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# OBSTETRIC ADMISSION DATABASE ASSESSMENT PART II

PATIENT IDENTIFICATION

## MEDICAL HISTORY

PREVIOUS HOSPITALIZATIONS: <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____ REASON: _____	PREVIOUS SURGERY:
PREVIOUS BLOOD TRANSFUSION: <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____ REASON: _____	* HEART DISEASE: <input type="checkbox"/> NO <input type="checkbox"/> YES * HYPERTENSION: <input type="checkbox"/> NO <input type="checkbox"/> YES
RECENT EXPOSURE TO COMMUNICABLE DISEASE: <input type="checkbox"/> NO <input type="checkbox"/> YES	RESPIRATORY PROBLEM: <input type="checkbox"/> NO <input type="checkbox"/> YES HEADACHE: <input type="checkbox"/> NO <input type="checkbox"/> YES
HERPES (HISTORY OF): <input type="checkbox"/> NO <input type="checkbox"/> YES LAST OUTBREAK: _____ CURRENT LESION? <input type="checkbox"/> NO <input type="checkbox"/> YES	SEIZURE: <input type="checkbox"/> NO <input type="checkbox"/> YES DIZZINESS: <input type="checkbox"/> NO <input type="checkbox"/> YES
STD: <input type="checkbox"/> NO <input type="checkbox"/> YES TYPE: _____ DATE: _____ TX: <input type="checkbox"/> NO <input type="checkbox"/> YES	* DIABETES: <input type="checkbox"/> NO <input type="checkbox"/> YES TYPE / CLASS: _____
CHICKEN POX (RECENT EXPOSURE): <input type="checkbox"/> NO <input type="checkbox"/> YES	BACK INJURY: <input type="checkbox"/> NO <input type="checkbox"/> YES
HIV (DRAWN IN PREGNANCY): <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____ RESULT: _____	UTI: <input type="checkbox"/> NO <input type="checkbox"/> YES TX: <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____
RPR / STS TESTING: <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____ RESULT: _____	TEST OF CURE: <input type="checkbox"/> POSITIVE <input type="checkbox"/> NEGATIVE
HBSAG (DRAWN): <input type="checkbox"/> NO <input type="checkbox"/> YES DATE: _____ RESULT: _____	VAGINAL INFECTIONS: DATE: _____ TX: _____ AMOUNT: _____ LAST USED: _____
GBS (GROUP BETA STREP) CULTURE: <input type="checkbox"/> POS <input type="checkbox"/> NEG TX: <input type="checkbox"/> NO <input type="checkbox"/> YES	SMOKE: <input type="checkbox"/> NO <input type="checkbox"/> YES
RUBELLA TITER DRAWN: <input type="checkbox"/> NO <input type="checkbox"/> YES IMMUNE: <input type="checkbox"/> NO <input type="checkbox"/> YES CHLAMYDIA: DATE: _____ TX: <input type="checkbox"/> NO <input type="checkbox"/> YES	OTHER COMMENTS:

<b>CARDIOVASCULAR</b> <b>LDR</b>	<b>POSTPARTUM UNIT</b>
SKIN: <input type="checkbox"/> WARM, DRY <input type="checkbox"/> COLD <input type="checkbox"/> CLAMMY <input type="checkbox"/> PALE <input type="checkbox"/> CYANOTIC <input type="checkbox"/> FLUSHED	VITAL SIGNS: T _____ P _____ R _____ BP _____ SKIN: <input type="checkbox"/> WARM, DRY <input type="checkbox"/> COLD <input type="checkbox"/> CLAMMY <input type="checkbox"/> PALE <input type="checkbox"/> CYANOTIC <input type="checkbox"/> FLUSHED
RADIAL PULSE: _____ RATE _____ RHYTHM _____ QUALITY	RADIAL PULSE: _____ RATE _____ RHYTHM _____ QUALITY
EDEMA: _____ LOCATION: _____ AMOUNT: _____	EDEMA: _____ LOCATION: _____ AMOUNT: _____

<b>RESPIRATORY</b> <b>LDR</b>	<b>POSTPARTUM UNIT</b>
DYSPNEA: <input type="checkbox"/> NO <input type="checkbox"/> YES BREATH SOUNDS: <input type="checkbox"/> CLEAR <input type="checkbox"/> WHEEZE <input type="checkbox"/> RALES <input type="checkbox"/> OTHER COUGH: <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> PRODUCTIVE <input type="checkbox"/> NON-PRODUCTIVE SPUTUM: <input type="checkbox"/> NO <input type="checkbox"/> YES COLOR: _____	DYSPNEA: <input type="checkbox"/> NO <input type="checkbox"/> YES BREATH SOUNDS: <input type="checkbox"/> CLEAR <input type="checkbox"/> WHEEZE <input type="checkbox"/> RALES <input type="checkbox"/> OTHER COUGH: <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> PRODUCTIVE <input type="checkbox"/> NON-PRODUCTIVE SPUTUM: <input type="checkbox"/> NO <input type="checkbox"/> YES COLOR: _____

<b>NEUROLOGICAL</b> <b>LDR</b>	<b>POSTPARTUM UNIT</b>
LOC: <input type="checkbox"/> ALERT <input type="checkbox"/> ORIENTED <input type="checkbox"/> CONFUSED <input type="checkbox"/> LETHARGIC REFLEXES: _____ CLONUS: _____ MOTOR ACTIVITY: <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> ABSENT	LOC: <input type="checkbox"/> ALERT <input type="checkbox"/> ORIENTED <input type="checkbox"/> CONFUSED <input type="checkbox"/> LETHARGIC REFLEXES: _____ EPIDURAL: <input type="checkbox"/> NO <input type="checkbox"/> YES MOTOR ACTIVITY: <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> ABSENT

\* If "YES", request Physician's Order for NUTRITIONAL CONSULT

RN / LDR SIGNATURE & TITLE \_\_\_\_\_ DATE \_\_\_\_\_

RN / PP SIGNATURE & TITLE \_\_\_\_\_ DATE \_\_\_\_\_

RN / LDR SIGNATURE & TITLE \_\_\_\_\_ DATE \_\_\_\_\_

## PART OF THE MEDICAL RECORD

GASTRO-INTESTINAL		LDR	POSTPARTUM UNIT
SPECIAL DIETARY NEEDS:			ABDOMEN: _____
* NAUSEA:	<input type="checkbox"/> NO <input type="checkbox"/> YES	ONSET: _____	
* OBESITY:	<input type="checkbox"/> NO <input type="checkbox"/> YES	WEIGHT: _____	
* VOMITING:	<input type="checkbox"/> NO <input type="checkbox"/> YES	ONSET: _____	ABDOMINAL INCISION: _____
* DIARRHEA:	<input type="checkbox"/> NO <input type="checkbox"/> YES	ONSET: _____	
* CONSTIPATION:	<input type="checkbox"/> NO <input type="checkbox"/> YES	ONSET: _____	BOWEL-SOUNDS: _____
* IF DAILY FOR 3 DAYS -or- UNEXPLAINED, INITIATE NUTRITIONAL CONSULT.		LAST BM: _____	

GENITO-URINARY		LDR	POSTPARTUM UNIT
URINE FREQUENCY:	<input type="checkbox"/> NO <input type="checkbox"/> YES		VOIDING QS: _____ FOLEY CATH: _____
BURNING:	<input type="checkbox"/> NO <input type="checkbox"/> YES		FUNDUS: HT: _____ CHARACTER: _____
			LOCHIA: AMT: _____ PERINEUM: _____

BREASTS		LDR	POSTPARTUM UNIT
BREASTS:	NIPPLES:		BREASTS: <small>IF BREAST FEEDING, INITIATE NUTRITIONAL CONSULT.</small> NIPPLES:
<input type="checkbox"/> SOFT	<input type="checkbox"/> NORMAL <input type="checkbox"/> INVERTED		<input type="checkbox"/> SOFT <input type="checkbox"/> ERECT <input type="checkbox"/> FLAT
<input type="checkbox"/> DRAINAGE	<input type="checkbox"/> FLAT		<input type="checkbox"/> FILLING <input type="checkbox"/> LACTATING <input type="checkbox"/> INVERTED

PSYCHO-SOCIAL		LDR
MARITAL STATUS:	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED	
<input type="checkbox"/> WIDOWED	<input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED	
FATHER OF BABY:	<input type="checkbox"/> INVOLVED <input type="checkbox"/> UNINVOLVED	
SUPPORT SYSTEM:	<input type="checkbox"/> AVAILABLE <input type="checkbox"/> UNAVAILABLE	
# OF CHILDREN AT HOME: _____	AGES: _____	
<b>CHECK APPLICABLE CONDITIONS BELOW:</b>		
* PREVIOUS PP BLUES Hx	<input type="checkbox"/> NO <input type="checkbox"/> YES	
* DEPRESSION	<input type="checkbox"/> NO <input type="checkbox"/> YES	
* PSYCHOSIS	<input type="checkbox"/> NO <input type="checkbox"/> YES	
* FEELINGS OF HARM TO SELF / BABY WITH THIS PREGNANCY	<input type="checkbox"/> NO <input type="checkbox"/> YES	
* If "YES" to Any Above, request SOCIAL SERVICE CONSULT		

DISCHARGE PLANNING		POSTPARTUM UNIT
ALL - PREPARATION FOR INFANT HOMECOMING:		
<input type="checkbox"/> CRIB	<input type="checkbox"/> CAR SEAT	<input type="checkbox"/> CLOTHING <input type="checkbox"/> BOTTLES <input type="checkbox"/> FORMULA

ADOLESCENT PATIENTS (12 - 19 YRS)	
ADOLESCENT - INITIATE NUTRITIONAL & SOCIAL SERVICES CONSULTS	
CURRENT SCHOOL GRADE _____	COLLEGE _____
HOW DO YOU LEARN BEST?	
<input type="checkbox"/> VIDEOS	<input type="checkbox"/> BOOKS <input type="checkbox"/> PICTURES
<input type="checkbox"/> LECTURES	<input type="checkbox"/> GROUPS <input type="checkbox"/> INDIVIDUAL
CHILD CARE UPON RETURNING TO SCHOOL / WORK _____	
HELP AT HOME	<input type="checkbox"/> PARENTS <input type="checkbox"/> FATHER OF BABY
	<input type="checkbox"/> OTHERS _____
SOURCE OF FINANCIAL SUPPORT	<input type="checkbox"/> SELF <input type="checkbox"/> PARENTS
	<input type="checkbox"/> OTHER (Explain): _____
IMMUNIZATION UP TO DATE	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> UNSURE
* (IF "NO" or "UNSURE", HANDOUT GIVEN?) <input type="checkbox"/> NO <input type="checkbox"/> YES	

FALL POTENTIAL / IMPAIRMENT		LDR
PHYSICAL DISABILITIES	<input type="checkbox"/> NO <input type="checkbox"/> YES	
LEARNING DISABILITIES	<input type="checkbox"/> NO <input type="checkbox"/> YES	
HEARING IMPAIRED	<input type="checkbox"/> NO <input type="checkbox"/> YES	
SIGHT IMPAIRED	<input type="checkbox"/> NO <input type="checkbox"/> YES	
SUBSTANCE USE	<input type="checkbox"/> NO <input type="checkbox"/> YES	
EPIDURAL / SPINAL	<input type="checkbox"/> NO <input type="checkbox"/> YES	
LANGUAGE BARRIER	<input type="checkbox"/> NO <input type="checkbox"/> YES	
OTHER (DESCRIBE BELOW)	<input type="checkbox"/> NO <input type="checkbox"/> YES	

REFERRALS		POSTPARTUM UNIT
BREAST FEEDING NUTRITIONAL CONSULT	<input type="checkbox"/> NO <input type="checkbox"/> YES	
ADOLESCENT NUTRITIONAL CONSULT	<input type="checkbox"/> NO <input type="checkbox"/> YES	
NUTRITIONAL CONSULT	<input type="checkbox"/> NO <input type="checkbox"/> YES	
SOCIAL SERVICES CONSULT	<input type="checkbox"/> NO <input type="checkbox"/> YES	
HOME CARE	<input type="checkbox"/> NO <input type="checkbox"/> YES	
WIC	<input type="checkbox"/> NO <input type="checkbox"/> YES	
ADOPTION	<input type="checkbox"/> NO <input type="checkbox"/> YES	
ST ANNS	<input type="checkbox"/> NO <input type="checkbox"/> YES	
OTHER: _____		

RN / LDR SIGNATURE & TITLE \_\_\_\_\_ DATE \_\_\_\_\_

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# OBSTETRIC ADMISSION DATABASE ASSESSMENT PART II

## PATIENT IDENTIFICATION

					UNIT ORIENTATION			
NONE	WITH PT	HOME	HOSP SAFE		ROOM	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	
GLASSES:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NURSE CALL SYSTEM	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	
CONTACTS:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BED CONTROL	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	
DENTURES:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PHONE / TV	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	
HEARING AID:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VISITING POLICY	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	
VALUABLES: Explain Policy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SMOKING POLICY	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	
OTHER (SPECIFY): _____					VIDEO TAPING POLICY	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	
				INFANT SECURITY				<input type="checkbox"/> LDR <input type="checkbox"/> PP UNIT

LEARNING NEEDS ASSESSMENT					
LDR			POSTPARTUM UNIT		
BREATHING / RELAXATION	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	MATERNAL SELF CARE	<input type="checkbox"/> INITIAL	<input type="checkbox"/> REVIEW
LABOR PROCESS	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	INFANT CARE	<input type="checkbox"/> INITIAL	<input type="checkbox"/> REVIEW
COMFORT MEASURES	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	BREAST FEEDING	<input type="checkbox"/> INITIAL	<input type="checkbox"/> REVIEW
PUSHING POSITIONS	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT	OTHER (SPECIFY): _____		
PRE-OP / POST OP C-BIRTH	<input type="checkbox"/> LDR	<input type="checkbox"/> PP UNIT			
OTHER (SPECIFY): _____					

PLAN OF CARE / STANDARDS OF CARE IMPLEMENTATION							
LDR				POSTPARTUM UNIT			
	IM	D	IN		IM	D	IN
CARE OF LABORING PATIENT				CESAREAN BIRTH: RECOVERY FROM			
ADMISSION PROTOCOL				VAGINAL BIRTH: RECOVERY FROM			
ANESTHESIA NSG MGMNT				DAILY CARE: POSTPARTUM MATERNAL			
ELECTRONIC FETAL MONITORING				DAILY CARE: POSTPARTUM INFANT			
NEWBORN: IMMEDIATE CARE OF				LATCH TOOL			
CESAREAN BIRTH: RECOVERY FROM				ADOLESCENT: PT CARE STANDARD			
VAGINAL BIRTH: RECOVERY FROM				PAIN MANAGEMENT:			
PRETERM LABOR: MGMNT OF				OTHER (SPECIFY): _____			
LABOR: INDUCTION / AUGMENTATION							
PIH / PREECLAMPSIA: MGMNT OF							
PAIN MANAGEMENT							
OTHER (SPECIFY): _____							

IM = Implemented      D = Demonstrated      IN = Initials

\_\_\_\_\_  
RN / LDR SIGNATURE & TITLE      DATE

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