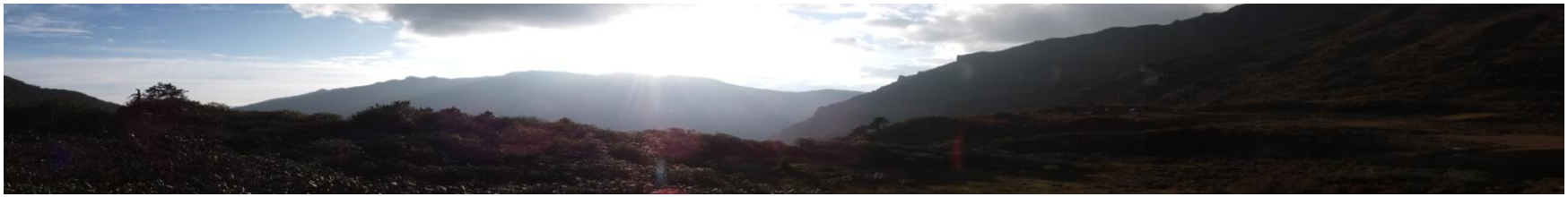


PRA-BC Orientation

“Hey Doc I’m Pregnant. Now what?”

Dr. Preveena Dharmaraj

with thanks to Dr. Karen Buhler and
Dr. Moira de Valence

Sept 2025

Vancouver
Division of Family Practice
A GPSC initiative

Program Disclosure/ Presenter Disclosure

No commercial conflicts to disclose

Situating ourselves, territorial acknowledgement

Living and working with gratitude on the traditional unceded homelands of the xʷməθkwəy̓əm (Musqueam), Skwxwú7mesh (Squamish), and Səl̓ílwətaʔ/Selilwitulh (Tsleil-Waututh) Nations

Photos:
- **Series: One Day Young by Jenny Lewis London, UK**
- **Vancouver Division of Family Practice**
- **Others generously donated by personal friends**

Learning Objectives

1. Develop a strategy for the first and second prenatal visits: what care is urgent and time sensitive?
2. Identify what tests should be ordered before referral to a maternity provider.
3. Utilize the guidelines set out by Perinatal Services BC
4. Engage the pregnant person in participating in their care
5. Review workflow efficiencies, structural supports, billing tips

What are your learning needs?

Case 1: Meera

Meera is a 35-year-old woman who presents to your walk-in clinic thinking that she is pregnant. She has regular periods and notes that her last menstrual period (LMP) was March 13 (today is May 8). She is certain of her LMP, which makes her gestational age approximately 8 weeks

What are her options regarding the pregnancy?

Case 1: Meera

- She has the option to continue the pregnancy or to pursue an elective termination (medical or surgical abortion)

- In Canada, providers are not compelled to provide medical services (such as abortion or medically assisted dying) that conflict with their personal beliefs, but providers **do have a duty to refer to another provider** who is able to provide those services

- Medical termination options can absolutely be provided in your family practice office and there are great resources to help prescribers

Case 1: Meera

You discuss with Meera that her urine pregnancy test in your office confirms she is pregnant. You ask Meera how she is feeling about the pregnancy and she confides she is very excited to be expecting a child. She and her partner had been hoping to conceive and are thrilled with the news.

What are the next steps?

“I’m pregnant, now what?”

- Timing is everything!

- WHAT MOTHER SAY SURVEY across Canada:
  - women said that the reason they did not get prenatal care when they needed it was: 1) care provider not available or 2) told them not to be seen till later in pregnancy

- As many as 25% of women in some areas are not accessing the best possible tests for PN genetic screening
- 35% of women do not receive an early ultrasound

BC Antenatal Record

British Columbia Antenatal Record Part 1

1. Primary maternity care provider name | Family physician / nurse practitioner name

Patient surname | Patient given name(s) | Date of birth (dd/mm/yyyy) | Age at EDD

Surname at birth | Preferred name / pronoun | Language preferred | Relationship status*

Highest level of education completed* | Occupation

Indigenous identity:* ☐ No response ☐ None ☐ First Nations ☐ Métis ☐ Inuk (Inuit) ☐ Outside Canada ☐ Status ☐ Non-status ☐ Pending | ☐ Live on reserve ☐ Live off reserve ☐ Live on & off reserve | Ethnicity*

Surname | Given name | Address | Phone number | Personal Health Number

Partner: Surname, given name(s) | Occupation | Biological father / donor: Surname, given name(s) OR ☐ Same as partner | Age | Ethnicity*

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

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

4. Obstetrical History **G**ravida ____ **T**erm ____ **P**reterm ____ **A**bortus (Induced ____ Spontaneous ____) **L**iving ____

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

5. Present Pregnancy

No Yes (specify)

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

6. Family History

No Yes (specify)

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

7. Medical History

No Yes (specify)

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

8. Lifestyle / Social Concerns

No Yes (specify)

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

9. Substance Use

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

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

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

Norm Abnorm (specify)

- ☐ ☐ Head & neck _____
- ☐ ☐ Breasts & nipples _____
- ☐ ☐ Heart & lungs _____
- ☐ ☐ Abdomen _____
- ☐ ☐ Musculoskeletal _____

Norm Abnorm (specify)

- ☐ ☐ Skin: ☐ Varicosities ☐ Other _____
- ☐ ☐ Pelvic _____
  STI test (dd/mm/yyyy) _____
  Pap test (dd/mm/yyyy) _____
- ☐ ☐ Other _____

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

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

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

British Columbia Antenatal Record Part 2

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

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

13. Investigations

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

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

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

Prenatal Genetic Investigations ☐ Declined

☐ SIPS ☐ IPS ☐ Quad ☐ CVS

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

Results

14. Edinburgh Perinatal / Postnatal Depression Scale* ☐ Declined

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

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

Follow-up _____

15. Ultrasounds & Other Imaging Investigations

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

16. Perinatal Considerations & Referrals

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

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

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

Plan to breastfeed: ☐ No ☐ Yes ☐ Undecided

Lifestyle / substance use _____

Pregnancy _____

Labour & birth _____

Breastfeeding _____

Postpartum _____

Contraception plan _____

Newborn _____

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

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

18. Sign-Offs

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

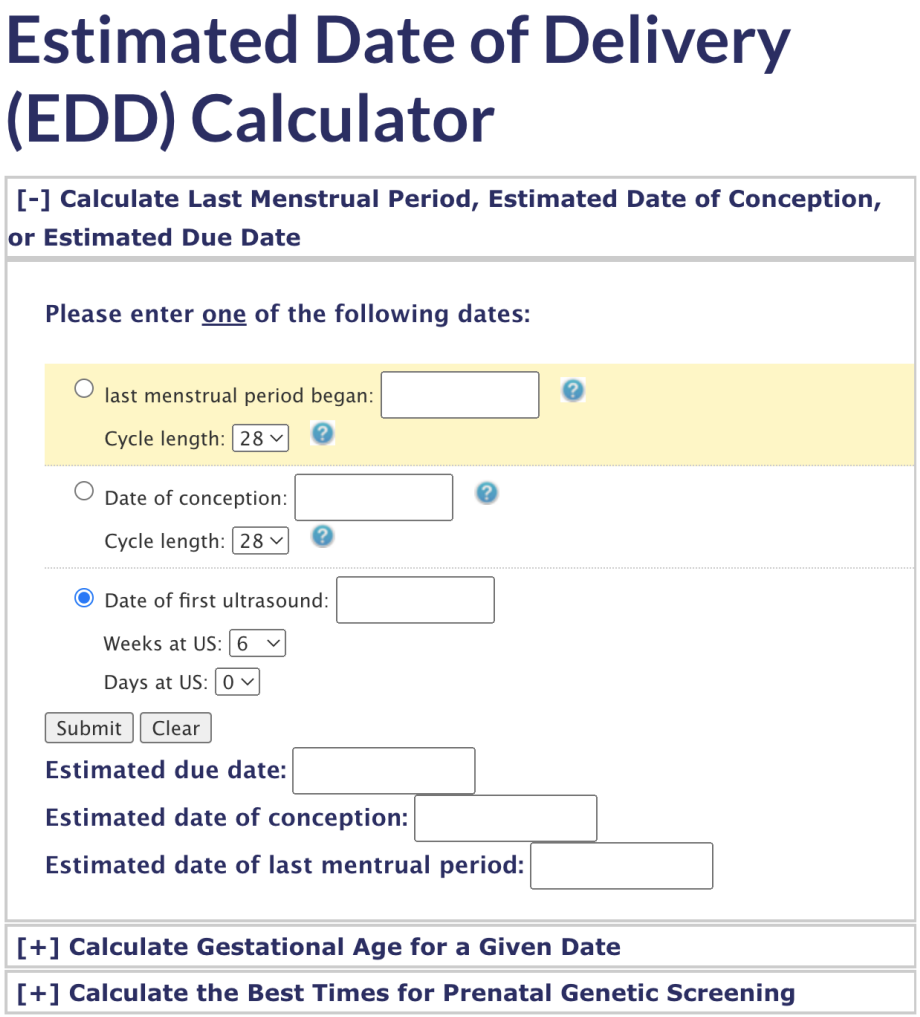
** Please refer to **Reference Page 2** on the back of this page for guidance and a list of discussion topics.*

First and Second Visit

must-do's:

1. Estimate due date
2. Early ultrasound
3. Lifestyle and risk assessment
    1. Folic acid
    2. Alcohol, substance use
    3. Mood/anxiety disorders
4. Screening blood work
5. Prenatal genetic screening
6. Early referral to local Public Health

STEP 1: Estimate Due Date from LMP



LINK

STEP 2: First Ultrasound

- Confirm due date with first trimester ultrasound

****new provincial recommendations are to do US at 11-13 weeks**

A first trimester dating ultrasound is recommended for all pregnant women/people, ideally timed between 11+0 and 13+0 weeks gestational age. Earlier ultrasounds should only be done if clinically indicated including where there is clinical suspicion of early pregnancy loss or ectopic pregnancy, previous history of ectopic pregnancy, or history of two or more early pregnancy losses.

- Current practice in British Columbia is to date the pregnancy according to the earliest ultrasound performed where **the crown rump length (CRL) measurement measures at 10mm or greater**, unless conception date is known from timed ovulation induction (Ovulation induction or in vitro fertilization -IVF), as per PSBC Ultrasound standards and SOGC Guideline No 388.

- BCWH uses the Robinson's chart

STEP 2: Early Ultrasound

- Why early ultrasound?
- Dating with ultrasound, even the detailed anatomy ultrasound done at 20 weeks, is more accurate than sure dates in a regular cycle
  - Only 10% of women ovulate on day 14 even with regular 28 day cycles
  - 25 % of women ovulate outside days 8-17
  - 10% of women ovulate twice in a cycle
  - Sperm can live 3-6 days
- Key benefit – reduces inductions for post dates by up to 40%

STEP 2: Early Ultrasound

Req for dating US:

- G2A1L0

4. **Obstetrical History** **G**ravida _____ **T**erm _____ **P**reterm _____ **A**bortus (Induced _____ Spontaneous _____) **L**iving _____

- LMP: Sept 10, 2024
- EDD by dates: June 17, 2024
- Current GA: 6w0
- Please see for dating ultrasound between 11-13 wks GA

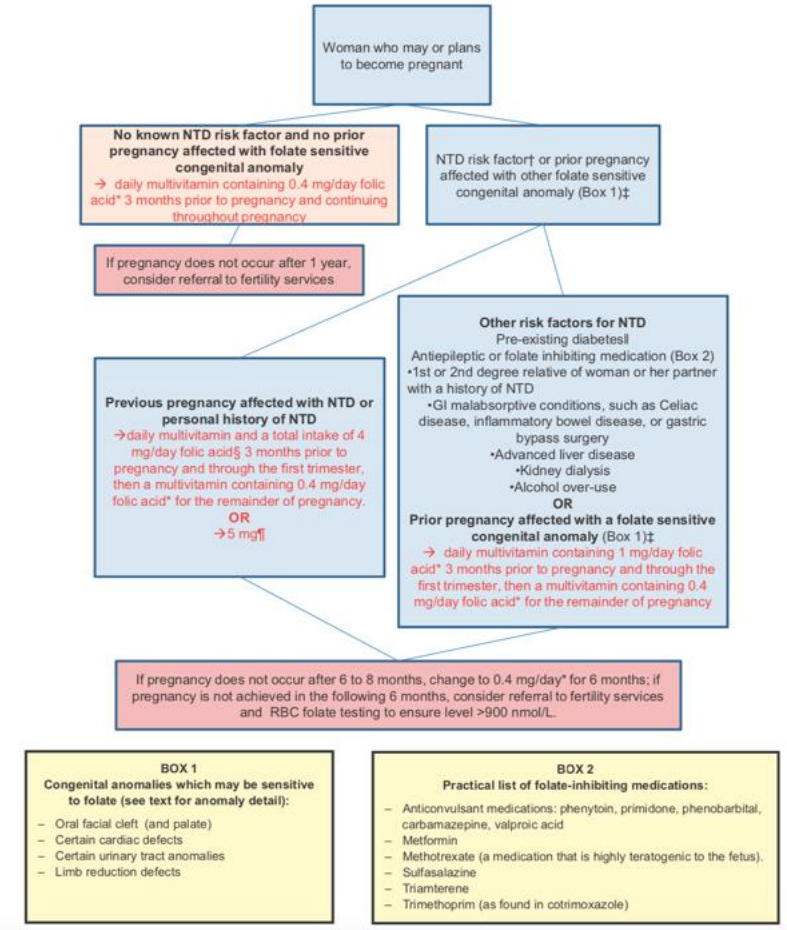
STEP 3: Lifestyle - Risk Assessment

- Exercise/Diet
  - Any dietary restrictions? Iron sources?
    Food safety counselling
  - Food security
- Substance use
  - Screen for EtOH, substance use and connect to appropriate resources
  - Pregnancy is a key time to motivate behavioural changes
  - RACE line has Perinatal Addictions support
- Other risks
  - Exposures: second hand smoke
  - Medications – OTC and prescribed
  - IPV
  - Mood/anxiety disorders – can refer to Perinatal Psychiatry

STEP 3: Lifestyle - Folic Acid

PER SOCG Guidelines:

- LOW RISK
  - 0.4mg/day
- MODERATE RISK
  - 1mg/day until 12 weeks, then 0.4mg/day
- HIGH RISK
  - 4g/day (practically can take 5mg pill for ease)



STEP 4: Labs

BLOOD AND URINE TESTING

Recommend to ALL Women:

- CBC
- Urine C&S
- Chlamydia and gonorrhea Nucleic Acid Amplification Test (urine, cervical or vaginal self-collection if avail.)
- HBsAg, STS/RPR, HIV, Rubella titre
- Blood ABO Group, Rh factor, and antibody screen

Additional Tests to Recommend/offer to Women with Risk Factors:

- HbA1c if at risk for Type 2 Diabetes
- anti-HCV if at risk for Hepatitis C
- TSH if clinically indicated
- Varicella antibody if history uncertain
- Ferritin if at risk for anemia
- HPLC (high performance liquid chromatography) for Thalassemia and Hemoglobinopathy carrier screening for all women EXCEPT those who are:
  - Japanese
  - Korean
  - Northern European Caucasian
  - First Nations or Inuit
- Tay-Sachs screen if woman or partner is/may be Ashkenazi Jewish (AKJ) descent; or AKJ carrier full screen if both are/may be of AKJ descent. Special form required, see resources.

Case 1: Meera

- You ask a few more questions to identify whether Meera may require additional tests. Meera adheres to a vegetarian diet. She does not recall whether she had chicken pox as a child. She thinks she had all of her routine childhood vaccines. She had a thorough medical review as part of the immigration process and does not have any significant medical conditions. She thinks there may have been a grandparent with diabetes but both her parents are healthy. All of her ancestors lived in India.

- **What additional tests would you order for Meera?**

Case 1: Meera

HEMATOLOGY

- [X] Hematology profile
- [ ] INR **PT-INR**
- [X] Ferritin (query iron deficiency)

On Anticoagulant? [ ] Yes [ ] No
Specify: _____

HFE - Hemochromatosis (check ONE box only)
- [ ] Confirm diagnosis (ferritin first, ± TS, ± DNA testing)
- [ ] Sibling/parent is C282Y/C282Y homozygote (DNA testing)

URINE TESTS

- [ ] Macroscopic → microscopic if dipstick positive
- [ ] Macroscopic → urine culture if pyuria or nitrite present
- [ ] Macroscopic (dipstick) [ ] Microscopic *

* Clinical information for microscopic required:

_____

CHEMISTRY

- [ ] Glucose – fasting (see reverse for patient instructions)
- [ ] Glucose – random
- [ ] GTT – gestational diabetes screen (50 g load, 1 hour post-load)
- [ ] GTT – gestational diabetes confirmation (75 g load, fasting, 1 hour & 2 hour test)
- [ ] GTT – non-gestational diabetes
- [ ] Hemoglobin A1c
- [ ] Albumin/creatinine ratio (ACR) - Urine

MICROBIOLOGY – LABEL ALL SPECIMENS WITH PATIENT'S FIRST & LAST NAME, DOB, PHN & SITE

ROUTINE CULTURE

On Antibiotics? [ ] Yes [ ] No Specify: _____

- [ ] Throat [ ] Sputum [ ] Blood [ ] Urine
- [ ] Superficial Wound, Site: _____
- [ ] Deep Wound, Site: _____
- [ ] Other: _____

VAGINITIS

- [ ] Initial (smear for BV & yeast only)
- [ ] Chronic/recurrent (smear, culture, trichomonas)
- [ ] Trichomonas testing

GROUP B STREP SCREEN (Pregnancy only)

- [ ] Vagino-anorectal swab [ ] Penicillin allergy

CHLAMYDIA (CT) & GONORRHEA (GC) by NAAT

Source/site: [ ] Urethra [ ] Cervix [X] Urine [ ] Vagina [ ] Throat [ ] Rectum

Other _____

GONORRHEA (GC) CULTURE

Source/site: [ ] Cervix [ ] Urethra [ ] Throat [ ] Rectum

Other _____

STOOL SPECIMENS

History of bloody stools? [ ] Yes

- [ ] *C.difficile* testing [ ] Stool culture [ ] Stool ova & parasite exam
- [ ] Stool ova & parasite (high risk, submit 2 samples)

DERMATOPHYTES

- [ ] Dermatophyte culture [ ] KOH prep (direct exam)

Specimen: [ ] Skin [ ] Nail [ ] Hair

Site: _____

MYCOLOGY

- [ ] Yeast [ ] Fungus Site: _____

HEPATITIS SEROLOGY

- [ ] **Acute viral hepatitis undefined etiology**
  Hepatitis A (anti-HAV IgM)
  Hepatitis B (HBsAg ± anti-HBc)
  Hepatitis C (anti-HCV)
- [ ] **Chronic viral hepatitis undefined etiology**
  Hepatitis B (HBsAg; anti-HBc; anti-HBs)
  Hepatitis C (anti-HCV)

Investigation of hepatitis immune status
- [ ] Hepatitis A (anti-HAV, total)
- [ ] Hepatitis B (anti-HBs)

Hepatitis marker(s)
- [ ] HBsAg

(For other hepatitis markers, please order specific test(s) below)

- [X] **HIV Serology**
  (patient has the legal right to choose not to have their name and address reported to public health = non-nominal reporting)
  - [ ] Non-nominal reporting

OTHER TESTS – Standing Orders Include expiry & frequency

- [ ] ECG
- [ ] FIT (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program
- [ ] FIT No copy to Colon Screening Program

LIPIDS

✓ one box only

Note: Fasting is not required for any of the panels but clinician may specifically instruct patient to fast for 10 hours in select circumstances (e.g. history of triglycerides > 4.5 mmol/L), independent of laboratory requirements.

- [ ] Full Lipid Profile - Total, HDL, non-HDL, LDL cholesterol, & triglycerides (Baseline or Follow-up of complex dyslipidemia)
- [ ] Follow-up Lipid Profile - Total, HDL & non-HDL cholesterol only
- [ ] Apo B (not available with lipid profiles unless diagnosis of complex dyslipidemia is indicated)

THYROID FUNCTION

For other thyroid investigations, please order specific tests below and provide diagnosis.

- [ ] Monitor thyroid replacement therapy (TSH Only)
- [ ] Suspected Hypothyroidism (TSH first, fT4 if indicated)
- [X] Suspected Hyperthyroidism (TSH first, fT4 & fT3 if indicated)

OTHER CHEMISTRY TESTS

- [ ] Sodium
- [ ] Potassium
- [ ] Albumin
- [ ] Alk phos
- [ ] ALT
- [X] B12
- [ ] Bilirubin
- [ ] GGT
- [ ] T. Protein
- [ ] Creatinine / eGFR
- [ ] Calcium
- [ ] Creatine kinase (CK)
- [ ] PSA – Known or suspected prostate cancer (MSP billable)
- [ ] PSA screening (self-pay)
- [ ] Pregnancy test
- [ ] ß-HCG – quantitative

urine C&S (r/o asymtomatic bacteuria in pregnancy)
prenatal group and antibody screen
Rubella titre, HBsAg, syphilis, thalessemia screen, varicella IgG

SIGNATURE OF PRACTITIONER	DATE SIGNED
"Electronically signed"	2025-04-06

DATE OF COLLECTION | TIME OF COLLECTION | COLLECTOR | TELEPHONE REQUISITION RECEIVED BY: (employee/date/time)

Case 1: Meera

- Because Meera is only 8 weeks by dates, you provide her with some resources to review her options for genetic screening and make a plan to discuss at the next visit in two weeks.

- **If she decides she would like to pursue genetic screening, what would her options be?**

- NIPT

or

- IPS : because she is 35 , she should have a nuchal translucency ultrasound in addition to the serum screening

STEP 5: Prenatal Genetic Screening

- Considerations for choice of test:
  - Access
  - Cost
  - Test performance

Available Tests for Prenatal Genetic Screening

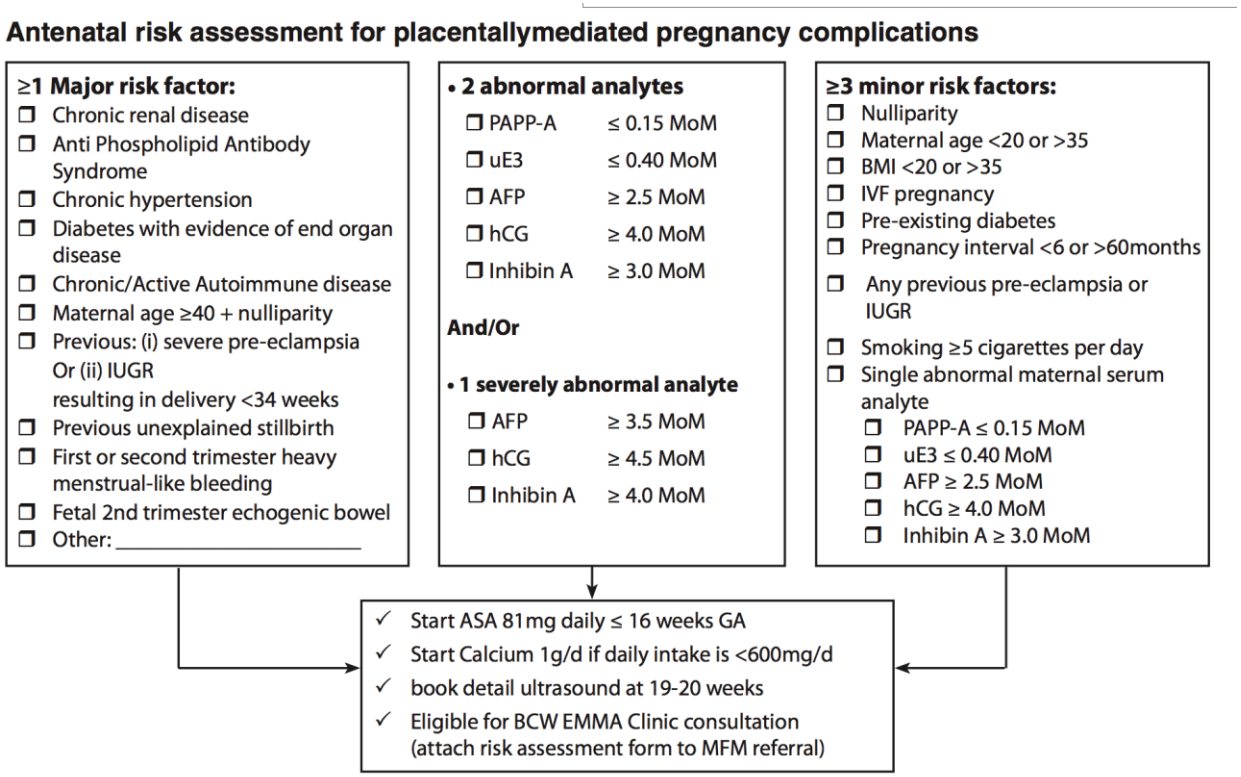
- **SIPS** – Serum Integrated Prenatal Screen: Part I at 9-13^{+6} wks; Part 2 at 14-20^{+6} wks.
- **IPS** – Integrated Prenatal Screen: SIPS + NT ultrasound at 11-13^{+6} wks.
- **Quad Screen** – SIPS Part 2
- **NIPT** – Noninvasive Prenatal Screen / cell-free fetal DNA: single serum test from 10 wks on.

Screening Options for Singleton Fetus at Time of First Visit			
Maternal Age	**9-13^{+6} weeks**	**14-20^{+6} weeks**	**≥ 21 weeks**
<35 yrs	SIPS and detailed US	Quad and detailed US	Detailed US
35-39 yrs (& all twins)	IPS and detailed US	Quad and detailed US	Detailed US
40+ yrs	IPS and detailed US	Quad and detailed US	Detailed US
	CVS or amniocentesis is available without prior serum screening		
All ages	Private Pay: NIPT from 10 wks on; FTS or NT at 11-14 wks		

STEP 6: Pre-eclampsia prevention

Before 16 weeks

1. If maternity care provider referral delayed
2. Consult for assistance as needed (RACE, colleague)
3. EMMA referral



Case 1: Meera

- **Will you be the one to deliver my baby?**

- If you refer Meera to another maternity provider, what information would you send along with the referral?
  - Antenatal record 1 and 2
  - Blood and urine testing results
  - Genetic screening results
  - Dating ultrasound
  - Pap test and STI screening results

Landscape of Maternity Care in BC

- Patients can choose to be cared for by (depending on availability):
  - Midwives - offer home or hospital births
  - FP-OBs
  - OB-GYNs
- Scope of community FPs depend on personal skill set and needs of the area

Case 2: Kyra

- Kyla is a 21 year old patient who presents for a visit in your family practice because she is tired all the time and has been gaining weight. She says her periods are always irregular and she doesn't remember when her last one was. She is sexually active with male partners and does not use contraception. Her mother Nancy is also a patient at your practice, who has been seeing you regarding anxiety. Nancy has been worried about Kyla, who dropped out of college this year. Urine pregnancy test in the office is positive. Kyla is surprised and ambivalent about the pregnancy. On examination, fundus is at the umbilicus.

- **What are her options regarding the pregnancy?**

Case 2: Kyra

- **What are her next steps if she continues with pregnancy?**

- Urgent ultrasound for dating and anatomy
- Blood work
- Offer genetic screening – Quad screen or NIPT

Case 2: Kyra

- You explain that as part of routine screening for pregnancy, you ask all patients about medications and substances that they use. You begin by asking her about any over the counter, traditional, or herbal medications. Then you ask her about any alcohol, smoking, or substance use. She initially says that she uses "pot once in a while, it helps with anxiety". You tell her you're sorry to hear she's been experiencing anxiety, and that you'd like to help her with that. You let her know that there are safer options in pregnancy if she chooses to continue. She then confides that over the past year, she has also been using stimulants, initially starting at parties, but becoming more regular and often using "downers" to come down after a high.
- She asks, "Are you going to report me to the government?"

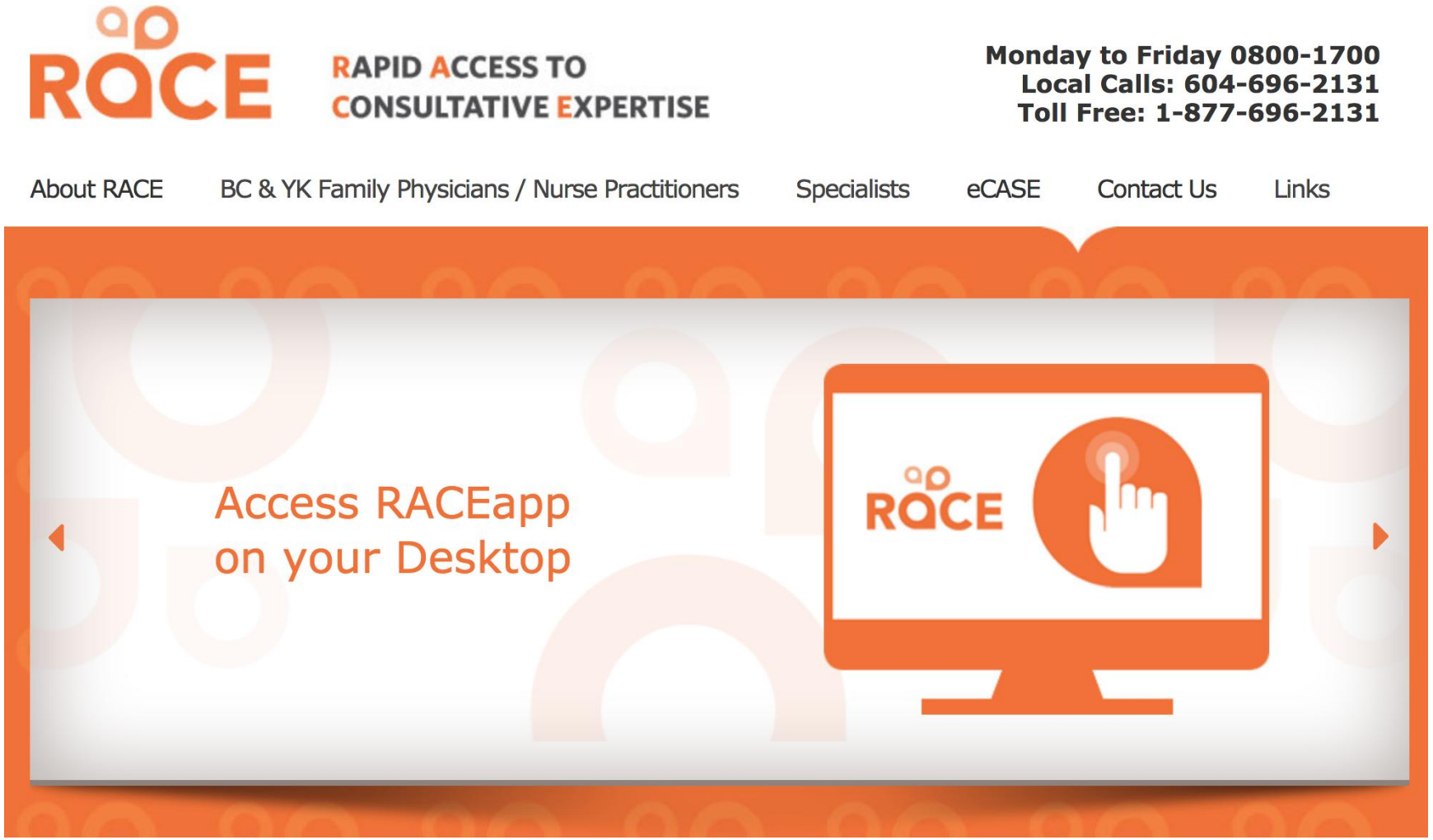
- **Do you have any legal requirement to report Kyla's pregnancy as a child protection concern?**

Substance use and Pregnancy

- Caring for people using substances during pregnancy is less about the "what" and more about the "how"
- Relationship is the foundation of effective care
- Harm reduction, patient centred philosophy
- The initial encounter is crucial
- Addictions research has shown that the client's first impression of welcome and acceptance by a treatment facility significantly increases the likelihood that they will develop an effective relationship with the facility

- As a family physician who may already have a relationship with the patient, you can have a significant impact on the patient's engagement and care

RACE – Urgent Consultation Resource

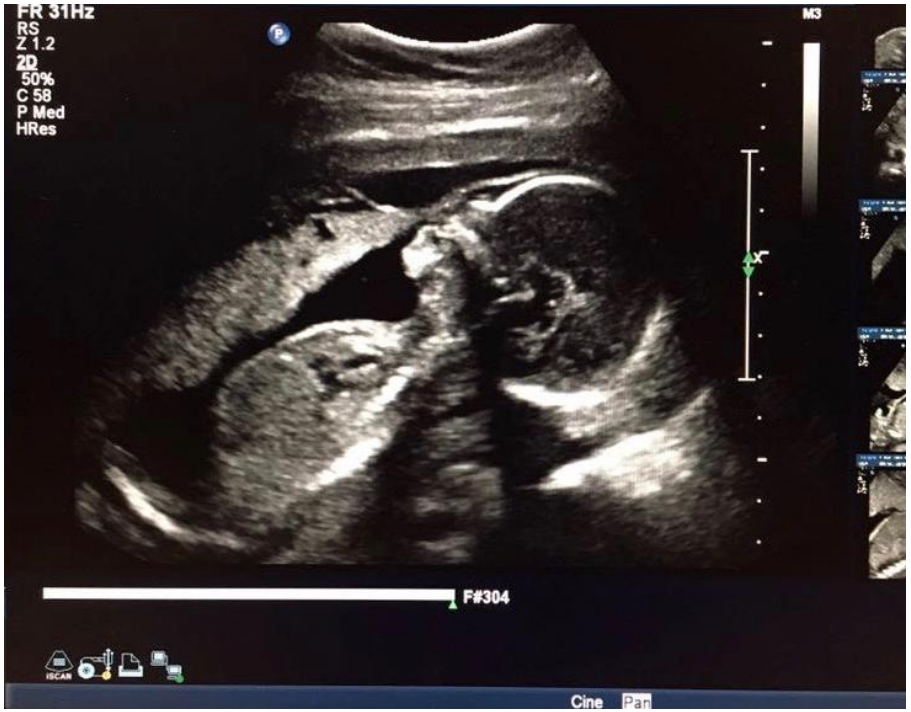


Perinatal Addictions, Perinatal Psychiatry, OBGYN

How do we get this all done?

Break it into multiple visits

First step: estimate due date based on LMP



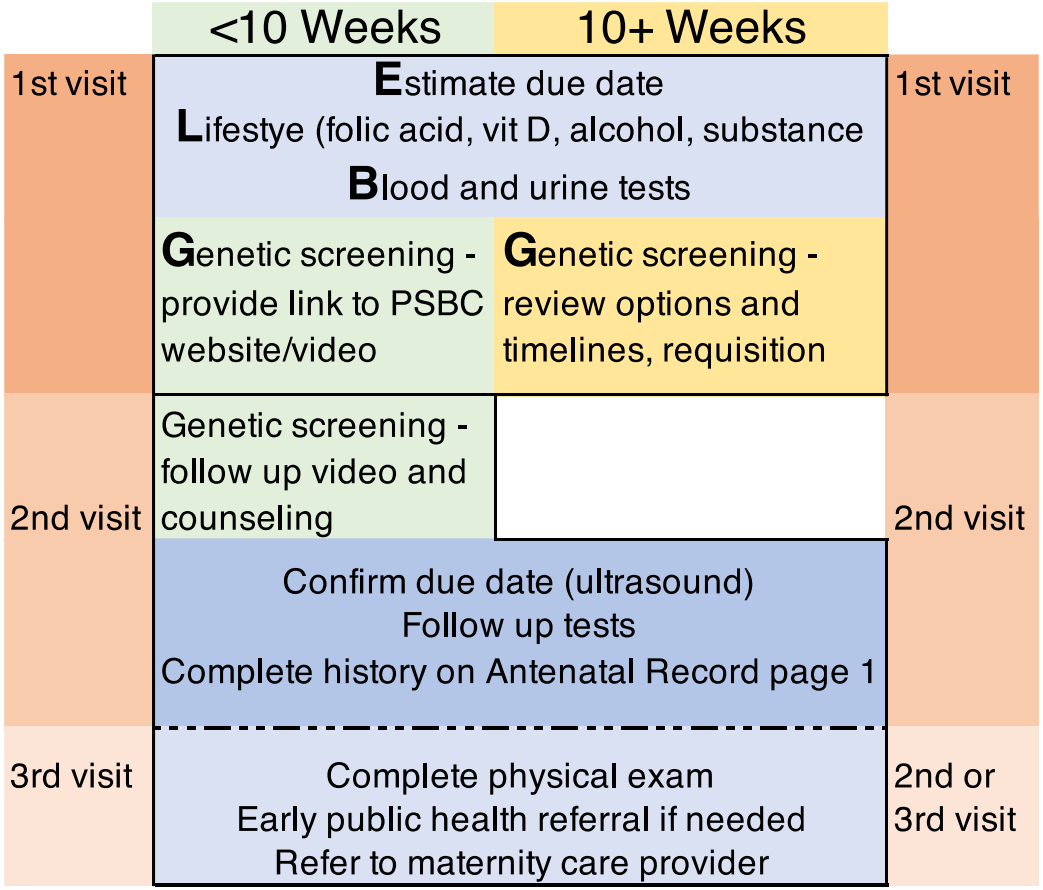
- Under 10 weeks, take a breath (can schedule multiple visits)
- 10+ weeks, get moving!

Summary of early visits

Time sensitive must do's:

Case study:
Meera, 8 weeks

1. Labs, ultrasound, folic acid + lifestyle, resources for genetic screening
2. Genetic counseling visit
3. CPX, referrals



Case study:
Kyla, 20+ weeks

1. Engagement , offer as acceptable to patient – labs, ultrasound, lifestyle, genetic screening
2. CPX , referrals, complete topics from #1

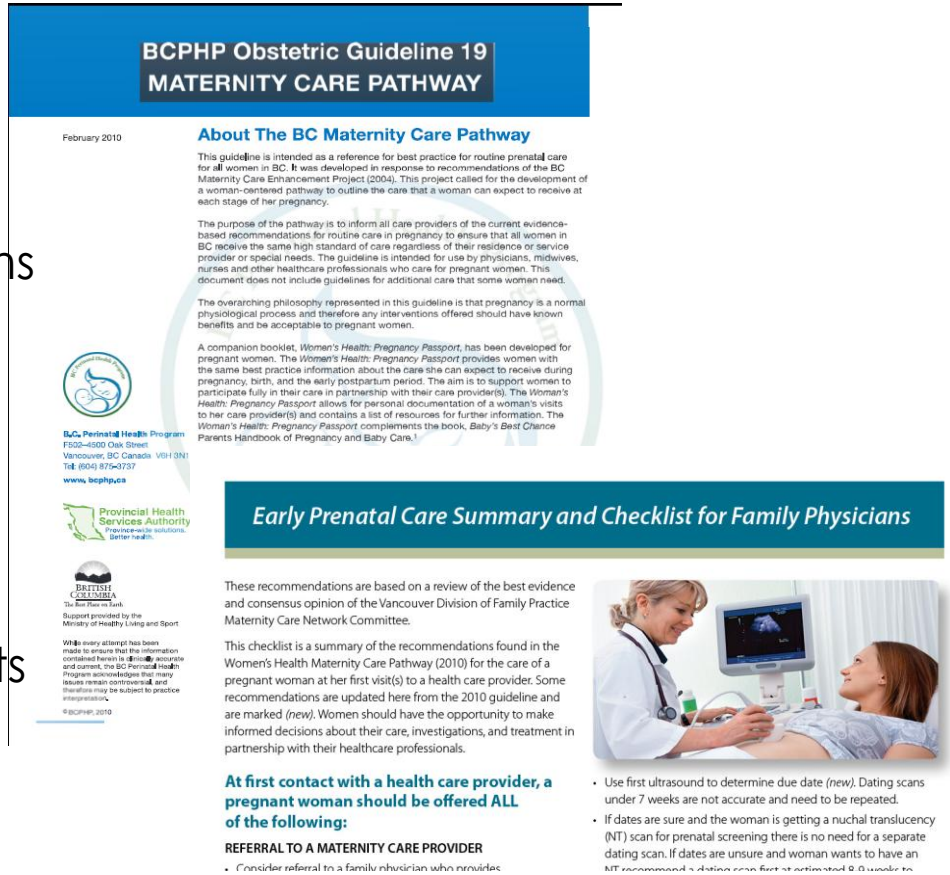
How do we get all this done?

1. Use reference cards and checklists
2. Automate processes
3. Give the pregnant person resources
4. Streamline referral processes (cards, tear-pads, printed info)
5. Work with EMR providers and user groups to streamline processes- create and share fillable forms

How do we get this all done?

1. Use reference cards and checklists

- Checklists
  - BC Maternity Care Pathway
  - Perinatal Services BC
- Information management systems – know what works for you
  - Evernote, Onenote, Google Drive, etc
- Templates in EMR
- Keep your resource reference lists from the Moodle modules!



BCPHP Obstetric Guideline 19
MATERNITY CARE PATHWAY

February 2010

About The BC Maternity Care Pathway

This guideline is intended as a reference for best practice for routine prenatal care for all women in BC. It was developed in response to recommendations of the BC Maternity Care Enhancement Project (2004). This project called for the development of a woman-centered pathway to outline the care that a woman can expect to receive at each stage of her pregnancy.

The purpose of the pathway is to inform all care providers of the current evidence-based recommendations for routine care in pregnancy to ensure that all women in BC receive the same high standard of care regardless of their residence or service provider or special needs. The guideline is intended for use by physicians, midwives, nurses and other healthcare professionals who care for pregnant women. This document does not include guidelines for additional care that some women need.

The overarching philosophy represented in this guideline is that pregnancy is a normal physiological process and therefore any interventions offered should have known benefits and be acceptable to pregnant women.

A companion booklet, *Women's Health: Pregnancy Passport*, has been developed for pregnant women. The *Women's Health: Pregnancy Passport* provides women with the same best practice information about the care she can expect to receive during pregnancy, birth, and the early postpartum period. The aim is to support women to participate fully in their care in partnership with their care provider(s). The *Women's Health: Pregnancy Passport* allows for personal documentation of a woman's visits to her care provider(s) and contains a list of resources for further information. The *Women's Health: Pregnancy Passport* complements the book, *Baby's Best Chance* Parents Handbook of Pregnancy and Baby Care.[1]

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Vancouver, BC Canada V6H 3N1
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www.bcphp.ca

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While every attempt has been made to ensure that the information contained herein is clinically accurate and current, the BC Perinatal Health Program acknowledges that many issues remain controversial and therefore may be subject to practice interpretation.

© BCPHP, 2010

Early Prenatal Care Summary and Checklist for Family Physicians

These recommendations are based on a review of the best evidence and consensus opinion of the Vancouver Division of Family Practice Maternity Care Network Committee.

This checklist is a summary of the recommendations found in the Women's Health Maternity Care Pathway (2010) for the care of a pregnant woman at her first visit(s) to a health care provider. Some recommendations are updated here from the 2010 guideline and are marked *(new)*. Women should have the opportunity to make informed decisions about their care, investigations, and treatment in partnership with their healthcare professionals.

At first contact with a health care provider, a pregnant woman should be offered ALL of the following:

REFERRAL TO A MATERNITY CARE PROVIDER

- Consider referral to a family physician who provides

- Use first ultrasound to determine due date *(new)*. Dating scans under 7 weeks are not accurate and need to be repeated.
- If dates are sure and the woman is getting a nuchal translucency (NT) scan for prenatal screening there is no need for a separate dating scan. If dates are unsure and woman wants to have an NT recommend a dating scan first at estimated 8-9 weeks to

Template Example Visit #1

S: ?Pregnant
No/Yes +'ve home test
Pregnancy is planned/unplanned, feels __

LMP: cycles regular q28d
GA: EDD: G_L_

No N/V, no bleeding or cramping
Last Pap/cervical ca screening:
Planning to attend __ for pregnancy care

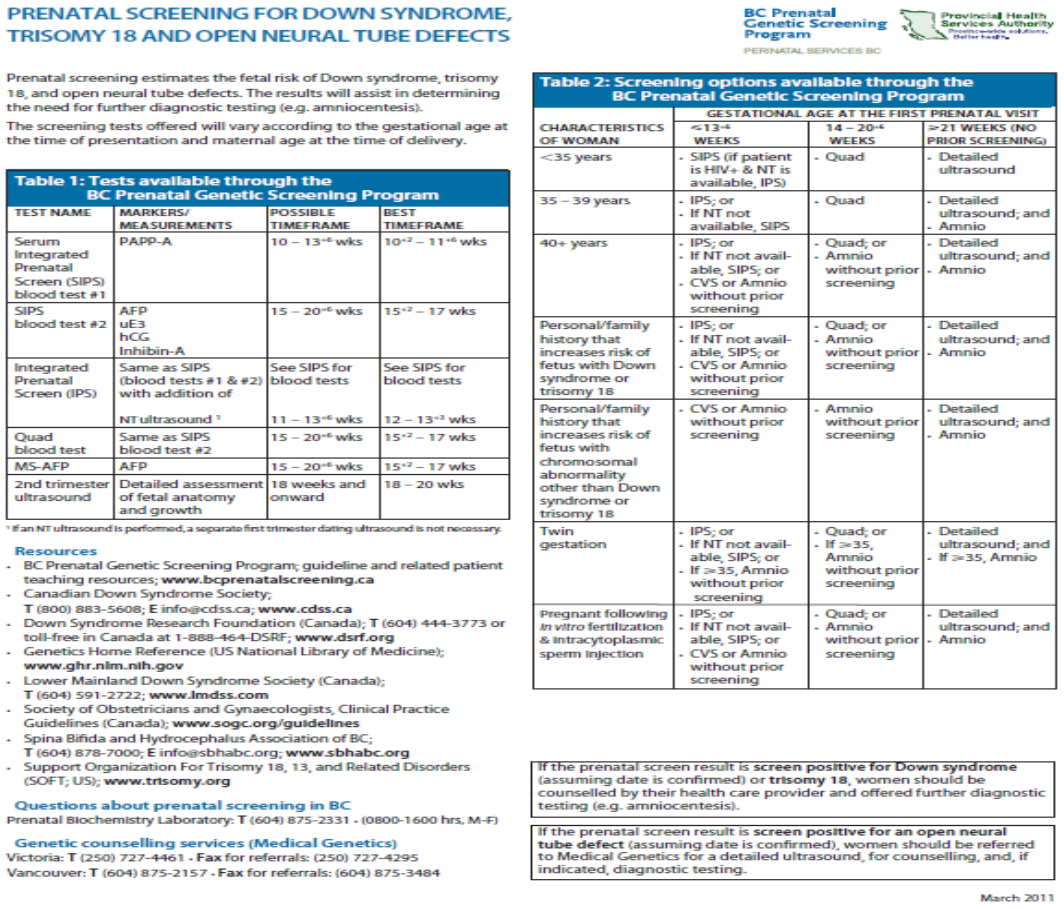
O/E: Appears well, NAD, smiling
BP
Urine preg test: +ve

A/P: Pregnancy
1. Pt plans to attend __ for pregnancy care and will self-register/ I will refer.
2. Discussed time sensitive issues including genetic screening, handout provided
3. Discussed folic acid, healthy lifestyle, avoidance of etoh and excessive caffeine, etc
4. Req provided for prenatal blood work and dating u/s
5. Pt to f/u here or with PN care provider prior to 10w if would like genetic screening

Time-savers & Resources

1. Use reference cards and checklists

- Perinatal Services BC, genetic screening provider resources
- Use prenatal genetic screening reference cards to remind yourself of timing and tests



PRENATAL SCREENING FOR DOWN SYNDROME, TRISOMY 18 AND OPEN NEURAL TUBE DEFECTS

BC Prenatal Genetic Screening Program
PERINATAL SERVICES BC

Provincial Health Services Authority province-wide solutions. Better health.

Prenatal screening estimates the fetal risk of Down syndrome, trisomy 18, and open neural tube defects. The results will assist in determining the need for further diagnostic testing (e.g. amniocentesis).

The screening tests offered will vary according to the gestational age at the time of presentation and maternal age at the time of delivery.

Table 1: Tests available through the BC Prenatal Genetic Screening Program

TEST NAME	MARKERS/ MEASUREMENTS	POSSIBLE TIMEFRAME	BEST TIMEFRAME
Serum Integrated Prenatal Screen (SIPS) blood test #1	PAPP-A	10 – 13⁺⁶ wks	10⁺² – 11⁺⁶ wks
SIPS blood test #2	AFP uE3 hCG Inhibin-A	15 – 20⁺⁶ wks	15⁺² – 17 wks
Integrated Prenatal Screen (IPS)	Same as SIPS (blood tests #1 & #2) with addition of NT ultrasound [1]	See SIPS for blood tests 11 – 13⁺⁶ wks	See SIPS for blood tests 12 – 13⁺³ wks
Quad blood test	Same as SIPS blood test #2	15 – 20⁺⁶ wks	15⁺² – 17 wks
MS-AFP	AFP	15 – 20⁺⁶ wks	15⁺² – 17 wks
2nd trimester ultrasound	Detailed assessment of fetal anatomy and growth	18 weeks and onward	18 – 20 wks

[1] If an NT ultrasound is performed, a separate first trimester dating ultrasound is not necessary.

Resources

- BC Prenatal Genetic Screening Program; guideline and related patient teaching resources; **www.bcprenatalscreening.ca**
- Canadian Down Syndrome Society; **T** (800) 883-5608; **E** info@cdss.ca; **www.cdss.ca**
- Down Syndrome Research Foundation (Canada); **T** (604) 444-3773 or toll-free in Canada at 1-888-464-DSRF; **www.dsrf.org**
- Genetics Home Reference (US National Library of Medicine); **www.ghr.nlm.nih.gov**
- Lower Mainland Down Syndrome Society (Canada); **T** (604) 591-2722; **www.lmdss.com**
- Society of Obstetricians and Gynaecologists, Clinical Practice Guidelines (Canada); **www.sogc.org/guidelines**
- Spina Bifida and Hydrocephalus Association of BC; **T** (604) 878-7000; **E** info@sbhabc.org; **www.sbhabc.org**
- Support Organization For Trisomy 18, 13, and Related Disorders (SOFT; US); **www.trisomy.org**

Questions about prenatal screening in BC

Prenatal Biochemistry Laboratory: **T** (604) 875-2331 - (0800-1600 hrs, M-F)

Genetic counselling services (Medical Genetics)

Victoria: **T** (250) 727-4461 - **Fax** for referrals: (250) 727-4295
Vancouver: **T** (604) 875-2157 - **Fax** for referrals: (604) 875-3484

Table 2: Screening options available through the BC Prenatal Genetic Screening Program

CHARACTERISTICS OF WOMAN	GESTATIONAL AGE AT THE FIRST PRENATAL VISIT: ≤13⁺⁶ WEEKS	14 – 20⁺⁶ WEEKS	≥21 WEEKS (NO PRIOR SCREENING)
<35 years	- SIPS (if patient is HIV+ & NT is available, IPS)	- Quad	- Detailed ultrasound
35 – 39 years	- IPS; or - If NT not available, SIPS	- Quad	- Detailed ultrasound; and - Amnio
40+ years	- IPS; or - If NT not available, SIPS; or - CVS or Amnio without prior screening	- Quad; or - Amnio without prior screening	- Detailed ultrasound; and - Amnio
Personal/family history that increases risk of fetus with Down syndrome or trisomy 18	- IPS; or - If NT not available, SIPS; or - CVS or Amnio without prior screening	- Quad; or - Amnio without prior screening	- Detailed ultrasound; and - Amnio
Personal/family history that increases risk of fetus with chromosomal abnormality other than Down syndrome or trisomy 18	- CVS or Amnio without prior screening	- Amnio without prior screening	- Detailed ultrasound; and - Amnio
Twin gestation	- IPS; or - If NT not available, SIPS; or - If ≥35, Amnio without prior screening	- Quad; or - If ≥35, Amnio without prior screening	- Detailed ultrasound; and - If ≥35, Amnio
Pregnant following *In vitro* fertilization & Intracytoplasmic sperm injection	- IPS; or - If NT not available, SIPS; or - CVS or Amnio without prior screening	- Quad; or - Amnio without prior screening	- Detailed ultrasound; and - Amnio

If the prenatal screen result is **screen positive for Down syndrome** (assuming date is confirmed) or **trisomy 18**, women should be counselled by their health care provider and offered further diagnostic testing (e.g. amniocentesis).

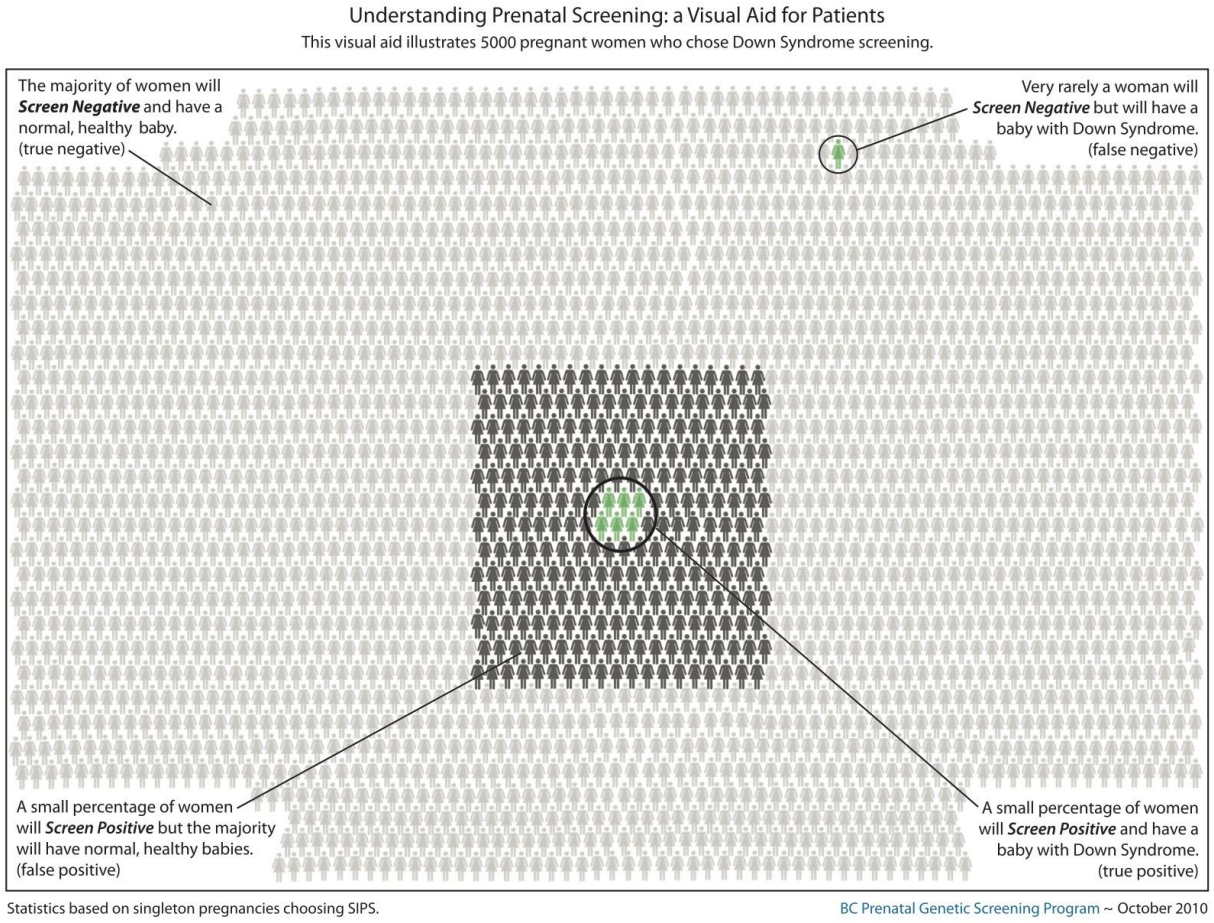
If the prenatal screen result is **screen positive for an open neural tube defect** (assuming date is confirmed), women should be referred to Medical Genetics for a detailed ultrasound, for counselling, and, if indicated, diagnostic testing.

March 2011

Time-savers & Resources

1. Use reference cards and checklists

- Perinatal Services BC aid:
- Use visual aids for explaining tests and meaning of false positive and false negative



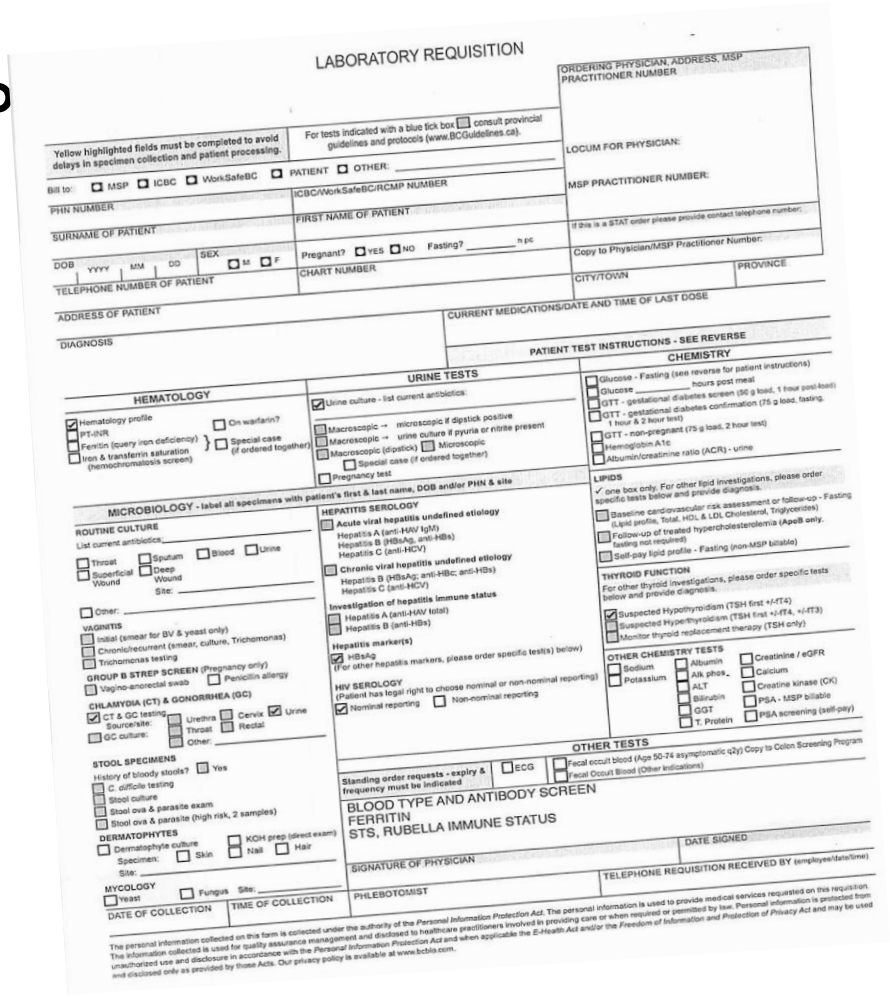
Time-savers & Resources

2. Automate processes: history & labs

- **Standardized resource package fo patients**
- **History form pre-fillable**
  - Includes TWEAK, screening Q
  - Focus on important information

    *in resource package
- **Preprinted Lab Requisition**
  - e-form auto-filled or
  - Preprinted lab form

    *in resource package
  - Customize additional tests as needed



LABORATORY REQUISITION

Yellow highlighted fields must be completed to avoid delays in specimen collection and patient processing.

For tests indicated with a blue tick box ☐ consult provincial guidelines and protocols (www.BCGuidelines.ca).

ORDERING PHYSICIAN, ADDRESS, MSP PRACTITIONER NUMBER

LOCUM FOR PHYSICIAN:

MSP PRACTITIONER NUMBER:

Bill to: ☐ MSP ☐ ICBC ☐ WorkSafeBC ☐ PATIENT ☐ OTHER:

PHN NUMBER

ICBC/WorkSafeBC/RCMP NUMBER

SURNAME OF PATIENT

FIRST NAME OF PATIENT

If this is a STAT order please provide contact telephone number:

DOB YYYY MM DD

SEX ☐ M ☐ F

Pregnant? ☐ YES ☐ NO Fasting? _____ h pc

Copy to Physician/MSP Practitioner Number:

TELEPHONE NUMBER OF PATIENT

CHART NUMBER

CITY/TOWN

PROVINCE

ADDRESS OF PATIENT

CURRENT MEDICATIONS/DATE AND TIME OF LAST DOSE

DIAGNOSIS

PATIENT TEST INSTRUCTIONS - SEE REVERSE

HEMATOLOGY

☑ Hematology profile
☐ PT-INR
☐ Ferritin (query iron deficiency)
☐ Iron & transferrin saturation (hemochromatosis screen)
☐ On warfarin?
☐ Special case (if ordered together)

URINE TESTS

☑ Urine culture - list current antibiotics:
☐ Macroscopic → microscopic if dipstick positive
☐ Macroscopic → urine culture if pyuria or nitrite present
☐ Macroscopic (dipstick) ☐ Microscopic
☐ Special case (if ordered together)
☐ Pregnancy test

CHEMISTRY

☐ Glucose - Fasting (see reverse for patient instructions)
☐ Glucose _____ hours post meal
☐ GTT - gestational diabetes screen (50 g load, 1 hour post-load)
☐ GTT - gestational diabetes confirmation (75 g load, fasting, 1 hour & 2 hour test)
☐ GTT - non-pregnant (75 g load, 2 hour test)
☐ Hemoglobin A1c
☐ Albumin/creatinine ratio (ACR) - urine

MICROBIOLOGY - label all specimens with patient's first & last name, DOB and/or PHN & site

ROUTINE CULTURE

List current antibiotics:

☐ Throat ☐ Sputum ☐ Blood ☐ Urine
☐ Superficial Wound ☐ Deep Wound
Site:
☐ Other:

VAGINITIS
☐ Initial (smear for BV & yeast only)
☐ Chronic/recurrent (smear, culture, Trichomonas)
☐ Trichomonas testing

GROUP B STREP SCREEN (Pregnancy only)
☐ Vagino-anorectal swab ☐ Penicillin allergy

CHLAMYDIA (CT) & GONORRHEA (GC)
☑ CT & GC testing Source/site: ☐ Urethra ☐ Cervix ☑ Urine ☐ Throat ☐ Rectal
☐ GC culture: ☐ Other:

STOOL SPECIMENS
History of bloody stools? ☐ Yes
☐ C. difficile testing
☐ Stool culture
☐ Stool ova & parasite exam
☐ Stool ova & parasite (high risk, 2 samples)

DERMATOPHYTES
☐ Dermatophyte culture Specimen: ☐ Skin ☐ KOH prep (direct exam) ☐ Nail ☐ Hair
Site:

MYCOLOGY
☐ Yeast ☐ Fungus Site:

HEPATITIS SEROLOGY

☐ Acute viral hepatitis undefined etiology
Hepatitis A (anti-HAV IgM)
Hepatitis B (HBsAg, anti-HBs)
Hepatitis C (anti-HCV)

☐ Chronic viral hepatitis undefined etiology
Hepatitis B (HBsAg; anti-HBc; anti-HBs)
Hepatitis C (anti-HCV)

Investigation of hepatitis immune status
☐ Hepatitis A (anti-HAV total)
☐ Hepatitis B (anti-HBs)

Hepatitis marker(s)
☑ HBsAg (For other hepatitis markers, please order specific test(s) below)

HIV SEROLOGY
(Patient has legal right to choose nominal or non-nominal reporting)
☑ Nominal reporting ☐ Non-nominal reporting

LIPIDS

✓ one box only. For other lipid investigations, please order specific tests below and provide diagnosis.
☐ Baseline cardiovascular risk assessment or follow-up - Fasting (Lipid profile, Total, HDL & LDL Cholesterol, Triglycerides)
☐ Follow-up of treated hypercholesterolemia (ApoB only. Fasting not required)
☐ Self-pay lipid profile - Fasting (non-MSP billable)

THYROID FUNCTION

For other thyroid investigations, please order specific tests below and provide diagnosis.
☑ Suspected Hypothyroidism (TSH first +/-fT4)
☐ Suspected Hyperthyroidism (TSH first +/-fT4, +/-fT3)
☐ Monitor thyroid replacement therapy (TSH only)

OTHER CHEMISTRY TESTS

☐ Sodium ☐ Potassium ☐ Albumin ☐ Alk phos ☐ ALT ☐ Bilirubin ☐ GGT ☐ T. Protein ☐ Creatinine / eGFR ☐ Calcium ☐ Creatine kinase (CK) ☐ PSA - MSP billable ☐ PSA screening (self-pay)

OTHER TESTS

Standing order requests - expiry & frequency must be indicated

☐ ECG ☐ Fecal occult blood (Age 50-74 asymptomatic q2y) Copy to Colon Screening Program ☐ Fecal Occult Blood (Other indications)

BLOOD TYPE AND ANTIBODY SCREEN
FERRITIN
STS, RUBELLA IMMUNE STATUS

SIGNATURE OF PHYSICIAN

DATE SIGNED

DATE OF COLLECTION

TIME OF COLLECTION

PHLEBOTOMIST

TELEPHONE REQUISITION RECEIVED BY (employee/date/time)

The personal information collected on this form is collected under the authority of the *Personal Information Protection Act*. The personal information is used to provide medical services requested on this requisition. The information collected is used for quality assurance management and disclosed to healthcare practitioners involved in providing care or when required or permitted by law. Personal information is protected from unauthorized use and disclosure in accordance with the *Personal Information Protection Act* and when applicable the *E-Health Act* and/or the *Freedom of Information and Protection of Privacy Act* and may be used and disclosed only as provided by those Acts. Our privacy policy is available at www.bcbla.com.

Time-savers & Resources

2. Automate Processes: US and SIPS

- **Pregnant person can book their own U/S (for some labs)**
  - Indicate best time on requisition by their dates
- **Use Pregnancy Dating Tool to determine dates for SIPS**
  - Website: Perinatal Services BC -> Estimated Date of Delivery Calculator
  - *EMR integration : some EMRs will assist with this
- **Attach early ultrasound to SIPS/IPS form if available.**
  - Saves time copying in CRL etc.

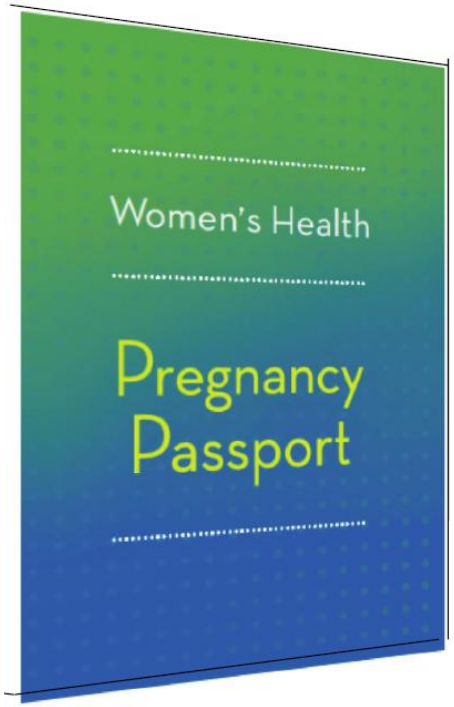
How do we get this all done?

3. Engage the pregnant person in their care

- BC Guideline for maternity care: Pregnancy Passport for patients

- Patient handouts and resources
  - I.e. genetic screening, diet and exercise

- Apps for patients:
  - https://www.smartmomcanada.ca/
  - Developed by Northern Health Authority in BC and endorsed by SOGC!

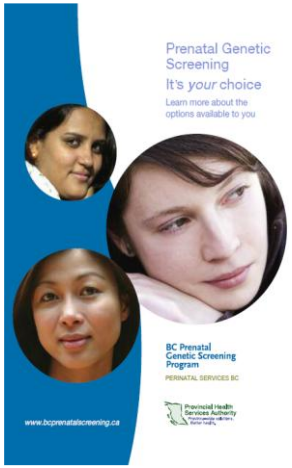


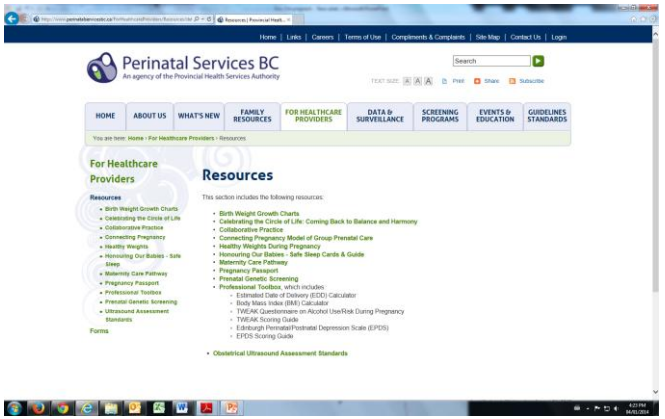
Time-savers & Resources

3. Engage the pregnant person in their care

Offer resources for information on prenatal genetic screening before discussion, if time permits:

- Video: Prenatal Genetic Screening-Its Your choice https://www.youtube.com/watch?v=UTQ1KFGqnXY
- Patient Decision Aid *link is in resource list
- Refer women to PSBC website or give pamphlets





Time-savers & Resources
3. Engage the pregnant person in their care

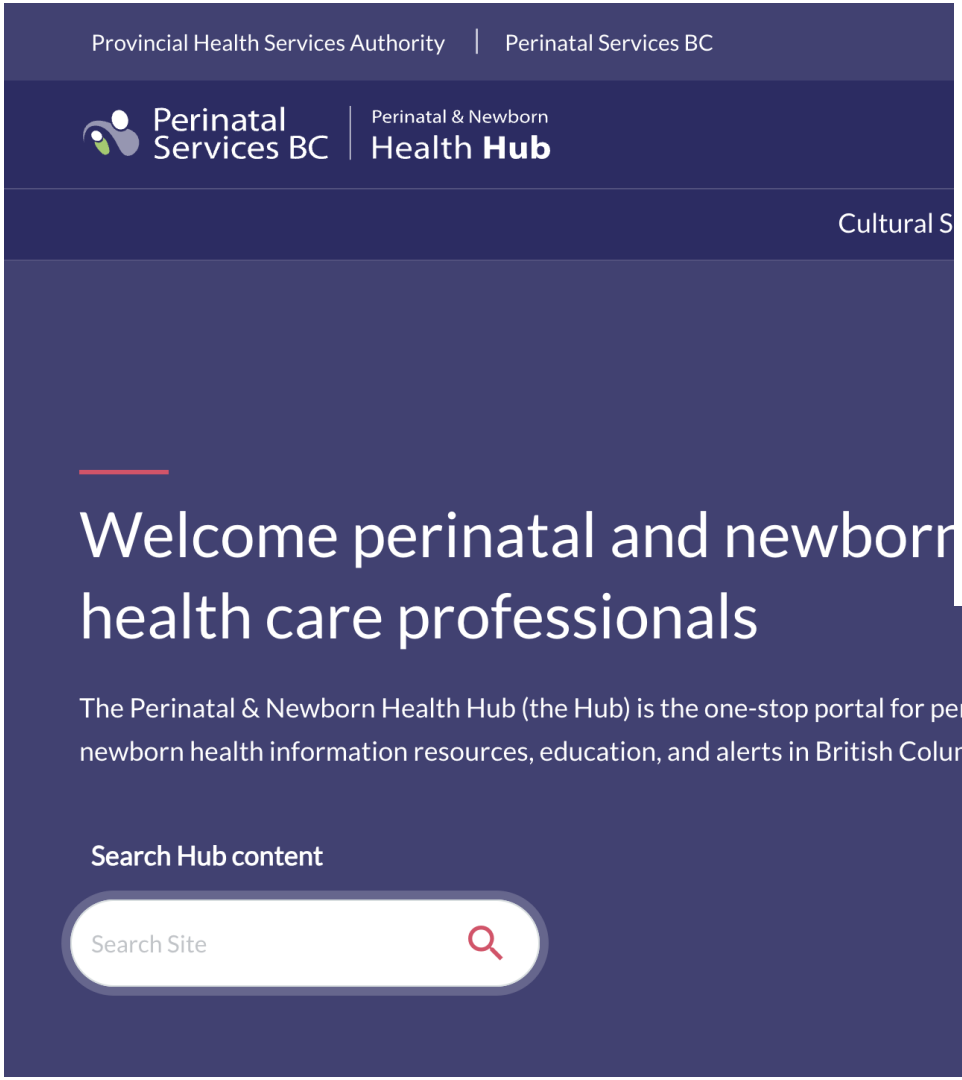
FAQ for patients
Pregnancyvancouver.ca

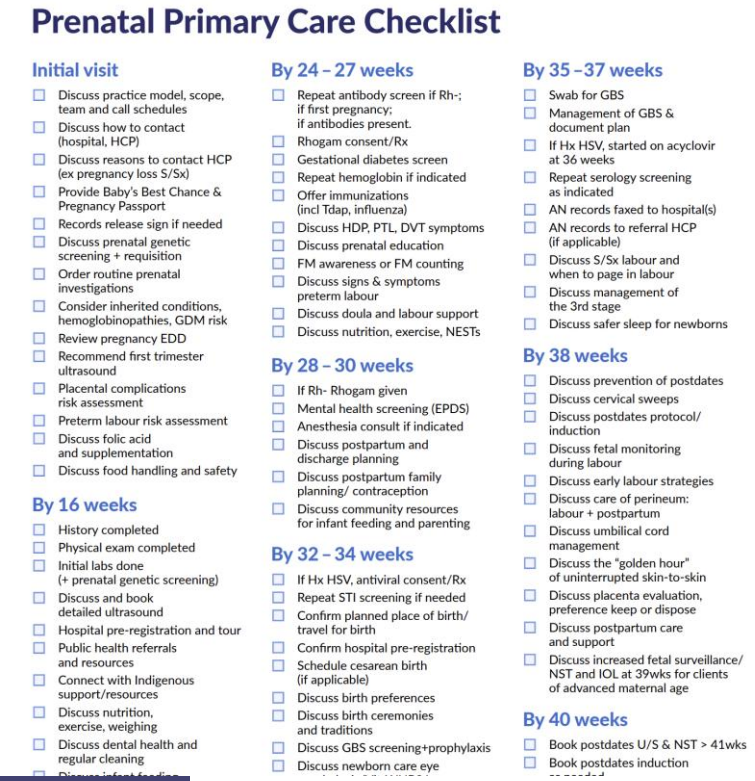
Resources for patients

Baby's Best Chance, free PDF

Contents

Provider Resources





Prenatal Primary Care Checklist

Initial visit

- ☐ Discuss practice model, scope, team and call schedules
- ☐ Discuss how to contact (hospital, HCP)
- ☐ Discuss reasons to contact HCP (ex pregnancy loss S/Sx)
- ☐ Provide Baby's Best Chance & Pregnancy Passport
- ☐ Records release sign if needed
- ☐ Discuss prenatal genetic screening + requisition
- ☐ Order routine prenatal investigations
- ☐ Consider inherited conditions, hemoglobinopathies, GDM risk
- ☐ Review pregnancy EDD
- ☐ Recommend first trimester ultrasound
- ☐ Placental complications risk assessment
- ☐ Preterm labour risk assessment
- ☐ Discuss folic acid and supplementation
- ☐ Discuss food handling and safety

By 16 weeks

- ☐ History completed
- ☐ Physical exam completed
- ☐ Initial labs done (+ prenatal genetic screening)
- ☐ Discuss and book detailed ultrasound
- ☐ Hospital pre-registration and tour
- ☐ Public health referrals and resources
- ☐ Connect with Indigenous support/resources
- ☐ Discuss nutrition, exercise, weighing
- ☐ Discuss dental health and regular cleaning

By 24 – 27 weeks

- ☐ Repeat antibody screen if Rh-; if first pregnancy; if antibodies present.
- ☐ Rhogam consent/Rx
- ☐ Gestational diabetes screen
- ☐ Repeat hemoglobin if indicated
- ☐ Offer immunizations (incl Tdap, influenza)
- ☐ Discuss HDP, PTL, DVT symptoms
- ☐ Discuss prenatal education
- ☐ FM awareness or FM counting
- ☐ Discuss signs & symptoms preterm labour
- ☐ Discuss doula and labour support
- ☐ Discuss nutrition, exercise, NESTs

By 28 – 30 weeks

- ☐ If Rh- Rhogam given
- ☐ Mental health screening (EPDS)
- ☐ Anesthesia consult if indicated
- ☐ Discuss postpartum and discharge planning
- ☐ Discuss postpartum family planning/ contraception
- ☐ Discuss community resources for infant feeding and parenting

By 32 – 34 weeks

- ☐ If Hx HSV, antiviral consent/Rx
- ☐ Repeat STI screening if needed
- ☐ Confirm planned place of birth/ travel for birth
- ☐ Confirm hospital pre-registration
- ☐ Schedule cesarean birth (if applicable)
- ☐ Discuss birth preferences
- ☐ Discuss birth ceremonies and traditions
- ☐ Discuss GBS screening+prophylaxis
- ☐ Discuss newborn care eye

By 35 –37 weeks

- ☐ Swab for GBS
- ☐ Management of GBS & document plan
- ☐ If Hx HSV, started on acyclovir at 36 weeks
- ☐ Repeat serology screening as indicated
- ☐ AN records faxed to hospital(s)
- ☐ AN records to referral HCP (if applicable)
- ☐ Discuss S/Sx labour and when to page in labour
- ☐ Discuss management of the 3rd stage
- ☐ Discuss safer sleep for newborns

By 38 weeks

- ☐ Discuss prevention of postdates
- ☐ Discuss cervical sweeps
- ☐ Discuss postdates protocol/ induction
- ☐ Discuss fetal monitoring during labour
- ☐ Discuss early labour strategies
- ☐ Discuss care of perineum: labour + postpartum
- ☐ Discuss umbilical cord management
- ☐ Discuss the "golden hour" of uninterrupted skin-to-skin
- ☐ Discuss placenta evaluation, preference keep or dispose
- ☐ Discuss postpartum care and support
- ☐ Discuss increased fetal surveillance/ NST and IOL at 39wks for clients of advanced maternal age

By 40 weeks

- ☐ Book postdates U/S & NST > 41wks
- ☐ Book postdates induction

Timesavers and Resources
4. Streamline referrals

- Use Pathways or local referral networks
- Give patient known options for care-provider
- Tear sheets, business cards
- Patient makes own appointments
- Standardized process for transfer of records with your staff and what to include.

Pathways – Family Practice OB

Pathways

Home | Resources | Forms | Favourites | You | Search

ALL SPECIALTIES | FAMILY PRACTICE

Specialists | Clinics | Pearls | Red Flags | Patient Info | Forms | Inline Files | Physician Resources | Community Services

Showing all specialists who accept referrals in Primary care obstetrics. Clear all filters.

Hide results from other specialties.

Family practitioner	Specialties	Accepting New Referrals?	Average Non-urgent Patient Waittime	City
Dimithra Hippola GP	Obstetrics / Gynecology and Family Practice	✔	Within one week	Vancouver
Hasan Abdessamad	Obstetrics / Gynecology	✔	Within one week	Vancouver
Alison MacInnes GP	Family Practice	✔	Within one week	Vancouver
Barra O'Briain GP	Family Practice	✔	Within one week	Vancouver
Tania Kung GP	Family Practice	✔	Within one week	Vancouver
Xin-Yong Wang GP	Family Practice	✔	Within one week	Vancouver and Richmond
Florina Feng GP	Family Practice	✔	Within one week	Vancouver and Richmond
Eric Cattoni GP	Family Practice	✔	Within one week	Vancouver
Renee Fernandez GP	Family Practice	✔	1-2 weeks	Vancouver
Dale Steele	Obstetrics / Gynecology	✔	1-2 weeks	Vancouver
Jan (Janis) Ferguson GP	Family Practice	✔	1-2 weeks	Vancouver
Michelle Yuen GP	Family Practice	✔	1-2 weeks	Vancouver
Donna McLachlan GP	Family Practice	✔	1-2 weeks	Vancouver
Yasmin Garcia GP	Family Practice	✔	1-2 weeks	Vancouver
Nasha Grant GP	Family Practice	✔	1-2 weeks	Vancouver
Catherine Lee GP	Family Practice	✔	1-2 weeks	Vancouver
Emily-Kate Higgins GP	Family Practice	✔	1-2 weeks	Vancouver

Filter Family practitioners

Accepts referrals for —

- ☐ ADHD: Pediatric
- ☐ ADHD: Adult
- ☐ Accepting new nursing home patients for ongoing care
- ☐ Accepting new office patients for ongoing care
- ☐ Acupuncture
- ☐ Alcohol issues
- ☐ Allergy testing
- ☐ Ankle
- ☐ Anxiety
- ☐ Autism
- ☐ Aviation medicine
- ☐ Birth control counseling
- ☐ Botox for chronic migraine
- ☐ Botox injections: cosmetic
- ☐ Botox neuromuscular
- ☐ Breastfeeding support/Lactation consultation
- ☐ Cancer chemotherapy
- ☐ Cast
- ☐ Child and youth addiction medicine
- ☐ Circumcision - Infant
- ☐ Cognitive behavioral therapy
- ☐ Cosmetic dermatology
- ☐ Cryotherapy
- ☐ Depression

Time-savers & Resources

5. EMR optimization

- Create prenatal order sets in your EMR
- Customize early prenatal care flow sheets or templates

Billing – LFP MODEL

COMPLETE AND APPROPRIATE CHARTING IS ESSENTIAL

TIME CODES

1. **98010** Direct patient care (per 15 min)
2. **98011** Indirect patient care (per 15 min)
3. **98012** Clinical Admin time (per 15 min) – max 10% of total hours

VISIT CODES

1. **98031** In person visit
2. **98032** Virtual visit
3. **98022** Minor procedure or diagnostic test – i.e. urinalysis
4. **98021** Standard procedure – i.e. pap test

Billing – Fee for Service

COMPLETE AND APPROPRIATE CHARTING IS ESSENTIAL

1. **14091** Prenatal visit, subsequent examination
   Can use 2-3 visits for initial assessment, partial history, genetic screening counseling, and results.

2. **14090** Prenatal visit, complete examination
   Complete history and physical exam for pregnancy, including pap test if due. May be billed a second time when referred to a maternity care provider.

3. **G14076** Attachment Patient Telephone Fee (1500/yr.). Must chart the two-way conversation that would replace a patient visit, and have billed:
   - Attachment Participation G14070 or
   - Maternity Care Network Initiative G14010

Billing cont.

4. **14002** Perinatal Health Risk Assessment
   Bill in addition to in person visit. Consider using "Rx for Health" tear sheets. You should be discussing full med hx, screening and results so ideal for first visit or CPE

5. **00120** Counseling, minimum 20 minutes, condition recognized as difficult by medical profession AND patient distressed

6. **00100** Visit in office, regular office visit can be billed for non-pregnancy related issues

Resource: https://bcfamilydocs.ca/simplified-guide-to-fees/

Billing cont.

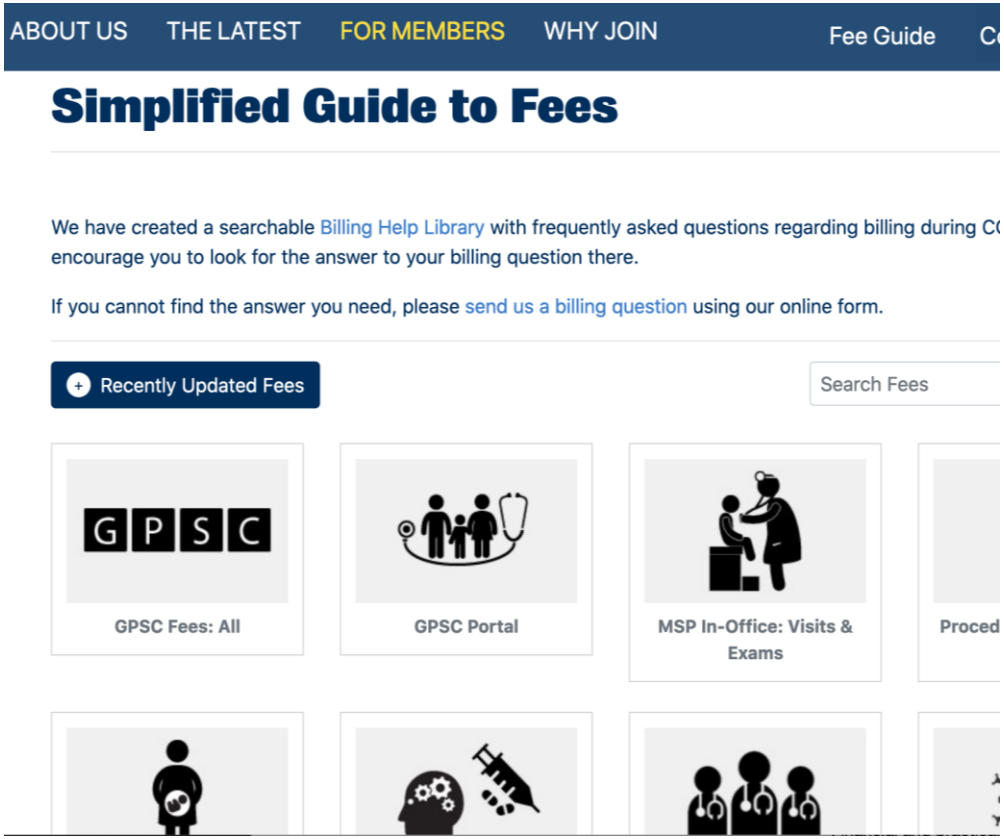
00120 Counseling:

- *Counselling is defined as the discussion with the patient, caregiver, spouse or relative about a medical condition which is recognized as difficult by the medical profession or over which the patient is having significant emotional distress, including the management of malignant disease. Counselling, to be claimed as such, must not be delegated and must last at least 20 minutes.*
- *Counselling is not to be claimed for advice that is a normal component of any visit or as a substitute for the usual patient examination fee, whether or not the visit is prolonged. For example, the counselling codes must not be used simply because the assessment and/or treatment may take 20 minutes or longer, such as in the case of multiple complaints. The counselling codes are also not intended for activities related to attempting to persuade a patient to alter diet or other lifestyle behavioural patterns. Nor are the counselling codes generally applicable to the explanation of the results of diagnostic tests.*

Billing resources

- BC Family Doctors (formerly Society of General Practitioners of BC) https://bcfamilydocs.ca/ paid membership
- Local Divisions of Family Practice https://divisionsbc.ca/
- List of ICD-9 codes billable in BC:

https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/diagnostic-code-descriptions-icd-9



Bringing it all together

A sample timetable: Meera

1. **First visit: confirm pregnancy, establish due date (20-30 min)**
   - Patient instructed to come 10-15 min early for appointment by office staff
     - Given standardized pregnancy resource package
     - Staff show her how to take her weight and do her urine screening for future appointments
   - Completed pregnancy history in waiting room, form corresponds to antenatal record page 1, quick review in appointment
   - Address any urgent concerns: folic acid, alcohol, violence…
   - Order labs (Standard prenatal set in EMR + any additional specific) and give requisition for her to book US
   - Establish provisional due date and check timing for genetic screening
   - Give woman resources for decision re genetic screening

Billing:

- **00100 (Visit in office) + 14002 (Perinatal health risk assessment) + 15120 (UPT)**
- **LFP – 98010 x 2 (Direct Care for 30 min) + 98031 (in person visit) + 98022 (UPT)**

Bringing it all together

A sample timetable: Meera - VIRTUAL

1. **First visit: confirm pregnancy, establish due date (20-30 min)**
   - Patient emailed prenatal history form and returned to office before appointment, corresponds to antenatal record page 1, quick review in appointment
   - Address any urgent concerns: folic acid, alcohol, violence…
   - Order labs (Standard prenatal set in EMR + any additional specific) and give requisition for her to book US – by secure patient portal or faxing directly to lab central intake / ultrasound for her
   - Establish provisional due date and check timing for genetic screening
   - Email "first prenatal email" including genetic screening video and website

Billing:

- **13437 (Telehealth visit) – consider breaking this into 2 visits**
- **LFP – 98010 x 2 (Direct Care for 30 min) + 98032 (virtual visit)**

Bringing it all together

A sample timetable: Meera

2. Second visit: genetic screening (10-20 min)

- Review options for genetic screening, using PSBC graphics as needed
- Confirm patient's decision
- Fill in requisitions using tips above and establish how will she be notified

Billing: ICD-9=V26.3, Genetic counselling

- **00100 (Visit in office)**
- **LFP - 98010 x 1 (Direct Care for 15 min) + 98031 (in person visit)**

3. Third visit: complete the Hx and CPx (20-30 min)

or postpone if more counseling re genetic screening needed

Billing: ICD-9= 30B, prenatal care

- **14090, Complete history and physical examination in pregnancy**
- **LFP - 98010 x 2 (Direct Care for 30 min) + 98031 (in person visit) OR 98021 (if pap done)**

Bringing it all together

A sample timetable: Meera - VIRTUAL

2. Second visit: genetic screening (10-20 min)

- Review options for genetic screening, using PSBC graphics as needed
- Confirm patient's decision
- Fill in requisitions using tips above and establish how will she be notified

Billing: ICD-9=V26.3, Genetic counselling

- **13437 (Telehealth visit)**
- **LFP - 98010 x 1 (Direct Care for 15 min) + 98032 (virtual visit)**

3. Third visit: complete the Hx and Cpx (20-30 min)

or postpone if more counseling re genetic screening needed

Billing: ICD-9= 30B, prenatal care

- **14090, Complete history and physical examination in pregnancy**
- **LFP - 98010 x 2 (Direct Care for 30 min) + 98031 (in person visit) OR 98021 (if pap done)**

A new vision for early pregnancy care:

1. You understand the timing of essential elements of early care. Patients
2. You are confident with 1st prenatal visits.
3. You have more information and resources to provide
4. Your care is more efficient.
5. Your patients are more engaged in their care
6. You have FP colleagues to refer to and consult with.
7. Your care is making a difference.

Cultural Safety:

LOOKING TO THE FUTURE: ANTI-RACISM AND MATERNITY CARE

- How do we cultivate an anti-racist maternity practice?
  - Race affects maternity outcomes in North America
  - Disparities are magnified by the pandemic, which has shown to disproportionately affect racialized and marginalized populations
  - Multiple obstacles if language/trust/SES limitations
- **Considerations:**
  - Trauma-informed care
  - Consider our lens of what is “normal” - maternity care may look different in different countries
  - Consider blocking longer initial appointments to allow time for questions, help to navigate booking appointments
  - Consider using an interpreter
  - Write things down - numbered list of things to be done for next appointment

Cultural Safety:

LOOKING TO THE FUTURE: ANTI-RACISM AND MATERNITY CARE

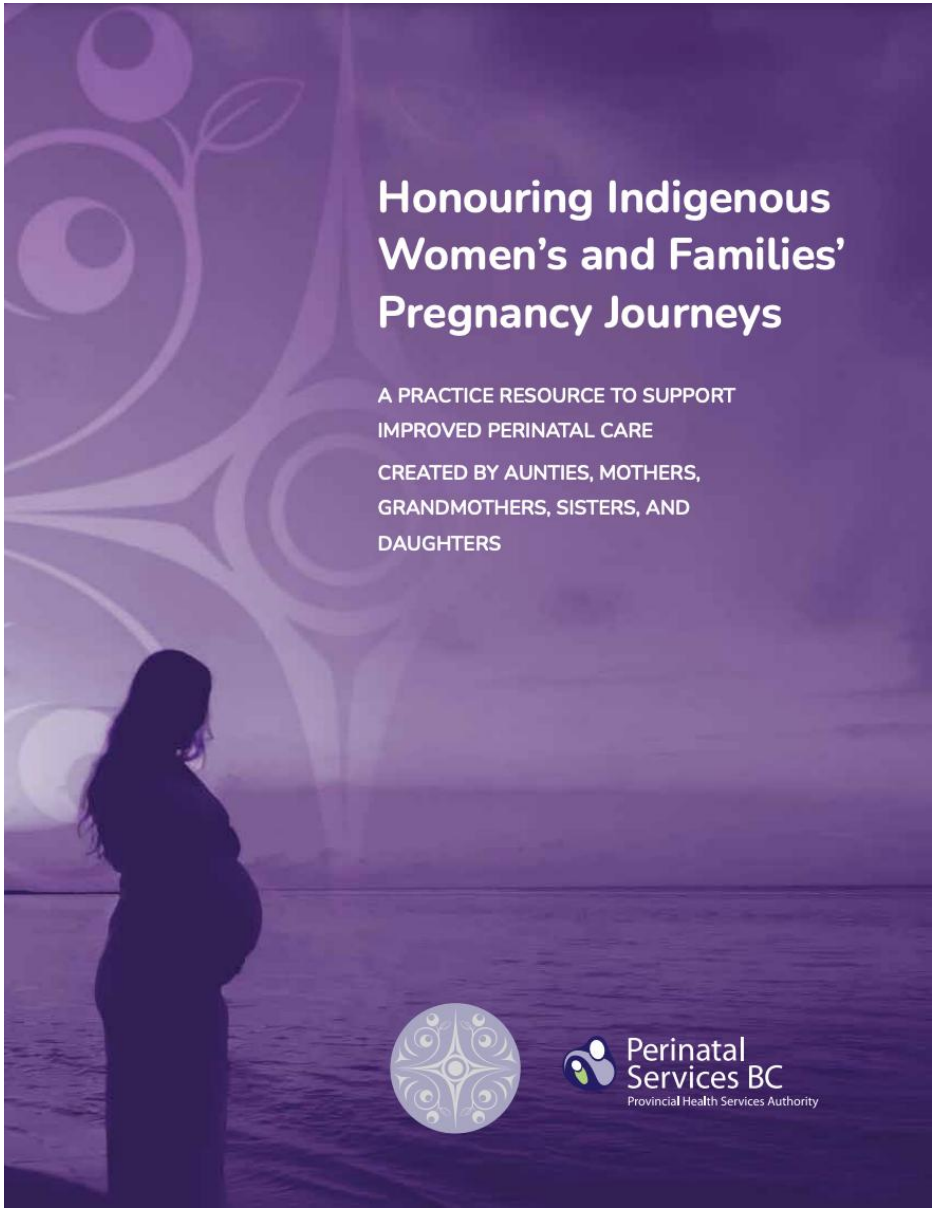
- **Indigenous populations:**
  - Cannot assume that our healthcare systems are directly transferrable to Indigenous populations
  - Consider how colonization has impacted these communities and caused inequalities, and how these have been amplified by the pandemic

ACTIONS:

- Educate yourself - ex. San'yas Indigenous Cultural Safety Course - understand the history to prevent re-traumatization
- Be open to modifying practice and asking patients for guidance
- Connect patients with resources: social workers for maternity care resources including prenatal nutrition program, public health nurses, aboriginal health navigator
- Understand FNHA Health Benefits
- Can apply for doula care (Doula for Aboriginal Families Grant Program) to allow for continuity of care, trust relationship, cultural competency and advocacy through labour process

Cultural Safety in Indigenous communities:

- Relational care
- Strength and resilience based practice
- Decolonizing medical language
- Self-determination and autonomy
- Understanding the history
- Know your resources – what is covered, doula program, health liaison



http://www.perinatalservicesbc.ca/Documents/Resources/Honouring_Indigenous_Womens_and_Families_Pregnancy_Journeys.pdf

Future directions:

APPENDIX C-4: ANTI-RACISM RESOURCES

- Spoken Language Interpreter: http://www.phsa.ca/health-professionals/professional-resources/interpreting-services#Access--interpreters
- Healthiest Babies Possible: http://www.vch.ca/locations-services?search_term=Healthiest+Babies+Possible+Program*
- Health Care System Navigation: https://patienteduc.fraserhealth.ca/file/finding-your-way-around-our-health-care-system-a-g-229674.pdf
- Pacific Immigrant Resource Society: https://pirs.bc.ca/
- San'yas Indigenous Cultural Safety Training: http://www.sanyas.ca/
- FNHA Doula Program: https://www.fnha.ca/wellness/wellness-for-first-nations/women-men-children-and-families/doula-services
- Aboriginal Health Navigator: http://www.vch.ca/Locations-Services/result?res_id=771
- Directory of BIPOC Counsellors: www.healingincolour.com

Questions?

Break

Reconvene in 15 minutes