Provincial Perinatal Registry Database

CODING MANUAL

Version – October 2020

Note: Please forward any comments/revisions to:
Mr. Phil Murphy – Manager - Clinical Epidemiology; Program Data & Quality; NLCASS; CHIRPP
Children’s and Women’s Health Program | Eastern Health
Janeway Children’s Health and Rehabilitation Centre
St. John’s, Newfoundland & Labrador

TEL: (709) 777 – 4867 *FAX: (709) 777 – 4125*

WWW.PPNL.CA PHIL.MURPHY@EASTERNHEALTH.CA

Contents of this publication may be reproduced
in whole or in part provided the intended use is
for non-commercial purposes and full acknowledgement
is given to the Perinatal Program Newfoundland and Labrador.

Suggested citation: Perinatal Program Newfoundland and Labrador.
Perinatal Database. 3M Entry Screens Coding Manual. St. John’s, NL. October 2020.

Perinatal Program Newfoundland and Labrador
The Janeway Children's Health and Rehabilitation Centre
Health Science Centre
St. John's, Newfoundland and Labrador, Canada
A1B 3V6

Telephone: (709) 777 - 4656
Fax: (709) 777 - 4125
www.ppnl.ca

© 2020 Perinatal Program Newfoundland and Labrador

CONTENTS

	Page
Background	7
The Provincial Perinatal Registry Goals	7
Collection of Data	8
Technical Notes	10
3M Screen #13 - Reproductive Care	
Gestation in Weeks	12
Date of Last Menses	14
Delivery Date / Time	14
Unknown Delivery Date / Time	15
Number of Previous Deliveries	16
Number of Previous Pre-Term Deliveries	16
Number of Previous Spontaneous Abortions	17
Number of Previous Therapeutic Abortions	17
Breastfeeding on Discharge	18
3M Screen #15 – Mother's Information	
Prenatal Record Available	19
Living Arrangements of Birth Parents	19
Mother's Work Status	20
Mother's Work Location	20
Mother's Education Level	21
Father's Date of Birth	21
Unknown Father's Date of Birth	22
Father's Age	22
Location Mother Admitted From	23
Smoked Before Pregnancy	24
Smoked During Pregnancy	24
Exposure to Second Hand Smoke	25
Alcohol Use Before Pregnancy	26
Current Alcohol Use (During Pregnancy)	26
Drugs during Pregnancy	27
Drugs during Pregnancy – Other	29
Preconceptual Folic Acid	29
Intending to Breastfeed	30
Previously Tested Positive for COVID-19	31

3M Screen #16 – Previous Obstetrical History	
Gravida	31
Parity	32
Date of Last Delivery	32
Date of Last Abortion (Spontaneous or Therapeutic)	33
Date of Last Menstrual Period	34
Number of Previous Live Births	34
Number of Previous Preterm Births	35
Number of Previous Low Birth Weight Infants (less than 2500 grams)	35
Number of Previous High Birth Weight Infants (4000 grams or more)	36
Number of Previous Stillbirths	37
Number of Previous Neonatal Deaths	37
Number of Previous Spontaneous Abortions	38
Number of Previous Therapeutic / Medical Abortions	38
Number of Previous Abortions (Type of Unknown)	39
Number of Previous Caesarean Sections	39
Type of Primary (First) Antenatal Care Provider	40
Identity of Primary (First) Antenatal Care Provider	41
Type of Secondary (Second) Antenatal Care Provider	41
Identity of Secondary (Second) Antenatal Care Provider	41
Type of Other (Third) Antenatal Care Provider	42
Identity of Other (Third) Antenatal Care Provider	42
Date of First Antenatal Visit	43
Prenatal Education	43
First Ultrasound Exam Date	44
Estimated Gestational Age at First Ultrasound	44
Ultrasound at 18 to 20 weeks	45
Amniocentesis	45
Chorionic Villi Sampling	46
Cell Free DNA Result	46
Maternal Serum Screening Result	47
Rubella	48
Syphilis	48
Hepatitis B (HBsAg)	49
HIV	50
Insulin Required for Pre-existing Diabetes	51
Insulin Required for Gestational Diabetes	51
Urinary Tract Infection	52
3M Screen #17 – Labour and Delivery	
Height (cm)	53

Height (inches)	53
Pre-Pregnancy Weight (kg)	54
Pre-Pregnancy Weight (lbs)	55
Pre-Delivery Weight (kg)	55
Pre-Delivery Weight (lbs)	56
Pain Management	57
Type of Labour	58
Primary Indication for Induction	58
Primary Indication for Induction - Other	59
Labour Date and Onset Time	59
Rupture of Membranes Date and Time	60
Spontaneous Rupture of Membranes	60
Questionable Rupture of Membranes	61
Tocolytics	61
Antenatal Steroids for Induction of Fetal Lung Maturity	62
Fetal Heart Monitor	63
Type of Primary Care Provider at Delivery	64
Type of Primary Care Provider at Delivery - Other	64
Need for Postpartum Red Blood Cell Transfusion	65
Primary Indication for Caesarean Section	65
Primary Indication for Caesarean Section - Other	66
Secondary Indication for Caesarean Section	67
Secondary Indication for Caesarean Section - Other	68
First Stage Start Time	68
Second Stage Start Time	69
Third Stage (Delivery) Start Time	69
Fourth Stage (Delivery of Placenta) Start Time	70
Skin to Skin	70
3M Screen #18 – Newborn Information	
Birth Number	71
Birth Sequence	71
Stillborn	71
Place of Birth	72
Place of Birth - Other	72
Gestational Age	73
Gestational Age Assessment Method	75
Birth Length (cm)	75
Head Circumference (cm)	76
APGAR Score at 1 minute	76
APGAR Score at 5 minute	77

Bag Mask Ventilation	77
Endotracheal Tube Ventilation	78
Assisted Ventilation greater than 30 mins	78
Continuous Positive Airway Pressure (CPAP)	79
Bronchopulmonary Dysplasia (BPD) at 28 days of age	80
Bronchopulmonary Dysplasia (BPD) at 36 weeks corrected age	80
Type of First Enteral Feed	81
Breastfeeding from Birth to Discharge	82
Medical Indication for Supplementation	82
CCHD Screening	83
CCHD Screening Result	84
NICU Transport Reason	84
Appendix –	
Sample Forms	85

BACKGROUND

Perinatal Program Newfoundland and Labrador (PPNL) was initiated in 1979 and evolved from the need to improve the quality of perinatal (maternal/ newborn) care in the province. The PPNL's mandate, as directed and supported by the Provincial Perinatal Advisory Committee, is to strive to improve pregnancy outcomes and provide a follow-up clinic to infants at high risk for developmental delay.

On April 1, 2005 the reporting structure of the PPNL changed from reporting to the Department of Health and Community Services (DHCS) to reporting to Eastern Health. Funding of the PPNL is still provided through an operational grant by the DHCS. The current mandate of the PPNL was adopted following a program evaluation in 1996, and reaffirmed by the Perinatal Advisory Committee in 2012-13. The mandate encompasses the following terms of reference:

1. Organization and implementation of the Perinatal Follow-Up Clinic for high-risk infants
2. Development and implementation of a Provincial Perinatal Database System
3. Facilitation and support of research and quality assurance initiatives in perinatology and developmental outcomes
4. Development of guidelines for perinatal care, including obstetrical and neonatal care
5. Review and implementation of appropriate nationally developed programs, related to perinatal health
6. Provision of educational services and resources to centers providing perinatal care
7. Prevention and health promotion advocacy in improving perinatal outcomes

One of the mandates of PPNL is the collection and analysis of perinatal data for the purpose of monitoring and improving perinatal care and outcomes through the Provincial Perinatal Registry. Rollout of the Registry began in 2001, with full provincial participation since January 1, 2013.

The Provincial Perinatal Registry Goals

a) To aggregate and report on perinatal events, care processes, and outcomes at the provincial, regional and community levels, enabling:

- Individual hospitals and staff to perform comparisons. Comparative aggregate data will permit:
    - Providers to examine their practice in relation to outcome.
    - Program / service managers / administrators to monitor aspects of practices, performance and results.
    - Policy developers / decision makers to analyze outcome / practice.
- Care provider reviews of clinical processes, practices and outcomes in order to improve the quality of perinatal care in the province and to minimize perinatal morbidity and mortality. This can result in the development of practice guidelines or educational program initiatives (under PPNL).
- Support the development of effective program / clinical resource management of providing data that may be analyzed to optimize the use of clinical resources to improve utilization, resource allocation and quality of care / outcomes and / or reduce cost.
- Support the development of effective program planning by providing aggregate data that may be analyzed to optimize resource allocation, to improve quality of care / outcomes and / or reduce costs.

b) To support perinatal health services research aimed at improving the delivery of patient care by providing authorized researchers with access to information from a very extensive perinatal database.

<u>Collection of Data</u>

PPNL houses the provincial perinatal database, which consists of data collected from 10 obstetrical facilities throughout Newfoundland and Labrador. Perinatal data is imported into the central Provincial Perinatal Registry via 3M Health Information Systems (HIS). Standardized reports are created by PPNL staff and information is routinely extracted from all contributing sites. The data fields within 3M Data Entry and Reporter consist of information entered by Health Information Management Professionals (i.e., coders) which supports requirements for the Canadian Institute for Health Information (CIHI) (diagnosis and intervention information) and PPNL (labour and delivery and maternal/newborn outcome information). The various health record forms used to capture information are not

standardized through the province (with the exception of the Newfoundland and Labrador Prenatal Record and the Live Birth Notification Form) nor all Regional Health Authorities.

Recommended and alternative sources for data collection are listed through this document and is based primarily on what coders across the province have communicated with PPNL.

Sources of data information are typically found on the following forms:

- LABOUR AND DELIVERY RECORD/SUMMARY (Paper Chart / Scanned / Meditech)
- OBSTETRICAL NURSING CARE PLAN / SUMMARY
- PHYSICIAN'S HISTORY AND PHYSICAL
- ADMISSION ASSESSMENT AND HISTORY/INDIVIDUAL CARE PLAN
- BABY FEEDING CHART
- ADMISSION / DISCHARGE SUMMARIES
- PARTOGRAM
- POSTPARTUM FLOW SHEET
- REPORTS (CLINIC, MEDITECH)
- PROGRESS NOTES
- MEDITECH PATIENT CARE INQUIRY AND LAB REPORTS
- CORRESPONDENCE (i.e., consult sheet) IF THE PATIENT IS FROM ANOTHER HOSPITAL OR RESIDENCE CODE, THE PHYSICIAN OR HOSPITAL SENDS IN PERTINENT PARTS OF THE PATIENTS CHARTS.

NOTE: Please inform PPNL through ppnl@easternhealth.ca if data is retrieved from any additional sources not listed above.

Data is extracted within 3M HIS once the coders have the discharged health records entered. The lag for this is typically 4-6 months and subsequent linking of maternal and newborn records and analysis is performed. Quality assurance is done by Health Record Analysts before records are submitted to CIHI and also by PPNL once the data has been extracted.

Any data field that requires an update (e.g., change in definition, removal or addition of input values) or creation of a new data field, requires collaboration and consultation between PPNL, Health Information Management Professionals in all four RHAs, the Provincial Health Information Management Leadership Committee and NLCHI.

PPNL establishes strict policies to ensure that privacy concerns are addressed at both the provider (hospital) and provincial level. PPNL is aided with privacy expert advice form the:

- Access to Information & Protection of Privacy Act (ATIPPA)
- Personal Health Information Act (PHIA)
- PPNL data access / release policies and procedures
- Federal / Provincial acts and regulations

The collection, use, and disclosure of PPNL data is governed by the conditions outlined in the Data Users Agreement (presently in development) between PPNL and every Regional Health Authority. The information in the Provincial Perinatal Registry is used only for the purposes for which it was collected.

Technical Notes

Note Regarding Date:

- FOR ALL DATES - if the DAY of the month is missing (i.e. ONLY YEAR AND MONTH IS Documented for example: JAN 2015) PLEASE ENTER 1 FOR THE DAY of the month. (i.e. 2015/01/01).
- FOR ALL DATES - WITH A TIME of 00:00 HRS PLEASE ENSURE THAT the date is correct. 00:00 HRS REFERS TO THE FIRST HOUR OF THE NEXT DAY FOR EXAMPLE MIDNIGHT ON JAN 26TH IS ACTUALLY JAN 27TH. BE AWARE TO ENTER the PROPER DATE in the appropriate field.
- FOR ALL DATES – IF A DATE IS UNAVAILABLE THE UNKNOWN DATE FIELDS SHOULD BE COMPLETED (YES OR NO).

Note Regarding 3M Data Entry field Input:

- For each field please select one of the available values from the list provided in the **Type/Format of Data.**
- If one of the options is not warranted PLEASE enter **99** if UNKNOWN OR NOT AVAILABLE AND **88** if NOT APPLICABLE.

Note Regarding Validation notes for each field:

- To assist with data quality, please read the validation notes provide with each indicator field.

Note Regarding 3M FLAGS/POP-UPS:

- A MESSAGE WILL “POP UP” IF YOU DON’T ENTER IN A VALUE FOR EACH FIELD.

Note Regarding Edits:

- To assist with data quality, some edits will be built in the live data entry field however ROUTINE / END OF MONTH EDITS ARE PERFORMED ON THE MAJORITY OF FIELDS.

Note Regarding Provincial Standards:

- For each indicator field, if a provincial standard exists it will be presented.

Note Regarding Perinatal Fields that are also coded through ICD-10:

- To assist with data quality surveillance, previous manuals had perinatal fields that were also coded in Chapter 7 (ICD-10) (e.g., Pre-existing Diabetes, Gestational Diabetes). The purpose of this was to help validate the coded data and it identifies errors or omissions. To reduce workload, those perinatal fields were removed from this manual. Routine audits and re-abstraction work similar to CIHI will be performed to confirm validity.

PERINATAL PROGRAM NL DATABASE

REPRODUCTIVE CARE (3M screen #13)

13.1 – Gestation in Weeks

3M Prompts – Data Entry (*Gestation in weeks*) / Reporter (*GestationWeeks*)

Definition – Gestational age is the common term used during pregnancy to describe how far along the pregnancy is. It is measured in weeks, from the first day of the woman's last menstrual cycle to the current date. A normal pregnancy can range from 38 to 42 weeks. Infants born before 37 weeks are considered premature. GESTATION AGE ON MOM'S CHART IS BASED ON MOM'S ADMISSION DATE WHILE GESTATION AGE FOR NEWBORNS IS BASED ON WHEN BABY WAS BORN.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Physician Newborn Admission
2. Discharge/Labour and Delivery Record
3. Live Birth Notification Form
4. Nursing Newborn Admission Discharge
5. Newborn Assessment Labour & Delivery

Type/Format of Data – Numeric (2 digits), for example: 39 weeks

Validation - For OBS Delivered records, a number greater than 43 is NOT VALID for number of weeks.

- Enter 99 for UNKNOWN gestation in weeks.

- Enter 88 for NOT APPLICABLE.

Flag(s) - If gestation is greater than 43, a pop up message "NOT A VALID ENTRY" should appear in Data Entry.

- If gestation is less than 20 weeks when admitted to Caseroom for Delivery (OBS Delivered Main Patient Service), a pop up message "IS THIS CORRECT?" should appear in Data Entry.

Scenario – If different Gestational Ages are found within the chart (e.g., discharge summary, Ballard Score, Labour and Delivery Record/Summary), the discharge summary entry is

probably the best choice considering it is typically an agreed upon measure. Refer to provincial standard below.

Provincial Standard – NLCHI (2012) now incorporated into the Discharge Abstracting Manual (DAD), Group 18, Field 06, Gestational Age, Provincial/Territorial Variations for Newfoundland and Labrador. (For this year, the most recent version of the DAD Manual is Fiscal 2018-2019).

RECORDING GUIDELINE: Physician documentation remains the primary source for collecting gestational age information on the newborn/neonate chart. If physician documentation is deficient, documentation from the nursing staff can be used as a secondary source. The gestational age recorded on the mother's chart at the time of delivery may not match the gestational age recorded on the newborn's chart. Only the gestational age recorded on the newborn/neonate chart should be entered on the newborn/neonate abstract.

DOCUMENTATION HIERARCHY:

For each of the patient groups below, coders should attempt to find the gestational age on the first document listed. If not available, the second and third documents listed should be used in that order as alternative sources of the information.

The most reliable place to find gestational age at birth for the following categories of newborns/neonates is as follows:

NEWBORNS/NEONATES BORN IN THE FACILITY:

1. Discharge Summary or equivalent documents such as the Physician Newborn Admission & Discharge Form or Short Stay Summary
2. Copy of the Labor and Delivery Record
3. Live Birth Notification Form
4. History and Physical upon Admission

NEWBORNS/NEONATES ADMITTED FROM ANOTHER FACILITY:

1. Discharge Summary or equivalent documents such as the Physician Newborn Admission & Discharge Form or Short Stay Summary
2. Physician Referral Letter
3. Transfer Notes from the Transport Team
4. History and Physical upon Admission/Admission Note

NEWBORNS/NEONATES ADMITTED FROM HOME OR BORN ENROUTE:

1. History and Physical upon Admission.

13.2 – Date of Last Menses – MANDATORY FOR THERAPEUTIC ABORTIONS CASES ONLY WHEN GESTATIONAL AGE IS NOT AVAILABLE.

3M Prompts – Data Entry (*Date of Last Menses*) / Reporter (*LastMenses*)

Definition – refers to the dating of the current pregnancy, by convention, starting from the first day of a woman's last menstrual period (LMP).

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical upon Admission
3. Obstetrical Nursing History & Admission Note
4. Obstetrical Nursing Care Plan
5. Labour Partogram
6. Labour and Delivery Record / Summary

Type/Format of Data – Date (YYYY/MM/DD), for example: 2015/02/10

Validation
- A date after Admit Date AND Delivery Date (and possible other date) is NOT VALID.
- If only Year and Month is known, enter 01 for the Day (DD).
- If date is unknown, enter YES in the next field (**Unknown Date of Last Menses**).

Flag(s) – cross reference with Admit/Delivery/Discharge dates.

13.3 – Delivery Date / Time

3M Prompts – Data Entry (*Deliver Date/Time*) / Reporter (*DeliveryTime*)

Definition – refers to the date and time a mother delivered or gave birth to a baby (live or stillborn). The time (using the 24-hour clock) recorded on the mother's abstract to identify when the baby was born.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record / Summary
2. Obstetrical Nursing Care Plan
3. Labour Partogram
4. Live Birth Notification (date only)

Type/Format of Data – Date (YYYY/MM/DD HH:MM), for example: 2015/02/10 09:33

Validation
- A date before Admit Date is NOT VALID.
- A date after Discharge Date is NOT VALID.
- A date in the procedure should match projects.
- If only Year and Month is known, enter 01 for the Day (DD).
- If time unknown enter 00:00 for HH:MM (PPNL recognizes that a valid midnight time is 00:00 as well)
- If date is unknown, enter YES in the next field (**Unknown Delivery Time**).

Flag(s) – cross reference with Admit/Delivery/Discharge dates.

Edit by Health Records/3M – Yes

13.4 – Unknown Delivery Time

3M Prompts – Data Entry (Unknown Delivery Time)/ Reporter (*DeliveryNoTime*)

Definition – refers to if the Delivery Date / Time is unknown.

Type/Format of Data – Numeric

Input	*Value*
1	**YES**

Validation – required to be completed if Delivery Date / Time is missing or unknown.

Fields 13.5 through 13.8 ARE RELEVANT TO THERAPEUTIC ABORTION CASES IN NEWFOUNDLAND AND LABRADOR RECORDS.

CODERS TYPICALLY WILL BYPASS OBS DELIVERED CASES AND LEAVE BLANK.

FOR THERAPEUTIC ABORTION CASES PLEASE ENTER 99 FOR ALL FIELDS WITH UNKNOWN INFORMATION.

UPDATED IN 2015/16 DAD MANUAL.

13.5 – Previous Deliveries (complete for therapeutic abortions)

3M Prompts – Data Entry (*Previous Deliveries*) / Reporter (*PrevDeliv*)

Definition – refers to the number of previous deliveries.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Labour Partogram
4. Live Birth Notification (only for Therapeutic Abortions that result in a liveborn)
5. Delivery Record

Type/Format of Data – Numeric

- Enter the number in range of 00-20.
- Enter 99 if not available.
- Enter 88 if not applicable.

Validation – should not exceed the number entered for Parity (# times given birth) (chapter 16 in 3M).

Flag(s) – if entry is greater than 20.

Edit by Health Records / 3M – Yes

13.6 – Previous Preterm Deliveries (complete for therapeutic abortions)

3M Prompts – Data Entry (*Prev Preterm Deliveries*) / Reporter (*PrevPreTermDelv*)

Definition – This field identifies the number of previous pre-term deliveries, meaning 20 to 36 completed weeks.

Location of Data – Found on the Newfoundland and Labrador Prenatal Record.

Type/Format of Data – Numeric

- Enter the number in range of 00-20.
- Enter 99 if not available.
- Enter 88 if not applicable.

Validation – should not exceed the number entered for Parity (# times given birth) (chapter 16 in 3M).

Flag(s) – if entry is greater than 20.

13.7 - Previous Spontaneous Abortions (complete for therapeutic abortions)

3M Prompts – Data Entry (*Prev Spont Abortions*) / Reporter (*PerSpontAborts*)

Definition – This field identifies the number of previous pregnancies ending in spontaneous abortion (miscarriages).

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Obstetrical Summary
4. Labour Partogram
5. Labour Delivery Record / Summary

Type/Format of Data – Numeric

- Enter the number in range of 00-20.
- Enter 99 if not available.
- Enter 88 if not applicable.

Validation – should not exceed the number entered for Parity (# times given birth) (chapter 16 in 3M).

Flag(s) – if entry is greater than 20.

13.8 - Previous Therapeutic (or Medical) Abortions (complete for therapeutic abortions)

3M Prompts – Data Entry (*Prev Therap Abortion*) / Reporter (*PrevTherapAbort*)

Definition – This field identifies the number of previous pregnancies ending in therapeutic or medical abortion.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan

3. Obstetrical Summary
4. Labour Partogram
5. Labour Delivery Record / Summary

Type/Format of Data – Numeric

- Enter the number in range of 00-20.
- Enter 99 if not available.
- Enter 88 if not applicable.

Validation – should not exceed the number entered for Parity (# times given birth) (chapter 16 in 3M).

Flag(s) – if entry is greater than 20.

13.9 – Breastfeeding on Discharge (complete for OBS Delivered abstracts)

3M Prompts – Data Entry (*Breastfeeding at Discharge) /* Reporter (*Breastfeeding*)

Definition – refers to whether a mother was breastfeeding her infant at the time of discharge from the hospital/facility.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Obstetrical Nursing Care Plan
2. Postpartum Parent Support Program
3. Nursing Notes
4. Obstetric Discharge Summary

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Validation – Only 1 through 3 are valid entries.

Flag(s) – If a number other than Yes, No or Unknown is entered.

Edit by Health Records / 3M – Yes

MOTHER'S INFORMATION (3M screen #15)

15.1 – Prenatal Record Available

3M Prompts – Data Entry (*Prenatal Record Avai*) / Reporter (*PerRecAvail)*

Definition – refers to the availability of the Newfoundland and Labrador Prenatal Record.

Location of Data – If form is present within the Mother's Chart.

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**

Validation – Only 1-2 are valid entries.

Flag(s) – If a number other than 1 through 2 is entered.

15.2 – Living Arrangements of Birth Parents

3M Prompts – Data Entry (*Living Arrangement*) / Reporter (Per*LivingArran)*

Definition – refers to the living arrangements of the birth parents.

Location of Data – Found on the Live Birth Notification Form.

Type/Format of Data – Numeric

Input	*Value*
1	**LIVING TOGETHER AS A COUPLE**
2	**NOT LIVING TOGETHER AS A COUPLE**
3	**UNKNOWN**

Validation – Only 1 through 3 are valid entries.

Flag(s) – If a number other than 1 through 3 is entered.

15.3 – Mother's Work Status

3M Prompts – Data Entry (*Work Status*) / Reporter (*PerWrkStat)*

Definition – refers to paid employment during pregnancy. Full-Time is defined as greater than 4 days (28 hours) per week. Part-Time is defined as less than or equal to 4 days (28 hours) and greater than one day (7 hours) per week. If the mother is a casual employee with an unknown number of hours, code as Part-Time. If the mother is a seasonal employee during pregnancy, code as Full-Time. **IF NO OR UNKNOWN BYPASS/SKIP NEXT FIELD (MOTHER'S WORK LOCATION)**

Location of Data – Found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – Numeric

Input	*Value*
1	**NO *(INCLUDES SICK LEAVE)***
2	**PART-TIME**
3	**FULL-TIME**
4	**UNKNOWN**
5	**STUDENT**

Validation – Only 1 through 5 are valid entries.

Flag(s) – If a number other than 1 through 5 is entered.

15.4 – Mother's Work Location

3M Prompts – Data Entry (*Work Location*) / Reporter (*PerWorkLoc)*

Definition – refers to whether the Mother worked inside or outside of her residence during pregnancy.

Location of Data – Found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – Numeric

Input	*Value*
1	**INSIDE HOME**
2	**OUTSIDE HOME**
3	**UNKNOWN**
4	**NOT APPLICABLE**

Validation – Only 1 through 4 are valid entries.

Flag(s) – If a number other than 1 through 4 is entered.

15.5 – Mother's Education Level

3M Prompts – Data Entry (*Mother's Education*) / Reporter (*PerMothered)*

Definition – refers to the level of education achieved by the mother at time of delivery.

Location of Data – Found on the Live Birth Notification Form

Type/Format of Data – Numeric

Input	*Value*
1	**HAS NOT GRADUATED FROM HIGH SCHOOL**
2	**GRADUATED HIGH SCHOOL**
3	**BEYOND HIGH SCHOOL**
4	**COLLEGE OR UNIVERSITY DEGREE (INCLUDING TRADE)**
5	**EDUCATION UNKNOWN**

Validation – Only 1 through 5 are valid entries.

Flag(s) – If a number other than 1 through 5 is entered.

15.6 – Father's Date of Birth

3M Prompts – Data Entry (*Father's Birth Date*) / Reporter (*PerFathBDt)*

Definition – refers to the Father's date of birth during the pregnancy.

Location of Data – Found on the Newfoundland and Labrador Prenatal Record and Live Birth Notification Form

Type/Format of Data – Date (YYYY/MM/DD HH:MM), for example: 2015/02/10 09:33

Validation
- A date before Admit Date is NOT VALID.
- A date after Discharge Date is NOT VALID.
- A date in the procedure should match projects
- If only Year and Month is known, enter 01 for the Day (DD).

- If time unknown enter 00:00 for HH:MM (PPNL recognizes that a valid midnight time is 00:00 as well)
- If date is unknown, enter YES in the next field (Unknown Father's Date of Birth)

Flag(s) – cross reference with Admit/Delivery/Discharge dates.

Edit by Health Records/3M – Yes

15.7 – Unknown Father's Birth Date

3M Prompts – Data Entry (Unknown Father's Birth Date*)/* Reporter (*NoFBirthDate*)

Definition – refers to if the Father's Birth Date is unknown.

Type/Format of Data – Numeric

Input	*Value*
1	**YES**

Validation – required to be completed if Father's Birth Date is missing or unknown.

15.8 – Father's Age

3M Prompts – Data Entry (*Fathers Age*) / Reporter (*PerFathAge)*

Definition – refers to the age (years) of the Father during the pregnancy.

Location of Data – Found on the Newfoundland and Labrador Prenatal Record and Live Birth Notification Form

Type/Format of Data – Numeric

Validation – should equal to the difference in years of the Father's date of birth from the present year (year which form is completed).

- Enter 99 for UNKNOWN if Father's Age is not available.
- Enter 88 if not applicable.

Flag(s) – cross reference with Admit/Delivery/Discharge dates.

15.9 – Location Mother Admitted From

3M Prompts – Data Entry (*Admitted From*) / Reporter (*PerAdmfrm)*

Definition – refers to the patients' location immediately prior to entering the hospital. If the mother is transferred from another facility, select hospital from the dictionary. The code for the other hospital should be completed in the transfer section.

Location of Data – Found on the Admission/Discharge Form

Type/Format of Data – Numeric

Input	*Value*
1	**Birthing Centre** - Unit or free-standing facility providing care for normal deliveries, whether by physician or midwife, but not for operative deliveries (C-Sections etc).
2	**Home** - Place of residence, either permanent or temporary, at the time of labour. Infants born en-route from home are included in this category.
3	**Hospital/Health Centre** - Transfer from any other hospital or health centre. Infants born enroute from another hospital or health centre are included in this category.
4	**Midwifery Facility** - Centre run by midwives providing normal delivery services, whether freestanding or in a hospital.
5	**Community Clinic** - Transferred from a healthcare facility that is staffed by Regional Nurses/ Nurse Practitioner, in remote, isolated communities. Infants born enroute from another community clinic are included in this category.
6	**Non-Home** - Transfer from any other temporary residence such as Hotel, Motel, Hostel, etc. Infants born enroute from another temporary residence are included in this category.
7	**Unknown** - Location is unknown.
8	**Clinic of Reporting Centre** - Transfer from clinic of reporting centre such as Women's Health Clinic, Maternal Fetal Assessment Unit, and Ultrasound in the Health Sciences Centre in St. John's.

Validation – Only 1 through 8 are valid entries.

Flag(s) – If a number other than 1 through 8 is entered.

15.10 – Smoked Before Pregnancy

3M Prompts – Data Entry (*Smoked before Preg*) / Reporter (*PerSmokePre)*

Definition – refers to tobacco smoking prior to pregnancy.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical
3. Obstetrical Nursing Care Plan
4. Obstetrical Admission

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – Unknown should only be coded if the care provider has not marked Y (YES) or N (NO) in the lifestyle section of the Newfoundland and Labrador Prenatal Record. Other forms like the Obstetrical Nursing Care Plan does not clarify tobacco smoking prior to pregnancy. If YES is documented in one location only, choose YES.

Validation – Only 1 through 3 are valid entries.

15.11 – Smoked During Pregnancy

3M Prompts – Data Entry (*Currently Smoking*) / Reporter (*PerCurrsmok)*

Definition – refers to tobacco smoking at any time during the prenatal period. The lifestyle section is usually completed during the first visit; however, the time of the first visit will vary. This variable will indicate smoking at any time during pregnancy.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical
3. Obstetrical Nursing Care Plan
4. Obstetrical Admission
5. Child Youth and Family Services Form

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – Unknown should only be coded if the care provider has not marked Y (YES) or N (NO) in the lifestyle section of the Newfoundland and Labrador Prenatal Record. Other forms like the Obstetrical Nursing Care Plan does not clarify tobacco smoking prior to pregnancy. If YES is documented in one location only, choose YES.

Validation – Only Yes, No or Unknown are valid entries.

15.12 – Exposure to Second Hand Smoke

3M Prompts – Data Entry (*Snd Hand smoke exp*) / Reporter (*PerSecsmok)*

Definition – refers to exposure to second hand tobacco smoke during pregnancy (MAINLY FOR NON-SMOKING MOTHERS). The mother is living with a tobacco smoker or works in an environment with smokers.

Location of Data – Found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – Unknown should only be coded if the care provider has not marked Y (YES) or N (NO) in the lifestyle section of the Newfoundland and Labrador Prenatal Record. Other forms like the Obstetrical Nursing Care Plan does not clarify exposure to second-hand smoke during pregnancy. If YES is documented in one location only, choose YES.

Validation – Only 1 through 3 are valid entries.

- If entry has YESs, then Current Smoking should NOT be YES. (The exposure really only applies to NON-SMOKERS).

Flag(s) – YES if Current Smoking is YES.

15.13 – Alcohol Use Before Pregnancy

3M Prompts – Data Entry (*Alco Use Bef Preg*) / Reporter (*PerPreAlcohol)*

Definition – refers to use of alcohol **BEFORE** pregnancy. The lifestyle section is typically filled out during the first prenatal visit; however, the time of the first visit may vary.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical
3. Obstetrical Nursing Care Plan
4. Obstetrical Admission

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – Unknown should only be coded if the care provider has not marked Y (YES) or N (NO) in the lifestyle section of the Newfoundland and Labrador Prenatal Record. Other forms like the Obstetrical Nursing Care Plan does not clarify alcohol use before pregnancy. If YES is documented in one location only, choose YES.

Validation – Only Yes, No or Unknown are valid entries.

15.14 – Current Alcohol Use (During Pregnancy)

3M Prompts – Data Entry (*Alcohol Current Use*) / Reporter (*PerCurrAlcohol)*

Definition – refers to use of alcohol **DURING** pregnancy. The lifestyle section is typically filled out during the first prenatal visit; however, the time of the first visit may vary.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical
3. Obstetrical Nursing Care Plan
4. Obstetrical Admission

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – Unknown should only be coded if the care provider has not marked Y (YES) or N (NO) in the lifestyle section of the Newfoundland and Labrador Prenatal Record. Other forms like the Obstetrical Nursing Care Plan does not clarify alcohol use during pregnancy. If YES is documented in one location only, choose YES.

Validation – Only Yes, No or Unknown are valid entries.

15.15 – Drugs During Pregnancy – Includes Prescription, Over the Counter, Street/Illicit Drugs

3M Prompts – Data Entry (Drugs) / Reporter (Drugs*1) UP TO SIX CAN BE ENTERED*

Definition – refers to any drug use **DURING** pregnancy. The lifestyle section is typically filled out during the first prenatal visit; however, the time of the first visit may vary. **This indicator will capture whether or not there was use during pregnancy NOT whether or not drugs were prescribed.**

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical
3. Obstetrical Nursing Care Plan
4. Obstetrical Admission

Type/Format of Data – Numeric

Input	*Value*
1	**METHADONE**
2	**SUBOXONE**
3	**STIMULANTS (eg. Cocaine, Methamphetamine, Ritalin)**
4	**OPIOIDS (eg. Morphine, Oxycodone, Heroine, Percocet, Codeine)**

5 **DEPRESSANTS (eg. Barbiturates, Benzodiazepines (Lorazepam (Ativan), Clonazepam))**

6 **CANNABINOIDS (eg. Marijuana, Hashish, Shatter)**

7 **PSYCHOACTIVE/HALLUCINOGENS (eg. Ecstasy, LSD, mushrooms, Special K)**

8 **SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIs) – such as:**

Celexa (Citalopram), Sertraline (Zoloft, Lustral), Fluoxetine (Prozac), Fluvoxamine (Faverin, Fevarin, Floxyfral, and Luvox), Paroxetine (Paxil),

Or Serotonin–Norepinephrine Reuptake Inhibitors (SNRIs) – such as:

Venlafaxine (Effexor, Effexor XR and Trevilor), Desvenlafaxine (Pristiq, Khedezla), Duloxetine (Cymbalta, Yentreve)

9 **TRICYCLIC ANTIDEPRESSANTS (TCAs) – such as:**

Amitriptyline (Elavil, Endep, Levate), Nortriptyline (Sensoval, Aventyl, Pamelor), Desipramine (Norpramin), Imipramine (Tofranil, Tofranil-PM), Trimipramine (Surmontil, Rhotrimine, Stangyl), Clomipramine (Anafranil, Clofranil), Mirtazapine (Avanza, Axit, Mirtaz, Mirtazon, Remeron, Zispin)

10 **SOLVENTS/INHALANTS (eg. glue, aerosol sprays, gasoline)**

11 **OTHER – such as:**

Antihypertensives, diabetic agents, nonsteroidal anti-inflammatory drugs (NSAIDs) (ibprofen, ASA, antibiotics, supplements (folic acid, vitamin D, calcium, iron), Thyroid medications, etc.

12 **UNKNOWN**

13 **NONE**

Notes – Up to six drug uses can be entered. Duplicate entry is not allowed within the six fields. SSRIs and SNRIs are within one category and more similar than TCAs. If drug use is not on the chart choose **NONE** and skip the drug2-drug6 fields. If drug use occurred but the type is unknown, then choose **UNKNOWN**. If option 10 (**OTHER**) is selected the next field must be completed.

Validation – Only 1 through 13 are valid entries.

Flag(s) – If a number other than 1 through 13 is entered.

15.16 – Drug Use During Pregnancy - Other

3M Prompts – Data Entry (*Drug1OtherSpecify*) / Reporter (*Drug1Other)*

Definition – refers to the substance/drug use **DURING** pregnancy not included in the previous list.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical
3. Obstetrical Nursing Care Plan
4. Obstetrical Admission

Type/Format of Data – Text

Validation – Option 10 in the previous field must have been selected.

Flag(s) – Yes

15.17 – Preconceptual Folic Acid

3M Prompts – Data Entry (*Precon Folic Acid*) / Reporter (*PerPreFolic)*

Definition – refers to folic acid intake (eg. Multivitamins or Materna) PRIOR to conception or knowledge of pregnancy.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Obstetrical Admission

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – Unknown should only be coded if the care provider has not marked Y (YES) or N (NO) in the Preconceptual Folic Acid boxes on of the Newfoundland and Labrador Prenatal

Record. A care provider may just note Folic Acid but not Preconceptual Folic Acid. Other forms like the Obstetrical Nursing Care Plan may note folic acid intake use during pregnancy. If YES is documented in one location only, choose YES.

If you see on the Prenatal Record "FOLIC ACID", which is indicative of an old form being used (eg. 1998 oldest-dated form), please take note of the physician/office and notify PPNL at 777-4867.

Validation – Only Yes, No or Unknown are valid entries.

Flag(s) – If a number other than Yes, No or Unknown is entered.

15.18 – Intending to Breastfeed

3M Prompts – Data Entry (*Intending to Breastfeed)* / Reporter (*PerIntToBreastFeed*)

Definition – refers to the mother's intention to breastfeeding following birth.

Location of Data – Found on the Newfoundland and Labrador Prenatal Record.

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**UNDECIDED**
3	**NO**
4	**MISSING/UNKNOWN**

Validation – Only 1-4 are valid entries.

Flag(s) – If a number other than 1 through 4 is entered.

15.19 – Previously Tested Positive for COVID-19

3M Prompts – Data Entry (*PrevTestPositivCOVID)* / Reporter (*PrevTestPositivCOVID*)

Definition – refers to the mother previously testing positive for COVID-19.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Meditech - Patient Care Inquiry - Laboratory Data - Microbiology Referred - RESP PATH PCR or COVID19I

2. Found on COVID-19 Triage Screening Tool
3. Obstetrical Nursing Care Plan and SHARE of Information (Part III)

Type/Format of Data – Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**MISSING/UNKNOWN**

Validation – Only 1-3 are valid entries.

Flag(s) – If a number other than 1 through 3 is entered.

PREVIOUS OBSTETRICAL HISTORY (3M screen #16)

16.1 – Gravida

3M Prompts – Data Entry (*Gravida*) / Reporter (*PerGravida)*

Definition – refers to the number of pregnancies, including the present pregnancy. Includes Abortions.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical
3. Labour and Delivery Record / Summary
4. Obstetrical Nursing Care Plan
5. Obstetrical Admission

Type/Format of Data – Numeric

Notes – Twins/Triplets/etc are considered 1 pregnancy. Enter 99 if not available.

Validation – Should never be less than what is entered for **Parity** (number of times giving birth).

Edit by Health Records / 3M – Yes (if less than entry for Parity (16.2)).

16.2 – Parity

3M Prompts – Data Entry (*Parity*) / Reporter (*PerParity)*

Definition – refers to the number of times given birth to a fetus, which resulted in one or more infants weighing 500 grams or more at birth or > 20 weeks gestation (regardless of whether the infants were stillborn, died after birth or lived). This excludes the present pregnancy.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical
3. Labour and Delivery Record / Summary
4. Obstetrical Nursing Care Plan
5. Obstetrical Admission

Type/Format of Data – Numeric

Notes – For twin pregnancy consider 2 fetuses. For triplet pregnancy consider 3 fetuses. Enter 99 if not available.

Validation – Should never be more than what is entered for **Gravida** (number of times being pregnant).

Edit by Health Records / 3M – Yes

16.3 – Date of Last Delivery

3M Prompts – Data Entry (*Last Delivery*) / Reporter (*PerDateldel)*

Definition – refers to the date of which the mother last delivered a liveborn(s) or stillbirth(s).

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Live Birth Notification Form

Type/Format of Data – Date (YYYY/MM/DD), for example: 2015/02/10

Validation - A date after Admit Date is NOT VALID.

- A date after Discharge Date is NOT VALID.

- A date after Delivery Date is NOT VALID.
- If only Year and Month is known, enter 01 for the Day (DD).
- If time unknown enter 00:00 for HH:MM (PPNL recognizes that a valid midnight time is 00:00 as well).
- If date is unknown, enter YES in the next field (**Unknown Date of Last Delivery**).

Flag(s) – cross reference with Admit/Delivery/Discharge dates.

16.4 – Date of Last Abortion

3M Prompts – Data Entry (*Last Abortion*) / Reporter (*PerDateAb)*

Definition – refers to the latest date of which the mother had an abortion. This applies to spontaneous, therapeutic and unknown abortion types.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record.

Type/Format of Data – Date (YYYY/MM/DD), for example: 2015/02/10

Validation – - A date after Admit Date is NOT VALID.

- A date after Discharge Date is NOT VALID.
- A date after Delivery Date is NOT VALID.
- If only Year and Month is known, enter 01 for the Day (DD).
- If time unknown enter 00:00 for HH:MM (PPNL recognizes that a valid midnight time is 00:00 as well).
- If date is unknown, enter YES in the next field (**Unknown Date of Last Abortion**).

Flag(s) – cross reference with Admit/Delivery/Discharge dates.

16.5 – Date of Last Menstrual Period

3M Prompts – Data Entry (*Last Menstrual Perd*) / Reporter (*PerLMP)*

Definition – refers to the dating of the current pregnancy, by convention, starting from the first day of a woman's last menstrual period (LMP).

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Physician's History and Physical upon Admission
3. Obstetrical Nursing History & Admission Note
4. Obstetrical Nursing Care Plan
5. Obstetrical Admission
6. Labour Partogram
7. Labour and Delivery Record / Summary

Type/Format of Data – Date (YYYY/MM/DD), for example: 2015/02/10

Validation – A date after Admit Date is NOT VALID.

- A date after Discharge Date is NOT VALID.
- A date after Delivery Date is NOT VALID.
- If only Year and Month is known, enter 01 for the Day (DD).
- If time unknown enter 00:00 for HH:MM (PPNL recognizes that a valid midnight time is 00:00 as well).
- If date is unknown, enter YES in the next field (**Unknown Date of Last Menstrual Period**).

Flag(s) – cross reference with Admit/Delivery/Discharge dates

---

16.6 – Number of Previous Live Births

3M Prompts – Data Entry (*Prev Live Births*) / Reporter (*PerPrevLB)*

Definition – refers to the number/count of live births previously delivered by the mom. A live birth refers to a fetus weighing at least 500 grams in weight or > 20 weeks gestation in which there is breathing, beating of the heart, pulsation of the umbilical cord or movement of voluntary muscle.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record and Live Birth Notification Form and on some Obstetrical Admission forms.

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous live births enter 0 (zero).

- If the number of previous live births is Unknown or Not Available enter 99.

- Enter 88 if not applicable.

16.7 – Number of Previous Preterm Births

3M Prompts – Data Entry (*Prev Preterm Births*) / Reporter (*PerPrevPRE)*

Definition – refers to the number/count of preterm births previously delivered by the mom. A preterm birth refers to infants up to and including 36 weeks and 6 days gestation. An infant at 37 completed weeks gestation or more would be considered term. For example, if the chart indicates that the infant is 37 weeks, and 2 days this is a term infant.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record and on some Obstetrical Admission forms.

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous preterm births enter 0 (zero).

- If the number of previous preterm births is Unknown or Not Available enter 99.

- Enter 88 if not applicable.

16.8 – Number of Previous Low Birth Weight Infants

3M Prompts – Data Entry (*Prev Low Birth Wgt*) / Reporter (*PerPrevLBW)*

Definition – refers to the number/count of low birth weight LIVE births previously delivered by the mom. Low birth weight refers to infants weighing less than or equal to 2499 grams (5 lbs 8 oz).

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan

3. Obstetrical Admission

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous low birth weight live births enter 0 (zero).

- If the number of previous low birth weight live births is Unknown or Not Available enter 99.
- Enter 88 if not applicable.

16.9 – Number of Previous High Birth Weight (4500 grams plus) Infants

3M Prompts – Data Entry (*Prev High Birth Wgt*) / Reporter (*PerPrevHBW)*

Definition – refers to the number/count of high birth weight LIVE births previously delivered by the mom. High birth weight refers to infants weighing 4500 grams or more (9 lbs 15 oz).

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Obstetrical Admission

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous high birth weight live births enter 0 (zero).

- If the number of previous high birth weight live births is Unknown or Not Available enter 99.
- Enter 88 if not applicable.

16.10 – Number of Previous Stillbirths

3M Prompts – Data Entry (*Prev Stillbirths*) / Reporter (*PerPrevSB)*

Definition – refers to the number/count of stillbirths previously delivered by the mom. Stillbirths refers to a fetus at least 500 grams in weight or > 20 weeks gestation in which there is no breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement of voluntary muscle.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Obstetrical Admission
4. Live Birth Notification Form.

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous stillbirths enter 0 (zero).

- If the number of previous stillbirths is Unknown or Not Available enter 99.

- Enter 88 if not applicable.

16.11 – Number of Previous Neonatal Deaths

3M Prompts – Data Entry (*Prev Neonatal Deaths*) / Reporter (*PerPrevNND)*

Definition – refers to the number/count of neonatal deaths previously delivered by the mom. Neonatal Deaths refers to if a death of the neonate occurs during the first 28 completed days of life.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Obstetrical Admission

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous neonatal deaths enter 0 (zero).

- If the number of previous neonatal deaths is Unknown or Not Available enter 99.

- Enter 88 if not applicable.

16.12 – Number of Previous Spontaneous Abortions

3M Prompts – Data Entry (*Prev Spont Abortions*) / Reporter (*PerPrevSA)*

Definition – refers to the number/count of prior pregnancies ending in abortion or birth prior to 20 weeks.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Obstetrical Admission

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous spontaneous abortions enter 0 (zero).

- If the number of previous spontaneous abortions is Unknown or Not Available enter 99.

- Enter 88 if not applicable.

16.13 – Number of Previous Therapeutic/Medical Abortions

3M Prompts – Data Entry (*Prev Therap Abortions*) / Reporter (*PerPrevTA)*

Definition – refers to the number/count of prior pregnancies ending in a therapeutic or medical abortion.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Obstetrical Admission

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous therapeutic/medical abortions enter 0 (zero).

- If the number of previous therapeutic/medical abortions is Unknown or Not Available enter 99.

- Enter 88 if not applicable.

16.14 – Number of Previous Abortions (Type Unknown)

3M Prompts – Data Entry (*Prev Abortion Unknown*) / Reporter (*PerAbortUnknown)*

Definition – refers to the number/count of prior pregnancies ending in abortion with the type unknown.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan
3. Obstetrical Admission

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous abortions with type unknown enter 0 (zero).

- If the number of previous abortions (type unknown) is Unknown or Not Available enter 99.
- Enter 88 if not applicable.

16.15 – Number of Previous Caesarean Sections

3M Prompts – Data Entry (*Prev Cesarean Sect*) / Reporter (*PerPrevCS)*

Definition – refers to the number/count of prior pregnancies ending in a caesarean section procedure.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record

2. Physician's History and Physical
3. Obstetrical Admission

Type/Format of Data – numeric

Notes – Enter the number in a range of 00-20. If there were no previous caesarean sections enter 0 (zero).

- If the number of previous caesarean sections is Unknown or Not Available enter 99.

- Enter 88 if not applicable.

Validation – Check the Live Birth Notification Form to help verify if the mother had prior caesarean sections.

Flag(s) – Should not exceed the number entered for Gravida.

16.16 – Type of Primary (First) Antenatal Careprovider

3M Prompts – Data Entry (*Prev Antenat Provider*) / Reporter (*PerPrimAntprov)*

Definition – refers to the individual type that initially provided antenatal care.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – numeric

Input	*Value*
1	**FAMILY PRACTICE PHYSICIAN / GENERAL PRACTITIONER**
2	**OBSTETRICIAN**
4	**MIDWIFE**
6	**REGISTERED NURSE**
7	**OTHER (PLEASE SPECIFY)**
8	**UNKNOWN**
9	**NURSE PRACTITIONER**
10	**RESIDENT**
11	**SURGEON**
12	**PARAMEDIC/AMBULANCE ATTENDANT**
13	**MOTHER**
14	**FAMILY/FRIEND**

Validation – Only 1, 2, 4, 5, 6, 7, 8-14 are valid entries.

16.17 – Identity of Primary (First) Antenatal Careprovider

3M Prompts – Data Entry (*Pr Antenatal Care Pr*) / Reporter (*PerPriAntprovID)*

Definition – refers to the individual name that was the first to provide antenatal care.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – choose from a look-up table.

Notes – The list of doctors provided in the look-up tables may not be up to date. If a careproviders name is not available or unknown leave blank.

16.18 – Type of Secondary (Second) Antenatal Careprovider

3M Prompts – Data Entry (*Sec Antenat Provider*) / Reporter (*PerSecAntprov)*

Definition – refers to the individual type that was the second to provide antenatal care.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Input	*Value*
1	**FAMILY PRACTICE PHYSICIAN / GENERAL PRACTITIONER**
2	**OBSTETRICIAN**
4	**MIDWIFE**
6	**REGISTERED NURSE**
7	**OTHER (PLEASE SPECIFY)**
8	**UNKNOWN**
9	**NURSE PRACTITIONER**
10	**RESIDENT**
11	**SURGEON**
12	**PARAMEDIC/AMBULANCE ATTENDANT**
13	**MOTHER**
14	**FAMILY/FRIEND**

Validation – Only 1, 2, 4, 5, 6, 7, 8-14 are valid entries.

16.19 – Identity of Secondary (Second) Antenatal Careprovider

3M Prompts – Data Entry (*Sec Antenat Care*) / Reporter (*PerSecAntprovID)*

Definition – refers to the individual name that was the second to provide antenatal care.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – choose from a look-up table.

Notes – The list of doctors provided in the look-up tables may not be up to date. If a careproviders name is not available or unknown leave blank.

16.20 – Type of Other (Third) Antenatal Careprovider

3M Prompts – Data Entry (*Oth Antenat Provider*) / Reporter (*PerOtherAntprov)*

Definition – refers to the individual type that was the third to provide antenatal care.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Input	*Value*
1	**FAMILY PRACTICE PHYSICIAN / GENERAL PRACTITIONER**
2	**OBSTETRICIAN**
4	**MIDWIFE**
6	**REGISTERED NURSE**
7	**OTHER (PLEASE SPECIFY)**
8	**UNKNOWN**
9	**NURSE PRACTITIONER**
10	**RESIDENT**
11	**SURGEON**
12	**PARAMEDIC/AMBULANCE ATTENDANT**
13	**MOTHER**
14	**FAMILY/FRIEND**

Validation – Only 1, 2, 4, 5, 6, 7, 8-14 are valid entries.

16.21 – Identity of Other (Third) Antenatal Careprovider

3M Prompts – Data Entry (*Other Antenatal Care*) / Reporter (*PrOtherAntprvID)*

Definition – refers to the individual name that was the third to provide antenatal care.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – choose from a look-up table.

Notes – The list of doctors provided in the look-up tables may not be up to date. If a careproviders name is not available or unknown leave blank.

16.22 – Date of First Antenatal Visit

3M Prompts – Data Entry (*Frst Antenatal Visit*) / Reporter (*PerVisit1)*

Definition – refers to the date of the first antenatal (before giving birth) visit.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – Date (YYYY/MM/DD), for example: 2015/02/10

Validation – A date after Admit Date and Delivery Date (and possible other dates) is NOT VALID.

- If only Year and Month is known, enter 01 for the Day (DD).
- If date is unknown, enter YES in the next field (**Unknown Date of First Antenatal Visit**).

Flag(s) – cross reference with Admit/Delivery/Discharge dates.

16.23 – Prenatal Education

3M Prompts – Data Entry (*Prenatal Education*) / Reporter (*PerEducation)*

Definition – refers to the prenatal education that a mother attended/received/accessed prior to giving birth during the present pregnancy.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part II Interdisciplinary
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Physician's History and Physical
6. Nursing Admission Assessment
7. Obstetrical Admission

Type/Format of Data – numeric.

Input	*Value*
1	**ATTENDED GROUP PRENATAL CLASSES**
2	**ATTENDED ONE ON ONE SESSIONS**
3	**RECEIVED/USED LITERATURE OR VIDEOS**
4	**INTERNET/WEBSITES/ON-LINE**
5	**NO SERVICES**

6 REFUSED SERVICES
7 UNKNOWN (BLANK, A NOTED SLASH, "AWARE")
8 UNSPECIFIED PRENATAL EDUCATION (Y ON PRENATAL EDUCATION IN OBSTETRICAL ADMISSION)

Validation – Only 1 through 8 are valid entries.

16.24 – First Ultrasound Exam Date

3M Prompts – Data Entry (*First Ultrasound Dt*) / Reporter (*PerUSDate)*

Definition – refers to the initial date recorded for an ultrasound during the antepartum period (before giving birth) of the present pregnancy.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record AND Meditech-PCI-Diagnostic Imaging – Ultrasound.

Type/Format of Data – Date (YYYY/MM/DD), for example: 2015/02/10

Validation – A date after Admit Date and Delivery Date (and possible other dates) is NOT VALID.

- If only Year and Month is known, enter 01 for the Day (DD).
- If date is unknown, enter YES in the next field (**Unknown Date of First Ultrasound Exam**).

Flag(s) – cross reference with Admit/Delivery/Discharge dates.

16.25 – Estimated Gestational Age at First Ultrasound

3M Prompts – Data Entry (*Est Gestational Age*) / Reporter (*PerEstGestAge)*

Definition – refers to the estimate of gestational age (18 weeks 6 days) by calculating the difference between first ultrasound date and last menstrual period date.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record AND Meditech-PCI-Diagnostic Imaging – Ultrasound.

Type/Format of Data – numeric: Number (2 digit) Number (1 digit)

Examples: 09 weeks 2 days, 18 weeks 4 days

Validation – A number greater than 42 is not valid for number of weeks. A number greater than 6 is not valid for days. If the estimated gestational age is not available (or cannot be calculated), enter 99 for unknown in weeks and 9 for unknown in days.

16.26 – Ultrasound at 18 to 20 weeks

3M Prompts – Data Entry (*USat18to20weeks*) / Reporter (*PerUSat18to20weeks)*

Definition – refers to if a mother had at least one or more ultrasounds during pregnancy, indicate 1 for Yes, 2 for NO or 3 for UNKNOWN, if one of them was during 18-20 weeks gestation as recommended by SOGC.

Location of Data – Can be found on a number of locations within the chart, such as but no limited to:

1. Newfoundland and Labrador Prenatal Record
2. Imaging in Meditech (ULTRASOUND)

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – SCAN A RECORD WITH AN EXAM NAME ‘OBS 2-3 TRIMESTER’.

Validation – Only 1 through 3 are valid entries.

16.27 – Amniocentesis

3M Prompts – Data Entry (*PerAmnioNew*) / Reporter (*PerAmnioNew)*

Definition – refers to a test during which your doctor takes a small sample of amniotic fluid from around your baby. This fluid contains some of your baby's cells which hold essential genetic information. This sample is then examined in a laboratory to check for any chromosomal abnormalities.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – This indicator is an update on the previous Amniocentesis at 20 weeks or less and will capture all Amniocentesis performed.

Validation – Only 1 through 3 are valid entries.

16.28 – Chorionic Villi Sampling (CVS)

3M Prompts – Data Entry (CVS*New*) / Reporter (*PerCVSNew)*

Definition – refers to a prenatal test in which a sample of chorionic villi is removed from the placenta for testing. During pregnancy, the placenta provides oxygen and nutrients to the growing baby and removes waste products from the baby's blood. CVS is a form of prenatal diagnosis to determine chromosomal or genetic disorders in the fetus.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – This indicator is an update on the previous Chorionic Villi Sampling at 20 weeks or less and will capture all Chorionic Villi Sampling performed.

Validation – Only 1 through 3 are valid entries.

16.29 – Cell-Free Fetal DNA Result

3M Prompts – Data Entry (*Cell Free DNA Result*) / Reporter (*PerCellFreeDNAResult)*

Definition – Cell-free fetal DNA testing (e.g., **Harmony**) is a new screening test that indicates if a woman is at increased risk of having a fetus with Down syndrome (trisomy 21), Edward syndrome (trisomy 18) and Patau syndrome (trisomy 13). With this test, a sample of the

woman's blood is taken after 10 weeks of pregnancy. The test measures the relative amount of free fetal DNA in the mother's blood. The test determines the chance that the fetus has Down syndrome, Edward syndrome or Patau syndrome based on the relative amount of DNA from chromosomes 21, 18 and 13.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record or in Meditech.

Type/Format of Data – numeric

Input	*Value*
1	**NEGATIVE**
2	**POSITVE**
3	**UNKNOWN**
4	**DECLINED**

Notes - if blank on Newfoundland and Labrador Prenatal Record or in Meditech select 3 (UNKNOWN).

Validation – Only 1 through 4 are valid entries.

16.30 – Maternal (Prenatal) Serum Screening Result

3M Prompts – Data Entry (*Mat Ser Scr Result*) / Reporter (*PerMSSResult)*

Definition – refers to the test result of the serum screening.

Location of Data – Can be found on the Newfoundland and Labrador Prenatal Record.

Type/Format of Data – numeric

Input	*Value*
1	**NEGATIVE**
2	**POSITVE**
3	**UNKNOWN**
4	**DECLINED**

Notes - if blank on Newfoundland and Labrador Prenatal Record or in Meditech select 3 (UNKNOWN).

Validation – Only 1 through 4 are valid entries.

16.31 – Rubella

3M Prompts – Data Entry (*Rubella*) / Reporter (*PerRubella)*

Definition – refers to the reactivity of rubella immunity.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Meditech Labs (Referred Serology) (Eastern Health)
4. Meditech – Admission Assessment OBS (Central Health)
5. Meditech – Newborn Interagency Referral (Central Health)
6. Obstetrical Nursing History and Admission Note (Western Health)
7. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
8. Physician's History and Physical
9. Labour and Delivery Record
10. Obstetrical Admission

Type/Format of Data – numeric

Input	*Value*
1	**REACTIVE (AKA IMMUNE REACTIVE – SEROLOGY 10 OR MORE)**
2	**NON-REACTIVE (AKA NON-IMMUNE – SEROLOGY UNDER 10)**
3	**UNKNOWN**

Validation – Only 1 through 3 are valid entries.

16.32 – Syphilis

3M Prompts – Data Entry (*VDRL*) / Reporter (*PerVDRL)*

Definition – refers to the reactivity of Syphilis immunity.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Meditech Labs (Referred Serology) (Eastern Health)
4. Meditech – Admission Assessment OBS (Central Health)
5. Meditech – Newborn Interagency Referral (Central Health)
6. Obstetrical Nursing History and Admission Note (Western Health)

7. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
8. Physician's History and Physical
9. Labour and Delivery Record
10. Obstetrical Admission

Notes – this field may be called VDRL on some forms.

Type/Format of Data – numeric

Input	*Value*
1	**REACTIVE (AKA IMMUNE REACTIVE – SEROLOGY 10 OR MORE)**
2	**NON-REACTIVE (AKA NON-IMMUNE – SEROLOGY UNDER 10)**
3	**UNKNOWN**

Validation – Only 1 through 3 are valid entries.

16.33 – Hepatitis B (HBsAg)

3M Prompts – Data Entry (*HBsAg*) / Reporter (*PerHBsAg)*

Definition – refers to the reactivity of Hepatitis B immunity.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Meditech Labs (Referred Serology) (Eastern Health)
4. Meditech – Admission Assessment OBS (Central Health)
5. Meditech – Newborn Interagency Referral (Central Health)
6. Obstetrical Nursing History and Admission Note (Western Health)
7. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
8. Physician's History and Physical
9. Labour and Delivery Record
10. Obstetrical Admission

Type/Format of Data – numeric

Input	*Value*
1	**REACTIVE (AKA IMMUNE REACTIVE – SEROLOGY 10 OR MORE)**
2	**NON-REACTIVE (AKA NON-IMMUNE – SEROLOGY UNDER 10)**
3	**UNKNOWN**

Validation – Only 1 through 3 are valid entries.

16.34 – HIV

3M Prompts – Data Entry (*HIV*) / Reporter (*PerHIV)*

Definition – refers to the reactivity of HIV immunity.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Meditech Labs (Referred Serology) (Eastern Health)
4. Meditech – Admission Assessment OBS (Central Health)
5. Meditech – Newborn Interagency Referral (Central Health)
6. Obstetrical Nursing History and Admission Note (Western Health)
7. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
8. Physician's History and Physical
9. Labour and Delivery Record
10. Obstetrical Admission

Type/Format of Data – numeric

Input	*Value*
1	**REACTIVE (AKA IMMUNE REACTIVE – SEROLOGY 10 OR MORE)**
2	**NON-REACTIVE (AKA NON-IMMUNE – SEROLOGY UNDER 10)**
3	**UNKNOWN**
4	**DECLINED**

Validation – Only 1 through 4 are valid entries.

MEDICAL RISK FACTORS FOR THIS PREGNANCY (3M screen #16)

Fields 16.35 through 16.36: UNIQUE CIRCUMSTANCES

IN HOPSITAL – NOW NEEDS INSULIN	**ALREADY ON INSULIN**
Insulin Required for PED – NO	**Insulin Required for PED – YES**
Insulin Required for GDM – YES	**Insulin Required for GDM – NO**

16.35 – Insulin Required for Pre-existing Diabetes

3M Prompts – Data Entry (*PED Insulin Required*) / Reporter (*Diabins)*

Definition – refers to if insulin was required for the pre-existing diabetic.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)
6. Physician's History and Physical

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Validation – Only 1 through 3 are valid entries.

16.36 – Insulin Required for Gestational Diabetes

3M Prompts – Data Entry (*GDM Insulin Required*) / Reporter (*GesIns)*

Definition – refers to if insulin was required for the gestational diabetic.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)
6. Physician's History and Physical

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Validation – Only 1 through 3 are valid entries.

16.37 – Urinary Tract Infection

3M Prompts – Data Entry (*Urinary Tract Infec*) / Reporter (*UTI)*

Definition – refers to an infection in any part of your urinary system (kidneys, ureters, bladder and urethra) is or was present DURING THE CURRENT PREGNANCY prior to delivery and documented by the careprovider.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)
6. Physician's History and Physical

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – Code if the condition was present AT ANY TIME POINT DURING THE CURRENT PREGNANCY.

Validation – Only 1 through 3 are valid entries.

LABOUR AND DELIVERY (3M screen #17)

17.1 – Height in cm

3M Prompts – Data Entry (*Height in cm*) / Reporter (*PerHghtcm)*

Definition – refers to the mother's height in centimetres.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)

Type/Format of Data – numeric

Notes – Metric measurement is preferred if both are available. When centimeters are entered, the corresponding number of inches will be calculated automatically in the next field (height in inches). Enter up to one decimal place, when available.

Code 999 for an unknown value.

Validation – none

Flag(s) – an alert will occur if the height is under 122 cm.

17.2 – Height in inches

3M Prompts – Data Entry (*Height in inches*) / Reporter (*PerHghtin)*

Definition – refers to the mother's height in inches.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record

2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)

Type/Format of Data – numeric

Notes – Metric measurement is preferred if both are available. When centimeters are entered, the corresponding number of inches will be calculated automatically in the previous field (height in cm). Enter up to one decimal place, when available.

Code 999 for an unknown value.

Validation – none

Flag(s) – an alert will occur if the height is under 48 inches (4 feet).

17.3 – Pre-Pregnancy Weight in Kilograms

3M Prompts – Data Entry (*Pre-Preg Wgt kg*) / Reporter (*PerPrewgtkg)*

Definition – refers to the mother's pre-pregnancy weight in kilograms.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)

Type/Format of Data – numeric

Notes – May be entered in metric or in imperial measurement - kilograms are preferred if both are available. When kilograms are entered the corresponding number of pounds will be calculated automatically in the next field (pre-pregnancy weight in pounds). Enter up to one decimal place, when available.

Code 999 for an unknown value.

If weight in recorded in a range, code the highest weight. (eg, 60-65 kg: Code 65 kg).

If pre-pregnancy weight is unknown, subtract weight gain (if documented) from pre-delivery weight.

Validation – none

Flag(s) – an alert will occur if the weight is under 45 kg.

17.4 – Pre-Pregnancy Weight in Pounds

3M Prompts – Data Entry (*Pre-Preg Wgt lbs*) / Reporter (*PerPrewgtlb)*

Definition – refers to the mother's pre-pregnancy weight in pounds.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)

Type/Format of Data – numeric

Notes – May be entered in metric or in imperial measurement - kilograms are preferred if both are available. When pounds are entered the corresponding number of kilograms will be calculated automatically in the previous field (pre-pregnancy weight in kilograms). Enter up to one decimal place, when available.

Code 999 for an unknown value.

If weight in recorded in a range, code the highest weight. (eg, 130-135 lbs: Code 135 lbs).

If pre-pregnancy weight is unknown, subtract weight gain (if documented) from pre-delivery weight.

Validation – none

Flag(s) – an alert will occur if the weight is under 100 lbs.

17.5 – Pre-Delivery Weight in Kilograms

3M Prompts – Data Entry (*Pre Delivery Wgt kg*) / Reporter (*PerDelwgtkg)*

Definition – refers to the mother's pre-delivery weight in kilograms.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)

Type/Format of Data – numeric

Notes – If the pre-delivery weight is not available on the **Obstetrical Nursing Care Plan** or **Admission Notes**, the patient's last weight on the **Newfoundland and Labrador Prenatal Record** can be used (if it was documented within one week of delivery).

May be entered in metric or in imperial measurement - kilograms are preferred if both are available. When kilograms are entered the corresponding number of pounds will be calculated automatically in the next field (pre-pregnancy weight in pounds). Enter up to one decimal place, when available.

Code 999 for an unknown value.

If weight in recorded in a range, code the highest weight. (eg, 70-75 kg: Code 75 kg).

If pre-delivery weight is unknown, add pre-pregnancy weight and weight gain (if documented).

Validation – none

Flag(s) – an alert will occur if the weight is under 45 kg.

17.6 – Pre-Delivery Weight in Pounds

3M Prompts – Data Entry (*Pre Delivery Wgt lbs*) / Reporter (*PerDelwgtlb)*

Definition – refers to the mother’s pre-delivery weight in pounds.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Newfoundland and Labrador Prenatal Record
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Obstetrical Nursing History and Admission Note (Western Health)
4. Admission Assessment and History Obstetrics (Labrador Grenfell Health)
5. Meditech – Admission Assessment OBS (Central Health)

Type/Format of Data – numeric

Notes – If the pre-delivery weight is not available on the **Obstetrical Nursing Care Plan** or **Admission Notes**, the patient's last weight on the **Newfoundland and Labrador Prenatal Record** can be used (if it was documented within one week of delivery).

May be entered in metric or in imperial measurement - kilograms are preferred if both are available. When pounds are entered the corresponding number of kilograms will be calculated automatically in the previous field (pre-pregnancy weight in kilograms). Enter up to one decimal place, when available.

Code 999 for an unknown value.

If weight in recorded in a range, code the highest weight. (eg, 150-155 lbs: Code 155 lbs).

If pre-delivery weight is unknown, add pre-pregnancy weight and weight gain (if documented).

Validation – none

Flag(s) – an alert will occur if the weight is under 100 lbs.

17.7 – Pain Management

3M Prompts – Data Entry (*New Pain Mgmt Method*) / Reporter (*NewPain)*

Definition – refers to the type of pain management used DURING LABOUR (not at delivery eg, local). A variety of labour management techniques are available. Several factors influence pain management options, such as physician, nursing and patient preference, and the availability of staff and resources to facilitate.

Location of Data – Can be found on the Labour and Delivery Record.

Type/Format of Data – numeric

Input	*Value*
1	**NONE**
2	**ENTONOX**
3	**EPIDURAL**
4	**NARCOTICS (EG, MORPHINE, NUBAIN, FENTANYL)**
5	**OTHER (EG, TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION, HYPNOSIS)**
6	**UNKNOWN**
7	**NOT APPLICABLE**
8	**LOCAL**

Notes – Up to four different pain management methods used DURING LABOUR can be coded. **This is not to be confused with anesthetic techniques.**

If the mother is having a planned elective caesarean section where she has not laboured, Narcotics or Entonox cannot be selected. Please select 7 (Not Applicable).

If a pain method is not mentioned in the chart, choose NONE in the first pain management field and skip the remaining three fields.

17.8 – Type of Labour

3M Prompts – Data Entry (*Type of Labour*) / Reporter (*Labour Type)*

Definition – refers to the form/onset type in which an expectant mother starts labouring and is ready to deliver her baby/babies. **Spontaneous labour** refers to a labour beginning and progressing without mechanical or pharmacologic stimulation. **Induced labour** refers to a labour that brought on by mechanical or other extraneous means, usually by the intravenous infusion of oxytocin and/or prostaglandin. **No labour** is selected for those who have an elective caesarean section.

Location of Data – Can be found on the Labour and Delivery Record.

Type/Format of Data – numeric

Input	*Value*
1	**SPONTANEOUS**
2	**INDUCED**
3	**NO LABOUR (ELECTIVE C/S)**

Notes – If the patient goes into labour after the last administration of medication (prostaglandin and/or oxytocin) for the purpose of inducing labour, the labour should be coded as induced. Unknown cannot be selected.

17.9 – Primary Indication for Induction

3M Prompts – Data Entry (*Indic for Induction*) / Reporter (*Indicate)*

Definition – refers to the main reason for having to be induced during labour.

Location of Data – Can be found on the Labour and Delivery Record.

Type/Format of Data – numeric

INPUT	*VALUE*
1	**POST DATES**
2	**SROM**
3	**DECREASED AMNIOTIC FLUID**
4	**HYPERTENSION - PIH**
5	**IDDM/GDM (DIABETES)**
6	**IUGR/ NO GROWTH**
7	**TWIN**
8	**PUPP/CHOLESTATIC JAUNDICE**
9	**THROMBOCYTOPENIA**
10	**PREVIOUS STILLBIRTH/POOR OBSTETRICAL HISTORY**
11	**SEIZURE**
12	**ANTIBODIES - ABO**
13	**MACROSOMIA AT TERM**
14	**TERM**
15	**SOCIAL/GEOGRAPHIC**
16	**OTHER (PLEASE SPECIFY)**
17	**NO INDICATION GIVEN**
18	**STILLBIRTH AT TERM**
19	**NOT APPLICABLE**

Notes – If primary indication NOT in the provided list, please complete the next field **Per Ind Induce Other** (PerIndInduceOther in Reporter).

17.10 – Primary Indication for Induction Other

3M Prompts – Data Entry (*Per Ind Induce Other*) / Reporter (*PerIndInduceOther)*

Definition – refers to the reason that was not in the list for Primary Indication for Induction.

Location of Data – Can be found on the Labour and Delivery Record.

Type/Format of Data – text

17.11 – Labour Date and Onset Time

3M Prompts – Data Entry (*Labour Dt/Onset Time*) / Reporter (*LabDate)*

Definition – refers to the date and time in which labour started.

Location of Data – Can be found on the Labour and Delivery Record.

Type/Format of Data – Date (YYYY/MM/DD HH:MM), for example: 2015/02/10 10:55

Notes – Leave blank for elective caesarean section cases.

Validation

- A date before Admit Date is NOT VALID.
- A date after Discharge Date is NOT VALID.
- If only Year and Month is known, enter 01 for the Day (DD).
- If date is unknown or not applicable, enter YES in the next field (**Unknown/Not Applicable Labour Date**).

17.12 – Rupture of Membranes Date and Time

3M Prompts – Data Entry (*Rupture Date/Time*) / Reporter (*ROM)*

Definition – refers to the date and time in which the rupture of the amniotic sac, usually at the start of labor. It may be spontaneous or artificial.

Location of Data – Can be found on the Labour and Delivery Record OR Labour and Delivery Flow Chart

Type/Format of Data – Date (YYYY/MM/DD HH:MM), for example: 2015/02/10 10:55

Notes – If there is more than one rupture of membranes, record the EARLIEST time.

If there is more than one rupture of membranes, record the earliest time.

If the patient has an elective C-section and there is no history of prior rupture of membranes, use the time of birth as the rupture of membranes, since the membranes would have been ruptured at the time of delivery.

If only Year and Month is known, enter 01 for the Day (DD).

If date is unknown or not applicable, enter YES in the next field (**Unknown/Not Applicable Rupture of Membranes Date**).

Validation - A date after Discharge Date is NOT VALID.

17.13 – Spontaneous Rupture of Membranes

3M Prompts – Data Entry (*Spontaneous*) / Reporter (*SponROM)*

Definition – refers to if the rupture of the amniotic sac occurred spontaneously.

Location of Data – Can be found on the Labour and Delivery Record

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

17.14 – Questionable Rupture of Membranes

3M Prompts – Data Entry (*Questionable*) / Reporter (*Quest)*

Definition – refers to a questionable ruptured amniotic sac.

Location of Data – Can be found on the Labour and Delivery Record

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

17.15 – Tocolytics

3M Prompts – Data Entry (*Tocolytics Admin*) / Reporter (*Toco)*

Definition – refers to medication given to prevent or stop premature labour - typically ritodrine, indomethacin (indocid), or nifidepine (adalat, procardia). This will usually occur when the woman is 34 weeks gestation or less.

Location of Data – Can be found on the Labour and Delivery Record and/or Medication Orders.

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

17.16 – Antenatal Steroids for Induction of Fetal Lung Maturity

3M Prompts – Data Entry (*Antenatal Steroids*) / Reporter (*Steroid)*

Definition – refers to medications given to pregnant women expecting preterm delivery. They have been shown to reduce the morbidity and mortality of hyaline membrane disease. Betamethasone and dexamethasone are used with the intention to help the lungs of a premature fetus develop before the fetus comes out. They are given when the fetus is expected to be delivered within 24 to 48 hours. Treatment consists of 2 doses of 12 mg of betamethasone given intramuscularly 24 hours apart or 4 doses of 6 mg of dexamethasone given intramuscularly 12 hours apart. Optimal benefit begins 24 hours after initiation of therapy and lasts 7 days. Betamethasone is preferred over dexamethasone because it is thought to have better prophylaxis of brain softening of premature fetus. Antenatal steroids are currently used up to 36 weeks in some parts of the world obstetric practice.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Medication Order
2. Obstetrical Nursing Care Plan (Eastern Health) – Part I
3. Outpatient Assessment Record
4. Correspondence from another hospital

Type/Format of Data – numeric

Input	*Value*
1	**ONE COMPLETE COURSE (2 DOSES)**
2	**ONE INCOMPLETE COURSE (1 DOSE)**
3	**NONE**
4	**UNKNOWN**

Notes – Usually occurs when the woman is 34 weeks gestation or less or when a woman has been admitted for threatened preterm labour. Earlier admissions for PROM may have tocolytics and steroids recorded. These cases should be captured here.

If dates/times of administration are available, score as noted in Section A or B. If dates are not available, but completeness is discussed, score as noted in Section C. If dates and completeness are not discussed, score as in Section D.

A. COMPLETE is defined as receipt of either two doses of 12 mgs of corticosteroids (betamethasone, beta, celestone, dexamethasone, cortisone,

dihydrocortisone but NOT prednisone) given 24 hours apart or 6 mgs of dexamethasone, given 12 hours apart any time before delivery.

B. PARTIAL is defined as one dose given at any time prior to delivery. If the chart does not mention steroid administration, assume none.

C. If no dates of administration are given, but the chart refers to “complete” or partial doses, score as such.

D. If no dates of administration are given and the chart does not refer to “completeness”, but indicates that steroids were administered, score as “partial”. If the chart specifies that two or more doses were administered score as “complete”.

17.17 – Fetal Heart Monitor

3M Prompts – Data Entry (*Fetal Heart Monitor*) / Reporter (*PerFHR)*

Definition – refers to a device used to monitor the fetal heartbeat and the strength of the mother's uterine contractions during labor.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record
2. Labour and Delivery Flow Chart / Record
3. Labour Partogram (Western Health / Labrador - Grenfell Health)
4. Obstetrical Nursing Care Plan (Eastern Health) – Part I
5. Meditech – Newborn Interagency Referral (Central Health)

Type/Format of Data – numeric

Input	*Value*
1	**ELECTRONIC FETAL HEART MONITORING**
2	**INTERMITTENT AUSCULTATION**
3	**NONE (EG, AS IN SOME STILLBIRTHS)**
4	**UNKNOWN**
5	**BOTH EFHM AND INTERMITTENT AUSCULTATION**

Notes – Scalp Clip is a form of Electronic Fetal Heart Monitoring.

17.18 –Type of Primary Care Provider at Delivery

3M Prompts – Data Entry (*Caregiver at Deliv*) / Reporter (*PerCareprov)*

Definition – refers to the speciality type of the primary person who provided care during the delivery.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record
2. Labour and Delivery Flow Chart / Record
3. Admission/Discharge Summaries
4. Meditech

Input	*Value*
1	**FAMILY PRACTICE PHYSICIAN / GENERAL PRACTITIONER**
2	**OBSTETRICIAN**
4	**MIDWIFE**
6	**REGISTERED NURSE**
7	**OTHER (PLEASE SPECIFY) ***
8	**UNKNOWN**
9	**NURSE PRACTITIONER**
10	**RESIDENT**
11	**SURGEON**
12	**PARAMEDIC/AMBULANCE ATTENDANT**
13	**MOTHER**
14	**FAMILY MEMBER / FRIEND**

Validation – Only 1, 2, 4, 6 - 14 are valid entries.

Notes – If 7-Other is selected, complete next field Care Prov Other.

17.19 –Type of Primary Care Provider Delivery - Other

3M Prompts – Data Entry (*Care Prov Other*) / Reporter (*PerCareProvOthe)*

Definition – refers to the speciality type of the primary person who provided care during the delivery that is not included in the previous indicator list (17.20).

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record
2. Labour and Delivery Flow Chart / Record

3. Admission/Discharge Summaries
4. Meditech

Type/Format of Data – text

Notes – Don't enter in a type that is already in the previous indicator list (17.20).

17.20 –Need for Postpartum Red Blood Cell Transfusion

3M Prompts – Data Entry (*Red Blood Transf*) / Reporter (*PerBlood)*

Definition – refers to if the obstetrical patient required a red blood cell transfusion during the postpartum period. This field applies to the mother NOT the baby.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Blood Transfusion Report
2. Meditech – Blood Bank Products

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

17.21 –Primary Indication for Caesarean Section

3M Prompts – Data Entry (*Prim Ind Fr Caes Sec*) / Reporter (*PerPrimIndCS)*

Definition – refers to if the leading reason to have a caesarean section performed.

Location of Data – can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record
2. Labour and Delivery Flow Chart / Record
3. Admission/Discharge Summaries
4. Operating Room Reports
5. Obstetrical Admission

Type/Format of Data – numeric

Input	*Value*
1	**PREVIOUS CAESAREAN SECTION**
2	**BREECH PRESENTATION**
3	**ATYPICAL OR ABNORMAL FETAL HEART TRACING (FORMERLY KNOWN AS NON-REASSURING FETAL HEART RATE PATTERN)**
4	**FAILURE TO PROGRESS, DYSTOCIA, CEPHALOPELVIC DISPROPORTION, UTERINE INERTIA**
6	**MALPRESENTATION (TRANSVERSE LIE, SHOULDER, BROW, FACE; EXCLUDE BREECH)**
7	**PLACENTA PREVIA**
8	**MAJOR PLACENTAL ABRUPTION**
9	**PROLAPSE OF THE UMBILICAL CORD**
10	**PREECLAMPSIA/ECLAMPSIA**
11	**UNKNOWN**
12	**MATERNAL REQUEST**
13	**MULTIPLE PREGNANCY (I.E., TWIN, TRIPLET)**
14	**FAILED INDUCTION**
15	**IUGR**
16	**FETAL ANOMALY**
17	**OTHER (PLEASE SPECIFY)**
18	**FAILED VACUUM/FORCEPS**
19	**NOT APPLICABLE**

Notes – If primary indication NOT in the provided list, please complete the next field **Pr Prim Ind CS Other** (PerPrimIndCSOth in Reporter).

17.22 –Primary Indication for Caesarean Section - Other

3M Prompts – Data Entry (*Pr Prim Ind CS Other*) / Reporter (*PerPrimIndCSOth)*

Definition – refers to if the leading reason to have a caesarean section performed that is not included in the previous indicator list (17.23).

Location of Data – can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record
2. Labour and Delivery Flow Chart / Record
3. Admission/Discharge Summaries
4. Operating Room Reports
5. Obstetrical Admission

Type/Format of Data – text

Notes – Don't enter in a type that is already in the previous indicator list (17.23).

17.23 –Secondary Indication for Caesarean Section

3M Prompts – Data Entry (*Sec Ind Fr Caes Sec*) / Reporter (*PerSecIndCS)*

Definition – refers to if the second reason to have a caesarean section performed.

Location of Data – can be found on a number of locations within the chart, such as but not limited to:

6. Labour and Delivery Record
7. Labour and Delivery Flow Chart / Record
8. Admission/Discharge Summaries
9. Operating Room Reports
10. Obstetrical Admission

Type/Format of Data – numeric

Input	*Value*
1	**PREVIOUS CAESAREAN SECTION**
2	**BREECH PRESENTATION**
3	**ATYPICAL OR ABNORMAL FETAL HEART TRACING (FORMERLY KNOWN AS NON-REASSURING FETAL HEART RATE PATTERN)**
4	**FAILURE TO PROGRESS, DYSTOCIA, CEPHALOPELVIC DISPROPORTION, UTERINE INERTIA**
6	**MALPRESENTATION (TRANSVERSE LIE, SHOULDER, BROW, FACE; EXCLUDE BREECH)**
7	**PLACENTA PREVIA**
8	**MAJOR PLACENTAL ABRUPTION**
9	**PROLAPSE OF THE UMBILICAL CORD**
10	**PREECLAMPSIA/ECLAMPSIA**
11	**UNKNOWN**
12	**MATERNAL REQUEST**
13	**MULTIPLE PREGNANCY (I.E., TWIN, TRIPLET)**
14	**FAILED INDUCTION**
15	**IUGR**
16	**FETAL ANOMALY**
17	**OTHER (PLEASE SPECIFY)**
18	**FAILED VACUUM/FORCEPS**
19	**NOT APPLICABLE**

Notes – If primary indication NOT in the provided list, please complete the next field **Pr Sec Ind CS Other** (PerSecIndCSOth in Reporter).

17.24 –Secondary Indication for Caesarean Section - Other

3M Prompts – Data Entry (*Pr Sec Ind CS Other*) / Reporter (*PerSecIndCSOth)*

Definition – refers to if the second reason to have a caesarean section performed that is not included in the previous indicator list (17.30).

Location of Data – can be found on a number of locations within the chart, such as but not limited to:

6. Labour and Delivery Record
7. Labour and Delivery Flow Chart / Record
8. Admission/Discharge Summaries
9. Operating Room Reports
10. Obstetrical Admission

Type/Format of Data – text

Notes – Don’t enter in a type that is already in the previous indicator list (17.25).

Fields 17.25 through 17.28 ARE RELEVANT TO LABOUR STAGES START TIMES ON LABOUR AND DELIVERY RECORDS.

17.25 –First Stage Start Time

3M Prompts – Data Entry (*S Tm Frst Stg Lab*) / Reporter (*PerFStageST)*

Definition – In the first stage of labour, your cervix has to move forward (anterior position), ripen and open, so your baby can be born. By the end of this stage your cervix will be fully dilated, and open to about 10cm (3.9in) in diameter.

Location of Data – can be found on the Labour and Delivery Record and Obstetrical Admission (Meditech) and possibly other locations.

Type/Format of Data – Date (YYYY/MM/DD HH:MM), for example: **2015/02/10 10:55**

Notes – If the time of Labour Date/Onset Time is entered then you can skip to the second stage of labour start time.

- If unknown, leave blank and complete next field.

Validation – A date after Discharge Date is NOT VALID.

17.26 – Second Stage Start Time

3M Prompts – Data Entry (*S Tim Sec Stg Lab*) / Reporter (*PerSStageST)*

Definition – In the second stage of labour, mothers begin pushing the baby down the vagina (the birth canal).

Location of Data – can be found on the Labour and Delivery Record and Obstetrical Admission (Meditech) and possibly other locations.

Type/Format of Data – Date (YYYY/MM/DD HH:MM), for example: **2015/02/10 10:55**

Notes – For elective caesarean sections this field is typically left blank on the Labour and Delivery Record. If the time is entered then you can skip to the third stage (delivery time) of labour start time.

If unknown, leave blank and complete next field.

Validation – A date after Discharge Date is NOT VALID.

17.27 – Third Stage (Delivery) Start Time

3M Prompts – Data Entry (*Delivery Time*) / Reporter (*PerDelTime)*

Definition – The third stage of labour begins once your baby is born, and ends when you deliver the placenta and the empty bag of waters that are attached to the placenta (membranes). These come away as your uterus contracts down after the birth.

Location of Data – can be found on the Labour and Delivery Record and Obstetrical Admission (Meditech) and possibly other locations.

Type/Format of Data – Date (YYYY/MM/DD HH:MM), for example: **2015/02/10 10:55**

Notes – If the time of Delivery Date Time is entered then you can skip to the fourth stage (delivery of placenta) of labour start time.

- If unknown, leave blank and complete next field.

Validation – A date after Discharge Date is NOT VALID.

17.28 – Fourth Stage (Delivery of Placenta) Start Time

3M Prompts – Data Entry (*Delivery Time*) / Reporter (*PerDelTime)*

Definition – refers to the date and time of the placenta delivery.

Location of Data – can be found on the Labour and Delivery Record, Obstetrical Admission (Meditech) and possibly other locations.

Type/Format of Data – Date (YYYY/MM/DD HH:MM), for example: **2015/02/10 10:55**

Validation – A date after Discharge Date is NOT VALID.

17.29 – Skin to Skin

3M Prompts – Data Entry (*SkintoSkin*) / Reporter (*PerSkintoSkin)*

Definition – refers to whether or not the newborn was put skin-to-skin immediately (within 10 mins) after birth.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Infant Data Flow Sheets
2. Nursing Newborn Admission Discharge Form
3. Physician Newborn Admission Discharge Form
4. Nursing Notes
5. Meditech (e.g., Infant Newborn Assessment)

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**
4	**N/A, NOT INDICATED**

Validation: If NO is selected the next field should be skipped. If UNKNOWN is selected the next field should also be UNKNOWN.

Notes – At time of Version Update, this information may only be available at some of the hospitals in the province. The goal is to capture this provincially.

NEWBORN INFORMATION (3M screen #18)

18.1 – Birth Number

3M Prompts – Data Entry (*Birth Number*) / Reporter (*PerBirthNum)*

Definition – refers to the number of fetuses, which the expectant mother carried to delivery during the present pregnancy.

Location of Data – can be found on the Labour and Delivery Record/Summary.

Type/Format of Data – numeric

Validation – reminder if the birth number is greater than 1, a multiple birth diagnosis should be coded.

18.2 – Birth Sequence

3M Prompts – Data Entry (*Birth Sequence*) / Reporter (*PerSeq)*

Definition – refers to the order of birth during the present pregnancy.

Location of Data – can be found on the Labour and Delivery Record/Summary.

Type/Format of Data – numeric

Input	*Value*
1	**SINGLETON, OR FIRST BORN OF TWINS, TRIPLETS, ETC.**
2	**SECOND BORN OF TWINS, TRIPLETS, ETC.**
3	**THIRD BORN OF TRIPLETS, ETC.**
4	**FOURTH BORN OF QUADRUPLETS, ETC.**
5	**ETC. IF APPLICABLE**

18.3 – Stillborn

3M Prompts – Data Entry (*Stillborn*) / Reporter (*PerStill)*

Definition – refers to when the fetus (at least 500 grams in weight or > 20 weeks gestation in which there is no breathing, beating of the heart, pulsation of the umbilical cord or unmistakable movement of voluntary muscle) died.

Location of Data – can be found on the Labour and Delivery Record/Summary.

Type/Format of Data – numeric

Input	*Value*
1	**DEATH BEFORE LABOUR ONSET**
2	**DEATH DURING DLEIVERY AND LABOUR**

Validation – Main Patient Service and diagnosis should indicate stillbirth.

18.4 – Place of Birth

3M Prompts – Data Entry (*Place of Birth*) / Reporter (*PerPlace)*

Definition – refers to where the baby was born (stillbirth or liveborn).

Location of Data – can be found on a number of locations within the chart, such as but not limited to:

1. Admission/Discharge Summaries
2. Neonatal Transport Form
3. Meditech

Type/Format of Data – numeric

Input	*Value*
1	**CLINIC/DOCTOR OFFICE**
2	**FREE STANDING BIRTH CENTRE**
3	**HOSPITAL**
4	**IN TRANSPORT (E.G., AMBULANCE/CAR)**
5	**OTHER (E.G., PARKING LOT)**
6	**RESIDENCE**
7	**UNKNOWN**

Notes – If place of birth not in the provided list, please complete the next field Per Place Birth Other.

18.5 – Place of Birth - Other

3M Prompts – Data Entry (*Place of Birth Other*) / Reporter (*PerPlaceOther)*

Definition – refers to where the baby was born (stillbirth or liveborn) that is not included in the previous indicator list (18.5).

Location of Data – can be found on a number of locations within the chart, such as but not limited to:

1. Admission/Discharge Summaries

2. Neonatal Transport Form
3. Meditech

Type/Format of Data – text

18.6 – Gestational Age

3M Prompts – Data Entry (*Gestational Age*) / Reporter (*PerGestAge)*

Definition – Gestational age is the common term used during pregnancy to describe how far along the pregnancy is. It is measured in weeks, from the first day of the woman's last menstrual cycle to the current date. A normal pregnancy can range from 38 to 42 weeks. Infants born before 37 weeks are considered premature. GESTATION AGE ON MOM'S CHART IS BASED ON MOM'S ADMISSION DATE WHILE GESTATION AGE FOR NEWBORNS IS BASED ON WHEN BABY WAS BORN.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Physician Newborn Admission
2. Discharge/Labour and Delivery Record/Summary
3. Nursing Newborn Admission Discharge
4. Newborn Assessment Labour & Delivery

Type/Format of Data – Numeric (2 digits) Number (1 digit), for example: 39 weeks 2 days

Notes - This field is reserved for an estimate other than a neonatal assessment/clinical estimate. This field will usually be calculated by dates. The physician newborn admission form and the nursing newborn form both specify a date calculation. If a gestational estimate is available by U/S use this estimate and record by U/S as the method.

Validation - For Newborn records, a number greater than 42 is not valid for number of weeks. A number greater than 6 is not valid for days.

- Enter 99 for unknown gestation in weeks and 9 for unknown in days.

- **Charts with discrepancies of gestational age need to be identified and pulled for audit. If the documentation is unclear and there are discrepancies please contact PPNL's Clinical Epidemiologist 709-777-4867**

Flag(s) – If gestation is greater than 42. If gestation is less than 20 weeks when admitted to Caseroom for Delivery (OBS Delivered Main Patient Service).

Scenario – If different Gestational Ages are found within the chart (e.g., discharge summary, Ballard Score, Labour and Delivery Record), the discharge summary entry is probably the best choice considering it is typically an agreed upon measure. Refer to provincial standard below.

Provincial Standard – NLCHI (2012) now incorporated into the Discharge Abstracting Manual (DAD), Group 18, Field 06, Gestational Age, Provincial/Territorial Variations for Newfoundland and Labrador. (For this year, the most recent version of the DAD Manual is Fiscal 2018-2019).

RECORDING GUIDELINE: Physician documentation remains the primary source for collecting gestational age information on the newborn/neonate chart. If physician documentation is deficient, documentation from the nursing staff can be used as a secondary source. The gestational age recorded on the mother's chart at the time of delivery may not match the gestational age recorded on the newborn's chart. Only the gestational age recorded on the newborn/neonate chart should be entered on the newborn/neonate abstract.

DOCUMENTATION HIERARCHY:

For each of the patient groups below, coders should attempt to find the gestational age on the first document listed. If not available, the second and third documents listed should be used in that order as alternative sources of the information.

The most reliable place to find gestational age at birth for the following categories of newborns/neonates is as follows:

NEWBORNS/NEONATES BORN IN THE FACILITY:

1. Discharge Summary or equivalent documents such as the Physician Newborn Admission & Discharge Form or Short Stay Summary
2. Copy of the Labor and Delivery Record
3. Live Birth Notification Form
4. History and Physical upon Admission

NEWBORNS/NEONATES ADMITTED FROM ANOTHER FACILITY:

1. Discharge Summary or equivalent documents such as the Physician Newborn Admission & Discharge Form or Short Stay Summary
2. Physician Referral Letter
3. Transfer Notes from the Transport Team
4. History and Physical upon Admission/Admission Note

NEWBORNS/NEONATES ADMITTED FROM HOME OR BORN ENROUTE:

1. History and Physical upon Admission.

18.7 – Gestational Age Assessment Method

3M Prompts – Data Entry (*Gestational Method*) / Reporter (*PerGAmethod)*

Definition – refers to the method in which the gestational age was determined.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Physician Newborn Admission
2. Discharge/Labour and Delivery Record/Summary
3. Nursing Newborn Admission Discharge
4. Newborn Assessment Labour & Delivery
5. Obstetrical Nursing Care Plan

Type/Format of Data – Numeric

Input	*Value*
1	**LAST MENSTRUAL PERIOD (LMP)**
2	**ULTRASOUND (U/S)**
3	**BOTH LMP AND U/S DOCUMENTED**
4	**UNKNOWN**

Notes - If a gestational age is quoted and the method used is questionable choose unknown.

18.8 – Birth Length

3M Prompts – Data Entry (*Birth Length*) / Reporter (*PerLength)*

Definition – refers to the length of the newborns body at birth. Measured in centimetres.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Nursing Newborn Admission Discharge
2. Newborn Assessment
3. Physician Newborn Admission Discharge
4. New Assessment Labour and Delivery
5. Partogram

Type/Format of Data – numeric (centimeters)

Notes – Enter up to one decimal place, when available. Code 99 for an unknown value.

18.9 – Head Circumference

3M Prompts – Data Entry (*Head Circumference*) / Reporter (*PerHC)*

Definition – refers to the circumference of the newborn's head at birth. Measured in centimetres.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Nursing Newborn Admission Discharge
2. Newborn Assessment
3. Physician Newborn Admission Discharge
4. New Assessment Labour and Delivery
5. Partogram

Type/Format of Data – numeric (centimeters)

Notes – Enter up to one decimal place, when available. Code 99 for an unknown value.

18.10 – APGAR Score at 1 minute

3M Prompts – Data Entry (*Apgar Score 1 min*) / Reporter (*PerApgar1)*

Definition – refers to the APGAR score (first assessment given to a newborn to quickly evaluate a newborn's physical condition) documented at 1 minute of life for the newborn.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record
2. Nursing Newborn Admission Discharge
3. Newborn Assessment
4. Physician Newborn Admission Discharge
5. New Assessment Labour and Delivery
6. Partogram

Type/Format of Data – numeric

Notes – Enter a number from 0 to 10. Code 99 for an unknown value.

Validation – A number greater than 10 is not valid with the exception of 99 for unknown.

18.11 – APGAR Score at 5 minutes

3M Prompts – Data Entry (*Apgar Score 5 min*) / Reporter (*PerApgar5)*

Definition – refers to the APGAR score (second assessment given to a newborn to quickly evaluate a newborn's physical condition) documented at 5 minutes of life for the newborn.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record
2. Nursing Newborn Admission Discharge
3. Newborn Assessment
4. Physician Newborn Admission Discharge
5. New Assessment Labour and Delivery
6. Partogram

Type/Format of Data – numeric

Notes – Enter a number from 0 to 10. Code 99 for an unknown value.

Validation – A number greater than 10 is not valid with the exception of 99 for unknown.

Fields 18.12 through 18.16 ARE RELEVANT TO NEWBORN VENTILATION ON NEONATAL RESPIRATORY CARE CHART.

18.12 – Bag and Mask

3M Prompts – Data Entry (*Resuscitate-Bag-Mask*) / Reporter (*PerPPBM)*

Definition – refers to whether or not a bag valve mask (an airway apparatus used to cover the patient's nose and mouth and begin ventilating the lungs manually by squeezing a reservoir of oxygen or air) was given to the newborn.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record/Summary
2. Neonatal Respiratory Care Chart

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

18.13 – Endotracheal Tube

3M Prompts – Data Entry (*Endotracheal Tube*) / Reporter (*PerEttube)*

Definition – refers to whether or not a flexible tube was inserted nasally, orally, or through a tracheostomy into the trachea or the newborn to provide an airway, as in tracheal intubation.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record/Summary
2. Neonatal Respiratory Care Chart

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – Not to be confused with ET Suction for meconium.

18.14 – Assisted Ventilation greater than 30 minutes

3M Prompts – Data Entry (*Ventilation > 30 minutes*) / Reporter (*AssisVent30)*

Definition – refers to whether or not the newborn has received assistance in breathing that lasted more than 30 minutes.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record/Summary
2. Neonatal Respiratory Care Chart

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

18.15 – Continuous Positive Airway Pressure (CPAP)

3M Prompts – Data Entry (*CPAP*) / Reporter (*PerCPAP)*

Definition – refers to whether or not the newborn received continuous positive airway pressure (CPAP). CPAP is the positive end-expiratory pressure (PEEP) provided continuously to a spontaneously breathing newborn. In the Resuscitation Area, CPAP is typically charted as PEEP times X number of minutes. Following the initial resuscitation, CPAP is generally charted as CPAP with a PEEP of X.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Labour and Delivery Record/Summary
2. Neonatal Respiratory Care Chart

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – This method is considered to be non-invasive. For babies being transferred to another hospital, please check transfer forms (if included in chart or Meditech) to confirm if CPAP was administered.

Fields 18.16 and 18.17 ARE RELEVANT TO BRONCHOPULMONARY DYSPLASIA (BPD) WHICH IS A PULMONARY DISEASE OF PREMATURITY. BPD IS TYPICALLY DEFINED WHEN TWO OF THE FOLLOWING ARE MET:

1 - Abnormal chest x-ray not typical of any other disease.

2 - Clinical respiratory distress greater than two weeks.

3 - PCO2 of greater than 60 mm Hg on 2 or more occasions after one week of age with no other obvious cause.

18.16 – Bronchopulmonary Dysplasia (BPD) in O_2 at 28 days of age

3M Prompts – Data Entry (*Bronchopul Dys 28d*) / Reporter (*BPD28)*

Definition – refers to pulmonary disease of prematurity. This infant must still be on oxygen at 28 days of age.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Physician Newborn Admission Discharge Form
2. Physician Consultations
3. Progress Notes

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

18.17 – Bronchopulmonary Dysplasia (BPD) in O_2 at 36 weeks corrected age

3M Prompts – Data Entry (*Bronchopul Dys 36w*) / Reporter (*BPD36)*

Definition – refers to pulmonary disease of prematurity. This infant must still be on oxygen at 36 weeks correct age (e.g., an infant born at 30 weeks gestation would be 36 weeks corrected age after a 6 week length of stay or 42 days).

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Physician Newborn Admission Discharge Form
2. Physician Consultations
3. Progress Notes

Type/Format of Data – numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

Notes – The following table will aid in coding.

Gestation at Birth	Length of stay to reach 36 weeks corrected age
23 weeks	13 weeks or 91 days
24 weeks	12 weeks or 84 days
25 weeks	11 weeks or 77 days
26 weeks	10 weeks or 70 days
27 weeks	9 weeks or 63 days
28 weeks	8 weeks or 56 days
29 weeks	7 weeks or 49 days
30 weeks	6 weeks or 42 days
31 weeks	5 weeks or 35 days
32 weeks	4 weeks or 28 days

18.18 – Type of First Enteral Feed

3M Prompts – Data Entry (*Type of First Enteral Feed*) / Reporter (*PerTypeofFirstEnteralFeed)*

Definition – refers to the type of initial oral feed given to the newborn following birth.

Location of Data – Found as the FIRST ENTRY on the Infant Data Flow Sheets or under feeding/comments on the Newborn Assessment Labour & Delivery form and on Patient Care Notes.

May also be located in Meditech – Lactation Consultation Notes AND Nursing Notes.

Type/Format of Data – numeric

Input	*Value*
1	**HUMAN MILK (INCLUDES COLOSTRUM, EXPRESSED HUMAN MILK, DONOR HUMAN MILK AND ATTEMPTED BREASTFEEDING)**
2	**FORMULA (COMMERCIAL INFANT FORMULA)**
3	**GLUCOSE / SUGAR WATER (NOT IV)**
4	**UNKNOWN (E.G., TYPE/ROUTE NOT DOCUMENTED)**

5 HUMAN MILK / FORMULA COMBINATION

6 NOT APPLICABLE (NEVER RECEIVED AN ENTERAL FEED (E.G., STILLBIRTH OR NEONATAL DEATH)

18.19 – Breastfeeding from Birth to Discharge (EXCLUSIVE)

3M Prompts – Data Entry (*Breastfeeding*) / Reporter (*Perbfeed)*

Definition – refers to whether or not the newborn was breastfed exclusively or not during their initial hospital admission from birth.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Infant Data Flow Sheets
2. Nursing Newborn Admission Discharge Form
3. Physician Newborn Admission Discharge Form
4. Nursing Notes
5. Breastfeeding Assessment

Type/Format of Data – numeric

Input	*Value*
1	**EXCLUSIVE (No liquid NOT EVEN WATER other than human milk since birth)**
2	**NON-EXCLUSIVE ((Predominant/Partial (any breastfeeding) Human milk includes supplemental feeds of liquid or nonhuman milk)**
3	**NO BREASTFEEDING (no breastmilk since birth)**
4	**UNKNOWN (No information available)**

Notes – Please scan ALL entries from birth to discharge in determining whether or not the newborn was fed human milk exclusively.

18.20 – Medical Indication for Supplementation

3M Prompts – Data Entry (*MedicalndSupp*) / Reporter (*PerMedIndSupp)*

Definition – refers to whether or not the newborn received supplemental feeds of liquid or nonhuman milk due to a medical reason during their initial hospital admission from birth.

Location of Data – Can be found on a number of locations within the chart, such as but not limited to:

1. Infant Data Flow Sheets
2. Nursing Newborn Admission Discharge Form
3. Physician Newborn Admission Discharge Form
4. Nursing Notes
5. Meditech

Type/Format of Data – numeric

Input	*Value*
1	**MEDICALLY INDICATED**
2	**NON-MEDICALLY INDICATED**
3	**UNKNOWN**
4	**NOT APPLICABLE (Formula fed babies with non-human milk)**

Notes – At time of Version Update, this information may only be available at some of the hospitals in the province. The goal is to capture this provincially.

18.21 – CCHD Screening

3M Prompts – Data Entry (*CCHDScreening*) / Reporter (*CCHDScreening)*

Definition - Critical Congenital Heart Disease is a term that refers to a group of serious heart defects that can affect the structure or vessels of the heart and are present from birth. Pulse oximetry is used to screen all healthy newborns between 24 - 36 hours of life, before discharge.

Location of Data - Can be found on the:

1. Newborn Pulse Oximetry Screening for Critical Congenital Heart Disease (CCHD) form
2. Physician Newborn Admission/Discharge Form
3. Nursing Newborn Admission Discharge

Type/Format of Data - Numeric

Input	*Value*
1	**YES**
2	**NO**
3	**UNKNOWN**

4 N/A, NOT INDICATED (e.g., Antenatal Diagnosis by Prenatal Ultrasound, or by ECHO before 24 hours)

Validation: If NO is selected the next field should be skipped. If UNKNOWN is selected the next field should also be UNKNOWN.

18.22 – CCHD Screening Result

3M Prompts – Data Entry (*CCHDScreeningResult*) / Reporter (*CCHDScreeningResult)*

Definition - Refers to the result of the Critical Congenital Heart Disease Screening.

Input Value

1 PASS (NO FURTHER FOLLOWUP REQUIRED)

2 REFER (ADDITIONAL DETAILED CLINICAL ASSESSMENT BY MOST RESPONSIBLE PHYSICIAN REQUIRED)

3 UNKNOWN

Note to Coders: A REFER may ultimately result in a PASS if CCHD is ruled out following clinical assessment.

Validation: UNKNOWN should be selected only if the previous field had UNKNOWN selected.

18.24 – NICU Transport Reason

3M Prompts – Data Entry (*NICUTransportReason*) / Reporter (*NICUReason)*

Definition – The reason indicated for transporting a neonate baby to a Newborn Intensive Care Unit (NICU).

Location of Data – Can be found on the:

1. Neonatal Transport Form
2. Letter from Referring Physician
3. Physician Newborn Admission/Discharge Form
4. Progress Notes
5. Nursing Notes
6. Meditech

Type/Format of Data – Free Text

APPENDIX:

SAMPLE FORMS

SAMPLE FORMS

Newfoundland and Labrador Prenatal Record

Live Birth Notification Form

Newfoundland Labrador

Government of Newfoundland and Labrador
Service NL, Vital Statistics Division
LIVE BIRTH NOTIFICATION 2020

1. Registration number | | | | 10 | | | | |
Department Use Only

Privacy Notice
Personal information contained on this form is collected under the authority of the Vital Statistics Act 2009, and will be used to register the birth, update or amend other vital event records, and provide extracts or search notices for administrative, statistical, research, medical and law enforcement purposes.
If you have any questions about the collection or use of this information, please contact a Vital Statistics Client Representative at the following location: →

Vital Statistics Division
Service Newfoundland and Labrador
P.O. Box 8700
St. John's, NL Canada A1B 4J6
T (709) 729-3308

Part A – Mandatory for Registration of Birth (Required within 48 hours of delivery)

INFANT

2. Surname — Full Given Name(s)
3. Sex ☐ M ☐ F ☐ Unknown
4. Date of Birth MMDDYYYY
5. Locality of Birth ☐ Hospital ☐ Private Home ☐ Other Health Care Facility ☐ Unknown ☐ Other **(Specify)** → ______
6. Hospital — Hospital Code
7. Place of Occurrence City / Town
8. Infant's Admit #
9. Infant's Hospital Chart #

MOTHER

10. Surname, Full Given Name(s)
11. Maiden Name and Initials
12. Health Care Number
13. Date of Birth MMDDYYYY
14. Age at Delivery
15. Birth Place **(Province/Territory-Country if Outside Canada)**
16. Usual Home Address — SGC Code — Postal Code — Telephone Number ( )
17. Complete Mailing Address — Postal Code
18. Legal Marital Status of Birth Mother
☐ Never Married ☐ Legally Married and Not Separated ☐ Legally Married but Separated ☐ Divorced ☐ Widowed ☐ Unknown
19. Living Arrangements of Birth Parents ☐ Living Together as a Couple ☐ Not Living Together as a Couple ☐ Unknown
20. Marital Relationship of Birth Parents of this delivery **(Legally Married to Each Other)** ☐ Yes ☐ No ☐ Unknown
21. Education ☐ Has not Graduated High School ☐ Graduated High School ☐ Beyond High School ☐ College or University Degree **(including trade)** ☐ Unknown

OTHER PARENT

22. Surname, Full Given Name(s)
23. Date of Birth MMDDYYYY
24. Age
25. Birth Place **(Province/Territory-Country if Outside Canada)**

HEALTH HISTORY AND MEDICAL CERTIFICATION OF BIRTH

27. Total Number of Children Ever Born to this Mother **(Including this delivery)** Number Liveborn ______ Number Stillborn ______
28. Complete Date of Last Delivery **(prior to this delivery)** MMDDYYYY
29. Total Number of Infants in this Delivery **(Including Live & Stillborn)**
☐ Single birth ☐ Twin ☐ Triplet ☐ Quadruplet ☐ Quintuplet
30. Number of Stillborn in this Delivery ☐ None Number: ______
31. Multiple Birth-Birth Order: ☐ 1st ☐ 2nd ☐ Other **(Specify)** ______
32. Gestational Age ______ weeks ______ days
33. Was this Birth due to Medical Termination of Pregnancy? ☐ Yes ☐ No
34. Birth Weight ______ grams
35. Delivered by **(Surname, Given Name) - Identify Only One Person**
36. Designation of Attendant **(Select one only)** ☐ Medical Doctor ☐ Midwife ☐ RN ☐ Unknown ☐ Other **(Specify)**
37. Signature for Certification of Birth
38. Date MMDDYYYY
39. Prior C/Section(s) ☐ Yes ☐ No
40. Substance Use During Pregnancy ☐ Cigarette Smoking ☐ Vaping (nicotine/non-nicotine) ☐ Alcohol ☐ Cannabis/ Cannabinoids ☐ Methadone/ Suboxone ☐ Opioids ☐ Inhalants/ Solvents ☐ Stimulants ☐ Other ☐ None
41. Prenatal Care began at Num. of Weeks → ______
42. Supports Available (check one only) ☐ Husband / Partner ☐ Lives Alone ☐ Living with Parents / Other supports
43. Prenatal Care Provider **(Check all that apply)** ☐ Family Doctor/GP ☐ RN ☐ Midwife ☐ OBS / GYN ☐ NP ☐ None ☐ Other **(Specialty)** ______
44. Maternal Risk Factors
☐ None ☐ Gestational Diabetes ☐ Pre-existing Diabetes ☐ Hypertension **(Chronic)**
☐ Anemia **(<100G/L)** ☐ Violence during pregnancy ☐ Antepartum Hemorrhage ☐ Depression ☐ Hypertension **(Assoc. Pregnancy)**
Pre-pregnancy BMI: ☐ 25.0 - 29.9 ☐ 30+
☐ Isoimmunization ☐ IUGR ☐ UTI ☐ Other **(Specify)** ______
Dx Code
45. Labour Onset (check one only) ☐ Spontaneous ☐ Induction ☐ No labour
46. Delivery Presentation ☐ Vertex ☐ Breech ☐ Other **(Specify)** ______ Dx Code
47. Method of Delivery ☐ Vaginal Spontaneous ☐ Vaginal Assisted ☐ C/Section ➢ **Reason(s) for C/Section:** Dx Code
48. Interventions / Complications of Delivery (check all that apply)
Delivery Interventions ☐ None ☐ Episiotomy ☐ Forceps ☐ Vacuum Extraction
Delivery Complications Dx Code ☐ None ☐ 3rd Degree Tear ☐ 4th Degree Tear ☐ Shoulder Dystocia ☐ Postpartum Hemorrhage ☐ Other **(Specify)** ______
(Do not record 1st and 2nd degree tears)
49. Apgar Score At 1 ______ At 5 ______
50. Mother's Admit Number
51. Mother's Chart Number

DISTRIBUTION: White and Green - Vital Statistics Goldenrod - Hospital Pink - Health and Community Services

8-2300-73.1: 2019-10-08

Sample Obstetrical Nursing Care Plan (Kardex) – Part I

Eastern Health
General Site

Obstetrical
Nursing Care Plan Part I
Women's Health Program

Name:
MCP#:
Chart #:

Admission Date: Time: Dr. Notified:
Admitting Diagnosis: Other Diagnosis:
Operations/Dates: Type of Delivery:
Delivery Date: Time: Sex: Feeding:
Gravida: Para: Abortion: Stillbirth:
NND SIDS No. of Living Children:
LMP: EDC:
Gestational Age on Admission: Present Gestational Age:
Previous C/S: VBAC
TPR: BP: FH Ultrasound Date:
Wt: Ht:
Rubella Status: ☐ Immune ☐ Non Immune
HbsAg
Group B Strept: HIV
Blood Group: Rh
Rhogam Given: Date
Admission Blood Done: ☐ Yes ☐ No
Admission Urine Done: ☐ Yes ☐ No

Accommodation Requested
Marital Status:
Support Person
Address:
Phone

Allergies	Reaction	Consultation	Notified	Visited
1.				
2.				
3.				
4.				

Teaching (pencil)	Labour & Delivery Assessment (pencil)	Hygiene	Diet	Date
		Mouth Care		
		Dentures		
Parental Fluids (pencil)		Pericare		
		Bath		

C	A	S/T	S	Date	Activity	Date

Breast Care:
Episiotomy:
Sutures: Siderails
Dressing: Aids

Tests/Investigations (Pencil)	Treatments (Pencil)

TPR	B/P	FHR
Non Stress Test		Biophysical Profile
Fetal Movement Count		Glucometer
I/O	Wt	Alb
Urinalysis	CBC	T/S

ch-0120 2000/06

Sample Obstetrical Nursing Care Plan (Kardex) – Part II

Eastern Health
General Site

Obstetrical
Nursing Care Plan Part II
Women's Health Program

Nursing Assessment

Name:
MCP#:
Chart #:

Review of Systems

Respiratory ☐ No Problem ☐ Problem
Describe:

Smoking ☐ No ☐ Yes Amount per Day

Musculoskeletal ☐ No Problem ☐ Problem
Describe:

Weight gain during pregnancy
Weight loss during pregnancy

Neurological ☐ No Problem ☐ Problem
Describe:

Skin ☐ No Problem ☐ Problem
Describe:

Cardiovascular ☐ No Problem ☐ Problem
Describe:

Gastrointestinal ☐ No Problem ☐ Problem
Describe:

Alcohol during pregnancy ☐ No ☐ Yes
Amount

Genitourinary ☐ No Problem ☐ Problem
Describe:

Previous UTI's ☐ Yes ☐ No
Previous STD's ☐ Yes ☐ No

Past History

Problem with Previous Pregnancy/Delivery ☐ No ☐ Yes
Describe:
Previous Surgery ☐ No ☐ Yes
Describe:
Medical Condition ☐ No ☐ Yes
Describe:
Previous Blood Transfusion ☐ No ☐ Yes
Reaction:

Present Medications (prescribed or non prescribed)

Name of Medication	Dose/Schedule	Taken Today
1.		
2.		
3.		
4.		
5.		

Interdisciplinary Teams

Social Work
Pastoral Care
Prenatal Classes
Physiotherapy
Dietetics

Family History

Congenital Anomalies
Infants/Childhood Deaths
Mental/Physical Disabilities
Diabetes
Heart Disease
Hypertension

Current Pregnancy

Abdominal Palpation: Membranes Intact ☐ Yes ☐ No
Presentation: Date Ruptured Time
Position: Colour of Fluid
Engagement:
1st Positive Pregnancy Test Date:
Method of Birth Control Used:
Problems with this Pregnancy ☐ No ☐ Yes
Describe:

Previous Admission with this Pregnancy ☐ No ☐ Yes
Date:
Reason:
Breastfeeding ☐ No ☐ Yes
Previous Experience ☐ No ☐ Yes
Breasts ☐ No Problem ☐ Problem
Describe:

Comments

Nurse's Signature ____________ Date: ____________

ch-0120 2000/06

Sample Labour Delivery Record

Eastern Health
Child/Women's Health Program

Labour Delivery Record

CR1450 0104 08 2012

SECTION 1 - TO BE COMPLETED BY PHYSICIAN

ANTEPARTUM STATUS

LMP
EDC
Gestn. At Del.
☐ Singleton
☐ Twins
☐ Other

Grava
Para
Abort
SB
NND

ABO Rh
Blood Group
Rh Titre
HGB
Rubella Titre
HB Ag.
Group B Strep

MEDICAL HISTORY ☐ Normal ☐ Abnormal
Specify:

Problems Previous Pregnancy or Infant ☐ No ☐ Yes
Specify:

COMPLICATIONS OF THIS PREGNANCY ☐ None
☐ Bleeding ☐ Toxemia ☐ Diabetes
☐ PROM ☐ Premature Labour ☐ IUGR

LABOUR ☐ Spontaneous
Indication for Induction:
☐ Induced — ☐ ARM ☐ Oxytocin ☐ Prostaglandin
☐ Augmented
☐ Prior Caesarean ☐ Attempted VBAC

DELIVERY ☐ SVD
☐ Operative/Vaginal
Rotation Traction
☐ Outlet Manual ☐
☐ Low Vacuum ☐ ☐
☐ Mid Forceps ☐ ☐
☐ Trial
Position at Delivery
Operative Indication:
Position at Intervention

Caesarean ☐ LS Trans. ☐ LS Vert. ☐ Classical
Breech ☐ Spont. ☐ Assisted ☐ Forceps ☐ Extracted
Episiotomy ☐ None ☐ Midline ☐ Mediolateral
Lacerations ☐ None ☐ Cervical ☐ Perineal ☐ Vaginal
☐ Anal Sphincter ☐ Rectal Mucosa

Placenta ☐ Spont. ☐ Assisted ☐ Manual
Umbilical Vessels ☐ 3 ☐ 2 Abnormalities:

Post Partum Estimated Blood Loss ______
Oxytocin ☐ None ☐ Bolus ☐ Infusion
☐ Ergometrine
☐ Prostaglandin

FETAL HEART Interpretation ☐ Electronic ☐ Auscultation

Last Fetal pH Result ______ Time ______

Stillbirth Last Fetal Movement ______ FHR ______

Signature of Delivering Physician

SECTION 2 - TO BE COMPLETED BY NURSE

MEMBRANE RUPTURE
☐ Spontaneous
☐ Questionable
☐ ARM
Date
Time
Duration
T. ≥ 38 in Labour

MECONIUM ☐ Yes ☐ No Time First Noted ______

1st STAGE Date ______ Time ______ Dur. ______
2nd STAGE Date ______ Time ______ Dur. ______
DELIVERY Date ______ Time ______
3rd STAGE Date ______ Time ______ Dur. ______

DRUGS
Time (Within 24 Hours) Drug/Dose/Route

ANAESTHESIA
☐ Local ☐ None ☐ Entonox ☐ Spinal
☐ Epidural ☐ Pudendal ☐ General
Signature:

SECTION 3 - TO BE COMPLETED BY PHYSICIAN & NURSE

Sponge and Needle Count
Initial Count: Sponges ______ Needles ______
1st Signature ______
2nd Signature ______
Final Count: Sponges ______ Needles ______
1st Signature ______
2nd Signature ______

SECTION 4 - TO BE COMPLETED BY NEONATAL TEAM

CONDITION AT BIRTH	1 min	5 min	10 min
Tone			
Colour			
Respiration			
Response			
Heart Rate			
APGAR SCORE			

RESUSCITATION:
☐ None
☐ Oxygen Only
☐ Pos. Pres. Bag and Mask
☐ Pos. Pres. Bag and Tube
☐ Pos. Pres. Began
______ to ______
☐ ET Suction
Meconium ☐ Yes ☐ No

BABY ☐ Girl ☐ Boy Weight ______ Cord pH ______

COMMENTS:

Signature of Neonatal Nurse/Physician

WHITE - MOTHER'S CHART CANARY - INFANT'S CHART PINK - PHYSICIAN'S OFFICE GOLD - DISCHARGE SUMMARY ch-0104 2014/04

Sample Labour and Delivery Summary (Meditech)

```
RUN DATE: 06/05/16    PATIENT CARE INQUIRY - EH **LIVE**  for HAYSUSA          PAGE 1
RUN TIME: 1144                     PATIENT ASSESSMENT
RUN USER: HAYSUSA
                                Labor and Delivery Summary

Patient:                                                       Age/Sex:
Account #:                                                     Unit #:
Admit Date:                                                    Location:
Status: DIS IN                                                 Room/Bed:
Attending: ELLIOTT,DR. CLAIRE

 Gravida: 1     Para: 0
 EDD: MAR 1/16            LMP: 15/06/15            Gestation(wks): 40    days: 6
# of living children: 0   Abortions: 0       Stillbirths: 0    NND: 0    SIDS: 0
     Blood group: O                 Group B Strep status: Negative
            RH: Positive                     HIV status: Non reactive
Risk Indicators:
   Previous preg: Not applicable/none          This preg: Not applicable/none
---------- First Stage ----------
     Onset date: 08/03/16      Time: 1930        Duration: 2.45
     Spontaneous: Y
  Induced:   Type:                            Indication:
Augmented: N Type:
Membranes ruptured: Artificial rupture membra  Date: 08/03/16 Time: 2200  Duration: 1.20
           Color: Clear
--------- Second Stage ---------
Complete Dilatation:     Date: 08/03/16        Time: 2215     Duration: 1.05
Active Pushing:          Date: 08/03/16        Time: 2215     Duration: 1.05
Delivery:                Date: 08/03/16        Time: 2320
Presentation: Cephalic                     Position: Occiput Anterior
Mode:
1.Spontaneous Vaginal:
2.Assisted Vaginal: Y  Forceps:                          Vacuum: Yes
                          Type:                            Type: Electric
3.Caesarean: N  Indication:                        Uterine Inc:
Episiotomy: Y Type: Right Mediolateral
Laceration: N Type:
--------- Third Stage ---------
Date: 08/03/16 Time: 2324   Duration: 4 MIN
 Placental delivery: Controlled cord traction   Umbilical vessels: 3
     Abnormalities:
Blood loss after delivery(mLs): 200
-- Labor/Delivery Meds --      Given: Y
Medication: SYNTCINON          Dose: 10      Medication:                   Dose:
  Route: IM  Date: 07/03/16    Time: 2321      Route:     Date:            Time:
Medication:                    Dose:         Medication:                   Dose:
  Route:     Date:             Time:           Route:     Date:            Time:
Anesthesia: Pudendal
--- Infant Data ---
  Livebirth: Y    Stillbirth:          Last Fetal Movement Date:           Time:
Gender: M   Birth order:   of          Last Fetal Heart    Date:           Time:
   Wgt (kg): 3.250     Wgt (lbs): 7       Wgt (oz): 2.64
Length (cm): 52      Length (in): 20.47     Head Circumference: 34.5 (cm)
Cord pH done: Y     Arterial: Y      Venous: Y
--- Apgars ---         -- 1 min --     -- 5 min --      -- 10 min --
              Muscle tone: 1            | 2            |
                    Pulse: 2            | 2            |
                 Reflexes: 1            | 1            |
               Skin color: 2            | 2            |
             Respirations: 1            | 2            |
```

Sample Obstetrical Admission – Part 1 (Meditech)

```
RUN DATE: 06/05/16    PATIENT CARE INQUIRY - EH **LIVE**  for HAYSUSA               PAGE 1
RUN TIME: 1144                       PATIENT ASSESSMENT
RUN USER: HAYSUSA
                                    Obstetrical Admission

Patient:                                                          Age/Sex:
Account #:                                                        Unit #:
Admit Date:                                                       Location:
Status: DIS IN                                                    Room/Bed:
Attending: ELLIOTT,DR. CLAIRE

        Date of Admission:                               Time:
Information obtained from: Patient/Resident
Comments:
Next of Kin:
Person to notify in Emergency:
Advance Health Care Directive: N  If yes, copy for chart:      Booklet given:
*Ensure Identification Band on*       *Allergy Armband on if applicable*
Arrival to Unit: Ambulatory
Language: English              Interpreter required: N  *Shift F8 for telephone numbers*
Comments:
Patient's understanding of reason for admission:
? IN LABOR
Ability to read: Y       Ability to write: Y
Comments:
General appearance (emaciated, pale, expression, etc.):
PLEASANT LADY ?IN EARLY LABOR
Do you wish to identify your religion so we can provide you with services from the Pastoral
Care Department:
Do you have any special needs/instructions related to your culture: N
Comments:
                             --------Clinical Data--------
         Temp: 36.3               Temp Source: Oral
        Pulse: 78                Pulse Source: Monitor
         Resp: 20                     O2 Sat: 98 %
Blood Pressure: 128/80         Blood Pressure Source: LF/LYING
 Ht:   (ft)          Ht:       (in)      Ht:          (cm)
Wgt:        (lb)     Wgt:      (oz)      Wgt:         (kg)   BMI: .00
FHR:   1. 144               2.                     3.                    4.
Location: LQ         Location:            Location:            Location:
  Source: UTWR         Source:              Source:              Source:
Comments:
Previous Admissions/Operations/Procedures:
             Admission/operation/procedure                                      Date
:                                                                        :
:                                                                        :
:                                                                        :
:                                                                        :
:                                                                        :
:                                                                        :
Have you ever had an anesthetic: N  Problems with anesthetic: Patient: N Family: N
Comments:
Any upcoming medical investigations or appointments: N
Comments:
Use of tobacco products in the last 6 months: N   Quit:    When:
                     Type and amount per day:
                   Smokers helpline referral:
      Eastern Health smoking policy reviewed:
  Have you had alcohol during this pregnancy: N
                              Amount per day:
```

Sample Obstetrical Admission – Part 2 (Meditech)

```
RUN DATE: 06/05/16    PATIENT CARE INQUIRY - EH **LIVE**  for HAYSUSA              PAGE 2
RUN TIME: 1144                     PATIENT ASSESSMENT
RUN USER: HAYSUSA
                                  Obstetrical Admission

Patient:                                                          Age/Sex:
Account #:                                                        Unit #:
Admit Date:                                                       Location:
Status: DIS IN                                                    Room/Bed:
Attending: ELLIOTT,DR. CLAIRE

          Do you use/abuse other substances: N
 Are you using or have you used Street Drugs: N
Name and when last taken:
Are you presently receiving Methadone treatment for Opioid dependence: N
*If yes, notify Physician*
Comments:
                            -------- CURRENT PREGNANCY HISTORY --------
Gravida: 1    Para: 0    EDD: MAR 1/16           LMP: 15/06/15
# of living children: 0    Abortions: 0    Stillbirths: 0    NND: 0    SIDS: 0
Present gestational age: 40+6      Abdominal palpation:
Presentation: VERTEX
Membranes ruptured: No                       Color:
              Date:              Time:       Amount:
 Tightenings: Y   Frequency: q 5  min
Contractions: N   Date:            Time:          Frequency: q     min   Duration:      secs
              Strength:
 Adequate resting tone:
  Method of assessment: Tocotransducer
Fetal movement: Y
Weight gain: 27          Weight loss:
Previous admissions during this pregnancy: N
Describe:
         PV bleeding: N       Type II Diabetes: N        Nausea/vomiting: N
Gestational Diabetes: N          Hypertension: N             Headaches: N
     Type I Diabetes: N        Blurred vision: N        Edema: N   Pain: N
Date of first ultrasound: 08/31/15              Previous Non-stress Test: Y
Comments:
Have you had any visits to Maternal Fetal Assessment Unit: N
Comments:
 Prenatal care: Y  Prenatal education: Y
Breast feeding: Y  Previous breast feeding experience: N
Describe:
 Rubella status: Reactive                   Group B Strep status: Negative
     HIV status: Non reactive                       HBsAg status: Non reactive
Syphilus status: Non reactive
Maternal serum screening: N                 Sexually Transmitted Infections: N
Comments:
Blood group: O              RH: Positive
     Rhogam: N      Date given:
Are you currently taking any medications: N
  Was folic acid taken preconceptionally: Y
  Have you been taking prenatal vitamins: Y
                            -------- OBSTETRICAL HISTORY --------
wt of largest babe:                wt of smallest babe:
      Previous C/S: N                    VBAC: N                    PPH: N
   Placenta Previa: N           Abruption: N        Premature birth: N
 Retained placenta: N     Prolonged labor: N     Precipitous labor: N
Operative vaginal delivery:
Comments:
```

Sample Physician Newborn Admission and Discharge

Eastern Health
Child/Women's Health Program

Physician
Newborn Admission
and Discharge

NB1020 0114 05 2012

*Please do not write on top of this sheet

Father's Name	Mother's Maiden Name	Marital Status	Telephone Number	Sex

Birth Date	Birth Weight	Head Circ. (cm.)	Body Length	Type Feeding

Admission Exam

☐ General, ☐ Tone, ☐ Colour
☐ Skin, ☐ Activity ☐ Temperature
☐ Nutritional Status
Soft tissue wasting ☐ Yes ☐ No
☐ Skull Shape
☐ Fontanelle and Sutures
☐ Eyes ☐ Nose ☐ Palate
☐ Respiratory System
☐ Rate ☐ Retractions
☐ Cardio-Vascular System
☐ Femoral Pulsations
☐ Abdomen ☐ Umbilicus
☐ Anus ☐ Genitalia
☐ Neurological ☐ Clavicles
☐ Skeletal ☐ Hips ☐ Feet

Brief History:________________

Diagnosis/Problem:________________

Management:________________

Date:__________

Name Signature

Discharge Exam

☐ Tone ☐ Blood Group-Mom
☐ Activity ☐ Blood Group - Baby
☐ Skin
☐ Umbilicus
☐ Cardiovascular System
☐ Murmurs ☐ Femorals
☐ Respiratory System
☐ Hips ☐ Spine ☐ Feet
☐ Feeding ☐ Jaundice
☐ Discharge Weight__________gm.
☐ Discharge Head Circ.__________cm.
☐ Discharge Summary to Follow

Discharge Diagnosis:________________

Follow-up Arrangements:________________

Date:__________

Name Signature

ch-0114 2014/04

White Copy: Chart Yellow Copy: Family Physician

Sample Newborn Assessment Labour & Delivery

Eastern Health
Child/Women's Health Program

Newborn Assessment
Labour & Delivery

Date & Time of Birth: ____________

Weight: ____________ gms

Gestation: ____________ weeks (dates)

Head Circumference: ____________ cm

I.D. Band Number: ____________ checked by:

Length: ____________ cm

1. ____________ 2. ____________

HN Number: ____________

Time of Assessment	Normal Yes	Normal No	If No, Please Comment
Head			
Face			
Neck			
Chest			
Respiratory Rate			
Colour			
Heart Rate			
Rhythm			
Abdomen			
Genitalia			
Anus			
Legs			
Arms			
Feet			
Signature			

Cord Care ____________

Erythromycin Opthalmic Ung. ____________

Time ____________ Initials ____________

Vitamin K ____________

Time ____________ Initials ____________

Comments: ____________

Signature

Date & Time	Temperature	Heart Rate	Respirations	Glucose	Feeding	Urine	Meconium/Stool	Initials

Initials	Nurse's Signature/Status

TPR at birth and every hour x 4
Glucose - See Policy: Guidelines for Care of the Healthy Newborn

ch-0116 2014/04

Sample Progress Notes

Eastern Health

Progress Notes

Name:

HCN:

Date of Birth:

Discipline Codes

A -	Audiology	PC -	Pastoral Care
AE -	Adult Education	PH -	Pharmacy
CK -	Clinical Kinesiology	PR -	Prosthetics
D -	Dentistry	PT -	Physiotherapy
DT -	Dietitian	P -	Psychology
MD -	Medical	RT -	Respiratory Therapy
N -	Nursing	SLP -	Speech Language
OR -	Orthotics	SW -	Social Work
OT -	Occupational Therapy	TR -	Therapeutic Recreation

PN1010 0096 07 2012

Date/Discipline	Time	Focus	D = Data A = Action R = Response

PN1010

ch-0096 2013/11

Sample Resuscitation Record

Eastern Health

Resuscitation Record (Part I)

Name:

HCN:

Date of Birth:

Gestation: ____________ Time of Birth: __________

Weight: ______ Head Circumference: ______ Length: _______

Type of Delivery: __________

Apgar Score: 1min______ 5min ______ 10min _______ ID Band # ______________

INITIAL RESUSICITATION

☐ Positive Pressure Bag & MaskVentilation:

Time: Started: _________ Stopped: _________

☐ PEEP: Time Started:________ Time Stopped:__________

☐ Intubation Time:_______ Size Tube: ________

Number of Attempts:____ Length of Procedure: _______

☐ Ventilation: Time Started ________ Time Stopped:_______

☐ Nasal CPAP: Time Started ___________

☐ Pulse Oximeter: Time Started: __________

☐ Cardiac Monitor, Time Started: _________

☐ Time 1st Respiration _____________

Time Heart Rate less than or equal to 100 ___________

☐ Chest Compression started ________ ended ________

☐ Resuscitation stopped ____________

☐ Drugs Used ____________________

☐ Nasogastric Tube: Oral ☐ Right nare ☐ Left nare ☐ Size __________ Time _____________

☐ IV Access: Peripheral IV ☐ Size _______ Time ______ Location ___________

Umbilical Arterial Catheter ☐ Size ______ Time ______ Umbilical Venus Catheter ☐ Size ______ Time ______

☐ Chest Tube: Size ________ Site __________ Time ________ ☐ Blood Cultures: Site _______ Time ________

☐ Vitamin K: Time ______ Signature ______________ ☐ Erythromycin: Time ______ Signature ______________

☐ Glucose 2hour: Time _____ Results _________ ☐ Cord Clamp Secured: ☐ 3 Vessels ☐ 2 Vessels

☐ Surfactant: Time: ________ 2nd dose Time ________

Time of Assessment	Normal		If No, Please Comment
	Yes	No	
Tone			
Head			
Face			
Neck			
Chest			
Respiratory			
Colour			
Heart Rate			
Abdomen			
Genetalia			
Anus			
Legs			
Arms			
Feet/Hand			
Fotenelle/Sutures			

Name: ______________________________ Date: ______________

Signature: ______________________________

Ch-0263 2014/05

Sample Obstetrical Nursing History and Admission Note

Western Memorial Regional Hospital
Corner Brook, Nfld.

Obstetrical Nursing History and Admission Note

Admission Date: ______ Time: ______ hrs. Marital status: ______ Age: ______

Reason for admission: ______ Religion: ______

Refusal of blood: ☐ Yes ☐ No

Obstetrical History

Para: ___ Gravida: ___ Abortions: ___

Stillbirths: ___ Neonatal deaths: ___

Year	Gest.	Outcome/Comments

Present Pregnancy

LNMP: ______ E.D.C.: ______

Weight gain: ______ Present Weight: ______ Height: ______

Complications: ______

Hospitalization this pregnancy: ☐ Yes ☐ No Date: ______ Reason: ______

Blood work done this pregnancy:

Rh/group ☐ Yes ☐ No ☐ On Chart ______

Coombs ☐ Yes ☐ No ☐ On Chart

Medications/Comments: ______

Tests done this pregnancy:

Amniocentesis ☐ Yes ☐ No Date: ______

Ultrasound ☐ Yes ☐ No Date(s): ______

Pelvimetry ☐ Yes ☐ No Date: ______

NST/OCT ☐ Yes ☐ No Date: ______

Other: ______

Health/Medical History

Significant past illness: ______

Previous surgery: ______

Previous blood transfusions: ☐ Yes ☐ No

Reactions: ______

Allergies: ☐ Yes Specify: ______

☐ No ______

Smoking: ☐ Yes ☐ No Cigs./Day ______

Alcohol: ☐ Yes ☐ No Amt./Day ______

Dentures: ☐ Yes ☐ No Type: ______

Glasses: ☐ Yes ☐ No

Contacts: ☐ Yes ☐ No

Prosthesis: ☐ Yes ☐ No Specify: ______

Family History

(Fill in blanks with "m" for maternal or "p" for paternal)

Diabetes ☐ Yes ☐ No ___ Renal Disease ☐ Yes ☐ No ___

Hypertension ☐ Yes ☐ No ___ Epilepsy ☐ Yes ☐ No ___

Heart Disease ☐ Yes ☐ No ___ Hereditary ☐ Yes ☐ No ___

Mental/Physical Retardation ☐ Yes ☐ No

Comments: ______

Childbirth/Childcare Preparation

Prenatal Classes ☐ Yes ☐ No

Breastfeeding ☐ Yes ☐ No

Bottlefeeding ☐ Yes ☐ No

Keeping Baby ☐ Yes ☐ No

Seeing Baby ☐ Yes ☐ No

Comments: ______

Vital Signs on Admission: T___ P___ R___ BP___ FH___

Urine: to lab ☐ Yes ☐ No Sugar___ Ketones___ Albumin___

CBC slip sent ☐ Yes ☐ No

Prep: ☐ Yes ☐ No Type ______ **Enema:** ☐ Yes ☐ No Type ______

Nursing Assessment:

Orientated to unit: ☐ Yes ☐ No Dr. ______ notified @ ______ Hrs. ______ R.N.

Sample Newborn Record

WESTERN MEMORIAL REGIONAL HOSPITAL
Corner Brook, NL
NEWBORN RECORD

SECTION A: (To Be Completed By Nurse)

SURNAME:	BIRTH DATE & TIME	Eye Prophylaxis	Passed Meconium YES NO
SEX:	Type ANAES.	CORD BLOOD SENT	YES VOIDED NO
GEST. AGE Wks.	RACE RELIGION	YES IDENTABAND ON NO	IDENTABAND #
Mother's Blood Group	TEMP RESP.	VITAMIN K 1 MG	CRY: High Pitched Strong Weak Artificial
DOCTOR	0° /MIN	Time of First Cry /Min Spont/Stimulated	
Birth Weight	APEX BEAT		
Head Circumference	LENGTH AT BIRTH		
Chest Circumference			

Apgar Score

TIME (minutes)	1 Min	5 Min	10 Min	15 Min
HEART RATE				
RESP. EFFORT				
MUSCLE TONE				
RESPONSE TO CATHETER IN NOSE				
COLOR				
TOTAL				

RESUSCITATION: OXYGEN THERAPY

Suction: Oral Nasopharyngeal Mask only P.P. Bag and Mask E.T. Tube & Bag

TRANSFER NOTES: DATE AND TIME:

SIGNATURE:

SECTION B: (To Be Completed By Physician)

	✓ NOR. x ABN.	ADMISSION EXAMINATION Description of Abnormal Findings	✓ NOR. x ABN.	DISCHARGE INFORMATION Description of Abnormal Findings
1. General				
2. Skin				
3. Nutritional Status				
4. Skull Shape				
5. Fontanell & Sutures				
6. Eyes				
7. Ears				
8. Nose				
9. Mouth				
10. Respiratory system				
11. Thorax				
12. Heart				
13. Abdomen				
14. Umbilicus				
15. Anus				
16. Genitalia				
17. Trunk				
18. Extremities				
19. Reflexes				

SIGNATURE M.D. SIGNATURE M.D.

DISCHARGE SUMMARY:

Discharge Weight

Type of Feeding DR'S SIGNATURE: DATE:

ABNORMAL NORMAL

I Certify that I have reviewed the chart of this admission and accept responsibility for the contents.

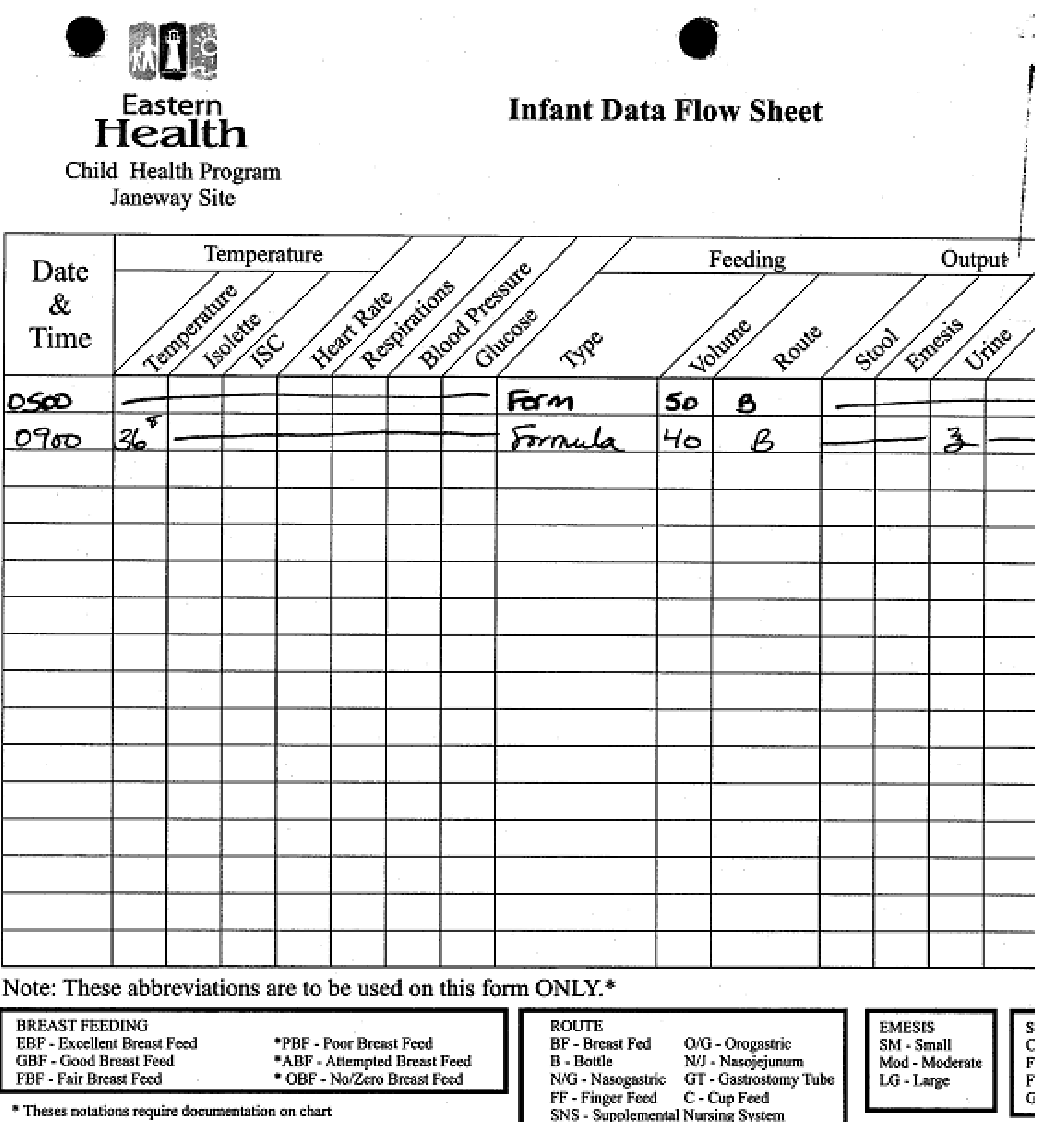
Signature ______________________ Date: ____________

APPROVED: MAC January 1995
ISSUED: March 1986
REVIEWED/REVISED: September 1996/December 2001

White Sheet-Chart Copy
Green Sheet-Physician's Copy

900-153

Sample Infant Data Flow Sheet



Eastern Health
Child Health Program
Janeway Site

Infant Data Flow Sheet

Date & Time	Temperature							Feeding			Output		
	Temperature	Isolette	ISC	Heart Rate	Respirations	Blood Pressure	Glucose	Type	Volume	Route	Stool	Emesis	Urine
0500	—	—	—	—	—	—	—	Form	50	B	—	—	—
0900	36^{8}	—	—	—	—	—	—	Formula	40	B	—	—	3

Note: These abbreviations are to be used on this form ONLY.*

BREAST FEEDING
EBF - Excellent Breast Feed
GBF - Good Breast Feed
FBF - Fair Breast Feed
*PBF - Poor Breast Feed
*ABF - Attempted Breast Feed
* OBF - No/Zero Breast Feed

* Theses notations require documentation on chart

ROUTE
BF - Breast Fed
B - Bottle
N/G - Nasogastric
FF - Finger Feed
SNS - Supplemental Nursing System
O/G - Orogastric
N/J - Nasojejunum
GT - Gastrostomy Tube
C - Cup Feed

EMESIS
SM - Small
Mod - Moderate
LG - Large

Sample OBS Client Care Plan and Newborn Assessment

Labrador-Grenfell Health

CHARLES S. CURTIS MEMORIAL HOSPITAL
OBS CLIENT CARE PLAN

Admitting Diagnosis:	Confirmed Diagnosis:
Other Medical Conditions/Previous Deliveries:	
Procedure/Surgery/EDC:	

Antenatal Details	Date Ordered	Lab Tests/ X-Rays	Date Completed
Gravida: Para: Blood Group: Rubella Status:			

Post Natal Details

Days	Delivery Date	Baby
1	Date:	Sex: M
2	Time:	F
3	Type:	Apgar:
4	3rd Stage:	Weight:
5	Blood Loss:	Feeding:
6	Perimeum:	
7	Cord Blood:	
8	Rhogam	

Allergies:

Date Sent	Consults	Date Seen

Date Ordered	Teaching and Discharge Planning	Date Completed

Labrador-Grenfell Health

NEWBORN ASSESSMENT

Date Ordered	Date Done	Tests	Date Ordered	Date Done	Tests

MATERNAL HISTORY:
Gravida ______ Para ______ EDO ______
Blood Group ______
Medical Problems: 1. ______
2. ______
Delivery Problems: 1. ______
2. ______
Type of Delivery: ______
Date and Time: ______
Maternal Sedation: 1. ______
2. ______
3. ______

INFANT ASSESSMENT:
Gestation ______ Apgar 1 min ______ 5 min ______
Birth Weight ______ kg ______ lbs.
Respiration ______ Apex ______ Temperature ______
Head ______ Length ______
Colour ______ Cry ______ Activity ______
K1 ______ Erythromycin ______
Abnormalities ______
______
Feeding Bottle ______ Breast ______

INFANT BLOOD GROUP:

PKU Due ______
Done ______

Gift Pack ______
PPSP ______
Picture ______
Tax Forms ______
MCP ______
Birth Announcement ______

DISCHARGE INFORMATION:

Weight: ______ Head Circumference: ______
Length: ______
Appointments: ______

Sample Baby Feeding Chart

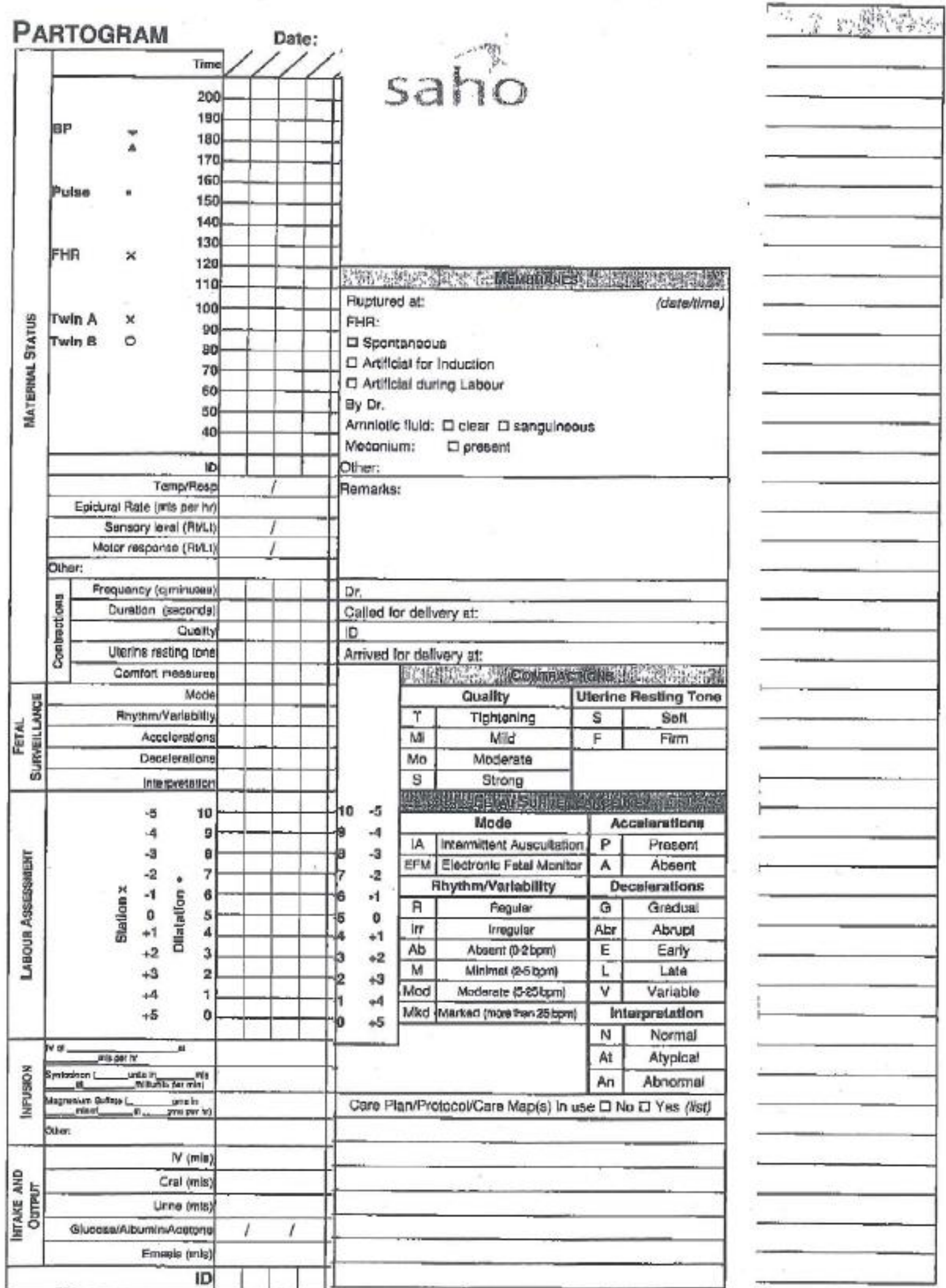
BABY FEEDING CHART

BABY OF ______________________

AT BIRTH	DATE						
D.O.B. Time	WET DIRTY	WET DIRTY	WET DIRTY	WET DIRTY	WET DIRTY	WET DIRTY	WET DIRTY
Weight kg lbs	W D	W D	W D	W D	W D	W D	W D
Length cm	W D	W D	W D	W D	W D	W D	W D
O.F.C cm Passed Urine	W D	W D	W D	W D	W D	W D	W D
	W D	W D	W D	W D	W D	W D	W D
Passed Meconium	W D	W D	W D	W D	W D	W D	W D
	W D	W D	W D	W D	W D	W D	W D
Type of Feeding	W D	W D	W D	W D	W D	W D	W D
	Weight						
ON DISCHARGE	Eyes						
Date	Mouth						
Weight kg O.F.C. cm	Skin						
Feeding at Discharge	Umbilicus						
	Buttocks						
	Sign.						

HLC-027

Sample Partogram



PARTOGRAM

Date:

saho

Time

MATERNAL STATUS

BP ▼ ▲

Pulse •

FHR ×

Twin A ×

Twin B ○

200, 190, 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60, 50, 40

ID

Temp/Resp

Epidural Rate (mls per hr)

Sensory level (Rt/Lt)

Motor response (Rt/Lt)

Other:

Contractions: Frequency (q minutes), Duration (seconds), Quality, Uterine resting tone, Comfort measures

FETAL SURVEILLANCE: Mode, Rhythm/Variability, Accelerations, Decelerations, Interpretation

LABOUR ASSESSMENT

Station × / Dilatation •

Station	Dilatation
-5	10
-4	9
-3	8
-2	7
-1	6
0	5
+1	4
+2	3
+3	2
+4	1
+5	0

INFUSION

IV of ________ at ________ mls per hr

Syntocinon (____ units in ____ mls at ____ mU/min) (ml/min)

Magnesium Sulfate (____ gms in ____ mls at ____ gms per hr)

Other:

INTAKE AND OUTPUT

IV (mls)

Oral (mls)

Urine (mls)

Glucose/Albumin/Acetone

Emesis (mls)

ID

MEMBRANES

Ruptured at: (date/time)

FHR:

☐ Spontaneous

☐ Artificial for Induction

☐ Artificial during Labour

By Dr.

Amniotic fluid: ☐ clear ☐ sanguineous

Meconium: ☐ present

Other:

Remarks:

Dr.

Called for delivery at:

ID

Arrived for delivery at:

CONTRACTIONS

Quality		Uterine Resting Tone	
T	Tightening	S	Soft
Mi	Mild	F	Firm
Mo	Moderate		
S	Strong		

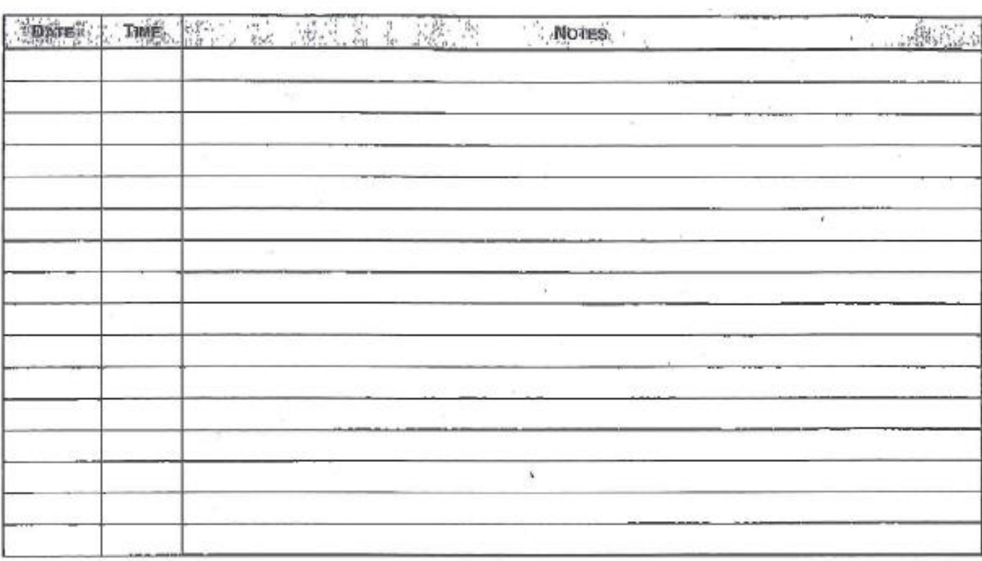
FETAL SURVEILLANCE

Mode		Accelerations	
IA	Intermittent Auscultation	P	Present
EFM	Electronic Fetal Monitor	A	Absent
Rhythm/Variability		**Decelerations**	
R	Regular	G	Gradual
Irr	Irregular	Abr	Abrupt
Ab	Absent (0-2 bpm)	E	Early
M	Minimal (2-5 bpm)	L	Late
Mod	Moderate (6-25 bpm)	V	Variable
Mkd	Marked (more than 25 bpm)	**Interpretation**	
		N	Normal
		At	Atypical
		An	Abnormal

Care Plan/Protocol/Care Map(s) in use ☐ No ☐ Yes (list)

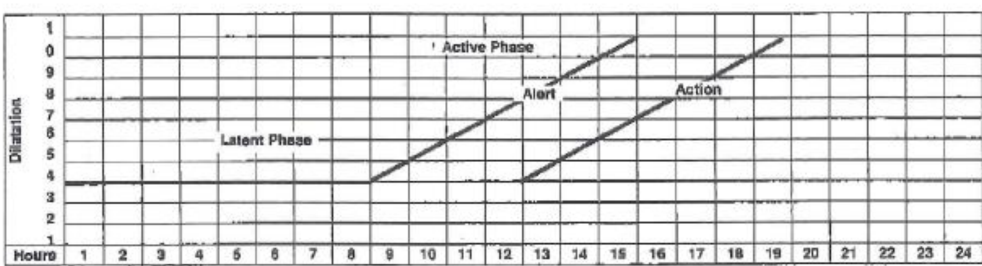
SAHO NISS Copyright. Not to be reproduced in an

Sample Partograph



DATE	TIME	NOTES

CERVICAL – PARTOGRAPh



NOTE: This labour progression graph is included as a reference tool only.

Definitions:

Latent Phase: from the onset of labour until the cervix reaches 3 cm dilatation.

Active Phase: once 3 cm dilatation is reached, labour enters the active phase. The cervix dilates at a rate of 1 cm/hour or faster in the active phase in 90% of primigravidae.

Alert Line: drawn from 3 cm to 10 cm represents this rate of dilatation. If cervical dilatation moves to the right of the alert line, it is slow and an indication of delay of labour (dystocia).

Action Line: is drawn 4 hours to the right of the alert line. It is suggested that if cervical dilatation reaches this line, there should be a critical assessment of the cause of delay and a decision about the appropriate management to overcome this delay.

SOURCE: WHO, adapted with permission from Preventing Prolonged Labour: a practical guide, The Partograph Part I: Principles and Strategy, 1994.

PGOB-033.4, February 2006

Sample Delivery Record

Central Health

DELIVERY RECORD

UNIT:
MCP#:
ACCT:
DOB:

REASON FOR ADMISSION: TRUE LABOR ☐ SUSPECTED LABOR ☐
MEMBRANES RUPTURED ☐ INDUCTION ☐ ELECTIVE SECTION ☐ OTHER ☐

LNMP ☐ GRAV. ☐ ABNORMALITIES OF PREVIOUS PREGNANCIES: ☐ NO ☐ YES SPECIFY
DUE ☐ PARA. ☐
GESTN. AT DEL. ☐ ABORT. ☐ ANTEPARTUM STATUS ABNORMALITIES OF PREVIOUS INFANTS: ☐ NO ☐ YES SPECIFY

COMPLICATIONS OF THIS PREGNANCY: NONE ☐ BLEEDING ☐ TOXEMIA ☐ DIABETES ☐
HEART ☐ OTHER ☐
SPECIFY
FETAL SIZE AVERAGE ☐ ABOVE AVERAGE ☐ BELOW AVERAGE ☐
X-RAY PELVIMETRY: YES ☐ NO ☐ NORMAL ☐ ABNORMAL ☐
CATHETERIZED ☐ YES ☐ NO

MEMBRANES RUPTURED: SPONT. ☐ ARM ☐ DATE ______ TIME ______ MECONIUM: ☐ YES ☐ NO

FIRST STAGE: SPONT. ☐ INDUCED ☐ BEGAN DATE ______ TIME ______ DURATION ______
IF INDUCED, INDICATION:
BY ARM ☐ OXYTOCIN ☐
LABOR STIMULATED ☐ ARM ☐ OXYTOCIN ☐

SECOND STAGE: BEGAN DATE ______ TIME ______ DURATION ______

DELIVERY: SPONT. ☐ OPERATIVE ☐ EASY ☐ DIFFICULT ☐ PRECIPITATE ☐
FORCEPS: LOW ☐ MID ☐ HIGH ☐ VACUUM EXTRACTOR ☐ A.C.H. ☐
ROTATION: MANUAL ☐ FORCEPS ☐
ANALGESIA WITHIN 6 HRS. NONE ☐ ROUTE
DRUGS
DOSE ☐ TIME ☐

POSITION AT DEL. ☐
POSITION AT INTERFERENCE ☐
BREECH: ☐ SPONTANEOUS ☐ ASSISTED ☐ EXTRACTED
CESAREAN: ☐ LOW ☐ CLASS. ☐ HYSTER.
ANESTHESIA NONE ☐ BEFORE ☐ AFTER ☐ DELIVERY

FETAL HEART: REGULAR 120-160 ☐ UNDER 120 ☐ OVER 160 ☐ IRREGULAR ☐ NEVER HEARD ☐
MECONIUM: ☐ NONE ☐ IN FLUID ☐ STAINING BABY
GEN. ☐ TIME ______ SPINAL ☐
EPIDURAL ☐ LOCAL ☐
PUDENDAL ☐ OTHER ☐

INDICATION FOR OPERATIVE DELIVERY
(IF REPEAT SECTION, STATE SO, AND GIVE INDICATION FOR FIRST)
LACERATIONS: CERVICAL ☐ VAGINAL ☐ PERINEAL 1 2 3 4 HEMATOMA ☐ REPAIR ☐ EPISIOTOMY ☐

THIRD STAGE: DELIVERY DATE ______ TIME ______
THIRD STAGE ENDED DATE ______ TIME ______ DURATION ______

PLACENTA DELIVERY: SPONT. ☐ ASSIST ☐ MANUAL ☐ WGT ☐
UMBILICAL VESSELS 2 ☐ 3 ☐
ABNORMS
BLOOD LOSS: BEFORE ☐ AFTER ☐ DELIVERY
OXYTOCIC: NONE ☐ BEFORE ☐ AFTER ☐ SEPARATION
TYPE DOSE ROUTE

BABY BOY ☐ GIRL ☐ WEIGHT ______ ALIVE ☐ STILLBORN ☐
RESUSCITATION: NONE ☐
OXYGEN ONLY ☐
POSITIVE PRESSURE BAG & MASK ☐
POSITIVE PRESSURE BAG & TUBE ☐
DURATION: AGE ______ TO ______ MIN.

CONDITION 1,5, & 10 MINUTES AFTER BIRTH (GRADE AS 0, 1 OR 2)
TONE ____ ____ ____
COLOUR ____ ____ ____
RESPIRATION ____ ____ ____
RESPONSE ____ ____ ____
HEART RATE ____ ____ ____
FIRST BREATH ______ MINS
FIRST CRY ______ MINS
SUSTAINED RESPIRATIONS ______ MINS

ASPHYXIA: NONE ☐ MOD. ☐ SEVERE ☐
APGAR: 10, 9, 8, 7, 6, 5, 4, 3, 2, 1
STAGE: 0, 1, 2, 3, 4

COMPLICATIONS OF LABOUR & DELIVERY, OR INFANT: NONE ☐ YES ☐ SPECIFY:

DELIVERED BY ______ SIGNATURE ______

Form # 4546

Mother's Chart

FORM 4546

Sample Labour Partogram

JAMES PATON MEMORIAL REGIONAL HEALTH CENTRE
LABOUR PARTOGRAM

Name Age Doctor

Allergies ______

OBS History P ☐ G ☐ LMP ______ EDC ______ Abortions ☐ S.B. ☐ N.D. ☐

Previous OBS complication or significant illness ______

Contractions: Onset Date ______ Time ______ Bleeding: Yes ☐ No ☐ If yes, amount ______

Membranes: Intact ______ SRM ______ ARM ______ Date ______ Time ______ Colour ______ Mec. ______

Medications prior to labour ______

Prostaglandin Induction: Yes ______ No ______ Type & Dosage ______ Dates ______ Time ______

Fetal Activity: Yes ______ No ______ Last fetal movement felt ______

Comments ______

	SIGNATURE & STATUS	INITIALS

Sample Delivery and Recovery Room Data

DELIVERY AND RECOVERY ROOM DATA

ully Dilated Date____ Time ____ hrs

lectronic Monitoring: Yes ☐ No ☐ External ☐ Scalp Electrode ☐

ime																	
HR																	
P																	

lurses Delivery Room Notes:

Oxytocic Following Delivery ☐ With Ant. Shoulder ☐ After Placenta ☐

Type: ____ Dose: ____ Route: ____

Given by: ____

Perineum Infiltration: Yes ☐ No ☐ Type: ____

Time: ____ Doctor: ____

Epis. Yes ☐ No ☐ Time: ____ Doctor: ____

Perineal Lacerations: 1 2 3 4

Other Lacerations: ____

Repaired by: ____

Type of Delivery: ____ Sex: M ☐ F ☐

Time: ____ Position: ____ Del'd by: ____

Apgars at: 1 min ____ 5 ____ 10 ____ Wt ____

Corded: Yes ☐ No ☐ Details: ____

Placenta & Membrane: Time ____

Appearance: ____

Blood Loss: ____

lother's Companion: None ☐ Persons ____ Present during labour ☐ Present during delivery ☐

atheterized: Yes ☐ No ☐ Time ____ hrs Colour/Amt ____ Sutures: Type ____

loctor ____ Time Called ____ Time Arrived ____ Resident ____ Time Called ____ Time Arrived ____

bstetrician ____ Time Called ____ ____ Pediatrician ____ Time Called ____ Time Arrived ____

lursery Staff ____ Called ____ Arrived ____ OBS Nurses Present ____

PONGE COUNT	NEEDLE COUNT	INSTRUMENT COUNT
1st Count	1st Count	1st Count
Additional	Additional	Additional
2nd Count	2nd Count	2nd Count
Signature 1st Count	Signature 1st Count	Signature 1st Count
Signature 2nd Count	Signature 2nd Count	Signature 2nd Count

Sample Physician Newborn Admission & Discharge

Central Health

PHYSICIAN
NEWBORN ADMISSION & DISCHARGE

BIRTHDATE TIME	BIRTH WEIGHT ______(gms)	HEAD CIRC ______(cm)	CHEST CIRC ______(cm)	BODYLENGTH ______(cm)	MATERNAL HX P______ G______ EDC ______ BldGrp ______	APGAR1 ______ APGAR5 ______

RISK FACTORS IN MOTHER

DELIVERY ☐ Vaginal ☐ Forceps ☐ Vacuum ☐ C/S

CLINICAL GESTATIONAL ASSESSEMENT

	<36 wk	36-37 wk	38-40 wk	41+ wk
Breast Tissue	☐ Absent	☐ 2 mm	☐ 4 mm	☐ 7 mm
Sole Creases	☐ Single Ant. Crease	☐ Anterior 1/3	☐ Few Posterior	☐ Full
Ear Cartilage	☐ Nil	☐ Some	☐ Still	☐
Testes	☐ In Canal	☐ Descended	☐	☐
Scrotum	☐ Few Regae	☐ More	☐	☐

Gestational Age (Dates) ______ wk

Gestational Assessment (Physical Exam) ______ wk

Hypoglycemia Screening
Time ______ Results ______

ADMISSION EXAM ☑ NORMAL ☒ ABNORMAL

- ☐ General - Tone, Activity, Color
- ☐ Skin
- ☐ Nutritional Status-Soft Tissue Wasting ☐ Yes ☐ No
- ☐ Skull Shape ☐ Fascies
- ☐ Fontanelle and Sutures
- ☐ Eyes
- ☐ Ears
- ☐ Nose
- ☐ Mouth
- ☐ Palate
- ☐ Respiratory System
- ☐ Heart
- ☐ Femoral Pulsations
- ☐ Abdomen Liver (______cm) Spleen (______cm)
- ☐ Umbilicus
- ☐ Anus ☐ Moro ☐ Hearing
- ☐ Genitalia ☐ Suck Reflex
- ☐ Neurological ☐ Neck
- ☐ Skeletal, Clavicle, Hips, Feet, Spine, Hands

DISCHARGE EXAM ☑ YES Comments (if Abnormal)

- ☐ Tone, Activity
- ☐ Skin - Jaundiced ☐ Yes ☐ No Bilimeter or Lab results ______
- ☐ Heart
- ☐ Respiratory
- ☐ Umbilicus
- ☐ Feeding ☐ Breast ☐ Bottle Formula, Type
- ☐ Discharge Weight ______ gms
- ☐ Blood Group ______
- ☐ Hgb ______
- ☐ Head Circumference
- ☐ Skeletal ☐ Clavicle ☐ Hips ☐ Feet

DISCHARGE DIAGNOSIS

- ☐ Normal
- ☐ Other

COMMENTS

Date ______ Signature ______

COMMENTS

Date ______ Signature ______

549

Patient Chart

Form 549

Sample Newborn Interagency Referral - Meditech

RUN DATE: 09/03/15
RUN TIME: 0845
RUN USER: PARJEN

Central Health NUR **LIVE**
PATIENT ASSESSMENT

PAGE 1

NEWBORN INTERAGENCY REFERRAL

Patient:
Account #:
Admit Date:
Status: ADM IN
Attending: SHEEHAN,DR.ANN

Age/Sex
Unit #:
Location: JPNUR
Room/Bed: JPNUR-D

Attending Physician: Telephone Number:
Receiving Hospital:
Receiving Physician:
Accompanied By:
Diagnosis/Reason for Transfer:
Baby's Birthdate: Time: Sex of Baby: Birth Weight(gms):
Gestational Age: Weeks: Days: By:
Apgar: 1 min - 5 min - 10 min - Vitamin K: Erythromycin:

INITIAL RESUSCITATION:
Respirations: O2: %: Intubated: If yes, time: ETT Size:
Meconium in liquor: Vigorous: Suction meconium below cords:
Compressions: Time initiated: Time stopped:
Medication/Dosage/Time:
IV: ETT: U/V:

POSTNATAL COURSE:
IV: Volume: Rate(mls/hr): Site:
Cannula Size: Inserted: Date Time
Umb Line - Volume: Rate(mls/hr): Site: Size:
Catheter Position (cms): Inserted: Date Time
Ventilated: Settings:Oxygen % Rate Pressure Peep CPAP: Mode: Settings:Flow L/min FIO2 Temp
Temperature: Source: Pulse: Respirations:
Blood Pressure: Site: O2 Sat: % Perfusion:

ACCOMPANYING REPORTS:
Lab reports: Cord/blood gases: Cord Blood: Consent:

Baby Baptized: Given Name:
Parents touched or held baby: Feeding Plan:
Comment:

MATERNAL HISTORY:
Name: MCP: Age:
P: G: A: Multiples: SB: PTL: PTD:
TLAC: VBAC: LMP: EDC: By
VDRL Hepatitis HIV TB Blood Group
Rubella Result: IU/mL
Mother's GBS Status: Treated in Labor: First Dose: Date Time
Past Obstetrical History:

DATE: 09/03/15
TIME: 0845
USER: PARJEN

Central Health NUR **LIVE**
PATIENT ASSESSMENT

PAGE 2

NEWBORN INTERAGENCY REFERRAL

Patient:
Account #:
Admit Date:
Status: ADM IN
Attending: SHEEHAN,DR ANN

Age/Sex
Unit #:
Location: JPNUR
Room/Bed: JPNUR-D

LABOR AND DELIVERY:
Fetal Monitoring: External: Internal: IA: CEFM:
Length of labor - 1st stage: hrs, mins 2nd stage: hrs, mins
AROM: SROM: Date: Time: Color:
Type of Delivery: Medications: Amt:

Anaesthesia:

Post Partum Complications:

Occurred Date: 09/03/15
Monogram: JH Initials: PARJEN Name: HOWSE,JENNIFER
Occurred Time: 0844
Nurse Type: RN

Sample Admission Assessment - Meditech

```
RUN DATE: 06/03/15          Central Health Nursing **TEST**                 PAGE 1
RUN TIME: 1508                   PATIENT ASSESSMENT
RUN USER: MORGDEN
                           ADMISSION ASSESSMENT - OBS

Patient: TEST,MOTHER OTHER PROV                          Age/Sex: 53 F
Account #: IN0000029/14                                  Unit #: W000117
Admit Date: 15/07/14                                     Location: 4B
Status: ADM IN                                           Room/Bed: 4001-B
Attending: AARTS,MARY-ANNE

Primary Diagnosis:    y
Secondary Diagnosis:
Information given by:                      Admitted from:

OBSTETRICAL HISTORY
Gravida     Para     Abortions     SB:    NND
LMP         EDC          Gestation: Weeks    Days    By
**************************************CLINICAL DATA************************************
Temperature:        Pulse:      Respirations:      Blood Pressure:
Oxygen Saturation:
Wgt: lb        oz       kg         Source:         Pre pregnancy wt:
Hgt: Ft    in      cm        Source:
Fetal Monitoring- IA:    NST:    EFM:   (See documentation under Fetal Monitoring)

*************************************ALLERGIES***************************************
     Allergies:   List:
 Latex Allergy:
Food Allergies:   List:

Diet:
Pt Description of
Present Condition
PRESENT PREGNANCY
Fertility Treatment: Y -               Multiple Pregnancy: Y - *QUADDRUPL
Prenatal Ed:            Prenatal Care    # Weeks Began:     Prenatal Record:
 Bleeding:    -                              Pain: Y -
Headaches:    -                               PIH:    -
   Rashes     -                             Edema:    -
 Diabetes:    -                            Reflexes
Communicable Infection Exposure: Y -                                       (Shift F8)
Admissions this Pregnancy:    -

Physician Specialist:   -
Tests: U/S    -                          Group B Strep           Pap Smear:
       NST    -                            Amnio   -
    Rhogam    -                            Urine Dip    -
 Hepatitis              VDRL           HIV          Rubella Result: 104.3IU/mL
Glucose Screening Y -                              Blood Group

Feeding Plan:                          Planned  VBAC    PP T/L
PHYSICAL ASSESSMENT
In Labor    Contr Started 21/01/15 Time     Freq (mins)          Duration (sec)
Intensity                                    Resting Tone:           Coping:
Membranes Ruptured           Date          Time         Amt         Color
PV Discharge:
Fetal Activity      Any Change
Fundal Height (cms):     Lie:           Presentation:
Position:             Dilatation:     Effacement:            Station:
Nitrazine:              Ferning:
```