

MATERNAL FLOW *(See Instructions)*

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month	Day Year
4. Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White	
5. Ethnic Origin	<input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported	
6. Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	
7. County of Residence		

DETERMINATION OF EDC	DATE OF:	EDC:
LMP	_____	_____
LNMP	_____	_____
First Uterine size (_____ wks.)	_____	_____
Quickening	_____	_____
Ultrasound — 1 st U/s (_____ wks.)	_____	_____
Ultrasound	_____	_____
Best EDC: _____		

Health Department/Clinic Name: _____

Height _____ Pre-Pregnancy Weight _____ Pre-Pregnancy BMI _____

Per IOM:* Overweight Underweight Normal weight

Recommended weight gain range (per IOM): _____ - _____

Pre-pregnancy wt _____ + low range _____ = _____ (Min)
 Pre-pregnancy wt _____ + high range _____ = _____ (Max)

INFLUENZA VACCINE OFFERED YES NO
 Pt Refused N/A (non-seasonal)

DATE GIVEN _____ Lot # _____
 Injection Location _____ RN Signature _____

Problems/Risks Identified	Date Identified	Date Resolved
1. Using Risk Guide <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes view "Risk Guide" form)		
2.		
3.		
4.		
5.		
6.		

Meds Prescribed	Start Date	Stop Date
1.		
2.		
3.		
4.		
5.		
6.		

Visit Date (Year)	Weeks Gest. (best est.)	Fundal Ht. (cm)	Blood Pressure	Urine (glucose/Protein)	Weight (Min _____ Max _____)	< Min Wt? OR > Max Wt? (Y/N)	Edema	Fetal presentation (≥ 36 wks)	Fetal Heart Rate	Fetal Movement	Contractions	Vaginal Bleeding/Rupture of Membranes	Cervix Exam (Dil/Eff./Sta.)	PNV (Taking Y/N/ Needs Refill)	Next Appointment	Interpreter (initials)	Provider (initials)	Allergies/Drug Reactions: (Identify) _____ _____ _____	Latex Allergy <input type="checkbox"/> Yes <input type="checkbox"/> No	Comments / Plans of Care

MATERNAL HEALTH FLOW SHEET

Instructions

Purpose: To assess and document patient's weight and health progression throughout the pregnancy.

Instructions: Refer to link <http://whb.ncpublichealth.com/provPart/forms.htm> for a list of definitions pertaining to this form, print and use as needed.

This form is to be completed by the appropriate staff and reviewed by the clinical provider. Use agency policy approved codes. This form is not a mandatory form and may be used at the discretion of the health department.

The following are specific instructions for filling out the WT/BMI Box:

- **Pre-pregnancy Weight** — Determine weight before pregnancy occurred to the best of your ability. Every effort should be made to obtain documented pre-pregnancy weight.
- **Pre-pregnancy BMI** — Using height and pre-pregnancy weight, calculate BMI using a BMI wheel, chart or online calculator.
- **Weight Classification** — Based on pre-pregnancy BMI, determine patient's weight status (underweight, normal weight or overweight).*
- **Weight Gain** — Based on weight classification, determine recommended gestational weight gain range.*

* As per Institute of Medicine (IOM) guidance below:

Prepregnancy BMI	BMI+ (kg/m ²)	Total Weight Gain (lbs)	Rates of Weight Gain* 2 nd and 3 rd Trimester (lbs/week)
Underweight	<18.5	28–40	1 (1–1.3)
Normal weight	18.5–24.9	25–35	1 (0.8–1)
Overweight	25.0–29.9	15–25	0.6 (0.5–0.7)
Obese (includes all classes)	≥30.0	11–20	0.5 (0.4–0.6)

NOTE: Per new IOM guidelines; revised May 2009.

To Calculate BMI go to www.nhlbisupport.com/bmi

Example:

1. Height 5'5".
2. Pre-pregnancy weight 170 lbs.
3. BMI 28
4. Weight Classification: Overweight
5. Recommended Gestational Weight Gain: 15–25 pounds
6. Pre-pregnancy wt 170 lbs + 15 lbs (low end of recommended weight gain range) = 185 lbs (minimum weight gain recommendation)
7. Pre-pregnancy wt 170 lbs + 25 lbs (high end of recommended weight gain range) = 195 lbs (maximum weight gain recommendation)
8. This patient advised to gain 15–25 pounds. As pregnancy progresses, if weight presents as less than 185 lbs or greater than 195 lbs, ideal weight gain counseling is required.

Instructions for the “Problems/Risk Identified” Box:

If you plan to use the “Risk Guide” Form check off the yes box and make sure the “Risk Guide” Form is in sequence by being the form before this page. This will allow easy access to the Risk Guide problem list and reminds individuals to refer to the Risk Guide form. One can either document other problems by using numbers 2–6 or leave this area to be utilized once the Risk Guide has reached its capacity.

Determination of EDC box, Influenza box, and the medication box are all self explanatory.

Specific Instructions for the Visit Flow Sheet Section:

- Document date of visit
- Document gestational age for that particular visit
- Provider is to document fundal height
- Document patient's BP, urine dipstick info, weight, and signs of edema
- Under the “weight column” document the patient's minimum and maximum weight gain or loss based on the BMI and math you have obtained on this form
- Provider is to document fetal presentation and fetal heart rate or place a positive symbol if fetal heart rate is present and normal
- Document if patient is complaining of contractions, vaginal bleeding or rupture of membranes, and if there is fetal movement
- If provider does a cervical exam he/she should document dilatation/effacement and station
- If the patient is taking prenatal vitamins (PNV) place a “Y” in the top box, if not place a “N” in the top box and do the same for PNV refills in the bottom box
- Next appointment, interpreter's initials, and the provider's initials are self explanatory
- Use the Comments column to document notes for that visit or write “see progress notes” if you are using a progress note sheet for comments

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:
<http://whb.ncpublichealth.com/provPart/forms.htm>