UNIVERSITY MEDICAL CENTER
INTERDISCIPLINARY

Disclaimer: is a suggested interdisciplinary plan of care. This is only a guideline. The patient problem, outcomes and interventions may be changed to meet the individual needs of the patient. Physician/Medical orders supersede all pre-printed interventions identified on

ADDRESSOGRAPH

Antepartum

ESTIMATED LOS: _____ **Days** **Date placed on map:** _____

INCLUSIONARY CRITERIA:
All patients admitted with an obstetrical and/or secondary medical diagnosis will be placed on this , unless there is a case-specific .

CRITERIA FOR REMOVING PATIENTS FROM _____ **:**
Remove patients from this caremap when delivery occurs.

Primary Diagnosis: _____ **Secondary Diagnosis:** _____

Gravida: _____ **Para:** _____ **SAB:** _____ **TOP:** _____ **LC:** _____

Blood Type: _____ **Rhogam:** **Date Given:** _____ **Date Given:** _____

Pertinent Maternal Past/Present Medical History: _____

_____

Allergies: _____

CONSULTS OR DISCIPLINES INVOLVED/NOTIFIED:

1. Bereavement Counselor — Initials/Date/Time notified: _____
2. Dietary/Nutrition — Initials/Date/Time notified: _____
3. Discharge Planning — Initials/Date/Time notified: _____
4. NICU — Initials/Date/Time notified: _____
5. Social Service — Initials/Date/Time notified: _____
6. Perinatal CNS — Initials/Date/Time notified: _____
7. MFM — Initials/Date/Time notified: _____
8. Childbirth / High Risk Education — Initials/Date/Time notified: _____
9. Other: _____ — Initials/Date/Time notified: _____

SIGNIFICANT EVENTS THIS ADMISSION:

Date/Event: _____

Date/Event: _____

Date/Event: _____

Date/Event: _____

RN Signature: _____ **Date/Time:** _____

RN Signature: _____ **Date/Time:** _____

Instructions for Documentation:
OUTCOMES/INTERVENTIONS:

- Initial when met or completed
- Use notation N/A, if not applicable for the timeframe
- Initial and circle, if not met or completed

Supplemental Documentation is required on the Interdisciplinary Progress Record when an outcome or intervention is initialed and circled, indicating it was not met or completed as stated.

MR# _____

Intructions
Items with * require a physician order.
Weight is taken at least weekly on Monday.
Urine protein is checked at least weekly on Monday.

Progress Notes:
Transferred from: L&D: _____ ER: _____ MD office: _____ Other: _____
Transferred to Antepartum Room #: _____ Time: _____ am / pm
Accompanied by: RN: _____ Husband: _____ Significant Other: _____ Other: _____
Via: Stretcher: _____ Wheelchair: _____ Ambulatory: _____

Item	On Chart	Requested	Not Applicable
Consent for Delivery			
Prenatal Record			
EBC Module #1:			

Initial Assessment:
T: _____ P: _____ R: _____ BP: _____ FHR: _____
Location: _____
Contractions: Yes _____ No _____ Quality _____ Frequency_____
Membranes: Intact _____ Ruptured _____ Vaginal Fluid Leakage _____ Vaginal Bleeding _____
IV Solution: Yes _____ No _____ Type: _____
Foley Catheter: N/A _____ Clear Urine _____ Other _____
Oriented to Room / Unit _____ Bed in Low Position _____ Call Bell explained / within reach _____
Side Rails Up_____ Emergency call bell explained _____ Plan of care reviewed _____ID bracelet on _____
Instructed to Request Assistance getting OOB _____ N/A _____
Plan of Nursing Care discussed with patient _____

RN signature: _____

Post Critical High Risk Antepartum

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES

D = DAYS E = EVENINGS N = NIGHTS

Problem/ Needs	Day 0 - GA _____ Date: _____				Problem/ Needs				
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of treatment plan, diet, medications, and activity; participates in decision making / plan of care.				Alterations in ADL's / Activity due to:	Able to perform ADL's with: ____ assistance ____ independently			
Fetal Well Being	NST Reactive								
	FHR Baseline								
	N								
	D								
	E								
Maternal Well Being	Vital Signs / Temperature WNL				Anxiety / Fear related to High Risk Pregnancy Outcome	Able to express / verbalize feelings of fear / anxiety.			
	Decrease / absence of vaginal fluid leakage / bleeding.					Significant other expresses interest and involvement in decision making.			
	Verbalizes understanding of how to detect / count fetal movement.								
	Verbalizes individual sleep needs being met.				Discharge Planning				
	Weight appropriate.								
	Homan's sign negative								
Pain Management	Pain free or verbalizes relief after intervention.				Patient Safety	Remains injury free in a safe environment.			
	States < 3 contractions per hour or states decrease in abdominal cramping/ contractions. States decrease or absent intermittent thigh, back, abdominal or pelvic pain.					ID bracelet on			
					Skin Integrity	No evidence of skin breakdown.			
					Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories					Patient Care Categories				
Discharge Plan (1)	Assess need for Discharge Planning, Social Services and/or other:				Nutrition (2)	* Diet: _____ Encourage / provide fluids			
						% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
						High risk nutritional assessment completed.			

* indicates medical orders needed

INTERVENTIONS (continued) MR# _____

Patient Care Categories	*Day 0 GA* _____ *Date:* _____				*Patient Care Categories*				
Assessment & Treatments (3)	Assess q ___ hrs. while awake: - Vital Signs & BP - Vaginal Discharge - Breath Sounds - Homan's Sign (q24) - Emotional status / coping mechanism - Review plan of care - Weight on admission				***Teaching & Psycho-social*** (4)	Assess patient / family satisfaction.			
						Encourage verbalization of fears / concerns.			
	I & O q shift. * TED's (if on complete bedrest) remove daily					Learning needs / teaching plan: _____ _____ _____ _____ _____ _____ _____			
	* IV insertion IV / PIID: _____ Site: _____					MFM Consults			
	* EFM q: _____								
	* Specimen Collection:								
	Linen change / HS Care Comfort Care				***Specimens & Diagnostics*** (5)	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Special Procedures Type: _____ _____ _____ _____ _____ _____					* Tests / Procedures _____ _____ _____ _____ _____ _____			
					Safety & Activity (6)	* Activity level:			
						Functional Screen for planned BR>4 days			
						Physical Therapy Consult for Pre-existing neuromuscular disorder			
						Bladder / bowel with assist for complete bedrest			
						Showers/Bathes Self			
						Bathes self with assist.			
Priority of Care									

** indicates medical orders needed*

Post Critical High Risk Antepartum

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day 1 - GA _____ Date: _____	N	D	E
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of treatment plan, diet, medications, and activity; participates in decision making / plan of care.			
Fetal Well Being	NST Reactive			
	FHR Baseline			
	N			
	D			
	E			
Maternal Well Being	Vital Signs / Temperature WNL			
	Decrease / absence of vaginal fluid leakage / bleeding.			
	Verbalizes understanding of how to detect / count fetal movement.			
	Verbalizes individual sleep needs being met.			
	Homan's sign negative			
Pain Management	Pain free or verbalizes relief after intervention.			
	States < 3 contractions per hour or states decrease in abdominal cramping/ contractions. States decrease or absent intermittent thigh, back, abdominal or pelvic pain.			

Problem/ Needs		N	D	E
Alterations in ADL's / Activity due to:	Able to perform ADL's with: ____ assistance ____ independently			
Anxiety / Fear related to High Risk Pregnancy Outcome	Able to express / verbalize feelings of fear / anxiety.			
	Significant other expresses interest and involvement in decision making.			
Discharge Planning				
Patient Safety	Remains injury free in a safe environment. ID bracelet on			
Skin Integrity	No evidence of skin breakdown.			
	ID bracelet on			
Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		N	D	E
Discharge Plan (1)	Discharge plan initiated and communicated to patient / family.			

Patient Care Categories		N	D	E
Nutrition (2)	* Diet: _____ Encourage/Provide fluids			
	% of diet consumed:			
	Breakfast _____ %			
	Lunch _____ %			
	Dinner _____ %			
	High risk nutritional assessment completed.			

** indicates medical orders needed*

INTERVENTIONS (continued)

MR# _____

ıtient Care ategories	Day 1 GA _____ Date: _____	N	D	E	
sessment & reatments (3)	Assess q ___ hrs. while awake: - Vital Signs & BP - Vaginal Discharge - Breath Sounds - Homan's Sign (q24) - Emotional status / coping mechanism - Review plan of care				
	I & O q shift.				
	* TED's (if on complete bedrest) remove daily				
	* IV insertion IV / PIID: _____ Site: _____				
	* EFM q: _____				
	* Specimen Collection				
	Linen change / HS Care Comfort Care PRN				
	* Special Procedures Type: _____ _____ _____ _____ _____ _____				
riority of Care					

Patient Care Categories		N	D	E	
Teaching & Psycho-social (4)	Assess patient / family satisfaction.				
	Encourage verbalization of fears / concerns.				
	Learning needs / teaching plan: _____ _____ _____ _____ _____ _____ _____				
	MFM Consults				
Specimens & Diagnostics (5)	Lab / diagnostics results reviewed; MD notified if indicated.				
	* Tests / Procedures _____ _____ _____ _____ _____ _____ _____				
Safety & Activity (6)	* Activity level:				
	Functional Screen for planned BR>4 days				
	Physical Therapy Consult for Pre-existing neuromuscular disorder				
	Exercize program designed by PT, completed by patient				
	Bladder / bowel with assist for complete bedrest				
	Showers/Bathes Self				
	Bathes self with assist.				

** indicates medical orders needed*

Post Critical High Risk Antepartum

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day 2 - GA _____ Date: _____	N	D	E	Problem/ Needs		N	D	E
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of treatment plan, diet, medications, and activity; participates in decision making / plan of care.				Alterations in ADL's / Activity due to:	Able to perform ADL's with: ____ assistance ____ independently			
Fetal Well Being	NST Reactive								
	FHR Baseline								
	N								
	D								
	E								
Maternal Well Being	Vital Signs / Temperature WNL				Anxiety / Fear related to High Risk Pregnancy Outcome	Able to express / verbalize feelings of fear / anxiety.			
	Decrease / absence of vaginal fluid leakage / bleeding.					Significant other expresses interest and involvement in decision making.			
	Verbalizes understanding of how to detect / count fetal movement.								
	Verbalizes individual sleep needs being met.				Discharge Planning				
	Weight appropriate.								
	Homan's sign negative								
Pain Management	Pain free or verbalizes relief after intervention.				Patient Safety	Remains injury free in a safe environment.			
	States < 3 contractions per hour or states decrease in abdominal cramping/ contractions. States decrease or absent intermittent thigh, back, abdominal or pelvic pain.					ID bracelet on			
					Skin Integrity	No evidence of skin breakdown.			
					Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		N	D	E	Patient Care Categories		N	D	E
Discharge Plan (1)	Assess need for changes in Discharge Plan and communicated to patient/ family.				Nutrition (2)	* Diet: _____ Encourage / provide fluids			
						% of diet consumed: Breakfast _____% Lunch _____ % Dinner _____ %			
						High risk nutritional assessment completed.			

** indicates medical orders needed*

INTERVENTIONS (continued)

MR# _____

Patient Care Categories	Day 2 GA _____ Date: _____	N	D	E
Assessment & Treatments (3)	Assess q ___ hrs. while awake: - Vital Signs & BP - Vaginal Discharge - Breath Sounds - Homan's Sign (q24) - Emotional status / coping mechanism - Review plan of care			
	I & O q shift.			
	* TED's (if on complete bedrest) remove daily			
	* IV IV / PIID: _____ Site: _____			
	* EFM q: _____			
	* Specimen Collection:			
	Linen change / HS Care Comfort Care			
	* Special Procedures Type: _____ _____ _____ _____ _____ _____			
Priority of Care				

Patient Care Categories		N	D	E
Teaching & Psycho-social (4)	Assess patient / family satisfaction.			
	Encourage verbalization of fears / concerns.			
	Learning needs / teaching plan: _____ _____ _____ _____ _____ _____ _____			
	MFM Consults			
Specimens & Diagnostics (5)	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Tests / Procedures _____ _____ _____ _____ _____ _____ _____			
Safety & Activity (6)	* Activity level:			
	Functional Screen for planned BR>4 days			
	Physical Therapy Consult for Pre-existing neuromuscular disorder			
	Exercize program designed by PT, completed by patient			
	Bladder / bowel with assist for complete bedrest			
	Showers/Bathes self			
	Bathes self with assist.			
	Transport by staff.			

** indicates medical orders needed*