



**Prenatal Guidelines**



NAME: \_\_\_\_\_ G \_\_ P\_\_ A \_\_ Alive \_\_ DOB: \_\_\_\_\_

Expected date of confinement \_\_\_\_\_ as determined by \_\_\_\_\_ dates only U/S

| <b>INITIAL VISIT _____ Weeks Gestation</b>               |                  |                |                           |
|--|------------------|----------------|---------------------------|
| <b>Specimen</b>  | <b>Date done</b> | <b>Results</b> | <b>Comments/Treatment</b> |
| 1) VDRL  |                  |                |                           |
| 2) HEPATITIS B   |                  |                |                           |
| 3) RUBELLA   |                  |                |                           |
| 4) GROUP & Rh FACTOR                                     |                  |                |                           |
| 5) HEMOGLOBIN  |                  |                |                           |
| 6) URINE CULTURE   |                  |                |                           |
| 7) If known diabetic, do FBS & 2 hr pc glucose           |                  |                |                           |
| 8) If not diabetic:                                      |                  |                |                           |
| a) 50 gm GTT with 1 hr pc glucose                        |                  |                |                           |
| b) 75 gm GTT with hourly glucose x 2                     |                  |                |                           |
| 9) HIV   |                  |                |                           |
| 10) HANGING DROP   |                  |                |                           |
| 11) PAP  |                  |                |                           |
| 12) G.C.   |                  |                |                           |
| 13) CHLAMYDIA  |                  |                |                           |
| 14) Vitamin D 100,000 IU po at first visit               |                  |                |                           |
| <b>16 WEEKS – Date tests due: _____</b>                  |                  |                |                           |
| 1) TRIPLE SCREEN (AFP/MSS)                               |                  |                |                           |
| 2) ULTRASOUND indication:                                |                  |                |                           |
| <b>24-26 WEEKS – Date tests due: _____</b>               |                  |                |                           |
| 1) 50 gm GTT with 1 hr pc glucose                        |                  |                |                           |
| 2) 75 gm GTT with hourly glucose x 2                     |                  |                |                           |
| <b>28 WEEKS – Date tests and vitamin D due: _____</b>    |                  |                |                           |
| 1) ANTIBODY SCREEN                                       |                  |                |                           |
| 2) HEMOGLOBIN  |                  |                |                           |
| 3) Vitamin D 100,000 IU at 26-30 wks                     |                  |                |                           |
| 4) Recto-vaginal swab for <input type="checkbox"/> Strep |                  |                |                           |
| 5) Repeat cervical swabs as needed                       |                  |                |                           |
| <b>36 WEEKS – Date tests due: _____</b>                  |                  |                |                           |
| 1) Recto-vaginal swab for <input type="checkbox"/> Strep |                  |                |                           |
| 2) Repeat cervical swabs as needed                       |                  |                |                           |

## DIABETES SCREENING

The initial screening test is a 50 gm oral glucose load, given at any time of day, followed by a plasma glucose at 1 hour.

If the 1-hour value is  $\geq 7.8$  mmol/L, proceed to the 75 gm GTT.

If the 1-hour value after 50 gm load is  $\geq 10.3$  mmol/L, the diagnosis of **Gestational Diabetes** can be made without further testing.

| Oral Glucose Tolerance Test<br>(2 hour 75 gm) |               |
|---|---------------|
| Fasting                                       | > 5.3 mmol/L  |
| 1 hour  | > 10.6 mmol/L |
| 2 hour  | >8.9 mmol/L   |

If 2 or more values are exceeded, the diagnosis is **Gestational Diabetes**.  
If 1 value is exceeded, the diagnosis is **Impaired Glucose Tolerance of Pregnancy**.

**Impaired Glucose Tolerance of Pregnancy (IGT of Pregnancy)** is carbohydrate intolerance in pregnancy and should not be confused with IGT in the non-pregnant person.

IGT of pregnancy carries some of the same implications as does GDM and, therefore, should be treated in the same fashion.