



Place Patient Label here.

NOVA SCOTIA PRENATAL RECORD

Part 1 - Date completed (YYYY/MON/DD) _____

Demographics

Last name		First name		Gender	Pronoun
Address			Contact phone # Alternate phone #		Leave message <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth YYYY/MON/DD	Age at EDD	Highest level of education completed	Employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation	Culture/beliefs/practices
Language: <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Mi'kmaq <input type="checkbox"/> Arabic <input type="checkbox"/> Other			Indigenous identity: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> First Nations <input type="checkbox"/> Métis <input type="checkbox"/> Inuit		Relationship status Partner involved <input type="checkbox"/> Yes <input type="checkbox"/> No
Partner's name		Gender	Age	Partner employed <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation
Prenatal care provider(s)		Baby's care provider in hospital		Primary care provider	Baby's care provider in community

Pregnancy Dating

EDD (FINAL) YYYY/MON/DD

Last menstrual period (LMP) YYYY/MON/DD	EDD by LMP YYYY/MON/DD	Dating U/S YYYY/MON/DD	Gestational age (GA)	EDD by U/S YYYY/MON/DD	Assisted Reproductive Technology (ART) <input type="checkbox"/> Yes <input type="checkbox"/> No	EDD by ART YYYY/MON/DD
Length of cycle _____ Regular <input type="checkbox"/> Yes <input type="checkbox"/> No		Planned pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No		Multiple pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No	Chorionicity	Embryo Transfer YYYY/MON/DD

Obstetrical History

Gravida _____	Term _____	Preterm _____	Abortus _____	Living children _____	Stillbirth _____			
Date YYYY/MON/DD	Place of birth	Gest. age	Type of birth	Complications/Comments e.g. PPH, GDM, IUGR, etc.	Birth weight	Sex	Current health	Nursing duration

Health History

Allergies (include reaction) <input type="checkbox"/> Latex <input type="checkbox"/> NKDA		Previous surgery <input type="checkbox"/> Yes <input type="checkbox"/> No		Past medications		Current medications	
Anesthesia comp. <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiovascular <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> hypertension <input type="checkbox"/> previous GHTN	Neurology <input type="checkbox"/> Yes <input type="checkbox"/> No	Hematology <input type="checkbox"/> Yes <input type="checkbox"/> No	Infectious diseases <input type="checkbox"/> HSV <input type="checkbox"/> HIV <input type="checkbox"/> Hep B <input type="checkbox"/> Hep C <input type="checkbox"/> Other	MSK/Rheumatology <input type="checkbox"/> Yes <input type="checkbox"/> No
Gynecology/Breast Gastrointestinal/Liver Renal/Genitourinary Endocrine <input type="checkbox"/> Thyroid <input type="checkbox"/> previous GDM <input type="checkbox"/> T1DM <input type="checkbox"/> T2DM				Mental Health <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Previous PPD <input type="checkbox"/> Bipolar <input type="checkbox"/> Eating disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other _____		Family History <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Anesthesia comp. <input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Thromboembolic <input type="checkbox"/> Mental health <input type="checkbox"/> Genetic anomalies <input type="checkbox"/> Other _____	
Comments							





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Part 2 - Date completed (YYYY/MON/DD) _____

Current Pregnancy

Nausea/vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Travel (self/partner)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Calcium/vitamin D	<input type="checkbox"/> Yes <input type="checkbox"/> No
Illness/rash/fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Preconception folic acid	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infant feeding plan: <input type="checkbox"/> nursing <input type="checkbox"/> non nursing <input type="checkbox"/> undecided	
Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Prenatal vitamins	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Clinical Exam

Height	Weight	Pre-pregnancy BMI	Recommended gestational weight gain see worksheet 1	Comments
BP	Lungs	Heart	Abdomen	
			Pelvic exam	Female genital cutting <input type="checkbox"/> Yes <input type="checkbox"/> No

Lifestyle/Risk Factors

Relationship issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Financial/housing issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parenting concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dietary restrictions/concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of trauma/abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Barriers accessing care	<input type="checkbox"/> Yes <input type="checkbox"/> No	Occupational risks	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food security concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intimate partner violence	<input type="checkbox"/> Yes <input type="checkbox"/> No	Social support concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral hygiene concerns	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	<input type="checkbox"/> Yes <input type="checkbox"/> No

Substance Use

Tobacco - past 6 months #cigs/day Quit YYYY/MON/DD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol - past 6 months #/week Last drink YYYY/MON/DD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Comments/Follow-up
Tobacco - current use #cigs/day <input type="checkbox"/> Ceremonial	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alcohol - current use #drinks/day /week	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Nicotine replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	≥ 4 drinks at one time	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vaping during pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Substance use in pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cannabis - past 6 months	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cocaine <input type="checkbox"/> Methamphetamines		
Cannabis - current use #/times used/day /week	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Opioids <input type="checkbox"/> Other		
Method Strength		Route _____		
		Substance use disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Opioid agonist therapy		

Ethnicity

Acadian	<input type="checkbox"/>	South Asian	<input type="checkbox"/>
Black	<input type="checkbox"/>	White	<input type="checkbox"/>
East Asian	<input type="checkbox"/>	Other	<input type="checkbox"/>
Indigenous	<input type="checkbox"/>	Unknown	<input type="checkbox"/>
Latin American	<input type="checkbox"/>	Prefer not to say	<input type="checkbox"/>
Middle Eastern	<input type="checkbox"/>		
Southeast Asian	<input type="checkbox"/>		

Genetic Risk Assessment

Donor gamete: Egg <input type="checkbox"/> Yes <input type="checkbox"/> No	Hemoglobinopathy/Thalassemia screen (CBC, Hgb electrophoresis) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	Consanguinity (blood relation) <input type="checkbox"/> Yes <input type="checkbox"/> No
Sperm <input type="checkbox"/> Yes <input type="checkbox"/> No		
Egg age ≥ 35 at EDD <input type="checkbox"/> Yes <input type="checkbox"/> No	Referral to Medical Genetics (see worksheet 2): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
Ethnicity gamete	Specify _____	

Genetic Screening/Investigations

No genetic screening <input type="checkbox"/> Counseled and declined			
MST 9-13+6 weeks	<input type="checkbox"/> Counseled <input type="checkbox"/> Completed <input type="checkbox"/> Declined	EPR	<input type="checkbox"/> Counseled <input type="checkbox"/> Completed <input type="checkbox"/> Declined <input type="checkbox"/> NA
NT 11-13+6 weeks	<input type="checkbox"/> Counseled <input type="checkbox"/> Completed <input type="checkbox"/> Declined <input type="checkbox"/> NA	NIPT	<input type="checkbox"/> Counseled <input type="checkbox"/> Declined <input type="checkbox"/> MSI <input type="checkbox"/> Self pay
MST 15-20+6 weeks	<input type="checkbox"/> Counseled <input type="checkbox"/> Completed <input type="checkbox"/> Declined	CVS/Amniocentesis	<input type="checkbox"/> Yes <input type="checkbox"/> No Other <input type="checkbox"/> Yes <input type="checkbox"/> No
Comments			





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Part 3 For additional information refer to the "Guidelines for Antenatal Laboratory Screening and Testing" resource.

Ultrasound/Biophysical Profile

Date YYYY/MON/DD	GA	Results	Date YYYY/MON/DD	GA	Results

Initial Lab Investigations

Test	Results	Date YYYY/MON/DD
Hemoglobin		
Platelets		
ABO/Rh (D)		
Antibody screen	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	
Hemoglobin A1c		
Fasting Plasma Glucose	<input type="checkbox"/> NA	
Syphilis	<input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive	
HbsAG	<input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive	
HIV	<input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive	
Urine C&S		
Varicella*	<input type="checkbox"/> Immune <input type="checkbox"/> Non-immune	
Rubella*	<input type="checkbox"/> Immune <input type="checkbox"/> Non-immune	
Pap due	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Last pap results	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

24-28 Weeks Lab Investigations

Test	Results	Date YYYY/MON/DD
Hemoglobin		
Platelets		
ABO/Rh (D)		
Repeat Antibodies	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	
GCT 50 g	1 hour _____ <input type="checkbox"/> GDM	
OGTT 75 g	<input type="checkbox"/> NA Fasting _____ 1 hour _____ 2 hour _____ <input type="checkbox"/> GDM	
Syphilis	<input type="checkbox"/> Non-reactive <input type="checkbox"/> Reactive	
Group B strep (35-37 weeks)	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	
GC/Chlamydia (35-37 weeks)	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	

Additional Tests (as indicated)

Ferritin	<input type="checkbox"/> NA		
TSH	<input type="checkbox"/> NA		
GC/Chlamydia**	<input type="checkbox"/> Negative <input type="checkbox"/> Positive		

Screening Tool Results (see worksheets 3 and 4)

WAST	<input type="checkbox"/> Negative <input type="checkbox"/> Positive	EPDS score	EPDS score	EPDS score	T-ACE score <input type="checkbox"/> NA as no alcohol consumed
Date YYYY/MON/DD		Date YYYY/MON/DD	Date YYYY/MON/DD	Date YYYY/MON/DD	Date YYYY/MON/DD

Rh CARE NA

<input type="checkbox"/> Rh (D) Neg	Paternal/Donor blood type _____
Rh (D) Alloimmunization	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rho(D) IG (28-29+6 weeks)	Date YYYY/MON/DD _____
<input type="checkbox"/> Additional Rho(D) given	Date YYYY/MON/DD _____
Bleeding/other event in pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No
	_____ weeks

Recommended Vaccines

Influenza vaccine <input type="checkbox"/> NA	Lot Number _____
Date YYYY/MON/DD	
Hepatitis B vaccine <input type="checkbox"/> NA	Lot Number _____
Date YYYY/MON/DD	
Tdap vaccine at 27-32 weeks	Lot Number _____
Date YYYY/MON/DD	
Other _____	Lot Number _____
Date YYYY/MON/DD	

*Perform serology if immunity unknown ** Perform GC/Chlamydia screening early in pregnancy for those at risk.





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Part 4 Use 'Additional Prenatal Visit' page when additional space is required.

Refer to the "Nova Scotia Prenatal Record Companion Document".

Issues/Management Plan

EDD (FINAL) YYYY/MON/DD

- HSV treatment indicated
 Low dose aspirin indicated
 Progesterone (preterm birth prevention) indicated
 Social concerns (adoption, child protection, etc.)

Referral follow up:

- Obstetrics Medical Genetics Anesthesia Diabetes Centre Dietician
 Neonatology Pediatrics Mental Health Social Work Other

At approximately 36 weeks: Copy of prenatal record to hospital and/or with patient

Prenatal Visits Gravida _____ Term _____ Preterm _____ Abortus _____ Living children _____ Stillbirth _____

Date YYYY/MON/DD	Wt. (kg)	BP	GA	Fundal height	Fetal HR	FM	Pres/ Pos.	Cig/ day	Comments: e.g. IPV, mental health, sub. use	Next visit	Initials

Care Provider Signature

Print name	Signature	Initials	Print name	Signature	Initials





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Additional Prenatal Visits

Issues/Management Plan

EDD (FINAL) YYYY/MON/DD

Blank area for Issues/Management Plan with horizontal lines.

Prenatal Visits Gravida _____ Term _____ Preterm _____ Abortus _____ Living children _____ Stillbirth _____

Date YYYY/MON/DD	Wt. (kg)	BP	GA	Fundal height	Fetal HR	FM	Pres/ Pos.	Cig/ day	Comments: e.g. IPV, mental health, sub. use	Next visit	Initials

For Reference Only





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NOVA SCOTIA PRENATAL RECORD

Additional Prenatal Visits

Issues/Management Plan

EDD (FINAL) YYYY/MON/DD

Prenatal Visits Gravida _____ Term _____ Preterm _____ Abortus _____ Living children _____ Stillbirth _____

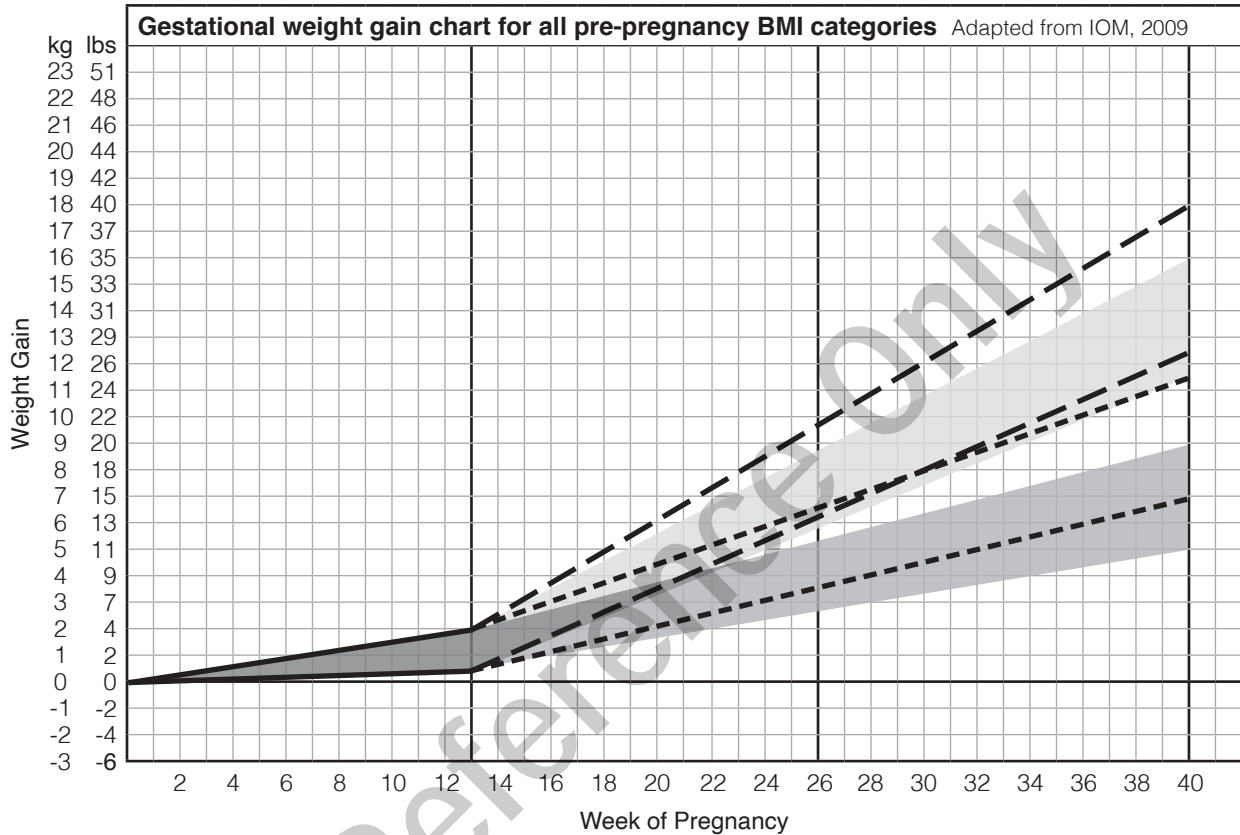
Date YYYY/MON/DD	Wt. (kg)	BP	GA	Fundal height	Fetal HR	FM	Pres/ Pos.	Cig/ day	Comments: e.g. IPV, mental health, sub. use	Next visit	Initials



NOVA SCOTIA PRENATAL RECORD

Worksheet 1 Height _____ Weight _____ Pre-Pregnancy BMI _____

Recommended total weight gain _____



Legend	Prepregnancy BMI	Recommend total weight gain	GWG/week in 2 nd 3 rd trimester
—	< 18.5 kg/m ²	12.5-18 kg (28-40 lbs)	0.5 kg (1-1.3 lbs)
▒	18.5-24.9 kg/m ²	11.5-16 kg (25-35 lbs)	0.4kg (0.8-1 lbs)
- - -	25-29.9 kg/m ²	7.5-11.5 (15-25 lbs)	0.3 kg (0.5-0.7 lbs)
▒	>30 kg/m ²	5-9 kg (11-20 lbs)	0.2 kg (0.4-0.6 lbs)

- The y axis represents gestational weight gain (the 0 is the pre-pregnancy weight). The x axis represents weeks of pregnancy.
- Plot the accumulated weight gain on the along the y axis, above the weeks of pregnancy along the x axis.

Care Considerations for Increased Pre-Pregnancy BMI

Pre-pregnancy BMI ≥ 30 kg/m²

- Fasting plasma glucose with initial bloodwork
- Dating U/S – transvaginal for optimal accuracy
- 3rd Trimester U/S for fetal growth (serial)

5A's of Healthy Pregnancy weight gain

Ask – for permission to talk about weight

Assess – potential root cause

Advise – pregnancy weight gain risk and options

Agree – on a realistic SMART plan to achieve healthy behaviour outcomes

Assist – in identifying barriers and facilitators

Pre-pregnancy BMI ≥ 40 kg/m²

- Consider anesthesia consult to assess risks/delivery planning
- Weekly biophysical at 36 weeks
- Thyroid screening with initial blood work

If weight gain is below or above recommendations:

Assess for clinical issues (such as edema) and explore the root causes of inappropriate weight gain, including

- **Mental** (e.g. insomnia)
- **Metabolic** (e.g. medications)
- **Mechanical** (e.g. reduced mobility)
- **Milieu** (e.g. employment)





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Worksheet 2

Genetic Screening and Assessment¹

One's ethnicity is an important piece of risk assessment as some populations are known to have a higher incidence of certain genetic conditions, such as:

- Ashkenazi Jewish (Tay Sachs, Canavan, Familial dysautonomia)
- French Canadian from Saguenay Lac-St Jean, Charlevoix, Bas-St-Laurent (Tay Sachs, CF)

All pregnant persons and their partners should have a three-generation family history taken.

Referral to Medical Genetics should be considered for those from higher risks populations and those with a personal or family history of:

- congenital anomaly e.g. congenital heart defect, neural tube defect
- intellectual disability or developmental delay
- genetic syndrome e.g. neurofibromatosis, Noonan syndrome
- chromosomal disorder e.g. Down syndrome (trisomy 21), familial translocation
- muscular disorder e.g. X-linked Duchenne and Becker muscular dystrophies
- bleeding disorder e.g. X-linked hemophilia A or B
- stillbirth
- sudden unexplained death
- other major health concerns such as cardiomyopathy, neurological disease, epilepsy, hearing loss, autism, and psychiatric disorders
- consanguinity

Hemoglobinopathies

- α thalassemia
- β thalassemia
- Sickle cell disease

Screening recommendations

Offer to individuals from the following at-risk populations/ethnic backgrounds when red blood cell indices reveal a mean cellular volume (MCV) < 80 fl OR electrophoresis reveals an abnormal hemoglobin type

- African
- Mediterranean
- Middle East
- South East Asian
- Western Pacific
- Caribbean
- South American

Method of carrier screening:

- Complete blood count
- Hemoglobin (Hb) electrophoresis (HE) or Hb high performance liquid chromatography (HHPLC)
- Quantification of Hb alpha 2 and fetal Hb
- Serum ferritin/H bodies (blood smear stain using brilliant cresyl blue) if microcytosis (MCV < 80 fl) and/or hypochromia (mean cellular Hb < 27 pg) in the presence of a normal HE or HHPLC assessment

Refer for genetic consultation if both members of a couple are carries of thalassemia OR a combination of thalassemia and hemoglobin variant.

¹ Wilson, R. and De Bei, I. (2016) Joint SOGC–CCMG Opinion for Reproductive Genetic Carrier Screening: An Update for All Canadian Providers of Maternity and Reproductive Healthcare in the Era of Direct-to-Consumer Testing. Retrieved from: [https://www.jogc.com/article/S1701-2163\(16\)39347-1/pdf](https://www.jogc.com/article/S1701-2163(16)39347-1/pdf)





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Worksheet 3

T-ACE Alcohol Screening Tool¹

The T-ACE screening tool is a measurement tool of four questions that are significant identifiers of pregnancy risk drinking (i.e., alcohol intake sufficient to potentially damage the embryo/fetus).

The T-ACE score has a range of 0-5. The value of each answer to the four questions is totaled to determine the final T-ACE score.

A total score of 2 or more indicates a positive outcome for pregnancy risk drinking and the pregnant person should be referred for further assessment.

Screening is not required if initial assessment reveals no alcohol is consumed.

One drink is equivalent to: 12 ounces of beer or cooler; 5 ounces of wine; 1.5 ounces of hard liquor

Tolerance	How many drinks does it take to make you feel high?	≤ 2 drinks = 0	> 2 drinks = 2	_____ score
Annoyed	Have people annoyed you by criticizing your drinking?	Yes = 1	No = 0	_____ score
Cut Down	Have you felt you ought to cut down on your drinking?	Yes = 1	No = 0	_____ score
Eye Opener	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover	Yes = 1	No = 0	_____ score
Total Score:				_____

Women Abuse Screening Tool (WAST)²

The WAST specifically screens for verbal, emotional, physical, and sexual abuse and is used to help determine if the pregnant person is experiencing domestic violence. If the answers to questions 1 and 2 are “a lot of tension” and “great difficulty” the screen is considered positive and the remaining 6 questions should be answered.

- | | | | |
|--|---|--|-------------------------------------|
| 1. In general how would you describe your relationship? | <input type="checkbox"/> A lot of tension | <input type="checkbox"/> Some tension | <input type="checkbox"/> No tension |
| 2. Do you and your partner work out your arguments with: | <input type="checkbox"/> Great difficulty | <input type="checkbox"/> Some difficulty | <input type="checkbox"/> No tension |
| 3. Do arguments ever result in you feeling down or bad about yourself? | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| 4. Do arguments ever result in hitting, kicking, or pushing? | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| 5. Do you ever feel frightened by what your partner says or does? | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| 6. Has your partner ever abused you physically? | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| 7. Has your partner ever abused you emotionally? | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |
| 8. Has your partner ever abused you sexually? | <input type="checkbox"/> Often | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Never |

1 Sokol, J., Martier, S., Ager, J. (1989). The T-ACE questions: practical prenatal detection of risk-drinking. American Journal of Obstetrics and Gynecology, 160(4):863-870.

2 Brown, J., Lent, B., Brett, P, Sas, G. and Pedersen, L. (1996). Development of the Woman Abuse Screening Tool for use in family practice. Family Medicine, 28, 422 -28.





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Worksheet 4

Edinburgh Perinatal/Postnatal Depression Scale (EPDS)¹

Depression is the most common complication of childbearing. The 10-question EPDS is a valuable and efficient way of identifying patients at risk for perinatal depression. Pregnant persons who score above 13 are likely to be suffering from a depressive illness of varying severity. A careful clinical assessment should be carried out to confirm the diagnosis. Consider other causes for symptoms such as anemia, poor sleep, and lack of energy. Thyroid dysfunction, anemia, or bereavement should be excluded before diagnosing a depression.

Perform screening using the EPDS ideally once in each trimester of pregnancy.

- 0 to 10** Monitor
- 11-13** Monitor, support, and provide education. Repeat EPDS in 2 weeks time. If still elevated, refer for further assessment.
- ≥ 14** Requires further assessment, diagnosis, and appropriate management as the likelihood of depression is high. Referral to a psychiatrist/psychologist may be necessary.
- Item #10** Any individual who scores 1, 2, or 3 on item 10 requires further evaluation before leaving the care provider's office to ensure their own safety and that of their baby.

In the presence of a negative EPDS screen, using a score of 5 or greater on the anxiety specific EPDS questions (4, 5, 6) may be helpful in identifying those who could benefit from further anxiety screening and treatment.

In the past 7 days

1. I have been able to laugh and see the funny side of things
 - 0 As much as I always could
 - 1 Not quite so much now
 - 2 Definitely not so much now
 - 3 Not at all
2. I have looked forward with enjoyment to things
 - 0 As much as I ever did
 - 1 Rather less than I used to
 - 2 Definitely less than I used to
 - 3 Hardly at all
3. I have blamed myself unnecessarily when things went wrong
 - 3 Yes, most of the time
 - 2 Yes, some of the time
 - 1 Not very often
 - 0 No, never
4. I have been anxious or worried for no good reason
 - 0 No, not at all
 - 1 Hardly ever
 - 2 Yes, sometimes
 - 3 Yes, very often
5. I have felt scared or panicky for no very good reason
 - 3 Yes, quite a lot
 - 2 Yes, sometimes
 - 1 No, not much
 - 0 No, not at all
6. Things have been getting on top of me
 - 3 Yes, most of the time I haven't been able to cope
 - 2 Yes, sometimes I haven't been coping as well as usual
 - 1 No, most of the time I have coped quite well
 - 0 No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping
 - 3 Yes, most of the time
 - 2 Yes, sometimes
 - 1 Not very often
 - 0 No, not at all
8. I have felt sad or miserable
 - 3 Yes, most of the time
 - 2 Yes, quite often
 - 1 Not very often
 - 0 No, not at all
9. I have been so unhappy that I have been crying
 - 3 Yes, most of the time
 - 2 Yes, quite often
 - 1 Only occasionally
 - 0 No, never
10. The thought of harming myself has occurred to me
 - 3 Yes, quite often
 - 2 Sometimes
 - 1 Hardly ever
 - 0 Never

Total Score _____

¹ Cox, J.L., Holden, J.M., and Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786

