



CLINICAL RECORD FORMS

(no 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

Labour: First Stage

Support person(s) _____

Client screened for signs and symptoms of infectious disease Initials: _____

PREGNANCY SUMMARY

EDB: _____ 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 _____

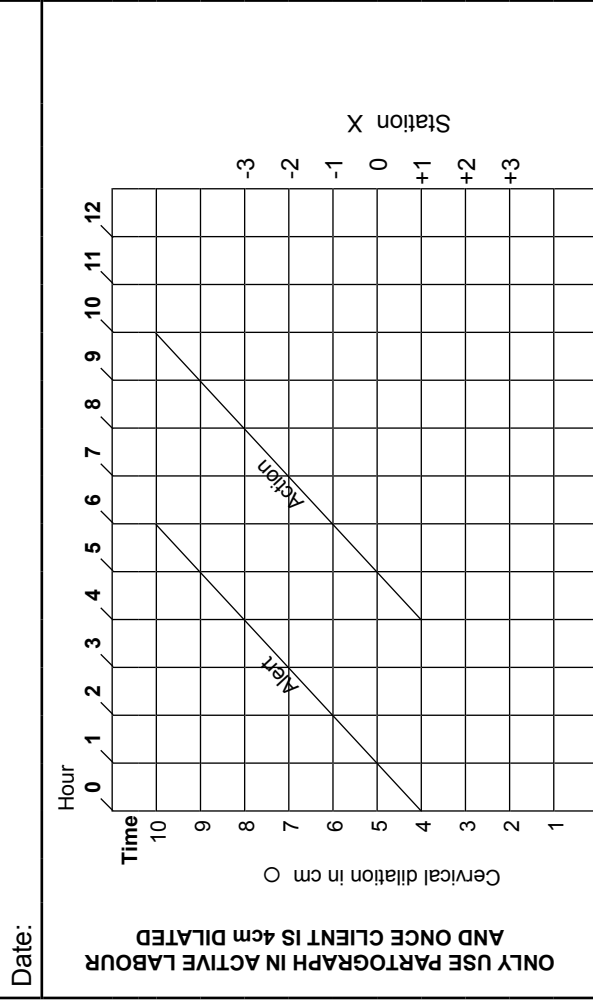
Active labour began: _____

Primary midwife for labour: _____

Client name: _____

DOB: DD/MM/YYYY _____

OR OPTIONAL LABEL



VAGINAL EXAMINATIONS

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

LEGEND	
Effacement %	Fetal Position:
Cervix	L = Left
Position	R = Right
A = Anterior	0 = Occiput
M = Mid	S = Sacrum
P = Posterior	M = Mentum
	Sc = Scapula
	A = Anterior
	T = Transverse (lateral)
	P = Posterior
Membranes:	Fluid:
I = Intact	Quantity:
SROM = Spontaneous	Ø = Absent
rupture of membranes	Sc = Scant
ARM = Artificial	Mod = Moderate
rupture of membranes	L = Large
R = Ruptured	Colour:
	CL = Clear
	BT = Blood tinged
	B = Bloody
	Mec = Meconium
Show:	Sc = Scant
	Mod = Moderate
	L = Large

Client name: _____
 DOB: DD/MM/YYYY

OR OPTIONAL LABEL

Labour: First Stage (Page ___ of ___)

Date: _____		CONTRACTIONS		CLIENT ASSESSMENT AND NARRATIVE NOTES	
TIME	FETAL ASSESSMENT rate/rhythm/accel/decel	freq/length/intensity/resting tone	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:		Contraction:		
Rhythm (for 1A)	Accelerations	Decelerations	Intensity	Resting Tone	Intensity	Resting Tone	
R = Regular I = Irregular	√ = Present/spontaneous ↑ = bpm Ø = Absent/not heard SS = Present/scalp stimulation	√ = Present ↓ = bpm X sec Ø = Absent/not heard	Mild = Mild Mod = Moderate St = Strong	S = Soft F = Firm	Mild = Mild Mod = Moderate St = Strong	S = Soft F = Firm	
Medication charting: drug, indication, dose, route							

Client name: _____
 DOB: DD/MM/YYYY
 OR OPTIONAL LABEL

Labour: First Stage (Page ___ of ___)

Date: _____		CONTRACTIONS		CLIENT ASSESSMENT AND NARRATIVE NOTES	
TIME	FETAL ASSESSMENT rate/rhythm/accel/decel	freq/length/intensity/resting tone	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:		Contractions:	
Rhythm (for 1A) R = Regular I = Irregular	Accelerations √ = Present/spontaneous ↑ _____ bpm ∅ = Absent/not heard SS = Present/scalp stimulation	Intensity Mild = Mild Mod = Moderate St = Strong	Resting Tone S = Soft F = Firm
Decelerations √ = Present _____ bpm X _____ sec ↓ _____ bpm X _____ sec ∅ = Absent/not heard			
Medication charting: drug, indication, dose, route			

Client name: _____
 DOB: DD/MM/YYYY

OR OPTIONAL LABEL

Labour: First Stage (Page ___ of ___)

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:		Contraction:	
Rhythm (for 1A) R = Regular I = Irregular	Accelerations √ = Present/spontaneous ↑ _____ bpm Ø = Absent/not heard SS = Present/scalp stimulation	Intensity Mild = Mild Mod = Moderate St = Strong	Resting Tone S = Soft F = Firm
Decelerations √ = Present _____ bpm X _____ sec ↓ _____ bpm Ø = Absent/not heard		Medication charting: drug, indication, dose, route	

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

OR OPTIONAL LABEL

Labour: Second Stage Page 1 of ____

	Date	Time	Plan for third stage management: _____ _____
Full dilation			_____
Active pushing started			2nd midwife notified: _____h arrived: _____h

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

Transfer: Indications: _____
 private vehicle ambulance transfer record attached
 Hospital: _____
 Time of departure: _____

LEGEND	Fetal Auscultation:			Contractions:		
	Rhythm (for 1A) R = Regular I = Irregular	Accelerations √ = Present/spontaneous ↑ _____ bpm ∅ = Absent/not heard SS = Present/scalp stimulation	Decelerations √ = Present ↓ _____ bpm X ____sec ∅ = Absent/not heard	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: Second Stage Page ___ of ___

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

LEGEND	Fetal Auscultation:			Contractions:		
	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	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

Immediate Postpartum/Third Stage and Labour Summary

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

THIRD STAGE / PLACENTA

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

TOTAL ESTIMATED BLOOD LOSS _____ mL >500 mL <500 mL

POSTPARTUM MEDICATIONS

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

DATE:	Onset	End	Duration	Total active labour	PLACE OF BIRTH:
Latent 1 st stage					Planned: <input type="checkbox"/> home <input type="checkbox"/> hospital <input type="checkbox"/> birth centre <input type="checkbox"/> other Actual: <input type="checkbox"/> home <input type="checkbox"/> hospital <input type="checkbox"/> birth centre <input type="checkbox"/> other
Active 1 st 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 rd stage					Presentation at birth: fetal: <input type="checkbox"/> vertex <input type="checkbox"/> other: _____ Amniotic fluid at birth: <input type="checkbox"/> clear <input type="checkbox"/> meconium (length of ROM: _____)

Client name: _____

DOB: DD/MMM/YYYY _____

OR OPTIONAL LABEL

Perineal Repair/Instrument Record/Departure

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

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

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

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

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

- | | | |
|---|---|---|
| <input type="checkbox"/> 1. Appearance | <input type="checkbox"/> 7. Abdomen | <input type="checkbox"/> 10. Void |
| <input type="checkbox"/> 2. Skin | <input type="checkbox"/> <i>Umbilicus</i> | <input type="checkbox"/> 11. Meconium |
| <input type="checkbox"/> 3. Head and neck | <input type="checkbox"/> <i>Vessels (three)</i> | <input type="checkbox"/> 12. Neurological |
| <input type="checkbox"/> <i>Eyes</i> | <input type="checkbox"/> 8. Genitourinary | <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 & 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 & fontanelles</i> | <input type="checkbox"/> 9. Musculoskeletal | <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"/> 4. Heart sounds | <input type="checkbox"/> <i>Spine</i> | <input type="checkbox"/> <i>Babinski</i> <input type="checkbox"/> <i>Grasp</i> |
| <input type="checkbox"/> 5. Femoral pulses | <input type="checkbox"/> <i>Clavicles</i> | |
| <input type="checkbox"/> 6. Lungs | <input type="checkbox"/> <i>Arms and hands</i> | |
| | <input type="checkbox"/> <i>Legs and feet</i> | |

Additional Notes (number and describe abnormal findings):

Initials: _____

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

Baby of: _____

OR OPTIONAL LABEL

Newborn Summary and Postnatal Care (Page 1)

Baby name: _____

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

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

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

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

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

Client name: _____ Client #: _____
 DOB: DD/MM/YYYY _____

OR OPTIONAL LABEL

Client Summary and Postnatal Care (Page 1)

Date/time of birth: _____ Location: _____
 Birth details:
 Date/time of hospital admission (if applicable): _____
 Date/time of hospital discharge (if applicable): _____
 Allergies: _____
 Blood group/RH: _____ Indirect Coombs: - / + 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: _____ Contraception discussed: _____
 Swabs done: _____
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/MM/YY Client #: _____

OR OPTIONAL LABEL

Client Summary and Postnatal Care (Page 2)

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

Date/Time	Notes	Initials

Client's name: _____

DOB: _____ DD/MM/YYYY

OR OPTIONAL LABEL

Assessment Record (Page 1)

Date: _____	<input type="checkbox"/> 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 _____ GA _____	
Allergies: <input type="checkbox"/> NKA <input type="checkbox"/> Yes, specify/reactions: _____	
Blood Group: ____ Rh: ____ Rubella: I / non-I / equiv Hep B: - / + HIV: - / + / unknown	
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	
Additional relevant history _____	

ASSESSMENT

Position by Palpation: _____				AMNIOTIC FLUID TESTS (if indicated)				
FHR	Time						Sterile speculum: <input type="checkbox"/> Yes <input type="checkbox"/> No Fluid visualized: <input type="checkbox"/> Yes <input type="checkbox"/> No Ferning: <input type="checkbox"/> Pos <input type="checkbox"/> Neg Nitrazine: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> equiv Description of fluid: _____	
	Mode (IA, EFM)						Speculum sterilization load/tracking # and date: _____	
	FHR (bpm)						Membranes: <input type="checkbox"/> Intact <input type="checkbox"/> Ruptured <input type="checkbox"/> Equivocal Since (date/time): _____	
	Rhythm/variability							
	Accelerations						VAGINAL EXAM	
	Decelerations						Time	
Classification						Cx dilation (cm)		
CONTRACTIONS	Mode (Palp, Toco)						Cx effacement (%)	
	Frequency (q ____ min)						Cx position (Ant, Mid, Post)	
	Duration (sec)						Cx consistency (Soft, Med, Firm)	
	Intensity (Mild, Mod, St)						Station	
	Resting tone (Soft, Firm)						Fetal position	
Initials						Initials		
VITAL SIGNS				Initials		FETAL ASSESSMENT LEGEND		
Time:	BP:	P:	T:			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	Decelerations √ = Present Ø = Absent/not heard E = Early V = Variable * L = Late * P = Prolonged * * Charting includes: ↓ ____ bpm x ____ sec
Time:	BP:	P:	T:					
URINE								
Time:	Protein:	Ketones:	Other:					

Client's name: _____
DOB: _____ DD/MM/YYYY _____
OR OPTIONAL LABEL

Assessment Record (Page 2)

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

MEDICATIONS

<input type="checkbox"/> dimenhydrinate Time: _____	<input type="checkbox"/> __ mg PO <input type="checkbox"/> __ mg IM	<input type="checkbox"/> acetaminophen ____ mg PO Time: _____ <input type="checkbox"/> Pen G ____ million units IV Time: _____	<input type="checkbox"/> other antibiotic (name, dose, route, time): _____ _____ <input type="checkbox"/> other medications (name, dose, route, time): _____ _____
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CARE PLAN

<input type="checkbox"/> Admitted to birth centre: meets eligibility for admission
<input type="checkbox"/> Active labour: charting started on Labour Record
<input type="checkbox"/> Discharged from birth centre
<input type="checkbox"/> Not active labour: midwife to depart
<input type="checkbox"/> Transferred to _____ Date _____ Time _____ h
Midwife name: _____
Student name: _____

TEACHING/FOLLOW-UP

<input type="checkbox"/> When to page midwife
<input type="checkbox"/> Other _____
Plan for follow-up: _____ _____ _____ _____ _____

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

OR OPTIONAL LABEL

Client Transfer Record

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

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

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

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

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

Client name: _____

DOB: DD/MM/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: _____ Attending midwife: _____
 Time EMS arrived: _____ Departure time: _____ Report given to (if applicable): _____
 Time hospital called: _____ by: _____ Time of transfer to MD (if applicable): _____
 Arrival time at hospital: _____ Emergency contact: _____
 Receiving hospital: _____ Telephone number: (____) _____

Ambulance private vehicle

HISTORY GA: _____ Length of labour: _____ h

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

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

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

CARE DURING TRANSPORT/NARRATIVE

Time	HR	RR	O 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: <input type="checkbox"/> YES <input type="checkbox"/> NO										
<i>See page 2 for intubation for ventilation, LMA, chest compressions, UVC and epinephrine</i>											
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) (typical range: 20-25 cm H ₂ O)											
Room air / 40% / 100% (see legend below)											
Respiratory effort (absent, weak cry, strong cry, grunting)											
CPAP (√ note pressure) (5 cm H ₂ O) turn on O ₂ and consider intubation											

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		Pre-ductal SpO ₂ Target	
RA	Room air (self-inflating bag not connected to O ₂)	1 min	60% - 65%
40%	O ₂ concentration with self-inflating bag connected to O ₂ without reservoir	2 min	65% - 70%
100%	O ₂ concentration with self-inflating bag connected to O ₂ with reservoir	3 min	70% - 75%
M	Mask adjustment (seal)	4 min	75% - 80%
R	Reposition airway ("sniffing")	5 min	80% - 85%
S	Suction (mouth then nose)	10 min	85% - 95%
O	Open mouth, lift jaw forward		
P	Pressure increase		
A	Airway alternative (LMA or ET)		

Baby's name: _____

DOB: _____

Baby of: _____

Newborn Resuscitation Record (Page 2)

Laryngeal Mask Airway

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

Time inserted: _____

By whom: _____

Endotracheal Tube

Insertion for ventilation

Blade size (circle): 0 1 Tube size (circle): 3.0 3.5 4.0

Free flow O₂ 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

Time inserted: _____

attempts: _____

Time elapsed: _____

By whom: _____

Medication by ETT

Epinephrine 1:10,000 ET tube dose: 1 mL/kg (max 3mL) in 3mL syringe = _____

Followed by several PPV breaths

Time admin: _____

By whom: _____

Signs of Effective Air Entry Legend (LMA + ETT)

- Vapour in ET tube with exhalation
- CO₂ detector purple → yellow
- Equal breath sounds over both lungs
- Symmetrical mvmnt of chest
- Decreased/absent breath sounds over stomach
- Improvement of HR + SPO₂
- No gastric distension (ET)

UVC Insertion

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

Time of insertion: _____

Depth noted: _____

Inserted by: _____

Medication by UVC

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

Time admin: _____

Instrument sterilization load/tracking# (if applicable)

Date

Midwives present and roles: _____

Documentation by: _____

If this form is filled out as a late entry: _____ Time: _____ Name _____ 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.