PRENATAL

NORMAL

PREGNANCY

These are guidelines for uncomplicated pregnancies. Frequency of visits and care rendered should be determined by a woman's individual needs and risks

Procedure	First trimester (week 0-14)	Second trimester (weeks 15-28)	Third trimester (weeks 29-42)	Postpartum (4-8 weeks after delivery)
Obstetrical Evaluations **»***No Pap before age 21 unless patient has a history of *HIV or patient is immunocomprosed.*	By 6 to 8 weeks: Initial evaluation which includes: • Medical Psychiatric, family (w/ attention to genetic d/o) & social hx (w/ attention to substance use and domestic violence) • History of current pregnancy • Voluntary, informed genetic screening (e.g.,cystic fibrosis) • Infection history • Physical exam including height, weight, BMI and blood pressure • *HIV counseling and testing with consent • Labwork –blood type and Rh, antibody screen, hemoglobin, hematocrit, urinalysis, hepatitis B surface antigen, syphilis screening; **»**Pap smear (21 yrs and older), rubella titre, GC/Chlamydia, hemoglobin electrophoresis (as indicated), Urine C & S • History Prior Pregnancy/Compl. • Flu shot (if anticipates pregnancy) • PPD (for at risk patients) • Aneuploidy Screening • Ultrasound in first trimester • Sickle Cell testing if status unknown. • If traveled oversea, ask about Zika Virus.	Between 15-18 weeks: Tetra screen (includes AFP) * Offer early gestational diabetes at high risk (BMI over 27, first degree relative with diabetes, previous gestational diabetes, any history of glucose intolerance) Offer genetics referral and amniocentesis or fetal scan if age 35 or > at EDC, or as clinically indicated (At 17-22 weeks: Ultrasound, earlier if indicated) At 24-28 weeks: Gestational diabetes screening (even if early screen was neg.) *Between 27 and 36 weeks Tdap including immediate postpartum. At 28 weeks: -if Rh negative unsensitized woman, repeat antibody testing and if still unsensitized, should received D (Rho[D]) immune globulin -hemoglobin and hematocrit -repeat syphilis screening (as indicated), repeat *HIV screening, Chlamydia if appropriate *TDAP is now recommended to every patient, every pregnancy starting at 28 weeks.	• VBAC counseling if appropriate. • 35-37 weeks: Group B Strep culture (if not using clinical risk factor prevention strategy) • Routine testing for everyone and test 5 weeks later, if undelivered • Confirm fetal position • 41 weeks – once or twice weekly, fetal surveillance • Beyond 41 weeks, non-stress test and amniotic fluid index once to twice a week : consider delivery no later than 42 weeks • *TDAP is now recommended to every patient, every pregnancy starting at 28 weeks.	

Procedure	First trimester (week 0-14)	Second trimester (weeks 15-28)	Third trimester (weeks 29-42)	Postpartum (4-8 weeks after delivery)
	At 8-12 weeks: discuss quadruple screen vs. CVS, early amniocentesis, nuchal translucency, PAPPA-A, free BHCG (integrated vs. sequential). Offer Genetic Counselling if >35 yo at delivery. Non- Invasive Prenatal Testing (NIPT)	Offer genetics referral and amniocentesis or fetal scan if age 35 or > at EDC, or as clinically indicated		
Routine Office Visits	Every 4 weeks: Blood pressure, weight, fundal height, fetal heart rate, urine protein and glucose is clinically indicated. After quickening, evaluation for fetal movement, preterm labor, leakage of fluid/vaginal bleeding		Every 2-3 weeks until 36 weeks, then weekly until delivery: Blood pressure, weight, fundal height, fetal heart reate and presentation, urine protein and glucose, evaluation for fetal movement, preterm labor, leakage of fluid/vaginal bleeding.	**4-6** weeks after delivery: Physical exam including weight and blood pressure Or other as needed.
Patient Education	• Nutrition, exercise, sexual activity, work activities, environmental hazards • Tobacco, alcohol and drug restriction • Toxoplasmosis precautions • Travel • Dental health • Prescription for prenatal vitamins with folate and DHA) • To discuss and offer aneuploidy testing	• Discuss and offer aneuploidy testing • Childbirth classes • Breast feeding versus bottle-feeding • Post partum/Birth Control • Sign form if indicated (for Medicaid at 28 weeks for sterilization) • Discuss pre-term labor and prevention	• Admission, labor, delivery and anesthesia planning • Infant feeding, lactation support services • Post partum birth control • Labor onset, rupture of membranes, abnormal bleeding • Preparation for discharge including newborn car seat. • Newborn care, including circumcision • Encourage patient to choose pediatrician early for their newborn	• Family planning • Reproductive health promotion

Amended from: American Academy of Pediatrics and American College of Obstertricians and Gynecologists, Guides for Prenatal Care.1st- 5th Edition
Based Primarily on the US Preventive Services Task Force: Guide to Clinical Preventive Services

***Virginia State Law Governing HIV Testing:**

§ 32.1-37.2. Consent for testing for human immunodeficiency virus; condition on disclosure of test results; counseling required; exceptions.

- Prior to performing any test to determine infection with human immunodeficiency virus, a medical care provider shall inform the patient that the test is planned, provide information about the test, and advise the patient that he has the right to decline the test. If a patient declines the test, the medical care provider shall note that fact in the patient's medical file.
- Every person who has a confirmed positive test result for human immunodeficiency virus shall be afforded the opportunity for individual face-to-face disclosure of the test results and appropriate counseling. Appropriate counseling shall include, but not be limited to, the meaning of the test results, the need for additional testing, the etiology, prevention and effects of acquired immunodeficiency syndrome, the availability of appropriate health care, mental health care and social services, the need to notify any person who may have been exposed to the virus and the availability of assistance through the Department of Health in notifying such individuals.
- C. Opportunity for face-to-face disclosure of the test results and appropriate counseling shall not be required when the tests are conducted by blood collection agencies. However, all blood collection agencies shall notify the Board of Health of any positive tests.
- D. In the case of a person applying for accident and sickness or life insurance who is the subject of a test to determine infection for human immunodeficiency virus, insurers' practices including an explanation of the meaning of the test, the manner of obtaining consent, the method of disclosure of the test results and any counseling requirements shall be as set forth in the regulations of the State Corporation Commission.

§ 54.1-2403.01. Routine component of prenatal care.

- As a routine component of prenatal care, every practitioner licensed pursuant to this subtitle who renders prenatal care, including any holder of a multistate licensure privilege to practice nursing, regardless of the site of such practice, shall inform every pregnant woman who is his patient that human immunodeficiency virus (HIV) screening is recommended for all pregnant patients and that she will receive an HIV test as part of the routine panel of prenatal tests unless she declines (opt-out screening). The practitioner shall offer the pregnant woman oral or written information that includes an explanation of HIV infection, a description of interventions that can reduce HIV transmission from mother to infant, and the meaning of positive and negative test results. The confidentiality provisions of § 32.1-36.1, test result disclosure conditions, and appropriate counseling requirements of § 32.1-37.2 shall apply to any HIV testing conducted pursuant to this section. Practitioners shall counsel all pregnant women with HIV-positive test results about the dangers to the fetus and the advisability of receiving treatment in accordance with the then current Centers for Disease Control and Prevention recommendations for HIV-positive pregnant women. Any pregnant woman shall have the right to refuse testing for HIV infection and any recommended treatment. Documentation of such refusal shall be maintained in the patient's medical record.

TDAP Reference.

- http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Update_on_Immunization_and_Pregnancy_Tetanus_Diphtheria_and_Pertussis_Vaccination
- http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm