



OUTPATIENT FETAL MONITORING REFERRAL



From ID: OBXX104997C

Rev: June 25, 2020

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Name: _____ Contact Number(s): _____ PHN: _____

EDD _____ Interpreter needed? Yes No Language _____

Please see guidelines on reverse for indication and frequency (indicate condition)

<input type="checkbox"/> Advanced maternal age	<input type="checkbox"/> Fetal Growth Restriction <10th percentile (see reverse):
<input type="checkbox"/> Antepartum Hemorrhage (chronic abruption)	<input type="checkbox"/> Isolated Oligohydramnios
<input type="checkbox"/> Antiphospholipid Syndrome	<input type="checkbox"/> Isolated Polyhydramnios
<input type="checkbox"/> Cholestasis of pregnancy	<u>Multiple Pregnancy (no other complications or IUGR):</u>
<u>Diabetes:</u>	<input type="checkbox"/> Di/Trichorionic <input type="checkbox"/> Twins <input type="checkbox"/> Triplets
<input type="checkbox"/> Pregestational or gestational requiring insulin	<input type="checkbox"/> Mono/DiTriamniotic <input type="checkbox"/> Twins <input type="checkbox"/> Triplets
<input type="checkbox"/> Pregestational with microvascular end organ disease or comorbid condition	<input type="checkbox"/> Obesity
<input type="checkbox"/> Falling insulin requirements	<input type="checkbox"/> Postdates
<u>Hypertension</u>	<input type="checkbox"/> Previous stillbirth (include gestational age at demise)
<input type="checkbox"/> Well controlled pre-existing	<i>Note: Patients with decreased fetal movement to have an assessment at an acute care site ONLY</i>
<input type="checkbox"/> Gestational and pre-eclampsia	

Other: _____

Additional comments: _____

Frequency if different than guideline _____ Please explain: _____

Next U/S booked? Date: _____ Location: _____

Referred by: _____ Date: _____

Primary Care Provider (if different from referring provider): _____

Obstetrician (if consulted): _____

Phone Number: _____ Fax Number: _____

Please fax completed referral to the Outpatient Fetal Monitoring Clinic with:

- Antenatal Part 1 and 2
- **All** ultrasound reports in this pregnancy
- Consultations & lab work related to maternal diagnosis

Hospital	Phone	Fax	Hospital	Phone	Fax
Abbotsford (ARH)	604-851-4817	604-851-4813	White Rock (PAH)	604-541-5826	604-535-4570
Burnaby (BH)	604-412-6293	604-412-6237	New West (RCH)	604-520-4182	604-520-4183
Chilliwack (CGH)	604-795-4107	604-795-4155	Maple Ridge (RMH)	604-463-1818	604-463-1886
Langley (LMH)	604-514-6034	604-533-6447	Surrey (JPOCSC)	604-582-4559	604-582-3775

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Guidelines for Frequency of Outpatient Fetal Monitoring

Indication	Frequency (COVID)	Gestational Age
Advanced maternal age (greater than or equal to 40 years at EDD)	2X /week(FMC)	39 weeks ‡
Antepartum Hemorrhage (chronic)	Weekly (FMC)	At diagnosis*
Antiphospholipid antibody syndrome ^{MFM}	Weekly (FMC)	37 weeks
Cholestasis of Pregnancy	Weekly (FMC)	At 37 weeks ‡
Decreased fetal movement - URGENT assessment at acute site only	Once (call ahead to unit)	At diagnosis*
Diabetes (OB/MFM consultation recommended) <ul style="list-style-type: none"> • Pre-gestational ^{MFM} or gestational diabetes on insulin • Pre-gestational with microvascular end organ disease or comorbid condition ^{MFM} • Falling insulin requirements ^{MFM} greater than or equal to 15% from peak total daily dose after 20 weeks 	Weekly (FMC) 2X /week (FMC) Weekly	36 weeks 32 weeks At diagnosis*
Fetal Growth Restriction AC/EFW <10th percentile with: <ul style="list-style-type: none"> • Umbilical artery Doppler normal or increased resistance but with end-diastolic flow present • Advanced abnormal fetal Doppler velocimetry (e.g. intermittent, absent umbilical artery end-diastolic flow or worse) 	Weekly (FMC) As per MFM	At diagnosis*
Hypertension <ul style="list-style-type: none"> • Pre-existing (sBP greater than or equal to 140 &/or dBP greater than or equal to 90 before 20 weeks) ^{MFM} • Gestational hypertension (sBP greater than or equal to 140 &/or dBP greater than or equal to 90 on 2 occasions ≥ 15 min apart) or pre-eclampsia WITHOUT adverse feto-placental conditions • Pre-eclampsia WITH abnormal fetal growth <u>or</u> fluid <u>or</u> umbilical artery Doppler ^{MFM} 	Weekly (FMC) Weekly 2X /week	35 weeks At diagnosis* At diagnosis*
Isolated oligohydramnios - intact membranes (SDP less than 2 cm) ^{MFM}	2X /week (FMC)	At diagnosis*
Isolated polyhydramnios (AFI greater than or equal to 250 mm with no other complications) ^{MFM}	Weekly (FMC)	At diagnosis*
Multiple Pregnancy (with no other complications or IUGR) <ul style="list-style-type: none"> • Dichorionic twins • Trichorionic triplets • Monochorionic diamniotic twins ^{MFM} 	2X /week (FMC)	38 weeks 36 weeks 36 weeks
Obesity (pre-pregnant BMI greater than or equal to 40 kg/m ²)	Weekly (FMC)	37 weeks
Postdates (no other risk factors)	2X /week (FMC)	41 weeks
Previous stillbirth of unknown etiology greater than or equal to 20 weeks or 500 gm	Weekly (FMC)	32 weeks or 1-2 weeks before previous stillbirth (if earlier than 32, start at 28 weeks)

* gestational age to begin: Minimum 26⁺⁰ weeks

‡ NST if not induced

^{MFM} Maternal Fetal Medicine referral recommended

X - time; BMI - body mass index; EDD- estimated date of delivery; dBP - diastolic blood pressure; sBP - systolic blood pressure; SDP - single deepest pocket; OB - obstetrical