

# CLINICAL RECORD FORMS

*(with 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: DD/MM/YYYY \_\_\_\_\_

OR OPTIONAL LABEL

# Labour Record

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

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

## PREGNANCY SUMMARY

EDB: DD/MM/YYYY    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: \_\_\_\_\_

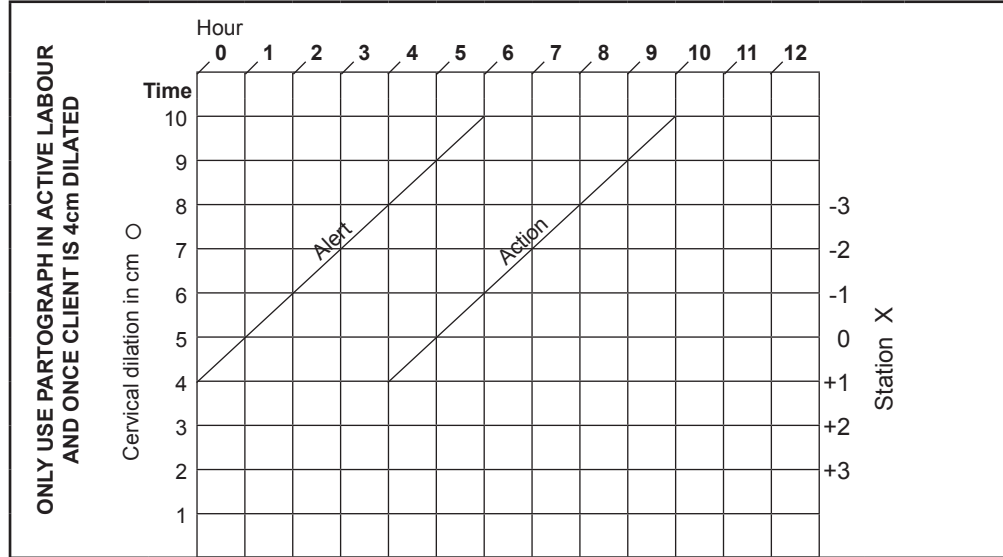
Relevant history: \_\_\_\_\_

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

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

OR OPTIONAL LABEL

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

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

| TIME | FETAL HEART RATE<br>rate / rhythm / accel / decel / class | CONTRACTIONS<br>freq / length / intensity / resting tone | VITAL SIGNS<br>P / BP / temp | CLIENT ASSESSMENT AND NARRATIVE NOTES<br>e.g. progress, position, activity, coping, medications, intake, output, plan | Initials |
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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> | <b>LEGEND</b>   | <p><b>Fetal Heart Rate:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:20%; border: none;"><b>Rhythm</b><br/>R = Regular<br/>I = Irregular</td> <td style="width:20%; border: none;"><b>Accelerations (accel)</b><br/>√ = Present/spontaneous<br/>∅ = Absent/not heard<br/>SS = Present/scalp stimulation</td> <td style="width:20%; border: none;"><b>Decelerations (decel)</b><br/>√ = Present*<br/>∅ = Absent/not heard<br/>*chart description</td> <td style="width:20%; border: none;"><b>Classification (class)</b><br/>N = Normal<br/>AbN = Abnormal</td> </tr> </table> | <b>Rhythm</b><br>R = Regular<br>I = Irregular                 | <b>Accelerations (accel)</b><br>√ = Present/spontaneous<br>∅ = Absent/not heard<br>SS = Present/scalp stimulation | <b>Decelerations (decel)</b><br>√ = Present*<br>∅ = Absent/not heard<br>*chart description | <b>Classification (class)</b><br>N = Normal<br>AbN = Abnormal | <p><b>Contractions:</b></p> <table style="width:100%; border: none;"> <tr> <td style="width:50%; border: none;"><b>Intensity</b><br/>Mild = Mild<br/>Mod = Moderate<br/>St = Strong</td> <td style="width:50%; border: none;"><b>Resting Tone</b><br/>S = Soft<br/>F = Firm</td> </tr> </table> | <b>Intensity</b><br>Mild = Mild<br>Mod = Moderate<br>St = Strong | <b>Resting Tone</b><br>S = Soft<br>F = Firm |
| <b>Rhythm</b><br>R = Regular<br>I = Irregular   | <b>Accelerations (accel)</b><br>√ = Present/spontaneous<br>∅ = Absent/not heard<br>SS = Present/scalp stimulation | <b>Decelerations (decel)</b><br>√ = Present*<br>∅ = Absent/not heard<br>*chart description   | <b>Classification (class)</b><br>N = Normal<br>AbN = Abnormal |   |  |   |   |  |   |
| <b>Intensity</b><br>Mild = Mild<br>Mod = Moderate<br>St = Strong  | <b>Resting Tone</b><br>S = Soft<br>F = Firm   |  |   |   |  |   |   |  |   |
| <p><b>Medication charting:</b> drug, indication, dose, route</p>  |   |  |   |   |  |   |   |  |   |

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

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

*OR OPTIONAL LABEL*

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

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

| TIME | FETAL HEART RATE<br><small>rate / rhythm / accel / decel / class</small> | CONTRACTIONS<br><small>freq / length / intensity / resting tone</small> | VITAL SIGNS<br><small>P / BP / temp</small> | CLIENT ASSESSMENT AND NARRATIVE NOTES<br><small>e.g. progress, position, activity, coping, medications, intake, output, plan</small> | Initials |
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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:  |   |
|--------|---|---|--|---|--|---|
|        | <p>Rhythm</p> <p>R = Regular</p> <p>I = Irregular</p> | <p>Accelerations (accel)</p> <p>√ = Present/spontaneous</p> <p>Ø = Absent/not heard</p> <p>SS = Present/scalp stimulation</p> | <p>Decelerations (decel)</p> <p>√ = Present*</p> <p>Ø = Absent/not heard</p> <p>*chart description</p> | <p>Classification (class)</p> <p>N = Normal</p> <p>AbN = Abnormal</p> | <p>Intensity</p> <p>Mild = Mild</p> <p>Mod = Moderate</p> <p>St = Strong</p> | <p>Resting Tone</p> <p>S = Soft</p> <p>F = Firm</p> |

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

Client name: \_\_\_\_\_  
 DOB: DD/MM/YY\_\_\_\_\_  
**OR OPTIONAL LABEL**

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

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

| TIME | FETAL HEART RATE<br>rate / rhythm / accel / decel / class | CONTRACTIONS<br>freq / length / intensity / resting tone | VITAL SIGNS<br>P / BP / temp | CLIENT ASSESSMENT AND NARRATIVE NOTES<br>e.g. progress, position, activity, coping, medications, intake, output, plan | Initials |
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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:                 |  |                      |
|------------------------------|--|---------------------------------|--|-------------------------------|--|----------------------|
| R = Regular<br>I = Irregular | <b>Rhythm</b>  | <b>Accelerations</b><br>(accel) | <b>Decelerations</b><br>(decel)                            | <b>Classification (class)</b> | <b>Intensity</b>                             | <b>Resting Tone</b>  |
|                              | ∅ = Absent/not heard<br>SS = Present/scalp stimulation | √ = Present/spontaneous         | √ = Present*<br>∅ = Absent/not heard<br>*chart description | N = Normal<br>AbN = Abnormal  | Mild = Mild<br>Mod = Moderate<br>St = Strong | S = Soft<br>F = Firm |

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

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

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

OR OPTIONAL LABEL

## Immediate Postpartum/Third Stage and Labour Summary

| Date <u>DD/MMM/YYYY</u> |              |        |        |   |          |
|-------------------------|--------------|--------|--------|---|----------|
| Time                    | BP, P [T, R] | Lochia | Uterus | Notes (Assessments, interventions, responses to interventions, breastfeeding, void) | Initials |
|                         |              |        |        |   |          |
|                         |              |        |        |   |          |
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### THIRD STAGE / PLACENTA

|  |  |   |
|--|--|---|
| Delayed cord clamping<br><input type="checkbox"/> yes <input type="checkbox"/> no  | <b>Elements of 3rd Stage Management Used:</b><br><input type="checkbox"/> Breastfeeding<br><input type="checkbox"/> Client effort<br><input type="checkbox"/> Controlled cord traction<br><input type="checkbox"/> Prophylactic oxytocin | <b>PPH Management</b><br><input type="checkbox"/> Uterine massage<br><input type="checkbox"/> Bimanual compression<br><input type="checkbox"/> Uterotonics (chart below)<br><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): _____<br>_____<br>_____  |
| <input type="checkbox"/> Placenta born in water  |  | Initials: _____   |

**TOTAL ESTIMATED BLOOD LOSS** \_\_\_\_\_ mL  >500 mL  <500 mL

### POSTPARTUM MEDICATIONS

| <input type="checkbox"/> oxytocin: 10 units IM      time: _____ initials: _____<br><input type="checkbox"/> oxytocin: 5 units IV push      time: _____ initials: _____<br><input type="checkbox"/> acetaminophen ___ mg p.o.      time: _____ initials: _____<br><input type="checkbox"/> ibuprofen ___ mg p.o.      time: _____ initials: _____<br><input type="checkbox"/> _____ | <input type="checkbox"/> misoprostol: ___ units sublingual      time: _____ initials: _____<br><input type="checkbox"/> misoprostol: ___ units per rectum      time: _____ initials: _____<br><input type="checkbox"/> ergonovine: _____ dose      time: _____ initials: _____<br><input type="checkbox"/> carboprost: _____ dose      time: _____ initials: _____<br><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<br>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: _____<br>Amniotic fluid at birth: <input type="checkbox"/> clear <input type="checkbox"/> meconium<br>(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: HH:MM   | <input type="checkbox"/> With epinephrine |
| <input type="checkbox"/> Lidocaine 2%      _____ cc infiltrated      TIME: HH:MM   | <input type="checkbox"/> Xylocaine gel 2% |
| Repair underway: HH:MM      Repair complete: HH:MM   |   |
| Notes: _____<br>_____<br>_____<br>_____  |   |
| 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):<br>_____ |
| 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: <u>DD/MMM/YYYY</u> | Time: <u>HH:MM</u> |

**Transfer:** Indication: \_\_\_\_\_

ambulance     private vehicle     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: \_\_\_\_\_ DD/MMM/YYYY \_\_\_\_\_ HH:MM

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 |
|------|----|----|------|--|--|----------|
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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<br>Time: _____ Initials: _____                             | Heart rate         | Absent      | <100         | >100              |       |        |  |
| <input type="checkbox"/> Erythromycin eye prophylaxis<br>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: DD/MMM/YYYY Time: HH:MM  
 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 |
|------|-------|----------|
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Baby of: \_\_\_\_\_

OR OPTIONAL LABEL

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

## Newborn Summary and Postnatal Care (Page 1)

| Date/time of birth:  |     |          | Date/time of discharge (if applicable):   |      |               | NEWBORN SCREENING   |       |        |                  |        |          |
|--|-----|----------|---|------|---------------|---|-------|--------|------------------|--------|----------|
| Sex: ____ HC: ____ cm L: ____ cm   |     |          | Birthweight: ____ g ____ lb ____ oz   |      |               | 10% loss =  |       |        |                  |        |          |
| HC#:   |     |          | Apgars: ____/____/____  |      |               | TSB/TCB ( <i>circle</i> ) @ 24-72 hours <input type="checkbox"/> offered <input type="checkbox"/> declined <input type="checkbox"/> done<br>Hours old: _____ result _____ risk level: _____ (chart repeat tests in narrative) |       |        |                  |        |          |
| Cord gases: Arterial pH _____ BE _____ Blood type: _____                 |     |          | Venous pH _____ BE _____ Direct Coombs: - / +   |      |               | NSO @ 24-48 hrs: date: ____/____/____ time: _____<br>blood spot result: _____ CCHD result: _____<br>comfort measures: _____   |       |        |                  |        |          |
| <input type="checkbox"/> Vitamin K <input type="checkbox"/> Erythromycin |     |          | Red Reflex <input type="checkbox"/> R <input type="checkbox"/> L  |      |               | Notes (e.g. resus, paed consult, GBS risk factors, issues for follow-up: _____)   |       |        |                  |        |          |
| <input type="checkbox"/> Vitamin D discussed _____                       |     |          | <input type="checkbox"/> HBIG <input type="checkbox"/> HBV: birth <input type="checkbox"/> HBV: 4 wks<br><input type="checkbox"/> not indicated |      |               |   |       |        |                  |        |          |
| Date + Time  | Day | Location | T/HR/RR/HS  | Eyes | Skin/Jaundice | Umbilicus   | Urine | Stools | Feeding/Comments | Weight | Initials |
|  |     |          |   |      |               |   |       |        |                  |        |          |
|  |     |          |   |      |               |   |       |        |                  |        |          |
|  |     |          |   |      |               |   |       |        |                  |        |          |
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|--|--|--|--|---|--|--|--|
| <b>Second physical assessment (check if normal)</b>  |  |  |  | <b>Final visit</b>  |  |  |  |
| Date: _____  |  |  |  | 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<br><input type="checkbox"/> Heart sounds/rhythm <input type="checkbox"/> HR _____ <input type="checkbox"/> Hips <input type="checkbox"/> Clavicle<br><input type="checkbox"/> Symmetry of movement <input type="checkbox"/> Responds to sound and movement<br><input type="checkbox"/> Descended testes in males <input type="checkbox"/> Umbilicus Weight: _____ |  |  |  | Physical assessment and developmental markers (check if normal)<br><input type="checkbox"/> Head & neck <input type="checkbox"/> Clavicles <input type="checkbox"/> Abdomen <input type="checkbox"/> Umbilicus <input type="checkbox"/> Skin<br><input type="checkbox"/> Hips <input type="checkbox"/> Heart sounds <input type="checkbox"/> HR _____ <input type="checkbox"/> Lungs <input type="checkbox"/> RR _____<br><input type="checkbox"/> Smiling <input type="checkbox"/> Cooing <input type="checkbox"/> Gaze and tracking <input type="checkbox"/> Head control<br>Feeding: _____ Initials: _____ |  |  |  |
| Urine: _____ Stools: _____ Initials: _____   |  |  |  | Length: _____ cm<br>HC: _____ cm  |  |  |  |
| Narrative notes and feeding: _____   |  |  |  | Narrative notes: _____  |  |  |  |
| _____  |  |  |  | _____   |  |  |  |
| _____  |  |  |  | _____   |  |  |  |
| _____  |  |  |  | <input type="checkbox"/> Vaccination discussed <input type="checkbox"/> F/up visit booked with _____  |  |  |  |

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

OR OPTIONAL LABEL

## Newborn Summary and Postnatal Care Record (Page 2)

Narrative notes: (feeding plan, informed choice discussions, additional testing, etc.)

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

| Date/Time | Notes | Initials |
|-----------|-------|----------|
|           |       |          |
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Client name: \_\_\_\_\_

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

OR OPTIONAL LABEL

# Client Summary and Postnatal Care (Page 1)

Date/time of birth: DD/MMM/YYYY HH:MM Location: \_\_\_\_\_

Birth details: \_\_\_\_\_

Date/time of hospital admission (if applicable): DD/MMM/YYYY HH:MM

Date/time of hospital discharge (if applicable): DD/MMM/YYYY HH:MM

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:

- Pregnancy spacing
- VBAC
- Rpt OGCT
- Pelvic floor muscle exercise
- Folic acid
- Thyroid
- PPD
- Rpt CBC

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ 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: _____<br>_____ |  |
| 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 _____<br>_____  |  |

| 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> <td></td> </tr> <tr> <td>Mode (IA, EFM)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>FHR (bpm)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Rhythm/variability</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Accelerations</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Decelerations</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Classification</td> <td></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 |  |  |
|  |  |   |  |  |   | <b>FHR</b>          | Time                       |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Mode (IA, EFM)             |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | FHR (bpm)                  |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Rhythm/variability         |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Accelerations              |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Decelerations              |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Classification   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Description of fluid: _____  |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Speculum sterilization load/tracking # and date: _____   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Membranes: <input type="checkbox"/> Intact <input type="checkbox"/> Ruptured <input type="checkbox"/> Equivocal  |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Since (date/time): _____   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td rowspan="7" style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>CONTRACTIONS</b></td> <td>Mode (Palp, Toco)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Frequency (_____/10 mins)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Duration (sec)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Intensity (Mild, Mod, Str)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Resting tone (Soft, Firm)</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Pulse</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Temp</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>   |  |   |  |  | <b>CONTRACTIONS</b>   | Mode (Palp, Toco)   |                            |  |  |   | Frequency (_____/10 mins) |  |  |  |  | Duration (sec) |  |  |  |  | Intensity (Mild, Mod, Str) |  |  |  |  | Resting tone (Soft, Firm) |  |  |  |  | Pulse         |  |  |  |  | Temp           |  |  |  |  | INTERNAL EXAMINATIONS  |  |  |
|  |  |   |  |  |   | <b>CONTRACTIONS</b> | Mode (Palp, Toco)          |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Frequency (_____/10 mins)  |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Duration (sec)             |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Intensity (Mild, Mod, Str) |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Resting tone (Soft, Firm)  |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Pulse                      |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Temp   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td rowspan="3" style="writing-mode: vertical-rl; transform: rotate(180deg);"><b>VITALS</b></td> <td>BP</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Initials</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>  |  |   |  |  | <b>VITALS</b>   | BP                  |                            |  |  |   | Initials                  |  |  |  |  | Time           |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   | <b>VITALS</b>       | BP                         |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  |   |                     | Initials                   |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Cx dilation (cm)   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Cx effacement (% or ____cm long)   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Cx position (Ant, Mid, Post)   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Cx consistency (Soft, Med, Firm)   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Station  |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Fetal position   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| Initials   |  |   |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="3"><b>LEGEND</b></td> </tr> <tr> <td style="width:33%;"> <b>Rhythm (for IA)</b><br/> R = Regular<br/> I = Irregular<br/><br/> <b>Variability (for EFM)</b><br/> Ø = Absent (undetectable)<br/> Min = Minimal (≤ 5 bpm)<br/> Mod = Moderate (6-25 bpm)<br/> Mar = Marked (&gt; 25 bpm) </td> <td style="width:33%;"> <b>Decelerations</b><br/> √ = Present<br/> Ø = Absent/not heard<br/> E = Early<br/> V = Variable *<br/> L = Late *<br/> P = Prolonged *<br/> * Chart description </td> <td style="width:33%;"> <b>Accelerations</b><br/> √ = Present/spontaneous<br/> Ø = Absent/not heard<br/> SS = Present/scalp stimulation<br/><br/> <b>Classification</b><br/> N = Normal<br/> ATYP = Atypical<br/> ABN = Abnormal </td> </tr> </table> |  |   |  |  | <b>LEGEND</b>   |                     |                            | <b>Rhythm (for IA)</b><br>R = Regular<br>I = Irregular<br><br><b>Variability (for EFM)</b><br>Ø = Absent (undetectable)<br>Min = Minimal (≤ 5 bpm)<br>Mod = Moderate (6-25 bpm)<br>Mar = Marked (> 25 bpm) | <b>Decelerations</b><br>√ = Present<br>Ø = Absent/not heard<br>E = Early<br>V = Variable *<br>L = Late *<br>P = Prolonged *<br>* Chart description | <b>Accelerations</b><br>√ = Present/spontaneous<br>Ø = Absent/not heard<br>SS = Present/scalp stimulation<br><br><b>Classification</b><br>N = Normal<br>ATYP = Atypical<br>ABN = Abnormal |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
|  |  |   |  |  | <b>LEGEND</b>   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |
| <b>Rhythm (for IA)</b><br>R = Regular<br>I = Irregular<br><br><b>Variability (for EFM)</b><br>Ø = Absent (undetectable)<br>Min = Minimal (≤ 5 bpm)<br>Mod = Moderate (6-25 bpm)<br>Mar = Marked (> 25 bpm)   | <b>Decelerations</b><br>√ = Present<br>Ø = Absent/not heard<br>E = Early<br>V = Variable *<br>L = Late *<br>P = Prolonged *<br>* Chart description | <b>Accelerations</b><br>√ = Present/spontaneous<br>Ø = Absent/not heard<br>SS = Present/scalp stimulation<br><br><b>Classification</b><br>N = Normal<br>ATYP = Atypical<br>ABN = Abnormal |  |  |   |                     |                            |  |  |   |                           |  |  |  |  |                |  |  |  |  |                            |  |  |  |  |                           |  |  |  |  |               |  |  |  |  |                |  |  |  |  |  |  |  |





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 DD/MMM/YYYY 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: DD/MMM/YYYY | 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: DD/MMM/YYYY    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: _____<br>Oxytocics: _____ # of doses: _____<br>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) |                          |                            |          |
|                              |     |                 |                   |                                       |                |                           |                          |                            |          |
|                              |     |                 |                   |                                       |                |                           |                          |                            |          |
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| <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: DD/MMM/YYYY    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: (_____) _____               |
| <input type="checkbox"/> Ambulance <input type="checkbox"/> private vehicle |   |

|  |                                     |
|--|-------------------------------------|
| <b>HISTORY</b>   | GA: _____ Length of labour: _____ h |
| Membranes: Length of Rupture: _____ h Amniotic fluid at birth: <input type="checkbox"/> Clear <input type="checkbox"/> Meconium-stained  |                                     |
| GBS + / - / unknown IAP medication: _____ # of doses: ____ Last dose: _____ h <input type="checkbox"/> Adequate prophylaxis  |                                     |
| Placenta transferred to hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No Details: _____  |                                     |
| <input type="checkbox"/> Gases collected <input type="checkbox"/> Segment of cord transported  |                                     |
| <b>Relevant maternal pregnancy/labour history/newborn interventions prior to transport including medications:</b><br><i>(attach copy of antenatal records)</i> _____                                       |                                     |
| _____  |                                     |
| _____  |                                     |
| _____  |                                     |
| Initial apgars: 1 min: _____ 5 min: _____ 10 min: _____ <input type="checkbox"/> See <b>Resuscitation Record</b> attached  |                                     |
| Vitamin K: <input type="checkbox"/> Yes <input type="checkbox"/> No Erythromycin: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Void <input type="checkbox"/> Meconium |                                     |

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

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

## Newborn Resuscitation Record (Page 2)

|   |       |   |
|---|-------|---|
| <b>Orogastric Tube</b> Inserted? Y / N<br>(8F; nose to earlobe to xyphoid/sternum midpoint) Gastric contents on drawback? Y / N   |       | Time inserted: _____  |
| <b>Laryngeal Mask Airway</b> Attempted? Y / N<br><input type="checkbox"/> Test inflation with 4mLs air & deflate<br><input type="checkbox"/> Insert: open side to tongue, hard side to palate<br><input type="checkbox"/> Once placed, inflate with 2-4 mLs air<br>Signs of effective air entry <input type="checkbox"/> YES <input type="checkbox"/> NO (see below)<br>LMA placement assessed to be correct <input type="checkbox"/> YES <input type="checkbox"/> NO<br>(if no, chart repeat attempts) <input type="checkbox"/> Secured with tape  | Notes | Time inserted: _____<br>By whom: _____<br># attempts: _____<br>Products used: _____   |
| <b>Intubation</b> Attempted? Y / N<br>Blade size (circle): 0 1 Tube size (circle): 3.0 3.5<br>Free flow O <sub>2</sub> while intubating <input type="checkbox"/> YES <input type="checkbox"/> NO<br>Cords visualized <input type="checkbox"/> YES <input type="checkbox"/> NO<br>Signs of effective air entry <input type="checkbox"/> YES <input type="checkbox"/> NO (see below)<br>Tip to lip (circle) 7.5 8.0 8.5 9.0 9.5<br>Tube placement assessed to be correct <input type="checkbox"/> YES <input type="checkbox"/> NO<br>(f no, chart repeat attempts) Secured with <input type="checkbox"/> tape <input type="checkbox"/> neobar | Notes | Time inserted: _____<br>By whom: _____<br># attempts: _____<br>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<br>Epinephrine 1:10,000 ETT dose: 1 mL/kg (max 3mL) in 3mL syringe = _____ mLs<br><input type="checkbox"/> Followed by several PPV breaths   |       | Time admin: _____<br>By whom: _____   |
| <b>Umbilical Venous Catheterization</b> Attempted? Y / N<br><input type="checkbox"/> Stopcock attached to UV catheter <input type="checkbox"/> Catheter primed with normal saline <input type="checkbox"/> Stopcock left on<br><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<br><input type="checkbox"/> Insertion depth noted: _____ <input type="checkbox"/> Secured with opsite/tegaderm/tape   |       | Time inserted: _____<br>By whom: _____<br># attempts: _____<br>Depth noted: _____   |
| <b>Intraosseous Access</b> Attempted? Y / N<br><input type="checkbox"/> Extension set primed <input type="checkbox"/> Leg stabilized <input type="checkbox"/> Landmark: flat inner aspect of tibia<br><input type="checkbox"/> Wiped with antiseptic <input type="checkbox"/> Needle positioned at 90° to bone<br><input type="checkbox"/> Inserted with drill or hand until loss of resistance felt <input type="checkbox"/> Stylet removed<br><input type="checkbox"/> Primed extension set attached <input type="checkbox"/> Secured to leg  |       | Time inserted: _____<br>By whom: _____<br># attempts: _____<br>Product used (circle):<br>Cook / Arrow / _____<br>Leg (circle): left / right |
| <b>Medication by UVC or IO</b> Administered? Y / N<br>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<br>Time of first dose: _____ (repeat q 3 mins prn) Times of next doses: _____<br>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: _____<br>Time hospital called: _____ By: _____ Receiving Hospital: _____   |       |   |
| Clinicians involved (e.g. midwives, students, EMS, birth centre aides): _____<br>_____  |       |   |
| Documentation by: _____   |       |   |
| If this form is filled out as a late entry: DD/MMM/YYYY Time: _____ Name _____ Initials _____   |       |   |







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

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

*OR OPTIONAL LABEL*

## Signature Page

| Name | Signature | Initials | Designation (RM, student, second attendant) | CMO registration # |
|------|-----------|----------|---|--------------------|
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**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.