MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*	ISSUANCE DATE
LOCAL FORM TITLE *(Optional)*	

Reason for Hospital Admission

- ❒ Spontaneous Active Labor - uterine contractions associated with progressive dilation of the cervix.
- ❒ Augmentation of Labor - uterine contractions insufficient to make changes in dilation of the cervix. However, admission is warranted for obstetric or other medical indications.
- ❒ Induction of Labor - absence of significant uterine contractions.
- ❒ Spontaneous Rupture of Membranes

Reason for Induction or Augmentation of Labor

- ❒ Post term pregnancy - greater than or equal to 41 weeks gestation
- ❒ Premature Rupture of Membranes (PROM) - amniotic fluid leak prior to onset of labor
- ❒ Gestational Hypertension - pregnancy-related high blood pressure
- ❒ Preeclampsia - pregnancy-related high blood pressure associated with urine protein
- ❒ Severe Preeclampisa - pregnancy-related very high blood pressure associated with urine protein
- ❒ Chronic Hypertension - high blood pressure prior to pregnancy
- ❒ Pregestational Diabetes - diabetes prior to pregnancy
- ❒ Gestational Diabetes, Type A1 - pregnancy-related diabetes, not requiring medication
- ❒ Gestational Diabetes, Type A2 - pregnancy-related diabetes, requiring Insulin or Glyburide
- ❒ Intrauterine Growth Restriction (IUGR) - extremely small size of baby
- ❒ Oligohydramnios - very low levels of amniotic fluid
- ❒ Previous Stillbirth
- ❒ Logistics / Psychosocial -_____

  _____

- ❒ Abnormal Antenatal Testing -_____
- ❒ Other - _____

Confirmation of Fetal Maturity

Establishing that your pregnancy has completed 39 weeks of gestation can greatly diminish the risk of fetal pulmonary (lung) problems in the newborn. Unless you are already in labor, it is inappropriate to induce/augment delivery of your baby prior to 39 weeks. If an important maternal-fetal medical condition is present (such as those listed above), then induction/augmentation may be appropriate. Fetal maturity has been confirmed by:

- ❒ Ultrasound measurement at less than 20 weeks of gestation supports gestational age of 39 weeks or greater.
- ❒ Fetal heart tones have been documented as present for 30 weeks by Doppler technique.
- ❒ It has been 36 weeks since a positive serum or urine hCG pregnancy test result.
- ❒ Amniocentesis: FLM _____
- ❒ The gestational age is recognized to be less than 39 weeks, but the maternal-fetal medical condition(s) warrant delivery at this time.

The Gestational Age of this pregnancy is: _____ weeks, ____ days.

Estimate of Fetal Weight: _____ pounds, or _____ grams.

Fetal Presentation: _____, assessed by ultrasound / pelvic exam *(circle)*.

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

Maternal Pelvis

The pelvic anatomy and pelvic size of most women is sufficient that a trial of labor can be undertaken.
Some women have a very small pelvic outlet, and would be advised to consider cesarean delivery instead.

❒ Unproven, but assessed to be adequate for this estimated fetal weight.
❒ Proven to _____ lbs., and assessed to be adequate for this estimated fetal weight.
❒ Likely inadequate for this estimated fetal weight.

Cervix: _____ / _____ / _____ / _____ / _____
dilation effacement station consistency position

Bishop Score Total: _____

Dilation:	(0) Closed	(1) 1-2 cm	(2) 3-4 cm	(3) 5-6 cm
Effacement:	(0) 0-30%	(1) 40-50%	(2) 60-70%	(3) 80%
Station:	(0) -3	(1) -2	(2) -1, 0	(3) +1, +2
Cervix Consistency:	(0) Firm	(1) Medium	(2) Soft	
Cervix Position:	(0) Posterior	(1) Middle	(2) Anterior	

INITIAL PLAN OF CARE *(check all that apply)*

Cervical Ripening
❒ Misoprostol (Cytotec)
❒ Dinoprostone (Cervidil,Prepidil)
❒ Balloon Device

Labor Induction and/or Augmentation
❒ Oxytocin (Pitocin)
❒ Oxytocin (Pitocin) - possibly later
❒ Amniotomy (breaking bag of water)

❒ Observation of Labor

I certify that the information above is correct, and that I have discussed the indication(s) for hospital admission with the patient, alternatives, and outlined a reasonable plan of care for her delivery. I have offered to answer any questions, and have answered fully to those questions. I believe that the patient understands what I have explained and has consented to the outlined plan of care.

_____ _____
Signature & Stamp of Attending Physician or Nurse-Midwife *Date & Time*

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	

PATIENT ACKNOWLEDGMENT OF COUNSELING FOR LABOR ADMISSION, INDUCTION, AND/OR AUGMENTATION

(Page 3 only to be used in conjuction with Essentris Note NHJE Labor and Delivery History and Physical)

Privacy Act Statement: The authority to request this information is contained in 5 U.S.C. Section 301 and Department Regulation.

Patient Initial each Item below:

_____ 1. I understand the reasons (indications) for my hospital admission, and the reasons recommended for observation, cervical ripening, induction, and/or augmentation of labor.

_____ 2. I understand that most women who undergo induction of labor will delivery vaginally (naturally). However, the likelihood of eventual cesarean delivery is increased with induction/agumentation, when compared to women in spontaneous labor.

_____ 3. I understand the most common techniques and medicines for cervical ripening, induction, and augmentation of labor. I understand there are side effects and risks associated with theses medicines.

_____ 4. I understand an alternative to hospital admission is to await spontaneous labor or leaking amniotic fluid.

_____ 5. The attending physician or nurse-midwife has outlined an initial plan-of-care with me, and I agree this is the best option at this time.

_____ 6. I understand that medical circumstances may change. The labor and delivery of my baby is a dynamic process, requiring constant assessment and re-evaluation by my health care team. I am empowered to contribute to the decision making process.

_____ 7. I understand that cesarean delivery is not recommended at this time. I may discuss elective cesarean delivery with a credentialed physician at any time, upon my request.

_____ 8. I have read (or have had read to me) the above information, and I understand it. I will let my healthcare team know if I want to change my decisions. I have received all of the information I want, and all of my questions have been answered to my satisfaction.

_____ _____

Signature of Patient *Date & Time* *Signature of Witness* *Date & Time*

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	