**OBSTETRICS – L&D TRIAGE/ADMISSION NOTE**

*\*Patients often come with a folder of their prenatal history or their information can often be found on the electronic medical record system. For example, information about previous deliveries, PMHx, etc. can be filled out according to antenatal records and clarified/confirmed by the patient on assessment. It is important to review some history before seeing the patient, as current pregnancy complications or previous pregnancy outcomes may be important to know.*

*\*Review the case with the resident/fellow. Clarify what exams are ok to do independently (likely cardiac, respiratory, and abdominal exams if indicated). Do not perform speculum, bimanual exams, or cervical checks without your resident or staff.*

**ID:** age, GTPAL, gestational age, GBS status, Rh status, obstetrician

**CC**: ?labour, ?SROM, bleeding, pain, N/V, fall, IOL

**HPI**:

* *4 Cardinal questions:*
  + *Contractions:* since when, last how long, how often, how painful
    - “Are you experiencing consistent cramping or contractions?”
  + *Vaginal Bleeding:* quantify (soaking a pad, with wiping, just spotting etc.), since when, how long, associated with pain, placenta previa?, associated with intercourse/trauma?
    - “Are you experiencing any vaginal bleeding or spotting?”
  + *Rupture of Membranes:* gush vs. leaking vs. trickle of fluid, soaked through underwear/pants?, any colour?, still leaking in triage?
    - “Are you experiencing any leaking from the vagina, where you feel you’ve broken your waters?”
  + *Fetal Movement* (guideline: 6 FM in 2 hours): how often? last FM? kick counts? tried lying still, movement, cold juice?
    - “Are you experiencing fetal movements today?”
* IOL: Confirm the reason for induction. Examples include: post-dates (41+ weeks), IUGR, oligohydramnios, GDM, preeclampsia, etc.
* Elevated BP: how long and how many readings, any previous history, associated symptoms (headache, visual changes, shortness of breath, epigastric pain, swelling or erythema of the peripheries), any medications etc.
* Pain: OPQRST
  + Differential includes, but not limited to:
    - Pregnancy related: round ligament pain (usually ≥ 20wks GA, may be bilateral, radiating to groins, resolves with rest), placental abruption, labor
    - Non-pregnancy related: MSK-related, UTI (can be asymptomatic), trauma, appendicitis, gallstones, renal colic etc.
* Trauma: when did it occur, mechanism, injury to abdomen, MVC (speed, type of car, seatbelt use), any loss of consciousness
  + Pearl: safety screens should be conducted routinely in pregnancy. This may be better performed together with your resident, if applicable.
* Last meal: if patient may need OR for CS, what time, what was eaten

**Current Ob Hx:** HTN? GDM (controlled on what?)? **Most recent U/S** (note estimated fetal weight, BPP score, growth percentile, vertex/breech/transverse, distance of placenta from cervix, amniotic fluid index)? Prenatal screening results? Any infections? Any bleeding? Serology status? Last VE/ dilation in a clinic?

**Past OB Hx:** Year, gestation, type of delivery (vaginal/CS, vacuum/forceps assisted, including SA and TA and if D&C was required), complications during pregnancy/delivery/postpartum (previous GDM, PIH, tears, PPH, etc.), length of labour, health of baby (size, resus., NICU stay)

**PMHx:** any medical conditions, note asthma and vaccination status

**PSHx:** Note abdo/pelvic surgeries, previous procedures to the cervix (i.e. LEEP)

**Meds:** PNVs?

**Allergies:** medications? shellfish (applicable to iodine based surgical prep)? latex?

**SHx:** Support system (who is present with them?), how far they live (helpful when trying to decide whether to send them home for monitoring)

**Substance Hx:** smoking, alcohol use, drug use (including marijuana)

**P/E:**

* General appearance: Note if in any distress
* Vital signs: Temperature, BP, HR, RR, O2Sat
* Abdominal exam: Full exam if complaint of abdo discomfort/pain, Leopold’s maneuvers
* For patients presenting with elevated BP or signs or symptoms of preeclampsia, add on the following exams: reflexes, clonus

**Investigations:**

* FHR tracing: baseline heart rate, note variability (minimal, moderate, marked), presence of accels, presence and type of decels (variable, early, late)
* Toco: Q\_min, duration
* Sterile speculum exam (\*to be done with resident/staff):
  + If suspecting SROM:
    - Check for pooling of fluid, Nitrazine test for pH, ferning on microscopy (only swab the ‘watery’ looking discharge to place on slide)
    - Valsalva cough, pad check, walking/ gravity
  + Helpful for assessing dilation when digital exam may not be appropriate (e.g. placenta previa)
  + Assessment of vaginal bleeding: check cervix, polyps, vaginal trauma etc.
* Cervical Exam for Labour Assessment (\*to be done with resident/staff):
  + Dilation, effacement, station, position
* Urine dip: depending on symptoms (pain, elevated BP)
* Bloodwork: if applicable
* Ultrasound: if applicable

**Assessment:**

In summary, Age/G\_P\_/ at \_\_ gestational age, in active labour, SROM, PVB etc.

**Plan:**

Admit, ARM, Pitocin

\*Ask if they have a plan for pain management.

### **OBSTETRICS - LABOUR PROGRESS NOTE**

Date and time

**Subjective:**

Analgesia: epidural?

Pitocin? Dose?

Coping?

**Objective:**

FHR assessment – baseline, note variability, accels, deccels

Contractions – frequency, strength

**Exam**: cervical dilation, effacement, station, position, fluid (meconium? blood tinged? clear?)

If ARM – head well applied before and after ARM? FHR after ARM?

**Impression:** progress or not, reassuring fetal status or not

**Plan:** continue current management or change, reassess in \_\_ hours

###### **OBSTETRICS - DELIVERY NOTE**

*\*Note: Depending on the site, this is frequently done by the resident/fellow/staff.*

Date and time

**Brief history: \_\_year old G\_P\_ at \_\_\_weeks GA. Presented for IOL/spontaneous labor/ SROM etc. Uncomplicated/ complicated pregnancy by \_\_\_\_\_. GBS pos/neg. Otherwise healthy patient. Progressed well in labour with oxytocin for augmentation.**

**Type of delivery**: SVD, vacuum, forceps, C/S

**Obstetrician**: staff name

**Assistants**: fellow, resident, medical student

**Anesthesia**: epidural, spinal, combined spinal/epidural, local, nitrous oxide, none

**Delivery:** vertex/breech, shoulder dystocia, complications

**Infant**: liveborn male/female child, birthweight, APGAR score

**Placenta**: spontaneous or gentle cord traction or manual removal, intact, 3 vessels cord

**Laceration/Episiotomy**: degree of laceration, repaired with \_\_\_\_ suture, DRE performed?

**Blood loss: \_\_\_ cc**

**Complications:** Shoulder dystocia (maneuvers used), PPH (medications given)

**POSTPARTUM ROUNDING**

*\* On the paper list of postpartum patients (often can be printed, depending on the site), you can write the patients' initials and room numbers as identifiers. If there are names or other identifying information, please make sure you discard the paper in a secure shredding box (often in Med Ed student centres or around the nursing stations).*

**ID:** age, GTPAL, PPD\_, type of delivery (CS, SVD, forceps, vacuum), complications (3rd/4th degree laceration, PPH)

**S: (head to toe screening)**

Most important questions for meeting discharge criteria:

* **Pain well controlled?** Analgesia use?
* **Tolerating PO intake?**
* **Voiding well?**
* **Passing flatus/BM?**
* **Ambulating?** Calf swelling?
* **Lochia within normal limits?** (bleeding - minimal, moderate, heavy?)

Nausea/vomiting?

Headache, visual changes

Chest pain/SOB?

Breastfeeding?

**O:**

General appearance, vital signs

Cardiorespiratory exam: if applicable

Abdominal exam: Uterine fundus (feel uterus around umbilicus, 1-2cm below/above), incision if applicable (look at dressing and see if soaked, dry blood, fresh blood etc.)

Perineum: typically not required but sometimes indicated; \*only perform with resident/staff

Calves: edema, erythema, tenderness

**Investigations:** POD#1 Hb level in C/S patients, PPD\_ Hb in PPH patients

**Assessment:** Well, recovering OR not well, complicated recovery - differential diagnosis if applicable

**Plan**: encourage ambulation, encourage PO intake, DAT, advance diet. Investigations. Outstanding goals required to meet for discharge.

**GYNAECOLOGY - CONSULTS**

\**Write these on the appropriate consultation sheet, hospital dependent. Please ensure you leave a little bit of space for your resident to write a note. Some sites require dictations in addition to written consult notes; make sure you document the important details you want to dictate*

*\*Review the case with the resident/fellow on your team. If they are busy for a long period of time (e.g. stuck in an OR or delivery) or if it’s urgent, reach out to the chief resident or staff if on call.*

**Date and time:**

**Referring MD:**

**Reason for referral:**

**ID**: age, gender/sex, GTPAL, LMP

**CC**: bleeding, discharge, pain etc

**HPI**:

* Bleeding
  + Quantify: How many pads? How often do you need to change? Need to double up? Flooding? Wake up in the middle of the night to change pad?
  + Anemia symptoms: dizziness, syncope, chest pain, shortness of breath, extreme fatigue? Iron supplementation needed?
* Discharge: smell, colour, associated symptoms (burning, vulvar pain, rash/lesions, bleeding), STI testing, sexual history
* Pain history: OPQRST
* 4 D’s of endometriosis: dysmenorrhea, dyspareunia, dysuria, dyschezia
* Pertinent ROS: Abdominal pain? Urinary symptoms? Fever? Diarrhea? N/V?
* Last meal – if potentially surgical

**Past Gyne Hx** *(if applicable – may already be covered in HPI depending on CC)***:**

* Menses: age of first period (menarche), LMP (first day of period), frequency, duration, heaviness, dysmenorrhea, regularity, specifically note timing associated with menstruation such as intermenstrual bleeding, post-coital bleeding
* Sexual history \*May not be required or appropriate for all patients. Ensure the setting is appropriate if you’re asking these questions.
  + Current or past STI’s
  + 6 P’s (people, pregnancy, protection, practices, past, and problems)
  + Contraception: OCP, IUD, etc.
* Pap smear: most recent result, any previous abnormal results
* History of cysts or fibroids

**Past OB Hx:** if applicable, may not always be relevant

**PMHx**: Any chronic medical condition. Special note of history of fibroids, endometriosis, malignancy, etc.

**Past surgeries:** Special note of abdo/pelvic surgeries and procedures to the cervix (i.e. biopsies, LEEP)

**FHx**: Gyne problems, malignancies, Lynch Syndrome, BRCA

**Social** **Hx**: Smoking, alcohol, drug use

**Medications:** OCP, hormone replacement

**Allergies**

**Physical Exam:**

* Vitals: postural if bleeding may be an issue
* General appearance
* Cardiac/Respiratory exam if applicable
* Abdominal exam
* Pelvic exam: speculum, bimanual exam, general inspection

**Investigations:** U/S, B-hCG, Blood group and screen, CBC, PTT/INR, urinalysis, vaginal/cervical swabs

**Assessment:**

Differential diagnosis

**Plan:**

More investigations, admission/discharge, treatment/ no treatment, outpatient referral, disposition

**GYNAECOLOGY – PROGRESS NOTE (INPATIENT)**

Date and time

**ID:** Post-op day (POD) #X [or post-admission day (PAD #X) if not post-op], procedure or diagnosis

**Subjective:**

Most important questions for meeting discharge criteria:

* **Pain well controlled?** Analgesia use (PCA or PO/IV meds)?
* **Tolerating PO intake?** (Diet - NPO, DAT, fluids); N/V?
* **Voiding well?** (spontaneously, to Foley)
* **Passing flatus/BM?**
* **Ambulating?** Calf swelling?

PVB, pad count, clots (if appropriate)

Symptoms of hypovolemia (dizzy, lightheaded etc)

Other problems e.g. CP, SOB…

**Objective:**

General, most recent vitals (\*PEARL: The trend of vitals is important; document time of Tmax if patient has had previous fever, or HR max if previously tachycardic etc. Also note if there was a fever O/N as the last set of vitals might be from the morning.)

Chest: dyspnea? WOB? Wheezing? Equal bilateral air entry?

Abdo: soft/distended, guarding, tender, peritonitic signs?

Incision: clean & dry, etc.

Periphery: calves tender/edematous/erythema, etc.

Labs: Hb

Fluids In’s/Out’s: if applicable, if abdominal/pelvic drains or urinary Foley present

**Assessment:**

Well POD# or differential diagnosis if problem exists

**Plan:**

Investigations e.g. CBC, CXR, US, CT, leg dopplers

Advance diet, encourage ambulation, d/c Foley, home

## OR NOTE

Date:

ID:

Preoperative Diagnosis: (suspected diagnosis/ reason for surgery)

Postoperative Diagnosis: (suspected diagnosis after surgery, could be different than above)

Procedure:

Surgeon: staff name

Assistants: fellow/resident/medical student

Anesthetist:

Type of anesthesia: general vs. epidural vs. sedation

Findings:

Specimen:

Complications:

Blood loss:

Count correct?