AGE:	RELIGION:	HOLY COMMUNION:	DIET:	TPR:	BP:	WT:	I & O:	OXYGEN

ACTIVITY:	EMERGENCY NOTIFY:	TELEPHONE:	ALLERGIES:

ROOM #:	NAME:	OB PHYSICIAN:	PEDIATRICIAN:
	LANGUAGE:		NOTIFIED: SEEN:

G / P:	AB:	BLOOD TYPE: GBS: Antibody Screen: Serology:	RHOGAM INDICATED:	DELIVERY DATE / TIME: TIME: DATE:	DELIVERY TYPE ☐ C-SECTION ☐ VAGINAL	ANESTHESIA ☐ Epid'l ☐ Spinal ☐ Gen'l ☐ Local ☐ Pudencal

NSY: ☐ TN ☐ SCN	SEX: ☐ M ☐ F	WT:	APGARS	GESTATIONAL AGE:	INFANT BLOOD TYPE:	COOMBS:	BR / BT:

CIRCUMCISION:

ST. ANN'S PT:

REQUESTED:

ADOPTION AGENCY:

PERMIT:

COMMENTS:

DONE:

MARITAL STATUS:	EDC:	PRENATAL CARE:	PRENATAL CLASSES:

SIGNIFICANT MEDICAL / SURGICAL Hx:

ANTEPARTUM COMPLICATIONS:

DELIVERY COMPLICATIONS:

EPISIOTOMY:

MEDICATIONS IN LABOR:

Special Notice: Mother

Special Notice: Infant

IV Fluids: Mother

TESTS / LAB STUDIES: MOTHER

DATE	LAB X RAY, OTHER TESTS	REQ	SCHED	COMPL
	DAILY			
	PRN			

DATE	TREATMENTS

TESTS / LAB STUDIES: INFANT

DATE ORDERED	DATE TO BE DONE	TEST	DATE ORDERED	DATE TO BE DONE	TEST

PKU:

T_4:

X RAYS:

TREATMENTS:

COMMENTS:

DISCHARGE PLANNING:

REFERRAL:	NEEDED:	MADE:
FOLLOWED-UP:	AGENCY:	

PATIENT PLANS AFTER DISCHARGE:

PATIENT RISK:
FACTORS IDENTIFIED:

SPECIFIC PATIENT TEACHING NEEDS	DATES TAUGHT

ASSESSMENT OF PATIENT AND FAMILY:

NURSING ORDERS

ROOM #:	NAME:	TYPE OF DELIVERY:	OB Physician Pediatrician	ADM DATE: