

OBSTETRICAL ASSESSMENT AND TRIAGE RECORD																																													
Naval Hospital, Oak Harbor																																													
Date: ___/___/___ Time: _____																																													
Provider: _____ Contacted By _____ Time: _____	Allergies/Sensitivity: <input type="checkbox"/> None <input type="checkbox"/> Latex <input type="checkbox"/> Other _____ _____ _____																																												
Prenatal Record Available: <input type="checkbox"/> Yes <input type="checkbox"/> No Last Clinic Visit: / /	General Health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Poor Significant History or OB Medical Complications: _____ _____																																												
Patient Arrived Via: <input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher Other: _____	Medications/Drugs/herbs: <input type="checkbox"/> None <table style="width:100%; border-collapse: collapse;"> <tr> <th style="width:40%;">Type/Dose</th> <th style="width:20%;">Last taken</th> <th style="width:40%;">With Patient</th> </tr> <tr> <td>_____</td> <td>_____</td> <td>Yes / No</td> </tr> </table>	Type/Dose	Last taken	With Patient	_____	_____	Yes / No	_____	_____	Yes / No	_____	_____	Yes / No	_____	_____	Yes / No																													
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Support Persons: _____ FOB involved: <input type="checkbox"/> Yes <input type="checkbox"/> No Name _____	Tobacco Use: <input type="checkbox"/> No <input type="checkbox"/> Yes Amount _____ Alcohol Use: <input type="checkbox"/> No <input type="checkbox"/> Yes Amount _____ Free from apparent physical and emotional abuse <input type="checkbox"/> Yes <input type="checkbox"/> No _____																																												
Reason For Visit: <input type="checkbox"/> R/O labor <input type="checkbox"/> Bleeding <input type="checkbox"/> R/O SROM <input type="checkbox"/> R/O PROM <input type="checkbox"/> Decreased Fetal Movement <input type="checkbox"/> Preeclampsia/HTN <input type="checkbox"/> Hyperemesis <input type="checkbox"/> Trauma _____ <input type="checkbox"/> Other _____	Communications Barriers: <input type="checkbox"/> None <input type="checkbox"/> Other: _____ <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%;">G</td> <td style="width:12.5%;">P-</td> <td style="width:12.5%;">AB</td> <td style="width:12.5%;">LB</td> <td style="width:12.5%;">LMP</td> <td style="width:12.5%;">EDC</td> </tr> </table>	G	P-	AB	LB	LMP	EDC																																						
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	Last Oral Intake: Fluids ___/___/___ Time: _____ Solids ___/___/___ Time: _____																																												
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	Miscellaneous: _____ _____																																												
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Patient Symptoms: <input type="checkbox"/> Pam (0-10) _____ Location _____ Chronic/Acute <input type="checkbox"/> Contractions: Onset: ___/___/___ @ _____ Frequency _____ Strength _____ <input type="checkbox"/> Leaking Amniotic Fluid: Onset: ___/___/___ @ _____ Color: <input type="checkbox"/> Clear <input type="checkbox"/> Bloody <input type="checkbox"/> Meconium Other: _____ <input type="checkbox"/> Vaginal Bleeding: Onset: ___/___/___ @ _____ <input type="checkbox"/> None <input type="checkbox"/> Bloody Show <input type="checkbox"/> Frank bleeding (associated) with abd. pain	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th>Time</th> <th>Medication</th> <th>Dose</th> <th>Route/Site</th> <th>Signature</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Time	Medication	Dose	Route/Site	Signature																																							
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Fetal Activity: <input type="checkbox"/> Present <input type="checkbox"/> Diminished <input type="checkbox"/> Absent Vaginal Exam: <input type="checkbox"/> None <input type="checkbox"/> SVE <input type="checkbox"/> Sterile Speculum Exam (findings: _____) Membranes: <input type="checkbox"/> Intact <input type="checkbox"/> Leaking <input type="checkbox"/> Ruptured <input type="checkbox"/> Nitrazine (pos/neg) Urinary: <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Urgency <input type="checkbox"/> Dysuria	INTAKE (IV)																																												
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ADDRESSOGRAPH _____ _____ _____	Test: NST. <input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive <input type="checkbox"/> US/BPP Follow up findings: _____ _____																																												
	DIAGNOSIS AND DISPOSITION																																												
	Diagnosis: <input type="checkbox"/> False Labor <input type="checkbox"/> Active Labor <input type="checkbox"/> Threaten PTL <input type="checkbox"/> UTI <input type="checkbox"/> Hyperemesis <input type="checkbox"/> Preeclampsia <input type="checkbox"/> Discomforts Other: _____ Disposition: <input type="checkbox"/> Admit <input type="checkbox"/> Transfer to: _____ <input type="checkbox"/> Discharge to home accompanied by _____ <input type="checkbox"/> Instructions _____ <input type="checkbox"/> Follow-up to: _____																																												
	Provider Signature _____ Date: ___/___/___ Time _____ RN Signature _____ Date: ___/___/___ Time _____																																												

