

Pregnancy: Clinical Practice and Process Support

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Preconception

Preconception Visit	
History and Physical Examination	• Complete history and physical exam (H&P) • Assess impact of current medical issues (e.g., Diabetes, hypertension (HTN))
Investigations/Referrals to Consider	• Complete Blood Count (CBC) • Rubella titer • Gonorrhea, Chlamydia, Syphilis, HIV, Hep B, Hep C • Cervical cancer screening • Glucose testing (if risk factors exist) • Review recommendations from previous pregnancies if applicable. Consider timing between pregnancies. • Carrier screening (based on family hx – special authorization required)
Counselling	• Lifestyle considerations: - Smoking/Alcohol/Other (see Substance Use on page ____) - Weight and Nutrition (see Weight Gain on page ____) - Sleep patterns - Exercise (see Exercise on page __) - Cycle monitoring/tracking • Healthy relationships/screen for intimate partner violence • Sexual activity: For low-risk patients, sex including vaginal, oral, and anal sex is normal and safe during pregnancy. Those at increased risk of preterm labour (multiple gestation, history of preterm birth or short cervix) or who have placenta previa are usually advised to abstain from sex.ⁱ • Review additional risks associated with Maternal age >40 years: spontaneous abortion, placenta previa, gestational diabetes mellitus, pre-eclampsia, need for C-section, preterm delivery, fetal growth restriction, stillbirth, and congenital anomalies, especially an additional X chromosome or trisomy 13, 18, or 21 (see Genetic Screening on page ____).ⁱⁱ • Reproductive hazards (see CFHS Instr 4440-20)
Medications, Immunizations, and Supplementation	• Medication profile: Review safety (OTC and prescriptions) • Immunizations: ○ Influenza vaccine should be offered to all patients during flu seasons to help protect both the mother and infant. ○ Live vaccines during pregnancy are not recommended. Non-immune patients should be counselled to receive immunization either before conceiving or in the postpartum period. ○ COVID 19 vaccine is recommended prior to pregnancy, in any trimester, and during breastfeeding. Vaccination

	timing should be planned to maximize maternal benefit. Booster doses should be offered based on regular schedules. ⁱⁱⁱ • Prenatal vitamins and folic acid supplementation^{iv}: Should be started 3 months prior to conception or as soon as conception is confirmed. At the time of writing, Prenatal vitamins are covered under the CAF Drug Benefit List under special authorization. ○ Low Risk patients: 0.4 mg daily (included in most prenatal vitamins) ○ Medium Risk patients: 1 mg daily until 12 weeks' gestation ▪ Risks include personal family history of folate sensitive anomalies, pre-existing diabetes, maternal malabsorption syndrome, medications that affect folate metabolism ○ High Risk patients: 4 mg daily until 12 weeks' gestation ▪ Risks include previous pregnancy with or maternal or paternal personal history of neural tube defect.
CERM, administration	• Arrange referrals as required. Considerations for early referral to specialized care include multiple gestation, complex chronic disease, medications requiring personalized advice, complete placenta previa, fetal abnormalities seen on ultrasound, advanced maternal age (>40 years), previous preterm birth, previous pre-eclampsia, or previous gestational diabetes on insulin.

First Trimester (up to 14 weeks)

Initial Visit	
Confirmation of pregnancy (ideally between 6-12 weeks)	
History and Physical Examination	• Review History (obstetrical, family, medical) • Physical assessment (height, weight, BP) (utilize local/provincial prenatal record)
Investigations / Referrals to Consider	Laboratory tests: • Confirm pregnancy through serum or urine beta HCG • CBC, type and screen • HIV, Syphilis, Rubella Ab, Varicella Ab, HBsAg, Gonorrhea/chlamydia • Consider Hep C if patient/partner high-risk or living in a high-risk area • Urine culture (see Urinary Tract Infections on page __) • Cervical cancer screen (if not up to date) • Early Diabetes Screening: Consider A1C and/or Fasting Blood Glucose (FBG) if at risk for gestational diabetes. Risk factors include prediabetes (Hba1c >6.0), obesity (BMI >30kg/m²), maternal age >35 years, history of gestational diabetes, history of delivery a baby weighing more than 4kg, history of PCOS, family history of diabetes,

	ethnicity at increased risk of developing diabetes (Hispanic, Indigenous, South or East Asian, American or Pacific Island descent, Arabic descent), or current use of corticosteroids. Patients with risk factors for diabetes or gestational diabetes should be offered screening in the first half of pregnancy and repeated at 24-28 weeks if normal.^v Imaging: - Dating Ultrasound (US) between 7 and 13 weeks should be offered to all pregnant patients Genetic Screening: - Review available options for genetic screening within geographic region (eFTS/ NIPT/ MSS)
Counselling	- Same as preconception counselling, if not discussed - Discuss whether pregnancy was planned or if wish to terminate or explore other options (adoption) - Review options for prenatal care including Obstetrician (OB) / Family medicine-OB / Midwife - Discuss options regarding newborn care: civilian family doctor or pediatrician - Screen for intimate partner violence - Assess for and manage nausea (can affect 80% of pregnancies, worse in the first trimester)^{vi} - Discuss fitness and nutrition - Discuss food safety in pregnancy. For more information, refer to the following Food safety in pregnancy brochure - Discuss heat exposure. Hot tubs and saunas should generally be avoided during pregnancy, especially in the first trimester, as prolonged exposure to high temperatures may increase the risk of neural tube defects and other complications.^{vii} Mental Health Screening: Validated screening tools include the Edinburgh Postnatal Depression Scale (EPDS), Whooley Questions, The Patient Health Questionnaire-2 (PHQ-2), and Generalized Anxiety Disorder (GAD-2).^{viii}
Medications and Supplementation	- Review medication profile. Balance the medication's reproductive safety against the benefits of treating the mother's condition and the risks of leaving a condition untreated. Consider the dose, duration, and critical gestational timing to minimize fetal risk. For more information, refer to resources such as Firstexposure.ca - Review prenatal folic acid supplementation (see Preconception Visit Counselling) - Review indications for acetylsalicylic acid (ASA): Low dose ASA can decrease the risk of pre-eclampsia and fetal growth restriction. Indications include previous history of placental insufficiency

	syndromes, inflammatory conditions, pre-gestational hypertension, obesity >30kg/m², maternal age >40 years, IVF use in current pregnancy, pre-gestational diabetes (type 1 or 2), multiple gestation, renal disease, and previous history or placental abruption or infarction. If indicated, patient at risk should be counselled to start 162 mg ASA between 12 and 16 weeks' gestation and continue until 36 weeks' gestation.^{ix}
MELs, Administration	• TCAT: Balancing medical confidentiality against specific MELs “giving away” the pregnant state, providers can assign more generic MELs until about 12-14 weeks gestation, at which point TCAT x 12 months is assigned with more comprehensive MELs. Depending on the member's privacy needs, TCAT x 6 months with a specified reassessment date is reasonable as well. There is no ‘one size, fits all’ template of MELs during pregnancy. Utilize the MEL choices within CFHIS to suit the clinical and psychosocial factors to the member's needs.^x • May be referred to civilian delivering physician/midwife at this time for transfer of care • <i>Referral to OB/GYN or midwife is based on local availability and medical need see Medical Administration of Pregnant Members para 6. (medical travel can be supported on a case-to-case basis)</i> <u>Specific environments:</u> • Aircrew (AC) members should be referred immediately to Aviation Med qualified clinician/Flight Surgeon. Temporary downgrade of air factor is in accordance with operational criteria set out by the division surgeon of 1 Canadian Air Division. Most aircrew with uncomplicated pregnancies may continue flight status with some restrictions up to 24 weeks gestation after consultation with flight surgeon. Exceptions include ground-based Aerospace Controllers (AEC) and Aerospace Control Operators (ACOP) who may be assessed by the flight surgeon as fit designated Control Positions until the end of the 34th week of gestation. See Flight Surgeon guidelines (FSG) 300-02 and FSG 100-02 for additional details and restrictions. • RCN members may continue to serve onboard large platform vessels until 20 weeks gestation under specific restrictions/ conditions (see NAVGEN 042/17)

Mental Health Screening

Poor mental health and mental illness are common in pregnancy. Up to 50% of pregnant patients can suffer from some form of perinatal mental illness (PMI) which can extend into the post-partum period. The most common forms of PMI are mood and anxiety disorders. Without early intervention, patients may experience chronic symptoms that persist in the postnatal period and can have lasting impacts on the well-being of the patient and their baby. Untreated depression

during pregnancy/postpartum is associated with increased maternal and neonatal morbidity and mortality. Validated screening tools include the Edinburgh Postnatal Depression Scale (EPDS), [Whooley Questions](#), [The Patient Health Questionnaire-2 \(PHQ-2\)](#), and [Generalized Anxiety Disorder \(GAD-2\)](#).^{xi}

Exercise

Patients should be encouraged to focus on both aerobic and strength-conditioning exercises in pregnancy. Benefits of exercise include fewer newborn complications, reduced number of C-sections or instrumental deliveries, and a decreased incidence of urinary incontinence, excessive weight gain, and depression^{xii}. More information can be found in the [CSEP 2019 Canadian Guideline for Physical Activity throughout Pregnancy](#). If available, patients can also be referred to the [PNP3](#) program offered by PSP.

Substances

Smoking: Smoking during pregnancy, including e-cigarettes, is associated with increased complications including spontaneous abortion, preterm labour, premature rupture of membranes, placenta previa, placental abruption, fetal growth restriction (FGR) (previously called intrauterine growth restriction) and low birth weight.^{xiii} Patients can be referred to their local health promotion team to access the [STF Butt Out](#) program, which includes:

- 1st line: psychological intervention
- 2nd line: nicotine replacement and pharmacotherapy for smoking cessation

Alcohol: Alcohol use in pregnancy is directly linked with fetal alcohol spectrum disorder (growth restriction, facial dysmorphism, neurological abnormality and brain damage). There is no safe level for maternal drinking. For patients with diagnosed or suspected Alcohol Use Disorder, refer to mental health for evaluation and support.

Cannabis: Cannabis consumption may have long term cognitive and behavioral consequences for children exposed in utero. There is limited research in this area; however, cannabinoids are lipophilic and can cross the placenta and blood brain barrier as well as accumulate in breast milk. There are over 400 chemicals in cannabis and more research is needed to understand how they can impact pregnancy and the fetus.^{xiv}

Caffeine: High caffeine consumption may be associated with increased risk of pregnancy loss but is not associated with increased risk of birth defects. For pregnant patients, recommendations are that caffeine intake is limited to 300mg per day (approximately 500mL of drip coffee or 1.2L of strong black tea).

Herbal Teas: Some herbal teas are not safe in pregnancy, including chamomile, aloe, senna, stinging nettle, and kombucha tea. Other herbal teas may be safe in pregnancy in moderation (up to two to three cups per day), such as ginger, orange peel, rose hip, citrus peel and linden flower.^{xv}

Nausea

Non-pharmacological approaches: Frequent small meals, avoiding stimuli such as strong smells, discontinue iron supplements until 12-14 weeks (continue taking folic acid), Ginger 250 mg four times per day by mouth can improve gastric mobility. Pressing the Nei Guan (P6) acupressure point (3 finger breadths above the wrist between the two tendons) firmly for 1-2 minutes in a gentle circular motion can help relieve nausea and anxiety.

Pharmacological stepwise approach:

- 1st line: 10 mg doxylamine succinate and 10 mg pyridoxine HCl combined (DiclectinTM). Start with 1 tab in the morning, 1 tab in the afternoon, and 2 tabs in the evening. Maximum of 8 tabs/day.
- If no relief, add Dimenhydrinate (GravolTM) 50 mg every four to six hours orally or rectally. Consider adding Metoclopramide 5-10 mg every 8 hours orally/IM, Chlorpromazine 10-25 mg every 4 to 6 hours orally or 25-50 mg every 4 hours IM, Prochlorperazine 5-10 mg every 6 to 8 hours orally/rectally/IM, or Promethazine 12.5-25 mg every 4 to 6 hours orally/IM.
- If no relief, consider Ondansetron 4 mg every 8 hours orally/ODT. Safety is controversial during the first trimester as it may be associated with birth defects (most commonly cleft palate). Risks/benefits must be discussed with the patient.
- If refractory, consider other causes of nausea. GERD may be present as nausea and can be treated with oral H2 antagonist (Ranitidine 150 mg twice daily OR Famotidine 20 mg daily or twice daily) or oral proton pump inhibitors (Pantoprazole 20-40 mg daily or twice daily OR Lansoprazole 30 mg daily OR Omeprazole 20-40 mg daily OR Esomeprazole 20-40 mg daily). **NOTE:** Rabeprazole is not recommended in pregnancy.^{xvi}

Urinary Tract Infections^{xvii}

Urinary Tract Infections (UTIs) are common in pregnancy and are associated with preterm birth and low birthweight.

Diagnosis: If initial culture at first prenatal visit is negative, there is no need to re-screen. Treat if colony count > 100X10⁵CFU/mL. Acute cystitis should be suspected based on the presence of symptoms. Pyelonephritis should be suspected if fever >38.0°C and symptoms or positive urine studies. Refer to emergency care for inpatient treatment.

Treatment: 1st line: Cephalexin 250-500 mg four times daily OR Amoxicillin 500 mg three times daily OR Nitrofurantoin 50-100 mg four times daily (**NOTE:** should be avoided >36 weeks' gestation) OR Fosfomycin 3g in a single dose

2nd line: Trimethoprim / Sulfamethoxazole 2 tabs twice daily OR Trimethoprim 100 mg twice daily (**NOTE:** both should be avoided in the first trimester and in the last 6 weeks of pregnancy)

Bleeding in the first trimester^{xviii xix xx xxi}

Bleeding in the first trimester occurs in approximately 25% of pregnancies. A detailed history of bleeding presentation should be obtained. Vaginal bleeding like or greater than menses is abnormal and concerning. The patient should be directed to emergency care for assessment.

Common causes include:

- **Implantation bleed:** Typically occurs 2-3 weeks after fertilization. Often light, self-limiting spotting. Not associated with adverse outcomes.
- **Cervical bleed:** Can occur after intercourse or pap test. Often light, self-limiting spotting. Not associated with adverse outcomes.
- **Subchorionic hemorrhage:** Bleeding between the wall of the uterus and the sac (chorion) surrounding the embryo inside the uterus. Often self-limiting. Most patients will go on to have a viable pregnancy but it can lead to miscarriage.
- **Miscarriage:** Can affect approximately 10% of clinically recognized pregnancies. Presents with vaginal bleeding, cramping, and ultimately passage of products of conception. Management includes expectant, medical, and surgical management

through shared decision-making and informed consent. Hemodynamically unstable patients should be referred to emergency care. Patients with recurrent early pregnancy loss (>3) should be referred to a specialist.

- **Ectopic pregnancy:** Occurs when the gestational sac is outside of the uterus, about 2% of pregnancies. Often diagnosed in the first trimester, an immediate consultation with gynecology is required. May present as a gynecologic emergency.
- **Placenta previa / low lying placenta:** Occurs when the placenta covers the internal os of the cervix (placenta previa) or is located less than 2cm from the os (low-lying placenta). It is often diagnosed at the time of the anatomy ultrasound (19-21 weeks). A low-lying placenta may resolve as pregnancy progresses. Bed rest is not indicated, but patients should be advised to abstain from sexual activity. Obstetrical consult should be initiated.

Investigations should include a complete blood count, quantitative β -hCG, blood type and screen, and ultrasound to confirm pregnancy location if not already performed.

Hemodynamically unstable patients should be directed to emergency care.

Management is based on cause and patient preference but may include:

- **Serial β -hCG level:** In early first trimester, β -hCG level is expected to double every 48-72 hours. This can be used to track viability of pregnancy.
- **Rh_o (D) immune globulin (Rhogam):** Administration to Rh-negative patients presenting with vaginal bleeding varies based on gestation. At less than 8 weeks, recommend against administration. Between 8 to 12 weeks, recommend administration, however, in individuals who are more risk adverse, Rhogam may be considered. At greater than 12 weeks, Rhogam 300mg intramuscularly should be administered.
- **Transvaginal ultrasonography:** A gestational sac should be seen on transvaginal ultrasonography (TVUS) when β -hCG levels reach 1,500 to 3,000 mIU/mL. TVUS can be used to confirm pregnancy location/viability and may identify source of bleeding.
- **Mifepristone/misoprostol:** May be considered for medical management of early pregnancy loss up to 12 weeks' gestation. The most effective regimen is oral mifepristone 200 mg then, 24 hours later, 800 mcg misoprostol buccally or vaginally. When available, this should be recommended over misoprostol alone.

Bed rest or progestins should NOT be recommended to prevent early pregnancy loss in patients with first trimester bleeding as these interventions have not been proven to be effective.

Genetic Screening Options				
Based on SoC, patient requirements and provincial guidelines				
NOTE: Maternal age over 40 years should be offered advanced genetic screening. ^{xxii}				
	Investigation Component	Gestational age for testing	Detection Rate ^{xxiii}	False Positive Rate
Non-invasive prenatal testing (NIPT)	Maternal blood test for free placental DNA	9-10 weeks and onward	99%	Under 0.1%

Enhanced First Trimester Screening (eFTS)	Blood test and ultrasound	11 to 13 (+6) weeks	85-90%	Approx 3%
Integrated Prenatal Screening (IPS)	Two tests: First trimester- nuchal translucency and blood test Second trimester – Quad serum test	1 st trimester: 10 – 13 (+6) weeks 2 nd trimester: 15 – 20 (+6) weeks	85-90%	2-4%
Maternal Serum Screening (MSS)	Blood test	15 – 20 weeks	80%	Approx 5%

Second trimester (from 14-28 weeks)

14-16 weeks (Book appointments every 4 weeks until 28 weeks)	
History and Physical Examination	• Inquire about general wellbeing including mental health • Assign gestational age (GA) • Assess weight, BP • Fetal heart rate (FHR) (after 15 weeks) • Start ASA if applicable (see Initial Visit, Medications and Supplements)
Investigations / Referrals to Consider	• Correct estimated due date based on 1st ultrasound • Order fetal anatomy ultrasound to be done at 19 to 21 weeks
Counselling	• Review first trimester investigations • Recommend prenatal classes available in local area • Discuss how to contact clinic or delivering clinician and what to do in emergency
MELs, Administration	• Discuss with member that sick leave (SL) in 3rd trimester is reserved for medical issues that cause harm to baby and/or mother (e.g., HTN, preterm labor, threatened labor) • Members should ensure they maintain some Annual Leave to ensure comfort in the final trimester of pregnancy • Members may engage with CoC to determine administrative accommodations • Members are recommended to review QR&O 16.26; QR&O 16.27; DAOD 5001-2; and CF Leave Manual to be familiar with leave entitlements • TCAT (12 months) for pregnancy should be in place by this time
17-21 weeks	
History and Physical Examination	• Weight and BP • Fundal height (>20 weeks) • Fetal heart rate

	• Presence of fetal movement (starting around 20 weeks GA)
Investigations / Referrals to Consider	• Fetal anatomy ultrasound, if not already ordered (19 to 21 weeks) • Urine Dip for proteinuria if positive for hypertension > 20 weeks (systolic BP (SBP) $\geq$ 140 mm Hg and/or a DBP $\geq$ 90 mm Hg)
Medications and Supplementation	• Consider indications for progesterone use. Progesterone 200 mg per vagina should be initiated between 16 and 24 weeks to prevent spontaneous preterm birth in: singleton pregnancy with a short cervix (<25mm) or previous spontaneous preterm birth. With multiple gestation and a short cervix (<25mm), use 400 mg of progesterone 200 mg per vagina at bedtime. Continue therapy until 34-36 weeks.^{xxiv}
24-28 weeks	
History and Physical Examination	• Weight and BP • Fundal height • Fetal heart rate • Fetal movements
Investigations / Referrals to Consider	• CBC to assess for iron deficiency. Anemia in pregnancy is diagnosed when the hemoglobin is less than 110g/L. First line treatment consists of oral iron supplementation with 40-100mg of elemental iron daily or every other day to decrease side effects. Parenteral iron is safe and effective from second trimester and onwards and should be considered for patients that cannot tolerate oral iron or with a poor response to oral therapy. • Gestational Diabetes Mellitus (GDM) screening^{xxv} should be offered to all patients. - non-fasting 50g GCT; or - fasting 75GTT if risk factors • Repeat prenatal antibodies • If Rh negative: arrange for Rh immune globulin at 28 weeks • Consider repeat STI screening for high-risk patients
Counselling	• Review anatomy ultrasound and if any finding warrants further investigations • Review where to present if experience emergencies (emergency room vs obstetrical triage)
MELs, Administration	• AC restrictions apply

Dental work in pregnancy^{xxvi}

Dental work is generally safe during pregnancy, with the second trimester being the preferred time for routine care. Preventative treatments, cleanings, and addressing urgent dental issues like infections are encouraged, while elective procedures can often be postponed until after delivery.

Third trimester (28 weeks until delivery)

28 weeks	
History and Physical Examination	- Weight and BP - Fetal heart rate - Fetal Movement - Fundal Height
Investigations / Referrals to Consider	- Offer Tdap between 27-32 weeks regardless of vaccination history^{xxvii} (however may be given up to the date of delivery – DND 6636-53) - Confirm patient received Rh immune globulin 1500IU (300mg) IM if mother is Rh negative
Counselling	- Discuss importance of self-monitoring for fetal movement and kick counts - Review second trimester blood work and diabetes screening - Ensure referral for specialized diabetes care if diagnosed with gestational diabetes - Discuss how to contact clinic or delivering clinician and what to do in emergency
MELs, Administration	Clinician to complete part 1 of DND 2268 – Application Form Maternity/Parental Benefits form
Transfer of care to delivering physician	
Typically occurs at 28 weeks	
History and Physical Examination	To be followed by delivering physician every 2 weeks until 36 weeks, then every week until delivery
MELs, Administration	Any recommendations for SL or modification of duties by an external civilian physician must be reviewed and supported by a CDU clinician. - Partial days/limited hours considered on case-by-case basis with medical reasoning to support decision - Members may be encouraged to use remaining annual leave as this will not be accumulated in most circumstances - May start maternity leave 8 weeks prior to estimated due date (EDD). Discuss with patient as this would be a personal choice-related leave vs illness-related leave. Patients should consult their admin/maternity support clerk to discuss options.
32 to 40 weeks	
History and Physical Examination	Followed weekly by delivering physician starting at 36 weeks
Investigations / Referrals to Consider	Rectovaginal swab ordered by delivering clinician at 36 weeks

Counselling	• Ensure ASA discontinued at 36 weeks • If RSV immunization of the infant is unlikely to occur, RSV immunization may be offered to pregnant patients between 32-36 weeks of gestation to allow for transmission of antibodies through the placenta.^{xxviii} • Confirm patient has started antiviral therapy if history of genital herpes • Acyclovir 400 mg po TID or 200 mg po QID - or • Valacyclovir 500 mg po BID
MELs, Administration	• Sick leave may be considered based on patient status until delivery and should be recommended at any time during the pregnancy when the member is unfit for any duty, e.g. when serious complications arise. Recommendations for sick leave or modification of duties provided by an external civilian clinician must be authorized by the CAF HCP.

Weight Gain^{xxix}

While gestational weight gain recommendations are based on pre-pregnancy BMI, weight stigma can negatively impact prenatal health. Clinicians should consider individual factors such as genetics, health, socioeconomic status, cultural beliefs, family and/or partner support, and access to nutrition and physical activity.

Pre-Pregnancy BMI:	<u>≤ 18.5</u>	<u>18.5-24.9</u>	<u>25.0-29.9</u>	<u>>30.0</u>
Recommended total weight gain:	12.5-18 kg	11.5-16 kg	17-11.5 kg	5-9 kg

Postpartum

Immediate Postpartum Care	
History and Physical Examination	• Weight and BP • Review birth history (cesarean or vaginal) - examine any tears or incisions • Review medications that were held during pregnancy • Review mental health and support network
Investigations / Referrals to Consider	• Removal of staples (Post operative day #4-5 if applicable)
Counselling	• Discuss breastfeeding (investigate if breastfeeding support covered) • Discuss contraception consideration
MELs, Administration	• Sick Leave beginning day after discharge from hospital: • 14 days - vaginal delivery • 28 days - C-section (requires sign off by B/WSurg)

	• Include dates of hospitalization on CF2018 for MATA/PATA clerk
Postpartum Visit (6-16 weeks)	
History and Physical Examination	• Outreach to patient (phone or in person appointment) • Review mental health and support network • Weight and BP (if in person)
Investigations / Referrals to Consider	• Screen for postpartum depression, if signs exist use standardized tool^{xxx} • Repeat diabetes screen if positive during pregnancy • Cervical cancer screen - if due/overdue
Counselling	• Contraception and intercourse counselling • Breastfeeding assessment • If applicable, review considerations for future pregnancies
MELs, Administration	○ Mental health referral if needed. ○ TCAT removal not before 12 weeks post-partum to ensure recovery from delivery. ○ Following completion of sick leave, a member wishing to terminate their maternity leave early to return to work will be given the appropriate MELs as required. Recommendations for sick leave or modification of duties provided by an external civilian clinician must be authorized by the CAF HCP.

Resources

For Health Care Providers:

+WDH Prof Tech e-mail: SFD Prof Tech@CMP CF H Svcs Gp@ Ottawa-Hull wdhproftech-sfdproftech@forces.gc.ca

Canadian Society for Exercise Physiology. (2025). *2019 Canadian Guideline for Physical Activity throughout Pregnancy*. <https://csepguidelines.ca/guidelines/pregnancy>

Canadian Society for Exercise Physiology. (2025). *2025 Canadian Guideline for Physical Activity, Sedentary Behaviour and Sleep throughout the First Year Postpartum*. <https://csepguidelines.ca/guidelines/postpartum>

Government of Alberta. (2025). *Pregnancy: Health and Nutrition*. <https://myhealth.alberta.ca/health/Pages/Conditions.aspx?hwid=hw197814#aa88982>

Leduc, D. (2017). Maternity Leave in Normal Pregnancy. *Journal of Obstetricians Gynaecologists of Canada*, 33(8). pp. 864–866. [http://www.jogc.com/article/S1701-2163\(16\)34992-1/pdf](http://www.jogc.com/article/S1701-2163(16)34992-1/pdf)

Maternal Newborn Child & Youth Strategic Clinical Network. (2024). *Alberta Antenatal Pathway*. <https://www.albertahealthservices.ca/assets/about/scn/ahs-scn-mncy-antenatal-pathway.pdf>

National Library of Medicine. (2006-). *Drugs and Lactation Database (LactMed®)*. <https://www.ncbi.nlm.nih.gov/books/NBK501922>

Tingley, K. & Horton, J. (2021, December). Obstetrical Ultrasound During Pregnancy. *Canadian Journal of Health Technologies*. <https://www.ncbi.nlm.nih.gov/books/NBK594334>

For Patients:

Alberta Health Services. (2025). *Healthy Parents Healthy Children*. <https://www.healthyparentshealthychildren.ca> (hardcopy resources also available)

Canadian Society for Exercise Physiology. (2025). *CSEP Get Active Questionnaire*. <https://csep.ca/category/publications/get-active-questionnaire>

Government of Alberta. (2025). *Pregnancy*. <https://myhealth.alberta.ca/Health/Pages/conditions.aspx?hwid=hw197814>

The Society of Obstetricians and Gynaecologists of Canada. (2025). *Pregnancy Info*. <https://www.pregnancyinfo.ca>

Province of British Columbia. (2025). *Baby's best chance: Parents' handbook of pregnancy and baby care*. <https://www.healthlinkbc.ca/pregnancy-parenting/babys-best-chance>

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ⁱⁱ The American College of Obstetricians and Gynecologists. (2022, August). *Obstetric Care Consensus: Pregnancy at age 35 years or older*. <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2022/08/pregnancy-at-age-35-years-or-older>

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^{iv} Wilson, R.D. & O'Connor, D.L. (2022). Guideline No. 427: Folic Acid and Multivitamin Supplementation for Prevention of Folic Acid–Sensitive Congenital Anomalies. *Journal of Obstetrics and Gynaecology Canada*, 44(6), pp. 707 – 719.

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- ^{vii} Health Link BC. (2023, June 14). *Pregnancy hot tub and sauna use*. <https://www.healthlinkbc.ca/healthwise/pregnancy-hot-tub-and-sauna-use>
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- ^x Ref: CF H Svcs Gp Instruction 3100-23/4440-20, DAOD 5003-5
- ^{xi} Shea, A., Jumah, N.A., Forte, F., Cantin, C., Bayrampour, H., Butler, K., Francoeur, D., Green, C., Cook, J. (2024, October). Guideline No. 454: Identification and Treatment of Perinatal Mood and Anxiety Disorders. *Journal of Obstetrics and Gynaecology of Canada*, 46(10). <https://pubmed.ncbi.nlm.nih.gov/39424138/>
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