Guideline for Midwifery Obstetric Ultrasound Service

Lead Author (s)	Sophie Wong
Lead Executive	Jenifer Winslade
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Policy on a Page: Key Messages

Aim:

This guideline has been developed to support clinical decision-making in the context of the midwifery ultrasound service within Aneurin Bevan University Health Board.

Summary of key changes (for revised documents only)

- More detailed guidance for multiple pregnancies.
- New sections of clinical escalation.
- Expanded growth scan guidance.
- More comprehensive eligibility criteria for serial growth scanning.
- Greater detail on screening requirements.

Key Requirements:

- Midwifery sonographers must undertake ultrasound examinations in line with national and Health Board guidance.
- All scans must meet required image quality standards and be accurately documented and reported.
- Abnormal findings must be escalated and referred via the appropriate clinical pathway.
- Multiple pregnancies require specialist assessment and referral.
- Growth surveillance must be undertaken according to identified risk factors and local guidance.

Target Audience:

All staff working within Maternity services within Aneurin Bevan University Health Board.

Training:

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal.

Contents

1. Introduction/Overview

The National Service Framework Guideline (Department of Health and Social Care, 2004) states that pregnancy women should be provided with appropriate outpatient servicers within their community to support sustainability and care quality.

The Aneurin Bevan University Health Board (ABUHB) midwifery ultrasound service sits as an interface between midwifery-led care and obstetric-led care services. It exists as a clinical gatekeeper between obstetric high-risk and midwifery

2. Scope

These guidelines apply to all midwives undertaking diagnostic ultrasound in Aneurin Bevan University Health Board. Midwife sonographers work within appropriate clinical governance frameworks and have a direct impact upon patient care, wellbeing and management. They must report and act on their findings, both in the event of expected and unexpected pathologies. As a result, their actions and diagnostic findings are pivotal in determining the appropriate future management of women under their care.

3. Statement/Background

If you have difficulty understanding any part of this guideline- including due to learning, sensory, or communication needs- please speak with your Line Manager or contact the authors of this guideline for support or clarification.

Staff must take a proactive approach to identifying and meeting the accessibility and communication needs of people with disabilities and/or language barriers, including offering information in alternative formats, arranging interpretation or communication support as required, and not relying solely on individuals to request adjustments.

The term "woman/ women" will be used throughout this document however, it is recognised that this refers to all pregnant, birthing and postnatal people regardless of gender identification.

4. Aim

This guideline has been developed to support clinical decision-making in the context of the midwifery ultrasound service within Aneurin Bevan University Health Board, in addition to safeguarding effective service provision and high-quality patient care.

This guideline should be read in conjunction with the following documents-

- Guideline for the Management of the Small for Gestational Age (SGA) Fetus (ABUHB, 2026a)
- Management of Pregnancy with Large for Dates Fetus Guideline (ABUHB, 2023)
- Integrated Care Pathway for Pregnancy Loss over 20 Weeks (ABUHB, 2026b)

Please refer to Section 11 for a full list of references.

5. Main Body

List of Abbreviation

ABUHB Aneurin Bevan University Health Board

AC Abdominal Circumference

AFI Amniotic Fluid Index

ANC Antenatal Clinic

APH Antepartum Haemorrhage

ASW Antenatal Screening Wales

BPD Biparietal Diameter

CWS Clinical Workstation System

CRL Crown-Rump Length

CTG Cardiotocography

DQASS Down's Syndrome Screening Quality Assurance Support Service

DAU Day Assessment Unit

DOB Date of Birth

EDD Estimated Date of Delivery

ECV External Cephalic Version

EFW Estimated Fetal Weight

EPAU Early Pregnancy Assessment Unit

FL Femur Length

FMs Fetal Movements

GA Gestational Age

GDM Gestational Diabetes Mellitus

GROW Gestation Related Optimal Weight (chart/programme) Perinatal institute

GUH Grange University Hospital

HC Head Circumference

LFD Large for Dates

LGA Large for Gestational Age

MW Midwife

NHS National Health Service

NICE National Institute for Clinical Excellence

NMC Nursing and Midwifery Council

NT Nuchal Translucency

PACS Picture Archiving and Communication System

PADR Performance Appraisal and Development Review

PI Pulsatility Index

PNMH Perinatal Mental Health

RADIS Radiology Information System

RCOG Royal College of Obstetricians and Gynaecologists

SGA Small for Gestational Age

SFH Symphysis Fundal Height

SOP Standard Operating Procedure

SOR Society of Radiographers

UO1T/UDAVY Ultrasound exam codes for early pregnancy referral

USS Ultrasound Scan

Nuchal Translucency First Trimester Screening

For those patients who have consented to Down's, Edward's and Patau's syndrome screening, a dating ultrasound scan should be performed between 11 weeks and 2 days' gestation and 14 weeks and 1 day of gestation.

CRL/ HC

This early pregnancy ultrasound scan dates the pregnancy by accurately measuring the crown rump length (CRL) or head circumference (HC) to provide a gestational age. From this measurement, an accurate estimated date of delivery (EDD) is provided.

The expected CRL measurement is between 45.00mm-84.00mm (11 weeks and 2 days' gestation and 14 weeks and 1 day of gestation). If the CRL measurement is above 84.00mm, the HC measurement must be used instead. HC measurements cannot be used if they are below 88.00mm (13 weeks and 3 days' gestation). This is in accordance with Antenatal

Screening Wales (ASW) guidance and therefore do not recommend the use of biparietal diameter (BPD) measurements.

If the CRL is less than 45.00mm, the woman must be recalled for a further scan at a correct gestation.

If the CRL is greater than 84.00mm the second trimester quadruple (QUAD) test should be offered. Please note, the QUAD test should not be offered for multiple pregnancies.

NT

Where it is not possible to obtain the NT measurement on the same day as the CRL, the woman should be referred for the QUAD test. The CRL measurement obtained can be used for the subsequent QUAD test.

Intrauterine Death (IUD)

In the event of no fetal heart activity at the time of the dating ultrasound scan, the woman should be referred to the Early Pregnancy Assessment Unit (EPAU) in the Grange University Hospital, and the ultrasound scan examination code changed to UO1T or UDAVY.

Image and Report Storage

The Soliton/ Radiology+ obstetric reporting module should be used to report all early pregnancy ultrasound scans.

- A clear and concise ultrasound report should be produced and authorised by the person performing the ultrasound examination as an integral part of the examination. Examination codes, such as !NTNUT and !NTLTE should be used when required.
- The scan report is a legal document and forms a part of the medical record. The scan report and associated images and/or cine loops are required for a record of the scan and are to be stored electronically. In accordance with national requirements, these must be stored for 25-years.
- Adequate identifiers are required to be entered on all images relevant to the woman, which are the date and time of the examination.
- In cases of a congenital anomaly, the CARIS button should be ticked.

Image Quality

- The magnification of the image should be such that the fetal head and thorax occupy the whole screen.
- A mid-sagittal view of the face should be obtained. This is defined by the presence of the echogenic tip of the nose and rectangular shape of the palate anteriorly, the translucent diencephalon in the centre and the nuchal membrane posteriorly. Minor deviations from the exact midline plane would cause non-visualisation of the tip of the nose and visibility of the maxilla (Image 1).
- The fetus should be in a neural position, with the head in line with the spine. When the fetal neck is hyperextended, the measurement can be falsely increased and when the neck is flexed, the measurement can be falsely decreased.
- Care must be taken to distinguish between fetal skin and amnion.
- The widest part of the translucency must always be measured.
- Measurements should be taken with the inner border of the horizontal line of the callipers placed ON the line that defines the nuchal translucency thickness- the crossbar of the calliper should be such that it is hardly visible as it merges with the white line of the border, not in the nuchal fluid.
- In magnifying the image (pre or post freeze zoom), it is important to turn the gain down. This avoids the mistake of placing the calliper on the fuzzy edge of the line which causes an underestimate of the nuchal measurement.
- During the scan, more than one measurement must be taken and the maximum one that meets all the above criteria should be recorded in the database.
- The umbilical cord may be around the fetal neck in about 5% of cases and this finding may produce a falsely increased NT. In such cases, the measurements of NT above and below the cord are different and, in the calculation of risk, it is more appropriate to use the average of the two measurements.

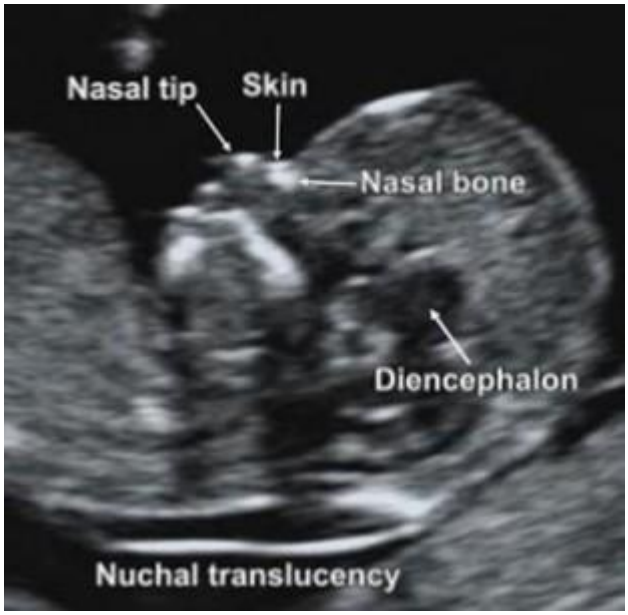

Image 1 Mid-sagittal view of the face

Please refer to the NHS Fetal Anomaly Screening Programme (FASP): programme overview (NHS England, 2013) for further information.

In the event of an adnexal pathology, such as ovarian cyst, mass or fibroid- accurate measurements should be taken and these should be escalated to a consultant obstetrician. Please refer to the Guideline for Early Pregnancy Assessment Unit (EPAU) (ABUHB, 2025a) and the Management of Ovarian Cysts in Pregnancy (ABUHB, 2025b) guidelines for further information pertaining to the management of adnexal pathology identified in early pregnancy.

Twins and Multiple Pregnancies

In cases where there is a multiple pregnancy, the following should be met:

- Chorionicity
- Number of fetuses

Determining the chorionicity and amnionicity allows women to be assigned to the correct plan of care for their pregnancy. In order to confirm chorionicity, scan images should be reviewed by Sophie Wong (Ultrasound Governance Lead), Leanne Edwards (Ultrasound Services Manager) or the Consultant Obstetricians with special interest in fetal medicine or multiple pregnancies.

Pregnancy risks, clinical management and subsequent outcomes are different for monochorionic and dichorionic twin pregnancies (and for monochorionic, dichorionic and trichorionic triplet pregnancies). Therefore, accurate determination of chorionicity is important.

Recording of the number of fetuses, chorionicity and amnionicity should be made on Soliton/ Radiology+.

For women with multiple pregnancies under the care of Nevill Hall Hospital (NHH), consultant-led care (CLC) referral is via Badgernet *'Fetal medicine referral- NEVILL HALL CLINIC Referral'*. For women with multiple pregnancies under the care of the Royal Gwent Hospital (RGH), CLC referral is via *'Twin clinic ROYAL GWENT Referral'.*

Biometry

As with singleton pregnancies, CRL or HC should be used to date the pregnancy with multiples. Measurements are to be entered into Soliton/ Radiology+.

Soliton/ Radiology+ will automatically use the CRL of the **largest** twin to generate an estimated due date.

NT

Again, as with singleton pregnancies, an NT can be measured for twins. If only one NT is achievable, combined screening can be offered but the result will be less accurate. Monochorionic twins will receive the result of the pregnancy, dichorionic twins will receive the result for one fetus for which both measurements were obtained. Please refer to Antenatal Screening Wales Policy, Standards and Protocols 2023 (Public Health Wales, 2024) for further information.

The QUAD test is **not** offered for multiple pregnancies.

Serial Scans

Midwife sonographers are not expected to perform multiple pregnancy growth ultrasound scans.

For monochorionic twins, scans 2-weeks from dating should be performed until birth. These scans are performed in the fetal medicine department/ high-risk antenatal clinic.

For dichorionic twins, scans 4-weeks from the anomaly scan should be performed. These scans are performed by the radiology service. All growth scan appointments for dichorionic twins are generated via the radiology department.

Screening for Preterm Birth/ Delivery

Preterm birth (PTB) is the leading cause of perinatal morbidity and mortality worldwide. Cervical length is a good predictor of PTB with a strong inverse relationship between cervical length in mid-pregnancy and the risk of preterm birth.

Midwife sonographers does not currently provide this service. Please refer to the Pre term Labour and Birth Guideline (ABUHB, 2024a).

Private Scan Referrals

For women who have received a private ultrasound scan and obstetric review is required, the referral pathway is dependent upon gestational age as detailed below.

- 4 weeks- 14 weeks' gestation: Early pregnancy unit (extension 23984)
- 14 weeks- 19 weeks and 6 days' gestation: Emergency gynaecology unit (extension 23556)
- Greater than 20 weeks' gestation: Maternity triage (extension 23530)

Ongoing clinical management will be dependent upon presentation and the clinical team providing care.

Growth Scans

Please refer to the Guideline for the Management of the Small for Gestational Age (SGA) Fetus (ABUHB, 2026a) for risk factors meeting the criteria for serial growth scanning.

Image Quality

Growth scan images should include the below as a minimum-

- Confirmation of intrauterine pregnancy
- Presentation
    - If breech- accurate assessment of legs flexed or extended with image labelled/ annotated.
- HC
    - Accurate HC which is measured as an ellipse around the perimeter of the fetal skull. This should be a rugby football shape, centrally positioned with continuous midline echo broken at one third of its length by the cavum septum pellucidum, anterior walls of the lateral ventricles centrally placed around the midline and the choroid plexus should be visible within the posterior horn of the ventricle in the distal hemisphere.
    - At an advanced gestation or where the fetal head is in a poor position for accurate measurement, every attempt must be made to obtain the above measurements, i.e., tilting the bed, asking the woman to lie on her side. Please note, the estimated fetal weight will not be accurate if the HC is not obtained.
- Abdominal circumference (AC)
    - Accurate AC should be measured on a transverse section through the fetal abdomen that is as close as possible to circular in shape. Care must be taken to identify the spine and descending aorta posteriorly, the umbilical vein in the anterior one third of the abdomen and the stomach bubble in the same plane with a single rib.
- Femur length (FL)
    - Accurate FL should be measured as perpendicular to the beam as possible, enlarged with posterior acoustic shadowing.
- Placental location and in relation to the cervical os

    - Any women with anterior low-lying placenta with a previous history of caesarean section should be escalated to a consultant obstetrician, if not already done so, as placental accreta spectrum needs to be excluded.
- Fetal bladder and stomach
- Umbilical artery dopplers should be undertaken
- Observe for fetal movements and take note of any lack thereof
- Fetal heart rate
- Single deepest pool
    - If the single deepest pool is deemed to be low, an amniotic fluid index should be undertaken
- Intergrowth charts are to be used for all measurements, i.e., HC/ AC/ FL/ UAD
- All biometry should be entered into the Badgernet system, in addition to any other relevant findings identified during the examination
- The GROW chart via the Badgernet system will then be generated and the growth trend will need to be assessed
- The report that is generated from the Badgernet system requires inputting into the Soltion/ Radiology+ system.

Intrauterine Growth Restriction

In the event that intrauterine growth restriction is suspected, please refer to the Guideline for the Management of the Small for Gestational Age (SGA) Fetus (ABUHB, 2026).

Large for Gestational Age

In the event that large for gestational age (LFGA)/ accelerated growth is suspected, please refer to the Management of Pregnancy with Large for Dates Fetus Guideline (ABUHB, 2023) and the All Wales Midwifery-Led Care Guideline (Wales Maternity & Neonatal Network, 2022).

Intrauterine Death

In these sad cases, a confirmatory scan is required. If a suitably trained clinician is available, a second opinion/ confirmatory scan should be undertaken to confirm the intrauterine death (IUD). In the event that a

second opinion cannot be sought due to an absence of a second suitably trained clinician, the woman would require a second opinion/ confirmatory scan once admitted to the hospital for ongoing management of her IUD. Please refer to the Integrated Care Pathway for Pregnancy Loss over 20 Weeks (ABUHB, 2026b).

Fetal Heart Concerns

Any concerns regarding the fetal heart must be escalated and referred to the maternity triage unit in the Grange University Hospital (GUH). Please refer to the Fetal Medicine Services Pathway for Referral and Management Guideline (ABUHB, 2024b).

Suspected Anomaly

Any woman with a suspected fetal anomaly should be referred to fetal medicine.

Presentation Scans

If a presentation scan is required as the presentation cannot be gauged through abdominal palpation, the following should be performed/ captured-

- Assessment of the fetal heart rate
- The presentation labelled with body mark and annotated accordingly
- Biometry is not required

If a non-cephalic presentation is identified at/ post 36-weeks' gestation, please make an urgent appointment with an obstetrician in the antenatal clinic.

Criteria for Access to the Midwifery Ultrasound Service

The midwifery ultrasound service provides the following-

- Dating ultrasound scans
- Serial growth ultrasound scans
- Presentation ultrasound scans

The midwifery ultrasound service does **not** provide the following-

- Ultrasound scanning for multiple pregnancies

- Cervical length scanning
- Umbilical artery dopplers

All referrals to the midwifery ultrasound service **must** be completed via the Badgernet system.

The criteria for access to the midwifery ultrasound service is as below-

'Moderate' risk
Current Smoker/
Illegal Drug and/or alcohol misuse
Women ≥40yrs old at conception
Previous gastric bypass surgery
Booking BMI ≥35
Fibroid ≥6cm or multifibroid uterus

Table 1 Moderate SGA risk factors

'High' risk
Any previous pregnancy with evidence of FGR/placental insufficiency i.e. previous PET/ PIH with SGA/ FGR/ tailing growth
Evidence of tailing/slow growth on ultrasound
Evidence of abnormal Umbilical Dopplers
Previous early onset PET <32wks
Unexplained Oligohydramnios
Previous SGA <10th centile
Previous Stillbirth
Pre-existing HTN
Maternal Autoimmune conditions (see list below)
Drugs (e.g betablockers, chemotherapy agents)
Any renal impairment

Low Papp-A <0.41 MoM
IVF donor egg pregnancy
Previous Placental Abruption
Previous Hx of VTE
Current eating disorder under specialist care
BMI <18.5 PLUS eating disorder/medical condition affecting nutrition.
Current Cancer diagnosis
Maternal Cystic Fibrosis/PKU/Cyanotic CHD
Late Booker >20+0
X2 or more moderate risks

Table 2 High SGA risk factors

Risk factors that develop in pregnancy (list not exhaustive):

Pregnancy Induced HTN/Pre-eclampsia
Ongoing hyperemesis >20wks
Unexplained APH >20wks requiring hospital admission
2 vessel umbilical cord
Echogenic bowel
Gestational Diabetes

Table 3 SGA risk factors that develop in pregnancy

In the presence of the above risk factors, surveillance should start at 28-weeks or as soon as risk factors develop if >28-weeks' gestation.

Autoimmune conditions (list not exhaustive)

- Diabetes including GDM
- APLS
- SLE
- Sjogren's
- Hyperthyroidism (inc treated and now hypothyroid)

- Addison's Disease
- Multiple Sclerosis
- Crohn's
- Ulcerative Colitis
- Coeliacs

Drugs (list not exhaustive):

- Betablockers
- Chemotherapy agents
- Warfarin
- Regular steroids
- Biologics

Any woman deemed at high risk should be considered for uterine artery dopplers between 18- 24-weeks at their Lead Consultant Obstetrician's discretion. This allows for an additional scan at 24 weeks for EFW, umbilical doppler and amniotic fluid measurement if uterine artery dopplers are abnormal.

Scan at 34 and 38wks	**Tick**
IVF pregnancy (OWN EGG)	
Previous LFDs	
Previous baby NICU admission for cooling	
X3 consecutive miscarriages	
Previous second trimester miscarriage	

Table 4 Other risk factors

6. Roles and Responsibilities

It is the responsibility of the multidisciplinary team to ensure that this guideline is adhered in the context of the midwifery ultrasound service within Aneurin Bevan University Health Board.

7. Consultation

All new or significantly revised policies will be subject to consultation within the division via the Clinical Effectiveness Forum (CEF) and with relevant professional groups and/ or individuals present.

Individuals with expertise in obstetrics, midwifery and ultrasonography have been consulted with in the development of this policy.

8. Equality Impact Assessment

An equality impact assessment has been carried out and approved as this guideline prioritises care based on standardised assessment and clinical need.

9. Training Requirements

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical/ educational supervision.

10. Audit and Review

This policy will be reviewed on a 3-yearly basis, unless significant changes to clinical practice/ national policy arise.

Maternal/ neonatal outcomes will be monitored via the local maternity dashboard. Adverse maternal/ neonatal outcomes will be reviewed on an individual basis via local governance arrangements.

All instances of missed SGA diagnosed at the time of birth are audited by the Ultrasound Governance Lead for Maternity Services, with review of USS frequency, USS quality and to generate a % error. This data is also provided to the Perinatal Institute for the purpose of taxonomy generation and national oversight.

In addition to the above, audits assessing CRL and NT measurements are completed by the Ultrasound Governance Lead for Maternity Services. In

the event that concerns are identified regarding USS quality, one-to-one support is provided an individual basis by the Ultrasound Governance Lead for Maternity Services.

Down's Syndrome Quality Assurance Support Service (DQASS) also undertakes independent audit and statistical monitoring to ensure accuracy in calculating risks for Down's, Edward's, and Patau's syndromes. Any concerns identified regarding USS quality is flagged to the Ultrasound Governance Lead for Maternity Services for ongoing management.

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12. Appendices

Appendix 1- Antenatal Risk Factors for SGA

Scans max 4wks apart from 28wks or from diagnosis	**Tick**
Any evidence of previous FGR/placental insufficiency, i.e. previous PET/ PIH with SGA/ FGR/ tailing growth	
Previous SGA <10th centile	
Previous Stillbirth	
Pre-existing HTN	

PIH/PET this pregnancy	
Maternal Autoimmune conditions (see list)	
Drugs (e.g betablockers, chemotherapy agents)	
Any renal impairment	
Low Papp-A <0.41 MoM	
Ongoing hyperemesis >20wks	
Unexplained APH requiring hospital admission	
IVF donor egg pregnancy	
Previous Placental Abruption	
Previous Hx of VTE	
Current eating disorder under specialist services	
BMI <18.5 PLUS current eating disorder/medical condition affecting nutrition.	
Cystic Fibrosis/PKU	
Maternal Cyanotic CHD	
Current Cancer diagnosis	
X2 or more moderate criteria	
2 vessel umbilical cord	
Fetal Echogenic Bowel	
Gestational Diabetes	
Late booker >20+0 gestation	
Other – please justify	

Scan from 32wks max 4wks apart	**Tick**
Current Smoker at booking	
Illegal Drug and any alcohol misuse	
Women ≥40yrs old at conception	
Previous gastric bypass surgery (NOT gastric band)	
Booking BMI ≥35	
Fibroid ≥6cm or multifibroid uterus	
X2 moderate risk factors – REFER TO HIGH RISK	

Scan at 34 and 38wks	**Tick**
IVF pregnancy (OWN EGG)	
Previous LFDs	
Previous baby NICU admission for cooling	

X3 consecutive miscarriages	
Previous second trimester miscarriage	

Scans x2 max 4wks apart to assess growth trajectory	**Tick**
SFH - <10th centile or static growth	

Print …… Sign …… Date ……/……/……