Cheat Sheet

- NVP affects approximately 70–80% of all pregnant women.
- 35% of pregnant women experience symptoms that are of clinicalsignificance.
- 30% of pregnant women require time off work to manage their symptoms.
- It is estimated that up to 1.5% of women suffer from hyperemesis gravidarum (HG)[1].
- The cause of HG remains unknown, and there is no 'cure'. Treatment usually revolves around trying to limit the severity of the symptoms.
- Milder forms of NVP may end between 12 and 16 weeks; however, those with more severe symptoms and HG often report that though the intensity of symptoms may decrease around this time, up to 60% continue to suffer from nausea and/or vomiting until birth.
- 'Morning Sickness' is an erroneous term as most women experience symptoms of nausea and vomiting at various times throughout the day. Pregnancy sickness is a more appropriate term to use.
- The advice to eat 'little and often' may help in milder cases of NVP, but dietary changes are often not enough for more severe forms, especially HG.
- Similarly, the advice to eat such things as ginger and dry crackers may help milder forms of NVP but is often completely irrelevant to a woman who is struggling to keep any food or liquid down.
- Rest is a vital aspect of managing the symptoms of nausea and vomiting as stress and exhaustion can exacerbate symptoms. Therefore, pressure to 'carry on as normal' can make matters worse.
- Symptoms can become so severe that the pregnant woman may experience dehydration, production of ketones, nutritional deficiencies, electrolyte imbalances, and weight loss.
- Admittance to hospital for IV fluids may be necessary.
- Prior to the development of IV treatment, HG was a significant cause of maternal death. Although the last deaths in the UK due to complications of HG were in the 1990s, the severity of this condition should not be forgotten or underestimated.
- Anti-emetic medication may be prescribed to try and limit the severity of the symptoms. Though none are currently licensed in the United Kingdom for use during pregnancy, many have been used successfully for decades without any known effect on the foetus.
- Pregnant women whose weight gain is low in association with HG through out their pregnancy have a higher risk of preterm labour, babies with low birth weight, and babies who are small for their gestational age. The risks increase if HG is still uncontrolled or untreated in the second trimester.
- The emotional stress of prolonged and severe nausea and vomiting is high and support is crucial.
- Antenatal depression, postnatal depression, and post traumatic stress disorder may accompany or follow a pregnancy complicated by severe NVP and HG.
- HG can be so traumatic that sufferers may request a termination of their pregnancy and/or decide against further pregnancies.

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[1] Some studies suggest this is a low estimate given the difficulty in diagnosing HG.

How to Tell the Difference Between Normal Pregnancy Sickness and Hyperemesis Gravidarum
Courtesy of Pregnancy Sickness Support

Symptoms	'Normal' or Mild Pregnancy Sickness	Moderate–Severe Pregnancy Sickness	Hyperemesis Gravidarum
Occurrence rates	Around 80% of all pregnant women suffer from pregnancy sickness of some degree	Around 30% of all pregnant women require time off work, & 35% have symptoms of clinical significance	Between 1–2% of all pregnant women will be diagnosed with Hyperemesis Gravidarum
Typical onset and duration of nausea and/or vomiting	Begin around 4–6 weeks, generally ease between 12 and 20 weeks	Begin around 4–6 weeks, may last beyond 12–20 weeks	May begin before pregnancy confirmed, typically peak at 9–13 weeks, but often last throughout entire pregnancy.
Severity of nausea and/or vomiting	Varies, however typically short periods of nausea and infrequent vomiting episodes. Easily managed through lifestyle and diet changes	Will often impact quality of life, with regular nausea and/or daily vomiting episodes while symptoms continue	Nausea often constant, with multiple vomiting episodes per day. Affects ability to eat, drink, and care for self and others.
Weight loss	Minimal, if any	May lose several lbs while symptoms persist	Weight loss is often severe and rapid. > 5% of pre-pregnancy weight is common with Hyperemesis
Clinical Symptoms	None	May suffer from dehydration and weight loss. If left untreated, moderate–severe pregnancy sickness can lead to hyperemesis	Dehydration, weight loss, ketosis, electrolyte imbalances. If left untreated, can lead to other complications
Affect on Quality of Life	Minimal, if any	May need to adapt working pattern, rest more, and accept extra help at home while symptoms persist	Quality of life affected completely. Often bed-bound or house-bound, unable to eat, drink, speak, read, watch TV, cope with bright lights or look after self in any way.
Treatment Options	Changes to diet and lifestyle should be enough. Eating 'little and often', ginger and acupressure may help	Changes to diet and lifestyle may help, but typical advice like ginger and acupressure often ineffective. Anti-emetics may be suggested.	Medical treatment is crucial in attempting to limit the severity of symptoms. Anti-emetics, IV hydration, and steroids may all be considered.
Other considerations	None	Emotional and psychological support may be requested to cope with mental strain of sickness	Antenatal depression, postnatal depression, and post-traumatic stress disorder can be common in women with such severe symptoms

It is important to note that this is a very basic introduction to the differences between 'normal' pregnancy sickness, moderate–severe pregnancy sickness and HG.

The distinction between moderate–severe pregnancy sickness and HG is often unclear.

spewing mummy

Pregnancy Sickness Support

A Thorough Assessment of Nausea and Vomiting in Pregnancy and Hyperemesis Gravidarum

The assessment questions below and suggested investigations will help you ensure you are covering everything and give you the opportunity to answer the woman's questions and concerns. Without a thorough assessment, you can't go forward with developing a care plan, so taking the time to go through these questions is valuable. We have tried to keep them applicable to both the community and hospital setting as women with hyperemesis may present in a range of different settings. Due to this, some parts may be more or less relevant to your particular area of work. Our notes are in italics. We have used NVP rather than HG as a starting point as this is likely to be an assessment which will aid diagnosis of severity. However, if a woman has already been admitted with hyperemesis, then some sections will be less relevant.

General

- What stage of pregnancy from last monthly period (LMP) are you?
- Is this your first pregnancy?
- Did you experience nausea and vomiting of pregnancy (NVP) in previous pregnancy?
- If yes, was the NVP/HG better or worse than this pregnancy?
- How long ago did the NVP start, from LMP?
  NVP usually starts about day 39 (5.5 weeks) from LMP. In about 13% of pregnant women, NVP will start before a missed period, and for 90% of women, NVP will start before day 56 from LMP.

Vomiting

- Are you vomiting?
- If yes, how long ago did vomiting start?
- How many times a day are you vomiting?
- Is vomiting getting more frequent?
- How much fluid are you vomiting each time – i.e. a cupful or a) more b) less?
- Have you been vomiting blood or bile?

Signs of Dehydration

- Have you got a dry mouth and lips?
- Is your urine very dark or of small quantity which you pass less frequently than 8 hourly?
- Does your urine contain ketones?
  (Ketostix tests are available from a chemist or online about £6 for a container of 50). 3 or 4+ of ketones is a factor for immediate admission to hospital but any ketones should be considered for admission. Some women will know what ketones are, particularly if they have suffered HG before, whereas women in their first pregnancies likely will not.

Weight Loss

- Have you lost weight compared to your pre-pregnancy weight? If so, how much?
  Loss greater than 5% of pre-pregnancy weight is significant and is one factor to be considered for hospital admission.

Nausea

- Do you have episodes of nausea?
- Or, is the nausea constant?
- If episodic, then do you keep a daily diary of your episodes so that you can judge when you will be able to eat and drink and be ready to do so?
- If the nausea is constant, then is it affecting your ability to eat and/or drink?
- Does anything make your NVP worse?
  Usual replies include noxious odours, fried or fatty food, cooked food, meat or fish, tea or coffee, smell of perfume, cigarette smoke, being hungry, positional change, movement, fatigue, and others.
- Does travelling make your NVP worse?
  If distance to a hospital is a problem then consider if home IV is possible in their area.
- Does anything improve your NVP?
  Evidence-based advice includes the following points, but remember that for full-blown hyperemesis, eating and drinking at all may be impossible.

1. ***Eating and drinking.*** *Eat what you like (according to current government guidelines for pregnancy), when you like, including your cravings, in small frequent quantities and when you first wake up, to prevent feeling too hungry. Drink what you like (according to current government guidelines for pregnancy). Try lemonade, cold water, sucking ice cubes, or sorbets.*
2. ***Rest.*** *Women say rest is the second most important way to relieve their NVP. Lying down when NVP is severe and after eating a meal is often effective. You will not be able to 'work off' NVP by taking increased exercise.*
3. ***Avoid unpleasant odours.*** *Your nose is your worst enemy at present, and odours which may normally have been no problem may now make your nausea much worse. You may smell odours no one else can detect.*
4. ***Support.*** *Get help if possible, with household duties, shopping, and with your children.*
5. ***Avoid*** *loud noises, bright lights, and other sensory stimulation.*
6. ***Enjoy*** *what you really like, for example, music, TV, DVDs, radio, reading, or whatever you can manage.*

Effects on Well-being and Lifestyle

- Does NVP affect your Activities of Daily Living (ADLs), that is, shopping, cooking, housework, parenting?
  As soon as a woman's ADLs are affected, this indicates that safe effective medication, usually tablets, is advisable to treat NVP. Early treatment reduces the incidence of admission to hospital for HG.
- Does NVP affect your mood or attitude to life, for example, does it make you feel depressed?
  50% of women with severe NVP feel depressed most of the time due to the condition.
- Does your NVP affect your partner's lifestyle or employment?
  There is on line support and information for partners, and there is a section in this book for them.
- Do you have paid employment? If yes, are you allowed to take things easy at work or have time off?
  Up-to-date information about employment rights is on the PSS website.

Treatment

- Are you taking a pregnancy vitamin with folic acid?
- Have you taken any complimentary or alternative treatments for nausea for NVP, for example, herbal treatment, ginger, anything from a health food shop, or used acupressure bands? If yes, what was it, and was it helpful?
  Asking what they have tried is very different to suggesting that they try these things. Knowing what they have already tried will aid your assessment and help them feel listened to. It is also an opportunity to discuss evidence-based treatment and risk/benefit assessments.
- How do you feel about taking tablets to treat your NVP if you were sure they would not affect your baby?
  Here, you can reassure that there is safe effective treatment for NVP.
- Have you been prescribed any treatment by your GP or by hospital doctors? If so, then what?
- Is there anything you would like to ask us about NVP?
  Be careful not to give false promises of complete recovery at 12 weeks. It is better to be realistic about the duration of hyperemesis and discuss longer-term coping strategies for the next few months. Disappointment over the pregnancy will already be profoundly felt, so a 'prepare for the worst, hope for the best' attitude can be helpful.

Future Support

- What support do you have at home?
- What form of future support do you need to help manage your condition?
- Would you like a referral to the charity Pregnancy Sickness Support?

Investigations

The following investigations should be standard during the diagnosis and management of the patient with hyperemesis although ongoing frequency will depend on the case severity and the initial results:

- Weight of patient
- Urinalysis
- Full blood count (FBC), urea and electrolytes (U&E) – possibly daily
- Liver function test (LFT), thyroid function test (TFT)
- Calcium and phosphate levels if severe
- Blood glucose
- Mid stream specimen urine (MSSU)

A MUST (Malnutrition Universal Screening Tool) or PUQE (Pregnancy-Unique Quantification of Emesis) should be used to assess the effectiveness of intervention. The PUQE tool is available in the Appendix.

On a first admission, a scan may be appropriate to assess for multiple foetuses and rule out a molar pregnancy.

Care Plan for the Patient Suffering with Hyperemesis Gravidarum

Care Plan for .....

Date of admission .....

Weeks gestation at admission .....

Pregnancy number .....

Children at home .....

History of twins: yes / no .....

Weight at admission: ..... KG

Height ..... CM

BMI .....

Patient reported weight loss..... ..... or

% of pre-pregnancy weight loss .....

Blood Pressure ...../.....

Ketone level on admission .....

TED Stockings provided? YES / NO .....

Aims of Care Plan:

1. Reduce nausea and vomiting
2. Reduce presence of ketones and increase hydration
3. Prevent further weight loss
4. Provide emotional and psychosocial support to.....
5. Provide a comfortable environment for.....

Nursing Actions for Care Plan:

1. Reduce Nausea and Vomiting

- Ensure medication is provided on time to enable stable blood levels of anti-emetics.
- Reduce sensory stimulation by providing a side room away from 'smelly areas', if possible, and ensuring staff are quiet and free from perfume whilst providing care.
- Provide snacks when required where possible.
- Review effectiveness of medication and interventions daily or as required, using MUST or PUQE tool.

2. Reduce Presence of Ketones

- Provide IV fluids as per prescription. *(See Part 2, Chapter 5 for more info)*
- Warm IV fluids to 37 degrees before administration, if possible. *This is to reduce calorific loss from cold IV fluid administration.*
- Encourage oral fluids when they can be tolerated.
- Provide information on suitable fluids for pregnancy and tips on getting fluids, for example, via ice lollies.
- Monitor ketones as per hospital policy or three times per day.

3. Prevent Further Weight Loss

- Encourage oral food intake where possible.
- Provide information on fortifying food and fluid. *(Information available on PSS website and in chapter 6)*
- Ensure medication regime is controlling vomiting and nutrient loss. Adjust timings to maximise ability to eat at mealtimes.
- Provide snacks as and when ..... feels able to eat.

4. Provide Emotional and Psychosocial Support to

.....

- Where available, discuss referral to peri-natal mental health team for support with psychological impact of HG and refer if appropriate.

- Provide information about PSS charity and make referral to support network if required.
- Ensure ..... has an advocate for ward rounds with doctors if she is struggling with speaking due to nausea and vomiting.
- Ensure informed consent is obtained for treatments.
- Provide written information about hyperemesis and any treatments or medication.

5. Provide a Comfortable Environment for.....

- Provide a side room where possible to reduce sensory stimulation such as smell and sound and reduce distress from public vomiting and episodes of incontinence.
- Ensure staff are free from perfumes or cigarette smoke.
- Provide pressure relieving mattress to reduce the risk of pressure damage from prolonged bed rest.
- Ensure vomit bowls and urine samples are removed promptly and adequate empty receptacles provided.

A Management Plan for Hyperemesis Gravidarum

To be kept in Patient-held Notes

Estimated Due Date .....

Or LMP .....

This is pregnancy number .....

I have children at home .....

History of twins yes / no

Weight pre-pregnancy: ..... KG

Weight now: ..... KG,

Weight loss to date .....kg (..... %)

Height ..... CM

BMI .....

I vomit on average .....times per day

I am nauseated ..... hours per day

Times my nausea is less bad .....(if applicable)

Current medications I am on, not for hyperemesis:

.....

.....

.....

Adults whom I give permission to discuss my condition with my Healthcare Providers are

.....

.....

My medical history:

.....

.....

.....

.....

.....

For me the worst symptoms are

.....

.....

.....

.....

.....

Management of Hyperemesis:

First line: .....

Treatment	Tick by patient	Tick by doctor/ script given
Cyclizine (50 mg 3 × a day)		
or Promethazine (Avomine) (25mg 3 × a day)		
And B6/pyridoxine (10mg 3 or 4 × a day)		
Other		

Review of effectiveness, side effects, changes to report:

.....

.....

.....

Need for antacid addressed and prescribed if required? .....Yes/no

If the condition still worsens, the following criteria will indicate needing to move on:

Symptom	Indication to move on, tick:	Method of monitoring (delete as required):	Agreed by doctor:
Vomiting >5 per day		Patient reporting	
Weight loss >5% of pre-preg weight		Patient reporting/weighing at surgery	
Fluid intake <500 ml per day		Patient reporting	
Urine output <500 ml per day		Patient reporting	
Nausea/vomiting preventing reasonable level of functioning		Patient reporting	
Other			
Other			

If the above deterioration is indicted, I would like to try the following treatments and in the following preferred order (i.e. write first, second, third, etc):

Treatment	Preferred route of administration, delete as appropriate:	Order of preference to try	Tick by doctor and dose/route to prescribe:
Prochlorperazine (Stemetil)	Oral/IM injection		
Metoclopramide (Maxolon)	Oral/IM injection		
Ondansetron (Zofran)	Oral tablets/oral melts/suppositories/injection		
Domperidone (Motilium)	Oral		
Other _____			
Other _____			

Indications for requiring IV Fluids/admission to hospital:

Symptom	Indication to move on, tick:	Method of monitoring (delete as required):	Agreed by doctor:
Vomiting preventing intake of oral medication/not responding to medication		Patient reporting	
Ketones in urine		Patient reporting (Ketostix required)/urine tested by surgery	
Weight loss >10% of pre-preg weight		Patient reporting/weighing at surgery	
Fluid intake <500 ml per day, despite medication		Patient reporting	
Urine output <500 ml per day despite medication or not passing urine for more than 12 hours		Patient reporting	
Other_____			
Other_____			

In the event of requiring IV Fluids, in order to avoid admission via A&E, my preferred option is:

Service	Available in area?	Preferred option (write preference first, second, etc)	Doctors comments/ referral to be arranged.
IV hydration at home via local Acute Care Service	Yes/No		
IV hydration as day patient at			
hospital	Yes/No		
Admission to ..... hospital	Direct referral to ward available Yes/No		
Other _____			
Other _____			
Other _____			

In the event of requiring IV Fluids, in order to avoid admission via A&E, my preferred option is:

.....

.....

In the event of my not responding to treatments so far discussed,

I would like to be admitted to ..... hospital to try Steroid Therapy.

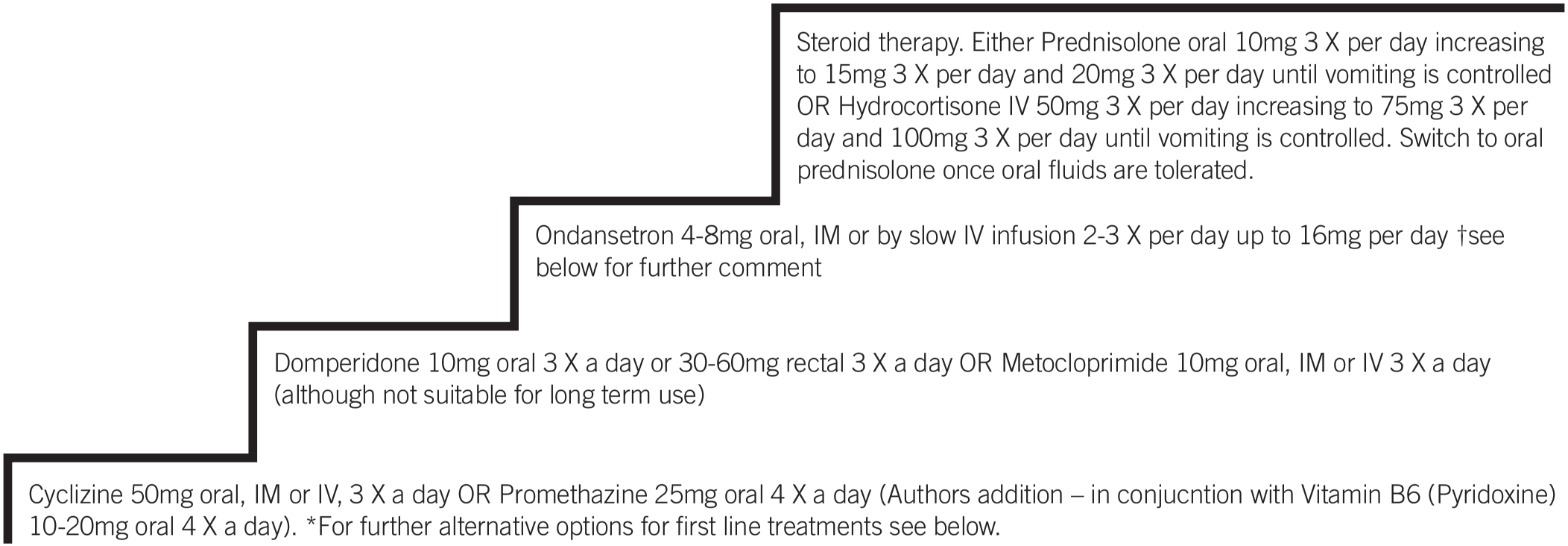
My consultant is .....

Telephone/email .....

Self-help I have tried or am using (fill in and tick as appropriate):

Referral to local counselling service to help with the emotional distress caused by HG	Yes/No
I will seek peer support from Pregnancy Sickness Support.	
I will	
I will	
I will	

Treatment Ladder for Hyperemesis Gravidarum



*Further first-line alternatives include

- Prochlorperazine 5–10 mg 3–4 x a day, oral or 12.5 mg 3 x a day IM or IV or 25 mg rectal once a day.
- Chlorpromazine 10–25 mg 4–6 hourly oral, IM, or IV or 50–100 mg 3–4 x a day rectal.
- Doxylamine 10 mg plus pyridoxine 10 mg up to 8 tablets per day.

† Although many women find ondansetron very effective and recent studies have increased confidence in its safety, the authors come into contact with many women who find the constipation side effect of ondansetron almost as unbearable as the symptoms it is controlling. Bowel management must therefore be addressed when prescribing this, and laxatives should be prescribed where necessary. The severity of constipation should not be underestimated, and it should not be assumed it is due to pregnancy and dehydration when a woman is on ondansetron

PUQE Scoring

In the table below, mark the answer to each question which best describes your own experience, and then use the scores next to each of your answers to give you a final 'score'. By doing this regularly, you can assess the effectiveness of the treatments and your progress. This PUQE score was developed by the Motherisk Program in Canada.

Pregnancy Unique Quantification of Emesis and Vomiting Score (PUQE) – over 24 Hours	
In the last 24 hours, for how long have you felt nauseated of sick to your stomach?	Please circle the one answer
Not at all 1 hour or less 2–3 hours 4–6 hours More than 6 hours	1 2 3 4 5
In the last 24 hours, have you vomited or thrown up?	Please circle the one answer
I did not throw up 1 to 2 3 to 4 5 to 6 7 or more times	1 2 3 4 5
In the last 24 hours, how many times have you had retching or dry heaves without bringing anything up?	Please circle the one answer
No times 1 to 2 3 to 4 5 to 6 7 or more times	1 2 3 4 5
On a scale of 1–6, how would you rate your nausea and/or vomiting today, if 1 is acceptable and 6 is extremely debilitating?	Please circle the one answer 1 2 3 4 5

This table can help you prepare for an appointment in advance:

Symptoms:	How many times a day are you vomiting? How much fluid and food have you kept down in 24/hours? How often are you passing urine? Have you lost much weight? What other symptoms are you experiencing, for example, dizziness, headaches, etc? Is movement, sound, and smell triggering vomiting?
Your concerns:	What are your main worries? That you are severely dehydrated? That you have lost so much weight? That you are bed-bound and getting sores or at risk of DVT? That your baby is at risk from the dehydration and starvation? That you are getting depressed from the isolation and relentless sickness? That you are going to lose your job over this?
Questions:	Is it safer to take medication or not? If you are not being admitted now, then at what point should you be concerned that you need to go to hospital? What signs and symptoms should you look out for that things are more serious? What is the best route for speaking to the GP? Can you email or phone to speak to them? Could you monitor your ketones at home? Are there other medication options and routes, such as, injections, suppository, melts?

Symptoms:	
Your concerns:	
Questions:	

Questionnaire prior to planning next pregnancy

Think about your care providers:

Was your GP supportive and sympathetic?	Yes	No
If No, is changing GP an option?	Yes	No
Did you see a consultant and was he/she helpful?	Yes	No
*If your consultant previously was good, then ask to be referred for a pre-pregnancy consultation them	Yes	No
Was your midwife helpful and supportive?	Yes	No
If No, is there the option of other midwives in the area?	Yes	No
Were your family and friends helpful and supportive?	Yes	No
Have you got plans for childcare in place if required?	Yes	No

Your current state of health:

Are you fit and healthy?

Height .....

Weight .....

Use Google to work out your BMI .....

Do you need to put on weight or lose some weight before this pregnancy? It is good to have some reserves to lose, but it is not good to be overweight – write your own plan here:

.....

.....

.....

In your last pregnancy, which medications helped and which didn't:

Last pregnancy I tried: Buccastem, pyridoxine (vitamin B6), promethazine, cyclizine, Stemetil, metoclopramide, ranitidine, Omeprazole, domperidone, ondansetron (alongside lactulose), steroids,

other.....
(delete/add as a appropriate)

Other things I tried: Hypnotherapy, acupuncture and acupressure bands, ginger capsules (250 mg × 4 per day),

other.....

What worked .....

What did not work.....

Side effects I experienced .....

I do not want to try..... again.

The most helpful medications were .....

.....

.....

Medications I did not try last time but would like to discuss with the doctor this time are.....

.....

Were you able to keep oral medications down?	Yes	No	
Were you offered soluble medications or suppositories?	Yes	No	
Was acid reflux a problem?	Yes	No	Not sure
If Yes, were you given treatment for it?			Not sure

Hospital admission:

If you were admitted to hospital during your last pregnancy, how did you find it?.....

For example, a relief to be in hospital and receiving fluid and medication IV or distressing and stressful .....

.....

.....

.....

If you found it stressful and distressing, can you pinpoint why? For example, admission via A&E, unsympathetic staff, disturbed sleep, busy ward, smells, sensory stimulation, separation from husband/children, etc., side effects from treatments, needle phobia.

.....

.....

.....

If you had the option of IV fluids as a day patient, did you prefer that?	Yes	No

Do you know about other services in your local area, such as Hospital at Home or Acute Care at Home as an alternative to hospital admission?

.....

Preparing for your next pregnancy:

Do you hope to try pre-emptive medication?	Yes	No

Other medications I wish to be considered: Buccastem, pyridoxine (vitamin B6), promethazine, cyclizine, Stemetil, metoclopramide, ranitidine, Omeprazole, domperidone, ondansetron (alongside lactulose), steroids, other.....

(delete/add as a appropriate)

Hospital admission:

- Do you want to request day patient treatment if it is available? Bear in mind there are pros and cons, such as extra travelling and extra needles for new IV sites!
- If you went through A&E last time, can you avoid that this time?
- Do you have a preferred hospital to go to?

Weekly Fluid Balance Chart:

To use this chart, use a regular cup/bottle/mug that you know how much it holds and can estimate how much you have had. If you use a mug that holds 200 ml and you drink one and a half during the morning, you'll have an intake of 300 ml (include ice lollies and jellies too). To monitor output, use a measuring jug to monitor your urine output. If you need to monitor vomit output, you can either use a vessel which you can estimate quantity in or use kitchen scales (1 mg = 1 ml) but don't forget to delete the weight of the bowl.

At the end of 24 hours, add up the totals and minus the output from the input to work out the balance.

	Morning 6 a.m.–12 p.m.		Afternoon 12 p.m.–6 p.m.		Night 6 p.m.–6 a.m.		Totals for 24 hours		
	Intake	Output	Intake	Output	Intake	Output	Intake	Output	Balance +/-
Day 1									
Day 2									
Day 3									
Day 4									
Day 5									
Day 6									
Day 7									

Pre-pregnancy Care Plan

Before pregnancy/while trying to conceive, I will take:

Treatment	Tick by patient	Tick by GP/script given
Folic acid		
B6/pyridoxine (10 mg 3 or 4 × a day)		
Other		

Once I am pregnant, I want to start taking:

Treatment	Tick by patient	Tick by GP/script given
Cyclizine (50 mg 3 × a day)		
OR Promethazine (Avomine) (25 mg 3 × a day)		
And (continue with) B6/pyridoxine (10 mg 3 or 4 × a day)		
Other		

If my condition still worsens, the following criteria will indicate needing to move on:

Treatment	Preferred route of administration, (delete as appropriate):	Order of preference to try	Tick by doctor and dose/route to prescribe:
Prochlorperazine (Stemetil)	Oral/IM injection		
Metoclopramide (Maxolon)	Oral/IM injection		
Ondansetron (Zofran)	Oral tablets/oral melts/suppositories/injection		
Domperidone (Motilium)	Oral		
Other			
Other			

In addition to anti-emetic medication, I would also like to have an antacid treatment, particularly if my symptoms continue beyond the first trimester.

I would like to try omeprazole/ranitidine (delete as appropriate).

Notes:.....

.....

Indications for requiring IV Fluids/admission to hospital:

Symptom	Indication to move on, tick:	Method of monitoring (delete as required):	Agreed by doctor:
Vomiting preventing intake of oral medication/not responding to medication		Patient reporting	
Ketones in urine		Patient reporting (Ketostix required)/urine tested by surgery	
Weight loss >10% of pre-preg weight		Patient reporting/weighing at surgery	
Fluid intake <500 ml per day, despite medication		Patient reporting	
Urine output <500 ml per day despite medication or not passing urine for more than 12 hours		Patient reporting	
Other			
Other			

Notes:.....

.....

Weekly Drug Chart:

If you find it hard to keep on top of what to take when, particularly if you are drowsy, then ask your partner to fill this chart in and set alarms on your phone for medication time. Tick when you've taken your dose.

	Morning		Lunchtime		Tea time		Bedtime	
	Medication and dose	Taken ✓	Medication and dose	Taken ✓	Medication and dose	Taken ✓	Medication and dose	Taken ✓
Day 1								
Day 2								
Day 3								
Day 4								
Day 5								
Day 6								
Day 7								