Association of Ontario Midwives
Delivering what matters.

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

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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.

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Client name: _____
DOB: DD/MMM/YYYY _____

OR OPTIONAL LABEL

Labour Record

Date: _____

☐ Client screened for signs and symptoms of infectious disease Initials: ___

Support person(s):

PREGNANCY SUMMARY

EDB: DD/MMM/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

Intrapartum antibiotic prophylaxis strategy:
☐ based on GBS + status
☐ based on GBS + status and risk factors
☐ based on risk factors
☐ declines prophylaxis

Rubella: I / Non-I / Indet
HBsAg: R / NR
Syphilis: R / NR
HIV: R / NR
Chlamydia: + / -
GC: + / -

Current medications: _____

Relevant history: _____

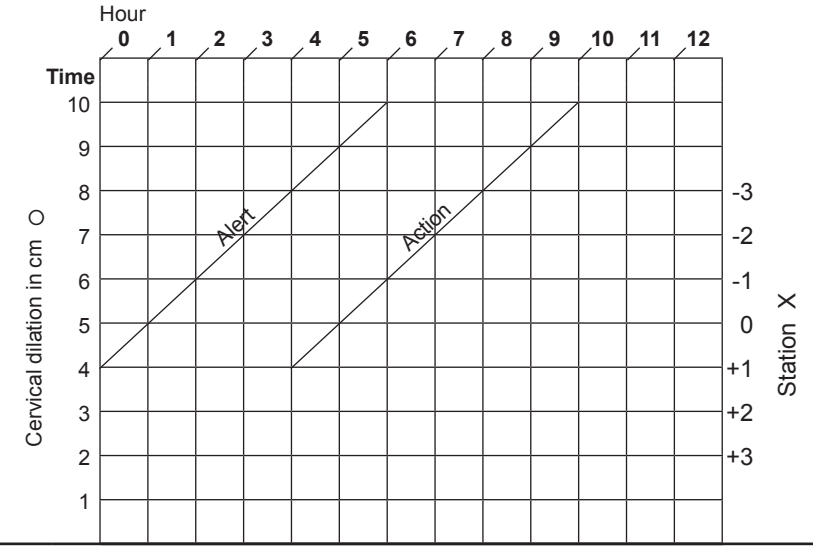
Onset of labour and initial assessment: ☐ See **Assessment Record**

Membranes: ☐ intact ☐ ruptured time of rupture:_____
description of fluid _____

Active labour began:

Form completed by:

ONLY USE PARTOGRAPH IN ACTIVE LABOUR AND ONCE CLIENT IS 4cm DILATED



INTERNAL EXAMINATIONS

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

LEGEND

Internal Examinations:

Effacement:
(% or __cm long)

Cervix Position:
A = Anterior
M = Mid
P = Posterior

Fetal Position:
L = Left
R = Right

O = Occiput
S = Sacrum
M = Mentum
Sc = Scapula

A = Anterior
T = Transverse (lateral)
P = Posterior

Membranes:
I = Intact
SROM = Spontaneous rupture of membranes
ARM = Artificial rupture of membranes
R = Ruptured

Show:
Sc = Scant
Mod = Moderate
L = Large

Fluid:
Quantity:
Ø = Absent
Sc = Scant
Mod = Moderate
L = Large

Colour:
CL = Clear
BT = Blood tinged
B = Bloody
Mec = Meconium

Bloodwork:

R = Reactive
NR = Nonreactive
I = Immune
Non-I = non immune
Indet = Indeterminate

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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: _____

Transfer: ☐ Client Transfer Record attached

Indications: _____

_____

☐ private vehicle

☐ ambulance called at: _____ ☐ arrived at: _____

Hospital: _____

Time of departure: _____

LEGEND

Fetal Heart Rate:

Rhythm
R = Regular
I = Irregular

Accelerations (accel)
√ = Present/spontaneous
Ø = Absent/not heard
SS = Present/scalp stimulation

Decelerations (decel)
√ = Present*
Ø = Absent/not heard
*chart description

Classification (class)
N = Normal
AbN = Abnormal

Contractions:

Intensity
Mild = Mild
Mod = Moderate
St = Strong

Resting Tone
S = Soft
F = Firm

Medication charting: drug, indication, dose, route

Normal birth package: page 1 back

Association of Ontario Midwives
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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

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OR OPTIONAL LABEL

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_____

☐ private vehicle

☐ ambulance called at: _____ ☐ arrived at: _____

Hospital: _____

Time of departure: _____

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Mild = Mild
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Resting Tone
S = Soft
F = Firm

Medication charting: drug, indication, dose, route

Normal birth package: page 2 back

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
☐ yes ☐ no

Elements of 3rd Stage Management Used:
☐ Breastfeeding
☐ Client effort
☐ Controlled cord traction
☐ Prophylactic oxytocin

PPH Management
☐ Uterine massage
☐ Bimanual compression
☐ Uterotonics (chart below)
☐ Other: _____

Placenta and membranes delivered: Date: _____ Time: _____ Complete: ☐ Yes ☐ No

Notes (cord insertion, # of vessels, presence of knots; sent to pathology for testing, given to parents, disposed of, looks incomplete): _____

_____

_____

☐ Placenta born in water Initials: _____

TOTAL ESTIMATED BLOOD LOSS _____mL ☐ >500 mL ☐ <500 mL

POSTPARTUM MEDICATIONS

☐ oxytocin: 10 units IM time:_____ initials:___
☐ oxytocin: 5 units IV push time:_____ initials:___
☐ acetaminophen ___ mg p.o. time:_____ initials:___
☐ ibuprofen ___ mg p.o. time:_____ initials:___
☐ _____

☐ misoprostol: ___ units sublingual time:_____ initials:___
☐ misoprostol: ___ units per rectum time:_____ initials:___
☐ ergonovine: _____ dose time:_____ initials:___
☐ carboprost: _____ dose time:_____ initials:___
☐ _____

Time	Medication, IV fluid (if not charted above)	Dose	Route	Site	Initials

DATE:	Onset	End	Duration	Total active labour
Latent 1st stage				
Active 1st stage				
Time fully dilated				
Time started pushing		TIME OF BIRTH		
3rd stage				

PLACE OF BIRTH:
Planned: ☐ home ☐ hospital ☐ birth centre ☐ other
Actual: ☐ home ☐ hospital ☐ birth centre ☐ other

☐ live birth ☐ stillbirth

Position at birth: client: _____
☐ waterbirth
Presentation at birth: fetal: ☐ vertex ☐ other: _____
Amniotic fluid at birth: ☐ clear ☐ meconium
(length of ROM:_____)

Client name: _____
DOB: DD/MMM/YYYY _____

OR OPTIONAL LABEL

Perineal Repair/Instrument Record/Departure

PERINEUM, VAGINA AND VULVA

☐ Intact
☐ Laceration: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th degree ☐ Vaginal ☐ Perineal ☐ Labial
☐ Episiotomy: ☐ Midline ☐ Mediolateral: ☐ Left ☐ Right
☐ Other trauma: _____
Repaired: ☐ Yes ☐ No Repaired by: _____

REPAIR Materials used: _____

☐ Lidocaine 1% _____cc infiltrated TIME: ☐ Lidocaine 2% _____cc infiltrated TIME:	☐ With epinephrine ☐ Xylocaine gel 2%

Repair underway: Repair complete:

Notes: _____
_____
_____
_____
_____ Initials: _____

POSTPARTUM NEWBORN/MATERNAL BLOOD COLLECTION

Cord blood: ☐ collected ☐ not collected If collected, collected for: ☐ ABO type + factor ☐ Arterial gases ☐ Venous gases ☐ Section of cord ☐ Kleihauer Betke ☐ Other: _____	Client blood sample: ☐ Not collected ☐ Collected	Samples will be submitted to lab: (name of lab): _____

INSTRUMENTS USED (birth and suturing)

Sterilization load/ tracking #/ tray #	Date sterilized

DEPARTURE

☐ reviewed postpartum instructions as per protocol
Client-specific departure instructions: _____
_____
Client departure (if birth at clinic, birth centre or other site) Date: Time:

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:

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_2 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

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

Additional Notes (number and describe abnormal findings):

Initials:

MEDICATIONS

☐ Vitamin K 1 mg IM ☐ R ☐ L thigh
Time: _____ Initials: _____
☐ Erythromycin eye prophylaxis
Time: _____ Initials_____
☐ Other: _____ Initials_____
If declined or parents refused access to baby, document informed choice discussion on *Narrative Notes or a refusal to treat form (if used in your setting)*

APGAR SCORES	0	1	2	1 Min	5 Min	10 Min
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			

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 ☐ 1st hr ☐ 2nd 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: - / +		
☐ Vitamin K ☐ Erythromycin	Red Reflex ☐ R ☐ L	
☐ Vitamin D discussed _____	☐ HBIG ☐ HBV: birth ☐ HBV: 4 wks ☐ not indicated	

NEWBORN SCREENING

TSB/TCB *(circle)* @ 24-72 hours ☐ offered ☐ declined ☐ done
Hours old: _____result _____ risk level: _____ (chart repeat tests in narrative)

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: _____
_____

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

Second physical assessment (check if normal)

Date: _____
☐ Skin ☐ Head ☐ Eyes ☐ Mouth ☐ Neck ☐ Lungs ☐ Abdomen
☐ Heart sounds/rhythm ☐ HR_____ ☐ Hips ☐ Clavicle
☐ Symmetry of movement ☐ Responds to sound and movement
☐ Descended testes in males ☐ Umbilicus Weight: _____
Urine: _____ Stools: _____ Initials: _____

Narrative notes and feeding:_____
_____
_____
_____

Final visit

Date: _____
Age:_____
Weight: _____g
____lb_____oz
Length: _____ cm
HC: _____ cm

Physical assessment and developmental markers (check if normal)
☐ Head & neck ☐ Clavicles ☐ Abdomen ☐ Umbilicus ☐ Skin
☐ Hips ☐ Heart sounds ☐ HR_____ ☐ Lungs ☐ RR_____
☐ Smiling ☐ Cooing ☐ Gaze and tracking ☐ Head control
Feeding: _____
Initials: _____

Narrative notes: _____
_____
_____

☐ Vaccination discussed ☐ 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

Client name: _____
DOB: _____ Client #: _____

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

Narrative notes/Referrals: _____
_____ Initials _____

Client name: _____

DOB: _DD/MMM/YYYY_____ 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

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Client's name: _____
DOB: _____ DD/MMM/YYYY

OR OPTIONAL LABEL

Assessment Record (Page 1)

Date: _____

☐ 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: _____

HISTORY

G _____ T _____ P _____ A _____ L _____ EDB _____ GA _____

Allergies: ☐ NKA ☐ Yes, specify/reactions: _____

GBS: - / + / unknown / declined Last swab: _____
Intrapartum antibiotic prophylaxis strategy:
☐ based on GBS+ status ☐ based on GBS+ status and risk factors
☐ based risk factors only ☐ declines prophylaxis

Blood Group: Rh:
RhIG received? Y / N

Previous C/S? Y / N
Plans TOLAC? Y / N

Additional relevant history _____

ASSESSMENT

Position by Palpation: _____

FHR	**Time**				
	Mode (IA, EFM)				
	FHR (bpm)				
	Rhythm/variability				
	Accelerations				
	Decelerations				
	Classification				
CONTRACTIONS	Mode (**P**alp, **T**oco)				
	Frequency (_____/10 mins)				
	Duration (sec)				
	Intensity **(**Mild, Mod, Str**)**				
	Resting tone (**S**oft, **F**irm)				
VITALS	Pulse				
	Temp				
	BP				
Initials					

AMNIOTIC FLUID TESTS (if indicated)

Sterile speculum: ☐ Yes ☐ No Fluid visualized: ☐ Yes ☐ No
Ferning: ☐ Pos ☐ Neg Nitrazine: ☐ Pos ☐ Neg ☐ equiv
Description of fluid: _____

Speculum sterilization load/tracking # and date: _____

Membranes: ☐ Intact ☐ Ruptured ☐ Equivocal
Since (date/time): _____

INTERNAL EXAMINATIONS

Time		
Cx dilation (cm)		
Cx effacement (% or ___cm long)		
Cx position (Ant, Mid, Post)		
Cx consistency (Soft, Med, Firm)		
Station		
Fetal position		
Initials		

LEGEND

Rhythm (for IA)
R = Regular
I = Irregular

Variability (for EFM)
Ø = Absent (undetectable)
Min = Minimal (≤ 5 bpm)
Mod = Moderate (6-25 bpm)
Mar = Marked (> 25 bpm)

Decelerations
√ = Present
Ø = Absent/not heard
E = Early
V = Variable *
L = Late *
P = Prolonged *
* Chart description

Accelerations
√ = Present/spontaneous
Ø = Absent/not heard
SS = Present/scalp stimulation

Classification
N = Normal
ATYP = Atypical
ABN = Abnormal

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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

☐ dimenhydrinate
Time: _____

☐ __ mg PO
☐ __ mg IM

☐ acetaminophen ____ mg PO
Time: _____

☐ Pen G ____ million units IV
Time: _____

☐ other antibiotic (name, dose, route, time):_____
_____

☐ other medications (name, dose, route, time): _____
_____

CARE PLAN

☐ Admitted to birth centre: meets eligibility for admission
☐ Active labour: charting started on Labour Record
☐ Discharged from birth centre
☐ Not active labour: midwife to depart
☐ Transferred to _____
Date _____ Time _____h

Midwife name: _____
Student name: _____

TEACHING/FOLLOW-UP

☐ When to page midwife
☐ Other _____
Plan for follow-up: _____
_____
_____
_____
_____
_____
_____

Extra forms: page 2 back

Client name: _____
DOB: _____ DD/MMM/YYYY

OR OPTIONAL LABEL

Client Transfer Record

REASON FOR TRANSFER: _____

Time of birth: _____

Time EMS called: _____ by: _____
Time EMS arrived: _____ Departure time: _____
Time hospital called: _____ by: _____
Arrival time at hospital: _____
Receiving hospital: _____
☐ Ambulance ☐ private vehicle

Attending midwife: _____
Report given to (if applicable): _____
Time of transfer to MD (if applicable): _____
Emergency contact: _____
Telephone number: (_____) _____

CLIENT HISTORY (or attach copy of OAR) ☐ 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: ☐ NKA ☐ Yes, specify/reactions: _____
_____
Current medications: _____
History of LSCS or other uterine surgery: _____
Relevant medical/obstetrical history: _____
_____

LABOUR AND BIRTH Onset of labour date: Time: _____ h

Membranes: ☐ Intact ☐ Ruptured Length of rupture: _____ h Meconium: ☐ Present ☐ Absent
Most recent internal exam: Time: _____ h Dilation: ___ cm Station: ____ Effacement: _____ Position: _____
Summary of fetal heart status: _____
Birth date: _____ Time: _____h
Placenta: ☐ In situ ☐ Delivered: Time: _____ h ☐ Transferred to hospital
Interventions: _____
Client condition at departure: Time: _____h BP: _____ P: _____ Other: _____

MEDICATIONS PRIOR TO TRANSPORT

Medications during labour: _____
_____

GBS antibiotics: _____ # of doses: _____
Oxytocics: _____ # of doses: _____
Other: _____

CARE DURING TRANSPORT 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)			
UPON ARRIVAL AT HOSPITAL									

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

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

Make copy for receiving hospital staff

Extra forms: page 2 front

Client name: _____

DOB: DD/MMM/YYYY

OR OPTIONAL LABEL

Client Transfer Record

NARRATIVE

Time	Notes	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: _____
Time EMS arrived: _____ Departure time: _____
Time hospital called: _____ by: _____
Arrival time at hospital: _____
Receiving hospital: _____
☐ Ambulance ☐ private vehicle

Attending midwife: _____
Report given to (if applicable): _____
Time of transfer to MD (if applicable): _____
Emergency contact: _____
Telephone number: (_____) _____

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	0_2 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

Association of Ontario **Midwives**
Delivering what matters.

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				
Time **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_2 (%) (right hand)												
Approx pressure from pressure gauge (typical range: 20-25 cm H_20)												
Room air / O_2NR / 100% (see legend below)												
CPAP (√ note pressure) (5 cm H_2O)												
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										

LEGEND

RA	Room air (self-inflating bag not connected to O_2)
O_2NR	Self inflating bag with O_2 No Reservoir
100%	O_2 concentration with self inflating bag with reservoir, T piece or flow inflating bag
S	Self inflating bag
F	Flow inflating bag
T	T-piece resuscitator

M	Mask adjustment (seal)
R	Reposition airway ("sniffing")
S	Suction (mouth then nose)
O	Open mouth, lift jaw forward
P	Pressure increase
A	Airway alternative (LMA or ET)

Pre-ductal SpO_2 Target

Right hand or wrist

1 min	60% - 65%
2 min	65% - 70%
3 min	70% - 75%
4 min	75% - 80%
5 min	80% - 85%
10 min	85% - 95%

Extra forms: page 4 front

Association of Ontario Midwives
Delivering what matters.

Baby's name: _____
DOB: DD/MMM/YYYY _____
Baby of: _____

Newborn Resuscitation Record (Page 2)

Orogastric Tube Inserted? Y / N
(8F; nose to earlobe to xyphoid/sternum midpoint) Gastric contents on drawback? Y / N
Time inserted: _____

Laryngeal Mask Airway Attempted? Y / N
☐ Test inflation with 4mLs air & deflate
☐ Insert: open side to tongue, hard side to palate
☐ Once placed, inflate with 2-4 mLs air
Signs of effective air entry ☐ YES ☐ NO (see below)
LMA placement assessed to be correct ☐ YES ☐ NO
(if no, chart repeat attempts) ☐ Secured with tape

Notes

Time inserted: _____
By whom: _____
attempts: _____
Products used: _____

Intubation Attempted? Y / N
Blade size (circle): 0 1 Tube size (circle): 3.0 3.5
Free flow O_2 while intubating ☐ YES ☐ NO
Cords visualized ☐ YES ☐ NO
Signs of effective air entry ☐ YES ☐ NO (see below)
Tip to lip (circle) 7.5 8.0 8.5 9.0 9.5
Tube placement assessed to be correct ☐ YES ☐ NO
(f no, chart repeat attempts) Secured with ☐ tape ☐ neobar

Notes

Time inserted: _____
By whom: _____
attempts: _____
Time elapsed: _____

Signs of Effective Air Entry (LMA and intubation)

- Improvement of HR + SpO_2
- CO_2 detector purple → yellow
- Equal breath sounds over both lungs
- Symmetrical mvmnt of chest
- Decreased/absent breath sounds over stomach
- Vapour in ET tube with exhalation
- No gastric distension (ET)

Medication by ETT Administered? Y / N
Epinephrine 1:10,000 ETT dose: 1 mL/kg (max 3mL) in 3mL syringe = _____ mLs
☐ Followed by several PPV breaths

Time admin: _____
By whom: _____

Umbilical Venous Catheterization Attempted? Y / N
☐ Stopcock attached to UV catheter ☐ Catheter primed with normal saline ☐ Stopcock left on
☐ Cord cleaned, tied and cut to ~2cm ☐ Catheter inserted 1-4 cm ☐ Flashback seen after drawing back
☐ Insertion depth noted: _____ ☐ Secured with opsite/tegaderm/tape

Time inserted: _____
By whom: _____
attempts: _____
Depth noted: _____

Intraosseous Access Attempted? Y / N
☐ Extension set primed ☐ Leg stabilized ☐ Landmark: flat inner aspect of tibia
☐ Wiped with antiseptic ☐ Needle positioned at 90° to bone
☐ Inserted with drill or hand until loss of resistance felt ☐ Stylet removed
☐ Primed extension set attached ☐ Secured to leg

Time inserted: _____
By whom: _____
attempts: _____
Product used (circle):
Cook / Arrow / _____
Leg (circle): left / right

Medication by UVC or IO Administered? Y / N
Epinephrine 1:10,000 UVC or IO dose: 0.1 mL/kg = _____ mLs (rapidly) ☐ 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

Instrument sterilization load/tracking# (if applicable)	**Date**

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: DD/MMM/YYYY Time: _____ Name _____ Initials _____

Extra forms: page 4 back

Client's name: _____

DOB: _____ DD/MMM/YYYY

OR OPTIONAL LABEL

Narrative Notes

(including notes not on other records or requiring further details, such as informed choice discussions and/or recommendations and decisions, changes in care plan, treatments/interventions, responses to treatments, etc.)

Date: _____ Page 1 of _____

Time	Notes	Initials

Client's name: _____

DOB: _____ DD/MMM/YYYY

OR OPTIONAL LABEL

Narrative Notes

(including notes not on other records or requiring further details, such as informed choice discussions and/or recommendations and decisions, changes in care plan, treatments/interventions, responses to treatments, etc.)

Date: _____ Page _____ of _____

Time	Notes	Initials

Client name: _____

DOB: DD/MMM/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.