UNIVERSITY MEDICAL CENTER LABOR PROGRESS RECORD

TARSE PAGENT INPOLABEL NERE

DA		Admission Date:									T diffit Hallie							_ MR#		
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LABOR PROGRESS RECORD

MEDICAL RECOR

REV. 6/15/05

M N E	L - LAGITIAI			Accelerations \(\mathcal{S} = \text{None} \text{V} = \text{Variable} \\ P = \text{Periodic} \text{L} = \text{Late} \\ E = \text{Early} \end{array}						Patient Name MR#											
I = Internal A = Auscultation P = Palpation LTV: Ø = Absent			N = Non-Periodic P = Prole Contractions M = Mild Mod = Moderate S = Strong				longed		Membranes/Fluid Condition I = Intact C = Clear B = Bloody S = SROM M = Meconium A = AROM		id				MD A : R : H : B : C :	MD Notification A = Attending					
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UNIVERSITY MEDICAL CENTER LABOR PROGRESS RECORD

APPA PATENT INFO LAGEL HERE

Admission Date:		Patient Name	MR#
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AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# ____

	INTAKE												OUTPUT							
. "										_				URIN	1E					
									,	IV SITE CONDITION	PO INTAKE	FOLEY	VOIDED	PROTEIN	KETONES	BLOOD	GLUCOSE	EMESIS		
#BAG										≥8	9	6	9	PR	五	BL	GL	EM		
23:00-00:01																				
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20:00-21:00																				
21:00-22:00																				
22:00-23:00																				
TOTAL																				
24 HOUR TOTAL								IALC												

SIGNATURE	INITIALS	SIGNATURE	INITIALS
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PHYSICAL ASSESSMENT KEY: ✓= Yes X= Not Evaluated NA=Not Applicable NN= see Nurse's Notes

AFFIX PATIENT INFO LABEL HERE

Patient Name	MR#

	PHYSICAL ASSESSMI	ENT SUMMA	\RY	2.50(0.000)		
DATE:	TIME INITIALS					j√
	Alert, oriented, appropriate behavior, speech clear					
ي	No unexpected weakness or c/o dizziness					
Neurologic	Denies headache or visual disturbance					
ro	DTR's +1 to +3 no clonus					
len	Able to relax, no seizure activity or jitters					
	This is rotal, no solute delivity or justice					
	Skin warm and dry and pink					
	Mucous membranes moist, good skin turgor				1	
Ľ	Heart rate without irregularities					
ato	No complaints of chest pain or discomfort					
Cardiovascular/Respiratory	No edema of extremities					
es	No facial or pre-sacral edema					
II/R	Skin intact, no rashes or bruises noted					
n n	IV site without puffiness, induration, drainage or tenderness					
386			8			
00	Breathing easily. Respirations regular and normal for labor					
<u>r</u>	No supplementary oxygen needed for mother					
Ça	Lungs clear with good breath sounds to both bases					
	No rhinitis, nasal stuffiness or cough					
240	No nausea or vomiting					
-	Bowel sounds present, no hypo/hyperactivity					
E	No epigastric pain					
	No diarrhea or constipation					
	Tolerating at least 50% of diet					
	Coning offsetively with labor					
sychologic	Coping effectively with labor SO coping with labor					
응	Call bell in reach/Side rails up when in bed					
Ch.	Can ben in reach/Side rans up when in bed					
Psy						-
	Labor Process					
					_	
=	C/Section					
Education	Epidural					
nca	Pushing					
豆	Pain Management					
	Delivery: Vaginal					
	Bracelet on				-	
	Side rails up: Call bell in reach					
	EFM:		·			
>	Pulse oximeter alarms on:			F. E		
Safety	Lower limit 90				73.	4
Sa	Cardiac monitor on:					
	Alarms set 60 low / 120 high: Pulse					
	BP alarms high 150/90					
1	Fall Risks Assessed		1			

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR#

TIME:		NURSE'S PROGRESS NOTES
		· · · · · · · · · · · · · · · · · · ·
	3	
1 mg		
(")	Cervical vertebrae	
va La	CG CB T1	
C6 - 13 - 15 - 15	Thoracic vertebrae	
Ca - 112 18 17 17 17 17 17 17 17 17 17 17 17 17 17	Tio To	
1100	Lumbar vertebrae	Notify anesthesiologist for scores > 2 at any time
Cr Ca La	Sacral	
	LATERAL VIEW	Bromage 3 (complete) - unable to move feet or knees
	LS	
S1 S1		Bromage 2 (almost complete) - able to move feet only Bromage 0 (none) - full flexion of knees & feet