Maternity Consultation and Referral Guideline

1. Guiding Principles

Within the South West women have the choice of a number of models of care: including but not limited to Midwifery Group Practice, exclusive General Practitioner Obstetrics (GPO) led care, consultant led care, and shared care arrangements between different providers. It is imperative that risk based assessment is completed on all women throughout their pregnancy. This guideline is aimed to provide all SW health care providers a framework to assist in decisions in determining level of clinician care and most appropriate place of birth.

This document is to be read in conjunction with the WACHS Maternal and Newborn Care Capability Framework Policy.

2. Guideline

Consultation: Consultation is the seeking of professional advice from a qualified, competent health care provider with the relevant knowledge and skills to make decisions about the woman's care.

Referral: Referral is defined as the transfer of primary responsibility from one health care provider to another qualified health service provider or professional.

Collaboration: Collaboration refers to all members of the health care team working in partnership with both the woman and each other to provide the highest standard of, and access to, health care.

All models of care are collaborative

Patients with category C conditions require consultant obstetrician review and input. Patients may still be suitable for shared care.

Clinicians must be mindful of the cumulative effect of Category B conditions. Although some Cat B conditions are "minor" others can have a significant impact upon the pregnancy once combined. It is encouraged that if **> 2 category B conditions** are identified the patient is considered for specialist review.

This is not necessarily a handover of care. Referral letter to Bunbury Antenatal Doctor Clinic (ADC) are to include specifically the intention for consultation or referral, and capacity to support shared care if suitable.

Documentation post ADC appointment to include recommended model of care i.e. GPO/Shared Care/Obstetric led and Intended place of birth. Copy of documentation to be sent to referring clinician.

Tertiary review (sub specialty clinic or USS) requires referral to King Edward memorial Hospital (KEMH) or Fiona Stanley Hospital.

Individual credentialing is site specific, in keeping with the sites scope of practice and clinical service framework. This needs to be considered when determining if consultation and/or referral is required during pregnancy and labour.

If urgent review is required, please phone obstetric team member on call.
DO NOT use e-referral system.

For indications, please refer to:

Appendix 1: Indications at Commencement of Care
Appendix 2: Indications developed/discovered during pregnancy
Appendix 3: Indications during Labour and Birth
Appendix 4: Indications during the postpartum period
Appendix 5: Social indications

3. Definitions

Category A	Low risk, management within scope of Midwife
Category B	Med risk, GPO led care
Category C	High risk, Discuss/Refer to Consultant Obstetrician
Category T	Tertiary care required

4. Roles and Responsibilities

Regional Medical Directors and Regional Nurse Directors are:

- Responsible for ensuring that all Medical and Midwifery staff involved in provision of Maternity care have access to this policy
- Accountable for ensuring compliance with this policy.

Medical and Midwifery staff

- Responsible to have knowledge and understanding of the Maternity consultation and Referral guideline to ensure the best possible outcome for the patient.
- Responsible for working within their credentialed scope of practice in their assessment, management and transfer of care.

All Staff are required to work within policies and guidelines to make sure that WACHS is a safe, equitable and positive place to be.

5. Compliance

Guidelines are designed to provide staff with evidence-based recommendations to support appropriate actions in specific settings and circumstances. As such, WACHS guidelines should be followed in the first instance. In the clinical context, where a patient's management should vary from an endorsed WACHS guideline, this variation

and the clinical opinion as to reasons for variation must be documented in accordance with the Documentation Clinical Practice Standard.

WACHS staff are reminded that compliance with all policies is mandatory.

6. Records Management

All WACHS corporate records must be stored in the approved Electronic Documents and Records Management System as per WACHS Records Management Policy

All WACHS clinical records must be managed in accordance with Health Record Management Policy.

7. Evaluation

Monitoring of compliance with this document is to be carried out by the Site Maternity Unit Manager, every 12 months using the following means or tools:

- Review of Datix CIMS for missed escalation of care.

8. Standards

National Safety and Quality Health Service Standards –
Comprehensive Care Standard: 5.7, 5.10, 5.11, 5.12, 5.13
Communicating for Safety Standard: 6.9, 6.11

9. Legislation

Health Services Act 2016 (WA)

10. References

ACM Referral and Consultation Guidelines 4th Edition, 2021
WACHS Maternal and Newborn Care Capability Framework Policy
WNHS Statewide Maternity Shared Care Guideline, 2021

11. Related Forms

WACHS SW Special Pregnancy Instruction Sheet

12. Related Policy Documents

WACHS Maternal and Newborn Care Capability Framework Policy
WACHS Maternity Care Clinical Conflict Escalation Pathway Policy
WACHS Maternity and Neonatal Consultation and referral Guideline for Clinical Service Level
WACHS Role of the Endorsed Privately Practicing Midwife for Private Patients at WACHS Maternity Sites

13. Related WA Health System Mandatory Policies

MP 0084/18 Credentialing and Defining Scope of Clinical Practice Policy

14. Policy Framework

Clinical Governance, Safety and Quality

15. Appendices

Appendix 1: Indications at Commencement of Care
Appendix 2: Indications developed/discovered during pregnancy
Appendix 3: Indications during Labour and Birth
Appendix 4: Indications during the postpartum period
Appendix 5: Social indications

This document can be made available in alternative formats on request for a person with a disability

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Directorate:	Nursing & Midwifery	**EDRMS Record #**	ED-CO-22-151369
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Appendix 1: Indications at the Commencement of Care

MEDICAL CONDITIONS		
Anaesthetic difficulties		
Malignant Hyperthermia or neuromuscular disease or family history	C	
Previous failure or complication (e.g. difficult intubation, failed epidural)	B	Requires referral to hospital anaesthetic clinic, plus obstetric team should be aware of past anaesthetic complications
Connective Tissue Autoimmune Disease		
Periarteritis nodasa	C	
Scleroderma, rheumatoid arthritis, Sjorgen's syndrome	C	B if any connective tissue autoimmune disease is inactive
SLE – active OR major organ involvement OR hypertension OR on medication OR positive Ro/La OR coexisting antiphospholipid syndrome OR ITP	C	
SLE – inactive, no renal involvement, no hypertension, or only skin/joint problems	B	As long as Ro/La antibody and antiphospholipid status negative, Ideally part of preconception workup
Other autoimmune disease	B/C	**C** if ACTIVE autoimmune disease as high risk for developing pre-eclampsia
Body Mass Index		
BMI < 18	C	Any woman with a previous gastric surgery or bypass to be categorised as C – includes bypass, gastric banding, gastric sleeve etc. As Per KEMH policy > 45 require referral to anaesthetic as per WACHS policy Site of birth dependent upon CSF of hospital
BMI >35 - <40	B	
BMI >35 with co-morbidities (heart disease, hypertension, sleep apnoea	C	
BMI >40	C	
BMI >50	T	Follow Bunbury High BMI pathway
Cardiovascular disease		
Arrhythmia/palpitations; murmurs; recurrent, persistent or associated with other symptoms	C	NB If the woman has congenital heart disease the risk of fetal congenital heart disease varies between 6-50%- may need tertiary anatomy scan Palpitations – if stable and investigations normal B Murmurs – if investigations normal (ECG + echo) B, if any abnormalities C Low Threshold for tertiary referral All patients with pre-existing HTN require specialist review, many then suitable for shared care.
Cardiac valve disease	C	
Cardiac valve replacement	C	
Cardiomyopathy	C	
Congenital cardiac disease	C	
Hypertension	C	
Ischaemic Heart disease	C	
Pulmonary hypertension	C	
Other cardiac disease	B/C	

Drug Dependence or misuse		
Use of alcohol and other drugs	B/C	C if disclosed drug is teratogenic C if significant drug abuse is likely to require MDT involvement and increased fetal surveillance
Medicine use the effect of drugs on the pregnant woman and the unborn child, lactation and/or neonate. Information is available from Mother safe 1800 647 848		
Endocrine		
Addison's Disease, Cushing's Disease or other endocrine disorder requiring treatment	C	
Diabetes mellitus – gestational diabetes in previous pregnancy (recommend early OGTT)	A	A/B – previous uncomplicated neonatal outcome following diet control B – high risk for GDM in subsequent pregnancy/ required treatment in previous. Even if early OGTT negative requires close monitoring and repeat OGTT
Diabetes mellitus – Either pre-existing or newly diagnosed type 1 and type 2 diabetes	C	B/C - previous complicated neonatal outcome
Hypothyroidism – stable treated / new diagnosis	B/C	C – if unstable hypothyroidism may need referral to endocrinologist and should be flagged to specialist team
Hyperthyroidism -	B	C - if active disease on treatment or positive TSH receptor antibodies. Risk of fetal/neonatal thyrotoxicosis, require serial ultrasound for fetal growth/ goitre
Other thyroid disease	B/C	
Gastrointestinal		
Hepatitis B with positive serology (HBsAg+)	C	B/C – depends on viral load
Hepatitis C	B	C – if active disease/ impaired liver function
Inflammatory Bowel Disease – this includes ulcerative colitis and Crohn's disease	B	C if any previous surgery for GIT disease. Obstetric team need to be involved to plan mode of delivery
Cholelithiasis	A	
Cholestasis	C	
Gastric banding/sleeve	B	
Gastric bypass surgery	C	
Other GIT disease	B	
Genetic		
any condition	B	Ideally part of pre-conception work-up Direct referral from GPO to genetics may be appropriate. If clear from genetics point of view to continue care B. C – if know to have hereditary condition or significant genetic

		problem/congenital anomaly affecting previous pregnancy for early obstetric team referral. May need tertiary input
Haematological		
Anaemia at commencement of care irrespective of how treated or whether it responds to treatment: anaemia defined as Hb < 105g/L	B	C - Hb < 90g/L
Coagulation disorders	C	
Women declining blood products	B/C	
Haemoglobinopathies	B/C	C if partner also carrier, consider tertiary /haematology review
Haemolytic anaemia	C	
Other antibodies detected	B/C	For discussion with Consultant. may need tertiary review
Rhesus antibodies	C	
Rhesus negative requiring Anti D	A	
Thalassaemia	C	
Thrombocytopaenia < 150 ($x10^9$/L)	C	A/B if platelets > 100 and stable based upon serial results
Thrombo-embolic process-family history or underlying pathology	C	
Previous history of DVT or pulmonary Embolism in a prior pregnancy	B	
Acute or current DVT or Pulmonary embolism	C	
Thrombophilia - Anti-phospholipid antibodies and hereditary thrombophilia other than MTHFR mutation (heterozygous)	C	B if haematologist/physician determines patient doesn't require clexane and previous pregnancy unaffected
Thrombophilia – MTHFR mutation (heterozygous)	B	
Thrombophilia – no previous obstetric complications or maternal thrombosis	C	
Thrombophilia – on warfarin, previous obstetric complications or maternal thrombosis	C	
Infectious disease		
Cytomegalovirus	C	
Chlamydia	A/B	
Previous GBS neonate	B	
Genital Herpes Primary infection Recurrent infection	 B A*/B	
Gonorrhoea	B	
Hepatitis B with positive serology (HBsAG+)	C	
Hepatitis C	B	
History of pre-pregnancy cytomegalovirus, Rubella, Parvovirus, Toxoplasmosis, Varicella	A	
Human Papilloma Virus (HPV)	A/B	
HIV infection	C	May require tertiary review
Listeriosis	C	May require tertiary review
Parasitic infection	A/B	

Parvovirus infection	C	
Rubella	C	
Syphilis Positive serology and treated Positive serology and not treated	 B C	
Trichomoniasis	A/B	
Toxoplasmosis	C	
Tuberculosis Active Past history and treated	 C B/C	B if treatment compete and clear C if any ongoing concerns. i.e. respiratory effort
Varicella/Zoster Virus infection	C	
Identified public health concerns eg: Influenza H1N1, SARS-CoV-2, COVID-19	C	
Other infection with which no familiarity	B	
Maternal age		
<16 years	B	
>40 years	B	
First pregnancy and >40 years	B	Recognising the cumulative impact of this upon other risk factors
Neurological		
AV malformations	C	
Bell's Palsy	A	
Epilepsy with mediation or seizure in the last 12 months	B/C	Shared care arrangement recommended. C – intrapartum care if seizure activity in last 12 months OR previous pregnancy
Epilepsy without medication or in the past without treatment and no seizures in the last 12 months	B	
Multiple sclerosis	C	May be suitable for shared care after obstetric review
Muscular dystrophy or myotonic dystrophy	C	
Myasthenia gravis	C	
Spinal cord lesion (paraplegia or quadriplegia	C	
Subarachnoid haemorrhage, aneurysms	C	
Other neurological conditions	B/C	C if nulliparous i.e. effects on pregnancy unknown. B if previous unaffected pregnancy
Organ Transplants	C	
Perinatal Mental Health Problems – History of		
Care during pregnancy and birth will depend on the severity and extent of the mental health status EPDS > 12	 B	
EDPS – positive response to Q10 self-harm	B/C	
Psychiatric condition requiring medication	B	
Puerperal psychosis	B/C	B – Requires referral to ADC to ensure Social Work involvement and correct referrals. Ongoing GPO care for pregnancy and birth

Renal function disorders		
Disorder in renal function, with or without dialysis	C	
Glomerulonephritis	C	
Pyelitis	B	
Previous kidney surgery with potential to impair kidney function during pregnancy i.e. removal of a kidney etc.	C	
Urinary tract infection/s Current Past history of recurrent	 A/B A/B	
Other renal	B	
Respiratory Disease		
Asthma - mild	B	
Asthma – moderate (i.e. oral steroids in the last year and maintenance therapy)	B/C	B if previous unaffected pregnancy C if oral steroids/hospitalisation in previous pregnancy or if ever required HDU/ICU admission
H1 N1 (current)	C	
Severe lung function disorder	C	
Sarcoidosis (can exacerbate during pregnancy)	C	
History of COVID-19 (history of past infection)	B	
Cystic fibrosis	C	
Smoking at first antenatal visit	B	
Skeletal problems		
These include conditions that may cause severe pain during labour History of developmental skeletal disorders	 B/C	B if previous unaffected pregnancy otherwise C
Osteogenesis imperfecta	C	Increased maternal and fetal risks. May need tertiary review
Scheuermann's disease	C	
Scoliosis (with or without rods)	B/C	Ensure anaesthetic review
Spondylolisthesis	B/C	
System/connective tissue diseases		
Marfan's syndrome, Raynaud's disease and other systemic and rare disorders	C	
Dermatological disease requiring systemic therapy	B/C	C if previous pregnancy requiring oral/IM steroids, Risk of diabetes, hypertension
Malignancy – any history or current	C	
Genetic conditions	C	
PRE-EXISTING GYNAECOLOGICAL DISORDERS		
Cervical abnormalities		
Abnormal CST results requiring follow-up during pregnancy	B	
Cervical amputation	C	
Cervical surgery including cone biopsy, laser excision or LLETZ biopsy	B/C	C if cone biopsy, > 1 LLETZ or LLETZ > 10mm depth =- these women are at increased risk of preterm birth and require close

		cervical surveillance +/- progesterone
Cervical surgery with subsequent term vaginal birth	A/B	
Cervical surgery without subsequent term vaginal birth	B/C	C - see above Recommend obstetric consultation for individualised risk assessment
Female Genital mutilation	B	C – may have implications for delivery, corrective surgical training part of FRANZCOG curriculum
Fibroids	B/C	position /size of fibroid important. C - refer if cervical or lower segment (may affect presentation and delivery) or if large i.e. > 5cm (increased risk of PTB. PPH)
Infertility treatment	B/C	Any assisted reproductive technology, particularly IVF, ICSI and donor oocyte use, is associated with increased potential risks – multiple pregnancy, PTB, SGA, perinatal mortality, CS, placenta praevia, abruption, preeclampsia and birth defects. Appropriate monitoring should be in place with low threshold for specialist referral
Intrauterine contraceptive device (IUCD) in situ	C	Require specialist review if potentially ongoing pregnancy. High risk of miscarriage, PTB, chorioamnionitis.
Pelvic deformities (trauma, symphysis rupture, rachitis	B/C	B if previous unaffected pregnancy, otherwise C
Pelvic floor reconstruction		
Colpo-suspension following prolapse, fistula and/or previous rupture	C	
Uterine abnormalities		
Myomectomy/hysterotomy	C	
Bicornuate uterus/unicornuate uterus or other congenital reproductive tract anomaly (this includes vaginal septum)	C	
PREVIOUS MATERNITY HISTORY		
Antenatal:		
ABO - incompatibility	B	
Active blood incompatibility - anti-Red cell antibodies (including but not exclusively Rh, Kell, Duffy, Kidd) -Anti-platelet antibodies (neonatal alloimmune thrombocytopaenia- NAIT)	C	
Autoimmune thrombocytopaenia	C	C- if platelets < 100 Anaesthetic review if < 100
Cardiac issues	B/C	
Cervical weakness (and/or cervical suturing	C	

procedure)		
Endocrine • Gestational Diabetes – diet controlled • Gestational Diabetes - uncontrolled +/- medication	B B/C	
Fetal		
IUGR < 10th percentile	B/C	B - < 10th percentile C - < 3rd percentile
Macrosomia > 4.5kg - uncomplicated	B	
Perinatal death	B/C	Early specialist review and decision for ongoing pregnancy care provider
Rhesus isoimmunisation	C	
Grand multiparity – defined as parity >= 5	B	X if requiring IOL
Hypertension		
Chronic hypertension	B/C	
Eclampsia/Severe pre-eclampsia (including HELLP)	C	
Gestational hypertension	B	
Pre-eclampsia	B	
Obstetric Cholestasis	B/C	
Placenta		
Abruption	C	Risk of recurrence – previous abruption is most predictive risk factor
Accreta	C	
Manual Removal	B/C	C if ≥ 2 MROP – highly likely to reoccur
Previous labour/birth		
Preterm birth (< 37 weeks) in a previous pregnancy	B/C	CSF - indicates any previous birth 13-35 weeks and woman should have shared care with regional site.
History of preterm prelabour rupture of membranes +/- preterm birth	B	
History of preterm birth	B/C	
Recurrent miscarriage (3 or more first trimester)	C	particularly if no live births
Symphysis pubis dysfunction	A	
Termination of pregnancy (TOP): > 3	B	Risk factor for PTB – Cx length at anatomy scan, low threshold for specialist referral
Trophoblastic disease; Hydatiform mole or vesicular mole, within last 12 months	C	
Previous mi-trimester loss	B/C	C – depends on gestation and cause. May fit criteria for progesterone treatment, may require tertiary review
Intrapartum:		
Caesarean Section • classical/midline incision • T incision	B/C B/C B B/C	

• LUSCS • Two or more prev caesarean sections (no history of vaginal birth) • Two or more prev caesarean sections (history of vaginal birth/successful VBAC)	B/C	
Forceps or vacuum birth	A/B	
Maternal collapse	C	
Perinatal or other laceration • 3rd or 4th – functional recovery • 3rd or 4th – persistent dysfunction • Cervical laceration • Episiotomy – midline/bilateral/with extension	 B C B/C A/B/C	
Post-partum haemorrhage • > 500mL: non-symptomatic, no treatment • Minor 500-1000ml symptomatic +/- requiring additional treatment • Major 1000mls +	 B B/C C	CSF – level 2 sites AN care only for past history PPH >1000mls. IP care at level 3+ sites (Bunbury or Busselton)
Shoulder dystocia	B/C	XC– if severe i.e. internal manoeuvres, significant maternal or fetal injury, resuscitation/SCN admission. Need discussion re Mode of delivery
Postpartum:		
Pelvic Floor dysfunction • Dyspareunia • Faecal incontinence • Urinary incontinence	B/C	
Neonatal:		
Congenital and/or hereditary disorder of a previous child	B	Detailed discussion of screening options +/- tertiary review may be warranted
Previous neonate GBS infection	B	
Neonatal asphyxia: apgar <7 at 5 mins	B	
Stillbirth or neonatal loss	B/C	
History of psychological or mental health concerns		
Antenatal depression and/or anxiety Postnatal depression Puerperal psychosis Other significant perinatal mental health	B A/B/C C C	

Appendix 2: Indications developed/discovered during pregnancy

CLINCIAL INDICATIONS DURING PREGNANCY		
Cardiac		
Palpitations	A/B	
Palpitations – prolonged, symptomatic or associated with significant symptoms	B/C	
New onset cardiac condition	C	
Cervical Weakness	B/C	
Cervical shortening <25mm	B	
Cervical shortening with risk factors for preterm birth	C	
Preterm cervical dilation	C	
Cervix cytology abnormalities	B/C	C – if colposcopy recommended
Ectopic pregnancy	C	
Endocrine		
Diabetes mellitus Gestational diabetes diet controlled Gestational diabetes uncontrolled +/- requiring insulin	 B C	C if diagnosed < 20/40. High risk pregnancy 35, highly likely to require insulin.
Thyroid disease Subclinical hypothyroidism Hypothyroidism Hyperthyroidism	 A/B B	C if unstable hyper or hypothyroidism New hyperthyroidism Dx in pregnancy warrants obstetric physician/endocrinology review
Addison's disease, Cushing's disease or other endocrine disorder requiring treatment	C	
Fetal		
Fetal anomaly	C	May need tertiary review
Fetal death in utero	B/C	For specialist consultant to determine appropriate place of birth
Discrepancy with SFH	B/C	
LGA with no other risk factors	A	
LGA with risk factors (diabetes, previous shoulder dystocia)	B	
Macrosomia >4000gm or 90th centile	C	
Polyhydramnios/ Oligohydramnios	C	
Small for dates with normal liquor and dopplers	A/B	
FGR	B/C	Be mindful of site CSF Arrange ultrasound and refer as required – particularly for asymmetrical growth
FGR with concerning features (Oligohydramnios, abnormal dopplers)	C	
Fibroids	**B**	C – if increasing size or symptomatic

Gastro-intestinal and Hepatobiliary		
Cholecystitis or biliary colic	B	
Cholestasis	C	
Hepatitis B or C positive serology	B/C	Consider hepatology referral
Acute hepatitis (any cause) or jaundice	B	
Appendicitis	C	
Inflammatory Bowel disease including ulcerative colitis and Crohn's disease	B	C if any previous surgery. Recommend gastroenterology review +/- obstetric review if active disease in pregnancy
Other acute gastrointestinal of hepatobiliary presentation	B	
Haematological		
Anaemia Hb < 105	B	
Severe anaemia Hb <70 +/- MCV >100fL	C	
Blood group incompatibility	C	
Coagulations disorders	B/C	C – if severe or caused pregnancy complications in the past
Mean corpuscular volume (MCV) < 80	B	
Rhesus negative requiring Anti- D	A	
Thrombosis or thrombophilia (other than MTHFR mutation)	C/X	X – thrombosis
Thrombocytopaenia < 100 x 10^9	C	B- if platelets > 100 and stable
Hernia Nuclei Pulposi (slipped disc)	**B**	
Hyperemesis Gravidarum	**B**	
Hypertension		
Any type with proteinuria (>/= 2+ or > 0.3g/24hurs)	C	
Eclampsia / HELLP	C	
Gestational hypertension; any hypertension after 20 weeks gestation	C	B – if not requiring treatment or stable on low dose single agent with normally grown baby
Pre-eclampsia ; BP of >140/90 and/or relative risk of > 30/15mmHg from BP at commencement of care And any of: • proteinuria > 0.3g/24 hours; or • protein/creatinine ratio >=30mg/mmol or 2+ protein on dipstick testing • platelets < 150 x 10^9L • abnormal renal or liver function	C	
Infectious diseases		Consider need for tertiary/MFM review as per RANZCG C-Obs-30
COVID		COVID 19 – always refer to latest WA Health policy. COVID suspected or positive is not a reason for referral or transfer of care alone.
Chlamydia	A/B	
Cytomegalovirus	C	

Genital herpes - Late in pregnancy – active lesions -Primary infection - Recurrent (consider antivirals to begin at 36 weeks)	 C B/C A/B	NB. Specialist should be informed about any primary HSV in pregnancy >38 weeks. Caesar is recommended if primary episode in 3rd trimester (especially but no limited to the last 6 weeks)
GBS infection	A/B	
Gonorrhoea	B/C	C – if Dx in late pregnancy
HIV infection	C	
Human Papilloma virus	A/B	
Listeriosis	C	
Parvovirus infection	C	
Rubella	C	
Syphilis	C	
Toxoplasmosis	C	
Tuberculosis -active - past history and treated	 T B/C	Active TB for tertiary management.
Varicella/Zoster virus infection	C	
Other		
Malpresentation/non-cephalic presentation at full term/unstable lie	B/C	
Breech presentation (refer for ECV at 35 weeks)	B/C	To counsel women on risk v benefit of ECV. C- if ECV requested. T – if requesting vaginal breech birth
Multiple pregnancy	C	
No prior prenatal care (at full term)	B/C	
Neurological		
Migraines	B	
Stroke	C	
New onset of seizures	C	
Neuropathies or palsies	B/C	
Perinatal mental health issues		
EDPS > 12 OR positive response to Q10 self-harm	B/C	B/C - Dependent upon services already in place. Shared Care (GPO/ADC) recommended for establishment of long-term therapeutic relationship.
Mental health issue requiring medication	B/C	
Acute and unstable mental health concern	C	
Antenatal depression and anxiety	B	
Placental indications		
Placental abruption	C	
Placenta accreta, increta or percreta	C	
Placenta praevia	C	
Vasa praevia	C	
Pregnancy Duration		
Post-term pregnancy (>=42 completed weeks of 294 days)	C	

Postdates pregnancy – gestational age >= 41 completed weeks or 287 days	B	
Preterm labour (threatened or actual) and birth	B/C	B > 37weeks as per CSF
Preterm rupture of membranes	B/C	
Reduced fetal movement in third trimester	B/C	NOTE; recommended guidelines for DFM C – if ongoing DFM i.e. ongoing maternal concern despite normal Ix or >= 2 presentation
Renal function disorders		
Haematuria or proteinuria (>=2+)	B/C	C – if proteinuria – assess for atypical /developing PET, or underlying renal disorder increasing risk of PET
Urinary tract infections	A/B	
Pylonephritis	C	
Respiratory disease		
Asthma	A/B/ C	As per CSF : moderate to severe asthma to birth in level 5 site.
Pneumonia	C	
Severe lung function disease	C	
COVID-19	C	
Sepsis	**C**	
Surgery during pregnancy	**C**	C if abdominal surgery. Suitable for shared care once risk of PTB has passed. Be mindful of VTE risk if musculoskeletal surgery in pregnancy
Symphysis pubis dysfunction (pelvic instability)	**A**	
Uncertain duration of pregnancy by amenorrhoea > 20 weeks	B	
Vaginal blood loss		
Recurring loss prior to 12 weeks	A/B	
At or after 12 weeks	B	
Potentially significant clinical presentation during pregnancy e.g. acute abdominal pain, palpitations, neurological symptoms, intractable headaches	B	C if >= 2 presentation of concern

Appendix 3: Indications during labour and birth

Clinical indications during labour and birth		
Amniotic Fluid Embolism	C	
Controlled ARM (non engaged fetal head)	C	
Breech presentation	B/C	Consider site CSF and resources.
Fetal death during labour	C	
GBS positive	A	
Genital herpes active in late pregnancy or at onset of labour	C	
Haemorrhage		
Intrapartum haemorrhage Asymptomatic and/or < 50mL Symptomatic and /or > 50mL	 B C	
Postpartum Haemorrhage Asymptomatic and/or < 1000mL Symptomatic and/or > 1000mL Any PPH >1500mls	 B C C	
Hypertension • Eclampsia • Gestational • Preeclampsia	C	
Maternal collapse/Shock	C	
Meconium stained liquor	B	
Multiple pregnancy	C	
Non-vertex position	B/C	Consider Site CSF and resources.
Pathological CTG	B/C	
Placental abruption and/or praevia (suspected or confirmed)	C	
Rupture of membranes		
Rupture of membranes at term (not in labour) > 18 hours	B	
Rupture of membranes at term > 18 hours	B	
Pre-labour preterm rupture of membranes (PPROM) before 37 weeks	C	
Preterm labour < 37 weeks	C	
Prolapse cord or cord presentation	C	
Prolonged labour		
Prolonged active 1st stage of labour Nulliparae: <=0.5cm/hr Mulitparae: 1cm/hr Take into consideration descent and rotation of fetal head, and changes in strength, duration and frequency of contractions. Consider ease or difficulty of access and/or transfer to referral services e.g. location/theatre	B/C	Clearly document decision of which clinician responsible for ongoing care. • if labour crosses alert line for discussion with Obstetric team • if labour crosses action line for transfer of care. Reference: KEMH guideline. labour (first stage): management

		of delay
Prolonged 2nd stage labour Nulliparae: >=2 hours without descent > 1 hour of expulsive effort without descent Multiparae: -with an epidural: >=2 hours including >= 30 mins of expulsive effort without descent -without an epidural : >= 1 hour without descent Consider ease or difficulty of access and/or transfer to referral services e.g. location/theatre	B/C	As per KEMH guidelines Second stage of labour – management of delay **Nulliparous woman** - Birth would be expected to take place within 3 hours of the start of the active second stage -Suspect delay if progress, in terms of descent and /or rotation of the presenting part, does not occur after 1 hour of active second stage -Diagnose delay in the active second stage at 2 hours and consider Obstetric consultation **Multiparous women** - Birth would be expected to take place within 2-3 hours of the start of the active second stage -Suspect delay if progress, in terms of descent and/or rotation of the presenting part, does not occur after 30 minutes of active second stage -Diagnose delay in the active second stage at 1 hour and consider Obstetric consultation
Regional anaesthetic (epidural, spinal)	B	
Retained placenta	B/C	B- at Busso C- at Bunbury if theatre required
Shoulder dystocia	B/C	Activate code blue response appropriate to site
Suspicious fetal heart rate pattern	B/C	Activate code blue response appropriate to site in accordance to WACHS policy
Third or fourth degree perineal tear	B/C	C – for fourth degree
Unengaged head in active labour in primiparae	B/C	
Uterine inversion	C	
Uterine rupture	C	
Vasa praevia	C	
Vital signs Persistent deviation from normal: tachycardia, decreased urine output, hypertension, hypotension Temperature 38 degree or more on 2 consecutive reading at least an hour apart	B/C B/C	Management as per WACHS maternal sepsis policy. To consider transfer to regional centre +/- need for HDU management
Oxytocin infusion for any indication	B/C	B - for IOL C – As per delay in progress policy.
Hb < 90g/L in labour	C	

Appendix 4: Indications for consultation and referral to Obstetric consultant

- Hypertension – persistent, preeclampsia, eclampsia
- Faecal incontinence
- Puerperal psychosis
- Secondary postpartum haemorrhage – symptomatic
- Prolapse – uterine, cystocele, rectocele
- Pulmonary embolism
- Stroke
- Sepsis
- Thrombophlebitis or thromboembolism

Appendix 5: Management of social indicators

Management of social indicators such as:

- Adoption
- Current or previous child protection concerns
- FDV
- Financial issues
- Learning disabilities
- Pregnancy during teenage years
- Significant social isolation
- Other vulnerabilities

Should all be managed with collaboration of team members such as midwifery, GP/O, social work team, aboriginal liaison officer, child health ect to ensure that the woman is receiving comprehensive family centred care to support and ensure best outcome for Mother and Baby.