easternhealth

Eastern Health Guideline/Procedure/Protocol

Title

Maternity Care Planning and Consultation

1. Sponsorship

Executive Sponsor (Title)	ED SWMMS
Director Sponsor (Title)	PD Women and Children & Acute Specialist Clinics
Coordinating Author (Name and Title)	Dr Penelope Sheehan EH Director of Obstetrics and Gynaecology

2. Commissioning

2.1 Commissioning *(completed by Author in consultation with Sponsors listed above)*		
2.1.1 Is this guideline, procedure or protocol new?	Yes ☒ Go to 2.1.4 No ☐ Objectify no: ____ Go to 2.1.2	
2.1.2 Will this guideline, procedure or protocol help EH achieve a desired outcome / is it still required?	Yes ☐ go to 2.1.3 No ☐ Detail reason for proposed decommissioning: ______________________________	
2.1.3 Summarise reason for review and changes made:		
2.1.4 Purpose of guideline, procedure or protocol	To assist with detection of fetal growth restriction in antenatal clinics	
2.1.5 Scope	EH-Wide ☐ Program-specific ☒ Directorate specific ☐	Corporate Procedure ☐
2.1.6 Are there existing policy documents relevant to this topic? (If yes, consider if can be incorporated into existing document)	Yes ☐ Title and number No ☒	
2.1.7 With which EH Standard would this guideline, procedure or protocol align?	Appropriate and Effective Care	
2.1.8 Who will be consulted (stakeholders)?	Antenatal NUM Obstetricians Safer Baby Collaborative Working group	
2.1.9 Which committees are required to endorse this guideline, procedure or protocol?	Maternity Quality and Safety	
2.1.10 Which committee will approve this guideline, procedure or protocol?	Women and Children	
2.2 Commissioning committee approval to develop/review guideline/procedure/protocol *(completed by committee Secretary or delegate)*		

Approval to proceed with development Yes ☒ No ☐ Reason (if no):
Date Commissioned: 8 October 2019
Name of committee that approved commissioning: Clinical Practice Committee

Title

Maternity Care Planning and Consultation

1. **Context**

All women receiving pregnancy care at Eastern Health are assigned a clinical pathway of care: Green, Red or Red MFM. This pathway of care is recorded in the woman's BOS management plan and a copy of this plan provided and kept in her handheld maternity record.

Should a complication/s be detected in pregnancy, the following guidelines define the appropriate level of lead clinician for assessment and planning of ongoing care.

An amber indication requires assessment by the appropriate level of clinician, followed by a decision on which pathway the woman is now assigned - either Green pathway if the indication is not complicating this pregnancy, or Red pathway if the indication is complicating this pregnancy.

A red indication usually means ongoing care in the Red pathway. The frequency of visits will vary, depending on the individual needs of the woman. Antenatal care will be planned by the lead clinician (indicated in guidelines) and a schedule of visits with midwives and/or doctors decided. The indication for the key visits with the lead clinician should be documented and defined in the management plan.

2. **Definition of terms**

For purposes of this procedure, unless otherwise stated, the following definitions apply:

Maternity Care Clinician	Experienced	Trainee	Clinician Code
Primary	Registered Midwife	Graduate Midwife HMO	1
Secondary	Maternity Team Coordinator AMUM Maternity Team CMS	Junior Obstetric Registrar (Levels 1-3) Unaccredited Registrar	2
Tertiary	Consultant Obstetrician	Senior Obstetric Registrar (Level 4 {or equivalent} and above)	3
Maternal Fetal Medicine	MFM Consultant	MFM Registrar, Senior Obstetric Registrar Level 5&6	MFM

2.2 Abbreviations

For purposes of this procedure, unless otherwise stated, the following abbreviations shall apply:

ACIS Adenocarcinoma in situ (of the uterine cervix)

bHCG	Beta Human Chorionic Gonadotropin
BMI	Body Mass Index
CIN	Cervical Intraepithelial Neoplasia
CMC	Clinical Midwifery Consultant
DHHS	Department of Health and Human Services (Child Protection)
DM	Diabetes Mellitus
ESBL	Extended Spectrum Beta-Lactamases
FDIU	Fetal Death In Utero
FGR	Fetal Growth Restriction
GDM	Gestational Diabetes Mellitus
GP	General Practitioner
GTT	Glucose Tolerance Test
Hb	Haemoglobin
HELLP	Haemolysis, Elevated Liver (enzymes), Low Platelet (count)
HIV	Human Immunodeficiency Virus
HMO	Hospital Medical Officer
IOL	Induction of Labour
LFT	Liver Function Test
LLETZ	Large Loop Excision of the Transformation Zone (of the cervix)
MFM	Maternal Fetal Medicine
MGP	Midwifery Group Practice
MSST	Maternal Serum Screening Test
OCD	Obsessive Compulsive Disorder
PAPP-A	Pregnancy Associated Plasma Protein A
PCOS	Polycystic Ovarian Syndrome
PPH	Post Partum Haemorrhage
PTSD	Post Traumatic Stress Disorder
TSH	Thyroid Stimulating Hormone
USS	Ultrasound Scan
UTI	Urinary Tract Infection

3. **Name of Standard to which Guideline, Procedure or Protocol relates**

Appropriate and Effective Care

4. **Processes**

Directions for Use

Amber Assessment

An amber indication requires assessment by the appropriate level of clinician indicated in this guide, followed by a decision on which pathway the woman is now assigned. This assessment may be a documented discussion, consultation and/or collaboration with a higher level clinician. The pathway

options are either green pathway if the indication is not complicating this pregnancy or red pathway if the indication is complicating this pregnancy.

The management plan should identify amber indications, especially if deemed appropriate to continue care in the green pathway. This is to enable effective communication and awareness of potential risk factors.

A red indication usually means ongoing care in the Red pathway. The level of clinician appropriate for leading ongoing care is defined in this document.

Red Pathway

The frequency of visits in the red pathway will vary, depending on the individual needs of the woman.

Red pathway antenatal care will be planned by the lead clinician, as indicated in this guide, and this plan will be documented and accessible to other clinicians caring for the woman.

Some women will have multiple clinical indicators. For these women, the appropriate level of clinical care and pathway will be determined by the lead clinician.

An appropriate schedule of visits for the woman's clinical needs should be decided, using the skills of both midwives and doctors taking into account the scope of practice of all clinicians.

All women in the Red pathway should see a midwife in the third trimester for a comprehensive plan, to include labour, birth and postnatal care.

Indications for re-referral to the lead clinician should be considered.

Key visits with the lead clinician, or specific re-referral indications should be clearly defined, particularly for planning for labour and birth.

This plan should be documented and recorded in the 'management plan' section in Birthing Outcomes System (BOS).

MFM referrals

Many pre-existing conditions requiring referral to MFM also require booking visit earlier than the regular 16 weeks. A guide to these conditions and the timing of the booking visit is given for each condition. If there is a question about whether the woman should be reviewed early, information and guidance should be requested from the MFM clinicians.

Clinician Code

The Clinician Code Table (see definitions) defines the appropriate clinician to provide maternity care, according to the amber or red indications. Women in the green pathway will have maternity care provided by primary clinicians: Clinician Code 1.

Note: This document has been developed having regard to general circumstances. It is the responsibility of every clinician to take account of both the particular circumstances of each case and the application of these guidelines. In particular, clinical management must always be responsive to the needs of the individual woman and particular circumstances of each pregnancy.

Indications at Booking - Pre-existing Medical Conditions

CONDITION	CLINICIAN	GOOD PRACTICE POINT
Anaesthetic Difficulties		
Previous anaesthetic failure or complication (e.g. difficult intubation, failed epidural)	2	Refer for anaesthetic review in 2nd trimester
Malignant hyperthermia or neuromuscular disease	3	

Cardiovascular		
Maternal cardiovascular conditions, including: Congenital heart disease Acquired valve disease Arrhythmias	MFM	Booking visit at 14 weeks
Ischaemic heart disease	MFM	Booking visit at 14 weeks
Essential or Chronic hypertension	3	Consider referral to Obstetric Medicine and arrange baseline pre-eclampsia screen

Connective Tissue/ System Disorders		
Rare maternal disorders such as: Rheumatoid Arthritis Systemic Lupus Erythematosus (SLE) Scleroderma Polyarteritis nodosa Anti-phospholipid syndrome Marfan's syndrome Other systemic and rare disorders	MFM	Booking visit at 12 weeks Refer to Obstetric Medicine

Diabetes mellitus		
Pre-existing Type 1 Diabetes	MFM	Booking visit at 10 weeks Appropriate for COGU morphology scan and 16 week US Offer Antenatal Breastfeeding Class Refer to Obstetric medicine Refer to endocrinology
Pre-existing Type 2 Diabetes on insulin/medication	3	Booking visit at 10 weeks Refer to MFM for fetal cardiology USS at 24/40 Appropriate for COGU morphology scan and 16 week US Growth Scans at 28, 30, 32, 34, 36, 38 weeks Offer Antenatal Breastfeeding Class Refer to Obstetric Medicine Refer to endocrinology
Identified risk factors eg. Ethnicity, PCOS, Previous GDM, Previous Macrosomia, BMI >30, 1st degree relative with DM or Hx of GDM, Age ≥ 40, Corticosteroid/Anti-Psychotic use	1	Arrange early OGTT 12-18/40 Offer Antenatal Breastfeeding Class

Drug Dependence or misuse		
Pharmaceutical use e.g. analgesics, sedatives, tranquilisers	3	Refer to SMS
Prescribed use of Methadone or Buprenorphine	3	Refer to SMS
Alcohol and/or other drug use	3	Refer to SMS

Gastro-intestinal		
Inflammatory bowel disease (Including ulcerative colitis and Crohn's disease, Bariatric surgery	MFM	Consider Dietitian, refer to Gastroenterology through Obstetric Medicine

Genetic		
Considering invasive testing	2	
Known Parental Carriers of a genetic syndrome where prenatal testing may be considered (E.g. Thalassaemia, Cystic fibrosis)	MFM (Genetics)	
Consanguinity		

Haematological		
Haemoglobinopathy (carrier state)	1	Refer to Thalassaemia Screening in Pregnancy Guideline
Thrombo-embolic disease ie. Personal history and underlying pathology and/or positive family history	3	Refer to Obstetric Medicine
Coagulation disorders e.g. von Willibrands	MFM	Refer to Obstetric Medicine
Sickle cell disease (homozygous)		Refer to Obstetric Medicine
Thalassaemia (homozygous)		Refer to Obstetric Medicine
Anaemia at booking defined as Hb >10 - <11.5g/dl	1	Order Iron studies, Thalassaemia screen, see Anaemia in Pregnancy guideline
Anaemia at booking defined as Hb >9 - <10g/dl	2	
Anaemia at booking defined as Hb <9g/dl	3	Consider referral to Obstetric Medicine

Infectious Diseases		
Hepatitis B with positive serology (Hep B S Ag+)	2	Refer to Obstetric Medicine
Hepatitis C (Hep C Antibody +)	2	
HIV infection	MFM	Refer to Infectious Disease Physician
Syphilis	3	Refer to Infectious Disease Physician
Herpes genitalis: primary infection	3	
Herpes genitalis: recurrent infection	3	
Tuberculosis: active or a history of	3	Refer to Infectious Disease Physician
Recent history of viral, microbial or parasitic infections	3	

Liver Disorders		
Chronic hepatitis/Liver Disease	MFM	Refer to Obstetric Medicine
Portal hypertension		

Malignancy		
Current Malignancy	MFM	
Chemotherapy within 3 months of conception		
Previous malignancy	3	
Previous chemotherapy and/or radiotherapy	3	Consider need for Echocardiogram and/or spirometry

Maternal Age		
Under 18 years	1	
Over 40 years	2	

Maternal BMI at conception		
BMI <18	2	Refer to Dietitian
BMI 35-40	2	Early OGTT 12-18 weeks, arrange growth US 30 and 36 weeks
BMI >40 without co-morbidities/complexities	3	Early OGTT 12-18 weeks, arrange growth US 30 and 36 weeks Refer to Obstetric Medicine
BMI ≥ 40 with co-morbidities/complexities	3	
BMI ≥50	3	

Mental health		
Depression/anxiety (currently stable)	1	Communicate with GP
Depression/anxiety (currently unstable)	2	Conduct risk assessment. Refer to PEHS
Bipolar affective disorder or schizophrenia (currently stable)	2	Liaise with current mental health provider
Bipolar affective disorder or schizophrenia (currently unstable)	3	Refer to PEHS
Other e.g. PTSD, OCD, Personality Disorder	2	Refer to PEHS

Neurological		
Epilepsy, un-medicated and no seizures within last 12 months	2	
Epilepsy, with medication or seizure in last 12 months	MFM	Refer to Obstetric Medicine Booking visit at 12 weeks
Benign intracranial hypertension	MFM	Refer to Obstetric Medicine
Subarachnoid haemorrhage, aneurysms	MFM	
Multiple sclerosis		
AV malformations		
Myasthenia gravis		
Spinal cord lesion (paraplegia or quadriplegia)		
Muscular dystrophy or myotonic dystrophy		
Spina bifida		
Cerebrovascular accident		

Renal function disorders		
Renal impairment, with or without dialysis	MFM	
Recurrent urinary tract infections	2	Renal tract USS Consider prophylactic antibiotics

Respiratory disease		
Mild asthma	1	
Moderate asthma (E.g. oral steroids in the past year and / or need for maintenance/prophylactic therapy)	2	Refer to Obstetric Medicine
Severe lung function disorder	3	Refer to Obstetric Medicine
Restrictive Lung Disease	MFM	
Cystic Fibrosis		
Pulmonary hypertension		

Thyroid disorders		
Hypothyroidism	2	
Hyperthyroidism	3	Arrange thyroid function blood tests at booking Refer to Obstetric Endocrinology
Graves' Disease with positive TSH receptor antibodies	MFM	Refer to Obstetric Endocrinology
Addison's Disease Cushing's disease Other endocrine disorder requiring treatment		

Social		
Previous DHHS involvement (woman or partner)	1	Refer to SMS Offer Social Work
Acting against medical advice compromising the health and safety of the woman and/or baby	3	
Homelessness	1	
Safety/Domestic violence	1	
Grief and Loss	1	
Social isolation	1	
Refugee/Asylum Seeker	1	
Aboriginal/Torres Strait Islander	1	Refer to AHLO
Refusal of blood products	3	

Surgical		
Organ transplant	MFM	Refer to Obstetric Medicine.
Bariatric surgery	3	Refer to Obstetric Medicine. Refer to Dietitian.
Previous abdominal surgery	2	
Breast augmentation/reduction	1	Offer Lactation Consultant

Other pre-existing conditions		
Intellectual disability	1	Refer to SMS, offer social work
Physical disability	2	

Indications at Booking - Pre-existing Gynaecological Conditions

CONDITION	CLINICIAN	GOOD PRACTICE POINT
Cervical abnormalities		
Previous cone biopsy or multiple LLETZ	MFM	Refer to Preterm Labour Clinic at 16 weeks
Cervical surgery (e.g. single LLETZ)	2	
Abnormalities in cervix cytology	2	

Pelvic floor reconstruction		
Colpo-suspension following prolapsed uterus	3	Refer to Urogynaecology
Fistula and/or previous rupture and vaginal repair	3	Refer to Perineal Clinic

Uterine abnormalities		
Myomectomy/ hysterotomy	3	
Congenital Uterine anomalies eg. Bicornuate	MFM	Refer to Preterm Labour Clinic at 18 weeks

Other gynaecological		
Intra Uterine Contraceptive Device (IUCD) insitu	3	
Infertility treatment (this pregnancy)	2	
Female genital mutilation (FGM)	2	Examination to assess type. Consider need for antenatal deinfibulation

Indications at Booking - Pre-existing Maternity History

CONDITION	CLINICIAN	GOOD PRACTICE POINT
Fetal growth disturbance		
Previous baby >4.5kg	2	Arrange GTT 12-18 weeks
Previous baby diagnosed FGR, or <2.8kg	3	Consider commencing Aspirin prior to 14 weeks
Previous FGR baby requiring delivery before 32/40	MFM	Consider commencing Aspirin prior to 14 weeks

Grand multiparity		
Parity >5 previous births	2	

Haematological disorders		
Maternal red cell antibodies	MFM	
History or family history of neonatal alloimmune thrombocytopaenia (NAIT)	MFM	

Hypertensive disorders		
Hypertension in a previous pregnancy	2	Consider commencing Aspirin before 14 weeks Refer to Obstetric Medicine before 16 weeks
Pre-eclampsia in a previous pregnancy	2	
Severe pre-eclampsia, eclampsia or HELLP in previous pregnancy	3	Consider commencing Aspirin before 14 weeks Refer to Obstetric Medicine before 16 weeks
Previous severe pre-eclampsia, eclampsia or HELLP requiring delivery prior to 32/40	MFM	Refer to Obstetric Medicine before 16 weeks

Mental Health		
Previous antenatal/postnatal depression	1	Refer to PEHS
Previous postpartum psychosis	3	Refer to PEHS

Obstetric Emergency or Assisted birth		
Previous Forceps or vacuum extraction	1	
Caesarean section- Lower Segment Caesarean Section	3	
Previous classical caesarean section	3	
Shoulder dystocia	2	

Placental abnormalities		
Manual removal of placenta	2	
Previous Placenta accreta/increta/percreta	3	

Pregnancy abnormalities		
Recurrent miscarriage (three or more times)	3	Refer to MFM ONLY if patient has previously been evaluated in Recurrent Miscarriage Clinic
Pre-term birth <30 weeks in a previous pregnancy	MFM	Refer to Preterm Labour Clinic at 14 weeks
Pre-term birth <37 weeks in a previous pregnancy	2	
Child with congenital and/or hereditary disorder	MFM (genetics)	
Cervical insufficiency	MFM	Refer to Preterm Labour Clinic at 14 weeks
Elective cerclage	3	
Previous placental abruption	3	Consider commencing Aspirin ideally before 16 weeks
Cholestasis of pregnancy	3	

Poor perinatal outcomes		
History of mid-trimester loss	MFM	Refer to Preterm Labour Clinic at 14 weeks
Neonatal death	3	Offer social work
FDIU (Stillbirth)	3	
Previous baby with serious birth trauma requiring ongoing care	3	

Postpartum haemorrhage (as a result of)		
Cervical tear	3	
Other causes (>1000mls)	3	
Previous PPH requiring B Lynch suture or uterine arterial ligation or embolism	3	

Severe perineal trauma		
3rd degree	3	
3rd degree with urinary or faecal incontinence	3	Refer to Perineal Clinic
4th degree	3	
4th degree with urinary or faecal incontinence	3	Refer to perineal Clinic

Other pre-existing maternity history		
Previous breastfeeding problems/did not breastfeed previous child	1	Offer Lactation Consultant

Indications Developed/Identified During Pregnancy

CONDITION	CLINICIAN	GOOD PRACTICE POINT
Antenatal screening		
Risk factors for congenital abnormalities	3	Consider hospital based morphology scan
Low PAPP-A on 1st trimester screen < 0.45 MoM	2	Refer to "Antenatal Detection of Fetal Growth" Guideline Organise 30 and 36 week growth scans.
Suspected fetal abnormalities	MFM	
Increased risk of aneuploidy based on T1 combined test or MSST or non-invasive prenatal testing	MFM	Genetics

Cervical Cytology		
Cervical cytology - high grade (CIN II & III or ACIS)	3	
Cervical cytology - low grade (CIN I)	2	

Diabetes Mellitus		
Gestational diabetes requiring insulin (well controlled)	2	Refer to Obstetric Endocrine Offer Antenatal Breastfeeding Class
Gestational diabetes requiring insulin (poor control)	3	Offer Antenatal Breastfeeding Class
Gestational diabetes stable on diet control	2	If stable and no complications of pregnancy consider ongoing review in midwife clinic Offer Antenatal Breastfeeding Class

Early pregnancy disorders		
Hyperemesis gravidarum	2	Offer referral to dietitian
Recurrent PV bleeding >12 weeks but prior to 20 weeks	2	

Fetal presentation/ growth concerns		
Non-cephalic presentation at full term	3	
Breech presentation ≥34/40	2	
Head not engaged at full term (primigravida)	2	
Initial symphyseal fundal height <10th centile, static fundal height, slow growth on chart.	2	Refer to guideline
SGA/FGR	3	
FGR <34/40	MFM	

Haematological disorders		
Bleeding disorders	MFM	Refer to Obstetric Medicine
Maternal Red Cell Antibodies		
Thrombosis	3	Refer to Obstetric Medicine
Anaemia in pregnancy defined as Hb >10 -<11.5g/dl	1	Refer to guideline
Anaemia in pregnancy defined as Hb >9 - <10g/dl	2	Refer to guideline
Anaemia in pregnancy defined as Hb <9g/dl	3	Refer to guideline

Hypertensive Disorders		
Gestational hypertension >20/40	2	Refer to Obstetric Medicine
Pre-eclampsia	3	Refer to Obstetric Medicine at 6 weeks postpartum
Eclampsia	3	

Infectious Diseases		
HIV infection	MFM	Refer to Perinatal Infectious Diseases Physician
Rubella		
Toxoplasmosis		Refer to Perinatal Infectious Disease Physician
Cytomegalovirus/Parvovirus infection		Refer to Perinatal Infectious Disease Physician
Primary Varicella infection		
Tuberculosis: active tuberculosis process	3	Refer to Perinatal Infectious Disease Physician
Hepatitis B with positive serology (Hbs-Ag+)	3	Refer to Obstetric Medicine
Hepatitis C	3	
Herpes genitalis- primary infection	3	
Herpes genitalis- infection late in pregnancy	3	
Herpes genitalis- recurrent infection	3	
Syphilis- Positive serology and treated	3	Refer to Perinatal Infectious Disease
Syphilis -Positive serology and not yet treated	3	Refer to Perinatal Infectious Disease
Syphilis- Primary infection	3	Refer to Perinatal Infectious Disease
Drug resistant infections eg. ESBL UTI	2	Refer to Perinatal Infectious Disease

Medical/surgical issues		
Laparotomy during pregnancy	3	

Mental health disorders		
Presence of mild to moderate depression/anxiety	1	Assess, refer to GP, community providers as appropriate
Presence of moderate to severe depression/anxiety	2	Conduct risk assessment, refer to GP if not currently receiving treatment
Risk of harm to self/baby	2	Conduct risk assessment
Presence of psychosis/mania	3	Conduct risk assessment, refer to GP if not currently receiving treatment

Multiple Pregnancy (complex)		
Complex multiple pregnancy: monochorionic twin pregnancy higher order multiple Pregnancy (e.g. triplets) DCDA twins with additional complicating factors (e.g. discordant growth, fetal anomalies, abnormal Dopplers, complex medical disorders)	MFM	
Multiple pregnancy	3	Ensure a chorionicity scan is performed prior to 14 weeks .

Pain disorders	Clinician	Good Practice Point
Back, pelvic or other joint pain	1	Refer to physiotherapy

Post-term pregnancy		
Pregnancy lasting longer than 41 completed weeks	1	Arrange IOL between 41+3 and 42 completed weeks, CTG and AFI every two days
Pregnancy lasting longer than 42 completed weeks	3	

Placental abnormalities		
Low lying placenta ≤34/40	2	Arrange ultrasound at 34/40
Placenta praevia	3	
Suspected placenta accreta/percreta/increta	MFM	
Anterior low lying placenta with previous caesarean section	MFM	Refer following Morphology ultrasound
Vasa praevia	MFM	
Suspected placental abruption	3	

Renal function disorders		
Recurrent urinary tract infections	2	Organise renal tract USS and consider prophylactic antibiotics
Pyelonephritis	2	

Respiratory disease		
Asthma	1	
Acute respiratory illness	3	

Threat of or actual pre-term birth		
Cervical insufficiency	MFM	Refer to preterm Labour Clinic at 14 weeks
Threatened pre-term labour <34 weeks	3	
Threatened pre-term labour 34-37 weeks	2	
Pre-term prelabour rupture of membranes <26 weeks	MFM	
Pre-term prelabour rupture of membranes 26-37 weeks	3	

Other high risk pregnancy issues		
Antepartum haemorrhage > 20 weeks	3	
No prior antenatal care at <37 weeks	2	Consider referral to SMS
No prior antenatal care at full term ≥37 weeks	3	
Poor antenatal attendance: failure to attend two consecutive or more than four scheduled appointments	2	Inform AUM/Obstetrician
Concealed pregnancy	3	Consider referral to SMS/Social Work
Planned adoption	1	Refer to social work
Surrogacy	1	Refer to social Work
Fetal death in utero	3	Refer to Pregnancy Loss Coordinator
Acting against medical advice compromising the health and safety of the woman and/or baby	3	
Borderline viability (22-24/40) where preterm delivery possible	MFM	Consider neonatology consultant review

Thyroid disorders		
Hypothyroidism	2	Refer to Obstetric Endocrinology
Hyperthyroidism	3	Refer to Obstetric Endocrinology
Graves disease with positive TSH receptor antibodies	MFM	

Uncertain gestation of pregnancy		
>20/40 and uncertain of dates	3	

Uterine abnormalities		
Fibroids ≥3cm and ≤6 cm or multiple fibroids	2	
Fibroids ≥6cm	3	

5. **Scope**

Applicability

These guidelines apply to all midwives and doctors who provide care to women during the antenatal period. These guidelines apply to both hospital and community based antenatal clinic settings. These guidelines apply to Maternity Bookings

Responsibility

The Clinics Manager, Midwifery Maternity and Obstetric Team Leads will review and update as required between formal review periods.

Authority
Exceptions to the clinical practices described in this guideline can only be authorised by an Executive, Divisional or Clinical Services Director, or Consultant Obstetrician.

6. **Level of Supporting Evidence Available**
   Expert opinion

7. **Tools and techniques**
   Expected pathways of care

8. **References**

Australian College of Midwives (2013). *National midwifery guidelines for consultation and referral (3rd edition).* Available from https://issuu.com/austcollegemidwives/docs/guidelines2013

9. **Development History**
   New guideline developed July 2020

10. **Attachments**
    Nil

Development / Review (complete this section after development/review, prior to approval)

<table>
<tr><td colspan="2">Key external information sources consulted:
Legislation ☐ External benchmarks X External standards X Risk Register Item ☐ Other ☐
Provide specific details:

(NB: The following text is to be included in all Guidelines, Procedures or Protocols)
"REMINDER: Charter of Human Rights and Responsibilities Act 2006 – All those involved in decisions based on this policy / guideline have an obligation to ensure that all decisions and actions are compatible with relevant human rights"
Consider making additional reference to the Charter of Human Rights and Responsibilities Act 2006, as relevant.</td></tr>
<tr><td>Key Stakeholders consulted in development/review eg. IPAC, OHS, Support Services, ICT, Residential Care, Legal Counsel.</td><td>Title/Name
Antenatal NUM
Obstetricians
Safer Baby Collaborative Working group</td></tr>
<tr><td>Consumer consulted</td><td>Yes ☐ No X</td></tr>
<tr><td>Implementation plan developed and attached?</td><td>Yes –Guideline/Procedure/Protocol is new or significantly revised X
No –Guideline/Procedure/Protocol has undergone only a minor revision ☐</td></tr>
<tr><td>Guidelines, Procedures or Protocols to be removed following approval</td><td>Document Numbers & Titles</td></tr>
<tr><td>Further comments/notes</td><td></td></tr>
<tr><td>Key search words</td><td>Fetal growth, SGA, LGA, maternity planning</td></tr>
</table>

Endorsement and Approval

Endorsement by relevant committee (*completed by committee or delegate)*		
Name(s) of Endorsing Committee(s) *e.g. Quality & Strategy Committee, CPC, Expert Advisory Committee.*	Conditions of endorsement	Date Endorsed dd/mm/yy
Maternity Quality and Safety		1/10/2020
Women and Children Q+S		15/10/ 2020

Approval by relevant committee *(completed by committee or delegate)*		
Approved for		1 Year (Extreme Risk) ☐ 2 Years (High Risk) ☐ 3 Years (Moderate or Low Risk) ☒
Alignment of Guideline, Procedure or Protocol EH-Wide Program or Directorate-specific Corporate Procedure	Clinical Practice Committee Program Quality & Strategy Committee *Specify: Women and Children* Executive Committee Board/Board Committee Date of next review: 15/10/2023 *Please notify coordinating author and Manager Clinical Governance of approval*	Date approved dd/mm/yy ☐ / / ☒ 15/10/2020 ☐ / / ☐ / /

Publishing

Date approval notified to Manager Clinical Governance *(completed by Manager Clinical Governance)*	20/11/2020
Date forwarded to policy administrator *(completed by QPI Executive Assistant)*	23/11/2020
Date published on Objectify *(completed by publishing administrator)*	1/12/2020