HUTTmaternity
Hutt Valley Maternity Care

Referral GuidelinesPLUS

Huttmaternity

HuttMaternity, Hutt Valley DHB Local implementation of the Referral Guidelines (Maternity)						
Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale

Welcome to the first edition of Huttmaternity Referral Guidelines PLUS.

This document is based on the MOH Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines), and has localized the information, provided more description on when to refer women and clinical recommendations / rationale.

It covers all the referral reasons to Secondary Care Services for pre-existing and/or co-existing medical conditions, but does not include categories for Labour & Birth, or Services Following Birth.

The aim of this document is to encourage timely referrals and provide the clinician with clinical recommendations.

All referrals must include copies of tests; ultrasound scans available and a customized growth chart (GROW) as appropriate.

Further information for women can be found on our website or Facebook

www.Huttmaternity.org.nz or www.facebook.com/huttmaternity

HuttMaternity, Hutt Valley DHB
Local implementation of the Referral Guidelines (Maternity)

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
1000-2000 Pre-existing and/or co-existing medical conditions						
Anaesthetics						
1001	Anaesthetic difficulties	Previous failure or complication (e.g. difficult intubation, failed epidural, severe needle phobia)	Consultation	Anaesthetist	3rd trimester	Refer to Obstetric Anaesthetic Clinic • LMCs to use pale yellow Anaesthetic Referral form and leave in Secondary Care Clinic Basket in Chart room. • All others to send referral to Obstetric Anaesthetic Clinic, Maternity Assessment Unit, Hutt Hospital
1002	Malignant hyperthermia or neuromuscular disease		Consultation	Anaesthetist	3rd trimester	
Autoimmune/rheumatology						
1003	SLE/connective tissue disorder	Active, major organ involvement, on medication	Transfer	Obstetrician	ASAP	• Aspirin 100mg EC tabs OD from 12/40 • Calcium 1.5g tabs OD 8-20 weeks (if diet low in calcium) • Baseline PET bloods • ANA and ENA bloods • Random urine PCR • UA Doppler at 20/40 scan Risk of IUGR Risk of pre-eclampsia Risk of Fetal Congenital Heart Block if Ro/La positive
1004		Inactive, no renal involvement, no hypertension, or only skin/joint problems	Consultation	Obstetrician	When identified	
1005	Thrombophilia including antiphospholipid syndrome	On warfarin, previous obstetric complications or maternal thrombosis	Consultation / Transfer	Obstetrician	1st trimester	NB. Warfarin is teratogenic from 6/40 onwards. • If on Warfarin contact Ob Physician or GP to arrange change to therapeutic low molecular weight heparin as soon as possible and prior to appointment • Refer to Obstetric Anaesthetic Clinic
1006		No previous obstetric complications or maternal thrombosis	Consultation	Obstetrician	1st trimester	
Cardiac						
1007	Arrhythmia/palpitations; murmurs	Recurrent, persistent or associated with other symptoms	Consultation	Obstetrician	When identified	Most palpitations are benign. Diagnosed arrhythmias require decision re place of birth plus birth management plan. GP to see palpitations and undiagnosed murmurs or childhood murmur. Refer to Ob Physician if diagnosed with an arrhythmia e.g. AF, SVT, VT.
1008	Cardiac valve disease	Mitral/aortic regurgitation (and other valve lesions)	Consultation	Obstetrician	1st trimester	Decision re place of birth Refer to Obstetric Anaesthetic Clinic
1009		Mitral/aortic stenosis	Transfer	Obstetrician	1st trimester	Decision re place of birth Refer to Obstetric Anaesthetic Clinic
1011	Cardiac valve replacement		Transfer	Obstetrician	1st trimester	Decision re place of birth: • Mechanical valves refer to Maternal Fetal Medicine, CCDHB • Refer to Obstetric Anaesthetic Clinic

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
1012	Cardiomyopathy		Transfer	Obstetrician	When identified	Decision re place of birth Refer to Obstetric Anaesthetic Clinic
1013	Congenital cardiac disease		Consultation / Transfer	Obstetrician	1st trimester	Decision re place of birth ⇒ ***PN paeds*** Refer to Obstetric Anaesthetic Clinic
1014	Hypertension	>140/90 or on antihypertensive medication	Consultation	Obstetrician	1st trimester	• Aspirin 100mg EC tabs OD <20/40 Risk of pre-eclampsia • Baseline PET bloods Risk of IUGR • Random urine PCR • UA Dopplers at 20/40 scan
1015		>150/100	Transfer	Obstetrician	Immediate	Immediate risk - Call on-call Obstetric RMO without delay
1016	Ischaemic heart disease		Transfer	Obstetrician	1st trimester	Refer to Obstetric Anaesthetic Clinic
1017	Pulmonary hypertension		Transfer	Obstetrician	ASAP	Decision re place of care and birth
Endocrine						
1019	Diabetes	Pre-existing (insulin dependent or non-insulin dependent)	Transfer	Obstetrician		As per algorithm ⇒ ***PN paeds***
1020		Gestational, well controlled on diet	Consultation	Obstetrician		As per algorithm
1021		Gestational, requiring insulin	Transfer	Obstetrician		As per algorithm
1022	Thyroid disease	Hypothyroidism (Hypothyroidism due to treated Graves' disease requires referral)	Consultation	Obstetrician	1st trimester	• Monitor fetal growth (LMC) as risk of IUGR • Monitor TSH each trimester Target TSH <2.5 first trimester; <3.0 second and third trimesters
		Hyperthyroidism	Consultation	Obstetrician	1st trimester	• Monitor fetal growth (LMC) as risk of IUGR • Monitor TSH each trimester Target TSH <2.5 first trimester; <3.0 second and third trimesters Measure thyroid stimulating immunoglobulin at 32/40 ⇒ ***PN paeds***
1023	Hypopituitarism		Consultation	Obstetrician	1st trimester	
1024	Prolactinoma	Microprolactinoma not on medication All others	Consultation	Obstetrician	When identified	Macro requires closer monitoring
	Other endocrine disorder significant in pregnancy	Addison's disease, Cushing's disease	Consultation	Obstetrician	When identified	
Gastroenterology						
1025	Cholelithiasis	Symptomatic	Consultation	Obstetrician		

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
1026	Cholestasis of pregnancy		Consultation / Transfer	Obstetrician	On diagnosis	
	Previous fatty liver in pregnancy		Consultation	Obstetrician	< 20/40	UA Dopplers at 20/40
1027	Inflammatory bowel disease (Crohns or ulcerative colitis, excluding Irritable Bowel Syndrome IBS)	Active or on medication	Consultation	Obstetrician	< 20/40	
1028		Inactive When past surgery: referral recommended	Consultation Consultation	Obstetrician	< 20/40	May have adhesions so possible complications from surgery should be assessed e.g. Perianal disease that may indicate Caesarean
1029	Hepatitis	Acute	Consultation	Obstetrician	On diagnosis	Call on-call Obstetric RMO without delay, consult with Obs Physician
1030		Chronic active	Consultation	Obstetrician	<28/40	Hepatitis B with a high viral load will be offered Tenofovir from 28- 30/40 to reduce fetal transmission ⇒ ***PN baby vaccination***
1081		Active chronic on immune-suppressants	Transfer	Obstetrician		
1031	Oesophageal varices		Transfer	Obstetrician	1st trimester	
Genetic						
1033	Marfan's		Transfer	Obstetrician	1st trimester	
1032	Any genetic condition significant in pregnancy		Transfer	Obstetrician	1st trimester	
Haematological						
1034	Anaemia	Hb < 90 g/l, not responding to treatment	Consultation	Obstetrician	When identified	• B12, iron stores, thalassaemia screen • Commence iron treatment if iron deficit and monitor response • Aim to have improvement prior to birth • If little or no response consider referral for iron infusion
1035	Haemolytic anaemia		Consultation / Transfer	Obstetrician	Immediate	Call on-call Obstetric RMO without delay
1036	Bleeding disorders	Including Von Willebrands	Consultation	Obstetrician	2nd trimester	• Request previous notes
1037	Thalassaemia		Consultation	Obstetrician	<20/40	• Check ferritin and B12 (ferritin can be high • Only prescribe iron meds if ferritin low • Screen partner at booking (if both parents positive fetus may be affected)

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
1038	Thrombocytopenia	Pre-existing or 1st trimester	Consultation	Obstetrician	1st trimester	• Exclude PET / HELLP
		2nd or 3rd trimester	Consultation Consultation	Obstetrician	When known 36 weeks	• Exclude pre-eclampsia and HELLP • Repeat FBC and request LA, ACA, TORCH, EBV and HIV screen prior to appointment
1039	Sickle cell disease		Transfer	Obstetrician	On diagnosis	• Sickle anaemia is prevalent in sub-Saharan Africa, South and Central America, Saudi Arabia; India; Turkey, Greece, and Italy. • One or both parents may be carriers • Carriers may also have a sickle cell crisis when hypoxic. Refer carriers and transfer affected women
1040	Thromboembolism	Suspected deep vein thrombosis, pulmonary embolism	Transfer	Obstetrician	Emergency	ED for initial diagnosis, Haematology and Ob Physician will provide further management
		Previous thromboembolism	Consultation	Obstetrician	1st trimester	DVT/PE requires early referral for prophylactic low molecular weight heparin.
1041	Thrombophilia		Consultation	Obstetrician	1st trimester	
Infectious diseases						
1042	CMV/toxoplasmosis		Consultation / Transfer	Obstetrician	On diagnosis	Call on-call Obstetric RMO
1044	HIV positive		Consultation / Transfer	Obstetrician	On diagnosis	
1045	Listeriosis		Consultation / Transfer	Obstetrician	On diagnosis	Call on-call Obstetric RMO
1046	Rubella		Consultation	Obstetrician	If acute infection suspected	• If exposed, check antibodies • If antibodies negative, repeat 2/52, if antibodies positive call on-call Obstetric RMO
1047	Syphilis		Consultation	Obstetrician	On diagnosis	⇒ ***PN paeds***
1048	Tuberculosis	Active	Consultation / Transfer	Obstetrician	On diagnosis	• Contact Infection control
		Contact	Primary	GP		

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
1049	Varicella	Active	Transfer	Obstetrician	On diagnosis	• Keep out of hospital if possible • Call on-call Obstetric RMO
		Contact	Primary	GP	When identified	• Woman to see GP • IgG and IgM titres on booking bloods. • If the pregnant woman is not immune to VZV (Ig G neg)and she has had a significant exposure, she should be offered varicella-zoster immunoglobulin (VZIG) as soon as possible. VZIG is effective when given up to 10 days after contact
Neurological						
1050	Arteriovenous malformation, CVA, TIA		Consultation / Transfer	Obstetrician	1st trimester <20/40	
1051	Epilepsy	Controlled	Consultation	Obstetrician	1st trimester	• Preconception planning preferred • Folic Acid 5mg OD before 12 weeks
1052		Poor control or multiple medications	Transfer	Obstetrician	1st trimester	• Folic acid 5mg OD before 12 weeks
1053	Multiple sclerosis		Consultation	Obstetrician	>20/40 2nd trimester	See after anatomy scan Refer Obstetric Anaesthetic Clinic Consider earlier if primigravida
1054	Myasthenia gravis		Consultation / Transfer	Obstetrician		Refer to Obstetric Anaesthetic Clinic
1055	Spinal cord lesion		Consultation / Transfer	Obstetrician	When identified	5 mg Folate if Spina Bifida Refer to Obstetric Anaesthetic Clinic
1056	Muscular dystrophy or myotonic dystrophy		Consultation / Transfer	Obstetrician	When identified	

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
Mental health						
1058	Current alcohol or drug misuse/ dependency		Consultation	Obstetrician	When identified	Consider Maternal Wellbeing and Child Protection Group (Vulnerable Women Group) Offer referral to Social Worker
	Depression and anxiety disorders		Consultation	Obstetrician	When identified	If woman very anxious, Obstetrician consultation is appropriate Check for needle phobia Consider Maternal Wellbeing and Child Protection Group (Vulnerable Women Group) Offer referral to Social Worker If stable and under GP management – primary care. Offer Mothers Matter website, monitor for deterioration. If on SSRIs – baby needs monitoring for PN withdrawal. If under Community mental health team – obstetric referral If deterioration depression & anxiety or new dx in pregnancy – refer MMH clinic to see obstetrician & MMH nurse. NB MMH will not see woman already under community psychiatry. If risk of harm / suicide – CATT team If hx of psychosis or bipolar disorder – Obstetrician referral, MMH(if not already under a community psychiatry team) If on sodium valproate – 5mg folic acid and URGENT obstetrician referral.
1059	Other mental health condition	Stable and/or on medication e.g. bipolar disorder	Consultation	Obstetrician	When identified	Combined birth plan ⇒ ***PN paeds*** Offer Referral to Social Worker
		Acute unstable psychosis	Transfer	CATT Team	Immediate	• Refer CATT Team

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
Renal disease						
1061	Glomerulonephritis		Transfer	Obstetrician	<20/40	• Aspirin 100mg EC tabs OD 12wks Risk of pre-eclampsia • Calcium 1.5g tabs OD 8-20 weeks (if diet low in calcium) Risk of IUGR • Baseline PET bloods • Random urine PCR • Monthly MSU • UA Dopplers at 20/40 scan and serial growth scans
1062	Proteinuria	Chronic	Consultation	Obstetrician	<20/40	• Aspirin 100mg EC tabs OD 12wks Risk of pre-eclampsia • Calcium 1.5g tabs OD 8-20 weeks (if diet low in calcium) Risk of IUGR • Baseline PET bloods • Random urine PCR • Monthly MSU • UA Doppler at 20/40 scan and serial growth scans
1063	Pyelonephritis	History of pyelonephritis	Consultation	Obstetrician	>20/40	• Serum creatinine x1 • Monthly MSU • May require prophylactic antibiotic
		Acute	Consultation	Obstetrician	Immediate	Call on-call Obstetric RMO Risk of preterm labour
1064	Renal failure		Transfer	Obstetrician	Immediate	Call on-call Obstetric RMO
1065	Renal abnormality or vesico-ureteric reflux		Consultation	Obstetrician	1st trimester <20/40	• Aspirin 100mg EC tabs OD 12wks ⇒ ***PN paeds*** • Calcium 1.5g tabs OD 8-20 weeks (if diet low in calcium) • Baseline PET bloods Risk of UTIs • Random urine PCR Risk of pyelonephritis • Serial growth scans May be at risk of pre-eclampsia

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
Respiratory disease						
1066 1067	Asthma	Mild or moderate	Primary	GP	1st trimester	Ask about steroid use & hospital admissions in past year
1068		Severe (continuous or near continuous oral steroids, or any ICU admission)	Consultation	Obstetrician	When identified	• GTT at 18/40 Risk of GDM • Serial growth scans Risk of IUGR • Refer to Obstetric Anaesthetic Clinic
1069	Acute respiratory condition		Primary	GP	When identified	
1070	Cystic fibrosis		Transfer	Obstetrician		
Transplant						
1080	Organ transplant (excl renal transplant) Renal transplant		Transfer	Obstetrician	When identified	
2000-3000 Previous gynaecological conditions or surgery						
2001	Cervical surgery including OF 2 OR MORE cone biopsy or LLETZ	Without subsequent term vaginal birth	Consultation	Obstetrician	After scan at 12-14/40	• Arrange USS for Cervical Length at 12-14/40. Refer if cervical length <2.5 cm
2003	Congenital abnormalities of the uterus	Without previous normal pregnancy outcome	Consultation	Obstetrician	Early second trimester	Request any previous gynae notes To determine type of abnormality
2007	Myomectomy		Consultation	Obstetrician	>20/40	Request placenta scan for accreta Decision re mode of birth
2008	Previous uterine perforation		Consultation	Obstetrician	>20/40	
2009	Prolapse	Previous surgery	Consultation	Obstetrician	32/40	Decision re mode of birth
2010	Vaginal abnormality	E.g. septum	Consultation	Obstetrician	>20/40	
2011	Female genital mutilation		Consultation	Obstetrician	>20/40	Cultural support
3000-4000 Previous maternity history						
3001	Previous placental abruption		Consultation	Obstetrician	1ST trimester	• Aspirin 100mg EC tabs OD 12 wks • UA Doppler at 20/40 scan
3002	Alloimmune thrombocytopenia	Risk to fetus of thrombocytopenia	Transfer	Obstetrician	1st trimester	• Risk to fetus of thrombocytopenia

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
3003	Caesarean section		Consultation	Obstetrician	1st or 2nd trimester	Refer early for mode of delivery discussion Second consultation at 36/40
3004	Cervical incompetence		Transfer	Obstetrician	1st trimester	• Scan of cervix length at 12/40 (NT scan) • Consider cervical stitch at 14/40
3005	Trophoblastic disease	Hydatidiform mole or vesicular mole, within last 12 months	Consultation	Obstetrician	1st trimester	• Inform radiologist of history at all scans. • Send placenta for histology post birth • Postnatal 6/52 HCG titres if <5 discharge to GP, if > 5 refer to clinic
3008	Hypertensive disease	Past H/O Preeclampsia	Consultation	Obstetrician	1st trimester	• Aspirin 100mg EC tabs OD 12/40 • Calcium 1.5g tabs OD 8-20 weeks (**if diet low in calcium**) • Baseline PET bloods • UA Dopplers at 20/40 scan • Significant risk of recurrence
3009	Large for gestational age	Birth weight > 97th percentile on customized growth chart	Consultation	Obstetrician	After GDM screening^	• HbA1c at booking • GTT as per algorithm ^If GDM screen and growth normal, no need to be seen Needs GROW chart
3010	Intra-uterine growth restriction (IUGR)	Birth weight < 5th percentile on population chart; 10th percentile if a customized growth chart is used	Consultation	Obstetrician	1st trimester	• Aspirin 100mg EC tabs OD 12/40 • Folic acid 5mg tabs OD • UA Dopplers at 20/40 scan • Serial growth scans plotted on customized growth chart from 28/40
3011	Manual removal		Consultation	Obstetrician	3rd trimester^	• Request previous notes • Correct iron deficiency • Discuss and consider Active Management of Third Stage ^If uncomplicated may not need to be seen 16G IV access in labour
3012	Perinatal death		Consultation	Obstetrician	1st trimester	
3013	Postpartum haemorrhage	> 1000 ml	Consultation	Obstetrician	3rd trimester	• Request previous notes • Correct iron deficiency • Recommend Active Management of Third Stage • 16G IV access in labour

3014	Preterm birth	< 35 weeks	Consultation	Obstetrician	14/40	Cervix length at 12-14/40
		<28 weeks	Consultation	Obstetrician	1st trimester	Cervix length at 12/40 (NT scan) Needs progesterone from 12/14 – early referral to clinic to facilitate
3015	Recurrent miscarriage	Three or more	Consultation	Obstetrician	On diagnosis of pregnancy	Do not refer after 12/40
3016	Shoulder dystocia		Consultation	Obstetrician	3rd trimester	• Request previous notes • GDM screening Decision re mode of birth
3017	Termination of pregnancy	Previous uterine perforation, or three or more surgical terminations	Consultation	Obstetrician	<20/40	
3018	SUDI (Sudden unexplained death of an infant)		Primary		<20 weeks	Explore any risk factors e.g. smoking
3019	Fetal congenital abnormality		Consultation	Obstetrician	1st trimester	
3020	Third or fourth degree tear		Consultation	Obstetrician	3rd trimester	Decision re mode of birth
4000-5000 Current pregnancy						
4001	Acute abdominal pain		Consultation	Obstetrician	On identification	Call on-call Obstetric RMO
4002	Abdominal trauma		Consultation	ED or Obstetrician	On identification	Call on-call Obstetric RMO • Requires 4 hour CTG • +/- Anti D
4003	Abnormal CTG		Consultation	Obstetrician	On identification	
4034	Advanced Maternal Age	Defined as age over 40	Consultation	Obstetrician	3rd Trimester	Consult regarding IOL by 40 weeks (may be telephone consult)
4004	Antepartum haemorrhage		Consultation	Obstetrician	On identification	Call on-call Obstetric RMO

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
4005	Blood group antibodies	Determine if antibodies implicated for HDN	Consultation	Obstetrician	On identification	• Anti-D, anti-c and anti-K antibodies most often implicated in causing haemolytic disease of newborn but also anti-C -E [-cE], -Fya, and –Jka • Consideration of testing father of baby • Monthly titres • Decision re place of birth and plan for baby • At birth: cord blood test for FBC and DAT • Presence of maternal antibodies can make blood X-match difficult • Admission group and X-match -allow 2-4 hours
4006	Eclampsia		Emergency	Emergency team	Immediate	Community 111 Emergency call Hospital 777 Adult Resus and Obstetric Code 2
4007	Fetal abnormality		Consultation	Obstetrician	When identified	• Triage depends on abnormality ⇒ ***PN paeds*** e.g. dilated renal pelvis does not need antenatal consultation • Place of birth may be affected
4008	Gestational proteinuria	> 0.3 g / 24 hours proteinuria protein/creatinine ratio ≥ 30mg/mmol or 2+ protein on random dipstick testing	Consultation	Obstetrician	When identified	Call on-call Obstetric RMO
4009	Gestational hypertension	New hypertension presenting after 20 weeks with no significant proteinuria	Consultation	Obstetrician	When identified	• PET bloods • Call on-call Obstetric RMO
4010	Intrauterine death		Consultation	Obstetrician	When identified	
4011	IUGR/small for gestational age (SGA)	Estimated fetal weight (EFW) < 10th percentile on customized growth chart, or abdominal circumference (AC) < 5th percentile on ultrasound, or discordancy of AC with other growth parameters, normal liquor	Consultation	Obstetrician	When identified	• Repeat Dopplers & liquor volume in 7 days • Repeat growth, Dopplers and liquor volume in 2 weeks • Customized growth chart
4012	IUGR/small for gestational age (SGA)	EFW < 10th percentile on customized growth chart, or AC < 5th percentile on ultrasound, OR discordancy of AC with other growth parameters, reduced liquor or abnormal umbilical Doppler	Transfer	Obstetrician	Immediate	Urgent transfer If abnormal umbilical or middle cerebral artery (MCA) Doppler Customized growth chart
4013	Infant large for gestational age	EFW on a customized growth chart > 90th percentile	Consultation	Obstetrician	After GTT result	• Immediate GTT (GTT may be done up to term) • Customized growth chart

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
4035	Jehovah's Witness		Consultation	Obstetrician	2nd Trimester	
4015	Malignancy		Consultation	Obstetrician	When identified	
4016	Malpresentation	> 36 weeks; breech, transverse, oblique or unstable lie	Consultation	Obstetrician	37-38/40 for ECV	• Confirmation scan. If breech, size of baby and liquor volume
4017	Morbid obesity	Body mass index (BMI) > 40	Consultation / Transfer	Obstetrician	Late 1st trimester	• HbA1c at booking • GDM screen as per algorithm • Refer to Obstetric Anaesthetic Clinic
4017	Obesity	BMI > 35	Consultation	Obstetrician	30/40	• HbA1c at booking • GDM screen as per algorithm • Monitor weight gain and refer if gained >30kg • 4/52 growth scans from 24/40 • Plot on GROW chart
4018	Multiple pregnancy	Twins and higher order multiples - DCDA	Consultation	Obstetrician	After anatomy scan	May refer earlier if indicated
		Twins and higher order multiples - MCDA	Transfer	Obstetrician	When identified	• NT recommended. Discordant NT measurements can indicate early twin to twin transfusion and require early referral • Growth scans 2 weekly from 16/40
		Triplets and higher multiples	Transfer	Maternal fetal medicine	When identified	Refer to Maternal Fetal Medicine
4019	Oligohydramnios	Deepest fluid pocket < 2 cm on scan or amniotic fluid index < 8	Consultation	Obstetrician	Immediate	Call on-call Obstetric RMO if AFI <5
4020	Placenta praevia; vasa praevia	Complete praevia at or > 32 weeks	Transfer	Obstetrician	After follow-up scan (no bleeding)	• Complete praevia: follow up scan at 32 weeks and refer • Marginal praevia (placenta <2 cms from cervical os): follow up scan at 32 weeks and refer if still praevia • Vasa praevia always transfer when known
4021	Polyhydramnios	Scan pools >8	Transfer	Obstetrician	After scan to confirm	• GTT ⇒ ***PN paeds*** • If GTT normal: Rescan in 2 weeks then refer if confirmed (Can be gestation dependent)
4022	Pre-eclampsia	BP of ≥ 140/90 and any of: 1. protein/creatinine ratio ≥30mg/mmol or 2+ protein on dipstick testing 2. platelets < 150 x 10/9/l 3. abnormal renal or liver function 4. imminent eclampsia	Consultation / Transfer	Obstetrician	When identified	Call on-call Obstetric RMO without delay

Code	Condition	Description	Referral Category	Triage by	Timing	Recommendations/Rationale
4023	Preterm rupture of membranes	< 37 weeks and not in labour	Consultation	Obstetrician	When identified	Call on-call Obstetric RMO NO VE
4024	Prolonged pregnancy	Refer in a timely manner for planned induction by 42 weeks	Consultation	Obstetrician		• 41 week scan for fetal well-being, liquor volume • After scan, virtual postdates referral with scans, antenatal notes • Plan induction after 41 weeks.
4025	Premature labour	34 – 37 weeks	Consultation	Obstetrician	When identified	Call on-call Obstetric RMO ***⇒PN paeds***
4026	Premature labour	< 34 weeks	Transfer	Obstetrician	When identified	Call on-call Obstetric RMO ***⇒PN paeds transfer<35 weeks*** <32 weeks will need to transfer to CCDHB for access to NICU
4027	Prelabour rupture of membranes at term		Consultation	Obstetrician	When identified	Consult with on-call Obstetric RMO and plan made for IOL Offer immediate IOL as practical vs expectant management (inform woman small risk of chorioamniotis) • Ensure not HSV or GBS positive • Assess fetal and maternal well-being when SROM identified • Refer sooner if unsure • NO VE
4028	Confirmed reduced fetal movements	Following normal cardiotocograph but still concern – may require liquor/ growth asst	Consultation	Obstetrician	When identified	Refer if ongoing concerns or not reassured by CTG
4029	Herpes genitalis	Active lesions	Consultation	Obstetrician	Immediate if in labour	Call on-call Obstetric RMO • May consider CS if in labour especially if primary lesions • If SROM, refer immediately (CS offered < 4hours) • May consider Acyclovir if occurs in pregnancy • May consider prophylaxis: Acyclovir at 36/40
4031	Uterine fibroids		Consultation	Obstetrician	>20/40	Request assessment of fibroid size at scans to ascertain growth comparison Risks of preterm labour and IUGR (dependent on position of fibroid in relation to placenta)
4032	Urinary tract infection (UTI)	Recurrent	Consultation	Obstetrician	When identified	May require prophylactic antibiotic
4033	Influenza-like illness		Primary	GP		If influenza A, watch carefully for maternal complications and refer if concern (keep out of hospital where possible) Consider toxoplasmosis, cytomegalovirus (CMV), herpes, and other infectious diseases (TORCH),