

High Risk OB and Antenatal Testing

High Risk OB visits:

- Per routine for now, attempt to space out visit to minimum medically necessary on case by case basis. Use telemedicine visits where possible.

Multiple Gestation Management:

- Same management as singletons until 32 weeks if uncomplicated.
- FHR checks and BP check / urine dip every 2 weeks from 32-36 weeks, then weekly until delivery.
- Monthly growth scans starting at 24 weeks.
- After 24 weeks, they need to be seen in person if there are any concerns.

Essential High Risk OB indications (Antenatal Testing Frequency):

TWICE WEEKLY

- IUGR (twice weekly testing with UA doppler >95%, weekly if <95%ile)
- Preeclampsia / Gestational hypertension (twice weekly testing)

WEEKLY TESTING

- cHTN on meds (well-controlled)
- GDM on meds (could consider kick counts if well controlled)
- Type 1 or 2 DM (weekly testing if controlled)
- Multiple gestations (per AP testing guidelines)
- Cholestasis (start at diagnosis OR 28 weeks, whichever is later)
- Obesity BMI > 40 – (start at 36-37 weeks)
- AMA > age 40 – (start at 37 weeks)
- Other less common antenatal testing indications per guidelines

Non-Essential US:

- Dating/viability BEFORE 12 WEEKS WITHOUT AN INDICATION
- Screening fetal echo (IVF)
- Follow up suboptimal views unless specifically recommended (Requires MFM consensus).

Essential US:

- Dating/Limited anatomy/Sequential screening (11-13 weeks)
- Routine Anatomy 20-23 weeks
- Fetal echo for DM or 1st degree relative with CHD (to be done at time of anatomy US)
- TTTS screening (q2 weeks)
- Cord Doppler's for IUGR q2 weeks if normal, weekly or as indicated if elevated
- Growth q6-8 weeks for routine indications (ie controlled HTN, DM, obesity BMI>35)

Continue to monitor as clinically appropriate:

- Cholestasis
- Post dates
- Oligohydramnios