Module Presentation

How to best use the Modules

To make the best use of this training we encourage you to complete each Module in order following the format below:

1. Read *Module Presentation*. Added explanations can be found in the HELPER Guidelines and in the extra information section if there is one.
2. Complete the *Extraction/Scenario* training exercises
   The extraction exercises use de-identified and altered patient medical records. The information is then entered into the provided section from the Birth Certificate Workbook.
   The Scenarios are situations you may encounter as you collect information from your patients' medical records.
3. Check your responses using the answer sheets in the "Answers" section.
4. Complete the Module specific *Evaluation*, faxing or emailing the completed evaluation to: rosemary_varga@urmc.rochester.edu.
   We will use these evaluations to identify areas where the training can be improved.
5. If not already done, read extra training materials, if available.

If you have questions about how to answer any of the requests for information in the NYS Certificate of Live Birth Training Modules,

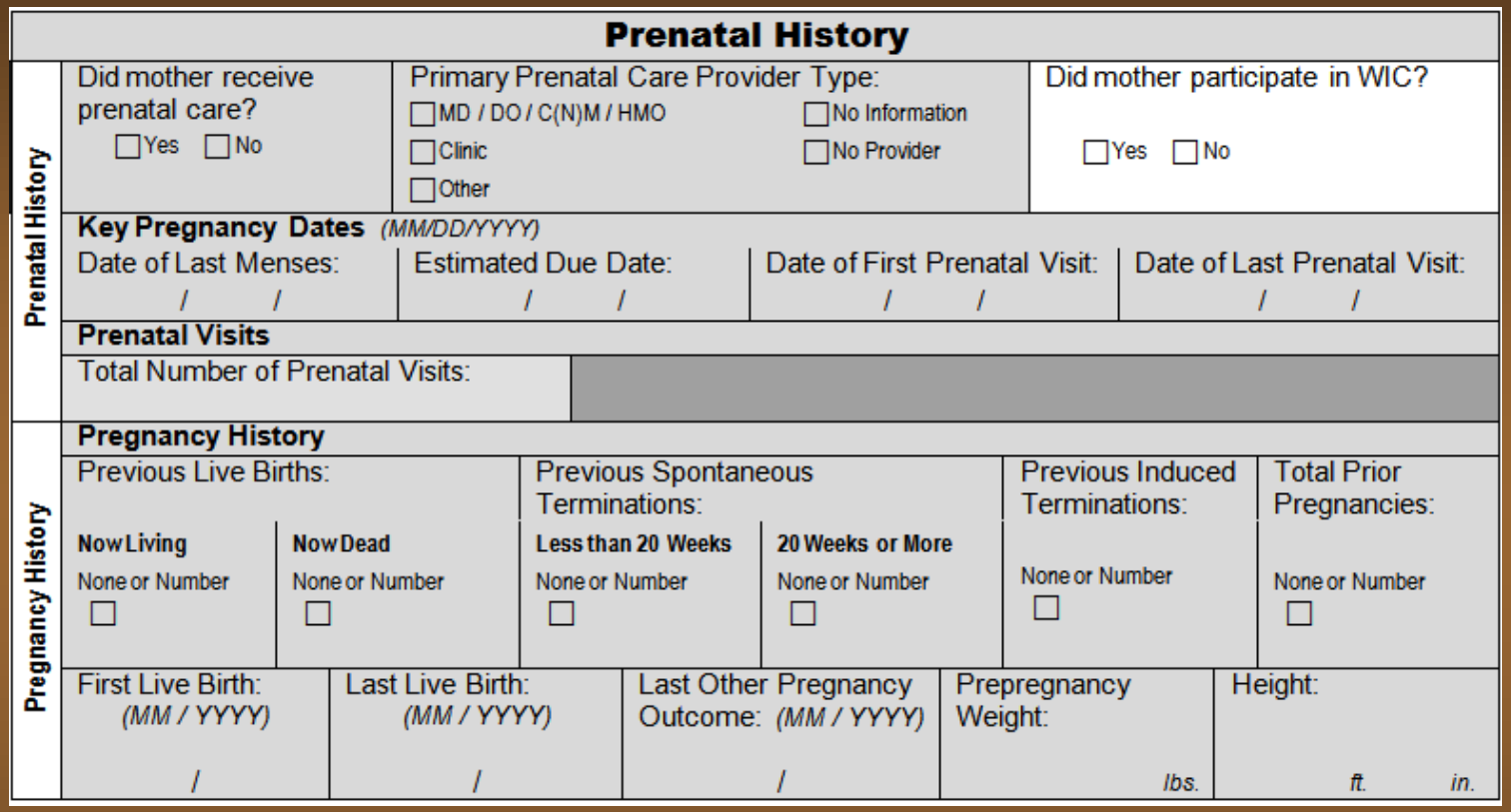
Please, contact Rosemary Varga (585-275-8737).

*"Coding" is a convenient although slightly misleading term for entering the needed information in the Statewide Perinatal Data system. True "coding" is the entry of predetermined numbers into a system that can then rate the material. We do not use numbers rather we enter the requested information.

Module Five

Prenatal History Section

Prenatal History Fields



Prenatal History

Prenatal History

Did mother receive prenatal care? ☐ Yes ☐ No

Primary Prenatal Care Provider Type: ☐ MD / DO / C(N)M / HMO ☐ No Information ☐ Clinic ☐ No Provider ☐ Other

Did mother participate in WIC? ☐ Yes ☐ No

Key Pregnancy Dates *(MM/DD/YYYY)*

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
/ /	/ /	/ /	/ /

Prenatal Visits

Total Number of Prenatal Visits:

Pregnancy History

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number ☐	**Now Dead** None or Number ☐	**Less than 20 Weeks** None or Number ☐	**20 Weeks or More** None or Number ☐	None or Number ☐	None or Number ☐

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
/	/	/	*lbs.*	*ft.* *in.*

Check the mother's chart, online or paper, for a copy of the prenatal record. It may be in the form of a packet from the prenatal care provider's office or in your computer system either as its own file or in the media section.

Primary Prenatal Care Provider Type

Primary Prenatal Care Provider Type:

- ☐ MD / DO / C(N)M / HMO
- ☐ Clinic
- ☐ Other
- ☐ No Information
- ☐ No Provider

MD = Medical Doctor
DO = Doctor of Osteopathy
C(N)M = Certified (Nurse) Midwife
HMO + see below

PRIMARY PRENATAL CARE PROVIDER

Select the primary setting in which prenatal care was given:

- private office (MD, DO, midwife, managed care plan health center)
- clinic
- other
- no information - select if mother received prenatal care but provider type unknown
- no provider - select if mother received no prenatal care

Did mother participate in WIC?

Did mother participate in WIC?

☐ Yes ☐ No

PARTICIPATION IN WIC DURING PREGNANCY

Select yes if the mother received food support through the Special Supplemental Food Program for Women, Infants and Children (WIC).

Did mother participate in WIC should be checked if mother received WIC services during pregnancy (does not apply to services infant may receive after birth)

Key Pregnancy Dates

Key Pregnancy Dates *(MM/DD/YYYY)*			
Date of Last Menses: / /	Estimated Due Date: / /	Date of First Prenatal Visit: / /	Date of Last Prenatal Visit: / /

NYS GUIDELINES

DATE LAST NORMAL MENSES BEGAN

Enter the month, day and year on which the mother's last normal menses began for this pregnancy. If the exact day is unknown, but the month and year are known, obtain an estimate of the day from the mother or her physician. Entries such as "BEG" for beginning, "MID" for middle and "END" for the end of the month should be converted to '07', '15' and '24'.

ESTIMATED DUE DATE

Enter the month day and year on which the mother is expected to deliver her child(ren).

Do not use the pregnancy wheel to determine last menstrual period (LMP). The *Date of Last Menses* should be based on the Prenatal Care Record or Medical History. It is OK to provide just month and year if that is all that is known.

Key Pregnancy Dates

Key Pregnancy Dates *(MM/DD/YYYY)*			
Date of Last Menses: / /	Estimated Due Date: / /	Date of First Prenatal Visit: / /	Date of Last Prenatal Visit: / /

NYS GUIDELINES

DATE OF FIRST PRENATAL CARE VISIT

Enter the date upon which the mother first presented for prenatal care. Include only the visit to a private physician or to a clinic or outpatient department of a hospital in which the mother's health history was taken and an initial physical examination for this pregnancy was performed. Do not include a visit in which only the fact of pregnancy was confirmed. The preferred source of this information is the prenatal care medical record. If an exact date is not available, try to get an estimate such as beginning, middle or end of the month. These estimates should be converted to '07', '15' and '24', respectively. If no prenatal care was received, leave the date blank.

DATE OF LAST PRENATAL CARE VISIT

Enter the date upon which the mother's last prenatal care visit. Include only a visit to a private provider or to a clinic or outpatient department of a hospital in which the mother received prenatal care. Do not include healthcare visits unrelated to pregnancy care, e.g. emergency room care for an injury. If an exact date is not available, try to get an estimate such as beginning, middle or end of the month. These estimates should be converted to '07', '15' and '24', respectively. If no prenatal care was received, leave the date blank.

A prenatal visit solely for the purpose of determining that the women is pregnant is <u>not counted</u> as a prenatal care visit and the <u>date is not recorded as the *Date of First Prenatal Visit*.</u> Consult appointments with High Risk providers are counted as prenatal visits

Prenatal Visits

Prenatal Visits
Total Number of Prenatal Visits:

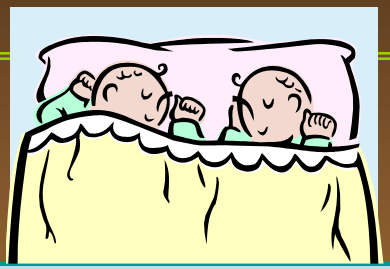
NYS GUIDELINES

NUMBER OF PRENATAL VISITS

Enter the total number of prenatal visits made by the mother to a physician or prenatal clinic for the purpose of prenatal care. A prenatal visit includes all regular visits to a doctor or clinic and any other visits to a doctor, clinic or emergency room for treatment of a pregnancy related problem. If an exact date is not known estimate the number of visits.

Please note a slight change from the original guidelines:
Prenatal care visits should be those in clinics or doctor's offices. For example, ***A labor check or visit to ER should not be counted.*** A pregnant woman may come to the hospital a few times near the end of her pregnancy, but have no or very little routine prenatal care. If the hospital visits are counted, it may look like the woman had several prenatal care visits when in fact she had none at all.

Previous Live Births



Previous Live Births:

Now Living	Now Dead
None or Number ☐	None or Number ☐

In the case of twins, both born alive, *the birth of Twin A* ***changes the number of previous live births for Twin B, increasing it by '1' (to reflect the birth of Twin A).***

NYS GUIDELINES

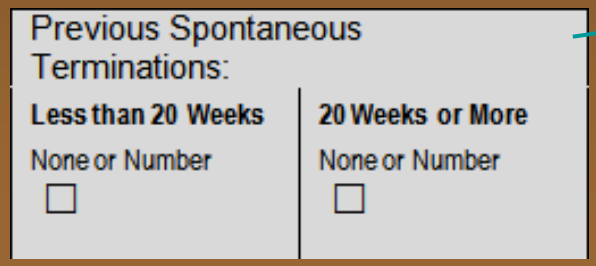
PREVIOUS LIVE BIRTHS, NOW LIVING

- Enter the number of previous children born alive to this mother who are still alive at the time of this birth.
- Do not include the child for whom this certificate is being completed.
- If this is a multiple delivery, include any of the set previously born alive and are still living when the child named on this certificate was delivered.
- Indicate "None" if this is the first live birth to this mother or if all previous children are dead.

PREVIOUS LIVE BIRTHS, NOW DEAD

- Enter the number of previous children born alive to this mother who are now dead.
- If this is a multiple delivery, include in your count any of the set previously born alive who died before the delivery of the child named on this certificate.
- If none, indicate None.

Previous Spontaneous Terminations



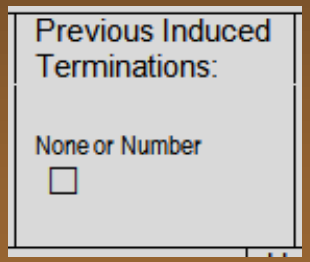
Molar pregnancies, blighted ova, vanishing twins are non-viable pregnancies. These may end spontaneously or by a procedure, such as a D&C. However these should always be coded as spontaneous terminations regardless of final mode of pregnancy completion.

NYS GUIDELINES

PREVIOUS SPONTANEOUS TERMINATIONS - GESTATIONS OF 20 WEEKS OR MORE AND PREVIOUS SPONTANEOUS TERMINATIONS - LESS THAN 20 WEEKS GESTATION

- Enter only previous spontaneous fetal deaths.
- Enter the number of spontaneous fetal deaths in the space that corresponds to the gestation of the fetus at death. For example, fetal deaths of less than 20 weeks gestation (under 5 months) should be entered in the space labeled Less than 20 Weeks.
- If this is the mother's first pregnancy or if all previous pregnancies resulted only in live born infants or induced terminations, indicate None.
- If this is a multiple delivery, include in your count all fetuses in the set which were born dead prior to the infant that is named on this certificate.

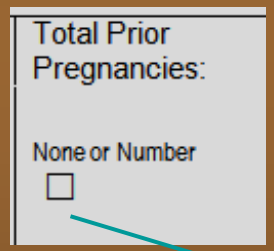
Previous Induced Terminations/Total Prior Pregnancies



NYS GUIDELINES

PREVIOUS INDUCED TERMINATIONS OF PREGNANCY

- Enter the total number of fetal deaths resulting from an induced termination of pregnancy prior to the birth of the infant named on this certificate.
- If this is the mother's first pregnancy or if all previous pregnancies resulted in live born infants or spontaneous fetal deaths, indicate none.



TOTAL PRIOR PREGNANCIES

- Enter the total number of times that the mother was pregnant prior to this pregnancy.
- Count every previous pregnancy regardless of whether it resulted in live birth or fetal death.
- A previous pregnancy that resulted in a multiple delivery counts only as one pregnancy. If this is the mother's first pregnancy, enter "00".

In the case of twins, both born alive, the birth of Twin A changes the number of previous live births for Twin B, increasing it by '1' (to reflect the birth of Twin A) but ***the Total Prior Pregnancies (number) remains unchanged.*** *(There has not been another pregnancy from Twin A to Twin B.)*

First/Last Live Birth

NYS GUIDELINES

First Live Birth:
(MM / YYYY)
/

DATE OF FIRST LIVE BIRTH

- Enter the month and year of the first live birth born to this mother.
- Do not enter the date of this live birth if it is a single birth.
- If this is the first pregnancy for this woman AND it is her second, third, etc. member of a set, enter the date of birth of the first live born child.

Last Live Birth:
(MM / YYYY)
/

DATE OF LAST LIVE BIRTH

- Enter the month and year of the last live birth born to this mother.
- Do not enter the date of this live birth if it is a single birth.
- If this is the mother's first live birth, leave this item blank.
- If this is her second live birth, repeat the date entered in first live birth.
- For a multiple delivery, if this certificate is for the second, third, etc. member of the set, then the required date is the month and year of the last set member born alive prior to the child named on this certificate. Usually this date will be the same as for the child named on this certificate. If all previous set members were born dead or if this certificate is for the first set member, enter the month and year of the last delivery involving a live birth.

In the case of twins, both born alive, the birth of Twin A changes the number of previous live births for Twin B, increasing it by '1' (to reflect the birth of Twin A). The Total Prior Pregnancies (number) remains unchanged and ***the date of the last live birth for Twin B becomes twin A's birth date***. If this is mom's first live birth, Twin A's birth date becomes date of first live birth as well.

Last Other Pregnancy Outcome

Last Other Pregnancy Outcome: *(MM / YYYY)*

/

Remember to record in this field the date when the last pregnancy ended, which did not end in a live birth.

NYS GUIDELINES

DATE OF LAST OTHER PREGNANCY OUTCOME

- Enter the month and year of the mother's last spontaneous or induced termination.
- If this is the mother's first delivery or if all previous deliveries resulted in only live born infants, leave this item blank.
- For a multiple delivery, if this certificate is for the second, third, etc. member of the set and previously delivered set members were born dead, enter the month and year of the last set member born dead. Usually this will be the same date as the birth date of the child named on this certificate.
- If all previously delivered set members were born alive, or if this certificate is for the first set member, enter the month and year of the last delivery involving a fetal death.

Prepregnancy Weight/ Height

Prepregnancy Weight:

lbs.

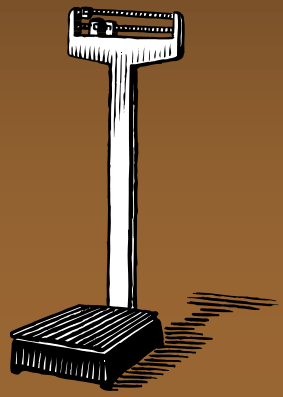
Height:

ft. *in.*

NYS GUIDELINES

PREPREGNANCY WEIGHT
Enter the mother's weight prior to this pregnancy.

MATERNAL HEIGHT
Enter the mother's height in feet and inches.



When a weight range is given, use the upper weight in the range. For instance 155-160, enter as 160 lbs

The
End

Extraction Exercises

Module 5 – Prenatal History

Extraction Exercise #1

Below are abridged chart notes and an abridged example of a patient summary created for Birth Certificate Registrars.
Fill in the appropriate answers on the Birth Certificate Work Book excerpts (last page).

Abridged Prenatal Chart note 1 –Clinic – Nurse Practitioner

Date of Service: 6/30/2014 10:00 AM

HPI:

Patient is a 40 yo year old G9P6 female at 8w1d gestation by 1st trimester USN (dates adjusted from LMP) with a single intra uterine pregnancy. Today she is doing well. She has noted some vaginal odor without discharge, itching, or irritation and wonders if she has BV. Denies any complaints of vaginal bleeding or pelvic pain. She has had mild headaches with pregnancy, yesterday this was bad enough that she took Tylenol and this resolved. She has had some mild nausea without emesis. She is completing a partial day mental health program today and then has an intake for ongoing therapy through the mental health clinic on 7/7/2014. She feels her mood is stable. She denies any problems with previous pregnancies.

OB/GYN History

-Typical menses: regular every 28-30 days, bleeding flow is moderate, lasting 5-6 days with cramps that are Mild.
-History of abnormal pap smear: Yes- remotely.
-Last pap smear: Date: 10/12/2010. Results: no abnormalities/negative HPV.
-The patient is sexually active. She has sex with males and is not in a mutually monogamous relationship.
-STD History: HSV2 on serology only, no prior hx of genital outbreaks.

PAST MEDICAL HISTORY:

Diagnosis	Date
• Abnormal Pap smear	
• Anxiety	
• Closed dislocation of patella, left, subsequent encounter	2/11/2015
• Depression	
• Dizziness of unknown cause	2/10/2015
Feb 2015: ENT evaluation reviewed: No significant findings; Likely myofascial ;	
• Herpes simplex without mention of complication	
• Hypertension	11/06/2013
never treated with meds	
• Pain in joint, lower leg	1/21/2015
Feb 2015: Ortho eval reviewed; continue brace and PT: Fu 3-4 weeks; No work until that time;	
• Polycythemia	11/9/2013

PAST SURGICAL HISTORY:

Procedure	Laterality	Date
• Tonsillectomy		
• Cholecystectomy		

PROBLEM LIST:

Patient Active Problem List

Diagnosis	Code
• Obesity	E66.9
• Anxiety state	F41.1
• Nausea without vomiting	R11.0
• Depression	F32.9
• Polycythemia	D75.1
• Laryngopharyngeal reflux (LPR)	J38.7
• Elevated LFTs	R79.89
• Insomnia	G47.00

- HSV-2 seropositive R89.4

MEDICATIONS:

Current Outpatient Prescriptions

Medication

- Prenatal Vit-Fe Fumarate-FA (SE-NATAL 19) 29-1 MG CHEW
- zolpidem (AMBIEN) 10 MG tablet
- docusate sodium (COLACE) 100 MG capsule

ALLERGIES:

Allergen	Reactions
Adhesive Tape	Itching
Leaves discoloration on skin	
Codeine	
Penicillin	
Shellfish Allergy	Hives and Rash

SOCIAL HISTORY:

Lives with her mother, grandfather and 4 children. Currently on leave from work as mental health therapy aide at RPC. She is estranged from husband. FOB is involved and supportive. She denies feeling verbally or physically threatened at home and work.

Personal Hx/Prenatal Risks:

AMA.
Obesity.
Depression and anxiety.
HSV2 positive serology.
.

Social History

Substance Use Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Never Used
- Alcohol use No
  Comment: none with pregnancy
- Drugs: Denies

Assessment & Plan:

40 y.o. G9P6 female at 8w1d gestation

1. Pap smear and tests for GC, Chlamydia, Trich collected. Consent obtained for HIV, Utox, and CF. All applicable prenatal labs were ordered, but not yet obtained. Will follow up with patient for any abnormal results. Pregnancy warning symptoms were reviewed. Handouts given.
2. Infant feeding plan: Patient was counseled regarding feeding choices, including benefits of breastfeeding, and consequences of formula feeding. Patient is planning to breast feed. WIC breastfeeding form was completed and faxed. Patient education material was provided to the patient.
3. AMA. Patient desires referral to genetics for counseling on testing options. First trimester screen was not ordered today pending this visit. Referral initiated and patient is aware she will be contacted.
4. Obesity. Reviewed recommended goal for weight gain this pregnancy. TSH, Hgb A1C, early 1 hour GTT, CMP, and baseline preeclampsia labs ordered. 24 hour urine supplies and teaching per nursing staff today. .
5. History of HTN on medical record but has never been treated. Normotensive readings at recent visits. Baseline preeclampsia labs ordered as above.
6. Vaginal odor with discharge noted on exam. Vaginitis screen obtained and patient will be contacted with abnormal results.
7. Constipation. Rx for Colace e-scribed today.

8. History of polycythemia on medical record. Patient states this is resolved. Will await prenatal test results and review history with MD if necessary.
9. Follow up. She was advised to RTC in 4 weeks or on a PRN basis. I have asked her to be seen by an MD at next visit to review her history and confirm this plan of care.

Abridged Prenatal Chart note 2 – Registered Nurse

06/30/2014 GA: 8w1d

_____**, RN** 6/30/2014 9:44 AM Signed MRN: _____

Patient is a 40 yo G9P6. She is now 8w1d weeks, and requesting prenatal care. Estimated Date of Delivery: 2/8/15
Pt states this is an unplanned but accepting of pregnancy.
FOB is a friend and will be supportive, but they are not in a relationship.
PCP started pt. on Disability from her job on 05/15/2014.
Pt has been attending a Day Program through SMH for anger management issues. Today is the last day.
Pt has future apt. without-pt BH.
Pt states she also suffers from anxiety and depression.
Her 15 y/o daughter last school year was “raped" by a teacher. Daughter attempted suicide sometime after this.
Her daughter was living with her Father at the time. Since has moved back with her Mom.
Court date is pending for September.
Discussed Genetic Counseling with pt. due to AMA, She will further discuss this at today's NOB.
Pt consented for CF, states her Sister has CF. Form given to pt. Copy for scanning.

Dating established by: (U/S or LMP) U/S

Patient reports nausea.

(Please note ethnicity AA)

OB/GYN History: The patient has an STD history of HSV and her HIV status is unknown.

Barriers to education/learning assessment

Person assessed: patient

Factors that affect learning:
Physical: wears glasses for night driving
Emotional: Anxiety and Depression. Anger issues that were work related
Misc: None

Patient has support system for learning: yes
family member, name: sister: _____

Ability/readiness to learn (ability to grasp concepts, respond to questions, follow directions)
Comprehension: Good
Motivation: Ask questions
Preferred learning method: Visualization and Doing

Educational background
Highest level of education completed: Obesity (>30 BMI) Body mass index is 43.42 kg/(m^2).
Patient requests nutritional consultation: Yes

Some College
Baby Basics Book given and used to aid in teaching. used as a review

Nutritional Risk Assessment
Obesity (>30 BMI) Body mass index is 43.42 kg/(m^2).
Patient requests nutritional consultation: Yes

Infection History:
- History of Chicken pox: Yes
- Has patient been vaccinated: N/A
- Does the patient own a cat? No
- if yes, was the patient educated? N/A
- History of TB or positive PPD? No
- History of STD's: Yes

Social History:
Patient is on disability since 05/15/2013 from Rochester Psych - from PCP..

Patient has a stable home environment. Lives with her Mother and four of her children. Father of the baby is involved with the pregnancy.

- Do you have any history of domestic violence in the past year? No
- Do you feel unsafe with your partner? No
- Do you have any issues with transportation, food, housing, financial assistance, childcare, clothing, baby supplies? No
- Do you feel you need to see social work? No
- Do you have any history with post-partum depression? No

Prior CPS involvement with patient or FOBs other children? Yes, now closed

If yes, referral to SW indicated.
Social work referral was not made.

Transportation:
How will you get to your appointments? Pt will drive
Educated on Medicaid bus pass? N/A
Provided phone number for Medicaid bus pass request? N/A

Abridged Prenatal Chart note 3 Clinic – Attending

_____**, MD** 8/1/2014 10:43 PM Attested, Last edited by: _____, MD (8/2/2014 9:40 AM)
GA 12w5d

41 y.o. yo G15P6026 @ 12w5d wks ega with a pregnancy complicated by AMA, obesity depression, anxiety, h/o hypertension, polycythemia, elevated LFTs,ASUCS pap in pregnancy, and HSV2, presents today for a routine OBC. Patient was notified today that her cell free DNA was normal. Patient is excited to learn that the baby is a girl. She complains of vaginal discharge and itching and states that she thinks that she has a yeast infection.

Laboratory Results:
GENETICS

CFTR Allele 1	Negative
CFTR Allele 2	Negative
Interp.CF32M	No Mutation

Abridged Prenatal Chart note 4 – Attending

11/11/2014 11:03 AM GA 27w2d
OB Check
- Fetal unilateral renal pyelectasis 11/11/2014
  -Negative NIPT previously
  <> Recheck sono @ 32wks - ordered 11/11

Abridged Prenatal Chart note 5 – Attending

1/19/2015 5:47 PM GA 37w1d
Patient is a 41 y.o. female being seen today for her obstetrical visit. She is at 37w1d gestation. Patient reports + FM. occasional contractions. No SROM. She has noticed more vaginal irritation since visit last week and denies discharge.
HSV: no concerns. Taking Valtrex daily for suppression.
CHTN: denies headaches, vision changes or epigastric discomforts. Completing weekly NST's. Aware of plan for 39 week induction or prn based on any changes in status

Abridged Prenatal Chart note 6 – Registered Nurse Ultrasound

1/30/2015 8:38am

Fetal non-stress test for singleton pregnancy

Pre Procedure Diagnosis: Chronic hypertension during pregnancy, antepartum
Post Procedure Diagnosis: NST (non-stress test) reactive
Chronic Hypertension affecting pregnancy
38 weeks gestation of pregnancy
NST Start Time: 1/30/2015 8:34 AM
Uterine Irritability: No
Contractions:

End Time: 1/30/2015 9:04 AM **Duration of test (min):** 31
Location of NST Fetal Heart Tracing: Archived electronically in CPN
Interpreting Provider Recommendations: Suggest repeat NST in 5-7 days (weekly) or as indicated by clinical condition.
Comments: Induction planned for 39 weeks on Feb 1.
Next Test Date: 2/1/2015
Test performed By: RN 1/30/2015 8:38 AM

Abridged Chart note 6 - Attending

OBSTETRICS ADMISSION HISTORY & PHYSICAL

Reason for Admission (Chief Complaint): IOL for CHTN

HPI

41 yo G9P6026 at 39w2d admitted for IOL for CHTN. Patient has not been on meds this pregnancy and had normal HELLP labs with the exception of elevated AST. Other risks include Obesity, HSV2 seropositive only, GBS positive, Hx depression and anxiety (would like to start meds after delivery sees a counselor), GBS pos with PCN allergy/hives, AMA. Cervix 3/20/-2. Will plan to start Pitocin and AROM ASAP. Pt desires PP BTL. Has had prior cholecystectomy. Reviewed with patient that she is not ideal candidate given obesity and prior umbilical incision. We will re-assess fundus after delivery. Pt aware that interval tubal may be more appropriate. Neg SSE. EFW 3400 by ultrasound, 3500gms to my exam. Anticipate NSVD. Will have PPH kit in room as patient is grand multip.
.

Assessment & Plan

Patient is a 41 y.o. G9P6026 at 39w0d with pregnancy complicated by risks outlined previously admitted for IOL for CHTN.

Admit to LDRP
- Insert IV
- CBC, T&S, and Syphilis screen sent on admission.
- Cervix: *3/20/-3 / Membranes: Intact
- Presentation: vertex by US / EFW: 3403 grams by US 1/13
- Category fetal heart tracing. Intermittent EFM.

Labor Plan
- Vanc for GBS+ status, penicillin allergy with hives and resistance on sensitivities.
- Consider AROM when appropriate

Postpartum planning
- Rh positive / HIV negative / GBS positive
- Infant: female.
- Feeding: Breast and bottle
- PPBC: BTL

Abridged Birth Certificate Summary

Patient **06/30/2014 (06/30/14 to present)**

Birth Date:	07/01/75	Age (as of 02/01/15):	41	Race/Ethnicity:	Not Hispanic or Latino		
History:	G9P6026	Estimated Date of Delivery:	02/08/15	Gestational Age:	39w0d	Blood Type:	A RH POS

Prenatal Vitals

Enc. Date	GA	Pulse	BP	Weight	Height	Pain Assessment	Alb/Glu	Fundal Height (cm)	Fetal Heart Rate	Fetal Movement	Presentation	Dil/Eff/Sta
6/30/14	8w1d	80	110/80	122 kg (269 lb)	1.676 m (5' 5.98")	Two / Other (comment)* / Intermittent	Negative / Negative					
		*Pain Loc: left side area *Pain Descriptors: cramping										
8/1/14	12w5d	85	129/70	121.6 kg (268 lb)	1.676 m (5' 6")	Zero						
8/30/14	16w6d	86	135/74	119.9 kg (264 lb 4.8 oz)	1.676 m (5' 5.98")	Zero			152	Present		
9/28/14	21w0d		135/75	118.4 kg (261 lb)	1.676 m (5' 5.98")							
11/11/14	27w2d	86	132/75	120.4 kg (265 lb 8 oz)		Zero			141	Present	Vertex	
12/1/14	30w1d	96	134/71	122.2 kg (269 lb 8 oz)	1.676 m (5' 5.98")	Zero		33 cm	144	Present	Vertex	
12/9/14	31w2d	84	110/74	122.5 kg (270 lb)	1.676 m (5' 5.98")	Zero						
12/15/14	32w1d	88	122/76	122.5 kg		SIX / / BACK / / Aching / Continuous						
		*Pain Loc: pain at night only										
12/23/14	33w2d	91	141/73	122.5 kg (270 lb)	1.676 m (5' 5.98")	SIX / / ABDOMEN / / Aching / Continuous		37 cm	145	Present		
1/6/15	35w2d	94	140/78	122.5 kg (270	1.676 m (5' 5.98"	Zero		38 cm	146	Present		

				lb)	)							
1/13/15	36w2 d	91	139/78	122 kg (269 lb)	1.676 m (5' 5.98")	Two / Intermittent / ABDOMEN / / Sharp	38 cm	158	Present			
1/19/15	37w1 d	91	126/71	120.8 kg (266 lb 4.8 oz)	1.676 m (5' 5.98")	SEVEN / / / / Pressure / Continuous	38 cm	140	Present	Vertex		Closed / 50 / Ballotable
1/26/15	38w1 d	90	128/72	119.9 kg (264 lb 4.8 oz)	1.676 m (5' 5.98")	Zero	42 cm	134	Present	Vertex		Closed / 50 / Ballotable
2/1/15	39w0 d	Admission Dx: Pregnancy Dept: OB										

TWG: 0.454 kg (1lb) Pregravid weight: 119.7 kg (264 lb) Number of fetuses: 1 Height: 1.651 m (5' 5") BMI: 43.9

Progress Notes (Episode)

LDRP

Dating Summary

Working EDD: 02/08/15 based on Ultrasound on 06/24/14

Based On	EDD	GA Dif	GA	User	Date
Last Menstrual Period on 04/21/14 (Approximate)	01/26/15	+1w6d		System action - copied	06/30/14
Ultrasound on 06/24/14	02/08/15	Working	7w2d	RN	06/30/14

OB History

Gravida	Para	Term	Preterm	AB	TAB	SAB	Ectopic	Multiple	Living
9	6	6		2	2				6

	Outcome	Date	GA	Labor/2nd	Weight	Sex	Delivery	Anes	PTL	Living	Name	Location	Delivering Clinician
1	Term	4/1989					Vag-Spont			Y			
2	Term	5/1995					Vag-Spont			Y			
3	Term	6/1997					Vag-Spont			Y			
4	Term	2/2000					Vag-Spont			Y			
5	Term	3/2002					Vag-Spont			Y			
6	Term	7/2003					Vag-Spont			Y			
7	Therapeutic Abortion	9/2010											

8	Therapeutic Abortion	11/2011								
9	Current									

Social History

Category	History
Smoking Tobacco Use	**Never Smoker**
Smokeless Tobacco Use	**Never Used**
Tobacco Comment	
Alcohol Use	**No; (none with pregnancy)**
Drug Use	**No**
Sexual Activity	**Yes; Male partners; Birth Ctrl/Protection: None**
ADL	**Not Asked**

Concurrent Nursing Documentation Maternal Information

ABO RH BLOOD TYPE

Date	Value	Ref Range	Status
02/01/2015	A RH POS		Final

HBV S AG

Date	Value	Ref Range	Status
07/13/2014	NEG		Final

Comment:
Test Method: CMIA

RUBELLA IGG AB

Date	Value	Ref Range	Status
07/13/2014	POSITIVE		Final

Comment:
TEST METHOD: Multiplex flow immunoassay

HIV 1&2 ANTIGEN/ANTIBODY

Date	Value	Ref Range	Status
07/13/2014	Nonreactive		Final

Comment:
Test Method: CMIA

RAPID HIV 1&2

Date	Value	Ref Range	Status
09/29/2011	NEG		Final

Comment:
TEST METHOD:Lateral Flow Immunoassay

SYPHILIS SCREEN

Date	Value	Ref Range	Status
07/13/2014	Neg		Final

Comment:
TEST METHOD: BioPLEX(Multiplex Flow Immunoassay)

GROUP B STREP CULTURE

Date	Value	Ref Range	Status
01/13/2015	Streptococcus agalactiae (Group B) detected		Final

Comment:
Organism identified from broth culture by amplification.

Facility-Administered Medications as of 2/1/2015

Medication	Dose	Frequency	Last Dose
• Vancomycin (VANCOCIN) IV 1,000	1,000 mg	Q12H	1,000 mg at

mg		02/01/15 0850

Weights (since admission)

Date/Time	Height	Weight	Pre-Pregnancy Weight	Pregnancy weight change (kg)	BMI (Calculated)	BSA (Calculated - sq m)	Who
02/01/15 0857	1.651 m (5' 5")	120.2 kg (265 lb)	--	--	44.2	2.35 sq meters	JB

Module 5 – Prenatal History

Extraction Exercise 1 Work Book excerpts

Prenatal History

Prenatal History

Did mother receive prenatal care?
☐ Yes ☐ No

Primary Prenatal Care Provider Type:
☐ MD / DO / C(N)M / HMO ☐ No Information
☐ Clinic ☐ No Provider
☐ Other

Did mother participate in WIC?
☐ Yes ☐ No

Key Pregnancy Dates *(MM/DD/YYYY)*

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
/ /	/ /	/ /	/ /

Prenatal Visits

Total Number of Prenatal Visits:

Pregnancy History

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number ☐	**Now Dead** None or Number ☐	**Less than 20 Weeks** None or Number ☐	**20 Weeks or More** None or Number ☐	None or Number ☐	None or Number ☐

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
/	/	/	*lbs.*	*ft.* *in.*

See next page for answers

Module 5 – Prenatal History

Extraction Exercise #1 Answers

Prenatal History

Prenatal History

Did mother receive prenatal care?	Primary Prenatal Care Provider Type:	Did mother participate in WIC?
X Yes ☐ No	☐ MD / DO / C(N)M / HMO ☐ No Information X Clinic ☐ No Provider ☐ Other	☐ Yes X No

Key Pregnancy Dates *(MM/DD/YYYY)*

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
04 / 21 /14	02 / 08 / 15	06 / 30 / 14	01 / 26/ 15

Prenatal Visits

Total Number of Prenatal Visits: **13**

Pregnancy History

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living	**Now Dead**	**Less than 20 Weeks**	**20 Weeks or More**		
None or Number	None or Number	None or Number	None or Number	None or Number	None or Number
6	X	X	X	☐ 2	☐ 8

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
4/1989	8/2003	1/2011	264 *lbs.*	5 *ft.* 5 *in.*

WIC info was found under 'Assessment and Plan', page 2

Pre-pregnancy weight and height found at the end of the Pre-natal visits lists.

Last Menses found in Progress Notes – Dating Summary

Module 5 – Prenatal History

Extraction Exercise #2

Below are abridged chart notes and an abridged example of a patient summary created for Birth Certificate Registrars.
Fill in the appropriate answers on the Birth Certificate Work Book excerpts (last page).

Prenatal Chart note 1– Private Group : Physician's Assistant

_____,**PA** 1/28/2016 12:56 PM Signed
ID: Patient is a 34 yo. G3P1011 at 12w3d by early ultrasound who presents today for her NOB visit.

HPI: Pt had abnormal 1st trimester screen showing increased risk for trisomy 21. Opted for cfDNA testing, drawn 1/25/16. Also concerned about viral illness that she had in first trimester. Did not meet NYSDOH criteria for zika testing. Was with friends who live in FL while visiting Maryland. Planning early anatomic at 16 weeks and repeat 18-20 for growth/HC. Very stressed over all of these things. Depression screen positive today and pt attributes to this. Is not interested in medication. Would consider counseling; has done this in the past for anxiety. Declines referral today though. Denies HI/SI.

Chart note: Computer Connection Result
Viewed by Patient on Wed Aug 2, 2016 11:25:17 AM EDT--------
Hi patient,
Follow-up anatomic scan is normal. Growth and fluid volume also appropriate.
Hope you're doing well.
_____, PAC

Abridged Registrars Summary Birth Certificate

LDRP

Dating Summary

Working EDD: 11/06/16 set by _____, PA on 04/28/16 based on Ultrasound on 03/23/16

Based On	EDD	GA Dif	GA	User	Date
Last Menstrual Period on 01/27/16 (Approximate)	11/01/16	+5d			
Ultrasound on 03/23/16	11/06/16	Working	7w3d	_____, PA	

OB History

Gravida	Para	Term	Preterm	AB	TAB	SAB	Ectopic	Multiple	Living
3	1	1	0	1	0	1	0	0	1

#	Outcome	Date	GA	Labor/2nd	Weight	Sex	Delivery	Anes	PTL	Living	Name	Location	Delivering Clinician
1	Term	06/2014	39w1d	6h 39m / 0h 33m	2866 g (6 lb 5.1 oz)	M	Vag-Spont	EPIDURAL-	N	Y	BOY	Other	DO
2	Spontaneous Abortion	01/2011											
3	Current												

Encounters related to Labor and Delivery Encounter on 10/24/2016 with _____, MD

Date	Encounter Type	Provider	Department	Reason

1/24/2017	Labor and Delivery Encounter	MD	OB	PROM (premature rupture of membranes),PROM (premature rupture of membranes)
10/24/2016	History	MD	OB	Not found
10/24/2016	Anesthesia Event	MD	OB	Not found
10/24/2016	Anesthesia	MD	OB	Not found
10/23/2016	Routine Prenatal	MD	OB	OB CHECK; ROUTINE PRENATAL VISIT
10/16/2016	Routine Prenatal	CNM	OB	OB CHECK; ROUTINE PRENATAL VISIT
10/5/2016	Routine Prenatal	CNM	OB	OB CHECK; ROUTINE PRENATAL VISIT
9/19/2016	Routine Prenatal	MD	OB	OB CHECK; ROUTINE PRENATAL VISIT
9/6/2016	Routine Prenatal	CNM	OB	OB CHECK; ROUTINE PRENATAL VISIT
8/21/2016	Routine Prenatal	CNM	OB	OB CHECK; ROUTINE PRENATAL VISIT
8/15/2016	Labor and Delivery Encounter	MD	Triage	Not found
7/24/2016	Routine Prenatal	CNM	OB	OB CHECK; ROUTINE PRENATAL VISIT
6/29/2016	Routine Prenatal	MD	OB	OB CHECK; FOLLOW-UP
6/26/2016	Routine Prenatal	CNM	OB	OB CHECK; ROUTINE PRENATAL VISIT
5/29/2016	Routine Prenatal	MD	OB	OB CHECK; ROUTINE PRENATAL VISIT
4/28/2016	Initial Prenatal Clinical Support	PA	OB	NEW OB VISIT; INITIAL PRENATAL VISIT

Hospital Problems

	Priority	Class	Noted - Resolved
Active Problems			
PROM (premature rupture of membranes)			10/24/2016 - Present

Non-Hospital Problems

	Priority	Class	Noted - Resolved
Active Problems			
Supervision of normal pregnancy	High		2/29/2016 - Present
Abnormal first trimester screen	Medium		1/27/2016 - Present
H/O viral illness in first trimester	Medium		2/27/2016 - Present
History of postpartum depression, currently pregnant			10/5/2016 - Present
Group B streptococcal infection in pregnancy			10/18/2016 -

		Present

Resolved Problems

RESOLVED: Female infertility of unspecified origin		1/25/2013 - 6/18/2014
RESOLVED: Irregular menses		4/26/2013 - 6/18/2014
RESOLVED: Pregnancy with history of infertility		11/1/2013 - 6/18/2014
RESOLVED: Antepartum bleeding, second trimester		1/6/2014 - 6/18/2014
RESOLVED: PROM (premature rupture of membranes)		6/18/2014 - 6/16/2014
RESOLVED: SVD (spontaneous vaginal delivery)		6/18/2014 - 6/16/2014
RESOLVED: SVD (spontaneous vaginal delivery)		6/18/2014 - 2/23/2015
RESOLVED: Missed abortion		12/30/2015 - 10/14/2016
RESOLVED: Anxiety	Low	11/25/2013 - 10/23/2016

Medical History

Past Medical History	Date	Comments
Eating disorder [F50.9]	**bulemia 2000, anorexia 1996**	
Depression [F32.9]	**1996**	
GERD (gastroesophageal reflux disease) [K21.9]		**alka seltzer prn**
HPV in female [A63.0]	**2002**	**hx of condylomata removal**
Varicella [B01.9]		

Pertinent Negatives	Date Noted	Comments
Basal cell carcinoma [C44.91]	**8/26/2014**	
Melanoma [C43.9]	**8/26/2014**	
Squamous cell carcinoma [C80.1]	**8/26/2014**	

Surgical History

Past Surgical History	Laterality	Last Occurrence	Comments
Anterior cruciate ligament repair [SHX115]	**Left**	**2005**	
Knee arthroscopy [SHX127]	**Left**	**2005**	
Cervical polyp removal [SHX88]		**2012**	**Dr. Quereshi**
HYSTEROSCOPY [SHX211]		**2012**	**small resection of endometrium**

Social History

Category	History
Smoking Tobacco Use	**Never Smoker**
Smokeless Tobacco Use	**Never Used**
Tobacco Comment	

Alcohol Use	**No**
Drug Use	**No**
Sexual Activity	**Yes; Male partners**
ADL	**Not Asked**

Concurrent Nursing Documentation Maternal Information

ABO RH BLOOD TYPE

Date	Value	Ref Range	Status
10/24/2016	O RH POS		Final

HBV S AG

Date	Value	Ref Range	Status
03/28/2016	NEG		Final

Comment:
Test Method: CMIA

RUBELLA IGG AB

Date	Value	Ref Range	Status
03/28/2016	POSITIVE		Final

Comment:
TEST METHOD: Multiplex flow immunoassay

HIV 1&2 ANTIGEN/ANTIBODY

Date	Value	Ref Range	Status
03/28/2016	Nonreactive		Final

Comment:
Test Method: CMIA

SYPHILIS SCREEN

Date	Value	Ref Range	Status
8/02/2016	Neg		Final

Comment:
TEST METHOD: BioPLEX(Multiplex Flow Immunoassay)

GROUP B STREP CULTURE

Date	Value	Ref Range	Status
10/05/2016	Streptococcus agalactiae (Group B) detected		Final

Comment:
Organism identified from broth culture by amplification.

Facility-Administered Medications as of 10/24/2016

Medication	Dose	Frequency	Last Dose
• [COMPLETED] penicillin G potassium injection 5 Million Units	5 Million Units	Once	5 Million Units at 010/24/16 0743
Followed by			
• penicillin G potassium IVPB 3 Million Units	3 Million Units	Q4H	3 Million Units at 10/24/16 1146

Chromosome Analysis

**** No results found for the last 7440 hours. ****

Weights (since admission)

Date/Time	Height	Weight	PrePregnancy Weight	Pregnancy weight change (kg)	BMI (Calculated)	BSA (Calculated - sq m)	Who
01/24/16 0753	1.524 m (5')	78 kg (172 lb)	68 kg (150 lb)	9.98 kg	33.7	1.82 sq meters	DE

Pain Medications (Filter: ERX PAIN MANAGEMENT CM (Medications Shown)) As of 010/24/16 1345

None

Nursing Epidural Events

Date/Time	Epidural Procedures
10/24/16 1135	Additional Bolus Given- Second half or Additional Bolus in same visit
10/24/16 1128	Additional Bolus Given- Second half or Additional Bolus in same visit
10/24/16 1126	Bolus Dose Given- First Half Bolus or Full Dose Bolus
10/24/16 1118	Test Dose Given
10/24/16 1116	Epidural Catheter Placed
10/24/16 1100	Anesthesia Positioning for Epidural

Anesthesia Record

Anesthesia Record

Steroidal Medications (Filter: ERX GENERAL PQRI GLUCOCORTICOID MEDICATIONS MEASURE 180 Medications Shown)

None

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
10/24/16 0626	Admission	Observation	OB	LDRP	

Module 5 – Prenatal History

Extraction Exercise #2 Work Book excerpts

Please enter the correct information

Prenatal History

Prenatal History

Did mother receive prenatal care?
☐ Yes ☐ No

Primary Prenatal Care Provider Type:
☐ MD / DO / C(N)M / HMO ☐ No Information
☐ Clinic ☐ No Provider
☐ Other

Did mother participate in WIC?
☐ Yes ☐ No

Key Pregnancy Dates *(MM/DD/YYYY)*

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
/ /	/ /	/ /	/ /

Prenatal Visits

Total Number of Prenatal Visits:

Pregnancy History

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number ☐	**Now Dead** None or Number ☐	**Less than 20 Weeks** None or Number ☐	**20 Weeks or More** None or Number ☐	None or Number ☐	None or Number ☐

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
/	/	/	*lbs.*	*ft.* *in.*

See next page for answers

Module 5 – Prenatal History

Extraction Exercise #2 Answers

Prenatal History

Prenatal History

Did mother receive prenatal care?	Primary Prenatal Care Provider Type:	Did mother participate in WIC?
X Yes ☐ No	X MD / DO / C(N)M / HMO ☐ No Information ☐ Clinic ☐ No Provider ☐ Other	☐ Yes X No

Key Pregnancy Dates *(MM/DD/YYYY)*

Date of Last Menses:	Estimated Due Date:	Date of First Prenatal Visit:	Date of Last Prenatal Visit:
1 / 1 / 16	11 / 06 / 16	04 / 28 / 16	10 / 23 / 16

Prenatal Visits

Total Number of Prenatal Visits: 11

Pregnancy History

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number	**Now Dead** None or Number	**Less than 20 Weeks** None or Number	**20 Weeks or More** None or Number	None or Number	None or Number
☐ 1	X	☐ 1	X	X	☐ 2

First Live Birth: *(MM / YYYY)*	Last Live Birth: *(MM / YYYY)*	Last Other Pregnancy Outcome: *(MM / YYYY)*	Prepregnancy Weight:	Height:
06 / 2014	06 / 2014	01 / 2011	150 *lbs*	5 *ft.* 0 *in.*

Re: Number of Prenatal Visits – Anesthesia visits not counted

Also note: the Pre-natal visits ended in October and the baby wasn't born until December. Please, refer to the 'Extra Information' section for added explanation.

Scenario Exercise(s)

Module 5 – Prenatal History

Scenario Exercises

Enter the correct information

Exercise #1

When counting the number of prenatal visits, does an OB Consult count as a visit?

___ Yes
___ No

Exercise #2

A woman, pregnant for the 1st time, delivered live twins on 02/07/12.

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number ___	Now Dead None or Number ___	Less than 20 weeks None or Number ___	20 weeks or more None or Number ___	None or Number ___	None or Number ___

First Live Birth: *(MM/YYYY)*	Last Live Birth: *(MM/YYYY)*	Last Other Pregnancy: Outcome: *(MM/YYYY)*	Prepregnancy Weight: ____ lbs.	Height: ___ft. ___in.

Exercise #3

34 year old woman with one prior pregnancy which resulted in a live birth (still living) in 2009 arrived at the hospital in labor @ 40 ⅐ week's gestation. This IVF pregnancy was initially a triplet pregnancy that was reduced to a twin pregnancy early in the first trimester (4/30/12). At 23 weeks gestation the woman experienced an FDIU of one of the remaining twins. The woman delivered the living twin without difficulty. The FDIU was delivered vaginally following the birth of the living twin.

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies
Now Living None or Number ___	Now Dead None or Number ___	Less than 20 weeks None or Number ___	20 weeks or more None or Number ___	None or Number ___	None or Number ___

First Live Birth: *(MM/YYYY)*	Last Live Birth: *(MM/YYYY)*	Last Other Pregnancy Outcome: *(MM/YYYY)*	Prepregnancy Weight: ____ lbs.	Height: ___ft. ___in.

See Module 5 Answer section for correct responses

Module 5 – Prenatal History

Scenario Exercises Answers

Exercise #1

When counting the number of prenatal visits, does an OB Consult count as a visit?

_X_ Yes
___ No

Exercise #2

A woman, pregnant for the 1st time, delivered live twins on 02/07/12. Enter information on Twin B.

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies:
Now Living None or Number	Now Dead None or Number	Less than 20 weeks None or Number	20 weeks or more None or Number	None or Number	None or Number
___ 1	_X_	_X_	_X_	_X_	___ 0

First Live Birth: *(MM/YYYY)*	Last Live Birth: *(MM/YYYY)*	Last Other Pregnancy: Outcome: *(MM/YYYY)*	Prepregnancy Weight:	Height:
02 / 2012	02 / 2012		____ lbs.	___ft. ___in.

Exercise #3

34 year old woman with one prior pregnancy which resulted in a live birth (still living) in 07/2009 arrived at the hospital in labor @ 40 ⅐ week's gestation. This IVF pregnancy was initially a triplet pregnancy that was reduced to a twin pregnancy early in the first trimester (4/30/12). At 23 weeks gestation the woman experienced an FDIU of one of the remaining twins. The woman delivered the living twin without difficulty. The FDIU was delivered vaginally following the birth of the living twin.

Pregnancy History

Previous Live Births:		Previous Spontaneous Terminations:		Previous Induced Terminations:	Total Prior Pregnancies
Now Living None or Number	Now Dead None or Number	Less than 20 weeks None or Number	20 weeks or more None or Number	None or Number	None or Number
___ 1	_X_	_X_	_X_	___ 1	___ 1

First Live Birth: *(MM/YYYY)*	Last Live Birth: *(MM/YYYY)*	Last Other Pregnancy Outcome: *(MM/YYYY)*	Prepregnancy Weight:	Height:
07/2009	04/2012	04/2012	____ lbs.	___ft. ___in.

Module Evaluation

Registrar Name:_____Hospital: _____Date:_____(MM/DD/YY)

MODULE FIVE EVALUATION

(Please mark the appropriate response)

1. **The medical record indicates that the infant was signed up for WIC after birth. Mom had not received WIC services prenatally. What would you enter in the field "Did mother participate in WIC?"**
   - o Yes
   - o No

2. **If day *Last Normal Menses* began is not known, it's OK to enter just the month and year.**
   - o True
   - o False

3. **When counting *Total Number of Prenatal Care Visits* a mother has had, you would count as the 1st visit a visit made solely to determine the fact that she is pregnant.**
   - o True
   - o False

4. **If a mother comes to the ER for a sprained ankle when she is 8 months pregnant this visit should be counted as a prenatal visit.**
   - o True
   - o False

5. **When a D&C is done to remove a molar pregnancy, the pregnancy would be noted in which field?**
   - o Spontaneous termination
   - o Induced termination

6. **When a mother, with no previous live births, gives birth to live twins, the *Number of Previous Live Births* for Twin A would be coded as "0" and for Twin B would be coded as:**
   - o "0"
   - o "1"
   - o Neither of the above

7. **When a mother, with no previous live births, gives birth to live twins, the *Total Number of Prior Pregnancies* for Twin A would be coded as "0". What would the Total Number of Prior Pregnancies be coded as for Twin B?**
   - o "0"
   - o "1"
   - o Neither of the above

Registrar Name:_____Hospital: _____Date:_____(MM/DD/YY)

8. **When a mother, with no previous live births, gives birth to live twins, the date of first and last live birth for Twin A would be blank. What would the *Date of First Live Birth* and *Date of Last Live Birth* be coded as for Twin B?**
    - Both date fields would be left blank
    - Date of First Live Birth would be left blank; Date of Last Live birth would be date of Twin A's birth.
    - Date of First Live Birth and Date of last Live birth would be date of Twin A's birth.

9. **When the *Pre-pregnancy Weight* in the prenatal care record is recorded as a range 135-140 lbs. you would enter the pre-pregnancy weight as:**
    - 135
    - 137
    - 140

10. **You would record *Last Other Pregnancy Outcome* (date) only for Live Births.**
    - True
    - False

See next page for answers

MODULE FIVE EVALUATION *ANSWERS*

1. **The medical record indicates that the infant was signed up for WIC after birth. Mom had not received WIC services prenatally. What would you enter in the field "Did mother participate in WIC?"**
   - Yes
   - No

   Answer: This question relates to services mother received while pregnant. Since she did not receive WIC prenatally the answer to this question is "No." (Slide 4)

2. **If day Last Normal Menses began is not known, it's OK to enter just the month and year.**
   - True
   - False

   Answer: The Date of Last Menses should be based on the Prenatal Care Record or Medical History. It is OK to provide just month and year if that is all that is known. (Slide 5)

3. **When counting Total Number of Prenatal Care Visits a mother has had, you *would* count as the 1st visit a visit made solely to determine the fact that she is pregnant.**
   - True
   - False

   Answer: A prenatal visit solely for the purpose of determining that the woman is pregnant is not counted as a prenatal care visit. (Slide 6)

4. **If a mother comes to the ER for a sprained ankle when she is 8 months pregnant, this visit should be counted as a prenatal visit**.
   - True
   - False

   Answer: Prenatal care visits should be those in clinics or doctor's offices for routine prenatal care. A labor check or ER visit should not be counted as a prenatal visit. (Slide 7)

5. **When a D&C is done to remove a molar pregnancy, the pregnancy would be noted in which field?**
   - Spontaneous termination
   - Induced termination

   Answer: Molar pregnancies or blighted ova should always be coded as spontaneous terminations regardless of final mode of pregnancy completion. (Slide 9)

6. **When a mother, with no previous live births, gives birth to live twins, the Number of Previous Live Births for Twin A would be coded as "0" and for Twin B would be coded as:**
   - "0"
   - "1'
   - Neither of the above

   Answer: There would be a change in the number of previous live births for Twin B, increasing it by '1' (to reflect the birth of Twin A). (Slide 8)

7. **When a mother, with no previous live births, gives birth to live twins, the Total Number of Prior Pregnancies for Twin A would be coded as "0". What would the Total Number of Prior Pregnancies be coded as for Twin B?**
    - "0"
    - "1"
    - Neither of the above

   Answer: The Total Number of Prior Pregnancies remains unchanged from Twin A to Twin B. (Slide 10)

8. **When a mother, with no previous live births, gives birth to live twins, the date of first and last live birth for Twin A would be blank. What would the Date of First Live Birth and Date of Last Live Birth be coded as for Twin B?**
    - Both date fields would be left blank
    - Date of First Live Birth would be left blank; Date of Last Live birth would be date of Twin A's birth.
    - Date of First Live Birth and Date of last Live birth would be date of Twin A's birth.

   Answer: The date of the first and last live birth for Twin B becomes Twin A's birth date. (Slide 11)

Extra Information

Module 5

Concerning prenatal visits:

From the HELPER Guidelines:

DATE OF LAST PRENATAL CARE VISIT

Enter the date upon which the mother's last prenatal-care visit. Include only a visit to a private provider or to a clinic or outpatient department of a hospital in which the mother received prenatal care. Do not include healthcare visits unrelated to pregnancy care, e.g. emergency room care for an injury. If an exact date is not available, try to get an estimate such as beginning, middle or end of the month. These estimates should be converted to '07', '15' and '24', respectively. If no prenatal care was received, leave the date blank.

NUMBER OF PRENATAL VISITS

Enter the total number of prenatal visits made by the mother to a physician or prenatal clinic for the purpose of prenatal care. A prenatal visit includes all regular visits to a doctor or clinic and any other visits to a doctor, clinic or emergency room for treatment of a pregnancy related problem. If an exact date is not known estimate the number of visits.

Prenatal care visits should be those in clinics or doctor's offices. A labor check should not be counted nor any other trip to the hospital. For example, a pregnant woman may come to the hospital a few times near the end of her pregnancy, but have no prenatal care or very little at all. If the hospital visits are counted, it may look like the woman had several prenatal care visits when in fact she had none at all. (Eileen Shields, NYSDOH 03/2009)

The number of pre-natal visits for the woman to be counted as having 'adequate pre-natal care' is 13. This number counts the bi-weekly and weekly visits at the end of the gestational period.

If a pre-natal is sent from a private office, it is often sent at 36 wk. with no follow-up to account for the remaining visits before the woman delivers.

The state is willing to accept this information as the last pre-natal visit.

It has been found, through research, that if the last date is at the 36 week visit, the woman's care will always be marked as being "inadequate". This would make any research studies incorrect.

While you can enter the information as you find it in the pre-natal, in order to have the most accurate data, you would need to ask the woman or call the OB provider's office to get an account of visits including the number not listed on the faxed pre-natal. (Varga, 2017)