screening (GBS)

Vaginal-rectal Swab ☐ Positive ☐ Negative ☐ Not Done
dd/mmm/yyyy**

Other Indications for Prophylaxis ☐ Y ☐ N

Initial Lab Investigations

Test	Date **	Results	Test	Date **	Results
Hemoglobin	dd/mmm/yyyy		Syphilis	dd/mmm/yyyy	
Urine C & S	dd/mmm/yyyy		Chlamydia	dd/mmm/yyyy	
HIV	dd/mmm/yyyy		Gonorrhea	dd/mmm/yyyy	
Hep B - antigen	dd/mmm/yyyy		Other, as needed (e.g. Ferritin)	dd/mmm/yyyy dd/mmm/yyyy dd/mmm/yyyy dd/mmm/yyyy	
Hep C - antibody	dd/mmm/yyyy				
Rubella	dd/mmm/yyyy				

Prenatal Genetic Investigations

Investigation	Results	Investigation	Results
Counselled and Declined dd/mmm/yyyy**		MSAFP (15-20+6 weeks) dd/mmm/yyyy**	
Integrated First Trimester NT+biochemistry dd/mmm/yyyy**		Cell-Free DNA dd/mmm/yyyy**	
Integrated Biochemical Screening Part 1 dd/mmm/yyyy** Part 2 dd/mmm/yyyy**		CVS/Amnio dd/mmm/yyyy**	
		Other Genetic Testing dd/mmm/yyyy**	
		NT Risk Assessment - Multiples Only dd/mmm/yyyy**	

2nd and 3rd Trimester Lab Investigations

Test	Date **	Results
Hemoglobin	dd/mmm/yyyy	
1Hr 50g GCT	dd/mmm/yyyy	
2Hrs 75g GTT	dd/mmm/yyyy	
	dd/mmm/yyyy	
	dd/mmm/yyyy	
	dd/mmm/yyyy	
	dd/mmm/yyyy	
	dd/mmm/yyyy	

Ultrasound

Date **	Place Done	Results
dd/mmm/yyyy		
dd/mmm/yyyy		
dd/mmm/yyyy		
dd/mmm/yyyy		
dd/mmm/yyyy		
dd/mmm/yyyy		
dd/mmm/yyyy		
dd/mmm/yyyy		

Vaccinations During Pregnancy		Vaccinations Postpartum	Newborn	
Influenza ☐ Received ☐ Declined dd/mmm/yyyy**	**Pertussis** (in every pregnancy at 27-32 weeks) ☐ Received ☐ Declined dd/mmm/yyyy**	☐ Rubella - if non-immune ☐ Varicella - if non-immune ☐ Other	☐ Hep B Prophylaxis ☐ HIV Prophylaxis	Other

Practitioner Signature	**Date** dd/mmm/yyyy**

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** (DATE FORMAT EXAMPLE: 04 JAN 2018)

Last Name, First Name		**Date of Birth** dd/mmm/yyyy ** **Age**	**PHN**	**EDB** dd/mmm/yyyy**
Date of First Visit dd/mmm/yyyy **	Planned Place of Birth	Practitioner for Delivery		
Practitioner in Community for Newborn		Practitioner in Hospital for Newborn		

Gravida	Term	Preterm	Live Children	Stillbirth	Neonatal/Child Death	Spontaneous Abortion	Induced Abortion

Issues	Plans

Visits

Date **	Gest Age (wks/days)	SFH	Weight	BP	Pres.	FHR	FM	Comments	Next Visit
dd/mmm/yyyy			kg						
dd/mmm/yyyy			kg						
dd/mmm/yyyy			kg						
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dd/mmm/yyyy			kg						
dd/mmm/yyyy			kg						

Screening Results (28 – 32 Weeks)

EPDS Score ____________
WAST II Score ___________
T-Ace Score _____________

Referrals Made

Discussion Topics (Check when done or N/A). Items discussed in any trimester may be ongoing.

1st Trimester

- ☐ Nausea/Vomiting
- ☐ Safety: Food, Medication, Environment, Infections, Pets
- ☐ Healthy Weight Gain
- ☐ Physical Activity/Exercise
- ☐ Seatbelt Use/Safe Travel
- ☐ Sexual Activity
- ☐ Resources (SOGC.org, skprevention.ca, etc.)
- ☐ TOLAC Counselling
- ☐ Oral Health/Dental Care
- ☐ Prenatal Classes/Education
- ☐ Harm Reduction/Substance Use & Smoking Cessation - Ask, Advise, Act
- ☐ Mental Health

2nd Trimester

- ☐ Prenatal Classes/Education
- ☐ Work Plan/Parental Leave
- ☐ Fetal Movements
- ☐ Infant Feeding and Support
- ☐ Mental Health
- ☐ Common Symptoms

Warning Symptoms

- ☐ Vaginal Bleeding
- ☐ Preterm Labour
- ☐ PROM
- ☐ Headache
- ☐ Visual Disturbance

3rd Trimester

- ☐ Birth Plan: Pain Management, Labour Support
- ☐ Type of Birth, Potential Interventions, TOLAC plan
- ☐ Admission Timing
- ☐ Infant Feeding and Support
- ☐ Breastfeeding
- ☐ Newborn Care/Screening Tests/ Circumcision/Follow-up Appt.
- ☐ Discharge Planning/Car Seat Safety
- ☐ Contraception
- ☐ Postpartum Care
- ☐ Tubal Ligation: PP/Interval
- ☐ Mental Health

Approx. 22 Weeks
- ☐ Copy of Record to Hospital
- ☐ Copy of Record to Patient/Client

Approx. 36 Weeks
- ☐ Copy of Record (updated) to Hospital
- ☐ Copy of Record (updated) to Patient/Client

*See Care Guide for details **Date: See example top of page 1