BC WOMEN'S HOSPITAL+ HEALTH CENTRE
Provincial Health Services Authority

Referral To Antepartum Home Care
BC Women's Hospital

Office: 604-875-3557
Fax: 604-875-3112

***Patients will not be triaged unless a completed Referral Form is sent**

Addressograph

Woman's Name:

Phone Number *(home)*: ______________________

(Cell): ______________________

Address:

City/Town & Postal Code:

Referral from:

☐ **Ambulatory Clinic**
☐ **Inpatient Care Unit**
☐ **Physician Office**

Most Responsible Care Provider name:

____

Primary Care Provider:

G___ T___ P___ A___ L___

Gestational Age (*weeks*)**:** _________

LMP: ______________________

EDD: ______________________

☐ Membranes intact
☐ Membranes ruptured
Date: ______________________

Risk Condition *(Choose all that apply)*
See reverse for criteria & key

☐ Hypertension
☐ Reduced Placental Function
☐ PPROM
☐ Threatened PTL
☐ Variance

Notes:

____
____
____
____

Cervical Assessment:
Date: ______________________
☐ EV scan ☐ Speculum ☐ V/E
Length: ______________________
Dilation: ______________________

Last Ultrasound:
Date: ______________________
Growth: ______________________
AFI: ______________________

Most Recent Non Stress Tests:
☐ Normal

Most Responsible Physician's Orders: Allergy: ______________________ ☐ NKA

____
____

Care Required: ☐ Per protocol for condition, see Activity Level Guide *(WW.04.01A)*

For admission to the Antepartum Home Care Program:

The woman('s): *(please checkmark)*
☐ Agrees to participate in APHC Program
☐ Family/partner support is available
☐ Lives within 30 min drive
☐ Meets the Risk Condition Criteria (on back)

Send a copy of the following forms:
☐ Antenatal Record Part I & Part II
☐ Lab Reports
☐ Ultrasounds

Physician's Signature: ______________________ CPSID#: ______________________
Print name: ______________________ Date: ______________________
Phone No.: ______________________ Pager No.: ______________________ Fax No.: ______________________

This form is for the sole use of the intended recipient(s) and contains confidential and privileged information. Any unauthorized use, disclosure or distribution is prohibited. If you are not the intended recipient please contact the sender and destroy all copies.

Risk Condition	Criteria (Must meet all criteria)*
Hypertensive Disorders	• Gestational Age 23-38 weeks • Systolic blood pressure ≥ 140mmHg and < 160mmHg and/or diastolic blood pressure ≥90 and < 110 measured, sitting, taken on two occasions at least 15 minutes apart. • Normal NST • Absence of significant headache, visual disturbance, epigastric pain. • Absence of progressive worsening symptoms • Absence of severe IUGR • Oxygen Saturation ≥ 97%

IUGR +/ or Decreased Placental Function	• Gestational age ≥ 23 weeks
	• Confirmation by ultrasound:
	  ○ Abdominal circumference < 10th percentile for gestational age
	  ○ Rate of growth less than expected
	  ○ Oligohydramnios (AFI < 50 mm)
	• NST – Normal NST

Preterm Premature Rupture of Membranes (PPROM)	• Gestational age ≥ 23 weeks
	• Clinical confirmation of rupture of membranes
	• Woman has been stable in hospital for a minimum of 72 hours following rupture and has started her antibiotic prophylaxis regimen
	• Cervical dilation closed on speculum exam
	• Longitudinal lie (except footling breech)
	• Absence of signs and symptoms of chorioamnionitis
	  ○ Baseline FHR <160 bpm,
	  ○ No abdominal tenderness or malodorous vaginal discharge
	  ○ Normal CBC and differential
	  ○ Temperature <37.5°C and no flu-like symptoms
	  ○ Absence of maternal tachycardia

Threatened Preterm Labour (TPTL)	• Gestational age of 20+0- 34+0 weeks • Cervical length ≤ 2.5cm by EV scan and **c**ervical dilatation ≤ 3 cm. • Increased uterine activity (up to four contractions per hour) with ≥ 2.5 cm cervical length and negative fetal fibronectin • Positive fetal fibronectin, with absence of contractions for 48 hours • Post-operative cervical cerclage
Variance / additional complications*	• Women with additional complications must be reviewed individually by the Antepartum Medical Program Director prior to admission to APHC Program. Example: Doppler abnormalities, previable PPROM

Key
^{0} = degree
C = Celsius
EV=Endovaginal
cm = centimetres
GTPAL = gravida term premature abortion living
IUGR = intrauterine growth restriction
NST = nonstress test
VE = vaginal exam
○ = days