Metro South Health

Reproductive Health & Termination of Pregnancy in MSHHS
AM1 – Session 2

21st April 2026

Dr Catriona Melville, Clinical Lead Reproductive Health, Senior Staff Specialist, Logan Hospital
Lynelle Phillips , Nurse Navigator LBH Early Pregnancy Assessment Unit & MSHHS Termination of Pregnancy Unit
Shelby Mahoney, Children by Choice

We care about you

Queensland Government

Metro South Health recognises and pays respect to the traditional custodians of the land and waters — the Yugambeh, Quandamooka, Jaggera, Ugarapul, Turrbal and Mununjali peoples — and to Elders, past, present, and emerging.

Artist | Kylie Hill

In our education today, we use the terms women, people, patients or individuals, when referring to those who are pregnant or planning to become pregnant. We also use the term mother, especially in the case of "mother-to-infant transmission".

We respectfully acknowledge that some pregnant people or those planning pregnancy may not identify as 'female' or as having a lived experience of 'womanhood' or 'motherhood', and strongly affirm that maternity care for individuals should be inclusive and respectful of the terms that are preferred by individuals

Acknowledgments

- Metro South Health and Hospital Service
- Maternity Services at Logan/Beaudesert/Redland Hospitals for their clinical input and support
- The Alignment team at MMH
- The > 1800+ GPs who've been through MSHHS or the MMH Alignment education and given us their feedback
- Dr Wendy Burton
- Dr Catriona Melville and the MSHHS Termination of Pregnancy Unit staff (Nellie Phillips, Nurse Navigator and Lama Hassan, Clinical Midwife)
- Dr Sanja Savic, Staff Specialist, O & G Dept, Logan Hospital
- Shelby Mahoney, Service Pathways Coordinator, Children by Choice
- Mr Demy Dorado, Customer Engagement Partner, Bayer Pharmaceuticals
- Yourselves

Introducing our team …..

- Facilitator: Dr Kim Nolan , GP - GPLO Maternity Share Care
- Lisa Miller, GPLO Midwife Manager (currently working on another project, and not available after hours)

House keeping

- **Raise your hand** if you want to contribute to the discussion or to ask any questions.
- **Phones on silent please**.

Reproductive Health & Termination of Pregnancy in MSHHS AM 1.2 Agenda

Time	Session name	Presenter	Delivery
5.30 pm	Dinner – sponsored by Bayer Pharmaceuticals	ALL	
6.00 pm	Welcome and Housekeeping. Case 1 Introduction	Dr Kim Nolan	GP Facilitator Microsoft Teams Quiz
6.10 pm	Children by Choice Presentation	Shelby Mahoney	PowerPoint
6.15 pm	Case 1 Discussion Termination of Pregnancy Guidelines and Decision Aids Options and Work Up for ToP	Dr Kim Nolan Shelby Mahoney Nellie Phillips	PowerPoint Microsoft Teams Quiz
6.50pm	Case 2 Discussion – Proceeding with a pregnancy termination in MSHHS	Dr Catriona Melville Nellie Phillips	PowerPoint Microsoft Teams Quiz
7.40-7-50pm	Leg stretch and Supper	ALL	
7.50pm	Termination of Pregnancy Services available in the region Questions	Dr Catriona Melville Nellie Phillips	PowerPoint
8.05 pm	Other Resources – Quick Overview	Dr Kim Nolan	PowerPoint
8.10pm	Feedback Questionnaire Information re Alignment, CPD, Newsletters & Future Events		PowerPoint

What suburb do you mostly work in?

https://forms.cloud.microsoft/r/0gSDqeR9ea

MSHHS GP Maternity Alignment 2026-Session 1.2

Case Study 1: JADE

Jade comes to see you with her grandmother, who is your regular patient. She is aged almost 17 years, and has an unplanned pregnancy, with uncertain date of LMP. She had been taking the OCP reliably she claims but fell pregnant when she could not afford the GP visit to obtain a repeat prescription. Jade states that terminating the pregnancy seems to be her best choice.

You have seen her occasionally when younger and visiting her GM but have not seen her for some years. You ask her grandmother to leave so you can speak to Jade alone.

What do you need to know from Jade as you go about outlining her pregnancy choices?

https://forms.cloud.microsoft/r/mVrnF44yUT

MSHHS GP Maternity Alignment 2026 - Session 1.2 A

Termination of pregnancy

Termination of Pregnancy Act December 2018

- Lawful termination may be performed by registered medical practitioners
- Up to gestational limit of 22 + 0, for any reason
- Gestation upward of 22+1; 2 x medical practitioner agreement that termination can be performed
- GPs advised to contact Nurse Navigator for ToP service to assist patients with limited other means to arrange an abortion.

Fast facts about termination of pregnancy

Half of Australian women will experience an unplanned pregnancy in their lifetime.

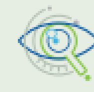
Between 10,000 and 14,000 terminations are performed in Queensland each year.

Most terminations are performed in the first trimester (up to 12 weeks) in the private sector.

While termination of pregnancy is one of the most common procedures performed for women, it can be inaccessible, expensive and heavily stigmatised.

By positioning termination of pregnancy as a health issue rather than a legal issue, the Act:

supports a woman's right to health including reproductive health and autonomy



provides clarity and safety for health practitioners providing terminations of pregnancy

brings Queensland legislation in line with other Australian jurisdictions.

Quick Exit Clear Browser History

Learning Portal Contraception Quiz Blog About Us

CHILDREN BY CHOICE

Queensland Wide Pregnancy Support Services

1800 177 725 Free & Confidential

Find a Health Service

Advice & Support For Professionals For Communities Get Involved Your Story, In Your Words Get in Touch Conference 2026

Search ...

Pregnancy support that puts you first

Compassionate guidance and resources, tailored to your journey.

Free & confidential helpline 1800 177 725

If you need support Contact Us

QLD wide pregnancy support services

Pregnancy Options

Will I regret having an abortion?

Read Article

Pregnancy Options

How to Support a Friend or Partner Exploring Their Pregnancy Options

Read Article

Reproductive Coercion and Abuse

Supporting Someone Experiencing Reproductive Coercion and Abuse

Read Article

Reproductive Coercion and Abuse

Recognising Reproductive Coercion and Abuse

https://www.childrenbychoice.org.au/blog/

Free & confidential helpline

1800 177 725

CHILDREN BY CHOICE

Children by Choice is an independent non-profit organisation, committed to providing unbiased information on all pregnancy options. Our counselling services are free for anyone in Queensland. We assist any pregnant person regardless of their background.

Free call 1800 177 725 (statewide)

Ground floor, 349 Coronation Dr, Milton Qld 4064

Open Monday to Saturday, 8am to 7pm

Summary

Children by Choice offers financial assistance funding to support people in Queensland experiencing financial hardship who need help covering the costs of abortion care and related essential services.

This program assists clients who have already explored public funding options and require additional financial support for services such as procedures, travel, accommodation, childcare, and contraception.

Healthcare providers, social workers, and other professionals can refer clients directly, or clients can self-refer.

For client-facing information, visit our **Financial Aid page.**

Children by Choice administers a financial assistance program funded by Queensland Health to support people in Queensland who face barriers to accessing abortion care.

Eligibility Criteria

To qualify for funding, applicants must meet all mandatory criteria below.

- **Residency or visa:** The client resides in or is temporarily resident in Queensland.
- **Financial hardship:** The client demonstrates insufficient funds to cover termination-related costs.
- **Exhausted public funding:** The client has attempted to access, or is ineligible for, public funding (e.g. Medicare, HHS travel subsidy).
- **Referral pathway:** Referral received from 13HEALTH, a healthcare provider, or through self-referral.
- **Clinical appropriateness:** Request aligns with Queensland legislation and accepted medical standards for termination of pregnancy.

What funding can cover

Funding may be approved for costs related to abortion care and associated needs, including:

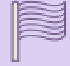
- Medical or surgical termination of pregnancy procedures
- Travel and accommodation associated with accessing care
- Childcare or dependent care during procedures
- LARC insertion following a procedure
- Other essential care costs, such as ultrasounds, medications, or a support person's travel

Inclusive, supportive care for every community
We know different communities face different challenges. Our support is here to meet your needs with respect and understanding.

Aboriginal and Torres Strait Islander

Aboriginal and Torres Strait Islander people can face barriers to safe, respectful reproductive healthcare. We're committed to providing culturally appropriate support and helping you access services that meet your needs.

Learn more



LGBTQIA+

LGBTQIA+ people can face unique challenges when accessing reproductive and sexual healthcare. We're here to support your choices with respect, inclusion, and understanding.

Learn more

Migrants & Refugee

At Children by Choice, we support people from migrant, refugee, and asylum-seeking backgrounds to make informed and confident choices about pregnancy, parenting, and reproductive health.

Learn more

People with disability

People with disability can experience discrimination, inaccessibility, or assumptions about their choices. We're here to make sure support is inclusive, respectful, and tailored to your needs.

Learn more

Rural and regional

Living outside major cities can make it harder to access local reproductive healthcare. We support rural and regional communities to reach the care they need, wherever they are.

Learn more

People in contact with the legal system

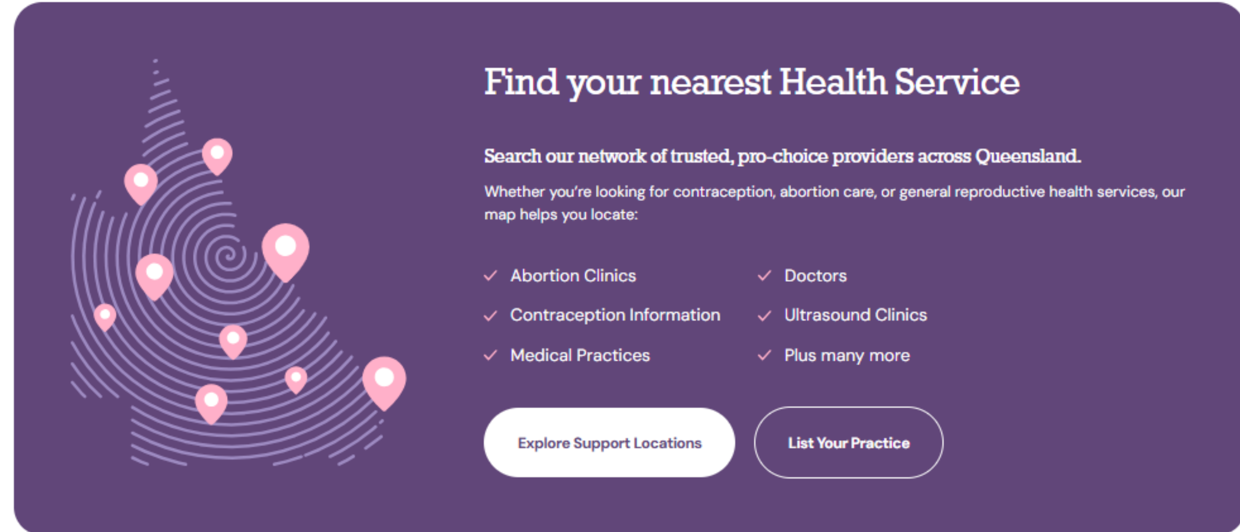
You may be in contact with the legal system if you are in prison, on probation, or recently released. It's important to know you still have the same rights to health care as anyone else.

Learn more

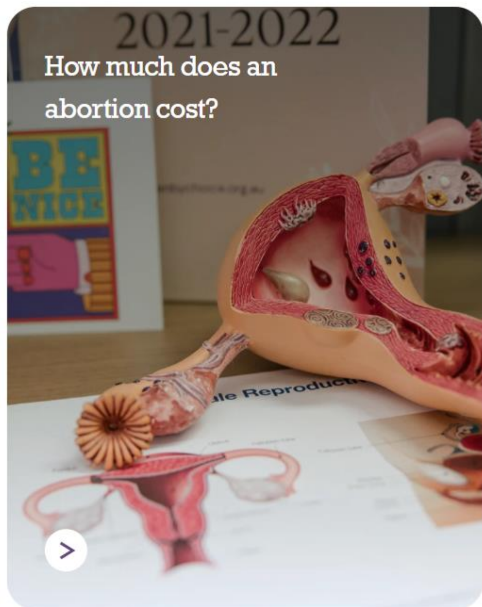
Young people

Young people can face stigma or uncertainty when it comes to their sexual and reproductive health. We offer confidential, judgment-free support to help you make the choices that are right for you.

Learn more



https://www.childrenbychoice.org.au/for-communities/



Training for Professionals

CHILDREN BY CHOICE

For Professionals

Training for Everyone

CHILDREN BY CHOICE

For Everyone

April 2026

Mon	Tue	Wed	Thu	Fri	Sat	Sun
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Search for events

All March May July September October November

Thu, 26 Mar, 12pm - 1pm AEST
Abortion Stigma Webinar March 2026
Online Event

Thu, 7 May, 12pm - 1pm AEST
Reproductive Coercion and Abus...
Online Event

Wed, 22 Jul, 12pm - 1pm AEST
Abortion Support Person Webinar Jul...
Online Event

Thu, 3 Sep, 8:30am - Sat, 5 Sep, 3...
Children by Choice's Reproductive Rights...
Venue details will be sent with registration confirmation

Thu, 24 Sep, 5pm - 6pm AEST
Finding the Right Fit: Guide to...
Online Event

Thu, 15 Oct, 12pm - 1pm AEST
Conscientious Objection 101...
Online Event

Downloadable Resources

Practical resources and information to support your work with clients and communities.

Learn more

Choosing the best contraception for you

Finding the right contraception can feel overwhelming, and it's normal to have questions. The best method depends on your lifestyle, future pregnancy plans, and whether you also want protection from sexually transmitted infections (STIs). You can compare **types of contraception** here .Whatever you choose, it's important to consider what works best for you and your body. If someone else is influencing or controlling your decision, read about **reproductive coercion and abuse**.

Take the contraception quiz

https://www.childrenbychoice.org.au/

Children by Choice Abortion and Contraception Services MAP -

https://www.childrenbychoice.org.au/information-support/abortion/queensland-abortion-providers/

Quick Exit

CHILDREN BY CHOICE
ASSOCIATION INCORPORATED

Log out

Abortion & Contraception Services

Queensland Wide Counselling, Information and Referral Services
1800 177 725

Filter services

If you are unable to find a local service, please call 1800 177 725

You can search for providers that suit your needs through using the filter below, and the postcode search located on the map.

Register Your Service

What services do you need?

- Abortion
- Contraception
- Fee Information
- Other Services
- Other Search Criteria
- Type of Provider

Results 163 results

ATSICHS Brisbane - Woolloongabba
55 Annerly Road, Woolloongabba 4102
07 3420 8900
Monday - Saturday 8.30 - 4
Services

Albany Care Medical Practice
Shop 1/720 Albany Creek Road, Albany Creek 4035
07 3264 6632
Tuesday, Wednesday & Friday 8am-4:30
Services

Algester Star Doctors
10 Silkwood Street, Algester 4115
07 3272 3688
Monday 8am - 4pm & Thursday 8am-12pm
Services

Amaroo Medical
10 Karobean Drive, Mareeba 4880
07 4092 5900
Monday, Tuesday, Wednesday and Friday 8:30-5pm Thursday 8:30-8pm
Services

Arana Hills Medical Centre
Shop14B/ 5-11 Patricks Road, Arana Hills 4054

Suburb

Practitioner
Hospital
Pharmacist
Pregnancy Options Counsellor
Imaging

Leaflet | Carto ©

Further information is available at:

GP to GP Referrals - Community HealthPathways Brisbane South (SpotOnHealth)

Home » Reproductive Rights and Abortion Conference » 2026 Conference

BEYOND ACCESS

REPRODUCTIVE RIGHTS & ABORTION CONFERENCE 2026

3-5 September 2026 | Brisbane Convention and Exhibition Centre

Children by Choice's Reproductive Rights and Abortion Conference 2026 is the only conference in Australia dedicated solely to abortion, reproductive rights and bodily autonomy.

ABOUT CLINICAL EDUCATION DAY

Participants will:

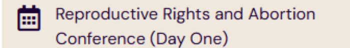
- Explore current debates and emerging issues in abortion care
- Build foundational knowledge across different models of abortion provision
- Strengthen understanding of evolving clinical practice and system-level considerations
- Engage in case-based discussions focused on complexity, risk, and access barriers
- Increase confidence to provide abortion care and navigate referral and service pathways

Registration Note: To maintain a professional clinical environment, an active AHPRA registration number is required for all ticket purchases via Humanitix.

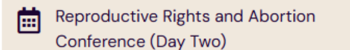
https://events.humanitix.com/childrenbychoicereproductive-rights-and-abortion-conference-2026

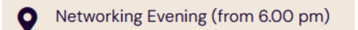
EVENT DATES

THURSDAY
3 September 2026

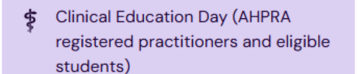


FRIDAY
4 September 2026





SATURDAY
5 September 2026



3–5 September 2026 in Brisbane (Meanjin), brings together healthcare professionals, researchers, advocates, and community organisations working across abortion and reproductive healthcare.

- **Two days** dedicated to research, community health initiatives, and advocacy
- **A new Clinical Education Day** designed for AHPRA-registered practitioners to build practical skills in abortion care and contraception*
- **Networking evening** included in all registration tickets

Across the three days, delegates will engage in plenary sessions, panels, and interactive breakout discussions addressing the most pressing issues in abortion and reproductive health. We anticipate over 300 delegates, including:

- Doctors and health practitioners from public and private sectors
- Allied health professionals
- Leaders from NGOs and community organisations
- Academics, researchers, and students

Our **2026 keynote speakers - Carly Findlay and Yumi Stynes -** will each bring unique perspectives on inclusion, culture, and reproductive justice. Their insights will spark ideas, challenge assumptions, and inspireaction.

For Professionals

Ask Your GP

> *If we simply ASK OUR GP we let them know that there is not only community need to improve access to abortion care but also community support for this service in our local area.*

ASK YOUR GP is a campaign to encourage GPs in Australia to consider providing early medication abortion. It is sponsored by Children by Choice and the South Australian Abortion Action Coalition (*saaac*).

Next time you visit a GP you can ask them 'For future reference, do you provide early medication abortion?' People of all genders, of all ages, regardless of whether or not they can become pregnant, can ask this question as a way of bringing the issue to the GP's attention.

"Not enough GPs are currently offering early medication abortion as part of their practice. Reasons for this vary, but information, support and training for health care providers is available from MSHealth"
https://www.ms2step.com.au/register/

Conscientious Objectors:

Where a health practitioner conscientiously objects to ToP care, they must disclose their objection and must inform the patient of their right to seek care from another doctor and ensure the patient has sufficient information to exercise that right.

They have a **professional responsibility and legal requirement** to ensure transfer of care without obstacle or delay, to a health practitioner or service who they believe can provide the requested service. They must treat any patient who has requested ToP with respect and compassion.

We believe that all clinicians who may encounter a patient considering a pregnancy termination need to have knowledge of the options available to patients, and we invite all to be involved in these case discussions.

Knowing your responsibilities as a conscientious objector in abortion care

FOR PROFESSIONALS

FREE

ONLINE WEBINAR

CONSCIENTIOUS OBJECTION

Thursday, 15th October 2026
12:00-1:00pm AEST
ONLINE via Zoom

CHILDREN BY CHOICE

[Conscientious Objection 101 Webinar - Lunchbox Learning October 2026 - Children by Choice]

Why is it important?

- First, it helps you understand your legal rights and obligations as a healthcare provider who objects to participating in abortions, preventing potential legal or ethical violations.
- Secondly, it enables you to communicate your objections clearly and respectfully to patients, colleagues, and employers, fostering mutual understanding and avoiding conflicts.
- Lastly, it allows you to identify alternative options for patients seeking abortion care, such as referring them to other providers or facilities

Pregnancy Support Counselling

Pregnancy advice and support

Back

4 CPD Hours

Educational Activities	3 CPD Hours
Reviewing Performance	1 CPD Hours

Mon 24th Feb 2025 - Tue 30th Dec 2025

Nationwide

e-Learning

Gplearning

View available sessions

For enrolment information

gplearning Helpdesk

1800 284 789

gplearning@racgp.org.au

Specific requirements – Women's health

Activity ID: 1173054

Course Overview

General practitioners (GPs) play a crucial role as the first point of contact for most women experiencing pregnancy-related issues. Non-directive counselling has been recognised as an effective approach to support women with pregnancy-related concerns. The Pregnancy Support Counselling initiative commenced on 1 November 2006. This initiative allows for Medicare Benefits Scheme (MBS) rebates for up to three non-directive pregnancy support counselling services per patient, per pregnancy for GPs who have completed training in non-directive pregnancy support counselling. This course has been designed to meet this training need and enable GPs to provide rebatable non-directive pregnancy support counselling to patients in their practice.

Learning Outcomes

1. Differentiate between non-directive counselling and more directive counselling
2. Outline non-directive, client or patient-centred counselling principles and techniques
3. Prepare, on-request, unbiased, evidence-based information about options and services available in relation to a current or previous pregnancy
4. Access up-to-date patient information about government and non-government support services, benefits and entitlements
5. Develop a systematic approach to maximise care for patients presenting with a previous or current pregnancy

Core Units

- Communication skills and the patient-doctor relationship
- Applied professional knowledge and skills

Contextual Units

- Mental health
- Pregnancy and reproductive health

Program Level Requirements

- Professionalism and Ethical Practice

MBS Item Number: 4001 - Pregnancy Support Counselling (or 92136 by video)

Professional attendance of at least 20 minutes in duration at consulting rooms by a general practitioner who is registered with the Chief Executive Medicare as meeting the credentialing requirements for provision of this service for the purpose of providing non-directive pregnancy support counselling to a patient who:

(a) is currently pregnant; or

(b) has been pregnant in the 12 months preceding the provision of the first service to which this item or item 81000, 81005 or 81010 applies in relation to that pregnancy

Fee: $89.35

Benefit: 100% = $89.35

Medicare benefits are available for a maximum of 3 services for each pregnancy.

https://mycpd.racgp.org.au/activity/1173054

Considering adoption …

Adoption Services
The Department of Families, Seniors, Disability Services and Child Safety is responsible for administering adoption legislation and providing services in Queensland to:

- parent/s considering adoption for their children
- children requiring adoptive placements

Phone: (07) 3097 5100 or free call on 1800 647 983 (Queensland only)
Fax: (07) 3097 5101
Email: ads@cyjma.qld.gov.au

https://www.qld.gov.au/community/caring-child/adoption/considering-adoption-for-your-child

Adoption Services

Address:
Level 11, 127 Creek Street
BRISBANE QLD 4000

Postal address
GPO Box 1789
BRISBANE QLD 4001

Telephone:
(07) 3097 5100 or 1800 647 983
(free call within Queensland)

Fax:

(07) 3097 5101

Email
ads@cyjma.qld.gov.au

Free legal advice

Contact Legal Aid Queensland on 1300 651 188 for free legal advice and information.

.. or Kinship care

Kinship care means a child is looked after by relatives, close friends, or trusted adults in their community. These carers may include grandparents, aunts or uncles, or other trusted adults close to the family, and can provide stability and belonging. It prioritizes maintaining and respecting familial, cultural, and community connections, with carers undergoing assessment to ensure they can provide a safe environment.
kinship carer, you will need to provide a safe, stable and supportive environment for the child or young person in your care and meet the emotional, educational and social needs of the child.

For Aboriginal and Torres Strait Islander children, kinship care may include carers from the child's own community or language group.

If patients are considering kinship care and for more information, consult the Queensland Government's resources on foster and kinship care.

Approval Process: Carers must be approved by the Department of Child Safety. A "provisional" approval can be issued for immediate placement, followed by a full assessment.
Support and Funding: Approved kinship carers can receive financial assistance, practical support, training, and ongoing advice to help meet the child's needs.
How to Apply: Individuals can apply to become a kinship carer online via the Queensland Government website or by calling 1300 550 877.
Support Organization: The Queensland Foster and Kinship Care (QFKC) offers support, advocacy, and information for kinship carers, ensuring they are included in a responsive care system.

Informing women re reproductive choices

What does Jade need to know from you as you go about outlining her choices, once she has decided to undergo ToP?

Women require sufficient information about each of the abortion options prior to the procedure in order to enter shared decision making and prepare themselves physically, emotionally and logistically for abortion.

Cultural sensitivity and respectful simple language is recommended in discussions. All of the following are considered important to women - rank these factors you see most to least important:

[MSHHS GP Maternity Alignment 2026 – Session 1.2 B]

More history from Jade.....

https://forms.office.com/r/eb7Su3Ab9Y

Initially she presented at 7 weeks gestation and had an USS proving an intrauterine pregnancy, but the GP she consulted arranged no follow up. Now she is about 12 weeks' gestation.

- What ToP options can be offered to her?
- What tests should you order?
- What tests should be included in the STI screen?

MSHHS GP Maternity Alignment 2026 - Session 1.2 C – Fill out form

1. Consider offering a choice of medical or surgical abortion up to 14 weeks pregnant, as both methods are safe, effective and acceptable. Medical history and service availability will also need to be considered (1 Point) *

- ◯ Correct
- ◯ Incorrect

2. For women considering pregnancy termination, which tests are recommended: (1 Point) *

- ☐ Pregnancy test - quantitative preferred
- ☐ Haemoglobin
- ☐ Blood Group
- ☐ US evidence of intrauterine pregnancy
- ☐ STI screen

3. The STI screen should include testing for: (1 Point) *

- ☐ Syphilis
- ☐ Gonorrhoea and Chlamydia by Urinary PCR
- ☐ Gonorrhoea and Chlamydia by Self Collect or Endocervical PCR swab
- ☐ Trichomonas
- ☐ Hepatitis BsAg and HIV Serology
- ☐ Hepatitis C Serology
- ☐ Mycoplasma
- ☐ Bacterial Vaginosis

MSHHS GP Maternity Alignment 2026 - Session 1.2C

STI/BBV TESTING TOOL FOR ASYMPTOMATIC PEOPLE

STEP 1 Starting a Conversation

Offering routine sexually transmissible infection/blood borne virus (STI/BBV) testing helps people feel more comfortable and willing to discuss their sexual health. A key first step is to try and build rapport with the person.

Examples of how routine STI/BBV testing can be offered:

Young people (16–29 years)
"STIs are very common, and often people don't even know they have one. We encourage all sexually active young people to get tested regularly for STIs. Would you like a sexual health check-up today?"

Reproductive health consultations
"While you're here for contraception advice/cervical screening it's a good time to talk about other areas of sexual health, like having a sexual health check-up..."

Travel consultations
"Some people take risks when they are overseas including having unprotected sex. If you like, we could do a sexual health check-up before you go and when you return."

Hepatitis B vaccination
"Have you had hepatitis B vaccinations? They protect against an infection that can be sexually transmitted. Do you want to talk about this today?"

General health consultation
"While you're here, we offer all young people routine STI tests. Would you like a check-up?"

REVIEWED · MAY 2025

Patient has symptoms that could be caused by an STI?
www.sti.guidelines.org.au

Sexual history

Engage the person in a culturally appropriate way about these topic areas to identify potential risks and which tests to do:

- When did you last have testing for STIs?
- When did you last have sex?
- In the last 3 months, who have you had sex with - i.e. regular or casual partner(s)?
- Does/do your sexual partner(s) have a penis or a vagina?
- When you have sex, is it vaginal, oral and/or anal sex?
- When was the last time you had sex without a condom?
- Have you ever injected drugs or used methamphetamine?
- Have you ever been diagnosed with (or thought you had) an STI? *Explain symptoms if necessary.*
- Are you or could you be pregnant?

See the Australian STI Management Guidelines for how to do a detailed sexual health risk assessment.

To assess HIV, hepatitis B and C risk see www.testingportal.ashm.org.au

For online education modules on sexual health see www.thinkgp.com.au

This testing tool and a guide on self-collection of samples are available at: www.health.qld.gov.au/sexhealth

Developed by NSW STI Programs Unit, NSW Australia, and reproduced with permission by the Sunshine Coast Hospital and Health Service, ASHM and Communicable Diseases Branch 2018.
www.health.nsw.gov.au/sexualhealth/Pages/stipu.aspx

STEP 2B How to test[1] – infection, specimen site and test type

"Self-collection is the preferred testing method for chlamydia, gonorrhoea and trichomoniasis."

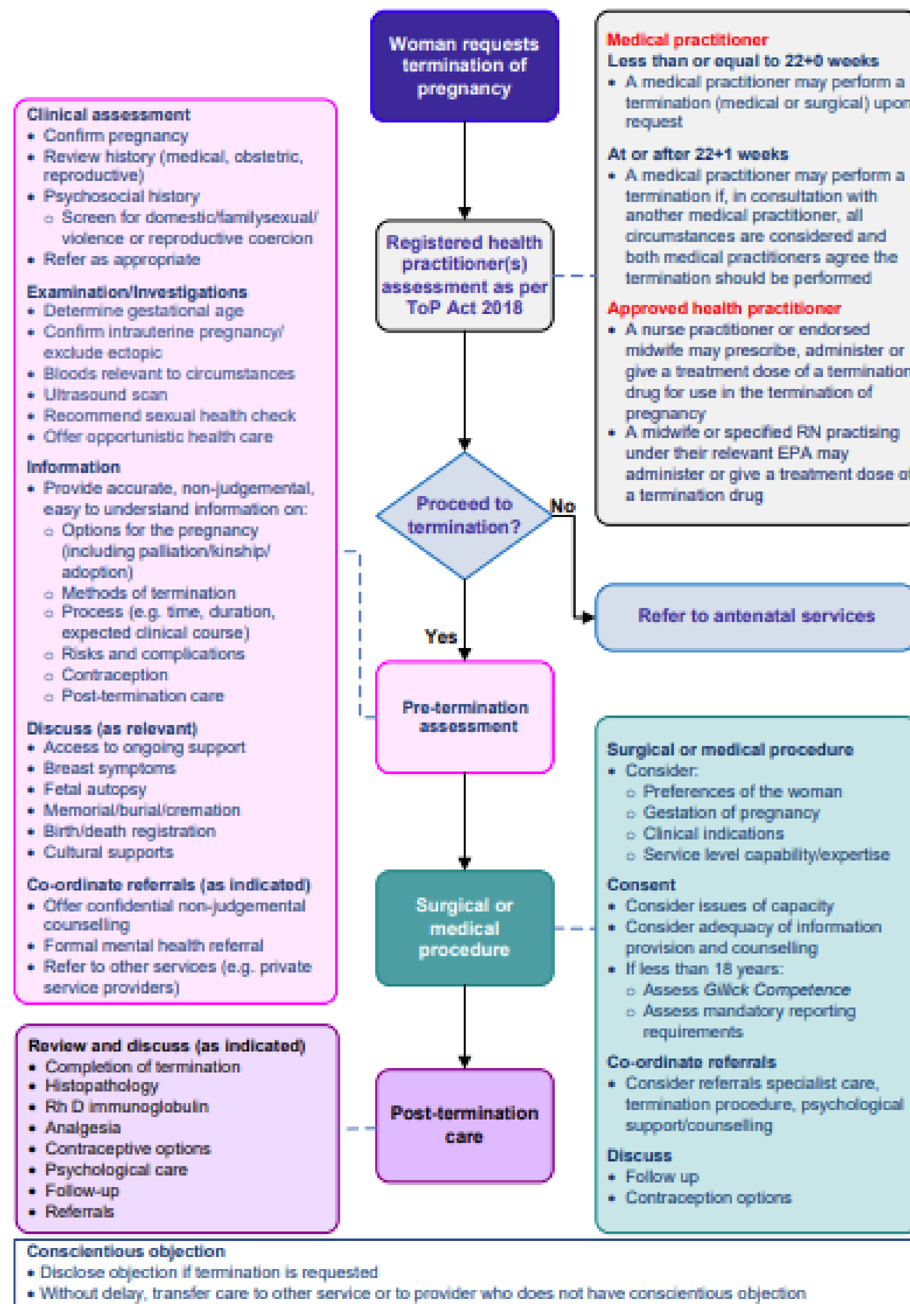
INFECTION	SPECIMEN COLLECTION SITE	TEST
FEMALES AND TRANS PEOPLE WITH A VAGINA/CERVIX		
CHLAMYDIA	Vaginal swab* (best test if not examined) OR Endocervical swab** (best test if examined) First catch urine* (at any time of the day) Rectal swab* (if patient has anal sex or ano-rectal symptoms)	Chlamydia NAAT (PCR)
GONORRHOEA	Vaginal swab* (best test if not examined) OR Endocervical swab** (best test if examined) First catch urine* (at any time of the day) Rectal swab* (if patient has anal sex or ano-rectal symptoms)	Gonorrhoea NAAT (PCR) + culture if discharge present If possible, test for culture at time of treatment to determine anti-microbial sensitivity and contribute to anti-microbial resistance surveillance.
TRICHOMONIASIS	High vaginal swab** First catch urine* (at any time of the day)	Trichomoniasis NAAT (PCR)
MALES AND TRANS PEOPLE WITH A PENIS		
CHLAMYDIA	First catch urine* (at any time of the day) Plus throat swab* (for MSM) Plus rectal swab* (for MSM)	Chlamydia NAAT (PCR)
GONORRHOEA	First catch urine* (at any time of the day) Plus throat swab* (for MSM) Plus rectal swab* (for MSM)	Gonorrhoea NAAT (PCR) + culture if discharge present If possible, test for culture at time of treatment to determine anti-microbial sensitivity and contribute to anti-microbial resistance surveillance.
TRICHOMONIASIS	First catch urine* (at any time of the day)	Trichomoniasis NAAT (PCR)
	*consider self-collected **health provider-collected	
EVERYONE		
SYPHILIS	Blood	Syphilis serology
HIV	Blood	HIV antibody/antigen
HEPATITIS A	Blood	Total hepatitis A antibodies
HEPATITIS B	Blood	Hepatitis B surface antigen, core antibody, surface antibody
HEPATITIS C	Blood	Hepatitis C antibody and if positive, hepatitis C NAAT (PCR) to determine if patient has chronic hepatitis C or reinfection after treated hepatitis C.

More information... Query about syphilis? Call the Qld Syphilis Surveillance Service **1800 032 238** | HIV, Hepatitis B & C Testing Portal **www.testingportal.ashm.org.au**

STEP 3 Contact tracing/partner notification[1,10]

INFECTION	HOW FAR BACK TO TRACE
CHLAMYDIA	6 months
GONORRHOEA	2 months
SYPHILIS	Primary syphilis – 3 months plus duration of symptoms Secondary syphilis – 6 months plus duration of symptoms Early latent syphilis – 12 months
HIV	Start with recent sexual or injecting drug use needle-sharing partners. Outer limit is onset of risk behaviour or last known HIV negative test result.
HEPATITIS B	6 months prior to onset of acute symptoms. If asymptomatic, according to sexual history. For newly acquired cases contact your local Public Health Unit and/or specialist.
HEPATITIS C	6 months prior to onset of acute symptoms. If asymptomatic, according to risk history. For newly acquired cases contact your local Public Health Unit and/or specialist. Contacts via parenteral exposure (shared needles, injecting equipment) should be tested if possible. Children of mothers who are hepatitis C positive should be tested.
TRICHOMONIASIS	Unknown; important to treat all sexual partners.

STI/BBV testing tool for asymptomatic people



Guideline: Termination of pregnancy (health.qld.gov.au)

- Around 25% women undergo a termination of pregnancy in their reproductive lifetime.
- (In Australia, estimated rate of termination of pregnancy is 15 per 1000 women between the ages of 15–49 years – most states do not report numbers).
- Rate of unintended pregnancy in Australia estimated at 38/1000 women compared to 64/1000 women aged 15-49 worldwide.
- Since mifepristone approval in Australia, the proportion of surgical terminations has declined but overall rate of termination of pregnancy has not increased.

1.https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf
2. https://www.guttmacher.org/fact-sheet/induced-abortion-worldwide

Flowchart: Medical termination at or less than 63 days of pregnancy

Clinical assessment

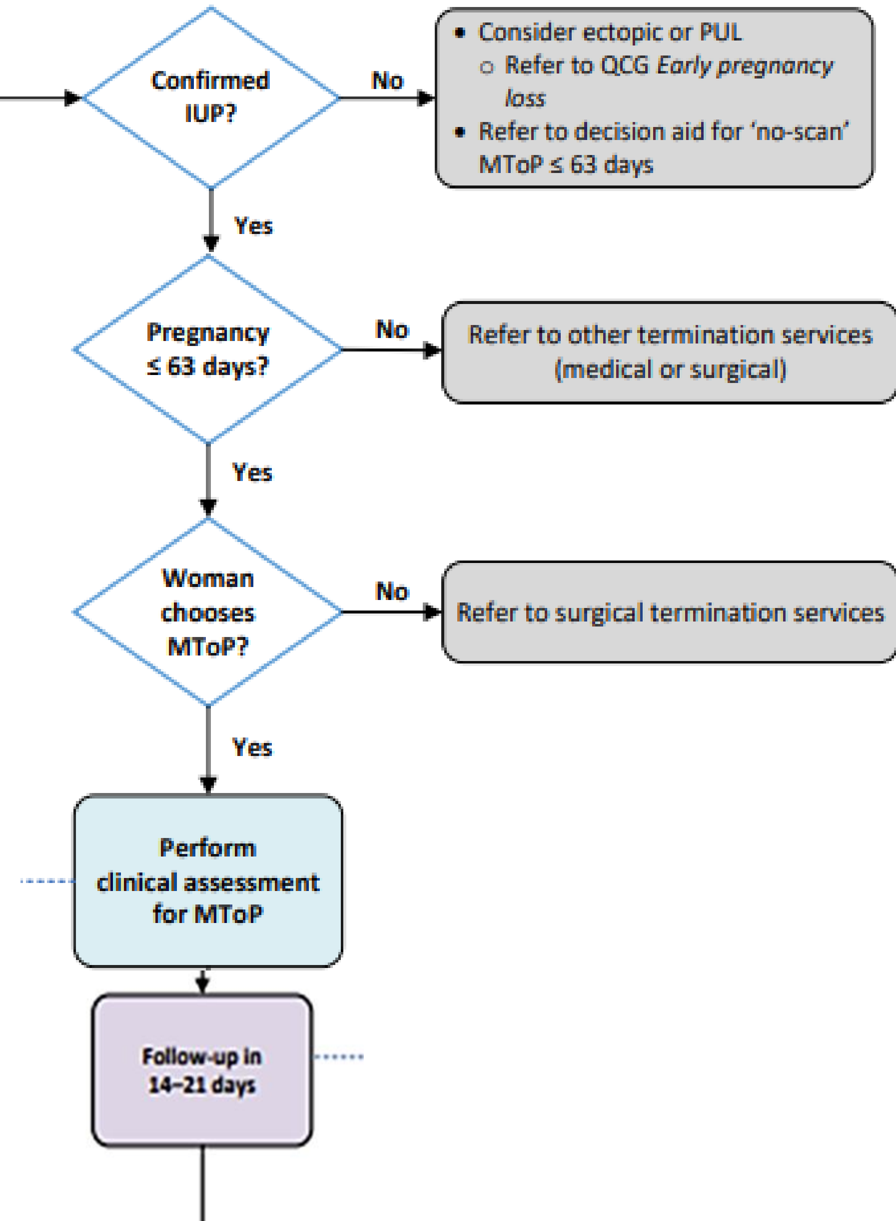
- Review history (medical, reproductive and obstetric)
- Psychosocial history
  - Refer as appropriate
- Exclude contraindications
- Seek written consent
- Remove IUD
- Discuss contraception
- Consider need for bloods
- Recommend sexual health check
- Offer opportunistic health care
  - Cervical screening test
  - Smoking cessation advice
  - Substance use
- Refer as indicated to other services

Self administration of medication

- Provide instructions (how/when)
- Advise on:
  - Expected pain and bleeding
  - Pain management
  - Potential complications/side effects
  - Availability of support person
  - Importance of follow-up
  - Accessing emergency care
  - Actions if no onset of bleeding within 24 hours after misoprostol
  - Contraception commencement
  - Fertility and resuming sexual activity
  - Availability of counselling or specialist support services

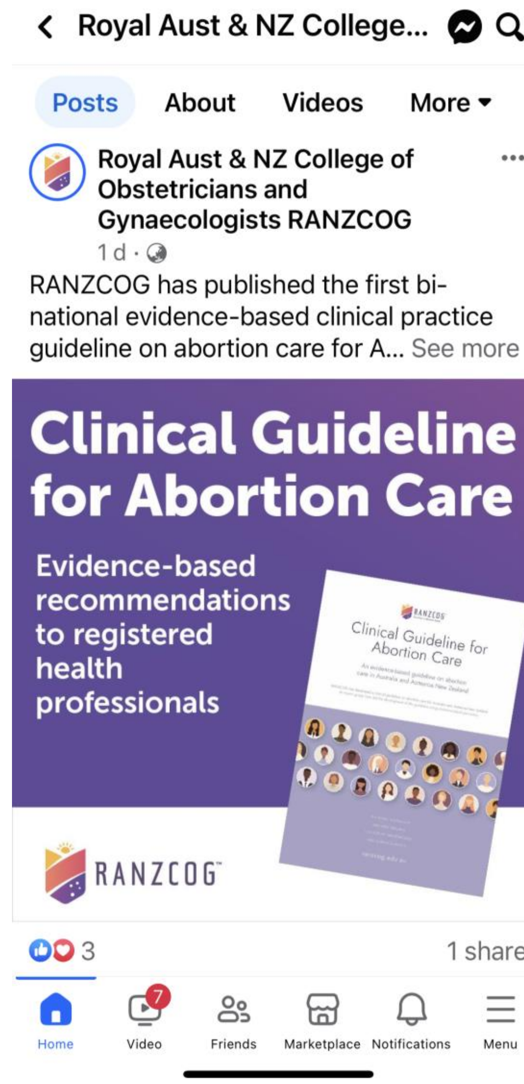
Request for termination healthcare

- Offer non-directive pregnancy related counselling
- Urinary pregnancy test
- Recommend USS
- Confirm location and gestation
- Counsel about termination options



[Guideline: Termination of pregnancy (health.qld.gov.au)]

RANZCOG – Clinical Guideline for Abortion Care and Patient Resource Launch – 30th October 2023



[Clinical Guideline for Abortion Care - RANZCOG]

Clinical Guideline for Abortion Care

An evidence-based guideline on abortion care in Australia and Aotearoa New Zealand

RANZCOG has developed a clinical guideline on abortion care for Australia and Aotearoa New Zealand. An expert group have led the development of the guideline using evidence-based processes.

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

ranzcog.edu.au

Abortion Decision Aid

An information tool to guide the discussion about whether to have a medical or a surgical abortion

THE ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF OBSTETRICIANS

Clinical Guideline for Abortion Care - RANZCOG https://ranzcog.edu.au/resources/abortion-guideline/

If Jade was intellectually disabled, how would your management change?

Termination of a pregnancy of an adult who lacks capacity is considered to be “special healthcare”

- An attorney, legal guardian or substitute decision-maker cannot give consent for another person to undergo a termination
- The Queensland Civil and Administrative Tribunal may consent for an adult with impaired capacity to undergo a termination “only if the Tribunal is satisfied that it may be performed by a medical practitioner under the ToP Act”

https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf - Guideline: Termination of pregnancy

Or if she was only 13years old……

Gillick competence

Children aged < 16 years can consent if they have sufficient understanding and intelligence to fully understand what is involved in a proposed treatment, including its purpose, nature, likely effects and risks, and chances of success, and the availability of other options.

Consider asking questions to assess their understanding, such as:

"We have discussed the treatment – can you tell me what it involves?"
"I have offered a treatment – can you tell me why?"
"Are there any other options we have discussed?"
"Can you tell me the risks associated with the treatment?"
"Can you tell me what could happen if you don't have the proposed treatment?"

Fraser guidelines (The 5 Musts)

Young person has sufficient maturity and intelligence to understand the nature and implications of the proposed treatment.

Young person cannot be persuaded to tell their parents or to allow the general practitioner to tell them.

Young person is very likely to begin or continue having sexual intercourse with or without contraceptive treatment.

Young person's physical or mental health is likely to suffer unless they receive the advice or treatment.

The advice or treatment is in the young person's best interests

Sparrow N. Care Quality Commission. Care Quality Commission; Nigel's surgery 8: Gillick competency and Fraser guidelines. 2018.

https://brisbanesouth.communityhealthpathways.org/17305.htm

Easy English Resources - Children by Choice

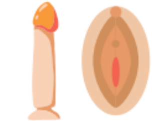
Consent
Easy English

What is Consent?

CHILDREN BY CHOICE

Sexual consent

Sexual consent is when people agree to have sex.



Sex is when a penis is in a vagina or a bottom.

It is also when fingers or a mouth are on a penis or vagina.

Sex without consent is **never** okay.

You can say **no**.

You can change your mind at any time.

You cannot give informed consent if...

- someone is trying to force you

- you are sleeping

- you are drunk or have taken drugs

- you don't understand what they are asking you to do

- you're under 16 years old.

Reproductive Coercion and Abuse
Easy English

What is Reproductive Coercion and Abuse?

CHILDREN BY CHOICE

Co-designed with a group of women with intellectual and learning disabilities and informed by consultation with key stakeholders from violence, disability and health-related services

https://youtu.be/gUGmmBfTuiQ

Pregnancy Options - Children by Choice

https://www.childrenbychoice.org.au/wp-content/uploads/2023/01/A3-DASHER-Poster-1-372x372-png.webp

Easy English Resources

For practitioners:
Use these resources to support your clients to understand their options and rights in regards to Consent, Contraception, Pregnancy Options and Reproductive Coercion and Abuse.

Scan the QR codes to download the books.

They can help you understand more about your sexual and reproductive health.

Find out more about this project on our website: www.childrenbychoice.org.au

CHILDREN BY CHOICE ASSOCIATION INCORPORATED

Funded by 100 WOMEN

Queensland Government

[Multicultural Resources - Children by Choice](#)

[Reproductive Healthcare Across the Gender Spectrum Resources - Children by Choice](#)

Multicultural Resources

The Culture and Language Inclusive Practice Studio (CLIPS) was a collaborative work led by the Multicultural Project Officer, in conjunction with the social work placement student from Children by Choice, in collaboration with resettlement organisations, interpreters and health care providers. This Practice Studio had a deliberate focus on working directly with the community to co-create culturally appropriate and in-language resources on topics of reproductive health, understanding access to abortion in Queensland and recognising the signs of reproductive coercion and abuse.

A4 Downloadable Posters

Case Study 2: Jasmine

Jasmine comes to see you with her husband – you have cared for her partially in her last two pregnancies. She has Fijian Indian ethnicity and was diagnosed with gestational diabetes in her previous pregnancies despite having a BMI of 16-17 before each pregnancy. She was working in child -care prior to having children, but had such severe nausea and vomiting, as well as light headedness in pregnancy, she had quit work from about 7 weeks each time. Both births were by Caesarean section – the first because of delay in labour/cephalo-pelvic disproportion, and the second elective only 11 months ago.

You discussed contraception with her 5 months ago, and she declined LARC. The couple are saving to purchase a home – currently they live with her in-laws. She continues to breastfeed and has had no periods.

They present in early pregnancy – urine pregnancy test done because of nausea & fatigue and having decided ToP may be their best option.

You counsel them at length re their options and arrange a quantitative pregnancy test and USS for dating. The transvaginal USS locates a possible intrauterine pregnancy (? 5w + 1d) and the ßhCG level is 1200Iu/l.

What are their options?

MSHHS GP Maternity Alignment 2026 - Session 1.2 D

When you submit this form, it will not automatically collect your details like name and email address unless you provide it yourself.

* Required

1. MS-2 Step is considered suitable for women who: (1 Point) *

- [ ] Have an intrauterine pregnancy of intrauterine and ≤ 9 weeks (63 days) on USS
- [ ] Will have a support person available until the termination is complete or for 24hrs after taking Misoprostol.
- [ ] Plan to travel overseas or to remote Australia safely within a week of taking Misoprostol (Step 2).
- [ ] Have a twin pregnancy or uterine fibroids.
- [ ] Can communicate by telephone (e.g. have an interpreter available if required) if have symptoms or signs of concern.
- [ ] Have an IUD in situ

2. MToP performed in the community can be undertaken up until 63 days of gestation (1 Point) *

- [ ] Recommended regimen: Mifepristone 200 mg orally, followed by dose of misoprostol 800 mcg buccally (or sublingual/vaginally), 36 to 48 hours after mifepristone
- [ ] With incomplete early medical termination, surgical evacuation is the treatment of choice.
- [ ] If STI screen results are not yet available, treat routinely with empiric antibiotics to prevent endometritis.
- [ ] Commence discussions re future contraception at the first visit
- [ ] Anti D is required for all completed abortions in women who have an Rh Negative blood group.

[MSHHS GP Maternity Alignment 2026 - Session 2 D]

Termination of Pregnancy – Medical

For gestation ≤ 9 weeks (63 days), GP management with MS 2 Step is appropriate

- MS 2 Step prescribing is available to all GPs from August 2023
- Pregnancy must be confirmed to be intrauterine and ≤ 9 weeks (63 days) on USS
- Online training and resources provided by MS Health on MS-2step for registered health practitioners to enable them to understand the pharmacology and prescribe the medication - go to https://www.ms2step.com.au/
- Queensland Health Termination of Pregnancy Clinical Guideline and Presentation, which are intended to provide evidence-based information and guide clinical practice.
- "Prescribing MS-2 Step" page on Health Pathways - https://brisbanesouth.communityhealthpathways.org/17305.htm
- For those who do not wish to prescribe, see GP to GP referrals page on Brisbane South Health Pathways. Please refer on in a timely manner to ensure these patients can access all available reproductive choices.

MS2-Step

- For women ≤9 weeks gestation (63 days gestation)
- Mifepristone/ Misoprostol combination
- Day 1 - Mifepristone turns off progesterone
- 36-48 hours after - Misoprostol induces uterine contractions to expel POC
- Follow up plan in place

Consent to treatment with MS-2 Step® (mifepristone, misoprostol)

Please ensure you have read the accompanying Patient Information Booklet before completing this consent to treatment form. Please note that the risks mentioned in the list below and in the Patient Information Booklet are not exhaustive or inclusive of all possible complications, but are rather the ones generally known or associated with a medical termination of pregnancy.

In addition, please note:

- Possible side effects of this treatment include heavy or prolonged bleeding, severe cramping which may not be relieved by pain medication, nausea, vomiting, diarrhoea, dizziness, headache, fever and chills.
- There is around a 1% (1 in 100) chance that this treatment will fail to end the pregnancy. If this happens, or if the treatment is not completed after it has begun, there is a risk the medications may harm the fetus if the pregnancy continues. Surgical termination or a repeat medical termination is strongly recommended.
- There is up to a 4% (4 in 100) chance of incomplete abortion (retained pregnancy tissue or clot) which may require surgery or more medication.
- There is a 1-2% (1-2 in 100) chance of heavy bleeding (haemorrhage) requiring surgical treatment, and a 0.1-0.2% (1-2 in 1,000) risk of requiring a blood transfusion.
- There is less than 1% (1 in 100) chance of an infection occurring. Although serious infections are very rare in medical termination of pregnancy, they can be potentially life threatening. Symptoms of persistent abdominal pain or feeling unwell or feeling weak with or without a fever following the treatment should be reported to your healthcare practitioner without delay.

Please read carefully before signing:

I, (print name):

of, (print address):

consent to Medical Termination of Pregnancy using mifepristone and misoprostol.

The nature, consequences and risks of this treatment have been explained to me, as well as alternatives, including not proceeding with treatment.

I have been informed of the risks and side effects of this treatment and acknowledge the risks outlined above, including treatment failure which may require a surgical procedure to complete the abortion.

I understand that if I decide not to complete the treatment once it has begun, or if treatment fails to end the pregnancy, there is a risk of harm to the fetus if I continue the pregnancy.

I have discussed and understand how I will access emergency care, if it is needed.

I am aware that I must have follow up 14-21 days after taking MS-2 Step and comply with any other follow up arrangements as advised by my healthcare practitioner.

Consent to treatment with MS-2 Step® (mifepristone, misoprostol)

← Continued from previous page

I have received written information about the treatment and aftercare which has been discussed and explained to me in a language I understand, and have had the opportunity to ask questions.

I am satisfied that I have been given the opportunity to explore all options regarding my pregnancy and am consenting to termination of this pregnancy of my own freewill.

Patient name:

Signature: / /

Guardian name (if required):

Signature: / /

I confirm that, in my opinion, the patient understands the nature and purpose of the combination of medications used to perform a medical abortion, which has been explained to her in terms suited to her understanding and is able to give informed consent.

Health practitioner name:

Signature: / /

MS2Step-Consent-Form.pdf

Prescribing MS-2 Step

Early MTOP (≤ 63 days' gestation) similar to a miscarriage.

Australian based observational study concluded

- many people felt bleeding, pain /cramps, and overall experience was as expected, or better than expected.
- Many would use MS-2 Step again (78%) and most would recommend the method to a friend (91.8%).

Goldstone P et al. Early medical abortion using low-dose mifepristone followed by buccal misoprostol: a large Australian observational study. Med J Aust. 2012 Sep 3;197(5):282-6

Brisbane South (SpotOnHealth)

HealthPathways

Brisbane South (SpotOnHealth)

Assessment

1. If new to prescribing MS-2 Step, consider self- and general practice-preparedness.

Self- and general practice-preparedness

- Be aware training is strongly recommended but is no longer a legal requirement. Online training takes approximately 3 to 4 hours to complete.
- Confirm MTOP is covered by medical indemnity insurance, especially if prescribing without undergoing training.
- Create practice-based checklists, autofills, templates, letters, information for patients, and consent forms. See also:
  - True Relationships and Reproductive Health – Medical Termination of Pregnancy
  - Sexual Health Victoria – Medical Abortion Resources
  - MS-2 Step Consent Form
- Consider:
  - developing a practice protocol to manage urgent calls from patients with adverse events or complications from MS-2 Step.
  - ordering patient information booklets from MS Health.
  - joining the Australian Contraception and Abortion Primary Care Practitioner Support Network (AusCAPPS) for peer support and further resources.

2. If not already done, have a general discussion with the patient to ensure they are well-informed about their termination options – see the Termination of Pregnancy (TOP) pathway.
   - Take a trauma-informed care approach – it is not necessary to repeat non-directive pregnancy counselling at every visit.
   - Consider asking the patient whether they prefer the term "abortion" or "termination".

If the clinician has a conscientious objection to involvement in TOP care, there is a professional responsibility and legal requirement to ensure transfer of care within a reasonable time frame. TOP requests are time-critical for both legal requirements and medical reasons.

"Prescribing MS2Step" Brisbane South Health Pathways (2026)

Prescribing MS-2 Step

This pathway is intended to assist prescribers in providing medical terminations of pregnancy (MTOPs) in community settings, up to 63 days' gestation. See also Termination of Pregnancy (TOP).

Background

About medical termination of pregnancy (MTOP)

Assessment

1. If new to prescribing MS-2 Step, consider self- and practice-preparedness.
2. If not already done, have a general discussion with the patient to ensure they are well-informed about their termination options – see the Termination of Pregnancy (TOP) pathway.
   - Take a trauma-informed care approach – it is not necessary to repeat non-directive pregnancy counselling at every visit.
   - Consider asking the patient whether they prefer the term "abortion" or "termination".
3. Take a history:
   - Symptoms
   - Gynaecological and obstetric history
   - Psychosocial situation
   - Medical history, medications, and allergies
   - Contraindications or precautions for MTOP.
4. If Aboriginal and Torres Strait Islander patient, consider barriers to sexual healthcare and employ strategies to mitigate their effect.
5. Assess the patient's capacity to consent and risk of harm.
6. Confirm pregnancy by urine or serum beta hCG testing, or point of care ultrasound (POCUS).
7. Determine gestation by clinical means.
8. Arrange an ultrasound, if accessible, as this is the preferred method of confirming the gestational age and location of the pregnancy, particularly for inexperienced providers.
9. Arrange other investigations if not already done.
10. Assess if the patient meets the eligibility criteria.

https://brisbanesouth.communityhealthpathways.org/17305.htm

Before prescribing

Prescribing

Follow-up and management of complications

1. Arrange follow-up (can be in person, by phone, or via telemedicine).
   - Arrange initial follow-up 3 to 7 days after mifepristone (step 1)
   - If the patient is having follow-up quantitative beta hCG, check for adequate drop in beta hCG levels
   - Arrange further follow-up at 14 to 21 days after MTOP
2. If the quantitative beta hCG measurement has not dropped appropriately, arrange a pelvic ultrasound to assess possible causes.
3. Manage complications:
   - Manage medication administration problems (e.g., vomiting or delayed administration of tablets).
   - If symptoms suggestive of ongoing pregnancy, arrange an urgent ultrasound and quantitative beta hCG, looking for viable intrauterine pregnancy or ectopic pregnancy. Manage the patient according to ultrasound results.
   - If haemorrhage, arrange emergency assessment. Consider further monitoring of FBC and iron studies at follow-up, and manage as appropriate.
   - Manage retained products of conception (RPOC):
     - Examine the patient
     - Arrange investigations
     - If ultrasound indicates retained products of conception, treatment options include expectant, medical, or surgical management, depending on the clinical situation.
   - Manage infection:
     - Examine the patient
     - Arrange investigations
     - If moderate to severe infection, arrange emergency assessment.
     - If mild infection, treat with antibiotics.
   - Report significant suspected adverse effects and complications to both:
     - the Therapeutic Goods Administration (TGA).
     - MS Health on **1300-515-883**.
4. Assess the patient's feelings about their experience. Most individuals report feeling a range of emotions after medical termination, including relief, sadness, and guilt. If any symptoms of abnormal mood or grief, request counselling services if necessary.

Consider ordering patient information booklets and pre-printed consent forms from MS Health

MS-2-Step-Patient-information-booklet.pdf (ms2step.com.au)

Download an electronic copy of the Patient Information booklet and the Patient Consent to Treatment form directly from the *MS-2 Step*® website www.ms2step.com.au by clicking on the 'Training & education tab' and selecting 'My certification & practice registration'.

Precautions for mToP: require additional consideration and management before prescribing, but MTOP may still be considered after appropriate counselling

- Twin pregnancy – usually suitable, but patients may prefer surgical termination due to volume of tissue required to be passed closer to 63 days' gestation.
- Established or multiple risk factors for cardiovascular disease, including hypertension – rare risk of serious cardiovascular accidents after administration of misoprostol.
- Suspected acute adrenal failure.
- Aged > 35 years & smokes ≥ 15 cig/day – these patients excluded from MS-2 Step trials (still safer than a term pregnancy…)
- Asthma – bronchospasm can be triggered, and inhaled corticosteroids have reduced efficacy.
- Anaemia – MS-2 Step may be offered to patients with chronic mild anaemia.
- Breastfeeding – data limited; MS-2 Step product information advises to avoid MS-2 Step when breastfeeding. Therapeutic Guidelines advises breastfeeding is not a contraindication to use of mifepristone and misoprostol. If MS-2 Step is used, misoprostol can cause diarrhoea in a breastfed infant.
- Epilepsy – possible increased seizure risk.
- Malnutrition (including obese patients who may be malnourished).
- Insulin-dependent diabetes – MS-2 Step can cause nausea/vomiting and may affect diabetes control.
- Use of medications metabolised by CYP450 and CYP3A4 (includes some anticonvulsants, St John's Wort, dexamethasone, and some antibiotics) – may increase risk of incomplete abortion.
- Hepatic disease and renal disease – specific data is lacking.
- There is no increased risk for patients who have had a Caesarean section or have uterine fibroids.

"Prescribing MS2Step"
Brisbane South Health Pathways

8. Arrange an ultrasound, if accessible, as this is the preferred method of confirming the gestational age and location of the pregnancy, particularly for inexperienced providers.

Ultrasound

A transvaginal scan by an experienced sonographer is the gold standard in the first trimester, as a transabdominal scan may be less accurate. [4]

- If the patient is unsure about dates, arrange an ultrasound within one week.
- If very early gestation (less than 5 to 6 weeks), arrange quantitative beta hCG to guide timing of the ultrasound scan for confirmation of intrauterine pregnancy:
  - If beta hCG < 1500 IU/L (local guidelines may vary), delay ultrasound unless there is a suspicion of ectopic or non-viable pregnancy.
  - If beta hCG > the discriminatory zone, arrange high-quality transvaginal ultrasound.
- Notify the provider that the scan is for an unintended pregnancy, to avoid inappropriate comments to the patient.
- Advise the patient a transvaginal scan may be required to accurately determine early gestation.
- Also consider the patient's psychological well-being, including cultural safety and financial hardship arising from the need to travel for ultrasound.

9. Arrange other investigations if not already done.

Other investigations

- Quantitative beta hCG ≤ 24 hours before taking mifepristone (step 1) if using quantitative beta hCG to ensure completion of MTOP at follow-up.
- STI screening – recommended for all pregnant patients. Note that STI screening should not delay providing timely abortion care.

STI screening

- Test for chlamydia and gonorrhoea PCR via one of the following:
  - Self-collected vaginal swab (more sensitive) or first-catch urine (less sensitive) – give the patient instructions for self-collection.
  - Endocervical PCR, if the patient is being examined with a speculum.
  - Anorectal swab (self-collected), if the patient has anal sex. Give the patient instructions for self-collection.

- If less than 21 days after sexual contact, advise the patient that:
  - they are still within the incubation period.
  - repeat screening is required to confirm a negative result.
- If the patient is Aboriginal and Torres Strait Islander, or with a partner who is Aboriginal and Torres Strait Islander, also test for *Trichomonas vaginalis* PCR.
- Arrange blood tests for:
  - HIV antigen and antibody – repeat test if patient exposed within previous 6 weeks (window period)
  - syphilis serology – repeat test if patient exposed within previous 12 weeks (window period)
  - hepatitis B serology – (HepBsAg, HepBsAb, HepBcAb) if born prior to 1987, HIV positive, or injecting drugs.
- Consider other investigation if symptomatic – see Sexual Health Check.

- FBC, ferritin, E/LFT if suspicion of underlying haematological, renal, or hepatic abnormalities.
- Blood group if patient suspected to be > 10 weeks' gestation.
- Cervical screening, if appropriate and not up to date.

https://brisbanesouth.communityhealthpathways.org/17305.htm

Contraindications for mToP

- Lack of access to emergency medical care in the 14 days following start of the treatment (i.e., administration of mifepristone)
- Suspected or confirmed ectopic pregnancy.
- Gestational trophoblastic disease
- Asthma uncontrolled by therapy.
- Intrauterine device (IUD) in place

  If intrauterine device (IUD) is present, threads are visible, and < 12 weeks gestation, consider removal if confident to do so. If IUD left in situ, notify the TOP provider to ensure prompt removal before medical TOP or during a surgical TOP

- Uncertainty about gestational age.
- Chronic adrenal failure.
- Concurrent long term oral corticosteroid therapy.
- Suspected or known haemorrhagic disorders or treatment with anti-coagulants.
- Inherited porphyria – there is a theoretical risk of precipitating or exacerbating attacks of porphyria, but no data are available.
- Hypersensitivity to mifepristone, misoprostol (or any prostaglandin), or any of the excipients used in MS-2 Step.
- Pregnancy not confirmed by an ultrasound or biological test such as urine or serum ßhCG.

1. Regarding early medical Termination of pregnancy, anti-emetics and analgesia should be offered: (1 Point) *

- [ ] Routinely to all women for the first 24 hours
- [ ] As single dose ibuprofen 1600 mg (off-label use) followed by ibuprofen 400-600 mg tds. Maximum dose 2400 mg/24 hours while symptoms of pain persist.
- [ ] Offering paracetamol 1000 mg 4-6 hourly prn (maximum 4000 mg/24 hours) instead of Ibuprofen
- [ ] Selective narcotic analgaesia may be required in some patients.
- [ ] Antiemetic is usually recommended 30 minutes prior to administration of Misoprostol.

2. From 14-22 weeks pregnant (1 Point) *

- [ ] Women are offered a choice of medical or surgical abortion from 14-22 weeks' gestation, as both methods are safe although medical abortion is associated with higher risk of incomplete abortion and may require surgical evacuation.
- [ ] Ultrasound determination of gestation should be routinely undertaken in women > 14 weeks' seeking ToP.
- [ ] Women can access surgical abortion up to 22 weeks' gestation in Qld.
- [ ] Feticide is generally not performed under 22 weeks' gestation.
- [ ] Women with a previous caesarean section can undergo medical abortion between 14-22 weeks' gestation.

MSHHS GP Maternity Alignment 2026 - Session 2 E

3. If the gestational sac is expelled, and bleeding and pain settle within a few days, the medical termination can be considered completed. (1 Point) *

- True
- False

[MSHHS GP Maternity Alignment 2026 - Session 2 E]

4. Possible short- and long-term complications associated with abortion procedures, including an expected increase in these risks based on the specific woman's medical history (for example previous uterine surgery) include: (1 Point) *

- [ ] Anaesthetic complications or medication side effects
- [ ] Damage to the uterus or pelvic infection
- [ ] Severe bleeding
- [ ] Ongoing pregnancy
- [ ] Incomplete abortion
- [ ] Increased risk of infertility, cancer, or mental health issues

MSHHS GP Maternity Alignment 2026 - Session 1.2 E

You can print a copy of your answer after you submit

Submit

2. Arrange medications for MTOP:

https://brisbanesouth.communityhealthpathways.org/17305.htm

- Prescribe the following:
  - MS-2 Step
  - An antiemetic

Antiemetic

- Consider prescribing an antiemetic e.g., metoclopramide 10 mg orally or ondansetron 4 mg, taken 30 to 60 minutes before mifepristone (step 1) and misoprostol (step 2). Additional antiemetics can be taken if required (as per usual dosing instructions).
- Check full prescribing data, dosage, drug interactions, and contraindications when prescribing.

  - Analgesia

Analgesia

- Advise the patient to reduce pain by resting, using hot packs, massaging the lower abdomen, and appropriate use of analgesia.
- When prescribing analgesia, consider patient preference and previous experiences with pain.
- Note that:
  - non-steroidal anti-inflammatories are most effective.
  - paracetamol preparations with codeine are more effective than paracetamol alone.
- Consider prescribing analgesia to take 30 to 60 minutes before misoprostol (step 2). Options include:
  - paracetamol 1000 mg with or without codeine 60 mg orally.
  - a nonsteroidal anti-inflammatory e.g., ibuprofen 400 to 1600 mg (off-label use) orally with a snack, or indometacin 100 mg rectally.

  Additional analgesia can be taken if required as per usual dosing instructions.
- Check full prescribing data, dosage, drug interactions, and contraindications when prescribing.

- Give the patient clear instructions on how to take the medications.
- Consider the use of an MS-2 Step Timeline and Bleeding Guide.

MToP: MS-2 Step Timeline and Bleeding Guide

true relationships & reproductive health

Step 1

Date/Time	Instructions
	If required, take Ondansetron 4mg wafer dissolved on tongue, allow 30 minutes to take effect.
	Follow with 1 tablet of Mifepristone, swallowed whole. If you vomit within 1 hour of taking Step 1, please contact the clinic as it will need to be repeated.

Step 2 (to be taken 36 to 48 hours after Step 1)

Date/Time	Instructions
	Ondansetron 4mg wafer dissolved on tongue, allow 30 minutes to take effect.
	Take 2 Paracetamol + codeine phosphate tablets and 400/800/1600mg of Ibuprofen and have a snack. Your healthcare provider will confirm that these pain medications are safe for you to take.
	Place 4 Misoprostol tablets (total misoprostol 800 micrograms) in your mouth between your cheek and gums (2 tablets on each side of your mouth) for 30 minutes. After 30 minutes, use water to rinse and swallow whatever is left of the tablets. If your nausea or vomiting is too severe, all 4 Misoprostol tablets can be placed in the vagina instead.

What to expect next

- Expect bleeding and cramps to commence 1-4 hours after taking the misoprostol tablets.
- These symptoms typically last for 4-6 hours.
- An additional dose of 2 Paracetamol + codeine phosphate tablets has been provided. These can be used 4-6 hours after the initial dose if required for pain.
- Further Ibuprofen doses of 400-600mg can be taken every 8 hours after the initial dose, up to a maximum of 2400mg in 24 hours.
- Ongoing bleeding, like a period, can last for about 10-16 days.
- Additional light bleeding can continue for 30 days or more.

IMPORTANT: **If no bleeding occurs within 24 hours** of taking the misoprostol tablets, contact a doctor's clinic

MToP: MS-2 Step Timeline and Bleeding Guide – TRUE

RANZCOG

5.10 Medical or surgical abortion and pain relief

Good Practice Point 11

The guideline development group recommends that analgesia for surgical or medical abortion should be individualised to patient preferences, clinical need, clinician capabilities, local policies and/or contextual factors.

5.10.1 Pain relief up to 14 weeks pregnant

Recommendation 14	Evidence-based recommendation	Strong

For surgical abortion up to 14 weeks pregnant offer combination of:

- Pre-procedure analgesia with non-steroidal anti-inflammatory (NSAID) medications
- Conscious or deep sedation with the possible addition of paracervical block

GRADE of evidence: Moderate

Good Practice Point 12

For surgical abortion up to 14 weeks pregnant, general anaesthesia could be offered if clinically indicated or patient preference.

Recommendation 15	Evidence-based recommendation	Strong

For medical abortion up to 14 weeks pregnant offer a single dose ibuprofen 1600 mg (off-label use), followed by ibuprofen 400 mg to 600 mg eight-hourly. A maximum dose of ibuprofen 2400 mg can be taken in 24 hours while symptoms of pain persist.

GRADE of evidence: Moderate

Good Practice Point 13

For medical abortion up to 14 weeks pregnant, pain relief can be optimised by:

- Offering paracetamol (1000 mg 4 to 6 hourly as required with a maximum 4000 mg per 24 hours) in addition to ibuprofen with antiemetic 30 minutes prior to administration of misoprostol
- Considering selective use of opiate analgesia

CLINICAL SERVICES
Medical

* For REFERENCE ONLY - not for use in general practice or patient distribution.

msiaustralia.org.au

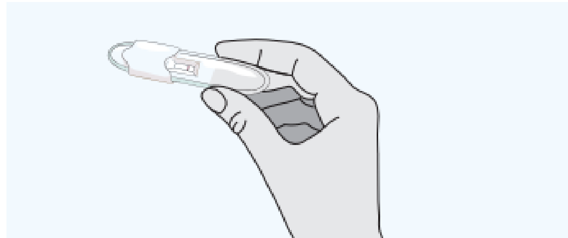
Continuing pregnancy

What is it: The pregnancy remains and may continue to grow.

Action/treatment: May need a repeat medical abortion or a surgical procedure.

Around 1 in 100 procedures

ⓘ If you have a continuing pregnancy and decide to keep the pregnancy, the medication may have damaged the fetus.

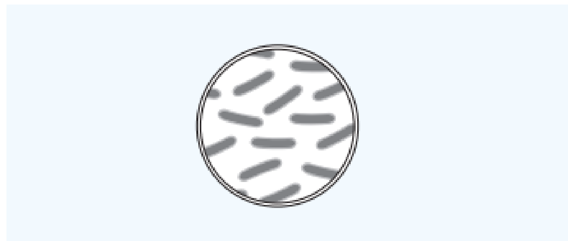


Infection

What is it: When bacteria enters the body and can cause disease. This is uncommon and serious infection from abortion is rare.

Action/treatment: We will test you for infections to reduce the risk of infection.

Occurring in less than 1 in 100 people

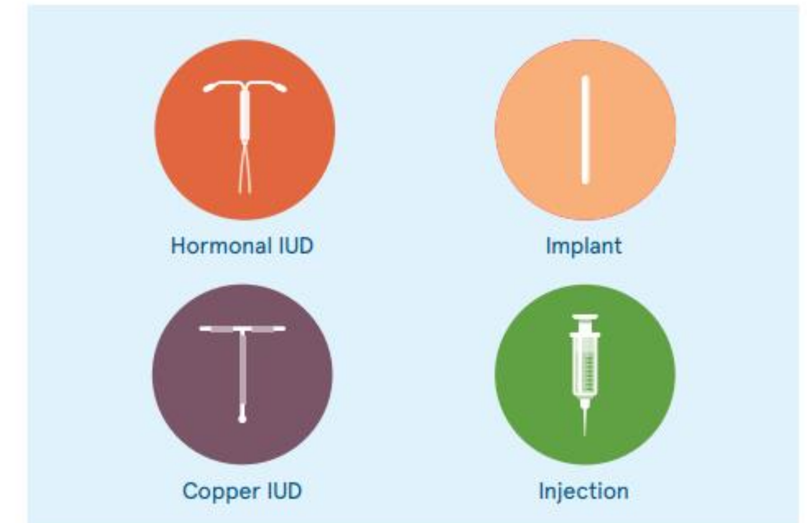


ⓘ Regardless of what contraception you are using, you should not have vaginal intercourse for 1 week after your procedure.

Contraception after your medical abortion

In most cases you can start a contraceptive method immediately. If you have chosen an IUD this can be inserted as soon as we have confirmed your abortion is complete.

- Long-acting reversible contraception (LARC) options (e.g. IUDs, implants, injections) are the most effective at preventing pregnancy.
- We can provide a prescription for other hormonal contraception options such as the contraceptive pill or vaginal ring.
- You can start contraception such as the contraceptive pill or vaginal ring the day after Step 2 of treatment (misoprostol) and these methods will be effective immediately.



https://www.msiaustralia.org.au/wp-content/uploads/1721-MSIAU-Clinical-Services-Medical-English-240920-WEB.pdf

MSHHS GP Maternity Alignment 2026 - Session 2 F

When you submit this form, it will not automatically collect your details like name and email address unless you provide it yourself.

* Required

1. Regarding follow up after early medical abortion (EMA): (1 Point) *

Please select at most 5 options.

- [ ] Minimal bleeding following Misoprostol, serum β-hCG upward trend and ongoing pregnancy symptoms may indicate failed mToP.
- [ ] If using urine β-hCG, ongoing pregnancy is excluded by a negative low-sensitivity urine pregnancy test at 14-21 days after Mifepristone.
- [ ] If using serum β-hCG, ongoing pregnancy is excluded by decrease in serum β-hCG level of 80% or more from ingestion of mifepristone (if β-hCG taken within 72 hours) to 8-16 days afterwards.
- [ ] After early medical abortion (<10 weeks), clinical follow-up can be by telehealth/phone.
- [ ] An USS should be arranged for the 2-4 weeks post EMA to exclude RPOC.

[MSHHS GP Maternity Alignment 2025 - Session 2 F]

2. Contraceptive options available and timing of initiation following abortion. (1 Point) *

- [ ] For women having mToP. depot MPA may given at time of medical abortion (including prior to pregnancy expulsion), after discussing the potential small added risk of ongoing pregnancy
- [ ] For contraceptive implants, wait at least a fortnight following ToP (medical or surgical) so as not to confuse the bleeding pattern.
- [ ] With intrauterine contraceptive (IUC), immediate insertion should be offered at the time of surgical ToP.
- [ ] With intrauterine contraceptive (IUC), immediate insertion should be offered at the time of the follow up hCG (urine or serum)
- [ ] Oral contraceptive pills started days 1-4 following ToP are immediately effective

Follow up after ToP

3. Make arrangements to ensure the pregnancy has been successfully terminated.

Arrangements to ensure the pregnancy has been successfully terminated

- If using quantitative beta HCG to ensure completion of MTOP at follow-up:
  - provide the patient with pathology request forms, if not already done.
  - check for adequate drop in beta hCG levels.

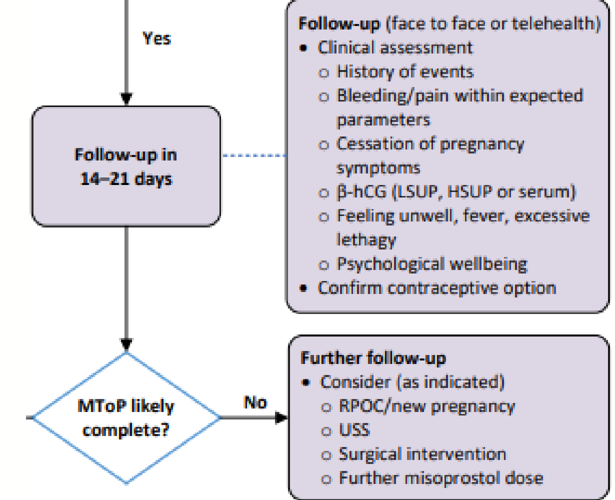
> **Adequate drop in beta hCG levels**
>
> The patient does not have a continuing viable pregnancy if beta hCG levels taken 7 to 14 days apart drop by ≥ 80%. Do not expect the beta hCG levels to return to zero in this time.

- If using urinary beta hCG, consider providing the patient with a low-sensitivity urinary beta hCG test (e.g., Check4-hCG) to do at home, or rebook the patient for a test at the practice.

Prescribing MS-2 Step - Community HealthPathways Brisbane South (SpotOnHealth)

Follow up after ToP

Follow-up is recommended 7-14 days after termination of pregnancy



- Enquire re
  - symptoms suggestive of ongoing pregnancy (failed termination)
  - signs of infection or retained products of conception (RPOC)
  - any abnormal vaginal bleeding or discharge, pain, or fever.
- If concerns re possible infection, retained products of conception, or abnormal bleeding: - perform examination
  - Temp/BP/Pulse, Uterine tenderness/? Involution, ? Clots at os

  \+ arrange investigations – swabs incl STI screen, ? βhCG test, ? FBC, ? TVUS
- For medical termination of pregnancy (MToP), consider a 7–14-day post-ToP serum βhCG test to confirm successful ToP - **1% = failure rate with MToP; 4% = Rate of RPOC.**
- Expect βhCG levels taken 7-14 days following ToP to drop by ≥ 80% compared to bloods taken at time of mToP (Do not expect to return to zero in this time)
- **Contraception and future pregnancy planning (start at first visit)**
- Ask patient's feelings about their experience - mental health risk is reduced by good supports

Brisbane South Health Pathways - Follow Up after ToP

Post mToP advice:

Exercising and other activities

- Normal activities and exercise can be recommenced when feel well enough.
- For the first 7 days, recommend patients don't:
    - go swimming
    - have baths or spas
    - have vaginal sex
    - put anything in the vagina, including tampons.

Expect next period in 4-6 weeks – it may be heavy.

Fertility will return within 2 weeks.

Symptoms of RPOC

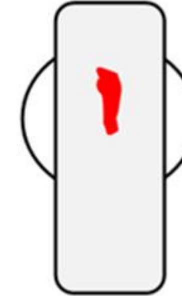
Patients recommended SEEK MEDICAL ASSISTANCE if:

- Bleeding heavier than a normal period +/- clots at 7/7, or that waxes and wanes, but as heavy as a normal period at 7 days
- Persistent cramps at 7 days, especially if severe and not responding to simple analgaesia.
- Heavy bleeding that has not reduced by 14 days
- Further bleeding after next menstrual period, which can be heavy and may not occur for 6 weeks post misoprostol
- If any time, heavy bleeding with 2+ saturated sanitary pads per hour for more than two consecutive hours or passing large clots (tennis ball sized)
- Note that if a patient starts hormonal contraception immediately after miscarriage or termination, they may experience prolonged abnormal bleeding. However, delaying contraception might not be safe!

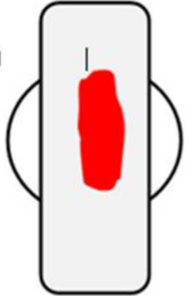
A bleeding guide for women undergoing a medical termination of pregnancy (MToP)

How much am I bleeding?

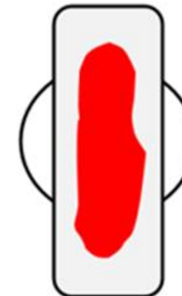
Scant amount
Blood only on toilet paper when wiped or less than 3 cm stain on maxi pad within one hour.



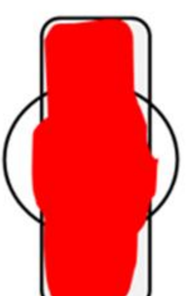
Light amount
Less than 10 cm stain on maxi pad within one hour.



Moderate amount
Less than 15 cm stain on maxi pad within one hour.



Heavy amount
Saturated maxi pad within one hour.



IMPORTANT: If you soak through more than 4 maxi pads in 2 hours, or pass a clot larger than the size of a lemon, you need to contact a doctor's clinic during business hours, or healthdirect on 1800 022 222 after hours, or present to your **nearest Emergency Department.**

Refer to "Principles of post early medical abortion care" from the Royal Women's Hospital Melbourne

Principles of post early medical abortion care

Establish accurate expectations for normal pain and bleeding following administration of MS2Step.

- Heavy bleeding with clots in the first 24 hours is expected.
- Over 7 days bleeding will gradually become lighter.
- On average bleeding lasts for 10 to 16 days and may continue for up to 30 days or until next menstrual period.
- Cramping pain may be experienced for several days.

Clinical assessment is the key to management.

Be guided by the presenting signs and symptoms and use this to determine the need for investigation and ongoing management.

Distinguish between expected but troublesome bleeding and abnormal or pathological bleeding.

Assess bleeding pattern: duration, volume, passage of clots.

Troublesome bleeding may be considered as bleeding that the woman perceives as problematic however is within normal parameters. Normal bleeding can last for up to 4 weeks, but should be becoming lighter without clots or significant cramping.

Consider the role of any hormonal contraception used since the abortion procedure and its influence on the bleeding pattern.

Abnormal or Pathological bleeding patterns include:

At 7 days:	• bleeding is heavier than the normal menstrual period or contains clots • persistent cramps unrelieved by simple analgesia • bleeding that waxes and wanes and has been as heavy as a normal period for at least the past 24 hours	**At any time:** • Heavy bleeding is considered to be 2 (or more) saturated sanitary pads per hour for consecutive hours passing large clots woman feels faint perceives the bleeding as heavy
At 14 days:	• bleeding is heavy or persistent • bleeding that has not markedly reduced since Misoprostol administration	
At 4-5 weeks:	• bleeding is ongoing after next expected menstrual period.	

Routine use of ultrasound scan (USS) is not recommende

Routine USS is NOT recommended as blood clots, debris, or thickened endometrium are common findings and are not usually clinically relevant. Endometrial thickness is not clinicall useful for predicting the need for surgical intervention. ***Follow the symptoms not the scan result.***

USS investigation earlier than 2 weeks post Misoprostol is unlikely to assist management when the patient is clinically well, and βhCG is dropping.

Ultrasound scan is indicated in the following presentations:

- Suspicion of ectopic
- An increasing βhCG from baseline is suspicious for ongoing pregnancy
- Persistent symptoms of pregnancy
- Abnormal bleeding patterns
  - significant increase in bleeding after initial passage of products of conception (POC)
  - at 14 days post Mifepristone - persistent and/or heavy bleeding
  - at 30 days post Mifepristone - ongoing bleeding
  - following Misoprostol - absent or light bleeding or bleeding less than four days.

Diagnosis of incomplete abortion/ retained products of conception (RPOC)

RPOC indicates an incomplete abortion and refers to nonviable placental or fetal tissue retained in the uterine cavity or cervical canal.

Management of RPOC is based on signs and symptoms, clinical stability, patient preference and access to surgery. Asymptomatic or incidental findings of RPOC do not routinely require management.

Consider concurrent infection.

Infection

The most common infections are endometritis, urinary tract infection and undefined genital tract infection.

May present with prolonged or return of bleeding and/or crampy pain.

Examine patient to:

- take endocervical and high vaginal swabs,
- check any tenderness or pain over uterus or cervix

Commence empirical treatment while waiting for results.

Risk of STI: if possible check pre procedure screen, any treatment prescribed & administered. Consider risk of new STI infection associated with new or untreated partner.

Use βhCG measurement to assess resolution of pregnancy

Follow up on the clinical signs and symptoms and use an objective measure i.e. serum beta or low sensitivity urine hCG to confirm the abortion procedure.

- Serum beta hCG pathology taken between day 8 -16. A decrease in serum beta hCG levels of 80 percent or more from ingestion of Mifepristone (if βhCG taken within 72 hours) excludes an ongoing pregnancy.
- Low sensitivity urine hCG self-administered at day 14 -21 detects a hCG level of 1000 mIU/mL and above. A negative result excludes an ongoing pregnancy.

For management of RPOC consider:

Expectant management: allows for spontaneous passage of products of conception (POC). Allow up to 2 weeks for spontaneous resolution and expect and manage ongoing pain and bleeding over this time,

Or

Medical management:
Prescribe: misoprostol 800mcg (4 x 200mcg tablets) buccal followed by a repeat dose of 400mcg (2 x 200mcg tablets) 4 hours later if POC not yet passed. Prescribe analgesia and anti-emetics. Arrange follow up. Ensure patient is aware of side effects associated with misoprostol.

Surgical management recommended if:

- hemodynamically unstable
- evidence of infection
- unacceptably heavy bleeding
- moderate to severe anaemia

Further resources:

See: Early medical abortion webpage:
thewomens.org.au/health-professionals/clinical-resources/early-medical-abortion-ema

Clinical guidelines
thewomens.org.au/health-professionals/clinical-resources/clinical-guidelines-gps
Abortion: Medical management to 9 weeks of pregnancy
Abortion or Miscarriage Management of presentation following medical or surgical abortion or miscarriage

Adverse Events

- Significant Adverse Events should be reported to the TGA
  - Template within clinical software
  - Online at https://aems.tga.gov.au
  - Can also be reported to MS Health via their website

- Admission to hospital for D&C / Hemorrhage

- Reporting SAE's provides accurate real-world data

Early Medical Abortion Education

Promoting excellence in compassionate abortion care education, the following resources may assist new and emerging clinicians:

- Sexual and Reproductive Health Australia (SRHA) National Certificate for Doctors - Theory Face to Face (NSW) | Family Planning: - offered over a three-month period; Comprises pre-workshop online learning, a practical and interactive two-day face-to-face workshop and online assessment.
- Termination of pregnancy – a good practice guide for Tasmanian care providers (womenshealthtas.org.au)
- Early medical abortion - Women's Health Victoria (whvtraining.com.au) – free online training module
- AusCAPPS Network (The Australian Contraception and Abortion Primary Care Practitioner Support) Network

family planning australia

Factsheets | Clinics | Education & training | International | Research | Advocacy

Medical Abortion Online

Register Here

Course description

Who should attend?

Course structure

Eligibility / Prerequisite

Assessment

Course cost

Recognition / Accreditation

RACGP

Find health information

Request an appointment

Book a course

Resources in your language

Got questions? Get the right answers

Call or email Talkline

1300 658 886

SUPPORT OUR WORK

Your donations help us to deliver vital sexual and reproductive health services in the Pacific

DONATE NOW AT

The Australian Contraception and Abortion Primary Care Practitioner Support Network

A network for professionals working with women to optimise reproductive health.

About this network

- How to use this network
- Meet the team
- Get in touch
- Our project and mission

Chat with peers and experts

Providers near you

Resource Library

Our project and mission

AusCAPPS Network is an NHMRC-funded project designed to connect the primary care workforce and increase women's access to contraception and abortion.

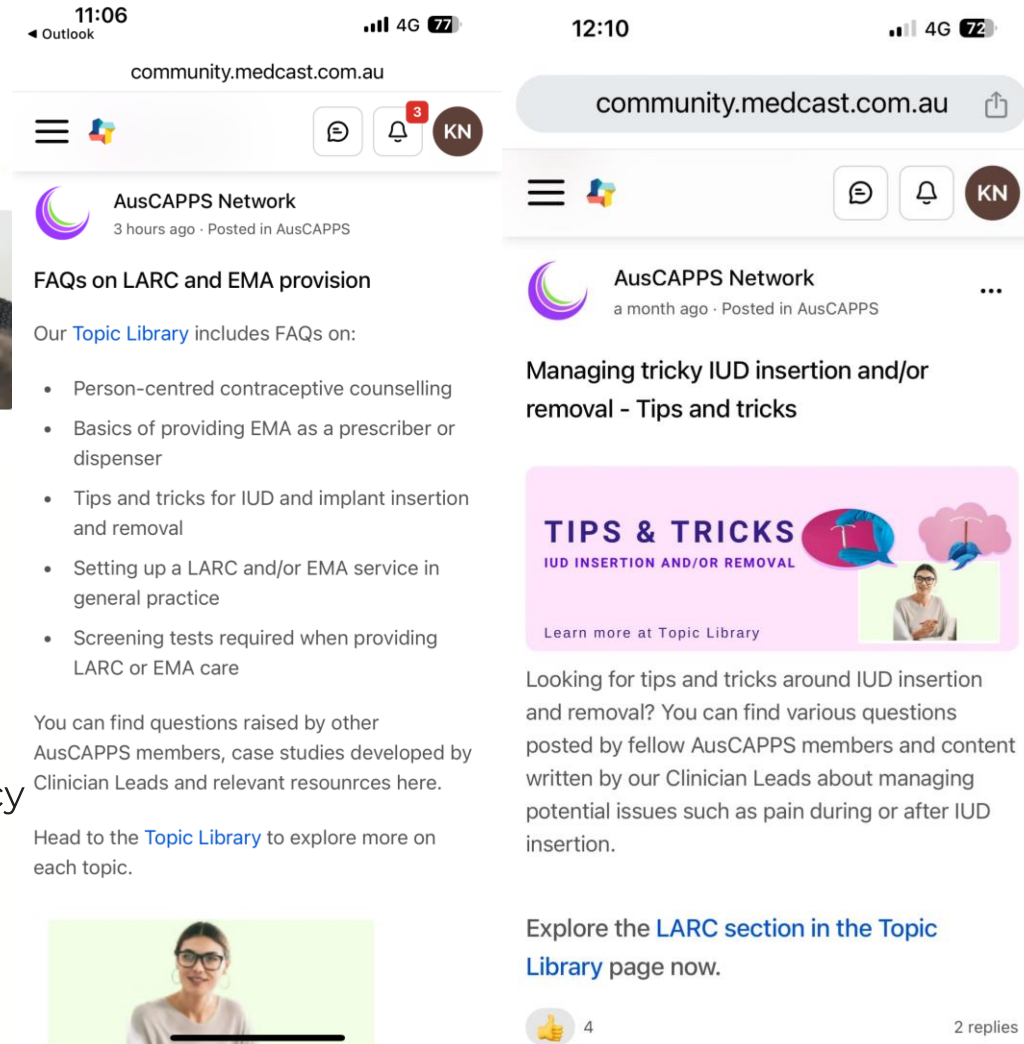
Intrauterine device (IUD) and contraceptive implant use among Australian women remains low, despite being safe and effective for women and pregnancy capable people of all ages.

Early medical abortion is also under-utilised in primary care, despite it being an effective and less-invasive option than surgical termination.

These inequities are magnified in rural and regional areas.

AusCAPPS Network aims to:

- Increase women's access to long-acting reversible contraceptive (LARC) methods (IUDs and implants).
- Increase women's access to safe, affordable early medical abortion (EMA), including for women from the most vulnerable populations.



AusCAPPS | Medcast

19 days post EMA: Case Study

Gemma phones your practice. She is distressed and demands an appointment. She is 19 days post EMA and is still bleeding. The GP who prescribed EMA for her is on annual leave. She explains that she is about to go on a family holiday, and didn't think she would still be bleeding.

What is your approach?

Assess Gemma's bleeding to determine the need for further investigation and ongoing management. I would want to distinguish between **expected bleeding** (albeit troubling), and **abnormal or pathological bleeding**.

I would ask Gemma about her bleeding pattern, the duration and volume of bleeding, whether she is currently passing clots, and whether she is experiencing any cramping pain, fevers or malaise.

Gemma tells you she is currently well. No fevers. No signs of anaemia. She experienced heavy bleeding in the first 4-6 hours post MS2Step and passed some large clots. Her bleeding subsequently eased over 5 days, and she is now experiencing light bleeding. She is not passing any clots and has no pain.

Gemma reports she has not had her follow up pregnancy test as she has misplaced the pathology form and informs you her pregnancy symptoms have subsided. You see she had a beta HCG within a day of commencing MS2Step, is was 18695 mIU/ml.

Where to from here?

1. Reassurance. On average, post EMA bleeding lasts for 10 -16 days and may continue for up to 30 days or until the next menstrual period. It is so important we take the time to establish accurate expectations for normal bleeding post EMA.
2. Exclude ongoing pregnancy. A decrease of beta HCG levels of 80% a week post Mifepristone excludes ongoing pregnancy.

Mifepristone excludes ongoing pregnancy.

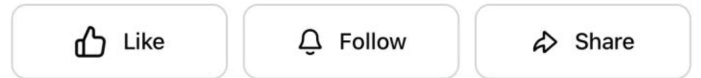
The Royal Women's has recently developed the following resource: Principles of post early medical abortion care. It is an excellent, simple guide that we have saved to our desktop in the clinic! We often also refer clients to it as a tool for reassurance, and to assist them identify abnormal bleeding.

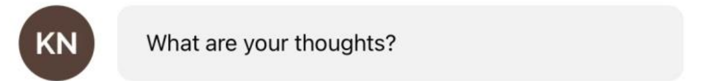
Gemma had her repeat beta HCG. Her results were: 2612 mIU/ml indicating a >80% drop.

Incidentally, her bleeding has also stopped.

How do you ensure your clients have accurate expectations about bleeding post EMA?

See less





Case Study 3 - Josie

27-year-old patient referred to our MFM department with fetal anomalies noted by external ultrasound provider.

Gravida 3, para 2 (both vaginal deliveries).

Patient had ultrasound at 11+ weeks showing a significant neural tube defect. Anencephaly confirmed by our MFM consultant and options and likely outcomes discussed.

The patient decided to opt for ToP and was seen by the reproductive health team at 13+0 weeks gestation.

Questions:

- What are the options for TOP at this gestational age?
- What are the potential risks and complications of these options and the reasons one may be preferenced over the other?

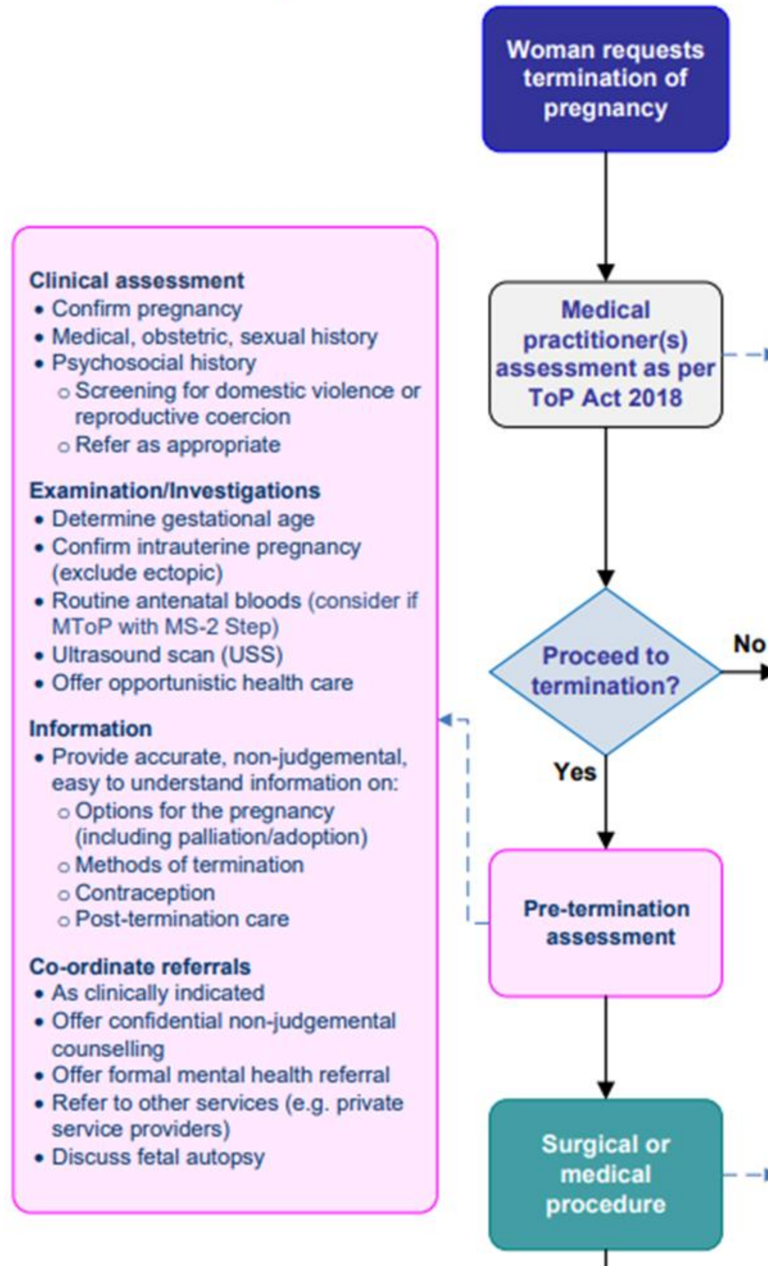
Leg Stretch and Supper

Termination of Pregnancy - services available in the region

- MSHHS provides service to patients within catchment
- Local hospital services prioritise appointments for women with complex healthcare needs or significant social disadvantage - (complex psychosocial concerns, mental health issues, safety issues, behavioural issues, homelessness and/or alcohol/drug issues, low health literacy, lower socio economic, diverse cultural population)
- **Metro South Hospital Reproductive Health service - Metro South-wide service**
  - Offering specialised support for women seeking access and information for a termination of pregnancy and patient risk assessment re eligibility
  - Consultant, Nurse navigator and clinical midwife
  - Surgical termination of pregnancy now available (limited appointments)
  - Women are offered flexibility in appointment times, +/- phone appointments
  - Written referral (preferably SMART referral) required after contacting Nurse Navigator (preferred via CRH/SMART Referral)
  - Referral information: **Termination of Pregnancy Service**

  https://metrosouth.health.qld.gov.au/referrals/gynaecology/termination-of-pregnancy **OR**
  https://brisbanesouth.communityhealthpathways.org/82377.htm

  - **Contact** Phone: 0459 462 478 (NN) (Mon – Fri 9am to 4pm) or 07 2891 5578 (CM)



Essential referral information

Referrals need to be complete and have all relevant investigations attached as per Termination of Pregnancy Clinical Guidelines https://www.health.qld.gov.au/qcg/publications#top

Incomplete referrals lead to delays - Be Timely!

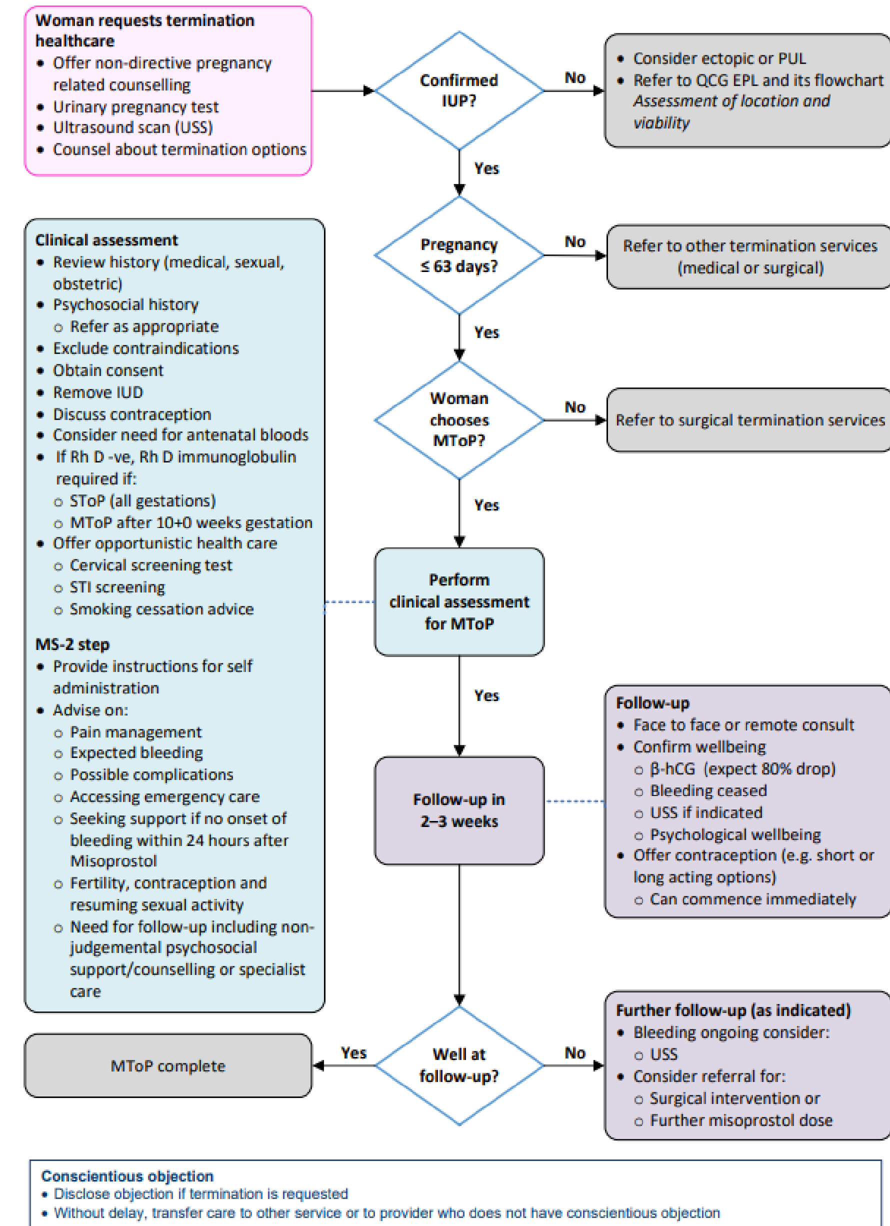
- Medical, surgical and obstetric history
- Menstrual history and last menstrual period (LMP) date
- Results of a physical examination as indicated by patient history, vital signs, and BMI
- Must have confirmation of pregnancy (βhCG) and gestation with:

  USS proven intrauterine pregnancy *

  "Refer Your Patient" - Gynaecology - Termination of Pregnancy
- Ensure sensitive treatment noted on USS request - If appropriate, ask women about their preference to see/hear USS images.
- *A yolk sac or fetal pole must be seen to confirm an intrauterine pregnancy.

Additional referral information:

- If all ToP routine antenatal screening not required, but consider based on history/opportunistically with other serum tests
- Blood group and Antibody screen if > 10/40 + consider BBV screening.
- Quantitative β hCG will be repeated at time of mifepristone, so can be followed-up to ensure completed MToP (80% drop β hCG expected)
- HPV vaccination history & CST result if previously done
- STI screen - endocervical PCR swab for chlamydia + gonorrhoea + syphilis +/- other STI screens as indicated
- History of smoking/ substance use and alcohol
- History of DFV or sexual violence/reproductive coercion
- Mental Health Status



https://www.health.qld.gov.au/__data/assets/pdf_file/0034/735298/f-top-ms.pdf

Queensland Virtual Early Medical Termination of Pregnancy Service

Who can have a virtual medical termination?

- If you can't access a medical termination through your local health care services, our service may be an option for you.
- You must:
  - live in Queensland and not be travelling overseas or to very remote area within the next month
  - be less than 9 weeks pregnant
  - live or be able to stay at a place less than a 2-hour drive from a 24-hour emergency medical service in case there are complications.
- https://www.qld.gov.au/health/children/pregnancy/termination-of-pregnancy/virtual-early-medical-termination-of-pregnancy-service
- Access the virtual medical termination service can be without a referral from your GP by filling in the online form or by calling 13 HEALTH (13 43 25 84).

Your privacy

My Health Record

If you're worried about what people can see on your My Health Record, the Australian Digital Health Agency has information about privacy and how your personal details are managed.

Medicare

Only the medicines will show on your Medicare record.

•Once you turn 14, your parent or guardian can't access your Medicare claims history, even if you're listed on their Medicare card.

•If you're over 14, you can open your own myGov account.

•If you're over 15, you can get your own Medicare card if you're enrolled in Medicare.

QVEMToPS

Additional service, not meant to replace community services, but specific attention and access pathways developed for women/pregnant people that face additional barriers accessing mToP services including but not limited to:

• those who identify as First Nations	• Medicare Ineligible
• Transgender/Gender Diverse	• Socioeconomically Disadvantaged
• CALD	• Adolescents and Young People
• Asylum Seekers/Refugees	• Victim/Survivors of Domestic Violence
• Rural and Remote	• Pregnant people with a Disability.

- · Access can be direct from Qld Govt website (online form), or Health Direct Australia or 13HEALTH or from Primary Care Providers or via HHSs (with nurse navigators).
- Staffed by a Gynaecologist and 2 GPwSI (and 2-3 nurse prescribers being trained). Digital scripts can be generated (for MS2-Step + Ondanestron + Pain relief (Ibuprofen)) and can be filled at community pharmacies or hospital pharmacies (later cheaper for those without Medicare card).
- · Children by Choice have some funding available for those who cannot afford dating USS.
- · Guidelines developed from Qld Clinical Guidelines and RANZCOG Guidelines (for pain management) and followed up by phone 2 weeks later.
- No information in other languages at this time but working on same in 12 most commonly spoken languages (? by EOFY), but the online form is also currently only in English. Aboriginal and Torres Strait Islander Health Workers at SCUH (and in Cairns HHS) helping out if no service locally for First Nations support.

Queensland Health

Queensland Clinical Guidelines

short GUIDE

Rh D negative women and pregnancy

Sensitising events

Aspect	Consideration
First 12+6 weeks of pregnancy[6]	• Miscarriage[26] ○ Excludes threatened miscarriage—consider confirming gestational age by ultrasound scan • Termination of pregnancy[26] (medical or surgical) from 10+0 weeks gestation[32] • Ectopic pregnancy[26] • Molar pregnancy[26] • Chorionic villus sampling[26]

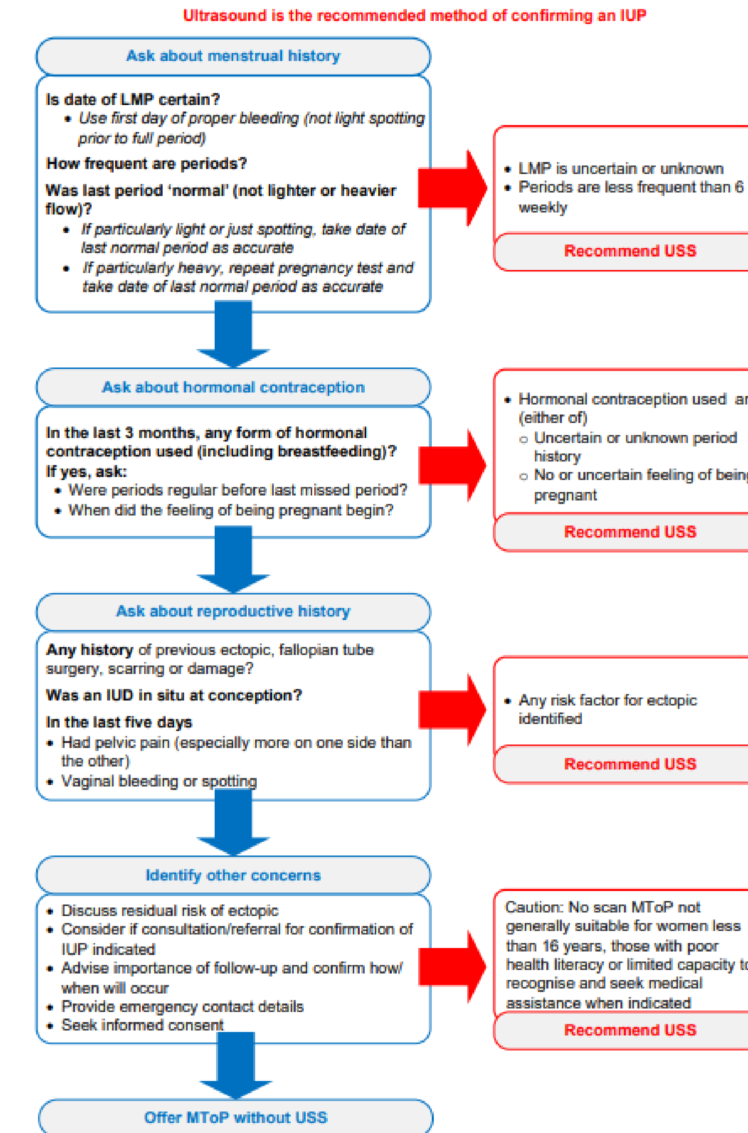
https://www.health.qld.gov.au/__data/assets/pdf_file/0016/1219003/g-rhd-negative.pdf

Also endorsed in RANZCOG Abortion Guideline:
https://ranzcog.edu.au/resources/abortion-guideline/

Medical ToP without USS

[Flowchart: Decision aid for no scan MToP at or less than 63 days gestation]

After 14 weeks pregnant, all women seeking an abortion should have an ultrasound scan to confirm gestational age and position of placenta, if had previous uterine surgery.



“VEMA” Very Early Medical Abortion – Patient Information

An ultrasound scan has been unable to demonstrate a pregnancy within your uterus (no evidence of a yolk sac or fetal pole in an intrauterine gestational sac)**, despite a positive pregnancy test.**

There are four possibilities to explain this:

1. Your pregnancy is very early and not yet visible
2. The pregnancy has stopped growing and may therefore miscarry itself
3. You have started to miscarry - this would be associated with vaginal bleeding and abdominal cramping
4. The pregnancy is not inside the uterus, but in the fallopian tube. This is called an **ectopic pregnancy** and while uncommon is potentially a very serious gynaecological condition.

Are you at risk of an ectopic pregnancy? If you have the following risk factors for ectopic pregnancy you will need further testing before you can proceed with a medical termination:

- previous ectopic pregnancy
- intrauterine contraceptive device in place
- history of pelvic inflammatory disease or tubal surgery
- signs or symptoms of ectopic pregnancy (severe abdominal pain, unilateral pelvic or shoulder tip pain, onset of weakness, heavy bleeding)
- gestation estimated by dates is incompatible with the quantitative serum human chorionic gonadotrophin (hCG) measurement

What to do from here?

Your doctor has determined that you are not at a very high risk of ectopic pregnancy.

The medical termination tablets will not treat an ectopic pregnancy.

An ectopic pregnancy needs urgent treatment at a hospital, with alternative management.

Delayed treatment of an ectopic pregnancy can be life-threatening.

[Pregnancy of Unknown Location and Informed Consent for Very Early Medical Abortion - from TRUE Relationships and Reproductive Health]

You have two options for what to do next:

1. **Wait** and have **further testing** to ensure this is not an ectopic pregnancy.

  a. This will involve further blood tests and/or scans.

  b. This may mean waiting a week or more before starting the medical termination.

  c. If there is an ectopic pregnancy, urgent treatment for this can be arranged with your local hospital.

  d. If you have pain or bleeding while waiting, we will know that you need to be checked at hospital

2. **Go ahead** with the medical termination **now**. This is the VEMA (Very Early Medical Abortion) PROTOCOL.

  a. This means no more waiting or scans before starting the termination.

  b. **More blood tests** are needed during the termination process so an ectopic pregnancy can be picked up.

    i. The first blood test is on the day you take the first tablets (Day 1)

    ii. The second blood test is a few days after this (Day 5 or 7)

  c. These blood tests might be able to find an ectopic pregnancy sooner compared to waiting and scanning again.

  d. If there is an ectopic pregnancy, urgent treatment for this can be arranged with your local hospital.

  e. These tablets aren’t dangerous if there is an ectopic pregnancy but might make it harder to tell if you need to go to hospital. Pain and bleeding can be caused by the tablets, but also by an ectopic pregnancy.

  f. Starting the medical termination earlier can mean less intense bleeding and pain, and less chance of needing further treatment for an incomplete termination

Important Message

Because one of these four options, an ectopic pregnancy, is potentially life-threatening, it is essential that you undertake the blood tests we have recommended. In the meantime, if you experience severe constant abdominal pain, especially one-sided pain, heavy vaginal bleeding, shoulder tip pain or feel faint or weak, you must present to your local hospital Emergency Department immediately.

Resources available in MSH region

- 13 HEALTH – 13 43 25 84 provides health information, referral and services to the public
- Children by Choice – 1800 177 725 offers free all-options pregnancy counselling, information and referrals Qld wide
- 1800 For Women – free phone counselling for women, especially rural and remote, but also from priority communities (see next slide for list)
- Red Nose Grief and **Loss**/SANDS - 1300 308 307 – 24/24 support line Provide support to grieving individuals and families.

- For patients who may have made decision for ToP due to fetal abnormalities or other health concerns

- Harrison's Little Wings not for profit organisation supporting women & their families who have receive a poor diagnosis in pregnancy, or Mum has a Maternal health issue that puts her life or her baby's life at risk https://harrisonslittlewings.org.au/contact-us/
- Women's Health Qld – 1800 017 676 offers health promotion, information and education services for women and health professionals
- True Relationships and Reproductive Health provides expert reproduction and sexual healthcare
- Termination of Pregnancy Clinical Guidelines https://www.health.qld.gov.au/qcg/publications#top – provides patient information + Flowcharts/ Education for Health Professionals
- Key facts about the Termination of Pregnancy Act https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/termination-pregnancy/termination-pregnancy-act-facts.PDF

1800 4 WOMEN - free phone counselling for women in regional and remote Queensland. It's confidential, non-judgemental, and you don't need a referral to access support.

You'll talk to the same qualified counsellor or midwife, and you can choose appointment times that work for you. There's no need to travel, and the service is completely free.

Find out more at https://wheq.org.au/1800-4-women/
Or call 1800 496 636
1800 4 WOMEN can help you with:

- Non-crisis mental health support
- Grief & loss counselling post miscarriage, stillbirth and neonatal death
- Midwifery support and advice
- Specialist domestic, family, and sexual violence counselling
- Referral services

Available to all women, girls and gender-diverse folks in Queensland, especially those who are geographically and socially isolated, and from priority communities, including:

- First Nations women
- Culturally and Linguistically Diverse women
- Women with disability
- Members of LGBTQIA+ communities
- Rural and remote women
- Women in contact with justice systems, including those in custody

How do you ask women about DV?

- **Every** woman – are you safe at home?

"In addition to the blood tests and ultrasound scans we recommend in pregnancy; we ask every woman questions about how she is feeling and if she is safe. Anxiety, depression and domestic violence are common conditions, and they may occur for the first time or get worse in pregnancy."

"Are you safe?"

- DFV screening for ALL at 28/40 visit (to claim 16591 Item Number)

Resources

- Domestic Violence Hotline 1800 811 811(Immediate refuge 24/7)
- 1800Respect 1800 737 732 (Counselling 24/7)
- DVConnect Mensline 1800 600 636
- Queensland Government domestic and family violence resources for
    - Cultural and linguistically diverse communities
    - Women with disability

- REFERRAL TO DFV LOCAL LINK/Centre for Women and Co.
- Facilitate **early referral** to hospital is best GP strategy for pregnant women
- Flag concerns/suspicions
- Enable social worker support

THE CENTRE FOR WOMEN & CO.

Specialist Domestic Violence & Women's Wellbeing Services

Domestic and Family violence specialist service - Centre for Women & Co.
https://bsphn.org.au/community-health/commissioning/domestic-and-family-violence

Recognise, Respond, Refer program:

Offers **one-point of referral** for patients affected by domestic and family violence, as well as **advice and support for general practices** to enable better identification & response to domestic and family violence.

REFERRALS TO DFV LOCAL LINK - Eligible for referral to DFV Local Link if:

- affected by domestic & family violence, including perpetrators seeking behavior change support
- a patient of a general practice in the Brisbane South region.

Can provide the following for referred patients via telephone or face-to-face (at a general practice or at The Centre for Women and Co.)

- undertake a risk assessment
- provide initial support and advice on next steps
- connection with appropriate supports/services
- safely and securely provide feedback to referrer on outcomes of referral.

GENERAL PRACTICE DFV SUPPORT AND ADVICE

DFV Local Link can also provide the following to general practice staff over the phone or via practice visits:

- confidential advice on managing patients affected by DFV
- information sessions re primary care role in responding to DFV
- connection to RACGP accredited DFV training opportunities
- support to implement practice-level measures to enable safe and supportive responses to DFV in the general practice

DFV Local Link service is for General Practices only, but midwives and other medical staff can contact the DFV services directly on the contact information provided.

For secure referrals: search for "The Centre for Women & Co." on Medical Objects. (Medical Objects: CT4114000YV)
Available: Mon - Fri 9am – 4pm
Closed weekends and Public Holidays

DFV Local Link Coordinator for Redlands and Logan Regions
redlandslocallink@centreforwomen.org.au
loganlocallink@centreforwomen.org.au
Contacts: 0460 626 502 | 0482 811 980
or FAX: 07 3144 5602

99 Steps: DFV support CALD Women -
Logan& Beenleigh through Access Gateway
https://www.ssi.org.au/our-services/domestic-family-violence/99-steps/
Phone: 07 3412 8282 or email:
acsl.99Steps@ssi.org.au

Beaudesert/Jimboomba Service - (Scenic Rim) currently operated by YFS - Phone: 0417 078 108 ; https://www.yfs.org.au/
Email: LocalLink@yfs.org.au

Brisbane South Service:
Brisbane Domestic Violence Service (BDVS)
Phone: 3217 2544; https://bdvs.org.au/
Email: bdvs@micahprojects.org.au

STATISTICS TELL US THAT LESS THAN ONE THIRD OF WOMEN IMPACTED BY DOMESTIC AND FAMILY VIOLENCE DISCLOSE THEIR EXPERIENCE TO PROFESSIONALS.

Some reasons why include:

- shame & embarrassment
- belief the abuse is normal or they are somehow to blame
- fear of the abuser and consequences of disclosing
- belief or hope that the perpetrator will change
- fear of judgement from others
- belief that it is their job to manage the situation and keep other family members safe.

For women and children from culturally and linguistically diverse backgrounds, the pressure NOT to disclose is even more real. Fears around disclosure can be compounded by the person using violence as a tool for further control and abuse.

For example, many families are totally reliant on the person using violence (e.g. financially and because their English is better) and have great fear about leaving the relationship due to lack of resources.

The person using violence can also threaten to harm family members in the victim's country of origin or to send the victim home without their children to maintain control over them.

DOMESTIC AND FAMILY VIOLENCE IS NEVER OKAY IN ANY CULTURE OR RELIGIOUS BACKGROUND, ALTHOUGH SOMETIMES PEOPLE TRY TO USE THIS AS AN EXCUSE.

CALD Booklet

Working with women from culturally and linguistically diverse backgrounds who have experienced DFV.

READ OUR BOOKLET

https://www.centreforwomen.org.au/s/CFW99Steps-BOOKLETONLINE.pdf

Please help us make our events better!

https://forms.office.com/r/0SNZTDiCJV

Takeaways:

- mToP prescribing available for all, but training recommended and for GPs must be < 63days
- Termination Nurse Navigator for MSHHS available if eligible
- Discuss CONTRACEPTION at first consult and at follow up, especially LARCs
- Provide Psychosocial History in referral – allows wrap around services to be mobilised for women (& their families) if referral identifies these risks.
- At least know of a colleague who can counsel and undertake an mToP for your patients.

Brisbane South Antenatal Shared Care Summary – February 2026

Brisbane South Antenatal Shared Care

Process

Pre-Conception Unique role for GPs!

- Folate and iodine supplementation for all
- Rubella serology +/- vaccination
- Varicella serology if no history +/- vaccination
- Influenza Vaccination in season + and COVID (follow current guidelines)
- Cervical screening if due
- Chlamydia test/treat <30yrs
- Smoking cessation
- Alcohol cessation
- Discuss and offer reproductive carrier screening e.g., CF, SMA & FXS (or extended panel)
- Consider referral to preconception clinic e.g., Mater, Logan Pre-pregnancy assessment.

First GP Visit(s)
(May take more than one consultation)

- Confirm pregnancy & dates. Scan after 7/40
- Scan if dates uncertain *or* risk of ectopic (previous ectopic, tubal surgery) *or* previous pregnancy complications/medical risks
- Folate and iodine supplementation for all
- Review medical, surgical, psych, family history, medications, allergies etc.- update GP records ± create My Health Record shared health summary.
- Identify risk factors for pregnancy.
- Discuss and offer genetic carrier testing, anomaly screening +/- NIPT.
- BP, weigh, calculate BMI, physical examination.
- Discuss smoking, nutrition, alcohol, physical activity; dietary advice (listeria) & drug avoidance; Assess emotional well-being and screen for DFV if safe to do so.
- Consider early Aspirin use if risk factors for pre-eclampsia/IUGR – before 16 weeks *(see over)*
- Offer influenza and COVID (follow current guidelines) vaccination as soon as practical.
- Discuss models of care

First Trimester Screening Tests
(cc. ANC on all request forms) – all requested tests to be reviewed and actioned by referring clinician.

- FBC, Ferritin, blood group and antibodies, rubella, Hep BsAg, Hep C, HIV, syphilis serology, MSU (treat asymptomatic bacteriuria)
- Discuss and offer Genetic Carrier Screening to ALL
- Discuss and offer screening for anomalies in ALL:
  1. Nuchal Translucency Scan + First Trimester Screen (free ßhCG, PAPPA) $K11\text{-}13^{+6}$ *OR*
  2. Non-Invasive Prenatal Testing > K9 (Higher failure rate in multiple pregnancy, not Medicare funded, first trimester scan recommended) *OR*
  3. Triple Test (AFP, Oestriol, hCG) K15-22 if too late for first TM testing. Not if twins or diabetes

  Discuss/ offer CVS/Amniocentesis if appropriate.
- Order Rhesus-D NIPT of Rh Negative non-alloimmunised patients (timing is lab dependent.)
- Cervical screening test if due, Dry swab (PCR) if lesions/chancre present.
- Varicella serology (if no varicella history /vaccination)
- OGTT after K12 (or HbA1c) if high risk for Diabetes *(see box below)*
- ELFT, TFTs, Vit D, chlamydia/gonorrhoea *only recommended for at risk women (see over)*

Uncomplicated pregnancy

- Refer privately for detailed scan (placenta, morphology, cervical length) at 18-20 weeks.
- First Midwifery Booking visit at 14-16/40 with medical visit at 14-20/40 (18-20/40 combined RM/doctor visit MMH)
- **You are responsible for her care until she is seen by the hospital, after which the responsibility is shared.**
- GP visits to be scheduled around hospital appointments to ensure timely review of results.
- **All investigations to be reviewed by referring clinician and required follow up arranged or referrals made.**

GP Visits: 14, 24, 28, 31, 34, 38, 40 weeks
(More frequent if clinically indicated)

- Record or place printed copy of notes/ results in Pregnancy Health Record (PHR)
- Schedule, education, and assessment as per the PHR
- K26-28 GTT, FBC, Ferritin, Blood group and antibody screen, Syphilis Serology
- Syphilis PCR (dry swab) anytime as clinically indicated).
- K36 Hb, (Ferritin if indicated), Syphilis serology)
- **Vaccinations:** Offer influenza & COVID (any time); pertussis at K20-32 in each pregnancy & Abrysvo (RSV) between 28-36 weeks gestation.
- ANC review at K36 and at K40-41

High Diabetes in Pregnancy Risk
Please specify reason and include copy of results in referral.

- Previous GDM or baby > 4500g, PCOS, strong family hx, BMI > 30, maternal age ≥ 40, previous unexplained perinatal loss; multiple preg, high risk ethnicity, glycosuria; assisted reproduction; Medications – steroids, antipsychotics
- HbA1c up to 12/40 if early screening indicated, Consider OGTT at >10/40 as clinically indicated & patient tolerated. Avoid OGTT in post bariatric surgery patients.
- <u>URGENT</u> Hospital ANC referral if – **GDM = HbA1c 6-6.4%; Fasting ≥ 5.3 -6.9 mmol or 1-hr ≥ 10.6 or 2-hr 9-11 OR OVERT DIP = HbA1c ≥ 6.5%; Fasting ≥ 7.0 mmol or 2-hr ≥ 11.1 mmol**

Medical or Obstetric Complications? EARLY or URGENT ANC referral:

- GP referral letters are triaged by MW or consultant within same week.
- Please specify urgency and reasons in the referral letter
- Refer to local service – will liaise or make further referrals if required.
- ***Be sure to cc pathology and radiology and give women a copy of their results.***
- Cervical length < 35mm transabdo USS – arrange TVS; If < 25mm (TVS) commence 200mg vaginal progesterone daily; If < 10mm, URGENT referral? cerclage

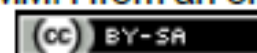
Rh Neg Mothers with unknown or positive fetal Rh status

- Antibody negative. offer 625 IU anti-D at 28 & 34 weeks' and for sensitising events.
- Dose can be given at local Hospital, OR GP—order via QML or Mater Blood Bank, delivered via courier to surgery.
  - QML 3371 9029
  - Mater 3163 8179
- AntiD not indicated for threatened miscarriage ≤ 12/40 (or ToP ≤ 10/40)

CONTACTS	Beaudesert	Logan	Redland	Mater
Secure e-Referral	SMART Referrals or Medical Objects/Health Link			
	Central Referral Hub: 1300 364 248			3163 8053
Updated information to be sent via Smart Referral (or ANC Fax	5541 9132	2891 6976	3488 3436	3163 8053
ANC phone	5541 9144	3086 3379	3488 3434	3163 1861
Perinatal Mental Health Services	3089 2734	3089 2734	3825 6214	3163 7990
GP Liaison Midwife	0482 677 946 or GPLO GP- 2891 5754			3163 1861
For Urgent Referral or Advice				
O&G Registrar	-	2891 8027	3488 3758	3163 6611
Obstetrician/GP Obs on call	5541 9174	3089 6963	3488 3111	3163 6612
Triage Midwife	5541 9181	2891 8811	3488 3044	3163 1861
For urgent MH referral/advice	1300 642255 (1300 MHCALL) for all centres			
Pregnancy Complications				
Complications e.g., bleeding, pain, incomplete miscarriages, altered fetal movts. (Logan EPAU - business hours only) ***Haemodynamically unstable women? Direct to ED/PAC***	On-Call GP Obstetrician 5541 9174	<14w 2891 8456 >16w Phone MAC Reg – 2891 8027 ED: 2891 8899	On-Call Obstetrician 3488 3111	Pregnancy Assessment Centre (PAC) 3163 6577

Modified by MSHHS and MMH from an original created by Drs Michael Rice, Mano Haran and Heng Tang

Version: February 2026



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Available at

https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program

https://www.metrosouth.health.qld.gov.au/__data/assets/pdf_file/0023/291704/bsphn-whole-of-region-summary.pdf

Maternity GP Shared Care
Additional Information and Advice

mater mothers' hospital | Metro South Health | Queensland Government

Additional Tests – STI screen, ELFT, TSH/TFTs, Vit D, TORCH serology

- Chlamydia and Gonorrhoea --test women < 30 years old and other high-risk women by self-collect PCR swab.
- ELFTs and urinary protein/creatinine ratio recommended for obese women (BMI > 30), hypertension or known or suspected renal or liver disease, autoimmune disease.
- Routine TFTs *are not* recommended in low-risk pregnant women. TSH generally drops in first trimester with the rise in HCG. If a woman has a TSH lower than the lab reference range, check free T4/T3—if these are normal, the woman *does not* need referral, if elevated, they will need clinical review, possibly referral – liaise with your local team. https://metronorth.health.qld.gov.au/wp-content/uploads/2017/10/thyroid-disorders-pregnancy.pdf
- Women with pre-existing hypothyroidism should have a TSH <2.5 in first trimester and <3.0 in the rest of the pregnancy. Lab reference ranges will reflect pregnancy recommendations if the woman is identified as being pregnant. Weekly doses usually need to increase by 30% during pregnancy, which is an extra 2 doses/week. Advise women to commence the higher dose as soon as they know they are pregnant.
- Vitamin D levels or supplementation are recommended for obese *or* dark-skinned women *or* those with little sun exposure *or* who cover themselves for religious or cultural reasons. Levels <50 may require supplements of 2000 IU/day. Levels <15 require higher doses and re-test after 3 months.
- Toxoplasma, cytomegalovirus, and herpes serology should *not* be performed routinely. If risk factors indicate a need for testing, please include risk in your referral as follow-up tests or other investigations or management may be needed.

Nutrition and Supplements

- Folate - 0.5 mg for all low risk, 2.5-5 mg if high risk (diabetic, obese, previous, or familial neural tube defect, anticonvulsants). Start one month before conception & continue to 12 weeks.
- Iodine 150mcg/day - recommended preconception, during pregnancy and while breastfeeding (folate + iodine supplement is available)
- 2-3 serves daily of calcium-rich food/drink (1g/day) OR add 500mg minimum daily supplement. RANZCOG recommend universal 400IU/day Vitamin D (e.g., 600mg Ca + 1000IU Vit D)
- Iron only needed if deficiency is identified however low dose is included in all pregnancy supplements. Avoid Vit A in pregnancy.
- Added supplements needed for women post Bariatric Surgery (including Vitamin A) – seek Dietitian input.
- Avoid or limit intake of large/predatory fish due to mercury content (Orange Roughy /Sea Perch, Shark/Flake, Swordfish, Marlin etc.)

Early Low Dose Aspirin (100-150mg)

Commence before 16/40 (stop at 36/40) to reduce incidence of placental disorders such as Pre-eclampsia & fetal growth restriction (FGR), preterm birth & perinatal mortality in those at increased risk. Take in the evening.

High Risk Factors - recommend if patient has one or more of:

- Hypertension
- Renal disease
- Auto-immune diseases e.g., SLE or anti-phospholipid syndrome
- Diabetes (Type 1 or Type 2)
- Previous History of pre-eclampsia

Moderate Risk Factors – consider if two or more are present:

- Primiparous
- BMI > 35
- Age > 40
- Multiple pregnancy
- Family history of pre-eclampsia (mother or sister)
- More than 10 years since last pregnancy

Preventing Infections

- Toxoplasmosis - Avoid feeding raw/undercooked meats to pets, avoid cat faeces/litter, wear gloves when gardening.
- Cytomegalovirus - Good hand hygiene; Care with urine, saliva, nappies of young children
- Influenza and COVID Vaccination at any stage antenatally; pertussis vaccinations 20-32 weeks & RSV 28-36 weeks (but up to time of delivery if missed; requires two weeks to be fully effective)
- Listeriosis - Avoid soft cheeses, un-pasteurised milk, pate, raw eggs, hot dogs, undercooked and deli meats, reheated leftovers, precut fruit, bean sprouts.

More Online Information and Education for GPs interested in Antenatal Care are available through:

- General Practice Liaison Officer (GPLO) Program webpage: https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program
- Mater Mothers www.materonline.org.au (Click on Shared Care Alignment for a range of resources for GPs) www.matermothers.org.au (Click on Mater Mothers' Hospital for resources for women)
- www.maternity-matters.com.au has consumer and clinician resources and links to reputable websites.

Early Pregnancy Complications (<20 weeks)

- Nausea and vomiting - decrease iron (but continue iodine and folate), try ginger, acupressure, pyridoxine 75 mg/day in divided doses, doxylamine (Cat A) Metoclopramide (Maxolon Cat A) and Phenothiazines like Prochlorperazine (Stemetil Cat C, po/pr/iv, safe in first trimester); Ondansetron may be effective but is relatively expensive. Even mild dehydration/ketonuria may benefit from IV fluids.
- Bleeding: check blood group and antibodies. Threatened miscarriage in rhesus-negative women without antibodies (and unknown fetal Rh status) after 12 weeks requires anti-D, before 12 weeks anti-D is not required unless the miscarriage completes, or you are concerned the woman may not re-present.
- Bleeding and pain: consider ectopic pregnancy!
- Consider advice from, or referral to, early pregnancy assessment unit (EPAU), pregnancy assessment centre (PAC) or emergency department at booking hospital (appointments may be required)

Beaudesert 5541 9111; Logan EPAU (< K14) 3299 8456 – 8-4 Mon-Fri only
Redlands 3488 3111; Mater PAC 3163 6577

Late pregnancy complications (>16/40 at Logan; >20/40 at other Brisbane South maternity hospitals)

- Bleeding – can do spec exam but avoid PVE. Exclude cervical dilation. Re-check placental site on original morphology scan, Rhesus neg mothers (with unknown fetal Rh Status) need anti-D.
- Abdominal pain - can do spec exam but no PVE. Exclude cervical dilation.
- Ruptured membranes - Review at hospital preferred. Can do spec exam but no PVE.
- Fundal height > 3cm above or below expected for gestational age – arrange USS & if IUGR confirmed, refer to ANC by Fax *and* Phone Obstetrician/Registrar; if LGA confirmed, refer back through ANC
- Perceived change in fetal movements beyond 28 weeks or no FH detected – arrange IMMEDIATE hospital review.
- Most should be referred to booking hospital birth suites, pregnancy/maternity assessment/observation units or Emerg. Dept.

Beaudesert 5541 9111; Logan MAC
Redlands 3488 3111; Mater PAC 3163 6577

For feedback on this document, please email MSHHS GPLO Maternity Team at GPLO_Maternity_Share_Care@health.qld.gov.au

Modified by MSHHS and MMH from an original created by Drs Michael Rice, Mano Haran and Heng Tang. Edited & updated by Drs Kim Nolan, Margaret Robin and Michael Rice – February 2026
www.materonline.org.au | www.https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program

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Queensland Government | Metro South Health

← Back to main site | Refer your patient

Refer your patient

Information to help you decide which treatment is best for your patients, how to refer them and view health records.

Home > Refer your patient > General Practice Liaison Officer (GPLO) Program

General Practice Liaison Officer (GPLO) Program

Our GP liaison officers help GPs refer patients to our hospitals. We also train GPs who want to work with our maternity services in shared care.

On this page

- How we help GPs
- Contact a liaison officer
- Maternity services support
- How to become an Aligned GP
- GP Maternity Shared Care online bridging program
- Resources

General Practice Liaison Officer (GPLO) Program Metro South Health

How we help GPs

We have 2 teams to support GPs, our GP liaison officers (GPLO) and our GPLO Maternity Shared Care Team.

Our GP liaison officers can help you:

- understand our services
- refer patients to our hospitals and health centres
- use Brisbane South HealthPathways
- update your practice details in the Secure Transfer Service (STS) address book
- use the Health Provider Portal to access your patients' health records.

Contact a liaison officer

You can talk to our liaison officers in person, over the phone or by email.

- Email: GPLO_Programs2@health.qld.gov.au
- Phone: 1300 364 155 select option 2 – Monday to Friday between 8 am and 4 pm.

Maternity services support

Our GPLO Maternity Shared Care Team is based at Logan Hospital. We work with maternity services teams in our hospitals and GPs who practise in the Metro South Health area.

We help with:

- referrals
- patient handovers
- liaise with the obstetric team on your behalf.

We also run GP alignment education events each year. Search our events for future sessions.

Contact the GPLO Maternity Shared Care Team

Dr Kim Nolan
M.B.B.S; DRANZCOG; FRACGP; DCH
GPLO General Practitioner – Maternity
Obstetrics and Gynaecology Department
Logan Hospital
Phone: 07 2891 5754
Email: GPLO_Maternity_Share_Care@health.qld.gov.au

Lisa Miller
General Practice Liaison Midwife Manager
Women's & Children's Services | Logan Bayside Health Network
Logan Hospital
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https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program

Great news for MSHHS Aligned GPs!

- After extensive negotiations on your behalf, MSHHS now hosts a public facing list of Aligned GPs, in keeping with MMH and Gold Coast University Hospital.
- Please email GPLO_Maternity_Share_Care@health.qld.gov.au if you do NOT want your name and suburb published. This is now to become OPT-OUT.
- Please encourage any of your colleagues who have allowed their MSHHS Alignment to lapse, or have never completed Alignment to do so, with this free publicity in mind!
- Great way to build a practice, baby by baby!!

Maternity
Logan Hospital

Care and services for women, babies, and families throughout pregnancy, during labour, birth, and after birth.

On this page

- Our services
- Pregnancy care
- Birth suite
- Going home from hospital
- Special care nursery
- Perinatal mental health
- After you have your baby
- Contact us

If you're in labour, please call us on 07 3299 8663 before you go to hospital so our midwives are ready for you.

If you're less than 20 weeks pregnant and need medical care, please get in touch with your GP or go to your closest emergency department.

Our services

Having a baby is an exciting and life changing journey. We can help you choose the pregnancy care that's right for you. This may depend on any medical or pregnancy health concerns you have.

As well as Logan Hospital, Metro South Health has birthing hospitals at Redland and Beaudesert. All of our hospitals will give you and your family the best level of care as you start your journey into parenthood.

Please see your GP or a private midwife for your first appointment. Once you decide who will be caring for you and your baby during your pregnancy and birth, they'll let us know.

Pregnancy care

Service Locations | Metro South Health

https://www.metrosouth.health.qld.gov.au/services/maternity/maternity-logan-hospital#section__pregnancy-care

Your options for care during pregnancy include:

- **GP shared care**—your GP works with the hospital to take care of you.
- **Hospital midwifery care**—midwives at the hospital look after you.
- **Private midwifery care**—you can choose your own midwife to take care of you.
- **Specialist obstetric care**—you'll get care from doctors who specialise in pregnancy and childbirth.
- **Midwifery Group Practice (MGP)**—a team of midwives will look after you.

More information on your maternity care options is available on the Queensland Health website.

GP shared care

If you don't have any complications, you may choose to have most of your pregnancy care with your GP.

We'd still like to see you for the first booking appointment and again at 20, 36 and 41 weeks. If you develop any complications during pregnancy, your GP will refer you to us for ongoing care.

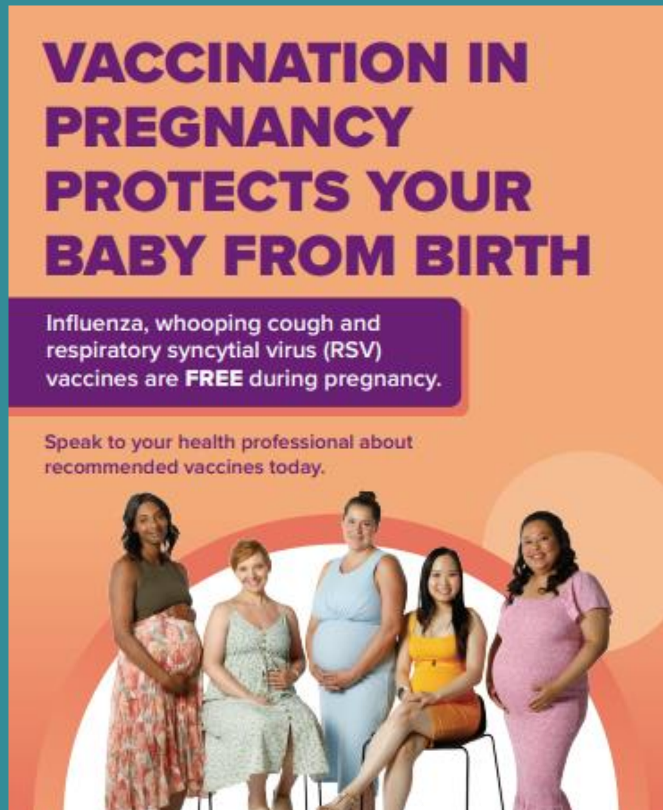
In GP shared care:

- most of your appointments will be with your GP
- you'll have 3 to 4 hospital appointments
- your baby will be born in hospital.

The Metro South GP Shared Care Alignment Program provides GP's with the latest information and health advice on obstetric and maternity care in shared care arrangements. See the full list of GP's who have completed the program.

Recommended Vaccines in Pregnancy

The Glen Hotel and Suites Eight Mile Plains, QLD
Tuesday, May 5 • 6:30 PM - 9PM
https://www.eventbrite.com.au/e/recommended-vaccines-in-pregnancy-tickets-1987573758616?utm_experiment=test_share_listing&aff=ebdsshios



Metro South Health

GP Education Event

Meal and Venue sponsored by

The Metro South GP Maternity Shared Care Team is pleased to invite you to an evening event as part of our commitment to ongoing quality GP education across Metro South.

Recommended Vaccines in Pregnancy

Date: Tuesday 5th May 2026: 6.30pm – 9.00pm Venue: The Glen Hotel, 24 Gaskell Street, Eight Mile Plains

This session is tailored for practitioners providing maternity care to families in Brisbane South, particularly within the Logan, Redland, and Beaudesert catchments. Midwives and General Practice nurses are also welcome.

This education evening will give you the opportunity to discuss optimal vaccine timing, vaccine hesitancy and the unfortunate potential consequences for infants of non-vaccinated women with Obstetricians, Paediatric specialists, and your GP colleagues.

Full dinner will be provided.

This activity is eligible for self-reported CPD points under educational activity and reviewing performance. CPD hours will be confirmed on the day.

In 2026, the Metro South GP Liaison Team will continue to be deliver a series of evening sessions as part of our delivery of GP education. All our sessions are open to all practitioners providing maternity care.

To attend please click this link or scan the QR code

Subscribe to

Metro South Health's GP Clinical Update

These emails will feature:

- New models of care
- Referral pathways
- Patient care information
- GP opportunities

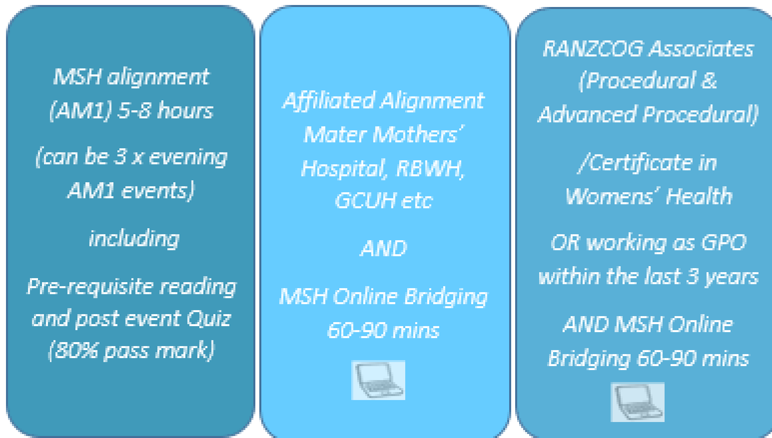
MSH MATERNITY SHARED CARE - LOGAN/BEAUDESERT/REDLAND HOSPITALS

Alignment and re-alignment options

How to be aligned with MSHHS

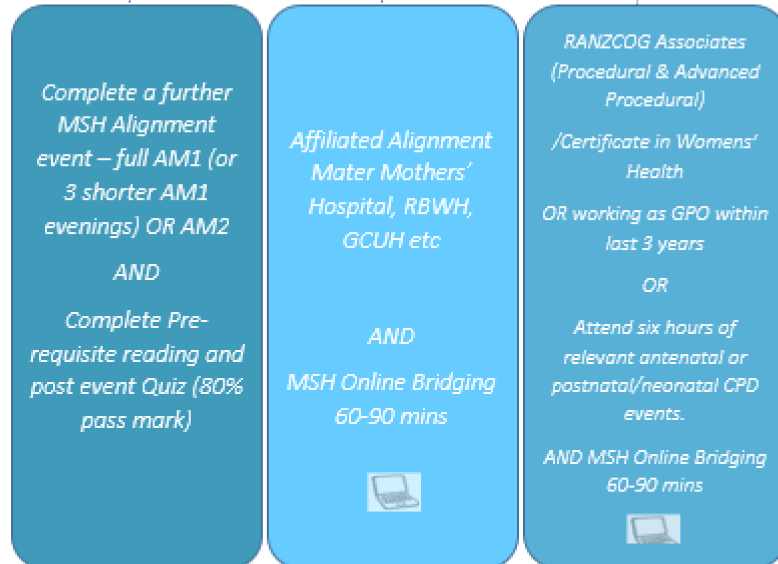
FIRST ALIGNMENT

Required for MSH Shared Care



SUBSEQUENT REQUIREMENTS

Re-alignment required once every 3 years



- Participate in a full AM1 event (or 3 x AM1 Evening events) if not already completed and undertake further training every 3 years.
- Case based and practical learning with our GP and specialist colleagues, as well as the Midwifery teams, Perinatal MH Team, and Allied Health.
- Alignment will need to be undertaken (or an alternative) every 3 years.

GPLO Maternity GP and Midwife Manager
General Practice Liaison Officer (GPLO) Program | Metro South Health
Email: GPLO_Maternity_Share_Care@health.qld.gov.au Phone: 07 2891 5754/0482 677 281

Maintaining Alignment

To maintain alignment after 3 years, you must either:

- repeat Alignment Seminar – can be MSHHS Alignment (5-8hrs total)

  OR an affiliated Alignment (MMH/RBWH/Nambour/West Moreton/GCUH) + complete the online bridge including Q&A.

OR

- attend six hours of relevant antenatal or postnatal/neonatal CPD education and complete online bridge including Q & A. The CPD events DO NOT need to be with the Metro South Health Services

OR

- Complete a RANZCOG Associate Training Program or Certificate in Women's Health + complete the online bridge

Further evening sessions (2-3hours) AM1 planned for 2026 – Foundation Course

MSH Maternity Shared Care Online Bridging Programme

- Programme is delivered via an interactive online learning module including an exam/quiz to complete.
- Available to GPs who are currently aligned to Shared Care at MMH (or an alternative SEQ Alignment) and wish to align with MSH.
- Takes approximately 1- 1 ½ hours to complete.
- Once complete, GPs will receive notice of completion which can be claimed as Continuing Professional Development (CPD), self- logged through the RACGP member portal or other associations.
- To access the MSH GP Maternity Shared Care Online Bridging Program, please email us on GPLO_Maternity_Share_Care@health.qld.gov.au

MMH Alignment

- To become aligned with MMH you can participate in an Alignment event run by MMH (AM1 then AM2/AM3/AM4)

OR

- after a MSHHS Alignment, GPs will need to complete MMH's online bridge including Q&A – accessed by contacting the MMH Alignment team and forwarding a copy of your certificate from completion of this event.
- MMH GP Liaison Midwife - Telephone 07 3163 1861, mobile 0466 205 710 or email GPL@mater.org.au

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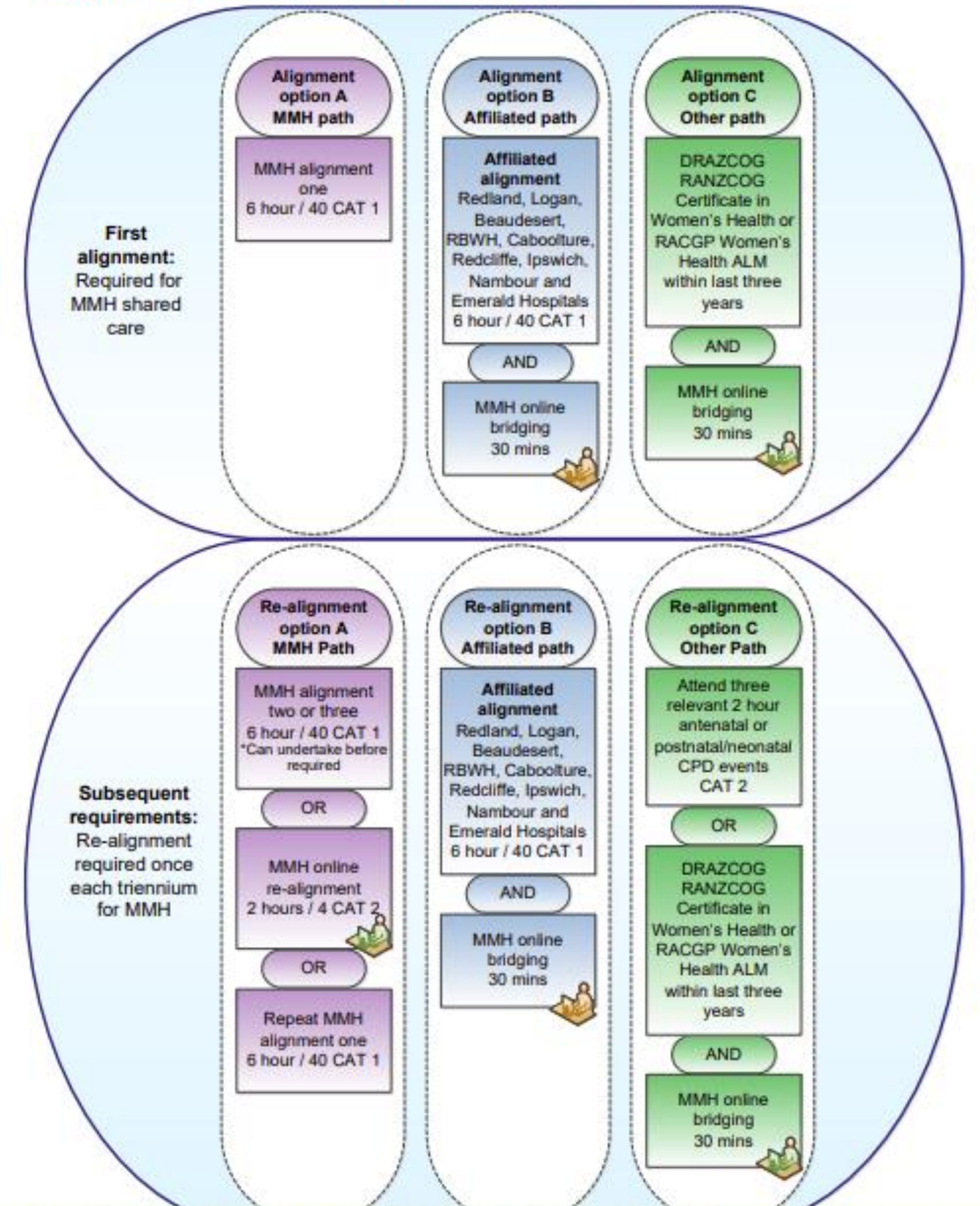
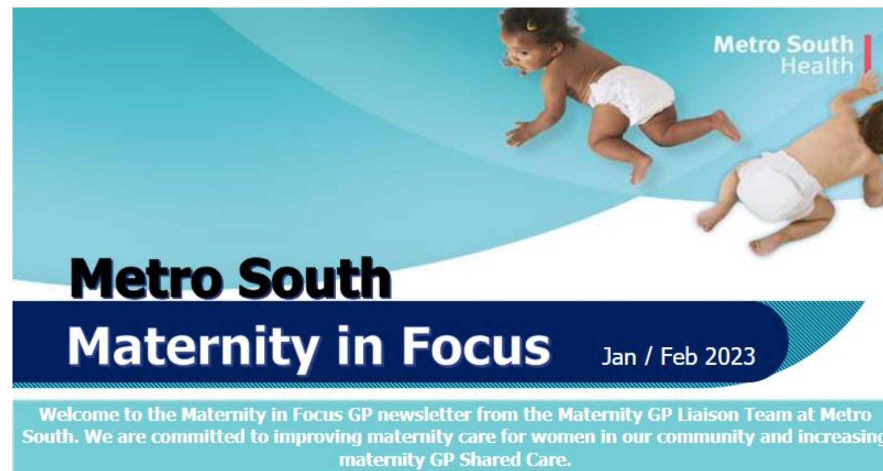


Thank you …. and three more things...

- Let us know if you would be happy to have your contact information available for pregnant women who don't have a regular GP, especially if you are able to offer mToP to new patients.
- MSHHS will hold your contact details – Alignment stays with the doctor, not the practice, so let us know if you move practice.
- Provide an updated email address so that we will be able to contact/update you in the future and forward our newsletter "Maternity in Focus" every few months



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Enjoy the remainder of your week!