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CONTRACEPTION AFTER AGE 35

I. INTRODUCTION

The years from age 35 to menopause can be referred to as the transition years. About 75% of pregnancies in women over age 40 are unintended. Perimenopausal women have the highest abortion rate of any group except women under age 15. The recent trend toward delayed childbearing and the recent emphasis on the potential benefits of the use of combined oral contraceptives make contraception in this age group important. Potential benefits of combined estrogen-progestin contraceptive use in healthy, nonsmoking women after age 35 include:

- A. Adequate contraception with reduced need for abortion.
- B. Control of irregular bleeding secondary to erratic ovarian functioning.
- C. Prevention of vasomotor symptoms associated with episodic declining estrogen levels.
- D. Reduction in risk ovarian and endometrial cancers.
- E. Reduction in risk rheumatoid arthritis.
- F. Possible bone sparing effect resulting in potentially less osteoporosis and associated fractures.
- G. Reduced risk of menorrhagia and associated anemia.
- H. Reduced risk of dysmenorrhea and mid-cycle pain of ovulation.
- I. Reduced risk of leiomyomata uteri.
- J. Reduced risk of ovarian cysts.
- K. Reduced need for surgical procedures, including:
 - 1. Sterilization
 - 2. Endometrial biopsy
 - 3. Dilatation and curettage
 - 4. Laparoscopy (diagnostic and operative)
 - 5. Hysterectomy
- L. Reduced risk of fibrocystic breasts and fibroadenomas.
- M. Reduced incidence of premenstrual syndrome.
- N. Probable decreased incidence of endometriosis.
- O. Possible protection against atherosclerosis.

Pregnancy in this age group is associated with an increased rate of spontaneous abortion, chromosomal anomalies, and maternal morbidity and mortality. Gynecologic problems, such as irregular bleeding, menorrhagia, dysmenorrhea, and premenstrual syndrome, are also more common. **Except for women who smoke, there is no age limitation on contraceptive choices.**

Certain medical conditions are more common in this age group and appropriate screening should be considered prior to prescribing contraception. Among these conditions are thyroid disease, diabetes mellitus, breast cancer and cardiovascular disease. Regular medical evaluations should be encouraged as appropriate in addition to the general gynecological evaluation.

The median age of menopause is 51.3 years, confirmed by amenorrhea for 1 year in symptomatic women. During the years leading up to the menopause fertility decreases, but is unpredictable. There are no tests to diagnose menopause early and reliably enough to guarantee a woman she is no longer at risk for pregnancy. Due to the variability of follicle stimulating hormone (FSH) blood levels in relation to symptoms and bleeding pattern, the use of FSH testing is no longer routinely recommended.

II. PLAN OF ACTION

- A. Complete the history and physical examination, and order laboratory testing as appropriate for age and identified risk factors.
- B. Provide preconception and genetics counseling as indicated.
- C. A couple that has completed their family may be candidates for permanent contraception. Provide information and or referral for tubal ligation or vasectomy.
- D. Appropriate periodic medical evaluations should be encouraged. The woman should be encouraged to communicate with her primary care provider regarding her contraceptive use.
- E. Combined estrogen/progestin contraceptives may be prescribed for women over 35 years of age who do not smoke and have no cardiovascular risks. Women over 35 with migraines should not have combined hormonal contraceptives prescribed.
- F. Unless otherwise indicated, low-dose combined oral contraceptives may be used up to age 55.
- G. Progestin-only contraception should be considered when estrogen-related risks are a concern.
- H. Both copper and progestin IUDs are appropriate for use until menopause.
- I. Barrier methods of contraception are more effective in the perimenopause since fertility is decreased.

III. FOLLOW-UP

- A. For clients using hormonal contraception during the perimenopause, evaluation of menopausal symptoms including bleeding patterns will usually dictate the timing of discontinuation of hormonal contraceptives and possible use of hormone replacement therapy (HRT).
- B. Use of non-hormonal contraception is advised until the diagnosis of menopause is secure.

REFERENCES

- 1. Hatcher RA et al. Contraceptive Technology. 19th Revised Edition. Ardent Media, Inc., New York, 2007
- 2. Ziemann M , Hatcher RA, et al. A Pocket Guide to Managing Contraception. Bridging the Gap Foundation, Tiger, GA, 2007

3. ACOG. *Precis: Primary and Preventive Care*. 3rd Ed., 2004
4. CDC Medical Eligibility Criteria for Contraceptive Use. *MMWR*, Vol. 57, No.RR-4, June 18, 2010
5. Speroff L, Darney P. *A Clinical Guide for Contraception*. 4th Ed., Lippincott Williams & Wilkins, Philadelphia, PA, 2004
6. ACOG. The Use of Hormonal Contraception in Women with Coexisting Medical Conditions. *Practice Bulletin #18*, July 2000

COMPONENTS OF A FAMILY PLANNING VISIT

I. INTRODUCTION

Delegate agencies must ensure that medical care services are provided under the supervision of a site medical director who is licensed and qualified physician with training and experience in family planning.

If colposcopy and related services (cryotherapy, excisional, biopsy) are provided on site, the Maryland Family Planning and Reproductive Health Program requirements for colposcopy services and quality assurance must be met (See Colposcopy Services and Quality Assurance Guideline).

The frequency and extent of investigation of the individual components are dependent on the type and frequency of each family planning visit, reason(s) for the visit, contraceptives in use and/or being considered for use and findings from the physical examination and laboratory testing. Similarly, revisits should be individualized based on the patient needs and the reason for the visit.

II. HISTORY

The initial comprehensive visit must include a complete medical history. Pertinent components of this history must be updated at subsequent clinical visits.

A. General History

1. Reason for visit
2. Age
3. Allergies- Drug, latex, food and seasonal
4. Current medications/vitamins/herbs
5. Current method(s) of contraception
6. Previous method(s) of contraception
7. Current primary care clinician

B. Sexual History

1. Age of onset
2. Number of partners in lifetime
3. Number of new partners since last visit
4. Number of current partners
5. Partner infection history
6. Gender of partners
7. Types of sex acts
8. High-risk behavior
9. Date of last vaginal intercourse

C. Obstetric History

1. Gravidity
2. Parity
3. Abortions (spontaneous or elective)
4. Preterm births
5. Living children
6. Delivery type(s)

7. Complications
 8. Date of last delivery / date of last pregnancy termination
 9. Breastfeeding
- D. Gynecologic History
1. Last menstrual period
 2. Menarche
 3. Length of cycle
 4. Length of flow
 5. Reproductive tract infection history: including abnormal Pap, HPV, HSV, gonorrhea, chlamydia, syphilis, bacterial vaginosis, trichomoniasis
 6. Surgery
- E. Current or Past Medical History
1. Asthma
 2. Cardiovascular disease
 3. Liver disease
 4. Kidney disease
 5. GI disease
 6. Headaches
 7. Diabetes mellitus
 8. Thromboembolic disease
 9. Coagulopathies
 10. Cancer: ovary, breast, uterus, cervix
 11. Mental health disorders
 12. Other medical problems
- F. Infectious Disease History
1. Hepatitis B and C
 2. HIV
 3. Tuberculosis
- G. Social History
1. Alcohol
 2. Smoking
 3. Drug use
 4. Domestic violence
 5. Sexual abuse/assault
 6. Child abuse
- H. Family History
1. Heart disease
 2. Diabetes
 3. Addictions
 4. Cancer (ovary, breast, uterus)

III. PHYSICAL EXAMINATION

The initial comprehensive visit must include a complete physical examination to include at least the following:

- A. Blood pressure
- B. Weight
- C. Height
- D. BMI

- E. Thyroid
- F. Heart
- I. Lungs
- J. Breasts
- K. Abdomen
- L. Extremities
- M. Pelvis
- N. Rectum (if indicated by age or risk)
- O. Skin

IV. COUNSELING

All clients should receive counseling on: STI/HIV transmission prevention (and should be offered screening); the importance of routine health maintenance screening procedures (and should be offered screening); methods to avoid unintended pregnancy; and on the importance of preconception care.

- A. The initial comprehensive visit must include counseling on the following:
 - 1. Importance of routine exams for preventative health maintenance:
 - a. Blood pressure evaluation
 - b. Breast exam
 - c. Pelvic exam
 - d. Pap smear
 - e. Colo-rectal screening (in individuals > 40)
 - f. STI screening including HIV
 - 2. Preventing unintended pregnancy
 - a. Abstinence/postponing sexual involvement
 - b. Contraceptive options
 - c. Emergency contraception
 - 3. Importance of preconception care and counseling
 - 4. Sexually transmitted infections/ HIV transmission
 - a. Partner selection
 - b. Barrier protection
- B. The following items should be included as indicated by history and physical exam:
 - 1. Weight/Diet/Nutrition
 - 2. Vitamins and Minerals
 - a. Iron
 - b. Folic acid
 - c. Calcium
 - 3. Exercise
 - 4. Psychosocial
 - a. Personal goals
 - b. Behavior/learning disorder
 - c. Abuse/neglect
 - d. Interpersonal/Peer/Family relationships
 - e. Family involvement
 - f. Domestic violence
 - g. Depression/Suicide
 - h. Lifestyle/Stress
 - 5. Health/Risk behaviors

- a. Substance abuse (drugs, tobacco, alcohol, prescription medications)
- b. Excess ultraviolet light
- c. Tattoos/Body piercing

V. LABORATORY TESTING

Laboratory tests should be provided as required by results of history, physical examination, and counseling components of visit. Specific laboratory testing may also be required for the provision of specific methods of contraception (refer to specific method guidelines).

The following laboratory tests must be available:

- A. Hgb/Hct
- B. Rubella screen
- C. Hepatitis B screen
- D. HIV
- E. STS
- F. VDRL or RPR
- G. Urine dipstick
- H. Pap
- I. GC
- J. Chlamydia
- K. HPV
- L. Urine pregnancy test (on site)

REFERENCES

1. ACOG. *Precis: Primary and Preventive Care*. 3rd Ed., 2004
2. Hatcher RA et al. *Contraceptive Technology*. 19th Revised Edition. Ardent Media, Inc., New York, 2007

INFERTILITY SERVICES

I. INTRODUCTION

Infertility services comprise an important part of comprehensive reproductive health care. Although infertility is defined as the absence of conception after at least one year of unprotected intercourse, some couples, especially those in the older reproductive age range, may request infertility evaluation before this threshold. The main objective of infertility medical services is to seek out and correct the causes of infertility, to provide accurate information and emotional support to each partner, and to advise clients when an appropriate time has been reached to seek further specialized care or to discontinue the evaluation.

II. GENERAL INFORMATION

The full range of infertility diagnosis and treatment services may not be able to be provided in a Title X Family Planning clinic site. The clinic site will be able to provide infertility care though limited evaluation, counseling and referral. Delegate agencies **must** provide Level I Infertility Services at a minimum, which includes initial infertility interview, education regarding causes and treatment options for infertility, physical examination, counseling, and appropriate referral. These services must be provided at the client's request.

Clinic personnel (APNs, RNs, and Clinic Assistants) may obtain client histories, identify risk factors, perform pregnancy testing, and provide client counseling, education, referral and follow-up. Because of the specialized educational, counseling, and medical care needs of infertility couples, and in light of the rapid rate of clinical advances in infertility care, only clinicians with special training and experience in this area may provide a more complex infertility service.

III. CLIENT SELECTION

- A. Basic Level 1 infertility information must be available to any client upon request. This also may represent an opportune time to offer pre-conceptual counseling.
- B. Involuntary infertility after unprotected intercourse with the same partner for one year or more, in the absence of a known cause of infertility.
- C. Presence of known, pre-existing male or female factors affecting fertility. The ideal circumstance for the performance of an infertility evaluation is the active involvement of both partners in the relationship. An attempt should be made to involve the male partner in education and counseling. A complete medical history and physical exam is not required before further evaluation of the female partner. Marriage should not be considered a prerequisite to infertility evaluation

IV. CLIENT EDUCATION/ INFORMED CONSENT

- A. Explore personal/couple concerns related to infertility. It is essential that clients be provided with basic information about human reproduction as it relates to their specific infertility situation. Initial client education and counseling should include:
 - 1. Information regarding normal reproductive anatomy and physiology, female and male infertility, including common causes, prevalence, evaluation and treatment
 - 2. Discussion of the emotional and time commitment required for an infertility work-up, including the potential for success
 - 3. Explanation of the services available and indications for referral
 - 4. Discussion of financial factors. Fees for referral services are the responsibility of the client
- B. Provide written and verbal information on fertility awareness through monitoring:
 - 1. Basal body temperature
 - 2. Menstrual cycle
 - 3. Cervical mucus
 - 4. Factors influencing male fertility

V. MEDICAL SCREENING AND EVALUATION

- A. History: A comprehensive medical and social history stressing reproductive factors must be obtained from each female client, and should be sought from male partners.
- B. History should include:
 - 1. Menstrual history and Last Normal Menstrual Period (LNMP)
 - 2. Pregnancy history
 - 3. Current and previous contraceptive methods
 - 4. Pelvic infections, sexually transmitted infections
 - 5. Pelvic surgery
 - 6. Medical history
 - 7. Medications (prescribed and over the counter)
 - 8. Occupational exposures-client and partner
- C. Physical Examination & Lab Testing (per delegate agency site Medical Director approved clinical protocols)

VI. REFERRAL

- A. Provided to individuals in the following categories:
 - 1. Women determined to have a medical condition which contraindicates pregnancy (i.e. severe diabetic vascular disease, ongoing substance abuse, etc.)
 - 2. Involuntary infertility after unprotected intercourse with same partner for 1 year or more in the absence of a known cause of infertility
 - 3. Individuals found to have congenital or acquired medical conditions
 - 4. Presence of known pre-existing male or female factors affecting fertility
- B. Referral sources
 - 1. Maintain a current list of infertility referral resources

2. Fees for referral services are the responsibility of the client
- C. Documentation
1. Documentation of the referral must be made in the client's medical record
 2. Education and counseling provided must be documented in the client's medical record.

REFERENCES

1. Hatcher RA et al. Contraceptive Technology. 19th Revised Edition. Ardent Media, Inc., New York, 2007
2. RESOLVE: The National Infertility Association <http://www.resolve.org/support-and-services>

PREGNANCY TESTING

I. INTRODUCTION

Early pregnancy testing has a number of benefits. A positive pregnancy test allows for early entry into prenatal services for those who wish to be pregnant or a discussion of options for those who do not wish to be pregnant. A negative pregnancy test provides the opportunity to discuss contraception for those who wish not to be pregnant or preconception counseling for those wishing to become pregnant.

A number of different pregnancy tests are available. The most common office pregnancy tests are urine immunometric assays that are specific for the Beta subunit of human chorionic gonadotropin (β -hCG). These tests provide accurate qualitative (positive or negative) test results for hCG levels from 5 to 50 mIU/mL. Most of these tests can detect pregnancy 7-10 days after conception and approximately 1 week before the next period is due. False-negative results can occur if the urine specimen is dilute or if the β -hCG level is too low to be detected by that specific test. False-positive results can occur due to product or laboratory error or due to a cross-reaction of hCG with luteinizing hormone.

Urine pregnancy tests do not quantitate the level of β -hCG present. The immunometric tests for urinary β -hCG are generally positive when the maternal serum levels of β -hCG are 25 mIU/mL or more.

After delivery or termination of pregnancy, β -hCG levels decrease slowly. A β -hCG level may be detected in the urine as long as 60 days (31-38 days usual range) after a first trimester abortion. As long as the β -hCG levels are dropping this should not cause concern.

High levels of β -hCG can confirm trophoblastic activity. These tests can detect concentrations of β -hCG as low as 5 mIU/mL. Serum β -hCG can be effective as an aid to diagnosing ectopic pregnancy, trophoblastic disease, impending abortion or possible retained placental fragments.

II. PLAN OF ACTION

- A. A urine pregnancy test should be performed upon the request of the client, when symptoms or physical findings suggest the possibility of pregnancy, and/or done in the process of monitoring certain contraceptive measures.
- B. The pregnancy test result and subsequent counseling should be documented in the family planning record and/or on a pregnancy test encounter form.
- C. The pregnancy test provides the “teachable moment”.
 1. Positive pregnancy test: desires to continue pregnancy
 - a. The client is encouraged to enter a prenatal care program within 2 weeks.

- b. The client should start taking a daily prenatal vitamin containing 0.4 mg of folic acid.
 - c. The client should be offered prenatal education to include the need for early prenatal care with emphasis on good health practices during pregnancy (e.g., good nutrition, avoidance of smoking, alcohol, drugs and exposure to other dangerous substances).
 - d. There needs to be a discussion of all medications and supplements the client is using.
 - e. The client needs to be assessed for supportive interventions and offered appropriate referrals to MCHIP, WIC, Healthy Start, DSS (adoption, foster care), genetic counseling, etc.
2. Positive pregnancy test: desires to terminate pregnancy
- a. The client needs to be referred to an appropriate health care facility/provider for termination options, details, timing, and costs.
 - b. The possibility of giving up the baby for adoption can be explored and resources and referrals made available.
 - c. The need for a timely decision about termination should be emphasized, along with encouraging a safer and healthier lifestyle in the meantime.
 - d. The need for effective contraception after pregnancy termination must be discussed.
3. Negative pregnancy test: desires pregnancy
- a. The client should be offered preconception counseling as outlined in this Family Planning Program Clinical Guidelines manual.
 - b. If infertility appears to be an issue, physician consultation and referral should be considered.
 - c. The client should start taking a daily multivitamin containing 0.4 mg of folic acid.
4. Negative pregnancy test: does not desire pregnancy
- a. If a missed period was the reason for the pregnancy test, offer the client a repeat urine pregnancy test in 2 weeks if there is still no menses.
 - b. If the need for contraception is immediate, offer the client one of the barrier methods of contraception.
 - c. Offer the client emergency contraception for any unprotected vaginal intercourse that occurred in the 120 hours prior to the current visit.
 - d. Offer advanced placement emergency contraception for future use.
 - e. Hormonal contraception may be offered if the client meets the criteria for the respective hormonal preparation being considered. No pelvic examination is required to begin the method.
 - f. Offer the client an appropriate family planning appointment or referral.

III. FOLLOW-UP

- A. A serum quantitative β -hCG should be considered if repeat urine pregnancy tests are negative in spite of evidence suggesting possible pregnancy.
- B. Follow-up appointments will depend on a client's contraceptive requirements, a client's menstrual history and clinical condition, and further need for pregnancy testing.

REFERENCES

1. Hatcher RA et al. Contraceptive Technology. 19th Revised Edition. Ardent Media, Inc., New York, 2007
2. Ziemann M , Hatcher RA, et al. A Pocket Guide to Managing Contraception. Bridging the Gap Foundation, Tiger, GA, 2007
3. ACOG. Precip: Obstetrics. 2nd Ed., 2000
4. Cunningham FG et al. Williams Obstetrics. 22nd Ed., McGraw-Hill, New York, 2005

REPRODUCTIVE LIFE PLAN (Preconception Counseling)

I. INTRODUCTION

A reproductive life plan is a set of personal goals about having or not having children and on the desired spacing between children. It also states how to achieve those goals. All clients need to make a reproductive life plan based on their own values, goals, and resources. Clients need to think about when and under what conditions they want to become pregnant. If they do not plan to have children, they need to think about how they will prevent pregnancy.

A reproductive life plan allows for planning for number and spacing of pregnancies and also for preconception counseling. Preconception counseling offers women an ideal time to plan their pregnancies and establish good health habits. Certain congenital anomalies and complications of pregnancy may be prevented if intervention occurs prior to conception. Fetal organogenesis occurs between 17-56 days after fertilization before many women have their first prenatal appointment or even realize they are pregnant. Promoting positive health behaviors and eliminating medical risks are most effective when initiated well before a woman becomes pregnant.

Since approximately 50% of all pregnancies are unintended, targeting only self-referred women who are planning their next conception will result in a significant number of missed opportunities for primary prevention. Counseling women of childbearing age allows for an identification of women with risk factors. As an example, we can educate women to avoid any teratogenic medications, get immunized to rubella, and take folic acid supplements to decrease their risk of neural tube defects. The active planning of pregnancy will maximize the benefits of appropriate interventions and adherence to good health habits to help insure a reduction of maternal and perinatal morbidity and mortality.

II. CLIENT SELECTION

A. Indications:

1. All females of childbearing age should be offered reproductive life planning/preconception education
2. All female clients of childbearing age should be assessed annually, targeting important issues in their personal and family history and educated on ways to obtain the best health possible to have a positive pregnancy outcome when they choose to become pregnant and to minimize modifiable risk factors. Planning a pregnancy affords the woman and her baby the healthiest and best start.
3. Those women who want to avoid or postpone pregnancy should receive appropriate counseling on contraceptive methods available and contraception initiation should be conducted as appropriate. Reproductive life plan/preconception care should be provided regardless of present desire to achieve pregnancy.

- B. Special emphasis related to preconception care should be provided when clients:
 - 1. Desire a pregnancy
 - 2. Have increased risks of pregnancy
 - 3. Are sexually active and:
 - a. Use no birth control
 - b. Use spermicidal agents only
 - c. Use any birth control method inconsistently
 - 4. Have previously experienced infant death, preterm delivery, and/or perinatal complications

III. MANAGEMENT OF WOMEN WITH SPECIAL CONDITIONS REQUIRING FURTHER EVALUATION

Referrals as indicated after reviewing history

IV. MEDICAL SCREENING AND EVALUATION

- A. Discuss client's plan for pregnancy as indicated depending on the type of visit: initial, annual, pregnancy testing or medical revisit.
- B. At clinic exam visits staff should:
 - 1. Review client's reproductive history: previous experiences with pregnancy, fertility, birth, and use of birth control
 - 2. Assess lifestyle, medical history and personal behaviors:
 - a. Activities of daily living: hours of sleep, physical activity
 - b. Medication use: prescription and over the counter
 - c. Tobacco use
 - d. Substance use: alcohol, drugs
 - e. Psychological concerns: depression, stress
 - f. Chronic health conditions: asthma, diabetes, heart, hypertension
 - g. Nutrition and diet issues: caloric intake, vitamin use, folic acid intake, anemia, eating disorders, obesity
 - h. Genetic disorders
 - i. Immunization status
 - j. Environmental exposures: solvents, radiation, lead, mercury, radon, nitrates at work or home
 - k. Family/partner involvement: social support
 - l. Intimate partner violence: domestic concerns
 - m. Health maintenance needs: screening tests as indicated
 - i. Pap smear,
 - ii. Sexually transmitted disease
 - iii. Urinalysis, blood tests,
 - n. Perform a physical exam; including a pelvic exam and a blood pressure check.
 - o. Based on the client's health and current presentation, suggest a course of action

V. CLIENT EDUCATION/COUNSELING

- A. Education should be provided on how to maintain and/or change lifestyle to promote a healthy reproductive life plan and positive pregnancy outcome in the future
- B. Education should be provided using a combination of written materials and/or verbal interaction related to health risks. Health promotion/disease prevention discussion topics may include:
 - 1. Smoking, Tobacco cessation:
Maryland's Quit Line 1-800-784-8664
<http://www.smokingstopshere.com/>
 - 2. Alcohol, Drug Use avoidance:
<http://www.marylandaa.org/>
 - 3. Nutritional intake recommendations:
www.mypyramid.gov
 - 4. Folic Acid intake recommendations:
www.cdc.gov/ncbddd/folicacid/index.html
 - 5. Ideal Body Weight recommendations:
www.cdc.gov/healthyweight/assessing/index.html
 - 6. Exercise recommendations:
www.cdc.gov/physicalactivity
 - 7. STI/HIV prevention:
www.cdc.gov/std/treatment/2010
 - 8. Genetic counseling:
<http://www.nsgc.org/tabid/69/Default.aspx>
 - 9. Vaccination recommendations:
www.cdc.gov/vaccines
 - 10. Gynecological exam recommendations:
ACOG Committee Opinion #483, "Primary and Preventive Care: Periodic Assessments," in the April 2011 issue of *Obstetrics & Gynecology*.
 - 11. Self-breast awareness recommendations:
www.cancer.org
 - 12. Birth control options available:
<http://www.womenshealth.gov/publications/our-publications/fact-sheet/birth-control-methods.cfm>
 - 13. Early prenatal care and education (stress importance of)
 - 14. Domestic violence prevention:
www.endabuse.org/health
 - 15. Additional preconception informational web sites:
 - a. <http://www.arhp.org/publications-and-resources/clinical-fact-sheets/folate>
 - b. http://www.ghi.com/pdf/reproductive_life_plan_2008-02.pdf
 - c. <http://www.cdc.gov/ncbddd/preconception/QandA.html>

VI. MANAGEMENT

- A. Assess the client's need for referrals
- B. Encourage the client to examine potential risks and make positive changes
- C. Encourage early prenatal care when pregnancy occurs

VII. FOLLOW-UP

- A. Follow-up on any referrals made
- B. Review client's Reproductive Life Plan on return visits.

VII. DOCUMENTATION

Reproductive Life Plan and Pre-conception counseling/education should be documented in the medical record.

REFERENCES

1. U.S. Department of Health and Human Services, Office of Women's Health
Health <http://www.womenshealth.gov/pregnancy/before-you-get-pregnant/preconception-health.cfm>
2. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention <http://www.cdc.gov/ncbddd/preconception/QandA.htm>