Documentation Standards
Obstetrical Records

The documentation listed below applies to ALL obstetrical records

1. OB Physical Assessment
   - Most guidelines recommend measurement at each antenatal visit – maternal weight, blood pressure measurements, fundal height and fetal heart auscultation.
     - Blood pressure screening is recommended at all prenatal visits throughout the pregnancy.
     - Measurement of fundal height should be performed at each visit during the second and third trimesters of pregnancy.
     - Fetal heart tones should be identified at 10–12 weeks and thereafter.
2. Nutritional assessment and counseling
   - Individual nutritional risk assessment including an assessment of pre-pregnancy body mass index (BMI), weight gained to date, if any, and specific nutritional risks at the initial prenatal care visit and continuing reassessment as needed.
3. Blood Type, D (Rh) and Antibody Screen
   - D (Rh) blood typing and antibody screening is recommended for all pregnant women at their first trimester.
   - The date of the labs and results need to be in the medical record or the lab results.
4. Rubella Titer
   - Rubella antibody testing should be completed in all women of childbearing age who lack evidence of immunity.
   - The medical record should contain documentation that a rubella titer was completed pre-conception or during first trimester. Both the date and the results should be documented.
5. Urinalysis
   - At each prenatal visit, a urine specimen should be checked (by dipstick) for the presence of sugar and/or protein.
   - The date and results should be documented in the record.
6. Pap Smear Test
   - The first prenatal examination provides an opportunity for cervical cancer screening with a Papanicolaou (Pap) test in women who have not been screened recently.
   - The date and results of the pap test need to be documented, including if screened recently.
7. STD Testing
   - All women found to be at high risk for sexually transmitted diseases should be screened for Neisseria gonorrhea and Chlamydia trachomatis at a preconception visit or during the first trimester.
   - The date of the labs and results need to be in the medical record or the lab results.

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8. Syphilis (VDRL or RPR) Testing
    - It is recommended that all pregnant women be screened for syphilis with serologic testing at the first prenatal visit and after exposure to an infected partner and at the time of delivery.
    - The date of testing and the results should be documented in the medical record or the lab results should be in the medical record.
9. Hemoglobin (Hgb) Assessment
    - An Hgb should be done to assess for anemia.
    - The results and date of test should be documented in the medical record or the lab results should be present.
10. HIV Counseling and Testing
    - All pregnant women should receive education and counseling about HIV testing as part of their routine prenatal care. HIV testing should be recommended at the first prenatal visit for all pregnant women, with their consent.
    - In the event of a refusal of testing, the refusal should be documented.
11. Hepatitis B surface antigen (HBsAg) Screening
    - Routine screening is recommended for all pregnant women during their first trimester.
    - The result and date of screening should be documented in the medical record, or the lab results should be present.
    - If the patient refuses the testing, that should be documented.
12. Depression Screening
    - Prenatal and postpartum screening should be conducted.
    - The screening can be subjective, as well as objective.
    - Screening tools such as the EPDS (Edinburgh Postnatal Depression Scale) can be used.
    - All screenings need to be documented in the medical record.
13. Preterm Delivery Risk Assessment
    - Preterm labor (PTL) risk includes medical and obstetrical history that might cause a woman to be a high risk for preterm delivery. Risk factors associated with preterm birth may include, but are not limited to the following:
        - Demographics: African-American, low socioeconomic status, under age 18 or over age 35.
        - History: prior preterm delivery, any 2nd trimester loss, mental illness, cervical cerclage
        - Lifestyle: substance abuse, domestic violence, family stress
        - Infection/inflammation: periodontal disease, pyelonephritis, sexually transmitted infections
        - Decidual Hemorrhage: trauma, vaginal bleeding after 12 weeks this pregnancy
        - Pathologic Distention of the Uterus: multiple gestations, uterine fibroids, polyhydramnios

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14. Alpha Fetoprotein Screening
    - Screening should be offered in the second trimester.
    - Triple Screen, Quad Screen and AFP are acceptable.
    - If the patient refuses testing, this should be documented.
    - The date the screening was conducted and the results should be in the medical record.
15. Diabetes Screening/GTT
    - Testing should be done during the 24th and 28th weeks of gestation.
    - The date and results of testing should be in the medical record.
    - In the event of a refusal of testing, the refusal should be documented.
16. Group B Strep Screen
    - CDC's guidelines recommend that a pregnant woman be tested for group B strep when she is 35 to 37 weeks pregnant.
    - Date of testing and results should be in the medical record.
    - In the event of a refusal of testing, the refusal should be documented.
17. Postpartum visit six week after delivery
    - A postpartum visit normally occurs within 4 to 6 weeks after delivery.
    - It should be documented in the medical record if the patient does not come in for a postpartum visit.
18. Psychosocial risk assessment conducted during the first prenatal care visit
    - A psychosocial risk assessment should be conducted and documented in the medical record.
19. Psychosocial risk assessment conducted during the post-partum visit
    - A psychosocial risk assessment should be conducted and documented in the medical record.
    - It should be documented in the medical record if the patient does not come in for a postpartum visit.
20. Documentation of referrals for psychosocial risk made, if indicated
    - If a referral is deemed necessary, it should be documented in the medical record.