# Prenatal Care Guidelines for the Family Health Center of Harlem

Revised October 2015

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The Prenatal Coordinator is available for assistance with the following:
a. Introduction to prenatal care at Harlem (in person or by phone)
b. Free doula program
c. Free prenatal yoga program
d. Tracking and follow up if missing patients
e. Assistance with getting patients to appointments who have difficulty navigating the health care system or need advocacy

The Prenatal Referral Clerk is available for assistance with the following:
a. Scheduling of OB and ultrasound appointments (Mount Sinai)
b. Processing of OB and ultrasound referrals
c. Getting ultrasound results from Mount Sinai
d. Getting OB consult reports from Mount Sinai
PART I:

VISITS AND CHARTING

INITIAL EVALUATION OF PREGNANCY

Negative pregnancy test:
If patient wishes to get pregnant, review preconception care:
1. Consider screening for pregestational diabetes, hypertension, advanced maternal age, substance abuse, recurrent miscarriage, infertility, family history of genetic disorders
2. Review current medications and discontinue any medications contraindicated in pregnancy
3. Prescribe prenatal vitamins
4. Schedule a follow up visit for well woman or chronic disease management

If patient does not wish to get pregnant:
1. Review contraceptive options, following efficacy-based counseling and evidence-based guidelines. Refer to the CDC Medical Eligibility Criteria as needed.
2. Review risks of STDs
3. Offer prenatal vitamins if a patient declines contraception
4. Schedule a follow up visit for well woman or chronic disease management

Positive pregnancy test:
All women should undergo unbiased options counseling at the time of their positive pregnancy test. Options include abortion, adoption, and raising the child.
If a patient does not plan to continue the pregnancy:
1. Provide counseling on abortion options. It is the responsibility of the provider to ensure that adequate counseling is done that day. If a particular provider is not comfortable doing this counseling, speak with a preceptor.
2. If a patient wishes to have medication abortion, speak with a preceptor – it is possible she would be able to get the medication abortion the same day.
3. If the patient is undecided, wishes to have an in-clinic abortion, or is ineligible for a medication abortion that day (i.e. uncertain dating, patient preference), schedule her for the next procedure clinic session. It is okay to overbook abortion patients.

4. If a patient wishes to have a termination elsewhere (because of desire for sedation, personal preference, etc), provide her with the contact information for:
   a. ParkMed – 646-898-2135
   b. Planned Parenthood – 212-965-7000, or 1-800-230-PLAN
   c. Mount Sinai Family Planning clinic

If the patient does plan to continue the pregnancy:

The remainder of this prenatal care guide will discuss the care of prenatal patients who wish to continue their pregnancy.

The following should be done at the time of positive pregnancy test. If possible, do the full Initial prenatal visit (OBHINITIALVISIT) and use guidelines below

1. **Start prenatal vitamins** with folic acid 800-1000mcg daily.

2. **Calculate preliminary EDD by LMP**.
   a. IF DATES ARE UNCERTAIN, please estimate a due date – consider abdominal exam or bimanual (must be confirmed by preceptor); this can always be revised.

3. **Take a full history – required!**
   a. Past medical, surgical and obstetrical, including mode of previous deliveries, infant weights, complication and GYN-specific history
   b. Assess need for immediate transfer to High Risk Obstetrics. See **Indications for Referral to OB** section

   - If a patient has an indication for transfer of care, place the order ASAP and inform the prenatal referral clerk. Assume it will take 2-4 weeks for their appointment, and order any pertinent labs and imaging that will be due in the meantime.

4. **Schedule first trimester dating ultrasound**:
   a. See **Gestational Dating Protocol** section for more information
   b. If dating is uncertain, schedule ultrasound ASAP
      - Dating is uncertain if: LMP unknown, irregular menses, birth control use < 3 months, or size/date discrepancy.
   c. If dating is reliable, schedule the U/S around 8-9 weeks gestation.
   d. Schedule for procedure clinic: OK to overbook
      - Monday AM, Tuesday AM or Thursday AM.
   e. Referral for outside dating ultrasound should ONLY be done if estimated gestational age is > 13 weeks. Send someone to Madison Radiology if it needs to be done soon.

5. **Check insurance status** – Refer to same day SW if uninsured – all pregnant women in NY are insurance eligible.

6. **Order initial prenatal labs**: Order through the SMART SET “PREGNATAL INITIAL VISIT” or results console of the prenatal chart. The ordering provider is responsible for following up prenatal labs – please discuss all abnormal results with a preceptor.
The following labs are required for every pregnancy (even if done in a prior pregnancy):

- ABO/Rh
- Antibody screen
- CBC with differential
- Rubella titer
- Varicella titer
- VDRL/RPR
- HepBsAg
- Gonorrhea/Chlamydia testing
- Urine Culture (ideal at 11 weeks)
- Urinalysis (once as baseline, then as indicated during prenatal course)
- Early GCT for any women with BMI > 30 or history of GDM

The following labs are optional but should be discussed, and documented if not done:

- Lead → Do verbal screen with NYC lead questions and labs if positive
- PPD or quantiferon gold → do verbal screen (see note template for questions) and labs if positive
- Pap smear testing if will be due for next screening by EDD
- Hepatitis C – all women with risk factors (IVDU, transfusion, transplant, high risk sexual behavior)

7. **Schedule initial prenatal visit within 1-2 weeks** - ideally with one of the delivering residents (.OBHBLOCK), but DO NOT DELAY follow up for continuity residents.

8. **Inbasket the prenatal coordinator and Dr. Baird/Dr. Shenko** an “FYI”

9. **Give patient Prenatal Packet** (kept in the precepting room on 3rd and 4th floors)

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**FIRST PRENATAL VISIT**

In addition to reviewing the list above, the following should be done at the first prenatal visit. This can also be done at the time of the pregnancy test. Most of these topics are found by scrolling through the prenatal visit navigator.

Regardless of gestational age, please use the .OBHINITIALVISIT template for your note:

1. **Make sure your visit encounter type** is either “INITIAL PRENATAL (65)” or “ROUTINE PRENATAL (66)”
   a. This must be changed before you start documenting!

2. **Start the Pregnancy Episode** (if not already done)
   a. Click “start pregnancy episode” which will be automatically named
   b. Link today’s encounter by checking the box

3. **Confirm dating and enter in the dating summary:**
   a. Enter LMP and any ultrasound, and select a working EDD.

4. **Obstetric Care Providers:** The resident prenatal team should be entered as “Resident.” The faculty preceptor for the Centering group should also be listed as “Group Visit Preceptor.”

5. **Full Medical and Obstetric History:**
a. This includes past medical history, past surgical history, medications, allergies, social history, family history, and obstetric history sections in the prenatal visit navigator in EPIC.
b. Be especially careful there are no indications for OB or high risk OB referral.

6. **Physical Exam**: A full physical should be documented in the prenatal visit navigator.

7. **Problem List**:
   a. Add pregnancy diagnosis: (V22.0 for 1st pregnancy, V22.1 for subsequent pregnancy, V23.9 for high risk pregnancy).
   b. Use .OBCHARTREVIEWTOOL inside the problem list and fill in as much detail as possible.
   c. Add other current pregnancy-related problems (i.e. Anemia, AMA, abnormal labs, etc) to the chart review tool, but also as separate problems in the problem list.

8. **TOLAC/VBAC**: If a patient has one prior C/S, please refer ASAP to Drs. Baird or Shenko for counseling. If a patient has two prior C/S, they must transfer care to OB.

9. **Labs**:
   a. Review all results and scan any paper reports into EPIC.
   b. Order any routine prenatal labs not already done (see list on last page)
   c. Update the problem list and chart review table with any available information
   d. Note that most FHCH patients are eligible for an early GCT

10. **Offer Genetic testing**: we MUST document that counseling was done, and be sure to document if a patient refuses. **No genetic test is required** and patients should be counseled that this is an individual decision based on their wishes and values.
    a. See Genetic Testing and Step by Step Directions for Sequential Screening sections for details
    b. The genetic testing includes:
       i. **Aneuploidy screening**
          1. Offer all women the sequential screen
          2. Offer all high risk women a referral to genetics and amniocentesis
       iii. **Ethnic carrier testing** – if not documented in prior pregnancy.
          1. Cystic fibrosis, Fragile X, and SMA.
          2. May include other testing for at-risk ethnic groups (e.g. women of Ashkenazi Jewish descent)

11. **Prenatal Checklist**: Fill out for relevant gestational age at EACH VISIT

12. **Depression Screening**: Screen using the PHQ-2 under “questionnaires”. PHQ-9 prn

13. **Group Prenatal**: Discuss Centering Pregnancy and provide group schedule. Patient may opt out. See group schedules in the 4th floor precepting room.

14. **Refer for Psychosocial Intake with Social Work**: All prenatal IFH patients must be seen by social work for a routine prenatal assessment. Placing a referral to SW in Epic does NOT alert the SW department; please ask a MOA to schedule, or contact your team social worker.

15. **Inbasket the prenatal coordinator and Dr. Baird/Dr. Shenko** an “FYI” that the patient was seen for initial visit. This enables the prenatal care team to add the patient to the “Harlem Prenatal” Patient List and assist with outreach and follow up.
EVERY SUBSEQUENT VISIT

(Q4 WEEKS UNTIL 30WKS, Q2 WEEKS UNTIL 36WKS, THEN WEEKLY UNTIL DELIVERY)

1. Review and Update:
   a. Medications
   b. Prenatal Checklist in the visit navigator
   c. Problem List:
      - Update the “pregnancy problem list” and the to-do list in the chart review tool within the problem list. Address any abnormal labs and “To Dos” for your partner to complete at next visit

2. Prenatal Vitals:
   a. Evaluate weight gain. Enter pre-pregnancy weight at bottom of vitals flow sheet in EPIC OB episode. Document weight and review OB growth chart at each visit.
      - If poor weight gain beyond first trimester (<10lbs by 20 weeks for patients with normal BMI), check TSH and free T4 and consider ultrasound and/or nutrition consult.
      - For our patients with elevated pre-pregnancy BMIs, weight goals may be different.

<table>
<thead>
<tr>
<th>BMI Category</th>
<th>Recommended weight gain</th>
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<tbody>
<tr>
<td>&lt;18.5</td>
<td>28 - 40lbs</td>
</tr>
<tr>
<td>18.5-24.9</td>
<td>25 - 35 lbs</td>
</tr>
<tr>
<td>25.0-29.9</td>
<td>15 - 25 lbs</td>
</tr>
<tr>
<td>&gt;=30</td>
<td>11-20 lbs</td>
</tr>
</tbody>
</table>

   b. Evaluate BP: BP’s > 140/90 (systolic, diastolic, or both) require a clean catch urine dip for protein and immediate transfer to L&D triage. Assess for signs and symptoms of pre-eclampsia.
      - See Elevated Blood Pressure section
   c. Beginning at 10 weeks: Evaluate FHT: FHT’s <120 or >160 bpm require consultation with OB (generally refer to L&D or OB ultrasonography for a BPP/NST (if appropriate for GA))
   d. Beginning at 20 weeks: Evaluate fundal height.
      - Fundal Height (FH) measurements that are 3 or more centimeters above or below gestational age require immediate referral for U/S to evaluate for macrosomia, IUGR, oligo/polyhydramnios.

3. Progress Note:
   a. All prenatal note templates start with OBH and are organized by gestational age.
POSTPARTUM VISIT

1. The official postpartum visit should occur between 3-8wks postpartum but for billing purposes can be until 16wks.
2. Postpartum visits can be scheduled as routine follow up visits (type 44).
3. Use the SMART SET “OB POSTPARTUM VISIT” to document and bill for the postpartum visit.
4. If patient needs to be seen in the first 1-3 weeks postpartum for issues these should be billed as problem visits with the appropriate codes (constipation, depression, nipple pain, mastitis, abdominal pain, etc.). Non-“official” postpartum visits should be billed using the appropriate E/M code (usually 99213).

CLOSING THE EPISODE / ENDING PREGNANCY CARE

1. Document delivery details (after delivery)
   a. Open new encounter:
      i. Type: “Obstetric Care/Delivery”
      ii. Date: date of delivery or transfer or end of pregnancy (miscarriage, termination, etc.)
   b. Go the Notes section and create OB Delivery/End of Pregnancy note with smartphrase .OBDELIVERY
      i. Complete smartphrase including reason pregnancy ended (delivery, miscarriage, transfer of care, termination, etc.).
      ii. If patient delivered, complete delivery information in the note (this is important for billing and reporting to the federal government to continue as a health center).
2. Update OB History section and unclick “currently pregnant” box
   i. G's and P’s should now be accurate
3. Resolve inactive pregnancy-related problems in the Problem List, i.e. “supervision of pregnancy”, “nausea and vomiting in pregnancy”
   a. Leave any problems that require follow up (i.e. anemia)
4. Resolve the OB episode
   a. In the chart review view, click on “More activities” in the lower left corner
   b. Open “Episodes of Care”
   c. Click on the pregnancy episode
   d. Click “Resolve episode”
PART II:

GUIDELINES FOR SCREENING AND ROUTINE CARE

GESTATIONAL DATING PROTOCOL

1. All patients get a first trimester ultrasound to confirm dates
   a. If dating is reliable, schedule the U/S around 8-9 weeks gestation.
      1. Dating is considered reliable only if:
         a. Patient is certain of 1st day of LMP
         b. LMP was normal in timing/amount/duration
         c. Regular menses (28-35 day cycles)
         d. No hormonal birth control x 3 month prior to conception and not breastfeeding
   b. If dating is uncertain, schedule ultrasound ASAP
   c. Schedule for procedure clinic: OK to overbook

1. Monday AM, Tuesday AM or Thursday AM.
2. Only the following attendings can do dating ultrasounds for desired pregnancies: Dr. Sara Baird, Dr. Lucia McLendon, Dr. Linda Prine, Dr. Rachel Rosenberg, Dr. Christina Shenko, Dr. Rupa Natarajan and Dr. Sarah Miller.
   a. Referral for outside dating ultrasound should ONLY be done if estimated gestational age is > 13 weeks. Send to Madison Radiology if it needs to be done soon.

2. LMP dating vs. U/S dating
   a. 1st trimester ultrasound (if ≥ 7 days difference between LMP and U/S, use U/S EDD)
   b. 2nd trimester ultrasound (if ≥ 14 days difference, use U/S EDD)
   c. 3rd trimester ultrasound (if ≥ 21 days difference, use U/S EDD)
3. Note: If using U/S for EDD, use the earliest U/S (do not change based on later U/S). Exception: If two U/S done prior to 10 weeks, use EDD from 8-9 weeks US (use EDD based on a crown-rump length preferentially over an EDD based off a measurement of a gestational sac)

**GESTATIONAL DIABETES SCREENING**

1. Gestational Diabetes Screens should be done at 24-28 weeks gestation for all women.

2. For women at higher risk, screen at the initial prenatal visit or as soon as possible. If negative, proceed with routine screening at 24-28 weeks.
   
   a. **Indications for early screening include:**
      
      I. Obesity (BMI ≥ 30)
      II. Previous history of GDM
      III. Strong family history of DM II
      IV. Consider in patients with a previous history of fetal macrosomia (4000 g or greater)

3. **GCT: Glucose Challenge Test (1 hour, 50gm oral glucose load)**
   
   a. Does not require fasting
   b. Cutoffs vary by institution; at Mount Sinai, normal is < 140 mg/dL
   c. Values of 140 mg/dL or higher indicates need for full 3 hour GTT.
   d. Use 130 mg/dL as cut-off for additional testing in women with risk factors (e.g., anyone on whom you are performing early testing)

4. **GTT: Glucose Tolerance Test (3hour, 100gm oral glucose load)**
   
   a. Patient must be fasting.
   b. Test should be performed in the morning after an overnight fast of at least 8 hours but not more than 14 hours and after at least 3 days of unrestricted diet (>150 g carbohydrate per day) and physical activity.
   c. The patient may drink water during the period of time she is fasting.
   d. The patient should remain seated and should not eat or smoke during the test.

Please note the following cutoff values for the 3 hour test:

- Fasting 95
- 1 hr 180
- 2 hr 155
- 3 hr 140

*If TWO or more of the values are abnormal, the diagnosis of gestational diabetes is made:

1. Transfer to High risk OB ASAP. Patient should be scheduled within 1 week
2. Schedule pt with Clinical Diabetes Educator (CDE) at IFH for teaching and glucometer in the meantime.

*If ONE of the values is abnormal:

1. Do dietary counseling, and refer to the CDE for teaching
GENETIC TESTING

Genetic testing is optional but should be offered to all patients. Women may also decline some or all genetic testing - document in Epic.

There are four components of genetic testing offered to all pregnant women:

1. Maternal Genetic Tests (only need to be performed once lifetime):
   a. Hemoglobin electrophoresis
   b. Ethnic carrier testing
2. Tests for fetal genetic/structural disorders (offered each pregnancy):
   a. Aneuploidy screening, which includes:
      1. Sequential screening for all women
      2. Amniocentesis or Chorionic Villi Sampling (CVS) for high risk women
   b. Screening for neural tube defects

GENETIC TESTING - ANEUPLOIDY

Genetic testing is optional but should be offered to all patients. Women may also decline some or all genetic testing - document in Epic.

Aneuploidy screening (frequently called “Down Syndrome screening”)

1. All women
   a. Sequential screen is the current standard of care and should be offered to all low risk women. See Step by Step instructions for Sequential Screen Testing on next page
      i. Step 1: nuchal translucency ultrasound + “Sequential 1” blood tests
      ii. Step 2: “Sequential 2” blood
   b. Cell-free Fetal DNA testing (i.e. Panorama or Harmony)
      i. This is a new test which is not yet being recommended for all patients
      ii. If a woman desires this testing, please speak with Drs. Baird or Shenko for instructions on how to get it done.

2. High risk – Women at high risk should be referred to Genetics at Mount Sinai ASAP
   a. Risk factors include
      i. Age > 35 at time of delivery
      ii. Abnormal screening test / sequential screen
      iii. History of pregnancy affected by genetic condition
      iv. Other risk or patient preference
   b. During the genetics appointment, they may be offered the following tests:
      i. **CVS**: performed between 10w 6d to 13w 6d: may be done the same day as the genetics appointment.
      ii. **Amniocentesis**: generally performed at 15-20 weeks but ideally 16-18 weeks. Sinai will schedule. Should be offered to all women of advanced maternal age or who are otherwise at risk for aneuploidy.
   c. **PLEASE NOTE**: if CVS or amnio is performed, the patient should ALSO be offered a MSAFP level to be checked between 15 and 20 weeks GA, to screen for neural tube defects, as direct genetic testing of the fetus does not, of course, screen for such malformations
3. Low risk but missed all or part of the Sequential screen – **Quad screen**
   a. If the patient misses the sequential screen, offer the Quad screen.
   b. The Quad screen is one blood draw.
   c. Ideally performed between 16-18 weeks but can be done between 15-22 weeks.
   d. Please order the **Quad Screen** and fill out all the requested information.
   e. This is a regular order that goes to CCL, not integrated genetics.
   f. Do NOT perform quad screening unless gestational age is known with reasonable certainty as interpretation of this test is based on accurate dating information.
   g. **Remember that quad screening requires a consent form (signed by patient and provider).**

**GENETIC TESTING - ETHNIC CARRIER TESTING AND OTHER**

Genetic testing is optional but should be offered to all patients. Women may also decline some or all genetic testing - document in Epic.

**Hemoglobin electrophoresis** - If not documented from prior pregnancy.
Recommended for all women in high-risk ethnic groups: Black, Latino, and Mediterranean descent.

**Ethnic carrier testing** – if not documented from prior pregnancy.
You MUST get written patient consent (on the back of the Integrated Genetics form). Please order these as HISTORICAL and fill out the triplicate requisition form. See Appendix
This includes:
   1. Cystic Fibrosis screen
   2. Fragile X
   3. Spinal Muscular Atrophy

**Neural tube defects** –
Screening for neural tube defects is indicated for any patient who does not get second trimester testing, including:
   1. Women who refuse aneuploidy screening
   2. Women who get first trimester screening (sometimes done by Sinai)
   3. Women at high risk who get CVS, amniocentesis, or fetal DNA testing

The screening test for neural tube defects is a maternal serum AFP level, performed between 15 and 20 weeks gestation

**Relevant Phone Numbers:**

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetics at Mount Sinai</td>
<td>212-241-6947</td>
</tr>
<tr>
<td>Invasive Testing (CVS, amnio) at MSH *generally scheduled through genetics</td>
<td>212-241-6551</td>
</tr>
<tr>
<td>Integrated Genetics (formerly Genzyme) (results for sequential screen/CF/Fragile X/SMA)</td>
<td>800-848-4436</td>
</tr>
<tr>
<td>CCL</td>
<td>212-420-4075, option 3</td>
</tr>
</tbody>
</table>
STEP BY STEP DIRECTIONS FOR SEQUENTIAL SCREEN TESTING

Genetic testing is optional but should be offered to all patients. Women may also decline some or all genetic testing - document in Epic.

Step 1: Get the nuchal translucency ultrasound and Sequential 1 blood test
1. NUCHAL ULTRASOUND: When gestational age is known, the provider places the order:
   a. US FETAL NUCHAL TRANSLUCENCY 1ST GESTATION - 76813
      i. In referral comments section, use “.OBULTRASOUNDREFERRAL”
      ii. Request ultrasound to be done between 11w0d and 13w6d GA. Provider must calculate the dates on a calendar and include in notes when to do the ultrasound.
   b. Order the SEQUENTIAL SCREEN 1 (HISTORICAL ORDER) [84163.HIS]
      i. This is a historical order – only so there is somewhere to scan the result – the order will always be listed as “collected”. The Epic order doesn’t do anything, so it’s ok to order ahead of time.
      ii. When the labs are drawn, you MUST order the actual lab using the Integrated Genetics triplicate requisition form. (See “BLOODWORK 1” below)
   c. Email or inbasket the prenatal referral clerk, letting them know that the order was placed
      i. Prenatal referral clerk sends referral to Mount Sinai.
      ii. Mount Sinai sends appointment details to prenatal coordinator/prenatal referrals team.
      iii. Prenatal referral team calls patient with appointment details.
   d. After the patient gets the ultrasound, Mount Sinai sends ultrasound report, which is placed in continuity resident’s mailbox
      i. Results should be reviewed by resident and scanned
      ii. One copy is kept in a red folder on prenatal coordinator’s desk.

2. BLOODWORK 1: After the ultrasound – ideally within 2-3 days, but it can be any day within the Sequential Screen timeframe, the patient should come to get the first set of bloodwork called the “Sequential 1”
   a. Complete the Integrated Genetics triplicate requisition form. It is found in the precepting rooms. See Appendix
      i. All data must be entered, including weight, collection date, date sent, and drawn by. Data for the right hand side is obtained in the nuchal translucency ultrasound report.
      ii. The physician must sign the form
      iii. The patient must sign the consent form on the back.
      iv. Any incomplete form will result in the test not being processed.
      v. Nurse or MA must copy of patient’s insurance card and send with form.
   b. The signed/completed form is sent with the blood work (two SST tubes) to Integrated Genetics.
   c. Results are faxed to 5th floor fax machine and placed in resident mailbox.
      i. Results should be reviewed by resident – the patient must be called with the results, then the result can be scanned.
   d. One copy is kept in a blue folder on prenatal coordinator’s desk.
Step 2: Second blood draw

1. BLOODWORK PART 2: Should be ordered between 15 and 21 weeks, but **ideally 16 -18 weeks.**
   a. Order the SEQUENTIAL SCREEN 2 (HISTORICAL) [82105.HIS]
   b. Again, this is a historical order only - the order will always be listed as “collected”.
   c. You MUST order the actual lab using the requisition form **which came with the sequential 1 results and will be scanned under “Media.”** You do NOT use the triplicate form. One copy is kept in a **green folder** on prenatal coordinator’s desk.
   d. Physician must sign the form.
   e. MA or nurse must print copy of patient’s insurance card and send with form.
   f. Results are faxed to 5th floor fax machine.
      i. Results should be reviewed by resident – the patient should be called with the results, then it can be scanned.
   g. One copy is kept in a **blue folder** on prenatal coordinator’s desk.
HOW TO REFER TO OB

There are multiple sub-specialty clinics within Mount Sinai’s OB department, and it is imperative that your referral is appropriately worded to direct the patient to the appropriate care.

You must contact the prenatal referral coordinator after placing all OB related referrals so they can be urgently processed.

See the next page (Indications for OB Referrals) to assist with choosing the correct referral location.

- **High Risk OB**: This office is where most of our referrals will go, for consultation regarding a medical co-morbidity (e.g. asthma, thyroid disease, anemia, etc). Referral MUST specify that the consultation is to High Risk OB. If you are transferring the patient’s care (e.g. she is on dialysis, has active substance use, is diabetic, etc), your consultation order MUST specific that you are requesting transfer of care, not merely a consultation.

- **OB ID Clinic**: This is for patients whose pregnancy is complicated by active infectious disease (HIV, Hepatitis C, etc). As above, please specify a referral vs a transfer of care. In general, the care of these patients will be transferred.

- **General Obstetrics**: Generally, consultation to general OB MD will be for TOLAC counseling; transfer of care to this office for any patient who will need a planned operative delivery. Please specify “OB MD” as otherwise these patients may be erroneously scheduled with a PA or midwife.

- **Family Planning Clinic**: for terminations up to 24 weeks and miscarriage management. As we can generally perform first trimester terminations of pregnancy and manage first trimester pregnancy losses in our office, you will generally be referring to Family Planning in cases of fetal malformations, etc, for 2nd trimester terminations. Please alert Dr. Shenko, Dr. Baird, Dr. McLendon, Dr. Rosenberg, Dr. Prine, the current women’s health fellow, or the prenatal coordinator if you have a patient who needs a second trimester termination, as this care is obviously quite time-sensitive; the prenatal team will assist you in facilitating this care in a timely fashion.

- **Urgent questions/consultation**: call Dr. Shenko first to assist with patient’s disposition plan; if she is unavailable, can also discuss case with MFM attending of the day: 212-241-8450
INDICATIONS FOR OB REFERRALS

The following guidelines have been adapted from Sinai guidelines – See Sinai intranet for additional information

**High Risk Care Exclusively**

- Cardiac disease, current/active maternal congenital
- Cervical incompetence or short cervix, current pregnancy
- Diabetes, gestational or pregestational
- Drug use, active current
- Hepatitis A or B, active (refer to ID Clinic)
- Hepatitis C (refer to ID Clinic)
- HIV positive (refer to ID Clinic)
- Hypertension, chronic on meds
- Isoimmunization: Rh, Kell, Duffy, E, c, etc
- IUGR (EFW <10th percentile)
- Liver disease, active
- Multiple gestations
- Preeclampsia, current
- Renal disease, severe/active
- Sickle cell disease
- Thalassemia (major only)
- Thrombophilia on anticoagulation
- ToRCH infection, current, except HSV
- Transplanted organ
- Tuberculosis, active (refer to ID Clinic)

**High Risk Consult (disposition to MD management to be determined after consultation)**

- Anemia, severe (HCT<25%)
- Asthma
- Cervical incompetence, history in previous pregnancy
- Autoimmune/connective tissue disorder
- Hepatitis B, chronic carrier
- Heart murmur, asymptomatic, no medication
- Hypertension, chronic, stable, no medication
- Jehovah’s Witness
- Neurologic disease, no medication
- Oligohydramnios
- Placenta previa, with previous C/S
- Previous pregnancy history of:
  - IUGR
  - Preterm labor
  - PPROM
  - Congenital anomalies
  - Cervical incompetence
  - Poor obstetric outcome (e.g. IUFD)
  - Recurrent SAB (3 or more)
Proteinuria, chronic, isolated
Renal disease, stable or previous
Seizure disorder, with or without medication
Thyroid disease: hypothyroid or hyperthyroidism

**OB MD Care Exclusively (transfer to OB)**

- Placenta previa, stable
- Previous classical cesarean, myomectomy, significant uterine surgery

**MD Consult *(disposition determined after consultation)* [IFH ADDENDUM: Discuss all such cases with Dr. Shenko; most of these patients may be managed in our office]*

- Anemia unresponsive to treatment (persistent HCT<30% after 2 months of treatment or if >35 weeks)
- Drug use, past history
- Grandmultiparity > 6
- Obesity (BMI > 35)
- Preeclampsia, history of previous
- Prior C/S (regardless of planned mode of delivery – ideal at 32 weeks if plan for TOLAC)
- Shoulder dystocia, prior pregnancy
- UTI, recurrent (≥2 in pregnancy)
TOLAC/PRIOR CESAREAN SECTION POLICY

1. All patients with one prior cesarean delivery need:
   a. Operative report must be obtained for all patients. Patients are only eligible for TOLAC if they have documentation of a low transverse uterine scar. Patients with a previous classical (vertical) uterine incision are ineligible for TOLAC due to increased risk of uterine rupture.
   b. Consultation ASAP with Dr. Shenko or Dr. Baird in the 1st trimester (or as soon as possible) for counseling about TOLAC.
   c. If, after counseling, the patient chooses to have repeat C-section, she will be transferred to OB. Undecided patients may remain with the FHC of Harlem for care.
   d. If, after counseling, the patient chooses TOLAC:
      i. She will sign consent during her initial consultation with Dr. Shenko/Dr. Baird and continue her care with Harlem. The consent forms are available on the website.
      ii. She will need to see OB for a one-time visit in the 3rd trimester at 32 weeks for repeat counseling and consent.
      iii. She will be asked to sign consent again when she arrives at Labor & Delivery to deliver.
      iv. Contact Drs. Shenko or Baird by 39-40 weeks if the patient is not delivered, to discuss induction versus scheduled C/S options.

2. If a patient has had more than one prior cesarean she should be transferred to OB. She may or may not be eligible for TOLAC. Repeat C-section is recommended in all cases for women who have had more than 2 previous cesarean sections.

3. Intrapartum management of patient desiring TOLAC:
   a. When the patient presents in labor, she is to be co-managed with the OB service (FM residents and FM attending with OB attending co-managing); attending notes are required in accordance with posted FOJP protocols.

WHEN THE PATIENT IS ADMITTED TO L&D, TOLAC CONSENT MUST BE SIGNED AND PLACED IN CHART. INFORMED CONSENT ABOUT RISK OF SHOULDER DYSTOCIA SHOULD ALSO BE GIVEN.
PART III:

SELECT CLINICAL GUIDELINES

IRON DEFICIENCY ANEMIA
1. Check CBC at initial prenatal visit and again at 24-28 weeks with GCT. 
2. If anemic at any point, check hemoglobin electrophoresis if not already performed. 
3. If Hct less than or equal to 25%: 
   a. Start ferrous sulfate three times a day and recheck CBC in 2-4 weeks. 
   b. If still less than or equal to 25%, refer to hematology for consultation for IV iron. 
4. If Hct is 25-30%: 
   a. Start Iron 325mg PO up to TID and recheck CBC in 1 month 
   b. If Hct now <25% or if post-treatment Hbg increases <1 g/dL/month, send iron studies and consult hematology for IV iron. 
5. Start weekly NST/BPP @ 32 weeks for severe anemia (Hct <25%). 
6. Refer to OB if anemia is present beyond 36 weeks gestation

SICKLE CELL TRAIT
Requires monthly urine cultures 
Advise the FOB to be tested to assess risk of fetus with sickle cell disease 
Consider referral to genetics

REFUSAL OF BLOOD PRODUCTS / JEHOVAH’S WITNESSES
Must have a high risk OB consult
GENITAL HERPES
Start suppressive antiviral therapy (acyclovir or valacyclovir) at 36 weeks until delivery for women with history of genital herpes. Discuss with patient that cesarean section will be indicated if she has active lesions at onset of labor.

ADVANCED MATERNAL AGE
In addition to all routine care:
Over aged 35 at the time of delivery - Refer to genetics for consultation and offer amniocentesis
Over aged 40 at the time of delivery – Schedule induction by 40+3 weeks instead of 41+3 weeks.

INDICATIONS FOR ASPIRIN
Start a low-dose aspirin (81 mg PO daily) for all patients with the following conditions. Aspirin should be started before 16 weeks gestation. Note that many of these conditions require transfer of care or consult to OB. Please start aspirin ASAP, as they will often not be seen by OB until after 16 weeks gestation.
1. History of preeclampsia
2. History of gestational hypertension
3. Pre-gestational (chronic) hypertension
4. Chronic kidney disease
5. Diabetes mellitus, any type
6. Autoimmune disease, including SLE and antiphospholipid syndrome

ELEVATED BLOOD PRESSURE
Hypertension is pregnancy is associated with significant risks of morbidity and mortality for both mother and fetus, including (but certainly not limited to) intra-uterine growth restriction and development of preeclampsia. ANY elevated blood pressure reading in pregnancy must be closely evaluated at the time it is noted. It is NEVER appropriate to document an elevated blood pressure on a pregnant woman and discharge her from the office without an assessment and plan for management.

Screen all pregnant women for signs/symptoms of preeclampsia

Any abnormal blood pressure should be confirmed using appropriate blood pressure technique (sitting x 5 minutes, feet on floor). If repeat blood pressure using appropriate technique is normal, this must be clearly documented in the medical record.

Definitions of hypertensive states in pregnancy:
   a. Hypertension: systolic BP ≥140 OR diastolic BP ≥90 mmHg
   b. Severe hypertension: systolic BP ≥160 OR diastolic BP ≥110 mmHg.

SEVERE HYPERTENSION IN PREGNANCY IS A MEDICAL EMERGENCY.

1. Chronic hypertension: predating pregnancy or present before 20 weeks gestational age.
   Please note that if hypertension was diagnosed prior to pregnancy, a pregnant woman still carries the diagnosis of chronic hypertension even if her measured blood pressure is within normal limits during the current pregnancy.
2. Gestational hypertension: arises after 20 weeks gestational age WITHOUT signs/symptoms of pre-eclampsia
3. Pre-eclampsia: hypertension with signs/symptoms (either proteinuria +/- other signs/symptoms OR may be diagnosed without proteinuria if has signs/symptoms or laboratory abnormalities consistent with pre-eclampsia. Often, patients with previously diagnosed chronic or gestational hypertension progress to developing pre-eclampsia.
4. Severe pre-eclampsia: pre-eclampsia with systolic BP ≥160 OR diastolic BP ≥110 mmHg OR pre-eclampsia with severe features. All patients with severe pre-eclampsia must be managed in the inpatient setting.

Clinical guidelines for women > 20 weeks gestation:
BP ≥ 140/90, regardless of symptoms:
Collect CLEAN CATCH urine and perform:
   a. Urine dip
   b. Full urinalysis
   c. Urine protein:creatinine ratio
2. Refer to Labor and delivery for full evaluation including BP monitoring and NST. Advise patient that, at minimum, she will have evaluation of fetal heart tracing for several hours as well as laboratory testing (e.g. bloodwork).

Given the high risks of morbidity/mortality for patients with hypertensive disorders of pregnancy, even women with high normal blood pressure may warrant work-up/baseline laboratory analysis. In general, with patients whose blood pressures are in the intermediate range (systolic BP 130-139, or diastolic BP 80-89), use the following guidelines:

Systolic BP 130-139, or Diastolic BP 80-89 AND has any symptoms OR at high risk
1. Collect clean catch urine and perform:
   a. Urine dip
   b. Full urinalysis
   c. Urine protein:creatinine ratio
2. Refer to Labor and delivery for full evaluation including BP monitoring and NST

Systolic BP 130-139, or Diastolic BP 80-89 AND asymptomatic AND low risk
1. Collect clean catch urine and perform:
   a. Urine dip
   b. Full urinalysis
   c. Urine protein:creatinine ratio
2. Draw Preeclampsia panel:
   a. CBC
   b. CMP
   c. Uric acid
   d. Consider checking PT/INR, LDH, albumin if concern for HELLP
3. Ensure that patient has adequate follow up in 1-2 days
   a. Confirm contact information
   b. Make follow up appointment before patient leaves
4. If patient has ANY lab abnormality or is high risk for poor follow up, refer to Labor and delivery for full evaluation including BP monitoring and NST
NAUSEA AND VOMITING

Nausea and vomiting in pregnancy affects most pregnancies. It is usually mild and self-limited. It usually starts within 4 weeks of the last menstrual period.
- 60% resolve by the end of the first trimester
- 87% resolve by 20 weeks gestation

See the AAFP article on “Nausea and Vomiting in Pregnancy” for an excellent summary of recommendations and workflow for medications. http://www.aafp.org/afp/2014/0615/p965.html#abstract

For any women experiencing nausea and vomiting in the pregnancy, evaluate the severity of the condition including:
1. PO tolerance
2. Hydration status
3. Signs and symptoms of other conditions which may also be present, such as migraine, gall bladder disease, GERD, gastroenteritis, UTI/pyelonephritis
4. Abnormal physical exam findings

While no lab testing is indicated for women with classic nausea and vomiting in pregnancy, women with atypical or severe symptoms should be further evaluated. Consider:
1. TSH
2. CMP
3. Urinalysis
4. CBC
5. Quantitative HCG (to assess for multiple gestations or molar pregnancy)
6. Amylase/lipase levels
7. Ultrasound (if not already done, to assess for multiple gestations or molar pregnancy)

Women with dehydration (diagnosed clinically, do not wait for lab results except UA to assess for ketonuria) should receive IV fluids. If IV fluids are available in clinic, this can be an acceptable option as long as clinical status is documented as improved. If IVF are not available, or patients signs and symptoms have not resolved (ie. patient still appears dehydrated or ketonuria is persistent), the patient should be referred to the Emergency Room for management.

Hyperemesis gravidarum is diagnosed when a patient’s nausea and vomiting is severe enough to cause fluid and electrolyte disturbances. It often requires hospitalization.

Treatment options for simple nausea and vomiting in pregnancy
1. Trial Vitamin B6 (pyridoxine) 25 mg BID
2. If there is no improvement
   a. Add doxylamine (Unisom) 12.5 - 25 mg BID
3. If there is no improvement
   a. Add metoclopramide (Reglan) 5-10 mg every 6 hours as needed OR promethazine (Phenergan) 12.5-25 mg every 4-6 hours as needed
4. If there is no improvement
   a. Stop metoclopramide/promethazine
   b. Add ondansetron (Zofran) 4-8 mg every 6 hours as needed
UTI AND ASYMPTOMATIC BACTERIURI A

All pregnant women should be screened for asymptomatic bacteriuria, as this condition is associated with increased risk of preterm birth. This screening (by urine culture) ideally happens at 11 weeks gestational age.

Asymptomatic bacteriuria is defined as a urine culture growing a pathologic organism >100K CFUs in the absence of any symptoms consistent with a urinary tract infection. Non-pathologic organisms include lactobacillus, diptheroids and do not need treatment.

1. Use an appropriate antibiotic (see below)
2. Follow-up urine culture 2-4 weeks post-treatment.
3. If bacteriuria is still present, the patient should be re-treated and re-screened. If still positive she may need monthly urine cultures, or antibiotic prophylaxis.

Urinary tract infection: diagnosed as in non-pregnant patients. Always send a confirmatory urine culture, even if treating empirically. If the patient is symptomatic, the threshold of 100K CFUs does not need to be reached in order to make the diagnosis (e.g. 10-50K CFUs in presence of symptoms could result in a diagnosis of UTI).

1. Treat with a 7-10 day course (it is by definition a complicated UTI)
2. Use an appropriate antibiotic (see below)
3. Any s/s pyelonephritis warrants inpatient evaluation and treatment.
5. Persistent bacteriuria after treatment and/or more than one UTI during pregnancy warrants a high-risk consultation.

Group B Streptococcus Asymptomatic Bacteriuria

1. >100K CFUs on urine culture:
   a. Treat as above, including follow up cultures to ensure resolution
   b. IN ADDITION: she is considered GBS positive for the remainder of pregnancy and will need of intrapartum GBS prophylaxis with antibiotics. Don’t send a rectovaginal swab at 35-37 weeks as she will be treated regardless of those results.
2. <100K CFUs on urine culture:
   a. She is considered to be GBS positive for the purposes of intrapartum GBS prophylaxis and requires antibiotics during labor. Don’t send a rectovaginal swab at 35-37 weeks as she will be treated regardless of those results.
   b. In the US, there are no clear national guidelines regarding the treatment of asymptomatic GBS bacteriuria with CFUs <100K. This is an opportunity for shared decision making.

Choice of antibiotics

1. Use the urine culture to guide your choice of antibiotics
2. Penicillins may be used for penicillin-sensitive organisms
3. Avoid use of trimethoprim (Bactrim) in the first trimester
4. Avoid use of sulfamethoxazole (Bactrim) past 35 weeks gestation
5. Avoid use of nitrofurantoin past 35 weeks gestation
PART IV:
LOGISTICS

HOW TO ORDER ULTRASOUNDS

You can either order ultrasound through the prenatal visit navigator under the “ultrasounds” tab, or by ordering the ultrasound individually through order entry or smartsets.

For ALL ultrasound orders, you must put in the comments: OBULTRASOUNDREFERRAL and complete the questions.

1. First trimester dating – Done at Harlem and Walton procedure clinic.
   Enter the “Ultrasound Pelvis – transvaginal aka Obstetric ultrasound” smartest
   Select “In-House Ultrasounds”
   Select the ultrasound that meets the indication (i.e. “Ultrasound for Pregnancy Dating”)

2. Nuchal Translucency Ultrasound: done at Mount Sinai between 11w0d and 13w6d.
   a. US FETAL NUCHAL TRANSLUCENCY 1ST GESTATION – CPT 76818.

3. Anatomy scan: Done at Mount Sinai. Routine anatomy scan ideal at 20 weeks. OK if early anatomy scan done at 16 weeks, will need repeat between 20-22 weeks.
   a. US PG UTER F&MAT DETAILED FTL ANTMC XM – CPT 76812

4. Growth scans: (put requested exam and indication in comments!)
   a. US OB, 2ND/3RD TRIMESTER - CPT 76811
5. **BPP**: All women to have AFI/NST (Modified BPP) beginning at 40 weeks, to be performed 1-2 times per week until delivery, as recommended by MFM.
   a. **AFI**: (put requested exam and indication in comments!)
      i. US OB, 2ND/3RD TRIMESTER - CPT 76818 or
      ii. FETAL BIOPHYSICAL PROFILE W/OUT NST-REFERRAL – CPT 76818
   b. **NST**:
      i. NST (FETAL NON-STRESS TEST) – CPT 5902

**Precepting a Prenatal Visit**

1. Open episode to review entire episode documentation (this can be done in chart review or in the Episode section)
   a. Review accuracy of Problem List, Medications, History, Dating, and completion or labs.
   b. Utilize OB Chart Review Tool (.OBCHARTREVIEWTOOL) and OB Telephone Guidelines for Preceptors as needed (Find on website).
2. Review checklist with resident to make sure all counseling and screening areas are covered and documented.
3. Review Vitals and Notes section with resident to make sure complete.
4. Write precept note using .OBHPRECEPT note. (Please note that you do not need to use .PRD when the chart comes back to you in your Cosign Charts work queue.)

**Setting Up Circumcision**

1. Patient should be asked whether she desires circumcision for male newborn during course of prenatal care.
2. Contact circumcision-certified Family Medicine attending as soon as patient delivers (next morning if delivery overnight) to coordinate time for circumcision at 24 hrs or later of life. Alternatively, you can ask to OB team to add the patient to their “Circ List” in Epic and the OB team will perform the circumcision for you. Sign out and coordinate plan with Inpatient team:
   a. Nursing needs to be notified of planned procedure so that feeds can be held 1 hour prior.
   b. Arrange for all equipment (including lidocaine without epinephrine) to be available at time of procedure.
   c. If newborn is admitted to NICU – communicate with NICU and await clearance for FP or OB attending to perform circumcision.

**Setting Up Inductions and Cesarean Sections**

Make sure patients know these are elective inductions and can be rescheduled at the last minute if there is problems with space or staff on L&D. Residents should discuss scheduling inductions with an FM-OB faculty when the patient is between 39 and 40 weeks (so we can schedule it 1-2 weeks ahead of time).

The induction must be scheduled through Jillian D’Angelo (see Appendix for scheduling form, which should be faxed to her attention).
She is also the person who should schedule planned/elective c-sections (for example, a patient who initially desired TOLAC who now choses a repeat c-section).

You will receive a fax back with the date and time of the scheduled induction; we are responsible for informing the patient of her induction appointment time.

Indications for induction of labor are many and varied. Please consult with your FM-OB faculty regarding any patient that might have an indication for an early induction of labor. These include but are not limited to:

1. Postdates (by 41+3 weeks)
2. Advanced maternal age ≥ 40 years of age → induction of labor should be scheduled for *40* weeks, not 41 weeks gestational age
3. Suspected fetal macrosomia (EFW >5000 g for non-diabetic patients, >4500g for diabetic patients) or history of LGA birth.
4. Medical complications of pregnancy (for example, cholestasis of pregnancy, preeclampsia, gestational hypertension, intrauterine growth restriction) may lead to an early (37-39 weeks GA) induction of labor. This decision is usually made in concert with MFM.
5. Fetal complications (failed NST, known fetal anatomic anomalies) may also lead to earlier induction of labor.

**SETTING UP TUBAL LIGATIONS**

Patients who desire postpartum tubal ligations need a sterilization consent form signed at least 30 days prior to delivery.

The form can be found here: [HTTP://WWW.HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/PUBLICATIONS/DOCS/LDSS/LDSS-3134.PDF](HTTP://WWW.HEALTH.NY.GOV/HEALTH_CARE/MEDICAID/PUBLICATIONS/DOCS/LDSS/LDSS-3134.PDF)

Patients do not need an OB consult or social work appointment in order to be eligible for tubal ligation. Any patient who wishes to have a tubal can opt to meet with one of our OB faculty to discuss, but referral to faculty should not delay consent for a patient who is sure about her decision, due to the necessary timing of consent.

Scan the signed sterilization consent form to both IFH and Sinai EPIC, and give her a copy to bring to L&D. The initial signature must be 30 days prior to delivery, and she will sign the second section of the consent just prior to the procedure.

If she has a C-section, they will perform the TL at the time of delivery. If she has a vaginal delivery, consult the on-call GYN team at the time of delivery and they will try to schedule her before discharge. If she cannot get the procedure done before discharge, they will schedule a laparoscopic procedure 6 weeks postpartum.
GROUP VISITS
All residents will offer group visit prenatal care under the Centering Pregnancy® model. Patients may opt out of group visits for individual prenatal care visits. Please discuss scheduling with your Centering Group attending and the Prenatal Coordinator. Clinic schedules and hospital call schedules may need to be adjusted on weeks of prenatal visits. Resources available from prenatal coordinator.

CODING
LOS = 99213
ICD-9 Code:
  Supervision of Normal First Pregnancy (V22.0) for primips
  Supervision of Other Normal Pregnancy (V22.1) for multips.
  Supervision of high risk pregnancy (V23.9) if there are any high risk conditions.

Include any and all other relevant diagnoses in the problem list and diagnosis list for ALL visits, such as:
Obesity in Pregnancy (649.10)
Nausea and Vomiting in Pregnancy (643.90)
Advanced Maternal Age in Pregnancy (659.60)
Hx of Preeclampsia, prior pregnancy, currently pregnant (V23.49)

OB BLOCK COVERAGE
Can be found in Epic – use smartphrase .OBHBLOCK

OB SMARTPHRASES AND SMARTSET

Smartphrases:

  .OBHBLOCK
  .OBHCHARTREVIEWTOOL
  .OBHINITIALVISIT
  .OBH8TO15WEEKS
  .OBH16TO23WEEKS
  .OBH24TO28WEEKS
  .OBH29TO35WEEKS
  .OBH36TO39WEEKS
  .OBH39TO42WEEKS
  .OBULTRASOUNDREFERRAL
  .OBHPRECEPT
Smart sets:

PRENATAL INITIAL VISIT
OB POSTPARTUM VISIT
ULTRASOUND PELVIS – TRANSVAGINAL

IMPORTANT NUMBERS

<table>
<thead>
<tr>
<th>Name</th>
<th>Email</th>
<th>Office Phone</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Christina Shenko</td>
<td><a href="mailto:cshenko@institute.org">cshenko@institute.org</a></td>
<td>212-423-4500 ext 4710</td>
<td>203-240-3347</td>
</tr>
<tr>
<td>Dr. Sara Baird</td>
<td><a href="mailto:sbaird@institute.org">sbaird@institute.org</a></td>
<td>212-423-4500 ext 4713</td>
<td></td>
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<tr>
<td>Dr. David English</td>
<td><a href="mailto:denglish@institute.org">denglish@institute.org</a></td>
<td>212-423-4500 ext 4713</td>
<td></td>
</tr>
<tr>
<td>Jillain D’Angelo, induction</td>
<td>212-241-7493; jillian.d'<a href="mailto:angelo@mountsinai.org">angelo@mountsinai.org</a></td>
<td></td>
<td></td>
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<tr>
<td>OB Clinic appointments</td>
<td>Discuss with prenatal referral clerk</td>
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</tr>
<tr>
<td>Genetics at Mount Sinai</td>
<td>212-241-6947; for procedural appts: 212-241-6551</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MFM Attending of the Day</td>
<td>212-241-8450</td>
<td></td>
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<tr>
<td>Integrated Genetics (former</td>
<td>212-698-0300</td>
<td></td>
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</tr>
<tr>
<td>Prenatal Coordinator at Harlem</td>
<td>212-423-4500 ext 4714</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHAT TO DO AT WALTON

Some special instructions for the folks at Walton:
1. TOLAC counseling can be done by Dr. Jasmin Roman
2. Please identify which hospital the patient plans to deliver at, and work with your prenatal coordinator to transfer that patient when appropriate
3. Additional Walton procedure clinic sessions are held on Thursday afternoons. Dating ultrasounds and terminations can be done at this time.
Appendix #1: Mount Sinai Request for Scheduled Delivery

REQUEST FOR LABOR INDUCTION (up to 2 weeks prior) ☐
REQUEST FOR C/SECTION (6 weeks prior) ☐

Please complete and fax to: (212) 241-1936, ATTN: Jillian D’Angelo

Physician: _______________ Contact: _______________ Phone: _______________ Fax: _______________

PATIENT NAME: ___________________ MRN: _______________ DOB: _______________

Patient’s phone #: ___________________ EDC: ___________________

Parity ________ B. Strep Status_______ Gestational age at Delivery: ______ wks ______ days
Based on ☐ US 6-20 wks ☐ other ___________________

Date/Time Requesting: Must provide 2 alternatives

______________________or ___________________or_____________________

☐ FLM positive ☐ Date FLM scheduled_________ (Patients pending FLM cannot be 1st case of day)

Indication for Delivery: Check all appropriate

☐ Abruption ☐ HIV infection ☐ Previa
☐ APL/Thrombophilia ☐ Isoimmunization ☐ Prior myomectomy
☐ Chronic HTN ☐ IUGR ☐ PROM
☐ Diabetes (type I or II) ☐ Liver disease (e.g., cholestasis of preg) ☐ Pulmonary Disease
☐ Fetal demise ☐ Multiple gestation ☐ Macrosomia
☐ (current/ previous 3rd trimester) ☐ Non-reassuring fetal status ☐ Other______ **
☐ Fetal malformation ☐ Oligohydramnios ☐ Perinatology consult obtained
☐ GDM with insulin ☐ Polyhydramnios and agrees w/plan:
☐ Patient choice/social ☐ Preeclampsia/GHTN __________________________

(consultant name)

C/Section (>39 wks) *If C/Section is prior to 39 weeks p-value/L/S required!
You MUST notify the Resident on labor floor on duty the night before of the results

☐ Prior C/S ( # of Prev C/S =_______) ☐ Patient choice
☐ Breech presentation ☐ Other malpresentation
☐ Twin w/o complication (ok >38 wks) ☐ Other________________________

Additional anticipated surgery_____________________________________________(e.g., BTL, hernia, other)
Associated medical condition/s_____________________________________________
Signed__________________ Print name__________________ Date faxed______________

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ Please fax H & P prior to admission~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Patient confirmed for _____________ at ___________________ PAT for C-Section: _____________ at _________
## Appendix #2: Antepartum Fetal Surveillance

### THE MOUNT SINAI HOSPITAL, NEW YORK, N.Y.

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>FETAL SURVEILLANCE*</th>
<th>ULTRASOUND EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antiphospholipid Syndrome</td>
<td>NST twice weekly from 32 weeks</td>
<td>Growth monthly</td>
</tr>
<tr>
<td>Asthma, severe</td>
<td>NST twice weekly from suspected diagnosis</td>
<td>Growth monthly</td>
</tr>
<tr>
<td>Cholestasis</td>
<td>NST twice weekly from 32 weeks</td>
<td>Growth monthly</td>
</tr>
<tr>
<td>Chronic hypertension</td>
<td>Modified BPP twice weekly from 32 weeks</td>
<td>Growth monthly</td>
</tr>
<tr>
<td>Collagen vascular disease</td>
<td>NST twice weekly from 32 weeks</td>
<td>Growth monthly&lt;br&gt; If +ro/la: fetal echo weekly 16-32 weeks, then weekly fetal heart check (heart block) every 2 weeks</td>
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<tr>
<td>Diabetes, A1</td>
<td>NST twice weekly from 39 weeks</td>
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<tr>
<td>Diabetes, A2</td>
<td>NST twice weekly from 32 weeks</td>
<td>Growth monthly</td>
</tr>
<tr>
<td>Diabetes, pre-gestational</td>
<td>NST twice weekly from 32 weeks</td>
<td>Growth monthly</td>
</tr>
<tr>
<td>Intrauterine growth restriction (IUGR)</td>
<td>BPP weekly upon diagnosis NST from 32 weeks</td>
<td>Growth every 2 weeks upon diagnosis&lt;br&gt; UA* dopplers weekly upon diagnosis</td>
</tr>
<tr>
<td>Oligohydramnios: AFI ≤ 5 or MVP** ≤ 2 cm</td>
<td>&lt;32 weeks: BPP weekly ≥ 32 weeks: modified BPP weekly</td>
<td>Growth every 2 weeks upon diagnosis&lt;br&gt;</td>
</tr>
<tr>
<td>Post-due date</td>
<td>Modified BPP from 40-40.5 weeks</td>
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</tr>
<tr>
<td>Preeclampsia, expectant management</td>
<td>Modified BPP twice weekly upon diagnosis</td>
<td>Growth monthly</td>
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<tr>
<td>Renal disease, chronic</td>
<td>NST from 32 weeks</td>
<td>Growth monthly</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>Growth monthly</td>
<td></td>
</tr>
<tr>
<td>Unexplained elevated MSAFP</td>
<td>Modified BPP from 36 weeks</td>
<td>Growth monthly</td>
</tr>
</tbody>
</table>

*UA: umbilical artery  
** Maximum vertical pocket
Appendix # 3

Integrated genetics requisition form for:
1. Panethnic testing
2. Sequential 1

Find this form in the 4th floor precepting room
See Directions for Sequential Screening for details
Integrated genetics requisition form for:

1. Sequential 2

Find this form under “media” or on the prenatal coordinator’s desk
See Directions for Sequential Screening for details
Appendix 4: Important milestones – quick guide

Every visit:
1. Use the .OBH smartphrases for your progress notes
2. Review the prenatal checklist in the visit navigator
3. Update the chart review tool in the problem list

< 11 weeks:
1. Routine prenatal labs
2. Genetic testing counseling and consent
3. Order the nuchal translucency scan

11 – 13 weeks:
1. Urine culture
2. Obtain nuchal translucency results and obtain Sequential 1

16-18 weeks:
1. If no sequential screen was done, obtain quad screen
2. If sequential screen was done, obtain Sequential 2
3. Order anatomy scan, to be done between 18-22 weeks

24-28 weeks:
1. Follow up anatomy ultrasounds, if indicated
2. CBC and GCT
3. Screen for depression
4. Rescreen for tobacco use
5. Rhogam at 28 weeks for Rh negative women

30-34 weeks:
1. Tdap
2. Offer repeat STD and HIV testing

35-36 weeks:
1. GBS testing
2. Confirm cephalic, with preceptor
3. Discuss contraception

37-38 weeks:
1. Review labor plan and offer membrane sweeping
2. Obtain nuchal translucency results and obtain Sequential 1

39-40 weeks:
1. Schedule modified BPP (AFI and NST) twice a week starting at 40 weeks
2. Schedule induction of labor, no later than 41 weeks 3 days unless other indication
3. Obtain nuchal translucency results and obtain Sequential 1