WRHA Public Health Nurses and Midwives Working Together

This document is a guide for collaborative care between WRHA midwives and public health nurses (PHNs) to support pregnant individuals, new parents and their infants.

For teamwork and collaboration, we outline roles between midwives and public health nurses.

Contents

1.0 Introduction

Midwives and PHNs share common values and goals including person-centred care, informed choice, a trauma-informed approach and evidence-informed practice. We are mutually committed to cultural safety and providing respectful care for all individuals.

A collaborative relationship between health professionals is essential for safe and quality care. Collaboration is best achieved through a team approach with effective communication.

Midwives and PHNs inform families of the healthyparentingwinnipeg.ca website, Healthy Baby programs and chest/breastfeeding support groups and services. Midwives and PHNs are committed to the 10 steps of the Baby Friendly Initiative to support chest/breastfeeding.

Midwives and PHNs communicate through:

- Referral forms
- Faxing encounter notes or letters – *midwives fax letters to Public Health Central Intake who will forward the letter to the PHN team based on the client's address. On the cover sheet, write: "Please forward this letter to the correct Public Health Nurse based on their postal code."*
- Emails (use WRHA Outlook global contacts as needed) – *PHN can contact midwives by email*
- Phone calls to on-call number if urgent

We are committed to using gender-inclusive and culturally sensitive language in the care we deliver. Our mutual goal is to embrace a strengths-based approach when assisting families.

2.0 Roles

A Midwife is the primary care provider throughout pregnancy, labour, birth and postpartum/newborn care until 6-8 weeks. In the postpartum period, midwives see families several times in their home during the first week and at the clinic at 2 weeks, 4 weeks and 6 weeks after the birth.

WRHA midwives work in practice groups. The midwifery clinics are at Access River East, Access Winnipeg West, Downtown (755 Portage Ave), Mount Carmel Clinic and Ode'imin (formerly know as the Birth Centre). There is also a Physician/ Midwife team at Kildonan Medical Centre.

A Public Health Nurse provides services and supports to pregnant and postpartum individuals and infants through assessment and promoting optimal health outcomes. The PHN:

- Connects families to appropriate community resources
- Education for healthy pregnancies and breast/chest feeding
- Supports breast/chest feeding via phone and/or home visiting services
- Screens for Families First home visiting program
- Supports enrollment in Families First Program as appropriate
- Conducts assessment of the new parent and infant if indicated
- Provides information on injury prevention and health promotion

Note: If the PHN identifies any abnormal clinical outcomes, the PHN follows their routine care pathways (i.e. an infant or postpartum parent has abnormal vitals or risks of postpartum depression). The PHN informs the midwife as soon as possible of their assessment and the care that they provided.

3.0 Prenatal Referrals

3.1 PHN referral to Midwifery Services

The PHN may refer any pregnant individual at any gestation to midwifery services.

The PHN particularly offers a referral when the pregnant individual:

- Has no prenatal healthcare provider or inadequate prenatal care
- Experiences inequity according to the social determinants of health
- Accepts a midwife referral
- Has Manitoba health number or will receive one during the pregnancy (if the client has moved to Manitoba from another province)

Note: If the PHN is unsure about medical risk factors and eligibility for midwifery care, the PHN is encouraged to complete the midwifery referral. The midwife conducts the risk assessment and consults with an obstetrician as needed.

Process for PHNs to refer a pregnant individual to midwifery care (see Appendix)

The PHN offers to refer the pregnant individual to a midwife. If the individual agrees, the PHN makes a referral with the individual or on their behalf.

1. If the person lives in the R2W postal code, they may be referred directly to Mount Carmel Clinic (MCC) midwifery services. The public health nurse calls 204-589-9412 to fill out a referral form with the admin person.

2. If the person experiences barriers to care and who lives outside of R2W, the PHN may call Ode'imin (formerly known as the Birth Centre) reception 204-594-0900 and request a "Rapid Intake". The rapid intake results in an appointment with a midwife within one (1) week. The midwife conducts an in-person initial visit with the client and determines next steps for their care. The rapid intake process is for people who have significant barriers with communication and transportation. Ode'imin reception books the visit on the phone and can offer to support the person with transportation resources.

3. For the person who does not experience barriers to care:
    a. The pregnant individual or PHN calls the all the intake line 204-947-2422 (ext. 307)
    b. For information about WRHA midwifery services see: Midwifery | Winnipeg Regional Health Authority (wrha.mb.ca)
    c. The PHN can complete a Midwifery Services Referral Form and fax (204-594-0707) to central midwifery intake Midwifery-Services-Referral-Form.pdf (odeimin.com)
    d. The PHN indicates on the referral form that the referral is from a public health nurse; midwives prioritize healthcare provider referrals
    e. It takes up to two weeks for a regular referral to be processed

4. If a PHN team is working in the same facility there may be an internal process for booking an appointment with a midwife.

3.2 Midwifery prenatal referral to Public Health

The midwife offers a prenatal referral to public health nursing services to pregnant individuals who experience inequity in the social determinants of health.

If the pregnant individual agrees, the midwife completes the Manitoba Public Health Nurse Prenatal Referral form in Accuro and faxes it to Public Health Central intake. In the "additional information" section, please include a description of indications for the referral. NOTE: PHN do not have access to Accuro. Manitoba Public Health Nurse Prenatal Referral (gov.mb.ca)

Note: If a prenatal referral to Public Health is done, the Postpartum Referral must be sent to central intake within 48 hours after the birth.

PHN's role for prenatal referrals to public health. The PHN:

- Contacts the individual via the telephone or home visit within two weeks of receipt of the prenatal referral as per the Provincial Public Health Nursing Standards: Prenatal, Postpartum and Early Childhood

  - http://www.wrha.mb.ca/extranet/publichealth/files/MBPHNStandards_PrePostEarlyYears.pdf
  - Provincial Public Health Nursing Standards | Health | Province of Manitoba (gov.mb.ca)
- Assesses the individual's readiness, preference, needs, existing resources and goals to determine the type, frequency and duration of services
- After contact, the PHN communicates with the midwife to give an update on care plans and collaborate if necessary based on the needs of the client
- Ongoing communication between the client, the PHN and the midwife may be minimal unless concerns or complexities arise

4.0 Postpartum Care

4.1. Midwifery routine postpartum care

The midwife:

- Conducts day 1 visit at hospital or home including newborn metabolic screening, jaundice screening, pulse oximetry screening
- Conducts two additional visits in the first week
- Is available 24-7 for urgent client concerns
- Assesses infant weight gain
- Creates feeding plans and increases the number of home visits as needed
- Assesses the dyad in the clinic at 2-3 weeks and again at 6 weeks postpartum
- Prescribes family planning methods as chosen by the client
- Discharges the family from midwifery care at 6-8 weeks postpartum
- Confirms the on-going primary care provider at midwifery discharge for infant and birthing parent

The midwife:

- Recommends a Postpartum Referral form (PPRF) in the immediate postpartum for all new parents inclusive of all place of birth options and social determinants of health
- Fills out the PPRF as soon as possible if there was a public health nurse Prenatal Referral
- Shares the benefits of public health nursing
  - Breastfeeding groups and lactation specialists
  - PHN knowledge of community resources and ongoing support for infant care and infant feeding
  - Possible access to the Families First Home Visitor program
- Reviews the PPRF if a hospital birth and adds notes for the PHN from midwifery
- Faxes the PPRF to public health central intake within 48 hours when the birth is outside of the hospital
- Considers including a note on inequities in social determinants of health if applicable
- Includes the preferred contact information for the midwife

At discharge from midwifery care, if the client has experienced complexities in the postpartum, the midwife writes a discharge letter to the PHN summarizing the issues and faxes it to Public Health Central Intake.

Note to PHN: When there is a homebirth or Ode'imin birth, a discharge weight and the LATCHR score is not documented on the PPRF due to discharge at 3-6 hours of age.

4.2 Public Health Nurse routine postpartum care

The PHN:

- Receives PPRF via Central Intake after discharge from hospital or within 48 hours from out-of-hospital birth
- Contacts the family within 7 days of receiving the PPRF ensuring not to overlap services with midwifery care
- Contacts the midwife if complexities arise on the phone call
- Together, with the family, determines the need and timing of public health nursing visit
- Provides services to the family in accordance with the Public Health Nursing Care Pathways (Postpartum and Newborn)
- Completes the Families First Screen and assessment as applicable, identifying the family's strengths and risks (see appendix)
- Maintains continuity of care whenever possible so that the PHN who has provided prenatal services also provides services during the postpartum period

Family First Home Visitor

Public Health Nurses share a variety of community resources with families. They consider a referral to the Families First home visiting service when there are 3+ risk factors on the Families First Screening Tool and 3+ variances within the Nursing Care Pathways. Enrollment in the Families First home visiting service is voluntary and families may choose to participate in the program for up to 3 years. The PHN completes the FFHV form. If the midwife is aware of people who may benefit from FFHV, they may communicate this to the PHN.

- Families First | Child and Youth Programs | Province of Manitoba (gov.mb.ca)
- brochure.pdf (gov.mb.ca)
- Screening form guidelines: Guidelines for the Completion of the Families First Screening Process.pdf
- Copy of the screening form: Microsoft PowerPoint - Chartier - Families First Screening in Manitoba (Nov 16) (gov.mb.ca)

During the home visits, Families First Home Visitors (FFHV) strive to: facilitate parent-child attachment; cultivate the growth of nurturing parent-child relationships; promote healthy childhood growth and development and support families to build strong family foundations and community connections. PHNs remain involved with the family as a case manager for the duration of the families is receiving home visiting services. See the appendix for more information.

5.0 Special circumstances

5.1 Midwifery client with complex needs

Individuals with complex needs may need the support of both the midwife and PHN visiting. A plan for collaborative care is determined by the PHN and midwife based on the needs of the individual and in the interest of not duplicating care.

The midwife may find the assigned PHN by faxing Public Health Central Intake through Accuro.

The PHN may find the midwife by their name listed on the Postpartum Referral and the midwifery contact list that is distributed to all teams by the Public Health Clinical Nurse Specialist.

Midwives work with the PHN to appropriately transition clients out of midwifery care. The midwife may send a discharge letter to the PHN to communicate discharge from midwifery care and request for ongoing support from PHN. Examples include if the new parent has ongoing mental health concerns, infant feeding issues or does not have a confirmed primary care provider.

5.2 Collaboration in Care of Antenatal Home Care Program Clients

Antenatal Home Care Program (AHCP) cares for clients who are experiencing specific high-risk hypertensive conditions and preterm premature rupture of membranes and threatened preterm labour. AHCP nurses seek to work collaboratively with midwives and general program public health nurses for shared clients. To learn more about the Antenatal Home Care Program, including who may be eligible for program follow up and to access referral forms, see the Guidelines for Healthcare Providers at antental-home-care-referral-guidelines-e.pdf (wrha.mb.ca)

The program case coordinator is available daily by phone at 204-792-5463 to discuss a potential referral and answer questions.

5.3 Home Phototherapy

Midwives and Public Health Nurses follow the WRHA Home Phototherapy guideline (2022): **home-phototherapy-clinical-practice-guidelines.pdf (wrha.mb.ca)**

If the midwife refers the infant to Children's ER for hyperbilirubinemia, the midwife requests that if the Home Phototherapy referral is needed and sent to the PHN, the ER nurse should include the names of the pediatrician and the midwife.

The most responsible provider for the infant on home phototherapy is the pediatrician.

The midwife collaborates with the assigned PHN as needed for updates on the therapy and both the midwife / PHN will work together to determine the plan for feeding support / ongoing infant assessment.

The provider who collects at TSB will assess the feeding at the same visit.

The midwife can communicate with the PHN for ongoing care planning. When the midwife becomes aware that the infant is put on the home phototherapy protocol, the midwife faxes a note to the PHN with the mother's information to Public Health Central Intake to collaborate with the PHN.

5.4 Feeding Plans

- Midwives document feeding plans in ACCURO and on paper charts that are in the home
- PHNs document feeding plans on paper feeding plan form that is left in the home
- MWs and PHNs may review all feeding plans made by each other to increase consistency
- In most cases, the midwives provide continuity of care with breastfeeding support and feeding plans to their clients
- If at any time the PHN identifies a feeding issue within the first 6 weeks of age, they support the family with the immediate concern and contact the midwife for follow-up care

5.5 MW Referral to PHN breastfeeding group or lactation specialist

If infant feeding is challenging or the family is seeking additional support, midwives may collaborate with PHN lactation specialists and refer parents to the public health breastfeeding groups.

If midwives request PHN to follow up on a newborn with feeding difficulties, the midwife provides a written assessment to the PHN with a request for lactation support. The midwife faxes this note to Public Central Intake.

5.6 Clients who live outside of WRHA

For out of region midwifery clients:

- PHN throughout Manitoba follows the provincial standard care pathways
- PHNs do not have the capacity to follow specific visit days and unless there is an urgent need
- If there is an urgent need, send a letter to Public Health Central intake and request that the assigned PHN call the midwife on-call
- Midwifery clients who live outside out of WRHA will connect with a PHN but not on the same schedule as the midwifery routine visit schedule

Appendix 1: Speaker Notes for MWs and PHNs when making referrals

For PHNs: Topics to include when offering a referral to midwifery services

Midwifery services are available to all pregnant people. Midwives:

- Provide primary care for pregnancy, birth and for 6 weeks after birth for you and your baby
- Are primary care providers in pregnancy and birth in hospital, at a birth center and home
- Consult and collaborate with other health care professionals if you or your baby need specialized care or additional services

If you'd like a referral, I can help you with a request for midwifery services.
If there is availability in the midwife's caseload, you will be contacted for an initial prenatal visit within two weeks and you will meet with the midwife.
If there is no availability the midwifery office will let me know, and I will help you find another option.

For Midwives: Topics to include when offering Prenatal Referrals to Public Health

Public health nurses:

- Offer family centered services that are respectful of people's lives and circumstances.
- Support health in all aspects.
- Assist you in improving your health during pregnancy, preparing for the birth; and if you plan to, help you get ready for breastfeeding and parenting.
- Share resources in your neighborhood, including housing, financing and other community programs like Healthy Baby and Families First
- If you accept the referral, you can expect a phone call from the PHN within the next two weeks.

For Midwives: Topics to include when offering Public Health Postpartum Referrals

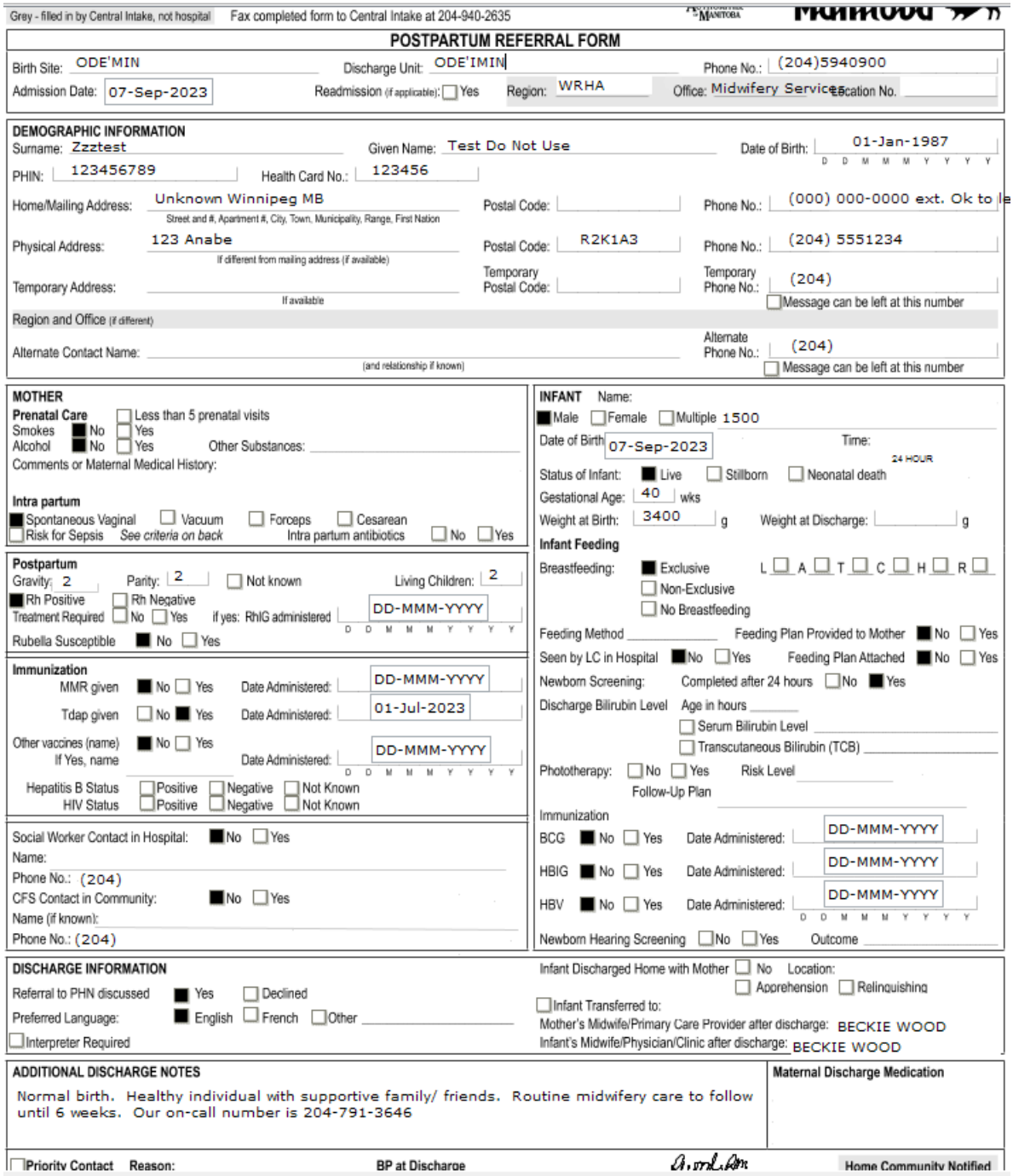
Postpartum referrals are offered to all families with newborns. The referral form has information about your pregnancy, labor and delivery, your baby and current family situation.
The public health nurse:

- Provides information about caring for yourself and your baby and will answer any questions you have about parenting, infant care and feeding.
- Connects you to resources that are of interest to you
    - The PHN is familiar with resources in your neighborhood, including housing, financing and other community programs
- Public Health Nurses and Midwives work as a team, with midwives available to you for the first six weeks after birth while Public Health Nurses may continue their work with families beyond this time frame.
- If you accept the referral, you can expect a phone call from the PHN within 7 days after the birth or discharge from hospital

Appendix 2: Postpartum Referral Form in Accuro for out of hospital births

Note: At out-of-hospital births, the family is discharged from Ode'imin or the midwives leave the homebirth at 3-6 hours postpartum. For this reason, there is no discharge weight or LATCHR score.

If the PHN needs to contact a midwife directly, there is a contact list circulated to all offices, email (find contact through global address book) or call Ode'imin reception at 204-594-0900



Grey - filled in by Central Intake, not hospital Fax completed form to Central Intake at 204-940-2635

POSTPARTUM REFERRAL FORM

Birth Site: ODE'MIN Discharge Unit: ODE'IMIN Phone No.: (204)5940900
Admission Date: 07-Sep-2023 Readmission (if applicable): ☐ Yes Region: WRHA Office: Midwifery Service Location No.

DEMOGRAPHIC INFORMATION
Surname: Zztest Given Name: Test Do Not Use Date of Birth: 01-Jan-1987 (D D M M M Y Y Y Y)
PHIN: 123456789 Health Card No.: 123456
Home/Mailing Address: Unknown Winnipeg MB (Street and #, Apartment #, City, Town, Municipality, Range, First Nation) Postal Code: Phone No.: (000) 000-0000 ext. Ok to le
Physical Address: 123 Anabe (If different from mailing address (if available)) Postal Code: R2K1A3 Phone No.: (204) 5551234
Temporary Address: (If available) Temporary Postal Code: Temporary Phone No.: (204) ☐ Message can be left at this number
Region and Office (if different)
Alternate Contact Name: (and relationship if known) Alternate Phone No.: (204) ☐ Message can be left at this number

MOTHER
Prenatal Care ☐ Less than 5 prenatal visits
Smokes ■ No ☐ Yes
Alcohol ■ No ☐ Yes Other Substances:
Comments or Maternal Medical History:

Intra partum
■ Spontaneous Vaginal ☐ Vacuum ☐ Forceps ☐ Cesarean
☐ Risk for Sepsis *See criteria on back* Intra partum antibiotics ☐ No ☐ Yes

Postpartum
Gravity: 2 Parity: 2 ☐ Not known Living Children: 2
■ Rh Positive ☐ Rh Negative
Treatment Required ☐ No ☐ Yes if yes: RhIG administered DD-MMM-YYYY (D D M M M Y Y Y Y)
Rubella Susceptible ■ No ☐ Yes

Immunization
MMR given ■ No ☐ Yes Date Administered: DD-MMM-YYYY
Tdap given ☐ No ■ Yes Date Administered: 01-Jul-2023
Other vaccines (name) ■ No ☐ Yes If Yes, name Date Administered: DD-MMM-YYYY (D D M M M Y Y Y Y)
Hepatitis B Status ☐ Positive ☐ Negative ☐ Not Known
HIV Status ☐ Positive ☐ Negative ☐ Not Known

Social Worker Contact in Hospital: ■ No ☐ Yes
Name:
Phone No.: (204)
CFS Contact in Community: ■ No ☐ Yes
Name (if known):
Phone No.: (204)

INFANT Name:
■ Male ☐ Female ☐ Multiple 1500
Date of Birth 07-Sep-2023 Time: (24 HOUR)
Status of Infant: ■ Live ☐ Stillborn ☐ Neonatal death
Gestational Age: 40 wks
Weight at Birth: 3400 g Weight at Discharge: g

Infant Feeding
Breastfeeding: ■ Exclusive L ☐ A ☐ T ☐ C ☐ H ☐ R ☐
☐ Non-Exclusive
☐ No Breastfeeding
Feeding Method Feeding Plan Provided to Mother ■ No ☐ Yes
Seen by LC in Hospital ■ No ☐ Yes Feeding Plan Attached ■ No ☐ Yes
Newborn Screening: Completed after 24 hours ☐ No ■ Yes
Discharge Bilirubin Level Age in hours
☐ Serum Bilirubin Level
☐ Transcutaneous Bilirubin (TCB)
Phototherapy: ☐ No ☐ Yes Risk Level
Follow-Up Plan

Immunization
BCG ■ No ☐ Yes Date Administered: DD-MMM-YYYY
HBIG ■ No ☐ Yes Date Administered: DD-MMM-YYYY
HBV ■ No ☐ Yes Date Administered: DD-MMM-YYYY (D D M M M Y Y Y Y)
Newborn Hearing Screening ☐ No ☐ Yes Outcome

DISCHARGE INFORMATION
Referral to PHN discussed ■ Yes ☐ Declined
Preferred Language: ■ English ☐ French ☐ Other
☐ Interpreter Required
Infant Discharged Home with Mother ☐ No Location: ☐ Apprehension ☐ Relinquishing
☐ Infant Transferred to:
Mother's Midwife/Primary Care Provider after discharge: BECKIE WOOD
Infant's Midwife/Physician/Clinic after discharge: BECKIE WOOD

ADDITIONAL DISCHARGE NOTES
Normal birth. Healthy individual with supportive family/ friends. Routine midwifery care to follow until 6 weeks. Our on-call number is 204-791-3646

Maternal Discharge Medication

☐ Priority Contact Reason: BP at Discharge Home Community Notified

Appendix 3: Family First Visitor and Screening Form Example

Families First offers home visiting support to families with children from pregnancy to school entry. Public Health Nurses when visiting with families complete a Public Health Nurse (PHN) assessment based on the Provincial Public Health Nursing Care Pathways for prenatal and postpartum families and the Provincial Families First Screening Tool. Public Health Nurses share a variety of community resources with families. They consider a referral to the Families First home visiting service when there are 3+ risk factors on the Families First Screening Tool and 3+ variances within the Nursing Care Pathways. Enrollment in the Families First home visiting service is voluntary and families may choose to participate in the program for up to 3 years. Regular weekly home visits with a Families First Home Visitor builds trust and rapport. As the children grow and parenting learning needs change service frequency decreases.

During the home visits, Families First Home Visitors (FFHV) strive to: facilitate parent-child attachment in the prenatal and postnatal period; cultivate the growth of nurturing parent-child relationships; promote healthy childhood growth and development and support families to build strong family foundations and community connections. FFHVs use a parent-led and family-centered approach to supporting families and embed tailoring that is specific to each family's unique circumstances. Families First Home Visitors are skilled in building secure attachment relationships between parent and child. They assist families to reach their goals. The approved curricula used by the FFHVs include Great Kids Inc.™ (GKI) curricula and Towards Flourishing (TF) curriculum. PHNs remain involved with the family as a case manager for the duration of the families is receiving home visiting services. FFHVs share their observations and intervention with the PHN case managers and support families to make their own self-referrals. PHN case managers are responsible for ongoing assessment and care planning. They act as an advocate on the family's journey of health and wellness.

18704

Families First **SCREENING Form**

2023 303066

NUMERICAL INFORMATION ONLY
Please do not write any names or addresses on this form. See detailed instructions on reverse.

○ Unable to complete screen

PREGNANT PERSON: Age: ___ When was pregnancy confirmed (weeks)? ___ Screened prenatally? ○ Yes ○ No

PHIN: ___ MHSC: ___

Residence Postal Code: ___ RHA ___ CA ___

Education: ○ Post secondary ○ Grade 12 ○ Less than Grade 12

BABY: Day ___ Month ___ Year 2023

Birth Date:

PHIN: ___

Sex: ○ Male ○ Female ○ Intersex

Family background of baby:
○ First Nations/Status Indian ○ Newcomer
○ Métis ○ Francophone
○ Inuit

○ **BIOLOGICAL FATHER** ○ **PARENTING PARTNER** *(if not biological father)*

Age: ___ PHIN: ___

Education
○ Post secondary
○ Grade 12
○ Less than Grade 12

A. CHILDREN WITH KNOWN DISABILITY

(Fill in 'yes' if risk factor is present, 'no' if it is not. If unknown, leave blank.)

1. Congenital anomaly or acquired disability. Include:. ○ Yes ○ No
   Major (probability of permanent disability) e.g., Down's syndrome, cerebral palsy, FASD
   Moderate (correction may be possible) e.g., cleft palate, loss of limb

B. DEVELOPMENTAL RISK FACTORS

2. Low birth weight (less than 2500 grams at birth). ○ Yes ○ No
3. High birth weight (greater than 4000 grams at birth). ○ Yes ○ No
4. Prematurity - an infant born at less than 37 weeks gestation. ○ Yes ○ No

Complications of pregnancy

5. Infections that can be transmitted in utero and may damage the fetus (e.g., rubella, HIV) ○ Yes ○ No
6. Alcohol use by pregnant person during pregnancy. If "yes", complete section D. ○ Yes ○ No
7. Drug use by pregnant person during pregnancy (If yes, type of use: ○ Cannabis ○ Other drugs). ○ Yes ○ No

Complications of labour and delivery

8. Difficult vaginal birth (forceps or vacuum) or emergency caesarean ○ Yes ○ No
9. Infant trauma or illness (e.g., convulsions, respiratory distress syndrome) ○ Yes ○ No
10. Family history of a disability not detectable at birth that could affect development (e.g., deafness, mentally disabled/challenged) ○ Yes ○ No
11. Multiple births (e.g., twins, triplets) ○ Yes ○ No
12. Pregnant person smoking during pregnancy (If Yes, # of cigs/day: ○ 1-5 ○ 6-10 ○ 11-15 ○ 16-20 ○ 20 +) ○ Yes ○ No
13. Diabetes diagnosed before pregnancy OR early in pregnancy (type 2) ○ Yes ○ No
14. Diabetes diagnosed in 3rd trimester of pregnancy (Gestational Diabetes). ○ Yes ○ No

C. FAMILY RISK FACTORS

15. Pregnant person's age at birth of first child is less than 18 years. ○ Yes ○ No
16. Pregnant person's highest level of education completed is less than grade 12. ○ Yes ○ No
17. On social assistance/income support or financial difficulties ○ Yes ○ No
18. Single parent family. ○ Yes ○ No
19. First prenatal visit occurred at/after 28 weeks gestation ○ Yes ○ No

Mental illness or disability in pregnant person and biological father OR parenting partner

20. Depression (including postpartum) . . . . . Pregnant person ○ Yes ○ No
21. Biological father of baby/Parenting partner ○ Yes ○ No
22. Anxiety Disorder . . . . . Pregnant person ○ Yes ○ No
23. Biological father of baby/Parenting partner ○ Yes ○ No
24. Schizophrenia or bipolar affective disorder . . . Pregnant person. ○ Yes ○ No
25. Biological father of baby/Parenting partner ○ Yes ○ No
26. Mentally disabled/challenged parent . . . . . Pregnant person. ○ Yes ○ No
27. Biological father of baby/Parenting partner ○ Yes ○ No
28. Antisocial type behaviours. . . . . Pregnant person ○ Yes ○ No
29. Biological father of baby/Parenting partner ○ Yes ○ No
30. Current substance abuse . . . . . Pregnant person ○ Yes ○ No
31. Biological father of baby/Parenting partner ○ Yes ○ No
32. Prolonged separation between baby and pregnant person (5 days or more with little or no contact). ○ Yes ○ No
33. Assessed lack of bonding (e.g., minimal eye contact, touching) ○ Yes ○ No
34. Social isolation (lack of social support and/or isolation related to culture, language or geography). ○ Yes ○ No
35. Relationship distress ○ Yes ○ No
36. Current or history of violence between parenting partners ○ Yes ○ No
37. Harsh and/or inappropriate discipline practices (including other children). ○ Yes ○ No
38. Existing file with Child and Family Services. ○ Yes ○ No
39. Pregnant person's own history of child abuse/neglect ○ Yes ○ No
40. Biological father /parenting partner's own history of child abuse/neglect. ○ Yes ○ No

D. ALCOHOL USE DURING PREGNANCY *(complete if answered "yes" to item B6)*

(See reverse for detailed instructions)

In this section, check the option that is most descriptive of alcohol use before the pregnant person knew they were pregnant:

Frequency How *often* did the pregnant person consume alcohol? ○ Less than once/mo ○ 1-4 days/mo ○ 2-3 days/wk ○ > 3 days/wk

Usual Amount How *much* alcohol would they consume in one sitting? ○ 1 or less ○ 2 to 3 drinks ○ 4 or more drinks

Binge Did they ever drink 4 or more drinks in one sitting? ○ Yes ○ No
How often did binge drinking occur? ○ Less than once a month ○ 1-4 days/month ○ 2-3 days/week ○ > 3 days/week

Once the pregnant person discovered their pregnancy, did how much or how often they consumed alcohol change ? *Select one response.* ○ No ○ Yes, reduced use ○ Yes, increased use ○ Yes, stopped altogether

Referrals to WRHA Midwifery Services

PREGNANT PERSON?
Refer to a midwife

Lives in R2W	Experiences barriers to care (does not live in R2W)	All Pregnant Individuals
Refer to Mount Carmel Midwifery	Refer to Ode'imin Rapid Intake	Refer to Midwifery Central Intake
Call 204-589-9412	Call 204-594-0900	Call 204-947-2422 (ext. 307)
PHN asks to book an appointment	PHN asks for Rapid Intake appointment	PHN or individual leaves a message
If the person needs, there is a drop-in prenatal clinic on Monday 1-4pm	Reception books appointment	Within 3 days, an intake staff calls to complete an intake (please say PHN referral)
Intake is done at first visit	Intake is done at first visit	Within 2 weeks a midwife calls client to book an appointment

*If the PHN team and midwifery practice works in the same facility, there may be internal processes for intakes. PHN and midwifery teams can determine this process.