UNIVERSITY MEDICAL CENTER

ANTEPARTUM/ LABOR & DELIVERY/ POSTPARTUM ADMISSION PROFILE

Patient Name _____ MR# _____

PART I: ADMISSION TO L&D OR ANTEPARTUM

Date: _____ **Time:** _____ **A.M. / P.M.**

Valuables	*N/A*	*Sent Home*	*Placed in Safe*	*Remains at Bedside*
Dentures/Partials/Caps				
Eyeglasses/Contacts				
Hearing Aid				
Clothing				
Prosthetic Devices:				
Other:				

Valuables: *I fully understand that HUMC is not responsible for any personal property brought in or retained at the bedside at anytime. I fully understand that HUMC provides a safe for my valuables should I wish to place them there for the duration of my hospital stay.*

_____ _____

Signature of Patient/Significant Other *Witness*

INTRODUCTORY INFORMATION

Admitted from: ❑ Admitting ❑ MD's Office ❑ E.T.D. ❑ Home ❑ Other: _____

Via: ❑ Ambulatory ❑ Stretcher ❑ Wheelchair Accompanied by: _____

Source of Information (if other than patient) Name: _____ Relationship: _____

History Deferred ❑ Yes (reason) _____

S/O Labor Support: _____ Relationship _____

Primary Language: _____ Interpreter Required: ❑ Yes ❑ Understands English ❑ Reads English

Obstetrician: _____ ❑ Notified Time: _____ AM / PM By: _____

Pediatrician: _____

Reason for Admission / Chief Complaint (per PT/SO): _____

❑ Onset of Labor ❑ Induction of Labor ❑ Cesarean Section: ❑ Primary ❑ Repeat Reason for Primary _____

❑ VBAC ❑ Vaginal Bleeding ❑ PROM ❑ Pre-term Labor ❑ NST/CST

❑ Other: _____

Contractions: ❑ Regular ❑ Began on: _____ at _____ AM / PM Freq: q _____ min. x _____ sec.
❑ None ❑ Irregular Quality: Mild / Moderate / Strong

Membranes: ❑ Intact ❑ Ruptured Date ____/____/____ Time: _____ AM / PM

Fluid: ❑ Clear ❑ Bloody ❑ Foul Smell ❑ Mec. Stained ❑ Unknown

Vaginal Bleeding ❑ None ❑ Normal Show ❑ Bleeding (describe): _____

Mother's Age	LMP / / ❑ Unknown	EDC / / by dates/sono	Est. G.A. Weeks	Prenatal Care ❑ Yes ❑ No Month Care Began:	Prenatal Rec. Available ❑ Yes ❑ No

BIRTHS:	Gravida	Full Term	Premi	Ab-Ect	Living	Stillborn	Multi Gest	Group B Strep: ❑ Neg ❑ Pos

Blood Type:	RH ❑ Positive ❑ Negative	Antepartum Rhogam: Date: / /	VDRL ❑ Negative ❑ Positive ❑ Unknown

HEP B Antigen: ❑ Negative ❑ Positive ❑ Unknown	Rubella: ❑ Immune ❑ Non-Immune	Elisa/Western Blot: ❑ Not Done ❑ Negative ❑ Positive

**** PLACE REFERRAL TO APPROPRIATE DISCIPLINE***

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ **MR#** _____

PAST/CURRENT MEDICAL HISTORY

Allergies:
Drugs: ❑ None — List/Explain Reaction: _____

Foods: ❑ None — List/Explain Reaction: _____

Other: (ie: Latex) ❑ None

Medical History: ❑ None ❑ Pulmonary Disease ❑ Cancer ❑ Cardiac Disease ❑ Blood Disorders ❑ Diabetes ❑ HTN
❑ Thrombosis ❑ Seizures ❑ Infections (Specify): _____ ❑ Mental Illness/PP Depression
❑ Renal Disease ❑ Past History of malignant hyperthermia ❑ HIV ❑ Other: _____

Last Hospitalizations/Surgery (List/Describe): ❑ None When _____

Where _____ Why _____

Type of Anesthesia: _____

PRESCRIPTIONS OVER-THE-COUNTER MED. (Med taken at home)

❑ No current over the counter or prescription medications. MEDICATION	DOSE	FRE-QUENCY	DATE/TIME LAST DOSE	LEFT AT HOME	SENT HOME	SENT TO PHARM	LEFT AT BS	REASON FOR TAKING

CURRENT MEDICAL TREATMENTS

❑ None OUTPATIENT/TREATMENT/THERAPY	DURATION	REASON/STATUS

PAIN HISTORY ASSESSMENT

In addition to/or aside from labor pain: Have you had pain in the last several weeks or months? ❑ No ❑ Yes Intensity _____ Duration _____

If yes, and intensity ≥ 4, continue with pain assessment.

ONSET/DURATION:

When did your pain begin? _____ How long is the pain episode? _____

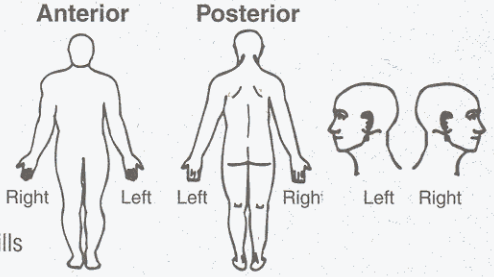
What relieves the pain? _____

What accompanies the pain? (dizziness, nausea, anxiety, etc.) _____

Pain interferes with: ❑ Sleep ❑ Physical Activity ❑ Emotions ❑ Work/School
❑ Appetite ❑ Relationships

PATIENT/FAMILY GOALS ❒ Complete Relief ❒ Intensity Goal _____ ❒ Improve coping skills
❒ Improve mobility ❒ Improve ADL skills ❒ Other _____

MARK LOCATION OF PAIN:



PATIENT CARE DATA

Consent #2 Signed: ❑ Yes ❑ No — Anesthesia Preference: ❑ None ❑ Regional ❑ General

❑ Tubal Ligation Consent Signed: ❑ Yes ❑ No — Prenatal Classes attended: ❑ Prepared Childbirth ❑ Breastfeeding ❑ Infant Care

NB Feeding Preference: ❑ Breast ❑ Bottle ❑ WIC — Circumcision: ❑ Yes ❑ No Consent Signed: ❑ Yes ❑ No

Dentures: ❑ No ❑ Upper ❑ Lower — Contacts: ❑ Yes ❑ No ❑ Left In

Last Oral Intake: Fluids: ____/____/____ Time: _____ AM / PM Type: _____

Solids: ____/____/____ Time: _____ AM / PM Type: _____

Illness (< 14 days prior to Admission) ❑ None ❑ Type/Tx: _____

Recent exposure to Communicable Disease ❑ None ❑ Type/Date: _____

Recent travel into foreign country? ❑ No ❑ Yes Explain: _____

Protective/Disease Specific Isolation ❑ None ❑ Yes _____

NICU Notified ❑ No ❑ Yes Reason _____

ASSESSMENT:

Height: _____ ❑ in. Pre-pregnant Weight: _____ lbs. ❑ est. Current Weight _____ lbs. WT gain this pregnancy: _____ lbs.

V/S: T: _____ P: _____ R: _____ BP: _____ FHR: _____ Location: _____

Urine: Protein: _____ Glucose: _____ Ketones: _____

Specimen sent to Lab: ❑ Yes ❑ No ❑ CBC ❑ Type, Rh, Screen ❑ PIH Profile ❑ Other: _____

Admission Vaginal Exam: ❑ Deferred ❑ Done Time: _____ AM / PM By: _____

Dil _____ Eff _____ Sta _____ Presentation: ❑ Vertex ❑ Breech ❑ Transverse ❑ Other _____

PLACE REFERRAL TO APPROPRIATE DISCIPLINE

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

PSYCHOSOCIAL

Marital Status: ❑ Married ❑ Single ❑ Separated ❑ Divorced

Father Involved: ❑ Yes ❑ No Others Involved ❑ No ❑ Yes Identify: _____

Other Children:: ❑ No ❑ Yes Ages: _____ Living with you: ❑ Yes ❑ No

Personal Habits: Smoke ❑ No ❑ Yes (_____ amount/day) Caffeine: ❑ No ❑ Yes Amount _____

ETOH/Drug Use: ❑ No ❑ Yes Abuse: ❑ No ❑ Yes :

Substance(s)	Amount/Day	Last Used
		Time: _____ AM / PM
		Time: _____ AM / PM

Describe any signs/symptoms of abuse or neglect: ❑ None ❑ Yes: _____

Comments: _____

Spiritual/Cultural Values: Religious Preference: ❑ Jewish ❑ Catholic ❑ Protestant ❑ Jehovah Witness ❑ Other _____

*Request for spiritual/cultural support: ❑ None ❑ Food ❑ Clergy Visit

Special Requests: _____

Patient Employed: ❑ Yes ❑ No S/O Employed: ❑ Yes ❑ No Patient Lives With: ❑ Spouse ❑ Family ❑ Alone ❑ Friend

Adequate Housing: ❑ Yes *❑ Homeless ❑ Shelter ❑ Other _____

*ADOPTION: ❑ N/A ❑ Under Consideration ❑ PLANNED: ❑ Agency ❑ Private SW Notified ❑ Yes

Comments: _____

Contact with Infant: ❑ Yes ❑ No Comments: _____

SAFETY

Bracelet on: ❑ Yes ❑ No ❑ Admin Notified Time: _____

Sensory Ability: Visually Impaired ❑ Yes ❑ No / Hearing Impaired ❑ Yes ❑ No / Speech Impaired ❑ Yes ❑ No

Physical Limitations ❑: Explain _____

EDUC. NEEDS

Oriented to Patient Care Environment ❑ Bed / Call Lights / Visitors ❑ Emergency Light / I.D. Band ❑ Patient ❑ Family/SO

Anticipated Patient/SO Learning Need: ❑ Diet ❑ Meds ❑ Dx/Illness ❑ Infant Care: Explain _____

❑ Self Care: Explain _____ ❑ Labor & Delivery ❑ Epidural ❑ Pushing ❑ Family Planning ❑ Pain Management

Advanced Directive: ❑ No ❑ Yes, Copy on Chart

❑ Yes, Copy Requested from: ❑ Patient/Family ❑ MD ❑ Medical Records ❑ Information Requested* ❑ Information Given

DISCHARGE PLANNING

Support System: Family/SO support who will be available to support/help you at home post discharge. ❑ Yes ❑ No

List _____

Where will mother be staying after discharge? ❑ Home ❑ Other Address: _____ Phone #: ( ) _____

Anticipated Discharge Needs: ❑ None ❑ Equipment/Supplies: _____

OB HISTORY

RISK FACTORS ASSOCIATED WITH PAST/PRESENT PREGNANCY ❑ NONE

	PAST	PRESENT		PAST	PRESENT
Incompetent Cervix	❑	❑	Infertility	❑	❑
Placenta Previa	❑	❑	Rx:		
Preterm Labor	❑	❑	Gestation Diabetes	❑	❑
PIH	❑	❑	Tx:		
Herpes	❑	❑	Infant > 9 lbs	❑	
Last Culture: ___/___/___	❑	❑	Infant with Congenital Anomalies	❑	❑
Other STD Type: _____	❑	❑	< 12 months since last delivery		❑
RX:	❑	❑			
Post Partum Hemorrhage	❑		Fetal/Neonatal Death	❑	❑
Prev. Cesarean #:	❑		Other:	❑	❑

*** PLACE REFERRAL TO APPROPRIATE DISCIPLINE***

AFFIX PATIENT INFO LABEL HERE

Patient Name _____ MR# _____

COLLABORATION

REFERRALS

❑ **SOCIAL SERVICES**
- ❑ No Prenatal Care
- ❑ ETOH/Drug Abuse - Positive Toxicity
- ❑ Transfer from another facility
- ❑ Inadequate support system
- ❑ Adoption
- ❑ Psych/medical condition that may impact infant care
- ❑ Homelessness/Inadequate home environment
- ❑ No Provision For Baby
- ❑ Adolescent & lack of support
- ❑ HIV Positive
- ❑ Suspected Abuse/Neglect of Mother/domestic violence
- ❑ Financial concerns / No Insurance
- ❑ Life threatening congenital anomalies

*❑ **NUTRITIONAL SERVICES** (*place on diet sheet)
- ❑ Diabetes
- ❑ Substance Abuse
- ❑ Teenage Pregnancy
- ❑ Hyperemesis
- ❑ < 20 lb Weight Gain during Pregnancy
- ❑ HIV/AIDS
- ❑ Homeless
- ❑ Morbid Obesity
- ❑ Vegan Vegetarian/Breastfeeding
- ❑ Higher Order Multiples/ Breastfeeding

❑ **DISCHARGE PLANNING** (for skilled nursing or rehab care)
- ❑ Catheter Management
- ❑ Wound Care
- ❑ Intravenous / Sub-cutaneous Therapy
- ❑ Physical Therapy
- ❑ Perinatal Bereavement Counselor for Fetal Loss
- ❑ Other: _____

NURSING CONSULTATIONS:
- ❑ Diabetes Consultation
- ❑ Lactation Consult
- ❑ Perinatal Bereavement
- ❑ Perinatal CNS
- ❑ Bloodless Medicine & Surgery
- ❑ Psychiatric CNS
- ❑ Enterostomal Therapist

PHYSICAL THERAPY CONSULTATION:
- ❑ Functional screen for planned Bed Rest > 4 days
- ❑ Pre-existing neuromuscular disorder
- ❑ Other: _____

Referrals made: ❑ No (Indicate Reason) ❑ Yes Comments: _____

PART I Completed by: _____ Date/Time: _____
(signature) (title)

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(signature) (title)

PART II: POST PARTUM Complete on admission to Post Partum/Post-Delivery

PSYCHOSOCIAL/ENVIRONMENTAL NEEDS

Coping Mechanism: Pt/SO positive coping mechanism appear to be present on interview/appropriate for needs during hospital stay/post-discharge care.

❑ Yes ❑ No Comments: _____

Pt/SO Concerns: What concerns you/SO most about your postpartum recovery and baby care? _____

Prepared for NB Clothing: ❑ Yes ❑ No Equipment/Supplies: ❑ Yes ❑ No Car Seat: ❑ Yes ❑ No

Comments: _____

Pt/SO Orientation: ❑ Bed / Call Lights ❑ Notification of nurse/first time OOB/emergency light ❑ General/discharge info
❑ Mother-Baby Care Handbook ❑ Security Issues: Visiting, Infant, Access to Nursery

EDUC. NEEDS

Anticipated Pt/SO Learning Needs: Family Adjustment: ❑ Sibling Needs

Maternal Self Care: ❑ Breast Care ❑ Perineal/Incision Care ❑ Diet ❑ Meds ❑ Post-Partum Changes ❑ Family Planning

Infant Care: ❑ Bathing ❑ Cord Care ❑ Diapering ❑ Formula Prep, freq.& amt. ❑ Bulb Syringe Use
❑ Temp. Taking ❑ Elimination

Breastfeeding: ❑ First Breastfeeding Experience ❑ Positioning/latch-on / off ❑ Freq. & Duration ❑ Hydration

Comments: _____

DISCHARGE PLANNING - REFER TO PART I OF PATIENT DATABASE

COLLABORATION

❑ **SOCIAL SERVICES**
- ❑ Not bonding
- ❑ Not coping/high risk for postpartum depression
- ❑ Patients who may need community linkage/referral

❑ **PASTORAL CARE**

❑ **DISCHARGE PLANNING** (for skilled nursing or rehab)
- ❑ Catheter Management
- ❑ Wound Care
- ❑ Physical Therapy
- ❑ Mother-Infant Home Visit (LOS <24hrs post NSVD)
- ❑ Mother-Infant Home Visit (LOS <48hrs post C/S)
- ❑ Other: _____

NURSING CONSULTATIONS:
- ❑ Diabetes Consultation
- ❑ Lactation Consult
- ❑ Perinatal Bereavement
- ❑ Perinatal CNS
- ❑ Bloodless Medicine & Surgery Consultation
- ❑ Psychiatric CNS
- ❑ Enterostomal Therapist

Referrals made: ❑ No (Indicate Reason) ❑ Yes

Comments: _____

PART II Completed by: _____ Date/Time: _____
(signature) (title)

*** PLACE REFERRAL TO APPROPRIATE DISCIPLINE**