

# CLINICAL RECORD FORMS

*(no watermarks)*

## **SUMMARY OF 2021 UPDATES**

### **A: NORMAL BIRTH PACKAGE**

- Labour Record
- Labour Notes
- Immediate Postpartum/Third Stage
- Labour Summary
- Perineal Repair/Instrument Record/Departure
- Immediate Newborn Care and Summary
- Newborn Narrative/Informed Choice Discussion

### **B: POSTPARTUM PACKAGE**

- Newborn Summary and Postnatal Care
- Client Summary and Postnatal Care

### **C: EXTRA FORMS**

- Assessment Record
- Client Transfer Record
- Newborn Transfer Record
- Newborn Resuscitation Record
- Narrative Notes
- Signature Page

## Updates to Clinical Record Forms

In 2021, the AOM updated the Clinical Record Forms that required high priority revisions. The AOM determined that those requiring most critical updates were the *Assessment Record*, *Labour Records*, and *Neonatal Resuscitation* forms. These forms have been edited for clarity, consistency and usefulness, and have been adjusted to match current guidelines (e.g. fetal health surveillance, newborn resuscitation program).

### ● **Assessment Record:**

- A vitals section has been added in response to the new Fetal Health Surveillance (FHS) guideline and so that parturient heart rate can be more easily charted with the fetal heart rate.
- History of caesarean has been added.
- Urine has been removed as protein dips are no longer routine. If a urine dip is done because of the specific clinical situation, this can be charted in the narrative notes.
- Cervical effacement has been changed from “%” to “% or cm long”.

### ● **Labour Record:**

- Previously the first page of *Labour: First Stage*, it is now a one-page form of its own.
- Previous caesarean section and chlamydia and gonorrhea results have been added to the history section, and public health bloodwork has been made consistent with the OPR.
- Gestational age has been added.

### ● **Labour Notes:**

- *First and Second Stage of Labour* pages have been amalgamated into one document called *Labour Notes* where all stages of labour can be charted.
- This form contains a distinct column for vital signs, making it easier to chart parturient heart rate throughout labour, and a column for contractions.
- Time of pushing, full dilation and backup midwife call and arrival can be filled in at the bottom of this form when it becomes relevant in the labour.

### ● **Neonatal Resuscitation:**

- On the first page, the order of boxes has been slightly changed for clarity and some minor edits to wording have been made.
- In the legend, the option to document PPV bag type has been added (self inflating, flow inflating or T piece resuscitator).
- In the legend, “40% oxygen” has been replaced with “self inflating bag no reservoir. NRP used to say that a self inflating bag with oxygen without a reservoir provided 40% oxygen. However, the manufacturer now says that this is not an oxygen blender and cannot be reliably used in this way. Midwives may still use it as a middle oxygen option, but the AOM wished to be clear that this is not reliably provide 40% oxygen.
- Boxes have been added for orogastric tube insertion and intraosseous access.
- Updates have been made to follow NRP guidelines (e.g. removal of size 4.0 ETT, updated tip to lip, removal of Ringer’s Lactate from volume expansion); space has been provided for subsequent doses of epinephrine.
- Ordering, checkboxes and wording have been streamlined for clarity.
- A section at the bottom has been added for calling EMS and hospital and the space for names has been changed from “midwives” to “clinicians involved” to represent students, Birth Centre Aides, EMS or anyone else who might participate.

Client name: \_\_\_\_\_

DOB: \_\_\_\_\_

# Labour Record

Date: \_\_\_\_\_

Client screened for signs and symptoms of infectious disease Initials: \_\_\_\_\_  
 Support person(s): \_\_\_\_\_

## PREGNANCY SUMMARY

EDB: \_\_\_\_\_ G \_\_\_ T \_\_\_ P \_\_\_ A \_\_\_ L \_\_\_ GA \_\_\_\_\_

Allergies:  NKA  Yes, incl. reactions: \_\_\_\_\_

Blood group: \_\_\_\_\_ Rh: \_\_\_ RhIG received? Y / N If no, why? \_\_\_\_\_  
 Previous c/s? Y / N Plans TOLAC? Y / N | n/a  
 GBS: - / + / unknown / declined Rubella: I / Non-I / Indet  
 Intrapartum antibiotic prophylaxis strategy: HBsAg: R / NR  
 based on GBS + status Syphilis: R / NR  
 based on GBS + status and risk factors HIV: R / NR  
 based on risk factors Chlamydia: + / -  
 declines prophylaxis GC: + / -

Current medications: \_\_\_\_\_

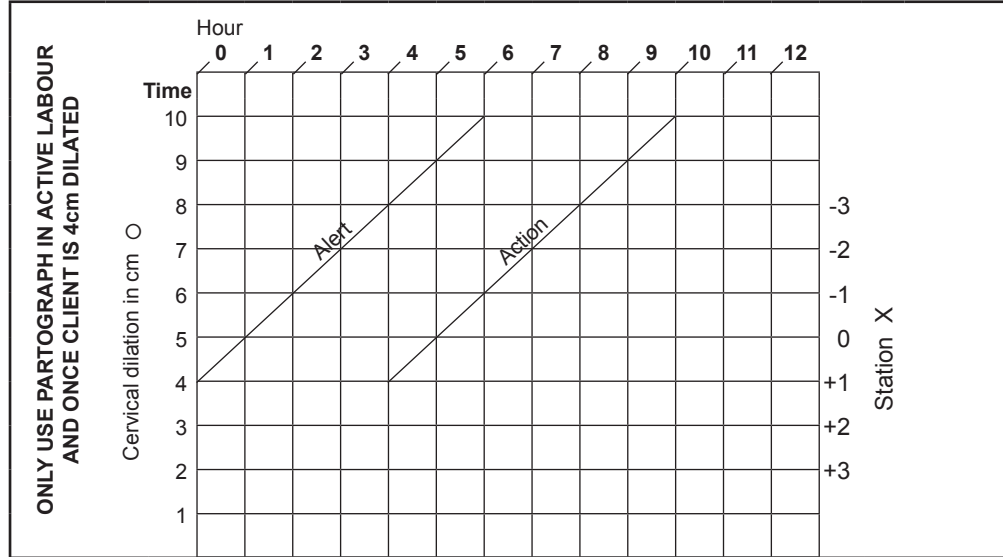
Relevant history: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Onset of labour and initial assessment:  See **Assessment Record**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Membranes:  intact  ruptured time of rupture: \_\_\_\_\_  
 description of fluid \_\_\_\_\_

Active labour began: \_\_\_\_\_

Form completed by: \_\_\_\_\_



## INTERNAL EXAMINATIONS

Time						
Dilation						
Effacement						
Cx Position						
Station						
Fetal Pos'n						
Mem/fluid						
Show						
Initials						

Internal Examinations:				Bloodwork:
<b>LEGEND</b>	<b>Effacement:</b> (% or ___cm long)	<b>Fetal Position:</b> L = Left R = Right O = Occiput S = Sacrum M = Mentum Sc = Scapula	<b>Membranes:</b> I = Intact SROM = Spontaneous rupture of membranes ARM = Artificial rupture of membranes R = Ruptured	R = Reactive NR = Nonreactive I = Immune Non-I = non immune Indet = Indeterminate
	<b>Cervix Position:</b> A = Anterior M = Mid P = Posterior	A = Anterior T = Transverse (lateral) P = Posterior	<b>Show:</b> Sc = Scant Mod = Moderate L = Large	
			<b>Fluid:</b> Quantity: Ø = Absent Sc = Scant Mod = Moderate L = Large Colour: CL = Clear BT = Blood tinged B = Bloody Mec = Meconium	

Client name: \_\_\_\_\_

DOB: DD/MMM/YYYY \_\_\_\_\_

OR OPTIONAL LABEL

## Labour Notes (Page \_\_\_)

Date: \_\_\_\_\_

TIME	FETAL HEART RATE rate / rhythm / accel / decel / class	CONTRACTIONS freq / length / intensity / resting tone	VITAL SIGNS P / BP / temp	CLIENT ASSESSMENT AND NARRATIVE NOTES e.g. progress, position, activity, coping, medications, intake, output, plan	Initials

Full Dilation @ \_\_\_\_\_ h Active Pushing @ \_\_\_\_\_ h 2nd midwife called @ \_\_\_\_\_ h Arrived @ \_\_\_\_\_ h 3rd stage plan: \_\_\_\_\_

<b>Transfer:</b> <input type="checkbox"/> Client Transfer Record attached Indications: _____ <input type="checkbox"/> private vehicle <input type="checkbox"/> ambulance called at: _____ <input type="checkbox"/> arrived at: _____ Hospital: _____ Time of departure: _____		<b>Fetal Heart Rate:</b> <b>Rhythm</b> R = Regular I = Irregular <b>Accelerations (accel)</b> √ = Present/spontaneous Ø = Absent/not heard SS = Present/scalp stimulation <b>Decelerations (decel)</b> √ = Present* Ø = Absent/not heard *chart description <b>Classification (class)</b> N = Normal AbN = Abnormal			<b>Contractions:</b> <b>Intensity</b> Mild = Mild Mod = Moderate St = Strong <b>Resting Tone</b> S = Soft F = Firm	
<b>Medication charting:</b> drug, indication, dose, route						



Client name: \_\_\_\_\_

DOB: DD/MM/YY \_\_\_\_\_

OR OPTIONAL LABEL

# Labour Notes (Page \_\_\_)

Date: \_\_\_\_\_

TIME	FETAL HEART RATE <small>rate / rhythm / accel / decel / class</small>	CONTRACTIONS <small>freq / length / intensity / resting tone</small>	VITAL SIGNS <small>P / BP / temp</small>	CLIENT ASSESSMENT AND NARRATIVE NOTES <small>e.g. progress, position, activity, coping, medications, intake, output, plan</small>	Initials

Full Dilation @ \_\_\_\_\_ h Active Pushing @ \_\_\_\_\_ h 2nd midwife called@ \_\_\_\_\_ h Arrived@ \_\_\_\_\_ h 3rd stage plan: \_\_\_\_\_

**Transfer:**  Client Transfer Record attached

Indications: \_\_\_\_\_  
 \_\_\_\_\_

private vehicle  
 ambulance called at: \_\_\_\_\_  arrived at: \_\_\_\_\_

Hospital: \_\_\_\_\_  
 Time of departure: \_\_\_\_\_

LEGEND	Fetal Heart Rate:				Contractions:	
	<b>Rhythm</b> R = Regular I = Irregular	<b>Accelerations</b> (accel) ✓ = Present/spontaneous Ø = Absent/not heard SS = Present/scalp stimulation	<b>Decelerations</b> (decel) ✓ = Present* Ø = Absent/not heard *chart description	<b>Classification (class)</b> N = Normal AbN = Abnormal	<b>Intensity</b> Mild = Mild Mod = Moderate St = Strong	<b>Resting Tone</b> S = Soft F = Firm

**Medication charting:** drug, indication, dose, route

Client name: \_\_\_\_\_  
DOB: DD/MM/YY\_\_\_\_\_

OR OPTIONAL LABEL

## Labour Notes (Page \_\_\_\_)

Date: \_\_\_\_\_

TIME	FETAL HEART RATE rate / rhythm / accel / decel / class	CONTRACTIONS freq / length / intensity / resting tone	VITAL SIGNS P / BP / temp	CLIENT ASSESSMENT AND NARRATIVE NOTES e.g. progress, position, activity, coping, medications, intake, output, plan	Initials

Full Dilation @ \_\_\_\_\_ h Active Pushing @ \_\_\_\_\_ h 2nd midwife called @ \_\_\_\_\_ h Arrived @ \_\_\_\_\_ h 3rd stage plan: \_\_\_\_\_

<p><b>Transfer:</b> <input type="checkbox"/> Client Transfer Record attached</p> <p>Indications: _____</p> <p><input type="checkbox"/> private vehicle</p> <p><input type="checkbox"/> ambulance called at: _____ <input type="checkbox"/> arrived at: _____</p> <p>Hospital: _____</p> <p>Time of departure: _____</p>	<p style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>LEGEND</b></p> <table border="1"> <tr> <th colspan="4">Fetal Heart Rate:</th> <th colspan="2">Contractions:</th> </tr> <tr> <td><b>Rhythm</b> R = Regular I = Irregular</td> <td><b>Accelerations (accel)</b> √ = Present/spontaneous ∅ = Absent/not heard SS = Present/scalp stimulation</td> <td><b>Decelerations (decel)</b> √ = Present* ∅ = Absent/not heard *chart description</td> <td><b>Classification (class)</b> N = Normal AbN = Abnormal</td> <td><b>Intensity</b> Mild = Mild Mod = Moderate St = Strong</td> <td><b>Resting Tone</b> S = Soft F = Firm</td> </tr> </table>	Fetal Heart Rate:				Contractions:		<b>Rhythm</b> R = Regular I = Irregular	<b>Accelerations (accel)</b> √ = Present/spontaneous ∅ = Absent/not heard SS = Present/scalp stimulation	<b>Decelerations (decel)</b> √ = Present* ∅ = Absent/not heard *chart description	<b>Classification (class)</b> N = Normal AbN = Abnormal	<b>Intensity</b> Mild = Mild Mod = Moderate St = Strong	<b>Resting Tone</b> S = Soft F = Firm
Fetal Heart Rate:				Contractions:									
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<b>Medication charting:</b> drug, indication, dose, route													

Client name: \_\_\_\_\_

DOB: DD/MMM/YYYY

OR OPTIONAL LABEL

## Immediate Postpartum/Third Stage and Labour Summary

Date					
Time	BP, P [T, R]	Lochia	Uterus	Notes (Assessments, interventions, responses to interventions, breastfeeding, void)	Initials

### THIRD STAGE / PLACENTA

Delayed cord clamping <input type="checkbox"/> yes <input type="checkbox"/> no	<b>Elements of 3rd Stage Management Used:</b> <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Client effort <input type="checkbox"/> Controlled cord traction <input type="checkbox"/> Prophylactic oxytocin	<b>PPH Management</b> <input type="checkbox"/> Uterine massage <input type="checkbox"/> Bimanual compression <input type="checkbox"/> Uterotonics (chart below) <input type="checkbox"/> Other: _____
Placenta and membranes delivered: Date: _____ Time: _____ Complete: <input type="checkbox"/> Yes <input type="checkbox"/> No		Notes (cord insertion, # of vessels, presence of knots; sent to pathology for testing, given to parents, disposed of, looks incomplete): _____ _____ _____
<input type="checkbox"/> Placenta born in water		Initials: _____
<b>TOTAL ESTIMATED BLOOD LOSS</b> _____ mL <input type="checkbox"/> >500 mL <input type="checkbox"/> <500 mL		

### POSTPARTUM MEDICATIONS

<input type="checkbox"/> oxytocin: 10 units IM time: _____ initials: _____ <input type="checkbox"/> oxytocin: 5 units IV push time: _____ initials: _____ <input type="checkbox"/> acetaminophen ___ mg p.o. time: _____ initials: _____ <input type="checkbox"/> ibuprofen ___ mg p.o. time: _____ initials: _____ <input type="checkbox"/> _____	<input type="checkbox"/> misoprostol: ___ units sublingual time: _____ initials: _____ <input type="checkbox"/> misoprostol: ___ units per rectum time: _____ initials: _____ <input type="checkbox"/> ergonovine: _____ dose time: _____ initials: _____ <input type="checkbox"/> carboprost: _____ dose time: _____ initials: _____ <input type="checkbox"/> _____				
Time	Medication, IV fluid (if not charted above)	Dose	Route	Site	Initials

DATE:	Onset	End	Duration	Total active labour	PLACE OF BIRTH:
Latent 1 <sup>st</sup> stage					Planned: <input type="checkbox"/> home <input type="checkbox"/> hospital <input type="checkbox"/> birth centre <input type="checkbox"/> other Actual: <input type="checkbox"/> home <input type="checkbox"/> hospital <input type="checkbox"/> birth centre <input type="checkbox"/> other
Active 1 <sup>st</sup> stage					<input type="checkbox"/> live birth <input type="checkbox"/> stillbirth
Time fully dilated					Position at birth: client: _____
Time started pushing					<input type="checkbox"/> waterbirth
3 <sup>rd</sup> stage					Presentation at birth: fetal: <input type="checkbox"/> vertex <input type="checkbox"/> other: _____ Amniotic fluid at birth: <input type="checkbox"/> clear <input type="checkbox"/> meconium (length of ROM: _____)

Client name: \_\_\_\_\_

DOB: DD/MMM/YYYY \_\_\_\_\_

OR OPTIONAL LABEL

## Perineal Repair/Instrument Record/Departure

PERINEUM, VAGINA AND VULVA	
<input type="checkbox"/> Intact	
<input type="checkbox"/> Laceration: <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th degree <input type="checkbox"/> Vaginal <input type="checkbox"/> Perineal <input type="checkbox"/> Labial	
<input type="checkbox"/> Episiotomy: <input type="checkbox"/> Midline <input type="checkbox"/> Mediolateral: <input type="checkbox"/> Left <input type="checkbox"/> Right	
<input type="checkbox"/> Other trauma: _____	
Repaired: <input type="checkbox"/> Yes <input type="checkbox"/> No      Repaired by: _____	
<b>REPAIR</b> Materials used: _____	
<input type="checkbox"/> Lidocaine 1%      _____ cc infiltrated      TIME: _____	<input type="checkbox"/> With epinephrine
<input type="checkbox"/> Lidocaine 2%      _____ cc infiltrated      TIME: _____	<input type="checkbox"/> Xylocaine gel 2%
Repair underway: _____	Repair complete: _____
Notes: _____ _____ _____ _____	
_____ Initials: _____	

POSTPARTUM NEWBORN/MATERNAL BLOOD COLLECTION		
Cord blood: <input type="checkbox"/> collected <input type="checkbox"/> not collected	Client blood sample:	Samples will be submitted to lab: (name of lab): _____
If collected, collected for:	<input type="checkbox"/> Not collected	
<input type="checkbox"/> ABO type + factor <input type="checkbox"/> Arterial gases	<input type="checkbox"/> Collected	
<input type="checkbox"/> Venous gases <input type="checkbox"/> Section of cord		
<input type="checkbox"/> Kleihauer Betke <input type="checkbox"/> Other: _____		

INSTRUMENTS USED (birth and suturing)	
Sterilization load/ tracking #/ tray #	Date sterilized

DEPARTURE	
<input type="checkbox"/> reviewed postpartum instructions as per protocol	
Client-specific departure instructions: _____	
Client departure (if birth at clinic, birth centre or other site) Date: _____	Time: _____

<b>Transfer:</b> Indication: _____	
<input type="checkbox"/> ambulance <input type="checkbox"/> private vehicle <input type="checkbox"/> client transfer record attached	

	Name (printed)	Time of departure		Name (printed)	Time of departure
2nd MW			Student MW		
Prim MW			Student MW		



Baby of: \_\_\_\_\_  
 Baby's name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ DD/MMM/YYYY

## Immediate Newborn Care and Summary

Date and time of birth: \_\_\_\_\_

Sex:  Male  Female  Ambiguous

Resuscitation:  No  Yes ( used **Neonatal Resuscitation Record**)

Antenatal/postpartum risk factors/concerns/issues to follow up: (maternal Hep B or GBS status, plans for postpartum monitoring of glucose or head circumference, SGA/LGA, etc.) \_\_\_\_\_

Time	HR	RR	Temp	Other Assessments (e.g. colour, O <sub>2</sub> saturation, breastfeeding, alertness)	Actions/Notes (e.g. stimulation, warming, assistance with breastfeeding, suctioning)	Initials

GA: \_\_\_\_\_ Weight: \_\_\_\_\_ grams \_\_\_\_\_ lb \_\_\_\_\_ oz HC: \_\_\_\_\_ cm L: \_\_\_\_\_ cm Chest (optional) \_\_\_\_\_ cm  
 Weight% for GA: \_\_\_\_\_ %ile

Time of exam: \_\_\_\_\_ (checkmark  if normal) HR: \_\_\_\_\_ bpm RR \_\_\_\_\_ /min Temp (axilla): \_\_\_\_\_ °C

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> <b>1. Appearance</b>             | <input type="checkbox"/> <b>7. Abdomen</b>          | <input type="checkbox"/> <b>10. Void</b>  |
| <input type="checkbox"/> <b>2. Skin</b>                   | <input type="checkbox"/> <i>Umbilicus</i>           | <input type="checkbox"/> <b>11. Meconium</b>                                    |
| <input type="checkbox"/> <b>3. Head and neck</b>          | <input type="checkbox"/> <i>Vessels (three)</i>     | <input type="checkbox"/> <b>12. Neurological</b>                                |
| <input type="checkbox"/> <i>Eyes</i>                      | <input type="checkbox"/> <b>8. Genitourinary</b>    | <input type="checkbox"/> <i>Tone</i>  |
| <input type="checkbox"/> <i>Red reflexes</i>              | <input type="checkbox"/> <i>Descended testicles</i> | <input type="checkbox"/> <i>Symmetry</i>  |
| <input type="checkbox"/> <i>Mouth &amp; palate</i>        | <input type="checkbox"/> <i>Patent anus</i>         | <input type="checkbox"/> <i>Arms and hands</i>                                  |
| <input type="checkbox"/> <i>Ears</i>                      | <input type="checkbox"/> <i>Patent vagina</i>       | <input type="checkbox"/> <i>Reflexes present</i>                                |
| <input type="checkbox"/> <i>Sutures &amp; fontanelles</i> | <input type="checkbox"/> <b>9. Musculoskeletal</b>  | <input type="checkbox"/> <i>Rooting</i> <input type="checkbox"/> <i>Sucking</i> |
| <input type="checkbox"/> <i>Nose, nares</i>               | <input type="checkbox"/> <i>Hips</i>                | <input type="checkbox"/> <i>Moro</i> <input type="checkbox"/> <i>Plantar</i>    |
| <input type="checkbox"/> <b>4. Heart sounds</b>           | <input type="checkbox"/> <i>Spine</i>               | <input type="checkbox"/> <i>Babinski</i> <input type="checkbox"/> <i>Grasp</i>  |
| <input type="checkbox"/> <b>5. Femoral pulses</b>         | <input type="checkbox"/> <i>Clavicles</i>           |   |
| <input type="checkbox"/> <b>6. Lungs</b>                  | <input type="checkbox"/> <i>Arms and hands</i>      |   |
|   | <input type="checkbox"/> <i>Legs and feet</i>       |   |

**Additional Notes** (number and describe abnormal findings):

Initials: \_\_\_\_\_

MEDICATIONS	APGAR SCORES						
	0	1	2	1 Min	5 Min	10 Min	
<input type="checkbox"/> Vitamin K 1 mg IM <input type="checkbox"/> R <input type="checkbox"/> L thigh Time: _____ Initials: _____	Heart rate	Absent	<100	>100			
<input type="checkbox"/> Erythromycin eye prophylaxis Time: _____ Initials: _____	Respiratory effort	Absent	Weak cry	Strong cry			
<input type="checkbox"/> Other: _____ Initials: _____	Reflex stimuli	No response	Grimace	Active withdrawal			
If declined or parents refused access to baby, document informed choice discussion on <i>Narrative Notes or a refusal to treat form (if used in your setting)</i>	Muscle tone	Limp	Some flexion	Well flexed			
	Colour	Pale/blue	Acrocyanosis	All pink			
	Total						
	Initials						

Baby of: \_\_\_\_\_  
Baby's name: \_\_\_\_\_  
DOB: DD/MMM/YYYY \_\_\_\_\_

Newborn departure from birth centre/clinic if different from client departure time: Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Person responsible for newborn if different from client: \_\_\_\_\_

- Skin to skin contact uninterrupted for at least 1 hour, within the first 2 hrs
  - Skin-to-skin interrupted within first 2 hours
  - With other person
- Opportunity to latch  1<sup>st</sup> hr  2<sup>nd</sup> hr
  - Latch achieved
  - No attempt bf or skin to skin within first 2 hours
  - Transport (no opportunity)

## Newborn Narrative/Informed Choice Discussions

Time	Notes	Initials

Baby of: \_\_\_\_\_  
 OR OPTIONAL LABEL

Baby name: \_\_\_\_\_

# Newborn Summary and Postnatal Care (Page 1)

Date/time of birth:		Date/time of discharge (if applicable):	
Sex: _____ HC: _____ cm	L: _____ cm	Birthweight: _____ g _____ lb _____ oz	10% loss = _____
HC#:	Apgars: _____ / _____ / _____		
Cord gases: Arterial pH _____ BE _____		Blood type: _____	
Venous pH _____ BE _____		Direct Coombs: - / + _____	
<input type="checkbox"/> Vitamin K <input type="checkbox"/> Erythromycin		Red Reflex <input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/> Vitamin D discussed _____		<input type="checkbox"/> HBIG <input type="checkbox"/> HBV: birth <input type="checkbox"/> HBV: 4 wks <input type="checkbox"/> not indicated	

Date + Time	Day	Location	T/HR/RR/HS	Eyes	Skin/Jaundice	Umbilicus	Urine	Stools	Feeding/Comments	Weight	Initials

NSO @ 24-48 hrs: date: \_\_\_\_\_ time: \_\_\_\_\_  
 blood spot result: \_\_\_\_\_ CCHD result: \_\_\_\_\_  
 comfort measures: \_\_\_\_\_

Notes (e.g. resus, paed consult, GBS risk factors, issues for follow-up): \_\_\_\_\_

<b>Second physical assessment (check if normal)</b>	<b>Final visit</b>
Date: _____ <input type="checkbox"/> Skin <input type="checkbox"/> Head <input type="checkbox"/> Eyes <input type="checkbox"/> Mouth <input type="checkbox"/> Neck <input type="checkbox"/> Lungs <input type="checkbox"/> Abdomen <input type="checkbox"/> Heart sounds/rhythm <input type="checkbox"/> HR _____ <input type="checkbox"/> Hips <input type="checkbox"/> Clavicle <input type="checkbox"/> Symmetry of movement <input type="checkbox"/> Responds to sound and movement <input type="checkbox"/> Descended testes in males <input type="checkbox"/> Umbilicus Weight: _____ Urine: _____ Stools: _____ Initials: _____	Date: _____ Age: _____ Weight: _____ g _____ lb _____ oz Length: _____ cm HC: _____ cm Narrative notes: _____
Physical assessment and developmental markers (check if normal) <input type="checkbox"/> Head & neck <input type="checkbox"/> Clavicles <input type="checkbox"/> Abdomen <input type="checkbox"/> Umbilicus <input type="checkbox"/> Skin <input type="checkbox"/> Hips <input type="checkbox"/> Heart sounds <input type="checkbox"/> HR _____ <input type="checkbox"/> Lungs <input type="checkbox"/> RR _____ <input type="checkbox"/> Smiling <input type="checkbox"/> Cooing <input type="checkbox"/> Gaze and tracking <input type="checkbox"/> Head control Feeding: _____ Initials: _____	
Narrative notes and feeding: _____ _____ _____ <input type="checkbox"/> Vaccination discussed <input type="checkbox"/> F/up visit booked with _____	



Client name: \_\_\_\_\_ Client #: \_\_\_\_\_  
 DOB: DD/MM/YYYY

OR OPTIONAL LABEL

## Client Summary and Postnatal Care (Page 1)

Date/time of birth: \_\_\_\_\_ Location: \_\_\_\_\_  
 Birth details: \_\_\_\_\_  
 Date/time of hospital admission (if applicable): \_\_\_\_\_  
 Date/time of hospital discharge (if applicable): \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
 Blood group/RH: \_\_\_\_\_ Indirect Coomb's: - / + p.p. HB: \_\_\_\_\_  
 RhIG admin  Rubella admin (chart details in Special notes or Narrative notes on reverse)  
 HBHC: \_\_\_\_\_

Medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Special notes (perineum, need for rubella immunization, RhIG,  
 DVT prophylaxis): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date/Time	Day	Location	Vital Signs	Breasts/Nipples	Fundus	Lochia	Perineum/Incision	Bladder/Bowels	Comments/psychosocial/narrative note #	Initials

FINAL VISIT Date: \_\_\_\_\_ Location of visit: \_\_\_\_\_

Lochia: \_\_\_\_\_ Breasts/nipples: \_\_\_\_\_  
 Bladder: \_\_\_\_\_ Bowels: \_\_\_\_\_  
 Pelvic exam/perineum: \_\_\_\_\_

Pap done:  Yes  No Follow-up: \_\_\_\_\_  
 Swabs done: \_\_\_\_\_ Contraception discussed: \_\_\_\_\_

Discussion topics:

<input type="checkbox"/> Pregnancy spacing	<input type="checkbox"/> VBAC	<input type="checkbox"/> Rpt OGCT	<input type="checkbox"/> Pelvic floor muscle exercise
<input type="checkbox"/> Folic acid	<input type="checkbox"/> Thyroid	<input type="checkbox"/> PPD	<input type="checkbox"/> Rpt CBC

Narrative notes/Referrals: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Initials \_\_\_\_\_

Client name: \_\_\_\_\_  
 DOB: DD/MM/YY Client #: \_\_\_\_\_

*OR OPTIONAL LABEL*

### Client Summary and Postnatal Care (Page 2)

Narrative: consults, informed choice discussions, Rubella or Rhig admin (date/exp date/lot#). Document sterilization load/tracking # and sterilization date for suture removal instruments or speculum if applicable.

Date/Time	Notes	Initials

Client's name: \_\_\_\_\_  
DOB: \_\_\_\_\_ DD/MM/YYYY

OR OPTIONAL LABEL

# Assessment Record (Page 1)

Date: \_\_\_\_\_

<input type="checkbox"/> Client screened for signs and symptoms of infectious disease	Initials: _____
Support person(s): _____	
Client's arrival time or midwife's arrival time at home: _____ h	
Reason for assessment: _____	
<b>HISTORY</b>	
G ____ T ____ P ____ A ____ L ____ EDB _____ GA _____	
Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Yes, specify/reactions: _____	
GBS: - / + / unknown / declined Last swab: _____	
Intrapartum antibiotic prophylaxis strategy:	
<input type="checkbox"/> based on GBS+ status	<input type="checkbox"/> based on GBS+ status and risk factors
<input type="checkbox"/> based risk factors only	<input type="checkbox"/> declines prophylaxis
Blood Group: Rh: _____	
RhIG received? Y / N	
Previous C/S? Y / N	
Plans TOLAC? Y / N	
Additional relevant history _____	

ASSESSMENT					AMNIOTIC FLUID TESTS (if indicated)																															
Position by Palpation: _____					Sterile speculum: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluid visualized: <input type="checkbox"/> Yes <input type="checkbox"/> No																															
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td rowspan="7" style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>FHR</b></td> <td style="text-align: center;">Time</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Mode (IA, EFM)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>FHR (bpm)</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rhythm/variability</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Accelerations</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Decelerations</td> <td></td> <td></td> <td></td> </tr> <tr> <td>Classification</td> <td></td> <td></td> <td></td> </tr> </table>					<b>FHR</b>	Time				Mode (IA, EFM)				FHR (bpm)				Rhythm/variability				Accelerations				Decelerations				Classification				Ferning: <input type="checkbox"/> Pos <input type="checkbox"/> Neg Nitrazine: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> equiv		
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Speculum sterilization load/tracking # and date: _____																																				
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Since (date/time): _____																																				
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						<b>CONTRactions</b>	Mode (Palp, Toco)																													
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							Pulse																													
Temp																																				
Time																																				
Cx dilation (cm)																																				
Cx effacement (% or ____cm long)																																				
Cx position (Ant, Mid, Post)																																				
Cx consistency (Soft, Med, Firm)																																				
Station																																				
Fetal position																																				
Initials																																				
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						<b>VITALS</b>	BP																													
							Initials																													
							<b>Rhythm (for IA)</b> R = Regular I = Irregular																													
							<b>Decelerations</b> √ = Present Ø = Absent/not heard E = Early V = Variable * L = Late * P = Prolonged * * Chart description																													
							<b>Accelerations</b> √ = Present/spontaneous Ø = Absent/not heard SS = Present/scalp stimulation																													
							<b>Variability (for EFM)</b> Ø = Absent (undetectable) Min = Minimal (≤ 5 bpm) Mod = Moderate (6-25 bpm) Mar = Marked (> 25 bpm)																													
<b>Classification</b> N = Normal ATYP = Atypical ABN = Abnormal																																				

Client's name: \_\_\_\_\_  
DOB: \_\_\_\_\_ DD/MMM/YYYY

OR OPTIONAL LABEL

## Assessment Record (Page 2)

Date: \_\_\_\_\_

Time	Narrative notes (including informed choice discussions and assessments not captured on page 1, e.g. fetal movement)	Initials

MEDICATIONS	
<input type="checkbox"/> dimenhydrinate Time: _____	<input type="checkbox"/> __ mg PO <input type="checkbox"/> __ mg IM <input type="checkbox"/> acetaminophen ____ mg PO Time: _____ <input type="checkbox"/> Pen G ____ million units IV Time: _____
<input type="checkbox"/> other antibiotic (name, dose, route, time): _____ <input type="checkbox"/> other medications (name, dose, route, time): _____	
CARE PLAN	TEACHING/FOLLOW-UP
<input type="checkbox"/> Admitted to birth centre: meets eligibility for admission <input type="checkbox"/> Active labour: charting started on Labour Record <input type="checkbox"/> Discharged from birth centre <input type="checkbox"/> Not active labour: midwife to depart <input type="checkbox"/> Transferred to _____ Date _____ Time _____ h  Midwife name: _____ Student name: _____	<input type="checkbox"/> When to page midwife <input type="checkbox"/> Other _____ Plan for follow-up: _____ _____ _____ _____ _____



Client name: \_\_\_\_\_  
 DOB: \_\_\_\_\_ DD/MMM/YYYY

OR OPTIONAL LABEL

# Client Transfer Record

REASON FOR TRANSFER: _____	
Time of birth: _____	_____
Time EMS called: _____ by: _____	Attending midwife: _____
Time EMS arrived: _____ Departure time: _____	Report given to (if applicable): _____
Time hospital called: _____ by: _____	Time of transfer to MD (if applicable): _____
Arrival time at hospital: _____	Emergency contact: _____
Receiving hospital: _____	Telephone number: (_____) _____
<input type="checkbox"/> Ambulance <input type="checkbox"/> private vehicle	

<b>CLIENT HISTORY</b> (or attach copy of OAR) <input type="checkbox"/> Attached	
G ___ T ___ P ___ A ___ L ___ EDB _____ GA _____ Blood group: _____ Rh: _____	
Rubella: I / non-I    Hep B: - / +    HIV: - / + / unknown    Hemoglobin: _____    GBS status: - / + / unknown / declined	
Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Yes, specify/reactions: _____	
Current medications: _____	
History of LSCS or other uterine surgery: _____	
Relevant medical/obstetrical history: _____	

<b>LABOUR AND BIRTH</b>	Onset of labour date: _____	Time: _____ h
Membranes: <input type="checkbox"/> Intact <input type="checkbox"/> Ruptured    Length of rupture: _____ h    Meconium: <input type="checkbox"/> Present <input type="checkbox"/> Absent		
Most recent internal exam: Time: _____ h    Dilatation: ___ cm    Station: ___    Effacement: _____    Position: _____		
Summary of fetal heart status: _____		
Birth date: _____ Time: _____ h		
Placenta: <input type="checkbox"/> In situ <input type="checkbox"/> Delivered: Time: _____ h <input type="checkbox"/> Transferred to hospital		
Interventions: _____		
Client condition at departure: Time: _____ h    BP: _____    P: _____    Other: _____		

<b>MEDICATIONS PRIOR TO TRANSPORT</b>	Medications during labour: _____
GBS antibiotics: _____	# of doses: _____
Oxytocics: _____	# of doses: _____
Other: _____	

<b>CARE DURING TRANSPORT</b>		IV fluid: _____	Rate: _____ mL/hr	Volume remaining on arrival: _____ mL					
Time	FHR	Pulse	BP	Contractions			Medications (Dose/route)	Notes (include blood loss)	Initials
				Frequency (q ___min)	Duration (sec)	Intensity (Mild, Mod, St)			

<b>UPON ARRIVAL AT HOSPITAL</b>									
<input type="checkbox"/> Care during transport charted by EMS personnel <input type="checkbox"/> Copy attached            Paramedic name: _____									

Student name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Midwife name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 If this form is filled out as a late entry: \_\_\_\_\_ Time: \_\_\_\_\_ Name \_\_\_\_\_ Initials \_\_\_\_\_



Baby of: \_\_\_\_\_  
 Baby's name: \_\_\_\_\_  
 DOB: \_\_\_\_\_

**Newborn Transfer Record** (attach Resuscitation Record p 1 and 2 if used)

REASON FOR TRANSFER: \_\_\_\_\_

Time of birth: \_\_\_\_\_

Time EMS called: \_\_\_\_\_ by: \_\_\_\_\_      Attending midwife: \_\_\_\_\_  
 Time EMS arrived: \_\_\_\_\_ Departure time: \_\_\_\_\_      Report given to (if applicable): \_\_\_\_\_  
 Time hospital called: \_\_\_\_\_ by: \_\_\_\_\_      Time of transfer to MD (if applicable): \_\_\_\_\_  
 Arrival time at hospital: \_\_\_\_\_      Emergency contact: \_\_\_\_\_  
 Receiving hospital: \_\_\_\_\_      Telephone number: (\_\_\_\_\_) \_\_\_\_\_  
 Ambulance     private vehicle

**HISTORY**      GA: \_\_\_\_\_      Length of labour: \_\_\_\_\_ h

Membranes: Length of Rupture: \_\_\_\_\_ h      Amniotic fluid at birth:  Clear     Meconium-stained  
 GBS + / - / unknown    IAP medication: \_\_\_\_\_ # of doses: \_\_\_\_    Last dose: \_\_\_\_\_ h     Adequate prophylaxis  
 Placenta transferred to hospital:  Yes     No    Details: \_\_\_\_\_  
 Gases collected     Segment of cord transported

**Relevant maternal pregnancy/labour history/newborn interventions prior to transport including medications:**  
 (attach copy of antenatal records) \_\_\_\_\_

Initial apgars: 1 min: \_\_\_\_\_ 5 min: \_\_\_\_\_ 10 min: \_\_\_\_\_     See **Resuscitation Record** attached  
 Vitamin K:  Yes     No    Erythromycin:  Yes     No     Void     Meconium

**CARE DURING TRANSPORT/NARRATIVE**

Time	HR	RR	O <sub>2</sub> Sat %	Colour	Muscle Tone	Reflex Stimuli	Resp. Effort	Temp	Notes (incl medications, dose/route, care provided)	Initials

Care during transport charted by EMS personnel     Copy attached    Paramedic name: \_\_\_\_\_

Midwife Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Student Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Make a copy for receiving hospital

Baby of: \_\_\_\_\_

Baby's name: \_\_\_\_\_

DOB: \_\_\_\_\_

# Newborn Transfer Record

## NARRATIVE

Time	Notes	Initials

Baby's name: \_\_\_\_\_

DOB: DD/MMM/YYYY \_\_\_\_\_

Baby of: \_\_\_\_\_

## Newborn Resuscitation Record (Page 1)

Date: \_\_\_\_\_

Date and Time of birth:										Meconium stained fluid: Y / N			
<b>Time</b> hhmm / mins of life (circle one)													
Heart rate (bpm)													
Respiratory rate (/min)													
Respiratory effort (weak cry, strong cry, grunting)													
Muscle tone (limp, some flexion, well flexed)													
Stimulation (√)													
Suction (√)													
PPV indicate bag type, LMA or ETT (see legend below)													
PPV effective? Y / N If N, chart corrective measures MRSOPA (see legend below)													
SPO <sub>2</sub> (%) (right hand)													
Approx pressure from pressure gauge (typical range: 20-25 cm H <sub>2</sub> O)													
Room air / O <sub>2</sub> NR / 100% (see legend below)													
CPAP (√ note pressure) (5 cm H <sub>2</sub> O)													
Chest compressions Y / N (prioritize effective ventilation)													

APGAR				1 Min	5 Min	10 Min	15 Min	20 Min	25 Min	30 Min
	0	1	2							
Heart rate	Absent	<100	>100							
Respiratory effort	Absent	Weak cry	Strong cry							
Reflex stimuli	No response	Grimace	Active withdrawal							
Muscle tone	Limp	Some flexion	Well flexed							
Colour	Pale/blue	Acrocyanosis	All pink							
Total										
Initials										
<b>LEGEND</b>	RA	Room air (self-inflating bag not connected to O <sub>2</sub> )			<b>M</b>	Mask adjustment (seal)			<b>Pre-ductal SpO<sub>2</sub> Target</b>	
	O <sub>2</sub> NR	Self inflating bag with O <sub>2</sub> No Reservoir			<b>R</b>	Reposition airway ("sniffing")				
	100%	O <sub>2</sub> concentration with self inflating bag with reservoir, T piece or flow inflating bag			<b>S</b>	Suction (mouth then nose)			1 min	60% - 65%
	S	Self inflating bag			<b>O</b>	Open mouth, lift jaw forward			2 min	65% - 70%
	F	Flow inflating bag			<b>P</b>	Pressure increase			3 min	70% - 75%
	T	T-piece resuscitator			<b>A</b>	Airway alternative (LMA or ET)			4 min	75% - 80%
									5 min	80% - 85%
									10 min	85% - 95%

Baby's name: \_\_\_\_\_

DOB: \_\_\_\_\_

Baby of: \_\_\_\_\_

## Newborn Resuscitation Record (Page 2)

<b>Orogastric Tube</b> Inserted? Y / N (8F; nose to earlobe to xyphoid/sternum midpoint) Gastric contents on drawback? Y / N		Time inserted: _____
<b>Laryngeal Mask Airway</b> Attempted? Y / N <input type="checkbox"/> Test inflation with 4mLs air & deflate <input type="checkbox"/> Insert: open side to tongue, hard side to palate <input type="checkbox"/> Once placed, inflate with 2-4 mLs air Signs of effective air entry <input type="checkbox"/> YES <input type="checkbox"/> NO (see below) LMA placement assessed to be correct <input type="checkbox"/> YES <input type="checkbox"/> NO (if no, chart repeat attempts) <input type="checkbox"/> Secured with tape	Notes	Time inserted: _____ By whom: _____ # attempts: _____ Products used: _____
<b>Intubation</b> Attempted? Y / N Blade size (circle): 0 1 Tube size (circle): 3.0 3.5 Free flow O <sub>2</sub> while intubating <input type="checkbox"/> YES <input type="checkbox"/> NO Cords visualized <input type="checkbox"/> YES <input type="checkbox"/> NO Signs of effective air entry <input type="checkbox"/> YES <input type="checkbox"/> NO (see below) Tip to lip (circle) 7.5 8.0 8.5 9.0 9.5 Tube placement assessed to be correct <input type="checkbox"/> YES <input type="checkbox"/> NO (f no, chart repeat attempts) Secured with <input type="checkbox"/> tape <input type="checkbox"/> neobar	Notes	Time inserted: _____ By whom: _____ # attempts: _____ Time elapsed: _____
<b>Signs of Effective Air Entry (LMA and intubation)</b> <ul style="list-style-type: none"><li>• Improvement of HR + SpO<sub>2</sub></li><li>• CO<sub>2</sub> detector purple → yellow</li><li>• Equal breath sounds over both lungs</li><li>• Symmetrical mvmnt of chest</li><li>• Decreased/absent breath sounds over stomach</li><li>• Vapour in ET tube with exhalation</li><li>• No gastric distension (ET)</li></ul>		
<b>Medication by ETT</b> Administered? Y / N Epinephrine 1:10,000 ETT dose: 1 mL/kg (max 3mL) in 3mL syringe = _____ mLs <input type="checkbox"/> Followed by several PPV breaths		Time admin: _____ By whom: _____
<b>Umbilical Venous Catheterization</b> Attempted? Y / N <input type="checkbox"/> Stopcock attached to UV catheter <input type="checkbox"/> Catheter primed with normal saline <input type="checkbox"/> Stopcock left on <input type="checkbox"/> Cord cleaned, tied and cut to ~2cm <input type="checkbox"/> Catheter inserted 1-4 cm <input type="checkbox"/> Flashback seen after drawing back <input type="checkbox"/> Insertion depth noted: _____ <input type="checkbox"/> Secured with opsite/tegaderm/tape		Time inserted: _____ By whom: _____ # attempts: _____ Depth noted: _____
<b>Intraosseous Access</b> Attempted? Y / N <input type="checkbox"/> Extension set primed <input type="checkbox"/> Leg stabilized <input type="checkbox"/> Landmark: flat inner aspect of tibia <input type="checkbox"/> Wiped with antiseptic <input type="checkbox"/> Needle positioned at 90° to bone <input type="checkbox"/> Inserted with drill or hand until loss of resistance felt <input type="checkbox"/> Stylet removed <input type="checkbox"/> Primed extension set attached <input type="checkbox"/> Secured to leg		Time inserted: _____ By whom: _____ # attempts: _____ Product used (circle): Cook / Arrow / _____ Leg (circle): left / right
<b>Medication by UVC or IO</b> Administered? Y / N Epinephrine 1:10,000 UVC or IO dose: 0.1 mL/kg = _____ mLs (rapidly) <input type="checkbox"/> flushed with 0.5-1.0 mL NS Time of first dose: _____ (repeat q 3 mins prn) Times of next doses: _____ Volume expansion NS 10 mL/kg (may repeat once) = _____ mLs over 5 - 10 mins		
<b>Instrument sterilization load/tracking#</b> (if applicable)		<b>Date</b>
Time EMS called: _____ By: _____ Time EMS arrived: _____ Departure time: _____ Time hospital called: _____ By: _____ Receiving Hospital: _____		
Clinicians involved (e.g. midwives, students, EMS, birth centre aides): _____ _____		
Documentation by: _____		
If this form is filled out as a late entry: _____ Time: _____ Name _____ Initials _____		







Client name: \_\_\_\_\_

DOB: DD/MM/YYYY \_\_\_\_\_

*OR OPTIONAL LABEL*

## Signature Page

Name	Signature	Initials	Designation (RM, student, second attendant)	CMO registration #

**Note:** This signature sheet should be included as a part of every record to ensure that the registration number, name, signature and initials of all students, midwives and support workers involved in care are consistently documented.