Shared health
Soins communs
Manitoba

Manitoba Prenatal Record

MEDICAL RECORD #
SURNAME
GIVEN NAME
DOB
SEX
MB FAMILY REGISTRATION #
PHIN

Address:		
City:	Province:	Postal Code:
Contact #: Primary #: - -	Secondary #: - -	Preferred pronouns:
Interpreter: ☐Yes ☐No	Language(s)	
Special Accommodation: ☐No ☐Yes (Specify)		
Occupation/Education:	Relationship status:	Partner/Support person name: / Relationship to patient:
Responsible Obstetrician / Family Physician / Midwife:	Referring Primary Care provider / Family Physician / Midwife / Nurse Practitioner:	
Newborn Care provider:	Planned place of birth:	Consultant(s):

Edinburgh (depression) and TACE (alcohol) questionnaires should be filled out by patient at first visit and reviewed by health care provider.

Gravida	Para	SA	TA	Term	Preterm	SB	NND	Living	Multiples	Ectopic	Molar

Year	Birth Site	GA	Birth Type	Sex	Birth Wt.	Pain Control	Obstetrical Complications	Neonatal Complications	Feeding	Child's Health
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										

Information for Intrapartum Care Provider:

Information for Newborn Care Provider:

FAMILY HISTORY

MEDICAL HISTORY

Diabetes	Hypertension
Thrombophilia	Bleeding Disorders
Anesthesia problems	

GENETIC HISTORY

Ethnic background	Egg:	Sperm:

Hemoglobinopathy screen
(Asian, African, Middle eastern, Mediterranean, Caribbean)
Screening done: ☐Yes ☐No Results: _____

Ashkenazi Jewish screen panel
☐Not applicable ☐Completed Results: _____

GENETIC FAMILY HISTORY

Genetic: ☐Cystic Fibrosis ☐Muscular dystrophy ☐Chromosomal disorder
☐Premature ovarian failure ☐Other _____
consider referring to genetics if any of the above are identified

Other: ☐Intellectual ☐Birth defects ☐Congenital heart ☐Developmental delay

☐Consanguinity

PATIENT HISTORY

MEDICAL HISTORY *(elaborate below)*

Cardiovascular	Hypertension
Diabetes	Renal/Bladder
Infections	Infertility
Neurologic	Endocrine
Respiratory	Gastrointestinal
Bleeding disorder	Thrombophilia

SURGICAL HISTORY:

ANESTHESIA COMPLICATIONS:

Name:	Date of Birth: D D M M M Y Y Y Y	PHIN:

MENTAL HEALTH

Anxiety:	☐ No ☐ Yes
Depression:	☐ No ☐ Yes
Bipolar disorder:	☐ No ☐ Yes
Psychosis:	☐ No ☐ Yes
Post-Traumatic Stress Disorder:	☐ No ☐ Yes
Attention Deficit Disorder:	☐ No ☐ Yes
Other:	☐ No ☐ Yes
Edinburgh Perinatal Depression Scale Score: *(patient to fill out questionnaire)*	

SUBSTANCE USE *(fill in where positive)*

Smoking:	☐ Past *Quit date:* _____ ☐ Current - Number per day or pack-years: _____ Interested in smoke cessation: ☐ No ☐ Yes
Alcohol:	☐ Past *Quit date:* _____ ☐ Current - amount:
TACE Questionnaire Score:	*(patient to fill out questionnaire)*
Non-Prescribed substance(s): Type:	☐ Past ☐ Current
Substance rehabilitation:	☐ Past ☐ Current
Opioid replacement therapy:	☐ Past ☐ Current

PREGNANCY DATING

LMP:	Certain: ☐ Yes ☐ No
Initial EDD:	
Cycles: Regular: ☐ Yes ☐ No ☐ Q Days:	
US date:	GA at US:
Confirmed EDD:	

HISTORY AT FIRST VISIT

Bleeding:	☐ No ☐ Yes
Nausea/Vomiting:	☐ No ☐ Yes
Pain:	☐ No ☐ Yes
Infection:	☐ No ☐ Yes
Other:	☐ No ☐ Yes

INITIAL PHYSICAL EXAM:

Date D D M M M Y Y Y Y

Height (cm):	Pre-pregnancy weight (kg):	Current weight (kg):	BMI / BP
Thyroid:		Vulva:	
Lungs:		Vagina:	
Heart:		Cervix:	
Abdomen:		Uterus:	
Breasts:		Adnexa:	
Pap smear (date last done) D D M M M Y Y Y Y	Result:	Extra comments:	

LAB RESULTS

	T1		T2		T3	
TEST	DATE	RESULT	DATE	RESULT	DATE	RESULT
Hgb						
Platelets						
Ferritin						
Rh/type *(once)*						
Antibodies						
HBs Ag						
HCV Ab						
Varicella *(once)*						
Rubella *(once)*						
Syphilis screen						
Gonorrhoea						
Chlamydia						
HIV						
Other STI *(eg HSV)*						
Urine culture						
GBS swab						
50 G OGTT						
75 G OGTT						
Hb A1C/Random BS						
Hb Electrophoresis *(once)*						
CMV *(if indicated)*						
Toxoplasma *(if indicated)*						
Parvovirus *(if indicated)*						
TSH						
T3/T4						
Other						

FETAL NUCHAL TRANSLUCENCY AND BIOCHEMICAL RESULTS

TEST	DATE	RESULT
Nuchal Translucency		
Maternal Serum Screen Trisomy 21 Trisomy 18 Spina Bifida Other		
NIPT		
Amniocentesis		
The following tests may not be applicable, please check with provincial practice guidelines before ordering		
PAPP-a Inhibin PLGF ☐ T1 ☐ T2-3 sFLT a-fetoprotein HCG Other		

FETAL SCANS

DATE	GA	RESULT

Rh Ig	☐ Given ☐ NA	☐ 28 wks ☐ Other wks

VACCINES

VACCINES		DATE
TDaP	☐ Accepted ☐ Declined	
Influenza	☐ Accepted ☐ Declined	
MMR	☐ Offer PP	
Varicella	☐ Offer PP	
COVID-19	☐ Completed ☐ Declined	

Legend:

BMI = Body Mass Index
BP = Blood Pressure
EDD = Estimated Date of Delivery
FH = Fetal Heart rate
FM = Fetal Movements
F/U = Follow Up
Fx = Fracture
GA = Gestational Age
LMP = Last Menstrual Period
NND = Neonatal Death
NT = Nuchal Translucency
PP = Postpartum
Pres = Presentation
PROM = Preterm Rupture of Membranes
SA = Spontaneous Abortion
SB = Stillbirth
SFH = Symphysis Fundal Height
TA = Therapeutic Abortion
TACE = T-ACE Screening test for alcoholism (Tolerance, Annoyance, (tried to) Cut-Back, Eye-opener)
US = Ultrasound
U.Prot = Urine Protein
Wks = Weeks
Wt = Weight
VBAC = Vaginal Birth After Cesarean section

Name:	Date of Birth: D D M M M Y Y Y Y	PHIN: _____

MEDICATIONS

Medication	Dose

ALLERGIES

Substance or Medication	Nature of Reaction

NUTRITION AND SOCIAL CHALLENGES AND SUPPORTS *(fill in where appropriate)*

Nutritional risks:	Financial factors:
Nutritional restrictions:	Social support challenges:
Folic Acid: ☐ No ☐ Yes ☐ pre-conception ☐ post-conception	Relationship challenges:
Occupational risks:	

Date	Wt	GA	BP	U.PROT	SFH	Pres	FH	FM	Comments	F/U	Signature

TOPICS FOR DISCUSSION *(check if discussed with patient)*

T1

- ☐ Emergency Contact
- ☐ Environmental safety
- ☐ Food safety
- ☐ Information sources
- ☐ Medication safety
- ☐ Nutrition
- ☐ On call system
- ☐ Pets
- ☐ Physical activity
- ☐ Referral to Penicillin allergy testing
- ☐ Routine Care
- ☐ Seat belts
- ☐ Sexual activity
- ☐ Travel
- ☐ Triage policies
- ☐ Vaccinations
- ☐ VBAC counselling
- ☐ Weight gain expectations

T2

- ☐ Antepartum vaccines
- ☐ Bleeding
- ☐ Fetal movements
- ☐ Mental Health
- ☐ Prenatal education
- ☐ Preterm Labour
- ☐ PROM
- ☐ Signs and Symptoms of Hypertensive disorders of pregnancy

T3

- ☐ Admission timing
- ☐ Assisted vaginal deliveries
- ☐ Birth plan
- ☐ Breastfeeding support
- ☐ Car seat safety
- ☐ Discharge planning
- ☐ Fetal movements
- ☐ Labour support
- ☐ Newborn care
- ☐ Pain management in labour
- ☐ Postpartum vaccines
- ☐ Potential interventions in labour
- ☐ PP care
- ☐ PP contraception Plan
- ☐ Screening tests for newborn
- ☐ Work plan

Name:	Date of Birth: D D M M M Y Y Y Y	PHIN:

Date	Wt	GA	BP	U.PROT	SFH	Pres	FH	FM	Comments	F/U	Signature

Name:	Date of Birth: D D M M M Y Y Y Y	PHIN: _____

T-ACE Screening Tool (Alcohol)

Response Key **1 Drink is equivalent to:** • 12 oz of beer • 12 oz of cooler • 5 oz of wine • 1.5 oz of hard liquor (mixed drink)	**Date** D D M M M Y Y Y Y **Response**	
1. How many drinks does it take to make you feel high?	≤ 2 drinks = 0	> 2 drinks = 1
2. Have people annoyed you by criticizing your drinking?	No = 0	Yes = 1
3. Have you felt you ought to cut down on your drinking?	No = 0	Yes = 1
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?	No = 0	Yes = 1
A total score of 2 or greater indicates potential prenatal risk and need for follow-up.	**Total Score =**	

Edinburgh Perinatal / Postnatal Depressions Scale (EPDS) Cox, Holden, Sagovsky, (1987).

In the past 7 days:		**Date** D D M M M Y Y Y Y
1. I have been able to laugh and see the funny side of things	☐ As much as I always could = 0 ☐ Not quite so much now = 1	☐ Definitely not so much now = 2 ☐ Not at all = 3
2. I have looked forward with enjoyment to things	☐ As much as I ever did = 0 ☐ Rather less than I used to = 1	☐ Definitely less than I used to = 2 ☐ Hardly at all = 3
3. I have blamed myself unnecessarily when things went wrong	☐ No, never = 0 ☐ No, not very often = 1	☐ Yes, some of the time = 2 ☐ Yes, most of the time = 3
4. I have been anxious or worried for no good reason	☐ No, not at all = 0 ☐ Hardly ever = 1	☐ Yes, sometimes = 2 ☐ Yes, very often = 3
5. I have felt scared or panicky for no very good reason	☐ No, not at all = 0 ☐ No, not much = 1	☐ Yes, sometimes = 2 ☐ Yes, quite a lot = 3
6. Things have been getting on top of me	☐ No, I have been coping as well as ever = 0 ☐ No, most of the time I have coped well = 1	☐ Yes, sometimes I haven't been coping as well as usual = 2 ☐ Yes, most of the time I haven't been able to cope = 3
7. I have been so unhappy that I have had difficulty sleeping	☐ No, not much = 0 ☐ Not very often = 1	☐ Yes, sometimes = 2 ☐ Yes, most of the time = 3
8. I have felt sad or miserable	☐ No, not much = 0 ☐ Not very often = 1	☐ Yes, quite often = 2 ☐ Yes, most of the time = 3
9. I have been so unhappy that I have been crying	☐ No, never = 0 ☐ Only occasionally = 1	☐ Yes, quite often = 2 ☐ Yes, most of the time = 3
10. The thought of harming myself has occurred to me	☐ No, never = 0 ☐ Only occasionally = 1	☐ Yes, quite often = 2 ☐ Yes, most of the time = 3
Total Score =	**Score of 1-3 on item 10 indicates a risk of self harm. Patient requires immediate mental health assessment and intervention as appropriate.** **Score > 9** Monitor, support and offer education **Score > 12** Follow up with comprehensive bio-psychosocial diagnostic assessment for depression	

Important notice

These 2 questionnaires are to be completed by the patient at the first visit and reviewed by health care worker for management if and when indicated by the scores above.