Your Hospital's Logo Here

OBSTETRIC ADMISSION DATABASE

ASSESSMENT PART II

PATIENT IDENTIFICATION

MEDICAL HISTORY

PREVIOUS HOSPITALIZATIONS: ☐ NO ☐ YES
DATE: REASON:

PREVIOUS BLOOD TRANSFUSION: ☐ NO ☐ YES
DATE: REASON: ☐ NO ☐ YES

RECENT EXPOSURE TO COMMUNICABLE DISEASE: ☐ NO ☐ YES

HERPES (HISTORY OF): ☐ NO ☐ YES
LAST OUTBREAK: CURRENT LESION? ☐ NO ☐ YES

STD: ☐ NO ☐ YES
TYPE: DATE: TX: ☐ NO ☐ YES

CHICKEN POX (RECENT EXPOSURE): ☐ NO ☐ YES

HIV (DRAWN IN PREGNANCY): ☐ NO ☐ YES
DATE: RESULT:

RPR / STS TESTING: ☐ NO ☐ YES
DATE: RESULT:

HBSAG (DRAWN): ☐ NO ☐ YES
DATE: RESULT:

GBS (GROUP BETA STREP) CULTURE: ☐ POS ☐ NEG
TX: ☐ NO ☐ YES

RUBELLA TITER DRAWN: ☐ NO ☐ YES | IMMUNE: ☐ NO ☐ YES

CHLAMYDIA: DATE: TX: ☐ NO ☐ YES

PREVIOUS SURGERY:

* HEART DISEASE: ☐ NO ☐ YES

* HYPERTENSION: ☐ NO ☐ YES

RESPIRATORY PROBLEM: ☐ NO ☐ YES

HEADACHE: ☐ NO ☐ YES

SEIZURE: ☐ NO ☐ YES

DIZZINESS: ☐ NO ☐ YES

* DIABETES: ☐ NO ☐ YES
TYPE / CLASS:

BACK INJURY: ☐ NO ☐ YES

UTI: ☐ NO ☐ YES
TX: ☐ NO ☐ YES DATE:

TEST OF CURE: ☐ POSITIVE ☐ NEGATIVE

VAGINAL INFECTIONS:
DATE: TX:

AMOUNT: LAST USED:

SMOKE: ☐ NO ☐ YES

OTHER COMMENTS:

CARDIOVASCULAR — LDR

SKIN: ☐ WARM, DRY ☐ COLD ☐ CLAMMY ☐ PALE ☐ CYANOTIC ☐ FLUSHED

RADIAL PULSE: _____ RATE _____ RHYTHM _____ QUALITY

EDEMA: LOCATION: AMOUNT:

POSTPARTUM UNIT

VITAL SIGNS: T _____ P _____ R _____ BP _____

SKIN: ☐ WARM, DRY ☐ COLD ☐ CLAMMY ☐ PALE ☐ CYANOTIC ☐ FLUSHED

RADIAL PULSE: _____ RATE _____ RHYTHM _____ QUALITY

EDEMA: LOCATION: AMOUNT:

RESPIRATORY — LDR

DYSPNEA: ☐ NO ☐ YES

BREATH SOUNDS: ☐ CLEAR ☐ WHEEZE ☐ RALES ☐ OTHER

COUGH: ☐ NO ☐ YES ☐ PRODUCTIVE ☐ NON-PRODUCTIVE

SPUTUM: ☐ NO ☐ YES COLOR: _____

POSTPARTUM UNIT

DYSPNEA: ☐ NO ☐ YES

BREATH SOUNDS: ☐ CLEAR ☐ WHEEZE ☐ RALES ☐ OTHER

COUGH: ☐ NO ☐ YES ☐ PRODUCTIVE ☐ NON-PRODUCTIVE

SPUTUM: ☐ NO ☐ YES COLOR: _____

NEUROLOGICAL — LDR

LOC: ☐ ALERT ☐ ORIENTED ☐ CONFUSED ☐ LETHARGIC

REFLEXES: _____ CLONUS: _____

MOTOR ACTIVITY: ☐ FULL ☐ PARTIAL ☐ ABSENT

POSTPARTUM UNIT

LOC: ☐ ALERT ☐ ORIENTED ☐ CONFUSED ☐ LETHARGIC

REFLEXES: _____ EPIDURAL: ☐ NO ☐ YES

MOTOR ACTIVITY: ☐ FULL ☐ PARTIAL ☐ ABSENT

* If "YES", request Physician's Order for NUTRITIONAL CONSULT

RN / LDR SIGNATURE & TITLE **DATE**

RN / PP SIGNATURE & TITLE **DATE**

RN / LDR SIGNATURE & TITLE **DATE**

PART OF THE MEDICAL RECORD

GASTRO-INTESTINAL — LDR

SPECIAL DIETARY NEEDS: _____

* NAUSEA: ☐ NO ☐ YES ONSET: _____

* OBESITY: ☐ NO ☐ YES WEIGHT: _____

* VOMITING: ☐ NO ☐ YES ONSET: _____

* DIARRHEA: ☐ NO ☐ YES ONSET: _____

* CONSTIPATION: ☐ NO ☐ YES ONSET: _____

* IF DAILY FOR 3 DAYS -or- UNEXPLAINED, INITIATE **NUTRITIONAL CONSULT**. LAST BM: _____

POSTPARTUM UNIT

ABDOMEN: _____

ABDOMINAL INCISION: _____

BOWEL-SOUNDS: _____

GENITO-URINARY — LDR

URINE FREQUENCY: ☐ NO ☐ YES

BURNING: ☐ NO ☐ YES

POSTPARTUM UNIT

VOIDING QS: _____ FOLEY CATH: _____

FUNDUS: HT: _____ CHARACTER: _____

LOCHIA: AMT: _____ PERINEUM: _____

BREASTS — LDR

BREASTS: ☐ SOFT ☐ DRAINAGE

NIPPLES: ☐ NORMAL ☐ FLAT ☐ INVERTED

POSTPARTUM UNIT

BREASTS: ☐ SOFT ☐ FILLING ☐ LACTATING

If BREAST FEEDING, INITIATE **NUTRITIONAL CONSULT.**

NIPPLES: ☐ ERECT ☐ FLAT ☐ INVERTED

PSYCHO-SOCIAL — LDR

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

FATHER OF BABY: ☐ INVOLVED ☐ UNINVOLVED

SUPPORT SYSTEM: ☐ AVAILABLE ☐ UNAVAILABLE

OF CHILDREN AT HOME: _____ AGES: _____

CHECK APPLICABLE CONDITIONS BELOW:

* PREVIOUS PP BLUES Hx ☐ NO ☐ YES

* DEPRESSION ☐ NO ☐ YES

* PSYCHOSIS ☐ NO ☐ YES

* FEELINGS OF HARM TO SELF / BABY WITH THIS PREGNANCY ☐ NO ☐ YES

* If "YES" to Any Above, request SOCIAL SERVICE CONSULT

FALL POTENTIAL / IMPAIRMENT — LDR

PHYSICAL DISABILITIES ☐ NO ☐ YES

LEARNING DISABILITIES ☐ NO ☐ YES

HEARING IMPAIRED ☐ NO ☐ YES

SIGHT IMPAIRED ☐ NO ☐ YES

SUBSTANCE USE ☐ NO ☐ YES

EPIDURAL / SPINAL ☐ NO ☐ YES

LANGUAGE BARRIER ☐ NO ☐ YES

OTHER (DESCRIBE BELOW) ☐ NO ☐ YES

_____

DISCHARGE PLANNING — POSTPARTUM UNIT

ALL - PREPARATION FOR INFANT HOMECOMING:

☐ CRIB ☐ CAR SEAT ☐ CLOTHING ☐ BOTTLES ☐ FORMULA

ADOLESCENT PATIENTS (12 - 19 YRS)

ADOLESCENT - INITIATE NUTRITIONAL & SOCIAL SERVICES CONSULTS

CURRENT SCHOOL GRADE _____ COLLEGE _____

HOW DO YOU LEARN BEST?

☐ VIDEOS ☐ BOOKS ☐ PICTURES

☐ LECTURES ☐ GROUPS ☐ INDIVIDUAL

CHILD CARE UPON RETURNING TO SCHOOL / WORK _____

HELP AT HOME ☐ PARENTS ☐ FATHER OF BABY ☐ OTHERS _____

SOURCE OF FINANCIAL SUPPORT ☐ SELF ☐ PARENTS

☐ OTHER (Explain): _____

IMMUNIZATION UP TO DATE ☐ NO ☐ YES ☐ UNSURE

*** (IF "NO" or "UNSURE", HANDOUT GIVEN?)** ☐ NO ☐ YES

REFERRALS — POSTPARTUM UNIT

BREAST FEEDING NUTRITIONAL CONSULT ☐ NO ☐ YES

ADOLESCENT NUTRITIONAL CONSULT ☐ NO ☐ YES

NUTRITIONAL CONSULT ☐ NO ☐ YES

SOCIAL SERVICES CONSULT ☐ NO ☐ YES

HOME CARE ☐ NO ☐ YES

WIC ☐ NO ☐ YES

ADOPTION ☐ NO ☐ YES

ST ANNS ☐ NO ☐ YES

OTHER: _____

RN / LDR SIGNATURE & TITLE **DATE**

RN / LDR SIGNATURE & TITLE **DATE**

RN / LDR SIGNATURE & TITLE **DATE**

PART OF THE MEDICAL RECORD

Your Hospital's Logo Here

OBSTETRIC ADMISSION DATABASE
ASSESSMENT PART II

PATIENT IDENTIFICATION

	NONE	WITH PT	HOME	HOSP SAFE
GLASSES:	☐	☐	☐	☐
CONTACTS:	☐	☐	☐	☐
DENTURES:	☐	☐	☐	☐
HEARING AID:	☐	☐	☐	☐
VALUABLES: Explain Policy	☐	☐	☐	☐

OTHER (SPECIFY): _____

UNIT ORIENTATION

ROOM	☐ LDR	☐ PP UNIT
NURSE CALL SYSTEM	☐ LDR	☐ PP UNIT
BED CONTROL	☐ LDR	☐ PP UNIT
PHONE / TV	☐ LDR	☐ PP UNIT
VISITING POLICY	☐ LDR	☐ PP UNIT
SMOKING POLICY	☐ LDR	☐ PP UNIT
VIDEO TAPING POLICY	☐ LDR	☐ PP UNIT
INFANT SECURITY	☐ LDR	☐ PP UNIT

LEARNING NEEDS ASSESSMENT

LDR

BREATHING / RELAXATION	☐ LDR	☐ PP UNIT
LABOR PROCESS	☐ LDR	☐ PP UNIT
COMFORT MEASURES	☐ LDR	☐ PP UNIT
PUSHING POSITIONS	☐ LDR	☐ PP UNIT
PRE-OP / POST OP C-BIRTH	☐ LDR	☐ PP UNIT

OTHER (SPECIFY): _____

POSTPARTUM UNIT

MATERNAL SELF CARE	☐ INITIAL	☐ REVIEW
INFANT CARE	☐ INITIAL	☐ REVIEW
BREAST FEEDING	☐ INITIAL	☐ REVIEW

OTHER (SPECIFY): _____

PLAN OF CARE / STANDARDS OF CARE IMPLEMENTATION

LDR

	IM	D	IN
CARE OF LABORING PATIENT			
ADMISSION PROTOCOL			
ANESTHESIA NSG MGMNT			
ELECTRONIC FETAL MONITORING			
NEWBORN: IMMEDIATE CARE OF			
CESAREAN BIRTH: RECOVERY FROM			
VAGINAL BIRTH: RECOVERY FROM			
PRETERM LABOR: MGMNT OF			
LABOR: INDUCTION / AUGMENTATION			
PIH / PREECLAMPSIA: MGMNT OF			
PAIN MANAGEMENT			
OTHER (SPECIFY):			

POSTPARTUM UNIT

	IM	D	IN
CESAREAN BIRTH: RECOVERY FROM			
VAGINAL BIRTH: RECOVERY FROM			
DAILY CARE: POSTPARTUM MATERNAL			
DAILY CARE: POSTPARTUM INFANT			
LATCH TOOL			
ADOLESCENT: PT CARE STANDARD			
PAIN MANAGEMENT:			
OTHER (SPECIFY):			

IM = Implemented **D** = Demonstrated **IN** = Initials

RN / LDR SIGNATURE & TITLE **DATE**

RN / PP SIGNATURE & TITLE **DATE**

RN / LDR SIGNATURE & TITLE **DATE**

PART OF THE MEDICAL RECORD

NURSING NOTES		
DATE:	**TIME:**	

PART OF THE MEDICAL RECORD