HER Foundation HG Assessment Form Instructions

Care of patients experiencing hyperemesis gravidarum is very complex, and treatments are often unfamiliar to obstetrical practitioners. HER has created a form for patients to fill out, along with a treatment template to expedite assessment and orders. Use with the HELP Score, which can be trended over time, is highly recommended.

*The **Pregnancy/Hyperemesis Gravidarum History** will only need to be completed once at the start of each pregnancy.*
*The **Visit Assessment** and **Plan of Care** should be completed at each visit.*

SUGGESTED ASSESSMENT PROTOCOL

Only the last two pages of the HG Assessment (pages 5-6) are filled out by the obstetrical clinician.

1. HELP Score: At every visit and at home daily, weekly or prn symptom changes.
2. HG Assessment: Health & HG History (pages 1-2) at start of pregnancy or first visit.
3. HG Assessment: Visit Assessment (pages 3-4) at each visit by patient.
4. HG Assessment: Plan of Care (pages 5-6) at each visit by clinician.

PREGNANCY/HYPEREMESIS GRAVIDARUM HISTORY

A general overview of previous HG symptoms to assist in anticipating potential complications and symptom duration and severity. HG pregnancies often are similar each time or worsen. Details on each pregnancy give insight into specific issues that may need attention or proactive management. A detailed table on **Treatment History** guides selection of medications. Often medications just don't work for a patient and omitting a lengthy trial period may prevent worsening of symptoms, not to mention unnecessary suffering. **Postpartum History** gives a long-term view to treating HG. Actively working to prevent recurrence of these issues through current management is ideal. It also may alert practitioners to possible contributing factors to current symptoms. The **Children**'s summary provides information into a mother's home responsibilities (e.g. special needs child) and potential adverse outcomes associated with her pregnancy complications.

HEALTH HISTORY

Health History identifies many of the known risk factors for HG, so when practitioners see multiple conditions are checked, they know that HG is likely to recur and may be more severe or prolonged.

VISIT ASSESSMENT

Weight loss is a key indicator of symptom severity, especially in women who are not on prescription medications. It is critical to determine how much weight is lost each visit to ensure nutrition is addressed before malnutrition occurs. Regardless of starting weight, significant nutritional deficiencies will occur within 1-2 weeks. **Current Care** provides the patient opportunity to list all medications and supplements being used to ensure consistency of care and allow monitoring for potential interactions and complications, such as Serotonin Syndrome from use of antidepressants with serotonin antagonists used as antiemetics. Questions specifically regarding tolerance of medications and side-effects are

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included so appropriate action can be taken. Other singular questions provide quick checks on nutritional interventions, IV condition, and an overall insight into the level of suffering as reflected by consideration of termination. Research finds women will consider terminating a wanted pregnancy when they lose hope and are more severely ill.

Symptom Assessment details triggers and key clinical information to screen for issues such as constipation, GI bleeding, and depression. Knowing triggers will also assist in determining a patient's ability to function in activities of daily living. A chart with common issues contributing to or resulting from HG are listed to assist in determining individual treatment needs and diagnosis of other conditions. For **Nutrition**, three questions are asked to assess intake and compare it to pre-pregnancy. **Psychosocial** questions detail stressors, level of functioning, and support as these are known to impact overall condition and pregnancy outcome.

PLAN OF CARE

Based on recommendations from the American College of Obstetrics and Gynecology as well as the HER Foundation, clinicians are given a series of questions that guide decisions on proper care for each patient and then order it quickly using preformatted lists. These last two pages should be used at each visit.

First, follow-up, consults and diagnostics are listed. Then a comprehensive list of **Medications & Essential Vitamins** often used for HG, as well as a few in current research trials for HG, are given with common fields prewritten (e.g. route). Important considerations such as side-effects and dosing are included. Drugs in the same class are grouped together to ensure only one is ordered. Rows to list medications to treat additional issues such as insomnia and reflux are prefilled. A blank line is included for prescribing other medications as needed to treat hypertension, diabetes, etc. Crucial vitamins like thiamin to prevent Wernicke's encephalopathy are listed as reminders.

Other Needs are listed to prompt clinicians to consider interventions in key areas such as nutrition, parenteral therapy, and education.

Finally, **Treatment Strategies** developed by expert clinicians at the HER Foundation are listed for reference.

Completion of this supplemental HG Assessment form will provide a comprehensive overview of patient condition and needs to optimize outcomes.

Contact Kimber MacGibbon, RN at the HER Foundation with questions. Kimber@HelpHER.org