# 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)* | |

Admit to: ☐ 4OB ☐MS 5 Service: ☐OB ☐FP ☐CNM

1. Providers/Attending:_____
2. Condition: _____
3. Allergies / Reaction:_____
4. Rh status: ☐ Positive ☐Negative: Administer RHOGAM per protocol
5. Rubella: ☐Immune ☐Non- immune/Equivocal: Administer MMR VACCINE per protocol
6. Assist with breastfeeding PRN
7. Vitals with fundus & lochia checks q 15" x4, then q 30" x2, then q1hr x4, then BID
8. Regular diet
   IV: 1000mL LR with 20 units pitocin, bolus & titrate to fundal firmness, then LR with 20 units pitocin
9. at 125mL/hour
   May discontinue IV if stable once 2L LR with pitocin complete, once pt is afebrile, tolerating po intake, and lochia minimal. Contact M.O. if criteria for IV discontinuation not met after 2L IV fluid complete
10. Up with assistance initially, then activity ad lib
11. Ice pack to perineum and sitz baths PRN perineal discomfort
12. Due to void in 6 hours; contact M.O. if unable to void
13. Labs: CBC on PPD 1 _____
14. Call M.O. for: heavy bleeding, severe pain, Temp >100.4$^{F}$ (>38$^{C}$), Pulse >120 or <60, RR >30 or <10, SBP >160 or <80, DBP >110 or <50, UOP <30 ml/hr x 2hr, or other emergent concerns
15. Epifoam, Dibucaine, and witch hazel pads to bedside with instructions to use per package directions
16. ☐Ibuprofen 800mg PO q 8 hrs with food
17. ☐Acetaminophen 650mg PO q 4 hours PRN mild pain/temp above 100.4F
18. ☐Prenatal Vitamin 1 tab PO daily.
19. ☐Surfak (docusate calcium 240mg) 1 cap PO daily
20. ☐Ferrous Sulfate (325mg) 1 tab PO daily
21. ☐Vitamin C 500mg 1 tab PO daily; give with ferrous sulfate
22. ☐Simethicone 80 mg PO four times daily PRN gas pain
23. ☐Naprosyn 500mg po BID with food

Other: _____

_____

RN signature (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 |
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