# Prenatal Timetable 2021

The DFSM prenatal timetable is a group effort of the Maternity Care Faculty of the Department of Family and Social Medicine, with consultation from the Department of Obstetrics and Gynecology. The timetable serves as a guide to provide optimal prenatal care for our patients. Our goal is to support the normal physiological process of pregnancy, intervening only when necessary and with the patient's agreement.

## COVID-19 Pandemic

Note that prenatal schedules may be adjusted for the COVID pandemic.
Please prescribe a scale and blood pressure cuff for all prenatal patients as televisits may be necessary

## Contacting OB-GYN

Please see separate referral guidelines for OBGYN and MFM referral

For urgent/emergent questions, call Wakefield documentation room on L&D (718 920-9343) and ask for the OBGYN attending on call; or Weiler L&D (718 904-3433) and ask for the OBGYN attending on call. (Please do not give these numbers out to patients).

For assistance with appointments

to OB: send email to obgynconsult@montefiore.org
to MFM: send email to mfmconsult@montefiore.org

For concrete, limited, nonemergent clinical questions: eConsult to OB or MFM

Do not use eConsults for appointment scheduling

Williams R, Schonberg D, Gervits M, Jochim A, Parente L.; Montefiore DFSM Maternity Faculty, MFM consultant E. Karkowsky: January 2021.

| Positive Pregnancy Test | | |
|---|---|---|
| **Task/Problem** | **Background** | **Plan: Rx/Counseling/ Advance Planning/Testing** |
| All patients see a provider for a focused history and physical exam.<br><br>History<br>Assess for:<br>risk of ectopic<br>risk from medical conditions<br>genetic risks/concerns | Rely on LMP for EDD only if "certain."<br>• No hormonal contraceptives in the 3 months before LMP<br>• Regular menses for past 3 months<br>• No vaginal bleeding since last LMP<br>• Firm LMP recall (within 3-5 days)<br>• LMP seemed like a "normal period" | Patients seeking termination[1]<br><br>1. Family Medicine<br>Repro health line 917-626-9627<br>2. OB Gyn<br>Montefiore Family Planning 718-405-8150<br>or fpconsult@montefiore.org<br>3. Planned Parenthood<br><br>Offer follow-up appt 4 weeks |
| If at risk for ectopic or gestational age uncertain, perform a vaginal exam<br><br>Perform options counseling | Risks for ectopic<br>• Prior ectopic<br>• Infertility treatment<br>• Prior PID<br>• Bleeding since LMP<br>• Pelvic pain<br>• IUD in situ | Patients who are uncertain<br>Options counseling<br>Schedule follow up appt 1-2wks<br>Offer Folic Acid |
| Add "positive pregnancy test" to problem list | Higher Genetic Risk<br>• Over age 35<br>• History of infant with genetic disease<br>• Personal or family hx of genetic disease | Patients continuing pregnancy<br>Order prenatal vitamins<br>Order prenatal labs<br>Order sonogram if indicated<br>Initial prenatal within 2 weeks<br>Review all medications<br>Social work all teens and prn |
| Physical exam | Physical findings Uterine size:<br>• 5-6 weeks lemon<br>• 7-8 weeks medium orange<br>• 9-10 weeks grapefruit | Site-specific protocols<br>WB: RN referral for intro to care<br>FHC: Call/message Prenatal coordinator |

## When to consider a sonogram:[2]

1. Uncertain dating

| Montefiore Ultrasound Dating Policy | |
|---|---|
| **Ultrasound date** | **Change from certain LMP date for difference of:** |
| <8 weeks (if transvaginal) | 4d |
| 8--13 6/7 weeks | 7d |
| 14--18 weeks | 10 days |
| Over 18 weeks | Repeat scan in 2-4 weeks to confirm |

2. Confirm an intrauterine pregnancy*
    a. Emergent scan through ED for patients with suspected ectopic
    b. Urgent scan for patients with at higher risk for ectopic: prior ectopic, IUD in-situ
3. Viability in question
4. Bleeding in early pregnancy
5. Absence of fetal heart tones after 10 - 12 weeks
6. Genetic testing (Nuchal translucency or First trimester screen at 11wks-13w6d)
7. Anatomy scan (18-21wks)
8. Growth scan for issues: Size-date discrepancy of 3 or more weeks between 20-36wks Hx IUFD, bariatric surgery, HTN, DM, uncertain fundal height, extreme weight change (26-32wks)
9. Biophysical (Urgent i.e., Decreased Fetal Movement) - Send to triage
10. Accreta scan for prior section with anterior placenta (28wks)
11. Presentation if uncertain at/after 36 weeks
12. Postdate testing (40wks)

*All patients with ectopic risk factors should have a sonogram ordered at pregnancy diagnosis

Prenatal Timetable 2021

| Each Appointment | | |
|---|---|---|
| **Task/Problem** | **Background** | **Plan: Rx/Counseling/Advance Planning/Testing** |
| History | Interval history including diet, exercise, work, and relationships. Acute illness and injury. Occurrence of contractions, loss of fluid, vaginal bleeding, fetal mvmt. | **Diet** "Not eating for two!"<br>• Folic acid supplement min 400ug<br>• Iron 28 mg daily<br>• Calcium 1200mg daily |
| Vitals | Pulse and respiratory rate are often elevated.<br>If BP over 140/90 repeat with manual cuff, if still elevated, additional evaluation is needed.<br>Utilize the EPIC Weight Gain graph<br>Advise </=4lbs first trimester; then .5 - 1lb/wk[3] | Avoid<br>• Caffeine >300mg<br>• Soft cheese, lunchmeat, raw meat, high mercury containing fish |
| Urinalysis | Urinalysis at initial visit & for elevated BP, UTI symptoms. | Prenatal vitamin content is not controlled by FDA – review content on OTC vitamins<br>Consider nutrition/health ed referrals |
| Fundal height | FH should correlate w/ gestational age from 20 – 36wks, (***lie patient flat for accurate measurement)*** | **Exercise[4]/Work[5]/Sex**: generally ok<br>Encourage breastfeeding, smoking cessation.<br>Check all meds for pregnancy risk – check www.Drugs.com |
| Fetal heart | If no FHT at 10 - 12wks, revisit in 2wks or order sonogram for viability/dates | or<br>https://mothertobaby.org/fact-sheets/<br>Organization of Teratology Specialists |
| Risks | Identify and continually modify risks, treat disease | Social work referral for teens and prn<br>Offer Healthy Start referral<br>Offer Nurse Family Partnership referral |
| Follow-up | Q4wk until 28; q2wk until 36; q1wk until 41wks | Next visit: schedule all visits in advance<br>Document patient education on prenatal checklist in Epic |
| Patient education | Cover diet/exercise/work/ & anticipatory guidance<br><br>Site of delivery<br>**Family Physicians Deliver at Wakefield**<br>**Repeat sections at Weiler** | Emergency contact: Patients should call their own clinic number |

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| Initial Prenatal Visit | | |
|---|---|---|
| **Task/Problem** | **Background** | **Rx/Counseling/Advance Planning/Testing** |
| **Before entering the room**:<br>Check results of screening studies<br>• Labs/Sonogram<br>• EDD information<br>• Check resident assignment<br><br>Complete initial prenatal in EPIC<br>• Dating<br>• History (Past, Family)<br>• Social (use FSI)<br>• **OB hx – fill in every box**<br>• Open note for Initial Prenatal<br>• Add complete PE including pelvic exam<br><br>Confirm dating<br><br>• Determine risk<br>• Add every risk to problem list!<br>• Should you consult/refer?<br><br>Pt education<br>• Document in prenatal checklist<br><br>Build rapport- with the patient | CBC, Type & Screen, Hemoglobin analysis, HIV, rubella, varicella, hepBSAg, hep C, syphilis, PAP (if due), GC/Chlamydia, lead level, HbA1C, urinalysis/urine culture.[6,7]<br>Consider COVID Antibody testing<br><br>Check that all labs were sent and reported. Pelvic exam is necessary for pelvimetry and confirming dates. An accurate EDD is important for prenatal care as milestones and screenings are timed. Pelvic exam should be performed at diagnosis or initial visit.<br><br>Screen for TB if indicated[8]<br>Screen all for ZIKA[9]<br>See consult guidelines.<br><br>N/V, wt. gain, breastfeeding, genetic testing & warning signs<br><br>Identify your role [resident family physician, providing prenatal care, delivery, and care for the whole family] and let the patient know how to contact you. | Determine primary and backup provider when rotation schedules are known.<br><br>Offer carrier testing for cystic fibrosis and SMA screening & genetic screening/testing if not done<br><br>Offer genetics referral to all patients<br><br>Refer for<br>☐ Risks as per guidelines<br>☐ WIC (form in EPIC)<br>☐ Sonogram if not done already<br><br>Address each RISK in EPIC with a Separate problem for each<br>☐ Refer as per consult guidelines[10]<br>Review plan for next visit<br><br>Obtain a valid phone number. Invite family to clinic visits (as allowed)<br><br>**Define site of delivery** |

| *Special circumstances | | |
|---|---|---|
| **Task/Problem** | **Background** | **Plan: Rx/Counseling/Advance Planning/Testing** |
| **Genetics**[11]<br><br>Counseling with option for screening and testing<br><br>Screening:<br>• Parents – SMA, CF & Fragile X<br>• NIPS (11-22wks) FTS (11-13wk6d) QUAD (14w-22w6d)<br>• AFP (15–22wk6d) if FTS or NIPS<br><br>Definitive Testing<br>• chorionic villi sampling (11 -14wks)<br>• amniocentesis (16-22wks) | Offer genetic counseling to all prenatal patients.<br><br>Advise genetic counseling to those higher risk, i.e., advanced maternal age, personal or family history of genetic disorder.<br><br>CF and SMA must be offered by NYS Law<br><br>Screening tests, like the QUAD, First Trimester screen or NIPS are not recommended for patients at increased risk. Genetic Counselors will review options.<br><br>NIPS screening can be done up until delivery but generally not done after viability. | Offer carrier screening for cystic fibrosis and Spinal muscular atrophy to all patients. Fragile X may also be done.<br><br>Patient education: early diagnosis provides options and better planning for care of affected fetus<br><br>Genetic counseling with Reproductive Genetics done by phone, group and or by individual appointment. Upon receive of referral, Genetics office will call patient to set up the appointment. |
| **High BMI** | >30<br><br>>35 with comorbidities (DM, HTN)<br><br>Obesity may obscure fundal height | Consider referral to nutritionist or health educator for counseling<br><br>Screening echo, offer sleep study for OSA symptoms<br><br>Growth sonograms at 26 and 32wks, earlier if necessary. |

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| **HIV**[12] | • Universal screening at initial visit<br>• Encourage 3T testing for HIV<br>• Encourage HIV testing for pregnant and postpartum patients with acute HIV symptoms.<br>• If HIV negative but at increased risk, offer PREP | Refer HIV positive patients to HIV HROB clinic – email to mfmconsult@montefiore.org |
| **Tuberculosis -** Screen based on risk[8] | CDC Risk Factors<br>• Exposed to someone with TB<br>• Work- or live-in prison, shelter, NH, other long-term care<br>• Recent immigrants (within 5 years) from Latin America, Caribbean, Africa, Asia, Eastern Europe, Russia | QuantiFERON can be used for screening or PPD+ patients<br><br>If QuantiFERON positive: order CXR after 20wks. **Isolate in labor until CXR, repeat CXR with each pregnancy.**<br><br>Consider prophylaxis during or after pregnancy |
| **Immunizations**[13] | Flu shot anytime in pregnancy<br>Tdap after 27-36wks<br>Hepatitis A – at risk<br>Hepatitis B – at risk | Advise family members to obtain vaccination for vaccinated for influenza and UTD on Tdap |
| **Herpes simplex virus**[14] | Treat for presence of or hx of genital HSV lesions, not presence of antibodies. Recommend prophylaxis 36 wks until delivery.<br><br>For initial outbreak in 3T offer treatment until delivered.<br><br>Symptoms or lesions at delivery. | Acyclovir 400mg tid or valacyclovir 500mg bid<br><br>Offer cesarean for delivery<br><br>Cesarean advised |

| **Diabetes Screening**[15,16]<br><br>See Family Medicine guideline: Diabetes in Pregnancy. Protocol for Screening Diagnosis and Management located on intranet | Prevalence of Diabetes in the Bronx is 12%. Montefiore policy to screen all patients for pre-existing diabetes at the initial prenatal visit.<br>**ADA screening recommendations for dx of overt (pregestational) diabetes**<br>A1c >= 6.5%<br>FPG >= 126 (fasting >= 8 hours)<br>Random PG >= 200 w/ LBS symptoms<br>2hr PG >= 200, 75g glucose load<br><br>We no longer use the 1hr GCT as a screening method for overt diabetes.<br><br>Consider nutritional counseling for patients at increased risk for diabetes |
|---|---|
| | **ADA Screening Recommendations for dx of gestational diabetes (24-28 wks)**<br>**One-step strategy**<br>After 8 hr. fast, perform a 75-g OGTT, plasma glucose drawn at fasting and at 1 and 2 h in women not previously diagnosed with diabetes. Dx GDM when any of the following are met or exceeded:<br>• Fasting: 92 mg/dL (5.1 mmol/L)<br>• 1 h: 180 mg/dL (10.0 mmol/L)<br>• 2 h: 153 mg/dL (8.5 mmol/L)<br><br>**Two-step strategy**<br>Step 1: Perform a 50-g GLT (non-fasting), with 1 hr. plasma glucose at 24–28 weeks of gestation in women not known to have diabetes. I If l hr. screen value is >/= 200 mg/dl patient is diagnosed with GDM. If 1 hr. plasma glucose level >/= 130 mg/dL but<200, then test with 100-g OGTT.<br><br>Step 2: After 8 hr. fast, perform a 100-g OGTT. Dx GDM following Carpenter-Couston criteria: when at least two* of the four plasma glucose levels are met or exceeded:<br>• Fasting: 95 mg/dL (5.3 mmol/L)<br>• 1 h: 180 mg/dL (10.0 mmol/L)<br>• 2 h: 155 mg/dL (8.6 mmol/L)<br>• 3 h: 140 mg/dL (7.8 mmol/L)<br>GDM, gestational diabetes mellitus; GLT, glucose load test; OGTT, oral glucose tolerance test.<br>*American College of Obstetricians and Gynecologists notes that one elevated value can be used for diagnosis. |

| Task/Problem | Background | Plan: Rx/Counseling/Advance Planning/Testing |
|---|---|---|
| **Short cervix[17]** | Hx cervical insufficiency, refer early to OB evaluate for possible cerclage<br>Measured on anatomy scan (18-20wks)<br><br>Transvaginal measurement <.25cm<br>MFM will often start therapy from ultrasound unit, if not, do not wait for consult | If measured short, obtain serial cervical lengths – every two weeks and start Oral progesterone (200mg) or vaginal gel (90mg) daily from dx to 37wks (can give 100mg capsules vaginally if gel not covered by insurance).<br>Consult MFM |
| **Hypertensive disorders[18]** | Increased risk for preeclampsia<br><br><br>History of chronic hypertension | Start low dose aspirin at 12wks, best if initiated before 18wks<br><br>Baseline “PEC” labs, including 24hr urine<br>Discontinue teratogenic medications<br>Consult MFM for uncontrolled BP<br>Refer to OB for controlled chronic HTN<br>Start low dose ASA<br>Growth scan<br>Antenatal testing (NST/BPP) Induce at 37wks |
| **Bariatric surgery19** | Caution regarding dyad nutrition and fetal growth. Follow labs for anemia and deficiency each trimester.<br><br>Loosen lap band<br><br>High suspicion for bowel obstruction | Check labs: cbc, ferritin, B1, B12, vit D. thiamine.<br><br>Avoid Glucola for GDM screen, see DM guideline<br>Consult MFM<br>Consider bariatric surgery consult |
| **Thyroid disease[20,21]** | Normal values differ in first trimester pregnancy<br>TSH has wider range in 1T (.25 – 4.7)<br>Free T4 does not change, Total T4 may be elevated<br><br>Thyroid antibodies can be associated with increased risk of loss | Increase thyroid dose by 25% at initial dx<br><br>Check TFTs at least each trimester<br><br>If not euthyroid on replacement or if hyperthyroid, refer to MFM or endocrine |

| Routine Prenatal Care | | | |
|---|---|---|---|
| **Task/Problem** | | **Background** | **Plan: Rx/Counseling/ Advance Planning/Testing** |
| **Second visit** | Follow up on labs and referrals<br>Follow up on op reports if needed<br>FTS (11-13w6d)<br>NIPS (11-22wks) | Rh negative – Rhogam 50ug for any bleeding<br>Sickle screen positive – offer testing FOB | Offer genetic screening and testing<br>Testing fetus requires amniocentesis |
| | Urine Culture (12 – 16wks)<br><br>AFP (15-22w6d, if patient had FTS or NIPS) or<br><br>Quad test (14 – 22w6d) | Screening for asymptomatic bacteriuria is done by culture. Urine dip may be entirely negative.<br>Treat all UTI in pregnancy for 7-10 days & do TOC<br>Elevated AFP (>2.5MOM) may be dating error, order ultrasound (if not done earlier) and refer to genetics.<br><br>Abnormal Quad - offer prompt referral to genetics | Parents should start thinking about birth plan, childcare . . .<br><br>Continue to promote healthy diet and exercise |
| | Structural survey (18 – 21wks) | Also called the anatomical survey or 2T scan, this sonogram shows all the body parts. Cervical length (CL) is also measured. | Gender may be identified.<br><br>CL requires transvaginal measurements. |

<table>
<tr><th colspan="2">Task/Problem</th><th>Background</th><th>Plan: Rx/Counseling/Advance Planning/Testing</th></tr>
<tr><td>12 - 20wks</td><td>Offer ASA to women with high risk of preeclampsia[22]</td><td>USPSTF Guidelines Recommend: Low-dose aspirin (60 to 150 mg/d) initiated between 12 and 28 weeks of gestation reduces the occurrence of preeclampsia, preterm birth, and IUGR in women at increased risk for preeclampsia (PEC).<br><br><u>High risk factors</u><br>• hx PEC<br>• Multiple gestation<br>• Chronic hypertension or renal disease<br>• Type 1 or 2 diabetes<br>• Autoimmune disease<br><br><u>Moderate Risk Factors</u><br>• Nulliparity<br>• Obesity (BMI >/= 30)<br>• Family hx of preeclampsia (mother or sister)<br>• Sociodemographic characteristics (African American race, low socioeconomic status)<br>• Age >/= 35 y<br>• Personal history factors (e.g., LBW, SGA, previous adverse pregnancy outcome, 10-y pregnancy interval)</td><td>Recommend Aspirin to patients with high risk factors<br><br>Consider Aspirin if “several moderate risk factors” are present.</td></tr>
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| Task/Problem | | Background | Plan: Rx/Counseling/Advance Planning/Testing |
|---|---|---|---|
| **After 20wks** | Watch BP and wt. gain | More than 2lb/wk is water weight, beware of PIH | Preterm labor/preeclampsia counseling |
| **24-28** | Repeat type & screen if Rh neg<br><br>GDM screening | If antibody screen is positive the pregnancy may require additional surveillance<br><br>2 step strategy<br>1hr glucose test with 50-gram Glucola (GCT).<br>**If 1hr >130 but <200, do 3hr test**<br>**{1hr >200 = GDM}**<br><br>3hr glucose test (Glucose Tolerance Test, GTT) is done with 100-gram Glucola. Must be fasting.<br><br>Fasting 95<br>1hr 180<br>2hr 155<br>3hr 140<br><br>Two values at or above level = GDM<br>One elevated = increased risk for macrosomia<br><br>**See above for 1-step 2hr test**<br>The 1-step, 2hr screen has more false positives compared to 2-step process and must be drawn fasting. | Discuss with Maternity Faculty or MFM<br><br>Birth plan<br><br>Circumcision preference<br><br>Contraceptive method (IUD, Nexplanon and depo available prior to discharge)<br><br>Discuss breastfeeding plans |

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| Task/Problem | | Background/Plan | Plan: Rx/Counseling/ Advance Planning/Testing |
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| **28 - 33** | Rhogam for Rh neg | 300ug Rhogam IM<br>[draw type & screen at/before Rhogam] | Kick counts, Preterm labor & PEC counseling |
| | 3T labs | Syphilis, CBC, HIV, GC/Chlamydia, HepBSAg[23] | Testing based on "Population risk" |
| | Immunizations | TdaP 27-36wks, influenza, Hep A and B for risk. | |
| | Sonograms | Growth<br>Placenta location<br>Previa should have resolved<br>Order accreta scan[24] | Repeat sonogram if needed<br>Still previa or low-lying placenta, speak with Maternity Faculty to schedule cesarean. Call MFM positive accreta scan |
| | <u>Consents</u> | | |
| | Tubal Ligation (TL) | NYC consent forms for TL<br>**Papers must be signed at least 30d in advance but no more than 6mo prior to delivery** | Use NYC consent. Double-check consent, must have staff witness, copy to media, and give second copy to patient. |
| | Labor after cesarean/Repeat cesarean | Patients sign a "mode of delivery" consent as part of prenatal care | Obtain operative report and refer all patients with prior c-section to maternity faculty/OB for counseling, consent, and scheduling. |

| Task/Problem | | Background | Plan: Rx/Counseling/ Advance Planning/Testing |
|---|---|---|---|
| **33 - 37** | Follow-up CBC<br><br>Immunizations<br><br>GBS screen (35-36 wks)<br><br>Repeat GC/Chlamydia<br><br>Verify vertex (by 36 wks) | If under treatment for iron deficiency anemia check ferritin. If <Hb less than 9, and ferritin low, consider iron infusion.<br><br>TdaP, flu (if not given earlier)<br><br>Swab by provider: vagina and rectum (through anal sphincter).<br><br>Urine testing is acceptable<br><br>Leopold maneuvers and vaginal exam. Preceptors repeat/supervise resident exam. If presentation is uncertain or suspect breech, discuss version and order sonogram asap. | Anticipatory Guidance<br>Review signs of labor & when & how to go to the hospital **411 method**<br>Decreased movement<br>Loss of fluid<br>Bleeding (more than spotting)<br>Decreased FM<br><br>Ambulance only for emergency<br><br>Questions:<br>How will she feed the baby?<br>Does she have a crib, car seat?<br>Circumcision for boy?<br>Infant provider?<br><br>Describe early breastfeeding<br>Colostrum superfood<br>Demand and supply<br><br>Breast pump prescription<br><br>Recommend perineal massage |

| Task/Problem | | Background | Plan: Rx/Counseling/ Advance Planning/Testing |
|---|---|---|---|
| **37 - 40** | Breast exam<br><br>Offer membrane stripping | Breast shell for flat nipples<br><br>Membrane stripping is as safe method to promote labor without increasing infection. When performed weekly from 38weeks. Advise patients that the procedure is often painful, and she may have bleeding.[25] | Review breastfeeding<br><br>Document infant provider in EPIC<br>Emphasize kick counts<br>Schedule post-date testing<br>Schedule induction of labor |
| **>40** | 40.5 weeks<br><br>41 weeks | Check Bishop score<br><br>Schedule post-date testing in MFAC<br>Schedule induction at/after 41 weeks. | Emphasize fetal kick counts<br><br>Schedule induction: enter referral for induction, call patient logistics, if no opening check epic schedule or call labor floor to identify open timeslot; enter referral in EPIC "labor induction" |
| **Postpartum** | 1. Initial 3-5 days after d/c<br><br>2. Routine – 1mo or 2mo postpartum<br><br>3. Additional – follow-up on medical complications | Same time as baby – check hemodynamic stability, mood, lactation, contraception.<br><br>Routine<br><br>GDM – screen for diabetes<br><br>HTN – assess control, cardiac risks<br><br>Anemia – reassess | Use EPIC "immediate postpartum" text<br><br>Use EPIC postpartum visit note<br><br>Use routine office visit |

## References

1. Goodman S, Wolfe M and the Teach Trainers Collaborative Working Group. *Early Abortion Workbook*, Fourth Edition. UCSF Bixby Center for Global Reproductive Health: San Francisco, CA (2012).

2. AIUM-ACR-ACOG-SMFM-SRU Practice Parameter for the Performance of Standard Diagnostic Obstetric Ultrasound Examinations. *J Ultrasound Med* 2018;9999:1-12.

3. Kominiarek MA and Peaceman AM. Gestational Weight Gain. Am J Obstet Gynecol. 2017 Dec; 217(6): 642–651.

4. Schonberg D, Williams RA. Physical Activity in Pregnancy: What Should the Family Physician Recommend? Family Doctor. A Journal of the New York Academy of Family Physicians. 2014:2(3);20-22.

5. University of California. Hastings College of Law. Center for Worklife Law. Pregnant at Work. Available at: https://www.pregnantatwork.org/healthcare-professionals/pregnancy/ Accessed on: 2Dec2020.

6. HRSA. Women's Preventive Services Initiative. Recommendations for Well-Woman Care. Available at: http://www.womenspreventivehealth.org Accessed on: 2Dec2020.

7.World Health Organization. WHO recommendations on antenatal care for a positive pregnancy experience. WHO 2016. Available at: https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/ Accessed on: 2Dec2020.

8. NYC DOH. Tuberculosis Clinical Policies and Protocols 2008, 4th Edition. Available at: https://www1.nyc.gov/assets/doh/downloads/pdf/tb/tb-protocol.pdf Accessed on: 2Dec2020.

9. Parente L, Wang C, Gervits M, Williams RA. Travel During Pregnancy. *Family Doctor. A Journal of the New York Academy of Family Physicians.* 2018:6(2);28-33.

10. Montefiore Medical Group. Ob Consult and Referral Montefiore Guidelines (11/18), Protocol for Screening Diagnosis and Management Department of Family and Social Medicine. Available at: Montefiore Intranet by secure access only (under review).

11. Wang C, Schonberg D, Gervits M, Williams RA. Ethical Dilemmas in Prenatal Genetic Testing: A Case-Based Approach. *Family Doctor. A Journal of the New York Academy of Family Physicians.* 2017:6(2);28-30.

12. NYS DOH. New York State Department of Health Aids Institute Clinical Guidelines Program. HIV Testing During Pregnancy, at Delivery, and Postpartum (7/2020).
Available at: https://www.hivguidelines.org/hiv-testing-acute-infection/hiv-testing-during-pregnancy/ Accessed on 2Dec2020.

13. CDC. Summary of Maternal Immunizations Recommendations. (7/17). Available at: https://www.cdc.gov/vaccines/pregnancy/downloads/immunizations-preg-chart-pdf Accessed on 17Dec2020.

14. ACOG. Management of genital herpes in pregnancy. Practice Bulletin No. 220. Obstet Gynecol 2020;135:e193–202. ACOG.

15. Montefiore Medical Group. Diabetes in Pregnancy. Protocol for Screening Diagnosis and Management Department of Family and Social Medicine (10/18). Available at: Montefiore Intranet by secure access only (under review).

16. ADA. American Diabetes Association Standards of Medical Care in Diabetes 2020. Available at: https://care.diabetesjournals.org/content/diacare/suppl/2019/12/20/43.Supplement_1.DC1/Standards_of_Care_2020.pdf Accessed on: Accessed on 29Nov2020.

17. ACOG. Prediction and Prevention of Preterm Births. Practice Bulletin 130 (Reaffirmed 2018). *Obstet Gynecol* 2012: 120 964-73.

18. ACOG. Chronic Hypertension in Pregnancy. Practice Bulletin No. 203. *Obstet Gynecol* 2019:133:e26-50.

19. ACOG. Bariatric Surgery and Pregnancy. Practice Bulletin No. 105. Obstet Gynecol. 2009 Jun;113(6):1405-13

20. ACOG. Thyroid Disease in Pregnancy. Practice Bulletin No. 223. Obstet Gynecol 2020;135;(6):e261–72.

21: Alexander et al. 2017 Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and the Postpartum. Available at: www.liebertpub.com/doi/pdfplus/10.1089/thy.2016.0457 accessed pm 17Dec2020.

22. USPSTF. Low-Dose Aspirin Use for the Prevention of Morbidity and Mortality From Preeclampsia: Preventive Medication, September 09, 2014. Available at: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/low-dose-aspirin-use-for-the-prevention-of-morbidity-and-mortality-from-preeclampsia-preventive-medication. Accessed on 28Nov2020.

23. NYS DOH. New York State Addendum for Congenital Syphilis Treatment Guidelines. Available at: https://www.health.ny.gov/diseases/communicable/syphilis/treatment_guidelines/guidelines.htm
Accessed on: 2Dec2020.

24. ACOG. Placenta Accreta Spectrum. *Obstetric Care Consensus.* DECEMBER 2018 American College of Obstetricians and Gynecologists. Available at: https://doi.org/10.1016/j.ajog.2018.09.042
Accessed on: 2Dec2020.

25. Boulvain M, et al. Membrane sweeping for induction of labour. Cochrane Database of Systematic Reviews 2005, Issue 1. Art. No.: CD000451