Antenatal Care Schedule
Midwife-led care

Women who are deemed Low Risk according to the Consultation and Referral Guidelines

***Midwife Led care* may be cared for in accordance with the following visit schedule.**

Visits may be by phone, telehealth or in person. (dependent on clinical need or situation)

AT EACH VISIT THE FOLLOWING WILL BE REVIEWED:

- History reviewed
- Standard antenatal examination – BP, FHR, S-F height, palpation
- Discuss and/or offer investigations as indicated
- Provide information according to clinical situation and as directed by the woman
- Arrange ongoing care
- Document in BOS Management Plan and print out notes

12-16 weeks: First visit with a Midwife and Doctor at Ballarat Health (phone booking prior)

- Obtain a health and Maternity history. Check current wellbeing. Confirm due date. Check screening tests results
- Measure weight and height. Calculate BMI
- Check blood pressure and fetal heart rate (if above 18 weeks, otherwise US in MOP to confirm)
- Consider need for FWT
- Check Test Results including:
  - Blood group and antibody screen, blood count, iron levels, thalassaemia screening, diabetes testing, vitamin D, infections in pregnancy, 1st trimester screening
  - If first trimester screening not done – offer NIPT/second trimester MSST
- Complete ICOPE, discuss safety at home and substance use, smokelyser breath test reading; complete Psychosocial assessment on BOS
- Discuss Aspirin/Caltrate if risk factors present
- Complete referrals as indicated
- Discuss options for maternity care and visit schedule
- Book Child Birth Education Class or online videos – see BHS website
- Administer flu vaccine if woman consents
- Doctor review – **request 28 week and 36-week pathology & morphology scan**
  - Model of care confirmed
  - FGR risk assessment and document
  - BMI>30 management if applicable
  - VTE prophylaxis
  - Correspondence Letter to GP
  - Management plan made and document in BOS

20 weeks: Midwife

- Review morphology ultrasound; note cervical length measurement (see flow chart if length is less than 35mm Transabdominally)
- Ensure Drs have ordered FBE/antibodies/OGTT/Iron studies to be completed at 28 weeks
- Administer Pertussis vaccination from 20 weeks

24 weeks: Midwife

- Discuss healthy diet, regular exercise and Pelvic floor exercises
- Administer Pertussis vaccination if not given previously
- Education checklist in BOS

28 weeks: Obstetric Review

- Provide handout Safe pregnancy and Movement matter brochure, discuss movements and settling to sleep on side
- Check results of investigations -GTT, FBE, antibodies, iron studies
- Administer Anti-D immunoglobulin if required – must have recent antibody test

31 weeks: Midwife

- Begin to discuss labour, birth, third stage and early parenting
- Repeat smokelyser breath test reading

34 weeks: Midwife

- GBS swab explained
- Give NST handout; hearing screen, Infant Hep B and Vit K pamphlet
- Discuss preparation for labour, birth and parenting planning, tailored towards the individual needs of the woman.
- Discuss Domcare - subcontracted service if out of region
- Review birth options/plans/support people
- Offer families birth suite/postnatal ward tour – 1st Sunday of month at 2pm
- Discuss non-pharmacological methods of pain relief at home
- Anti-D immunoglobulin given. No antibody screen required at 34/40 anti-D
- 36 week checklist –excluding GBS swab
- Provide information for expressing breast milk and provide kit (commence 36 wks)
- Request FBE/Iron studies

36 weeks: Obstetric review

- Discuss GBS swab and collect as required
- Review FBE/Iron studies
- If BMI >35 discuss possible IOL and rebook to Doctor

38 weeks: Midwife

- Discuss labour, regular contractions and SROM; when to come to hospital and other relevant information
- Discuss delayed cord clamping/blood gases

40 weeks: Midwife

- Request US for AFI/SD (b/w 40-41weeks)
- IOL booking request form
- Provide BHS 'Induction of labour' information sheet and RANCOG IOL brochure
- Consider Membrane stretch and sweep

41 weeks: Obstetric Review

- Review CTG and ultrasound
- VE to assess 'Bishop score' and consider 'stretch and sweep'

- CTG second daily from 41 weeks – in MOP
- AFI twice weekly from 41 weeks – in MOP (bedside Ultrasound)

Consultation and Referral Guidelines

Grampians Health Ballarat (Level 5) Traffic Light Consultation and Referral System

GREEN	**ACCEPT -** Suitable for midwifery-led care
AMBER	**REFER -** Requires consultation with Obstetrician. Following Obstetric consultation may be suitable to continue midwifery-led care or may require an individualised plan of care with additional Obstetric/Medical/Allied health reviews.
RED	**CONSULT -** Not suitable for midwifery-led care. Requires referral for Obstetric-led Care with midwifery support and/or transfer to a higher-level service.

This traffic light assessment tool supports flexibility and enables progression of care through risk categories as appropriate depending on condition and clinical presentation.

GREEN - ACCEPT

Normal risk pregnancies are considered 'Green' and are suitable for low risk models of care. All care should be provided within the clinician's professional scope of practice and within Grampians Health policies and procedures. Appropriate use of the traffic light tool should occur if a woman's pregnancy risk alters from normal risk and requires escalation.

AMBER - CONSULT

Pregnancies that are 'Amber' may be suitable for midwifery-led care in consultation with the Obstetrician. These women are flagged as Amber for various reasons and may require increased monitoring during their pregnancy. Increased monitoring may include additional pregnancy reviews and testing, transfer to Obstetrician-led care models and consultation with Medical Specialists/allied health.

Referral for any level of consultation should be clearly documented in the woman's clinical record including an individualised care plan and any change or transfer of care responsibility.

RED - REFER

Pregnancies that are 'Red' are identified as high-risk by the health service and are considered unsuitable for midwifery-led care. Transfer to the Obstetric Collaborative Care pathway is required.

Booking Assessment – Past Medical History	
Age	
<16 years	
17-24 years	
25-39 years	
>40 years	
Anaesthetic difficulties	
Previous failure or complication (e.g. difficult intubation) request anaesthetic consultation and referral	
Malignant hyperthermia or neuromuscular disease	
Body Mass Index (BMI) at booking	
BMI >17 or <30	
BMI 30-35 (refer to dietician/allied health)	
BMI <19 refer to dietitian	
BMI 35-50+	
Connective Tissue /System diseases	
Rare disorders such as: Systemic Lupus Erythematosus (SLE) Anti-phospholipid syndrome, Scleroderma, Rheumatoid arthritis, Periarteritis nodosa, Marfan's Syndrome, Raynaud's disease	
Cardiovascular	
Cardiovascular Disease	
Essential hypertension	
Drug dependence or misuse	
Alcohol consumption	
Drug use	
Smoking	
Endocrine	
Diabetes Mellitus – requiring insulin or oral medication	
Endocrine disorder requiring treatment such as: Addison's Disease, Cushing's Disease or other	
History of Gestational Diabetes Mellitus	
Pre-existing type 2 Diabetes Mellitus– diet controlled	
Subclinical Hypothyroidism	
Hypothyroidism	
Hyperthyroididsm	
Gastrointestinal	
Bariatric surgery	
Hepatitis B with positive serology (Hep B S AG+)	
Hepatitis C (Hep C Antibody + with active viral load)	
Hepatitis C (Hep C Antibody + with **no** active viral load)	
Inflammatory Bowel Disease including ulcerative colitis and Crohn's disease	
Genetic – any condition	
Haematological	
Acute/Current DVT or pulmonary embolism	
Anaemia at booking defined as Hb<100g/dl	
Anaemia at booking defined as Hb<90g/dl	
Coagulation disorders including Von Willebrand's	
Haemoglobinopathy	
Haemolytic/Megaloblastic/Sickle Cell anaemia	
Other antibodies	
Previous Hx of Deep Vein Thrombosis (DVT) or Pulmonary Embolism in pregnancy	
Rhesus antibodies	
Rhesus Negative blood group	
Thalassaemia	
Thrombocytopenia	
Thrombo-embolic process (family history)	
Thrombophilia (any type)	
Women declining use of blood products	
Infectious Diseases	
Any recent history of a viral, microbial parasitic infection	
Cytomegalovirus (active)	

Hepatitis A/B/C/D/E	
Herpes genitalis (primary infection)	
Herpes genitalis (recurrent infection)	
HIV infection	
Parvo-virus (active)	
Rubella (active)	
Syphilis - Positive serology and not yet treated	
Syphilis - Positive serology and treated	
Syphilis - Primary infection	
Toxoplasmosis	
Tuberculosis (active history of)	
Varicella/Zoster virus infection (active)	
Malignancy – current or previous history	
Mental Health Disorders	
EDPS at booking >12	
History or current mental health disorder with **main care provider** GP	
History or current mental health disorder with **main care provider** psychiatrist/primary mental health care team	
Pica	
Musculo-skeletal	
Pelvic deformities including previous trauma, symphysis rupture, rachitis	
Spinal deformities (e.g. scoliosis, slipped disc, etc) arrange anaesthetic review	
Neurological	
AV malformations	
Epilepsy with medication and/or seizure(s) in the last 12 months	
Epilepsy without medication and no seizures within the last 12 months	
Multiple sclerosis	

Muscular dystrophy or myotonic dystrophy	
Myasthenia gravis	
Spinal cord lesion (para or quadriplegia)	
Subarachnoid haemorrhage, aneurysms (history of)	
Organ Transplant (any)	
Renal function disorders	
Disorder in renal function with or without dialysis	
Urinary tract infections (recurrent/symptomatic)	
Respiratory disease	
Mild asthma	
Moderate asthma (oral steroids in the past year and/or maintenance therapy)	
Severe lung function disorder	
Pre-existing Gynaecological Disorders	
Cervical abnormalities	
Abnormalities in cervix cytology (diagnosed/follow up)	
Cervical surgery / cone biopsy	
Cervical Surgery with Subsequent vaginal birth	
Other cervical surgery	
Pelvic floor reconstruction	
Colposuspension following prolapsed uterus (if considering vaginal birth)	
Fistula and / or previous rupture and vaginal repair	
Uterine abnormalities	
Bicornuate uterus	
Myomectomy	
Other	
Infertility treatment (this pregnancy)	
Intra Uterine Contraceptive Device (IUCD) insitu	

Past Obstetric History	
Caesarean Section (any)	
Cardiac issues	
Cervical weakness including cerclage	
Cholestasis	
Endocrine	
Gestational diabetes – diet	
Gestational diabetes – insulin or uncontrolled	
Fetal growth disturbance	
History of Fetal Death in Utero	
Macrosomia > 4.5kg	
Previous baby > 4.0 kg	
Previous baby diagnosed FGR and/or <2.5kg	
Grandmultiparity >5	
Hypertensive disorders	
Eclampsia / HELLP syndrome	
Hypertension	
Pre-eclampsia	
Instrumental birth – forceps or vacuum	
Pelvic floor dysfunction	
Dyspareunia	
Urinary incontinence	
faecal incontinence	
Perineal trauma	
3rd/4th degree tear	
Haematoma requiring surgery	
Placenta	
Abruption	
Accreta, increta, percreta	
Manual removal	
Poor Perinatal Outcomes	
Asphyxia (APGAR <7 at 5 mins)	
Child with congenital and/or hereditary disorder	
Perinatal death	
Previous baby with serious birth trauma requiring ongoing care	
Postpartum Haemorrhage	
>500mls no treatment	
500-1000mls symptomatic +/- additional treatment	
>1000mls	
Preterm labour/birth	
History threatened preterm labour	
History of PPROM +/- preterm birth	
History preterm birth	
Shoulder Dystocia	
Trophoblastic disease	

Antepartum Period	
Pregnancy screening	
Low PAPP-A	
Risk factors for congenital abnormalities	
Suspected/confirmed fetal abnormalities	
Cervical	
Cervical cytology – High grade (CIN II & III)	
Cervical cytology – Low grade (CIN I)	
Preterm cervical shortening <25mm	
Early pregnancy disorders	
Hyperemesis gravidarum (persistent)	
Recurring vaginal blood loss prior to 16 weeks	
Vaginal blood loss after 16 weeks	
Endocrine disorders	
Gestational Diabetes Mellitus – diet	
Gestational Diabetes Mellitus – insulin or uncontrolled	
Proven hyper/hypothyroidism (stable)	
Proven hyper/hypothyroidism (unstable)	
Fibroids	
Fetal presentation / growth concerns	
Breech presentation >34 weeks gestation	
Failure of head to engage at full term (primigravida)	
Non-cephalic presentation at full term	
Oligohydramnios (AFI <5)	
Polyhydramnios (AFI >25)	
Suspected confirmed fetal macrosomia	
Suspected/confirmed FGR (<10th centile or incoordinate growth or <2400g at term)	
Symphysis – fundal height >3 cm or <3 cm above gestational age	
Haematological disorders	
Anaemia >37 weeks (Hb<100g/dl)	
Coagulation disorders	
Persistent Hyperemesis Gravidarum (with weight loss)	
Thrombocytopaenia	
Thrombosis	
Hypertensive disorders	
Chronic hypertension	
Eclampsia/ HELLP syndrome	
Gestational hypertension (>20 weeks gestation)	
Pre-eclampsia	
Infectious diseases	
Cytomegalovirus	
Herpes genitalis (primary infection) (infection late in pregnancy)	
Herpes genitalis (recurrent infection)	
HIV infection	
Parvo-virus (active)	
Rubella	
Syphilis – (primary infection) (positive serology and not yet treated)	
Syphilis – positive serology and treated	
Toxoplasmosis	
Tuberculosis (active history of)	
Varicella/Zoster virus infection	
Mental health disorders	
First presentation mental health disorder during pregnancy with main care provider GP	
First presentation mental health disorder during pregnancy with main care provider psychiatrist/primary mental health care team	
Musculo-skeletal	
Disc prolapse (anaes)	
Pelvic instability	

Neurological	
Carpal Tunnel	
Migraines	
New onset seizures	
Neuropathies or other palsies	
Placental abnormalities	
Antepartum haemorrhage unknown cause	
Low lying placenta ≥ 34 weeks	
Placenta accreta/percreta/increta	
Placenta praevia	
Single umbilical artery	
Suspected placental abruption	
Vasa praevia	
Post-term pregnancy	
>41 weeks completed gestation	
Renal dysfunction disorders	
Proteinuria (≥2)	
Pyelonephritis	
Urinary tract infection(s)	
Respiratory disease	
Acute respiratory illness	
Asthma – mild	
Asthma – moderate/severe	
Threat of / actual preterm labour/birth	
Cervical insufficiency	
Pre-term pre-labour rupture of membranes <37 weeks gestation	
Threatened pre-term labour <37 weeks gestation	
Pelvic Instability	
Psychological or perinatal mental health concerns (diagnosis in pregnancy)	
Sepsis	

Surgery in Pregnancy	
Vaginal blood loss	
Antepartum haemorrhage	
Recurring loss at or after 12 weeks	

Intrapartum	
Abnormal Maternal Observations Bradycardia, Tachycardia Hypertension, Hypotension Pyrexia >38 (2 consecutive readings at least an hour apart)	
Amniotic fluid embolism	
Artificial rupture/release of membranes (ARM)	
Controlled ARM (non-engaged fetal head)	
Induction of labour/augmentation with fetal head engaged	
Breech presentation	
Diagnosed prior to labour	
Diagnosed during labour	
Caesarean section	
Cord prolapse or presentation	
Collapse/shock	
Fetal death during labour/stillbirth	
Fetal monitoring	
Non-reassuring or abnormal features as per CTG	
GBS positive	
Genital herpes (active late pregnancy or at labour onset)	
Haemoglobin <110g/L in labour	
Intrapartum haemorrhage	
Postpartum haemorrhage	
Estimated blood loss (EBL) <500mL and symptomatic	
500mls or more	
Meconium stained liquor	
Non-vertex presentation	
Induction of labour	
Instrumental birth	
Newborn	
APGAR <7 @ 5 minutes or resuscitation required	
Cord avulsion	
Hypoglycaemia	
Respiratory distress	
Placental abruption and/or praevia (suspected or confirmed)	
Prolonged labour	
Retained placenta	
Rupture of membranes	
At term (>37 weeks) and <18 hours (no other risk factors)	
At term (>37 weeks) and ≥18 hours	
Rupture of Membrane GBS Positive	
Sepsis	
Shoulder dystocia	
Third or fourth degree perineal tear	
Unengaged head in active labour	
Uterine inversion	
Uterine rupture	
Vasa praevia	

Postnatal – Maternal	
Abnormal Maternal Observations/Suspected infection	
Abnormal fundal height	
Persistent hypertension	
Suspected wound infection	
Temperature over 38°C on >1 occasion	
Urinary retention	
Urinary/faecal incontinence	
Vulvar Haematoma	
Psychological or perinatal mental health concerns	
Post-dural headache	
Severe adverse maternal morbidity	
Anaemia requiring blood products	

Haemorrhage > 500mls	
Thromboembolism	
Thrombophlebitis	
Postpartum eclampsia	
Uterine prolapse	

Neonatal	
APGAR less than 7 at 5 minutes	**Please refer to ACM guidelines**
Abdominal distention	
Abnormal cry	
Abnormal finding on physical examination	
Abnormal heart rate or pattern	
Abnormal respiratory rate and/or pattern	
Abnormal cord gases	
Bleeding from any site	
Congenital abnormalities	
Cyanosis or pallor	
DHHS/CP involvement	

Excessive bruising, abrasions, unusual pigmentation and/or lesions	**Please refer to ACM guidelines**
Excessive moulding and cephalhaematoma	
Failure to pass urine or meconium within 24 hours of birth	
Feeding issues	
Hypoglycaemia	
Infant less than 2500g	
Infection of umbilical stump site	
Jaundice in the first 24 hours	
Less than 3 vessels in umbilical cord	
Requiring respiratory support CPAP	
Significant weight loss >10% birth weight	
Suspected clinical dehydration	
Suspected meconium aspiration	
Suspected pathological jaundice after 24 hours	
Suspected seizure activity	
Suspected sepsis	
Temperature instability	
Vomiting (bile stained/projectile/excessive)	

Grampians Health Ballarat (Level 5) Traffic Light Consultation and Referral System

This system of risk identification supports escalation to an appropriate healthcare professional or higher-level service for assessment and care planning. This tool should be used in conjunction with;

National Midwifery Guidelines for Consultation and Referral
file:///C:/Users/27864/Downloads/National-Midwifery-Guidelines-for-Consultation-and-Referral-4th-Edition-(2021)%20(2).pdf

Capability Framework for Victorian Maternity & Newborn Services.
https://www.health.vic.gov.au/publications/capability-framework-for-victorian-maternity-and-newborn-services

'Antenatal Consultation, Referral and Transfer' (CPP 0248).
http://govdocsearch.bhs.org.au/#/?dvid=-25185&dvc=CPP0248

*'Maternity Unit Inpatient Admission, Discharge and Transfer' (*CPP 0702)

http://govdocsearch.bhs.org.au/#/?dvid=-24964&dvc=CPP0702