

Brazos Valley Community Action Agency, Inc
Health Services

Policies and Procedures

Policy Subject / Title: Obstetric Services
Applicability: All BVCAA Community Health Centers providing obstetric services
Purpose: To be able to provide consistent, high quality obstetric care to clients seeking care from BVCAA Community Health Centers.

I. Registration and Eligibility

Client will register with BVCAA Registration / Eligibility personnel to determine appropriate funding source(s) for the client.

PROCEDURE: See Admin Policy and Procedure Manual for Registration and Eligibility, including documentation requirements for individual funding sources.

II. Consents and Contracts for Care

- A. The general consent for treatment, including the counseling and consent for HIV and other standard prenatal and postpartum testing, shall be obtained before or at the initial visit.
- B. Due to the vital nature of timely and appropriate delivery of obstetric care serves toward a positive pregnancy outcome, a Prenatal Client Contract was developed to ensure the obstetric client is duly informed of the expectations both she and the Center's staff may have of one another as partners toward that positive pregnancy outcome. This contract shall be discussed and signed at the initial prenatal visit.
- C. Quadruple testing for antenatal screening (Quad-Screen) shall be offered to all obstetric clients between 15-20 weeks following thorough counseling regarding the risks and benefits of such testing. Should a client decline to have the Quad-Screen performed, a Patient Declination Form for Quad-Screen shall be signed.
- D. A client that desire permanent sterilization following her current pregnancy via postpartum bilateral tubal ligation (BTL) shall receive thorough counseling regarding the risks and benefits of the BTL procedure, and the Sterilization Consent shall be signed no sooner than 90 days and no later than 30 days prior to the client's anticipated date of delivery.

PROCEDURE: See Appendix 1 of this policy for sample documentation of the BVCAA General Consent (1-A), Prenatal Client Contract (1-B), Patient Declination Form for Quad-Screen (1-C) and Sterilization Consent (1-D). All signed documents pertinent to the care of the client shall be made part of the client's electronic record.

III. Documentation of Care

Documentation of care provided to an obstetric client must be maintained within the electronic health record (EHR) system, specifically the “OB Flow Sheet” portion which shall be routinely updated to ensure compliance with all regulatory agencies governing the funding sources applicable to BVCAA clients.

PROCEDURE: See [Appendix 2](#) to this policy for screen shots and detailed documentation specifications for obstetric clients.

IV. Standards of Care

The BVCAA Medical Staff has adopted standards of care guidelines for a variety of common chronic diseases and conditions notable to the scope of care provided throughout the CHCs. These standards are maintained at www.bvcaa.org/guidelines.html. The guidelines are routinely monitored and updated as needed to reflect the latest acceptable standards.

PROCEDURE: Pertinent to this policy is the “Routine Prenatal Care” guideline. See [Appendix 3](#) to this policy for pages 1-2 of this guideline which summarizes care expectations (Screening Maneuvers, Counseling Education Intervention and Immunization & Chemoprophylaxis) by weeks of gestation.

V. Missed Appointments

BVCAA staff will make an attempt to contact those patients who fail to keep their appointments and document interaction with patient in the EHR system.

PROCEDURE: See Admin Manual for “Missed Appointment Policy and Procedure”.

VI. New OB Packet

Each new obstetric client shall be given a “New OB Packet” at their initial OB visit which contains important pregnancy and child health-related documents, some mandated by the state law that patients receive. The New OB Packet Contents (see [Appendix 4](#)) lists required documentation that must be included in each packet. Other helpful items from local, state and medical resources may be included in the packet, when available.

PROCEDURE:

1. Each clinic site shall designate one or more staff members to assemble New OB Packets which must contain all items listed on the New OB Packet Contents list.
2. If a required item is not available as packets are being assembled, the clinic/practice manager should be notified immediately.
3. Providers should also be made aware if a New OB Packet is missing required documentation, and a note of missing item(s) should be made on the Plan Tab of the client’s OB Flow Sheet. Missing required documentation shall be offered at the clients next prenatal visit, and a note made in the client’s OB Flow Sheet as to the date the missing required document was given.

APPENDIX 1B

ABC Women's Clinic



Prenatal Client Contract

The Client agrees to:

- Be presentable for all prenatal visits which include clean personal hygiene, being properly dressed for all prenatal visits with provider, and be respectful toward the center staff.
- Be an active participant in prenatal education.
- Keep appointments, and if unable to keep appointment, will notify the center as soon as possible to cancel and reschedule appointment in a timely manner.
- Ask questions when instructions or information given by staff is not understood.
- Keep the center staff informed when address or telephone number is changed.
- Follow the health care plan the Nurse Practitioner and Physician have developed.
- Once the baby has been born, notify the center as soon as possible for a post-partum appointment.

The Community Health Center staff agrees to:

- Follow all center guidelines and provide safe, courteous, and individualized care.
- Maintain confidentiality of all information obtained.
- Provide information and services to help each client meet their health care needs.
- Assist in linking client to community resources, e.g., transportation, special services, etc.

Patient's signature

Date

Center Staff

Date

APPENDIX 1C



ABC WOMEN'S CENTER

AFP CONSENT

I understand that I have been offered the screening test that could detect birth defects. These tests include screening for:

- Neural Tube Defect
- Heart Defects
- Down syndrome
- Trisomy 18
- Abdominal Wall Defects
- Cystic Fibrosis

I have been given the opportunity to have the following tests and/or procedures:

- Ultrasound
- MSAFP (Triple Screen)
- Amniocentesis
- Cystic Fibrosis Genetic Screening

The risks and benefits of the above procedure(s) have been explained to me as well as the risks of NOT having the procedure(s) performed. I have been given the opportunity to discuss these procedures with my physician and ask questions.

I voluntarily consent **NOT** to be tested to detect these conditions. I understand my child may be at risk for congenital birth defects. I also understand that the risk by not performing these tests may be failure to detect these conditions.

Patient Signature

Date

Witness Signature

Date

APPENDIX 1D

Sterilization Consent Form
(Fax Consent Form to 1-512-514-4229)

Client Medicaid or Family Planning Number:		Date Client Signed: / / (month/day/year)	
<p>Notice: Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.</p> <p align="center">Consent to Sterilization</p> <p>I have asked for and received information about sterilization from <u>College Station CHC</u> (doctor or clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as Temporary Assistance for Needy Families (TANF) or Medicaid that I am now getting or for which I may become eligible.</p> <p>I understand that the sterilization must be considered permanent and not reversible. I have decided that I do not want to become pregnant, bear children or father children. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.</p> <p>I understand that I will be sterilized by an operation known as a <u>Tubal Sterilization</u> (specify type of operation). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.</p> <p>I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.</p> <p>I am at least 21 years of age and was born on ____ (month), ____ (day), ____ (year). I, _____, hereby consent of my own free will to be sterilized by <u>College Station CHC</u> (doctor or clinic) by a method called <u>Tubal Sterilization</u> (specify type of operation).</p> <p>My consent expires 180 days from the date of my signature below.</p> <p>I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health and Human Services or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed. I have received a copy of this form.</p>			
Client's Signature:		Date of Signature: / / (month/day/year)	
<p>Notice: You are requested to supply the following information, but it is not required.</p> <p align="center">Race and Ethnicity Designation</p> <p>Ethnicity <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Hispanic or Latino Race (mark one or more) <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> White</p> <p align="center">Interpreter's Statement</p> <p>If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice and presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she has understood this explanation.</p> <p>Interpreter's Signature: _____ Date of Signature: / / (month/day/year)</p> <p align="center">Statement of Person Obtaining Consent</p> <p>Before _____ (client's full name), signed the consent form, I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.</p> <p>Signature of Person Obtaining Consent: _____ Date of Signature: / / (month/day/year)</p> <p>Facility Name: <u>College Station CHC</u> Facility Address: <u>1651 Rock Prairie, Ste 102 College Station, TX 77840</u></p> <p align="center">Physician's Statement</p> <p>Shortly before I performed a sterilization operation upon _____ (name of individual to be sterilized), on ____ / ____ / ____ (date of sterilization), I explained to him/her the nature of the sterilization operation _____ (specify type of operation), the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it. I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent. I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds. To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.</p> <p>(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)</p> <p>(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.</p> <p>(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):</p> <p><input type="checkbox"/> Premature delivery - Individual's expected date of delivery: ____ / ____ / ____ (month, day, year)</p> <p><input type="checkbox"/> Emergency abdominal surgery (describe circumstances): _____</p> <p>Physician's Signature: _____ Date of Signature: / / (month/day/year)</p> <p align="center">Paperwork Reduction Act Statement</p> <p>According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0937-0166. The time required to complete this information collection is estimated to average 1 hour 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: U.S. Department of Health & Human Services, OS/OCIO/PRA, 200 Independence Ave., S.W., Suite 537-H, Washington D.C. 20201, Attention: PRA Reports Clearance Officer</p> <p align="right">HHS-687</p> <p align="center">All Fields in This Box Required for Processing</p> <p> IPI: _____ NPI: _____ Taxonomy: _____ Benefit Code: _____ Provider/Clinic Telephone: _____ Provider/Clinic Fax Number: _____ Title Billed (check one): <input type="checkbox"/> V <input type="checkbox"/> X <input type="checkbox"/> XIX (Medicaid) <input type="checkbox"/> XX </p>			

APPENDIX 2

Pregnancy List:

eClinicalWorks (Patel,Ritu)

File Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help

eClinicalWorks 8.0 E 0 S 0 D 1 R 4 T 0 L 0 M 6

Admin Practice

Progress Notes

TEST, OB, 22 Y, F | Sel | Info | Hub

Medical Summary | Alerts | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | Notes

SF [dropdown] PN Rel [dropdown] Default [dropdown] Encounters << V 10/20/2005

Patient: **OB TEST** DOB: **10/20/1988** Age: **17 Y** GA: [dropdown] EDD: [dropdown]
 Phone: **111-180-1818** G: 5 P: 3, 0, 1, 3
 Ethnicity: **Non-Hispanic**
 Address: [text area]
 Primary Insurance: [text area]
 Encounter Date: **10/20/2005** Req No: **129391.310377**
 Provider: **DAVELYN EAVES-HOOD, MD**
 Referring Provider: [text area]
 Language: **English**
 Interpretation Service Requested: **No**
 Father of Baby: **Johnny B Good**

[Print / Fax Flow Sheet...](#) [Order Sets](#) [Treatment](#)

[Problem List](#) | [EDD](#) | [Flow Sheet](#) | [Risks](#) | [Labs/Imaging](#) | [Rx](#) | [Plans](#) | [Physical](#) | [Graphs](#) | [Notes](#) | [Form A](#) | [Genetics](#) | [History](#) | [Post Partum](#)

Pregnancy List

Preg Id	Status	Father of Baby			Discharge Date	Print / Fax
		First Name	M. Initial	Last Name		
1	Open	Johnny	B	Good	[dropdown]	[Print / Fax]

[Close Pregnancy](#) [Save](#)

[Overview](#) | [History](#) | [OS](#) | [Labs](#) | [DI](#)

- Advance Directive
- Problem List
 - V22.2 Pregnant state, incidental
- Current Medications [Stop Date](#)
- Allergies
- Immunization

[Consent](#) | [Advance Directive](#) | [Patient and Center Rights and Responsibility](#) | [Scope of Services](#) | [Alcance de servicios](#) | [Rights and Responsibility](#)

[Registry](#) | [Referrals](#) | [Messages](#) | [Documents](#) | [Billing](#)

[start](#) | [Inbox - Microsoft Out...](#) | [Outlook Web App - W...](#) | [eClinicalWorks \(Patel,...](#) | [OB Flow Sheet Comp...](#) | 11:21 AM

EDD Tab:

TEST, OB, 22 Y, F | Sel | Info | Hub

Allergies Billing Alert

Appt(L): 10/20/05
Language: English
Translator: No

Ins: Self Pay
Acc Bal: \$0.00
Guar: OB TEST
Gr Bal: \$0.00

CLICK TO EDIT

SECURE N

Medical Summary | Alerts | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | N

SF Rel

Patient: OB TEST DOB: 10/20/1988 Age: 17 Y
Phone: 111-180-1818 G: 5 P: 3, 0, 1, 3
Ethnicity: Non-Hispanic
Address:
Primary Insurance:
Encounter Date: 10/20/2005 Req No: 129391.310377
Provider: DAVELYN EAVES-HOOD, MD
Referring Provider:
Language: English
Interpretation Service Requested: No
Father of Baby: Johnny B Good

GA: ED
Risk Assessment:

Problem List | **EDD** | Flow Sheet | Risks | Labs/Imaging | Rx | Plans | Physical | Graphs | Notes | Form A | Genetics | History | Postpartum

Initial EDD

	Date	Weeks	Days	EDD	
LMP	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Sel"/>
Initial Exam	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Sel"/>
Ultrasound	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Sel"/>

Initial EDD

Initials

EDD Update

	Date	Weeks	Days	EDD	
Ultrasound	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Sel"/>
Addl. Ultrasound	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Sel"/>
Addl. Ultrasound	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="button" value="Sel"/>

Final EDD

Initials

1. When adding date for LMP or other items under the EDD tab, you MUST use the drop down error for the system to use the date properly. Typing the date directly will cause significant errors than may not be correctable.
2. Initial EDD:
 - a. Click the "SEL" button to the immediate right of the dating criteria you wish to use (LMP, Initial Exam, or Ultrasound)
 - b. This will place a due date below "Initial EDD" and populate the blue box at the top of the flow sheet
 - c. Place your initials under Initial EDD and then click **SAVE**
 - d. Once you confirm the Initial EDD is also the Final EDD, click the "Make Final EDD" button immediately right of Initial EDD, add your initials under Final EDD and then click **SAVE**
3. EDD Update:
 - a. If change in dating is necessary after the initial visit, use the EDD Update section.
 - b. Click the "SEL" button to the immediate right of the updated dating criteria you wish to use.
 - c. This will place a due date below the Final EDD
 - d. Place your initials under Final EDD and then click **SAVE**
4. **Do NOT lock the EDD tab**

Form A:

eClinicalWorks (Patel,Ritu)

File Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help

ew eClinicalWorks 8.0

E 0 S 0 D 1 R 4 T 0 L 0 M 6

Admin Practice

Progress Notes

TEST, OB , 22 Y, F Set Info Hub

H:111-180-1818
 DOB:10/20/1988

Allergies: Billing Alert

Appt(L): 10/20/05
 Language: English
 Translator: No

Ins: Self Pav
 Acc Bal: \$0.00
 Guar: OB TEST
 Gr Bal: \$0.00

CLICK TO EDIT

SECURE NOTES

ADV DIRECTIVE

Medical Summary | Alerts | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | Notes

SF [dropdown] PN Rel [dropdown] Default Encounters [dropdown] 10/20/2005

Patient: **OB TEST** DOB: 10/20/1988 Age: 17 Y
 Phone: 111-180-1818 G: 5 P: 3, 0, 1, 3
 Ethnicity: **Non-Hispanic**
 Address:
 Primary Insurance:
 Encounter Date: 10/20/2005 Req No: 129391.310377
 Provider: **DAVELYN EAVES-HOOD, MD**
 Referring Provider:
 Language: **English**
 Interpretation Service Requested: **No**
 Father of Baby: **Johnny B Good**

GA: EDD:
Risk Assessment:

Print / Fax Flow Sheet... Order Sets Treatment

Problem List | EDD | Flow Sheet | Risks | Labs/Imaging | Rx | Plans | Physical | Graphs | Notes | **Form A** | Genetics | History | Post Partum

Previous Pregnancies
 (Enter only numbers in the fields below)

Total Preg.	5
Full Term	3
Premature	0
AB. Induced	0
AB. Spontaneous	1
Ectopics	0
Multiple Births	0
Living	3

Menstrual History

Menarche(Age onset)	11
LMP	12/01/2010
Frequency:Q	Month
HCG+Date	1/24/2010
On BCP At Concept	No

Lock Defaults Save

Past Pregnancies
 No Past Pregnancies Exists.

Overview History OS Labs|DI
 - Advance Directive
 - Problem List
 + V22.2 Pregnant state, incidental
 - Current Medications Stop Date
 - Allergies
 - Immunization

Registry Referrals Messages Documents Billing

start Inbox - Microsoft Out... Outlook Web App - W... eClinicalWorks (Patel,... OB Flow Sheet Comp... 11:20 AM

History, Gathered at Initial Visit:

HPI:

Initial Prenatal Visit

105 year old female presents with c/o initial pregnancy visit with our clinic at weeks gestation Unreviewed

Gravida _____. Para _____.

PMH affecting pregnancy

c/o Pertinent PMH

Genetic Screening

Previous child with genetic condition _____. Family member with genetic condition _____.

Adult Immunization Screening

c/o Influenza Vaccine c/o Tetanus c/o Hepatitis B c/o Immunizations patient wishes to receive today: **UNREVIEWED**

TB Questionnaire

c/o TB Exposure c/o Place of Birth c/o Travel c/o High-risk Exposure c/o Previous TB Test

TB TEST REQUIRED BASED ON SCREENING **UNREVIEWED**.

Current Medication:

Medical History:

Allergies/Intolerance:

Gyn History:

OB History:

- See OB Flow Sheet, for details

Surgical History:

Hospitalization:

Family History:

Social History:

ROS:

unremarkable upon review of major systems, see HPI above

Objective:

Vitals:

Past Results:

Examination:

GYN

Utilize the "BVCAA – Initial OB Visit" template and complete ALL sections.

- There are numerous questions in the Pertinent PMH section, so be sure to answer all of them.
- Genetic screening lists pertinent positives, if none present then select "None"
- Assessment and Billing section are pre-populated. Be sure to remove the ones that do not apply.
- Standard OB labs are pre-ordered. Labs may be added or removed, as appropriate.
- Do not lock this note until the labs results have been received. This will allow the results to appear on this H&P which will be important for patient's L&D records.

GENERAL: **UNREVIEWED**. HEENT: **UNREVIEWED**. NECK: **UNREVIEWED**. HEART: **UNREVIEWED**. LUNGS: **UNREVIEWED**. BREASTS: **UNREVIEWED**. ABDOMEN: **UNREVIEWED**. EXTERNAL GENITALIA: **UNREVIEWED**. VAGINA: **UNREVIEWED**. CERVIX: **UNREVIEWED**. UTERUS: **UNREVIEWED**. ADNEXA: **UNREVIEWED**. ANUS/PERINEUM: **UNREVIEWED**. EXTREMITIES: **UNREVIEWED**. SKIN: **UNREVIEWED**. DEEP TENDON REFLEXES **UNREVIEWED**.

Physical Examination:

Assessment:

Assessment:

- Supervision of normal first pregnancy - V22.0 (Primary)
- Supervision of other normal pregnancy - V22.1

Plan:

Treatment:

Procedures:

Immunizations:

Diagnostic Imaging:

Lab Reports:

Lab:***Pap Lb, Ct-Ng, rfx HPV ASCU***

Lab:***Urine Culture, Routine***

Lab:***HIV w/ WBlot Confirmation***

Lab:Prenatal Profile I

Lab:Drug Profile, Ur, 9 Drugs

Lab:IH - Urinalysis

Preventive Medicine:

Next Appointment:

Billing Information:

Visit Code:

- 99203 Office Visit, New Pt., Level 3.
- 99214 Office Visit, Est Pt., Level 4.

Procedure Codes:

Flow Sheet:

eClinicalWorks (Hood, Davelyn Eaves)

File Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help

eClinicalWorks 8.0

E 2 S 0 D 35 R 0 T 4 L 5 M 0

Admin Practice

TEST, OB, 22 Y, F Sel Info Hub

Medical Summary | Alerts | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | Notes

SF [dropdown] Rel [dropdown] Bulleted [dropdown] Encounters [dropdown] 10/20/2005 DEH

Patient: OB TEST DOB: 10/20/1988 Age: 17 Y
 Phone: 111-180-1818 G: 5 P: 3, 0, 1, 3
 Ethnicity: Non-Hispanic
 Address: [dropdown]
 Primary Insurance: [dropdown]
 Encounter Date: 10/20/
 Provider: DAVELYN EAV
 Referring Provider:
 Language: English
 Interpretation Service Re
 Father of Baby: Johnny

GA: [dropdown] EDD: [dropdown]
 Risk Assessment:

Print / Fax Flow Sheet

Problem List | EDD

Prenatal Flow Sheet

Date	Weeks Gest.	Weight

Add New Visit

Care Items Due (Def)

Name
New OB Panel
HIV, first
Pap Smear
GC/Chlamydia Scree
Sickle Cell Screen

Notes: Browse...

Save Visit Defaults Cancel

Treatment

Notes | Form A | Genetics | History | Post Partum | Preg List | Discharge

Preterm labor signs	Edema	Dilation (cms)	Effacement (%)	Presentation	Next Appt.	Notes	Initials

Status

Not Ordered	Order
on*** Not Ordered	Order
Not Ordered	Order
tion*** Not Ordered	Order
bility* Not Ordered	Order

- At each prenatal visit, including initial, Click "Add New Visit" button and document the information requested there.
- Be sure to place your initials in the appropriate box and click Save Visit.

Registry Referrals Messages Documents Billing

start eClinicalWorks (Hood, ... Hotmail - davyedoc... OB Flow Sheet Comp... Obstetric Services P&... How to print OB flow ... 2:37 PM

Risks:

TEST, OB , 22 Y, F | Sel | Info | Hub

Allergies Billing Alert

Appt(L): 10/20/05
Language: English
Translator: No

Ins: Self Pay
Acc Bal: \$0.00
Guar: OB TEST
Gr Bal: \$0.00

CLICK TO EDIT

SECURE NOTES

ADV DIRECTIVE

Medical Summary | Alerts | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | Notes

SF PN Re

Encounter Date: 10/20/2005 Req No: 129391.310377
 Provider: DAVELYN EAVES-HOOD, MD
 Referring Provider:
 Language: English
 Interpretation Service Requested: No
 Father of Baby: Johnny B Good

1. The Risk Tab includes an important risk assessment that should be completed at this initial prenatal visit and routinely reviewed to ensure proper documentation of potential or present risks.
2. When "Yes" is chosen from the drop down menu, that associated Risk automatically populates the blue box at the top of the flow sheet.

Print / Fax Flow Sheet... Order Sets Treatment

Problem List EDD Flow Sheet Risks Labs/Imaging Rx Plans Physical Graphs Notes Form A Genetics History Post Partum Preg List Discharge

Risk Assessment Lock Save

At Risk		Add to Problems
Uterine/Cervical Malformation	No	<input type="checkbox"/>
Suspect pelvis	No	<input type="checkbox"/>
Rh Negative (nonsensitized)	No	<input type="checkbox"/>
Anemia (HCT<30%:HGB<10%)	No	<input type="checkbox"/>
STI	No	<input type="checkbox"/>
Acute pyelonephritis	No	<input type="checkbox"/>
Failure to gain weight	No	<input type="checkbox"/>
Abnormal presentation	No	<input type="checkbox"/>
Postterm pregnancy	No	<input type="checkbox"/>
History of Shoulder Dystocia	No	<input type="checkbox"/>
History of Postpartum Depression	No	<input type="checkbox"/>
Previous C-section	No	<input type="checkbox"/>

High Risk	
Diabetes mellitus	No
Hypertension	No
Thrombophlebitis	No
Placenta Previa	No
Herpes	No
Rh sensitization	No
Uterine bleeding	No
Hydraminos	No
Severe preeclampsia	No
Fetal growth retardation	No
Premature rupt. membranes	No
Multiple Preterm Pregnancies	No
Alcohol and drug abuse	No
Desires tubal ligation	No
Advanced Maternal Age	No
Teen Pregnancy	No
Grandmultiparity	No
Previous C-section	No

Lock Save

Problem List:

The screenshot shows the eClinicalWorks interface for a patient named OB TEST. The main content area is divided into several sections:

- Header:** Includes patient information (TEST, OB, 22 Y, F) and navigation options (Sel, Info, Hub).
- Medical Summary:** A large blue shaded area containing patient details such as GA (EDD), Risk Assessment, and various medical history notes.
- Problem List:** A table with columns for Problem Date Identified, Problem, Progress Note, and Entered By. An "Add Problem" button is located below the table.
- Overview Panel:** A sidebar on the right with tabs for Overview, History, OS, Labs, and DI. It lists various medical categories like Advance Directive, Problem List, Current Medications, Allergies, and Immunization.

A callout box with a black border and white background contains the following text:

Problem list is used to track pertinent problems that may affect the pregnancy. Whatever gets added to this tab will show in the blue shaded section that is always visible no matter which tab you are on.

Plan:

First Trimester	Defaults	Clear
Initial OB packet given & clinic routine discussed	<input type="text"/>	<input type="text"/>
Information for Parents of Newborns resource guide given to patient	<input type="text"/>	<input type="text"/>
Rights & Responsibilities; Prenatal Client Contract	<input type="text"/>	<input type="text"/>
Routine prenatal care / Physical changes / Fetal development	<input type="text"/>	<input type="text"/>
Nutrition / WIC / weight gain counseling	<input type="text"/>	<input type="text"/>
Breastfeeding encouraged	<input type="text"/>	<input type="text"/>
Substance Abuse (alcohol / tobacco / drugs)	<input type="text"/>	<input type="text"/>
Assessed risk for abuse / trauma / family violence	<input type="text"/>	<input type="text"/>
Danger signs / Problems / Emergency care	<input type="text"/>	<input type="text"/>
STI testing, including HIV, in pregnancy	<input type="text"/>	<input type="text"/>
Sexual activity, including safe safe and STI prevention	<input type="text"/>	<input type="text"/>
Health promotion, including dental care and immunizations	<input type="text"/>	<input type="text"/>
Exercise / Activity / Rest	<input type="text"/>	<input type="text"/>
Discomfort / relief measures discussed	<input type="text"/>	<input type="text"/>
Medications safe to use in pregnancy (incl. supplements, vitamins,herbs or otc drugs)	<input type="text"/>	<input type="text"/>
Toxoplasmosis precautions(cats/raw meat)	<input type="text"/>	<input type="text"/>
Environmental / X-ray hazards	<input type="text"/>	<input type="text"/>
Travel	<input type="text"/>	<input type="text"/>
Injury prevention / safe seat belt use	<input type="text"/>	<input type="text"/>

1. Education and care reminders, separated by trimester, are located under the Plans Tab.
2. These items are not optional. Based on state law and/or funding regulations, each item MUST be addressed.
3. Documentation is accomplished by using the drop down arrow to reveal a calendar. Choose the date the item was addressed.

Medicaid Referral (Emergency MCD)	<input type="text"/>	<input type="text"/>
Desire for sterilization addressed	<input type="text"/>	<input type="text"/>
Depression screening done	<input type="text"/>	<input type="text"/>

Second Trimester Defaults Clear

Fetal movement, kick counts	<input type="text"/>	<input type="text"/>
Signs / symptoms of preterm labor	<input type="text"/>	<input type="text"/>
Childbirth classes	<input type="text"/>	<input type="text"/>
Breastfeeding encouraged	<input type="text"/>	<input type="text"/>
Delivery arrangements	<input type="text"/>	<input type="text"/>
Umbilical Cord Blood Donation brochure given	<input type="text"/>	<input type="text"/>
Postpartum family planning	<input type="text"/>	<input type="text"/>

Third Trimester Defaults Clear

3rd Trimester, State-Mandated HIV Testing Verbal Consent	<input type="text"/>	<input type="text"/>
Labor signs	<input type="text"/>	<input type="text"/>
Fetal movement, kick counts	<input type="text"/>	<input type="text"/>
Signs / Symptoms of PIH	<input type="text"/>	<input type="text"/>
Anesthesia / Analgesia plans	<input type="text"/>	<input type="text"/>
Newborn care / Parenting / Selecting a pediatrician	<input type="text"/>	<input type="text"/>
Breastfeeding encouraged	<input type="text"/>	<input type="text"/>

Circumcision	<input type="text"/>	<input type="text"/>
Newborn car seat	<input type="text"/>	<input type="text"/>
Depression screening done	<input type="text"/>	<input type="text"/>
Post-partum depression / Resource list	<input type="text"/>	<input type="text"/>
Desires for post-partum family planning discussed	<input type="text"/>	<input type="text"/>
Assessed risk for abuse / trauma / family violence	<input type="text"/>	<input type="text"/>

Lock Defaults All Save

Care Items:

Template : [Default Template] Apply Template

GA: 0 Wks

Care Item	ASAP	16 - 20	19 - 20	24 - 28	28 - 32	35 - 37
New OB Panel	Red					
HIV, first	Red					
HIV, repeat					White	
Pap Smear	Red					
GC/Chlamydia Screen	Red					
AFP/QuadScreen		White				
Sickle Cell Screen	Red					
1 hr GTT				White		
Anatomy Scan			White			
GBS						White

Close Window

Care Items allow you to look at a one glance to see what items the patient may be due to have done:

- All patients should begin with the Default Care Item Template. Templates also exist for Gestational Diabetes and Rh Negative patients.
- Once the patient has been determined to fit either the Gestational DM or Rh Negative template:
 - Click the drop-down arrow to the immediate right of "Default Template" box.
 - Choose the appropriate template
 - Click "Apply Template" button
- If item is ordered from the Care Item Screen, the color of the bar will change:
 - Red is "Due / Past Due"
 - White is "Not Due"
 - Green is "Done"

If the items are not ordered from the Care Items section, then the item will remain on the page.

Template : [Gestation DM] Apply Template

GA: 0 Wks

Care Item	ASAP	16 - 20	19 - 20	28 - 32	28 - 30	33 - 34	34 - 36
New OB Panel	Red						
HIV, first	Red						
HIV, repeat				White			
Pap Smear	Red						
GC/Chlamydia Screen	Red						
AFP/QuadScreen		White					
Sickle Cell Screen	Red						
1 hr GTT					White		
Anatomy Scan			White				
GBS							White
Diabetes Education					White		
Dietician (@ CSMC)					White		
Begin Weekly NST						White	

Close Window

Template : [Rh Negative] Apply Template

GA: 0 Wks

Care Item	ASAP	16 - 20	19 - 20	24 - 28	28 - 30	35 - 37
New OB Panel	Red					
HIV, first	Red					
HIV, repeat					White	
Pap Smear	Red					
GC/Chlamydia Screen	Red					
AFP/QuadScreen		White				
Sickle Cell Screen	Red					
1 hr GTT				White		
Anatomy Scan			White			
GBS						White
RhoGam					White	
Repeat Coombs				White		

Close Window

Labs/Imaging:

The screenshot displays the eClinicalWorks interface for a patient named OB TEST. The patient's information includes DOB: 10/20/1988, Age: 17 Y, and Ethnicity: Non-Hispanic. The encounter date is 10/20/2005. The provider is DAVELYN EAVES-HOOD, MD. The father of the baby is Johnny B Good. The interface shows a 'Labs/Imaging' tab selected, with options to 'Order Labs' and 'Order Imaging'. A text box at the bottom right provides instructions on how to order labs and diagnostic imaging.

1. Labs and diagnostic imaging can be ordered from Labs/Imaging Tab OR via Treatment button OR switching to Progress Note format via the PN / FS button and ordering via the Treatment section there OR using the Treatment section under the Rx tab.

2. All labs and diagnostic imaging orders and attached reports will reside in the Labs/Imaging Tab.

Rx:

The screenshot displays the eClinicalWorks interface for a patient named OB TEST. The top navigation bar includes 'File', 'Patient', 'Schedule', 'EMR', 'Billing', 'Reports', 'Fax', 'Tools', 'Community', 'Lock Workstation', and 'Help'. The patient's name and demographic information are shown: 'TEST, OB, 22 Y, F'. Key data points include: Allergies: Billing Alert; Apppt(L): 10/20/05; Language: English; Translator: No; Ins: Self Pay; Acc Bal: \$0.00; Guar: OB TEST; Gr Bal: \$0.00. A 'CLICK TO EDIT' button is visible. The patient's encounter date is 10/20/2005. The main content area shows patient details: OB TEST, DOB: 10/20/1988, Age: 17 Y, GA: EDD: Risk Assessment. The 'Current Medication(s):' section is highlighted, and the 'Rx' tab is selected. The 'Allergies:' and 'Treatment:' sections are also visible. The bottom of the screen shows the Windows taskbar with the Start button and several open applications: 'Inbox - Microsoft Out...', 'Outlook Web App - W...', 'eClinicalWorks (Patel, ...)', and 'OB Flow Sheet Comp...'. The system clock shows 11:19 AM.

Rx Tab can be where Current Medications are logged, Allergies are notated and new medications may be prescribed via the Treatment section (Remember, other "Treatment" sections exist for ordering Rx, Labs, DI, etc. throughout the system.)

However, the Progress Note (PN) is the best place to document these items during the Initial Prenatal Visit.

Graphs: (self explanatory)

eClinicalWorks (Patel,Ritu)

File Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help

eClinicalWorks 8.0

E 0 S 0 D 1 R 4 T 0 L 0 M 6

Admin Practice

TEST, OB , 22 Y, F Sel Info Hub

H: 111-180-1818
DOB: 10/20/1988

Allergies
Billing Alert

Appt(L): 10/20/05
Language: English
Translator: No

Ins: Self Pay
Acc Bal: \$0.00
Guar: OB TEST
Gr Bal: \$0.00

CLICK TO EDIT

SECURE NOTES

ADV DIRECTIVE

Medical Summary | Alerts | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | Notes

SF [dropdown] PN Rel [dropdown] Default [dropdown] Encounters << V 10/20/2005

Patient: OB TEST DOB: 10/20/1988 Age: 17 Y
Phone: 111-180-1818 G: 5 P: 3, 0, 1, 3
Ethnicity: Non-Hispanic
Address:
Primary Insurance:
Encounter Date: 10/20/2005 Req No: 129391.310377
Provider: DAVELYN EAVES-HOOD, MD
Referring Provider:
Language: English
Interpretation Service Requested: No
Father of Baby: Johnny B Good

GA: EDD:
Risk Assessment:

Print / Fax Flow Sheet... Order Sets Treatment

Problem List | EDD | Flow Sheet | Risks | Labs/Imaging | Rx | Plans | Physical | Graphs | Notes | Form A | Genetics | History | Post Partum

Show Custom Graph

Weight Graph

Visit Date	Weight (lbs)
10/20/2005	0.45

Overview History OS Labs | DI

- Advance Directive
- Problem List
V22.2 Pregnant state, incidental
- Current Medications Stop Date
- Allergies
- Immunization

Registry Referrals Messages Documents Billing

start | Inbox - Microsoft Out... | Outlook Web App - W... | eClinicalWorks (Patel, ... | OB Flow Sheet Comp... | 11:19 AM

Notes: (place to add additional information about any visit – more space)

eClinicalWorks (Patel,Ritu)

File Patient Schedule EMR Billing Reports Fax Tools Community Lock Workstation Help

eClinicalWorks 8.0 E 0 S 0 D 1 R 4 T 0 L 0 M 6

Admin Practice

TEST, OB , 22 Y, F Sel Info Hub

H: 111-180-1818
DOB: 10/20/1988

Allergies
Billing Alert

Appt(L): 10/20/05
Language: English
Translator: No

Ins: Self Pay
Acc Bal: \$0.00
Guar: OB TEST
Gr Bal: \$0.00

CLICK TO EDIT

SECURE NOTES

ADV DIRECTIVE

Medical Summary | Alerts | Labs | DI | Procedures | Growth Chart | Immunization | Encounters | Patient Docs | Flowsheets | Notes

SF [dropdown] PN Rel [dropdown] Default Encounters << V 10/20/2005

Patient: **OB TEST** DOB: **10/20/1988** Age: **17 Y** GA: EDD:
Phone: **111-180-1818** G: 5 P: 3, 0, 1, 3
Ethnicity: **Non-Hispanic**
Address:
Primary Insurance:
Encounter Date: **10/20/2005** Req No: **129391.310377**
Provider: **DAVELYN EAVES-HOOD, MD**
Referring Provider:
Language: **English**
Interpretation Service Requested: **No**
Father of Baby: **Johnny B Good**

Print / Fax Flow Sheet... Order Sets Treatment

Problem List | EDD | Flow Sheet | Risks | Labs/Imaging | Rx | Plans | Physical | Graphs | Notes | Form A | Genetics | History | Post Partum

No Notes available.

Enter Notes : [Browse...](#)

Add to Notes

HPI Notes:

Patient Encounters [Show All](#)

No Patient Encounters Found

Overview History OS Labs | DI

- Advance Directive
- Problem List
V22.2 Pregnant state, incidental
- Current Medications Stop Date
- Allergies
- Immunization

Registry Referrals Messages Documents Billing

Consent Advance Directive Patient and Center Rights and Responsibility Scope of Services Alcance de Servicios Rights and Responsibility

start | Inbox - Microsoft Out... | Outlook Web App - W... | eClinicalWorks (Patel,...) | OB Flow Sheet Comp... | 11:20 AM

Post Partum:

HPI: ▼

Postpartum

Delivery: Date . Delivery by: **UNREVIEWED**. Maternal complications: **UNREVIEWED**. Newborn complications: **UNREVIEWED**. Mother and Infant Bonding: **UNREVIEWED**. Postpartum course: **UNREVIEWED**. Infant feeding: **UNREVIEWED**. Contraception plan: **UNREVIEWED**.

Depression Screening

c/o PHQ-2

ROS: ▼

unremarkable upon review of major systems, see HPI above

Objective:

Examination: ▼

GYN

HEART: **UNREVIEWED**. LUNGS: **UNREVIEWED**. BREASTS: **UNREVIEWED**. ABDOMEN: **UNREVIEWED**. EXTERNAL GENITALIA: **UNREVIEWED**. VAGINA: **UNREVIEWED**. CERVIX: **UNREVIEWED**. UTERUS: **UNREVIEWED**. ADNEXA: **UNREVIEWED**. ANUS/PERINEUM: **UNREVIEWED**. EXTREMITIES: **UNREVIEWED**.

Assessment:

Assessment: ▼

- Routine postpartum follow-up - V24.2 (Primary)

Plan:

Preventive Medicine:

Postpartum: Normal physiologic body changes following delivery . Signs and symptoms of common complications discussed . Care of the breast discussed . Care of the perineum and/or abdominal incision discussed . Advancement of physical activity and exercise discussed . Resumption of sexual activity discussed . Family planning discussed . Postpartum depression discussed .

Next Appointment:

Billing Information:

Visit Code:

- 99213 Office Visit, Est Pt., Level 3.

Discharge:

TEST, OB	Sel	Info	Hub	PM	Rel	Bulleted	Encounters	V 10/20/2005 DEH
Delivery Dates				Neonatal Info				
Delivery Date	<input type="text"/>			Father of Baby	<input type="text"/>			
Discharge Date	<input type="text"/>			Sex	<input type="text"/>			
Delivery at(weeks)	<input type="text"/>			If male, circumcision	<input type="text"/>			
Intrapartum Complications								
None	<input type="text"/>			Disposition	<input type="text"/>			
Hemorrhage	<input type="text"/>			Name of baby	<input type="text"/>			
Infection	<input type="text"/>			Complications/Anamolies	<input type="text"/>			
Hypertension	<input type="text"/>			Birth weight by <u>grams</u>	<input type="text"/>			
Other	<input type="text"/>			Birth weight by grams-baby 2	<input type="text"/>			
Delivery Info								
Labor	<input type="text"/>			Birth weight by grams-baby 3	<input type="text"/>			
Anesthesia	<input type="text"/>			Birth weight by grams-baby 4	<input type="text"/>			
Vaginal	<input type="text"/>			Birth weight by grams-baby 5	<input type="text"/>			
Cesarean	<input type="text"/>			Birth weight by grams-baby 6	<input type="text"/>			
Tubal Sterilization	<input type="text"/>			Birth weight by grams-baby 7	<input type="text"/>			
Note	<input type="text"/>			Birth weight by grams-baby 8	<input type="text"/>			
Delivered By	<input type="text"/>			Outcome Baby 1	<input type="text"/>			
Delivered by Grantee Provider	<input type="text"/>			Outcome Baby 2	<input type="text"/>			
				Outcome Baby 3	<input type="text"/>			
				Outcome Baby 4	<input type="text"/>			
				Outcome Baby 5	<input type="text"/>			
				Outcome Baby 6	<input type="text"/>			

The starred areas on this page must be completed before closing the pregnancy. In particular, birth weight **MUST** be documented in grams. If it is not, it will negatively affect required reports to the federal government that we are required to make each year. It can be completed by nursing or provider when then delivery note is scanned into the patient's chart.

The remaining information is best captured on the postpartum visit template.

APPENDIX 3

Health Care Guideline:
Routine Prenatal Care

Event 1	Preconception Visit 2	Visit 1 3 6-8 weeks **	Visit 2 10-12 weeks	Visit 3 16-18 weeks	Visit 4 22 weeks
Screening Maneuvers	Risk profiles 4 Height and weight/BMI 5 Blood pressure 6 History and physical 7 Cholesterol & HDL 2 Cervical cancer screening 2 Rubella/ rubeola 8 Varicella 9 Domestic violence 10 Depression 11	Risk profiles 4 GC/Chlamydia 4 Height and weight/BMI 5 Blood pressure 6 History and physical 7* Rubella 8 Varicella 9 Domestic violence 10 Depression 11 CBC 16 ABO/Rh/ Ab 17 Syphilis 18 Urine culture 19 HIV 20 [Blood lead screening 21] [VBAC 22] Viral hepatitis 26	Weight 5 Blood pressure 6 Fetal aneuploidy screening 24 Fetal heart tones 28	Weight 5 Blood pressure 6 Depression 11 Fetal aneuploidy screening 24 Fetal heart tones 28 OB Ultrasound (optional) 29 Fundal height 30	Weight 5 Blood pressure 6 Fetal heart tones 28 Fundal height 30
Counseling Education Intervention	Preterm labor education and prevention 12 Substance use 2 Nutrition and weight 2 Domestic violence 10 List of medications, herbal supplements, vitamins 13 Accurate recording of menstrual dates 14	Preterm labor education and prevention 12 Prenatal and lifestyle education 23 • Physical activity • Nutrition • Follow-up of modifiable risk factors • Nausea and vomiting • Warning signs • Course of care • Physiology of pregnancy Discuss fetal aneuploidy screening 24	Preterm labor education and prevention 12 Prenatal and lifestyle education 23 • Fetal growth • Review labs from visit 1 • Breastfeeding • Nausea and vomiting • Physiology of pregnancy • Follow-up of modifiable risk factors	Preterm labor education and prevention 12 Prenatal and lifestyle education 23 • Follow-up of modifiable risk factors • Physiology of pregnancy • Second-trimester growth • Quickening	Preterm labor education and prevention 12 Prenatal and lifestyle education 23 • Follow-up of modifiable risk factors • Classes • Family issues • Length of stay • Gestational diabetes • mellitus 32 (GDM) • [RhoGam 17]
Immunization & Chemoprophylaxis	Tetanus booster 7, 27 Rubella/ MMR 4 [Varicella/VZIG 9] Hepatitis B vaccine 7, 26 Folic acid supplement 15	Tetanus booster 7, 27 Nutritional supplements 25 Influenza 27 [Varicella /VZIG 9] [Pertussis 27]			

Numbers refer to specific annotations.

[Bracketed] items refer to high-risk groups only.

* It is acceptable for the history and physical and laboratory tests listed under Visit 1 to be deferred to Visit 2 with the agreement of both the patient and the provider.

** Should also include all subjects listed for the preconception visit if none occurred.

Event	Visit 5 28 weeks	Visit 6 32 weeks	Visit 7 36 weeks	Visit 8-11 38-41 weeks
Screening Maneuvers	Preterm labor risk 4 Weight 5 Blood pressure 6 Depression 11 Fetal heart tones 28 Fundal height 30 Gestational diabetes mellitus (GDM) 32 Domestic abuse 10 [Rh antibody status 17] [Hepatitis B, Ag 2b] [GC/Chlamydia 4]	Weight 5 Blood pressure 6 Fetal heart tones 28 Fundal height 30	Weight 5 Blood pressure 6 Fetal heart tones 28 Fundal height 30 Cervix exam 34 Confirm fetal position 35 Culture for group B streptococcus 36	Weight 5 Blood pressure 6 Fetal heart tones 28 Fundal height 30 Cervix exam 34
Counseling Education Intervention	Psychosocial risk factors 4 Preterm labor education and prevention 12 Prenatal & lifestyle education 23 <ul style="list-style-type: none"> • Follow-up modifiable risk factors • Work • Physiology of pregnancy • Preregistration • Fetal growth Awareness of fetal movement 33	Preterm labor education and prevention 12 Prenatal & lifestyle education 23 <ul style="list-style-type: none"> • Follow-up of modifiable risk factors • Travel • Contraception • Sexuality • Pediatric care • Episiotomy Labor & delivery issues Warning signs / pregnancy-induced hypertension [VBAC 22]	Prenatal & lifestyle education 23 <ul style="list-style-type: none"> • Follow-up of modifiable risk factors • Postpartum care • Management of late pregnancy symptoms • Contraception • When to call provider • Discussion of postpartum depression 	Prenatal & lifestyle education 23 <ul style="list-style-type: none"> • Follow-up of modifiable risk factors • Postpartum vaccinations • Infant CPR • Post-term management Labor & delivery update
Immunization & Chemoprophylaxis	[ABO/Rh/ Ab 17] [RhoGAM 17]			

Numbers refer to specific annotations.

[Bracketed] items refer to high-risk groups only.

APPENDIX 4

OB Packet To Contain:

- 1) OB prenatal guide information
- 2) **A parent's guide to raising healthy,happy children/calendar (Mandatory)**
- 3) **Umbilical cord blood donation-DSHS stock #6-73 (Mandatory)**
- 4) **Information for parents of Newborns-DSHS stock# 1-316 (Mandatory)**
- 5) **Folic Acid –CDC stock# 099-5141,099-6767 (Mandatory)**
- 6) **Pertussis Information (Mandatory)**
- 7) **Shaken Baby Syndrome Information (Mandatory)**
- 8) Mama's Club information/ parenting classes(provided by Aggieland Pregnancy Outreach)
- 9) Tobacco/substance abuse information
- 10) Breastfeeding information
- 11) Immunization information for adult/newborns
- 12) Babytalk magazine w/samples (ordering information go to www.babytalk.com)
- 13) STD facts-DSHS stock# 6-40
- 14) Safe medication List
- 15) HPV/Gardasil handout
- 16) A more comfortable pregnancy DSHS stock#13-172
- 17) Prevent Anemia-DSHS stock#13-67
- 18) Parent's guide to childhood immunizations-CDC
- 19) Clinic Provider flyer
- 20) WHP pamphlet