ADMISSION ASSESSMENT AND HISTORY – OBSTETRICS

Date/Time of Pre-admission:	Date/Time of Admission to Unit:	
Language spoken: ☐ En ☐ Fr ☐ Other: ☐ Translator required	**Reviewed and completed by:** ☐ See Notes	
Source of Information: ☐ Self ☐ Family ☐ Other: Prenatal record: ☐ Yes ☐ No	**Mode of Arrival:** ☐ Walking ☐ Stretcher ☐ Wheelchair ☐ Other:	
Occupation/Education:	**Maiden Name:** ☐ NA	**Age**
Diagnosis/Procedure: Date booked:		

Allergies: *(describe reaction(s))* ☐ None known ☐ Medi Alert on ☐ Agency Alert on	☐ Facility-specific allergy/intolerance record completed *(if applicable)*
☐ Drug:	☐ Latex:
☐ Food:	☐ Environment:

Key Contact: *(name, relationships, phone #s)*	**Attending Physician - Mom** Name:	**Attending Physician – Newborn** ☐ NA Name:
Legal Substitute Health Care Decision Maker *(name, relationship, ph#)* ☐Proxy ☐Personal Guardian ☐Nearest relative Copy of doc ☐Proxy ☐PG	**Notified:** Date/time: ID	**Notified:** Date/time: ID

	QUESTIONS	YES	NO	PATIENT'S RESPONSE AND INTERVIEWER'S COMMENTS
PH	**Personal care assistance**			
	Devices brought			Dentures: ☐ U ☐ L ☐ Glasses ☐ Contact lenses Hearing aids: ☐ Rt ☐ Lt ☐ Other:
ELIM	**Bowel problems**			
	Bladder problems *(describe)*			☐ Frequent UTIs
NUTR	**Specific diet**			☐ Regular ☐ Other:
	Food intolerance *(list with reactions)*			
MOB	**Physical limitations**			
	Devices brought *(list)*			

OBSERVATIONS AND MEASUREMENTS

TPR	BP	FHR	Wt (kg)	Ht (cm)
				Wt gain in preg.

Urine Dipstick
Glucose ______ Albumin ______
Ketones _______

Blood Glucose

Pain *(0-10)*	**ABO/Rh**	**Antibodies**

☐ See Prenatal Record *(otherwise complete table below)*

Rubella Titre:			☐ Collected on admission	☐ Not done prior to admission
Hep B	☐ Neg	☐ Pos	☐ Collected on admission	☐ Not done prior to admission
Hep C	☐ Neg	☐ Pos	☐ Collected on admission	☐ Not done prior to admission
VDRL	☐ Neg	☐ Pos	☐ Collected on admission	☐ Not done prior to admission
GBS	☐ Neg	☐ Pos	☐ Collected on admission	☐ Not done prior to admission
HIV	☐ Neg	☐ Pos	☐ Collected on admission	☐ Not done prior to admission
Other:				
Tests refused: *(list)*				

Systems Assessment *(CNS, CVS, Resp, GI, GUR, Integ, MS, EENT)*

☐ See Assessment Addendum
☐ See Additional Comments

Physical Assessment – Abdominal exam	Vaginal exam
Fundal Height:	Dilatation/Station:
Lie:	Effacement/Length:
Presentation:	☐ SVE by:
Position:	☐ Speculum by:

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OBSERVATIONS AND MEASUREMENTS

Patient's Description of Present Condition	Yes	No			
Contractions *(describe)*			Frequency: Date/time of onset:	Duration:	Strength:
Membranes ruptured			Amount: Nitrazine:	Colour: Date/time:	Ferning:
Vaginal discharge/show *(describe)*					
Fetal activity in last 24-72 hrs. *(describe)*			☐ as usual ☐ more than usual ☐ less than usual		
Other: *(describe)*					

T ______ **P** _______ **A** ______ **L** ______ **G** ______ **LMP** ______________ **EDC** **Gestation** ___________**wks** **Gestation** ___________**wks**

Comments:

History of Current Pregnancy	Yes	No	Response/Comments		Yes	No	Response/Comments ☐ see additional comments
Prenatal care				Gestational diabetes			☐ Diet ☐ Insulin dependent
Hospitalization(s) *(where/when/indications)*				Multiple pregnancy			☐ Twins ☐ Other:
Bleeding				Antenatal depression			
Hypertension				Other:			
with proteinuria				Other:			
Headaches/ Blurring of Vision				Tests: Ultrasound			
Pitting edema				Non-stress test			
Abdominal pain				Glucose screening			
Premature labour				Other:			

History of Past Pregnancies ☐ NA	Yes	No	Weight of largest:	smallest:	Yes	No	☐ see additional comments
Premature labour/delivery				Retained placenta			
Precipitous labour/delivery			Length:	Postpartum hemorrhage			
Prolonged labour/delivery			Length:	Postpartum depression			
Induction/ Augmentation				Labour analgesia/ anesthesia			
Malpresentation				Neonatal illness			
Forceps/Vacuum				Perinatal loss			
Cesarean section				Other:			

Pertinent Medical History	Yes	No	☐ See Prenatal Record		Yes	No	☐ see additional comments
Cardiovascular/ Bleeding disorders				Cancer			
Respiratory/TB				Kidney disease			
Diabetes			☐ Type I ☐ Type II ☐ Gestational	Antibiotic resistant organism(s)			
Congenital/Fetal anomalies				Sexually transmitted infections			
Surgery Anesthesia				HIV exposure			
Epilepsy/Seizures				Hepatitis			
Emotional				Other:			

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Section	Item	Yes	No	Details
MEDS	**Current Medications /Herbals** ☐ See Best Possible Medication History (BPMH)			
	Pharmacy of Choice: (*Name and Location)*			
TREATMENTS AND PROCEDURES	**Previous blood transfusions** *(when, indications)*			
	adverse reactions			
	Present treatments			☐ Physiotherapy ☐ Chiropractor ☐ Massage Therapy ☐ Complementary Therapies *(list)* ☐ Other:
TEACHING	**Learning needs**			Prenatal classes: ☐ Present pregnancy ☐ Previous pregnancies
	Breastfeeding this infant *(learning needs associated)*			
	Breastfeeding experience *(describe)*			
SAFETY	**Safety needs** *(includes safety needs of self and newborn)*			☐ Universal S.A.F.E. Precautions 1. In the past year, have you ever had any fall, including a slip or trip, in which you lost your balance and landed on the floor, ground, or lower level? ☐ Yes ☐ No a. Has medical attention been sought due to a fall? ☐ Yes ☐ No 2. Does the patient have any identifying gait, balance, and/or mobility difficulties? ☐ Yes ☐ No 3. Using clinical judgement, is this patient at risk of falling based on presenting symptoms? ☐ Yes ☐ No (Consider certain factors such as evolving illness (e.g. emerging delirium, impaired mobility, or new medications being prescribed), unfamiliar surroundings, acquired knowledge, other observations and assessments. If 'yes' to any of the questions, a comprehensive Fall Risk Assessment (e.g. Morse) must be completed along with care plan interventions.) ☐ Facility-specific falls risk assessment completed
PSYCHOSOCIAL	**Personal/Home/Work concerns** *(including readiness for newborn)*			Diversional activities:
	Family/Friends/Agencies for support *(who)* **in labour**			
	in hospital			
	on discharge			☐ Not keeping baby *(describe arrangements)*

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PSYCHOSOCIAL		Yes	No		
	Special requests *(including pain management, birthing plan)*				
	Spiritual/Ethnic aspects of care				
	Clergy visit			Affiliation:	
	Smoker *(# per day)*			Would you like assistance to quit: ☐ Yes ☐ No	
	Substance use *(alcohol, inhalants, illicit drugs, etc.) (what, when, how much, any treatment)*			☐ Alcohol screening test completed *(please specify)*	☐ In last 24 hours *(specify)*
	Mental, Emotional and Behavioral status *(including potential abusive relationship issues)* ☐ Facility-specific depression screening completed ☐ Edinburg Postnatal Depression Scale completed ☐ Other:				

Additional Comments:

Orientation to unit:	Yes	No	If No, why not?	**Disposition of belongings:** ☐ See facility-specific patient belongings form	**Date and ID**
Layout					
Routine					
Prenatal tour					

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