**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.