

MATERNAL HEALTH LABORATORY DATA

(See Instructions)

1. Last Name	First Name	MI
2. Patient Number		
3. Date of Birth (MM/DD/YYYY)	Month	Day Year
4. Race <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Other _____		
5. Ethnic Origin <input type="checkbox"/> Hispanic Cuban <input type="checkbox"/> Hispanic Mexican American <input type="checkbox"/> Hispanic Other <input type="checkbox"/> Hispanic Puerto Rican <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unreported		
6. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male		
7. County of Residence		

Initial Labs	Date	Result	Reviewed Date/Initials	Comments/Additional Labs
Blood Type	/ /	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O		
D (Rh) Type	/ /			
Antibody Screen	/ /			
HCT/HGB	/ /	_____ % _____ g/dL		
Pap Smear (if indicated)* Date of last Pap prior to this pregnancy	/ /			
Rubella Titer	/ /			
Varicella Titer	/ /			
Syphilis Screen	/ /			
Urine Culture for GBS	/ /			
HBsAg	/ /			<input type="checkbox"/> Positive Results Reported to Communicable Disease Nurse within 24 hours
Hepatitis C screening	/ /			
HIV (Initial)	/ /	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Declined		
HGB Electrophoresis (if indicated)	/ /	<input type="checkbox"/> Declined		HGB Electrophoresis of FOB (if indicated) Date: _____ Results _____ <input type="checkbox"/> Declined
Cystic Fibrosis (if indicated)	/ /	<input type="checkbox"/> Declined		
1st trimester genetic screening (if indicated)	/ /	<input type="checkbox"/> Declined		
PPD (if indicated)	/ /			
Chlamydia	/ /			
GC	/ /			
Early Diabetes Screen	/ /			
Other	/ /			
15–20 Week Labs	Date	Result	Date/Initials	
Multi Markers/Quadruple Serum Screen (optimally before 20 weeks)	/ /	<input type="checkbox"/> Declined		
Other	/ /			
24–28 Week Labs	Date	Result	Date/Initials	
HCT/HGB (if indicated)	/ /	_____ % _____ g/dL		
Diabetes Screen	/ /	1 hour _____		
2 or 3 hour GTT (if indicated)	/ /	____ FBS _____ 1 hour ____ 2 hours _____ 3 hours		
Other	/ /			
28–30 Week Labs	Date	Result	Date/Initials	
Syphilis Screen	/ /			
D (Rh) Antibody Screen (if indicated)	/ /			
D Immune Globulin (RhIG) given (28 wks) (if indicated)	/ /	Lot # _____ Signature: _____		
3 rd Trimester HIV (anytime between 28–36 wks)**	/ /	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Declined		
Other	/ /			
32–37 Week Labs	Date	Result	Date/Initials	
HCT/HGB	/ /	_____ % _____ g/dL		
GC (if <25 y.o. or ≥ 25 y.o. and in high risk behavior)	/ /			
Chlamydia (if <25 y.o. or ≥ 25 y.o. and in high risk behavior)	/ /			
Group B strep (36–38 wks as Indicated)***	/ /			
Other	/ /			

Instructions for Maternal Health Laboratory Data

Purpose: To assess, document and evaluate health related information on the prenatal patient.

Instructions: Laboratory Tests/Screenings

- In the first column, the laboratory data is divided into time specific sections to serve as a prompt for initiation and completion of the “required” (initial and repeat), “as indicated”, and “other” laboratory tests/screenings.
- The DATE should be documented indicating the date that the laboratory sample is collected or the test is performed.
- The RESULT column provides space for documentation of the results of the laboratory/screening test. If the laboratory results choices are listed, circle the appropriate result. If they are not listed, write in the result as appropriate.
- Note that in the RESULT column that corresponds to HIV, HGB Electrophoresis, Cystic Fibrosis, and Quadruple Screen, there is a block to indicate whether the client refused the test/screening. As appropriate, indicate client refusal by placing a check mark in the corresponding block.
- Note that at the end of each time interval section, there is an opportunity to document “other” test/screening that may be indicated. There is also space in the large column headed COMMENTS/ADDITIONAL LABS to document additional labs.
- In the REVIEWED column, document the date the result was reviewed with the client and the initials of the person providing the review.
- In the COMMENTS/ADDITIONAL LABS column, document any additional labs not indicated in the first column. This column also provides the opportunity for comments related to the laboratory test/screening. Signature of person making comments entry should be documented.
- Note that in the 28–30 Week Labs section, there is space for documenting the administration of D Immune Globulin (RhIG) at 28 wks, if indicated. The signature of the person administering this should be documented at the designated place in the RESULT column.
- Note that in the third trimester Gonorrhea and Chlamydia is repeated to everyone less than 25 years old (State law — 10A NCAC 41A .0204) or to anyone 25 years old or older and practicing risky sexual behaviors (multiple partner, new partner, substance use, limited prenatal care, etc).

Disposition: This form is to be retained in accordance with the records disposition schedule of medical records as issued by the Division of Archives and History.

Location: Go to the following link to access this form and print as needed:

<http://whb.ncpublichealth.com/provPart/forms.htm>