Appendix

REFERRAL PROTOCOL FOR THE OBSTETRIC CASES IN THE SECONDARY LEVEL HOSPITALS

Obstetric referrals are more complex and the decision making window is narrow. Maternity referral is based on the concerned Obstetrician's clinic al judgment depending on the nature of obstetric condition, facilities available locally and proximity to the referral centre.

There are essentially two types of referrals: Elective (Planned referral) and emergency referrals.

As the obstetricians experience and availability of supporting specialist services differ across the institutions, the individual practitioner can take decision according to the merit of individual case and what is given is only general guidelines.

The following are the conditions for referral

1. Patient shall be preferably seen by a Gynecologist before elective referral.

2.Emergency referrals can be done by the duty doctor after discussion with the gynecologist and making a note of that in the case records

3.Medico legal cases shall be examined as per the POCSO Act & Kerala Medico legal code. If gynecologist is essential for Medico legal examination, and not available in the hospital at the time of arrival of such cases, on call duty Gynecologist shall be called. In such cases facility for transport for Gynecologist shall be made available by the hospital administration or by the Health department. This can avoid unnecessary referral.

4.Stabilizing the patient before referral: All possible efforts shall be taken for stabilisation of the patient before referring to a higher institution. The condition of the patient shall be informed to the higher centre through phone. Proper referral card/note regarding the treatment details and condition of the patient should be sent along with. In case of life threatening cases a hospital staff shall accompany the patient.

5.The patient shall be transported preferably in ALS/BLS Ambulance. The hospital shall keep an emergency transportation kit in the casualty. If private Ambulance is used, an emergency kit containing essential drugs, Ambu Bag and mask and other essentials shall be sent with the staff accompanying the patient during the transportation. All High risk cases need to be referred preferably to tertiary care facility

6.If ambulance is not available in the institution, the private ambulance shall be hired for the transport of the patient. The expenses regarding the same should be met by the hospital from the JSSK, RSBY, HMC/HDC or any other fund available in the institution. After reaching the tertiary centre, transport for the return of the staff also should be arranged.The expenses for the same also shall be met by the hospital from the JSSK, RSBY, HMC/HDC or any other fund available in the institution.

7. If the patient requires ALS ambulance for the reference and the same is not available in the institution and 108 ambulance is not available at the time, the ALS private ambulance shall be hired using the JSSK, RSBY, HMC/HDC or any other fund available in the institution.

Elective antenatal references:

Risk assessment should be done at the first visit at all centers and early referral to be ensured.

Pregnancy with Heart Disease:

If known case of Heart disease or Heart disease detected during the antenatal visit shall be referred to Cardiologist for expert opinion. As per the opinion of cardiologist, low risk cardiac cases like MVP, mild MR etc shall be managed at the secondary level.

Hypertensive disorders

Uncomplicated gestational hypertension, that is if BP is controlled with drug* and no other complications present, can be managed at the secondary level. Complicated gestational hypertension shall be referred to higher centre.

Diabetes

Gestational diabetes mellitus and Pre-gestational diabetes, with controlled blood sugar and without complications shall be managed at the secondary level. Pre-gestational diabetes with complication and complicated GDM cases should be referred to tertiary centre sufficiently early.

The antenatal cases with Gestational diabetes mellitus and Pregestational diabetes, if neonatal complications are expected, the pediatric consultation shall be done in the antenatal period.

Multiple drug allergies

In case of history of drug allergy, the patient shashall be referred to Anesthesiologist for expert opinion and referred if needed. The

expenditure for testing the drug allergy shall be met from JSSK fund.

Thyroid disorders

Thyroid disorders can be managed in consultation with a physician. Uncontrolled cases can be referred.

Auto immune disorders

Systemic lupus erythematosis and other auto immune disorders should be referred to tertiary centre.

Anemia

Anemia with Hb less than 8 g at term should be referred to a tertiary care centre.

Jaundice complicating pregnancy

All cases of Jaundice complicating pregnancy should be referred. The patients with congenital hyperbilirubinemia with normal Liver function shall be managed at the secondary level.

Fever

For fever cases, follow the fever protocol in all cases and refer appropriately. *Short Febrile Illness including Influenza Like Illness (Ill) Management guidelines published by Public Health Division, Directorate of Health Services, Kerala.*

Seizure disorders

Seizure disorders shall be referred to neurologist for expert opinion and based on the opinion, controlled cases shall be managed at the secondary level. Patient with recurrent seizure attack, seizures not responding to the medication and seizure episode during the antenatal period shall be referred.

Mental disorders

Patients with mental disorders on drugs shall be referred to a Psychiatrist for consultation and referred if needed.

Anesthesia high risk patients.

All cases with anticipated anesthesia complications like morbid obesity can be referred. BMI shall be taken as an indicator for determining the obesity The BMI above 30 in the first trimester may be referred to tertiary institution.

The antenatal cases with height less than 135 cm shall be sent to anesthesiologist for consultation and referred if needed. Intrapartum, the patient with full stomach shall be assessed by an anesthesiologist and Gynecologist. The risk assessment shall be done and referred if needed. Intrapartum fever with clinical and or laboratory indicators suggestive of

sepsis shall be referred.

Hyperemesis

Majority of Hyperemesis can be managed at secondary level and nonresponding cases can be referred to a tertiary centre

Previous caesarean

Previous caesarean where complications are anticipated like previous LSCS with placenta previa, anomalies, IUD and complications during previous LSCS should be referred sufficiently early.

Ante partum hemorrhage

Antepartum hemorrhage cases not manageable at the secondary level with high maternal risk should be referred

Fetal Growth Restriction

Fetal Growth restriction severe enough requiring intensive neonatal care can be referred. The antenatal cases suspecting fetal growth restriction shall be consulted with pediatrician.

Placenta previa,

Placenta previa needing reference shall be referred by 34 weeks electively.

Placenta accreta.

All cases of placenta accreta should be referred.

Multiple pregnancies

Multiple pregnancies with complications not manageable at the secondary level should be referred.

Mal- presentation

Mal- presentation can be managed at the secondary level.

Emergency Referral

1. Do not refer ruptured ectopic, cord prolapse, failed induction and incomplete abortion if facilities for immediate intervention are available.
2. Bio hazard alone is not an indication for the referral.
3. Pre- term labour and Preterm Premature Rupture of Membrane (PPROM) can be referred to tertiary centre for neonatal care depending on the expected birth weight and neonatal care facility available.

4. Uncontrolled PPH and third stage complications can be referred in time after stabilizing the patients with measures like IV crystalloids, blood components transfusion, condom tamponade, continuous bladder drainage and oxytocin drip, and applying Non pneumatic anti shock garment if needed.
5. Eclampsia and impending Eclampsia shall be referred after giving loading dose of 4 g i/m and 4 g iv of Magnesium sulphate with proper after

giving intravenous Labetalol. The type of medication given should be communicated to the receiving centre by phone and a letter with details of medication given with time should be sent with the patient.

6. Any acute or severe post operative complications can be referred if the treating Gynecologist feels necessary.

7. Re laparotomy should be avoided in the periphery as far as possible.

8. Postnatal reference - Details of mother's treatment and investigations should be furnished in the reference card even if the mother is referred for baby's Sake.

9. Acute abdomen in pregnancy - Any case of acute abdomen in pregnancy shall be referred.

Back Referral

The tertiary institution can refer back the patient to the referring secondary level institution after treating the acute condition. However the proper instruction should :be provided for the further management at the secondary level.