BC Antenatal Record
(PSBC 1905 and 1905A)

Guide for Completion

January 2020

Perinatal Services BC
Provincial Health Services Authority

Summary of Changes

WHAT'S NEW?

The updated record was developed in accordance with current clinical guidelines and best practice recommendations, and with consultation from a variety of health care providers, including midwives, physicians, and nurses.

The updated Antenatal Record (PSBC 1905) replaces the 2013 version of the record (PSBC 1582).

[Note: Numbered items below correspond to the numbered sections of PSBC 1905 – Antenatal Record Part 1 and Part 2.]

1. DEMOGRAPHICS AND BACKGROUND

- → **Preferred name / pronoun:** New field was added to record the preferred name or pronoun(s) that a mother or pregnant individual would like their health care providers to use to identify their gender (or lack thereof).
- → **Indigenous Identity:** New fields were added to record Indigenous identity, status, and whether living on or off a reserve.
- → **Ethnicity:** Categories were added to this field based on standardized categories used by the Prenatal Genetic Screening Program at PSBC.
- → **Highest level of education:** Categories were added to this field based on standardized categories used by Health Information Management coders.
- → **Biological father / donor:** New field was added to be inclusive of families where the mother's or pregnant individual's partner is not the biological father.

3. DATING THE PREGNANCY

- → **Dating ultrasound:** This field was changed from "1st US" to "Dating US" to clarify that health care providers should input the ultrasound date that is being used to date the pregnancy.
- → **Menses cycle:** This field was deleted because menses cycle is not best-practice for dating the pregnancy.

5. PRESENT PREGNANCY

- → **ART:** This field was changed from "In-Vitro Fertilization (IVF)" to "Assisted Reproductive Technology (ART)" to ensure that all the various types of ART that a mother or pregnant individual may have used for this pregnancy can be recorded.
- → **Travel (self / partner):** This field was added to document any relevant travel within or outside of Canada that may cause exposure to any infectious and / or communicable diseases.

Summary of Changes *cont'd.*

7. MEDICAL HISTORY

- → **Cardiovascular:** Section was added to document current or previous hypertension in pregnancy.
- → **Endocrine:** New fields were added to document Type I and Type II Diabetes Mellitus, previous gestational diabetes, and / or thyroid disorders.
- → **Mental health:** New fields were added to document eating disorders and substance use disorders and to document the treatment regimen.
- → **Infectious diseases:** New field was added to align with the Society of Obstetricians and Gynecologists of Canada (SOGC) guidelines on screening for infectious diseases during pregnancy: "Management of Varicella Infection (Chickenpox) in Pregnancy" and "Guidelines for the Management of Herpes Simplex Virus in Pregnancy."
- → **Immunizations:** New fields were added to align with the 2018 SOGC guideline, "Immunization in Pregnancy."

8. LIFESTYLE / SOCIAL CONCERNS

- → **TWEAK Score:** This field was removed because it is a second level screen for alcoholism and dependence that is not part of universal screening for all pregnant individuals.
- → **Gender-based violence:** New field was added to align with BC Women's Hospital & Health Centre's statement on gender-based violence and to ensure that health care providers are recognizing, screening for, and recording all signs of violence during pregnancy.

9. SUBSTANCE USE

- → **Cannabis:** New section was added to document cannabis use in pregnancy as a result of the legalization of cannabis in October 2018.
- → **Alcohol, Tobacco, and Cannabis:** New fields were added to document alcohol, tobacco, and cannabis use in the three months before pregnancy and during pregnancy.
- → **Other Substances:** New section was added to document other substances, including methamphetamine, intravenous (IV) drugs, opioids, and / or prescription drugs.

10. INITIAL PHYSICAL EXAM

- → **Pelvic exam:** New fields were added to document the date of last STI and Pap test.

11. COMMENTS / FOLLOW-UP

- → The summary section was amended to include comments or follow-up required.

12. PLANNED PLACE OF BIRTH

- → New fields were added to document the planned place of birth at 20 weeks and 36 weeks and that this information has been faxed / copied to intended hospital of birth.

Summary of Changes *cont'd.*

13. INVESTIGATIONS

- → This section was reorganized for flow and consistency to document the result (e.g., negative or positive) of each itemized test and the required follow-up and / or comments.
- → **Chlamydia, Gonorrhea, Syphilis testing:** Individual new fields were added to ensure that chlamydia, gonorrhea, and syphilis screening and results are being documented during pregnancy.
- → **Gestational Diabetes Screen 2-Step Test:** This section was changed to align with the 2016 SOGC guideline, "Diabetes in Pregnancy," which recommends using the 2-step approach to screen for gestational diabetes. New fields were added to document if test declined and if diet controlled or insulin required.
- → **Prenatal Genetic Screening Investigations:** This section was changed to align with the genetic screening recommendations and testing offered as part of the BC Prenatal Genetic Screening Program. New field added to indicate if prenatal genetic screening was declined.

14. EDINBURGH PERINATAL / POSTNATAL DEPRESSION SCALE (EPDS)

- → New field was added to indicate if EPDS screening was declined.
- → **Anxiety sub-score:** New field was added to document the anxiety sub-score because the total EPDS score may not be indicative of an anxiety disorder; women who score high on the EPDS-3A may score low on the total EPDS score.
- → **Self-harm sub-score:** New field was added to document the self-harm sub-score because suicide is the most common cause of death during pregnancy and the self-harm sub-score allows for suicidal thoughts to be identified earlier during pregnancy.

15. ULTRASOUNDS & OTHER IMAGING INVESTIGATIONS

- → This section was expanded to include more rows to document ultrasounds or other imaging done during pregnancy.

16. PERINATAL CONSIDERATIONS AND REFERRALS

- → This section was added to document client's pregnancy type, VBAC eligibility, and plans to breastfeed.
- → An additional field to document "contraception plan" was added for postpartum considerations.

17. PRENATAL VISIT DOCUMENTATION

- → **Additional visits:** Another page was added to provide more space for health care providers to document the details of the antenatal visits.

REFERENCE PAGES AND DISCUSSION TOPICS

- → **Reference pages:** Pages were added to be used by health care providers as a guide and / or tools for completing specific sections of the Antenatal Record, including weight gain in pregnancy, and depression and anxiety screening.
- → **Discussion topics:** New fields were added to have trimester specific discussion topics as a checklist for health care providers to use during antenatal visits.

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4 W'S OF ANTENATAL DOCUMENTATION

- **WHEN?** During the antenatal period (i.e., from confirmation of pregnancy until birth or termination of pregnancy).
- **WHO?** Health care providers (e.g., Medical Doctors, Registered Midwives, and/or Nurse Practitioners).
- **WHAT?** Document the woman's or pregnant individual's health status, assessments, investigations, interventions, outcomes, and decisions throughout the antenatal period.
- **WHY?** To document pregnancy care accurately and completely and to facilitate communication and continuity of care.

Introduction

Perinatal Services BC (PSBC) has the provincial mandate to develop standardized clinical perinatal forms that are used by most health care providers in British Columbia (BC). These forms support best practice in perinatal care and act as clinical documentation tools. It is also within PSBC's mandate to collect and analyze data to evaluate provincial perinatal health outcomes and improve health services. To meet this objective, specific fields on the forms are collected as part of the BC Perinatal Data Registry (BCPDR).

The BC Antenatal Record (Form No. PSBC 1905, revised January 2020) was developed to document pregnancy care throughout the antenatal period. The form has been updated to ensure that it is evidence-based and aligned with current clinical guidelines, standards, and best practices. A number of Society of Obstetricians and Gynaecologists of Canada (SOGC) guidelines informed the revisions, along with other national, provincial and local policies and standards, and / or expert opinion.[1-25] Other changes in the form are intended to improve the format and flow, in an effort to make the form more user-friendly and support complete and accurate clinical documentation.

In addition, the BC Antenatal Record is a tool that facilitates communication and continuity of care between health facilities and care providers. This form is meant to serve as the pregnant individual's medical record throughout their pregnancy, and its completion should start at the first antenatal visit, with additional documentation occurring at all subsequent antenatal visits.

Form PSBC 1905A is available as a separate form when additional space is required for Section 17: Prenatal Visit Documentation.

At 20 weeks gestation, a copy of the Antenatal Record should be provided to the pregnant individual and to the hospital (either the planned hospital of delivery or the referral hospital for home births). This will ensure that important information is available if admission to the hospital occurs unexpectedly during pregnancy. At 36 weeks gestation, an additional copy of the Antenatal Record should be sent to the intended delivery hospital or referral hospital for home births.

Once documentation of the antenatal period is complete, the Antenatal Record should be photocopied and added to the pregnant individual's medical chart, the newborn's chart, with a third copy to remain with the physician / midwife.

A note on gender inclusion and the language of this document

This document uses gender-inclusive language. Health care providers play a critical role in creating a supportive environment for all patients, clients and families, including transgender, gender non-binary, and gender non-conforming (TGNC) people. Throughout this guide for completion, we typically refer to women, mothers, and / or pregnant individuals to recognize that not only cisgender women can and do become pregnant and seek care for their pregnancy, delivery, and postpartum care. Starting with the revised BC Antenatal Record, and throughout the continuum of care, PSBC invites providers to ask all patients and clients their preferred name and pronouns to use as part of our commitment to gender-inclusive practice.

Abbreviations and Acronyms

Abdo.	Abdominal
Amnio	Amniocentesis
ART	Assisted Reproductive Technology
BMI	Body Mass Index
BP	Blood Pressure
C / S	Cesarean Section
C & S	Culture And Sensitivity (Urine)
CBD	Cannabidiol
coag.	Coagulation
CV	Cardiovascular
CVS	Chorionic Villus Sampling
ECV	External Cephalic Version
EDD	Estimated Date of Delivery
EPDS	Edinburgh Perinatal / Postnatal Depression Scale
FHR	Fetal Heart Rate
FM	Fetal Movement
FP	Family Physician
GA	Gestational Age
GBS	Group B Streptococcus
GCT	Glucose Challenge Test
GDM	Gestational Diabetes Mellitus
GI	Gastrointestinal
GTT	Glucose Tolerance Test
GU	Genitourinary
Gyne.	Gyneocology
HBIg	Hepatitis B Immune Globulin
HBsAg	Hepatitis B Surface Antigen
HBV DNA	Hepatitis B Virus DNA
HepC	Hepatitis C
HIV	Human Immunodeficiency Virus
HR	Heart Rate
hrs	Hours
HSV	Herpes Simplex Virus
Ht	Height
ICSI	Intracytoplasmic Sperm Injection
Imm	Immune
Incl.	Include / including
IPS	Integrated Prenatal Screening
IUI	Intrauterine Insemination
IV	Intravenous
IVF	In Vitro Fertilization

Abbreviations and Acronyms *cont'd.*

LMP	Last Menstrual Period
MD	Medical Doctor
MFM	Maternal Fetal Medicine
mos	Months
MSP	Medical Services Plan
N / A	Not Applicable
Neg	Negative
Neuro.	Neurological
NIPT	Non-Invasive Prenatal Testing
Non-Imm	Non-immune
NP	Nurse Practitioner
N / R	Non-reactive
OB	Obstetrician
OTC	Over The Counter
Pap	Papanicolaou
Path.	Pathology
Pos	Positive
PPD	Postpartum Depression
preg.	Pregnancy
Pre-preg	Pre-Pregnancy
Pres.	Presentation
Prev.	Previous
PROM	Premature Rupture of Membranes
R	Reactive
Resp.	Respiratory
Rh	Rhesus
RhIg	Rh Immunoglobulin
RM	Registered Midwife
SIPS	Serum Integrated Prenatal Screen
STI	Sexually Transmitted Infection
Tdap	Tetanus, diphtheria, and acellular pertussis
T1	First Trimester
T3	Third Trimester
T1DM	Type 1 Diabetes Mellitus
T2DM	Type 2 Diabetes Mellitus
TSH	Thyroid Stimulating Hormone
US	Ultrasound
VBAC	Vaginal Birth After Cesarean
wks	Weeks
Wt	Weight

Clinical Practice Resources

In addition to the standardized fields that make up the Antenatal Record Part 1 and 2, a number of additional tools have been added to the back pages of the record (i.e., the Reference Pages) in order to help guide evidence-based antenatal care and assist with clinical documentation. These tools are summarized below.

Resource 1.
Health Canada Weight Gain Recommendations for Singleton Pregnancies
(Guidance for Section 10: Initial Physical Examination)

Section 10: Initial Physical Examination

Health Canada Weight Gain Recommendations for Singleton Pregnancies (adapted from Institute of Medicine, 2009)

Pre-pregnancy Weight Category	Pre-pregnancy Body Mass Index (BMI)	Mean Rate[1] of Weight Gain in 2nd and 3rd Trimesters		Recommended Total Weight Gain[2]	
		kg/wk	lb/wk	kg	lb
Underweight	<18.5	0.5	1.0	12.5–18.0	28–40
Normal weight	18.5–24.9	0.4	1.0	11.5–16.0	25–35
Overweight	25.0–29.9	0.3	0.6	7.0–11.5	15–25
Obese[3]	≥30.0	0.2	0.5	5.0–9.0	11–20

[1] Rounded values.
[2] Calculations for the recommended total weight gain range assume a gain of 0.5 to 2.0 kg (1.1 to 4.4 lbs) in the first trimester.
[3] A lower weight gain may be advised for women with a BMI of 35 or greater, based on clinical judgement and a thorough assessment of the risks and benefits to mother and child.

This table provides the gestational weight gain recommendations for mothers and pregnant individuals based on their pre-pregnancy Body Mass Index (BMI). Recommended rates of weight gain for the second and third trimester as well as recommended totals of weight gain are specified.

This table can be used to help determine how much a woman or pregnant individual should be gaining throughout their pregnancy, which should be discussed at the first antenatal visit and revisited throughout the pregnancy. For more information, please refer to **Health Canada**.

Clinical Practice Resources *cont'd.*

Section 14: Edinburgh Perinatal / Postnatal Depression Scale			
Edinburgh Perinatal / Postnatal Depression Scale Scoring Guide (Cox, Holden, Sagovsky, 1987; PSBC 2015)			
In the past 7 days . . .			
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	• Never = 0 • Hardly ever = 1	• Sometimes = 2 • Yes, quite often = 3

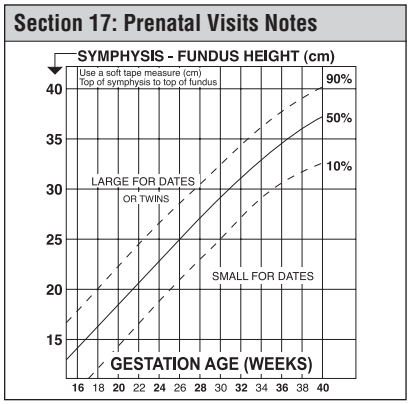
EPDS Scores – Interpretation and Actions		
Total score	**≥14** →	Follow up with diagnostic assessment and treatment, and consider referral to a mental health specialist, as appropriate.
	12–13 →	Monitor, support, and offer education.
Anxiety subscore (questions 3–5)	**≥6** →	Monitor, support, and offer education.
Self-harm subscore (question 10)	**1–3** →	Provide immediate mental health assessment and intervention, and consider referral to a mental health specialist, as appropriate.

Resource 2. Edinburgh Perinatal / Postnatal Depression Scale Scoring Guide *(Guidance for Section 14: Edinburgh Perinatal / Postnatal Depression Scale)*

This table provides the scoring guide for the Edinburgh Perinatal / Postnatal Depression Scale (EPDS). The EPDS questionnaire should be self-administered by the woman or pregnant individual at 28 – 32 weeks of gestation at the recommendation of the health care provider. The completed EPDS questionnaire should then be scored by the health care provider using this guide. This table also provides a summary EPDS score interpretations and recommended actions, follow-ups and referrals. For more information, refer to **Perinatal Services BC**.

Clinical Practice Resources *cont'd.*

Resource 3.
Symphysis-Fundus Height Graph
(Guidance for Section 17: Prenatal Visits Notes)



This graph illustrates the symphysis-fundus height relative to the gestational age. The graph can be used to monitor the development of the fetus throughout the pregnancy, by comparing the measured symphysis-fundus height to the reference symphysis-fundus height provided by the graph. Symphysis-fundus height cutoffs for the 50th percentile as well as the 90th percentile (large for gestational age) and the 10th percentile (small for gestational age) are also specified. For more information, please refer to the **World Health Organization**.

Clinical Practice Resources *cont'd.*

Discussion Topics			
1st–3rd Trimester (as indicated)			
☐ Nutrition/folic acid ☐ Healthy weight gain ☐ Physical activity	☐ Occupational concerns ☐ Personal safety ☐ Support system	☐ Mental health ☐ Substance use (i.e. alcohol, drugs) ☐ Sexual activity, STI risk factors, screening	☐ Immunization ☐ VBAC counseling (if applicable)
1st Trimester			
☐ Nausea/vomiting ☐ Safety: food, medications/vitamins/supplements, seatbelts ☐ Oral health	☐ Exposures: infections, pets, environment, occupation ☐ Travel ☐ Prenatal genetic screening	☐ Early pregnancy loss: signs/symptoms, what to do ☐ Routine prenatal care, emergency contact/on-call providers	☐ Breastfeeding: attitudes/beliefs ☐ Quality educational resources ☐ Public health services/programs
2nd Trimester			
☐ Bleeding ☐ Preterm labour: signs/symptoms ☐ PROM	☐ Lifestyle and social risk assessment ☐ Gestational diabetes screening ☐ Prenatal classes	☐ Birth options and practices that promote healthy birth ☐ Birth plan: travel to other community for delivery (if applicable)	☐ Breastfeeding and importance of immediate, uninterrupted skin-to-skin care ☐ Postpartum contraception
3rd Trimester			
☐ Fetal movement ☐ Emergency contact/on-call providers ☐ ECV, breech delivery, elective Cesarean delivery (if applicable) ☐ Indications for induction of labour ☐ Signs/symptoms of labour and admission timing	☐ Birth plan: labour support, pain management ☐ Potential interventions, use of blood products ☐ Genital herpes suppression ☐ GBS screening/prophylaxis ☐ Cord blood banking	☐ Erythromycin/ophthalmia neonatorum prophylaxis/ treatment ☐ Vitamin K prophylaxis ☐ Newborn care, screening, circumcision, follow-up ☐ Breastfeeding adjustment, skills, support	☐ Postpartum care ☐ Postpartum contraception ☐ Discharge planning, car seat safety ☐ Infant safe sleep ☐ Work plan, maternity leave ☐ EPDS screening

Resource 4: Discussion Topics

The **Reference Pages** also include a list of recommended discussion topics. Items that should be discussed throughout the entire pregnancy, as well as those specific to the first, second, and third trimester are listed. Please note, while this is a comprehensive list of discussion topics, it is not completely exhaustive. Additionally, not all listed topics may need to be discussed with every woman or pregnant individual. The health care provider should use their best clinical judgment to determine which listed topics and whether any additional topics need to be discussed with their client.

Completion of the Form

Place the patient **Addressograph / Label** in the dedicated space in the upper right corner of Page 1, Page 2, and any additional pages that are attached to the patient's Antenatal Record. If the addressograph or label is not available, record the mother's or pregnant individual's **Surname**, **Given name**, **Address**, **Phone number**, and **Personal Health Number** in the same space.

Section 1: Background

Item	Description
Primary maternity care provider name	Record the full name (i.e., given name and surname) of the primary care provider providing pregnancy care.
Family physician / nurse practitioner name	Record the full name (i.e., given name and surname) of the mother's or pregnant individual's Family Physician (FP) or Nurse Practitioner (NP). *Note: The FP / NP may be different from the primary maternity care provider, if they referred the mother or pregnant individual for care during pregnancy to another care provider.*
Patient surname	Record the mother's or pregnant individual's surname at the time of pregnancy. The surname is the family name associated with the mother and is usually, but not always, shared by family members.
Patient given name(s)	Record the mother's or pregnant individual's given (first) name(s).
Surname at birth	Record the mother's or pregnant individual's surname at birth. *Note: The mother or pregnant individual may have changed their surname (e.g., after marriage), and thus the surname at birth and the surname at the time of pregnancy may differ.*
Preferred name / pronoun	Record the mother's or pregnant individual's preferred name (if applicable), if the name that the mother or pregnant individual typically uses is different from the given name. This may also include other given names which may have been used previously, under which previous medical data may be documented. Some examples include a middle name, a nickname, or an English translation of an ethnic name. Ask and record the mother's or pregnant individual's preferred pronoun, regardless of if the individual typically uses "she / her" (e.g., she / her, he / him, they / them / their, ze, hir)
Date of birth (dd / mm / yyyy)	Record the mother's or pregnant individual's date of birth (following the dd / mm / yyyy format).
Age at EDD	Record the age of the mother or pregnant individual at the time of the estimated date of delivery (EDD). (e.g., if the mother or pregnant individual is currently 31 years old at the first antenatal visit and will be turning 32 at the time of the EDD, record 32).
Language preferred	Record the language that is most readily understood by the mother or pregnant individual, which may include sign language. *Note: This information may be important when English is not the mother's or pregnant individual's first language.*

Completion of the Form

Item	Description
Relationship status*	Determine the relationship status of the mother or pregnant individual at the time of pregnancy by identifying the most appropriate option from the following list and record it in the space provided (select one only): > **Married** > **Living with partner** > **Single (never married)** > **Separated or divorced** > **Widowed** > **Unknown** *Note: This list of relationship status options is presented on the back of Page 1 of the Antenatal Record for reference, as indicated by the asterisk (*).*
Highest level of education completed*	Determine the highest level of formal education completed by the mother or pregnant individual at the time of pregnancy by identifying the most appropriate option from the following list and record it in the space provided (select one only) : > **Less than high school** > **High school diploma** > **Trade or other certificate / diploma (not Bachelors)** > **Undergraduate university degree(s)** > **Postgraduate university degree(s)** > **Unknown** *Note: This information is important as it can be used to assess the mother's or pregnant individual's ability to comprehend oral and written communication, and may relate to her ability to understand and carry out health care recommendations.* *Note: If the mother or pregnant individual is enrolled in a program at the time of pregnancy, the certification completed up-to that point should be specified (e.g., if the mother or pregnant individual has a Bachelor's degree and has completed Year 1 of a Master's program,* ***'Undergraduate university degree(s)****' should be recorded).* *Note: This list of options of the highest level of education that has been completed is presented on the back of Page 1 of the Antenatal Record for reference, as indicated by the asterisk (*).*
Occupation	Record the work the mother or pregnant individual performs to earn a living, if applicable. *Note: This information is important as it may be an indication of the demands on the mother or pregnant individual and their exposure to occupational stressors and their access to economic resources..*

Completion of the Form

Item	Description
Indigenous identity*	Everyone should be asked this question, ***"Do you identify as an Indigenous or Aboriginal person?"*** Note that a mother or pregnant individual's response to this question is voluntary. If the mother or pregnant individual does not wish to answer or responds that she does not identify as an Indigenous or Aboriginal person, select '**No response'** or '**None**,' respectively, and skip to the next field – '**Ethnicity**.' If the mother or pregnant individual responds that she does identify as an Indigenous or Aboriginal person, select '**Yes**,' and specify the Indigenous or Aboriginal identity by selecting all of the following that apply: ☐ **First Nations** ☐ **Métis** ☐ **Inuk (Inuit)** ☐ **Outside of Canada** If '**First Nations**' is selected, specify also the mother's or pregnant individual's First Nations status by selecting one of the following: ☐ **Status** (registered under the Indian Act of Canada and known as a Registered Indian or Status Indian) ☐ **Non-status** ☐ **Pending** If 'F**irst Nations**' is selected, specify also where the mother or the pregnant individual lives by selecting of the following: ☐ **Live on reserve** ☐ **Live off reserve** ☐ **Live on & off reserve** *Note: A summary on how to ask the mother or pregnant individual about their Indigenous or Aboriginal status is presented on the back of Page 1 of the Antenatal Record , as indicated by the asterisk (*).*

Completion of the Form

Item	Description
Ethnicity*	Determine the ethnicity of the mother or pregnant individual by identifying all that apply from the following list, and record it in the space provided: > **Indigenous / Aboriginal** > **European – Western (e.g. English, Italian)** > **European – Eastern (e.g. Russian, Polish)** > **Asian – East (e.g. Chinese, Japanese, Korean)** > **Asian – South (e.g. Indian, Pakistani, Sri Lankan)** > **Asian – South East (e.g. Malaysian, Filipino)** > **Middle Eastern (e.g. Iranian, Lebanese)** > **African** > **Caribbean** > **Latin American (e.g. Argentinean, Chilean)** > **Other(s)** (specify) If the mother or pregnant individual identifies with an ethnicity that is not listed (i.e., '**Other**'), specify the ethnicity in the space provided. If the mother or pregnant individual does not know her ethnicity, record '**Do not know**' in the space provided. If the mother or pregnant individual does not wish to answer, record '**Prefer not to answer**' in the space provided. *Note: Ethnic or cultural identity is self-reported and should not be assumed / prescribed by the care provider.* *Note: Ethnic or cultural identify is often an indication of cultural beliefs / practices and the mother or pregnant individual may identify with more than one ethnic group.* *Note: This list of ethnicity options is presented on the back of Page 1 of the Antenatal Record for reference, as indicated by the asterisk (*).*
Partner: Surname, given name(s)	Record the surname and given name(s) of the mother's or pregnant individual's supportive partner at the time of pregnancy, if applicable. If the mother or pregnant individual does not have a partner, record '**N / A**' in the space provided. *Note: The mother's or pregnant individual's supportive partner and the biological father of the baby may or may not be the same individual.*
Occupation	Record the work the mother or pregnant individual's partner performs to earn a living, if applicable. *Note: This information is important as it may be an indication of the level of support that the mother or pregnant individual receives from the partner, based on the partner's work hours, frequency of travel, etc.*

Completion of the Form

Item	Description
Biological father / donor: Surname, given name(s)	Record the surname and given name(s) of the biological father (who may be the sperm donor) of the baby. If the biological father is also the mother's or pregnant individual's supportive partner, select '**Same as partner**' and leave the rest of the field blank.
Age	Record the age of the biological father / donor.
Ethnicity*	Determine the ethnicity of the biological father / donor by identifying all that apply from the following list, and record it in the space provided: > **Indigenous / Aboriginal** > **European – Western (e.g. English, Italian)** > **European – Eastern (e.g. Russian, Polish)** > **Asian – East (e.g. Chinese, Japanese, Korean)** > **Asian – South (e.g. Indian, Pakistani, Sri Lankan)** > **Asian – South East (e.g. Malaysian, Filipino)** > **Middle Eastern (e.g. Iranian, Lebanese)** > **African** > **Caribbean** > **Latin American (e.g. Argentinean, Chilean)** > **Other(s)** (specify) If the biological father identifies with an ethnicity that is not listed (i.e., '**Other**'), specify the ethnicity in the space provided. If the biological father does not know his ethnicity, record '**Do not know**' in the space provided. If the biological father does not wish to answer, record '**Prefer not to answer**' in the space provided. *Note: Ethnic or cultural identity is self-reported and should not be assumed / prescribed by the care provider.* *Note: Ethnic or cultural identify is often an indication of cultural beliefs / practices and the biological father may identify with more than one ethnic group.* *Note: The list of ethnicity options is presented on the back of Page 1 of the Antenatal Record for reference, as indicated by the asterisk (*).*

Completion of the Form

Section 2: Allergies, Medications, and Beliefs / Practices

Item	Description
Allergies (incl. reaction)	Record the mother's or pregnant individual's allergies and specify the reactions that are elicited. This includes seafood allergies and allergies related to X-ray dyes. Do not record environmental allergens. If the mother or pregnant individual does not have any known allergies, select '**None**'.
Medications / OTC drugs / herbals / vitamins	Record all of the medications, over the counter (OTC) drugs, herbal remedies, and vitamins that the mother or pregnant individual uses by documenting their specific names and dosages. If the mother or pregnant individual took folic acid for three months prior to becoming pregnant (i.e., preconception), select '**Preconception folic acid**'. If the mother or pregnant individual took / is taking folic acid during the first trimester (T1) of her pregnancy, select '**T1 folic acid**'. If the mother or pregnant individual is not taking any medications / OTC drugs / herbals / vitamins, select '**None**' *Note: Folic acid is critical for healthy fetal development, and thus the importance of continuing folic acid supplementation throughout the duration of the first trimester should be discussed with the mother or pregnant individual.*
Beliefs / practices (e.g., Jehovah's Witness)	Record any beliefs and / or practices that are important to the mother or pregnant individual, especially as they pertain to the pregnancy, birth, and postpartum period. If the mother or pregnant individual does not have any beliefs / practices, record '**None**.' *Note: Certain beliefs may have implications on the types of interventions that are acceptable to the client (e.g., Jehovah's Witness), and should therefore be discussed and documented in the client's medical record.*

Section 3: Menstrual History and Pregnancy Confirmation

Item	Description
Contraceptives: Type	Record all methods of contraception that were used by the mother or pregnant individual during the period immediately preceding the current pregnancy.
Last used (dd / mm / yyyy)	Record the date when contraceptives were used last prior to the confirmation of pregnancy (following the dd / mm / yyyy format).
Pregnancy planned	Specify whether or not the pregnancy was intended / planned by selecting one of the following options: ☐ **No** ☐ **Yes**
LMP (dd / mm / yyyy)	Record the first day of the mother's or pregnant individual's last normal menstrual period (LMP) (following the dd / mm / yyyy format).

Completion of the Form

Item	Description
EDD by LMP (dd / mm / yyyy)	Record the estimated date of delivery (EDD) based on dating of the pregnancy using the mother's or pregnant individual's last normal menstrual period (LMP).
Dating US (dd / mm / yyyy)	Record the date of the ultrasound (US) that was used to date the pregnancy (following the dd / mm / yyyy format). *Note: The dating US should be performed between 11 and 14 weeks of gestation (if possible) in order to obtain the most accurate estimate of gestational age.*
GA by US (wks / days)	Record the gestational age (GA) (in weeks and days) of the fetus at the time of the ultrasound (US) that was used to date the pregnancy.
EDD by US (dd / mm / yyyy)	Record the estimated date of delivery (EDD) based on dating of the pregnancy by ultrasound (US) (following the dd / mm / yyyy format).

Section 4: Obstetrical History

Item	Description
Gravida	Record the total number of all pregnancies, including all past and present pregnancies, regardless of gestational age, pregnancy type, and pregnancy outcome or time / method of termination. *Note: Twins or multiples should be counted as one pregnancy.* *Note: An ectopic pregnancy, a missed abortion, a blighted ovum and a hydatidiform mole are classified as a gravida and should contribute to the total number of all pregnancies.*
Term	Record the total number of previous pregnancies where the birth occurred at greater than or equal to 37 completed weeks gestation (i.e., gestational age $\geq 37^0$ weeks). *Note: A previous multiple pregnancy delivered at term should be counted as "1 term". If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as "1 term" and "1 preterm".*
Preterm	Record the total number of previous pregnancies where the birth occurred between 20 and 36 completed weeks gestation (i.e., gestational age $20^0 - 36^6$ weeks). *Note: Late terminations should contribute to the total number of previous preterm pregnancies.* *Note: A previous multiple pregnancy delivered preterm should be counted as "1 preterm". If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as "1 term" and "1 preterm".*
Abortus (Induced | Spontaneous)	Record the total number of previous induced terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 grams. Record also the total number of previous spontaneous terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 grams. *Note: An ectopic pregnancy, a missed abortion, a blighted ovum and a hydatidiform mole are classified as a gravida and should contribute to the total number of all pregnancies.*

Completion of the Form

Item	Description
Living	Record the total number of children that the client has given birth to who are presently living. *Note: A previous multiple pregnancy should be counted per living child (i.e., twin pregnancy = 2, triplet pregnancy = 3, etc.)*
Obstetrical History	
Date (mm / yyyy)	Record the date of all previous births (following the mm / yyyy format). *Note: Each row / entry should correspond with one child. For example, for a twin pregnancy, two entries should be completed, each corresponding to one of the two infants.* *Note: If certain fields are the same for all infants in a multiple pregnancy (e.g., date, place of birth, etc.), quotation marks (") can be used for the entries corresponding to the 2nd / 3rd / etc. infant, signifying that the information recorded in the cell above applies to the present cell as well.* *Note: All previous induced and spontaneous terminations should be recorded.*
Place of birth	Record the location where each respective birth (or termination) took place, such as home, the name of the hospital, or other.
GA (wks / days)	Record the gestational age (GA) (in weeks and days) at which each respective birth (or termination) took place.
Duration of labour (hrs)	Record the duration of labour (in hours) of each respective birth. The duration of labour is the time between the onset of labour defined by the presence of painful contractions and progressive dilation and effacement of the cervix, and the birth of the baby.
Mode of birth	Record the mode of birth of each respective birth (i.e., spontaneous vaginal delivery, assisted vaginal delivery – vacuum or forceps, or cesarean section).
Perinatal complications / comments	Record any comments and / or specify any complications that arose during labour, birth, or immediately postpartum for each respective birth. *Note: This information is important as previous perinatal complications may have an impact on the current pregnancy / birth.*
Sex	Record the sex of each respective baby for all live births and terminations (i.e., male, female, or undifferentiated [sex could not be determined; not uniquely defined]). For terminations (loss before 20 weeks) record, '**N / A'**.
Birth weight (g)	Record the birth weight (in grams) of each respective baby.
Breastfed (mos)	Record the length of time (in months) that each respective baby was breastfed.
Child's present health	Comment on the overall present health of each respective child, including if a childhood death occurred.

Completion of the Form

Section 5: Present Pregnancy

This section of the Antenatal Record includes topics that are important to discuss with the mother or pregnant individual during the first prenatal visit (or early on in the pregnancy). To complete this section, specify whether the item (i.e., event or condition) took place and / or is a concern by selecting '**No**' or '**Yes** (specify)'. If '**Yes**' is selected, specify more details about the event as described below.

Item	Description
ART	Specify whether assisted reproductive technology (ART) was used to conceive the current pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of ART used to conceive the current pregnancy by selecting one of the following: ☐ **Ovarian stimulation only** ☐ **Intrauterine insemination (IUI) only** ☐ **Ovarian stimulation + intrauterine insemination (IUI)** ☐ **In vitro fertilization (IVF)** (# of embryos transferred) (if IVF was used, it is implied that ovarian stimulation also occurred) ☐ **Intracytoplasmic Sperm Injection (ICSI)** (# of embryos transferred) (if ICSI was used, it is implied that ovarian stimulation and IVF also occurred) ☐ **Other** If '**IVF**' or '**ICSI**' is selected, record the number of embryos transferred in the space corresponding to the type of ART used. If '**Other**' is selected, specify the type of ART used to conceive the current pregnancy.
Bleeding	Specify whether any antepartum bleeding has occurred during the current pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, comment on the antepartum bleeding that has occurred during the current pregnancy by documenting when the bleeding occurred (i.e., before or after 20 weeks of gestation) and the type / approximate amount of bleeding.
Nausea	Specify whether there has been any nausea and / or vomiting during the current pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, comment on the nausea and / or vomiting that has been experienced during the current pregnancy and document how it is being treated (if applicable).

Completion of the Form

Item	Description
Travel (self / partner)	Specify whether the mother or pregnant individual and / or their partner have travelled and / or are planning to travel during the current pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, record whether the mother or pregnant individual and / or their partner have travelled and / or are planning to travel during the current pregnancy, the travel destination, and any precautions that may be recommended. *Note: This information is important in case travel has occurred or is being planned to destinations that have outbreaks of illnesses (e.g., Zika virus, malaria, dengue virus, chikungunya virus, ebola virus) that are harmful to mothers and pregnant individuals, as well as fetuses.*
Infection / rash / fever	Specify whether the mother and / or pregnant individual has had an infection, a rash, or fever (e.g., toxoplasmosis, listeria, CMV, parvo, TB, etc.) during the current pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of infection, rash, or fever that the mother or pregnant individual has had during the current pregnancy and document how it is being treated (if applicable).
Other	Specify whether the mother or pregnant individual has experienced any other complications or issues during the current pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the complications or issues that the mother or pregnant individual has experienced during the current pregnancy and document how they are being treated (if applicable).

Section 6: Family History

Item	Description
Anesthetic complications	Specify whether there is a maternal family history of complications from anesthetics by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of anesthetic complications experienced and document any other information that may impact the current pregnancy (e.g., who experienced the complications, how they were managed, outcomes).
Hypertension	Specify whether there is a maternal family history of hypertension by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of hypertension experienced (e.g., gestational hypertension) and document any other information that may impact the current pregnancy (e.g., who experienced the condition, how it was managed, outcomes).

Completion of the Form

Item	Description
Thromboembolic	Specify whether there is a maternal family history of thromboembolic conditions by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of thromboembolic conditions experienced and document any other information that may impact the current pregnancy (e.g., who experienced the condition, how it was managed, outcomes).
Diabetes	Specify whether there is a maternal family history of diabetes by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of diabetes experienced (Type I, Type II, gestational diabetes) and document any other information that may impact the current pregnancy (e.g., who experienced the condition, how it was managed, outcomes).
Mental health	Specify whether there is a maternal family history of mental health issues by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of mental health issues experienced (e.g., anxiety, depression, postpartum depression) and document any other information that may impact the current pregnancy (e.g., who experienced the issues, how they were managed, outcomes).
Substance use disorder	Specify whether there is a maternal family history of substance use disorder by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of substance use disorder experienced (e.g., alcohol dependence, drug dependence) and document any other information that may impact the current pregnancy (e.g., who experienced the disorder, how it was managed, outcomes).
Inherited conditions / defects (e.g. Tay-Sachs, Sickle Cell, Congenital Heart Defect, Cystic Fibrosis)	Specify whether there is a maternal and / or paternal family history of inherited conditions / defects by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of inherited conditions / defects experienced (e.g. Tay-Sachs, Sickle Cell, Congenital Heart Defect, Cystic Fibrosis) and document any other information that may impact the current pregnancy (e.g., who experienced the condition / defect, how it was managed, outcomes).
Other	Specify whether there is a maternal family history of any other conditions that may impact the current pregnancy in terms of management or outcomes by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the other conditions in the maternal family history that have been experienced and document any other information that may impact the current pregnancy (e.g., who experienced the condition, how it was managed, outcomes).

Completion of the Form

Section 7: Medical History

Item	Description
Surgery	Specify whether the mother or pregnant individual has previously had any significant surgical procedures, including transfusions, by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of surgical procedures that the mother has previously had and document any other information that may impact the current pregnancy (e.g., any complications, how they were managed, overall outcomes).
Anesthetic complications	Specify whether the mother or pregnant individual has previously had any significant complications from anesthetics by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of anesthetic complications experienced and document any other information that may impact the current pregnancy (e.g., how the complications were managed, outcomes).
Neuro.	Specify whether the mother or pregnant individual has previously had any significant neurological conditions or concerns (e.g., epilepsy, multiple sclerosis) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of neurological condition or concern and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes).
Resp.	Specify whether the mother or pregnant individual has previously had any significant respiratory conditions or concerns (e.g., chronic respiratory disease) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of respiratory condition or concern and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes).
CV	Specify whether the mother or pregnant individual has previously had any significant cardiovascular (CV) conditions or concerns by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of CV conditions or concerns by selecting all of the following that apply and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes): ☐ **Hypertension** ☐ **Previous hypertension in pregnancy (Prev. hypertension in preg.)** ☐ **Other** (e.g., mitral valve prolapse, cardiac disease) If '**Other**' is selected, specify the exact type of CV conditions that the mother has previously had.

Completion of the Form

Item	Description
Abdo / GI	Specify whether the mother or pregnant individual has previously had any significant abdominal / gastrointestinal (GI) conditions or concerns (e.g., chronic constipation, irritable bowel syndrome, gallbladder disease) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of abdominal / GI condition or concern and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes).
Gyne / GU	Specify whether the mother or pregnant individual has previously had any significant gynecological / genitourinary (GU) conditions or concerns (e.g., fibroids, endometriosis, abnormal Pap test that required treatment or further observation, urinary disorder, urinary tract infection, pyelonephritis, conditions complicating a previous pregnancy) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of gynecological / GU condition or concern and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes).
Hematology (e.g. transfusion, thromboembolic / coag.)	Specify whether the mother or pregnant individual has previously had any significant hematological conditions or concerns (e.g., transfusion, thromboembolist / coagulation concerns) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of hematological condition or concern and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes).
Endocrine	Specify whether the mother or pregnant individual has previously had any significant endocrine conditions or concerns by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of endocrine conditions or concerns by selecting all of the following that apply and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes): ☐ **Type 1 Diabetes Mellitus (T1DM)** ☐ **Type 2 Diabetes Mellitus (T2DM)** ☐ **Previous Gestational Diabetes Mellitus (Prev. GDM)** ☐ **Thyroid** ☐ **Other** If '**Other**' is selected, specify the exact type of endocrine conditions that the mother or pregnant individual has previously had.

Completion of the Form

Item	Description
Mental health	Specify whether the mother or pregnant individual has previously had any significant mental health issues or concerns by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of mental health issues or concerns by selecting all of the following that apply and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes resulting from the condition): ☐ **Anxiety** ☐ **Depression** ☐ **Previous Postpartum Depression (Prev. PPD)** ☐ **Bipolar** ☐ **Eating disorder** ☐ **Substance use disorder:** ☐ **Other** If '**Substance use disorder**' is selected, specify the type of opioid agonist therapy used (if applicable), by selecting all of the following that apply: ☐ **Methadone treatment** ☐ **Suboxone treatment** If '**Other**' is selected, specify the type of mental health issues or concerns that the mother or pregnant individual previously had.
Infectious diseases	Specify whether the mother or pregnant individual has previously had any significant infectious diseases that may impact the current pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of infectious diseases by selecting all of the following that apply: ☐ **Varicella (i.e., chicken pox)** ☐ **Herpes Simplex Virus (HSV)** ☐ **Other** If '**Other**' is selected, specify the exact type of infectious diseases that the mother or pregnant individual has previously had that may impact the current pregnancy. *Note: If the mother or pregnant individual has not previously had varicella but has been immunized against varicella, please document the date of the immunization.*

Completion of the Form

Item	Description
Immunizations	Specify whether the mother or pregnant individual has previously had any immunizations that may impact the current pregnancy in terms of management or outcomes by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of immunizations by selecting all of the following that apply: ☐ **Flu** (dd / mm / yyyy) ☐ **Tdap** (dd / mm / yyyy) ☐ **Other** If '**Flu**' or '**Tdap**' is selected, record the date of the last immunization (following the dd / mm / yyyy format). If '**Other**' is selected, specify the exact type immunizations that the mother or pregnant individual has previously had that may impact the current pregnancy.
Other	Specify whether the mother or pregnant individual has previously had any other significant conditions, issues or concerns that may impact the current pregnancy in terms of management or outcomes by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the other significant condition, issue or concern and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes).

Section 8: Lifestyle / Social Concerns

Item	Description
Diet / nutrition	Specify whether there are any concerns related to the mother's or pregnant individual's diet or nutrition, which may include standalone nutritional issues (e.g., anorexia, bulimia), specific diets / dietary restrictions (e.g., vegetarian diet, vegan diet), and / or any other conditions that require dietary modification (e.g., diabetes, obesity) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of dietary or nutritional concern and document any other information that may impact the current pregnancy (e.g., how the concern is managed, outcomes). *Note: A referral to a dietitian may be required for mothers or pregnant individuals with diabetes, obesity, or a restricted diet.*

Completion of the Form

Item	Description
Exercise	Specify whether there are any concerns related to the mother's or pregnant individual's physical activity (e.g., inadequate or excessive physical activity) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of physical activity concern and document any other information that may impact the current pregnancy (e.g., how the concern is managed, outcomes).
Financial	Specify whether there are any concerns related to the mother's or pregnant individual's financial situation (e.g., single parent, employment concerns, low socio-economic status) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of financial concern and document any other information that may impact the current pregnancy (e.g., how the concern is managed, outcomes).
Housing / food security	Specify whether there are any concerns related to the mother's or pregnant individual's housing and / or food security (e.g., unstable housing, living in a shelter, homeless, food insecurity / inability to access or afford a sufficient quantity of nutritious food) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of housing or food security concern and document any other information that may impact the current pregnancy (e.g., how the concern is managed, outcomes resulting from the housing / food security concern). *Note: A referral to a food bank or social services may be required for mothers with housing / food security concerns.*
Transportation	Specify whether there are any concerns related to the mother's or pregnant individual's access to safe transportation, particularly in regards to their ability to access care (e.g., not able to drive, distance from care provider, inability to afford public transportation) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of transportation concern and document any other information that may impact the current pregnancy (e.g., how the concern is managed, outcomes).
Safety	Specify whether there are any concerns related to the mother's or pregnant individual's personal safety and security (e.g., living in a dangerous neighbourhood) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of safety concern and document any other information that may impact the current pregnancy (e.g., how the concern is managed, outcomes resulting from the safety concern).

Completion of the Form

Item	Description
Gender-based violence	Specify whether there are any concerns that the mother or pregnant individual is or may be experiencing gender-based violence by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of gender-based violence that the mother or pregnant individual is or may be experiencing by selecting all of the following that apply: ☐ **Partner** (violence, including physical and / or emotional, committed by a current or previous intimate partner) ☐ **Non-partner** (violence, including physical and / or emotional, committed by someone other than the mother's or pregnant individual's current or previous intimate partner) *Note: Additional information and resources related to gender-based violence can be found **here**.*
Relationship / support	Specify whether there are any concerns related to the mother's or pregnant individual's social support network, including concerns about the relationship between the mother or pregnant individual and their partner (if applicable; e.g., partner not supportive of pregnancy, history of separation), and concerns about the level of support received from family, friends, and / or others (e.g., colleagues, community / religious groups, social worker) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of relationship or support network concern and document any other information that may impact the current pregnancy (e.g., how the concern is managed, outcomes resulting from the relationship or support network concern).
Other	Specify whether there are any other significant lifestyle or social concerns that may impact the current pregnancy by selecting one of the following ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the other significant lifestyle or social concerns and document any other information that may impact the current pregnancy (e.g., how the condition was managed, outcomes resulting from lifestyle or social concern).

Completion of the Form

Section 9: Substance Use

A harm reduction approach is recommended when discussing substance use during the antenatal period. When discussing substance use with a client, an introductory sentence can help facilitate effective engagement (e.g., *'I ask all of my clients these questions because it is important for their health and the health of their baby'*).

This section of the Antenatal Record should be revisited throughout the pregnancy in order to capture any relapsing use of alcohol, tobacco, cannabis, and / or other substances, as well as any cessation of substance use during pregnancy.

For mothers or pregnant individuals who use substances during the pregnancy, referrals to additional services and supports may be required, such as the **BC Smoking Cessation Program** or **QuitNow.ca**.

Item	Description
Alcohol	Specify whether the mother or pregnant individual has used alcohol **3 Months (Mos) Before Pregnancy (Preg)** or **During Pregnancy (Preg)** by selecting one of the following, under each column respectively: ☐ **No** ☐ **Yes** If '**Yes**' is selected, complete the additional fields (below) related to alcohol use for the given time period (i.e., column). If '**No**' is selected, skip the rest of the fields related to alcohol use for the given time period (i.e., column).
# Drinks per week	Record the number of alcoholic drinks consumed per week, on average, for the given time period.
4 or more drinks at one time	Specify whether 4 or more alcoholic drinks were consumed at one time, for the given time period, by selecting one of the following: ☐ **No** ☐ **Yes**
Quit alcohol	Specify whether the mother or pregnant individual has quit alcohol (before or during pregnancy) by selecting one of the following: ☐ **No** ☐ **Yes** If '**Yes**' is selected, record the date when the mother or pregnant individual quit alcohol (following the dd / mm / yyyy format).

Completion of the Form

Item	Description
Tobacco	Specify whether the mother or pregnant individual has used tobacco (i.e., cigarettes) **3 Months (Mos) Before Pregnancy (Preg)** or **During Pregnancy (Preg)** by selecting one of the following, under each column respectively: ☐ **No** ☐ **Yes** If '**Yes**' is selected, complete the additional fields (below) related to tobacco use for the given time period (i.e., column). If '**No**' is selected, complete the Exposed to 2nd-hand smoke field and skip the rest of the fields related to tobacco use for the given time period (i.e., column).
# Cigarettes per day	Record the number of cigarettes smoked per day, on average, for the given time period.
Exposed to 2nd-hand smoke	Specify whether the mother or pregnant individual was regularly exposed to 2nd-hand smoke (e.g., at home, at work), for the given time period by selecting one of the following: ☐ **No** ☐ **Yes**
Quit tobacco	Specify whether the mother or pregnant individual has quit tobacco (before or during pregnancy) by selecting one of the following: ☐ **No** ☐ **Yes** If '**Yes**' is selected, record the date when the mother or pregnant individual quit tobacco (following the dd / mm / yyyy format).

Completion of the Form

Item	Description
Cannabis	Specify whether the mother or pregnant individual has used cannabis **3 Months (Mos) Before Pregnancy (Preg)** or **During Pregnancy (Preg)** by selecting one of the following, under each column respectively: ☐ **No** ☐ **Yes** If '**Yes**' is selected, complete the additional fields (below) related to cannabis use for the given time period (i.e., column). If '**No**' is selected, skip the rest of the fields related to cannabis use for the given time period (i.e., column).
CBD product(s) only	Specify whether the cannabis used by the mother or pregnant individual is primarily a cannabidiol (CBD) only containing product by selecting one of the following: ☐ **No** ☐ **Yes** *Note: Cannabis products may contain different amounts of tetrahydrocannabinol (THC) and CBD, two of the most common compounds found in cannabis. While THC, which is known for its psychoactive properties, has been more heavily researched, the evidence on the effects of CBD on pregnancy and the fetus is still developing.*
# Times used per	Record the frequency of cannabis use, on average, for the given time period by documenting the number of times used and circling one of the following time periods: 'day', 'week', or 'month'.
Primary route	Specify the primary route of cannabis use (i.e., type used most commonly, on average), for the given time period, by selecting one of the following: ☐ **Smoke** (e.g., joint / spliff [cannabis rolled in cigarette paper], pipe / bong, blunt [cannabis rolled in hollowed out cigar wrappers]) ☐ **Vaporize** (breathe in dried or liquid cannabis vapours through a vaporizer) ☐ **Edible / oral** (e.g., baked goods, candies, chocolates, teas, sodas, cannabis oil or liquid ingested with food) ☐ **Other** (e.g., topical products, including tinctures, ointments, lotions applied to the skin)
Quit cannabis	Specify whether the mother or pregnant individual has quit cannabis (before or during pregnancy) by selecting one of the following: ☐ **No** ☐ **Yes** If '**Yes**' is selected, record the date when the mother or pregnant individual quit cannabis (following the dd / mm / yyyy format).
Other(s) During Preg	Specify whether the mother or pregnant individual has used other substances during pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** If '**Yes**' is selected, specify which other substances the mother or pregnant individual has used during pregnancy by selecting all of the following that apply: ☐ **Cocaine** ☐ **Opioids** ☐ **Methamphetamines** ☐ **Intravenous (IV) drugs** ☐ **Prescription drugs** ☐ **Other(s)** If '**Other(s)**' is selected, specify the other substance(s), such as Nicotine through vaping, that the mother or pregnant individual has used during pregnancy. Please use the Comments section, if more space is required.

Completion of the Form

Section 10: Initial Physical Examination

Note: The plane of reading for Section 5 – 9 of the Antenatal Record was from top to bottom. For 'Section 10: Initial Physical Examination' the plane of reading is from left to right for the vital signs assessment and top to bottom for the physical examination.

Item	Description
Date (dd / mm / yyyy)	Record the date of the mother's or pregnant individual's initial physical examination (following the dd / mm / yyy format).
Completed by (name)	Record the full name (i.e., given name and surname) of the care provider completing the mother's or pregnant individual's initial physical examination.
BP	Record the mother's or pregnant individual's blood pressure (BP) as assessed during the exam.
HR (per min)	Record the mother's or pregnant individual's heart rate (HR) – the number of heartbeats (per minute) – as assessed during the exam.
Ht (cm)	Record the height of the mother or pregnant individual (in centimeters).
Pre-preg. Wt.* (kg)	Record the pre-pregnancy weight of the mother or pregnant individual (in kilograms). *Note: The pre-pregnancy weight can be self-reported by the mother or pregnant individual, or it can be based on the weight measured at the first antenatal visit.*
Pre-preg. BMI*	Calculate the pre-pregnancy Body Mass Index (BMI) of the mother or pregnant individual. *Note: The BMI is the weight (in kilograms) divided by the height (in meters) squared.* *Note: An amount of weight that the mother or pregnant individual should be gaining throughout the pregnancy can be recommended based on the pre-pregnancy BMI, with the recommendations presented on the back of Page 1 of the Antenatal Record for reference, as indicated by the asterisk (*).*
Head & neck	Specify whether any abnormalities with the mother's or pregnant individual's head and neck were observed during the physical exam by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of head and neck abnormalities observed and document any other information that may impact the current pregnancy (e.g., how the abnormality is managed, outcomes resulting from the head and neck abnormality).
Breasts & nipples	Specify whether any abnormalities with the mother's or pregnant individual's breasts and nipples were observed during the physical exam by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of breast and nipple abnormalities observed and document any other information that may impact the current pregnancy (e.g., how the abnormality is managed, outcomes resulting from the breast and nipple abnormality).

Completion of the Form

Item	Description
Heart & lungs	Specify whether any abnormalities with the mother's or pregnant individual's heart and lungs were observed during the physical exam by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of heart and lung abnormalities observed and document any other information that may impact the current pregnancy (e.g., how the abnormality is managed, outcomes resulting from the heart and lung abnormality).
Abdomen	Specify whether any abnormalities with the mother's or pregnant individual's abdomen were observed during the physical exam by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of abdominal abnormalities observed and document any other information that may impact the current pregnancy (e.g., how the abnormality is managed, outcomes resulting from the abdominal abnormality).
Musculoskeletal	Specify whether any abnormalities with the mother's or pregnant individual's musculoskeletal system were observed during the physical exam by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of musculoskeletal abnormalities observed and document any other information that may impact the current pregnancy (e.g., how the abnormality is managed, outcomes resulting from the musculoskeletal abnormality).
Skin	Specify whether any abnormalities with the mother's or pregnant individual's skin were observed during the physical exam by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of skin abnormalities observed by selecting all of the following that apply: ☐ **Varicosities** ☐ **Other** If '**Other**' is selected, specify the type of skin abnormalities observed and document any other information that may impact the current pregnancy (e.g., how the abnormality is managed, outcomes resulting from the skin abnormality).

Completion of the Form

Item	Description
Pelvic	Specify whether any abnormalities with the mother's or pregnant individual's pelvic region were observed during the physical exam by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of pelvic abnormalities observed and document any other information that may impact the current pregnancy (e.g., how the abnormality is managed, outcomes resulting from the pelvic abnormality). Record also the dates of the last sexually transmitted infection (STI) test and the Pap test in the space corresponding to each test (following the dd / mm / yyyy format)
STI test (dd / mm / yyyy)	Record the date of the mother's or pregnant individual's last (STI) test (following the dd / mm / yyyy format).
Pap test (dd / mm / yyyy)	Record the date of the mother's or pregnant individual's last Pap test (following the dd / mm / yyyy format).
Other	Specify whether any other abnormalities were observed during the mother's or pregnant individual's physical exam by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the other abnormalities observed and document any other information that may impact the current pregnancy (e.g., how the abnormality is managed, outcomes).

Completion of the Form

Section 11: Comments / Follow-up

Item	Description
Comments / Follow-up (incl. details from sections 5 – 10)	Record any comments on the topics discussed and the assessments performed as specified in sections 5 to 10. Record also any plans for follow-up and / or outcomes from the follow-up.
Care provider (signature)	The care provider who completed this section, who is typically the main maternity care provider, should sign their name in the space provided. Specify also the title / designation of the care provider who completed this section by selecting one of the following: ☐ **Medical Doctor (MD)** ☐ **Registered Midwife (RM)** ☐ **Nurse Practitioner (NP)**

Section 12: Planned Place of Birth

Item	Description
Planned place of birth @ 20 wks	At 20 weeks of gestation, record where the mother or pregnant individual plans to give birth by specifying 'home' or documenting the name of the intended hospital. If a copy of the Antenatal Record (Part 1 and 2) was sent to the hospital (i.e., the intended place of birth or the referral hospital for planned home births), select '**Copy to hospital**'.
Planned place of birth @ 36 wks	At 36 weeks of gestation, record where the mother or pregnant individual plans to give birth by specifying 'home' or documenting the name of the intended hospital. If a copy of the Antenatal Record (Part 1 and 2) was sent to the hospital (i.e., the intended place of birth or the referral hospital for planned home births), select '**Copy to hospital**'.
Referral hospital	Record the name of the referral hospital. The referral hospital is the hospital to which a woman or pregnant individual would be transferred from home (for a planned home birth).
Confirmed EDD (dd / mm / yyyy)	Record the estimated date of delivery (EDD) as confirmed by ultrasound (US) or in-vitro fertilization (IVF) timing data (following the dd / mm / yyyy format). Specify the method of pregnancy dating used to confirm the EDD by selecting one of the following: ☐ **Ultrasound (US)** ☐ **In vitro fertilization (IVF)**

Completion of the Form

Section 13: Investigations

Item	Description
ABO	Record the mother's or pregnant individual's ABO blood group type (i.e., A, B, AB, or O). *Note: ABO blood group typing should be performed at the first antenatal visit.*
Rh factor	Record the mother's or pregnant individual's Rhesus (Rh) blood group type (i.e., positive or negative) *Note: Rh blood group typing should be performed at the first antenatal visit.*
Date (dd / mm / yyyy)	Record the date when red blood cell antibody screening was performed (following the dd / mm / yyyy format). *Note: Red blood cell antibody screening should be performed at the first antenatal visit.* *Note: If this is the first pregnancy or the mother or pregnant individual is Rh negative, antibody screening should be repeated at 26 – -28 weeks of gestation.* *Note: If the antibody screen is positive, repeat testing to identify the specific antibody present and monitor the titres is warranted.*
Antibody Titre	Record the antibody titre values in the spaces corresponding to the date of the red blood cell antibody screen.
Date RhIg given (dd / mm / yyyy)	Record the dates when the Rh Immunoglobulin (RhIg) was administered to the mother or pregnant individual (if applicable). *Note: Non-sensitized Rh negative mothers or pregnant individuals should receive RhIg at 28 weeks of gestation and within 72 hours after delivery of an Rh positive infant.* *Note: RhIg administration to non-sensitized Rh negative mothers or pregnant individuals may also be warranted after other potentially sensitizing events, such as miscarriage, threatened abortion, induced abortion, ectopic pregnancy, molar pregnancy, amniocentesis, chorionic villous sampling.* *Note: Non-sensitized Rh negative mothers or pregnant individuals should be offered RhIg, and verbal or written informed consent should be obtained prior to the administration of RhIg (a blood product).*
Hemoglobin (g / L)	Record the levels of hemoglobin in the blood (in grams per litre) in the spaces corresponding to the timing of the blood test (i.e., first trimester (T1) or third trimester (T3)).
Rubella	Specify the results of the rubella susceptibility screening by selecting one of the following: ☐ **Immune (Imm)** ☐ **Non-immune (Non-imm)**
Value (IU / mL)	Record the value of the rubella IgG antibody levels in the blood (in international units per milliliter), on which rubella immunity status was based.
Follow-up / Comments	If the mother or pregnant individual is determined to be non-immune to rubella, select '**Postpartum vaccine required**', to indicate the necessary follow-up. Document any additional information related to rubella screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).

Completion of the Form

Item	Description
HIV	Specify the results of the human immunodeficiency virus (HIV) testing by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)**
Follow-up / Comments	If the mother or pregnant individual is HIV negative at the time of the initial HIV test but is considered to be high risk (e.g., engages in unprotected sex or shares needles or other injection equipment), HIV testing should be repeated in the third trimester (T3); select '**T3 repeat if high-risk**' to indicate the necessary follow-up. Document any additional information related to HIV testing that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).
Syphilis	Specify the results of the syphilis screening by selecting one of the following: ☐ **Non Reactive (N / R)** ☐ **Reactive (R)**
Follow-up / Comments	Document any additional information related to syphilis screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).
HBsAg	Specify the results of the HBsAg screening by selecting one of the following: ☐ **Non Reactive (N / R)** ☐ **Reactive (R)**
HBV DNA (IU / mL)	If the mother or pregnant individual is HBsAg reactive, hepatitis B virus (HBV) DNA testing should be recommended and the HBV DNA viral load should be recorded in the space provided (in international units per milliliter).
Partner / household contact	If there is risk of newborn hepatitis B infection due to contact with the mother's or pregnant individual's partner or another household contact (e.g., father, nanny / child care provider), select '**Partner / household contact**'.
Follow-up / Comments	Specify the necessary follow-up based on maternal and household contact risk of hepatitis B infection by selecting all of the following that apply: ☐ **Anti-viral therapy required** (indicated for mothers or pregnant individuals if HBV DNA is > 200,000 IU / mL) ☐ **Newborn vaccine required** (indicated for newborns if any risk of hepatitis B infection due to maternal or household contact) ☐ **Newborn hepatitis B immune globulin (HBIg) required** (indicated for newborns if the mother or pregnant individual is HBsAg reactive, if the mother or pregnant individual is at high risk for hepatitis B infection and their status is unknown or negative, or the household contact has an acute hepatitis B infection) Document any additional information related to HBsAg screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).

Completion of the Form

Item	Description
Gonorrhea	Specify the results of the gonorrhea screening by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)**
Follow-up / Comments	If the mother or pregnant individual is positive for gonorrhea, the appropriate treatment should be recommended and gonorrhea screening should be repeated in the third trimester (T3); select '**T3 repeat if Pos**' to indicate the necessary follow-up. Document any additional information related to gonorrhea screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).
Chlamydia	Specify the results of the chlamydia screening by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)**
Follow-up / Comments	If the mother or pregnant individual is positive for chlamydia, the appropriate treatment should be recommended and chlamydia screening should be repeated in the third trimester (T3); select '**T3 repeat if Pos**' to indicate the necessary follow-up. Document any additional information related to chlamydia screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).
Urine C&S	Specify the results of the urine culture and sensitivity (C&S) screening by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)** *Note: Urine C&S screening should be performed during the first trimester.*
Culture	If the mother's or pregnant individual's urine C&S is positive, record the specific bacterium that is identified.
Follow-up / Comments	Document any additional information related to urine C&S screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).

Completion of the Form

Item	Description
GDM (@ 24 – 28 wks)	*Note: Gestational diabetes mellitus (GDM) screening should be performed at 24 – 28 weeks of gestation.* *Note: A two-step or one-step approach to screening GDM can be performed. The two-step screen consists of an initial 50 g glucose challenge test (GCT), followed, if positive / abnormal, by a 75 g oral glucose tolerance test (GTT). Alternatively, the one-step screen consists of just the 75 g oral GTT.* *Note: Overall GDM status is based on different cut-off values depending on whether the two-step or the one-step approach to screening is performed.*
GCT (50 g)	Specify the results of the GCT by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)**
Value (mmol / L) **@ 1 hr**	Record the value of the plasma glucose (in international units per milliliter) at 1 hour after the 50 g oral glucose load, on which GCT status was based.
GTT (75 g)	Specify the results of the GTT by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)**
Value (mmol / L) **@ Fasting** **@ 1 hr** **@ 2 hr**	Record the values of the plasma glucose (in international units per milliliter) at **fasting**, 2 hours, and 3 hours after the 75 g oral glucose load, on which GTT status was based.
Follow-up / Comments	If the mother or pregnant individual refuses to be screened for GDM, select '**GDM test declined**'. If the mother or pregnant individual is positive for GDM, specify the treatment approach that is undertaken to control her plasma glucose levels by selecting one of the following: ☐ **Diet controlled** (diet alone is effective at managing plasma glucose levels) ☐ **Insulin required** (in addition to dietary modification, insulin is required for managing plasma glucose levels) Document any additional information related to GDM screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).
GBS (@ 35 – 37 wks)	Specify the results of the group B streptococcus (GBS) screening by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)**
Date (dd / mm / yyyy)	Record the date that GBS screening is performed (following the dd / mm / yyyy format). *Note: GBS screening should be performed at 35-37 weeks of gestation.*
Follow-up / Comments	If a copy of the GBS test results was sent to the hospital (i.e., the intended place of birth or the referral hospital for planned home births), select '**Copy to hospital**'. Document any additional information related to GBS screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).

Completion of the Form

Item	Description
Other (e.g., Ferritin, TSH, HepC)	Record what other investigations were performed that were indicated by additional maternal risk factors (e.g., ferritin, thyroid stimulating hormone [TSH], hepatitis C [HepC]). Document any additional information related to the other investigations that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).
Prenatal Genetic Investigations	Specify which prenatal genetic investigations, including screening and diagnostic testing, were performed by selecting all of the following that apply: ☐ **Serum Integrated Prenatal Screen (SIPS)** ☐ **Integrated Prenatal Screen (IPS)** ☐ **Quad** ☐ **Non-invasive Prenatal Testing (NIPT) (Medical Services Plan (MSP)** (mother eligible for NIPT coverage by MSP) ☐ **Non-invasive Prenatal Testing (NIPT) (self-pay)** (mother not eligible for NIPT coverage by MSP, therefore paid out-of-pocket) ☐ **Other** ☐ **Chorionic villus sampling (CVS)** ☐ **Amniocentesis (Amnio)** If '**Other**' is selected, specify the type of prenatal genetic investigations that were performed. If the mother or pregnant indiviudual declined all prenatal genetic investigations, select '**Declined**'.
Results	Record the results of the prenatal genetic investigations. Document any additional information related to the prenatal genetic investigations that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).

Completion of the Form

Section 14: Edinburgh Perinatal / Postnatal Depression Scale*

Item	Description
EPDS	If the mother or pregnant individual declined the perinatal depression screening using the Edinburgh Perinatal / Postnatal Depression Scale (EPDS), select '**Declined**'. *Note: Screening for perinatal depression is recommended for all mothers at 28 – 32 weeks of gestation (and again at 6 – 8 weeks postpartum).*
Date (dd / mm / yyyy)	Record the date when perinatal depression screening using the EPDS is performed (following the dd / mm / yyyy format).
GA (wks / days)	Record the gestational age (GA) (in weeks and days) at which the perinatal depression screening using the EPDS is performed.
Total score	Record the mother's or pregnant individual's total score on the EPDS as per the scoring guide. *Note: The EPDS Scoring Guide is presented on the back of Page 2 of the Antenatal Record for reference, as indicated by the asterisk (*).*
Anxiety subscore (questions 3 – 5)	Record the mother's or pregnant individual's anxiety subscore on the EPDS (i.e., questions 3 to 5) as per the scoring guide. *Note: The EPDS Scoring Guide is presented on the back of Page 2 of the Antenatal Record for reference, as indicated by the asterisk (*).*
Self-harm subscore (question 10)	Record the mother's or pregnant individual's self-harm subscore on the EPDS (i.e., questions 3 to 5) as per the scoring guide. *Note: The EPDS Scoring Guide is presented on the back of Page 2 of the Antenatal Record for reference, as indicated by the asterisk (*).*
Follow-up	Record any follow-up that may be indicated by the results of the EPDS screening. Document any additional information related to perinatal depression screening that may impact the current pregnancy (e.g., management, follow-up, and / or outcomes).

Section 15: Ultrasounds & Other Imaging Investigations

Item	Description
Date (dd / mm / yyyy)	Record the date when the ultrasound or other imaging investigation is performed (following the dd / mm / yyyy format).
GA (wks / days)	Record the gestational age (GA) (in weeks and days) at which the ultrasound or other imaging investigation is performed.
Comments	Record any comments or information related to the ultrasound or other imaging investigation that may impact the current pregnancy (e.g., results, management, follow-up, and / or outcomes).

Completion of the Form

Section 16: Perinatal Considerations & Referrals

Note: Additional room is available on Page 3 of the Antenatal Record (optional page) to document any considerations and / or referrals related to the mother's or pregnant individual's lifestyle, including the following: substance use, pregnancy, labour and birth, breastfeeding, postpartum health, and / or the newborn's health.

Item	Description
Pregnancy type	Specify the pregnancy type by selecting one of the following: ☐ **Singleton** ☐ **Twin** ☐ **Multiple (3+)** If at conception the pregnancy is multifetal but the mother or pregnant individual undergoes multifetal pregnancy reduction to a twin or singleton pregnancy, select '**Multiple (3+)**' and include a note documenting that a multifetal reduction was performed.
VBAC eligible @ 36 wks	If the client has had a cesarean section for a previous pregnancy, indicate whether at 36 weeks of gestation, they are eligible to attempt a vaginal delivery for this pregnancy (i.e., VBAC) by selecting one of the following: ☐ **No** ☐ **Yes** If the client has previously never had a cesarean section, select '**N / A**' (i.e., not applicable). *Note: The gestational age at which VBAC eligibility is confirmed does not have to be 36 weeks exactly, but should reflect the mother's or pregnant individual's end of pregnancy eligibility (i.e., prior to labour).*
VBAC planned @ 36 wks	If the client has had a cesarean section for a previous pregnancy, indicate whether at 36 weeks of gestation they are planning to attempt a vaginal delivery for this pregnancy (i.e., VBAC) by selecting one of the following: ☐ **No** ☐ **Yes** If the client has previously never had a cesarean section, select 'N / A'. *Note: The gestational age at which a plan for VBAC is confirmed does not have to be 36 weeks exactly, but should reflect the mother's or pregnant individual's end of pregnancy planned mode of delivery (i.e., prior to labour).*
Plan to breastfeed	Specify whether the mother or pregnant individual is planning to breastfeed their baby by selecting one of the following: ☐ **No** ☐ **Yes** ☐ **Undecided** *Note: Planned breastfeeding during the antenatal period is associated with initiation and longer duration of breastfeeding. If the mother or pregnant individual is undecided about their breastfeeding plans, additional information and discussion about newborn feeding options and the risks / benefits of each may be warranted.*

Completion of the Form

Item	Description
Lifestyle / substance use	Record any considerations and / or referrals related to the mother's or pregnant individual's lifestyle, including any substance use. Document also any changes in lifestyle that may have occurred over the course of the pregnancy, which may differ from what was initially noted early in the pregnancy on the Antenatal Record Part 1.
Pregnancy	Record any considerations and / or referrals related to the mother's or pregnant individual's pregnancy.
Labour & birth	Record any considerations and / or referrals related to the mother's or pregnant individual's labour and birth.
Breastfeeding	Record any considerations and / or referrals related to breastfeeding.
Postpartum	Record any considerations and / or referrals related to the postpartum health.
Contraception plan	Record any considerations and / or referrals related to the postpartum contraception plan.
Newborn	Record any considerations and / or referrals related to the newborn's health.

Section 17: Prenatal Visit Documentation

Item	Description
Date (dd / mm / yyyy)	Record the date when the antenatal visit took place (following the dd / mm / yyyy format).
GA (wks / days)	Record the gestational age (GA) (in weeks and days) at which the antenatal visit took place.
BP	Record the mother's or pregnant individual's blood pressure (BP) taken during the antenatal visit.
Urine (if indicated)	If indicated, record whether urine testing for ketones and proteins occurred and the results of the testing.
Wt (kg)	Record the weight of the mother or pregnant individual (in kilograms) as measured during the antenatal visit.
Fundus (cm)	Record the mother's or pregnant individual's symphysis-fundal height (in centimeters) from the top of the fundus to the symphysis, as measured during the antenatal visit.
FHR (per min)	Record the fetal heart rate (FHR) – the number of heart beats (per minute), as measured during the antenatal visit.
FM	Specify whether fetal movement (FM) was detected at the antenatal visit.
Pres. & position	Record the presentation and the position of the fetus as identified at the antenatal visit. *Note: The presentation of the fetus is based on the part of the baby's body that is presenting in reference to the birth canal (e.g., cephalic, breech, shoulder).* *Note: The position of the fetus is based on the relationship between the baby's presenting body part and the mother's or pregnant individual's pelvis (e.g., Occiput – Anterior, Occiput – Posterior, Occiput – Transverse, Sacrum – Anterior, Sacrum – Posterior, Sacrum – Transverse).*

Completion of the Form

Item	Description
Comments*	Record any comments, discussions or other information related to the antenatal visit that may impact the current pregnancy (e.g., investigations, suggested activities, results, management, follow-up, and / or outcomes). *Note: A list of recommended discussion topics for each trimester of the pregnancy is presented on the back of Page 1 of the Antenatal Record for reference, as indicated by the asterisk (*).*
Next visit	Record the time of the mother's or pregnant individual's next scheduled antenatal visit by specifying the duration until the next visit (e.g., "next week") or by specifying the date (following the dd / mm / yyyy format).
Initials	The care provider who assessed and consulted the other at the antenatal visit should initial in the space provided.

Section 18: Sign-Offs

Note: Items in square brackets [ ] are category descriptions that are implied but not printed on the form.

Item	Description
[Care provider] (name) (signature)	Each care provider who provided any antenatal care should print their full name (including first name and surname) in one of the designated fields, and sign their name in the field corresponding to their entry.
[Title / designation]	Each care provider who provided any antenatal care should specify their title / designation by selecting one of the following: ☐ **Medical Doctor (MD)** ☐ **Registered Midwife (RM)** ☐ **Nurse Practitioner (NP)**

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British Columbia Antenatal Record Part 1

1. Primary maternity care provider name		Family physician/nurse practitioner name	
Patient surname	Patient given name(s)	Date of birth (dd/mm/yyyy)	Age at EDD
Surname at birth	Preferred name/pronoun	Language preferred	Relationship status*
Highest level of education completed*		Occupation	
Indigenous identity:* ☐ First Nations ☐ Métis ☐ Inuk (Inuit) ☐ No response ☐ None ☐ Status ☐ Non-status		☐ Live on reserve ☐ Live off reserve ☐ Live on & off reserve	Ethnicity*
Partner: Surname, given name(s)		Occupation	Biological father/donor: Surname, given name(s) OR ☐ Same as partner / Age / Ethnicity*

Surname Given name

Address

Phone number

Personal Health Number

2. Allergies (incl. reaction) ☐ None | Medications/OTC drugs/herbals/vitamins ☐ Preconception folic acid ☐ T1 folic acid | Beliefs/practices (e.g. Jehovah's Witness)

3. Contraceptives: Type	Last used (dd/mm/yyyy)	Pregnancy planned: ☐ No ☐ Yes	LMP (dd/mm/yyyy)	EDD by LMP (dd/mm/yyyy)	Dating US (dd/mm/yyyy)	GA by US (wks/days)	EDD by US (dd/mm/yyyy)

4. Obstetrical History Gravida _____ Term _____ Preterm _____ Abortus (Induced _____ Spontaneous _____) Living _____

Date (mm/yyyy)	Place of birth	GA (wks/days)	Duration of labour (hrs)	Mode of birth	Perinatal complications/comments	Sex	Birth weight (g)	Breastfed (mos)	Child's present health

5. Present Pregnancy

No Yes (specify)

- ☐ ☐ ART: (select one only)
  - ☐ Ovarian stimulation only
  - ☐ IUI only
  - ☐ Ovarian stimulation + IUI
  - ☐ IVF (# of embryos transferred) _____
  - ☐ ICSI (# of embryos transferred) _____
  - ☐ Other _____
- ☐ ☐ Bleeding _____
- ☐ ☐ Nausea _____
- ☐ ☐ Travel (self/partner) _____
- ☐ ☐ Infection/rash/fever _____
- ☐ ☐ Other _____

6. Family History

No Yes (specify)

- ☐ ☐ Anesthetic complications _____
- ☐ ☐ Hypertension _____
- ☐ ☐ Thromboembolic _____
- ☐ ☐ Diabetes _____
- ☐ ☐ Mental health _____
- ☐ ☐ Substance use disorder _____
- ☐ ☐ Inherited conditions/defects (e.g. Tay-Sachs, Sickle Cell, Congenital Heart Defect, Cystic Fibrosis)
  (Mother) _____
  (Biological father/donor) _____
- ☐ ☐ Other _____

7. Medical History

No Yes (specify)

- ☐ ☐ Surgery _____
- ☐ ☐ Anesthetic complications _____
- ☐ ☐ Neuro. _____
- ☐ ☐ Resp. _____
- ☐ ☐ CV: ☐ Hypertension ☐ Prev. hypertension in preg. ☐ Other _____
- ☐ ☐ Abdo./GI _____
- ☐ ☐ Gyne./GU _____
- ☐ ☐ Hematology (e.g. transfusion, thromboembolic/coag.) _____
- ☐ ☐ Endocrine: ☐ T1DM ☐ T2DM ☐ Prev. GDM ☐ Thyroid ☐ Other _____
- ☐ ☐ Mental health: ☐ Anxiety ☐ Depression ☐ Prev. PPD ☐ Bipolar ☐ Eating disorder ☐ Substance use disorder: ☐ Methadone treatment ☐ Suboxone treatment ☐ Other _____
- ☐ ☐ Infectious diseases: ☐ Varicella ☐ HSV ☐ Other _____
- ☐ ☐ Immunizations: ☐ Flu (dd/mm/yyyy) _____ ☐ Tdap (dd/mm/yyyy) _____ ☐ Other _____
- ☐ ☐ Other _____

8. Lifestyle/Social Concerns

No Yes (specify)

- ☐ ☐ Diet/nutrition _____
- ☐ ☐ Exercise _____
- ☐ ☐ Financial _____
- ☐ ☐ Housing/food security _____
- ☐ ☐ Transportation _____
- ☐ ☐ Safety _____
- ☐ ☐ Gender-based violence: ☐ Partner ☐ Non-partner
- ☐ ☐ Relationships/support _____
- ☐ ☐ Other _____

9. Substance Use

	3 Mos Before Preg	During Preg
Alcohol	☐ No ☐ Yes	☐ No ☐ Yes
# Drinks per week	_____	_____
4 or more drinks at one time	☐ No ☐ Yes	☐ No ☐ Yes
Quit alcohol: ☐ No ☐ Yes, date (dd/mm/yyyy)	_____	
Tobacco	☐ No ☐ Yes	☐ No ☐ Yes
# Cigarettes per day	_____	_____
Exposed to 2nd-hand smoke	☐ No ☐ Yes	☐ No ☐ Yes
Quit tobacco: ☐ No ☐ Yes, date (dd/mm/yyyy)	_____	
Cannabis	☐ No ☐ Yes	☐ No ☐ Yes
CBD product(s) only	☐ No ☐ Yes	☐ No ☐ Yes
# Times used per (circle to specify) day week month	_____	_____
Primary route: (select one only)	☐ Smoke ☐ Vaporize ☐ Edible/oral ☐ Other	☐ Smoke ☐ Vaporize ☐ Edible/oral ☐ Other
Quit cannabis: ☐ No ☐ Yes, date (dd/mm/yyyy)	_____	

Other(s) During Preg ☐ No ☐ Yes: (check all that apply)

☐ Cocaine ☐ Opioids ☐ Methamphetamines ☐ IV drugs ☐ Prescription drugs ☐ Other(s) _____

10. Initial Physical Examination Date (dd/mm/yyyy) _____ Completed by (name) _____

BP	HR (per min)	Ht (cm)	Pre-preg. Wt* (kg)	Pre-preg. BMI*

Norm Abnorm (specify)

- ☐ ☐ Head & neck _____
- ☐ ☐ Breasts & nipples _____
- ☐ ☐ Heart & lungs _____
- ☐ ☐ Abdomen _____
- ☐ ☐ Musculoskeletal _____
- ☐ ☐ Skin: ☐ Varicosities ☐ Other _____
- ☐ ☐ Pelvic _____
  STI test (dd/mm/yyyy) _____
  Pap test (dd/mm/yyyy) _____
- ☐ ☐ Other _____

11. Comments/Follow-up (incl. details from sections 5–10)

Care provider (signature) _____ ☐ MD ☐ RM ☐ NP

** Please refer to **Reference Page 1** on the back of this page for guidance and a list of discussion topics.*

REFERENCE PAGE 1

Section 1: Demographics and Background

Relationship status

Record in the appropriate field on the first page **one** of the following:

- **Married**
- **Living with partner**
- **Single (never married)**
- **Separated or divorced**
- **Widowed**
- **Unknown**

Highest level of education completed

Record in the appropriate field on the first page **one** of the following:

- **Less than high school**
- **High school diploma**
- **Trade or other certificate/diploma (not Bachelors)**
- **Undergraduate university degree(s)**
- **Postgraduate university degree(s)**
- **Unknown**

Indigenous identity

Everyone should be asked this question:

"Do you identify as an Indigenous or Aboriginal person?"

Responding to this question is voluntary.

If '**No response**' or '**None**,' skip to '**Ethnicity**.'

If 'Yes,' record the Indigenous or Aboriginal identity by checking **all** that apply from the following list on the first page:

- **First Nations**
- **Métis**
- **Inuk (Inuit)**

If the individual identifies as First Nations, specify whether they are '**Status**' or '**Non-status**,' and whether they '**Live on reserve**,' '**Live off reserve**,' or '**Live on & off reserve**.'

Ethnicity

Determine the ethnicities of the mother and the biological father/donor from the following list, and record **all** that apply in the appropriate fields on the first page:

- **Indigenous/Aboriginal**
- **European–Western (e.g. English, Italian)**
- **European–Eastern (e.g. Russian, Polish)**
- **Asian–East (e.g. Chinese, Japanese, Korean)**
- **Asian–South (e.g. Indian, Pakistani, Sri Lankan)**
- **Asian–South East (e.g. Malaysian, Filipino)**
- **Middle Eastern (e.g. Iranian, Lebanese)**
- **African**
- **Caribbean**
- **Latin American (e.g. Argentinean, Chilean)**
- **Other(s)** (specify) .....
- **Do not know**
- **Prefer not to answer**

Section 10: Initial Physical Examination

Health Canada Weight Gain Recommendations for Singleton Pregnancies (adapted from Institute of Medicine, 2009)

Pre-pregnancy Weight Category	Pre-pregnancy Body Mass Index (BMI)	Mean Rate[1] of Weight Gain in 2nd and 3rd Trimesters		Recommended Total Weight Gain[2]	
		kg/wk	lb/wk	kg	lb
Underweight	<18.5	0.5	1.0	12.5–18.0	28–40
Normal weight	18.5–24.9	0.4	1.0	11.5–16.0	25–35
Overweight	25.0–29.9	0.3	0.6	7.0–11.5	15–25
Obese[3]	≥30.0	0.2	0.5	5.0–9.0	11–20

[1] Rounded values.
[2] Calculations for the recommended total weight gain range assume a gain of 0.5 to 2.0 kg (1.1 to 4.4 lbs) in the first trimester.
[3] A lower weight gain may be advised for women with a BMI of 35 or greater, based on clinical judgement and a thorough assessment of the risks and benefits to mother and child.

Discussion Topics

1st–3rd Trimester (as indicated)

- ☐ Nutrition/folic acid
- ☐ Healthy weight gain
- ☐ Physical activity
- ☐ Occupational concerns
- ☐ Personal safety
- ☐ Support system
- ☐ Mental health
- ☐ Substance use (i.e. alcohol, drugs)
- ☐ Sexual activity, STI risk factors, screening
- ☐ Immunization
- ☐ VBAC counseling (if applicable)

1st Trimester

- ☐ Nausea/vomiting
- ☐ Safety: food, medications/vitamins/supplements, seatbelts
- ☐ Oral health
- ☐ Exposures: infections, pets, environment, occupation
- ☐ Travel
- ☐ Prenatal genetic screening
- ☐ Early pregnancy loss: signs/symptoms, what to do
- ☐ Routine prenatal care, emergency contact/on-call providers
- ☐ Breastfeeding: attitudes/beliefs
- ☐ Quality educational resources
- ☐ Public health services/programs

2nd Trimester

- ☐ Bleeding
- ☐ Preterm labour: signs/symptoms
- ☐ PROM
- ☐ Lifestyle and social risk assessment
- ☐ Gestational diabetes screening
- ☐ Prenatal classes
- ☐ Birth options and practices that promote healthy birth
- ☐ Birth plan: travel to other community for delivery (if applicable)
- ☐ Breastfeeding and importance of immediate, uninterrupted skin-to-skin care
- ☐ Postpartum contraception

3rd Trimester

- ☐ Fetal movement
- ☐ Emergency contact/on-call providers
- ☐ ECV, breech delivery, elective Cesarean delivery (if applicable)
- ☐ Indications for induction of labour
- ☐ Signs/symptoms of labour and admission timing
- ☐ Birth plan: labour support, pain management
- ☐ Potential interventions, use of blood products
- ☐ Genital herpes suppression
- ☐ GBS screening/prophylaxis
- ☐ Cord blood banking
- ☐ Erythromycin/ophthalmia neonatorum prophylaxis/treatment
- ☐ Vitamin K prophylaxis
- ☐ Newborn care, screening, circumcision, follow-up
- ☐ Breastfeeding adjustment, skills, support
- ☐ Postpartum care
- ☐ Postpartum contraception
- ☐ Discharge planning, car seat safety
- ☐ Infant safe sleep
- ☐ Work plan, maternity leave
- ☐ EPDS screening

British Columbia Antenatal Record Part 2

12. Planned place of birth @ 20 wks ☐ Copy to hospital | Planned place of birth @ 36 wks ☐ Copy to hospital | Referral hospital

Confirmed EDD (dd/mm/yyyy) _____ by: ☐ US ☐ IVF

13. Investigations

ABO	Rh factor	Date (dd/mm/yyyy) Antibody Titre	Date RhIg given (dd/mm/yyyy)	Hemoglobin (g/L)
		1.	1.	T1
		2.	2.	T3

Test	Results	Results/Follow-up/Comments
Rubella	☐ Imm ☐ Non-imm	Value (IU/mL) _____ ☐ Postpartum vaccine required
HIV	☐ Neg ☐ Pos	☐ T3 repeat if high-risk
Syphilis	☐ N/R ☐ R	
HBsAg	☐ N/R ☐ R	HBV DNA (IU/mL) _____ ☐ Anti-viral therapy required ☐ Newborn vaccine required ☐ Partner/household contact ☐ Newborn HBIg required
Gonorrhea	☐ Neg ☐ Pos	☐ T3 repeat if Pos
Chlamydia	☐ Neg ☐ Pos	☐ T3 repeat if Pos
Urine C&S	☐ Neg ☐ Pos	Culture _____
GDM (@24–28 wks)		☐ GDM test declined ☐ Diet controlled ☐ Insulin required
GCT (50 g)	☐ Neg ☐ Pos	Value (mmol/L) @ 1 hr _____
GTT (75 g)	☐ Neg ☐ Pos	Value (mmol/L) @ 1 hr _____ @ 2 hr _____ @ 3 hr _____
GBS (@35–37 wks)	☐ Neg ☐ Pos	Date (dd/mm/yyyy) _____ ☐ Copy to hospital

Other (e.g. Ferritin, TSH, HepC)

Prenatal Genetic Investigations ☐ Declined — **Results**

☐ SIPS ☐ IPS ☐ Quad ☐ CVS

☐ NIPT (MSP) ☐ NIPT (self-pay) ☐ Other _____ ☐ Amnio

14. Edinburgh Perinatal/Postnatal Depression Scale* ☐ Declined

Date (dd/mm/yyyy) _____ GA (wks/days) _____

Total score _____ Anxiety subscore (questions 3–5) _____ Self-harm subscore (question 10) _____

Follow-up _____

Surname Given name

Address

Phone number

Personal Health Number

15. Ultrasounds & Other Imaging Investigations

Date (dd/mm/yyyy)	GA (wks/days)	Comments

16. Perinatal Considerations & Referrals

Pregnancy type: ☐ Singleton ☐ Twin ☐ Multiple (3+)

VBAC eligible @ 36 wks: ☐ No ☐ Yes ☐ N/A

VBAC planned @ 36 wks: ☐ No ☐ Yes ☐ N/A

Plan to breastfeed: ☐ No ☐ Yes ☐ Undecided

Lifestyle/substance use _____

Pregnancy _____

Labour & birth _____

Breastfeeding _____

Postpartum _____

Contraception plan _____

Newborn _____

17. Date (dd/mm/yyyy)	GA (wks/days)	BP	Urine (if indicated)	Wt (kg)	Fundus (cm)	FHR (per min)	FM	Pres. & position	Comments*	Next visit	Initials

Please see the next page, British Columbia Antenatal Record Part 2 (cont'd), to record additional visits.

18. Sign-Offs

1. (name) _____ (signature) _____ ☐ MD ☐ RM ☐ NP

2. (name) _____ (signature) _____ ☐ MD ☐ RM ☐ NP

3. (name) _____ (signature) _____ ☐ MD ☐ RM ☐ NP

** Please refer to **Reference Page 2** on the back of this page for guidance and a list of discussion topics.*

  psbc@phsa.ca

REFERENCE PAGE 2

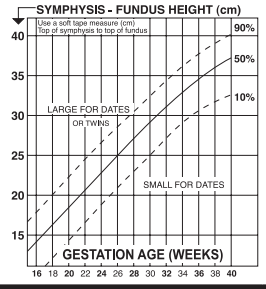
Section 14: Edinburgh Perinatal / Postnatal Depression Scale

Edinburgh Perinatal / Postnatal Depression Scale Scoring Guide (Cox, Holden, Sagovsky, 1987; PSBC 2015)

In the past 7 days . . .

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	• Never = 0 • Hardly ever = 1	• Sometimes = 2 • Yes, quite often = 3

Section 17: Prenatal Visits Notes



EPDS Scores – Interpretation and Actions

Total score	**≥14** →	Follow up with diagnostic assessment and treatment, and consider referral to a mental health specialist, as appropriate.
	12–13 →	Monitor, support, and offer education.
Anxiety subscore (questions 3–5)	**≥6** →	Monitor, support, and offer education.
Self-harm subscore (question 10)	**1–3** →	Provide immediate mental health assessment and intervention, and consider referral to a mental health specialist, as appropriate.

The EPDS should be completed between 28–32 weeks in all pregnancies, as well as 6–8 weeks postpartum.

Discussion Topics

1st–3rd Trimester (as indicated)

- ☐ Nutrition/folic acid
- ☐ Healthy weight gain
- ☐ Physical activity
- ☐ Occupational concerns
- ☐ Personal safety
- ☐ Support system
- ☐ Mental health
- ☐ Substance use (i.e. alcohol, drugs)
- ☐ Sexual activity, STI risk factors, screening
- ☐ Immunization
- ☐ VBAC counseling (if applicable)

1st Trimester

- ☐ Nausea/vomiting
- ☐ Safety: food, medications/vitamins/supplements, seatbelts
- ☐ Oral health
- ☐ Exposures: infections, pets, environment, occupation
- ☐ Travel
- ☐ Prenatal genetic screening
- ☐ Early pregnancy loss: signs/symptoms, what to do
- ☐ Routine prenatal care, emergency contact/on-call providers
- ☐ Breastfeeding: attitudes/beliefs
- ☐ Quality educational resources
- ☐ Public health services/programs

2nd Trimester

- ☐ Bleeding
- ☐ Preterm labour: signs/symptoms
- ☐ PROM
- ☐ Lifestyle and social risk assessment
- ☐ Gestational diabetes screening
- ☐ Prenatal classes
- ☐ Birth options and practices that promote healthy birth
- ☐ Birth plan: travel to other community for delivery (if applicable)
- ☐ Breastfeeding and importance of immediate, uninterrupted skin-to-skin care
- ☐ Postpartum contraception

3rd Trimester

- ☐ Fetal movement
- ☐ Emergency contact/on-call providers
- ☐ ECV, breech delivery, elective Cesarean delivery (if applicable)
- ☐ Indications for induction of labour
- ☐ Signs/symptoms of labour and admission timing
- ☐ Birth plan: labour support, pain management
- ☐ Potential interventions, use of blood products
- ☐ Genital herpes suppression
- ☐ GBS screening/prophylaxis
- ☐ Cord blood banking
- ☐ Erythromycin/ophthalmia neonatorum prophylaxis/treatment
- ☐ Vitamin K prophylaxis
- ☐ Newborn care, screening, circumcision, follow-up
- ☐ Breastfeeding adjustment, skills, support
- ☐ Postpartum care
- ☐ Postpartum contraception
- ☐ Discharge planning, car seat safety
- ☐ Infant safe sleep
- ☐ Work plan, maternity leave
- ☐ EPDS screening

British Columbia Antenatal Record Part 2 *(cont'd)*

16. Perinatal Considerations & Referrals *(cont'd)*

Confirmed EDD (dd/mm/yyyy) _____

Lifestyle/substance use _____

Pregnancy _____

Labour & birth _____

Breastfeeding _____

Postpartum _____

Contraception plan _____

Newborn _____

Surname _____ Given name _____

Address _____

Phone number _____

Personal Health Number _____

Cont'd from previous page of British Columbia Antenatal Record Part 2.

17. Date (dd/mm/yyyy)	GA (wks/days)	BP	Urine (if indicated)	Wt (kg)	Fundus (cm)	FHR (per min)	FM	Pres. & position	Comments	Next visit	Initials

18. Sign-Offs

1. (name) _____ (signature) _____ ☐ MD ☐ RM ☐ NP

2. (name) _____ (signature) _____ ☐ MD ☐ RM ☐ NP

3. (name) _____ (signature) _____ ☐ MD ☐ RM ☐ NP

Perinatal Services BC
Provincial Health Services Authority

Obtaining Copies of the BC Antenatal Record

For sites wishing to order forms or to obtain ordering information, please refer to the PSBC website:
perinatalservicesbc.ca/health-professionals/forms

If you have any questions or feedback about any of the PSBC perinatal forms, please email **psbc@phsa.ca** or call **604-877-2121**.