Document No: **2499420**

TITLE: MATERNITY REFERRAL & MODELS OF CARE

Contents

1. Purpose

This clinical guideline seeks to further define and locally operationalise the content and intent of the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) (TO HNZ, 2023).

It is intended to improve the safety and quality of maternity care by supporting all staff in Lakes who provide care to women/people who are pregnant or postpartum to;

- know when to refer a woman/person to hospital based services for additional advice or treatment
- understand the process for making and acknowledging a referral
- effectively communicate about who is undertaking various aspects of care
- be aware of who has overall clinical responsibility for the care at any given time

2. Scope

This guideline applies to all Te Whatu Ora Lakes Obstetrics and Gynaecology medical staff, students and administrative staff, all employed midwives and students, all LMC's who have a Te Whatu Ora Lakes Access Agreement and the women they provide care to.

3. Definitions

Term	Definition
Advice	Recommendation, information, suggestion.
ANC	Antenatal Clinic (Rotorua or Taupo).
ASUM Chart	Australian Society for Ultrasound in Medicine Chart
Clinical Responsibility	Responsibility of a practitioner for clinical evaluation; cooperation with other staff e.g. specialists, obtaining information on any previous examinations; providing information and/or records to other practitioners, decision making in consultation with woman/person and other staff.
Consultation	Process by which a referrer seeks an assessment, opinion and advice. May occur either in person, by telephone, videoconference, email or other means as appropriate in the situation.
GROW Chart	Gestation Related Optimal Weight Chart
LMC	A midwife, obstetrician or GP selected by the woman/person to provide the lead maternity care.
Midwifery Care	Care within the scope of a registered midwife that may be provided by an LMC or a Hospital employed midwife.
Phone Consult	Same as a face to face clinic appointment but conducted with the woman/person present via phone.
Referral	Request for advice or help with a specific issue. It should contain a woman's/person's relevant history, the presenting problem and what the referrer would like the recipient to provide.
Three Way Conversation	Between woman/person, LMC & Specialist, that should occur before a change of plan.
TO HNZ	Te Whatu Ora Health New Zealand
Transfer	Moving a woman/person to a different geographical location
Transfer of Clinical Responsibility	Clinical responsibility is formally transferred from one practitioner to another. May be from LMC to Obstetric Specialist or from an Obstetric Specialist back to an LMC. Also referred to as 'Transfer of Care'.
Transfer of Midwifery Care	Transfer of responsibility for midwifery care from one midwife to another. May be from LMC to Hospital Midwife or from Hospital Midwife back to LMC.
Triaged	Review of information contained in a referral by an Obstetric Specialist to determine whether or what further testing, monitoring, review or treatment is required and the timing of this.
USS	Ultrasound scan
Virtual Review	A review of a test result and plan for ongoing care without the woman/person present.

4. Guiding Principles

- The woman/person, her baby and family/whanau (as defined by the woman/person) are at the centre of all discussions, decisions and actions.
- The woman/person should have continuity of maternity care through a single point of contact regardless of how care is provided.
- The woman/person has the right to receive full, accurate, unbiased information about her options and the likely outcomes of her decisions. The woman/person has a right to make informed decisions on all aspects of care, including the right to decline care, and to decline referral for consultation or transfer of clinical responsibility to a specialist.
- Practitioners are responsible for their clinical decisions and actions, and for acting within their competency and scope of practice.
- Some allowance is given for local needs and conditions when approaching the process of referral for consultation, transfer of clinical responsibility and emergency transfer.
- Communication between all practitioners involved with providing care to a woman/person will include them, and will be open, clear, timely and appropriately documented.
- Transfer of clinical responsibility is a negotiated three-way process involving the woman/person, their Lead Maternity Carer and the practitioner who clinical responsibility is to be transferred to.
- All health practitioners are responsible for appropriately documenting their decisions, including any variation from the Referral Guidelines or other guidelines, and the circumstances of any such variation.

5. Referral

In general, a referral may be verbal, i.e. a request for advice or decision via a phone call, but otherwise must be written.

The LMC is responsible for the timing of referring a pregnant woman/person, with their consent, for a consultation or to transfer clinical responsibility if the condition warrants this, as per the Referral Guidelines (TO HNZ, 2023).

Further local information about the timing of referral and additional tests and treatment that may be required are outlined in *Appendix 4. Lakes Local Definitions of National Maternity Referral Guidelines.*

Written Referrals

A referral for an Antenatal Clinic (ANC) appointment **must be written** (electronic or handwritten), on;

- Lakes 'Women's Maternity Assessment Referral – LMC Process' (219729)
- Electronic form from a General Practitioner (G.P).

The written referral needs to;

- contain all background information; obstetric history, current pregnancy gestation etc.
- be accompanied by all available blood test results, ultrasound scans (USS), ASUM Chart and GROW Chart
- indicate what is being requested: either consultation or transfer of clinical responsibility

See *Appendix 5. Antenatal Clinic Processes* for details of the referral process.

The Obstetric team is responsible for providing accurate, unbiased information about the woman's options so she is able to make an informed decision about her ongoing care.

N.B.: Prior to, and up to the time of an appointment with an Obstetrician, the responsibility for maternity care remains with the LMC, until agreement is reached between the relevant parties on the ongoing model of care.

Urgent Referrals

If a referral is urgent i.e. the woman/person needs to be reviewed within the next week, then a different referral process should be followed.

See *Appendix. 3. Urgent Maternity Outpatient Referral Pathway* for the process.

See *Appendix 4. Lakes Local Definitions of National Maternity Referral Guidelines* for conditions that require an urgent referral.

6. Triage

Referrals that have been submitted to either Rotorua or Taupo Antenatal Clinic (ANC) will be triaged in Rotorua ANC each day Monday to Friday.

- Triage is initially done by an Obstetrician, then by any other local health professional whose input is needed into the woman's/person's care e.g. Obstetric Physician, Diabetes Team etc.
- Triage can only take place when all of the required information has been received, including all available test results i.e. a copy of the dating scan to confirm pregnancy viability.
- Triage may be deferred, or the referral declined, if there is insufficient information to complete the triage, in which case a request will be made by ANC for further information to be submitted. This will occur if a referral has also been sent to a tertiary unit (i.e. Fetal Medicine in Auckland) at the same time and the response or further information from the tertiary unit is yet to be sent to ANC by the referrer.
- Documentation of the triage process and outcome will be on the Maternity Multiagency Referral Prioritisation Form (20179140) which is scanned into the 'documents' section of the patient's IPM electronic patient record once completed. A letter may also be sent to the LMC.

N.B.: Even once triage has been completed, the responsibility for maternity care remains with the LMC until the time of an appointment with an Obstetrician and agreement has been reached between the relevant parties on the ongoing model of care.

If New Issues Arise

If a new issue arises during the pregnancy, after the original referral has been triaged, another referral needs to be submitted by the LMC. This is because the triage criteria and management plan for the new condition may be different to the original plan.

Any additional referral, in the same pregnancy, needs to be accompanied by the latest information, including, where applicable, the latest scan report and up-dated customised growth chart and ASUM chart (N.B. duplicate copies of information already supplied do not need to be sent).

7. Referral Type and Models of Care

Consultation

A referral is made to an appropriate person in the secondary care setting because;

- The LMC needs advice
- The particular condition meets the Referral Guidelines (TO HNZ, 2023) criteria for consultation

The outcome and ongoing management from a referral for consultation may be;

- one of the following models of care, or…
- a decision to transfer clinical responsibility to a specialist Obstetrician

Consultation Models of Care	Consultation Models of Care Description	Clinical Responsibility
• **LMC Care**	- Obstetrician reviews referral (triage), provides advice - Three-way conversation, if required - LMC acts on advice with agreement from woman/person e.g. ordering tests and reviewing results	LMC
• **LMC Care with Obstetrics (Obs.)** (formerly known as 'Shared Care')	- Obstetrician reviews referral (triage) - Three-way conversation, if required - Obstetrician to manage an aspect of care or specific condition (e.g. diabetes), ordering some tests and following up on the results of these - LMC acts on advice with agreement from woman/person e.g. ordering tests and reviewing the results of these - LMC shares latest information i.e. GROW chart with ANC	LMC

N.B: For women/people who have been unable to find a community based LMC, Hospital employed Midwives may be the LMC.

Ordering Tests

The LMC is able to order any additional tests recommended for surveillance of a well woman/person or baby with risk factors i.e. SGA pathway, with the woman's/person's consent, as part of primary care provision. Appendix 4. *Lakes Local Definitions of National Maternity Referral Guidelines* outlines additional tests that may be required.

Once an abnormal test result is received a conversation needs to take place and decision made about shared care or transferring clinical responsibility to the relevant Obstetrician (see 'Transfer of Clinical Responsibility' section below).

Transfer of Clinical Responsibility

A referral, request or decision is made for transfer of clinical responsibility to an appropriate person in the secondary / tertiary care setting because;

- the particular condition meets the Referral Guidelines (TO HNZ, 2023) criteria for transfer
- agreement, following a three-way conversation, for transfer of clinical responsibility to an Obstetrician
- N.B.: also need a three-way conversation about whether to transfer midwifery care

Transfer Models of Care	Transfer of Clinical Responsibility Description	Clinical Responsibility
• **Obstetric Care with LMC**	- Obstetrician reviews referral (triage) - Three-way conversation - Obstetrician manages care, orders additional tests and reviews results - LMC provides primary/community midwifery care and continues to share information with ANC - In labour a Hospital Midwife may also be involved in providing care	Obstetrician
• **Obstetric Care with Hospital Midwife**	- Obstetrician reviews referral (triage) - Three-way conversation - Obstetrician manages care, orders additional test and reviews results - Hospital Midwives provide midwifery care	Obstetrician

Any transfer of clinical responsibility should be clearly communicated and documented on/in;

- Obstetric Antenatal Clinic Outcome Form or Obstetric Virtual Review Outcome Form
- an Outpatient Clinic letter
- the Inpatient Antenatal/Intrapartum/Postnatal clinical notes

stating who has clinical responsibility for providing ongoing care.

Emergency

An emergency situation necessitates that clinical responsibility is transferred to the most appropriate practitioner available at the time.

Emergency Model of Care	Emergency Description	Clinical Responsibility
Emergency Care	- Clinical roles and responsibilities are dictated by the immediate needs of the mother and/or baby and the skills of the practitioners available (including those providing emergency transport, if required). - LMC is likely to have an ongoing role	Most appropriate practitioner

8. Antenatal Clinic

Pregnant women/people may receive Obstetric care as an outpatient under the Antenatal Clinic via any one or all of the following methods;

Face to Face Consult

If, after triaging, a woman/person needs to be seen in ANC, a face to face appointment will be arranged where the woman/person attends the ANC for review by an ANC Midwife and Obstetrician. This may be timed to also include other health professionals i.e. Obstetric Physician, Diabetes Team etc.

Once a woman/person has attended a face-to-face appointment in ANC the next step could be;

- Further Face to Face Appointment
- Telehealth or Phone Consult
- Virtual Review
- No further appointments – discharged to LMC Care

Telehealth or Phone Consult

If a plan of care has been made and further tests undertaken but there is no need to see the woman/person face to face for the next appointment, a 'Telehealth or Phone Consult' (also referred to as a 'Virtual Clinic Appointment') may be arranged.

This appointment is scheduled into the clinic list of the relevant clinician and takes place by the clinician phoning the woman/person at a time during that clinic list.

See Appendix 5 Antenatal Clinic Processes. for further details of the Telehealth or Phone Consult process.

Virtual Review

If a further test has been requested and needs to be reviewed by a clinician before the next scheduled appointment, the test result is reviewed by the ordering clinician (or on-call clinician) in person or electronically and a plan for ongoing care made and documented.

The woman/person is not involved in this process but is informed of the outcome by either the clinician or the ANC Midwife or the LMC.
See Appendix 5. Antenatal Clinic Processes for further details of the process.

Following each consult or virtual review, communication back to the LMC should include;

- an indication of what model of ongoing care has been agreed (to ensure clarity of who has overall clinical responsibility)
- a plan for ongoing management i.e., further appointments, future tests, follow-up on results

9. Associated Documents

- Internal Referral Form CRG/C/005
- Maternity Inter-Disciplinary Communication Record – 2166449
- Maternal Iron Optimisation Guideline - 1401933
- Maternity Multiagency Referral Prioritisation Form – 20179140
- Obstetric Antenatal Clinic Outcome Form – 2499422
- Obstetric Referral Criteria to Anaesthetic Pre-Assessment Clinic – 489169
- Obstetric Virtual Review Outcome Form – 2499430
- Perinatal Mental Health Pathway – 2419999
- Te Whatu Ora – Health New Zealand. 2023. Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington, New Zealand.
- Women's Maternity Assessment Referral – LMC Process - 219729

10. Acknowledgements

- Auckland DHB Local Guidance On the National Referral Guidelines (Maternity)
- Waikato DHB 'Maternity Consultation and Transfer of Care' draft guideline

11. Audit

Recommended audit measures for this guideline are;

1. Referrals are submitted using one of the two electronic forms/formats
2. Referrals received are accompanied by copies of all available test results
3. Referrals for an urgent consultation are submitted according to the Urgent Maternity Outpatient Referral Pathway
4. An Obstetric Antenatal Clinic Outcome Form is fully completed following each ANC appointment
5. An Obstetric Virtual Review Outcome Form is fully completed following each virtual review
6. Communication about the outcome and ongoing management following triage, outpatient appointment or virtual review includes an indication of the model on ongoing care

Authorised by: **Maternity Clinical Quality Improvement (CQI) Meeting**

12. Appendices

Appendix 1. Consultation – Notes and Process Map

Process for referral to a specialist for consultation

For the conditions listed in the consultation referral category, the referrer must recommend the woman/person (or parents) consult with a specialist.

Consultation can be in the form of a discussion between the referrer and the specialist on the phone or via videoconference or email. The consultation may result in the specialist seeing the woman/person (or baby) in person. The specialist consultation may be done by an individual health practitioner and may include review by a secondary services team. If they are not the referrer, the LMC should be consulted on the need for referral. The consultation should discuss ongoing responsibilities between the LMC and the specialist.

If a woman/person sees a GP before an LMC is chosen and the GP identifies a condition that requires a specialist consultation, the GP can refer as per process map 2. Once the woman/person has chosen an LMC, the GP should provide the LMC with all the relevant information.

The specialist to whom the woman/person (or baby) is referred may be an obstetrician, gynaecologist, radiologist, anaesthetist, physician, psychiatrist, surgeon, paediatrician or a service such as genetic services.

Roles and responsibilities

At the time of the consultation, the clinical responsibility for care remains with the LMC. The specialist should advise the LMC/referrer of recommended monitoring and provide a documented care plan that has been agreed between the woman/person (or parents), the specialist and the LMC. The specialist may become responsible for managing the specific condition if that is appropriate and warranted, and if the woman/person (or parents) agrees.

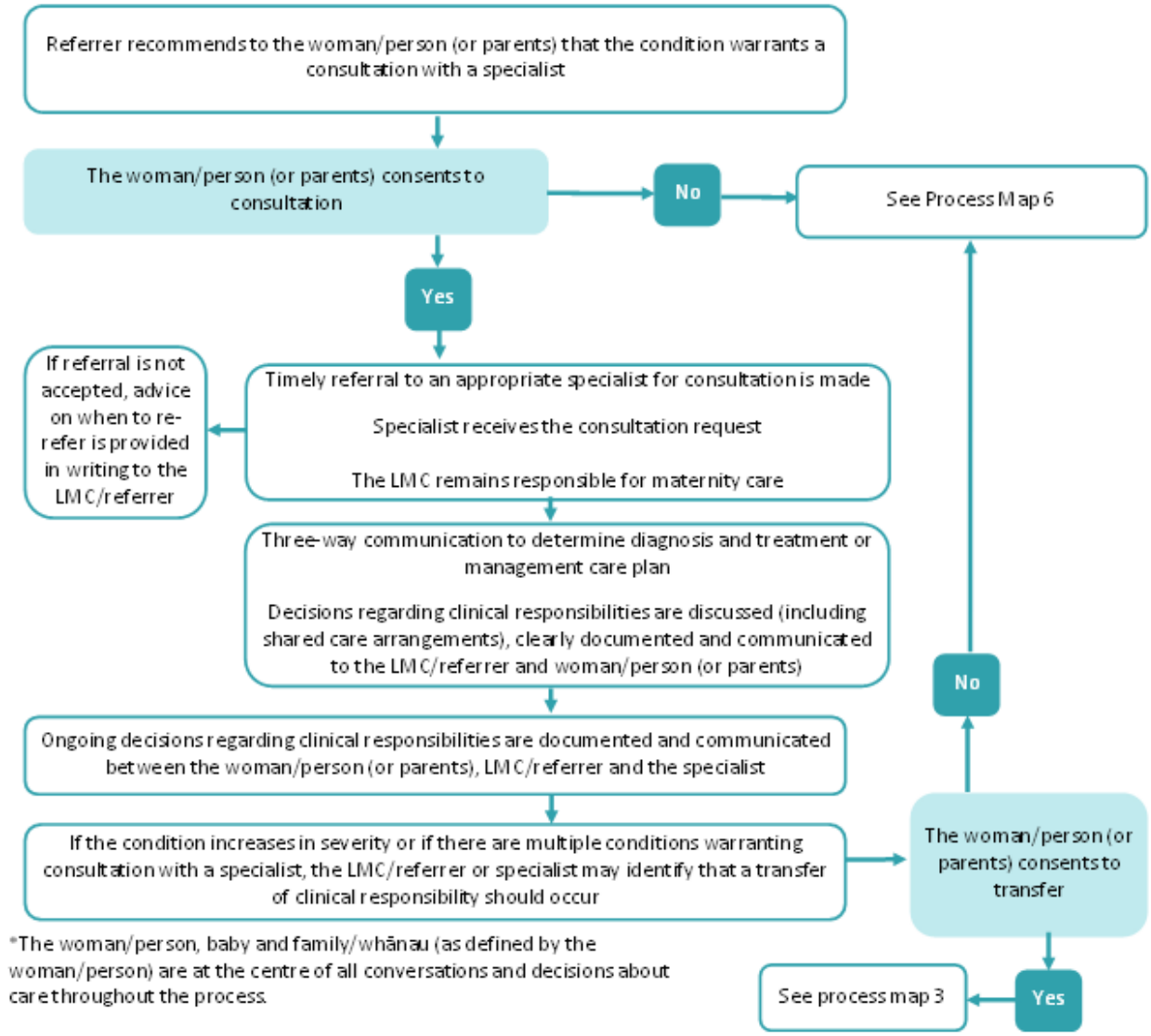
If the condition increases in severity, or if there are multiple conditions warranting consultation with a specialist, the LMC/referrer may request that the clinical responsibility for care be transferred to the specialist.

Communication

This process assumes that the decisions about a woman/person's (or baby's) care are based on a three-way conversation between the woman/person or parents, the LMC and the specialist. Where there is no LMC, communication must include the referrer.

The referrer should provide the specialist with access to all necessary clinical notes and information at referral. The specialist is responsible for informing the LMC of decisions, recommendations and advice as part of the documented plan of care following the consultation. Where there is no LMC, communication must include the referrer.

Process map 2: Referral to a specialist for consultation



(TO HNZ, 2023)

Appendix 2. Transfer of Clinical Responsibility – Notes and Process Map

Process·for·transfer·of·clinical·responsibility·for·care¶

Roles·and·responsibilities¶

If·a·condition·increases·in·severity·or·there·are·multiple·conditions·warranting·consultation·with·a·specialist,·the·LMC/referrer·may·request·that·the·clinical·responsibility·for·care·be·transferred·to·the·specialist.¶

For·the·conditions·listed·in·the·transfer·referral·category,·the·referrer·must·recommend·transfer·of·clinical·responsibility·for·care·to·a·specialist.·Once·clinical·responsibility·for·care·is·transferred,·clinical·decisions·and·decisions·on·the·roles·and·responsibilities·of·all·other·health·practitioners·involved·with·the·woman/person's·(or·baby's)·care·rest·with·the·specialist,·considering·the·needs·and·wishes·of·the·woman/person·(or·parents).·The·LMC·retains·clinical·responsibility·for·care·until·the·transfer·has·been·completed.¶

Continuity·of·care·should·be·preserved·wherever·possible,·and·there·is·potential·for·LMCs·to·retain·a·role·in·providing·care·for·the·woman/person·(or·baby),·especially·where·the·LMC·is·a·midwife.·For·example,·a·woman/person·who·is·pregnant·with·twins·requires·specialist·oversight·but·can·continue·to·receive·midwifery·care·from·an·LMC·midwife.·The·specialist·has·clinical·responsibility·and·a·clear,·written·care·plan·including·roles·and·responsibilities·is·documented·in·the·woman/person's·or·the·baby's·records.¶

An·LMC·may·decline·ongoing·involvement·with·a·woman/person's·(or·baby's)·care·if·the·clinical·situation·moves·outside·their·scope·of·practice·or·experience·or·unreasonably·impacts·on·their·workload.·The·LMC·must·ensure·that·all·relevant·care·is·transferred·appropriately.¶

Communication¶

It·is·critical·to·document·the·point·at·which·responsibility·for·coordination·and·provision·of·maternity·or·neonatal·care·is·formally·transferred·to·the·specialist.·This·requires:¶

- a·three-way·conversation·between·the·woman/person·(or·parents),·the·LMC·and·the·specialist·to·determine·that·the·transfer·of·clinical·responsibility·for·care·is·appropriate·and·acceptable·(where·there·is·no·LMC,·communication·must·include·the·referrer)¶
- the·LMC·to·provide·the·specialist·with·access·to·all·relevant·information,·including·any·relevant·clinical·notes,·test·results·(including·through·shared·platforms)·and·histories¶
- a·discussion·and·documented·decision·in·the·woman/person's·or·baby's·records·about·the·nature·of·the·ongoing·role·of·the·LMC·or·whether·all·care·is·transferred·to·the·specialist·and·the·hospital·midwifery·team.¶

Transfer·of·clinical·responsibility·for·care·requires·timely·and·full·communication·between·the·LMC·and·the·specialist.·All·other·health·practitioners·directly·involved·in·the·referral·process·(for·example,·the·GP·or·other·primary·health·care,·allied·health·or·kaupapa·Māori·services)·should·be·informed·of·the·decisions·made.¶

Meeting·local·conditions¶

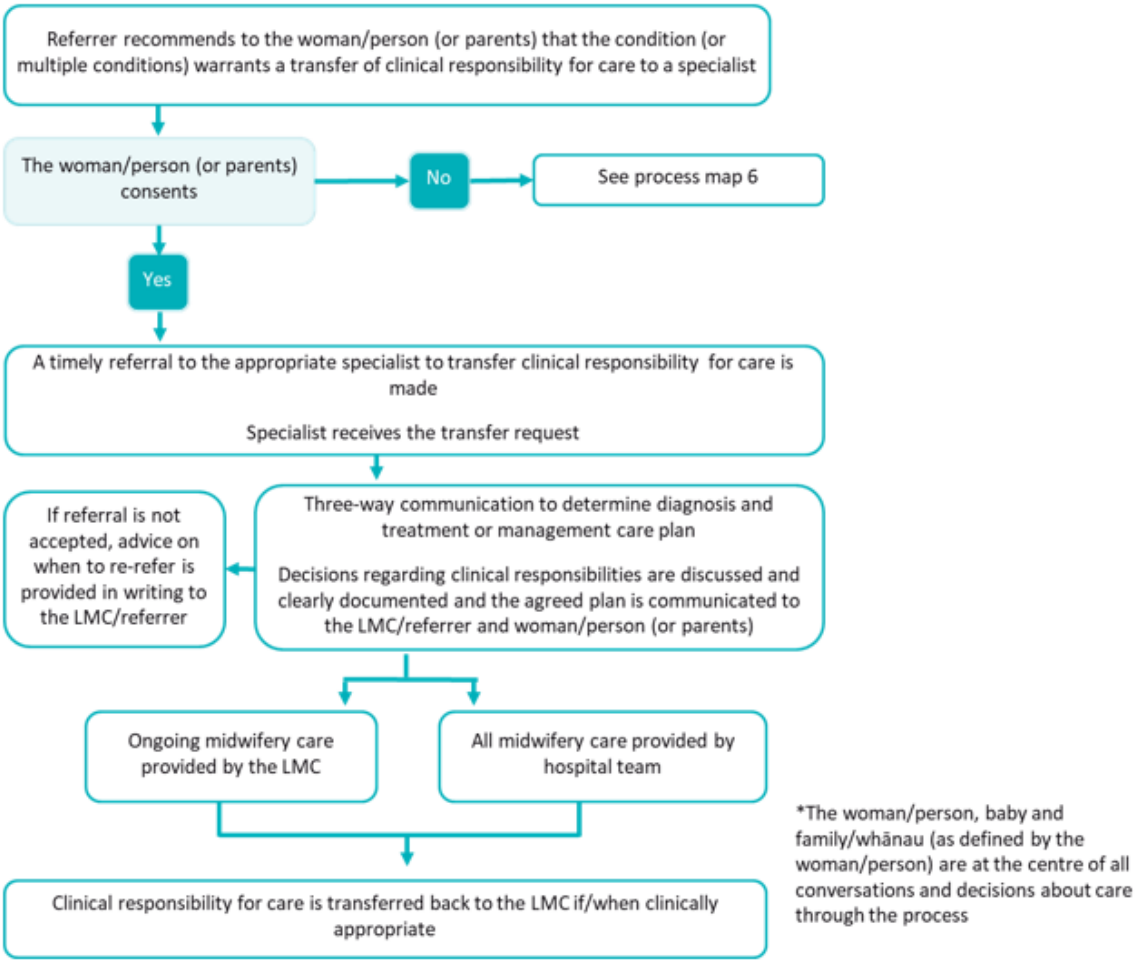
The·process·will·need·to·take·account·of:¶

- capacity·of·local/regional·secondary·health·care·services·to·see·women/people·(or·babies)·in·a·timely·manner¶
- access·to·the·required·specialist·services·in·the·area¶
- the·distance,·time·and·cost·for·the·woman/person·(or·baby)·to·reach·a·hospital·¶
- whether·an·in-person·consultation·with·a·hospital-based·specialist·(who·may·be·located·at·the·nearest·main·centre)·is·needed.·¶

These·factors·should·not·influence·whether·transfer·of·clinical·responsibility·for·care·to·a·specialist·is·made·but·may·be·pertinent·in·deciding·whether·service·capacity·can·meet·a·specific·clinical·need.¶

The·steps·in·process·map·3·should·be·reflected·in·local·processes·or·protocols.¶

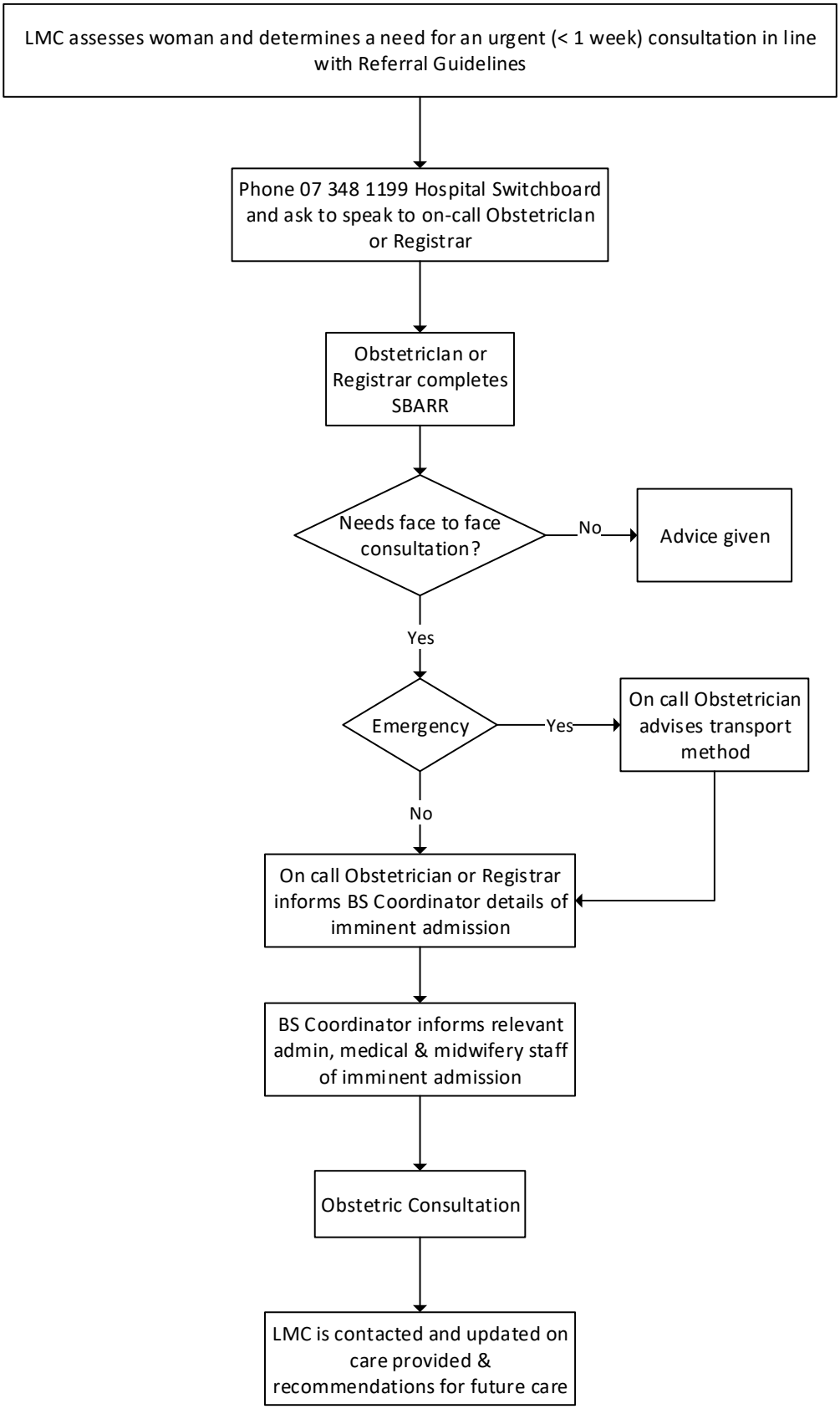
Process·map·3:·Transfer·of·clinical·responsibility·for·care¶



(TO HNZ, 2023)

Appendix 3. Urgent Maternity Outpatient Referral Pathway

Lakes DHB Urgent Maternity Outpatient Referral Process



Appendix 4. Lakes Local Definitions of National Maternity Referral Guidelines

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
1000–2000 Pre-existing and/or co-existing medical conditions						
Anaesthetics						
1001	Anaesthetic difficulties	Previous failure or complication (eg, difficult intubation, failed epidural, severe needle phobia)	Consultation	Anaesthetist	After anatomy USS	
1002	Malignant hyperthermia or suxamethonium apnoea		Consultation	Anaesthetist	After anatomy USS	
	Neuromuscular disease		Consultation	Ob. Physician	ASAP	Include name of diagnosis
				Obstetrician	After anatomy USS	
				Anaesthetist	2nd trimester after Obst.	
Autoimmune/rheumatology						
1003	SLE/connective tissue disorder	Active, major organ involvement, on medication	Transfer	Ob. Physician Obstetrician	ASAP	• Aspirin 100mg EC tabs nocte from 12/40 • Calcium 1.5g tabs OD 8-20 weeks • Baseline PET bloods, ANA and ENA bloods • Random urine PCR • UA Dopplers at anatomy scan
				Anaesthetist	After anatomy USS, after Obstetrician	
1004		Inactive, no renal involvement, no hypertension, or only skin/joint problems	Consultation	Ob. Physician Obstetrician	ASAP	• Consider aspirin • Baseline PET bloods, ANA and ENA bloods • Random urine PCR • UA Dopplers at 24/40 scan
				Anaesthetist	Third trimester	
1005	Thrombophilia including antiphospholipid syndrome	On warfarin, previous obstetric complications or maternal thrombosis	Transfer	Ob. Physician	Pre-pregnancy or ASAP	
				Obstetrician	After NT	
				Anaesthetist	After 28 week bloods	
1006		No previous obstetric complications or maternal thrombosis	Consultation	Obstetrician	1st Trimester	

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
Cardiac						
1007	Arrhythmia/palpitations; murmurs	Recurrent, persistent or associated with other symptoms (N.B.: respiratory sinus arrhythmia does not require referral)	Primary	G.P	When identified	
		Diagnosed arrhythmia or structural abnormality e.g. AF, SVT, VT, abnormal ECHO	Consultation	Ob. Physician	When identified	
1008	Cardiac valve disease	Mitral/aortic regurgitation	Consultation	Ob. Physician Obstetrician	14 weeks	
				Anaesthetist	After anatomy USS	
1009		Mitral/aortic stenosis	Transfer	Ob. Physician	14 weeks	
				Obstetrician	After NT	
				Anaesthetist	After NT, after Obst.	
1011	Cardiac valve replacement		Transfer	Ob. Physician	ASAP	Old notes, dating/viability USS
				Obstetrician	After NT	
				Anaesthetist	After NT, after Obst	
1012	Cardiomyopathy		Transfer	Ob. Physician	1st Trimester	Old notes
				Obstetrician	After NT	
				Anaesthetist	After NT, after Obst	
1013	Congenital cardiac disease		Consultation	Ob. Physician	ASAP	
				Obstetrician	After anatomy USS	
				Anaesthetist	After anatomy, after Obst	
1014	Hypertension	Hypertension confirmed pre-conception or prior to 20 weeks of gestation with or without a known cause, measured on two or more occasions at least four hours apart or on antihypertensive medication	Consultation	Obstetrician	After NT Consultation before 16 weeks of gestation	• Aspirin 100mg EC tabs nocte from 12wks • Baseline PET bloods • Urine protein creatinine ratio • UA Dopplers at 24/40 scan • Medication list • Recent BP
1015		Diastolic BP ≥ 110 mmHg or systolic BP ≥ 160 mmHg	Transfer	Obstetrician	Immediately	Call on-call Obstetrician without delay
1016	Ischaemic heart disease		Transfer	Ob. Physician	ASAP	
				Obstetrician	After NT	
				Anaesthetist	After NT and Obstetrician	
1017	Pulmonary hypertension		Transfer	Ob. Physician	ASAP	
				Obstetrician	After NT	
				Anaesthetist	After NT and Obstetrician	

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
Endocrine						
1019	Diabetes	Pre-existing (Type 1, Type 2, MODY)	Transfer	Diabetes Team + Dietician	Pre-pregnancy or ASAP	• Folic acid 5mg • Aspirin 100mg EC at night (from 12 wks)
				Obstetrician	After NT	
1020		Gestational, well controlled on diet or metformin	Consultation	Obstetrician, Diabetes Team + Dietician	At Diagnosis	Growth USS requested
1021		Gestational, requiring insulin	Transfer	Obstetrician, Diabetes Team + Dietician	At Diagnosis	Growth USS requested
1023	Hypopituitarism		Consultation	Obstetrician Ob. Physician	1st Trimester	
1076	Other known endocrine disorder significant in pregnancy	E.g., Addison's disease, Cushing's disease	Consultation	Obstetrician	After NT	
1024	Prolactinoma		Consultation	Obstetrician Ob. Physician	After NT	
1022	Thyroid disease	Hypothyroidism	Primary	G.P		
1018		Hyperthyroidism	Consultation	Ob. Physician	1st Trimester	• State 'hyperthyroid' or 'over active thyroid' • Current medication list • Old medications, if available • Monthly TFT in pregnancy • Thyroid antibodies
				Obstetrician	After anatomy USS	
Gastroenterology						
1077	Bariatric Surgery		Consultation	Obstetrician	2nd Trimester	
1025	Cholecystitis	Presenting as acute abdominal pain	Consultation	Obstetrician	When identified	
1026	Cholestasis of pregnancy		Transfer	Obstetrician	On diagnosis	LMC request Bile Salts at time of referral
1029	Hepatitis	Acute	Consultation	Obstetrician	On diagnosis	
1030		Chronic active	Consultation	Obstetrician	<28 weeks	
1081		Active chronic on immunosuppressant	Transfer	Obstetrician	1st Trimester	
1027	Inflammatory bowel disease	Active or on medication	Consultation	Obstetrician	<20 weeks	
				IBD Team	When identified	
1028		Inactive	Primary	G.P		
1031	Oesophageal varices		Transfer	Physician	ASAP	
				Obstetrician	1st Trimester	
1072	Previous fatty liver in pregnancy		Consultation	Obstetrician Ob Physician	<20 weeks	• UA Dopplers at 20/40 • Baseline PET bloods – including Bilirubin, glucose, coagulation screen

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
Genetic						
1032	Any known genetic condition significant in pregnancy		Transfer	Obstetrician Ob. Physician	ASAP	
1033	Marfan Syndrome		Transfer	Obstetrician, Ob. Physician	1st Trimester	
				Anaesthetist	3rd Trimester	
Haematological						
1034	Anaemia	Hb < 90 g/l, Ferritin >29 not responding to treatment	Consultation	Obstetrician	When identified	Follow Lakes Maternal Iron Optimisation Guideline - 1401933
1036	Bleeding disorders	Including Von Willebrands	Consultation	Obstetrician	2nd Trimester	• Request previous notes • Combined anaesthetic/obstetric birth plan
				Anaesthetist	3rd Trimester	
1035	Haemolytic anaemia		Transfer	Obstetrician Ob Physician	Immediate	Call on-call Obstetrician without delay with on-call physician support
1039	Sickle cell disease		Transfer	Obstetrician	After NT	
1037	Thalassaemia		Consultation	Obstetrician	After NT	• Ferritin & B12 • Father of baby screen to be requested at time of referral, if not done previously
1038	Thrombocytopaenia	Pre-existing or 1st Trimester	Consultation	Obstetrician	1st Trimester	• HIV screen completed • Obtain previous notes • Obstetrician discretion on physician input: may already have extensive input from Haematology
				Anaesthetist	3rd Trimester	
				Physician notes	1st Trimester	
		3rd Trimester (<150)	Consultation	Obstetrician	When identified	• Exclude pre-eclampsia and HELLP • Repeat FBC prior to appointment
				Anaesthetist		
				Ob. Physician	When identified	
1040	Thromboembolism	Suspected deep vein thrombosis, pulmonary embolism	Transfer	E.D Clinician Obstetrician	Urgent referral to E.D Once diagnosis confirmed	• ED for initial diagnosis - on-call Physician and Obstetrician will provide further management. • Follow-up with Ob. Physician and Obstetrician required
		Previous deep vein thrombosis, pulmonary embolism	Consultation	Obstetrician	1st Trimester	Notes review: as per guidelines.
1041	Thrombophilia		Consultation	Physician notes	1st Trimester	Name of thrombophilia and if have had previous clots

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
Infectious diseases** denotes a notifiable disease. Must also contact Toi Te Ora on diagnosis of these conditions https://www.toiteora.govt.nz/						
1042	CMV/toxoplasmosis	Acute	Transfer	Obstetrician	On diagnosis	Semi-urgent referral, call on-call Obstetrician
1044	HIV positive **		Transfer	Obstetrician HIV Team	On diagnosis	HIV Team consists of ID Physician and HIV Nurse
1045	Listeriosis **	Acute	Transfer	Obstetrician ID Service	On diagnosis	Semi-urgent referral, call on-call Obstetrician
1046	Rubella **		Consultation	Obstetrician	If acute infection suspected	• If exposed, check antibodies • If antibodies negative, repeat in 2/52. • If antibodies positive call on-call Obstetrician
1047	Syphilis **		Consultation	Obstetrician Sexual Health	On diagnosis	
1048	Tuberculosis	Active **	Transfer	Respiratory Physician	On diagnosis	
1073		Contact	Primary	G.P	When identified	
1049	Varicella	Acute	Transfer	Obstetrician	On diagnosis	Call on-call Obstetrician
		Contact	Primary	G.P	When identified	• D/W on-call Obstetrician • Request Varicella IgG and IgM titres
Mental health						
1058	Current alcohol or drug misuse/ dependency		Primary	See Perinatal Mental Health Pathway	When identified	
1078	Depression and anxiety disorders		Primary	See Perinatal Mental Health Pathway	When identified	• If woman very anxious, Obstetrician consultation is appropriate • Check for needle phobia
1059	Other mental health condition	Stable and/or on medication e.g., bipolar disorder	Consultation	Obstetrician Perinatal Mental Health Team	3rd Trimester	Combined birth plan
1079		Acute unstable psychosis	Transfer	Perinatal Mental Health Team	Immediate	• See Perinatal Mental Health Pathway for contacts in community and hospital • Notify on-call Obstetrician
1074		Complex mental health needs	Consultation	Perinatal Mental Health Team	When identified	• See Perinatal Mental Health Pathway for contacts in community and hospital

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
Neurological						
1050	Arteriovenous malformation, cerebrovascular accident, transient ischaemic attack		Consultation	Obstetrician	After NT	
				Ob Physician		
				Anaesthetist	After anatomy	
1051	Epilepsy	Controlled	Consultation	Physician notes	1st Trimester	• Preconception planning (Folic Acid 5mg OD one month prior) • Folic Acid 5mg OD before 12 weeks
				Obstetrician	28 weeks	
1052		Poor control or multiple medications	Transfer	Ob Physician	ASAP	
				Obstetrician	After NT in 1st Trimester	
1075		New diagnosis	Transfer	Ob Physician	ASAP	
				Obstetrician	After NT in 1st Trimester	
1053	Multiple sclerosis		Consultation	Physician notes	After NT	
				Obstetrician	After anatomy	
				Anaesthetist	2nd or 3rd Trimester	
1056	Muscular dystrophy or myotonic dystrophy		Transfer	Obstetrician	2nd Trimester	
1054	Myasthenia gravis		Transfer	Obstetrician	Before anatomy	
				Ob. Physician		
				Anaesthetist	After anatomy	
1055	Spinal cord lesion		Transfer	Obstetrician	2nd Trimester	Include degree of disability on referral
				Anaesthetist	3rd Trimester	
				Anaesthetist	3rd Trimester	

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
Renal disease						
1061	Glomerulonephritis		Transfer	Obstetrician Ob. Physician	After NT	• Baseline BP • Aspirin 100mg EC tabs nocte from 12wks • Calcium 1.5g tabs (if diet low in calcium) • Baseline PET bloods • Urine protein creatinine ratio & MSU
1062	Proteinuria	Chronic	Consultation	Ob. Physician	<20 weeks	• Baseline BP • Aspirin 100mg EC tabs nocte from 12wks • Calcium 1.5g tabs OD 8-20 weeks (if diet low in calcium)
				Obstetrician	After anatomy	• Baseline PET bloods • Serum creatinine • Random urine PCR • MSU • UA Doppler at anatomy
1063	Pyleonephritis	History of recurrent pyelonephritis	Consultation	Obstetrician	>20 weeks	• Serum creatinine • MSU
		Acute		Obstetrician	Immediate	Call on-call Obstetrician
1065	Renal abnormality or vesico-ureteric reflux		Consultation	Obstetrician	After NT	• Aspirin 100mg EC tabs nocte from 12wks • Calcium 1.5g tabs OD 8-20 weeks (if diet low in calcium) • Baseline PET bloods • MSU & random urine PCR
1064	Renal failure		Transfer	Obstetrician	Immediate	Call on-call Obstetrician and on-call physician
Respiratory disease						
1069	Acute respiratory condition		Primary	G.P	When identified	
1067	Asthma		Primary	G.P	1st Trimester	Ask about steroid use & hospital admissions in past year
		Moderate (using reliever more than twice per week)				
1068		Severe (continuous or near continuous oral steroids or hospitalisation)	Consultation	Ob Physician	ASAP	• GTT at 18/40 & also at 24 &28/40 • Anaesthetic input at the discretion of obstetrician and /physician
				Obstetrician	After anatomy	
				Anaesthetist	28 weeks	
1071	Chronic obstructive pulmonary disease (COPD)		Consultation	Ob Physician	ASAP	
				Obstetrician	After anatomy	
				Anaesthetist	28 weeks	

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
1070	Cystic fibrosis		Transfer	Ob. Physician	Pre-conception	
				Obstetrician	After NT	
				Anaesthetist	After anatomy	
Transplant						
1080	Organ transplant		Transfer	Obstetrician Ob. Physician	After NT	If renal transplant need baseline PET bloods
				Anaesthetist	3rd Trimester	
2000–3000 Previous gynaecological conditions or surgery						
2001	Cervical surgery including cone biopsy, laser excision or large loop excision of the transformation zone (LLETZ)	One LLETZ procedure with known depth excision ≥10 mm without subsequent term vaginal birth or more than one LLETZ procedure and/or cold knife cone biopsies	Consultation	Obstetrician	Before 16 weeks	• If LLETZ <10mm and all smears normal, no appointment needed • If depth unknown, >10mm, or recurrent procedures requires cervix length at anatomy scan
2003	Congenital abnormalities of the uterus	Without previous term pregnancy outcome	Consultation	Obstetrician	Before 16 weeks	Type of abnormality - request gynaecology notes
2011	Female genital mutilation		Consultation	Female Obstetrician	After MSS1	
2007	Previous uterine surgery	Myomectomy	Consultation	Obstetrician	After anatomy	Request placental check for accreta on anatomy scan
2008		Previous uterine perforation	Consultation	Obstetrician	After anatomy	
2009	Prolapse	With previous surgery	Consultation	Obstetrician	32 weeks	Without previous surgery – only see if debilitating symptoms
2010	Vaginal abnormality	E.g. septum	Consultation	Obstetrician	After anatomy	

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
3000–4000 Previous maternity history						
3002	Alloimmune thrombocytopaenia	As risk to fetus of thrombocytopenia	Transfer	Obstetrician	When identified	Will need referral to MFM
3003	Caesarean section		Consultation	Obstetrician	28 weeks	Obtain old operation notes
3019	Fetal congenital abnormality		Consultation	Obstetrician	When identified	Depends on abnormality
3023	Fetal Growth Restriction	Born ≥ 20+0 weeks with neonatal FGR diagnosis	Consultation	Obstetrician	Before 16 weeks	• Aspirin 100mg EC tabs nocte from 12/40 • Serial growth scans according to SGA Pathway
3008	Hypertensive disease	Pre-eclampsia with significant fetal growth restriction (FGR) or requiring birth < 34 weeks	Consultation	Obstetrician	Before 16 weeks	• Aspirin 100mg EC tabs nocte from 12/40 • Calcium 1.5g tabs OD 8-20 weeks • Baseline PET bloods and urine PCR • UA Dopplers at anatomy scan
3021		Previous eclampsia or HELLP	Consultation	Obstetrician	Before 16 weeks	• Aspirin 100mg EC tabs nocte from 12/40 • Calcium 1.5g tabs OD 8-20 weeks • Baseline PET bloods and urine PCR • UA Dopplers at anatomy scan
3011	Manual removal	With adherent placenta; consider previous management of third stage	Consultation	Obstetrician	After 28 week bloods	• Request previous notes • Correct iron deficiency • Discuss and consider active mgmt. of third stage *If uncomplicated may not need to be seen
3020	Obstetric anal sphincter injury	3a, 3b, 3c and 4th degree tearing, with or without symptoms	Consultation	Obstetrician	28 – 30 weeks	Request old notes
3012	Perinatal death		Consultation	Obstetrician	After MSS1	Request previous notes
3013	Postpartum haemorrhage	> 1000 ml	Consultation	Obstetrician	After 28 week bloods	• Request previous notes • Correct any iron deficiency • Recommend active mgmt. of third stage
3017	Previous dilation and curettage	Previous complications or three or more procedures	Consultation	Obstetrician	Before 16 weeks	Cervical length with anatomy USS
3001	Previous placental abruption		Consultation	Obstetrician	After anatomy	UA Doppler at anatomy scan
3014	Previous spontaneous preterm birth	16 – 31+6 weeks of gestation	Consultation	Obstetrician	Before 16 weeks	Cervical length at anatomy USS
3022		32 – 36+6 weeks of gestation	Consultation	Obstetrician	Before26 weeks	Cervical length at 16 weeks

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
3015	Recurrent miscarriage	Three or more	Consultation	Obstetrician	1st Trimester, before 16 weeks	
3016	Shoulder dystocia		Consultation	Obstetrician	After growth USS at 36 weeks	• Request previous notes • GTT at 28 weeks • Growth scan at 36/40
3018	SUDI (Sudden unexplained death of an infant)		Primary	Midwife	When identified	
3005	Trophoblastic disease	Hydatidiform mole or vesicular mole, within last 12 months	Consultation	Obstetrician	1st Trimester	• Scan at 6-8 weeks, and anatomy scan: 'previous mole' on all requests • Postnatal 6/52 HCG titres and results to GP for follow up • Virtual follow-up with written plan to LMC and GP
4000–5000 Current pregnancy						
4001	Acute abdominal pain		Consultation	Obstetrician	When identified	Call on-call Obstetrician
4002	Abdominal trauma		Consultation	E.D or Obstetrician	When identified	Call on-call Obstetrician
4003	Abnormal CTG		Consultation	Obstetrician	When identified	Call on-call Obstetrician
4004	Antepartum haemorrhage		Consultation	Obstetrician	When identified	Call on-call Obstetrician
4005	Blood group antibodies		Consultation	Obstetrician	When identified	Depends on titre and antibody type
4017	Class II obesity	Body mass index (BMI) 35-40 m2/kg	Consultation	Obstetrician	32 weeks	• GTT at 28 weeks • Growth according to SGA pathway (32 weeks)
4034	Class III obesity	BMI 40-49 m2/kg	Consultation	Obstetrician Anaesthetist	14 - 16 weeks	• If BMI >45 or if BMI >40 with comorbidity, see Anaesthetist in 3rd trimester
4035	Class IV obesity	BMI > 50 m2/kg	Transfer	Obstetrician Anaesthetist	14 - 16 weeks	• See Anaesthetist in 3rd trimester
4046	Contraceptive device in-situ	Includes both intrauterine devices/systems and implants	Consultation	Obstetrician	First trimester	
4047	Covid-19 *Refer to Health Pathway for risk stratification*	Active infection	Consultation	Obstetrician	When identified	
4036		Previous infection	Consultation	Obstetrician	When identified	
4006	Eclampsia		Emergency	Emergency Team	Immediate	Community: 111 Emergency call Hospital : 777 Obstetric Emergency

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
4007	Fetal abnormality		Consultation	Obstetrician	When identified	
4048	Fetal growth restriction (FGR)	Early-onset (< 32+0 weeks) *EFW customised or *AC < 3rd centile or *UA with absent or reversed end-diastolic flow or *EFW customised or *AC < 10th centile AND abnormal Doppler (*UA and/or *UtA)	Consultation	Obstetrician	When identified	PET screen Growth scan in 2 weeks, then review
4049		Late-onset (≥ 32+0 weeks) *EFW customised or *AC < 3rd centile or Two or more of: • *EFW customised or *AC < 10th centile • slowing fetal growth (*EFW or *AC decline > 30 centiles from 28+0 weeks) • abnormal Doppler (*UA, *CPR and/or *UtA)	Consultation	Obstetrician	When identified	
4050		EFW < 3rd centile OR at risk of birth < 28+0 weeks' gestation or at risk of birthweight < 1,000g	Transfer	Obstetrician	When identified	Call on-call Obstetrician
4008	Gestational proteinuria	Protein creatinine ratio ≥ 30	Consultation	Obstetrician	When identified	• PET screen • MSU, and repeat urine PCR documented • Growth scan
4009	Gestational hypertension	New onset hypertension after 20 weeks of gestation without signs of pre-eclampsia; systolic BP ≥140 mmHg or diastolic BP ≥90 mmHg measured on two or more occasions at least four hours apart	Consultation	Obstetrician	When identified	PET bloods Call on-call Obstetrician
4029	Herpes genitalis	Active lesions	Consultation	Obstetrician	When identified	Call on-call Obstetrician
4033	Influenza-like illness		Primary	G.P	When identified	
4010	Intrauterine death		Transfer	Obstetrician	When identified	Call on-call Obstetrician
4051	Isolated small for gestational age (SGA)	EFW and/or AC 3rd to <10th centile with normal Doppler measurements.	Consultation	Obstetrician	When identified	

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
4013	Infant large for gestational age	EFW > 90th centile **and** AC > 90th centile, in the absence of diabetes	Consultation	Obstetrician	After GTT result	Immediate GTT (GTT may be done up to term)
4015	Malignancy		Transfer	Obstetrician Physician	When identified	
4016	Malpresentation	> 36 weeks; breech, transverse, oblique or unstable lie	Consultation	Obstetrician	36-37 weeks for ECV	Confirmation scan. If breech, size of baby and liquor volume
4018	Multiple pregnancy	Dichorionic twins	Transfer	Obstetrician	After anatomy USS	All must see Anaesthetist in 3rd trimester
4037		Monochorionic twins and higher order multiples	Transfer		At diagnosis	
4019	Oligohydramnios	No pool depth ± 2 cm	Consultation	Obstetrician	Immediate	Call on-call Obstetrician
4038	Parvovirus B19 infection		Consultation	Obstetrician	When identified	
4020	Placenta praevia; vasa praevia	≥ 32 weeks	Transfer	Obstetrician	After follow-up USS (if no bleeding)	• Major placenta praevia – see at 24-26wks • If bleeding call on-call Obstetrician
4039	Polycystic kidneys	Maternal not fetal finding	Consultation	Obstetrician	When identified	
4021	Polyhydramnios	Mild (deepest pocket measurement 9-11 cm)	Consultation	Obstetrician	When identified	GTT
4040		Moderate (deepest pocket measurement 12-15 cm) or severe (deepest pocket measurement > 16 cm)	Transfer			
4022	Pre-eclampsia	New onset hypertension after 20 weeks of gestation (systolic BP ≥ 140 mmHg or diastolic BP ≥ 90 mmHg measured on two or more occasions at least four hours apart) with one or more of the following: proteinuria ≥ 30 mg/mmol, other organ dysfunction (renal, liver, neurological, haematological), or uteroplacental dysfunction (for example, fetal growth restriction, abruption)	Transfer	Obstetrician	Urgent, when identified	Call on-call Obstetrician without delay
4023	Preterm rupture of membranes	< 37+0 weeks and not in labour	Transfer	Obstetrician	When identified	Call on-call Obstetrician
4024	Prolonged pregnancy	Refer in a timely manner for planned induction by 42 weeks	Consultation	Obstetrician	When identified	• 41 week scan for liquor volume • Call On-call Obstetrician
4025	Premature labour	34 – < 37 weeks	Consultation	Obstetrician	When identified	Call on-call Obstetrician
4026		< 34 weeks	Transfer	Obstetrician	When identified	Call on-call Obstetrician

Code	Condition	Description	Referral category	Referral To	Timing of Assessment	Prerequisite Tests / Comments
4027	Pre-labour rupture of membranes at term	Consult before 24 hours	Consultation	Obstetrician	When identified	• Ensure not HSV or GBS positive • Assess fetal and maternal well-being when SROM identified • On-call obstetrician during daylight hours if well • On-call obstetrician at anytime if not well
4028	Persistent reduced fetal movements	Following normal cardiotocograph but still reduced movements – may require a scan for liquor assessment/ growth assessment	Consultation	Obstetrician	When identified	Call on-call Obstetrician
4041	Short cervix	Finding on ultrasound of a cervix < 25 mm prior to 24 weeks of gestation	Consultation	Obstetrician	As soon as possible after detection	
4054	Syphilis	First diagnosed in current pregnancy	Consultation	Obstetrician	When identified	
4042	Thromboembolism	Deep vein thrombosis, pulmonary embolism	Emergency	Emergency Team	Immediate	
4044		Investigated for possible DVT or PE (negative result)	Consultation	Obstetrician		
4032	Urinary tract infection (UTI)	Recurrent	Consultation	Obstetrician	When identified	If 3 positive MSU's recorded
4031	Uterine fibroids	Cervical fibroids, retroplacental fibroids, submucosal or intramural fibroids > 5 cm, multiple fibroids	Consultation	Obstetrician	>20 weeks	Request assessment of fibroid size at scans to ascertain growth comparison
4043	Velamentous cord insertion		Consultation	Obstetrician	When identified	

Appendix 5. Antenatal Clinic Processes

Referral and Triage Process

Referrals are sent to the relevant Antenatal Clinic (i.e. Taupo/Turangi to Taupo ANC) via email to;

- Rotorua: antenatal.clinics@lakesdhb.govt.nz
- Taupo: taupoantenatal.clinic@lakesdhb.govt.nz

N.B: If the matter needs review sooner than one week, please make an urgent referral via phone (*see Appendix 3. Urgent Maternity Outpatient Referral Pathway*).
If the matter is not urgent but an appointment is required within a certain timeframe (e.g. 1-2 weeks), please indicate this in the email and email title.

Referrals are received by Administrative staff before then being assessed by the relevant ANC Midwife and prepared for triage.

Triage is completed by a rostered Obstetrician, Monday to Friday at Rotorua ANC and documented on the Maternity Multiagency Referral Prioritisation Form (20179140).

- Once a referral has been triaged and accepted, any requested appointments are made by the relevant ANC.
- A copy of the Maternity Multiagency Referral Prioritisation Form is uploaded into the IPM electronic patient record. A letter may be sent to the LMC with any recommendations from the Obstetrician for further tests to be completed by the LMC (SMO will supply forms to LMC for tests that LMC is unable to order).
- If the triaging Obstetrician recommends an USS, a scan form is supplied and the scan is booked by the ANC Administrator or ANC Midwife.
- Either the radiology provider or the ANC Administrator will inform the woman/person of the scan appointment date and time.
- A letter with details of any ANC appointment is sent to the woman/person or, if appointment date is within 2 weeks, the woman/person is informed via phone or e-text.

Face to Face Clinic Process:

- An Obstetric Antenatal Clinic Outcome Form (2499422) is completed during and after an appointment as a record of that appointment and is filed in the clinical notes.
- A copy of the Obstetric Antenatal Clinic Outcome Form is emailed to the LMC's Te Whatu Ora Lakes email address within one day of the appointment OR the LMC is contacted via phone to confirm any changes to the ongoing plan.
- LMC and woman/person are also informed of the outcome via a copy of the clinic letter.
- An USS or blood tests may be ordered by the Obstetrician and booked/form supplied by the ANC. The results of these tests should be copied to the LMC but will be followed up by the ANC and reviewed virtually or at the next appointment.
- The LMC may be advised to order future laboratory tests or USS as part of ongoing primary care.

Video or Phone Consult Process:

If a plan of care has been made and further tests undertaken but there is no need to see the woman/person face to face for the next appointment, a 'Video or Phone Consult' (also referred to as a 'Telehealth' or 'Virtual' Clinic Appointment) may be arranged.

- This appointment is scheduled into the clinic list of the relevant clinician, as if the appointment was face to face, and takes place by the clinician phoning the woman/person at a time during that clinic list.
- An Obstetric Antenatal Clinic Outcome Form (2499422) (or Obstetric Virtual Review Outcome Form (2499430)) is completed during and after the appointment as a record of that appointment and filed in the clinical notes.
- A copy of the Obstetric Antenatal Clinic Outcome Form is emailed to the LMC's Te Whatu Ora Lakes email address within one day of the appointment OR the LMC is contacted via phone to confirm any changes to the ongoing plan.
- Further tests may be ordered by the Obstetrician and arranged by the ANC. The results of these tests should be copied to the LMC but will be followed up by the ANC and reviewed virtually or at the next appointment.
- The LMC may be requested/advised to arrange future blood tests or USS as part of primary maternity care, especially if the LMC has overall clinical responsibility for care.
- In the Inpatient Management System (IPM) this process of Video or Phone Consult is logged as 'Follow-up – Telephone' or 'Follow-up - Video'.

Virtual Review Process:

If a further test has been requested by the Obstetrician and booked by the ANC and needs to be reviewed by a clinician before the next scheduled appointment with the woman/person;

- An Obstetric Virtual Review Outcome Form (2499430) is completed by the ANC Midwife and sent with the results of the test or USS to the clinician via email or shown to them (or the on-call clinician) in person.
- The Obstetric Virtual Review Outcome Form is completed by the clinician with a plan for any further action and ongoing care and filed in the clinical notes as a record of that review.
- A copy of the Obstetric Virtual Review Outcome Form is emailed to the LMC, within one day of the completed virtual review, OR the LMC is contacted via phone to confirm the outcome of the virtual review, the agreed ongoing model of care and any further action needed as a result of the review.
- The ANC Midwife may contact the LMC and the woman/person directly by phone if any immediate action is required.
- The LMC discusses the information and any change in plan with the woman/person.
- In the Inpatient Management System (IPM) this process of Virtual Review is logged as a 'Contact'.