Reduced Fetal Movements (RFM)
Clinical Guideline

V3.0

June 2019
Summary

Summary: Algorithm for Management of Reduced Fetal Movement (RFM)

All pregnant women to be given Kicks Count leaflet by 28 weeks by their CMW. CMW explains what normal movements are and what actions the woman needs to take if she experiences a change in fetal movement pattern.

First telephone contact
- History confirms RFM
- If unsure, advise to focus on FM for 2 hours. If they do not feel normal movements over the next 2 hours, contact maternity unit.

>28 weeks
- No risk factors (Suitable for assessment in the community)
  - Detailed history / Identify risk factors
  - Maternal observations including urinalysis
  - Measure & plot fundal height measurement
  - Auscultate FH using Pinnard / Doppler

> 28 weeks with risk factors
- Any episode with a significant risk factor for still birth:
  - Suspected /confirmed SGA
  - Diabetes (type 1 and 2)
  - PV bleed / abdominal pain
  - PET / Hypertension
- Or a combination of other risk factors (previous stillbirth, smoking, maternal age, mental health etc.)

Below 28 weeks gestation
See a midwife for full A/N examination inc. assessment for risk factors & FH auscultation. If any abnormalities detected refer to DAU.

1st Episode: (or >3 weeks since last episode)
- SFH normal
- RFM resolved
- Normal CTG
- Reassure
- Complete documentation
- Kicks Counts sticker on front cover of notes
- Discharge home
- Advise to report further episodes RFM

Recurrent Episode: (<3 weeks since last episode)
- SFH normal
- RFM resolved
- Normal CTG

Abnormal CTG or Dawes / Redman criteria not met

To be referred to DAU for CTG and senior review.

Order USS within 24h via DAU – if not possible for daily CTGs until the scan appointment (USS not needed if last scan <2 weeks ago)

Senior Obstetric review for an Individualised Management Plan (IMP).
1. Aim/Purpose of this Guideline

1.1. To give guidance to Midwives and Obstetricians on the management of a woman who reports reduced fetal movements (RFM) as unrecognised or poorly managed episodes of reduced fetal movements have consistently been highlighted as contributory factors to avoidable stillbirths (MBRRACE-UK 2015).

1.2. To be used in conjunction with the following RCHT clinical guidelines (NEW 2018):
- Antenatal booking, antenatal care and information.
- Antenatal Guideline for antenatal CTG and Dawes Redman CTG analysis (NEW 2018).
- Day Assessment Unit Referral Criteria.
- Induction of labour.
- Pregnancy loss and early neonatal death.

1.3. The specific aims are to (NEW 2018):
- Ascertain gestation and obstetric history.
- Ascertain fetal well-being, reassure the woman and exclude fetal death.
- Exclude fetal growth restriction or small for gestational age (SGA) fetus.
- Assure more intensive assessment if appropriate.
- Delivery as appropriate.

1.4. This version supersedes any previous versions of this document.

1.5. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We can’t rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.infogov@nhs.net

2. The Guidance

This guidance is compiled from recommendations made in the Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline 57 – Reduced Fetal Movements (2011 updated 2017) and Saving Babies’ Lives 2019.
2.1 Antenatal Management

2.1.1 16 Week Midwife Appointment
The midwife should discuss fetal movements and give the woman the "Kicks Count" leaflet.

2.1.2 Advise women:
- Most women are aware of fetal movements by 20 weeks gestation.
- There is no reduction in the frequency of fetal movements in the third trimester.
- To be aware of their baby`s individual pattern of movement as there is currently no universally agreed definition of RFM (NEW 2018).
- To contact their community midwife or the Triage Line if they are concerned about a sudden change in fetal activity or a reduction in or cessation of fetal movement after 24 weeks gestation (NEW 2018).
- Women should not use a home Doppler as this can give false reassurance.

2.2 Subsequent antenatal appointments

2.2.1 Fetal movements should be discussed at each antenatal contact after 20 weeks gestation and the discussion recorded in the maternity notes.

2.2.2 Women should be offered a leaflet regarding RFM by 28 weeks of gestation. (NEW 2019)

2.2.3 Women who are concerned about RFM should not wait until the next day for assessment of fetal wellbeing (NEW 2018).

2.2.4 If women are unsure whether fetal movements are reduced, they should be advised to lie on their left side and focus on fetal movements for 2 hours. If they do not feel 10 or more movements in 2 hours they should contact their CMW or Triage Line immediately.

2.3 Initial Assessment by Community or Triage Midwife (telephone or face to face)

2.3.1 A detailed history should be taken recording the woman`s concern and her history.

2.3.2 Assess if there are additional risk factors for stillbirth and fetal growth restriction (FGR) which should be taken into account when assessing.
2.3.3 **Major risk factors:**
- Known SGA or FGR
- Abdominal pain (NEW 2018)
- Vaginal bleeding (NEW 2018)
- Diabetes (not GDM)
- Hypertension/PET

2.3.4 **Other risk factors**
- Trauma within previous 48 hours (NEW 2018)
- Smoking
- Multiple consultations for reduced fetal movements
- Previous history of IUD/ stillbirth / SGA (NEW 2018)
- Known congenital malformation
- Polyhydramnios/ Oligohydramnios (NEW 2018)
- Placental insufficiency
- Sedating drugs such as alcohol, benzodiazepines, methadone and other opioids (NEW 2018)
- Obesity
- Genetic factors
- Extremes of maternal age
- Issues with access to care e.g. women who are poor attenders

2.3.5 If after discussion it is clear that the woman does not have RFM and there are no risk factors for stillbirth she can be reassured.

2.3.6 If unsure, advise to focus on FM for 2 hours. If they do not feel normal movements over the next 2 hours advise to contact maternity unit.

2.3.7 If after discussion RFM is suspected the woman should be advised to attend for assessment. If any of the major risk factors are identified or there is a combination of other risk factors the assessment should take place on DAU.

2.3.8 Women with recurrent RFM who are over 38+6 weeks of gestation should be advised to attend DAU for assessment and individualised plan.

2.4 **Management of RFM before 24 weeks gestation**

2.4.1 Presence of a fetal heartbeat should be confirmed by auscultation with handheld Doppler device or pinard by the CMW within 8 hours (NEW 2018).

2.4.2 If fetal movements have never been felt by 24 weeks gestation, referral should be made for a Fetal Medicine scan to look for evidence of fetal neuromuscular conditions.
2.5. **Management of RFM between 24 and 28 weeks gestation** (NEW 2018)

2.5.1. Placental insufficiency may present at this gestation

2.5.2. Invite woman to attend CMW clinic / DAU or Triage if out of hours.

2.5.3. Take comprehensive history to assess risk factors for stillbirth.

2.5.4. Document maternal observations and urinalysis.

2.5.5. If gestation is over 25 weeks palpate the abdomen and record fundal height as per GAP protocol. Plot findings on customized growth chart and consider ultrasound scan if SGA suspected.

2.5.6. Fetal heart should be auscultated with a handheld Doppler device or pinard for a full minute. Palpate the maternal pulse to ensure a difference and record the findings.

2.5.7. If no fetal heartbeat heard contact DAU to arrange viability scan by midwife sonographer in Fetal Medicine Unit or Obstetric SpR if out of hours.

2.5.8. Routine CTG / ultrasound scan is not recommended.

2.5.9. If fetal movements have never been felt by 24 weeks gestation, referral should be made for a Fetal Medicine scan to look for evidence of fetal neuromuscular conditions.

2.5.10. If all the findings normal reassure the woman and discharge back to her scheduled antenatal care.

2.5.11. Record attendance on RFM record in the maternity notes and add a Kicks Count sticker on the front of the handheld notes. (Additional stickers may be used to highlight further RFM episodes after 28 weeks).

**2.6 Management of women with RFM at greater than 28 week’s gestation**

2.6.1 Invite woman for assessment.

2.6.2 Take history to assess risk factors using Checklist for Required Management of Reduced Fetal Movements (Saving Babies Lives 2, 2019) Record the duration of RFM episode.

2.6.3 Document maternal observations and urinalysis.

2.6.4 Palpate the abdomen and record fundal height as per GAP protocol. Plot findings on customized growth chart and consider ultrasound scan if SGA suspected.

2.6.5 Fetal heart should be auscultated with a handheld Doppler device or pinard for a full minute. Palpate the maternal pulse to ensure a difference and record the findings.
2.6.6 Perform computerized CTG using Dawes-Redman analysis as soon as possible.

2.6.7 If no fetal heartbeat or suspicious / pathological CTG discuss with SpR / Consultant immediately.

2.6.8 After one presentation women should be reassured that 70% pregnancies with a single episode of RFM are uncomplicated. Discharge back to continue scheduled antenatal care. Women should be advised to contact CMW / Triage Line again if they experience a further episode of RFM.

2.6.9 Record attendance and add a Kicks Count sticker on the front of the handheld notes. (Additional stickers to be used to highlight further RFM episodes after 28 weeks) (NEW 2018).

2.6.10 Offer an ultrasound scan if there are other clinical indications (e.g. the baby is SGA on clinical assessment). Review by the on call SpR/ Consultant if the assessment (CTG or USS) findings are abnormal or the woman has known risk factors for stillbirth. (NEW 2019)

2.6.11 Full details of the individualized assessment, discussion and management plan must be documented to ensure continuity of care is provided.

2.6.12 Record advice about follow up and when/ where to present if a further episode of RFM is perceived.

2.6.13 There is no evidence to support formal fetal movement counting (kick charts) after women have perceived RFM in those who have normal investigations.

2.7 Management of women who present with recurrent RFM after 28 weeks – use the checklist provided in Appendix 3

2.7.1 The episodes of RFM should be treated as recurrent if they are less than 3 weeks apart (NEW 2019)

2.7.2 At each contact, record the number of episodes of RFM that the woman has reported and whether they should be considered as recurrent (NEW 2019).

2.7.3 Invite the woman for assessment that includes maternal observations and urinalysis, palpation and measuring of fundal height as per GAP protocol.

2.7.4 Auscultate fetal heart with a handheld Doppler device or pinard for a full minute. Palpate the maternal pulse to ensure a difference and record the findings (NEW 2018).

2.7.5 Perform computerised CTG using Dawes-Redman analysis.
2.7.6 Offer a scan to assess growth, liquor volume and umbilical artery Doppler’s. If an appropriate scan has been performed within the previous two weeks and was normal a repeat scan is not required (NEW 2019)

2.7.7 Review by the SpR / Consultant on call.

2.7.8 If ultrasound assessment is not possible within 24 hours and FM have not resumed to normal CTGs should be performed daily until the scan

2.7.9 Induction of labour for RFM alone is not recommended prior to 39 weeks unless these are associated with other risk factors such as vaginal bleeding, SGA, hypertension or diabetes. (NEW 2019)

2.7.10 Low risk women reporting 1st episode of RFM after 38+6. The woman should be made aware that with recurrent episodes at this gestation she would be offered IOL and that the recommended place of delivery would be Delivery Suite.

2.7.11 Induction of labour should be offered to all women presenting with recurrent RFM after 38+6 weeks of gestation. (NEW 2019)

2.8 Women presenting in labour (NEW 2018)

2.8.1 All women should be questioned about fetal movements when presenting in labour.

2.8.2 If a woman has recent histories of RFM then perform a CTG (transfer to D/S if necessary).

2.8.3 Assess for risk factors regularly throughout labour (Each Baby Counts 2017).

2.8.4 Women with recurrent RFM should be cared for on Delivery Suite, have their history recorded in their notes and on the D/S Swiftboard.

3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>1. Induction of labour</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Documented assessments of fetal movements</td>
</tr>
<tr>
<td></td>
<td>3. Management of reported reduced fetal movements prior to stillbirth</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Lead</th>
<th>Antenatal Ward Manager 1 and 2</th>
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<tbody>
<tr>
<td></td>
<td>Bereavement Midwives 3</td>
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<table>
<thead>
<tr>
<th>Tool</th>
<th>Maternity notes audit 1 and 2</th>
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<tbody>
<tr>
<td></td>
<td>National Perinatal Mortality Review Tool (PMRT)</td>
</tr>
<tr>
<td></td>
<td>accessed via MBRRACE-UK portal - 3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Annually 1 and 2</th>
</tr>
</thead>
</table>
### Stillbirths on case by case basis

| Reporting arrangements | Maternity Forum  
|                         | Mortality Review Oversight Committee(for Stillbirths) - 3 |
| Acting on recommendations and Lead(s) | Patient Safety Team |
| Change in practice and lessons to be shared | Maternity Patient Safety / Bereavement Newsletter |

### 4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the ‘Equality, Inclusion & Human Rights Policy’ or the Equality and Diversity website.

4.2. **Equality Impact Assessment**

The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th><strong>Document Title</strong></th>
<th>Reduced Fetal Movements (RFM) Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>June 2019</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>June 2019</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>June 2022</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Karen Watkins, Obstetric Consultant and Magda Kudas, Antenatal Ward Lead Midwife.</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872-255036</td>
</tr>
<tr>
<td><strong>Brief summary of contents</strong></td>
<td>To give guidance to Midwives and Obstetricians on the management of a woman who reports reduced fetal movements (RFM).</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>RFM, reduced, fetal, movements, kicks, monitoring, Dawes, Redman, CTG, Scan</td>
</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
<td>June 2019</td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>REDUCED FETAL MOVEMENTS (RFM) – CLINICAL GUIDELINE V2.4</td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
<td>Maternity Guideline Group Obs and Gynae Directorate Divisional Board for noting Policy Review Group</td>
</tr>
<tr>
<td><strong>Care Group General Manager confirming approval processes</strong></td>
<td>Debra Shields, Care Group Manager</td>
</tr>
<tr>
<td><strong>Name and Post Title of additional signatories</strong></td>
<td>Not Required</td>
</tr>
<tr>
<td><strong>Name and Signature of Care Group/Directorate Governance Lead confirming approval by specialty and care group management meetings</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td></td>
<td>Name: Caroline Amukusana</td>
</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and</strong></td>
<td>Internet &amp; Intranet ✓ Intranet Only</td>
</tr>
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</table>
Related Documents:

- Draper ES, Kurnczuk JJ, Kenypn S (Eds) on behalf of MBRRACE-UK. MBRRACE-UK Perinatal Confidential Enquiry: Term, singleton, normally formed, antepartum stillbirth. Leicester: The Infant Mortality and Morbidity Studies, Department of Health Sciences, University of Leicester. 2015.
- GAP protocol Perinatal Institute
- Saving Babies Lives Care Bundle (2016) NHS England

Training Need Identified? No

Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
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<tbody>
<tr>
<td>May 2009</td>
<td>V1.0</td>
<td>Initial Issue of community DFM</td>
<td>Helen Ettle and Jane Stubbs Community Midwifery Team Leaders</td>
</tr>
<tr>
<td>May 2010</td>
<td>V2.0</td>
<td>Updated to clarify action to be taken on pathological CTG</td>
<td>Helen Ettle and Jane Stubbs Community Midwifery Team Leaders</td>
</tr>
<tr>
<td>June 2012</td>
<td>V2.1</td>
<td>Updated and compliance monitoring added</td>
<td>Helen Ettle and Jane Stubbs Community Midwifery Team Leaders</td>
</tr>
<tr>
<td>December 2012</td>
<td>V2.2</td>
<td>Community and hospital guideline amalgamated</td>
<td>Karen Stoyles Antenatal Ward Manager</td>
</tr>
<tr>
<td>Date</td>
<td>Version</td>
<td>Notes</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>---------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>17th December 2015</td>
<td>V2.3</td>
<td>Flow chart includes management for repeated episodes of RFM. FMIs to be discussed at each visit and documented. Number of episodes to be documented. Women advised not to use home Doppler. If scan not possible to have daily CTGs. Dawes Redman CTG to be used over 28/40 gestation.</td>
<td></td>
</tr>
<tr>
<td>March 2018</td>
<td>V2.4</td>
<td>Saving Babies Lives Care Bundle recommendations added and RFM checklist introduced. Management guidelines separated into below 24 weeks, 24-28 weeks and over 28 weeks. Women to be made aware of significance of fetal movements from early in their pregnancies and documented risk assessments continued throughout pregnancy and labour. See New 2018 in body of text.</td>
<td></td>
</tr>
<tr>
<td>May 2019</td>
<td>V3.0</td>
<td>Saving Babies Lives Care Bundle 2019 recommendations added. Definition of ‘recurrent RFM’ added</td>
<td></td>
</tr>
</tbody>
</table>

Karen Stoyles
Antenatal Ward Manager

Karen Stoyles
Bereavement Midwife

Karen Watkins
Obstetric Consultant
Magda Kudas
Antenatal Ward Manager

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.
### Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
<th>Reduced Fetal Movements (RFM) Clinical Guideline V3.0</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Directorate and service area:</strong></td>
<td>Obs and Gynae Directorate</td>
</tr>
<tr>
<td><strong>New or existing document:</strong></td>
<td>Existing</td>
</tr>
<tr>
<td><strong>Name of individual completing assessment:</strong></td>
<td>Karen Watkins Consultant Obstetrician and Magda Kudas, Antenatal Ward Lead Midwife</td>
</tr>
<tr>
<td><strong>Telephone:</strong></td>
<td>01872 252149</td>
</tr>
</tbody>
</table>

1. **Policy Aim**

   *Who is the strategy / policy / proposal / service function aimed at?*

   To give guidance to Midwives and Obstetricians on the management of a woman who reports reduced fetal movements (RFM)

2. **Policy Objectives**

   *Evidence based advice and information is given to pregnant women reporting reduced fetal movements*

3. **Policy – intended Outcomes**

   Improved fetal outcomes

4. **How will you measure the outcome?**

   Compliance Monitoring Tool

5. **Who is intended to benefit from the policy?**

   Pregnant women and their babies

6a **Who did you consult with**

   Workforce | Patients | Local groups | External organisations | Other |
   ----------------------------------------------
   | x                                                                 |

   b) Please identify the groups who have been consulted about this procedure.

   Maternity Guideline Group
   Obs and Gynae Directorate
   Divisional Board for noting
   Policy Review Group

What was the outcome of the consultation?

Guideline agreed
7. The Impact
Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

Are there concerns that the policy could have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Rationale for Assessment / Existing Evidence</th>
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<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
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<td>x</td>
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</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
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<td>x</td>
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</tr>
<tr>
<td>Religion / other beliefs</td>
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<td></td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Marriage and Civil partnership</td>
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<tr>
<td>Pregnancy and maternity</td>
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<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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<td>x</td>
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</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:
- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended.  
   Yes | No | x

9. If you are not recommending a Full Impact assessment please explain why.

Not indicated
This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.

A summary of the results will be published on the Trust’s web site.
### Reduced Fetal Movements (RFM) proforma

<table>
<thead>
<tr>
<th>Date:</th>
<th>Location: DAU/Community</th>
<th>Seen by:</th>
<th>Sign:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration of RFM</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Previous episode of RFM within last 3 weeks?</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Are there additional risk factors present?</strong> – if YES to any listed below refer for Obstetric review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there any vaginal bleeding/abdominal pain?</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the woman have diabetes? (not GDM)</td>
<td>Y/N</td>
<td></td>
<td></td>
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<tr>
<td>Does the woman have hypertension/pre-eclampsia?</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is baby SGA on scan?</td>
<td>Y/N</td>
<td></td>
<td></td>
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<tr>
<td>If not on scan pathway, are there concerns about fetal growth based on current SFH?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFH measurement (if not performed in last 2 weeks)</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFH plotted on GROW chart</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Is there a combination of other risk factors?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>GDM, smoking, mental health problems, previous still birth etc.</td>
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<tr>
<td><strong>CTG assessment - If CTG abnormal at any point or not met with 1 hour – immediate Obstetric review</strong></td>
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<tr>
<td>Dawes Redman CTG performed?</td>
<td>Criteria met in ....... minutes</td>
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<td><strong>Scan – if scan required book via DAU. If no appointments available within 24h for daily CTGs until scan</strong></td>
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<tr>
<td>Has the woman had a growth scan in last 2 weeks?</td>
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<tr>
<td>If NO, is a scan required?</td>
<td>Indications: recurrent RFM (within 3 weeks), major risk factors present (bleeding/SGA/high BP/diabetes)</td>
<td>Y/N</td>
<td></td>
</tr>
<tr>
<td>Scan booked?</td>
<td>Date:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Please note that if after obstetric review and planned scan is normal and fetal movements resumed to normal no further obstetric review is needed and the woman can be discharged.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Is the woman now happy with the FM’s?</strong> – if NO – refer to for Obstetric review</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RFM ≥39 weeks of gestation</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent episode – refer to DAU for individualised plan</td>
<td>Y/N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please note that if IOL accepted no scan referrals needed.