**Section 340.1550 Obstetrical and Gynecological Care**

*Every woman resident of child-bearing age shall receive routine obstetrical and gynecological evaluations as well as necessary prenatal care.* (Section 2-104(b) of the Act) In addition, women residents shall be referred immediately for diagnosis whenever pregnancy is suspected.

a) "Routine obstetrical evaluations" and "necessary prenatal care" shall include ata minimum, the following:

1) Early diagnosis of pregnancy;

2) A comprehensive health history, including menstrual history, methods of family planning that the patient has used, a detailed record of past pregnancies, and data on the current pregnancy that allow the physician to estimate the date of delivery;

3) Identification of factors in the current pregnancy that help to identify the patient at high risk, such as maternal age, vaginal bleeding, edema, urinary infection, exposure to radiation and chemicals, ingestion of drugs and alcohol, and use of tobacco;

4) A comprehensive physical examination, including an evaluation of nutritional status; determination of height, weight and blood pressure; examination of the head, breasts, heart, lungs, abdomen, pelvis, rectum, and extremities;

5) The following laboratory tests, as early in pregnancy as possible. Findings obtained from the history and physical examination may determine the need for additional laboratory evaluations:

A) Hemoglobin or hematocrit measurement;

B) Urinalysis, including microscopic examination or culture;

C) Blood group and Rh type determination;

D) Antibody screen;

E) Rubella antibody titer measurement;

F) Syphilis screen;

G) Cervical cytology; and

H) Viral hepatitis (HBsAg) testing;

6) A risk assessment that, based on the findings of the history and physical examination, should indicate any risk factors that may require special management, such as cardiovascular disease, maternal age more than 35 years, neurologic disorder, or congenital abnormalities;

7) Return visits, the frequency of which will be determined by the resident's needs and risk factors. A woman with an uncomplicated pregnancy shall be seen every four weeks for the first 28 weeks of pregnancy, every two to three weeks until 36 weeks of gestation, and weekly thereafter;

8) Determinations of blood pressure, measured fundal height, fetal heart rate, and, in later months, fetal presentation, and urinalysis for albumin and glucose. Hemoglobin or hematocrit level shall be measured again early in the third trimester. Glucose screening is recommended for women who are 30 years of age or older;

9) Evaluation and monitoring of nutritional status and habits;

10) Education for health promotion and maintenance;

11) Counseling concerning exercise and childbirth education programs; and

12) Postpartum review and evaluation four to eight weeks after delivery, including determination of weight and blood pressure and assessment of status of breasts, abdomen, and external and internal genitalia.

b) "Routine gynecological evaluations" shall include, at a minimum, the following:

1) An initial examination, the basic components of which are:

A) History; any present illnesses; menstrual, reproductive, medical, surgical, emotional, social, family, and sexual history; medications; allergies; family planning; and systems review;

B) Physical examination, including height, weight, nutritional status, and blood pressure; head and neck, including thyroid gland; heart; lungs; breasts; abdomen; pelvis, including external and internal genitalia; rectum; extremities, including signs of abuse; lymph nodes; and

C) Laboratory tests, including urine screen; hemoglobin or hematocrit determination and, if indicated, complete blood cell count; cervical cytology; rubella titer.

2) Annual updates, including, but not limited to:

A) History, including the purpose of the visit; menstrual history; interval history, including systems review; emotional history;

B) Physical examination, including weight, nutritional status and blood pressure; thyroid gland; breasts; abdomen; pelvis, including external and internal genitalia; rectum; other areas as indicated by the interval history;

C) Laboratory, including urine screen; cervical cytology, unless not indicated; hemoglobin or hematocrit determinations; and

D) Additional laboratory tests, such as screening for sexually transmitted disease, shall be performed as warranted by the history, physical findings, and risk factors.

c) When a resident is referred for a diagnosis of pregnancy and/or for prenatal care, the facility shall send the health care provider a copy of the resident's medical record, including a list of prescription medications taken by the resident; if known, the resident's use of alcohol, tobacco and illicit drugs; and any exposure of the resident to radiation or chemicals during the preceding three months.

d) Cancer screening shall include the following:

1) A periodic Pap test. The frequency and administration of Pap tests shall be according to the guidelines set forth in the "Guidelines for Women's Health Care", published by the American College of Obstetricians and Gynecologists; and

2) Mammography. The frequency and administration of mammograms shall be according to the guidelines set forth in the "Guidelines for Women's Health Care".

(Source: Amended at 35 Ill. Reg. 3442, effective February 14, 2011)