Government of Alberta

Delivery Record - Part Two

Intended hospital/ place of birth | Hospital/ place of birth

Referring Physician/Midwife | Maternal age | Maternal blood group

Gravida	Term	Preterm	S. Abort	Ind. Abort	Ectopic	Living	No.of Prior C/S's

Pregnancy Type ☐ Single ☐ Multiple ☐ A ☐ B ☐ C ☐ Other:

EDB Year Mo. Day | Gestational Age (Completed Weeks) | Total ARS | Total IRS

Assisted Conception ☐ Nil ☐ Ovulation induction ☐ IVF ☐ Intracytoplasmic sperm injection ☐ Other

Type Of Labour ☐ Spontaneous ☐ Induced ☐ Trial of labour after previous C/S

Cervical dilation on admission cm.

Induction ☐ Prostaglandin - Cervical ☐ Prostaglandin - Vaginal ☐ Oxytocin ☐ Foley cath ☐ ARM ☐ Other, *specify*

Augmentation ☐ ARM ☐ Oxytocin

Pain Management In Labour

	Medication	Dose	Time
☐ Nil ☐ Narcotic →			
☐ Inhalation ☐ Epidural time started:			
☐ Other, *specify*			

Anaesthesia ☐ Nil ☐ Local ☐ Pudendal ☐ Other, *specify* ☐ Epidural ☐ Spinal ☐ General

Medications ☐ Nil ☐ Antihypertensives ☐ Anticonvulsants ☐ Tocolytics

☐ Antibiotics ☐ <2 doses ☐ ≥2 doses First dose (Date/time)

☐ Other, *specify* ▸

☐ Steroids▸First Dose (Date / Time)▸ ▸ #Doses

Presentation In Labour ☐ Cephalic ☐ Cephalic after version ☐ Breech ☐ Other, *specify*

Vaginal Birth (✓all that apply)

☐ Spontaneous ☐ Vacuum ☐ Forceps ☐ Forceps w/rotation

Station: ☐ 0 ☐ +1 ☐ +2 ☐ +3 ☐ +4 (Outlet)

☐ Assisted breech ☐ Extracted breech ☐ Forceps to after coming head

Indication for assisted vaginal birth

Cesarean Birth (✓all that apply)

☐ Primary ☐ Repeat ☐ Elective ☐ Low segment ☐ Classical ☐ T incision

Dilation at last exam: cm.

Indication for cesarean birth:

Episiotomy ☐ Nil ☐ Mediolateral ☐ Midline

Laceration ☐ Nil ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Cervical ☐ Labial ☐ Periurethral ☐ Vaginal sidewall

Sutures:

Third Stage

Oxytocic: | Dose: | Route: | Time:

Placental / Cord Abnormality ☐ No ☐ Yes (Describe) ☐ To Pathology

Cord Vessels ☐ 3 ☐ 2

Placenta Delivery ☐ Spontaneous ☐ Manual

Blood Loss: ☐ Average (< 500 vag OR < 1000 c/s) ☐ Excessive (≥ 500 vag OR ≥ 1000 c/s)

Blood Transfusion ☐ No ☐ Yes

Obstetrical Comments

Mother's Postal Code

Description	Time Hrs / Min	Date Yr	Mo	Day	Duration of Labour
Adm. to hospital/birth centre					Hrs / Min Stage
Adm. to labour and delivery					
Start of labour					1 ______
Fully dilated					2 ______
Start of pushing					3 ______
Birth					Total
Placenta					
Rupture of membranes					☐ SRM ☐ ARM

Fetal Surveillance (*✓all that apply*) ☐ Nil ☐ Auscultation ☐ Electronic - External ☐ Electronic - Internal ☐ Normal ☐ Atypical ☐ Abnormal

Comments:

	Base Excess	Arterial Value	Venous Value
☐ Scalp pH ☐ Cord pH			

Meconium Fluid ☐ None ☐ Thin ☐ Thick

Resuscitative Measures (*✓all that apply*)

☐ No intervention ☐ Suction ☐ Bag & mask - room air ☐ O_2 Free flow _____% ☐ Bag / Mask O_2 _____%

☐ ET Tube-MEC ☐ ET Tube-PPV ☐ Chest compressions ☐ Medication *(specify)*

APGAR Score	0	1	2	1 Min	5 Min	10 Min
Heart rate	Absent	Under 100	Over 100			
Respirations	Absent	Slow irreg.	Good crying			
Muscle tone	Limp	Some flexion	Active			
Reflex	None	Grimace	Cough/Sneeze			
Colour	Blue or Pale	Body pink Limbs blue	Pink			
			Total ▶			

Stillbirth ☐ Antepartum ☐ Intrapartum | Signature: name/title

Medication For Baby Eye Care ☐ Yes ☐ No Vitamin K ☐ IM ☐ PO ☐ No

Birth Weight gms. **Sex:** ☐ Male ☐ Female ☐ Not Known

Pediatric Comments:

Anomaly	☐ Yes	☐ No	
Neonate voided	☐ Yes	☐ No	
Neonate passed meconium	☐ Yes	☐ No	
Breast feeding	☐ Yes	☐ No	
Breast fed after delivery	☐ Yes	☐ No	
NICU admission	☐ Yes	☐ No	
Maternal GBS status	☐ Neg	☐ Pos	☐ Not Known
Maternal hepatitis B status	☐ Neg	☐ Pos	☐ Not Known
Maternal HIV status	☐ Neg	☐ Pos	☐ Not Known
Maternal syphilis status	☐ Neg	☐ Pos	☐ Not Known

Antepartum Physician/Midwife | Intrapartum Physician/Midwife | Baby attendant(s) at delivery (name(s) / title)

Delivery Physician/Midwife | Consultant

Signature of Delivery Physician/Midwife | Nurse/other staff at delivery (name/title) | Baby Physician | Baby chart number | Baby Personal Health Number

Guidelines Delivery Record - Part Two

Admission to Hospital/Birth Centre: Document time (24hr clock) and date patient was admitted to hospital/birth centre regardless of the reason for admission.

Admission to Labour & Delivery: Document time (24hr clock) and date the patient was admitted for labour and birth. This will include admissions in spontaneous labour or for induction of labour.

Start of Active Labour: Indicate time, year, month, day that active labour was confirmed (dilatation greater than 3 cms and start of regular contractions). If the start of active labour is uncertain, document the time the woman experienced regular contractions.

Intended Hospital/Place of birth: Indicate the *planned hospital/place of birth* if it differs from the *hospital or place of birth. Note: place refers to home, alternative birthing centre or other province/country.*

EDB: Indicate the most reliable expected date of birth as determined by dates or ultrasound.

Gestational Age: Calculate the gestational age of the fetus in completed weeks based on the EDB.

Total ARS: Enter the total Antepartum Risk Score from *Delivery Record Part One.*

Total IRS: Enter the total Intrapartum Risk Score from *Delivery Record Part One.*

Type of labour: cervical dilation on admission: Document the cervical dilation in centimetres on admission if the patient is in spontaneous labour or if she is admitted for an induction.

Induction: Check the method(s) of induction used to effect labour in this patient. Note: Prostaglandin for cervical ripening is considered as an induction as the intent is to effect labour. Note that Cervidil would be documented as prostaglandin - vaginal. Include induction of labour if initiated as an outpatient. *Note: Circle the primary indication for induction on Delivery Record Part One.*

Augmentation: Check the method(s) used to improve the quality of uterine contractions in the labouring patient.

Fetal Heart Surveillance: Check all methods of fetal heart surveillance that apply. Indicate if **Fetal Monitoring** is normal, atypical or abnormal.

Comments: *Describe any fetal heart rate abnormalities.*

Pain management and/or anaesthesia: If epidural is *used both for analgesia and for cesarean birth, it should be checked in both places. If spinal or combined spinal and epidural is used please specify under other.*

Medications: Check all that apply. Steriods - indicate the date and time of first dose and total number of doses, including doses given prior to hospital admission. Antibiotics - indicate the date and time of first dose in space provided.

Obstetrical Comments: Document any relevant information relating to this birth, including the use of forceps or vacuum to facilitate descent, uterine rupture, third stage, abnormalities of placenta or cord, or fetal concerns.

Second stage of labour: Indicate the date and time of full cervical dilation (10 centimeters).

Resuscitative Measures: Check all that apply. A detailed description of resuscitation provided should be documented in the comments or progress notes.

APGAR SCORE: Score each category at 1 and 5 minutes and total. An infant with an APGAR score of less than 7 at 5 minutes should have a documented 10 minute APGAR. The APGAR score is to be assigned by the health care professional attending the baby after birth, ie. nurse, physician, midwife.

Stillbirth: If the baby is determined to have died in utero, check if the death was antepartum or intrapartum.

Signature: The person assigning the APGAR score is to sign name and title. Note: changes to the APGAR score are to be initialed and documentation as to the rational for changes given in the pediatric comments.

Pediatric Comments: Check all that apply. Comments could include description of resuscitative measures, fetal anomalies, baby's response to breast feeding, skin to skin contact etc. as is appropriate.

Baby Chart Number: The infant's chart identification number. Obtain **Baby Personal Health Number** if Live Birth.