Azienda Sanitaria Regionale Molise
ASREM
REGIONE MOLISE

Healthcare and Health

Pregnancy

Agenda

Mrs

_____

IF IT IS LOST, RETURN TO:

_____

Summary

PREGNANCY AGENDA... NICE TO MEET YOU

Dear Madam, the birth of a child is an opportunity for great change and growth, for the woman and for the couple[1].

Molise Region Health Service has thought of and designed me to accompany you during your "Birth Care Pathway"[2], to provide you with correct, complete and objective information to face your pregnancy and the birth event with serenity.

My objective is to provide you with a collaboration and communication tool between you and the professionals you will meet as part of the "Birth Care Pathway", in order to facilitate appropriate and informed choices and promote the health of the mother and child to improve the quality of care

Scientific evidence highlights how recording the events of the various stages of pregnancy in a single document (which the woman brings with her to every visit and which the professional gynecologist and obstetrician scrupulously update), allows us to provide better assistance and results in terms of health, both for the mother and the newborn.
I make clinical files available to record the progress of the pregnancy, the tests to be performed, information and advice.
The relevant service or professional will add indications and suggestions on additional or specialist assistance for the woman.
I also provide you with the references of the services of the Regional Health Service (consultants, general practitioners, specialist clinics, analysis laboratories, ultrasound services, birth centers) available to pregnant women to create an accessible birth care pathway that respects your personal choices.

I therefore present myself as:

- **a personal document** on which to report the data of the woman and her pregnancy;
- **a binder** that allows the woman and public or private operators to have (and share) orderly documentation and data on the woman and her unborn child, i.e. a wealth of information necessary for appropriate and personalized assistance.

  All personal data included in the Agenda or communicated to operators during meetings/interviews are protected by the Privacy Law currently in force and are part of the woman/midwife-doctor relationship;
- **an information tool** that indicates to the woman the stages of the birth process and provides her with the necessary information for the promotion of her health, helping her to choose among the various care models proposed regarding the physiology of pregnancy, childbirth, the puerperium, prenatal courses accompanying birth, integrated with any reports of specialist consultations, hospital admissions, visits to the emergency room, laboratory and diagnostic tests.

  Informed consent[3] qualifies every medical act.

[1] below, the term "**pregnant woman**" will include both the individual woman and the couple of parents
[2] the "**Birth Care Pathway**" is the set of services offered by the Molise Region to promote the health of women and children and to provide adequate assistance during pregnancy, labour, childbirth and subsequently during breastfeeding and the puerperium.
[3] **Informed consent** is the declaration of the person who, having received information on his health situation and on possible investigations and/or therapeutic interventions, having understood the risks and advantages, consents to the proposed treatment. Through informed consent, collaboration between the woman and the operators is made formal and official.

Inside you will find:

- ❖ the "**pregnancy diary**", designed as a guide which, term after term, illustrates the assistance offered to you;
- ❖ the "**pregnancy sheets or health reports**" in which the health professionals who monitors your pregnancy describes its progress;
- ❖ "**information sheets**", each dedicated to a specific theme (lifestyle, support during labour, breastfeeding, etc...) to help you to find the answers to the most common doubts during pregnancy and in the first days after birth more easily. The service or your health professional will add what is necessary, possibly giving you other brochures, if you need further assistance.

How to use the pregnancy agenda

This "Pregnancy Agenda" is distributed to all pregnant women in family counseling centers and public clinics located in the Districts and U.O. (Organizational Unit) of Gynecology and Obstetrics of the Region. Women assisted privately will be able to collect a copy from the family counseling center in their district of residence.

Every woman will carefully read, use and keep her own Diary and will be able to:

- consult it for information: on the physiology of pregnancy, on prenatal courses, on childbirth and on the puerperium;
- fill it in with her data and preferences regarding the possible choices;
- take it to appointments with health professionals and to the Birth Center where she will give birth;

The healthcare providers (public or private) that the woman has chosen for her pregnancy will take care of:

- filling it in and updating it during appointments;
- integrating it with any reports of specialist consultations, hospital admissions, visits to the emergency room, laboratory tests
- enriching it with messages of education, health promotion and prevention.

The Birth Care Pathway

Women will be able to choose whether to undertake their care pathway through the *Consultorio,* the Italian Public Health Centre (where there are a Midwife and a Gynecologist) or through a Gynecologist at a public or private clinic.

The gynecologist/obstetrician, the General Practitioner (GP), the clinics and other local centres constitute **the integrated healthcare network for pregnant women.**

Pregnant women will be assisted in such local Centres until their 37th week and, after that, they will be referred to a *Punto Nascita or Birth Centres* (the Italian Maternity wards) in the Regional Hospital Centers[1].

Access to **the local healthcare network does** not require a referral from your doctor and the premises are located in:

- ➢ Campobasso
- ➢ Bojano
- ➢ Isernia

[1] Both high and low risk pregnant patients who choose to be assisted at a private clinic will always be granted access to the services provided by the local consultancy network and any other public service.

- Termoli
- Larino

The *Consultorio* in Campobasso and Bojano have the “Cardarelli” hospital facility as their reference hospital, the *Consultorio* in Isernia has the “Veneziale” hospital as their reference hospital, while the *Consultorio* in Termoli and Larino have the “San Timoteo” hospital in Termoli as their reference hospital.

With a view to implementing Italian Ministerial Decree 71 (which provides for one *Consultorio* every 20,000 inhabitants; and one every 10,000 inhabitants for internal and rural areas), additional Public Health Centres (*Consultori*) may be established at *Casa della Salute* in Riccia and at *Casa della Salute* in Trivento.

The same may be envisaged for *Casa della Salute* in Frosolone, Venafro, Agnone and Montenero di Bisaccia.

The regional Punti Nascita (Birth Centres) are the Hospital Facilities:

- “Cardarelli” of Campobasso;
- “Veneziale” of Isernia;
- “San Timoteo” of Termoli

in these facilities there are clinics for full-term pregnancy (from the 37th - 41st week +0 days) and pregnancies beyond the term.
"At-risk or pathological pregnancies" (see infra sub "Pregnancy diary") must be referred only to the Campobasso Hospital, which has a Complex Operational Unit (the Italian *UOC – Unità Operativa Complessa*) of Gynecology and Obstetrics and where a specific clinic will be established.
At the Campobasso Hospital there is also a high-risk pregnancy clinic for invasive prenatal diagnosis (amniocentesis).

Access to *Punti Nascita* does not require a referral from your GP.

THE PREGNANCY DIARY

The **"pregnancy diary" is the set of services offered** to promote the health of women and children and to provide adequate assistance during pregnancy, labour, childbirth and subsequently during breastfeeding and the puerperium.

The basic services, divided into quarters, are those indicated in the national Physiological Pregnancy Guidelines. (SNLG 2023 Pregnancy-physiological available on the website of the Istituto Superiore di Sanità www.iss.it)
The first appointment generally lasts longer than the subsequent ones because it is necessary to collect information on the health of the woman, her partner and her family; it is also an opportunity to receive information on assistance and support during pregnancy, on legal rights that protect maternity and paternity, on antenatal courses, on lifestyle and on how to manage the most common symptoms (see relevant information sheets).

During the first visit, it is advisable to bring with you all the tests already carried out, in particular the documentation regarding the blood group, the vaccination certificate, previous illnesses, previous gynecological visits, pap-test results (particularly the latest one), everything that is believed to be useful in relation to the health of the mother and baby.

It is also advisable that any additional information deemed important is discussed with the gynecologist/obstetrician.
It may be useful for the woman to write down in advance the questions that she would like to ask or doubts to clarify during the interview with the obstetrician/gynecologist.

The state of health of the woman influences the progress of pregnancy.

*A **healthy woman**, not a carrier of chronic diseases, who does not take medicines or drugs, has a high probability of having a normal pregnancy, childbirth and post-birth, and of giving birth to a healthy newborn. Depending on the risk elements or pathologies present, the routes to be included in the Agenda may vary. These paths may sometimes require highly specialized skills in maternal and/or fetal diseases available only in some highly specialized structures.*

*In a **physiological** pregnancy, a health assessment every 4/6 weeks is useful, while for pregnancies with **complications** a greater number of meetings may be necessary. In any case, it is recommended that the woman be followed continuously and throughout the pregnancy by the same professional or small group of professionals.*

During each appointment, a health report will be produced:

- Obstetric visit. Vaginal exploration is carried out at the first meeting and whenever the need arises;
- Weight measurement. It is an indicator of correct nutrition and lifestyle and is carried out routinely at every check-up. It is used in conjunction with height to assess body mass index (BMI).
- Blood pressure tests. Useful test to diagnose any hypertension (high blood pressure) pre-existing pregnancy;
- Assessment of the recommended tests and prescription of subsequent ones;
- Auscultation of the fetal heartbeat (after the 12th week);
- Ultrasound scan (in some cases) only as a clinical support tool;
- *assessment of the couple's mental and emotionall well-being. Information is offered on local services/associations where you can find support and help (see information sheet "Mental and physical wellbeing"). You receive information on Birth Support courses (see information sheet) and we start talking about labour and birth (see information sheet on "Physiology of labour and birth").*

Pregnancy and vaccinations

*Between October and December every year, **the anti-flu vaccination** is offered free of charge by the Italian Health Service (see information sheet "Vaccinations and pregnancy"); furthermore, during the second trimester, **anti-Covid-19** vaccination with mRNA vaccine is offered. This vaccine is particularly recommended for pregnant women with risk factors for developing serious forms of Covid-19 or for those who, due to their work or personal needs, have a high risk of coming into contact with the coronavirus (see information sheet " Covid-19: vaccination during pregnancy").*

Finally, between the 28th and 32nd week of gestation, the whooping cough vaccine is offered (see information sheet "vaccinations and pregnancy").

Recommended tests and checks in the 1ST TRIMESTER in detail

(up to the 12th week + 6 days)

The World Health Organization recommends that the first meeting take place at least within the third month of pregnancy to easily plan the appropriate clinical checks and plan pregnancy care in the best way.
In particular**, an appointment by the 10th week** is useful for receiving information in case you want to carry out *screening tests and/or prenatal diagnosis* (see information sheet *"Ultrasound and prenatal diagnosis")* and is recommended to all women with undergoing illnesses and/or who regularly take medications.

BLOOD TESTS

***Blood type - RH factor**. Recommended in the 1st trimester, it is useful for detecting RH negative women.*
Indirect Coombs test. Important in monitoring RH negative pregnant women. Recommended to all the women during the first visit and subsequently repeated in the 3rd trimester.
Blood count. It is the only valid test for screening anemia during pregnancy. It is required every trimester.
Glycaemia. Used to detect pre-existing diabetes during pregnancy. It is recommended on the first visit.
Transaminase. Only in the 1st trimester, it is used to identify women to whom the hepatitis C test should be offered.
Abnormal hemoglobin's. The test is offered to all women in the 1st trimester of pregnancy if not carried out before pregnancy: it allows the identification of healthy carriers of the Mediterranean anemia and other forms of anemia.

TESTS FOR INFECTIOUS DISEASES

HIV. It is routinely offered in the 1st and 3rd trimesters because the effectiveness of treatment with antiviral drugs in HIV-positive pregnant women has been demonstrated.

Rubeo-Test (Rubella). Routinely recommended in the 1st trimester, it should be repeated in the 2nd trimester if the first test is negative (see information sheet "Vaccinations and pregnancy").

Toxo-Test (Toxoplasmosis). Recommended in the 1st trimester and to be repeated every 40 - 60 days in case of seronegativity. In this case, useful habits to prevent infection will be recommended (see information sheet on "Lifestyle during pregnancy").

Cytomegalovirus-Test is NOT routinely offered, but is recommended. If negative at the first determination, it must be repeated monthly, up to the 24th week of gestation. It is important to follow prevention measures to limit the risk of infection during pregnancy (see information sheet on "Lifestyles").

Test for Syphilis. It is recommended in the 1st trimester and to be repeated in the 3rd trimester. Maternal infection can be treated with specific antibiotic therapy, also valid for preventing transmission from mother to fetus.

Test for HCV (hepatitis C). The test is offered in the 1st trimester to women who have risk factors (patients undergoing hemodialysis, those who live with people with hepatitis C, those who have used injectable drugs, etc.).

URINALYSIS

Useful for the diagnosis of some pre-pregnancy diseases, for the diagnosis of urinary infections during pregnancy and for detecting the possible presence of proteins in the urine. It is recommended every trimester.

***Urine culture**. The test is proposed to verify the presence of a high bacterial rate in the urine (bacteriuria) which sometimes does not cause any symptoms. Asymptomatic bacteriuria is normally not worrying, but during pregnancy it must be identified in order to start treatment.*

***Testing for sexually transmitted diseases (chlamydia, gonorrhea).** The test is offered to women with risk factors (those who have had unprotected sexual intercourse with multiple partners, those who have been sexually assaulted, those who have a history of prostitution, those who have abused alcohol and drugs, etc.). In case of a positive result, antibiotic therapy must be started immediately to prevent the infection from passing to the baby during birth.*

OBSTETRIC ULTRASOUND SCAN / SCREENING ULTRASOUND SCAN

*The ultrasound scan in the 1st trimester has the aim of dating the pregnancy with certainty and verifying whether it is a twin pregnancy (*see information sheet *"Ultrasound and prenatal diagnosis").*
*The screening ultrasound, which is carried out between the 11th and 13th week, includes in particular the measurement of **nuchal translucency** to provide an estimate of the risk that the fetus is affected by Down syndrome and\or congenital anomalies (*see information sheet *"Ultrasound and prenatal diagnosis").*

PAP TEST – HPV DNA TEST

The following are proposed for the early diagnosis of cervical cancer:

- *the PAP test for women between 25 and 29 years old who have not had it performed in the last 3 years;*
- *the HPV test for women aged 30 or over who have not had it done in the last 5 years.*

Performing these tests during pregnancy does not pose a risk of miscarriage or other complications

Recommended tests and checks in the 2ND TRIMESTER in detail

(from the 13th week + 0 days to the 27th week + 6 days)

In this trimester, during the appointments the doctor or midwife evaluates test results, answers questions and clarifies doubts.
Weight and blood pressure are checked, fetal growth is assessed, the blood tests prescribed in the previous appointment are checked, the test for rubella and toxoplasmosis is repeated in non-immune subjects and in case there are risk factors for diabetes the oral glucose tolerance test (OGTT) is programmed.
An ultrasound commonly called Morphological ultrasound is proposed to be performed between the 19th and 21st week, for the diagnosis of any fetal anomalies.
The woman is informed about the pertussis vaccination (whooping cough) to be carried out in the following trimester (see sheet), the flu vaccination (in the period October-December) and the Covid 19 vaccine in women at risk (see sheet).
We inform you about prenatal courses, evaluate your mental and physical well-being and start talking about labour and birth (See sheet on expressing your preferences upon delivery)

BLOOD TESTS

Blood count. It is the only valid screening test for anemia during pregnancy. It is required every trimester.
OGTT. This test is offered to women who are at risk of developing gestational diabetes based on any risk factors (obesity or overweight, gestational diabetes in a previous pregnancy, family history of diabetes, age over 35 years, being from countries in the South Asia, in particular India, Bangladesh, Pakistan, the Caribbean, the Middle East). During the test, blood sugar level is initially checked with a blood sample taken while you are on an empty stomach. You are then invited to drink a glass of water in which a significant quantity of sugar is dissolved. Blood sugar level is then checked again after 60 and 120 minutes. Overall the test lasts approximately 2 hours.

TESTS FOR INFECTIOUS DISEASES
Rubeo-Test (Rubella). To be repeated in the 2nd trimester in case of a previous negative result (see also *"Recommended tests and checks in the 1st trimester").*
Toxo-Test (Toxoplasmosis). See "*Recommended tests and checks in the 1st trimester".*
CMV test (Cytomegalovirus) See *"Recommended tests and checks in the 1st trimester".*

URINALYSIS
Useful for the diagnosis of urinary infections during pregnancy and for detecting the possible presence of proteins in the urine. It is recommended every trimester.

MORPHOLOGICAL OBSTETRIC ULTRASOUND SCAN
The morphological ultrasound scan is carried out between the 19th and 21st week and serves to diagnose the possible presence of some congenital malformations of the fetus, to evaluate its growth, to evaluate any anomalies in the quantity of amniotic fluid (see information sheet "*Ultrasound scans and prenatal diagnosis")*

FUND-SYMPHYSIS MEASUREMENT

This is a check to verify that fetus is growing regularly. It is carried out by measuring the distance between the bottom of the uterus (i.e. the upper limit of the belly) and the pubic symphysis (i.e. the lowest point of the belly) with a tape measure, i.e. a common tape measure.

Recommended tests and checks in the 3rd TRIMESTER in detail

(from the 28th week + 0 days left)

During your appointments, the doctor or midwife answers your questions and clarifies any doubts. Blood pressure and maternal weight gain are checked and attention is paid to the mental and physical well-being of the woman/couple. Test results are evaluated and the assistance proposed in the last months of pregnancy is illustrated.
Contacts with the hospital chosen to give birth are planned around the 34th week; you receive information on postpartum care, on recommended tests after birth, on breastfeeding and newborn care (see related information sheets on page 69).
Between the 32nd and the 34th week, the fetus's right position for birth (cephalic presentation) is verified.
Around the 36th-37th week, your pregnancy history is examined at the birth center of your choice, based on what is reported in the diary, on mother and baby's health, on any risk factors for the birth itself, on test results recorded during pregnancy (in particular those performed between the 33rd and the 37th week). The hospital medical record is prepared and the woman is informed about the fetal well-being monitoring program. If the situation requires a cesarean section, the blood tests and anesthetic visit are required and will be carried out at the hospital that you have chosen for giving birth.
In pregnancies that go beyond the 41st week (as well as in those in which specific clinical indications arise), cardiotocographic monitoring (tracing to evaluate fetal well-being) and ultrasound scan evaluation of the quantity of amniotic fluid (AFI) are required. In the event that, in the aforementioned gestational period, labour does not start spontaneously, induction of labour is necessary and can take place through various methods (drugs, special devices or instrumental rupture of the membranes).

BLOOD TESTS
Indirect Coombs test*. Recommended to all the women during the first appointment and in the 3rd trimester (28 weeks).*
Blood count*. It is the only valid screening test for anemia during pregnancy. It is required every trimester.*

TESTS FOR INFECTIOUS DISEASES
HIV*. It is generally offered in the 1st and 3rd trimesters because the effectiveness of treatment with antiviral drugs in HIV-positive pregnant women has been demonstrated.*
Toxo-Test (Toxoplasmosis). *See "Recommended tests and checks in the 1st trimester".*

Test for Syphilis. *It is generally recommended in the 1st trimester and is repeated in the 3rd trimester. Maternal infection can be treated with specific antibiotic therapy, also valid for preventing transmission from mother to fetus.*
Hepatitis B*. It is recommended in the 3rd trimester. If the mother tests positive, there are effective therapies to prevent transmission of the infection to the child.*
CMV test (Cytomegalovirus) *See "Recommended tests and checks in the 1st trimester".*

URINALYSIS

Useful for the diagnosis of urinary infections during pregnancy and for detecting the possible presence of proteins in the urine. It is recommended every trimester.

AN-RH(D) IMMUNOPROPHYLAXIS

This therapy is routinely offered to all RH negative women at 28 weeks with a negative Coombs test.

VAGINAL-RECTAL swab

It is used to identify a group B beta-hemolytic streptococcus infection: it is offered to all women after 36 weeks.
For women who test positive, the doctor will offer antibiotic treatment during labour.

FUND-SYMPHYSIS MEASUREMENT *See "Recommended tests and checks in the 2nd trimester"*

Azienda Sanitaria Regionale Molise

ASREM

ATTESTATO DI GRAVIDANZA

La signora

_____

nata a _____

il _____

Residente a _____

Via_____

è attualmente alla _____ settimana di gravidanza

data dichiarata ultima mestruazione data presunta parto _____

Gravidanza diagnosticata con:

Test immunologico effettuato in data _____

Esame clinico effettuato in data _____

Esame ecografico effettuato in data _____

Data Firma e timbro del medico attestante

_____ _____

L'elenco e la descrizione delle prestazioni dell'INPS (Istituto Nazionale Previdenza Sociale) per la maternità possono essere trovate, nella formulazione più aggiornata, sul sito Inps (www.inps.it).

Dalla prima pagina del sito è possibile:

avere il numero telefonico 803164 che fornisce informazioni in otto lingue (il servizio è gratuito);

inserendo la parola "maternità" nello spazio per la ricerca, compariranno le prestazioni INPS per la maternità/paternità (indennità di maternità, assegno di maternità, indennità di paternità, ecc.);

- dalla sezione MODULI (sull'intestazione sempre della prima pagina) inserendo ancora la parola "maternità" si accede ali moduli che possono essere scaricati e compilati (domanda di congedo per maternità delle lavoratrici dipendenti, autocertificazione relativa ai periodi di maternità e malattia, domanda di assegno di maternità dello Stato – per gli aventi diritto, ecc.).

THE CLINICAL DIARY: PREGNANCY PROFILE AND HEALTH RECORDS

Health assessment is the result of the appointments between the woman and the health professional who takes care of the pregnancy and describes its progress.
The first pages of this clinical diary include the anamnestic forms that have to be completed by your healthcare professional in Italian. For relevant points, the English translation is provided in brackets.
You will be asked some questions aimed at assessing your health and how it may influence the health of your child. Any additional information you feel is important should be discussed with your gynecologist/obstetrician.

Below are the individual cards:

- REFERENCES FOR YOUR BIRTH CARE PATHWAY;
- CALENDAR OF APPOINTMENTS;
- PREGNANCY SHEET: early pregnancy - first appointment;
- CRITERIA FOR ASSIGNING APPROPRIATE HEALTHCARE PROFILE;
- TABLE OF TESTS;
- ULTRASOUND SCAN REPORTS (1st, 2nd and 3rd TRIMESTERS);
- BIRTH SUPPORT COURSE SHEET;
- HEALTH RECORDS – CLINICAL DIARY (with fetal growth assessment);
- PRENATAL SCREENING (with related informed consent forms);
- HIV TEST - INFORMATION FOR CONSENT TO PERFORMANCE;
  REFERRAL FORM FROM THE TERRITORIAL SERVICE TO THE BIRTH CENTRE;
- YOUR PREFERENCES FOR BIRTH;
- HOSPITAL DISCHARGE FORM;
- MEMBERSHIP TO THE LOCAL AND PUERPERICAL ASSISTANCE PROGRAMME;
- HEALTH BUDGET FOR PUERPERY CARE.

RIFERIMENTI PER IL VOSTRO PERCORSO NASCITA
(REFERENCES FOR YOUR BIRTH CARE PATHWAY)

Professionista che segue la gravidanza *Healthcare professional who takes care of your pregnancy* ☐ **ostetrico** *(obstetrician)* ☐ **ginecologo** *(gynecologist)*	
Cognome *(Surname)*	**Nome** *(Name)*
Indirizzo *(Address)*	
Tel. Fisso *(Work phone no.)*	**Cellulare** *(mobile phone no)*
Orari *(working hours)*	
Medico Di Medicina Generale *(General Physician)*	
Cognome *(Surname)*	**Nome** *(Name)*
Indirizzo *(Address)*	
Tel. Fisso *(Work phone no.)*	**Cellulare** *(mobile phone no.)*
Orari *(working hours)*	
E' In Carico A Specialisti? Per Quale Patologia? *(Are you being treated by any other healthcare professionals? What health issue are you being treated for?)*	
Patologia *(Health issue)*	
Dott./Dott.ssa *(Dr.)*	**Recapito** *(Contact details)*
Patologia *(Health issue)*	
Dott./Dott.ssa *(Dr.)*	**Recapito** *(Contact details)*
Riferimenti In Caso Di Emergenza *(Contacts in case of an emergency)*	
Ospedale *(Hospital)*	
Reparto/ Pronto Soccorso *(Ward/ ER Dept.)*	
Telefono *(phone no.)*	
Punto Nascita Previsto Per Il Parto *(Birth Centre chosen for delivery)*	
Ospedale *(Hospital)*	
Reparto *(Ward)*	
Telefono *(Phone no.)*	

CALENDARIO DEGLI APPUNTAMENTI (Calendar of appointments)

ESAMI/VISITE *(visits/checks)*	**TRIMESTRE** *(trimester)*	**DATA** *(date)*
DIAGNOSI PRENATALE	I TRIMESTRE *(1st trimester)*	
VISITE *(visits)*	I TRIMESTRE *(1st trimester)*	
	II TRIMESTRE *(2st trimester)*	
	III TRIMESTRE *(3rd trimester)*	
ECOGRAFIE *(ultrasound scans)*	I TRIMESTRE *(1st trimester)*	
	II TRIMESTRE *(2st trimester)*	
	III TRIMESTRE *(3rd trimester)*	
AMBULATORIO GRAVIDANZA A TERMINE *(checks for full-term pregnancy)*	III TRIMESTRE *(3rd trimester)*	
PUERPERIO *(Puerperium)*	POST PARTUM *(Postnatal checks)*	

SCHEDA DELLA GRAVIDANZA: inizio gravidanza - primo incontro

(Pregnancy data sheet: the beginning of your pregnancy – First appointment)

Nome e Cognome _____

Indirizzo _____

Telefono _____

Data di nascita _____ Nata a _____

Anni _____ Stato civile _____

Cittadinanza _____

Professione _____

Titolo di studio _____

Codice Fiscale _____

Se straniera:

Anno di ingresso in Italia _____

Necessita di mediazione **sì** **no**

Conoscenza dei diritti in gravidanza **sì** **no**

Coniuge – partner

Nome e Cognome _____

Gruppo sanguigno _____ Fattore RH _____

età _____

Professione _____

Titolo di studio _____

Rilievi anamnestici (familiarità per malattie genetiche, etc..) _____

_____

_____

_____

Situazione abitativa

Coabita con:

Partner **sì** **no** Altri adulti **sì** **no**

Minori **sì** **no** In carico ai servizi sociali **sì** **no**

Note _____

_____

Anamnesi familiare

Malattie generiche **sì** **no** Ipertensione **sì** **no** Diabete

sì **no** Trombofilia sì no Tireopatie -

Endocrinopatie **sì no**

Altro_____

Anamnesi Personale

Peso_____Altezza_____BMI _____

Gruppo Sanguigno_____

Alimentazione _____

Patologie di rilievo _____

Interventi chirurgici _____

Malattie genetiche_____

Emoglobinopatie _____

Allergie _____

Terapie in corso _____

N. sigarette/die (prima della gravidanza) _____

N. sigarette/die (durante la gravidanza) _____

Alcool **sì** **no** Sostanze stupefacenti **sì** **no**

Anamnesi Ostetrico-Ginecologica

Ultima mestruazione: **Data presunta del parto:** **Peso iniziale:** **BMI:**

Ridatazione ecografica _____ ***Data presunta del parto ecografica*** _____

Cicli regolari **sì** **no** Ultimo PAP TEST _____

Patologie ginecologiche _____

Chirurgia collo dell'utero _____

Chirurgia utero-annessi _____

ANNO	*PARTO EUTOCICO*	*PARTO DISTOCICO*	*T.C.*	*ABORTI*	*IVG*	*PESO NEONATO*	*FIGLI VIVENTI*	*PARTO IN ANALGESIA*	*ALLATTAMENTO*

Note _____

_____

_____

CRITERI ATTRIBUZIONE PROFILO ASSISTENZIALE APPROPRIATO

(Parameters to assign an adequate healthcare profile)

DATA / /

nome e cognome paziente_____

nome e cognome medic*_____

nome e cognome ostetric*_____

Principali fattori di rischio materno/ fetale (da rivalutare ad ogni visita e al ricovero)			
Fattori sociali		1	Eta <16>35 >40* (>RT)
		2	Malnutrizione BMI <18; Obesità BMI >30; BMI > 35* (>RT) BMI = Kg/m2
		3	PMA (procreazione medico assistita) *
		4	Svantaggio sociale/Violenza di genere/ mutilazioni genitali femminili
		5	Scarsi o ritardati controlli in gravidanza
		6	Esposizione a raggi e farmaci nell'attuale gravidanza
		7	Abuso di tabacco
		8	Abuso di alcool (sindrome alcolica fetale/malformazioni congenite)
		9	Uso di droghe (cocaina eroina e metadone, morfina)
Malattie preesistenti alla gravidanza		10	Malattie cardiache (congenite, ischemiche, valvolari) e relativo rischio
		11	Ipertensione/ preclampsia in precedenza
		12	Malattie respiratorie (asma severo, fibrosi cistica)
		13	Malattie renali (insufficienza renale acuta o cronica)
		14	Alterazioni endocrino-dismetaboliche o diabete compensato/scompensato
		15	Malattie neurologiche (sclerosi multipla, epilessia)
		16	Malattie muscolo scheletriche (scoliosi, traumi al bacino)
		17	Attuali o pregressi accidenti cerebrovascolari
		18	Malattie ematologiche (trombocitopenia, trombofilia) (>RT) Isoimmunizzazione M-F**
		19	Trapianto d'organo
		20	Malattia autoimmuni (>RT) Malattie reumatiche
		21	Malattie psichiatriche trattate con farmaci
		22	Malattie infettive (influenza, sifilide, HIV, HCB, HBV, MST, TORCH, Streptococco, TBC)
		23	Epatopatie attive (steatosi, insufficienza epatica lieve, media, grave)
		24	Infezioni urinarie- cistiti ricorrenti – calcolosi renale
		25	Tumori maligni
		26	Pregressa tromboembolia
		27	Malformazioni uterine/metroplastiche
		28	Miomi
		29	Aborto abituale (>3)
		30	Parità
		31	Malattie ereditarie in famiglia (anche partner)
Altri fattori di rischio della gravidanza attuale		32	Diabete gestazionale
		33	Preeclampsia/eclampsia/HELLP
		34	Precedente EPP/Trasfusioni/rischio rifiuto trasfusionale
		35	Colestasi gravidica/Atrofia giallo acuta del fegato
		36	Taglia cesareo pregresso
		37	Pregressa chirurgia addomino pelvica

		38	Metrorragie (1-2-3 Trimestre)
		39	Placenta previa
		40	Rischio placentazione (previa con pregresso TC/ accreta/percreta/increta)
		41	Altra patologia
Rischio fetale		**42**	Rischio fetale individuato dai test di screening
		43	Morte fetale o perinatale/aborto tardivo/parto pretermine (>23 e <34 settimana)
		44	Pregresso nato con basso peso alla nascita (lbsettimana) e ricoverato in TIN
		45	Diagnosi prenatale invasiva/cerchiaggio
		46	Rilievi ecografici anomali (strutturali fetali/anomalie genetiche)
		47	Gravidanze gemellari monocoriali mono-bi-amniotiche
		48	Anemia emoglobinopatie (1* e 3* TRIM. HB < 11,0/ 2 * Trim. HB <10, 5)
		49	Difetto di crescita accertato o sospsetto /Macrosomia fetale
		50	Presentazione anomala alla 32esima settimana
		51	Oligo-Polidramnios-Anidramnios

Gravidanza a basso rischio: assenza di patologie e di condizioni di rischio

Gravidanza a medio rischio: presenza di uno o più fattori di rischio (escludono la valutazione ostetrica e richiedono la valutazione del medico ginecologico)

Gravidanza a medio/alto rischio: patologia e/o quadro clinico in trattamento che necessita di una valutazione multidisciplinare

Gravidanza ad alto rischio (GAR I livello): presenza di una o + patologie e condizioni di rischio******. Richiedono gestione multidisciplinare in centri ad elevata complessità assistenziale

Gravidanza ad alto rischio (GAR II livello): presenza di una o + patologie e condizioni di rischio******* (rischio placentazione: previa con pregresso TC/accreta/percreta/increta) richiedono il trasferimento in strutture di II livello e conpresenza di radiologia interventistica

Rischio: basso medio medio/alto alto

Condizioni cliniche che giustificano l'assegnazione alla classe di rischio _____

_____

Livello assistenziale assegnato:

☐ ambulatorio generale di gravidanza/consultorio

☐ GAR I Livello ☐ GAR II livello

☐ Punto nascita I Livello ☐ Punto nascita II livello

☐ Altro _____

Firma del Medic* _____

Firma dell'ostetric* _____

TABELLA DEGLI ESAMI (SUMMARY OF RECOMMENDED TESTS)

Le caselle COLORATE Indicano le settimane in cui si raccomanda l'esecuzione dell'esame. *(The COLOURED boxes give an indication on the weeks during which each test is recommended.)*
La presenza di asterischi rinvia alle condizioni – esplicitate in calce – in presenza delle quali si raccomanda l'esecuzione dell'esame. (*Asterisks refer to the conditions explained at the bottom for which the test is recommended).*

Esami da eseguire *(recommended tests)*	**Preconcepimento o entro la 13° settimana** *(before conception or by 13th week)*	**Settimane di gravidanza** *(weeks of pregnancy)*					
		14-18	19-23	24-28	29-32	33-37	38-41
Gruppo sanguigni AB0 e Rh							
Coombs indiretto		*	*	**	*	*	*
HIV							
Rubeo-test	immune SI- ☐ NO ☐	**					
Toxo test	immune SI- ☐ NO ☐	**	**	**	**	**	
CMV test	immune SI- ☐ NO ☐	**	**	**			
ALT/AST							
VDRL/TPHA							
HBsAg							
HCV	***						
Emocromo							
Elettroforesi Hb							
Ferritinemia							
Glicemia		rischio diabete ☐ SI ☐ NO se SI OGTT		rischio diabete ☐ SI ☐ NO se SI OGTT			
Esame urine							
Urinocoltura							

(*) da eseguire mensilmente se RH negativo *(recommended monthly if RH is negative)* **(**) da** eseguire solo se NON *immune (ONLY recommended if you are NOT immune)*

ESAMI DA ESEGUIRE *(recommended tests)*	PRECONCEPIMENTO O ENTRO 13 SETT. *(before conception or by 13 week)*	**SETTIMANE DI GRAVIDANZA** *(weeks of pregnancy)*					
		14 – 18	19 – 21	22 – 27	28 – 32	33 – 37	38 – 41
Ecografia	(impegnativa codice 88.78)		(impegnativa codice 88.78)		(impegnativa codice 88.78)		
Screening biochimico	tra l'11° e la 13° sett.						
Tampone vagino-rettale per strepto B							
Tampone per Chlamydia e gonococco	***						
Pap – Test – HPVB test	***						

(***) da eseguire solo in presenza di fattori di rischio da LG nazionali Gravidanza Fisiologica (ONLY recommended in case of risk factors as per national Guidelines for a Physiological Pregnancy)

(****) se non eseguito nei tre anni precedenti *(if not done in the past 3 years)*

ESAMI PADRE (recommended tests for the father)

ESAMI DA ESEGUIRE *(recommended tests)*	**PRECONCEPIMENTO O ENTRO 13 SETT.** *(before conception or by 13 week)*	**SETTIMANE DI GRAVIDANZA** *(weeks of pregnancy)*					
		14 - 18	**19 – 23**	**24 – 28**	**29 - 32**	**33 - 37**	**38 - 41**
HIV							
Emocromo e assetto emoglobinico							
VDR/TPHA							

ECOGRAFIA DEL I TRIMESTRE DI GRAVIDANZA

(1st trimester ultrasound scan)

Cognome e nome …… Data di nascita…… UM ……

Epoca gestazionale dall'UM: _____sett. + ___gg; D.P.P. UM:_____

Epoca gestazionale ecografica: _____ sett.+___gg; DPP-ecografica:_____

Indicazione: Esame ecografico di screening del II trimestre.

Informazione: *la persona assistita acconsente all'effettuazione dell'indagine ecografica, adeguatamente informata su scopi e limiti dell'esame ecografico attraverso il colloquio con il proprio Ginecologo/ Ostetrica/ Medico ecografista (al quale ha avuto la possibilità di porre eventuali quesiti).*

Camera gestazionale intrauterina diametro medio: _____mm

Posizione della camera gestazionale (in pazienti pre-cesarizzate): fondo □ corpo □ istmo

Embrione / feto: rilevato □ non rilevato; □ unico □ gravidanza gemellare

Se gemellare: Corionicità _____ Amnionicità _____

Attività cardiaca: **presente** □ **assente**

Movimenti fetali**: presenti** □ **assente**

BIOMETRIA: CRL _____ mm BPD _____ mm

Valori biometrici : *corrispondenti / non corrispondenti* all' epoca di amenorrea.

Patologie uterine/annessiali

_____

Fattori limitanti l'esame**: no** □**sì : (**specificare)

_____

Note:_____

_____

Si informa la persona assistita degli esiti dell'esame ecografico effettuato e dei suoi limiti. Si rinvia la persona assistita al medico curante/ ostetrica.
Si allegano n° ___ fotogrammi (**stampati, CD, pendrive**)

Data _____ Operatore _____

Firma _____

ESAME DI SCREENING DEL II TRIMESTRE *(2nd trimester screening visit)*

Cognome e nome …… Data di nascita…… UM ……..……

Epoca gestazionale dall'UM: _____sett. + ___gg; D.P.P. UM:_____

Epoca gestazionale ecografica: _____ sett.+___gg; DPP-ecografica:_____

Informazione: *la persona assistita acconsente all'effettuazione dell'indagine ecografica, adeguatamente informata su scopi e limiti dell'esame ecografico attraverso il colloquio con il proprio Ginecologo/ Ostetrica/ Medico ecografista (al quale ha avuto la possibilità di porre eventuali quesiti).*

N° feti: ____

Se gemellare: Corionicità _____ Amnionicità _____

Attività cardiaca fetale: _____

Movimenti attivi fetali: _____

Placenta (localizzazione): _____

Presentazione fetale: _____

BIOMETRIA:

BPD: _____ CC: _____ MISURA DEL TRIGONO VENTRICOLARE: _____

DIAM. TRASVERSO CERVELLETTO (DTC): _____ CA: _____
LUNGHEZZA FEMORE: _____

Accrescimento fetale: valori biometrici *nella norma / anormali* per l'età gestazionale.

Anatomia fetale: visualizzati* :

1. **ESTREMO CEFALICO:**
   CSP: visualizzato □ non visualizzato _____
   CISTERNA MAGNA: visualizzato □ non visualizzato _____
   ORBITE: visualizzato □ non visualizzato _____
   LABBRO SUPERIORE : visualizzato □ non visualizzato _____

2. **COLONNA VETRETRALE (scansione longitudinale) :** visualizzato □ non visualizzato _____

3. **TORACE:**
   SITUS CARDIACO: _____
   SCANSIONE 4 CAMERE CARDIACHE: visualizzato □ non visualizzato _____
   CONNESSIONE VENTRICOLO ARTERIOSA SINISTRA: visualizzato □ non visualizzato _____
   CONNESSIONE VENTRICOLO ARTERIOSA DESTRA: visualizzato □ non visualizzato _____

4. **ADDOME:**
   PARETE ADDOMINALE ANTERIORE: **visualizzato** □ **non visualizzato**_____
   STOMACO**: visualizzato** □ **non visualizzato** _____
   RENI**: visualizzato** □ **non visualizzato** _____
   VESCICA**: visualizzato** □ **non visualizzato** _____

5. **ARTI:**
   OSSA LUNGHE DEI 4 ARTI**: visualizzato** □ **non visualizzato** _____
   MANI E PIEDI: **visualizzato** □ **non visualizzato** _____

* (per "visualizzato" si intende che l'organo o apparato indagato presenta caratteristiche ecografiche regolari per età gestazionale)

Fattori limitanti l'esame: **no** □**sì** (specificare) _____

Note:_____

Si informa la persona assistita degli esiti dell'esame ecografico effettuato e dei suoi limiti nella individuazione delle anomalie fetali.
Si rinvia la persona assistita al medico curante/ ostetrica.

Si allegano n° ___ fotogrammi **(stampati, CD, pendrive).**

Data _____ Operatore _____

Firma _____

ESAME DI SCREENING DEL III TRIMESTRE *(3rd trimester screening visit)*

Cognome e nome ……... Data di nascita…… UM ……...……

Epoca gestazionale dall'UM: _____sett. + ___gg; D.P.P. UM:_____

Epoca gestazionale ecografica: _____ sett.+___gg; DPP-ecografica:_____

Indicazione: Esame ecografico di screening del II trimestre

Informazione: *la persona assistita acconsente all'effettuazione dell'indagine ecografica, adeguatamente informata su scopi e limiti dell'esame ecografico attraverso il colloquio con il proprio Ginecologo/ Ostetrica/ Medico ecografista (al quale ha avuto la possibilità di porre eventuali quesiti).*

N° feti: ____

Se gemellare: Corionicità _____ Amnionicità _____

Attività cardiaca fetale: _____

Movimenti attivi fetali: _____

Placenta (localizzazione): _____

Presentazione fetale:

BIOMETRIA:

BPD: _____ CC: _____ MISURA DEL TRIGONO VENTRICOLARE: _____

CA: _____ LUNGHEZZA FEMORE: _____

Accrescimento fetale: valori biometrici *nella norma / anormali* per l'età gestazionale.
Se anormali specificare: Biometria pari al_____ percentile.

Anatomia fetale: visualizzati* :
4 CAMERE CARDIACHE: **visualizzato** □ **non visualizzato** _____
STOMACO**: visualizzato** □ **non visualizzato** _____
RENI**: visualizzato** □ **non visualizzato** _____
VESCICA: **visualizzato** □ **non visualizzato** _____

* (per "visualizzato" si intende che l'organo o apparato indagato presenta caratteristiche ecografiche regolari per età gestazionale)

Fattori limitanti l'esame: **no** □**sì** : (specificare)
_____

Note:_____

Si informa la persona assistita degli esiti dell'esame ecografico effettuato e dei suoi limiti.
Si rinvia la persona assistita al medico curante/ ostetrica.

Si allegano n° ___ fotogrammi (**stampati, CD, pendrive).**

Data _____ Operatore _____

Firma _____

BIRTH SUPPORT COURSE FORM (Italian Corso di Accompagnamento alla Nascita - CAN)

The local Consultorio *(public health center) and private centres organize prenatal and postnatal Birth Support Courses, in which you will be guided towards greater awareness of your body by experimenting with movements, positions, ways of breathing (stress management techniques, techniques to contain the pain of childbirth).*

The proposed meetings are a precious opportunity to strengthen primary prevention in a variety of ways:

- promote a **culture of birth in harmony with the natural rhythms** of childbirth and the emotional needs of the couple and the child;
- reduce the use of caesarean sections;
- promote protective conditions with regard to domestic accidents;
- spread the practice of breastfeeding;
- prevent conditions of psycho-social vulnerability of the couple or the individual;
- prevent relationship disorders;
- improve the mental and emotional well-being of the child, the new mother and the parental couple

This BIRTH SUPPORT COURSE will:

- help you understand the emotions and the mental and physical changes during pregnancy;
- discuss your expectations and fears;
- give you information about labour, birth and breastfeeding;
- instruct you in the use of pain-relief techniques;
- support you in your choices and in recognizing your needs;
- develop your self-esteem

The birth support course at *Consultorio* is free and does not require any prescription. You should book your place by the 20th week of pregnancy.

Inizio incontri *(Classes start on)*: _____Luogo *(Venue):*_____

Tel. di riferimento *(phone no. for information)*_____

CALENDARIO DEGLI INCONTRI

(TIMETABLE)

DATA *(date)*	**SI PARLA DI** *(topic)*	**CONDUCE** *(instructor)*

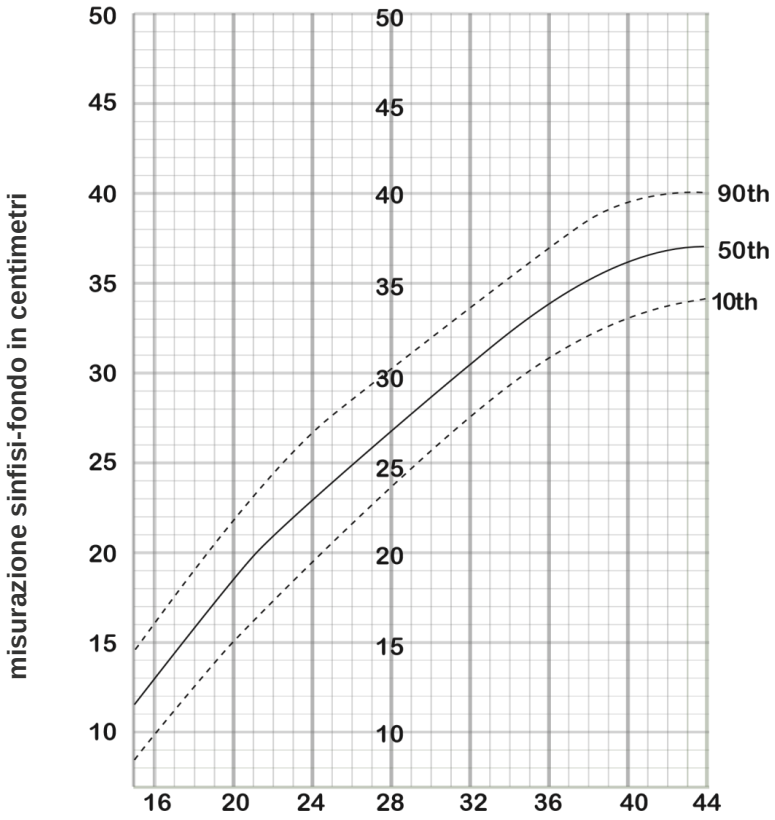
BILANCI DI SALUTE (*Health reports*) - DIARIO CLINICO *(Clinical diary)*

Nome e Cognome _____ Età____ Para____ Altezza_____cm
Gruppo sanguigno:

	DATA	E.G.	BCF	MAF	EDEMI/ VARCI		PESO	P.A.	URINE: PROTEINE /GLUCOSIO		Hb	ESAME VAGINALE
1												
2												
3												
4												
5												
6												
7												
8												
9												
10												
11												
12												
13												
14												

Valutazione dell'accrescimento fetale *(Fetal growth assessment)*

GRAFICO SINFISI-FONDO



carta della distanza sinfisi-fondo basata sui dati di Cardiff (Calvert JP. et al - 47) BMJ 285: 846 - 9 1982

PRENATAL SCREENING

Prenatal screening tests serve to highlight the risk of some trisomies (21, 13, 18).

If an increased risk emerges from these tests, specific invasive diagnostic investigations will be necessary, which may be able to express themselves with certainty.

The screening tests are non-invasive and therefore do not pose any risk to either the woman or the child.

The tests available are:

- **the combined test 11-13 weeks. + 6 days (ultrasound to measure nuchal translucency + blood sample for free HCG and PAPPA-A fraction dosage)**

The Screening ultrasound for the study of Nuchal Translucency is carried out between 11 weeks + 0 days and 13 weeks + 6 days (including pre and post Combined Test consultancy) which, associated in an algorithm with maternal age and blood levels of the free HCG fraction and of the PAPP-A provides an estimate of the probability that the fetus is affected by Down syndrome (Trisomy 21) and\or other chromosomal anomalies (Trisomy 13 and 18).

- **the cfDNA (or NIPT) test of circulating fetal DNA**

it is suggested that, in the event that the pregnant woman undergoes the circulating fetal DNA test, which is currently not available with costs borne by the NHS, unless otherwise provided for, this test is carried out after the combined test (with result: intermediate risk). Information on prenatal screening and diagnostics is discussed during the first meeting

TEST SCREENING PRENATALE

eseguiti presso _____

Test Combinato

data _____

esito: _____

Valutazione: _____

_____

_____

Firma_____

PRENATAL SCREENING INFORMED CONSENT (copy for the facility)

The following statement is the "declaration of informed consent". It must be completed and signed in duplicate: one will remain attached to the Agenda, the other is linked to the exam requirement and will be kept by the laboratory. By signing the document "Woman's expression of will regarding screening for chromosomal anomalies", the woman authorizes the carrying out of screening and diagnostic tests.

Woman's expression of desire for screening for chromosomal anomalies

I am aware that the decision to undergo a screening test is my choice and does not constitute an obligation or a routine examination. I have been informed about the possibilities and limitations of screening tests and prenatal diagnosis techniques for Down Syndrome (also known as trisomy 21) and for trisomies 18 and 13. I understand that for trisomies 21, 13 and 18 there is no cure. I have also been informed that, if the aforementioned anomalies are found before the fetus has the possibility of independent life, my possible request for termination of pregnancy will be evaluated by the doctor of the Service to whom I will turn, who will verify whether the conditions exist to accept it, in compliance with the rules established by Law 194/1978. I understand that the diagnosis of chromosomal anomalies can currently only be carried out using invasive techniques, such as sampling of amniotic fluid (amniocentesis) or placental tissue (chorionic villus biopsy), following each of which abortion can occur in approximately 1% of cases. It was explained to me that, in addition to the factor of maternal age, there are screening tests, that allow you to identify the risk, that is the probability that the fetus is affected by Down syndrome. In particular, I was given information related to the following screening tests:

Combined test □ 11th-13th week. + 6 days (ultrasound scan to measure nuchal translucency + blood sampling for free HCG and PAPPA-A fraction dosage)

I have understood that if the screening test is "positive" (i.e. presents a high risk of trisomies 21, 13 or 18), the diagnosis can be made by amniocentesis or chorionic villus sampling; if the test is "negative" (low risk) no further investigations are suggested, even if this does not give "certainty" that the fetus is healthy.

Ho discusso con il medico dr. _____ in merito alla capacità del test di screening di individuare correttamente i feti realmente affetti e la possibilità di risultati falsi positivi e falsi negativi.

Firma del sanitario _____

Ritengo queste informazioni sufficienti e complete e dichiaro di aver pienamente compreso le informazioni che mi sono state date. Avendo chiaro quanto sopra esposto decido di:

(I have discussed with dr. _____ the capability of the screening test of correctly identifying fetuses that actually have Down Syndrome, its limitations and the possibility of false positive and false negative results.
Signature of the healh professional_____
I believe that the information that has been provided is sufficient and complete and I declare that I have fully understood the information I have been given. In consideration of the aforementioned information I hereby decide:

***sottopormi** al test combinato di screening* *Data e Firma* _____

(to undergo the combined screening test) *(Date and Signature)*

***non sottopormi** al test combinato di screening* *Data e Firma*_____

(not to undergo the combined screening test) *(Date and Signature)*

PRENATAL SCREENING INFORMED CONSENT

The following statement is the "declaration of informed consent". It must be completed and signed in duplicate: one will remain attached to the Agenda, the other is linked to the exam requirement and will be kept by the laboratory. By signing the document "Woman's expression of will regarding screening for chromosomal anomalies", the woman authorizes the carrying out of screening and diagnostic tests.

Woman's expression of desire for screening for chromosomal anomalies

I am aware that the decision to undergo a screening test is my choice and does not constitute an obligation or a routine examination. I have been informed about the possibilities and limitations of screening tests and prenatal diagnosis techniques for Down Syndrome (also known as trisomy 21) and for trisomies 18 and 13. I understand that for trisomies 21, 13 and 18 there is no cure. I have also been informed that, if the aforementioned anomalies are found before the fetus has the possibility of independent life, my possible request for termination of pregnancy will be evaluated by the doctor of the Service to whom I will turn, who will verify whether the conditions exist to accept it, in compliance with the rules established by Law 194/1978. I understand that the diagnosis of chromosomal anomalies can currently only be carried out using invasive techniques, such as sampling of amniotic fluid (amniocentesis) or placental tissue (chorionic villus biopsy), following each of which abortion can occur in approximately 1% of cases. It was explained to me that, in addition to the factor of maternal age, there are screening tests, that allow you to identify the risk, that is the probability that the fetus has Down Syndrome. In particular, I was given information related to the following screening tests:

Combined test □ 11th-13th week. + 6 days (ultrasound scan to measure nuchal translucency + blood sampling for free HCG and PAPPA-A fraction dosage)

I have understood that if the screening test is "positive" (i.e. presents a high risk of trisomies 21, 13 or 18), the diagnosis can be made by amniocentesis or chorionic villus sampling; if the test is "negative" (low risk) no further investigations are suggested, even if this does not give "certainty" that the fetus is healthy.

Ho discusso con il medico dr. _____ in merito alla capacità del test di screening di individuare correttamente i feti realmente affetti e la possibilità di risultati falsi positivi e falsi negativi.

Firma del sanitario _____

Ritengo queste informazioni sufficienti e complete e dichiaro di aver pienamente compreso le informazioni che mi sono state date. Avendo chiaro quanto sopra esposto decido di:

(I have discussed with dr. _____ the capability of the screening test of correctly identifying fetuses that actually have Down Syndrome, its limitations and the possibility of false positive and false negative results.
Signature of the healh professional_____
I believe that the information that has been provided is sufficient and complete and I declare that I have fully understood the information I have been given. In consideration of the aforementioned information I hereby decide:

***sottopormi** al test combinato di screening* *Data e Firma* _____

(to undergo the combined screening test) *(Date and Signature)*

***non sottopormi** al test combinato di screening* *Data e Firma*_____

(not to undergo the combined screening test) *(Date and Signature)*

HIV TEST - INFORMATION FOR CONSENT TO PERFORMANCE

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS (Acquired Immune Deficiency Syndrome), an infectious disease that attacks and seriously compromises our body's defenses, putting our lives at risk if left untreated. A person who contracts HIV becomes HIV-positive and can transmit the infection to other people. We can all get it.
HIV is transmitted mainly through unprotected sexual intercourse (without a condom) with people with HIV, through blood (for example through needles used by people with HIV), or from a mother with HIV to her child during pregnancy, at the time of birth or through breastfeeding.
Being tested for HIV is especially important for pregnant women. There are specific therapies to greatly reduce the transmission of HIV from mother to child

It is necessary for the couple thinking of having a child to undergo an HIV test before pregnancy or at the beginning of it to protect their health and that of the child.

You can learn how to protect yourself from the infection by asking your doctor for information or by calling the (anonymous and free) "**Telefono Verde AIDS**" service of the Istituto Superiore di Sanità (the Italian health system) **800 861061**, from Monday to Friday, from 1.00 pm to 6.00 pm. 00

EXPRESSION AND ACQUISITION OF INFORMED CONSENT

When the diagnostic analysis aimed at ascertaining HIV infection is carried out, pursuant to and for the effects of Legislative Decree. lgs. n. 196/2003, following information, the data are collected for the sole purpose of informed consent. They are subject to professional secrecy and will not be disclosed to anyone, but kept exclusively within the facility where the test was carried out.

Consenso all'esecuzione del test HIV

Io sottoscritto/a (cognome e nome)_____

nato/a_____il_____/_____/ _____

Dichiaro

di aver ricevuto un'informazione comprensibile ed esauriente sull'atto sanitarioattraverso:

- l'informativa fornita;
- il colloquio con un operatore sanitario.

Liberamente, spontaneamente e consapevolmente, esprimo il consenso all'effettuazionedell'analisi diagnostica tendente ad accertare l'infezione da HIV.

Data_____/_____/ _____

Firma leggibile

_____

Firma dell'Operatore

_____

Privacy and free

The HIV test is free and you can ask to carry it out anonymously. In any case, maximum privacy protection and professional secrecy are guaranteed, even for foreign people without a residence permit. Communication of the HIV test result can be given exclusively to the person who underwent the sampling (Law 135 of 5 June 1990). The current law protects against discrimination resulting from testing positive for HIV and ensures that all people, Italian and foreign, receive any necessary therapies

MODULO DI INVIO DAL SERVIZIO TERRITORIALE AL PUNTO NASCITA

(Referral form from the local healthcare provider to the Birth Centre – Punto Nascita)

Data / /

Servizio di invio _____

Telefono_____

Medico ginecologo_____

Ostetrica _____

Cognome Nome_____

data nascita _____

età _____

U.M. _____ / ____ / ___

E.P.P. ____ / ____ / _____ E.P. ecografica _ /____ /___

W _____ Priorità _____

Elementi di attenzione dall'anamnesi_____

_____

_____

_____

_____

Elementi di attenzione dall'evoluzione della gravidanza _____

_____

_____

_____

_____

YOUR PREFERENCES FOR LABOUR, DELIVERY AND BIRTH

The woman will discuss the following aspects with her obstetrician/gynecologist to consider what is appropriate to choose to better enjoy the experience of childbirth.
Your choices may be satisfied compatibly with the physiological evolution of labour and birth and upon availability of the chosen Punto Nascita (Birth Centre).

luogo del parto *(place of delivery)*	
modalità del parto *(mode of delivery)*	
presenza di persona di fiducia durante il travaglio *(trusted person for support during labour)*	
posizione durante il travaglio e durante il parto *(preferred position for labour and delivery)*	
sollievo del dolore in travaglio *(pain-relief during labour)*	
accoglienza al neonato - contatto pelle a pelle *(welcoming your newborn – skin-to-skin)*	
rooming in	
alimentazione del neonato *(newborn's nutrition)*	
durata permanenza in ospedale *(duration of stay at hospital)*	
Altro *(notes)*	

ANAMNESI PER L'ALLATTAMENTO (BREASTFEEDING ANAMNESIS)

Allattamenti precedenti	*Sì, per_____mesi* *No, motivo_____*
Problemi nei precedenti allattamenti:	
Paure o dubbi:	
Vincoli lavorativi o altro:	
Condizioni che controindicano l'allattamento al seno:	Alcolismo o tossicodipendenza
	Tumore mammario
	Malattie rare congenite del neonato (es. Galattosemia)
	Sieropositività HIV
	Psicosi post-parto
	Assunzione permanente di farmaci controindicati
	Agenesia mammaria o mastectomia bilaterale
	Epatite in fase acuta
	Herpes bilaterale al capezzolo

HOSPITAL DISCHARGE

At the end of the hospital stay, the woman is handed a *discharge* sheet with a summary of the assistance provided during labour, birth and in the following days.

The woman will also receive reports on the care provided to the newborn which will constitute the beginning of the baby's health booklet.

With the discharge sheet, mother and child can go home.
To go home by car it is necessary to have an appropriate car seat or carrycot (group O for children weighing less than 10 kg) approved by European regulations marked with the acronyms ECE R-03 or ECE R44-04. Please follow the instructions provided in the instruction manual when installing it in your car.

FOGLIO DIMISSIONE OSPEDALIERA

(A CURA DEL PUNTO NASCITA) **data**_____/____/_____

Madre: Cognome Nome _____

data nascita_____età _____

PARTO

Data____ /_____ /_____ora_____**E.G.**_____

Profilassi antibiotica_____

Travaglio: - spontaneo **-** Indotto con_____

Rottura del sacco amniotico: - spontaneo **-** artificiale

Modalità parto: - Eutocico **-** Distocico **-** TC(indicazione)_____

Secondamento: - Spontaneo **-**

Manuale_____

Perdita ematica intrapartum:_____

Profilassi anti D _____

ESAME CLINICO DELLA PUERPERA (alla dimissione)____data____/____/

Utero_____

Perineo sutura: - Si **-** No

Emorroidi: - Si **-** No

Cicatrice laparotomica: - Si_____ **-** No

Minzione: - Regolare **-** Irregolare

Alvo: - Regolare **-** Irregolare

Fondo_____

Cervice _____

NEONATO

Cognome Nome _____

data nascita_____sesso _____

APGAR _____ **Peso alla nascita** _____g
Rianimazione: - No **-** Si, con _____

Taglio del funicolo: - Si, immediato **-** Si, ritardato

Contatto pelle a pelle: - Si **-** No

Allattamento al seno : - Precoce **-** Ritardato **-** No

Profilassi: Oculare Antiemor. Altro _____

ESAME CLINICO DEL NEONATO ALLA DIMISSIONE

Data	Settimana dalla nascita	Peso	Lunghezza	Circonferenza cranica	Ittero	Alimentazione durante la degenza	Note
						☐ Materna esclusiva ☐ Complementare ☐ Artificiale	

Rooming in nella struttura di degenza : - Si **-** No

RIFLESSO ROSSO → metodo: . . . . . .

esito:. . . . . .

necessità di controllo: . . . . . .

SCREENING AUDIOLOGICO → esito:. . . . . .

controllo: . . . . . .

Saturimetria per lo screening delle cardiopatie congenite→ . . . . . .

controllo: . . . . . .

Prescrizioni e indicazioni all'uso dei sostituti del latte materno: . . . . . .

. . . . . .

. . . . . .

. . . . . .

Vitamine : . . . . . .

Visita di controllo (data e luogo) : _____

The **Vaccinations** have led to a drastic reduction in infectious diseases in our country, but these still constitute a potentially serious danger for newborns. The vaccines currently available guarantee increasingly effective protection against a series of infectious diseases and at the same time present an increasingly reduced risk of side effects. It is therefore important for parents to make a conscious choice to protect their children against potentially fatal or seriously disabling diseases. The vaccines currently proposed are reported in the Vaccination Calendar reported in the National Vaccine Prevention Plan (PNPV) 2017-2019, published in the Official Journal of 18/2/2017, which provides for the free administration of the recommended vaccines. For

further details, ask your child's pediatrician and go to the website www.vaccinarsi.org. Vaccination Calendar reported in the PNPV 2017-2019

ADESIONE AL PROGRAMMA DI ASSISTENZA TERRITORIALE IN PUERPERIO (A CURA DEL PUNTO NASCITA)

(Registration form for the Program of local healthcare assistance and puerperium- COMPLETED BY THE STAFF AT PUNTO NASCITA – BIRTH CENTRE)

Io sottoscritto/a (cognome e nome) _____

nato/a a _____ il ___/___/_____

informata sull'offerta di assistenza territoriale in puerperio da parte dei Consultori di questa ASL, che prevede una visita di controllo da parte degli operatori consultoriali entro sette giorni dalla dimissione ospedaliera, dichiara di:

☐ **NON ADERIRE** ☐ **ADERIRE**

Data_____/_____ /_____Firma _____

La sottoscritta autorizza altresì il personale del Punto Nascita a segnalare i proprirecapiti telefonici al Consultorio di _____ per essere inserita nel programma di assistenza territoriale in puerperio.

Data_____/_____/_____Firma _____

L'operatore del punto nascita Firma _____

Segnalazione al consultorio di riferimento per presa in carico

☐ No ☐ Si _____

Segnalazione al pediatra di base per presa in carico

☐ No ☐ Si _____

ASSISTENZA IN PUERPERIO
(Assistance during puerperium)

PUERPERA

☐ Visita domiciliare ☐ Visita ambulatoriale

I settimana_____data / /

Genitali _____

Cicatrici _____

Alvo _____

Utero_____

Lochiazioni _____

Mammella _____

Minzione_____

Note _____

_____

_____

NEONATO

☐ Visita domiciliare ☐ Visita ambulatoriale

Giorni/settimane dal parto_____ data / /

Calo ponderale _____

Ritmi del bambino (sonno, pianto, evacuazione) _____

_____

Ittero _____

Allattamento esclusivo _____

Allattamento misto _____

Allattamento artificiale _____

Presa in carico dal PLS _____

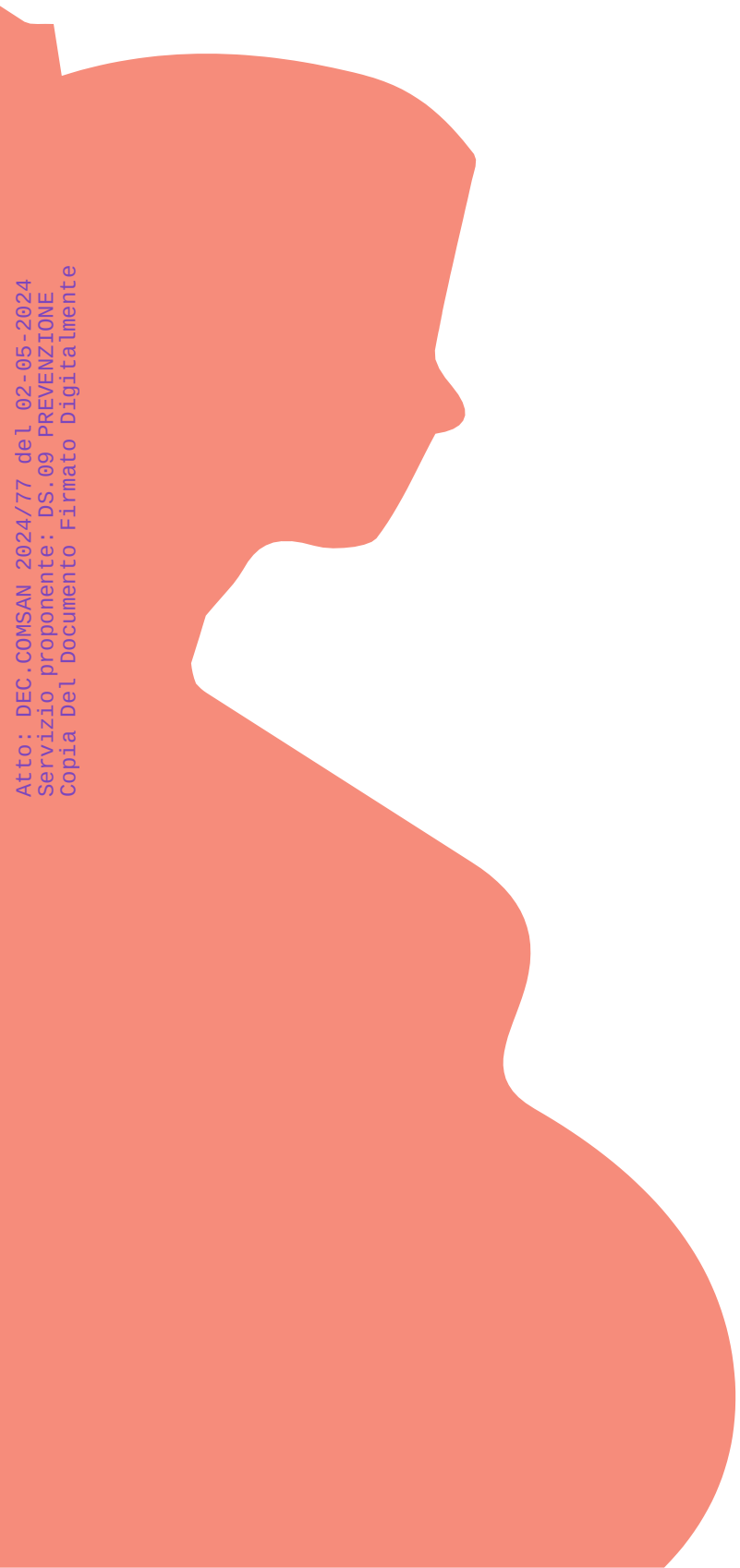
Note _____

_____

_____

INFORMATION SHEETS

- What rights during pregnancy?
- lifestyle (nutrition and hygiene, behaviors and lifestyle habits)
- laboratory tests
- ultrasound screening and prenatal diagnosis
- vaccinations and pregnancy
- Covid-19: vaccination during pregnancy
- vaccinations for newborns
- full-term pregnancy
- physiology of labour and birth
- breastfeeding
- puerperium
- mental and physical wellbeing
- umbilical cord donation
- important telephone numbers for your birth care pathway



What rights during pregnancy?

Italian law (Legislative Decree 151/2001) guarantees the protection of the health of the working mother and the child's right to adequate assistance.
*The **employed woman**[1] has the following rights:*

- *paid leave to carry out prenatal tests, clinical tests, specialist medical visits, if these must be carried out during working hours;*
- *not to be fired: the ban on dismissal runs from the beginning of the pregnancy until the child is 1 year old;*
- *not to be used for risky, burdensome and unhealthy work;*
- *5 months of compulsory abstention (maternity leave) from work paid at 80% (in some cases 100%) between before and after the birth of the child;*
- *to family allowances and tax relief for spouses and dependent children, including for immigrant women. If you have Italian citizenship you are entitled to family allowances also for minor children residing abroad;*
- *to paid maternity leave even if you have a fixed-term contract;*
- *to the reduction of working hours for the entire first year of the child's life.*

*Furthermore, **both employed parents** are entitled to a period of optional leave (parental leave), paid at 30% of the salary only within the 6th year of the child's life, which can be used after the period of compulsory leave and within the 12th year of the child's life. It is up to both mothers and fathers, up to a maximum of 6 months (even split) for the mother, and 7 months (also split) for the father.*
***Self-employed women** are granted a maternity allowance for the two months preceding the date of birth and for the three months following the same date. However, the allowance does not imply an obligation to abstain from self-employed work.*
***Women with atypical and discontinuous jobs** who do not benefit from maternity allowance or who benefit from an allowance below a certain ceiling can contact INPS where they will find assistance and information.*
***Non-working women, whether Italian, EU or non-EU, in possession of a residence card**, can submit an application for maternity allowance to the Department of Social Services of the municipality of residence and/or to the INPS office of residence, within 6 months from the birth of the child.*
***Foreign women without a residence card** can contact the counseling center and the volunteer associations that offer reception, information and assistance without running the risk of being reported for expulsion since Italian law guarantees healthcare even for undocumented migrants. They can apply for a maternity residence permit which is valid until the child's sixth month of life.*
*Furthermore, in Italy the law recognizes a woman's **right to give birth anonymously in hospital**. Italian law allows the mother not to recognize the child and leave him/her in the hospital where he or she was born.*

[1] other information regarding the protection of pregnant women's health at work can be found in the document "When a baby arrives" (third ed.) available on the website of the National Institute for Insurance against Accidents at Work (INAIL) at link:

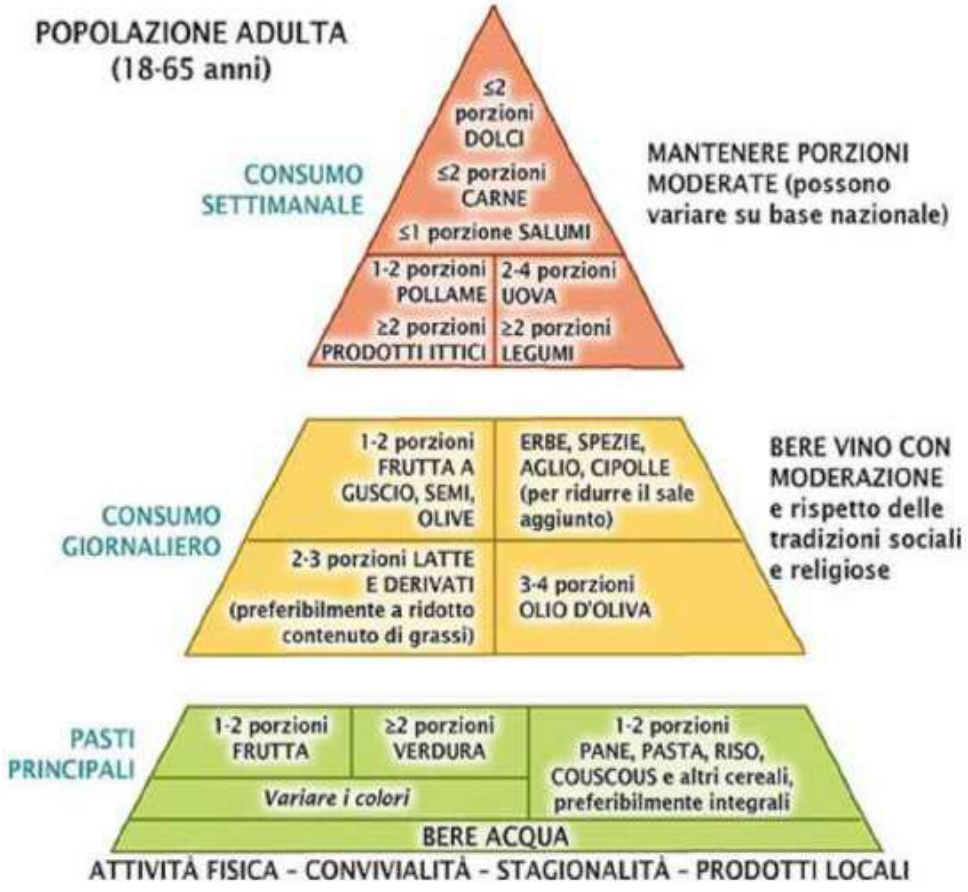
http://settimanasettimanasettimana.inail.it:80/Portale/appmanager/portale/desktop?nfpb=true&_pageLabel=PAGE_PUBBLICAZIONI&nextPage=PUBBLICAZIONI/Tutti_i_titoli/Pari_opportunita/Quando_arriva_un_bambino_(terza_edizione)info752606768.jsp

Lifestyle (nutrition and hygiene, behaviors and lifestyle habits)

Nutrition[1] contributes to the good progress of pregnancy and, if there are no nutritional deficiencies or other problems, there is no reason to change your eating style.
You must respect your wishes and, if you follow a particular diet, communicate it to your obstetrician/gynecologist

Good rules always, and especially during pregnancy, are:

- prefer a wide variety of foods such as seasonal vegetables and fruit (consume five divided portions throughout the day), bread, pasta, rice and other cereals, dairy products, meat, eggs, fish;
- avoid both prolonged fasting and very large meals;
- drink a lot of water;
- consume animal fats, sugar, salt in moderation;
- possibly eat fresh or well-cooked foods when you are not sure of their hygiene;
- avoid pre-packaged foods;
- heat dishes evenly and at high temperatures;
- it is recommended not to exceed 300 mg of caffeine per day, corresponding to two coffees, and to consume chocolate and tea in moderation.



There are some foods which, if not consumed with the right precautions, can be the cause of the onset of certain diseases, for example *Listeria monocytogenes* and *Toxoplasma gondii*.La tabella riporta l'elenco dei cibi a cui fare attenzione, le malattie che possono generare edi consigli per il consumo.

The table contains the list of foods to watch out for, the diseases they can cause and advice for consumption.

Food hygiene

If the toxotest is negative (i.e. you have never contracted toxoplasmosis) you need to:

- wash fruit and vegetables well;
- avoid eating raw meat and letting cats eat it;
- wear gloves when handling raw meat or wash your hands immediately after handling it;
- immediately wash all utensils that have been in contact with raw meat;
- wear gardening gloves and wash your hands well if you have touched the soil;
- if you have a cat at home, avoid changing the sandbox or do it with gloves. It is not necessary to remove the cat;
- any animal you have at home is not a danger but it is necessary to carefully follow the common hygiene rules for cleaning.

To avoid contracting listeriosis[2] it is important to:

- drink only pasteurized or UHT milk;
- do not eat cheeses made with raw milk;
- do not eat fresh meat pates;
- do not eat smoked fish;
- do not contaminate foods being prepared with raw foods;
- do not eat meat or delicatessen foods that have not been heated to high temperatures.

To avoid contracting salmonella[3] it is important to:

- do not eat raw or undercooked eggs;
- cook all foods of animal origin well;
- keep raw foods separate from cooked foods;
- refrigerate in small doses, to ensure rapid reduction of the temperature;
- protect foods from contamination by insects and rodents;
- wash your hands well before, during and after preparing food. In general, eating liver is not recommended due to the high vitamin A content.

To prevent cytomegalovirus[4] infection:

- do not share crockery (e.g. cups, glasses, cutlery), food (e.g. tasting baby food with the same spoon), linen (towels, napkins) hygiene tools (toothbrush);
- do not put pacifiers or anything else a child may have put in their mouth;
- do not kiss other children on the mouth;
- wash your hands carefully with soap and water after: changing the nappy, cleaning the baby's nose and mouth or after a bath, frequently washing toys and various surfaces (e.g. high chair, playpen).

[1]further information on the correct diet during pregnancy is available in the document Guidelines for a healthy diet of the National Research Institute for Food and Nutrition, at the address: http://settimanasettimanasettimana.inran.it/648/linee_guida.html

[2] further information on **listeriosis** is available on the website of the National Center for Epidemiology, Surveillance and Health Promotion, at the address: http://weekesettimanasettimana.epicentro.iss.it/problemi/listeria/listeria.asp

[3] further information on **salmonellosis** is available on the website of the National Center for Epidemiology, Surveillance and Health Promotion, at the address: http://settimanasettimanasettimana.epicentro.iss.it/problemi/salmonella/salmonella.asp

[4] Prevention of Primary Cytomegalovirus Infection in Pregnancy, Maria Grazia Revello et all. E BioMedicine 2 (2015) 1205–1210

Supplements

Folic acid is the only food supplement whose usefulness is scientifically proven for every woman starting from two months before conception and in the first three months of pregnancy (the recommended dose is 0.4 mg per day).
Other food supplements are only necessary in particular clinical conditions:

- **Vitamin D**, when there is little exposure to the sun or you follow a vegan diet;
- **Iron**, when the presence of iron deficiency anemia is ascertained;
- in case of particular diets, evaluate the intake of **Vitamin B12**.

Anti-nausea tips

In the morning it is advisable to eat crunchy dry foods (such as rusks and toast) and avoid foods rich in water or liquids. This small measure will allow you to overcome the morning crisis and be able to eat traditional foods for the rest of the day

Various ailments

Gastric acidity: *relief can be found by changing your diet (small and frequent meals, reduction of irritating foods) and your posture after meals (upright) and during sleep (raised). Antacids can be used, for other drugs there are no safety data.*

Constipation: *the introduction of dietary fiber can resolve the disorder or hemorrhoids.*

Varicose veins: *Wearing elastic stockings does not prevent varicose veins but may relieve their symptoms.*

Vaginal discharge: *An increase in vaginal discharge is a physiological change of pregnancy. Further diagnostic work-up is only necessary when the discharge is associated with itching, pain, bad odor or pain when urinating*

Smoking and Alcohol

Smoking during pregnancy is strictly discouraged.

Smoking increases the risk of spontaneous abortion, reduced fetal growth, cot death of the newborn and respiratory diseases of the child.

It is advisable not to consume alcohol during the entire pregnancy. The most frequent damages are: spontaneous abortion, fetal malformations, fetal growth retardation, mental retardation after birth. If there are difficulties, it is necessary to consult services specialized in care and help.

Narcotic substances (heroin, cocaine, amphetamine, etc.)

The habitual use of these substances during pregnancy causes different harm depending on the type of substance taken.
The most frequent are: spontaneous abortion, fetal malformations, pre-term birth, reduced fetal growth, abstinence crisis of the child at birth, greater risk of death in utero or in the first months after birth, alterations in child behavior and learning while growing up.
Pregnancy in women who habitually use drugs is considered high risk and must be followed up in specialized services.

[1] *Prevention of Primary Cytomegalovirus Infection in Pregnancy*, Maria Grazia Revello et all. E BioMedicine 2 (2015) 1205–1210

Drug information:

There are special free telephone services dedicated to future and new mothers, designed to offer "at home" information and clarifications for the prevention of congenital defects of the newborn and an assessment of the risks deriving from taking drugs during pregnancy and breastfeeding.

- Poison Control Center of the Riuniti Hospital of Bergamo: tel. 800883300 active 24 hours

- "Telefono Rosso" (Red Phone) of the A. Gemelli University Hospital of Rome: tel. 06/3050077 active from Monday to Friday, 9.00-13.00 and 14.00-16.00.

- **Teratological Information Service CEPIG** (Centre for genetic information) of the University - Hospital of Padua, tel.049/8213513, fax 049/8211425, active from Tuesday to Friday, 3.00pm-5.00pm.

- **Perinatal Toxicology of the Careggi Hospital of Florence**, tel. 055/4277731, active Monday 2.00pm-4.00pm, Wednesday and Friday 10.00am-12.00pm.

-**"Filo Rosso" (Red Thread)**, tel. 02/8910207; 06/5800897; 081/5463881.

- **Genetic "Filo Rosso**", tel. 0882/416291.

- **Poison Control Center of the University Hospital** "OO.RR." of Foggia, tel. 800183459,

NB: It is always necessary to talk about all disorders with those who follow us and agree on the therapy together, after evaluating the symptom

Sexual relations

Scientific evidence shows that sexual intercourse during pregnancy does not create problems for either the mother or the newborn. Some clinical conditions may require temporary suspension (e.g. blood loss, invasive diagnoses, presence of uterine contractions, etc.). Pregnancy can affect a woman's desire, these variations must be considered normal and respected also by the partner.

Physical activity

During pregnancy, physical changes occur that temporarily increase the laxity of the ligaments, which is useful for childbirth.
Moderate physical activity (e.g. walking, swimming) promotes circulation and general physical well-being. However, activities that require intense muscular effort, particularly strenuous sports or those with a risk of falling should be avoided.

Body care

The physical changes that occur during pregnancy (increase in volume of the abdomen and breasts, modification of capillary circulation) can encourage a different attention to body care. In general, it is not necessary to change one's habits and cultural traditions in personal hygiene care.
Since there are no scientific studies on body care products, it is generally advisable to read the label carefully and check the compatibility of the products with pregnancy.

Trips

To travel to countries for which specific vaccinations are recommended, it is best to follow the instructions of the Travel Medicine Centers (Diagnosis and Treatment Facility for Traveller's Illnesses - International Vaccinations ASL Roma/E of Via Plinio 31, tel. 06/68354005) .

By plane: long plane journeys, due to the immobility they require, increase the risk of venous thrombosis, but no greater risks have been highlighted during pregnancy: the use of elastic compression stockings is however advisable.

Each airline has its own rules regarding air travel and pregnancy. It is always advisable to ask for precise information when booking your flight. In the interest of pregnant passengers, a limit is generally recommended which is 36 weeks for physiological pregnancies and 32 for twin pregnancies.
After 28 weeks, pregnant women are invited to bring a doctor's certificate confirming the good progress of the pregnancy and the expected date of birth.

By car: although the law provides for the possible exemption for pregnant women (Law n.284 of 4 August 1989, art. 1, point f), the use of a seat belt is always recommended, except in absolutely exceptional certified cases by the attending physician. Numerous studies also document the benefits deriving from the use of a seat belt, positioned correctly, for pregnant women.

Laboratory tests

Laboratory tests are used to verify the presence of any pathologies that could have negative effects on the health of the mother and the newborn.
Below is a brief description of the tests required by the PDTA (Diagnostic Therapeutic Assistance Path) for physiological pregnancy.
The tests which, according to the ministerial calendar, are necessary to evaluate the well-being of mother and child are totally free.

- ***BLOOD CHROME:*** *detects the quantity of red and white blood cells, hemoglobin, platelets present in the blood. Reference values are different during pregnancy. The test must be performed within 13 weeks and repeated between 28-32 and 33-37 weeks.*
- ***GLUCOSE****: detects the amount of sugar present in the blood. The reference values are the same, even during pregnancy. It is used to evaluate the balance of sugar absorption. It must be performed within 13 weeks and must be repeated between 24-27 weeks in risk situations (OGTT).*
- ***ANTITREPONEMA IG:*** *Verifies the absence of syphilis, a disease which initially develops without symptoms. Syphilis, which can be contracted through sexual intercourse with sick people, if not treated, causes serious fetal damage, up to and including the death of the fetus. The treatment is based on antibiotics which can also be taken during pregnancy.*
- ***TOXOTEST:*** *searches for antibodies against toxoplasma, in the absence of which there is a risk of infection; therefore, the test must be repeated. Toxoplasmosis contracted during pregnancy can cause fetal injury: treatment varies based on gestational age.*
- ***RUBEO TEST****: searches for antibodies against rubella. If the woman has never had rubella, the rubeo test is negative. In this case it will be necessary to avoid any contact with sick people and undergo vaccination after giving birth.*
- ***ANTI-HIV ANTIBODIES:*** *tests for the presence or absence of antibodies against the AIDS virus. This is an examination of the utmost importance. In case of HIV positivity it is possible to undertake a specific care path which limits the possibility of contagion to the child. This test is protected by informed consent.*
- ***URINE TEST****: detects the substances present in the urine and the possible presence of bacteria. Urinalysis must be carried out monthly.*
- ***UROCULTURE:*** *checks whether the quantity of bacteria present in the urine is a sign of urinary tract infection.*
- ***HCVAB:*** *checks for the presence of hepatitis C and evaluates its contagiousness.*
- ***HBSAG:*** *checks for the presence of hepatitis B. Hepatitis B can be transmitted to the newborn. It is performed in the 3rd trimester. In case of positivity, the newborn will be administered gamma globulins and the first vaccination will be brought forward to birth, instead of to the third month of life.*
- ***SEARCH FOR GROUP B BETA HEMOLYTIC STREPTOCOCCUS****: look for the presence of the bacterium in the vaginal and rectal swab. It is performed at 36 – 37 weeks. If the*

outcome is positive, it will be necessary to subject the mother to antibiotic therapy and carry out checks on the newborn.

- ***HEMOGLOBIN ELECTROPHORESIS:*** *it is used for the prevention of Thalassemia and other forms of hemoglobinopathies. It must be requested if the MCH on the blood count is < 27.*

Circumstances may arise that require additional assistance *and, therefore, the execution of further and more specific investigations.*
These tests will be requested by the gynecologist and are ticket-free if the pathology and the relevant exemption code are indicated on the referral.
All other tests that may be required are the responsibility of the user.

Ultrasound screening - prenatal diagnosis

Ultrasound scan is a test that uses ultrasound to see the fetus before birth.
It is a harmless test, in fact ultrasound has been used in obstetrics for over 30 years.
With the approval of the new Lea, Essential Levels of Assistance, there are two ultrasound scans scheduled by the Ministry of Health during the 9 months and are completely paid for by the National Health Service, as long as they are carried out in the scheduled weeks.
The others can be performed free of charge only upon specific request of the gynecologist, who will have to certify the risk condition of the pregnancy.
Due to the limitations of the method, it is possible that some anomalies, even important ones, may not be detected. It is estimated that ultrasound in optimal conditions can diagnose 50% of malformations and the reliability depends on several factors: the week of pregnancy, the quality of the instrument used, the skill of the operator, the position of the fetus and the constitution maternal.
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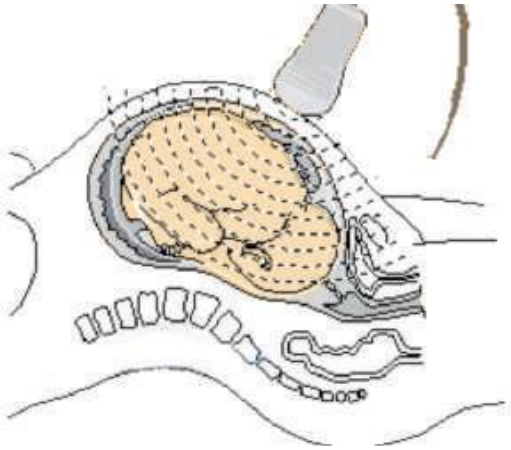


THE ULTRASOUND OF THE 1ST TRIMESTER OF PREGNANCY:
It is perhaps the most exciting one for the expectant mother, as it finally gives her the visual certainty of carrying a baby.

It is a very important test as it allows you to confirm the correct implantation of the fertilized egg in the uterus and to date the gestation more precisely.
Useful information to calculate, with a margin of error of 3-4 days maximum, the estimated date of birth (the "DPP" indicated in the report).
If necessary, for clinical reasons or for a doubtful date, it can be performed before the 11th week and in this case it may be necessary to perform it transvaginally. Furthermore, it can be seen whether the pregnancy is single or multiple and, in the second hypothesis, whether the twins "live" in the same gestational chamber and whether they have separate placentas (chronicity), in order to establish the most appropriate checks.
Otherwise, it is carried out between the 11th week and the 13th week, **and the evaluation of nuchal translucency can also be combined**, which however must only be carried out by accredited gynecologists. This is the measurement of the liquid layer that accumulates behind the neck of the fetus in that gestational period and which, combined with the examination of a blood sample, provides an estimate of the risk that the child is affected by certain pathologies, such as trisomy's 21, 13 and 18. It is performed abdominally, i.e. simply placing the probe on the belly, as happens with ultrasound scans during the second and third trimester of pregnancy

THE ULTRASOUND OF THE 2ND TRIMESTER OF PREGNANCY:

It is commonly called morphological as it evaluates the anatomy of the various organs of the fetus, in order to identify any anomalies or malformations.
According to the new guidelines it must be carried out between the 19th and 21st week of gestation. This ultrasound must be performed at this gestational age because the fetus is large enough to be able to analyze some fetal anatomical characteristics, in particular; the head and the structures of the central nervous system, the lips, the spinal column, the abdomen and the abdominal wall, the limbs, the stomach, the kidneys and the bladder. The location of the placenta, the quantity of amniotic fluid and fetal growth are also assessed.
Being a more complex investigation than the first, it also requires more time than the previous one.

ULTRASOUND IN THE 3RD TRIMESTER OF PREGNANCY (only in the presence of maternal or fetal risk):

This ultrasound is used to look for any anatomical anomalies that may appear late, check some parameters to monitor the growth of the baby, check the quantity of amniotic fluid and the position of the placenta, visualize the fetal position.
It is performed between the 30th and 32nd week, but with the approval of the new Lea, the essential levels of assistance, it is offered free of charge only in the presence of a risk of maternal or fetal pathology.

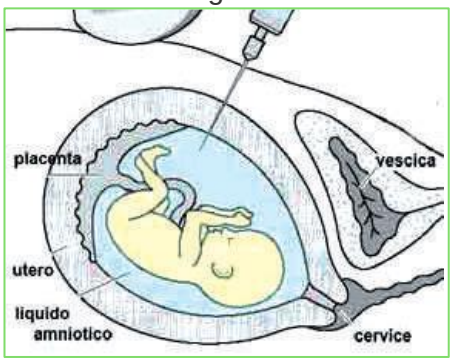
Test to assess the risk of Down syndrome and other chromosomal anomalies

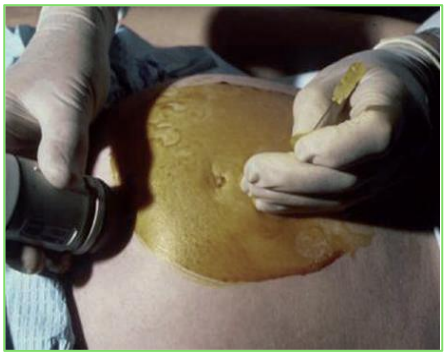
They are non-invasive tests that estimate a woman's risk of having a fetus affected by certain chromosomal anomalies: trisomy 21, trisomy 18, trisomy 13.
They are not diagnostic tests but express the probability that the fetus is affected by these anomalies. And any confirmation will only be obtained after more specific tests such as chorionic villus sampling and amniocentesis.
National guidelines consider 2 tests suitable: the combined test carried out in the first trimester and the tri-test which is carried out in the second trimester only for women who have not performed the combined test in the first trimester.

- Combined test is the combination of the bi-test (maternal blood sample) and the ultrasound measurement of Nuchal Translucency. It is performed between 11 and 13 weeks. False positives (test results that were erroneously altered) are approximately 50 out of 1000, false negatives (test results that were erroneously negative) are less than 1 in 1000. In addition to indicating an increased risk for chromosomal anomalies, it can also indicate a greater risk for some malformations that will be investigated with level II ultrasound scans. The exam must be carried out only by professionals accredited by national or international scientific societies.
- Tri-test: performed between the 15th and 18th week of pregnancy. It consists of a maternal blood sample to measure three substances produced by the fetus and the mother. The identification rate of chromosomal anomalies is lower than with the combined test (approximately 65\70% of all cases of trisomy 21, 18 and 13).
- Other tests: a new test allows the identification of the main numerical anomalies of the chromosomes (triomy 21,13,18) by extracting fetal DNA from the maternal blood.

Invasive tests for the diagnosis of Down Syndrome and other chromosomal anomalies
These are tests that allow the chromosomal composition of the fetus to be determined and therefore to diagnose numerical and structural anomalies of the chromosomes, through the sampling of amniotic fluid (Amniocentesis) or through the sampling of placental tissue (chorionic villus sampling). They have a risk of miscarriage of approximately 0.1-1% (1 case from 100-200 tests).

AMNIOCENTESIS: painless outpatient examination which consists in the sampling of a small quantity of amniotic fluid through a thin needle. It is performed between the 15th and 18th week.





VILLOCENTESIS: outpatient examination which removes, with a thin needle, a small amount of placental tissue (chorionic villi). It is performed between the 11th and 13th week.

Vaccinations and pregnancy

FOR THE MOTHER before pregnancy (or after)

Rubella and chickenpox are quite common diseases that, contracted during pregnancy, also put the baby at risk, especially if you get sick in the first trimester and, for chickenpox, even in the days close to giving birth.
The woman who is planning to become pregnant should know whether she has already contracted these diseases or whether she has been vaccinated.
If not, you can get vaccinated before conception and wait at least a month before becoming pregnant.
The woman who only discovered during pregnancy that she is still susceptible to these diseases must protect herself during pregnancy by avoiding contact with sick people and then, after giving birth, get vaccinated even during breastfeeding.

FOR THE MOTHER during pregnancy

During pregnancy, not all vaccinations are possible, but some are recommendable. This is the case with flu shots and anti-whooping cough vaccinations.
Flu vaccination: Flu can be risky for both mother and fetus, with increased risk of hospitalization, preterm birth, low birth weight and pregnancy loss. The anti-flu vaccination is recommended and offered free of charge to women who are in the second or third trimester of pregnancy at the start of the flu epidemic season.
Anti-whooping cough vaccination: whooping cough contracted by the newborn in the first months of life can be very serious or fatal and the source of infections is frequently the mother. The anti-pertussis vaccination (administered with the trivalent dTpa vaccine also for diphtheria and tetanus) is recommended for every pregnant woman, even if she has previously been vaccinated or is up to date with the ten-year boosters or has already had whooping cough.
The recommended period for vaccination is the third trimester of pregnancy (between the 28th and 32nd week) in order to allow the pregnant woman to produce sufficient antibodies and the consequent transplacental passage.
The dTpa vaccine has proven safe for both the pregnant woman and the fetus

Covid-19: vaccination during pregnancy

Vaccination with mRNa Vaccines is aimed at all pregnant women in the second and third trimesters.
The adverse effects of vaccination are similar to those of the general population: pain and swelling at the injection site, bone and muscle pain, fever and occur more after the second dose
During pregnancy The risk of falling ill with a severe form of Covid 19 occurs in the presence of concomitant pathologies (diabetes, hypertension, obesity)
The data collected so far on the safety of mRNA vaccines administered during pregnancy are reassuring and do not highlight an increase in risks for either the mother or the fetus, compared to the risks of the general population. Furthermore, the antibodies produced by the maternal immune system cross the placenta and are transmitted to the fetus which thus acquires protection against the coronavirus.
If pregnancy begins after receiving the first dose, there are no indications for terminating the pregnancy but it is advisable to delay the second dose until the beginning of the second trimester (unless there are conditions and pathologies that expose to the risk of Severe Covid 19)
If the woman is trying to become pregnant she should wait approximately 2 weeks after the second dose before attempting to conceive.

Vaccinations for newborns

Vaccinations represent one of the most effective and safe interventions in public health to protect healthy subjects who, due to some epidemiological, health, occupational or behavioral conditions, may be exposed to the danger of contracting certain infections.
Vaccination programs also aim to achieve the reduction and, when possible, the eradication of certain infectious diseases for which there is no therapy or which may cause serious complications.
The Vaccination Calendar of the Region lists the vaccinations actively and free of charge to the population by age group.

Vaccinations at birth

Vaccination against Hepatitis B virus: *recommended only in children of mothers who carry the Hepatitis B virus, the vaccination involves 4 doses: the first within 12-24 hours of birth, the second after a month, the third after 2 months and the fourth at the 11th-12th month also in conjunction with the other vaccinations. At the same time as the administration of the first dose, specific immunoglobulins will be used.*

Vaccinations in the first year of life

Vaccination against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae type B and hepatitis B. The first year of life is of fundamental importance to protect the child against these important diseases. It is recommended to vaccinate the child starting from the 61st day of life, precisely to provide rapid protection especially against whooping cough, the clinical severity of which is greater the earlier it is contracted.

Immunization against these 6 infectious agents is normally carried out using a single (hexavalent) vaccine.

Vaccination against pneumococcus: vaccination against this bacterium, which is the main cause of otitis and meningitis, is recommended, simultaneously with vaccination with hexavalent

Vaccination against meningococcus B: it is recommended for all newborns and should be carried out in the first year of life, 15 days after administering the hexavalent and pneumococcal vaccines

Rotavirus vaccination: administered orally, it is universally recommended for all children starting from the 6th week of life and can be administered with the other vaccinations required for the age.

Vaccination against influenza: starting from 6 months of life, it is recommended for children belonging to risk groups.

Vaccinations in the second year of life

Vaccination against diphtheria, tetanus, whooping cough, polio, Haemophilus influenzae type B and hepatitis B. The second year of life is the time for completion with the third dose of hexavalent vaccine.

Pneumococcal vaccination: the second dose of the combined pneumococcal vaccination is recommended.

Vaccination against meningococcal B: the fourth dose of this vaccine is recommended or the third dose if the cycle started after six months of life.

Vaccination against measles, mumps, rubella and chickenpox: the first dose of this vaccine is recommended starting from the age of one.

Vaccination against meningococcus C: protection of the child between the 13th and 15th month of life is recommended. As an alternative to the anti-meningococcal C vaccine, the tetravalent A,C,Y,WEEK135 vaccine could be used, with the aim of offering children broader protection for those meningococcal strains which, although still sporadic in our country, show a tendency to expansion, mainly as a result of climate change, travel, and migratory movements.

Influenza vaccination for children at risk. Vaccination against the hepatitis A virus for children at risk.

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WHAT TO PACK IN YOUR HOSPITAL BAG

MOTHER HOSPITAL BAG

- night gowns with buttons at the front (no, 2/3)
- a dressing gown,
- slippers (rubber slippers in case you need a shower),
- A bath towel,
- Washbag and toiletries,
- Hand and bidet towel set (fabric or disposable),
- Absorbent sanitary pads or knickers,
- Water, candy, light snacks

HOSPITAL BAG FOR YOUR NEWBORN

- 6 bodysuits size 1-3 months, (thermal cotton in winter, cotton in summer),
- 6 rompers or onesies (chenille in winter, cotton in summer),
- 1 camicino della fortuna, the Italian traditional good-luck shirt, (optional),
- 3 bibs,
- 1 towel to wrap the newborn up
- 1 blaket in natural fiber (wool or cotton),
- 1 pack of nappies size 1

Keep the newborn's changes of clothes in small single bags (one for each day), with the name tags and the mother's surname.

FULL TERM PREGNANCY

At 37 + 0 WEEKS

The maternal-fetal health assessment must be carried out at the **Birth Center** chosen for the birth, or identified as suitable for the clinical situation.

During the first meeting at the Full-Term Pregnancy Clinic at the Birth Centre, the following are assessed:

- the medical history
- current state of health
- the results of blood tests performed during pregnancy
- the methods envisaged for childbirth.

On this occasion it is very important to discuss and clarify any doubts the woman has about childbirth, what her expectations and/or needs are, and to check whether the Birth Center is able to provide adequate responses to specific requests (e.g. particular clinical situations, orientation for particular birth methods, such as water immersion or epidural analgesia, umbilical cord blood donation, etc.).

In this first meeting, the personalized care plan for the subsequent weeks of pregnancy is also explained to the woman and the rules of the department are clarified such as the possibility of being accompanied by a relative, reception times, hospitalization times for childbirth.

FROM 37 AND 41 WEEKS

Pregnancies between 37 and 42 weeks are considered full term.

The day of birth is not predictable, but the majority of babies are born around the 40th week. In this last period the child perfects the maturation of some functions, gains weight and positions himself for birth.

Generally, starting from the 38th week, the mother breathes better because "the abdomen lowers" and she begins to feel the contractions that prepare for labor.

If signs appear such as swelling (edema) in the legs, wrists, face, or loss of blood or amniotic fluid, abdominal pain, vision problems or other sensations perceived as annoying, or if you cannot perceive the usual movements of the fetus, it is important to go to the Birth Center as soon as possible to exclude maternal and/or fetal risk conditions.

In pregnancies beyond 41 weeks, or in those in which specific clinical indications arise, it is necessary to monitor the pregnancy more frequently.

What to prepare for the hospital

- the Pregnancy Agenda;
- identity document and health card;
- TEAM card for foreign women from EU countries;
- STP code (foreigners temporarily present) for women belonging to non-EU countries and without a residence permit;
- ENI code for women from EU countries and without a residence permit;
- personal effects of the mother and baby recommended by the Birth Center.

When to go to hospital

- when the contractions have been regular in intensity, frequency and duration for at least a couple of hours;
- when the rupture of the amniotic membranes occurs with leakage of liquid (loss or rupture of the "waters");
- when blood loss is more than a few drops;
- in all cases where you have doubts.

PHYSIOLOGY OF LABOUR AND BIRTH

Nature has planned childbirth in every detail: normally it is the fetus that initiates it, placing itself in a favorable position for birth and stimulating the start of uterine contractions.

SYMPTOMS BEFORE LABOR

Already in the last weeks of pregnancy, symptoms may appear that precede actual labor, namely:

- occasional and irregular contractions (compression and hardening of the abdomen with a sensation of pain in the back), which can also disappear in a short time;
- loss of mucus mixed with traces of blood (loss of the mucus plug);
- nausea and/or vomiting.

In the **hours before labor** (from a few hours to more than 24 hours), the following symptoms may occur:

- contractions become regular in intensity, duration and frequency. Unlike contractions before labor, these contractions do not weaken, but rather increase over time;
- small blood losses related to the preparation of the cervix. The leakage is generally a few drops, bright red;
- loss of amniotic fluid, due to rupture of the amniotic sac that surrounds the baby. Amniotic fluid is usually colorless and odorless. The loss is usually sudden and abundant;
- diarrhea, due to the hormones that prepare the cervix and is useful for clearing the intestines and preparing the body for childbirth.

PHASES OF LABOR AND BIRTH

The prodromal phase consists of the "transformation of the cervix", which softens, thins and shortens until it becomes completely flat.

The duration of this phase can be between a few hours and a few days.

The dilating phase is the actual labor; it serves to completely dilate the cervix, thanks to the contractions which become regular in duration and frequency.

It begins when the cervix is completely flat.

The duration is variable: it can also be very fast if the cervix is well thinned and the baby's head is well flexed in the pelvis. The average duration is 6-8 hours for a woman giving birth for the first time and 3-5 hours for a woman who has already had at least one birth.

Expulsive phase is the final moment of labor that leads to the birth of the baby.

It begins when the dilation reaches a diameter sufficient to allow the passage of the fetus.

Secondment is the final part of childbirth. In this phase, the placenta is expelled usually a short time after birth and in any case within an hour.

Postpartum. From the first hours after giving birth, and in the following days, the obstetrician or gynecologist checks the uterus and vaginal discharge (called lochi or lochiations).

Welcoming mother and child well means: respecting their desire/need to be together, making an effort to understand their requests and communicating serenity.

It is of fundamental importance in the very first moments, skin-to-skin contact and the early attachment of the baby to the mother's breast.

Having the baby close throughout the day allows the mother to recognize her needs and respond to them in time; It also allows the mother to adapt her rhythms to those of the baby, taking advantage of his sleep breaks to rest.

discharge from hospital. It is an opportunity for a dialogue with birth workers to consciously conclude the experience of pregnancy and childbirth and open the new phase of life for the woman and the family.

Puerperium is the period of time from birth to approximately 6 weeks afterwards.

METHOD OF BIRTH

Spontaneous vaginal birth is the birth chosen by mothers in a physiological condition of childbirth.
What is good to know about spontaneous vaginal birth:

- causes less pain after birth
- allows for easier physical recovery after giving birth
- increases the sense of self-esteem
- facilitates the relationship with the child
- it is less frequently associated with postpartum depression
- Allows for a better breastfeeding experience
- it is less frequently associated with postpartum infections

Cesarean birth *(surgical operation which consists of incision of the abdomen and uterus) is necessary if there are conditions of risk for you and/or the baby.*
What is good to know about cesarean birth:

- requires a longer hospital stay
- it causes more pain and greater difficulty moving and caring for the baby in the days following birth
- carries a greater risk of infection and anemia
- causes greater difficulty in starting breastfeeding
- has a higher risk of maternal mortality
- increases the frequency of pathologies affecting the placenta in subsequent pregnancies.

POSITIONS IN LABOR AND BIRTH

There is no single recommended position for labor and birth: the obstetrician suggests those most favorable to the progression of the birth and the containment of pain and invites the woman to choose the most comfortable ones for her.
In general, lying and supine positions are not recommended.
The possibility of moving and the upright position during the dilation period and the squatting/all fours position during the expulsion period seem to be able to reduce the duration of labor and guarantee greater well-being.

PAIN IN LABOUR

Labour pain has very particular characteristics and serves to promote the natural progression of labor and birth. Every woman has a completely subjective perception of pain in labor, conditioned by physical conditions, emotions, social, cultural and healthcare circumstances.

However, modern hospitals have **natural strategies (without the use of drugs) to reduce pain in labor:**

- continuity of care during labor and birth;
- "one-to-one" relationship (a woman-a midwife) at the time of labor-birth;
- emotional support: communication, information, listening, involvement in choices;
- relief actions: being able to move during labor, being able to choose the position for childbirth, a comfortable birth environment;
- relaxation techniques, massages;

These simple strategies and techniques, **in general, reduce the need for drugs to reduce pain**, **reduce the need for medical interventions for childbirth (use of oxytocin, episiotomy, cesarean section)** and increase the woman's satisfaction with the experience experienced.

With use of drugs. Epidural

An anesthetic visit is required in the weeks preceding the birth, some specific tests and the woman's informed knowledge

It consists of a puncture made by an anesthetist in the lumbar region (lower back) with which a thin catheter (tube) is inserted which remains for the entire duration of labor and removed after childbirth.

In this case, childbirth is medicalized: one is subjected to continuous monitoring of the heartbeat, there is a greater probability of an operative delivery (vac or forceps) and a greater risk of having a fever during and after childbirth.

FEEDING TIME

Breastfeeding is the natural continuation of the special relationship that was created with the baby during pregnancy.

It is a moment full of emotions that creates a unique and intense bond. In addition to being the best food, breastfeeding guarantees healthy psycho-physical development and satisfies the need for contact with the mother, which is therefore important on a relational level. Breastfed children have many health advantages, because they receive antibodies and because all the substances in the milk are present to protect them from diseases, for neurological development, of the immune system and of vision.

> **Breastfeeding begins as soon as possible, as soon as the mother feels up to it**. It would be ideal for the newborn to be placed close to the mother immediately after birth, in skin-to-skin contact and helped to attach to the breast.

The first milk (colostrum) is little but very rich in fats and antibodies and the newborn drinks a few drops but sometimes they are enough. Milk arrives after 3-4 days. It is important to breastfeed the baby whenever possible because sucking stimulates the production of hormones (prolactin and oxytocin) thanks to which the mammary glands produce milk.

You can breastfeed as long as you want. Milk can also integrate the diet during weaning.

Breastfeeding, although satisfying, is challenging, which is why family support is important.
No food must be given up so that the child "participates" in the tastes and flavors of the house. The important thing is a varied diet, rich in seasonal fruit and vegetables, and trying to drink lots of water to replenish fluids.
There are rare cases in which a woman cannot breastfeed her baby. This happens if the mother has undergone treatment for serious pathologies (tumors, HIV...), serious and total intolerance of the child to lactose (galactosemia), and total lack of breast milk.

- rely on a midwife and don't be afraid to contact her in case of difficulty,
- meet other new breastfeeding mothers in the last months of gestation, to begin to understand and learn the first secrets.

To breastfeed correctly there are numerous possible positions, but for each one it is important to check some aspects:

- Is mom comfortable? You can possibly help yourself with pillows if necessary, but it is necessary that the shoulders and arms can be relaxed.
- Baby's head and body in a straight line? Otherwise swallowing may be difficult.
- Is it possible to easily support the baby's neck, shoulders and back?

Finally, it is preferable that it is always the baby who is carried to the breast, and not the mother who leans over, with some exceptions which we will see shortly, such as the wolf position.
Remember that you are responding to your baby's needs: it is not possible to stay at home all the time and you have the right to feed him even while you are out and about. Indeed, you must be proud of your commitment and attention towards him/her!

CRADLE POSITION

The cradle position is the most used and is suitable for babies born at term from natural birth, because in the case of a caesarean section the mother may feel some discomfort in the abdomen in the first few days.

1. To start, sit comfortably in an armchair with armrests or on a bed with cushions available.
2. Turn the baby on his side, so that his face, stomach and knees are facing you.
3. You can use your arms and hands to help him, supporting his neck, back and bottom.
4. She brings the baby to her breast, resting his head in the crook of her elbow, with his nose in front of the nipple.

RUGBY-BALL POSITION

This position is particularly suitable in the case of a caesarean section, but in general also for all babies who show some initial difficulty in latching on correctly (perhaps because they were born a little early), because the mother can guide them with the help of her hand.
The position is also particularly suitable for women with very large breasts and/or slightly protruding nipples.

1. To adopt the rugby position, sit in an armchair and prepare a cushion nearby.
2. Lift your baby as if he were a rugby ball, with his arm on the same side of your breast as you want to start the feed.
3. Move the baby to your side, under your arm.

4. Gently place your hand behind the baby's head and bring it closer to the nipple; Feet and legs should be positioned at hip/back height and you can help him further with the other hand.

SIDE LYING POSITION

This position is perfect after a cesarean section, because the baby does not weigh on the belly.
It is also particularly suitable in the case of difficult natural births, because the mother can remain lying down and resting in bed.
Lie in bed on your side and place your baby next to you, so that his nose is in front of your nipple.
You can use a low pillow to make him more comfortable and use the part from the elbow to the hand to support his back, while the other hand remains free to help him if necessary.

BIOLOGICAL NURTURING

It is a particularly comfortable position for both, which favors the newborn's natural instinct to breastfeed.
The mother simply has to make herself comfortable in a semi-reclining position, with her back well supported by pillows or other things, and place the baby on her body, belly down.
It is an innate position, which is spontaneous for both because it is used instinctively after childbirth which in past centuries/millennia was as painful as today, but experienced in even more difficult conditions for the mother-child couple.
The baby sucks lying on the mother's body and this allows for an almost perfect attachment and sucking in a completely spontaneous and natural way, a bit like baby mammals in nature.

CROSS HUG POSITION

This position is similar to the cradle position, but the arms are arranged differently.
This is a variant that many mothers experience in the first weeks after giving birth, because it allows greater control over the way the newborn attaches to the breast.
In this case, instead of supporting the baby's head in the crook of the elbow, one arm supports the breast and the other remains around the baby's back. Support the baby's head, neck and shoulder by placing your hand at the base of the head, with the thumb and forefinger at the level of the back.
As in the cradle position, your bellies will be in contact.

POSITION OF THE WOLF

In this position the baby lies on his back, resting on the bed or on a pillow, while the mother on all fours above him offers him the breast. It is a possibility that is particularly useful in case of breast engorgement, as it stimulates the emptying of the breast even in the lower quadrants.

WHAT ARE THE SIGNS THAT BREASTFEEDING IS CORRECT?

1. The newborn seems comfortable with her and the mother feels no pain.
2. The baby's chest rests against the mother's body and she does not need to turn her head while sucking.
3. The areola is entirely (or almost entirely, if it is particularly large) hidden inside the baby's mouth.
4. The newborn's mouth is entirely filled by the breast.
5. The baby's tongue is positioned under the breast and is therefore hidden from the mother.
6. If the room is sufficiently quiet it is possible to hear that the baby is swallowing; in some cases swallowing is so silent that you only notice the difference when you take a moment's break.
7. Often the newborn's ears move slightly.
8. The newborn's lips are turned outwards, like those of a small fish (often the lower lip cannot be seen because it is covered).
9. The baby's chin is resting on the breast.

PUERPERIUM

It is the period from birth to approximately 6-8 weeks after. It is a phase of physical and psychological adaptation during which the uterus returns to the size and muscle tone of before pregnancy, breastfeeding is consolidated and the daily life rhythms of mother and baby are regularised. It is important to know that the rhythms of the day gradually change based on the physiology of breastfeeding and therefore it is best to live this period in the awareness that the mother-child adaptation will reach a harmonious balance over time, without making untimely predictions for the future ("He's a little tyrant, he doesn't leave me a moment free, he wants me all to himself day and night, ..."). Adaptation to the new situation (presence of the first child or a new child) with needs apparently very far from the family's usual life rhythms can sometimes create some difficulties and tension even in the couple. Due to hormonal changes and tiredness after giving birth, it is quite common to feel sad and melancholy. For some women, this condition may require psychological and/or medical support, in some cases even pharmacological support.

After giving birth, it is normal for discharge to come out of the vagina that contains placental residues called lochia or lochiations. They are not menstruation and can last up to three weeks after giving birth. Lochiations have a particular odor and are predominantly blood-tinged in the first week and creamy at the end. In the presence of foul-smelling vaginal discharge, perineal pain, difficulty in healing any perineal wound, breast pain, abundant discharge, urine, significant anxiety or fatigue, it is advisable to bring forward the meeting in the puerperium.

Women who do not have rubella antibodies are advised to be vaccinated after giving birth. In the month following vaccination it is necessary to avoid a new pregnancy while there are no contraindications to breastfeeding which can continue normally.

After childbirth, depending on personal needs, and in any case within 30-40 days, it is useful to have a meeting with the professional who followed the pregnancy to talk about the experience of your childbirth and for the evaluation:

- *obstetric conditions;*
- *of the perineum;*
- *mental and psychological well-being;*
- *any contraception;*
- *breastfeeding;*
- *information on opportunities to receive support from self-help groups or social and health services.*

There is evidence that group meetings between women who are going through the same experience allow them to share fears, anxieties, etc., recognizing the "normality" of such events and states of mind. The clinics offer meeting opportunities for postpartum women. At the end of the birth process, the Agenda will become the clinical documentation of the pregnancy and birth just experienced, useful for the obstetric anamnesis in the event of a subsequent pregnancy and will be connected with the child's health booklet which will follow the child from birth to adolescence. Inserting one or more photos of your pregnancy and baby can transform the document into an album of the experience you have just concluded.

Before leaving the hospital, the mother will be able to offer the department her opinion on her hospitalization experience, thus collaborating in the improvement of services.

The World Health Organization recommends, in the first days after birth, some behaviors that constitute an objective for all regional Birth Centres:

• help mothers so that they can hold the newborn in skin-to-skin contact immediately after birth so that the first feeding begins spontaneously
• show mothers how to breastfeed and how to maintain milk secretion even if they are separated from the newborn
• do not give newborns food or liquids other than breast milk, unless specifically prescribed by a doctor
• place the newborn in the same room as the mother, so that they spend 24 hours a day together during their stay in hospital
• encourage breastfeeding whenever the newborn requires nourishment
• do not give teats or pacifiers to newborns during the breastfeeding period
• encourage the creation of breastfeeding support groups even after discharge from hospital.

MENTAL AND PHYSICAL WELLBEING

During pregnancy, both parents experience intense emotions at the thought of the baby growing in the mother's womb.
Sharing our concerns with trusted people, or with chosen professionals (obstetrician, gynecologist, psychologist), asking for help - during pregnancy or in the puerperal period - is important to achieve and maintain a state of well-being, not only physical, but also psychic.
In some cases, however, the discomfort is deeper and then it becomes important to recognize that you need help, without fear of being judged, because it can happen to anyone. By contacting the counseling center directly, you will be able to find support and the therapeutic path best suited to your needs to overcome difficulties.
A space of support and dialogue open not only to future mothers, but also to future fathers.
Detecting these problems early allows you to receive the necessary support to have a peaceful pregnancy and avoid many complications that could arise if they were not identified.
In the absence of problems, the mother and baby must be able to continue to remain in close contact, without interruptions and in a natural way. The newborn looks around, turns his head at the sound of his mother's voice and sees at a distance of 20-30 cm which is the distance between her eyes and those of his mother when he is in her arms or at the breast. Skin contact and early sucking at the breast increase the mother's hormones and induce the production of stress, alarm and energy consumption hormones. Skin-to-skin contact activates innate reflexes that lead the newborn to move until it reaches the nipple on its own.

In the case of a caesarean section, it is possible, with the help of the operators present at the birth, not to remove the newborn from the mother and allow immediate contact.
If there are conditions that require separation, it is important to try to reunite mother and newborn as soon as possible.

ROOMING IN

Please continue the very close relationship between mother and baby, both should remain in the same room, both in the case of spontaneous birth and caesarean section. This allows the mother to learn to recognize the newborn's requests and respond to them appropriately, reassuring her about her maternal skills as well as getting her used to resting while the baby sleeps. At birth the sleep-wake rhythms are not different during the day and night hours and only as the weeks pass will the sleep periods become longer during the night hours interspersed with feedings which are very important as they are the richest and most nutritious
Gradually the mother and child will find their harmonious life balance and the best place to develop the mother-child-family relationship is certainly their home.

Discharge generally occurs after 47-72 hours in the case of spontaneous birth and 3-5 days in the case of caesarean section.

UMBILICAL CORD DONATION

Cord blood contains stem cells completely similar to those contained in the bone marrow from which red blood cells, white blood cells and platelets originate; due to these characteristics they can be used to treat various blood diseases.

Cord blood cell transplant is a valid alternative to bone marrow transplant and presents some advantages for those who receive the transplant (less risk of rejection, ready availability of the cells) and no disadvantages for those who donate it: the procedure, in fact, is harmless and painless for the mother and the newborn. Furthermore, if cord blood is not donated, it is destined to be discarded.

Donating cord blood means contributing to the possibility of life-saving treatments and research in the field of these diseases.

The donation defined as **allogeneic or solidarity,** i.e. made to treat a person other than the one who donates, is voluntary and free: no cost, in any of the phases, will be borne by the donor mother and family members.

Autologous storage is requested by parents when they want to conserve the cord blood for any future needs of the newborn, even if the newborn is healthy at the time of donation, in the theoretical hypothesis that during life it may develop a disease that can be treated with its own cells stem.

This conservation is not permitted in Italy as it is not supported by scientific evidence and therefore is not considered appropriate. However, it is possible to store cord blood in foreign banks by requesting specific authorization from the Health Directorate of the birth center.

To donate cord blood it is necessary to ascertain with the obstetrician or gynecologist your suitability for donation, the availability of the birth center for the collection and sign the informed consent.

YOU CAN ACCESS DIRECTLY AFTER THE 33 WEEK OF GESTATION THE TRANSFUSION CENTER OF THE HOSPITAL OR THE FAMILY CONSULTING CENTER

There are some contraindications to donation:

- *duration of pregnancy less than 35 weeks;*
- *feverish state of the mother;*
- *congenital malformations;*
- *congenital diseases of the mother or father;*
- *rupture of membranes for more than 12 hours;*
- *fetal stress;*
- *serological positivity or parental risk of transmitting infectious diseases.*

In the absence of contraindications, the blood will be collected from the umbilical cord in a sterile bag after cutting the cord and before expulsion of the placenta, painlessly for both vaginal birth and cesarean section.

IMPORTANT CONTACT DETAILS FOR YOUR BIRTH CARE PATHWAY

Consultori (Public Health Centres)

Contact one of the Obstetric clinics below to make an appointment:

Campobasso 0874.409001-0874.409003
Wednesdays from 3 to 5 pm
Fridays from 9 am to 12:00 (noon)
Bojano 0874.752340
Mondays from 3:30 pm 5:30 pm
Tuesdays from 10:30 am to 12:30 pm
Riccia 0874.714312
Mondays from 2:30 pm to 3:30 pm
Larino 0874.827329-0874.827328
Mondays and Tuesdays from 10:00 am to 12:00 (noon)
Tuesdays from 3:00 to 5:00 pm
Wednesdays from 9:00 am to 12:00 (noon)
Termoli 0875.717888
Tuesdays and Fridays from 9:30 am to 12:30 pm
Wednesdays from 3:00 to 5:00 pm
Venafro 0865.907903
Tuesdays and Wednesdays from 12:00 (noon) to 1:30 pm
Agnone 0865.722492
Mondays on 8:30 am to 2:00 pm
Mondays from 2:30 to 4:30 pm
Isernia 0865.442752
Mondays from 3:00 to 5:00 pm
Thursdays from 8:00 am to 1:00 pm

Hospitals

Presidio Ospedaliero "*Cardarelli*" di Campobasso:
Ostetricia e Ginecologia *(Obstetrics and Gynecology)* 0874 409 231
Ambulatorio *(Clinic)* 0874 409 411

Presidio Ospedaliero di Isernia:
Ostetricia e Ginecologia *(Obstetrics and Gynecology)* 0865442333
Ambulatorio *(Clinic)*: 0865442248

Presidio Ospedaliero di Termoli:
Ostetricia e Ginecologia *(Obstetrics and Gynecology)* 0875 7159359
Ambulatorio *(Clinic)*: 0875 7159383

Call center for Healthcare information and bookings

From a landline: 800 63 95 95

For mobile phones: 0875 752626

Breast & Cervix Screening Secretary Office:

0874.409449
0874.409249
0874.409160
Mon - Fri from 10:00 am to 12:00 (noon)

Vaccinations Office, Campobasso

0874.409128