### UNIVERSITY MEDICAL CENTER

**ANTEPARTUM/ LABOR & DELIVERY/ POSTPARTUM ADMISSION PROFILE**

**PART I: ADMISSION TO L&D OR ANTEPARTUM**

**Date:** ________  **Time:** ________ A.M. / P.M.

<table>
<thead>
<tr>
<th>Valuables</th>
<th>N/A</th>
<th>Sent Home</th>
<th>Placed in Safe</th>
<th>Remains at Bedside</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dentures/Partial/Caps</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyeglasses/Contacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Aid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clothing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Valuables:** I fully understand that HUMC is not responsible for any personal property brought in or retained at the bedside at anytime. I fully understand that HUMC provides a safe for my valuables should I wish to place them there for the duration of my hospital stay.

**Signature of Patient/Significant Other:**

**Witness:**

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**INTRODUCTORY INFORMATION**

- **Admitted from:**
  - ❑ Admitting
  - ❑ MD's Office
  - ❑ E.T.D.
  - ❑ Home
  - ❑ Other:

- **Via:**
  - ❑ Ambulatory
  - ❑ Stretcher
  - ❑ Wheelchair
  - ❑ Accompanied by:

- **Source of Information (if other than patient):**
  - Name: ___________________________
  - Relationship: __________________

- **History Deferred:**
  - ❑ Yes (reason)

- **S/O Labor Support:**
  - ___________________________
  - Relationship __________________

- **Primary Language:**
  - ___________________________
  - Interpreter Required: ❑ Yes ❑ Understands English ❑ Reads English

- **Obstetrician:**
  - ___________________________
  - ❑ Notified
  - Time: __________________
  - AM / PM By: __________________

- **Pediatrician:** ___________________________

- **Reason for Admission/Chief Complaint (per PT/So):**

  - ❑ Onset of Labor
  - ❑ Induction of Labor
  - ❑ Cesarean Section:
  - ❑ Primary
  - ❑ Repeat
  - Reason for Primary ___________________________
  - ❑ VBAC
  - ❑ Vaginal Bleeding
  - ❑ PROM
  - ❑ Pre-term Labor
  - ❑ NST/CST
  - ❑ Other:

- **Contractions:**
  - ❑ Regular
  - ❑ Began on: ___________________________
  - ❑ at: __________________ AM / PM
  - ❑ Freq: q __________ min. x __________ sec.

  - ❑ None
  - ❑ Irregular

  - Quality: Mild / Moderate / Strong

- **Membranes:**
  - ❑ Intact
  - ❑ Ruptured
  - Date: / / 
  - Time: __________________ AM / PM

- **Fluid:**
  - ❑ Clear
  - ❑ Bloody
  - ❑ Foul Smell
  - ❑ Mec. Stained
  - ❑ Unknown

- **Vaginal Bleeding:**
  - ❑ None
  - ❑ Normal Show
  - ❑ Bleeding (describe):

---

**Mother's Age**

<table>
<thead>
<tr>
<th>LMP / Unknown</th>
<th>Est. G.A. Weeks</th>
</tr>
</thead>
</table>

**BIRTHS:**

<table>
<thead>
<tr>
<th>Gravida</th>
<th>Full Term</th>
<th>Premi</th>
<th>Ab-Ect</th>
<th>Living</th>
<th>Stillborn</th>
<th>Multi Gest</th>
<th>Group B Strep:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>❑ Neg ❑ Pos</td>
</tr>
</tbody>
</table>

**Blood Type:**

<table>
<thead>
<tr>
<th>RH</th>
<th>Positive</th>
<th>Negative</th>
<th>Antepartum Rhogam: Date: / /</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>VDRL ❑ Negative ❑ Positive ❑ Unknown</td>
</tr>
</tbody>
</table>

**HEP B Antigen:**

<table>
<thead>
<tr>
<th>❑ Negative</th>
<th>❑ Positive</th>
<th>❑ Unknown</th>
<th>Rubella: ❑ Immune ❑ Non-Immune</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Elisa/Western Blot: ❑ Not Done ❑ Negative ❑ Positive</td>
</tr>
</tbody>
</table>

*PLACE REFERRAL TO APPROPRIATE DISCIPLINE*
## Allergies

- **Drugs:** None  
  List/Explain Reaction:  
- **Foods:** None  
  List/Explain Reaction:  
- **Other:** None

## Medical History

- **Medical History:**  
  - None  
  - Pulmonary Disease  
  - Cancer  
  - Cardiac Disease  
  - Blood Disorders  
  - Diabetes  
  - HTN  
  - Thrombosis  
  - Seizures  
  - Infections (Specify):  
  - Mental Illness/PP Depression  
  - Renal Disease  
  - Past History of malignant hyperthermia  
  - HIV  
  - Other:

## Last Hospitalizations/Surgery

- **List/Describe:** None  
- **When:**  
- **Where:**  
- **Why:**  

## Type of Anesthesia

- **No current over the counter or prescription medications:**  
- **MEDICATION:**  
- **DOSE:**  
- **FREQUENCY:**  
- **DATE/TIME LAST DOSE:**  
- **LEFT AT HOME:**  
- **SENT HOME:**  
- **SENT TO PHARM:**  
- **LEFT AT BS:**  
- **REASON FOR TAKING:**

## Pain History Assessment

- **In addition to/or aside from labor pain:** Have you had pain in the last several weeks or months?  
  - **No**  
  - **Yes**  
  - **Intensity:**  
  - **Duration:**  
- **If yes, and intensity ≥ 4, continue with pain assessment.**

## Onset/Duration

- **When did your pain begin?**  
- **How long is the pain episode?**  
- **What relieves the pain?**  
- **What accompanies the pain? (dizziness, nausea, anxiety, etc.)**  
- **Pain interferes with:**  
  - Sleep  
  - Physical Activity  
  - Emotions  
  - Work/School  
  - Appetite  
  - Relationships

## Patient/Family Goals

- **Complete Relief**  
- **Intensity Goal**  
- **Improve coping skills**  
- **Improve mobility**  
- **Improve ADL skills**  
- **Other**

## Pain Location of Pain

- **Anterior**  
- **Posterior**

## Consent #2 Signed

- **Yes**  
- **No**  

## Anesthesia Preference

- **None**  
- **Regional**  
- **General**

## Tubal Ligation Consent

- **Signed:** Yes  
- **No**  

## Prenatal Classes attended

- **Prepared Childbirth**  
- **Breastfeeding**  
- **Infant Care**

## NB Feeding Preference

- **Breast**  
- **Bottle**  
- **WIC**

## Circumcision

- **Yes**  
- **No**  

## Consent Signed

- **Yes**  
- **No**  

## Dentures

- **No**  
- **Upper**  
- **Lower**  

## Contacts

- **Yes**  
- **No**  
- **Left In**

## Last Oral Intake

- **Fluids:**  
- **Time:**  
- **AM / PM**  

## Solids

- **Time:**  
- **AM / PM**  

## Type:

## Illness (< 14 days prior to Admission)

- **None**  
- **Type/Tx:**

## Recent exposure to Communicable Disease

- **None**  
- **Type/Date:**

## Recent travel into foreign country

- **No**  
- **Yes**  

## Protective/Disease Specific Isolation

- **None**  
- **Yes**

## NICU Notified

- **No**  
- **Yes**  

## Reason:

## Assessments

- **Height:**  
- **Pre-pregnant Weight:**  
- **lbs.**  
- **est.**  
- **Current Weight:**  
- **lbs.**  
- **WT gain this pregnancy:**  
- **lbs.**  

## V/S

- **T:**  
- **R:**  
- **BP:**  
- **FHR:**  
- **Location:**

## Urine

- **Protein:**  
- **Glucose:**  
- **Ketones:**

## Specimen sent to Lab

- **Yes**  
- **No**  
- **CBC**  
- **Type, Rh, Screen**  
- **PIH Profile**  
- **Other:**

## Admission Vaginal Exam

- **Deferred**  
- **Done**  
- **Time:**  
- **AM / PM**  
- **By:**

## Dil

- **Eff**  
- **Sta**

## Presentation

- **Vertex**  
- **Breech**  
- **Transverse**  
- **Other**

## Place Referral to Appropriate Discipline
Marital Status: [ ] Married [ ] Single [ ] Separated [ ] Divorced
Father Involved: [ ] Yes [ ] No  Others Involved [ ] Yes [ ] No  Identify:
Other Children: [ ] No [ ] Yes  Ages:  Living with you: [ ] Yes [ ] No
Personal Habits:  Smoke [ ] No [ ] Yes ( amount/day)  Caffeine: [ ] No [ ] Yes  Amount
ETOH/Drug Use: [ ] No [ ] Yes  Abuse: [ ] No [ ] Yes  Yes  Amount
Substance(s)  Amount/Day Last Used
Time:  AM / PM
Time:  AM / PM
Describe any signs/symptoms of abuse or neglect: [ ] None [ ] Yes
Comments:

*Request for spiritual/cultural support: [ ] None [ ] Food [ ] Clergy Visit
Special Requests:
Patient Employed: [ ] Yes [ ] No  S/O Employed: [ ] Yes [ ] No  Patient Lives With: [ ] Spouse [ ] Family [ ] Alone [ ] Friend
Adequate Housing: [ ] Yes [ ] Homeless [ ] Shelter [ ] Other
*ADOPTION: [ ] N/A [ ] Under Consideration [ ] PLANNED: [ ] Agency [ ] Private SW Notified [ ] Yes
Comments:
Contact with Infant: [ ] Yes [ ] No  Comments:

Bracelet on: [ ] Yes [ ] No  Admin Notified Time:  Sensory Ability: Visually Impaired [ ] Yes [ ] No  Hearing Impaired [ ] Yes [ ] No  Speech Impaired [ ] Yes [ ] No
Physical Limitations [ ] Explain

Oriented to Patient Care Environment [ ] Bed / Call Lights / Visitors [ ] Emergency Light / I.D. Band [ ] Patient [ ] Family/SO
Anticipated Patient/SO Learning Need: [ ] Diet [ ] Meds [ ] Dx/Illness [ ] Infant Care: Explain
[ ] Self Care: Explain [ ] Labor & Delivery [ ] Epidural [ ] Pushing [ ] Family Planning [ ] Pain Management
Advanced Directive: [ ] No [ ] Yes, Copy on Chart
[ ] Yes, Copy Requested from: [ ] Patient/Family [ ] MD [ ] Medical Records [ ] Information Requested* [ ] Information Given

Support System: Family/SO support who will be available to support/help you at home post discharge. [ ] Yes [ ] No
List:
Where will mother be staying after discharge? [ ] Home [ ] Other  Address:  Phone #: ( )
Anticipated Discharge Needs: [ ] None [ ] Equipment/Supplies:

<table>
<thead>
<tr>
<th>RISK FACTORS ASSOCIATED WITH PAST/PRESENT PREGNANCY</th>
<th>NONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAST</td>
<td>PRESENT</td>
</tr>
<tr>
<td>Incompetent Cervix</td>
<td>[ ]</td>
</tr>
<tr>
<td>Placenta Previa</td>
<td>[ ]</td>
</tr>
<tr>
<td>Preterm Labor</td>
<td>[ ]</td>
</tr>
<tr>
<td>PIH</td>
<td>[ ]</td>
</tr>
<tr>
<td>Herpes</td>
<td>[ ]</td>
</tr>
<tr>
<td>Last Culture:</td>
<td>[ ]</td>
</tr>
<tr>
<td>Other STD Type:</td>
<td>[ ]</td>
</tr>
<tr>
<td>RX:</td>
<td>[ ]</td>
</tr>
<tr>
<td>Post Partum Hemorrhage</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

* PLACE REFERRAL TO APPROPRIATE DISCIPLINE

ANTEPARTUM/LABOR & DELIVERY/POSTPARTUM ADMISSION PROFILE  MEDICAL RECORD  PAGE 3

REV. 11/5/04
### Affix Patient Info Label Here

**Patient Name:**

**MR#**

### Referrals

**Social Services**
- No Prenatal Care
- ETOH/Drug Abuse - Positive Toxicity
- Transfer from another facility
- Inadequate support system
- Adoption
- Psych/medical condition that may impact infant care
- Homelessness/inadequate home environment
- No Provision For Baby
- Adolescent & lack of support
- HIV Positive
- Suspected Abuse/Neglect of Mother/domestic violence
- Financial concerns / No Insurance
- Life threatening congenital anomalies

**Nutritional Services** (place on diet sheet)
- Diabetes
- Substance Abuse
- Teenage Pregnancy
- Hyperemesis
- 20 lb Weight Gain during Pregnancy

**Discharge Planning** (for skilled nursing or rehab care)
- Catheter Management
- Wound Care
- Intravenous / Sub-cutaneous Therapy
- Physical Therapy
- Perinatal Bereavement Counselor for Fetal Loss
- Other:

### Nursing Consultations

- Diabetes Consultation
- Lactation Consult
- Perinatal Bereavement
- Perinatal CNS
- Bloodless Medicine & Surgery
- Psychiatric CNS
- Enteroostomal Therapist

### Physical Therapy Consultation

- Functional screen for planned Bed Rest > 4 days
- Pre-existing neuromuscular disorder
- Other:

### Educ. Needs

- Psychosocial/Environmental Needs
  - Coping Mechanism: Pt/SO positive coping mechanism appear to be present on interview/appropriate for needs during hospital stay/post-discharge care.
  - No Comments:
- Pt/SO Concerns: What concerns you/SO most about your postpartum recovery and baby care?

### Part I: Completed by:

**Signature**

**Title**

**Date/Time:**

### Part II: Post Partum

**Complete on admission to Post Partum/Post-Delivery**

- Coping Mechanism: Pt/SO positive coping mechanism appear to be present on interview/appropriate for needs during hospital stay/post-discharge care.
- No Comments:
- Pt/SO Concerns: What concerns you/SO most about your postpartum recovery and baby care?

### Part II: Completed by:

**Signature**

**Title**

**Date/Time:**

### Discharge Planning - Refer to Part I of Patient Database

**Social Services**
- Not bonding
- Not coping/high risk for postpartum depression
- Patients who may need community linkage/referral

**Pastoral Care**

**Nursing Consultations**
- Diabetes Consultation
- Lactation Consult
- Perinatal Bereavement

**Discharge Planning** (for skilled nursing or rehab care)
- Catheter Management
- Wound Care
- Physical Therapy
- Mother-Infant Home Visit (LOS: 24hrs post NSVD)
- Mother-Infant Home Visit (LOS: 48hrs post C/S)
- Other:

### Comments:

**signature**

**title**

**Date/Time:**

### Notes:

**Place referral to appropriate discipline**

**Antepartum/Labor & Delivery/Postpartum Admission Profile**

**Medical Record**

**Page 4**

**REV 11/5/04**