Maternal Newborn Triage Form

Date/ Time to MNB:_____
_____

Arrived from:
- ☐ Home
- ☐ Clinic
- ☐ ER

Chief Complaint:
- ☐ Contractions
- ☐ Leaking of Fluid
  - Time: _____
  - Color: _____
  - Amt: _____
- ☐ Bleeding
- ☐ Decreased FM
- ☐ Abdominal Pain
- ☐ Visual Changes
- ☐ Edema/Swelling
- ☐ Headaches
- ☐ Nausea/Vomiting
- ☐ Scheduled NST
- ☐ Other:

Domestic Violence:
☐ Yes ☐ No

Name: _____
SSN:_____
Doctor:_____
Age:_____ **G** _____ **P** _____ **AB** _____ **L** _____
EDC: _____ **Gestational Age:** _____
Allergies: _____
Medications:

Nursing Notes:_____

NST Please circle: **Reactive/Non-Reactive/NA**

Time			
BP			
Temp			
Pulse			
Resp			
Pain 0-10 site→			
FHR			
LTV			
CTX Freq/ palp			

SSE: – / + Pooling
– / + Nitrazine
– / + Ferning

SVE

Time			
Cm			
Effacement			
Station			
Exam by			

Labs: ☐ UA/C&S ☐ CBC
☐ PIH ☐ Abruption
☐ Other:

IV: gauge: _____site_____
start @: _____
LR @:_____or_____

Meds:

Time			
Name			
Dose			
Route			
Init.			

Doctors Orders: MD notified @ _____ of patient status.

Doctors Notes:

Disposition:
- ☐ Admit @ _____
- ☐ DC to home @ _____
- ☐ Transfer @ _____

Follow-up Care:
- ☐ Follow-up appt @ _____

_____
RN signature/Initials

_____
MD signature

Addressograph

NHROTA 3655-10