LABOUR SUMMARY AND DELIVERY RECORD - PART 1

Surname	Given name
Address	Home Community
Phone number	Date of Birth
Health Record #	HCP #

1. HOSPITAL / HEALTH CENTRE / BIRTHING CENTRE

Gravida	Term	Preterm	Abortion: Spontaneous ____ Therapeutic ____	Living	Ectopic

EDD *DD MM YYYY*	Gest. Age *Weeks + Days*	Blood Group & Type	Hgb on Admission

2. RISK FACTORS BEFORE LABOUR — GBS Status: □ Positive □ Negative □ Unknown

3. RISK FACTORS DURING LABOUR

ADMISSION:	Time:	Date: *DD MM YYYY*
Admission Weight: *kg*		Hep B Protocol: □ No □ Yes
Cervical Dilation on Admission: _________ cm		Trial of Scar (VBAC): □ No □ Yes
Pregnancy: □ Singleton	□ Twin A □ Twin B	□ Triplet A □ Triplet B □ Triplet C

4. LABOUR

□ None | □ Spontaneous | □ SROM | Date: *DD MM YYYY* Time: *00: 00*

□ Induced →	□ ARM	□ Oxytocin	□ Prostaglandin	□ Other: ____________	Indication/Comments:
	Date: *DD MM YYYY*		Time: *00: 00*	Performed by: □ Doctor □ Midwife	
□ Augmented →	□ ARM	□ Oxytocin	□ Other: ____________		Indication/Comments:
	Date: *DD MM YYYY*		Time: *00: 00*	Performed by: □ Doctor □ Midwife	

5. FETAL MONITORING

TYPE	NORMAL	ABNORMAL
Intermittent Auscultation		
External EFM		
Internal EFM		
IUPC		

FETAL BLOOD SAMPLING

Cord Blood Typing	□ Yes □ No
Cord Blood Gases UApH	
Lowest pH	

Liquor: □ Clear □ Meconium □ Bloody

TIME SUMMARY

	TIME	DATE
Membranes Ruptured		*DD MM YYYY*
1st Stage Started		*DD MM YYYY*
2nd Stage Started		*DD MM YYYY*
Baby Delivered		*DD MM YYYY*
Placenta Delivered		*DD MM YYYY*

DURATION

Stage	Hrs/Min
1st	
2nd	
3rd	

Duration of Ruptured Membranes: HOURS ____

6. CONSULTANTS

Obstetric / GP Obstetrics	Pediatric

7. BABY

Weight (g)	Sex	Stillbirth □ Antepartum □ Intrapartum	Fetal Autopsy: □ Yes □ No	Identification / Band No.

Congenital Malformations: | Health Record #

Umbilical Cord Complications / Abnormalities (2 vessel)

Placenta Abnormalities? □ No □ Yes (specify)

APGAR SCORES:

1 MIN	5 MIN	10 MIN

RESUSCITATION REQUIRED: □ Yes □ No

8. BLOOD LOSS

□ Estimated cc

□ Measured cc

9. ANALGESIA / ANAESTHESIA

	LABOUR	DELIVERY
Spinal		
General		
Narcotics		
50% NO_2, 50% O_2		
Local		
Pudendal		
Epidural		
Other		
None		

10. MEDICATION

MEDICATION	DOSE	ROUTE	TIME	DATE	SIGNATURE

Doctors/Midwife Present	Delivered By □ MD □ RM □ RN □ Other (specify): _________	Signature of Person Who Delivered Baby X
Others Present (Support person, family, etc.)	Nurse / Midwife Present	Nurse / Midwife Signature X

LABOUR SUMMARY AND DELIVERY RECORD - PART 2

Surname	Given name
Address	Home Community
Phone number	Date of Birth
Health Record #	HCP #

11. DELIVERY

Presentation & Position of Fetus: During Labour	At Delivery

12. VAGINAL DELIVERY

VBAC Eligible: □ Yes □ No
VBAC Attempted: □ Yes □ No

SPONTANEOUS	□ Easy	□ Moderate	□ Difficult
SHOULDER DYSTOCIA	□ Easy	□ Moderate	□ Difficult
(describe) ____			
VACUUM EXTRACTION	□ Low	□ Mid	□ Outlet
FORCEPS	□ Low	□ Mid	□ Outlet
	□ Traction	□ Mid-Moderate	□ Moderate-Severe
	□ Trial	□ Successful	□ Failed
ROTATION	□ Manual	□ Instrumental	
BREECH	□ Frank	□ Incomplete	□ ECV
	□ Complete		□ Breech Extraction
	□ Footling		□ Forceps

13. CAESAREAN DELIVERY

Cervical Dilation Prior to C-Section: ____________cm

Type:	□ Primary Elective □ Primary Emergency	□ Repeat Elective □ Repeat Emergency	□ N/A
Incision:	□ Low Segment Transverse □ Classical	□ Low Segment Vertical □ Other	□ N/A □ Unknown

List Indications in Order of Priority:

14. PERINEUM / VAGINA / CERVIX

□ Intact

□ Laceration □ 1st Degree □ 2nd Degree □ 3rd Degree □ 4th Degree

□ Episiotomy □ Median □ Mediolateral (□ Left □ Right) □ Extension

□ Cervical Tear □ Other Trauma: ____________________

Repair (specify): ____________

Performed by: ____________ Anaesthetic: ____________

15. ESTIMATED BLOOD LOSS:

□ < 500 mL □ 500-1000 mL □ >1000 mL

Measured: cc.

Blood transfusion:	□ No	□ Yes –Number of Units:	Intrapartum cc. Postpartum cc.

16. TRANSFER:

□ Intrapartum □ Postpartum **TO INSTITUTION:**____________

REASON FOR TRANSFER:

17. BIRTH INJURY

□ Cephalhematoma □ Fracture □ Nerve Paralysis
□ Other (specify): ____________________

18. THIRD STAGE

(Complications, Manual Removal, etc.)	Cord Clamping: □ <2 mins □ ≥ 2 mins

Placenta Complete?: □ Yes □ No

OTHER DELIVERY NOTES:

Signature – Attending Physician / Nurse / Midwife	Date
X	

19. PUERPERIUM

□ Normal □ Complications (specify)

□ Infection (Wound, UTI, etc.) (specify)

Rhogam: Eligible: □ Yes □ No
Date Given: DD MM YYYY

PP HgB
Date: DD MM YYYY Value:

Breastfeeding	Formula	Both

Contraception Offered: □ Yes □ No
Contraception Accepted: □ Yes □ No

POSTPARTUM FOLLOW-UP:

Pap Smear:	□ Yes	□ No
GDM Follow-Up:	□ Yes	□ No
Hypertension:	□ Yes	□ No
Rubella Vaccine:	□ Yes	□ No
Rhogam:	□ Yes	□ No

Mental Health/Post Partum Depression Assessment:
□ Not Done
□ Done → Referred □ Yes □ No

Discharge To: □ Home □ Other Med Facility
Discharge Time: 00: 00

20. PROGRESS NOTES:

Discharge Diagnosis:

Discharge Authorization: Signature	Date
X	