ANSC GP Resource Manual

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Central and Eastern Sydney PHN:
Funding: The Australian Government Department of Health is acknowledged as a funding body for Central and Eastern Sydney PHN.

Disclaimer: Whilst every reasonable effort has been made to ensure that the information given in this resource is accurate, Sydney Local Health District and Central and Eastern Sydney PHN will not accept liability for any injury, loss or damage arising directly or indirectly from any use or reliance on this information.

This Antenatal Shared Care (ANSC) GP Resource Manual is intended as a guide for general practitioners participating in the SLHD/CESPHN Antenatal Shared Care Program with RPA Women and Babies and Canterbury Hospital

Protocols and guidelines have been developed in conjunction with the Sydney Local Health District (SLHD) maternity facilities in an effort to provide consistent care for GP shared care patients.

The guidelines are expressed in broad principles, which allow for flexibility in clinical judgement in individual cases. Participation in shared care implies acceptance of the agreed guidelines.

This version has been updated and restructured to reflect service, configurations, contact numbers and clinical practice at the time of production

Information may change over the life period of the document. Updated protocols and guidelines will be published on the Central and Eastern Sydney PHN website – www.cesphn.org.au and Healthpathways Sydney - https://sydney.healthpathways.org.au

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Acknowledgement and thanks to all those who contributed to this document.
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Introduction to GP Antenatal Shared Care

The aim of this manual is to provide resources and references for general practitioners (GPs) involved in the shared care of low-risk antenatal patients with RPA Women and Babies and Canterbury Hospital. Women with moderate risk pregnancies will require individually tailored care and may receive most of their care from the antenatal clinic or high-risk clinics. Pregnancy risk may also alter during the course of the pregnancy.

An overall principle of shared maternity care requires that all parties provide comprehensive care, adequate documentation and maintain effective communication.

Overview

The Antenatal Shared Care (ANSC) program is a joint initiative of the Sydney Local Health District (SLHD) and the Central and Eastern Sydney PHN (CESPHN).

All women attending the RPA Women and Babies and Canterbury Hospital for management of their pregnancy and delivery have the option of having their antenatal care provided collaboratively by a Recognised ANSC GP and the hospital-based services. This is dependent upon their wishes, agreement by their GP and agreement by the hospital after assessment of risk factors.

For women, some of the benefits of shared care is the continuity and coordination of care; care provided within an established relationship; catering for the preferences and needs of women from culturally and diverse backgrounds, less travelling time; flexibility and convenience.

For GPs, shared care provides the opportunity to provide total patient care, including postnatal; development of linkages and communication with specialists and hospital staff; and access to continuing professional development in antenatal and postnatal care.

Program Registration

GPs wishing to participate in GP ANSC must be registered with the program. Registration for ANSC requires:

- Completion of an ANSC Program Application Form
- Current medical registration with AHPRA
- Current membership of a medical defence association
- Attendance at an ANSC Orientation Session facilitated by the GP Liaison Midwife. These sessions are held regularly throughout each year

GP Registrars are eligible to participate in the program but are required to be supervised by a Recognised GP within the practice.

ANSC GP Lists

GPs participating in the ANSC program are referred to as a Recognised ANSC GP. ANSC GP lists are sent by CESPHN ~3 monthly to the antenatal clinics at both RPA Women and Babies and Canterbury Hospital.
Clinical Advice and Support

GPs participating in antenatal shared care will be supported by and must follow the agreed scheduled visits as outlined in the SLHD Antenatal Shared Care Protocol.

1. For any clinical issues, concerns or advice which arise during the care of patients, please contact:
   Clare Jordan: SLHD GP Liaison Midwife (ph. 0425 230 662 or ph. 9515 7416) Mon-Thurs OR Hospital obstetric team (Registrars ph. RPA ph. 9515 6111 or Canterbury ph. 9787 0000)

2. For general program advice, please contact:
   Karen Wheeler: CESPHN Maternal Project Officer ph. 9799 0933 Mon-Thurs

   **Username:** connected ; **Password:** healthcare

   This is an online health information portal for GPs specific to the Sydney Local Health District (SLHD) and provides GPs with locally relevant information about assessment, management and referral options for specific conditions. NB. This manual will refer to Healthpathways Sydney for additional clinical and referral pathway information.
   (You will need to first log into Healthpathways to access referred links directly)

   Australian Government Department of Health.

5. The ANSC Program Advisory Group is a forum of ANSC representatives (including a panel of experienced ANSC GPs) which supports the program in developing program standards, education priorities and ongoing evaluation of SLHD ANSC activities. If you wish to contact an ANSC GP representative for advice or have issues you would like discussed, please contact CESPHN for their details.

Information and Updates

**Healthpathways Sydney**: [https://sydney.healthpathways.org.au](https://sydney.healthpathways.org.au)
   **Username:** connected ; **Password:** healthcare

Online health information portal for GPs specific to Sydney Local Health District (SLHD) regarding pregnancy, postnatal and women’s health issues. This manual will refer to Healthpathways Sydney for additional clinical and referral pathway information.

**Resource Laminates**
The SLHD ANSC Protocol and other useful resources are available as laminated copies to keep on your desk for easy reference.

The CESPHN ANSC webpage provides access to resources, protocols, guidelines and referral templates. All ANSC GPs are encouraged to visit the website regularly.

**CESPHN e-ANSC newsletter (bi-monthly)**
Important information and updates are distributed via the e-ANSC newsletter. Those GPs participating in the program are encouraged to join the ANSC GP email distribution list to receive this communication.

**CESPHN e-Newsletter: Sydney Health Weekly (weekly)**
Program news across CESPHN which may include maternal health information e.g. upcoming ANSC CPD events.
Ongoing Educational Requirements

There are on-going educational requirements to remain a Recognised ANSC GP. Each ANSC GP is required to accrue at least 12 Category 2 points for each Royal Australian College of General Practitioners (RACGP) triennium i.e over a three year period. This may be achieved through attendance at face-to face or on-line antenatal and/or postnatal specific Continuing Professional Development (CPD) education events.

Attendance at an educational activity is not restricted to those only offered by CESPHN. Participation in RACGP accredited ANSC events with other hospitals or services are accepted. Attendance at a clinical activity or placement is highly recommended but is not compulsory.

CESPHN ANSC educational events will be advertised in the CESPHN’s weekly e- newsletter and website. GPs are required to be a financial member of CESPHN to attend educational activities free of charge. GP Registrars are able to attend CPD free of charge whilst they are on rotation within the CESPHN area.

Opportunities to attend clinical placements are available. There is a requirement to complete Honorary Observer paperwork before participating in a hospital-based activity. For further information, please contact CESPHN ph. 9799 0933

Educational activity records are monitored and recorded by the CESPHN Maternal Health and CPD Project Officer. If a GP is unable to meet these educational requirements their ANSC Recognition will be withdrawn, and the GP will not be able to continue participating in the SLHD Antenatal Shared Care program.

RANZCOG Qualifications

GPs interested in extending their skills in this field may choose to undertake a Certificate of Women’s Health or a Diploma with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). For more information go to https://www.ranzcog.edu.au/Training/Certificate-Diploma

Quality Assurance

GPs participating in program will be expected to adhere to agreed policies and procedures as outlined in this ANSC GP Resource Manual when caring for their antenatal shared care patients. Breaches of ANSC protocol that affect patient outcomes will be recorded for quality assurance purposes. GPs may be contacted by the GP Liaison Midwife if policies and protocols are breached in order to maintain appropriate program standards. Repeated breach of protocols will be addressed by the SLHD Clinical Director of Women’s Health, Neonatology and Paediatrics which may result in GP ANSC Recognition being withdrawn, and the GP unable to continue participating in the SLHD Antenatal Shared Care program.
### Key Contacts

#### Program Contacts

<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare Jordan</td>
<td>SLHD GP Liaison Midwife</td>
<td>ph. 0425 230 662, ph. 9515 7416</td>
</tr>
<tr>
<td>Karen Wheeler</td>
<td>CESPHN Maternal and Child Health Project Officer</td>
<td>ph. 1300 986 991</td>
</tr>
</tbody>
</table>

#### RPA Women and Babies ph. 9515 6111

- General enquiries
- Paging medical, midwifery and nursing staff

#### Antenatal Clinic

First Hospital Appointment Bookings

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Clinic</td>
<td>ph. 9515 8090</td>
</tr>
<tr>
<td>Birth Centre</td>
<td>ph 9515 6405</td>
</tr>
<tr>
<td>Midwifery Group Practice</td>
<td>ph. 9515 8894</td>
</tr>
<tr>
<td>Delivery Ward</td>
<td>ph. 9515 8420</td>
</tr>
<tr>
<td></td>
<td>Direct line for GPs</td>
</tr>
<tr>
<td></td>
<td>ph. 9515 8444</td>
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</tbody>
</table>

#### Gynaecology Clinic

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
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</thead>
<tbody>
<tr>
<td>Diabetes Centre</td>
<td>ph. 9515 5888</td>
</tr>
<tr>
<td>Genetic Counselling</td>
<td>ph. 9515 5080</td>
</tr>
<tr>
<td>Lactation Consultant</td>
<td>ph. 9515 8422</td>
</tr>
<tr>
<td>Parent Education</td>
<td>ph. 9515 5284</td>
</tr>
<tr>
<td>Sexual Health Clinic</td>
<td>ph. 9515 3131</td>
</tr>
<tr>
<td>Aboriginal Liaison Midwife</td>
<td>ph.9515 6586</td>
</tr>
<tr>
<td>Perinatal Mental Health</td>
<td>ph. 9515 5873</td>
</tr>
<tr>
<td>Social Work</td>
<td>ph. 9515 6616</td>
</tr>
<tr>
<td>Thyroid Clinic</td>
<td>ph. 9515 7225</td>
</tr>
<tr>
<td>Hepatitis B (HBV)</td>
<td>ph. 9515 6228</td>
</tr>
<tr>
<td>Hepatitis C (HCV)</td>
<td>ph. 9515 7049</td>
</tr>
<tr>
<td>Early Pregnancy Assessment Service (EPAS)</td>
<td>ph.0429 728 608</td>
</tr>
<tr>
<td>Early pregnancy bleeding (&lt; 20 weeks pregnant)</td>
<td>fax. 9515 3454</td>
</tr>
<tr>
<td>Fetal Medicine Unit</td>
<td>ph. 9515 6042</td>
</tr>
<tr>
<td>cFTS, NIPT, CVS, Amniocentesis, Ultrasound</td>
<td>fax: 9515 6579</td>
</tr>
</tbody>
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#### RPA Women and Babies Executive Unit ph. 9515 8356

Director of Women’s Health, Neonatology and Paediatrics, SLHD
Canterbury Hospital ph. 9787 0000

• General enquiries
• Paging medical, midwifery and nursing staff

Antenatal Clinic
Antenatal Appointment Bookings: ph. 9787 0250
9787 0560

Faxing results to Antenatal Clinic fax. 9787 0431

Midwives Desk ph. 9787 0183
Midwifery Unit Manager ph. 9787 0577
Midwifery Group Practice ph. 9787 0000
Birthing Unit ph. 9787 0555
9787 0554

Midwife Practitioner ph. 9787 0572
Social Work ph. 9787 0121
Perinatal Mental Health ph. 9787 0000 page via switch
Diabetes Educator CNC ph. 9787 0248

Gynaecology Clinic (Outpatients Level 3) ph. 9787 0161 fax. 9787 0094
Substance Use in pregnancy & Parenting Support ph. 0436 601 980

Other Services

Mothersafe. ph. 9382 6539
Counselling service for women and healthcare providers concerned about exposures and medications during pregnancy and lactation. Further information: www.mothersafe.org.au

RPA Gynaecology Service fax. 9515 3454
Referrals by FAX ONLY. Referrals will be triaged to appropriate clinic. Staff will contact the woman within three business days after referral received. ONLY two attempts will be made to book appointment time.

Smoking Cessation Clinics RPA ph. 9515 7611
Croydon CHC ph. 9378 1306

Aboriginal Health Service ph. 9319 5823
Service provision for all Aboriginal women within Inner West/Central Sydney

RPA Breast Clinic ph. 9515 8844
Women with breast related problems.

RPA Lifehouse Colposcopy ph. 8514 0262
Women with abnormal pap smear results that require colposcopy such as CIN, HPV infection during pregnancy. Further information: http://www.mylifehouse.org.au/for-doctors/refer-a-patient/

RPA Fertility Unit General Enquires ph. 9515 8824
Appointments ph. 9515 7101

Interpreter Service ph. 131 450

Multicultural Health ph. 9562 0500

Poisons information service ph. 13 11 26

Domestic Violence Hotline ph. 1800 65 64 63
1800 RESPECT

Pregnancy, Birth and Baby Helpline ph. 1800 882 436
Models of Antenatal Care

Refer to Healthpathways Sydney – Antenatal Care First Consult

Public Care

Different models of antenatal care are available at RPA Women and Babies and Canterbury Hospital

GP Antenatal Shared Care (ANSC)
This program enables a woman to be cared for by a general practitioner (GP) during her pregnancy. This GP will have gained specific training and recognition to provide shared care with the hospital clinics.

GP ANSC provides regular and professional care throughout a pregnancy up until the time of baby birth and ongoing after the woman and baby leave hospital. Shared Care may be with the hospital Midwife Antenatal Care Clinic or Birth Centre (RPA only).

Midwife Antenatal Care Clinic (MAC) RPA or Canterbury
A midwife provides care, education and advice during the woman’s pregnancy. The clinic aims to provide continuity of antenatal care by endeavouring to schedule appointments with the same midwife at each visit.

The woman will only see a doctor if the midwives requires the woman to have a medical review. The delivery suite midwives will care for the woman in labour and childbirth.

Birth Centre - RPA only
A team of midwives provides care education and advice during the woman’s pregnancy. It is an option of care for low risk women who want minimal intervention with their labour and birth. The Birth Centre staff will also care for the woman in labour, birth and the immediate postnatal period. Ph. 9515 6405

Midwifery Group Practice (MGP) RPA or Canterbury
A team of midwives, each providing pregnancy, birthing, and early parenting support for a specified number of women per year. The nominated midwife acts in partnership with the women under her care to achieve a safe and rewarding pregnancy, birth, and early parenting experience. The nominated midwife will provide all antenatal clinic visits as well as care for her during labour.

For women having MGP care at Canterbury Hospital, if risk factors develop during the pregnancy, their care will be collaborative between the high risk clinics and the MGP midwife. The woman may give birth at RPA. MGP RPA ph 9515 8894 or Canterbury ph. 9787 0000

High Risk and Specialist Clinics
An obstetric team (obstetricians, obstetric registrar, and experienced midwives) provide care, education and advice for women with a complicated pregnancy.

All high risk referrals should be referred to the ANC for triage. The hospital will determine the timing and clinic allocation. RPA Women and babies: RPA Obstetric Referral Form – Fax 9515 3454. Canterbury Hospital: Canterbury Hospital Obstetric Referral Form – Fax 9787 0431

Women with a high risk pregnancy will remain with the High Risk Clinic or Specialist Clinic. Other specialised clinics may also be involved in care. Women with medium risk are given a management plan and return to their general practitioner or midwife for shared antenatal care.

Depending on the risk, women will give birth at RPA Women and Babies or Canterbury Hospital
**Aboriginal Liaison Midwife**
Designated midwife who assists in providing care for Aboriginal and Torres Strait Islander women, or women who are pregnant with an Aboriginal or Torres Strait Islander baby. Care may also be shared with general practitioners or the Aboriginal Medical Service at Redfern. Referral to Clinics and other obstetric care is arranged as needed. Midwives provide care during pregnancy, labour, birth, and the postnatal period while in hospital.

**Midwifery Discharge Support Program (MDSP)**
Option available for women who have had a normal pregnancy and an uncomplicated vaginal or caesarean birth, have good supports and are coping well and wish to go home early.

The midwife will visit daily to check both mother and baby and to support establishment of infant feeding.

<table>
<thead>
<tr>
<th></th>
<th>Normal discharge (within hours of birth)</th>
<th>MDSP (within hours of birth)/MGP</th>
</tr>
</thead>
<tbody>
<tr>
<td>First birth</td>
<td>48 to 72</td>
<td>4 to 48</td>
</tr>
<tr>
<td>Subsequent birth</td>
<td>24 to 48</td>
<td>4 to 24</td>
</tr>
<tr>
<td>Caesarean birth</td>
<td>96</td>
<td>72</td>
</tr>
</tbody>
</table>

**Private Care**
Private antenatal care and delivery options are available at RPA Women and Babies and Canterbury Hospital as well as at a variety of private hospitals around Sydney.

**Obstetric Visiting Medical Officers : RPA Women and Babies**

Dr. Sofia Smirnova  
RPAH Medical Centre  
Suite 404, 100 Carillon Ave  
NEWTOWN NSW 2042  
P - 9557 4888  
F - 9550 6257

Dr. Po-Yu Huang  
RPAH Medical Centre  
Suite 310, 100 Carillon Avenue  
NEWTOWN NSW 2042  
P - 9519 2704  
F - 9519 8605

Dr. Sue Jacobs  
RPAH Medical Centre  
Suite 409, 100 Carillon Ave  
NEWTOWN NSW 2042  
P - 9516 1616  
F - 9519 8662

Dr. Ian Hill  
RPAH Medical Centre  
Suite 320, 100 Carillon Ave  
NEWTOWN NSW 2042  
P - 9519 8929  
F - 9557 8094

Dr. Anthony Frumar  
RPAH Medical Centre  
Suite 408, 100 Carillon Ave  
NEWTOWN NSW 2042  
P - 9516 4308  
F - 9550 3927

Dr. Karuna Raja  
RPAH Medical Centre  
Suite 421, 100 Carillon Ave  
NEWTOWN NSW 2042  
P - 9550 5766  
F - 9557 2593

Dr. Louis Izzo  
53 Renwick St  
LEICHHARDT NSW 2040  
P - 9569 3454  
F - 9569 6553

Dr. David Kowalski  
Level 7, 187 Macquarie Street  
SYDNEY NSW 2000  
P - 9221 7390  
F - 9232 6270

Dr. Stephen Morris  
Suite 402, 135 Macquarie Street  
SYDNEY NSW 2000  
P - 9251 8550  
F - 9251 8525

Dr. Jason Ting  
RPAH Medical Centre  
Suite 302, 100 Carillon Ave  
NEWTOWN NSW 2042  
P - 9519 8881  
F - 9519 8881

Dr. Surya Krishnan  
RPAH Medical Centre  
Suite 312A, 100 Carillon Ave  
NEWTOWN NSW 2042  
P - 1300 738 690  
F - 9519 0332

Dr. Anthony Marron  
Suite 3.03  
205 Pacific Hwy  
St. Leonards NSW 2065  
P - 1300 330 990  
F - 1300 440 990
Gynaecology Visiting Medical Officers: RPA Women and Babies

Dr Nesrin Varol
171 Macquarie Street
SYDNEY NSW 2000
P - 9251 1525
F - 9252 6676

Dr Surya Krishnan
RPAH Medical Centre
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F - 9519 0332

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F - 1300 440 990

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F - 8883 4380

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EASTWOOD NSW 2122
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F - 9874 5543

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F -

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P - 9557 4883
F - 9550 6257

Dr Christopher Benness
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F - 9550 3927

Dr Mark Bowman
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SYDNEY NSW 2000
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F - 9232 5909

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## Obstetric & Gynaecology Visiting Medical Officers: Canterbury Hospital

<table>
<thead>
<tr>
<th>Name</th>
<th>Phone</th>
<th>Fax</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Viola GABRIEL</td>
<td>9744.7240</td>
<td>9744.7260</td>
<td>Suite 25 Level 4, 12 Railway Pde Burwood NSW 2134</td>
</tr>
<tr>
<td>Dr. Ann Prys</td>
<td>9701.0544</td>
<td>9701.0533</td>
<td>Suite 5B Level 1, 28 Burwood Rd Burwood NSW 2134</td>
</tr>
<tr>
<td>Dr. David KOWALSKI</td>
<td>9221.7390</td>
<td>9622.8686</td>
<td>L7, 187 Macquarie St, Sydney NSW 2000</td>
</tr>
<tr>
<td>Dr. Louis IZZO</td>
<td>9569.3454</td>
<td>9569.6553</td>
<td>53 Renwick St, Leichhardt NSW 2040</td>
</tr>
<tr>
<td>Dr. Jason TING</td>
<td>8065.3680</td>
<td></td>
<td>Suite 404/100 Carillon Ave, Newtown 2042</td>
</tr>
<tr>
<td>Dr. Wagdy NADA</td>
<td>9789.5038</td>
<td>9718.5326</td>
<td>Suite 107 L1, 308 Beamish St Campsie NSW 2194</td>
</tr>
<tr>
<td>Dr. Lourdes St. GEORGE (Affiliated VMO)</td>
<td>9744.5597</td>
<td>9747.5882</td>
<td>36 Belmore Street, Burwood NSW 2134</td>
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<tr>
<td>Dr. Kevin Pui Ru) KOH</td>
<td></td>
<td></td>
<td>Suite 1 Level 1/5 Arthur St, CABRAMATTA 2166</td>
</tr>
<tr>
<td>Dr. Aye (Su) HTUN</td>
<td>0412-287-279</td>
<td>9728-6287</td>
<td>Suite 8 1-5 Jacobs St Bankstown 2200</td>
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<tr>
<td>Dr. Sacha STROCKYI</td>
<td></td>
<td></td>
<td>1/556-558 Marrickville Rd, DULWICH HILL 2203</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ph: 0452-555-100, <a href="mailto:OBGYNSyd@gmail.com">OBGYNSyd@gmail.com</a></td>
</tr>
</tbody>
</table>

**Dr. Kevin Pui Ru) KOH**  
*Staff Specialist (P/T)*  
Department of O&G Canterbury Hospital  
Canterbury Road CAMPSIE NSW 2194  
Ph 9787-0000 pager 89132  
*Private Rooms:*  
M. 0423-595-088

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OBGYNSyd@gmail.com
Communications

Antenatal record card

SLHD maternity facilities use a hand-held “yellow” antenatal record card. These cards are issued to the woman by her GP at her initial visit and must be taken by the woman to her hospital booking visit.

At each visit, this card should be updated with routine findings and examinations and be sufficient to meet the care provider’s duty of care. Entries should be clear, concise and legible. If using clinical software, please print out each visit and include this with the hand-held record. GP’s should stamp their details on the top right hand corner of the card. It is helpful to note the external pathology provider to access results.

Completion of the antenatal record card is a requirement of the SLHD ANSC Protocol and is an important aspect of the communication process between the GP and the hospital. Women should be encouraged to carry their antenatal record card with them at all times throughout their pregnancy and to bring it to every appointment with all health professionals.

To ensure adequate communication, each request form should note the GP contact details. GPs ordering investigations should request copies of results be sent or faxed to the relevant hospital from external pathology providers or give copies to the woman to bring to her next antenatal clinic visit.

RPA Women and Babies Fax 9515 7452 Canterbury Hospital Fax 9787 0431

Suitability for antenatal shared care

GP ANSC is an option for all women who have been assessed by the hospital as healthy and with a low risk pregnancy. It is the hospital’s responsibility to establish a woman’s suitability for this model of care.

At hospital booking visit, women will be triaged according to their risk of developing pregnancy complications. Women triaged as Category A “low risk”, will see a midwife or ANSC GP for their second visit according to model of care. Women triaged as Category B or C may require a 2nd hospital visit to determine responsibility of care.

At Canterbury Hospital, women requesting ANSC with their GP will have a second visit with a VMO or Staff Specialist.

Recognised ANSC GP will receive a letter from the relevant hospital confirming this ongoing model of care.

Please reinforce with Practice staff that women who have opted for GP ANSC must have ALL scheduled antenatal visits attended by the Recognised ANSC GP. If you are away, the woman should be seen by another Recognised ANSC within your practice or referred to the hospital for the scheduled visit.

Indications for discussion, consultation and/or referral

There may be specific indications for discussion, consultation and/or transfer of care when first discussing a woman’s needs during initial visits. The National Midwifery Guidelines for Consultation and Referral may assist shared care GPs in stratifying risk, providing the best possible care and making decisions about future care arrangements for women at different stages of their pregnancy.
These indications are categorised as **Discuss**, **Consult** and/or **Refer** covering matters such as medical conditions, pre-existing gynaecological disorders, previous obstetric history and indications developed/discovered during pregnancy. The main purpose of the indication list is to provide a guide for risk-selection.

In any circumstances that need clarification, the GP should seek advice from the GP ASC Liaison Midwife or an O&G Registrar.

**Abnormal results**

Any investigations requested by the GP for a woman under his/her care must be followed up by the GP concerned. It is the primary responsibility of the provider ordering the test or noting an abnormal finding to ensure appropriate follow-up management and communication, irrespective of whether a copy has been sent to the relevant hospital. Contact the GP Liaison Midwife or refer to *Healthpathways Sydney* to discuss relevant referral pathways.

**Non-Attendance at antenatal clinic (ANC)**

If a woman does not attend an antenatal visit and no substitute appointment has been made, the ANC may attempt to contact the woman to arrange another appointment. If the woman is unable to be contacted or she refuses to attend, the referring GP will be notified.

**Admission during pregnancy**

If a woman is admitted to hospital during the antenatal period, she will receive a copy of the discharge summary and a copy sent to her GP.
Hospital Maternity Unit booking process

Refer to Healthpathways Sydney – Antenatal Care First Consult

NB: This booking information is only for public patients. It does not apply to women electing to have care from a private obstetrician practising at RPA Women and Babies and/or Canterbury Hospital

ALL women, regardless of whether a routine or high risk referral, are initially required to book their first hospital appointment ASAP. This visit should be scheduled for ~ 12-14 weeks gestation
To book: RPA online; Canterbury Hospital ph. 9787 0250 or 9787 0560. The GP should ensure that the woman has arranged this first hospital appointment. Be aware that this process differs between RPA Women and babies and Canterbury Hospital.

Early or Urgent Consult /High Risk assessment

It is important that if you see a woman in the first trimester who you may consider a risk of complication of pregnancy that they be referred for early review in pregnancy and do not wait until their first hospital booking in appointment. This is officially called a “consultation in pregnancy” and these consultations are seen in the various high risk pregnancy clinics at the hospital.

RPA Women and Babies:

For Referral:
Women must be referred to the antenatal clinic (ANC) in the first instance for triage. The hospital will then determine the timing and allocation to specialist clinic or clinics.

1) Arrange first hospital appointment by completing on-line booking form.
   The GP or woman can complete this process (Form can also be located on RPA Women and Babies Select ‘Information for Pregnant Women’; select ‘Public Patient Bookings’; complete ‘First Antenatal Appointment Form’ on-line and click ‘Submit’)

2) GP to complete RPA Women and Babies Obstetric Referral Form with adequate clinical information including:
   • Diagnosis
   • Previous obstetric history
   • Gynaecological disorders
   • Medical conditions including and treatment, medications, Specialists (name & location) and attach any recent specialist letters
   • Any other issues

Fax Obstetric Referral Form to ANC Fax: 9515 3454 for initial triage.

3) Complete “yellow” antenatal record card and give to woman to take to the specialist appointment
   Further assistance contact GP Liaison Midwife ph. 0425 230 662 or (urgent) O&G Registrar.

Appointment follow-up:
Following receipt of faxed referral, hospital staff will contact the woman via phone with appointment date and outlining further information that is required to brought to the appointment

Canterbury Hospital:

For Referral:

1) GP to complete Canterbury Hospital Obstetric Referral Form with adequate clinical information including:
   • Diagnosis
   • Previous obstetric history
• Gynaecological disorders
• Medical conditions including and treatment, medications, Specialists (name & location) and attach any recent specialist letters
• Any other issues

Fax Canterbury Hospital Obstetric Referral Form to ANC  Fax : 9787 0431

2) Complete “yellow” antenatal record card and give to woman to take to the specialist appointment

Further assistance contact Midwifery Unit Manager ph. 9787 0557 or GP Liaison Midwife ph. 0425 230 662 to discuss or (urgent) O&G Registrar. Upon assessment, the woman may be referred to RPAH.

Appointment follow-up:
Following receipt of faxed referral, hospital staff will contact the woman via phone with appointment date and outlining further information that is required to brought to the appointment

Routine/Low Risk obstetric assessment:

RPA Women and Babies:

For Referral :

1) Arrange first hospital appointment by completing on-line booking form.
The GP or woman can complete this process (Form can also be located on RPA Women and Babies Select ‘Information for Pregnant Women’; select ‘Public Patient Bookings’; complete ‘First Antenatal Appointment Form’ on-line and click ‘Submit’)

This appointment should scheduled for when the woman is ~ 12-14 weeks gestation.

2) GP to complete Obstetric Referral Form ( in lieu of GP referral letter) and antenatal “ yellow” record card. Give both to the woman to bring with her to the first hospital “booking in” appointment.
   o DO NOT fax or post the referral form as it is not a booking request.

Booking follow-up:
Hospital staff will contact the woman via mail (~ 2 weeks) with a letter noting appointment date and outlining documents that are required to be brought to the appointment. Failure to do this will result in the booking not being accepted. This includes:

• “Yellow”Antenatal Record Card
  o Obtained and completed by Recognised ANSC GP. The EDB must be noted in the appropriate place on this card before it can be accepted.

• All pathology and ultrasound results
  o Note external pathology provider to “cc” ALL results to ANC Fax 9515 7452
  o Document external pathology provider on antenatal record card (if results need to be followed-up)

• Medicare Card
  o For those patients that do not hold a Medicare card, charges will apply.

• Health Insurance  (if any)

• Photo Identification
  o Drivers licence or Passport etc.

• Recent documentation confirming home address
  o An official rental receipt, current residential tenancy agreement or council rate notice

At this appointment, women will be provided with the Hospital’s Maternity Information Package which contains resources and a number of patient information brochures. Allow ~ 2hrs for this appointment.
Canterbury Hospital:

For Referral:

1) Woman (or GP) to contact hospital to arrange first hospital appointment ph. 9787 0250 or ph. 9787 0560
2) GP to complete Canterbury Hospital Obstetric Referral Form and antenatal “yellow” record card. Give both to the woman to bring with her to the first hospital appointment
   o DO NOT fax or post the form as it is not a booking request.

Booking follow-up:
At time of booking, women will be given their appointment date and time as well as outlining the documents that are required to be brought to the appointment. Failure to do this will result in the booking not being accepted. This includes:

- **“Yellow” Antenatal Record Card**
  o Obtained and completed by Recognised ANSC GP. The EDB must be noted in the appropriate place on this card before it can be accepted.

- **All pathology and ultrasound results**
  o Note external pathology provider to “cc” ALL results to ANC Fax 9787 0431
  o Document external pathology provider on antenatal record card (if results need to be followed-up)

- **Medicare Card**
  o For those patients that do not hold a Medicare card, charges will apply.

- **Health Insurance** (if any)

- **Photo Identification**
  o Drivers licence or Passport etc.

- **Recent documentation confirming home address**
  o An official rental receipt, current residential tenancy agreement or council rate notice

At this appointment, women will be provided with the Hospital’s Maternity Information Package which contains resources and a number of patient information brochures. Allow ~ 2hrs for this appointment.

RPA Birth Centre

Women should contact the Birth Centre directly ph. 9515 6405 to book and arrange their first information session. This care option is available for low to moderate risk pregnancies and women committed to a natural birth.

Midwifery Group Practice (MGP) RPA or Canterbury

Women should directly contact the relevant MGP at either hospital to arrange booking
RPA Ph. 9515 8894  Canterbury ph. 9787 0000

Booking for Delivery at RPA Women and Babies

All antenatal patients need to book their bed for delivery after 20 weeks gestation. The woman will need to take her antenatal record card and registration form to the Booking Office: RPA Medical Centre Suite 210, Level 2, cnr Carillon Avenue and Missenden Road.

Whilst every effort will be made to accommodate all our expectant mothers, once the hospital reaches maximum capacity they will no longer be able to accept any additional bookings.

**The Booking Office is open from 7.30am till 5.00pm Monday to Friday**
Hospital Referral postcodes

Maternity Bookings within Sydney Local Health District (SLHD)
For those women who live in SLHD, bookings to the two maternity hospitals, RPA Women and Babies and Canterbury, will be initially made according to postcode boundaries as listed in tables below.

Transfers between the two hospitals will be according to existing hospital protocols.

Maternity Bookings to RPA and Canterbury External to SLHD
There will be no restrictions on bookings to RPA or Canterbury where place of residence is external to SLHD. This process will be monitored closely to ensure we meet the needs of women requiring maternal care.

RPA Women and Babies

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Canterbury Hospital

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Antenatal Shared Care Protocol: “At a glance”

Refer to Healthpathways Sydney – Antenatal Care First Consult

To ensure essential procedures are undertaken in regards to antenatal care, this “at a glance” checklist has been developed to outline important points in the SLHD ANSC protocol.

The needs of each pregnant woman should be reassessed at each visit throughout the pregnancy. The timing of antenatal visits may alter at the discretion of the GP and if the woman develops any risk factors.

Please ensure you consult the SLHD ANSC Protocol for more details regarding each visit.

Early pregnancy
Have you:

- Arranged all routine screening bloods (as per ANSC protocol)
  - FBC, blood group, antibody screen,
  - HepBsAg, anti-HCV, anti-HIV, syphilis serology, rubella titre, varicella IgG
  - Thalassaemia screening, include Hb EPG-screen partner if result abnormal
- Considered an STI check
- Arranged an “early consultation in pregnancy” appointment if considered a risk of complication
- Arranged early screening * for women identified as “at high risk” for gestational diabetes
- Discussed prenatal screening including Combined First Trimester Screening (cFTS); NIPT
- Referred to genetic counselling (if relevant)
- Recommended seasonal influenza vaccination
- Completed the antenatal record card (at each visit)
- Referred patient to arrange first hospital booking appointment at relevant hospital between 12-14 weeks gestation

Second trimester
Have you:

- Arranged gestational diabetes screening 75gm oGTT: 26-29 weeks
- Arranged blood tests (as per ANSC protocol)
- Arrange fetal morphology scan: 18-20 weeks
- Monitored fetal wellbeing especially fetal movements (at each visit)
- Completed the antenatal record card (at each visit)

Third trimester
Have you:

- Arranged blood tests (as per ANSC protocol)
- Recommend pertussis vaccination: 28 weeks
- Arranged third trimester ultrasound: 34-36 weeks (RPA only)
- Attended GBS screen: 35-37 weeks
- Monitored fetal well-being especially fetal movements (at each visit)
- Completed the antenatal record card (at each visit)

Clare Jordan, GP Liaison Midwife ph. 0425 230 662 can be contacted if you have any clinical questions or concerns.
# Antenatal Shared Care Protocol: Schedule of visits

## Antenatal Clinic

### GP Antenatal Shared Care Protocol Summary

**Antenatal Clinics – RPA Women and Babies, Canterbury Hospital**

#### ANSC GP role
- ANSC GP responsible for care prior to antenatal clinic (ANC) visit
- Any investigations requested by the GP for the woman under his/her care must be followed up by the GP concerned
- It is the responsibility of the provider ordering the test or noting an abnormal finding to ensure appropriate follow-up and communication, irrespective of whether a copy is sent to the hospital
- Schedule GP visits around ANC appointments and timely review of results
- Document visits in antenatal record card (yellow card)

#### Referrals
- ALL women should be referred for hospital ‘booking in’ appointment once pregnancy is confirmed
- ‘Booking in’ appointment should be attended ~12-14 weeks gestation
- Women with risk factors or significant complications require early referral

### Timing and investigations and actions

<table>
<thead>
<tr>
<th>Timing</th>
<th>Investigations and actions</th>
<th>Discussion and considerations</th>
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<tbody>
<tr>
<td>6-10 weeks</td>
<td>Confirm pregnancy (β-hCG) and dates; review medical, surgical, psychosocial factors, family history, previous pregnancies outcomes, medications, allergies etc.</td>
<td>Discuss SNAP: nutritional advice including folic acid and iodine supplements; drug avoidance (alcohol, smoking, other drugs); physical exercise</td>
</tr>
<tr>
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<td>Complete examination including BP, weight, calculate BMI, cardiac, respiratory, abdomen, thyroid, breast exam and identify any risk factors</td>
<td>Referral to genetic counselling if hereditary condition, consanguinity, previous baby with a genetic, chromosomal or congenital abnormality, recurrent miscarriages, abnormal thalassaemia screen</td>
</tr>
<tr>
<td></td>
<td>Offer seasonal influenza vaccination</td>
<td>Consider Vitamin D screening (if high risk)</td>
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<tr>
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<td>Routine antenatal screening blood tests - FBC, blood group, antibody screen, - Hep B sAg, anti-HCV, anti-HIV, syphilis serology, rubella, varicella - Thalassaemia screening, include HbEPG - screen partner if result abnormal</td>
<td>Consider screening for thyroid disease (if high risk)</td>
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<td>MSU – MC &amp; S - HVS PCR or first stream urine PCR for chlamydia (women aged &lt; 29 years or new partner) - Cervical screen (if due)</td>
<td>Models of antenatal care including timing and content of antenatal visits</td>
</tr>
<tr>
<td></td>
<td>Arrange early testing for hyperglycaemia in pregnancy if identified at risk (as per guidelines)</td>
<td>Arrange early “consultation in pregnancy” appointment if considered a risk of complication of pregnancy.</td>
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<td>Discuss and offer prenatal screening (optional) 10 weeks – Non-Invasive Prenatal Testing (NIPT) - first trimester ultrasound still recommended 11-13 +6 weeks - Combined First Trimester Screening (cFTS): nuchal translucency and biochemistry</td>
<td>All referrals for early or high risk consults will be triaged by the ANC and the hospital will determine the timing and allocation to specialist clinics.</td>
</tr>
<tr>
<td><strong>Administration</strong></td>
<td>Refer woman to ANC for ‘booking in’ appointment. Optimally ~12-14 weeks gestation (RPA online; TCH ph. 9787 0250)</td>
<td>FAX referral to ANC RPA 6515 7452 or Canterbury 9787 0431</td>
</tr>
<tr>
<td></td>
<td>Document visit in antenatal record card (yellow card)</td>
<td>Contact GP Liaison Midwife ph 0425 230 682 (if required)</td>
</tr>
<tr>
<td></td>
<td>Complete request forms: - Combined First Trimester Screening (cFTS) - ultrasound + blood test: 18-20 week morphology scan</td>
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### 12-14 weeks
- **Hospital Antenatal Clinic (ANC) Booking In appointment**
  - Review history, test results and clinical assessment
  - Complete psychosocial assessment– referral if required
  - RPA -Triage for risk of pregnancy complications and model of care. Confirms suitability for GP ANSC - GP contacted via letter
  - Canterbury -Triage for risk of pregnancy complications and model of care. Women will have VMO/ Staff Specialist appointment if requesting ANSC
  - Complete administrative details.

#### Tests
- Blood group and antibody screen
- Arrange early testing for hyperglycaemia in pregnancy for identified at risk patients (if not already attended)

### 18-20 weeks
- Attend morphology scan (RPA or external provider)

Models of antenatal care including timing and content of antenatal visits

Parent education and breastfeeding assessment

If risk factors identified, refer for early consult at hospital specialist clinic.
<table>
<thead>
<tr>
<th>Use of a fetal doppler for fetal heart rate monitoring is recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Concerns regarding reduced or absent fetal movements, contact relevant hospital labour ward or birthing unit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20-22 weeks</th>
<th>RPA - Routine antenatal visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height measurement, fetal movements* (from 20 weeks *) and fetal heart sounds.</td>
</tr>
<tr>
<td></td>
<td>Review morphology scan</td>
</tr>
</tbody>
</table>

Canterbury Hospital - Obstetrician Visit

<table>
<thead>
<tr>
<th>16-28 weeks (4 weekly visits)</th>
<th>Routine antenatal visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height measurement, fetal movements* and fetal heart sounds.</td>
</tr>
<tr>
<td></td>
<td><strong>Tests</strong></td>
</tr>
<tr>
<td></td>
<td>26-29 weeks: Arrangements testing for hyperglycaemia in pregnancy-75gm OGTT (as per guidelines)</td>
</tr>
<tr>
<td></td>
<td>FBC and antibodies</td>
</tr>
<tr>
<td></td>
<td>28 weeks: Recommend pertussis vaccination</td>
</tr>
<tr>
<td></td>
<td>Offer seasonal influenza vaccination (if not already given)</td>
</tr>
<tr>
<td></td>
<td>Complete ultrasound referral form: RPA - 3rd trimester ultrasound (36-37 weeks)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>30 weeks</th>
<th>Hospital review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds.</td>
</tr>
<tr>
<td></td>
<td>Review results of all investigations</td>
</tr>
<tr>
<td></td>
<td>Prophylactic Anti-D injection for Rh negative women</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>32-36 weeks (2nd weekly visits)</th>
<th>Routine antenatal visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds.</td>
</tr>
<tr>
<td></td>
<td><strong>Tests</strong></td>
</tr>
<tr>
<td></td>
<td>Repeat FBC</td>
</tr>
<tr>
<td></td>
<td>35-37 weeks: Group B streptococcus (GBS) screen</td>
</tr>
</tbody>
</table>

| 36-37 weeks | Attend 3rd trimester ultrasound |

<table>
<thead>
<tr>
<th>37 weeks</th>
<th>Hospital review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds.</td>
</tr>
<tr>
<td></td>
<td>Review results of all investigations</td>
</tr>
<tr>
<td></td>
<td>Prophylactic Anti-D injection for Rh negative women</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>38-40 weeks (weekly visits)</th>
<th>Routine antenatal visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds.</td>
</tr>
</tbody>
</table>

| 40-41 *' weeks | Visits as arranged with hospital clinic |

Postnatal

<table>
<thead>
<tr>
<th>Routine postnatal visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend baby health check (2 &amp; 6 weeks)</td>
</tr>
<tr>
<td>Attend maternal health check (6 weeks)</td>
</tr>
<tr>
<td>Complete psychosocial assessment and screening – arrange referral if required</td>
</tr>
<tr>
<td>Cervical screen (if due)</td>
</tr>
<tr>
<td>Arrange 75gm OGTT ~ 3-4 months post-partum for women diagnosed with GDM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clare Jordan GP Liaison Midwife</td>
</tr>
<tr>
<td>RPA Women and Babies</td>
</tr>
<tr>
<td>ph: 0425 230 662 ( Mon- Thurs )</td>
</tr>
<tr>
<td>Canterbury Hospital</td>
</tr>
<tr>
<td>ph: 9515 6111</td>
</tr>
<tr>
<td>ph: 9767 0000</td>
</tr>
</tbody>
</table>

September 2018
# Birth Centre

## GP Antenatal Shared Care Protocol Summary

### ANSC GP role
- ANSC GP responsible for care prior to Birth Centre (BC) visit
- Any investigations requested by the GP for the woman under his/her care must be followed up by the GP concerned
- It is the responsibility of the provider ordering the test or noting an abnormal finding to ensure appropriate follow-up and communication, irrespective of whether a copy is sent to the hospital
- Schedule GP visits around Birth Centre appointments and timely review of results
- Document visits in antenatal record card (yellow card)

### Referrals
- All women should contact Birth Centre ASAP once pregnancy is confirmed
- Booking in appointment should be attended ~ 12-14 weeks gestation
- Women with risk factors or significant complications require early referral for specialist consult

### Timing

<table>
<thead>
<tr>
<th>Confirm pregnancy</th>
<th>Investigations and actions</th>
<th>Discussion and considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tests</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-10 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine antenatal screening blood tests</td>
<td>- FBC, blood group, antibody screen, - HepB sAg, anti-HCV, anti-HIV, syphilis serology, rubella, varicella - Thalassaemia screening, include HbEPG – screen partner if result abnormal</td>
<td>Discuss SNAP: nutritional advice including folic acid and iodine supplements; drug avoidance (alcohol, smoking, other drugs); physical exercise</td>
</tr>
<tr>
<td>MSU – MC &amp; S</td>
<td></td>
<td>Referral to genetic counselling if hereditary condition, consanguinity, previous baby with a genetic, chromosomal or congenital abnormality, recurrent miscarriages, abnormal thalassaemia screen</td>
</tr>
<tr>
<td>HVS PCR or first stream urine PCR for chlamydia (women aged &lt; 29 years or with new partner)</td>
<td></td>
<td>Consider Vitamin D screening (if high risk)</td>
</tr>
<tr>
<td>Cervical screen (if due)</td>
<td></td>
<td>Consider screening for thyroid disease (if high risk)</td>
</tr>
<tr>
<td>Arrange early testing for hyperglycaemia in pregnancy if identified at risk (as per guidelines)</td>
<td></td>
<td>Models of antenatal care including timing and content of antenatal visits</td>
</tr>
<tr>
<td>Discuss and offer prenatal screening (optional) 10 weeks’ Non-Invasive Prenatal Testing (NIPT) - first trimester ultrasound still recommended 11-13 1/2 11-13 1/2 weeks - Combined First Trimester Screening (cFTS): nuchal translucency and biochemistry</td>
<td></td>
<td>Arrange early ‘consultation in pregnancy’ appointment if considered a risk of complication of pregnancy</td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td>FAX referral to ANC for triage RPA 9515 7452</td>
</tr>
<tr>
<td>Refer woman to Birth Centre for ‘booking in’ appointment. Optimally ~12-14 weeks gestation ph. 9515 6405</td>
<td></td>
<td>Contact GP Liaison Midwife ph 0425 230 662 (if required)</td>
</tr>
<tr>
<td>Document visit in antenatal record card (yellow card)</td>
<td></td>
<td>Overview of Birth Centre model of care</td>
</tr>
<tr>
<td>Complete request forms: - Combined First Trimester Screening (cFTS): ultrasound + blood test; 18-20 weeks morphology scan</td>
<td></td>
<td>Models of antenatal care including timing and content of antenatal visits</td>
</tr>
</tbody>
</table>

### ASAP

**First Birth Centre Information Session**

12-14 weeks

- Birth Centre Booking in appointment
  - Review history and complete administrative details
  - Clinical assessment and review test results
  - Complete psychosocial assessment—referral if required
- Tests
  - Blood group and antibody screen
  - Arrange early testing for hyperglycaemia in pregnancy for identified at risk patients (if not already attended)

18-20 weeks

- Attend morphology scan

**SLHD GP Liaison Midwife ph. 0425 230 662 or RPA ph. 9515 7416; Canterbury ph. 9787 0283 (Thurs)**
<table>
<thead>
<tr>
<th>Use of a fetal doppler for fetal heart rate monitoring is recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Concerns regarding reduced or absent fetal movements, contact relevant hospital labour ward or birthing unit</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20-22 weeks</th>
<th>Birth Centre Visit</th>
<th>Review morphology scan and test results – assess model of care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Routine antenatal visit</td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height measurement, fetal movements* and fetal heart sounds (from 20 weeks +)</td>
</tr>
<tr>
<td></td>
<td>Tests</td>
<td>Seek advice and/or refer for specialist consult if any abnormalities or concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss fetal movements and who to contact if any concerns</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage attendance at parent education and breastfeeding classes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss pertussis vaccination for household contacts</td>
</tr>
<tr>
<td>24-28 weeks (4 weekly visits)</td>
<td>Birth Centre review</td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds</td>
</tr>
<tr>
<td></td>
<td>Routine antenatal visit</td>
<td>Review results of all investigations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prophylactic Anti-D injection for Rh negative women</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Labour management, birth plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Antenatal and pelvic floor exercises</td>
</tr>
<tr>
<td>30 weeks</td>
<td>Birth Centre review</td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds</td>
</tr>
<tr>
<td></td>
<td>Routine antenatal visit</td>
<td>Seek advice and/or refer for specialist consult if any abnormalities or concerns</td>
</tr>
<tr>
<td>32 weeks</td>
<td>Birth Centre Review</td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds</td>
</tr>
<tr>
<td>34 weeks</td>
<td>Second Birth Centre Information Session</td>
<td>Signs of labour and when to contact hospital</td>
</tr>
<tr>
<td>36 weeks</td>
<td>Birth Centre review</td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds</td>
</tr>
<tr>
<td></td>
<td>Tests</td>
<td>Repeat FBC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35-37 weeks: Group B streptococcus (GBS) screen</td>
</tr>
<tr>
<td>36-37 weeks</td>
<td>Attend 3rd trimester ultrasound</td>
<td>Post-dates management</td>
</tr>
<tr>
<td>From 37 weeks</td>
<td>Weekly visits with Birth Centre</td>
<td>Monitor maternal and fetal well-being including maternal weight, B/P, fundal height, fetal movements* and fetal heart sounds</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prophylactic Anti-D injection for Rh negative women</td>
</tr>
<tr>
<td>Postnatal</td>
<td>Routine postnatal visit</td>
<td>Attend baby health check (2 &amp; 6 weeks)</td>
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<tr>
<td></td>
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<td>Attend maternal health check (6 weeks)</td>
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<td>Arrange 75gm oGTt ~ 3-4 months post-partum for women diagnosed with GDM</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Community support services e.g. Child &amp; Family Health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider support networks</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infant feeding and settling, safe sleeping</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Childhood Immunisation schedule family immunisation e.g. pertussis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss contraception</td>
</tr>
</tbody>
</table>

*Note: * indicates important or critical information.
**Hospital Clinics : Routine & Specialist**

Refer to *Healthpathways Sydney – Non-Urgent Antenatal Assessment*

**RPA Women and Babies: Routine Clinics**  ph 9515 7101

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal Booking Clinic</td>
<td>This clinic is the first contact women have with the hospital. Women will be triaged according to their risk of developing pregnancy complications. Women triaged as Category A “low risk”, will see a midwife or ANSC GP for routine second visit ~ 20-22 weeks. Women triaged as Category B or C may require a 2nd visit to determine responsibility of care.</td>
</tr>
<tr>
<td>Midwives Antenatal Clinic</td>
<td>Low risk antenatal clinic. GP ANSC women are seen at 30 weeks</td>
</tr>
<tr>
<td>Registrars Antenatal Clinic</td>
<td>GP ANSC women are seen at 37 and 41 weeks or as required clinically. Women with breech presentation detected at 36-37 weeks are referred to breech clinic directly for review to discuss external cephalic version (ECV)/birth options with Obstetrician and CMC</td>
</tr>
<tr>
<td>VMO Visit Clinic (~20 weeks)</td>
<td>Women triaged a Category B or C are referred to this clinic from Booking Visit for obstetric review. Confirmation of care option for the remainder of their pregnancy.</td>
</tr>
<tr>
<td>Birth after Caesarean(BAC)</td>
<td>For women who have had a previous Caesarean Section for review for possible vaginal birth. Women with known uterine fibroids; placenta praevia</td>
</tr>
</tbody>
</table>

**RPAH Specialist Clinics or Services**

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic Clinic</td>
<td>Women identified with:</td>
</tr>
</tbody>
</table>
|                                       | * pre-existing diabetes (including pre-conception) or newly diagnosed GDM or “Diabetes Mellitus in pregnancy” as per guidelines. Refer directly to Diabetic Centre ph: 9515 5888 Fax: 9515 5820. *
|                                       | * Other endocrine disorders                                                                  |
| Hypertensive/ Renal Disorders of Pregnancy Clinic (HDP) | Women identified with:                                                                      |
|                                       | * Booking BP 140/90 or greater                                                              |
|                                       | * Known renal disease                                                                      |
|                                       | * History of recurrent UTI’s in childhood or in pregnancy                                   |
|                                       | * History of essential/chronic hypertension                                                 |
|                                       | * Previous pregnancy complicated by hypertension                                            |
|                                       | * Family history of eclampsia                                                                |
|                                       | * Follow-up from hospital eg prescribed antihypertensives                                   |
|                                       | **When to admit:**                                                                           |
|                                       | * symptomatic hypertension                                                                  |
|                                       | * biochemical abnormalities                                                                 |
|                                       | * neurological symptoms                                                                     |
|                                       | * pharmacological treatment refinement                                                       |
|                                       | There are options for referral depending on clinical urgency:                               |
|                                       | **Urgent**: Day Stay Unit – same day                                                         |
|                                       | **Semi-urgent**: Day Stay Unit – ring O&G Registrar on call                                   |
|                                       | **Elective**: next HDP Clinic                                                                 |

26 ANSC GP Resource Manual v 8.0 . Once printed this document is no longer controlled September 2018
Medical Obstetric Clinic
Women identified with:

Pre-pregnancy conditions:
- Anomalies- uterine, acquired, congenital
- Pre-existing medical condition (other than hypertension or diabetes)

Previous pregnancy complications:
- 2nd trimester M/C, TOP or neonatal death
- Previous spontaneous pre-term delivery < 34 weeks, no subsequent term delivery (women need to be seen by 12 weeks to offer cervical assessment)

Current pregnancy
- Complex fetal anomaly
- Ante partum haemorrhage (APH)

Perinatal and Family Support Clinic
Women identified with:
- substance use risk for this pregnancy and/or other psychosocial issues.
- sharing care between RPA Women and Babies and AMS, Redfern

Twin + pregnancies Clinic
Women identified with:
- Twin + pregnancy
Women should be referred at the time of diagnosis or by 12 weeks.

Thyroid Antenatal Clinic
For referral criteria: Thyroid Disease Flowchart

Young Parent’s Clinic
Women identified:
- Aged <21 years and/or vulnerable i.e. intellectual disability, social difficulties

Perinatal Psychiatry
Women identified with:
- pre-existing mental illness or at risk of developing a perinatal mental health problem

Clinical Genetics Service
Women identified with:
- Personal or family history of genetic conditions (e.g. mental retardation, consanguinity, cystic fibrosis)
- Chromosomal disorders (e.g. trisomy, translocations)
- Congenital abnormalities or physical malformations
- Personal or family history of genetic haematology conditions (e.g. thalassemia, sickle cell disease, haemophilia, coagulation or platelet disorders

Urgent prenatal referrals – RPA ph. 9515 6111 (page Clinical Genetics service via switch)

Specialist Women’s Clinic
Refer to Healthpathways Sydney – Non Urgent Antenatal Assessment; Maternal Postnatal Check

Complete Gynaecology Booking /Referral Form Fax to ANC Fax. 9515 3454.
Appointments are triaged into appropriate clinic upon referral

NB: Referrals for colposcopy are to RPA Lifehouse NOT RPA Women and Babies

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Initial assessment of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endometriosis Clinic</td>
<td>Initial assessment of:</td>
</tr>
<tr>
<td></td>
<td>- Endometriosis</td>
</tr>
<tr>
<td>Pelvic Floor Clinic</td>
<td>Initial assessment of:</td>
</tr>
<tr>
<td></td>
<td>- pelvic floor weakness/prolapse</td>
</tr>
<tr>
<td></td>
<td>- postnatal follow up of 3rd and 4th degree tears</td>
</tr>
<tr>
<td>Gynaecology Clinic</td>
<td>- pelvic masses</td>
</tr>
<tr>
<td></td>
<td>- other noncancerous gynaecological conditions.</td>
</tr>
<tr>
<td>Abnormal Uterine Bleeding Clinic</td>
<td>- bleeding irregularities</td>
</tr>
<tr>
<td></td>
<td>- Post Hysteroscopy follow up</td>
</tr>
</tbody>
</table>
| Recurrent Miscarriage Clinic | • recurrent miscarriages (usually three or more)  
|                            | • previous stillbirth (one or more) who are pregnant  
|                            | • pre-conception advice and investigations |
| Specialist Contraception Clinic | • complex medical conditions requiring contraceptive advice and management  
|                               | • intrauterine device insertion (not undertaken in the community) |

**Other**

**Fertility Unit**

|   | For couples with concerns regarding their fertility: investigate, review and plan the appropriate treatment. GP referral required ph 9515 8824 |

**Reproductive Medicine Clinic**

|   | Disorders of sexual differentiation (transition from paediatric services i.e. Sydney and Westmead Children’s hospitals);  
|   | Pubertal disorders (primary or transition from paediatrics) and adolescent gynaecology (age ≥ 16yrs);  
|   | Polycystic ovary syndrome;  
|   | Hirsuitism and virilization;  
|   | Amenorrhoea and oligomenorrhoea;  
|   | Other menstrual disorders;  
|   | Female and male oncofertility. |
| GP Referral required. Complete [Reproductive Medicine Referral Form](Fax 9515 7976)  

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**Canterbury Hospital: Routine Clinics or Services**

**ph 9787 0250/ ph. 9787 0560**

**Women requiring complex or specialised care may be transferred to RPA Women and Babies.** Contact ANC Midwifery Unit Manager ph. 9787 0577 to discuss further. Women with BMI ≥50 or weight ≥150kg, pre-existing Type 1 diabetes, monochorionic (MC) twins or a major medical problem would be referred directly to RPA Women and babies.

**Antenatal Booking Clinic**

This clinic is generally the first contact women have with the hospital. Women will be triaged according to their current clinical risk utilising the [National Midwifery Referral Guidelines (3rd ed. Issue2)](ph 9787 0577). Women triaged as Category A: ‘low risk’ will have either midwifery or ANSC model of care. If Midwife care, the woman will see a midwife for routine second visit 20 – 22wks. If ANSC, the women will see an obstetrician for 2nd antenatal visit.

Women triaged as Category B or C will require an obstetrician for 2nd antenatal visit to determine a management plan and responsibility of care.

**Midwives Clinic**

|   | Low Risk antenatal clinic.  
|   | ANSC women are seen by a midwife at 30wk and 37wk hospital visit during a routine doctor’s clinic (to utilise the variety of interpreters) |

**Doctors Antenatal Clinic (O&G Staff Specialists, VMO, Registrar, SRMO,RMO)**

Women triaged Category A/B, B, B/C & C are seen through these clinics. Review and assessment of responsibility of care at a 2nd visits by an obstetrician. Further discussion – 36 wks if the woman has had a previous Caesarean and is wanting a vaginal birth by senior obstetrician. Consents for elective C/S  

ANSC women are reviewed at 40 – 41wks or as clinically required.

**Birth after Caesarean (BAC)**

For women who have had a previous Caesarean Section for review for possible vaginal birth. Patient Education Sessions are available, and women can be seen by a specialist BAC midwife.
### Endocrine Clinic

Women identified with:
- pre-existing type 1 diabetes (including pre-conception) should be referred directly to RPA Diabetic Centre ph: 9515 5888 fax: 9515 5820.
- Women newly diagnosed as GDM or “Diabetes Mellitus in pregnancy” as per protocol and any woman with pre-existing Type 2 diabetes. Complete and fax **Endocrine Maternity Clinic Referral form** and results. Fax 9787 0431
- Women newly diagnosed with Thyroid issues in pregnancy as per protocol. Complete and fax **Endocrine Maternity Clinic Referral form** and results. Fax 9787 0431

Low Risk women with well controlled GDM may be seen by the Low Risk GDM Midwife after initial consultation with the Endocrinologist.

### Diabetes Education

Small group education sessions are held six times per months for both women newly diagnosed and those with pre-existing diabetes. These must be prior booked and will be arranged following processing of the endocrine referral form and results.

### Preconception – Endocrine Clinic

Preconception advice for women with pre-existing diabetes, thyroid conditions, polycystic ovaries.

### Clinical Genetics Service

Women requiring urgent Prenatal referrals – ph O&G Registrar on-call via switch ph.9787 0000

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### Canterbury Hospital : Language Specific Clinics

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic and Chinese ANC</td>
<td><em>Chinese</em> (Mandarin &amp; Cantonese) Combined ANC &amp; Endocrine Clinic 0900 – 1200 &amp; 1300 – 1500 <em>Vietnamese</em> Combined ANC &amp; Endocrine Clinic 0900 – 1100</td>
<td></td>
</tr>
<tr>
<td>Arabic Midwife Clinic</td>
<td>Vietnamese ANC 0930 – 1130</td>
<td><em>Bengali</em> Combined ANC and Endocrine Clinic 1000 – 1500</td>
</tr>
<tr>
<td>1330 – 1630</td>
<td>Vietnamese ANC 0930 – 1130</td>
<td>Arabic Combined ANC and Endocrine Clinic 1300 – 1530</td>
</tr>
<tr>
<td>Arabic</td>
<td>Vietnamese ANC 0930 – 1130</td>
<td><strong>Rohingya</strong> 1000-1200</td>
</tr>
</tbody>
</table>
# Preconception Planning

**Refer to Healthpathways Sydney – Preconception Assessment**

GPs are in a unique position to see a woman prior to pregnancy and can provide opportunistic pre-pregnancy screening and advice. The aim of the pre-pregnancy consultation is to:

- provide the optimum situation for conception and pregnancy to occur in order to ensure the health of mother and child
- identify and manage potential problems for the fetus and mother, based on personal and family history
- provide education about the health care system and options available
- develop a rapport with the woman and her family

## GP guide for those planning a pregnancy

### Physical Examination

- Physical examination including blood pressure, body mass index, auscultation of heart sounds, breast examination
- PAP smear (if due)
- Discuss routine and recommended screening tests. FBC, blood group and antibodies, Hb EPG, syphilis and hepatitis B SAg; Hep C antibodies(HcV), HIV, if U/A positive for nitrates, then urine M/C/S
- All women with previous history GDM to have FGTT (75 gm)

### Immunisation

- Check immunisation status: measles, mumps, rubella, varicella, diphtheria, tetanus, pertussis, Hep B
- Recommend to wait 4 weeks after receiving MMR and/or varicella before trying to fall pregnant
- Recommend seasonal flu vaccination (also other adult carers) and review pertussis history. Pregnant women should be immunised against influenza. dTPa vaccine for Pertussis is recommended during the third trimester of each pregnancy. The optimal time for vaccination is between 28 and 32 weeks.

### Genetic/Family History

- Offer referral for genetic counselling if family history of hereditary condition, consanguinity, previous baby with genetic, chromosomal or congenital abnormality
- Discuss options for prenatal screening tests i.e. Combined First Trimester Screening (cFTS), NIPT, CVS, Amniocentesis
- Consider history of ethnic origins i.e. haemoglobinopathy screening if in high-risk racial groups at risk of thalassaemia, Hb sickle cell anaemia.

*If the pregnant woman is thalassaemia positive, her partner must be tested*

### Medical history

- Discuss pre-existing or past medical conditions on pregnancy
- Stabilisation of pre-existing medical conditions and assessment of mental health status prior to a pregnancy is necessary to optimise pregnancy outcomes

### Past reproductive/obstetric history

- Discuss any problems with previous pregnancies such as fetal loss, stillbirth, low birth weight, pre-term birth, or gestational diabetes.

### Pre-existing diabetes, Type 1 or Type 2

- Discuss potential pregnancy risks if complicated by sub-optimal glycomic control or unplanned
- All women with pre-gestational diabetes (Type 1 or Type 2) should be referred for preconception planning: RPA Diabetes Centre ph. 9515 5888; Canterbury Outpatient (Endocrinology) ph. 9787 0161 or an Endocrinologist with expertise in diabetes and pregnancy

### Diet

- Balanced diet – eat foods from each food groups daily
- Importance of increased leafy green vegetables
- Increased Calcium and Iron. Especially for vegetarian- check iron stores and B12
- Include iodine (iodised salt) and fluoride (fluoridised water) in diet.
- Discuss foods to avoid and risks of listeria containing foods eg chicken, salamis and sushi
### Folic Acid and Iodine supplements

- Discuss when to commence and recommended dosage
- Check B12 level prior to commencing folic acid

<table>
<thead>
<tr>
<th>Supplement</th>
<th>Dose</th>
<th>Indication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Folate</td>
<td>0.5mg/day</td>
<td>Preconception (minimum one month) to 14 weeks gestation</td>
</tr>
<tr>
<td></td>
<td>5mg/day</td>
<td>Preconception (minimum one month) to 14 weeks gestation for women considered at high risk for an open neural tube defect:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Personal /family history of an open neural tube defect</td>
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<tr>
<td></td>
<td></td>
<td>- A previous pregnancy with an open neural tube defect</td>
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<tr>
<td></td>
<td></td>
<td>- PMHx of diabetes mellitus</td>
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<tr>
<td></td>
<td></td>
<td>- Women taking anticonvulsants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- BMI &gt;35</td>
</tr>
<tr>
<td>Iodine</td>
<td>150mcgms/ day</td>
<td>Women who are pregnant, breastfeeding or considering pregnancy. Women with pre-existing thyroid conditions should seek advice from their medical practitioner before taking a supplement.</td>
</tr>
</tbody>
</table>

### Weight

- Active steps to correct high BMI
- Obesity –risk of infertility, PCOS

  Further information: “Obesity and pregnancy”
- Consider: “Get healthy in pregnancy” referral
- Underweight – possible period cessation, irregularity

### Dental Check

- Advice regarding dental hygiene and annual check-up recommended.

### Workplace/household

- Assessment regarding any potential workplace, household or recreational hazards and/or risks

### Travel/environmental

- Advice regarding reducing chance of infection at the time of conception and during the remainder of the pregnancy

### Fluoride Supplement

- Reinforce drinking tap water not bottled water

### Alcohol and Substance Use

- Discuss alcohol and substance use. Visit [www.alcohol.gov.au](http://www.alcohol.gov.au) for additional resources and information
- Advice to women that there is no known safe level of alcohol consumption during pregnancy is appropriate

### Smoking Cessation

- Encourage smoking cessation for either or both parents where relevant

  **Smoking Cessation Clinic:** ph. 9515 8613

### Medication Usage

- Discuss present and future use of medications including alternative therapies.

  **Mothersafe** ph. 9382 6539 for further advice if required.

### Exercise

- Recommendation for moderate intensity exercise most days if patient already does regular exercise
- If patient hasn’t been physically active, gentle exercise like walking, swimming

### Psycho-Social

- Assess family and social circumstances
- Screen and initiate an appropriate management plan for those with a pre-existing mental health disorder or history of mental illness
- Strongly encourage her partner’s involvement.
- Screen for domestic violence. Visit: [It's time to talk about DV](http://www.gptoolkit.nsw.gov.au) : NSW GP Tool Kit

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**Pregnancy Planning Clinic: Charles Perkins Centre/RPA Hospital**

A multidiscipline service providing comprehensive assessment of preconception health for women and/or couples planning pregnancy within the Sydney Local Health District.

To refer: Complete secure online form. The service will contact the patient by phone and mail the appointment time. For phone appointments: ph 9562 5600 or ph. 9562 5607
Early Pregnancy Assessment Service (EPAS)

Refer to Healthpathways Sydney – Early Pregnancy Assessment Service; Miscarriage and Ectopic Pregnancy

If patient is clinical unstable and less than 20 weeks pregnant, arrange immediate transfer to the Emergency Department.

Urgent referral: Contact Gynaecology Registrar (RPA ph. 9515 6111) for all pregnant patients < 20 weeks who need an urgent review or for a woman being sent to Emergency Department (ED).
If >20 weeks gestation, women should be sent to the Delivery Ward – after first contacting the O&G Registrar (RPA ph. 9515 6111)

RPA Women and Babies

The service aims to identify and manage ectopic pregnancies, and diagnose, treat, and support lower abdominal pain and/or vaginal bleeding in women who are under 20 weeks gestation. It is available to assist you with the management of your haemodynamically stable patient.

1. Check referral criteria
   Patient must:
   - be less than 20 weeks pregnant, and
   - have abdominal pain or vaginal bleeding, and
   - be experiencing only mild to moderate symptoms,
   - have an incomplete miscarriage or threatened miscarriage, confirmed by ultrasound.

Exclusion criteria
- Patient more than 20 weeks pregnant – ph. Obstetric Registrar (02) 9515-6111 for management in the Delivery Ward.
- Termination of pregnancy
- Dating scans
- Management of hyperemesis

2. Prepare required information
   - Pathology copy of blood group result
   - Most recent serum quantitative BHCG where available
   - Any previous ultrasound results
   - Significant medical history
   - RPAH Fetal Medicine ultrasound referral form
   - Complete EPAS Referral Form and give to patient to take to clinic

3. Inform the patient
   - Must present to the Women’s Ambulatory Care Reception (Level 5) at 7.30 am (Monday- Friday) the next business day. There are no appointment times and waiting times will vary.
   - Preparation requirements – a full bladder is not required and fasting from midnight is preferable.
   - If the patient consents a report will be mailed to the general practitioner on the day of consultation.
4. **Advice and/or guidance for referral**: The Clinical Midwifery Consultant (CMC) can be contacted Ph: **0429 728 608** between Mon-Sun: 8.00am-4.00pm Fax: 9515 3454

**Criteria for contacting EPAS CMC on the mobile phone**
- Advice regarding women with pain or PV bleeding in early pregnancy <20 weeks
- Inform hospital that a woman with an ectopic pregnancy is coming into ED
- Advice about whether an outside scan meets the criteria for a miscarriage or an intrauterine pregnancy of uncertain viability (IPUV)
- Complications following
  - Salpingectomy for an ectopic pregnancy
  - D&C for miscarriage
  - Medical management of miscarriage
  - Expectant management of miscarriage
- Assistance with the latter stages of a pregnancy of unknown location (PUL) when it is unlikely that this is an ectopic pregnancy
- Latter stages of management of methotrexate for an ectopic pregnancy/PUL
- Short cervix on a morphology ultrasound scan
- PV bleeding/PV discharge from 12 weeks to 19 weeks and 6 days

For all other non early pregnancy/gynaecological issues, please contact hospital O+G Registrar ph. 9515 6111.

**Canterbury Hospital**
If pregnant women < 20 weeks gestation and:
- requiring urgent review (e.g., experiencing vaginal bleeding), or are being sent to the Emergency Department, contact the gynaecology registrar via phone (02) 9787-0000.
- bleeding and/or have pain, haemodynamically stable, and willing to travel, refer to EPAS at RPA Hospital or St George Hospital
Prenatal Screening

Refer to Healthpathways Sydney – Genetic Screening for Fetal Anomalies

All women, regardless of age should be counselled and offered the option for screening for chromosomal anomalies.

Women should be given information about the purpose and implications of testing for chromosomal abnormalities to enable them to make informed choices about whether or not to have the tests. Information should be provided in a way that is appropriate and accessible to the individual woman, with particular regard given to language and literacy.

All ANSC GPs can directly refer women to RPA Fetal Medicine Unit (FMU) for the following tests
- Combined First Trimester Screening (cFTS)
- Non-Invasive Prenatal testing (NIPT)
- Chorionic Villus Sampling (CVS)
- Amniocentesis

Timing of procedures:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Gestation (weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Invasive Prenatal Testing (NIPT)</td>
<td>10 weeks onwards</td>
</tr>
<tr>
<td>Combined First Trimester Screening (cFTS)</td>
<td>11-13</td>
</tr>
<tr>
<td>Chorionic Villus Sampling (CVS)</td>
<td>15-19</td>
</tr>
</tbody>
</table>

Combined First Trimester Screening

For women attending RPA FMU for screening:

For women to receive their risk results when they attend their NT scan, first trimester serology should be collected after 10 weeks gestation but at least three days prior to her NT appointment.

For quality control purposes, serology testing must be attended at RPA Pathology (Sydney South West Pathology Service). Women can have blood collected from RPA Hospital, Level 5, – (Mon- Fri 7.00am-3.20pm) ; RPAH Medical Centre, Suite 317, 100 Carillion Ave, Newtown or Canterbury patients – Canterbury Hospital Pathology Service

For referral: GP to:
- complete RPA First trimester combined screening pathology request form.
  - This form is available as e-copy (PDF), MD, BP template. Advise women that blood should be collected from 10 weeks until at least 3 days prior to ultrasound appointment. It can be collected at RPAH or Canterbury Hospital Pathology Departments.
- complete Ultrasound request form (yellow or white) for NT scan
- provide woman with Patient Information Sheet to guide her through the process of First Trimester Screening
- provide Patient Information Brochures regarding:
  - combined First Trimester Screening
  - Non-Invasive Prenatal Testing (NIPT)
  - CVS & Amniocentesis.

Women requesting screening at private services will need to contact relevant service for any specific information.
RPA preferred model of testing is contingent screening. In this model women do cFTS first and then the risk from this test is used to define a cohort of women at intermediate risk that would potentially get most benefit from a second screening test using NIPT. Women with a cFTS risk between 1 in 50 and 1 in 2500 are placed in this intermediate risk group.
Pre-eclampsia screening

There is good evidence from a large RCT involving 29,000 women that combined first trimester screening (cFTS) can be used to predict early onset pre-eclampsia and that aspirin prophylaxis (150mg PO nocte) of high risk women prevents 80% of deliveries for pre-eclampsia before 34 weeks gestation.\(^6,7\)

We have demonstrated the same efficacy for screening and prevention of pre-eclampsia in a local population.\(^8\) Consequently we would recommend that all women are assessed for their risk of early onset pre-eclampsia at the time of combined first trimester screening.

The test involves details of maternal characteristics / history, standardised measurement of maternal blood pressure, standardised measurement of uterine artery Doppler (at the time of the NT scan) and measurement of biomarkers (PIGF and/or PaPP-A). All of this information is collected at the 11-13+6 week scan and collated to generate a risk for pre-eclampsia <37 weeks.

Approximately 10% of the population will have a risk >1 in 100 for pre-eclampsia <37 weeks reported. These women are deemed high risk and should be advised to take aspirin (unless contraindicated for another reason). The effect of aspirin is best if the drug is taken at night and if treatment is started <16 weeks gestation (ideally as soon after screening as possible).

Process of result disclosure following first trimester screening for early onset pre-eclampsia (as part of cFTS)

<table>
<thead>
<tr>
<th>Low Risk (&lt;1 in 100) for early onset pre-eclampsia (&lt;37 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Result forwarded by post to GP</td>
</tr>
<tr>
<td>• Result given to patient by GP</td>
</tr>
<tr>
<td>• Re-reference if further review needed</td>
</tr>
<tr>
<td>• Urgent matters 9515 06111</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increased Risk (&gt;1 in 100) for early onset pre-eclampsia (&lt;37 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Results given to patient by FMU</td>
</tr>
<tr>
<td>• Patient advised to take aspirin 150mg nocte up to 36 weeks</td>
</tr>
<tr>
<td>• If BP increased appointment in HDP clinic will be arranged</td>
</tr>
<tr>
<td>• Result copied by post to GP</td>
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</tbody>
</table>

Non-Invasive Prenatal Testing (NIPT)

NIPT relies on detection of fragments of fetal DNA that are present in the maternal circulation during pregnancy. NIPT was originally used to identify pregnancies affected by trisomies 21, 18 and 13. A number of commercial platforms are available and some of these offer screening for other chromosomal abnormalities such as sex chromosome aneuploidy (e.g. 45X, Turner syndrome; 47XYY, Klinefelter Syndrome) and/or microdeletions such as del22q11 (Di George Syndrome).

Although NIPT tests have very high sensitivity (>99%) and specificity (>99%) for trisomy 21, these test characteristics vary for other chromosome abnormalities and, as the prevalence of these conditions is low, positive predictive value is not 100%. That means that a positive test result should be regarded as indicative of a very high risk for aneuploidy – but this should be confirmed with invasive testing before making any decision about interrupting the pregnancy.

NIPT is not currently covered by Medicare and as such will incur out-of-pocket costs to the pregnant women.

RPAH can arrange NIPT testing for women who will book at RPA or Canterbury Hospital. The service includes pre- and post-test counselling and phlebotomy (free at point of care) – the patient has to pay the testing laboratory directly to perform the test.
RPAH would prefer women to have cFTS before deciding whether to have NIPT and would recommend a contingent model – where women at intermediate risk (1 in 50 to 1 in 2500 after cFTS) are offered NIPT. Tests can be performed before 11 weeks gestation (before cFTS) although this is not the preferred model. In this circumstance, women should have had an ultrasound scan (external provider) within two weeks of attending for NIPT and women need to bring a copy of the scan result with them at the time of NIPT testing.

**IMPORTANT REMINDER** : Even if women are having NIPT, it is important that they have an 11-13\(^6\) week scan. This scan also picks up a significant proportion of major structural abnormalities, identifies chorionicity (helping management of twin pregnancies) and is used to screen for pre-eclampsia and IUGR. None of these additional values are covered by NIPT.

**Patient Information brochures:**
NSW Genetic Education Centre : [Prenatal testing overview : Special tests for your baby during pregnancy](https://www.genetics.nsw.gov.au/publications/prenatal-testing-overview-special-tests-for-your-baby-during-pregnancy)
RPAH : [Combined First Trimester Screening](https://www.rpa.nsw.gov.au/services-and-programs/prenatal-testing/combined-first-trimester-screening)
Infections and Vaccinations in pregnancy

All women, considering pregnancy or pregnant, should be aware of their vaccination status and, if uncertain, liaise with their GP.

Live attenuated vaccines are not recommended during pregnancy (e.g. MMR, varicella, rotavirus, BCG, oral typhoid vaccine). Women should be advised to **wait at least 4 weeks** after receiving these vaccinations before trying to fall pregnant. If given inadvertently, specialist consultation is advised.

View pre-vaccination screening checklist (Australian Immunisation Handbook, 10th Ed) before administering any vaccination.

Varicella Screening

Refer to Healthpathways Sydney – Varicella and pregnancy

Screening for Varicella Zoster Virus (VZV) should be attended in the pre-conceptual period based on the negative history of previous unknown varicella infection. Women who have had a reliable history of varicella infection should be considered immune. Women who do not have a reliable history of varicella exposure or are VZV seronegative, should be offered VZV vaccination. **These women should be advised to avoid pregnancy for at least 4 weeks after vaccination.**

Management of Varicella during pregnancy

If your non-immune patients come into contact with or develops chicken-pox immediately arrange treatment by contacting: RPAH Women and Babies (Midwifery Nursing Unit Manager ph: 9515 7935 or the Obstetric Registrar via switch: 9515 6111) ; Canterbury Hospital (Midwives Desk ph 9787 0183)

**Please do not send patient straight into the clinic because of the risk of exposure to other patients attending the ambulatory care department.**

**Contact in pregnancy** – Check immune status

**Antibody level**
- Negative (10%) – Zoster Immunoglobulin (ZIG) within 96 hours
- Positive (90%) – no ZIG

**Varicella in pregnancy** - management depends on gestation and time of presentation

- **< 20 weeks**
  - Seek urgent obstetric advice. Will require closer fetal monitoring as prescribed by obstetric team

- **≥ 20 weeks**
  - Seek expert advice from obstetric team in regards to treatment.

If maternal patient is infected between:
- **7 days prior to 2 days post delivery**
  - Infection of baby has 20% mortality Refer baby to maternal unit. ZIG to infant within 96 hours of delivery.

- **3 and 28 days post delivery**
  - Establish immunisation status of mother
  - Refer infant of seronegative mothers to maternal unit for ZIG
  - Encourage breastfeeding
Seasonal Influenza Vaccination

Refer Healthpathways Sydney – Influenza Immunisation

Pregnant women are at an increased risk of influenza related complications for their unborn baby and themselves. Influenza vaccination is free and recommended for all pregnant women regardless of gestation. Safety is well established and both maternal and infant benefit are now proven.

Further Information:
- RANZCOG statement: Influenza vaccination for pregnant women
- Australian immunisation Handbook : Influenza
- Australian Department of Health – 2018 Influenza vaccination in pregnancy Information for health professionals
- Maternal Influenza Vaccination Evidence review

Pertussis (whooping cough) Vaccination

Refer Healthpathways Sydney - Pertussis Vaccine for Pregnant and Postpartum Women

Antenatal pertussis vaccination is recommended for all pregnant women in the third trimester (preferably at 28 weeks). The pertussis vaccine during pregnancy is the best way to protect newborns from day one with studies showing that it is more than 90 per cent effective in preventing whooping cough in infants.

Recommend vaccination with each pregnancy to provide maximal protection to every infant. This includes pregnancies which are closely spaced e.g., < 2 years. If vaccination during pregnancy is not planned or does not occur, recommend vaccination during the post-partum period, as soon as possible after delivery of the infant (preferably before hospital discharge), to reduce the likelihood of pertussis occurring in the mother and therefore provide some indirect protection to the infant.

It is important that all people in close contact with infants < 6 months of age are vaccinated at least two weeks before having close contact with the infant. Ensure that:
- all children in households with new babies are up to date with their pertussis vaccinations.
- adult household contacts and carers of newborn infants have received a pertussis booster within the past 10 years.

Further Information:
- Australian Immunisation Handbook : Pertussis
- Australasian Society of Infectious Diseases: Management of Perinatal Infections
- NSW Health Department Protect Your Newborn from Whooping Cough
- NCIRS Pertussis Fact sheet
- Mothersafe, ph. 9382 6539
- NSW Specialist Immunisation Service (NSWISS) telephone advice line

Do you require advice regarding immunisation for patients with complex or unusual medical backgrounds or who have had an adverse event following immunisation?

1800 NSWISS (1800 679 477) is a specialist immunisation advice line established to provide clinical advice and support to immunisation providers in NSW.

Patient Information Brochures : Influenza & Pertussis
- NSW Health : Protect your newborn from whooping cough
- NSW Health : Influenza Vaccination in Pregnancy. (also available in other languages)
- NSW Health : Pregnancy Protection and vaccination from preconception to birth
Pregnancy assessment and management

Urgent hospital admissions

An urgent hospital referral are required whenever the following occurs:

- Intractable vomiting with dehydration and ketosis.
- Preterm rupture of membranes.
- Threatened preterm delivery.
- Undiagnosed severe abdominal pain.
- Antepartum haemorrhage.
- Decreased foetal movements.
- Suspicion of death in-utero.
- Unusual headaches or visual disturbances.
- Seizures or “faints” in which seizure activity may have occurred.
- Dyspnoea on mild-moderate exertion, orthopnoea or nocturnal dyspnoea
- Symptoms or signs suggestive of deep vein thrombosis.
- Pyelonephritis.
- Symptoms or signs of pre-eclampsia
- Rupture of membranes and antepartum haemorrhage should go immediately to the Delivery Suite for assessment.

Notify O&G Registrar on call or GP Liaison Midwife if unsure whether the situation requires urgent assessment or an earlier clinic appointment. Referral should be accompanied by referral letter.

Hypertension in pregnancy

Refer to Healthpathways Sydney – Hypertension and pre-eclampsia in pregnancy and postpartum

Assessment

**Hypertension in pregnancy** is defined as:

1. Systolic blood pressure greater than or equal to 140 mmHg and/or
2. Diastolic blood pressure greater than or equal to 90 mmHg (Korotkoff 5)

**Severe hypertension** in pregnancy is defined as:

1. Systolic blood pressure greater than or equal to 170 mmHg and/or
2. Diastolic blood pressure greater than or equal to 110 mmHg.

These measurements should be confirmed by repeated readings over several hours or days unless severe hypertension or if symptoms are present even

Accurate blood pressure measurement will aid in antenatal assessment. Ensure the following:

- the woman is seated comfortably with her legs resting on a flat surface.
- correct cuff size for accurate blood pressure recording.
- measurement of blood pressure is undertaken at initial visit in both arms to exclude rare vascular abnormalities such as aortic coarctation, subclavian stenosis and aortic dissection. Generally the variation in blood pressure between the upper limbs should be less than 10 mmHg.

Mercury sphygmomanometers remain the gold standard for measurement of blood pressure in pregnancy.4

Further information:

- SOMANZ : Guidelines for management of Hypertensive Disorders of pregnancy
Discussing risk of pre-eclampsia

The combined first Trimester (cFTS) screening test may indicate risk of developing pre-eclampsia. Some women who are at high risk (> 1 in 100) of pre-eclampsia maybe advised to take low dose aspirin.

At first antenatal visit, it is important to assess all women for clinical risk factors for developing pre-eclampsia. Women should be given information about the symptoms of pre-eclampsia before 20 weeks gestation and the urgency of seeking advice from a health professional if they experience:

- headache;
- visual disturbance, such as blurring or flashing before the eyes;
- epigastric pain (just below the ribs);
- vomiting; and/or
- rapid swelling of the face, hands or feet.

Women should be asked if they have experienced any of the above at each blood pressure assessment. In pre-eclampsia, blood pressure may only be slightly elevated, but abnormal investigations or symptoms will be present.

When to admit:
- symptomatic hypertension
- biochemical abnormalities
- neurological symptoms
- pharmacological treatment refinement

Referral Options: Dependant on clinical urgency:
- Urgent: Day Stay Unit: same day - contact O&G Registrar on call
- Semi-urgent: Day Stay Unit - contact O&G Registrar on call
- Elective: next HDP Clinic - contact GP Liaison Midwife

Asymptomatic bacteriuria

Refer to Healthpathways Sydney – UTIs in pregnancy

Screening for asymptomatic bacteriuria in pregnancy allows treatment to be offered to decrease the risk of progression to pyelonephritis. Risk factors include history of UTIs, diabetes and anatomical abnormality of the urinary tract.

Mid stream urine culture is considered the standard for testing in pregnancy. Identification of UTI enables women to be treated with antibiotics and avoid the risks of complications.

Group Streptococcus (GBS)

Identifying women who are at risk of having a baby with Group B streptococcus enables treatment to be given during labour to prevent transmission of infection to the baby. Discussion about Group B streptococcus should take place at around 35 weeks gestation so that women have received information about preventive treatment before they go into labour.

Clinical risk factors for early onset GBS sepsis (EOGBS) are:
- Spontaneous onset of labour at ≤ 37 weeks gestation.
- Rupture of membrane ≥ 18 hours.
- Maternal fever ≥ 38°C.
- A previous infant with EOGBS.
- GBS bacteruria during the current pregnancy.
- Known carriage of GBS in current pregnancy.
- Clinical diagnosis of chorioamnionitis
- Other twin with current EOGBS
For antenatal screening, GBS screen should be attended **35-37 weeks gestation**. Specify “GBS screening” on request. Selective enriched media is used to improve sensitivity.

This swab can be clinician collected or patient self-collected.

### INSTRUCTIONS for the Collection of a genital swab for the detection of Group B Streptococcus (GBS)

1. Wash your hands with soap solution
2. Remove cap from sterile tube
3. Sit on toilet. Separate the labia (lip) 
4. Insert swab 2cm into vagina (front passage). Do not touch cotton end with fingers. Turn or rotate the swab once
5. Then with the same swab sweep in a downward direction over the perineum, towards the anus (back passage)
6. Place the swab into the sterile tube and ensure the cap fits firmly. Then place the sterile tube into the specimen bag
7. Wash your hands with soap solution

Ensure the sterile tube is fully labelled with name and medical record number

### Intrapartum prophylaxis

- **Antenatal culture-based approach**
  - Culture collection between 35 & 37 weeks gestation

- **Established GBS risk of transmission**
  - GBS bacterium in this pregnancy
  - Previous GBS proven sepsis

- **GBS risk factor-based approach**
  - Does the woman have any of the following risk factors?
    - Preterm (< 37 weeks) established labour
    - Maternal intrapartum pyrexia ≥ 38°C
    - Signs & Symptoms of suspected Chorioamnionitis
    - Rupture of membranes ≥18 hours in established labour

  - **GBS culture status**
    - unknown
    - positive
    - negative

  - **Recommend intrapartum antibiotic prophylaxis**

  - **Intrapartum antibiotic prophylaxis is not necessary**

  - **GBS risk factor**
    - positive
    - negative

### Further information:
- RANZCOG College Statement Maternal group B Streptococcus in pregnancy – screening and management
- NSW Health – Maternity – Maternal Group B Streptococcus and minimisation of neonatal early-onset GBS Sepsis

### Patient Information Brochure
NSW Health Pregnancy screening Group B streptococcus (NSW Health Publication. Translations available)
Clinical assessment and examination

All women should have a directed clinical assessment at each antenatal visit, with a focus on general well-being and early diagnosis of pregnancy complications. It is suggested that each visit include the following:

- BP
- Urinalysis
- Evidence of oedema
- Enquire about fetal movements
- Fetal presentation: after 26 weeks.
- Engagement of the head: after 37 weeks.
- Fetal Heart Rate – Recommended by Doppler: after 16 weeks
- Measurement of Symphysial-Fundal Height: after 20 weeks

Abdominal examination

- Assess the fetal size and growth
- Detect deviations from the normal
- Locate the fetal parts to indicate position and presentation
- Auscultate the fetal heart rate

Measuring symphysio-fundal height

Ensure the following is undertaken to optimise an accurate symphysio-fundal height measurement.

1. Mother semi-recumbent with empty bladder
2. Palpate to determine fundus with two hands
3. Secure tape with hand at top of the fundus. Measure with the tape scale facing downwards so avoiding less influenced by previous results.
4. Measure along longitudinal axis of uterus. Begin measuring from the highest point of the fundus since this is the more variable end point
5. Measure to top of symphysis pubis
6. Record measurements to the nearest 0.5 cm. Enter on antenatal record card

Measurement is in centimetres (1 cm = 1 wk) until 36 weeks when the uterus is at its highest level. After this time the fundal height falls. Between 24 - 34 weeks gestation the height of the uterus correlates closely with measurements in cms however obesity may distort the accuracy of these.

Women who have discrepancy between their fundal height and their gestation of +/- 3 cm or no growth over 2 week period should be referred to O&G Registrar for further investigations.
Inspection
Look at the abdomen and ascertain:
- Abdomen size (rough guide only) and shape
- Skin changes ie. striae gravidarum; linea nigra; scars

Palpation
The GP should ensure they have warm hands and use finger pads not tips. There are three different ways of palpating the pregnant abdomen.

Fundal palpation
This is used to determine the lie and the presentation.
- Face the head of the patient.
- Both hands should be on either side of the fundus, fingers held close together and curving around the uterus. The mass is grasped, using the palmar surfaces of the fingers with definite but gentle pressure.

Lateral palpation
This is used to determine the position of the fetus by locating the fetal back
- Can face either woman’s head or feet.
- Hands should be placed on both sides of the uterus.
- Pressure is applied with the palms to differentiate the degree of resistance between the two sides.
- Keeping hand to steady the uterus, and to press the foetus over towards the examining hand, which determines the presence of either:
  - A broad resistant back.
  - Small parts that slip under the fingers.
  - The back is mapped out as a smooth resistant mass

Pelvic palpation
This is used to determine presentation position and engagement. There are two methods:

1. Using both hands, palpate the lower segment of the pelvis by pressing firmly on either side of the midline just above the symphysis pubis. Use your left hand on the patient’s left side and your right hand on the patient’s right side (i.e. facing the end of the bed). Fingers should be pointed downwards and inwards.

2. Using the thumb and index finger of the right hand, firmly grip the presenting fetal part between the fingers (Pawlik’s grip). Note: this may cause pain and discomfort, so it is advisable to warn your patient beforehand

Lie
This is the relation of the long axis of the foetus to the long axis of the uterus.
Can be either: Longitudinal; Transverse; Oblique

Presentation
The part of the fetus which lies in the pelvic brim. There are five presentations:
Vertex; Breech; Shoulder; Face; Brow

Position
Position is defined by the relation of the denominator to six areas of the pelvic brim. These are right or left posterior, anterior or lateral. The denominator of the vertex is the occiput, and for the breech it is the sacrum. The lateral and anterior positions are regarded as normal.

Engagement
This is said to occur when the widest part of the presenting part has passed through the brim. Engagement is expressed in fifths. For example if the head is 3/5th above the pelvic brim it is NOT engaged.
Auscultation

Fetal Doppler use is highly recommended

Locate fetal heart by identifying fetal position and presentation. The fetal heart in a cephalic presentation is heard over the area where the scapula and the ribs come into contact with the uterine wall. In a breech position it can be heard at or below the level of the umbilici.

Auscultation of the fetal heart rate (FHR) at each antenatal visit provides little information other than demonstrating that the fetus is alive, and has no positive predictive value (NICE, 2008). However, listening to the fetal heart at each antenatal visit may be of real value to the woman and her family. It is therefore recommended that the woman be offered the opportunity to hear her baby’s heart beat at each antenatal visit. ³

Auscultate for one minute. Normal rate: 110-160 beats per minute with no irregularities

Monitoring of fetal movements

Regular enquiry about the number of fetal movements is an important aspect of ascertaining fetal wellbeing. Clinicians should emphasise the importance of maternal awareness of fetal movements at every routine antenatal visit.

The woman is the best person to tell that their baby is alive and well. Listening to the baby’s heartbeat is reassuring to the woman and health professional at the time that listening is occurring, but the baby’s movements tell us a lot more information.

All pregnant women should be routinely provided with verbal and written information: Pregnancy: Your baby’s movements and what they mean (translations available) regarding normal fetal movements during the antenatal period. Each woman should get to know the usual pattern and number of movements for her individual pregnancy.

All pregnant women should be advised to contact their maternity care provider if they have any concern about decreased or absent fetal movements and be advised not to wait until the next day to report decreased fetal movements (DFM). Maternal concern of decreased fetal movements (DFM) overrides any definition based on numbers of fetal movements. ²

Patient Information Brochure
Pregnancy: Your baby’s movements and what they mean (translations available)

Advice:
Contact the relevant hospital Delivery Ward or Birthing Unit for advice anytime day or night.

RPA Women and Babies : contact ph. 9515 6111 ask for Delivery Ward or Birth Centre
Canterbury Hospital : Contact Birthing Unit ph.9787 0555 or ph. 9787 0554
Oral health

All GP’s caring for pregnant women should: \(^1\)

1. Discuss oral health with women
   a. Explain that pregnancy does not cause dental problems but may make them more likely.
   b. Advise women to have their oral health checked and to tell the dentist that they are pregnant.

2. Provide advice on oral health to women experiencing nausea and vomiting
   a. Explain that vomiting exposes teeth to acid and give tips on how to reduce the impact

Patient Information Brochure:
NSW Health: Keep smiling while you are pregnant
Keep smiling while you are pregnant Oral Health video:

Vitamin D

There is limited evidence to support testing of all women for vitamin D status in pregnancy and the benefits and harms of vitamin D supplementation in pregnancy remain unclear.

Do not routinely recommend testing for Vitamin D status to pregnant women in the absence of a specific indication. If testing is performed, only recommend vitamin D supplementation for women with vitamin D levels lower than 50 nmol/L \(^1\).

Any investigations for a woman in regards to vitamin D must be followed up and managed by the GP requesting the test.
Hyperglycaemia in pregnancy

Refer to HealthpathwaysSydney – Hyperglycaemia in pregnancy

SLHD Diagnostic Process for Hyperglycaemia in Pregnancy (including GDM)

Define risk: High risk for hyperglycaemia in pregnancy is one or more high risk factors, or two or more moderate risk factors.

High risk factors (1 or more = HIGH RISK)
- Previous GDM
- Maternal age ≥ 40 years
- Family history of diabetes mellitus (1st degree relative with diabetes including sister with GDM)
- South Asian (Indian subcontinent) ethnicity

Moderate risk factors (2 or more = HIGH RISK)
- Maternal age 35 to 38 years
- Ethnicity: Asian, Aboriginal, Torres Strait Islander, Maori, Pacific Islander, Middle Eastern, non-white African
- BMI 25 - 35 kg/m² (overweight/Class 1 obesity)
- Polycystic ovarian syndrome (androgens not elevated)

Arrange tests for detection of hyperglycaemia

<table>
<thead>
<tr>
<th>1st Trimester (&lt;12 weeks gestation)</th>
<th>16 to 20 weeks gestation</th>
<th>26 to 28 weeks gestation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c or fasting blood glucose level (BGL)</td>
<td>75g oGTT</td>
<td>75g oGTT</td>
</tr>
</tbody>
</table>

HIGH Risk

LOW Risk

Notes:
- The 1-hour 50g glucose challenge test (GCT) is no longer to be requested.
- Before a 75g oral Glucose Tolerance Test (oGTT) the patient must fast for 8 to 12 hours.
- A 3 day high carbohydrate diet preparation is no longer needed for 75g oGTT.
- Women on metformin for PCOS/insulin resistance should cease the metformin 2 weeks before the oGTT.
- Ensure request form states that the patient is pregnant (POGTT= pregnancy oGTT) and note how many weeks gestation or Expected Date of Birth (EDB).
- Once there is a positive result, refer for management to the ‘Interpreting the results’ section.
- Unless already diagnosed with GDM or diabetes, an additional 75g oGTT should be done at any time in pregnancy if there is clinical concern.

Target weight gain in pregnancy

Counsel all pregnant women regarding their personal target weight gain in pregnancy (stratified as per pre-pregnancy BMI). Consider dietitian referral if obese/excessive weight gain.

| Institute of Medicine weight gain during pregnancy suggested guidelines |
|-----------------------------|--------------------------|--------------------------|
| BMI (kg/m²) | Classification | Singleton pregnancy total weight gain range Kg/wk | Rates of weight gain in 2nd and 3rd Trimester (Kg/wk) |
| <18.5 | Underweight | 12.5-18 kg | 0.51 (0.44-0.58) |
| 18.5-24.9 | Normal | 11.5-16 kg | 0.42 (0.36-0.50) |
| 25-29.9 | Overweight | 7-11.5 kg | 0.26 (0.23-0.33) |
| ≥30 | Obese (includes all Obesity Classes 1, 2 & 3) | 5-9 kg | 0.22 (0.17-0.27) |

Footnote to table:
The above calculations for rates of weight gain assume a 0.5-2Kg weight gain only during the first trimester, and presume a linear gestational weight gain throughout the 2nd and 3rd trimesters.

- The above recommended ranges are suggested to be used in combination with “good clinical judgment” and a discussion with each woman and her health care provider regarding diet and exercise.

- The BMI figures in the above table are derived from the World Health Organization’s “The international Classification of Adult Underweight, Overweight and Obesity according to BMI”.

References:
- RANZCOG College statement C-018-09: Management of Obesity in Pregnancy
Interpreting the results

First trimester testing <12 weeks gestation

**Gestational Diabetes (GDM):**
Diagnose Gestational Diabetes (GDM) if:

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting BGL</td>
<td>6.1 - 6.9 mmol/L or</td>
</tr>
<tr>
<td>HbA1c</td>
<td>40 - 47 mmol/mol (5.5 - 6.4%)</td>
</tr>
</tbody>
</table>

If early pregnancy fasting BGL 5.1-6.0 mmol/L:
- repeat fasting BGL at 12 weeks (refer to ‘Second and Third trimester testing’ for fasting BGL criteria to diagnose GDM/DM in pregnancy)
- if repeat fasting BGL at 12 weeks < 5.1 mmol/L, organise 75g oGTT at 16-20 weeks

Prompt referral of women diagnosed with GDM:
Those women should be seen within 2 weeks of referral, as far as possible.

RPA Women and Babies: RPAH Diabetes Centre
Ph. 9515 5888 Fax results: 9515 5820
Canterbury Hospital
Ph. 9787 0250 Fax referral & results: 9787 0431

“Diabetes Mellitus (DM) in pregnancy”: (as per ADIPS and WHO)
Diagnose “Diabetes Mellitus in pregnancy” if:

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting BGL</td>
<td>≥ 7.0 mmol/L</td>
</tr>
<tr>
<td>HbA1c</td>
<td>≥ 48 mmol/mol (6.5%)</td>
</tr>
</tbody>
</table>

Prompt referral of women diagnosed with “Diabetes Mellitus in Pregnancy”:
Those women should be assessed within 3 days and may need admission

RPA Women and Babies: RPAH Diabetes Centre
Ph. 9515 5888 Fax results: 9515 5820
Canterbury Hospital
Ph. 9787 0250 Fax referral & results: 9787 0431

Second and Third trimester testing (>12 weeks) – 75g oGTT

**Gestational Diabetes (GDM):**
Diagnosed if blood glucose level (BGL) elevated at any timepoint (i.e. only one abnormal value needed)

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting BGL</td>
<td>5.1 - 6.9 mmol/L</td>
</tr>
<tr>
<td>1-hour BGL</td>
<td>≥ 10.0 mmol/L</td>
</tr>
<tr>
<td>2-hour BGL</td>
<td>≥ 8.5-11.0 mmol/L</td>
</tr>
</tbody>
</table>

Prompt referral of women diagnosed with GDM:
These women should be seen within 2 weeks of referral, as far as possible.

RPA Women and Babies: RPAH Diabetes Centre
Ph. 9515 5888 Fax results: 9515 5820
Canterbury Hospital
Ph. 9787 0250 Fax referral & results: 9787 0431

“Diabetes Mellitus (DM) in pregnancy”: (as per ADIPS and WHO)
Diagnosed if ANY of the following criteria are met

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting BGL</td>
<td>≥ 7.0 mmol/L</td>
</tr>
<tr>
<td>HbA1c</td>
<td>≥ 48 mmol/mol (6.5%)</td>
</tr>
<tr>
<td>2-hour BGL</td>
<td>≥ 11.1 mmol/L</td>
</tr>
<tr>
<td>Random BGL</td>
<td>≥ 11.0 mmol/L and symptoms of hyperglycaemia</td>
</tr>
</tbody>
</table>

If BGL over 14 mmol/L, ketones should be also checked: If > 1.5 for blood ketones or > 1+ for urinary ketones:
Contact RPAH Diabetes Centre ph. 9515 5888 or Endocrinology Registrar for more urgent assessment as Type 1 diabetes presenting in pregnancy needs to be considered

Prompt referral of women diagnosed with “Diabetes Mellitus in Pregnancy”:
These women should be assessed within 3 days and may need admission

RPA Women and Babies: RPAH Diabetes Centre
Ph. 9515 5888 Fax results: 9515 5820
Canterbury Hospital
Ph. 9787 0250 Fax referral & results: 9787 0431
### Additional Assessments

#### Postnatal follow-up

All women who have had GDM are at high risk of future diabetes and require long term follow-up and support to maintain a healthy lifestyle. This includes regular exercise, healthy eating patterns and weight optimisation.

If the woman had:

- **GDM:** arrange 75 g oGTT at 3 to 4 months postnatally.

- "DM in pregnancy": the woman should continue to monitor her blood glucose in the immediate postnatal period and be reviewed prior to discharge as to whether any ongoing self blood glucose monitoring is needed.

If so, the frequency will depend on the blood glucose levels. Arrange **venous fasting BGL (BGL) 4 to 6 weeks postnatally.**

- \( \text{if BGL} \geq 7.0 \text{mmol/L OR HbA1c} \geq 48\text{mmol/mol [6.5%]} \), diagnostic of diabetes, likely Type 2.

- \( \text{NB: Diagnosis of diabetes does need further confirmation with a subsequent fasting BGL or HbA1c or 75g oGTT 6-12 months later.} \)

- \( \text{if BGL} < 7.0 \text{mmol/L and HbA1c < 48 mmol/mol (6.5%), arrange 75g oGTT 3 to 4 months postnatally.} \)

Arrange recalls for ongoing testing. Frequency of GTT will depend mainly on the previous GTT results.

<table>
<thead>
<tr>
<th>Frequency of 75g oGTT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum 75g oGTT indicates prediabetes (IFG/IGT)</td>
</tr>
<tr>
<td>Postpartum 75g oGTT normal</td>
</tr>
</tbody>
</table>

#### References and further information:

- [Healthpathways Sydney](https://sydney.healthpathways.org.au/)

### Pre-pregnancy assessment

As part of pre-pregnancy assessment for ALL women, assess their diabetes risk and organise appropriate screening.

Ensure effective contraception and appropriate pre-pregnancy planning.

This is especially important for:

1. Women confirmed to have ongoing diabetes – refer for pre-pregnancy counselling (see Healthpathways Sydney below in ‘References and further information’)
2. Women who have had gestational diabetes – ideally their glucose tolerance status should be known pre-pregnancy

2-hour 75g oGTT is the appropriate test – see table below for interpretation

#### Limitations of other testing processes:

(a) HbA1c (Medicare rebate requirements allow for funding for diagnosis in high risk people annually only) - if \( \geq 48 \text{mmol/mol (6.5%) it is consistent with diabetes, however it is NOT a sensitive test and diabetes or pre-diabetes may be present with much lower HbA1c levels} \)

(b) Fasting BGL - this is not a sensitive test and will miss many women who just have postprandial/post-glucose load hypoglycaemia which may be at the level of diabetes

If women do have abnormal glucose tolerance prior to pregnancy they should be referred for further pre-pregnancy diabetes counselling.

A pre-pregnancy counselling service is offered at both hospitals.

#### 75g oGTT Interpretation outside pregnancy

<table>
<thead>
<tr>
<th></th>
<th>Fasting (0hrs) BGL</th>
<th>2hour BGL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>(&lt; 6.1 \text{mmol/L})</td>
<td>(&lt; 7.5 \text{mmol/L})</td>
</tr>
<tr>
<td>Impaired Fasting Glucose (IFG)</td>
<td>(6.1-8.9 \text{mmol/L})</td>
<td>(&lt; 7.8 \text{mmol/L})</td>
</tr>
<tr>
<td>Impaired Glucose Tolerance (IGT)</td>
<td>(&lt; 6.1 \text{mmol/L})</td>
<td>(7.8-11.0 \text{mmol/L})</td>
</tr>
<tr>
<td>Diabetes</td>
<td>(7.0 \text{mmol/L or more})</td>
<td>(11.1 \text{mmol/L or more})</td>
</tr>
</tbody>
</table>
Management of Obesity in Pregnancy

Obesity in pregnancy is now one of the most important challenges in obstetric care. Approximately 50 per cent of women who become pregnant are either overweight (BMI>25 – 30) or obese (BMI>30). In addition, some women gain more than the recommended healthy weight increase during pregnancy and do not lose the additional weight post pregnancy, which increases the risks in the current and future pregnancies.

Definitions

Obesity during pregnancy is defined as a Body Mass Index (BMI) of 30 kg/m$^2$ or more calculated using the height and weight measured at the first antenatal consultation. The BMI is not a perfect measure given it does not take into account age or ethnicity; however, it is widely considered a good measure of obesity for the general population.

Maternal BMI is categorized by the WHO as follows:

• Underweight (BMI <18.5kg/m2)
• Normal (BMI 18.5-24.99 kg/m2)
• Overweight/pre-obese (BMI 25-29.99kg/m2)
• Obese class 1 (BMI 30-34.99 kg/m2)
• Obese class 2 (BMI 35-39.99 kg/m2)
• Obese class 3 (BMI ≥40 kg/m2)

Gestational weight gain:

Health professionals should be aware of current World Health Organisation guidelines for weight gain during pregnancy and advise patients to the following expected weight gain for their BMI at their first antenatal appointment. Weight gain should be discussed and monitored. See “Target weight gain in pregnancy “ as part of Diagnostic Process for Hyperglycaemia guidelines

Offer “Get Healthy in Pregnancy” Program

NSW Ministry of Health offers a free program “Get healthy in pregnancy” , which includes telephone advice from a qualified exercise physiologist. Referrals by any health practitioner or self refer.

Further information:

• RANZCOG College Statement: Management of Obesity in pregnancy

Healthy Eating for Pregnant Women

Healthy eating is important for pregnant women and their unborn babies. There are many nutritional issues to consider ensuring good health of both the woman and baby, during and after pregnancy. A wide varied diet is vital in supporting the growth and development of the foetus and the maintenance of the woman’s own health.

Further information including suggested meal plans, nutrients and food safety

• Department of Health : Eat for health

Patient Information Brochure :

NHMRC/ Department of Health: Healthy Eating During Your Pregnancy

Nausea and vomiting during pregnancy

Nausea and vomiting are common symptoms in early pregnancy. General advice can be accessed from RPAH Nausea and vomiting during pregnancy and Hyperemesis Gravidium guidelines
Thyroid disease in pregnancy

Refer to HealthpathwaysSydney – Thyroid disease in pregnancy

Thyroid Disease in Pregnancy

1. Who to screen pre- or in early pregnancy (TSH)
   - History of thyroid dysfunction, postpartum thyroiditis and/or thyroid surgery
   - Symptoms and/or clinical signs suggestive of thyroid dysfunction or goitre
   - Family history of thyroid disorder
   - Presence of thyroid or other autoantibodies
   - Type 1 diabetes mellitus
   - Prior irradiation of head or neck
   - Infertility (as part of the infertility work-up)
   - History of recurrent miscarriage and/or preterm delivery
   - Age ≥ 35

2. Thyroid function test reference ranges in pregnancy
   Use laboratory- and trimester-specific ranges. If unavailable, a TSH upper reference limit ≤0.5mIU/L below the non-pregnant TSH upper reference limit may be used; a TSH lower reference limit of 0.1, 0.2 and 0.3mIU/L may be used for the first, second and third trimesters respectively.

3. RPAH ANC Thyroid referral criteria
   (a) TSH ≥4mIU/L (on early pregnancy screen)
      Please try to limit referrals to those patients you are uncomfortable in managing or if patient has overt hypothyroidism i.e. an elevated TSH with low FT4 or if TSH ≥10mIU/L.
      - Always check TPOAb
      - Can discuss with Endocrinology registrar regarding Thyroxine dose if unsure
      - Monitor TSH every 4-6 weeks till 20 weeks with a final check at 26-32 weeks
      - If Thyroxine is commenced and TPOAb −ve, can stop Thyroxine at term. Check TFT 2-3 months postpartum
      - If Thyroxine is commenced and TPOAb +ve, halve Thyroxine dose at term and repeat TFT 2-3 months’ postpartum. Monitor for postpartum thyroiditis at 3, 6 and 12 months postpartum
      - Women on Thyroxine pre-pregnancy will generally require a 20 to 50% dose increase once pregnancy is confirmed. The dose of Thyroxine can be reduced to the pre-pregnancy dose at term
      TPOAb = thyroid peroxidase antibodies

   Suggested initial Thyroxine dose for hypothyroidism diagnosed in pregnancy:

<table>
<thead>
<tr>
<th>TSH (mIU/L)</th>
<th>Thyroxine dose (weight based calculation)</th>
<th>Thyroxine dose (approximate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ULN-5</td>
<td>1.1.5 mcg/kg/day</td>
<td>50-75 mcg</td>
</tr>
<tr>
<td>5-10</td>
<td>1.1.7 mcg/kg/day</td>
<td>75-100 mcg</td>
</tr>
<tr>
<td>&gt;10</td>
<td>1.2-2.5 mcg/kg/day</td>
<td>100-200 mcg</td>
</tr>
</tbody>
</table>

   ULN: upper limit of norm

   (b) Suppressed TSH (e.g. <0.01mIU/L)
      Check FT4, FT3 and TRAb
      - If FT4 and FT3 are normal with negative TRAb, repeat TFT in 4-6 weeks. May be due to transient gestational hyperthyroidism. Refer if TSH remains suppressed
      - Refer if elevated FT4 and/or FT3 and/or TRAb +ve

   (c) Past or current history of Graves’ disease:
      Check FT4, FT3 and TRAb
      Refer to determine
      - risk of fetal hyperthyroidism
      - need for monitoring and/or treatment in pregnancy
      - risk of postpartum flare
      NB risk of persistent TRAb post RAI and total thyroidectomy

   (d) Thyroid nodule
      Order TSH and ultrasound

Please ensure that ALL fields are completed on the referral form with CURRENT (ie <3 weeks) pathology prior to faxing to Endocrine Unit : FAX 9515 8728
Source: Dr Ash Dargya - Endocrinologist, RPAH (revised June 2018)
Julie Heithersy - Clinical Nurse Consultant, Endocrinology & Metabolism
The NHMRC recommends that all women who are pregnant, breastfeeding or considering pregnancy take an iodine supplement containing 150 micrograms each day. Women with pre-existing thyroid conditions should seek advice from their medical practitioner before taking a supplement.

Further information
NHMRC Guidelines
Anaemia and Iron Deficiency

Refer Healthpathways Sydney – Anaemia in pregnancy

Screening for Anaemia and Iron Deficiency

Consider at risk groups:

<table>
<thead>
<tr>
<th>Personal history-demographic</th>
<th>Medical history</th>
<th>Prior pregnancies</th>
<th>Current pregnancy</th>
<th>Family history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recent arrival from country with high incidence of anaemia (Africa/Asia/ Eastern Europe/ Central America/ Middle East/ Mediterranean) - Poor socio-economic status</td>
<td>Previous history of: - Vegan/vegetarian or poor diet - Iron deficiency/anaemia - Menorrhagia - Chronic gastrointestinal disease - Inherited blood disorder known - Heavy smoking - Chronic infections (e.g. malaria, worms) - Recurrent infection/poor healing - Recent blood donor</td>
<td>- High parity - Concurrent or extended breast feeding - Previous postpartum haemorrhage - Short pregnancy spacing</td>
<td>- Hyperemesis gravidarum - Poor appetite/vomiting - Teenage pregnancy - Signs or symptoms of anaemia</td>
<td>- Family history of anaemia, inherited blood disorders (thalassaemia, sickle cell disease) – if status unknown</td>
</tr>
</tbody>
</table>

Assessment
- Check for symptoms of anaemia such as fatigue, palpitations, and shortness of breath on exertion
- Consider non-pregnancy related cause of anaemia
- Assess dietary iron intake
- Screen for anaemia in early pregnancy, at 28 and 36 weeks as part of full blood count

Typical laboratory results of iron deficiency in pregnancy are:
- Hb < 105g/L
- MCV < 80 fL and
- Serum ferritin < 20 mcg/L.

Management
- If Hb is < 105g/L and MCV < 80 fL, and ferritin < 20 mcg/L, treat with oral iron and repeat FBC and ferritin in 4 weeks.
- If Hb < 95g/L and MCV and ferritin both low consistent with iron deficiency, and woman is unresponsive or intolerant to oral iron therapy then iron infusion is recommended. Discuss with Obstetric team.
- If Hb is < 80 g/L, assess clinically and speak with the obstetric registrar on call regarding appropriate urgent management.
- In all of the above, continue with oral iron treatment
All women should be routinely screened for Thalassemia (as per ANSC protocol)

Thalassaemia Screening in Pregnancy

- **Normal MCV/MCH & HbEPG**
  - Low risk of having a baby with a clinically significant haemoglobinopathy

- **Alpha thalassemia not excluded**
  - Low MCV and/or MCH
  - Normal HbEPG
  - Test Partner – FBC, HbEPG, Iron studies

- **Abnormal HbEPG* +/- abnormal FBC**
  - HbF >5%
  - *HbEPG: Carrier of a haemoglobinopathy such as alpha or beta thalassaemia, HbS, HbE, HbD;
  - **FBC: Low MCV and/or MCH

- **PARTNER**
  - Normal FBC
  - Normal HbEPG
  - Low risk of having a baby with a clinically significant haemoglobinopathy

- **PARTNER**
  - Abnormal FBC (low MCV &/or MCH) OR Abnormal HbEPG
  - REFER for GENETIC COUNSELLING
    - RPAH 9515 5080

- **TEST PARTNER**
  - (FBC, HbEPG, iron studies)
  - REFER for GENETIC COUNSELLING
    - RPAH 9515 5080

Referral must contain:
1. Name & contact of person completing form
2. Gestation
3. Ethnicity
4. Indicate if interpreter required & language
5. Partner’s name, DOB, and results if available

If partner unavailable for testing it may not be possible to clarify risk of a haemoglobinopathy

Thalassaemia screening in pregnancy 2017.docx
**Hepatitis**

**Hepatitis C virus (HCV) in pregnancy**
*Refer Healthpathways Sydney – Hepatitis C in pregnancy*

**Assessment**

1. Discuss risk factors for HCV infection
   - People who have ever injected drugs.
   - People born in regions with high hepatitis C prevalence e.g., Asia, Africa, Middle East, Eastern or Southern Europe.
   - Sexual partners of people with hepatitis C.
   - People with tattoos or skin piercings with poor infection control procedures, e.g., carried out in some overseas countries or in a custodial setting.
   - Recipients of organs, tissues, blood or blood products before February 1990 in Australia or at any time overseas.
   - People who are, or have been, incarcerated.

2. Examine for signs of liver disease
   - Hepatomegaly, hard or irregular liver, or splenomegaly
   - Easy bleeding or bruising
   - Palmar erythema
   - Spider naevi
   - Late signs e.g., jaundice, ascites

3. Screen for HCV antibodies in all pregnant women, including an HCV antibody test. Positive HCV antibodies indicate prior exposure to HCV. Provide pre-test counselling, if required.

**Antenatal Management**

If HCV positive status is confirmed, refer patient for liver condition assessment

**Hepatitis B virus (HBV) in pregnancy**
*Refer Healthpathways Sydney – Hepatitis B in pregnancy*

**Assessment**

1. Discuss risk factors for HBV infection

2. Examine for signs of liver disease:
   - Hepatomegaly, hard/irregular liver, or splenomegaly
   - Spider naevi
   - Palmar erythema
   - Muscle wasting
   - Late signs e.g., jaundice, ascites

3. Antenatal screening and provision of information on the neonatal hepatitis B vaccination program is required for all women. Test for HBsAg with pre-test counselling
HBsAg positive pregnant women

1. Complete hepatitis serology must be ordered – HBeAg, anti-HBe, HBV DNA, as well as LFT, coagulation studies.
2. Manage based on results of the blood tests and refer for liver clinic assessment as required

Postpartum management of HBsAg positive women

- All HBsAg women require postnatal follow-up 4 to 6 months after delivery.
- Lifelong monitoring is required by the general practitioner on at least an annual basis.

Infants of HBsAg positive mothers

- Infants require hepatitis B vaccination and hepatitis B immunoglobulin (HBIG) within 12 hours of birth to reduce risk of transmission by 90%.
- The general practitioner should receive a neonatal hepatitis B follow up letter upon the mother’s discharge from hospital, explaining the infants follow-up requirements.
- All infants born to HBsAg positive women must be followed up to ensure completion of their primary vaccination course and subsequent serology.
- Test for HBsAg and anti-HBs 3 months after 12-month childhood immunisation for HBV.
- If infant or child tests positive for HBsAg infection, contact Paediatric Viral Hepatitis Clinic – Children’s Hospital, Westmead ph. 9845 3989

Rh (D) Immunoglobulin

Refer Healthpathways Sydney – Rh(D) Immunogloblin and Rhesus negative Women

All pregnant women should be typed for ABO and Rh(D) blood grouping and antibodies as early as possible in pregnancy to help protect against Haemolytic Disease of the Newborn.

Retesting for antibodies again at 28 weeks is required for Rh(D) negative pregnant women.

If a woman is Rh D negative and has no preformed Anti-D antibodies, the GP should inform her about the need to prevent Rh D sensitization. All Rh (D) negative women (who have not actively formed their own Anti-D) should be offered Anti-D prophylaxis and when a sensitizing event occurs.

Further information:
- NSW Health – Maternity- RH (D) Immunogloblin (Anti D)
- RANZCOG College Statement : C-Obs 6 Guidelines for the use of Rh (D) Immunoglobulin (Anti-D) in obstetrics in Australia

Parent Education Classes

RPA Women and Babies and Canterbury Hospitals both offer a range of programs designed to help women, their partners and support people prepare for childbirth and parenting. Ideally courses should be booked when a woman is between 14 and 22 weeks pregnant. Costs are involved with most courses. Canterbury Hospital offer free Antenatal Breastfeeding Classes, held twice /month.

For further information or booking:
RPA Women and Babies ph. 9515 5284 or email: parent.education@email.cs.nsw.gov.au
Canterbury Hospital ph. 9787 0250 or 9878 0560
**Women requiring extra support**

All women are assessed for psychosocial risk factors at their first hospital 'booking in' visit. Specific questions are asked around issues such as domestic violence, family supports, psychological history including anxiety and depression, drug and alcohol use, and general coping mechanisms. Where issues are identified, women are referred, via a weekly intake meeting, to appropriate services such as social work, D&A, Young Parents, family support or Perinatal Mental Health services.

According to referral needs, women will be placed in one of three categories. These categories reflect the degree of risk they may have both antenatally and postnatally.

**HIGH RISK**: Women and families who have complex social histories and require additional care. i.e. drug and alcohol issues, history of or current domestic violence, psychiatric illness

**MODERATE RISK**: Women and families who require additional support. i.e. history of depression, PND, physical disabilities, history of neonatal death, multiple birth, young parents, cultural risks, CALD.

**LOW RISK**: Women in need of community supports. i.e. all clients

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**Perinatal and Family Drug Health Service (PAFDHS)**

This service is available to all women with a substance use concern from preconception, during pregnancy to the postnatal period. It aims to provide support, education and information to women and their families so they can make informed choices about the pregnancy.

**RPAH**

**Referrals can be made in the following ways:**

- Self-referral, GP, drug health service, antenatal clinic, pharmacy or early childhood health centre.
- GP can Complete SLHD Mental Health Psychological Assessment Form marked “Attention: GP Liaison Midwife CNC” and FAX 9515 7452 to the antenatal clinic
- Contact PAFDHS ph. 9515 7611 or ph. 9515 8298 and leave a message if necessary.
- Urgent consultations/queries please page via RPAH switch ph. 9515 6111

**Who to refer:**

- Pregnant women with ongoing heroin use should be considered an urgent referral.
- Women who have ongoing use of other substances.
- Pregnant women on pharmacotherapy (Methadone or Buprenorphine).
- Women requiring assistance with smoking cessation should be referred to the Quit helpline ph. 13 78481 (13 QUIT) or Smoking Cessation Clinics (see below)
- Women with exposure to drugs during early pregnancy may wish to access the service to discuss effects on fetal development even if drug use is not continuing. They can be referred to the clinic or to the Mothersafe information service ph. 9382 6539

**Canterbury Hospital**

Substance Use in Pregnancy & Parenting Service – ph 0436 601 980

**Smoking Cessation Clinics**

Drug Health Services offer one-to-one counselling support at RPAH (ph: 9515 7611, KGV building) and Croydon Community Health Centre (ph: 9378 1306). Contact service for further information and clinic times

**Further information**

NSW Health: [Tobacco smoking and pregnancy](#)
Department of Health – [Pregnancy and quitting](#)
Aboriginal Health

It has been widely documented and recognised that Aboriginal and Torres Strait Islander women have poorer perinatal outcomes compared to non-indigenous women. As birth outcomes influence the babies developmental outcomes, indigenous babies are suffering both long and short term. Currently Aboriginal women book into hospital much later in pregnancy, with one third of bookings occurring after 28 weeks.

A number of reports indicate that with the implementation of antenatal care specific to indigenous women it improves antenatal outcomes, attendance, screening and treatment. Evidence also suggests that Aboriginal women are more likely to attend a antenatal service when it has been specifically tailored to their needs and is culturally sensitive and culturally secure.

RPA Women and Babies Aboriginal Liaison Midwife (ALM)

The role of the Aboriginal Liaison Midwife is to:

- facilitates a bridge between Aboriginal women, their families and health care professionals at RPA.
- works in partnership with Indigenous families to promote maternal and infant physical, emotional and social wellbeing throughout the pregnancy
- provides a link to postnatal services in the catchment area.

The Aboriginal Liaison Midwife will care for any Aboriginal or Torres Strait Islander woman OR any woman who is currently pregnant with an Aboriginal or Torres Strait Islander baby. If the pregnancy is high risk, the ALM will still remain involved and continue with midwifery input along with the obstetric team.

The main roles and responsibilities of the Aboriginal Liaison Midwife are:

- ensure accessible antenatal, intrapartum and postnatal services are provided within a supported environment based on need of each individual indigenous family.
- support for women and their families throughout the pregnancy
- liaise with other team professionals as required
- advocate for the indigenous woman and family
- provide appropriate antenatal care tailored to the needs of the pregnancy
- education surrounding pregnancy, birth and the postnatal period
- promotion of breastfeeding and offer support and advice
- encourage regular antenatal attendance
- support staff to be culturally sensitive and culturally aware when dealing with Indigenous women

Referral:

Contact the ALM directly ph. 9515 6586 or Fax (9515 7452) referral to ANC: Attention “Aboriginal Liaison Midwife”. Once a referral has been made, the ALM will make the 1st ANC visit, arrange any further diagnostic tests if required and continue to see the women throughout their pregnancy. All services and supports eg social work, drug health, psychiatry and postnatal services will be accessed for the women according to need

Young Women

Refer Healthpathways Sydney – Antenatal care – Young women

Young women may have special pregnancy needs, not only physical, but also emotional and psychosocial. RPA offer a Young Parent Clinic for women younger than 21 years and/or vulnerable i.e intellectual disability, social difficulties. The clinic is serviced by designated GP, midwife and relevant allied health professionals.
Domestic violence

Refer Healthpathways Sydney – Family and Domestic Violence

Antenatal care provides an opportunity to ask women about exposure to violence especially at home or in their family. Asking questions may assist women to disclose their experiences of violence to health professionals and enable access to additional support and care, including community, legal and police support service.

Explain to all women that asking about domestic violence is a routine part of antenatal care and enquire about each woman’s exposure to domestic violence.

Health professionals should be aware of local resources and support services for women experiencing domestic violence and can be called for urgent assistance.

Key considerations in discussing and responding to domestic violence:

<table>
<thead>
<tr>
<th>Consideration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enquire about family violence when alone with the woman</td>
<td></td>
</tr>
<tr>
<td>Explain that the woman’s responses will be kept confidential (subject to legal requirements)</td>
<td></td>
</tr>
<tr>
<td>Actively listen to what the woman tells you</td>
<td></td>
</tr>
<tr>
<td>Do not blame or judge the woman or her partner</td>
<td></td>
</tr>
<tr>
<td>Inform the woman that she is not alone, there are other women experiencing family violence</td>
<td></td>
</tr>
<tr>
<td>Affirm that the woman has made an important step by discussing her experiences</td>
<td></td>
</tr>
<tr>
<td>Reinforce that family violence is against the law</td>
<td></td>
</tr>
<tr>
<td>Reinforce that the woman should not self-blame</td>
<td></td>
</tr>
<tr>
<td>Affirm that the decision to discuss family violence is a major step to enhance her safety</td>
<td></td>
</tr>
<tr>
<td>Assist the woman to assess her safety and that of children in her care</td>
<td></td>
</tr>
<tr>
<td>Discuss options for safe temporary accommodation if needed and available (eg safe house, family or friends, hospital, women's refuge)</td>
<td></td>
</tr>
<tr>
<td>Encourage the woman to access specialist support services (eg woman’s health centre, social worker, counsellor, mental health service, family violence and sexual assault service)</td>
<td></td>
</tr>
<tr>
<td>Inform the woman of her legal right to protection and provide information on legal support services</td>
<td></td>
</tr>
<tr>
<td>Inform the woman that disclosure of family violence may require further discussion and possible reporting in relation to child protection issues</td>
<td></td>
</tr>
<tr>
<td>Be aware of security supports that can be used to protect the woman and yourself if needed</td>
<td></td>
</tr>
<tr>
<td>Document a woman’s responses (ensuring that records are kept confidential and secure)</td>
<td></td>
</tr>
<tr>
<td>Report any incidents of violence according to organisational policy and jurisdictional legislation</td>
<td></td>
</tr>
</tbody>
</table>
**Questions used in assessment of family violence**

Within the last year, have you (ever) been hit, slapped or hurt in other ways by your partner or ex-partner? OR (In the last year,) has (your partner or) someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?  
Are you (ever) afraid of your partner or ex-partner (or someone in your family)?  
(In the last year) has (your partner or) someone in your family or household ever (often) put you down, humiliated you or tried to control what you can or cannot do?  
(In the last year), has your partner or ex-partner (ever hurt or) threatened to hurt you (in any way)?  
Would you like help with any of this now?  
Are you safe to go home when you leave here?

**Further information:**

**NSW**  
Domestic Violence Hotline : ph. 1800 656 463  
Child Protection .ph. 132 111   Mandatory reporting ph. 133 627

**National Hotline**  

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**Perinatal Mental Health**

**Refer Healthpathways Sydney – Perinatal Depression and anxiety**

Accurately identifying women experiencing symptoms of depression and anxiety enables referral for more formal mental health assessment and suitable follow-up. Screening and assessment should occur as part of routine antenatal and postnatal care.

When screening Aboriginal and Torres Strait Islander women, consider language and cultural appropriateness of the tool. Translated and validated versions of the EPDS with culturally relevant cut-off scores are available.

Health professionals will greatly benefit from identifying other professionals from whom they can seek advice, clinical supervision or support regarding mental health care in the perinatal period. Early referral is vital for patients who are currently experiencing anxiety and/or depression or at high risk of developing mental health issues.

The Centre for Perinatal Excellence (COPE) provides access to range of perinatal mental health resources to assist with screening, assessment and management of women including National Perinatal Mental Health Guidelines

**Summary of EBR** (evidence based recommendations) from National Perinatal Mental Health Guidelines

<table>
<thead>
<tr>
<th>EBR</th>
<th>Use the EPDS to screen women for a possible depressive disorder in the perinatal period.</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Arrange further MH assessment of perinatal woman with an EPDS score of 13 or more.</td>
<td>Strong</td>
</tr>
<tr>
<td>3</td>
<td>If using a tool to assess psychosocial risk, administer the ANRQ.</td>
<td>Strong</td>
</tr>
<tr>
<td>4</td>
<td>Provide structured psychoeducation to women with symptoms of depression in the perinatal period.</td>
<td>Strong</td>
</tr>
<tr>
<td>6</td>
<td>Recommend individual structured psychological interventions (CBT or IPT) to women with mild to moderate depression perinatally.</td>
<td>Strong</td>
</tr>
</tbody>
</table>
Perinatal Mental Health assessment and/or referral

Refer Healthpathways Sydney – Perinatal Mental Health Assessment

Consider:

- for urgent /crisis assessment ring the Mental Health Access Line 1800 011 511 (24 hours)
- requesting perinatal mental health assessment. For advice, contact the perinatal mental health
team during business hours at relevant hospital. They are not a crisis or emergency service.
- specific psychological therapy with a practitioner experienced at working with mothers and babies
via Better Access or Psychological Support Services (PSS)
- commencing or continuing pharmacological treatment if clinically indicated

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Sydney Local Health District

<table>
<thead>
<tr>
<th>Perinatal Mental Health Team</th>
<th>RPAH Clinical Nurse Consultant Perinatal Mental Health Team ph.9515 5873 Fax 9515 7452 Contact GP Liaison Midwife to confirm referral has been received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients with pre-existing mental illness or at risk of developing a perinatal mental health problem who are having their baby at SLHD maternity facility</td>
<td>Canterbury Hospital Perinatal Mental Health CNC ph. 9787 0000 and page # 82062 ph. 9787 0488</td>
</tr>
<tr>
<td>Consultation</td>
<td></td>
</tr>
<tr>
<td>Assessment of antenatal and postnatal mood disturbance</td>
<td>RPAH ph 9515 7101</td>
</tr>
<tr>
<td>Referral and liaison</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perinatal and Family Support Clinic</th>
<th>RPAH Drug &amp; Alcohol Intake ph. 9515 7611</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance use risk in pregnancy and/or other psychosocial issues</td>
<td></td>
</tr>
<tr>
<td>Referral and liaison</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perinatal Drug Health Services</th>
<th>RPA Women and Babies Ambulatory Care Social Worker ph. 9515 9902 or page through switch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance abuse problem and is pregnant or is the partner of a pregnant women</td>
<td></td>
</tr>
<tr>
<td>Referral and liaison</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Work Department</th>
<th>RPAH Women and Babies Ambulatory Care Social Worker ph. 9515 9902 or page through switch</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal service</td>
<td></td>
</tr>
<tr>
<td>Counselling support and support groups</td>
<td></td>
</tr>
<tr>
<td>Referrals</td>
<td></td>
</tr>
<tr>
<td>Advocacy</td>
<td></td>
</tr>
<tr>
<td>Practical assistance and education</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Early Childhood and Family Support Services</th>
<th>Central and Eastern Sydney PHN ph 9799 0933</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free service staffed by Child and Family Health Nurses who offer health, development and wellbeing checks for your child as well as support, education and information on all aspects of parenting.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>External Service Providers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Support Services (PSS)</td>
<td>Central and Eastern Sydney PHN ph 9799 0933</td>
</tr>
<tr>
<td>Targeted programme aimed at improving access to short term psychological services for financially disadvantaged and vulnerable patients who:</td>
<td></td>
</tr>
<tr>
<td>Are eligible for a mental health treatment plan,</td>
<td></td>
</tr>
<tr>
<td>Are likely to benefit from short term, goal oriented focussed psychological strategies.</td>
<td></td>
</tr>
<tr>
<td>Services are provided at no cost to the patient.</td>
<td></td>
</tr>
<tr>
<td>Providers need to be registered with PSS</td>
<td></td>
</tr>
</tbody>
</table>
| **Tresillian** | **Head Office**  
| Assessment  
| Day stay  
| Outreach services  
| Residential  
| Mental health nurses and psychiatrist | McKenzie Street  
| BELMORE NSW 2192  
| ph.9787 0800 |

If FACS are involved and Case Manager appointed, please contact Centralised Intake staff on 02 4734 4400 prior to completing referral form.

Referral Form: [https://www.tresillian.org.au/](https://www.tresillian.org.au/)

24 Hour Parent Helpline:  
ph. 9787 0855 or ph. 1800 637 357

| **Parent-Infant Unit, St Benedicts** | **St John of God Private Hospital**  
| Private psychiatric hospital  
| Services include:  
| Inpatient mother and baby unit  
| Individual and group therapy  
| Support groups  
| After care program | 13 Grantham Street  
| BURWOOD NSW 2134 |

Referral is required to a St John of God accredited psychiatrist for both inpatient and outpatient treatment.

*Private health insurance necessary*  
Inpatient and outpatient treatment depending on the level of individual cover

| **Jade House** | **Karitane**  
| Parent Baby Day Unit | Cnr The Horsley Drive and Mitchell Street  
| BARRAMAR 2163 |

*Monday - Friday 8.30am - 5pm*

Specialised day unit for women who have a diagnosis of or are at risk of developing a perinatal mood or anxiety disorder and are pregnant or have a baby up to 12 months.

Services include:  
| Individual and couple supportive therapy  
| Sessional psychiatric services  
| Parentcraft and child development  
| Mother, Infant Therapy Groups  
| Postnatal Issues Group | Referral form  
| fax 9794 2323  
| ph. 9794 2324 |

*No crisis referrals accepted*  
Parent helpline (7 days)  
1300 CARING - 1300 227 464

| **Mothersafe** | **Royal Hospital for Women**  
| Comprehensive counselling service for women and their healthcare providers concerned about drug or environmental exposures during pregnancy and lactation. | ph 9382 6539 |

Face-to-face counselling appointments –  
GP Referral required  
fax 9382 6070

| **Mental Health Access Line** | **Lifeline (24hours)**  
| Referral to mental health agencies, including local community mental health centres. 24 hours. | ph. 1800 011 511 |

|  | ph.13 11 14 |
## Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beyond blue</td>
<td>Pregnancy and early parenthood information and resources on perinatal depression including guides for women of ATSI and CALD backgrounds</td>
</tr>
</tbody>
</table>
| Panda Foundation                  | [www.panda.org.au](http://www.panda.org.au)  
Post and antenatal Depression Association  
Raising awareness of perinatal anxiety and depression  
Information Helpline: 1300 726306 Mon- Fri 9-7pm |
Raising awareness of perinatal anxiety and depression  
Information Helpline: 1300 726306 Mon- Fri 9-7pm |
| Pregnancy birth and baby Helpline  | [www.pregnancybirthbaby.org.au](http://www.pregnancybirthbaby.org.au)  
Support for women, partners and families  
Information helpline: ph. 1800 882 436 |
| Black Dog Institute               | [https://www.blackdoginstitute.org.au/](https://www.blackdoginstitute.org.au/)  
Information and resources on perinatal mental health |
SLHD Perinatal Mental Health Referral Flowchart

From Antenatal Clinic and Birth Centre:
- Women who have a history of psychosis
- Women who have ceased psychotropic medication due to pregnancy or lactation
- Women who are depressed, anxious or have any other mental illness/issue

Refer via perinatal intake form and meeting

From wards – antenatal, postnatal, DW:
- Women who are depressed, anxious, psychotic, at risk of PND, not coping
- Midwifery referrals direct to CNC – via RPA switch – ph. 9515 6111
- Medical referrals – via O&G team – consult to psychiatry. Page on call Consultation Liaison Psychiatry Registrar via RPA switch. – ph. 9515 6111

PERINATAL MENTAL HEALTH TEAM:
- Perinatal Psychiatrist
- Clinical Nurse Consultant – Perinatal Mental Health
- Consultation Liaison Psychiatry Registrar

Referrals taken from antenatal booking visit → to early postnatal period

From GP’s:
- Women who the GP would like to discuss with the team re management or request for consults

Referral form: Fax referral 9515 7452: Attention Perinatal Mental Health team.

To ensure that referral is received, please phone either Perinatal Mental Health on ph. 9515 5873 or GP Liaison Midwife on ph. 0425 230 662 to inform that referral has been faxed.

Outpatient medical referrals:
- Women who the consultant would like to discuss with the consultant psychiatrist

Refer direct to perinatal psychiatrist by using consult form (send to Department of Psychiatry via internal mail) or page via RPA switch – ph. 9515 6111

ECHC, MDSP, NICU, Paediatric ward:
- Women known to team – please discuss directly with clinician
- Women unknown to team, consider:
  - GP
  - Local Mental Health team – 1800 636825
  - Perinatal Mental Health team

From GP’s:
- For women whom a GP would like to discuss with the team regarding management or request for consult

Write a ‘referral’ letter Attention: Perinatal Mental Health Team. Contact ANC ph. 9787 0250 or ph. 9787 0560 for appointment with Mental Health Team.
If women already "booked in" – page Hospital Perinatal Mental Health via switch ph. 9787 0000 to discuss
If crisis- ring Hospital and asking to be put through to the hospital crisis team.
Labour, Birth and Hospital Discharge

The care of the woman during labour and birth is the responsibility of the maternity team at either RPA Women and Babies or Canterbury Hospital.

Overdue Pregnancies

Following the 40 week GP visit, advise patients to contact the clinic for their post dates appointment.

RPA Women and Babies: Women need to be seen at 41 weeks +1 day in the Registrars Post Dates clinic. Should this date fall on a weekend the women must be seen in the previous Thursday afternoon clinic.

Canterbury Hospital: Women are reviewed between 40 to 41 weeks. The appointment should be prior to 41 and not after this time. If an interpreter is needed please inform the antenatal clerk making the appointment to enable an interpreter to be booked.

Should women go into labour there is no need to call and cancel the clinic appointment.

Along with routine assessment an internal (P.V.) examination will be attended.

A management plan for induction of labour will be determined based on the findings. These will be fully discussed with the woman. Instructions, information and a planned date for their hospital admission will be given.

External Cephalic Version (ECV)

Breech presentation is common in premature pregnancies. The table below outlines the incidence of breech presentations and gestational age

<table>
<thead>
<tr>
<th>Gestation (weeks)</th>
<th>% Breech</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-24</td>
<td>33%</td>
</tr>
<tr>
<td>25-28</td>
<td>28%</td>
</tr>
<tr>
<td>29-32</td>
<td>14%</td>
</tr>
<tr>
<td>33-36</td>
<td>9%</td>
</tr>
<tr>
<td>37-40</td>
<td>3%</td>
</tr>
</tbody>
</table>

Therefore, the vast majority will turn spontaneously and require no intervention. Women should be reassured that a breech presentation during the early phases of pregnancy can be a normal finding and that no action need to be taken until at least 36-37 weeks. Breech presentation presents a problem when labour is pre-term, or when premature rupture of membranes occurs.

Consider referring all women 36-37 weeks with breech presentation where there is no other indication for caesarean section. Undertaken after 37 weeks, there is a reduced likelihood that the baby will revert spontaneously back to breech. Appointments: RPA ph.9515 7101; Canterbury Hospital ph. 9787 250 or 9787-0560

Patient Information Brochure:
Women having an External Cephalic Version
Your Breech Baby: Information for parents
RANZCOG: Breech Presentation at the End of your Pregnancy
Birth After Caesarean (BAC) Clinics

Women who have had a caesarean section (CS) at RPA Women and Babies or Canterbury Hospital will receive a discharge letter outlining information about their recent caesarean section. A copy of the letter is sent to the GP and also kept in the woman’s medical record. The letter provides a statement about the implications of the caesarean section specifically for this woman’s next pregnancy. The contents of this letter are discussed with the woman prior to her discharge.

RPA Women and Babies:
Appointments: ph. 9515 7101  
Completion of RPA Obstetric Referral Form

Women are encouraged to be referred to the hospital before 12 weeks in a subsequent pregnancy to discuss birth options. Consultations can be arranged prior to hospital booking visit to discuss the woman’s pregnancy plan.

Canterbury Hospital:
Appointments: ph: 9787 0250 or 9787 0560  BAC Midwife: ph: 9787 0183

Women are encouraged to be referred to the hospital before 12 weeks in a subsequent pregnancy to discuss birth options.

Education classes for women who have had one previous caesarean.

There are two sessions proposed:

- **Early pregnancy information classes** ideally for attendance prior to < 30 weeks of pregnancy and regardless of the woman’s thoughts about their next birth.
- **Preparation for labour classes** for attendance after ≥ 30 weeks of pregnancy.

Patient Information Brochures:
Have you had a Caesarean before? Birth After Caesarean Clinic: Canterbury Hospital
Vaginal Birth after Caesarean Labour Care
Hospital Discharge

RPA Women and Babies

RPA Women and Babies has formalised times of discharge related to the age of the newborn and depending on the well-being and health of the mother and baby.

- First time mothers who have given birth vaginally will be discharged at 72 hours of age of newborn.
- Multiparous women who have given birth vaginally will be discharged at 48 hours of age of baby.
- Women who have had a caesarean section will be discharged at 96 hours of age of newborn.

Women can still opt for the use of the Midwifery Discharge Support Program (MDSP) but need to make the decision early.

On discharge, a woman will receive a copy of her discharge summary and her baby’s blue book completed as required. No discharge summary will be generated for normal newborns but relevant discharge information will be written in the baby's blue book.

For the following newborns, the postnatal ward resident or NNP will generate and print the discharge summary on the postnatal ward for:
- All babies who had a confirmed significant abnormality that needed review by the neonatal consultant.
- All babies who required referral to another service
- Other babies as determined by the neonatologist covering the postnatal wards.

All babies who have been admitted to the nursery, and are discharged back to the postnatal ward, will have a summary generated and printed in the nursery prior to their return to the postnatal ward for inclusion with the final discharge paperwork.

Patient Information Brochure:
When do I go home after baby is born

Canterbury Hospital

Canterbury Hospital times of discharge are related to days post - delivery and depending on the well-being and health of the mother and baby.

<table>
<thead>
<tr>
<th></th>
<th>Normal Discharge</th>
<th>MDSP/MGP</th>
</tr>
</thead>
<tbody>
<tr>
<td>First time mothers#</td>
<td>48 to 72 hrs</td>
<td>4 to 48 hrs</td>
</tr>
<tr>
<td>Multiparous women#</td>
<td>24 to 48 hrs</td>
<td>4 to 24 hrs</td>
</tr>
<tr>
<td>Caesarean birth</td>
<td>96 hrs</td>
<td>72 hrs</td>
</tr>
</tbody>
</table>

# vaginal birth
Postnatal Information

Refer for Heathpathways Sydney – Maternal Postnatal Check

Immediate postpartum care occurs within the hospital setting or with the support of midwives over the following week. With increasing reductions in the length of stay, some GPs can be presented with early postpartum care issues and may identify problems that require referral back to hospital or paediatrician. Urgent hospital referrals include postpartum haemorrhage, genital tract sepsis, eclampsia, and thromboembolism.

A postnatal appointment with GP for baby ~ 2 weeks and 6 weeks and mother 6 weeks respectively. Early contact is encouraged to assess wellbeing, social risk factors, and level of support.

Baby : 1- 4 Weeks

Comprehensive assessment guide: Routine newborn assessment

Physical
- Age, weight, length, head circumference
- Feeding
- Examination:
  - Fontanelles, Eyes (Observation / corneal reflexes / white pupils
  - Cardiovascular, Umbilicus, Femoral pulses, Hip test for dislocation, Testes fully descended R / L.
  - Genitalia, Anal region, Skin, Reflexes

Discuss
- Health promotion: safe sleeping, SIDS prevention, vaccinations, benefits of breastfeeding

Maternal : 6 weeks post partum checklist

Physical:
- Check blood pressure
- Assess involution of uterus by palpation
- Check any suturing or LSCS wound (if necessary) adherence, discharge or signs of infection
- Perineum examination and care – healing process; exclude infection, hygiene, ice pack, pain relief
- Vaginal digital assessment of pelvic floor muscles. Encourage pelvic floor exercises.
- Check bladder and bowel function – incontinence: urinary or faecal assess severity, duration and frequency of symptoms.
- Breasts – lumps, engorgement, mastitis
- Nipples – cracks, grazes
- Pap smear if due
- Note LMP
- Check immunisation status
- Follow-up pregnancy complications ie Gestational Diabetes – refer for postnatal 75gm GTT at 2-3 months postpartum; Hypertension

Discuss:
- Enquire about general health
- Birth and any complications
- Family relationship and parenting issues
- Maternal sleeping / diet / exhaustion
- Assess maternal psychological wellbeing and coping with life changes (EPDS) – check support networks
- Contraception
- Intercourse – resumed, dyspareunia – discuss feelings, concerns
- Infant feeding – breast, formula, mixed
Feeding Support

Breastfeeding
Refer for Healthpathways Sydney – Breastfeeding

GPs have an important role in not only encouraging and supporting breastfeeding; and in supporting women to overcome breastfeeding difficulties. Timely support and management is the key to overcoming feeding problems to ensure continued breastfeeding.

Comprehensive information regarding breastfeeding and associated issues can be located in the SLHD Breastfeeding Policy

Infant Feeding Guidelines

The National Health Medical Research Centre Infant Feeding Guidelines are aimed at health workers to assist in providing consistent advice to the general public about breastfeeding and infant feeding. They provide advice and recommendations on breastfeeding, supporting mothers and parents, the introduction of solids, preparing infant formula and other common health related concerns.

The Infant Feeding Guidelines are relevant to healthy, term infants of normal birth weight (>2500g). Although many of the principles of infant feeding described here can be applied to low birth weight infants, specific medical advice is recommended for pre-term and underweight infants.

Further Information:
- NHMRC 2013 Infant Feeding Guidelines:

Breastfeeding Support Services

<table>
<thead>
<tr>
<th>Private Lactation Consultants</th>
<th>International Certified Lactation Consultants : Lactation Consultants Association of Australia and New Zealand (LCANZ) <a href="http://www.lcanz.org">www.lcanz.org</a> Click find a Lactation Consultant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation Consultant – for women that delivered at RPAH Women and Babies</td>
<td>ph. 9515 8422 or page through switch ph. 95156111</td>
</tr>
<tr>
<td>Lactation Consultant – for women that delivered at Canterbury Hospital</td>
<td>ph. 9787 0000 and page through switch ph. 9787 0000</td>
</tr>
<tr>
<td>Australian Breastfeeding Association (ABA)</td>
<td>Helpline: 1800 mum 2 mum – ph. 1800 686 268 <a href="http://www.breastfeeding.asn.au">www.breastfeeding.asn.au</a></td>
</tr>
<tr>
<td>Sydney Inner Metropolitan ABA</td>
<td><a href="https://www.breastfeeding.asn.au/contacts/groups">https://www.breastfeeding.asn.au/contacts/groups</a></td>
</tr>
<tr>
<td>Tresillian : 24 hour Parents help line</td>
<td>ph. 9787 0855</td>
</tr>
<tr>
<td>Karitane : 7day Careline</td>
<td>1300 CARING – ph. 1300 227 464</td>
</tr>
</tbody>
</table>
Urogynaecology Referrals

RPA Women and Babies

Urgent

- RPAH Emergency Department
- RPAH Urogynaecology fellow ph. 9515 6111 pager # 80604

Non-urgent

- Urogynaecologist - Incontinence/Prolapse/Peripartum issues
  - RPAH Pelvic floor clinic
  - Private Urogynaecologist - www.ranzcog.edu.au
- Allied Health
  - Community Nurse Continence Advisor
  - Sydney South West - 1800 556 533
  - Physiotherapy http://physiotherapy.asn.au/

Referrals to RPAH

- General Gynaecology clinic OR
  Pelvic Floor Clinic  Gynaecology Referral form required to be completed
- Primary and secondary reasons for referral
  - Past Hx: Medical conditions, previous abdomino-pelvic surgery/medications lists
- Note whether interpreter needed
- Useful pre-clinic investigations:
  - Bladder diary (www.urodynamic.com.au)
  - MSU result
  - Urodynamics results
  - Renal tract USS (if recurrent UTIs, haematuria)

Pelvic Floor Clinic
This is a tertiary referral service for women with incontinence, prolapse, follow-up of obstetric anal sphincter injury, perineal pain
Complete Referral Form and Fax ONLY 9515 3454
Child and Family Health

Refer Healthpathways Sydney – Maternal Postnatal Check

Early Childhood Health Centres provide a free service and are staffed by Child and Family Health Nurses who offer health, development and wellbeing checks for children as well as support, education and information on all aspects of parenting.

All referrals to Early Childhood Health Centres (ECHC) are via the Central Intake Line, no calls are directed straight to the clinic.

Central Intake Line - Appointment and Information Line
Ph: 9562 5400  Fax: 9787 0534
Hours: MONDAY – FRIDAY 8.30am-4.00pm       Email: cicfhn@ss wahs.gov.au

The Appointment and Information Line is for residents of Sydney Local Health District who may have delivered in a private or public hospital within the Sydney metropolitan area and / or have a child aged 0-5 years. In some instances, you may wish to contact Community Health staff to arrange priority follow-up for specific clients and / or to discuss ongoing continuity of care issues.

The Child and Family Nursing (CFHN) team offer a home visit to all women within 2 weeks following the birth of their baby to discuss feeding, settling and general parentcraft issues and to weigh and check the infant. Following this home visit women are given information about local child and family nursing clinics which they can access for regular checkups.

Recommended health screenings:

- □ 1 – 4 weeks
- □ 6 – 8 weeks
- □ 6 – 8 months
- □ 12 months
- □ 18 months
- □ 2 years
- □ 3 years
- □ 4 years

Groups:  New Parents, Breastfeeding support and Solids Groups

Referrals are available as required to any of the following allied health specialists: -

- Early Childhood Social Worker
- Hearing Specialist
- Nutritionist
- Dental ph. 9293 3333
- Speech Therapist
- Physiotherapist
- Orthoptist intake ph. 9378 1164

Other Referral Contacts

<table>
<thead>
<tr>
<th>Tresillian Family Care Centres</th>
<th>Central Intake: 02 4734400</th>
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<tbody>
<tr>
<td>Tresillian Family Care Centre at Canterbury is a second tier service that offers both residential and day stay programs for women finding it difficult to cope with being a parent</td>
<td>Canterbury Centre: Mc Kenzie Street Belmore 2192 Ph. 9787 0827</td>
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<tr>
<th>Sydney Hope Cottage</th>
<th>The Infants Home</th>
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<tbody>
<tr>
<td>● Develop parenting skills</td>
<td>17 Henry Street ASHFIELD NSW 2131</td>
</tr>
<tr>
<td>● Enhance parent / child skills</td>
<td>Ph. 9799 4844</td>
</tr>
<tr>
<td>● Reduce feelings of isolation/anxiety</td>
<td>(Mon-Fri 9am-4pm)</td>
</tr>
<tr>
<td>● Identify postnatal depression</td>
<td>Fax: 9799 4122</td>
</tr>
<tr>
<td>● Learn ways of setting boundaries</td>
<td><a href="mailto:mail@theinfantshome.org.au">mail@theinfantshome.org.au</a></td>
</tr>
<tr>
<td>● Day stay or home visiting</td>
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<tr>
<td>Health professional or self-referral</td>
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Referral Forms

Various clinics within SLHD require specific referral forms to be completed by the GP to ensure appropriate referral. Referral forms are available on the CESPHN website.

Note: Some Referral Forms are available as MD and BP templates for importing into clinical software programs. Prior to downloading, please view information on how to correctly import templates into software. “How to use these templates”

Patient Information Brochures

Various patient information brochures are available on CESPHN website regarding topics such as EPAS, Prenatal Screening, GBS, baby’s movements, GP ANSC Program.
References


5. Queensland Clinical Guidelines – Routine newborn assessment QLD Department Health


Document Control

<table>
<thead>
<tr>
<th>Author</th>
<th>Resource</th>
<th>Version</th>
<th>Reviewed by</th>
<th>Date</th>
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<tr>
<td>CESPHN</td>
<td>ANSC GP Resource Manual</td>
<td>Version 7.3</td>
<td>SLHD, CESPHN ANSC Advisory Group</td>
<td>June 2017</td>
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<tr>
<td>CESPHN</td>
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<td>September 2018</td>
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