Association of Ontario Midwives
Delivering what matters.

CLINICAL RECORD FORMS

(with watermarks)

A: NORMAL BIRTH PACKAGE
- Labour: First Stage
- Labour: Second Stage
- Immediate Postpartum/Third Stage and 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

Client name: _____

DOB: DD/MMM/YYYY _____

OR OPTIONAL LABEL

Labour: First Stage

Support person(s)

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

PREGNANCY SUMMARY

EDB: DD/MMM/YYYY | G __ T __ P __ A __ L __ | GA _____

Allergies: ☐ NKA ☐ Yes, incl. reactions: _____

Blood group: ___ Rh: ___ Hb: ____@____ wks Hep B: - / +

Rubella: I / non-I / equiv HIV: - / + / unknown

GBS: - / + / unknown / declined Intrapartum antibiotic prophylaxis strategy:

- ☐ based on GBS + status
- ☐ based on GBS + status and risk factors
- ☐ based on risk factors
- ☐ declines prophylaxis

Current medications: _____

Relevant history: _____

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

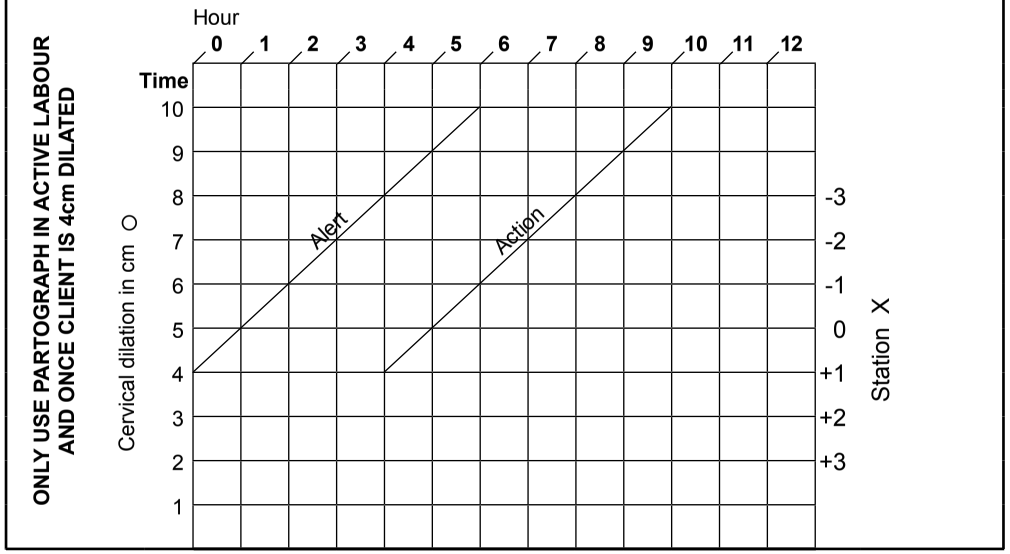
Membranes: ☐ intact ☐ ruptured time of rupture: _____

description of fluid _____

Active labour began:

Primary midwife for labour:

Date: DD/MMM/YYYY



VAGINAL EXAMINATIONS

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

LEGEND

Effacement %

Cervix Position

A = Anterior
M = Mid
P = Posterior

Fetal Position:

L = Left
R = Right

0 = 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

Fluid:

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

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

Show:

Sc = Scant
Mod = Moderate
L = Large

Client name: _____

DOB: DD/MMM/YYYY _____

OR OPTIONAL LABEL

Labour: First Stage (Page __ of __)

Date: DD/MMM/YYYY

TIME	FETAL ASSESSMENT rate/rhythm/accel/decel	CONTRACTIONS freq/length/intensity/resting tone	CLIENT ASSESSMENT AND NARRATIVE NOTES e.g. progress notes/position, activity, coping, plan, vitals, medications, intake, output)	Initials

Transfer: ☐ Client Transfer Record attached

Indications: _____

_____

☐ private vehicle

☐ ambulance

Hospital: _____

Time of departure: _____

LEGEND

Fetal Auscultation:

Rhythm (for 1A)
R = Regular
I = Irregular

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

Decelerations
√ = Present
↓ _____ bpm X ___sec
Ø = Absent/not heard

Contractions:

Intensity
Mild = Mild
Mod = Moderate
St = Strong

Resting Tone
S = Soft
F = Firm

Medication charting: drug, indication, dose, route

Client name: _____

DOB: DD/MMM/YYYY _____

OR OPTIONAL LABEL

Labour: First Stage (Page __ of __)

Date: DD/MMM/YYYY

TIME	FETAL ASSESSMENT rate/rhythm/accel/decel	CONTRACTIONS freq/length/intensity/resting tone	CLIENT ASSESSMENT AND NARRATIVE NOTES e.g. progress notes/position, activity, coping, plan, vitals, medications, intake, output)	Initials

Transfer: ☐ Client Transfer Record attached

Indications: _____

_____

☐ private vehicle

☐ ambulance

Hospital: _____

Time of departure: _____

LEGEND

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Contractions:

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Mild = Mild
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St = Strong

Resting Tone
S = Soft
F = Firm

Medication charting: drug, indication, dose, route

Client name: _____

DOB: DD/MMM/YYYY _____

OR OPTIONAL LABEL

Labour: First Stage (Page __ of __)

Date: DD/MMM/YYYY

TIME	FETAL ASSESSMENT rate/rhythm/accel/decel	CONTRACTIONS freq/length/intensity/resting tone	CLIENT ASSESSMENT AND NARRATIVE NOTES e.g. progress notes/position, activity, coping, plan, vitals, medications, intake, output)	Initials

Transfer: ☐ Client Transfer Record attached

Indications: _____

_____

☐ private vehicle

☐ ambulance

Hospital: _____

Time of departure: _____

LEGEND

Fetal Auscultation:

Rhythm (for 1A)
R = Regular
I = Irregular

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

Decelerations
√ = Present
↓ _____ bpm X ___sec
Ø = Absent/not heard

Contractions:

Intensity
Mild = Mild
Mod = Moderate
St = Strong

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

Labour: Second Stage Page 1 of ___

	Date	Time
Full dilation	DD/MMM/YYYY	
Active pushing started	DD/MMM/YYYY	

Plan for third stage management: _____

_____

_____

2nd midwife notified: _____h arrived:_____ h

Date:			
TIME	**FETAL ASSESSMENT** rate/rhythm/accel/decel	**NOTES** (contraction pattern, client position, progress, description of decelerations if present, plan)	Initials

Transfer: Indications: _____

☐ private vehicle ☐ ambulance ☐ transfer record attached

Hospital: _____

Time of departure: _____

LEGEND

Fetal Auscultation:

Rhythm (for 1A)	**Accelerations**	**Decelerations**
R = Regular I = Irregular	√ = Present/spontaneous ↑ _____ bpm Ø = Absent/not heard SS = Present/scalp stimulation	√ = Present ↓ _____ bpm X ___sec Ø = Absent/not heard

Contractions:

Intensity	**Resting Tone**
Mild = Mild Mod = Moderate St = Strong	S = Soft F = Firm

Medication charting: drug, indication, dose, route

Client name: _____

DOB: DD/MMM/YYYY _____

OR OPTIONAL LABEL

Labour: Second Stage Page ___ of ___

Date:			
TIME	**FETAL ASSESSMENT** rate/rhythm/accel/decel	**NOTES** (contraction pattern, client position, progress, description of decelerations if present, plan)	Initials

LEGEND

Fetal Auscultation:

Rhythm (for 1A)
R = Regular
I = Irregular

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

Decelerations
√ = Present
↓ _____ bpm X ___sec
Ø = Absent/not heard

Contractions:

Intensity
Mild = Mild
Mod = Moderate
St = Strong

Resting Tone
S = Soft
F = Firm

Medication charting: drug, indication, dose, route

Normal birth package: page 3 back

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

OR OPTIONAL LABEL

Immediate Postpartum/Third Stage and Labour Summary

Date DD/MMM/YYYY

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

Repair underway: HH: MM Repair complete: HH: MM

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: DD/MMM/YYYY Time: HH:MM

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		

Normal birth package: page 4 back

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_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: 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 ☐ 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

Newborn Summary and Postnatal Care (Page 1)

Baby name: _____

Date/time of birth: DD/MMM/YYYY HH:MM	Date/time of discharge (if applicable): DD/MMM/YYYY HH:MM
Sex: _____ HC:_____cm L:_____cm	Birthweight: _____g _____ lb ___oz
HC#:	
Cord gases: Arterial pH_____ BE _____ Blood type:_____ Venous pH_____ BE _____ Direct Coombs: - / +	
TSB/TCB *(circle)* @ 24-72 hours ☐ offered ☐ declined ☐ done Hours old: _____result _____ risk level: _____ (chart repeat tests in narrative) ☐ Vitamin D discussed _____	

Medications: ☐ Vitamin K ☐ Erythromycin ☐ HBIG ☐ HBV: birth ☐ HBV: 4 wks ☐ not indicated

Newborn screening: date DD/MMM/YYYY time_____ result: _____

Hearing screen: ☐ hospital ☐ referred to community screening ☐ pass ☐ refer ☐ declined ☐ unknown

Notes: (e.g. resuscitation, paed consult, GBS risk factors, issues for follow-up from initial exam, screening for CHD): _____

_____

_____

_____ 10% loss: _____

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

7-14 day visit and physical assessment (check if normal)

Date: _____

☐ Skin ☐ Head ☐ Eyes ☐ Mouth ☐ Neck ☐ Lungs ☐ Abdomen

☐ Heart sounds/rhythm ☐ HR_____ ☐ Hips

☐ 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: 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 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

Client's name: _____

DOB: _____ DD/MMM/YYYY _____

OR OPTIONAL LABEL

Assessment Record (Page 1)

Date: _____ DD/MMM/YYYY _____ ☐ Screened for signs and symptoms of infectious disease

Client's arrival time or midwife's arrival time at home: _____h

Reason for assessment: _____

HISTORY

G _____ T _____ P _____ A _____ L _____ EDB _____ DD/MMM/YYYY _____ GA _____

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

_____

Blood Group: ____ Rh: ____ Rubella: I / non-I / equiv Hep B: - / + HIV: - / + / unknown

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

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 (q __ min)				
	Duration (sec)				
	Intensity **(Mild, Mod, St)**				
	Resting tone (**S**oft, **F**irm)				
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): _____

VAGINAL EXAM

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

VITAL SIGNS				**Initials**
Time:	BP:	P:	T:	
Time:	BP:	P:	T:	
URINE				
Time:	Protein:	Ketones:	Other:	

FETAL ASSESSMENT 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)

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

Classification
N = Normal
ATYP = Atypical
ABN = Abnormal

Decelerations
√ = Present
Ø = Absent/not heard
E = Early
V = Variable *
L = Late *
P = Prolonged *
* Charting includes:
↓ ___bpm x _____ sec

See over for medications and narrative notes ➔

Extra forms: page 1 front

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

OR OPTIONAL LABEL

Assessment Record (Page 2)

Date DD/MMM/YYYY

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 _____ DD/MMM/YYYY _____ Time _____h

Midwife name: _____
Student name: _____

TEACHING/FOLLOW-UP

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

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

OR OPTIONAL LABEL

Client Transfer Record

REASON FOR TRANSFER: _____

Time of birth: _____

Time EMS called: _____ by: _____
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 DD/MMM/YYYY 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: DD/MMM/YYYY 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: DD/MMM/YYYY 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: DD/MMM/YYYY 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

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

Newborn Resuscitation Record (Page 1) *attach to* ***Newborn Transfer Record***

Time of birth:

Meconium stained fluid: ☐ YES ☐ NO
If yes: trachea suctioning before stimulation with ETT and mec aspirator: ☐ YES ☐ NO
If yes: tube size (circle): 3.5 4.0
Meconium seen in tube: ☐ YES ☐ NO
See page 2 for intubation for ventilation, LMA, UVC and epinephrine

attempts:_____
by whom: _____

Time:												
Heart rate (bpm)												
Respiratory rate (/min)												
Muscle tone (limp, some flexion, well flexed)												
Stimulation (√)												
Suction (√)												
PPV (indicate mask, LMA, ET)												
PPV effective? Y / N If N, chart corrective measures MRSOPA (see legend below)												
SPO_2 (%) (right hand)												
Approx pressure from pressure gauge (if attached):_____ (aim for 30-40cm H_20)												
Room air / 40% / 100% (see legend below)												
Respiratory effort (absent, weak cry, strong cry, grunting)												
CPAP (√ note pressure) (5 cm H_2O) turn on O_2 and consider intubation												
Chest compressions Y / N (prioritize effective ventilation, consider intubation)												
Orogastric tube 8F (√) (nose to ear to xyphoid / sternum midpoint)												
Gastric contents evident on drawback? Y / N												

Legend	
RA	Room air
40%	O_2 concentration with self-inflating bag **without** reservoir connected to oxygen
100%	O_2 concentration with self-inflating bag **with** reservoir connected to oxygen
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)

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

Newborn Resuscitation Record (Page 2)

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										

Laryngeal Mask Airway
Time inserted: _____
By whom:_____

Insertion:
☐ Test inflated with 4mls air + deflated (open side facing towards baby's tongue, closed side along baby's palate)
☐ Once placed inflated with 2-4 mLs air
Signs of effective air entry ☐ YES ☐ NO (see legend below)
LMA placement assessed to be correct ☐ YES ☐ NO (if no, chart repeat attempts in narrative section or on duplicate form)
☐ Secured with tape

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

Insertion for ventilation
Blade size (circle): 0 1 Tube size (circle): 3.0 3.5 4.0
Free flow 02 while intubating ☐ YES ☐ NO Cords visualized ☐ YES ☐ NO
Signs of effective air entry ☐ YES ☐ NO (see list below)
Tip to lip (circle) 3kg - 9cm 4kg - 10 cm
Tube placement assessed to be correct ☐ YES ☐ NO (if no, chart repeat attempts in narrative section or on duplicate forms)
Secured with ☐ tape ☐ neobar

Medication by ETT
Time admin:_____
By whom:_____

Epinephrine 1:10,000 ET tube dose: 1 mL/kg (max 3mL) in 3mL syringe = _____
☐ Followed by several PPV breaths

Signs of Effective Air Entry Legend (LMA + ETT)

- Vapour in ET tube with exhalation
- CO_2 detector purple → yellow
- Equal breath sounds over both lungs
- Symmetrical mvmnt of chest
- Decreased/absent breath sounds over stomach
- Improvement of HR + SPO_2
- No gastric distension (ET)

UVC Insertion
Time of insertion: ___
Depth noted: _____
Inserted by: _____

☐ Cord cleaned ☐ Cord tied ☐ Cord recut to 2 cm ☐ Stop cock attached to catheter
☐ 5F catheter filled with normal saline prior to insertion
☐ Catheter inserted 1-4 cm ☐ flashback seen ☐ Insertion depth noted: _____
☐ Secured with opsite/tegaderm/tape

Medication by UVC
Time admin:_____

Epinephrine 1:10,000 UVC dose: 0.1 mL/kg = _____(rapidly) ☐ flushed with NS up to 5mLs
Volume expansion N/S or R/L 10 mL/kg (may repeat once) = _____over 5 - 10 mins

Instrument sterilization load/tracking#	**Date**

Midwives present and roles: _____

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: _____DD/MMM/YYYY_____

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: _____DD/MMM/YYYY_____ 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.