Your Hospital's Logo Here

DATE:

PATIENT IDENTIFICATION

VITAL SIGNS				FETAL HEART RATE					CONTRACTIONS					OB ASSESSMENT					O_2
TIME	TEMP	B P	PULSE / RESP	MONITOR MODE	BASELINE	VARIABILITY	ACCELERATION	DECELERATION	MONITOR MODE	FREQUENCY	DURATION	INTENSITY	RESTING TONE	EFF / DIL	STATION	MEMBRANES	PRESENTATION	EXAMINER	FLOW / TYPE

PART OF THE MEDICAL RECORD

PATIENT IDENTIFICATION

OTHR	C N S			TEACHING		EPIDURAL				INFUSIONS				AMNIO-INFUSION	INTAKE		OUTPUT		
MATERNAL POSITION	REFLEXES R / L	CLONUS R / L	OTHER	TEACHING CODE	PATIENT RESPONSE	SENSORY LEVEL	MOTOR LEVEL	BLADDER CHECK	AMOUNT INFUSED			PITOCIN MU / MIN	MAGNESIUM SULFATE GM / HR	INFUSED / △ PAD	IV CODE	ORAL	URINE	EMESIS	INITIALS

PART OF THE MEDICAL RECORD

PATIENT IDENTIFICATION

DATE	TIME	NURSING NOTES

ALLERGIES

MEDICATIONS Drug / Dose / Site / Route	Date / Time	Initials

INTAKE / OUTPUT TOTALS		
12^{O} Total		
12^{O} Total		
24^{O} Total		

INITIALS	NURSE SIGNATURE / TITLE

PART OF THE MEDICAL RECORD

EPIDURAL ANESTHESIA RECORD

PATIENT IDENTIFICATION

CATHETER PLACED BY: _____ MD

BOLUS:

DATE: TIME:

CONTINUOUS INFUSION: ☐ Y ☐ N

SOLUTION:

INITIAL RATE _____ ml / hr

ADJUSTED RATE _____ ml / hr

DATE: TIME:

REDOSE BOLUS:

DATE: TIME:

GIVEN BY:

PRIMARY DOSE						REDOSE					
DATE / TIME	BP	PULSE	FHR	NOTE	INITIALS	DATE / TIME	BP	PULSE	FHR	NOTE	INITIALS

DISCONTINUATION OF EPIDURAL INFUSION

CATHETER D/C'd BY: _____ DATE: TIME:

AMOUNT INFUSED: _____ AMOUNT WASTED: _____

WASTED BY: NURSE'S SIGNATURE / TITLE: NURSE'S SIGNATURE / TITLE:

INFUSION RECORD

DATE UP	TIME UP	IV SOLUTION	AMOUNT UP	RATE	NURS INITL	DATE DOWN	TIME DOWN	AMOUNT IN	NURS INITL	CONT. PUMP(/)	AMOUNT WASTED

INITIALS:	NURSE'S SIGNATURE / TITLE:	INITIALS:	NURSE'S SIGNATURE / TITLE:
INITIALS:	NURSE'S SIGNATURE / TITLE:	INITIALS:	NURSE'S SIGNATURE / TITLE:

PART OF THE MEDICAL RECORD

INFUSION CODES

SITE CODES

RLA = R Lower Arm
RH = R Hand
RAC = R Antecubital
LLA = L Lower Arm
LH = L Hand
LAC = L Antecubital

IV CODE / SITE EVALUATION

O = Site without redness, warmth, swelling, induration
S = Symptomatic (see comments)
D/C = Discontinued
X = Other (see comments)

SITE CODES

↑ = New Bag
△ = Tubing
√ = Dressing Change
● = See Progress Record
( ) = Solution Amount Started

DEVICE / REGULATOR CODES

P = Pump (type)
Q = Quick Cath

TEACHING CODES

1. LDR Orientation
2. External FHR Monitoring
3. Internal FHR Monitoring
4. Breathing / Relaxation
5. Positions for Labor
6. Analgesia
7. Anesthesia
8. Medications
9. Induction / Augmentation
10. Positions for Pushing
11. NST / CST / OCT
12. Amniocentesis
13. Ultrasound / BPP
14. Labor Precautions
15. Preterm Labor
16. Transfer
17. Discharge
18. Amniotomy
19. Meconium
20. Amnionfusion
21. Diabetes
22. FDU
23. Chronic Hypertension
24. Pre-Eclampsia
25. Eclampsia
26. Pre-OP
27. Cesarean Birth
28. Post-Op
29. PCA
30. APS
31. Foley Catheter
32. IV Therapy
33. Immediate Newborn Care
34. Breastfeeding
35. Nursery Orientation

RESPONSES

V = Verbalizes understanding
R = Review Needed
* = See Progress Notes

ASSESSMENT CODES

FETAL HEART RATE

Monitor Mode
US = Ultrasound
SE = Spiral Electrode

Variability (amplitude range)
O = Absent (undetectable)
↓ = Minimal (5 bpm or less)
N = Moderate (6 bpm - 25 bpm)
↑ = Marked (26 bpm or greater)

Accelerations
+ = Present
O = Absent
less than 32 wks EGA: 10 bpm x 10 sec
32 or greater wks EGA: 15 bpm x 15 sec

Decelerations
+ = Present *
O = Absent
E = Early
V = Variable *
L = Late *
P = Prolonged *

* Requires comments in Nursing Notes regarding interventions & evaluation.

UTERINE CONTRACTIONS

Monitor Mode
T = Tocodynamometer
IUPC = Intrauterine Pressure Catheter

Intensity
1+ = Mild
2+ = Moderate
3+ = Strong

Resting Tone
P = Palpated Soft
(IUPC) = mmHg

OB ASSESSMENT

Membrane
I = Intact
I_B = Intact Bulging
R_A = Artificial Rupture
R_S = Spontaneous Rupture

Presentation
Vtx = Vertex
BR = Breech
T = Transverse
U = Undetermined

MATERNAL POSITION

R Lat = Right Lateral
L Lat = Left Lateral
S = Supine
SF = Semi-Fowlers
HF = High Fowlers
T = Trendelenberg
KC = Knee Chest

CNS

Reflexes
O = Absent
1+ = Minimal
2+ = Normal
3+ = Elevated
4+ = Hyperactive
may exhibit clonus

Clonus
# of Beats Counted

Other
E = Epigastric Pain
H/A = Headache
V = Visual Disturbances

EPIDURAL

Sensory Level
T4 = Nipple Level *
T6 = Xiphoid Level *
T8 = Lower Ribs
T10 = Umbilicus
T12 = Lower Abd

Motor Function
0 = Unable to move toes or bend knees
1 = Able to move toes; unable to bend knees
2 = Able to move toes & bend knees; but weak
3 = Able to move toes & bend knees easily
4 = Ambilating, if appropriate

* Requires notification of Anesthesia

AMNIOINFUSION

Pad
Y = Yes
N = No

OXYGEN

Flow
Liters per Minutes

Type
M = Mask
NC = Nasal Cannula

Bladder Check
P = Palpable
N = Nonpalpable

STANDARDS OF CARE

LABOR - HIGH RISK

1st Stage
1. BP, P, R, FHR & UA evaluated q 30 min during latent phase
2. BP, P, R, FHR & UA evaluated q 15 min during active phase
3. Temp q 4 hours with intact membranes
4. Temp q 2 hours with ruptured membranes
5. Temp q 1 hour if greater than 100.4

2nd Stage
1. BP, P, R every 15 min
2. FHR and UA evaluated every 5 min
3. Temp as above

LABOR - LOW RISK

1st Stage
1. BP, P, R, FHR & UA evaluated q 1 hour during latent phase
2. Temp as High Risk
3. BP, P, R, FHR & UA evaluated q 30 min during active phase

2nd Stage
1. BP, P, R, FHR & UA evaluated every 15 min
2. Temp as High Risk

Epidural
1. BP, P & FHR every 3 min for at least 20 minutes, then per Standard of Care
2. Remain at Bedside x 20 min
3. Oxygen at 8-10L/min per FM
4. Assess sensory level q 1 hr
5. Assess bladder status q 1 hr
6. Assess motor function q 1 hr
7. Record volume infused q 1 hr

MAGNESIUM SULFATE THERAPY

PREECLAMPSIA
1. BP, P, R, FHR & UA evaluation q 30 min
2. Temp as in active labor
3. Bedrest
4. Strict I & O q 1 hour
5. Foley Catheter per MD order
6. Reflexes q 2 hours
7. Mg levels per MD order

PRETERM LABOR
1. BP, P, R, FHR & UA evaluation q 1 hour
2. Strict I & O q 1 hour
3. Foley Catheter per MD order
4. Reflexes q 2 hours
5. Mg levels per MD order
6. Temp as in Active Labor
7. Bedrest

INDUCTION / AGUMENTATION

Pitocin
1. BP, P, R, FHR & UA evaluation with each adjustment to Pitocin rate or every 30 min
2. Temp as in active labor
3. Bedrest
4. Hourly intake
5. Measure all voids
6. Continuous EFM

Cervidil / Prepidil
1. BP, P, R, FHR & UA evaluation prior to insertion; then q 1 hour
2. Continuous EFM
3. Bedrest x 2 hours post insertion, then BRP if FHR tracing reassuring.

Cytotec
1. BP, P, R, FHR & UA evaluation prior to insertion; then q 30 min x 2 hrs; then q 1 hr if Pt is contracting < q 5 min.
2. Continuous EFM
3. Bedrest x 4 hrs post insertion; then BRP if FHR tracing reassuring.

PART OF THE MEDICAL RECORD

LABORATORY REPORTS

DATE / TIME			URINALYSIS	DATE	TIME	ADDITIONAL NURSING NOTES
WBC			APPEARANCE:			
Hg						
Hct			COLOR:			
PT						
PTT			Sp. Gravity 1.0 _____			
PLATELETS			pH:			
FIGRINOGEN			Protein:			
D-DIMER			Nitrite:			
GLU			Glucose:			
BUN			Ketones:			
Na+			Bilrubin:			
K+			Occult Blood:			
Cl			Urob. EU/dl			
CO2			Leukocytes:			
CR						
ALK PHOS			**MICROSCOPIC**			
LDH			Epith:			
SGOT			Mucus:			
SGPT			Bacteria:			
URIC ACID			Casts:			
TOTAL PROTEIN						
			Crystals:	**FINGERSTICK BLOOD SUGARS**		

Magnesium Sulfate Level Drawn	RESULT / TIME		DATE / TIME	RESULTS	DATE / TIME	RESULTS
		Amorphous:				
		Yeast:				
		Trichomas:				

PART OF THE MEDICAL RECORD