

Shared Maternity Care Workshop 2

Thursday 22 October 2026

The content in this session is valid at date of presentation

In collaboration with



Northern Health

Acknowledgement of Country

On behalf of the organisations here today North Western Melbourne PHN, Royal Woman's Hospital, Northern Hospital, Western Hospital and Mercy Health we acknowledge the Traditional Owners of the Kulin nation, on which our work in the community takes place. We pay respects to Elders past, present and emerging. and to any Aboriginal and Torres Strait Islander people in the session today.



Housekeeping – Zoom webinar



All attendees are muted



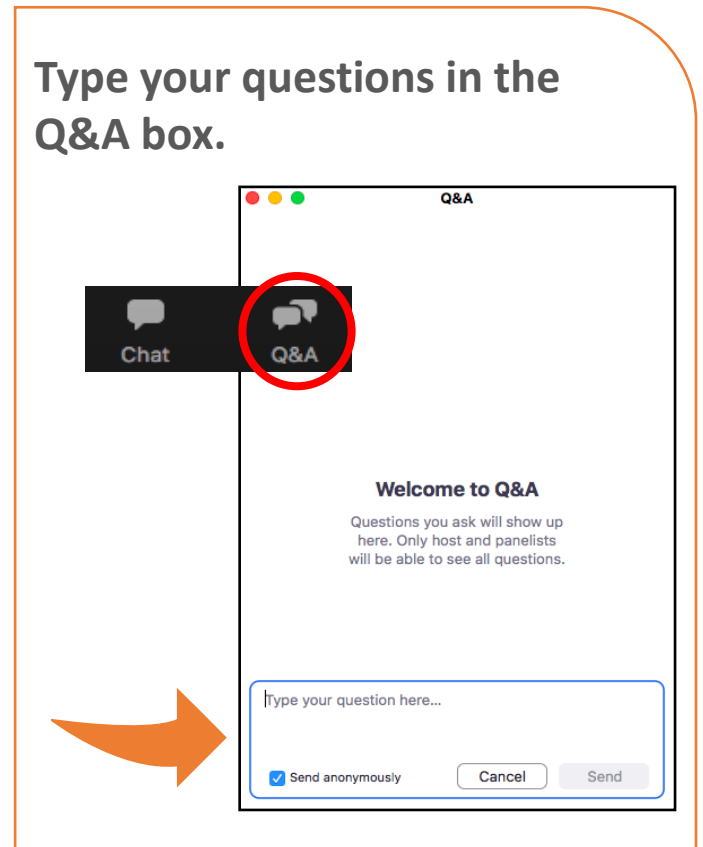
Please ask questions via the Q&A box only

- Q&A will be at the end of the presentation
- Questions will be asked anonymously to protect your privacy



This session is being recorded.

You will receive a link to this recording and copy of slides in post session correspondence.

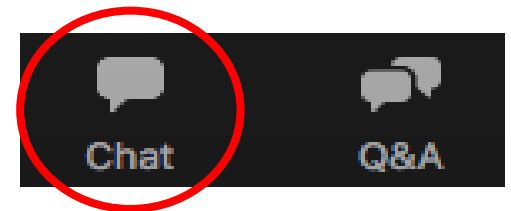


Housekeeping – Zoom webinar

Is your session name the same as your registration?

To ensure we can issue your certificates and CPD please ensure you have joined the session using the same name as your event registration (or phone number, if you have dialled in).

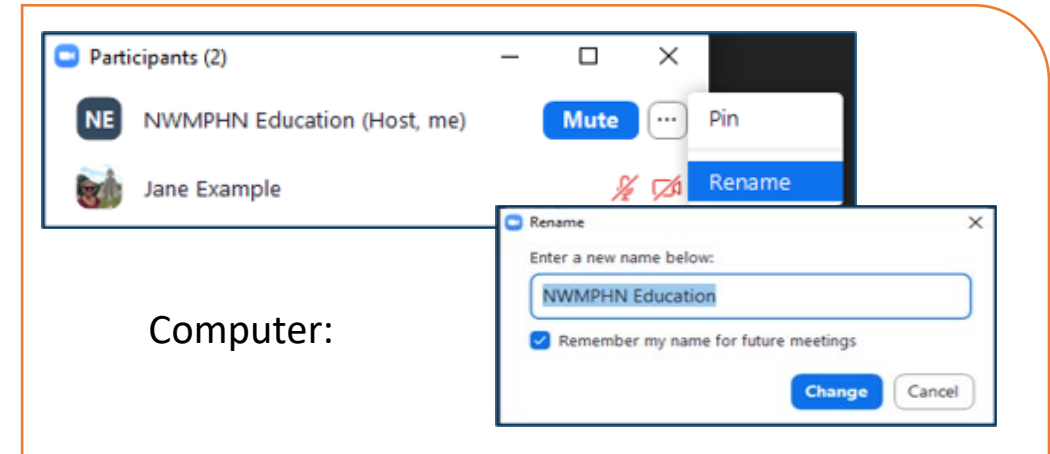
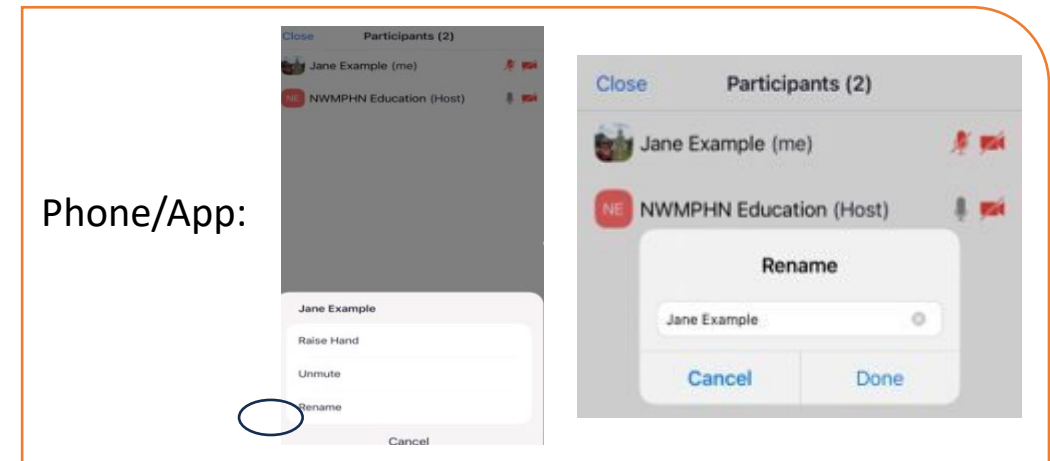
Not sure if your name matches, send a Chat message to 'NWMPHN Education' to identify yourself.



Housekeeping – Zoom webinar

How to rename yourself

1. Click on **Participants**
2. If using
 - App: click on your name
 - Computer: hover over your name and click the 3 dots
 - Mac: hover over your name and click More
3. Click on **Rename**
4. Enter the name you registered with and click **Done / Change / Rename**



Shared Maternity Care Workshop 2

22 October 2026

Pathways are written by GP clinical editors with support from local GPs, hospital-based specialists and other subject matter experts



- **clear and concise, evidence-based medical advice**
- **Reduce variation in care**
- **how to refer to the most appropriate hospital, community health service or allied health provider.**
- **what services are available to my patients**

HealthPathways – Shared Maternity Care

Search bar for quickly locating clinical pathways and conditions

Essential quick-access links for latest updates, Pathway updates, clinical resources and MBS items

Browse clinical suites via left-hand menu, organised into easy to navigate categories

Click 'Send Feedback' to add comments and questions about this pathway.



The screenshot shows the HealthPathways Melbourne website. At the top, there is a blue header with the Melbourne logo and a search bar containing the text 'antenatal third trimester'. Below the header, the left-hand menu is visible, listing various clinical categories under 'Obstetrics'. The main content area features a large banner image of a smiling female doctor with a stethoscope, with the text 'Melbourne HEALTHPATHWAYS' overlaid. Below the banner, there are three main sections: 'Health Alert' (dated 16 September), 'Latest News' (dated 3 September), and 'Pathway Updates' (listing updates from 27 September and 26 September). On the right side, there is a vertical list of quick-access links including 'ABOUT HEALTHPATHWAYS', 'BETTER HEALTH CHANNEL', 'RACGP RED BOOK', 'USEFUL WEBSITES & RESOURCES', 'MBS ONLINE', 'NPS MEDICINEWISE', and 'PBS'. At the bottom right, there is a blue button labeled 'SEND FEEDBACK'.

Pregnancy Medical Conditions

[Anaemia in Pregnancy](#)

[Asthma in Pregnancy](#)

[Hypertension and Pre-eclampsia in Pregnancy](#)

[Hypertension in Pregnancy and Postpartum](#)

[Thyroid Disease in Pregnancy](#)

Obstetrics

[Maternal Postnatal Check](#)

[Pregnancy and Postpartum Mental Health](#)

Pregnancy and Postpartum Mental Health

[Medications for Depression and Anxiety \(Pregnancy and Breastfeeding\)](#)

[Parent Infant Community Support](#)

[Perinatal Mental Health Referrals](#)

[Perinatal Mental Health \(Pregnancy and Postnatal\)](#)

Breastfeeding

[Breast Engorgement and Oversupply](#)

[Improving Milk Supply](#)

[Mastitis and Breast Abscess](#)

[Medications in Pregnancy and Breastfeeding](#)

[Sore, Tender, and Damaged Nipples in Breastfeeding](#)

[Tongue-tie \(Ankyloglossia\)](#)

[Breastfeeding Referrals](#)





Hypertension and Pre-eclampsia in Pregnancy

Red flags

- ▶ Severe hypertension – systolic blood pressure ≥ 170 mmHg, or diastolic > 110 mmHg
- ▶ Any symptoms or signs of pre-eclampsia, eclampsia, or HELLP syndrome
- ▶ New onset hypertension after 20 weeks' gestation, including in the early postpartum period

Background

About hypertension and pre-eclampsia in pregnancy

Assessment

1. At the first antenatal visit, screen for [risk of pre-eclampsia](#).
2. Consider [early pre-eclampsia risk assessment](#).
3. At each antenatal visit, ensure a [correct blood pressure \(BP\) reading](#):
 - Hypertension is defined as a systolic BP ≥ 140 mmHg and/or diastolic blood pressure ≥ 90 mmHg, on two or more readings.
 - Severe hypertension is defined as a systolic BP ≥ 160 mmHg, and/or diastolic blood pressure > 110 mmHg, and requires urgent assessment.
4. After 20 weeks' gestation, check for [symptoms and signs of pre-eclampsia](#).
5. If hypertension or symptoms of pre-eclampsia are found, perform a physical examination:
 - If newly diagnosed hypertension, perform a cardiovascular examination.
 - If > 20 weeks' gestation, check:
 - weight.
 - [symphysis-fundal height](#).
 - fetal movements and [fetal heart rate](#).
 - for peripheral oedema.
 - for hyperreflexia and clonus.

Management

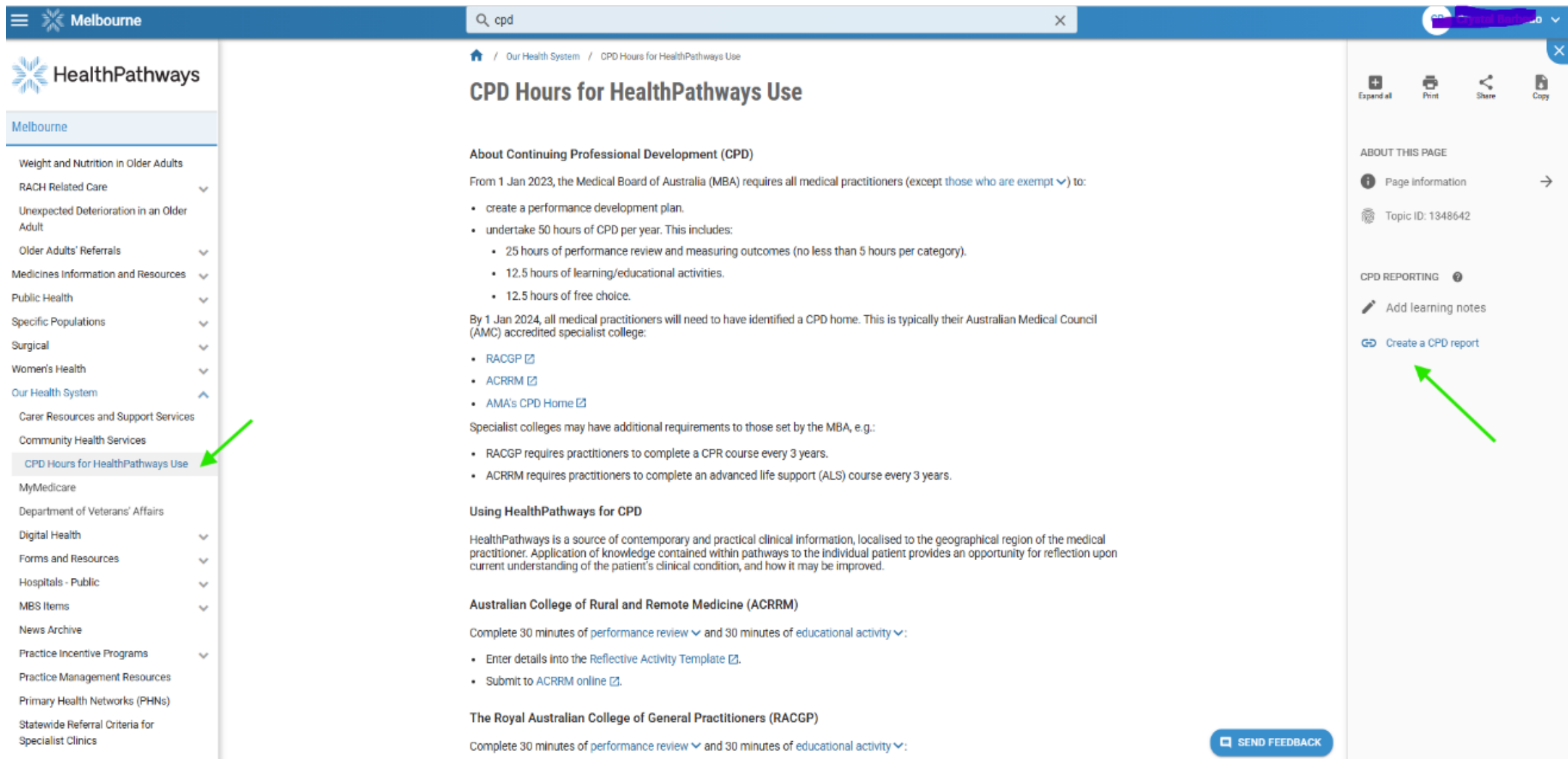
1. If the patient is clinically unstable or their systolic BP is ≥ 160 mmHg or diastolic blood pressure is > 110 mmHg, send to [emergency department](#) via ambulance.
2. Refer for [acute obstetric assessment](#) if:
 - suspected [pre-eclampsia](#).
 - > 20 weeks gestation with new-onset hypertension even if asymptomatic, as investigations should be done in a hospital setting.
 - worsening or difficult to control BP – a sudden increase in blood pressure at > 20 weeks' gestation can indicate pre-eclampsia.
 - concerns about fetal well-being e.g., [reduced fetal movements](#), suspected growth restriction.
 - any [abnormal pathology](#) results.
3. Manage further and follow up according to the stage and diagnosis:
 - [Prenatal \(preconception\) hypertension](#)
 - [Increased risk of pre-eclampsia](#)
 - [Chronic hypertension \(pre-existing or developing before 20 weeks' gestation\)](#)
 - [Gestational hypertension \(developing after 20 weeks' gestation\)](#)
 - [Postpartum development of pre-eclampsia](#)
 - [Postpartum follow-up of antenatal pre-eclampsia](#)
 - [Postpartum follow-up of chronic hypertension](#)

Referral

- Refer the patient to the [emergency department](#) via ambulance if clinically unstable or systolic BP ≥ 160 mmHg and/or diastolic BP > 110 mmHg.
- Refer for [acute obstetric assessment](#) if:
 - suspected pre-eclampsia or [HELLP syndrome](#).
 - > 20 weeks gestation with new-onset hypertension even if asymptomatic, as investigations should be done in a hospital setting.
 - worsening or difficult to control BP – a sudden increase in blood pressure at > 20 weeks' gestation can indicate pre-eclampsia.
 - concerns about fetal well-being e.g., [reduced fetal movements](#), suspected growth restriction.
 - the patient presents in the postpartum period with new onset pre-eclampsia.
 - any [abnormal pathology](#) results.
- If the patient is asymptomatic with new-onset hypertension after 20 weeks' gestation, phone the on-call [obstetric registrar/obstetrician](#) or [private obstetrician](#) to arrange same-day obstetric assessment.
- Seek [obstetric advice](#) if unsure about presentation of pre-eclampsia before 20 weeks' gestation.
- If difficult to control preconception hypertension (especially with concurrent medical problems or a history of pre-eclampsia), consider arranging [non-acute obstetric referral](#) for preconception counselling.
- Discuss with the [obstetric care provider](#) to arrange early pregnancy care and obstetric assessment if:

Learning
objective

HealthPathways – CPD Hours for HealthPathways Use



HealthPathways Melbourne

CPD Hours for HealthPathways Use

About Continuing Professional Development (CPD)

From 1 Jan 2023, the Medical Board of Australia (MBA) requires all medical practitioners (except those who are exempt ▼) to:

- create a performance development plan.
- undertake 50 hours of CPD per year. This includes:
 - 25 hours of performance review and measuring outcomes (no less than 5 hours per category).
 - 12.5 hours of learning/educational activities.
 - 12.5 hours of free choice.

By 1 Jan 2024, all medical practitioners will need to have identified a CPD home. This is typically their Australian Medical Council (AMC) accredited specialist college:

- [RACGP](#)
- [ACRRM](#)
- [AMA's CPD Home](#)

Specialist colleges may have additional requirements to those set by the MBA, e.g.:

- RACGP requires practitioners to complete a CPR course every 3 years.
- ACRRM requires practitioners to complete an advanced life support (ALS) course every 3 years.

Using HealthPathways for CPD

HealthPathways is a source of contemporary and practical clinical information, localised to the geographical region of the medical practitioner. Application of knowledge contained within pathways to the individual patient provides an opportunity for reflection upon current understanding of the patient's clinical condition, and how it may be improved.

Australian College of Rural and Remote Medicine (ACRRM)

Complete 30 minutes of [performance review](#) ▼ and 30 minutes of [educational activity](#) ▼:

- Enter details into the [Reflective Activity Template](#).
- Submit to [ACRRM online](#).

The Royal Australian College of General Practitioners (RACGP)

Complete 30 minutes of [performance review](#) ▼ and 30 minutes of [educational activity](#) ▼:

ABOUT THIS PAGE

- Page information →
- Topic ID: 1348642

CPD REPORTING

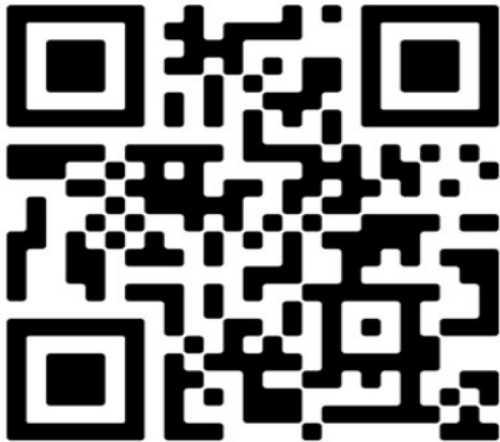
- Add learning notes
- [Create a CPD report](#)

SEND FEEDBACK

Access Now: Sign In or Scan to Register

Please click on the [Sign in or register](#) button to create your individual account or scan the QR code below.

If you have any questions, please email the team info@healthpathwaysmelbourne.org.au



The logo for Community HealthPathways Melbourne, featuring a stylized grid icon followed by the text "Community HealthPathways" and "Melbourne".

Welcome

This website is for health professionals only.

Important update: individual HealthPathways accounts are now required

To enhance the security and personalisation of your HealthPathways experience, shared logins are no longer available. All users will now need to access the site with an individual HealthPathways account.

Sign in or register to request access.

[Sign in or register](#)

Supported browsers:

- Chrome or Microsoft Edge on Android or Windows-enabled devices
- Safari on iOS devices

Get local health information, at the point of care

[What is HealthPathways?](#) ▾

[General enquiries](#) ▾

[Terms and conditions](#)

The logo for phn Eastern Melbourne, featuring the text "phn" in a bold, lowercase font, with "EASTERN MELBOURNE" and "An Australian Government Initiative" below it.The logo for phn North Western Melbourne, featuring the text "phn" in a bold, lowercase font, with "NORTH WESTERN MELBOURNE" and "An Australian Government Initiative" below it.

Clinical referral pathways across Southern Alliance PHNs

PHN region	Clinical referral pathway platform	Link
Eastern Melbourne PHN + North Western Melbourne PHN	HealthPathways Melbourne	Open platform
Gippsland PHN	Gippsland Pathways	Open platform
Murray PHN	HealthPathways Murray	Open platform
South Eastern Melbourne PHN	The Clinical and Referral Guidance Hub (the Hub)	Open the Hub
Tasmania PHN (Primary Health Tasmania)	HealthPathways Tasmania	Open platform
Western Victoria PHN	HealthPathways Western Victoria	Open platform
Country SA PHN + Adelaide PHN	HealthPathways South Australia	Open platform

Not sure which PHN applies? [Use the Australian Government PHN locator map](#)

HealthPathways Melbourne is having a makeover

A refreshed look designed to make key information and commonly used actions easier to find.

COMING SOON


Community HealthPathways
Melbourne

DRAFT

Resources

BF

 Home

PATHWAYS

About HealthPathways >

Summary of Referral Pages

Drafting Section

Aboriginal and Torres Strait Islander Health >

Acute Services >

Avoiding Hospital Presentations >

Allied Health and Community Nursing >

Child Health >

Investigations >

Legal and Ethical >

Lifestyle and Preventive Care >

Medical >

Mental Health >

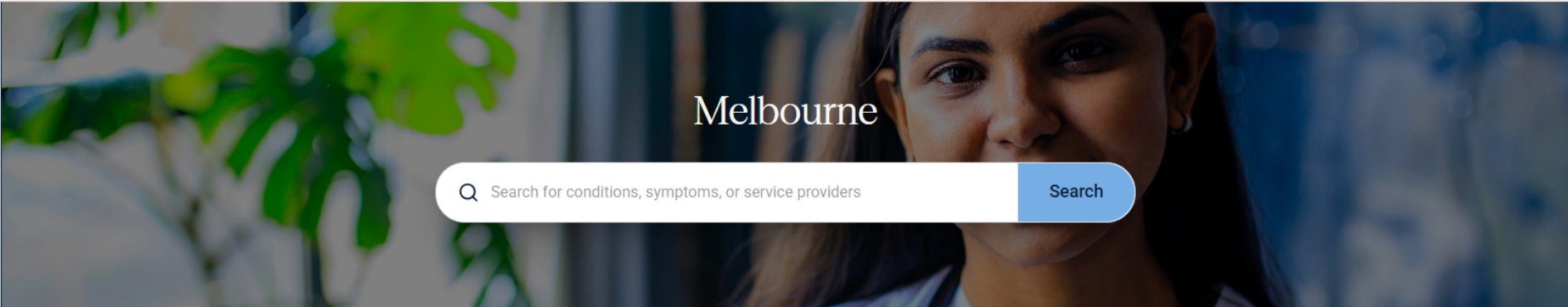
Older Adults' Health >

Medicines Information and Resources >

Public Health >

Specific Populations >

Surgical >



Melbourne

 Search for conditions, symptoms, or service providers

Search

 Recent News

4 September

 **Health.vic**
[Health alerts and advisories](#)

3 September

 **Therapeutic Good Administration (TGA)**
Check [safety alerts](#), [safety updates](#), [recall actions](#), and [medicine shortages](#).

28 August

H5N1 strain of avian influenza (also called H5 bird flu) detected in wild birds in Victoria
Risk of spread to people in Victoria is low. Consider in patients with influenza-like illness who have had contact with sick or dead birds or animals. See:

- [advice and alert](#)
- [Urgent Notifiable Conditions](#).

Seasonal flu vaccination is recommended.

 Resources

[About HealthPathways](#)

[Better Health Channel](#) 

[RACGP Red Book](#) 

[Useful Websites & Resources](#)

[MBS Online](#) 

[NPS MedicineWise](#) 

[PBS](#) 

[NHSD](#)

 Pathway Updates

 Send feedback

Speakers

A/Prof Alexis Shub, Obstetrician and Maternal Fetal Medicine, Mercy Hospital

An obstetrician and maternal fetal medicine specialist at Mercy Hospital for Women with expertise in diabetes, obesity and endocrine disorders in pregnancy. She is Director of Obstetrics, Head of the Emergency Department, Head of PIPER Perinatal, and Vice Chair of the Australasian Diabetes in Pregnancy Society.

Dr Ekaterina Jovic, Gynaecologist and Obstetrician, Northern Health

A gynaecologist and obstetrician. She serves as the acting Head of Obstetrics at Northern Health and is a core clinician at the Maven Centre. Known for her dedication to medical education, she also holds a role as a Clinical Teaching Fellow at the University of Melbourne.

Dr Siaw Wong, General and Obstetric Medicine Physician at the Mercy Hospital for Women and Northern Health

A General and Obstetric Medicine Physician at the Mercy Hospital for Women and Northern Health and currently serves as the Head of Obstetrics Medicine at Northern Health. She is passionate about providing exceptional care to women in pregnancy and supports healthcare professionals in achieving optimal outcomes for mothers and babies, from pre- conception to post-birth.

Fetal RhD NIPT

Folate

Other bits and pieces

A Prof Alexis Shub

Mercy Hospital Women
Royal Children's Hospital



Mercy Health

Care first

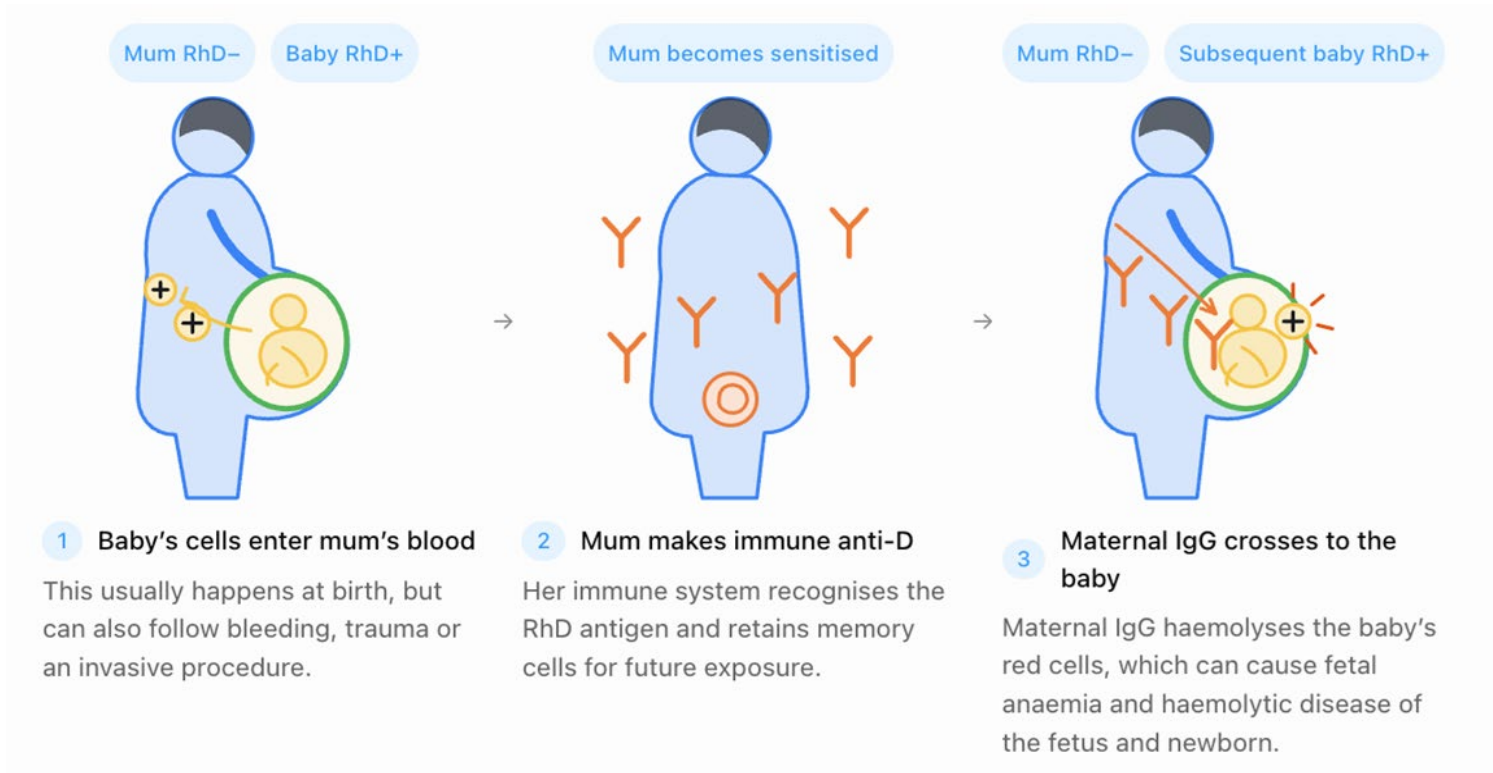
Shared maternity care practical update | October 2026

Why RhD matters: alloimmunisation & HDFN

This pregnancy

Next pregnancy

40% of Rh D
women have a
negative fetus –
Anti D not needed



The established paradigm: anti-D for all

Routine antenatal anti-D immunoprophylaxis

28 weeks

First routine antenatal dose

625IU IM injection to all non-sensitised RhD-negative women

34 weeks

Second routine antenatal dose

A further 625 IU recommended

Birth

Postnatal dose

PLUS: a dose after every potential sensitising event throughout pregnancy

Recent change – no longer required for threatened miscarriage before 12 weeks

Before Anti-D: 0.1 – 0.3% risk of alloimmunisation with immunisation
After Anti-D: 0.1 – 0.3% risk of alloimmunisation with immunisation

Recommendation 1

All Rh (D) negative women (who have not actively formed their own Anti-D) should be offered Anti-D in the following clinical situations:

First trimester (dose 250 IU)

- Abortion (after 10 weeks of gestation for surgical or medical abortions);
- Miscarriage;
- Chorionic Villus Sampling;
- Ectopic pregnancy;
- Molar pregnancy.

There is insufficient evidence to suggest that a **threatened** miscarriage before 12 weeks gestation necessitates Anti-D. However, where the bleeding is repeated, heavy or associated with abdominal pain or significant pelvic trauma, immunoprophylaxis may be administered to women with no preformed Anti-D antibodies (National Blood Authority Guidelines 2021).

Second and third trimester (basic dose 625 IU)

Where does anti-D come from?

A human, donor-derived product

There is **no recombinant substitute**.

Every dose is purified from the plasma of RhD-negative **donors** who carry high-titre anti-D antibodies: mostly hyperimmunised volunteers.

In Australia, plasma is collected by **Lifeblood** and fractionated by **CSL** into RhD Immunoglobulin. The program has run for 50+ years.

However, there is a fragile supply of anti-D

- **~180** regular donors
- Aging donors, fewer newer donors, ethical limitations

“The man with the golden arm” who saved 2.4 million babies

James Harrison OAM donated **1,173 times over 64 years**. His plasma helped produce an estimated **2.4 million doses** of anti-D.

James Harrison OAM passed away in 2025, aged 88





Mercy Health
Care first

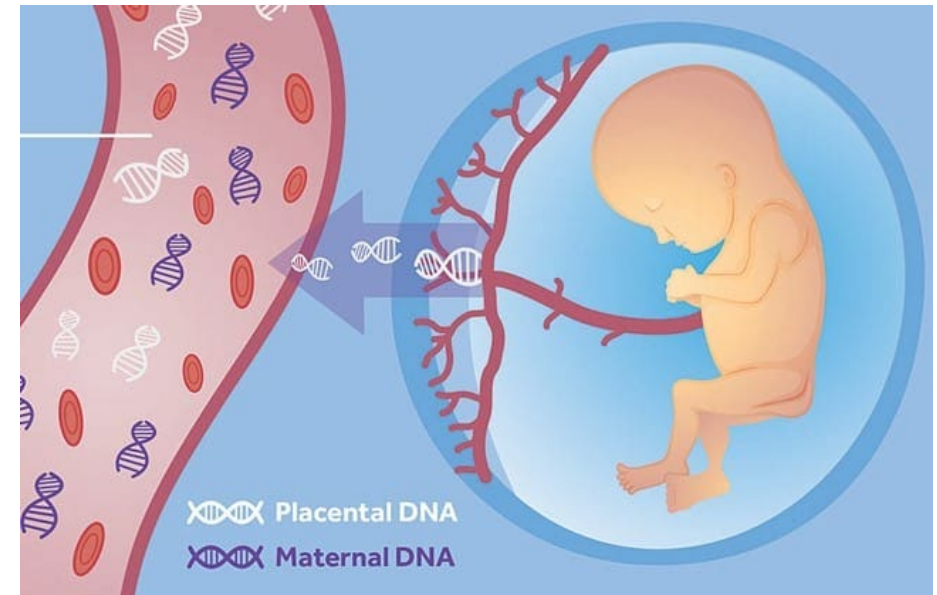
NIPT for fetal Rh D – how it works

cfDNA

Placental DNA (cell free DNA) is in maternal circulation from early pregnancy, and is cleared within a few hours of birth

RhD individuals do not have RhD gene, so in a RhD negative woman, any RH gene is fetal

Also used for aneuploidy screening





Is NIPT reliable for fetal Rh status ?

Standard of care in UK since 2016, Denmark, Netherlands, Norway, Finland

False negative results – predicted to be negative and found to be positive at birth

Technical errors, labelling errors

0.05% = 1 in 2000

Sensitivity 99-100% (Mustafa AJOG 2025)



Why is it better to know fetal Rh?

40% of women don't need Anti D

Scarce resource

Potential infective risk – **although no known infections**

Reduces costs and visits



3 different uses of cfDNA

RhD NIPT

Screening for non isoimmunised pregnancies

Predict fetal Rh to allow targeted Anti D use

Public and private providers

NIPT for aneuploidy

From 10 weeks

Only private – around \$4-500

NIPA

Determining fetal Rh (or other antigens) in isoimmunised pregnancy

Only through Life blood

Pregnancies generally cared for in a high risk clinic



Mercy Health

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Access in Melbourne

Lifeblood

From 15 weeks,
Samples are sent via the usual pathology provider.

[FRM-02742 NIPT Request form v4.pdf](#)

Melbourne Pathology / Sonic Genetics

- \$50 collection fee
- select Melbourne Pathology collection centres
- 11 weeks to <29 weeks

[fetalrhesus_requestform_2026.pdf](#)

Dorevitch

Test available from 11, but if neg before 18 need to retest, so suggest 18

Email: RedCellRefLab@redcrossblood.org.au

Dr James Daly 221517

PATIENT DETAILS Please complete or affix hospital label here		REQUESTING PRACITIONER DETAILS	
MRN/UR/Lab Number:		Provider No:	
Surname:		Surname and Initials:	
Given name(s):		Address:	
DOB: ☐ M ☐ F		Telephone:	
Address:		Email:	
		Signature:	
		Date: / /	
REFERRING PATHOLOGY LABORATORY Report will be issued to this laboratory for further distribution			
Pathology Lab:		Telephone:	
Email:			
CLINICAL NOTES (mandatory)			
Maternal ABO blood group and Rhd status:		Gestation (weeks):	
Maternal antibody screen results (if applicable):		EDC:	
TEST REQUEST Further information about this test can be obtained from the Lifeblood website			
☐ NIPT for fetal RhD (gestation ≥15 wks)		Storage and transport guidelines	
Please collect 1 x 6ml EDTA (essential) 1x Streck tube (where possible)		Store samples at 2-8°C. Pack with a frozen icepack but not in direct contact in compliance with IATA650 and IATA602 packing instructions (refer to IATA Dangerous Good Regulations). Transport time should not exceed 48 hrs.	
Send to Brisbane laboratory for arrival within 3 days from collection			
SPECIMEN COLLECTION		I certify that I collected the accompanying specimens from the above patient whose identity was confirmed by enquiry and/or examination of their name band and that I labelled the specimen immediately following collection and before leaving the patient.	
Collector's Name:		Signature:	
Collection Date and Time:		Gestation at time of collection (weeks):	
MEDICARE DETAILS Please complete at time of collection			
PLEASE ADVISE PATIENT STATUS AT THE TIME OF SERVICE OR SPECIMEN COLLECTION BY CIRCULING A, B, C OR D BELOW AND TICKING THE RELEVANT BOX		☐ INPATIENT ☐ OUTPATIENT	

genomic
diagnostics
A Healdus company

Patient Information	Requesting Clinician									
Surname: _____	Name: _____									
First Name: _____ M ☐ F ☐	Address: _____									
DOB: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr> </table> Phone: _____	D	D	M	M	Y	Y	Y	Y	Postcode: _____	
D	D	M	M	Y	Y	Y	Y			
Address: _____	Phone: _____ Fax: _____									
	Provider No. _____									
	Signature: _____									
Medicare No.: <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table> No. next to name: ☐										
PATIENT INFORMATION: Your treating practitioner has recommended that you use Genomic Diagnostics. You are free to choose your own pathology provider. However, if your treating practitioner has specified a particular pathologist on clinical grounds, a Medicare rebate will only be payable if that pathologist performs the service. You should discuss this with your treating practitioner.										
MEDICARE ASSIGNMENT: (Section 20A of the Health Insurance Act 1973) I offer to assign my right to benefits to the approved pathology practitioner ("APP") who will render the requested pathology services and any eligible pathology determinable service(s) established as necessary by the practitioner. In the event that I am issued an account for those services, I also authorise that APP to submit my unpaid account to Medicare so that Medicare can assess my claim and issue me a cheque payable to the APP for the Medicare Benefit.										
PRIVATE PAY: If I am not eligible for a Medicare rebate, I agree to pay for the cost of genetic testing.										
Patient Signature: _____										
Date: _____										
(Reason patient cannot sign)										

Fetal Rhesus D Testing (MBS #73420)

EDD:

(Patient must be between 11 - 29 weeks gestation for testing)



Douglass Hanly Moir Pathology
Sullivan Nicolaides Pathology
Melbourne Pathology
Capital Pathology
Clinipath Pathology
Bunbury Pathology

Clinpath Pathology
Robert Pathology
Launceston Pathology
North West Pathology
Southern IM Pathology

**INSTRUCTIONS
FOR THE PATIENT**
To find a collection center
please scan the QR code
visit sonicgenetics.com



FOR THE DOCTOR

This test should be requested by the doctor responsible for medical management of a pregnant patient (from 11 weeks' gestation but less than 29 weeks' gestation) who has a Rhesus D (RhD) negative blood group; if performed <18 weeks' gestation, repeat testing may be warranted.

Patient details

First name _____
Surname _____
Date of birth ____ / ____ / ____ Sex at birth Female - Pregnant
Address _____

Phone (mobile) _____
Medicare No. [] [] [] [] [] [] [] []

PATIENT STATUS AT TIME OF SERVICE OR SPECIMEN COLLECTION

(Required by law for all patients) Was the patient a

Private patient in a private hospital or approved day hospital?	☐ Yes	☐ No
Private patient in a recognised hospital?	☐ Yes	☐ No
Public patient in a recognised hospital?	☐ Yes	☐ No
Outpatient of a recognised hospital?	☐ Yes	☐ No

Test(s) requested

☒ **Fetal Rhesus screening**
Non-invasive prenatal testing of blood from an RhD-negative pregnant patient, who is non-alloimmunised (i.e. negative for anti-D antibodies), for the detection of the RHD gene from fetal DNA circulating in maternal blood (MBS Item 73420)

Please note: If testing is required for an alloimmunised patient (MBS item 73421) please contact your local Sonic Healthcare laboratory for further information.

Clinical information **REQUIRED**

This section must be completed for testing to proceed.

Requesting doctor

Name		
Address		
Phone		Provider No.
<p>I confirm that this patient has been counselled about the purpose, scope and limitations of the test and has given consent.</p>		
<p>DOCTOR SIGNATURE</p>		Date
<p>X</p>		

Copy reports to

Name _____

Address _____

FOR THE PATIENT - Patient and Financial Consent

I confirm that I have been informed about the purpose, scope and limitations of the test

MEDICARE ASSIGNMENT (Section 20A of the Health Insurance Act 1973):
I offer to assign my right to benefits to the approved pathology practitioner who will render the requested pathology service(s) and any eligible pathologist determinable service(s) established as necessary by the practitioner.

FINANCIAL ACKNOWLEDGEMENT:

☐ I do not agree to the laboratory contacting my treating doctor(s) to obtain information and result regarding this precertification for quality assurance purposes.

PATIENT SIGNATURE _____

Practitioner's Use Only (Reason for patient being unable to sign)

For pricing, please refer to our website - sonicaenetics.com.au

For pricing, please refer to our website - sonicgenetics.com.au



Mercy Health

Care first

Take-home messages

- Available** Fetal RhD NIPT is accessible through established pathology pathways.
Singleton pregnancies only
Once per pregnancy
- Timing** Testing available at 11 weeks; but ≥ 15 -18 weeks recommended
10 day TAT
- Cost** Free for Medicare eligible patients – public hospital complexity
Collection cost if collected at Melbourne Pathology
- Implications** Anti D/Kliehauer not needed if fetus Rh neg
Check baby cord blood at birth for group to confirm testing

Folate



Why folate?

Reduction in neural tube defects – spina bifida, anencephaly

RCT evidence of effectiveness
in women with previous NTD
extrapolated to others

When and how much?

1 month prior to conception
For 3 months of pregnancy



Folate - naturally occurring
Folic acid - synthetic version
Vitamin B9

Sources of folate

Most fruit and veg
Most pregnancies not planned – so universal
supplementation
Folic acid is added to breadmaking flour, (not gluten free
or organic), some cereals

Methyl folate
Activated folate



Who needs more?

Higher risk NTD, altered utilisation

Previous/FH NTD, diabetes,
anticonvulsant medication (valproate,
carbamazepine)

High BMI





Mercy Health
Care first



Cost per 100 tablets

\$6.49



\$3.49



\$10



\$37.48



\$12

Does folate cause autism/ADHD?

Supplements in pregnancy

Folate
Iodine
Pregnancy multivitamin

Fish oil /Omega 3

RCT for reduction preterm birth. Overall no benefit, post hoc analysis showed reduction PTB in women with low Omega 3 levels, but increased PTB in women with high levels . Testing only available in SA

Vitamin D – RCTs showing no maternal or fetal benefit in women with low Vit D

Raspberry leaf tea – taken to reduce need for induction. No data to support

Magnesium – taken for cramps – no data

Calcium – previously recommended for women with low calcium intake to prevent preeclampsia – changed recommendation



Makrides M, Best K, Yelland L, et al. A randomized trial of prenatal n-3 fatty acid supplementation and preterm delivery. N Engl J Med 2019; 381: 1035-1045.

*RANZCOG Vitamin and Mineral Supplementation and Pregnancy
Roth NEJM 2018*

Cooper Lancet Diab End 2016



4 th trimester and more

EKATERINA JOVIC

Physiology

- Uterine involution from 1000 g at term to 50-100 g pre-pregnancy size within 6 weeks
- Lochia heavy blood flow immediately following birth that rapidly reduces to a red-brown discharge by day 3-4 after birth (lochia rubra). The initial lochia rubra becomes pink (lochia serosa), and finally becomes a heavy white vaginal discharge (lochia alba). The duration of the flow of lochia is very variable. The mean duration is 22-27 days, but one in ten women will still have some bleeding at six weeks postpartum
- A sudden transient increase in bleeding between days 7-14 postpartum corresponding to the shedding of the decidua over the placental bed.
- It is common for women to describe the loss of a flattened blood clot, approximately 6 cm in diameter, on day 3-4 postpartum. This is probably only a cast of the uterine cavity.

Physiology

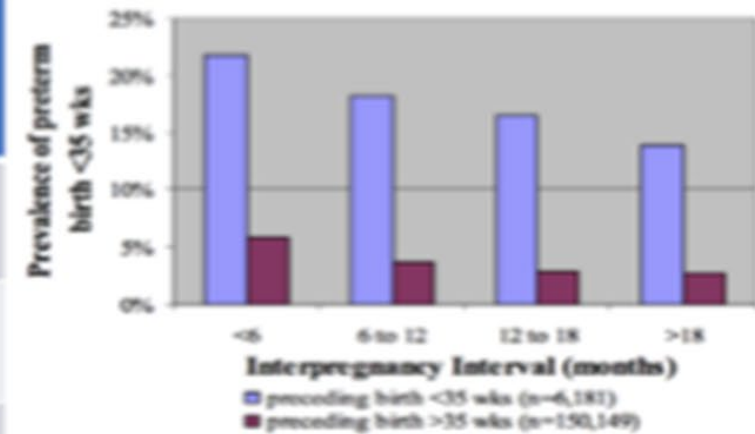
- By 6 weeks postpartum many of the physiological changes of pregnancy will have reverted back to a non-pregnant state.
 - cardiac output/plasma volume/blood pressure/tidal volumes/Hb
- In 16% of women, the early elation after childbirth can be extreme and meets the criteria for hypomania. It is a self-limiting condition.
- Postnatal 'blues' describes a transient state of tearfulness, anxiety, irritation and restlessness that typically occurs between the fourth and tenth days of the puerperium. Usually lasts 24–48 hours, though it may recur over the next 6-8 weeks.

Interpregnancy interval



- Missouri Department of Health birth certificate database for cohort study of 156,333 women with 2 births between 1989-1997

IPI (months)	Extreme PTB OR	PTB <35W OR	Recurrent PTB OR
<6	1.41 (1.13-1.76)	1.48 (1.37-1.61)	1.44 (1.19-1.75)
6-12	1.12 (0.91-1.38)	1.14 (1.06-1.23)	1.24 (1.02-1.50)
12-18	1.0 (0.93-1.09)	1.01 (0.92-1.12)	1.17 (0.96-1.44)



- Conclusion: Wait at least 12 months between delivery and conception

Previous caesarean section

Factors increasing success/safety

1. Reduction in BMI between caesarean and attempting VBAC
2. Age < 30
3. Maternal BMI < 30
4. Spontaneous on-set of labour <41 weeks/dilatation> 4 cm on admission
5. 18 months between caesarean and planned VBAC

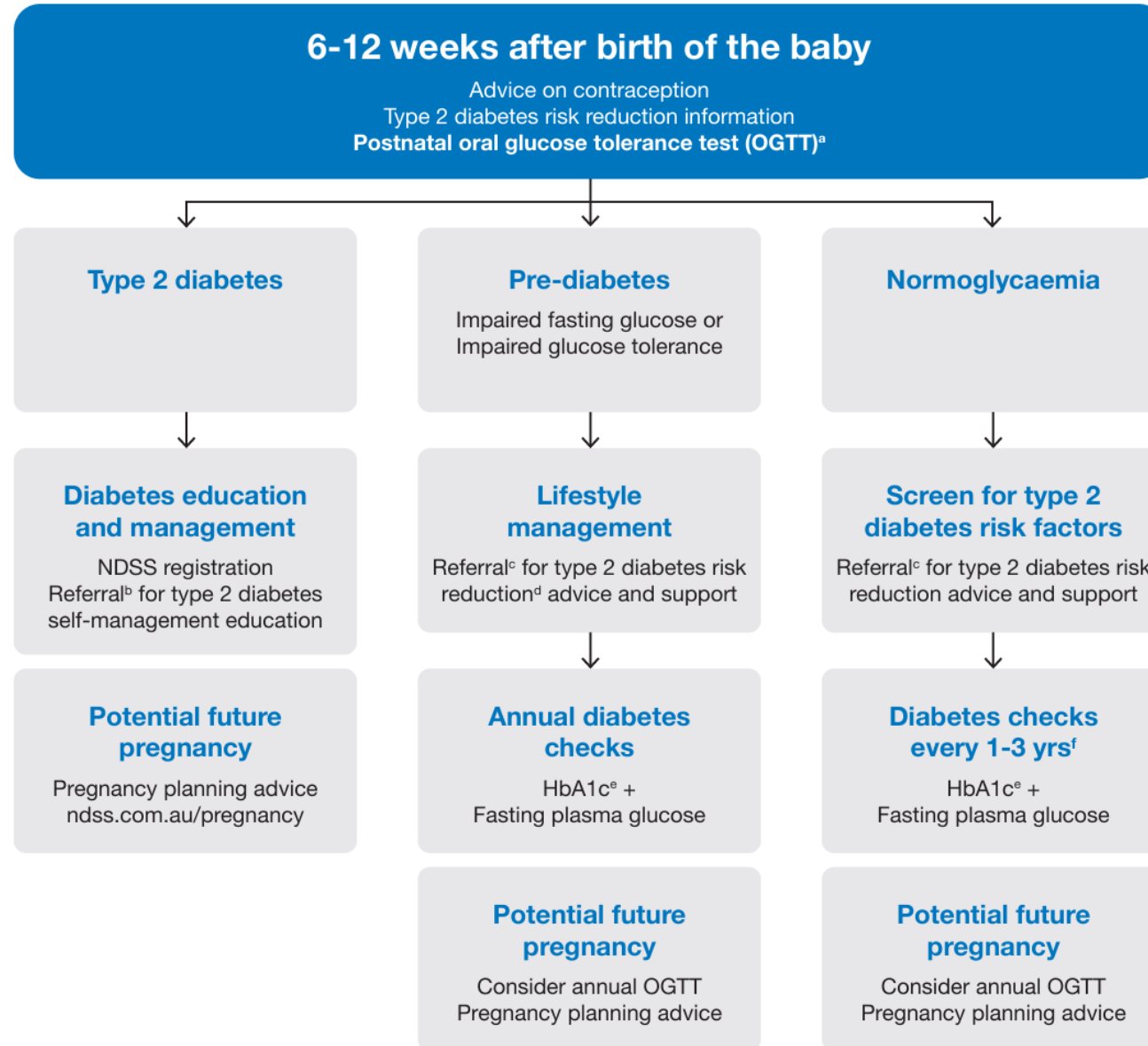
GDM postpartum

- OGTT 6-12 weeks postpartum
- 40% risk of recurrence in subsequent pregnancy
- Risk of developing type 2 DM ranging from 1.5-10% per year
- Annual OGTT if contemplating another pregnancy (?realistic)



**If 2020
was a
drink it
would
be the
Orange
Glucose
Tolerance
test Drink**

Gestational diabetes follow-up



What is new about GDM ?

Gestational diabetes mellitus:

- Fasting plasma glucose 5.3–6.9 mmol/l ;
- 1-h post 75 g oral glucose load > 10.6 mmol/l*;
- 2-h post 75 g oral glucose load 9.0 –11.0 mmol/l .

Australasian Diabetes in Pregnancy Society (ADIPS) 2025 consensus recommendations for the screening, diagnosis and classification of gestational diabetes

Arianne Sweeting, Matthew JL Hare, Susan J Jersey, Alexis L Shub, Julia Zinga, Cecily Foged, Rosemary M Hall, Tang Wong and David Simmons

Med J Aust II doi: 10.5694/mja2.52696

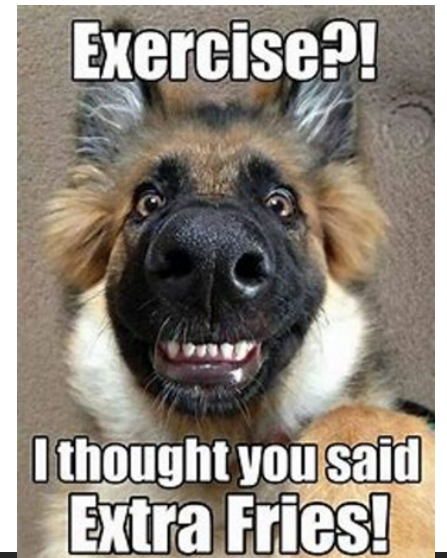
Published online: 23 June 2025

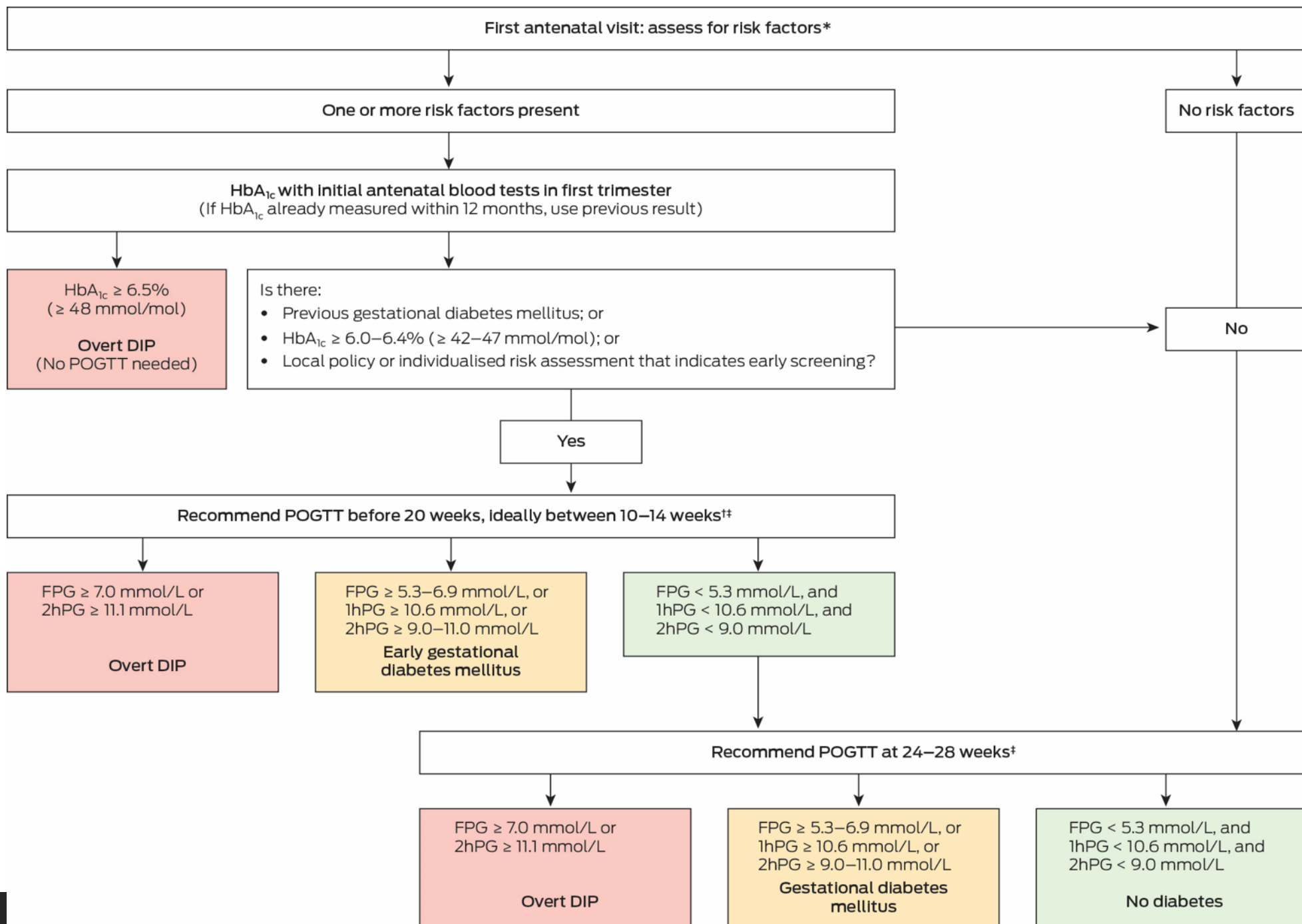
Effects of lifestyle interventions in pregnancy on gestational diabetes: individual participant data and network meta-analysis

BMJ 2026 ; 392 doi: <https://doi.org/10.1136/bmj-2025-084159> (Published 07 January 2026)

Cite this as: *BMJ* 2026;392:e084159

- Lifestyle interventions in pregnancy are likely to prevent gestational diabetes, with effects varying by diagnostic criteria used.
- Benefits were smaller among women with lower education, highlighting equity gaps.
- Interventions delivered in group formats and by newly trained providers enhanced effectiveness.
- Physical activity-based interventions were most effective





Risk factors for GDM

Risk factor	Odds ratio for gestational diabetes mellitus
Previous gestational diabetes mellitus	8.4–21.1
Obesity	5.6
Overweight	2.8
Family history of diabetes	2.3–3.5
Age	
30–34 years	2.7
35–39 years	3.5
≥40 years	4.9
Polycystic ovarian syndrome	2.0–2.9
Hypothyroidism	1.9
History of adverse pregnancy outcomes	
Macrosomia	2.5–4.4
Pre-term delivery	1.9–3.0
Congenital anomaly	3.2
Stillbirth	2.3–2.4
Pregnancy-induced hypertension	3.2
Multiparity	1.4

No established glycaemic treatment targets

Impact of different glycaemic treatment targets on pregnancy outcomes in GDM (S.K. Abell et al. Deabet Med.2019)

Observational study 4700

Service 1 <5.5 and <7.0

Service 2 <5.0 and <6.7

Results: no difference in LGA/SGA

Tighter control – more insulin use and 1 week earlier delivery, lower neonatal hypoglycaemia and jaundice but lower Apgars and higher intervention rate (both IOL and caesarean)

Hypothyroidism

- Reduce thyroxine dose to pre-pregnancy levels
- Regular TFT monitoring
- In women not taking Thyroxine preconception – stop Thyroxine following birth and check TFT 6 weeks postpartum
- The World health organisation recommends a daily intake of 250 mcg during pregnancy and lactation

Recommended trimester specific TSH levels	
Trimester	TSH
First	0.1-2.5 mIU/l
Second	0.2-3.0 mIU/l
Third	0.3-3.0 mIU/l

Postpartum thyroiditis

- Postpartum thyroiditis affects 1 in 20 women, thyroid antibodies positive women are at higher risk
- Majority of women present with isolated hypothyroidism (48%), but a biphasic presentation with hyperthyroidism followed by hypothyroidism (22%) and isolated hyperthyroidism (30%) are also common
- If hyperthyroidism, onset is usually about 3–6 months postpartum, self limiting may required B blockers for symptoms relief
- If hypothyroidism occurs, onset is usually between 6 and 12 months postpartum
- Thyroxine is initiated for symptomatic hypothyroid women or those trying to conceive, continuation of Thyroxine treatment throughout subsequent pregnancies reduces the risk of inadvertent hypothyroidism but, a high proportion of women will ultimately recover normal thyroid function, an attempt should be made to wean thyroxine 6–12 months after the final pregnancy
- Long term follow up with annual TFT

Perineal health and healing

- Women with perineal trauma can develop a range of complications, from short-term issues, such as wound infection and wound breakdown, to long-term problems such as psychosexual issues, dyspareunia, urinary incontinence, and pelvic organ prolapse
- If the perineal wound breaks down or there are ongoing healing concerns, refer the woman urgently to the maternity service
- Perineal lacerations tend to heal rapidly in the 14 days postpartum, while the genital blood supply is still relatively generous.
- Ask about perineal trauma and aim to provide safe environment for examination, encourage if a woman wishes to have a partner, support person or chaperone accompany them.

Perineum care early postpartum

1. RICE principle first 72 hours

Rest: lying or sitting down, no prolonged standing, lifting

Ice: ice in the pad will reduce swelling/pain – apply for 15 minutes every 2 hours

Compression: close fitting pants and pads usually feel more comfortable by adding support to the perineum.

Elevation: lying down combined with gentle pelvic floor exercises is the best option for assisting the perineum to heal.

2. Pelvic floor exercise – starting from lying down and slowly progress to sitting -> standing

Perineum care early postpartum

3. Avoiding constipation : increase hydration 2-3 l a day, fibre, gentle exercise such as walking
4. Correct posture to open bowel, sometimes gentle upward pressure on the perineum can help to empty the bowel
5. Shower to the perineum after emptying bowel
6. Changing pads frequently
7. Avoiding soap, talcum powder, creams
8. If altered bowel or bladder sensation will need referral to gynaecology clinic/pelvic floor physio

Infection



Most wound infections managed expectantly with the perineal wound healing by secondary intention.

When surgical management is considered:

- complete wound dehiscence
- wound dehiscence within 48 hours of the primary repair
- wound dehiscence of third-degree or fourth-degree tears
- necrotic tissue
- wounds associated with severe perineal discomfort

Incontinence

- Urinary incontinence is very common immediately after delivery but will persist in up to 30% of women at 3 months postpartum
- Encourage pelvic floor exercise and treat constipation
- Refer to pelvic floor physio if symptoms persists at 3 months
- Faecal incontinence affects up to 30% of women in the immediate postpartum period, reducing to about 10% of women at 3 months postpartum.
- Refer to pelvic floor physio/gynaecology clinic

Sexual health

- Women want information, support and reassurance regarding intimacy and sexual function after child birth
- Advice regarding the timing of resumption of sexual intercourse 6 weeks – physically ready
- Hormonal changes (prolactin, low oestrogen), sleep deprivation,
- Body changes, trying to shift mind from criticism to curiosity
- Space for grief and gratitude, they can co-exist
- Emotional safety is fundamental for desire, shift priority from sex/intercourse to intimacy

Vaginal lubricants

Used at time of sexual activity

- Water base (K-Y jelly, Astroglide, Bed intentions)
- Silicone base (Pjur, ID Millennium)
- Oil base (Simply Slick, Yes OB etc)

Lubricants

The ideal lubricant has a similar pH and osmolality to physiologic vaginal discharge - 4.5 and 1200 milliosmoles per kilogram, respectively.

- Water-based lubricants are familiar and inexpensive, but most commercial products have a high osmolality and pH in the range of 5 to 8. Hyperosmolar products disrupt the epithelium and may provoke cell necrosis. Water-based lubricants contain bactericidal compounds like chlorhexidine or methylparaben that may kill lactobacilli or otherwise impact genital microflora

Lubricants

- Silicone-based lubricants offer a better-matched osmolality and do not affect epithelial cell integrity, but have a neutral rather than acidic pH.
- The user experience of silicone-based lubricant is a long-lasting slippery sensation that is maintained in or under water.
- Silicone products are compatible with condom use
- Expensive

Lubricants

- Oil-based lubricants include any single-source unscented oil like coconut, olive, or avocado.
- High pH
- Readily available and doubles as an emollient but is incompatible with condoms.

Vaginal estrogen

Vagifem (oestradiol) pessary

Ovestin (oestriol) – cream or pessary

Typical regimen for these products daily for 2 weeks, then twice weekly

If prescribed short course only 6-12 weeks, confirm perineal tears healed



Contraception

Levonorgestrel intrauterine device

- Lasts up to 8 years
- Frequent spotting or bleeding in the first 3–6 months is common; thereafter, the device significantly reduces menstrual bleeding, amenorrhoea in 50% after 12 months of use
- High level of effectiveness 99.9%
- Can be inserted at time of caesarean/immediately post delivery < 48 hours (but higher risk of expulsion)
- Contraception clinics (Northern health, short waiting)

Contraception

Copper IUD

- Can be inserted at time or immediately after delivery if desired
- After 48 hours, insertion should be delayed until 28 days after childbirth
- Can last up to 10 years
- Caution in those with a history of dysmenorrhoea or high risk of sexually transmissible infections
- Contraception clinics (Northern health, short waiting)

Contraception

Implanon

- Can be inserted immediately postnatally
- Unpredictable bleeding patterns are common one in four ; one in five women may experience amenorrhoea
- Lasts up to three years
- High level of effectiveness, especially if inserted immediately after delivery

Contraception

Depot contraceptive injection

- Can be used in the immediate postnatal period
- Administered intramuscularly every 12 weeks
- Not recommended for women aged < 18 and >45 years
- May be associated with weight gain
- May have delayed return to fertility of 12–18 months
- Up to 70% of women develop amenorrhoea by 12 months

Contraception

Progesterone-only oral contraceptive pill

- Can be started immediately postnatally
- No effect on milk supply
- Counsel women on strict dosing timing to improve efficacy and that the pills are taken continuously (no sugar pills)

Combined oral contraceptive pill

- Avoid if breastfeeding (small reduction in milk supply) or immediate postnatal period (first 21 days)

Contraception

Barrier methods: male or female condoms, diaphragm

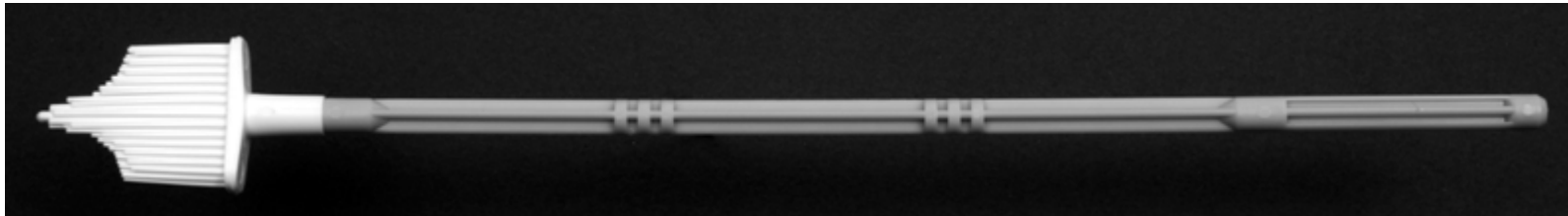
- Condoms, with typical use, have a high failure rate
- Women choosing to use a diaphragm should be advised to wait at least six weeks after childbirth before having it fitted because the size of the diaphragm required may change

Ethynylestradiol-releasing vaginal ring

- Can be used once the mother feels comfortable inserting it from >4 weeks postpartum
- Common side effects include vaginitis, change in vaginal discharge or irregular bleeding
- Women should check for the ring regularly to ensure it has not been expelled

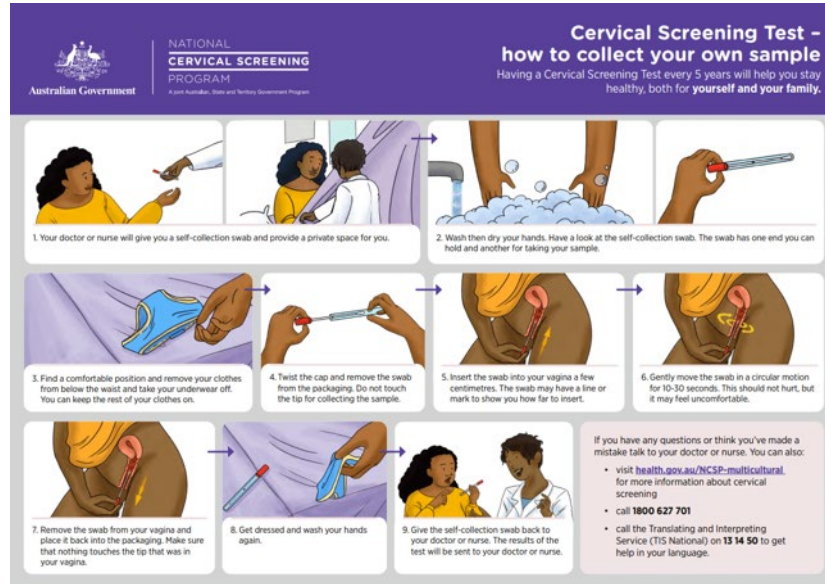
Cervical screening test

- Routine antenatal and postpartum care is an important opportunity to reach under-screened and never screened people who may not otherwise attend health services.
- The incidence of cervical cancer in pregnancy is low, with estimates in the literature ranging from 3.3 to 26 cases per 100,000 births
- If clinician collect **in pregnancy** use cyto-broom
- It is important to consider non-obstetric causes when a patient reports vaginal bleeding during pregnancy



Inclusion of self collect option

Screening participants with HPV (not 16/18) detected on a self-collected sample who do not return for a follow-up test 9 months or more after their initial Cervical Screening Test, can now be offered a self-collected HPV test as follow-up, rather than a co-test, because this will determine if the HPV infection has now been cleared and the person can then return to routine screening.



Colposcopy in pregnancy

Who needs colposcopy antenatally:

- HPV (not 16/18) detected with LBC prediction of pHSIL, HSIL or any glandular abnormality in pregnancy
- HPV 16/18 regardless of the LBC prediction

Please state clearly on referral – pregnant

- colposcopy will be triaged as high risk and experience colposcopist will perform it

Food for thoughts

Most notably, cervical cancer incidence in Aboriginal and Torres Strait Islander females is 13 per 100,000, approximately twice the national rate, and incidence is also higher among people who live in more remote areas or are more socioeconomically disadvantaged

Breastfeeding

- Antenatal expressing is commonly recommended from 36 weeks for women with diabetes
 - 1 in 4 will not get breastmilk at all
 - The amount is often quite small, on average about 5mls in total (not for each express)
 - Can cause mild contractions but not associated with PTB
- Women who are keen on breastfeeding or had prior issues can see lactational consultant antenatally
- [Breastfeeding Information - A to Z - La Leche League International](https://lila.org/breastfeeding-info/) : <https://lila.org/breastfeeding-info/>

Mood

Use the Edinburgh Postnatal Depression Scale (EPDS) to screen women for a possible depressive disorder 6-12 weeks

- Using a cut-off score of 13 as the diagnostic marker for depression is likely to accurately exclude those who do not have depression

- Women who score between 10 and 12 on the EPDS may be experiencing a minor episode and warrant further assessment and care

- Question 10 of the EPDS relates to self-harm; any positive answer immediate follow up

Postnatal depression

- Postnatal depression is seen in 10–15% of women
- Two key peaks when diagnosis is made: 2-4 weeks postpartum and 10-14 weeks postpartum
- Up to a third of women diagnosed with postnatal depression, symptoms started in the antenatal period
- Previous PND - 50% chance of recurrence if previously severe PND
- Selective serotonin reuptake inhibitors (SSRIs) are the first-line agents because they are generally non-sedating and well tolerated (Sertraline is the drug with the best evidence for safety in breastfeeding)

Postnatal depression

- CBT can be effective on its own or combined with medical treatment
- Improvement usually seen within 2 weeks of starting treatment, with resolution of symptoms over 6-8 weeks
- Pharmacological treatment should continue for at least 6 months
- Without treatment, 30% of women will still be depressed at 1year

Pelvic girdle pain

- Feature of late pregnancy for many women
- A disruption of the pubic joint of the anterior pelvic girdle. The joint is usually relatively fixed and permits little movement, but due to the effects of progesterone and relaxin in pregnancy, the increased range of movement sets up inflammation in the joint.
- For postpartum management: simple analgesia +/- physiotherapist
- Spontaneous resolution is normal, often over a period of months rather than weeks
- If no improvement refer to rheumatologist

What is new at Northern

Preeclampsia screening clinic

Eligibility criteria:

- Primiparous
- Singleton pregnancy
- Hold a valid Medicare card
- Early referral 10-12 weeks

Patient will be seen 11+3-13+6 and screen for risk of PET – placental growth factor (PIGF), history, Mean arterial pressure (MAP) – Fetal medicine foundation preeclampsia risk calculator

A calculated risk 1:100 or less identified women with high risk of PET – will be commenced on 150 mg of Aspirin until 36 weeks

Questions

The Teacher: Don't worry. The Questions aren't that hard.
The Questions:



Postnatal Follow-up of Hypertensive Disorders of Pregnancy

Dr Siaw Wong

*General & Obstetric Medicine Physician
Mercy & Northern Health*

Head of Medical Obstetrics, Northern Health



Presentation Outline

1

Pre-eclampsia & Hypertensive Disorders

Overview of hypertensive conditions during pregnancy

2

Postnatal Follow-up

Monitoring blood pressure & managing long-term cardiovascular risks

3

Recurrence Risk & Counselling

Evaluating future pregnancy risks and preconception guidance.

Hypertension in pregnancy

Prevalence & Overview

10–15%

All Pregnancies

Most common medical problem in pregnancy

3–3.3%

Pre-eclampsia (Australian Pregnancies)

0.4% <34/40 | 2.4% >34/40

Maternal Morbidity & Mortality

- Renal & liver failure
- DIC & **HELLP** syndrome
- Pulmonary oedema
- Cerebrovascular events (incl. **eclampsia**)
- Sepsis

Neonatal Morbidity & Mortality

- Preterm delivery
- Fetal growth restriction



¹<https://www.health.gov.au/resources/pregnancy-care-guidelines/part-d-clinical-assessments/risk-of-pre-eclampsia>.

Postnatal – Pre-eclampsia & Hypertensive Disorders

Key Postpartum Monitoring Alert

After delivery, blood pressure tends to fall but can **peak again 3–7 days postpartum**.

SOMANZ Guideline 2023

Strongly recommends GP review of blood pressure **within 1 week** of hospital discharge.

- Re-assess systemic blood pressure
- Titrate antihypertensive medications accordingly

Antihypertensive Therapy

- **No single agent** is proven superior to another overall.
- **Enalapril** offers renal protection & reduces proteinuria.
- **Other Agents:** Labetalol, Methyldopa, Nifedipine.
- ✓ **All options are safe during breast-feeding**

Postnatal – Pre-eclampsia & Hypertensive Disorders

< 6 WEEKS POST-PARTUM

Blood Pressure Assessment

- Ensuring target blood pressure <140/90 met

Medication Management

- **Antihypertensives**
- **NSAID Avoidance** where possible. NSAIDs known to raise blood pressure in adults with hypertension

Mental Health Screening

- Screen for features of post-partum depression +/- anxiety.
- **Edinburgh Postnatal Depression Scale (EDPS) screening tool**

Postnatal – Pre-eclampsia & Hypertensive Disorders

3-6 MONTHS POSTPARTUM

BP & Cardiovascular Assessment

- Consider 24-hr ABPM
- **Secondary hypertension screen:**
Consider screen +/- specialist review if BP $\geq 130/80$ (ABPM), $\geq 140/90$ (clinic), or if on antihypertensives

Lab & Metabolic Screening

- **Ensure normalization of abnormal pathology results:**
FBE, UEC, LFTs, urine PCr, Urine ACr.

Mental Health Screening

- Screen for features of post-partum depression +/- anxiety.
- **Edinburgh Postnatal Depression Scale (EDPS) screening tool**

Postnatal – Pre-eclampsia & Hypertensive Disorders

YEARLY REVIEW

Cardiovascular Risk Profile

- Annual review of metabolic, cardiovascular, and renal risk factors
- Key checks: BP, weight, lipid & glycaemic profile, urine protein analysis

Future Pregnancy Planning

- Emphasise importance of pre-conception care
- Early pre-eclampsia prophylaxis: **aspirin (150mg nocte before 16/40)**, regular exercise, dietary +/- calcium supplementation (1000mg daily)

Pregnancy as a window to your future health

Know your risk: Women who have had preeclampsia in their pregnancy may be at a higher risk of the following later in life:



4x higher risk of developing high blood pressure



2x higher risk of developing heart disease



2-4x higher risk of type 2 diabetes mellitus



2x higher risk of developing stroke



4-8x higher risk of kidney disease



2 in 3 women will die from a cardiac disease

Medical Obstetrics at Home (MOAH) service

Hospital in the Home & Telehealth Care | Supporting women with hypertension & pre-eclampsia during pregnancy & up to 6 weeks postpartum

Service Overview & Care Model

- **Clinical Team:** Run by midwives & obstetric medicine physicians at Northern Health
- **Service Schedule:** Operates 3 days a week (Mon, Weds, Fri)
- **Remote Support:** Loan blood pressure machines provided with telehealth consults to assist with antihypertensive titration

Admission Criteria

- **Catchment Area:** Residential postcode within NH catchment area
- **Entry Pathways:**
 - Initial presentation via Virtual ED
 - Direct presentation or admission to NH ED or wards



Hospital contacts

Royal Women's Hospital

Switch P: 03 8345 2000

Shared care: shared.care@thewomens.org.au P: 03 8345 2129

GP Liaison E: gp.liaison@thewomens.org.au P: 03 8345 2064

GP Quick Access P: (03) 8345 2058

Northern Hospital

Effie Noulas

GP Liaison Midwife

E: maternitysharedcare@nh.org.au

P: 0481 222 508 (Office hours)

MAC: (03) 8405 2277 (After hours)

Mercy Hospital for Women

primarycare@mercy.com.au

For urgent care: Emergency - 2nd on Reg - P: (03) 8458 4444 (option 0)

Western Hospital

General Practice Integration Unit (for shared care credentialing)

Ph: 8345 1735 Email: gp@wh.org.au.

For non-urgent enquiries regarding current Shared Maternity Care. Contact Shared Maternity Care

Co-ordinator: Maternitysharedcare@wh.org.au

Measuring outcomes for today

To obtain Measuring Outcomes hours for this session use the RACGP's Measuring Outcomes Tool.

Follow these five steps:

1. Log-in to myCPD
2. At very top of myCPD, click on 'Log'
3. From drop-down menu, click on 'Measuring Outcomes Tool'
4. Complete the form
5. Once you have completed the form, go to top of form and click 'Submit'



Thank you for attending. What's next?

After this session you will receive:

1

Slides, resources and the recording of this session within the week

2

RACGP CPD hours will be uploaded within 14 days.

3

Attendance certificate will be received within 4-6 weeks.

- **Register for more education sessions here:**
nwmpnhn.org.au/resources-events/events
- **Past education sessions can be found here:**
nwmpnhn.org.au/resources-events/resources
- **Session Survey Link** <https://www.surveymonkey.com/r/QMBFZ9M>

Feedback - QR code

We welcome your feedback.
Let us know if you got what
you needed from this session.

