Alberta Health Services

Antenatal Home Visit Order Set

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
PHN	ULI ☐ Same as PHN / MRN
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

Referral Acceptance Requirements

☐ **Client fits program criteria**.
See Alberta Referral Directory and search keyword 'Antenatal' for program details.

☐ **Referral form has been completed, and submitted with this Order Set.**

Indication for Admission

☐ Cholestasis of Pregnancy
☐ Decreased Placental Function
☐ Fetal Surveillance
☐ Hypertensive Disorder
  ☐ Instruct patient to hold hypertensive medication
  if BP is less than _____/_____

☐ Multi-Fetal Gestation
☐ Placenta Previa/Antepartum Hemorrhage
☐ Preterm Labour
☐ Preterm Prelabour Rupture of Membranes

Edmonton Zone only:

☐ Prenatal Assessment *Specify what is required (fundal height, FHR, BP etc)*

_____

_____

Orders

☐ Non-Stress Test ☐ _____ times a week ☐ Other _____

☐ Blood Pressure ☐ _____ times a week ☐ Other _____

☐ Activity Considerations *(see guidelines on Side B)*
  ☐ Normal activities of daily living
  ☐ Normal activities of daily living with rest periods
  ☐ Exercise allowed *(provide specific orders on Side B)*
  ☐ Exercise NOT allowed

☐ Other Orders *(specify)*

Edmonton Zone Only

Daily Urine Dip ☐ Yes ☐ No

☐ Betamethasone 12 mg IM
Two (2) doses 24 hours apart

Lab Tests

Connect Care Provider ID

Connect Care Submitter ID

Frequency: ☐ Weekly ☐ Other _____

☐ CBC ☐ Diff ☐ No Diff
☐ ALT
☐ AST
☐ Bile Acids
☐ Creatinine
☐ LD
☐ Urate
☐ Urine Protein Random *(Creatinine Ratio)*
☐ Other _____

☐ Serum Ferritin ☐ Once only
☐ Syphilis ☐ Once only ☐ Monthly

☐ Urinalysis ☐ Once only ☐ Monthly
☐ Urine Culture ☐ Once only ☐ Monthly

Edmonton Zone only:

☐ 26 Week Follow-up ABO/Rh, Antibody Screen
☐ 24 - 28 weeks: GDS and Hemoglobin

Physician Name	Physician Signature	Date *(dd-Mon-yyyy)*	Time *(hh:mm)*

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Activity Considerations

Consider: Gestational age and high-risk condition, maternal physical condition pre-pregnancy and maternal preference and values.

Activities of Daily Living Examples: walking outdoors, stairs, housework, childcare, driving and work.	*Patients will only be instructed to modify activities of daily living if experiencing symptoms and will be advised to contact most responsible health provider.* **Physician recommendation comment:**
Rest Periods and Lifestyle Modifications Example: sexual activity.	*Rest in comfortable position(s) periodically throughout the day. Consider increasing restful periods if experiencing symptoms. If symptoms persist, follow recommendations given by the physician.* **Physician recommendation comment:**
Exercise Defined as any activity that is intentional or planned with the purpose of raising ones heart rate to maintain or improve good physical health (ACOG, 2020; SOGC/ CSEP, 2019).	**Please indicate your recommendation:** *(See table below for contraindications)* ☐ **NO – may not exercise** or ☐ **YES – may exercise** please comment any physician recommendations. *(e.g. type, duration and intensity of activity.)*

SOGC/CSEP (2019) Table of Contraindications for Exercise

Absolute Contraindications:	**Relative Contraindications:**
Ruptured Membranes	Recurrent pregnancy loss
Premature Labour	Gestational Hypertension
Unexplained persistent vaginal Bleeding	A history of spontaneous preterm birth
Placenta previa after 28 weeks' gestation	Mild/moderate cardiovascular or respiratory disease
Preeclampsia	Symptomatic anemia
Incompetent cervix	Malnutrition
Intrauterine growth restriction	Eating Disorder
High-order multiple pregnancy (e.g. triplets)	Twin pregnancy after the 28th week
Uncontrolled type 1 diabetes	Other significant medical conditions
Uncontrolled hypertension	
Uncontrolled thyroid disease	
Other serious cardiovascular, respiratory, or systemic disorder	