USA FAMILY MEDICINE OBSTETRICS GUIDE

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USA HEALTH | FAMILY MEDICINE

RESIDENCY PROGRAM | www.fammed.usouthal.edu

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- BR chief: 3-2814
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- L&D 3-2336 (front)
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- IT 445-9123

UH Phone Numbers:

- 3rd floor: 77467
- 4th floor: 77545
- 5th floor: 77672
- 6th floor: 77616
- Bed Control: 77212
- IR: 77157
- Lab 77220
- OR: 77164
- PACU: 77172
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- Pharmacy: 77388
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- Radiology Reading Room: 77155
- STICU (1-8): 77602
- STICU (9-16): 77735
- Wound: 71653

FM Attending Cell Numbers

Molokhia: 251-454-4193

Pfleeger: 228-697-8571

Sollie: 256-221-0569

(Prefix C&W 415-, USAMC 471-)

LABOR & DELIVERY

This guide serves as a tool during your OB rotations and while taking FM OB call. Please note that an attending (FM, OB, MFM) may make other medical decisions that differ from the document.

Continuity Patients

- All the Family Medicine OB patients have been followed by one primary provider who provides the bulk of or all their prenatal care.
- If the continuity provider is an FM attending, that attending should be notified.
- If the continuity provider is an FM resident, that resident should be called into L&D when delivery is imminent (8cm for multiparous and 9-10cm for nulliparous) or earlier as determined by distance to travel or the on call attending if the backup protocol needs to be initiated.
    - This only pertains to the actual delivery, not any other obstetric care
        - If the patient comes into the screening room or is admitted for observation, the on call resident will provide all the care for the patient
        - You should still send the patient's OB continuity provider an update
    - If the patient is definitely being admitted to Labor & Delivery, you need to contact the continuity provider in person (i.e., call them or page them and have them call back) to let them know as well as the FM attending covering OB
    - Until the continuity provider steps onto the L&D floor, you are providing all the care for the patient
        - This generally means you do the admission, write the H&P, and write a few strip notes before the continuity resident arrives
- If a FM continuity patient needs to go to c-section, the FM OB fellow currently in Mobile should be contacted.

Rounding on Postpartum Patients

- 2^{nd} floor = routine; 3^{rd} floor = complicated
- Know 24h vitals on all patients (including pattern of mild and severe range BPs, and UOP on all POD#1 C/S and any patient with pre-eclampsia)
- Know rubella status and birth control on day of discharge
- Know if breastfeeding or formula feeding so that can appropriately counsel and prescribe birth control on day of discharge
    - If breastfeeding, use progesterone only contraception (drospirenone or norethindrone pill, depo shot, nexplanon, or IUD)
    - Typically start birth control no earlier than 3 weeks postpartum unless is LARC
    - If wants a nexplanon and has Medicaid, needs to be done before discharge
- NSVDs discharge on PPD#1-2, C/S on POD#2-4
    - If has hypertensive disease monitor BPs for 72h (can come in to get BP check)
    - If delivered after 9p can stay an extra day (depends on insurance, BCBS can stay extra day if delivery after 6 PM, other private insurance if delivery after 10 PM, Medicaid has no coverage for extra night even if late delivery)
- Postpartum precautions:
    - Pelvic rest x 6 weeks
    - No heavy lifting
    - Return for VB > menses, foul smelling D/C, temp > 100.4, PreE precautions or other acute changes.
    - Closer f/u if concerned for PP depression

PP Discharge Checklist

1. OB Discharge Powerplan initiated in Cerner
    - Needs AM CBC resulted before discharge
2. Discharge summary within 1 week in Cerner
    - Note if had any complications (PPH etc.)
    - Note if had A1DM/A2DM as patient will need 2h GTT at 4-6 weeks postpartum!
    - Note if had abn pap requiring PP colpo!
    - Include their primary OB in the DC summary (helps when the attendings have to send it to outside providers)
3. Discharge medication reconciliation in Cerner
4. ERx or Print Prescriptions
    - Colace, Iron, +/- Motrin, +/- birth control
    - Percocet 5/325 #15 for SVD with 3rd/4th degree lacs, and for routine SVD of Bodie and Holliday patients
    - Percocet 5/325 #30 for cesareans
    - If 3rd/4th laceration, remind patient no rectal suppositories for 6 weeks and maintain bowel regimen
5. Send Message to Janeen McCoy
    - **Send a message to Janeen McCoy under subject select "Hospital Discharge-Clinic Appointment Request"**
    - Know/double check who is the primary OB provider to send patient to that provider for postpartum visits
    - If ↑BP need daily check x 72 hr and f/u 1 week for BP check additionally

OB Emergencies – HAVE NURSE NOTIFY ON-SITE OB TEAM AND FM ATTENDING! DO NOT LEAVE PATIENT!

- Obstetric/Postpartum Hemorrhage
    - 2 large bore IV's and fluid boluses
    - STAT CBC and type & cross
    - (Request PPH kit with meds if PP)
    - Consider coags with fibrinogen
    - Consider insertion of foley
    - Primary Causes: Uterine atony, lacerations, retained products of conception, coagulation defects, uterine inversion

- Severe range blood pressures on a pregnant patient
    - BP's ≥160/110; increased risk for stroke
    - Request immediate manual re-check of BP
    - Notify attending <u>BEFORE</u> giving any IV meds
    - IV anti-hypertensives (hydralazine 5mg or labetalol 20mg) or PO Procardia 10mg IR
    - Ensure patient is on the monitor when meds given and start serial BP q15min

- Eclampsia
    - Turn pt on left side, suction, and supplemental oxygen
    - Give magnesium sulfate (6gm bolus if IV, 5g IM in each buttock if no IV access)
    - Can try Lorazepam 4mg IV at 2mg/min if intractable seizures
    - Notify Anesthesia

- Shoulder Dystocia → Retraction of fetal head against maternal perineum (turtle sign)
    - Call for help!
    - Maneuvers: First try: McRoberts (hyperflexion and abduction of hips) and suprapubic pressure. Evaluate for episiotomy. Remove the posterior arm. Rotational maneuvers (Rubin II, Rubin II + Woods Screw, Reverse Woods Screw). Roll the patient onto all fours (Gaskins). Repeat.

- Non-reassuring fetal status
    - Change maternal position
    - D/C Pitocin if on pitocin
    - Consider terbutaline 0.25mg if contracting a lot and maternal HR < 120
    - Start O2
    - Start IVF bolus
    - If laboring, do SVE with scalp stimulation and/or place internal monitors if necessary
    - Consider requesting U/S if unable to trace baby at all
- Cord Prolapse
    - Do NOT remove hand
    - Elevate presenting part to reduce compression on umbilical cord
    - Call stat CS for cord prolapse and announce time of c/s call

Admitting Full-Term Laboring Patients - PROCESS

1. Obtain HPI and Full Medical Hx
2. Perform physical exam including SVE (have RN or another physician confirm)
3. Do Leopold's for EFW and a BSUS for Presentation
4. Confirm relevant PNL like T&S and GBS status
5. *Assess if wants LARC (Medicaid pts) inpatient/counsel*
6. *Assess if patient wants a BTL*
    a. *If Medicaid, papers must have been signed for 30 days if full term and 72 hours if preterm*
    b. *Make sure the nurse prints out the Medicaid papers and has BTL vs. BS on the consent*
    c. *Counsel patient about BTL vs bilateral salpingectomy*
7. Consent patient for appropriate procedures:
    a. Vaginal Delivery: NSVD, OVD (both forceps and vacuum), C/S, Blood Transfusion, BTL vs. BS or LARC if appropriate, and Circ if appropriate; add D&C if <24w, add uterine rupture risk of 1% if is TOLAC
    b. C/S: C/S, Blood transfx, BTL/LARC or Circ PRN

Contraception

Unless is a LARC or depo shot, usually wait at least 3 weeks before starting hormonal birth control.

- Pills
    - Ortho-Micronor is a Progestin only (for patients **Breastfeeding or migraines w/ aura)** counsel MUST TAKE AT SAME TIME EACH DAY, if >1h off = baby. Slynd is also a progestin only option and there are coupons available, does not have to be taken same time each day, has same effectiveness of combined OCP.
    - Sprintec is COC that is $4/mo at Walmart

- Patch
  - Ortho-Evra or Xulane 1 patch Qwk x 3 wk, off 1 wk
  - Limited use in women > 130% ideal body weight
- Ring
  - Nuvaring 1 ring PV x 3 wk, off 1 wk
  - Annovera 1 ring PV x 3 weeks then off 1 wk, lasts for one year
- Shot
  - Depo-Provera 150 mg IM Q3 mo, can give shot before leave hospital, remember causes irregular bleeding for first few shots
- Implant
  - Nexplanon 68 mg x 3 years
  - Must counsel side effects of *irregular bleeding*!!
  - Can insert postpartum inpatient in Medicaid pts
- IUD
  - Kyleena 19.5 mg x 5 years
  - Mirena 52 mg x 8 years → can insert postpartum within 10 min of placenta delivery or at time of c/s if Medicaid and appropriately counselled/consented → side effect is irregular VB until amenorrhea, counsel about risk of expulsion
  - Liletta 52 mg x 5 years

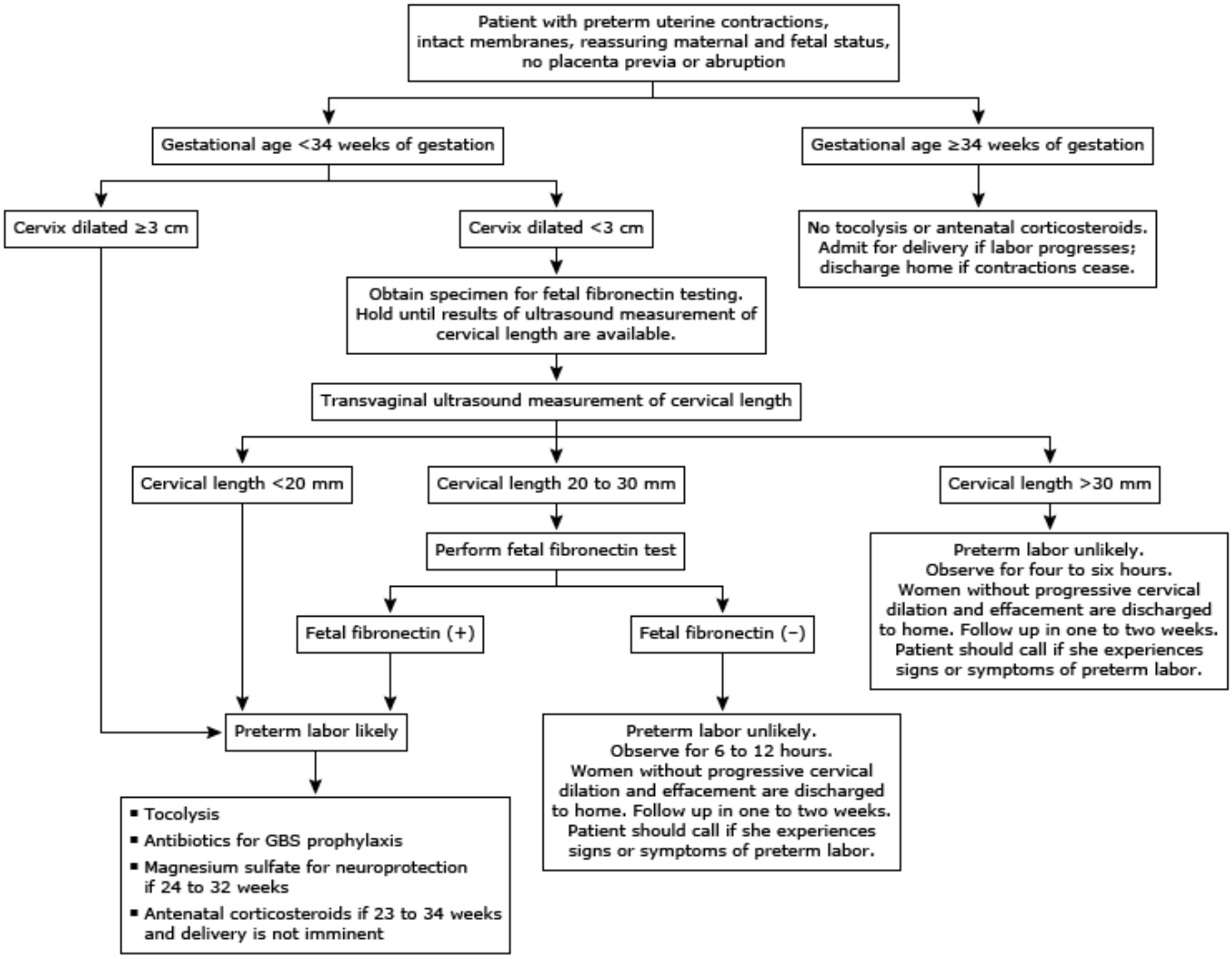
COMMON PATIENT SCENARIOS

4 big questions for every patient: Vaginal bleeding, leakage of fluid, feeling contractions, and decreased fetal movement.

SCREENING ROOM >20W

- **Labor Check >37+0w (cc: ctx's, abdominal pain)**
  - Confirm dating/Placenta (EMR)
  - Perform SVE (nurse/upper level check behind you)
  - Confirm presentation with US
  - Review vitals and FHT with upper level/attending
  - < 4cm repeat exam in 1 hour
  - > 4cm discuss with attending the plan
- **SROM at >37+0w**
  - Confirm dating & presentation
  - Review vitals and FHT with upper level/attending
  - SSE: Ferning, nitrazine, pooling, valsalva
    - If equivocal, talk to attending before using amnisure!!
- **Preterm Labor Check (< 37+0w)**
  - Ask: hydration status, recent intercourse, change in vaginal discharge, and UTI Sx
  - Confirm dating/Placenta (EMR, etc)

- Review vitals and FHT with upper level/attending
- *If < 34 weeks <u>do FFN before SVE</u>*
- *Confirm one more time no ROM complaint*
- SVE (only after did FFN if < 34w) *and*
  - Dilated 1-2cm or ctx send FFN
  - Closed, hold FFN
  - Wet prep, genprobe
- If + PTL → Admit, U/S, BMZ (under 34 weeks); Mag for NP prn (if < 32 weeks), PCN for GBS ppx**,** Make sure did GBS and GC swabs!!
- Consider tocolysis depending on the GA



- If 34+0 to 36+6 and preterm delivery is anticipated within 7 days and no previous course received, may consider BMZ, discuss with attending prior to ordering (ACOG Committee Opinion 713).
- May discuss cervical length with OB chief, need a sonographer or provider that has been trained to perform cervical lengths

- **PPROM**

    - Confirm dating & presentation
    - Review vitals and FHT with upper level/attending
    - SSE**:** Pooling, ferning, nitrazine, valsalva
        - If equivocal, talk to attending before amnisure!!
    - Do **NOT** perform SVE until talk to attending
    - If + ROM exam → Admit, U/S, latency abx, BMZ; Mag NP (less than 32 weeks)**,** do GBS & GC swabs!!

- **Vaginal Bleeding ("VB")**

    - Confirm dating, placental location, & presentation
    - Assess for any trauma, recent sex or SVE
    - *Do NOT perform SVE if placenta previa*
    - SSE to examine cervix and any blood in vault
        - GBS, genprobe, wet prep
    - CBC, T&S, Coags with fibrinogen if active VB
    - Review vitals and FHT with Chief
    - If pt Rh- consider Rhogam workup
    - Call upper-level/attending if heavy bleeding or NRFHRS

- **R/O Pre-Eclampsia**

    - Assess for headache, vision changes, upper abdominal pain (*do not lead patient*)
    - Review old records for previous elevated BPs
    - Serial BPs q15min ordered
    - Order CBC, CMP, LDH, Uric Acid, Creatinine Urine Random, Protein Urine Random, UA
    - Review vitals and FHT with upper-level/attending
    - If admit, do U/S, get "24 hour urine protein" on case by case basis
    - Call attending if severe BP >160/>110 before treating any severe BPs on your own

- **Fall/Trauma**

    - Assess for uterine tenderness, ctx, irritability, vaginal bleeding, fetal compromise
    - Note mechanism and time of fall/trauma, where on the body the trauma occurred
    - CEFM until 4 hours from event
    - T&S, CBC, coags, fibrinogen, KB stain if Rh negative
    - Assess if need rhogam workup
    - Review vitals and FHT/toco with upper-level/attending
    - Ultrasound for signs of abruption

- **No Prenatal Care**

    - Do Dating Ultrasound
    - NPNC labs**:** CBC, T&S, RPR, Hepatitis B Surface Antigen, HCV antibody, Rapid HIV Ag/Ab scrn, Rubella IgG quant, UDS, Group B Strep Culture (or Pen Allergic Culture!), GC (i.e. "chlamydia trachomatis rRNA Amp" and "Neisseria gonorrhea rRNA Amp")
    - Review vitals and FHT with Chief

- **Cramping/Abdominal Pain**
    - Ask: hydration status, recent intercourse, change in vaginal discharge, and UTI Sx
    - Review vitals and FHT & Toco with Chief
    - If pre-term, confirm no ROM complaints then do FFN (if < 34w) followed by SSE
    - If closed: Hydrate, Pain cocktail, UA, and consider vaginitis swabs (wet prep and gen probe)
- **DKA concern**
    - Know meds taken and what patient had eaten in last 12h; any vomiting? Fever? Diarrhea?
    - Accucheck, acetone, CBC, CMP, HA1c, UA, normal saline bolus, consider VBG
    - Review vitals and FHT & Toco with Chief
- **SS Pain Crisis**
    - Obtain labs: T&S, CBC, CMP, reticulocyte panel,
    - Give D5 ½ NS bolus
    - Attempt to treat pain with patient's at home medication, if they have already taken that then can start with IV Dilaudid 0.5 or 1 mg
    - If pain does not improve with the above or there is concern for crisis → admit
    - Orders include: spirometry, stool softener, Lovenox for DVT PPx, SCDs, D5 ½ NS for fluids
- **Decreased Fetal Movement**
    - EFM
    - If initially nonreactive/non-reassuring, can try
        - IV LR bolus
        - Drinking ice cold water
        - Drinking something sugary (juice, soda, etc.)
        - Have patient lay on her left side
    - Consider BPP if NST non-reactive or if patient still not feeling movement
    - If continuing to be nonreactive/non-reassuring after interventions, discuss with your senior/attending

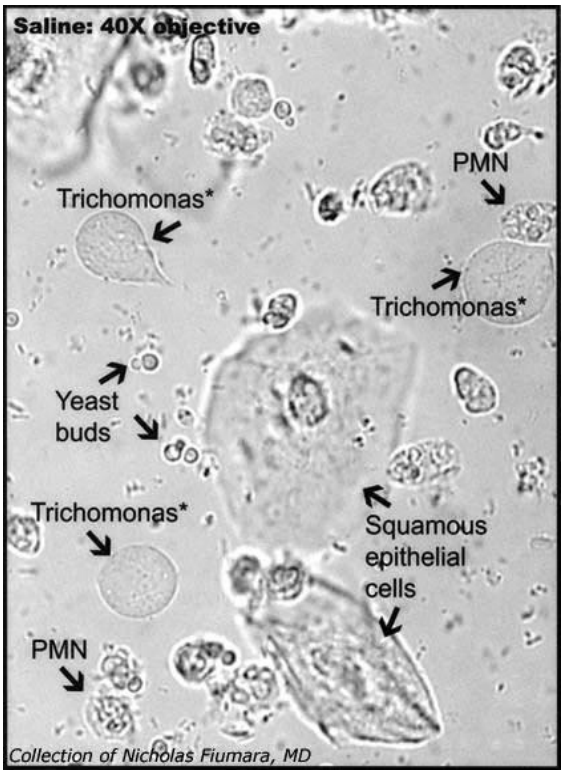
SCREENING ROOM < 20W OR PEDS EC

Get a UCG! (nurses do this automatically)

- **VB (pregnant)**
    - SSE & SVE
    - CBC, T&S; beta when appropriate
    - Confirm IUP with U/S
    - Rhogam if Rh neg

- **VB (non-pregnant)**
    - Menstrual history and birth control history
    - CBC, T&S, UCG, pad count
    - Likely recommend OCPs so assess for contraindications
- **Heavy VB/Hemorrhage/Unstable Pt**
    - 2 large bore IVs and Bolus NS
    - Shot gun labs: CBC, *T&C*, CMP, Coags
    - Call upper-level!!
- **Hyperemesis < 3 -5 days**
    - Order patient actually weighed
    - NPO order with IVF bolus and IV Reglan 10mg
    - CBC, CMP, and UA
    - Confirm IUP (consider βhCG)
    - PO challenge before discharge
- **Hyperemesis >5-7 days**
    - Order patient actually weighed
    - NPO order with banana bag (MVI 10mL + thiamine + folic acid) and IV reglan 10mg
    - Get CBC, CMP, UA, Amylase, Lipase, pre-albumin
    - Confirm IUP
    - PO challenge before discharge
- **Pelvic Pain (pregnant < 20w)**
    - Assess for acute abdomen (ruptured ectopic, etc.)
    - Confirm IUP
        - Consider ectopic if βhCG > 3500 with no IUP
    - SSE, bimanual, genprobe, wet prep, and UA
- **Pelvic Pain (non-pregnant)**
    - Menstrual history
    - Assess for acute abdomen (ovarian torsion, etc.)
    - SSE & Bimanual (check for CMT)
    - Wet prep & genprobe
    - Consider CBC
    - Consider TV U/S for possible torsion, TOA etc.
- **Post-Partum ↑BP**
    - ≥160/110 call chief
    - Assess for headache, vision changes, and upper abdominal pain
    - Assess for prior hypertensive disease and if had magnesium before
    - Serial BPs q15min, CBC, CMP, LDH, uric acid

- **Bartholin's Gland Cyst/Abscess**
    - Assess if can I&D the abscess (i.e. did it come to a "head" or is it still deep)
    - If doing I&D, make sure to consent patient
    - Obtain full PPE for procedure
    - I&D kit, lidocaine, word catheter, saline syringe+ needle to inflate
    - Leave in for 4-6 weeks, f/u in 1 wk for checkup



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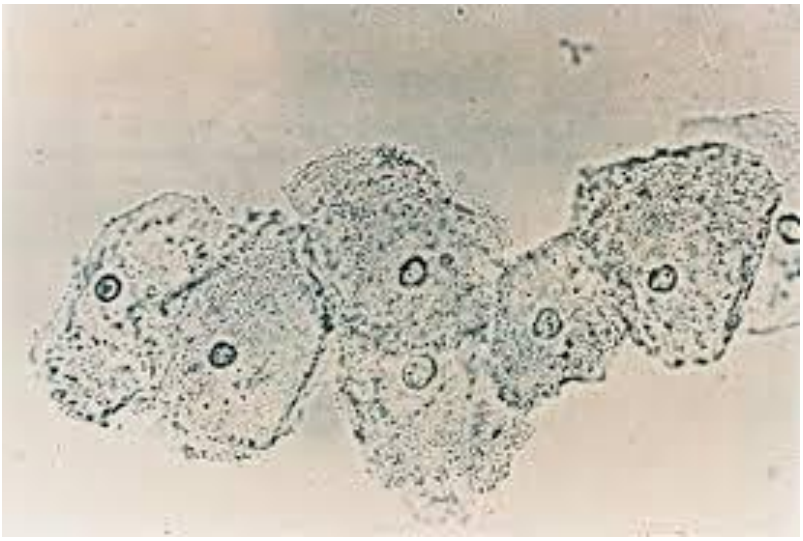


ADMISSION GUIDELINES/CERNER

OVERARCHING TIPS

- First line of HPI in every SR note or admission H&P should ALWAYS be written in this format:
  20 yo G2P1001 with IUP @ 39+6 by LMP c/w 12+3 week U/S and EDD of 12/25/11 presents with [x]
- Always review dating criteria in Cerner (for above) before proceeding on management of patient because sometimes nurses and other providers do not update the dating U/S in Cerner and *dates may be way off*!!
- Specify name of **primary** provider and clinic at top of every SR note or admission H&P → important later for making discharge follow-up appts appropriately!
- Always do BSUS for presentation and document it!
- Always attempt to do Leopold's/EFW and document it!
- **ALWAYS HAVE A NUMBERED PROBLEM LIST**

- Always ask if patient desires BTL or LARC if >20w
- Always consent for a possible D&C if laboring < 24w
- Consents must be re-documented for every admission.
- Obtain prenatal records if available
- For any OB patient admitted, there must be Cerner documented HIV status
- For any HROB admission, must have U/S of IUP and need to add to the Cerner patient list
- For every OB admission > 22w, must do a GBS and Genprobe (unless prior GBS in chart < 5w prior)
- Check all urine culture results during the pregnancy for GBS negative or GBS unknown patients to see if had GBS bacteriuria qualifying for PCN ppx

ADMITTING PATIENTS FOR SVD

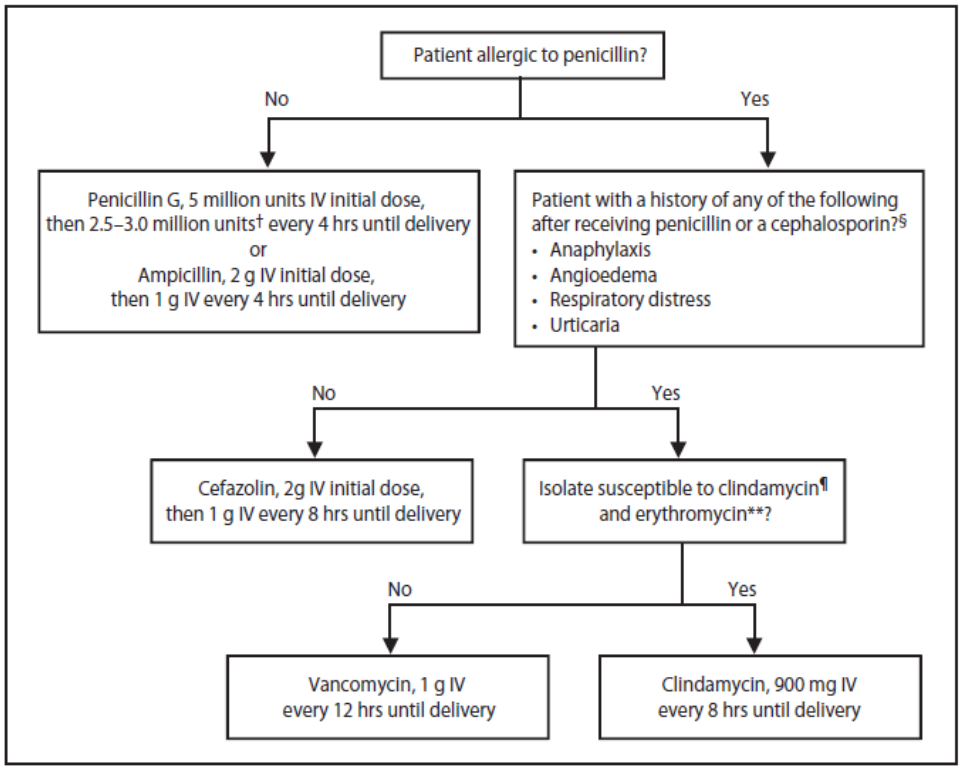
1. Patient Status Order (admit to inpatient)
2. Do admission reconciliation of actual patient meds
3. Order "OB Labor" powerplan
   - Review all orders
   - Click to add OB Oxytocin
   - Click to add OB Misoprostol (if needed, no for TOLAC)
   - Click to add OB Epidural
   - Click to add Group B Strep Ppx (PRN, see next pg)
   - Click to add butorphanol 1mg and 2mg (not if on methadone or suboxone/tex or cocaine or heroin)
   - Click to add Zofran
   - Add any appropriate labs like UDS, *Rapid HIV if NPNC or no documented HIV status*, CMP if HTN or coags with fibrinogen if concerned for VB, etc.
4. Write on L&D White Board
5. Put on Kolkin list
6. Write H&P
   - Put at top of H&P the patient's primary Ob provider (do not just look at last note, must examine chart or ask patient – including location of the clinic)
   - Include PNLs
   - Include Leopolds
   - Include BSUS finding of presentation
   - Include appropriate consents (i.e., add D&C if < 24w gestation, or uterine rupture if a TOLAC)
   - Update inappropriate consents (i.e., "*declines"* BTL if she did not consent or delete BTL if she is < 21)

OPTIONS FOR INDUCTION

- Cytotec (cervical ripening)
  - Use if cervix is closed or slightly dilated, FHR is stable, and contractions are spaced out enough
  - Pt must remain in bed for 2 hours after placement for adequate absorption
    - Have them go to the bathroom before placing the Cytotec
  - Cannot use if contractions are more frequent than 3 per 10 minutes
  - Do not use for TOLAC (trial of labor after c-section)

    - Strip note q2h
    - Consider PO Cytotec (recommended by Cochrane review)
        - Increased efficacy and pt does not have to stay in bed
        - More GI side effects
- Foley bulb
    - Use if cervix is even 1cm dilated for mechanical dilation
    - Fill with 40cc saline
        - Different residents have different preferences, but on average, people fill with 40cc
    - When the Foley bulb comes out, pt should dilated about 3-4cm
    - May also use Cook's catheter, fill each balloon with 60cc, may ask OB resident for help if never used before
- Pitocin (aka Oxytocin aka "Pit")
    - PowerChart has 3 different dosing regimens: Cervical ripening, Low Dose, High Dose
    - Typically, when starting Pit, we use the Low Dose protocol (but confirm which one to use before ordering)
        - This starts at 2units and titrates up to 24units based on FHR and contraction pattern
        - The nurse does this titration per protocol
- AROM (artificial rupture of membranes)
    - Do not attempt until head is well applied to reduce risk of cord prolapse
    - Record color of fluid and time of AROM on strip note and OB signout

Recommended regimens for intrapartum antibiotic prophylaxis for prevention of early-onset group B streptococcal (GBS) disease*



ADMITTING PATIENTS FOR C/S

1. Patient Status Order ("admit to inpatient")
2. Do admission reconciliation of actual patient meds
3. Determine what type of C/S is needed (see next page): appropriately notify RNs with type & time C/S called
4. Order "OB Cesarean Section Admission ERAS"
   - Review all orders
   - Add to powerplan any appropriate labs like UDS, *Rapid HIV if NPNC or no documented HIV status*, CMP if HTN or coags with fibrinogen if concerned for VB, etc.
5. Write on L&D White Board
6. Put on Kolkin list
7. Write H&P
   - Put at top of H&P the patient's primary Ob provider (do not just look at last note, must examine chart or ask patient – including location of the clinic)
   - Include PNL if not already in Cerner (i.e., WC, etc.)
   - Include Leopolds
   - Include BSUS finding of presentation
   - Include appropriate consents
   - Update inappropriate consents (i.e., "*declines"* BTL if she did not consent or delete BTL if she is < 21)

Cesarean section classifications

URGENCY	DEFINITION	CATEGORY	TIMELINES	EXAMPLE
Stat	Immediate threat to life of the mother or fetus	1	As fast as safely possible. Better outcomes seen < 20 minutes (ideally delivery in 10 min)	Prolapsed cord, ruptured uterus, terminal bradycardia, maternal cardiac arrest
Urgent	Maternal or fetal compromise likely	2	30 minutes-no data	Category III tracing (except bradycardia)
Timely	Maternal or fetal compromise imminent	3	30 to 75 minutes-no data	Category II tracing with recurrent variables, Breech or transverse presentation with ACD, arrest of decent
As soon as safely possible	Required early delivery	4	No data	Arrest of dilation with Category I tracing
None	Suits the patient and L&D staff	5	N/A	Elective RCS

ADMITTING PATIENTS FOR PPROM < 34W

1. Patient Status Order ("admit to inpatient")
   - If on Mag or Loop, admit to CW obgyn intermediate
2. Do admission reconciliation of actual patient meds
3. Order "OB Premature Rupture of Membranes"
   - Review all orders
   - Click to add "Ob Magnesium Therapy" if < 32w for NP (click to add 6g bolus if normal kidney fx and modify mag drip details to 12h duration)
   - Click to add betamethasone (if already received one dose, modify so 2nd dose as a set time at q24)
   - Click to add PRNs (hydroxyzine, famotidine, promethazine, emollients)
   - **NEVER add Tylenol (or NSAID) to orders**
   - Click to add "Chlamydia" and "Gonorrhea" as well as the appropriate GBS Culture Swab for Lab (*make sure that you swabbed the patient when admit!!*)
   - Add to powerplan any appropriate labs like UDS, *Rapid HIV if NPNC or no documented HIV status*, CMP if HTN or coags with fibrinogen if concerned for VB, etc.
   - Add to powerplan "MFM/OB Ultrasound"
4. Write on L&D White Board
5. Put on HROB Kolkin list and add to HROB Cerner list
6. Write H&P
   - See prior guidelines about primary Ob provider, Leopolds, BSUS, appropriate consents, etc.
   - HPI should be twice the length of a normal HPI for a routine laborer as a general rule for HROB admits
   - Review any records received with patient
7. Call NICU 3-1270 to notify of consult

ADMITTING PATIENTS FOR PTL < 37W

1. Patient Status Order ("admit to inpatient")
   - If on Mag or Loop, admit to CW obgyn intermediate
2. Do admission reconciliation of actual patient meds
3. Order "OB Preterm Labor Admit"
   - Review all orders
   - Click to add "Ob Magnesium Therapy" if < 32w for NP (click to add 6g bolus if normal kidney fx and modify mag drip details to 12h duration)
   - Click to add "OB Group B Strep Prophylaxis" and appropriately choose an abx
   - Click to add betamethasone-for <34 weeks, (if already received one dose, modify so 2nd dose as a set time at q24)
   - Click to add "Chlamydia" and "Gonorrhea" as well as the appropriate GBS Culture Swab for Lab (*make sure that you swabbed the patient when admit!!*)
   - Add to powerplan PRNs for nausea, GERD, etc.
   - Add to powerplan any appropriate labs like UDS, *Rapid HIV if NPNC or no documented HIV status*, CMP if HTN or coags with fibrinogen if concerned for VB, etc.
   - Add to powerplan "MFM/OB Ultrasound"
4. Write on L&D White Board
5. Put on HROB Kolkin list and add to HROB Cerner list

6. Write H&P
   - See prior guidelines about primary Ob provider, Leopolds, BSUS, appropriate consents, etc.
   - HPI should be twice the length of a normal HPI for a routine laborer as a general rule for HROB admits
   - Review any records received with patient
7. Call NICU 3-1270 to notify of consult

ADMITTING PATIENTS FOR SEVERE PRE-ECLAMPSIA < 34W

1. Patient Status Order ("admit to CW obgyn intermediate")
2. Do admission reconciliation of actual patient meds
3. Order "OB Preeclampsia Admission"
   - Review all orders
   - Click to add "Ob Magnesium Therapy" (click to add 6g bolus if normal kidney fx and modify mag drip details to 24h duration)
   - Click to add betamethasone (if already received one dose, modify so 2nd dose as a set time at q24)
   - add to powerplan PRNs for nausea, GERD, etc
   - Click to add 24h UTP and/or urine spot protein labs
   - Click to add "Chlamydia" and "Gonorrhea" as well as the appropriate GBS Culture Swab for Lab (*make sure that you swabbed the patient when admit!!*)
   - Add to powerplan any appropriate labs like UDS, *Rapid HIV if NPNC or no documented HIV status*, or coags with fibrinogen if concerned for VB, etc.
   - Add to powerplan "MFM/OB Ultrasound"
4. Write on L&D White Board
5. Put on HROB Kolkin list and add to HROB Cerner list
6. Write H&P
   - See prior guidelines about primary Ob provider, Leopolds, BSUS, appropriate consents, etc.
   - HPI should be twice the length of a normal HPI for a routine laborer as a general rule for HROB admits
   - Review any records received with patient
7. Call NICU 3-1270 to notify of consult

MAIN OR ETIQUETTE

Before Case

- Assist with draping with warm blankets, putting on seatbelt, and putting on SCDs before Time-Out
- After patient is intubated, assist with:
    - discarding blankets
    - removing foot of bed
    - positioning patient in stirrups as indicated
    - tucking arms as indicated (typically will tuck arms for laparoscopic cases)
- Depending on situation (attending and scrub tech), can assist in prepping the abdomen
- Sterilely drape patient with assistance

After Case

- Make sure someone swept the vagina (as indicated)
- Assist with cleaning the patient of any blood or skin prep residue
- Assist with removing all drapes from the patient
- Assist with re-assembling the bed and carefully removing legs from stirrups as indicated
- Assist with removing stirrups, stirrup latch, and any arm boards from the bed as indicated
- Assist with obtaining 2 warm blankets from the warmer to place on patient
- Assist with placing seatbelt on patient
- Assist with bringing the bed into the room once CRNA oks
- Make sure at least one resident always stays with the patient until the patient is rolled to PACU

DRUGS

OB Meds

- Labor
    - Cytotec 25 mcg PV Q4 hours
    - Cervidil 10 mg PV x 12 hr
    - Terbutaline 0.25 mg SC Q20 min (max 3); can do half dose of 0.125 mg instead to not stop all contractions
    - Cytotec 20 mL PO q1 hr x4
    - Cytotec 200 mcg in 200 mL sterile water
    - Can increase to 40 cc Q1 hr
    - Pitocin per protocol
- HTN
    - Labetalol 100 mg PO BID (first line; initial dose; max dose 2400 mg/day)
    - Procardia XL 30 mg PO Qday
    - Norvasc 5-10 mg PO Qday
    - Hydralazine 10 mg PO TID (not first line therapy)
    - HCTZ 12.5-25 mg PO Qday (not to start during pregnancy, may continue though)
- Severe Range BP
    - Hydralazine 5-10 mg IV Q20 minutes

        - Labetalol 10-20 mv IG Q15 minutes - *Don't use in patients suspected of using cocaine*
        - Procardia 10-20 mg IR Q30 minutes

    - Labor Pain
        - Stadol 1-2 IV Q 3-4 hr (do not use if opioid dependent)
        - Dilaudid 1-2 mg IV Q3-4 hr (if opioid dependent)
    - Preterm Labor
        - Magnesium 6g IV bolus then 2g/hr IV
        - Betamethasone 12mg IM q 24h x 2 doses
        - PCN G 5 million units IVPB then 2.5 million units IVPB q4h
    - PPROM
        - 48h: Ampicillin 2g IV q6hr + Erythromycin 250mg IV q6h THEN
        - 5 days: Amoxicillin 250mg po q 8 + Erythromycin 333mg po q 8h
        - Instead of Erythromycin, can use Azithromycin 500mg IV q24h for 2 days then Azithromycin 250mg PO daily for 5 days
    - Prolonged rupture ($\underline{\geq}$ 18 hours)
        - Ampicillin 2g IV q6
    - Chorioamnionitis
        - Ampicillin 2g IV q6hr
        - Gentamicin 5mg/kg IV q8h (of ideal body weight)
    - Endometritis
        - Clindamycin 900mg IV q 8hr
        - Gentamicin 5mg/kg q8hr
    - Mastitis: Dicloxacillin 500mg po q6h x 10 days
    - C-section prophylaxis
        - Ancef 2-3gm IV (based on weight)
    - PP Hemorrhage
        - Hemabate 0.25mg IM q 15min (max 8) (cannot use in asthma)
        - Methergine 0.2mg IM q 2-4 hr prn (cannot use in HTN)
        - Misoprostol 800-1000 mcg PR
    - Stress Dose Steroids
        - Hydrocortisone 50 mg IV x1 then 25 q8 for 24 then resume home dose or taper
        - Hydrocortisone 100mg IV Q8 in labor and then for 24 hr PP (Williams page 1001)
    - Hyperemesis
        - Vitamin B6 25mg po TID-QID
        - Doxylamine 12.5mg po TID
        - Phenergan 25mg IV/PO/PR q 4-6h prn
        - Reglan 10mg IV/PO q8h prn
        - Robinul 1-2mg po TID prn ptyalism
        - Zofran 4mg PO/IV q 4h prn
    - Constipation
        - Colace 100mg po BID prn
        - Dulcolax 1 PR q6 prn

- **PRN meds**
    - Benadryl 25mg PO/IV q4-6h prn itching
    - Colace 100mg PO BID prn constipation
    - Dulcolax 5mg PO, 1-3 tabs qd prn for constipation; 1 supp PR BID until BM

- Esgic 1-2 tab PO Q6 hr prn HA (will test positive for barbiturates)
- Maalox 30 cc PO Q6 hr prn indigestion
- Mag citrate 300 cc po x1
- Miralax 17 gm PD q day for constipation
- Protonix 40 mg PO QD or BID
- Pepcid 20 mg PO/IV BID prn indigestion
- Simethicone 80-120 mg PO qid prn for distention/ flatulence
- Tylenol 500-1000mg PO Q4-6 hr prn fever, pain (max 4g/day)
- Motrin 600mg PO q8h PRN mild pain
- Vistaril 25mg-50mg PO/IM prn anxiety (can be used for severe itching too)
- Flexeril 10mg PO Q8 prn pain (muscle relaxer)

- **Anemia**
  - Type & Cross _ units (must spell out units) of PRBCs
  - Transfuse _ units (must spell out units) PRBCs each over two hours
  - Premedicate w/ Tylenol 650 mg/1g PO x1 & Benadryl 50 mg PO x1 30 minutes prior to transfusion
  - CBC 4 hours after last unit
- **Anti-emetics**
  - Phenergan 12.5-25 mg IV/PO Q4-6 prn nausea
  - Reglan 5-10 mg IV/PO TID (QAC, QHS)
  - Doxylamine 5mg (Rx) 2 tab PO BID or OTC as Unisom SleepTABS (not SleepGels – which contain benedryl) 25 mg ½ tab PO BID – TID
    AND Pyridoxine 25mg po TID (Diclegis components)
  - Zofran 4 Q4 or 8 mg Q8 IV/PO prn n/v (last line due to possible fetal effects, try to avoid in first trimester)
- **PP Hemorrhage**
  - Methergine 0.2 mg PO TID x 2 day (cannot use in HTN)
  - Hemabate 250 mcg IM x1 (cannot use in Asthma)
  - Cytotec 1000mg PR x1
- **Chlamydia (in asymptomatic patients)**
  - Doxycycline 100 mg PO BID x 7 days (not in pregnant patients!)-this is the preferred method if not pregnant! or
  - Azithromycin 1 g PO x1
  - Abstain from sex for one week after completion of therapy
  - *Perform TOC for GC/Cl in4 weeks if high risk or pregnant patient, otherwise retest at 3 months*
- **Gonorrhea (in asymptomatic patients)**
  - Rocephin 500 mg IM x1
  - Azithromycin 2g PO x1 plus Gentamicin 240mg IM x1 if severe allergy to cephalosporin
  - *Perform TOC for GC/Cl in 4 weeks if high risk or pregnant, otherwise retest at 3 months*
  - Abstain from sex for one week after completion of therapy
- **Trichomoniasis**
  - Flagyl 500 mg BID x 7 days is preferred or
  - Flagyl 2gm PO in a single dose
    - Remind patient NOT to consume EtOH during course of treatment
    - TOC at 4 weeks for pregnant patients, Retest at 3 months otherwise

- **Candida**
  - Diflucan 150mg PO X1 dose
    - Not in pregnancy
    - Caution with multiple doses during pregnancy (Cat D with second dose)
  - Miconazole 2% qhs x 7 days
- **PID**
  - Outpatient treatment: Rocephin 250 mg IM x1 + Doxycycline 100 mg PO q 12 hours x 14 days with or without Flagyl 500 mg BID x 14 days.
  - Inpatient treatment:
    - Mefoxin 2 gm IV q 6 hours + Doxycycline 100 mg PO q 12 hours; Flagyl can be added in certain situations.
    - Gentamycin 3-5mg IV q 24 hours + Clindamycin 900 mg IV q 8h
- **Chorioamnionitis**
  - Ampicillin 2 g IV Q6 hr
  - Gentamicin 1.5 mg/kg IV Q8 hr (of ideal body weight)
- **Endometritis**
  - Clindamycin 900 IV Q8 hr
  - Gentamicin 5 mg/kg IV Q24 hr
  - Plus or minus Ampicillin 2 g IV Q6 hr
- **Hyperemesis:**
  - Vitamin B6 (pyridoxine) 25 mg PO TID
  - Doxylamine 5mg (Rx) 2 tab PO BID-TID or OTC as Unisom SleepTABS (not SleepGels – which contain benedryl) 25 mg ½ tab PO BID – TID
  - Diclegis
  - Zofran 4 mg PO/IV q 4-6 hr scheduled or PRN
  - Phenergan 25 mg IV/PO q 4-6 hr PRN
  - Reglan 10 mg IV/PO q 8 hr scheduled or PRN
  - Robinul 1-2 mg PO TID prn ptyalism
  - Robinul 0.1-0.2 mg IV TID prn ptyalism
  - Multivitamin bag IV daily
- **PPROM**
  - Ampicillin 2 g IV Q6 hr x 48 hr then Amoxicillin 250 mg PO Q8 x 5 days
  - Azithromycin 500 mg IV Q24 x 2 then Azithromycin 250 mg PO Q24 x 5 days
- **Psych**
  - GAD → Buspar 7.5 mg PO BID to start (max 60 mg/day), Category B
  - Anxiety → Vistaril 25-100 mg PO Q6 hr
    - If patient agitated: Vistaril 100 mg IM x 1
  - Insomnia → Benadryl 25-50 mg PO QHS
  - Postpartum Depression → Zoloft 25-50 mg PO Qday
- **Pre-Eclampsia**
  - Magnesium sulfate 6g IV over 30 minutes and then Magnesium sulfate IV @ 2g/hr, and then for 24 hrs after delivery
  - Labetalol IV (call chief) 20-40-60-80-80. Max IV dose is 300 mg per day. PO max is 2400 mg per day
  - Hydralazine IV (call chief) 5-10-10-10. Max dose IV 20 mg/day
  - Procardia IR 10 mg (can use if no IV)
  - If still inc BP's p delivery start:

        - Procardia XL 30 Qday or
        - Labetalol 200 mg BID
- **PTL**
    - Procardia 10 mg PO Q6 hr (not with mag)
    - Celestone 12 mg IM q24 x2
    - PCN G 5 million units IVPB, and then 2.5 million units IVPB Q4 hr
- **Pain**
    - Percocet 5/325 1-2 pills PO Q4-6 hr prn pain
    - Oxycodone 5-10 mg 1-2 tabs PO Q4-6 prn pain
    - Dilaudid 2 mg IV/PO Q3-4 hr pain
    - Stadol 1-2 mg IVPB Q3-4 hr (Do **not** give if the patient is on Methadone or chronic opiates)
    - Toradol 30-60 mg IV Q6 hr (Do not give if renal compromise, concern for bleeding or HTN)
    - Flexeril 5-10mg PO TID prn muscle spasm
- **URI**
    - Mucinex 600 mg PO BID prn cough, congestion
    - Benadryl 25-50 mg PO 4-6 hr prn itching
    - Robitussin 1 tsp PO Q4-6 hr prn cough
- **UTI**
    - Macrobid 100 mg PO BID x 7 days (pregnant) - caution in first trimester and late third trimester due to potential concern for hemolytic anemia
    - Bactrim DS 1 tab PO BID x 3 days (non-preg)
    - Cipro 250 mg PO BID x 3 days (non-pregnant)
    - Pyridium 100-200 mg PO TID prn(orange pee)
    - Urispas 100-200 mg PO TID prn (blue pee)
    - B&O suppository 15-A one per vagina/rectum Q6 prn bladder spasm
- **Pyelonephritis**
    - Outpatient: Ciprofloxacin 500mg po BID x 7days + Levaquin 750mg qday x 5-7 days + Rocephin 1g IV/IM x1 (in ER)
    - Inpatient: Rocephin 1g IV q day + Levaquin 750mg IV q 24h x 5 days
- **BV**
    - Flagyl 500mg PO BID x 7 days or 2g PO x1 (add anti-emetic 2/2 nausea)
    - Clindamycin 300mg PO BID x7d (for first trimester pregnant)
- **Menorrhagia**
    - Premarin 25mg IV q6h if acute
    - Premarin 2.5mg po q6h if improved x7 days then increase to 10mg x 14days
    - Provera 10mg po x5-10 days
    - Depo Provera 150mg IM x1d
- **Amenorrhea**
    - Provera 5-10mg po qday x5-10days (start day 16 or 21 of cycle)
- **Endometriosis**
    - Lupron 3.75mg IM q 1 month x 6 months
    - Lupron 11.25mg IM q 3 months x 6 months
- **Contraception**
    - Depo-Provera 150mg IM q 3 months Disp 1 syringe, refills 3
    - NuvaRing 1 ring PV x3 weeks then off x 1 week
    - OrthoEvra Patch 1 q week x 3 weeks. Apply 1 patch each week. Disp 3 patch, Refill 11
    - Ortho micronor 1 tab PO daily same time. Disp 1 pack. Refills 11 *start 3w post delivery

OBSTETRICS POINTERS

- Use earliest US due date if LMP differs by:
  - ≤8+6 wk More than 5 days
  - 9+0–15+6 More than 7 days
  - 16+0–21+6 More than 10 days
  - 22+0–27+6 More than 14 days
  - ≥28+0 More than 21 days
- BPP Scoring (2 pts for each item)
  - Fetal breathing: 1 episode lasting >30s in 30m
  - Gross body movement: at least 3 body/limb movements in 30m
  - Fetal tone: 1 active extension w/ return to flexion of fetal limbs/trunk in 3m
  - AFI: 1 MVP >2cm x 2cm or AFI >8
- Modified BPP Scoring: + 2 pts for a reactive NST
- U/S – amniotic fluid assessment
  - AFI (Normal = 5-20cm)
    - Oligohydramnios < 5cm
    - Polyhydramnios ≥ 25cm
  - MVP (Normal = 2-8cm)
    - Oligohydramnios = <2cm
    - Polyhydramnios = >8cm
- Dx of early pregnancy failure
  - Mean GS diameter >/= 25 mm and no FHT
  - IUP with CRL ≥7mm and no FHT
  - Intrauterine gestational sac without an embryo with FHT 11 days after a scan showing a gestational sac and yolk sac OR 14 days after a scan showing a gestational sac without a yolk sac
  - *Repeat Beta hCG in 48 hours. Should rise by at least 50%*

SAMPLE NOTES/DICTATION TEMPLATES

Pro-Tip: make each of these an auto-text

OBSTETRICS H&P

Chief Complaint: _____

History of Present Illness: This is a __ yo G_P____ at __ weeks and __ days by (__wk US or LMP) with an EDD of _____ presenting to labor and delivery for _____ (discussion of what brought her in today). Expecting a BG/BB. Would like ___ for pain control. Planning ___ for contraception. Planning to breast/bottle feed. FOB (name, relationship, involvement).

Prenatal Care has been provided by: Dr. _____ at (Institution) since ____ weeks gestational age
Desired Pediatric Care Provider: Dr. _____ at _____

OB Review of Systems:
Contractions: (frequency, duration, intensity, time of onset)
Fetal Movement: (present or absent)
Leakage of fluid: (yes or no, if yes, when)
Vaginal bleeding: (yes or no, if yes, when first noticed)

Prenatal Labs:

Blood Type: (A/B/AB/O)
RH: (Neg/Pos/unknown)
Rubella: (immune/non-immune/unknown)
Treponema Ab: (NR/Pos/unknown)
HBsAg: (NR/reactive/unknown)
HepC Ab: (NR/reactive/unknown)
HIV (1^{st} trimester): (neg/pos/unknown)
HIV (3^{rd} trimester: (neg/pos/unknown)
GC/Chlam (1^{st} trimester): (neg/pos/unknown)
GC/Chlam (3^{rd} trimester): (neg/pos/unknown)
1hour glucola: ____ (fasting) _____ (1h)
GBS: (neg/pos/unknown)

Aneuploidy screening: (FTS/Quad Screen/MSAFP/Cell Free DNA/ Other (explain))

Most Recent Prenatal Ultrasound:
date, fetal position, placental location (anterior/posterior/fundal/low-lying), EFW with percentile
Abnormalities: (hypocoiled cord, uterine senechiae, succenturiate lobe of placenta, etc)

Prenatal Issues:

- List any complications (UTI, preterm labor, gestational DM, HTN/PIH, etc) and what was done for those complications including triage visits and steroid courses (with dates).
- Did the patient receive steroids during the pregnancy? (yes/no)
- If yes: How many courses? (1/2)
- If yes: Dates received: _____

Obstetrical history:
G1: (SVD/C-section) at ___ wga, (male/female) infant weighing _____ grams, analgesic (epidural/other)
Induction? (yes/no) If this was an induction, please list the indication: _____
Complications: (shoulder dystocia/post partum hemorrhage/none/other)

G2: (SVD/C-section) at ___ wga, (male/female) infant weighing _____ grams, analgesic (epidural/other)
Induction? (yes/no) If this was an induction, please list the indication: _____
Complications: (shoulder dystocia/post partum hemorrhage/none/other)

Gynecological history:
Menarche: ____ yo
Menses: (regular/irregular)
Last pap smear: result and date
STI Hx: _____

PMH:
PSH:
FH: (birth defects, CF, twins, DM)
Meds:
Allergies:
SH: (drugs, alcohol, tobacco (# of cigs/day), home situation, social supports)

Physical Exam:
Vital Signs:
General:
CVS:
PULM:
GI:
Leopold's
EFW
GU:
SVE: (1-10) cm/ (0-100%) effaced / (-4 - +4) station/(anterior/mid/posterior)/(soft/medium/firm)
Calculate Bishop score
SSE: _
EFM: baseline _, (absent/minimal/moderate/marked) variability, accels (present/absent), (early/late variable/no) decelerations
TOCO: contractions every _ minutes

Bedside US: (cephalic/breech/transverse/other)

Assessment:

1. This is a __ yo G__P___ @ __ weeks __ days set by LMP/US here with _____ or here for induction of labor for (indication).
2. Fetal heart tones Category (1/2/3) (if 2/3 state why)
3. Bishops score ___ (if induction)
4. Maternal problems/risk factors (listed) (eg. Pre-eclampsia w/o severe features, gDMA1, GBS +, etc)

Plan:

1. Admit to L&D
2. Anticipate SVD
3. Will start induction with (cytotec/AROM/foley bulb/oxytocin)
4. Dr. _____ (OB provider) notified
5. Will get CBC, type and screen
6. Expecting Boy/Girl, planning to breast feed, going to ___for pediatric care, desires circ
7. Contraception choice
8. Pain control in labor plans
9. GBS status and abx
10. Consent for c-section signed
11. Plan for any of the problems listed in the assessment portion
12. Consults planned: (Obstetrics/MFM/NICU/IM/other/none)
13. Discussed with Dr. _____ (OB attending on for the day) and OB team.

INTRAPARTUM "STRIP" NOTE

Can do each as an individual note or one OB inpt progress note that you addend throughout the day (preferred)

S: uncomfortable/comfortable, feeling fetal movements, concerns, nursing updates

O: VS including BP and HR
EFM___ baseline, ___variability, __- accels, ___ decels, Category 1/2/3
Toco: contraction pattern
SVE: dilation/effacement/station/consistency/position
Membrane Status: SROM (at 1800 to clear fluid); AROM (at 1800 to thick meconium)
Pitocin at __ mU/min (when applicable)

A/P: age GP @ GA by LMP/US being induced for _____ (indication); any other active issues, s/p foley bulb, cytotec 25mcg PV x 3 (when applicable)

1. Category of strip
2. Labor – early/active, progressing/needs augmentation
3. Pain – Epidural/Stadol/natural
4. GBS – and if on abx
5. Anticipate SVD
6. Plan of care discussed with patient, RN, and Dr. _____ (FCM OB attending) as well as OB team members (resident, attending)

RECOVERY NOTE – AFTER DELIVERY

S: concerns, pain level, bleeding and amount, breast feeding? bonding?
ROS: CP/SOB/N/V/headache

O: Vitals
Gen
CV/Pulm
Abdomen (include fundus, position, and lochia)
LE (include edema and calf tenderness)

A/P: age GP @ GA by LMP/US s/p SVD/PCS/RCS with/without complications

1) AVSS
2) Pain management
3) Breast/bottle
4) Blood type
5) Vaccinations
6) OK to transfer to floor.

MAG NOTE

S: uncomfortable/comfortable, feeling fetal movements, concerns, nursing updates
ROS: HA/visual changes, RUQ pain, Epigastric pain, nausea/vomiting, CP, SOB

O: VS (list all BPs and HRs since last check)
Gen
CV/Pulm
Abd
Ext
Neuro (reflexes)
I/O: hourly urine output

A/P: age GP @ GA by LMP/US with preeclampsia with/without severe features

1) Continue mag for seizure prophylaxis for 24 hours after delivery

2) Any new signs/symptoms of worsening disease
3) +/- rechecking preeclampsia labs
4) +/- need for medications for blood pressure control
5) Management of other acute issues
6) Otherwise continue routine OB management

DELIVERY NOTE

If you phone dictate, dictate an operative report

Attending provider at delivery:
Assistant:

Pre-Delivery diagnosis: single IUP @ GA, active labor, include any diagnosis to be managed during labor (e.g. preeclampsia w/o severe features, gDMA1, etc)

Post-delivery diagnosis: single IUP @ GA, now delivered live, term AGA BB/BG by spontaneous vaginal delivery/vacuum assisted vaginal delivery, second degree laceration, any other issues encountered during delivery

Anesthesia:
Estimated blood loss:
Complications: laceration, shoulder dystocia, retained placenta, PPH
Placenta delivery: spontaneous vs manual extraction
Post-delivery Condition: stable

Indication: age GP @ GA set by LMP/US, Blood type and PN labs, pregnancy complicated by ___, plus any complications since admission – augmentation, pain control, mag, PET labs

Findings: viable male infant, weight (in grams), APGARS, intact placenta with 3 vessel cord

Operative report: The patient progressed to 10 cm, 100% effaced, and +1 station, pushed over intact perineum (or midline episiotomy) with/without anesthesia to deliver a viable male/female infant with weight and Apgars. Head of neonate restituted to [head positon]. No nuchal cord was present. Body and shoulders delivered without difficulty. Cord was clamped and cut. Neonate was delivered to mother's abdomen and nursing staff. Placenta delivered spontaneously and intact with 3 vessel cord. IV oxytocin was started prior to delivery of placenta and fundal massage was used for hemostasis. The vagina, cervix, placenta and perineum were inspected. A second degree laceration was noted (or labial tear, or whatever lacerations were found). Second degree laceration repaired as noted below (see procedure note template). The vagina was swept. No sponges were left behind. Mother and infant stable in the immediate postpartum period. Drs: __ and __ were present throughout for the delivery (and repair).

******ADDITIONS TO DELIVERY NOTE AS INDICATED:***
Vacuum Assisted Delivery:
Indication: _____ (e.g. maternal exhaustion, non-reassuring fetal heart rate)
Vacuum used: Kiwi, etc
Procedure: Cup was placed at the flexion point of the fetal head at +___ station. Maternal tissue was excluded from the vacuum cup. Vacuum applied during contractions up to ___ mmHg and reduced between. There was/was not advancement in station with each pull.

Number of pulls: ___
Number of involuntary releases: __
Total minutes of application: __

Laceration Repair Notes:
VAGINAL WALL LACERATION: Under appropriate lighting the vaginal walls were carefully inspected and a laceration was identified of the __ vaginal wall, and the length, depth, and apex of the laceration identified. 1% Lidocaine w/o epinephrine was used for local anesthesia. The laceration was closed using ____ (size) Vicryl suture on a ___ needle (CT-1, etc) in a running fashion which provided adequate hemostasis. Once this was accomplished the remainder of the vagina and cervix were carefully visualized with no additional lacerations noted.

FIRST DEGREE: Under appropriate lighting and analgesia the perineum was carefully evaluated and inspected. The extent of the laceration was noted to be a first degree which involved injury to the perineal skin and vaginal epithelium only. The perineal muscles were carefully evaluated and noted to be intact. Using ___ (size) Vicryl suture on a ___ needle, the vaginal mucosal apex was carefully identified, and the suturing was initiated at the apex and in a progressive fashion the vaginal mucosa was reapproximated in a running fashion down to the perineal body. The hymenal ring was then carefully reapproximated and the repair was stopped at that point and the knot was buried in a subcuticular fashion. Excellent hemostasis was achieved.

SECOND DEGREE: After appropriate positioning, lighting and anesthesia, the perineum was carefully evaluated and the degree of injury was noted. The epithelium was disrupted along with the perineal skin. The laceration did extend to the perirectal fascia and into the perineal body. The anal sphincter was carefully inspected and noted to be intact. Beginning at the vaginal apex, using a ___ (size) vicryl suture on a ___ needle the vaginal mucosa was reapproximated to the vaginal opening. The perirectal fascia was reapproximated and closed. The hymenal ring was then reapproximated and the suture was transferred to the external vagina. A crown stitch was then placed in the bulbocavernosus muscle. Disruption in the perineal body or bulbocavernosus muscles was reapproximated using a ___ (size) vicryl suture on a ___ needle in a running fashion. The perineal epithelium was then closed in a subcuticular fashion. Hemostasis was satisfactorily achieved.

THIRD DEGREE: Under appropriate lighting and anesthesia, evaluation of the extent of the episiotomy was accomplished. She was noted to have a third degree laceration which extended down to the fascia and musculature of the perineal body involving the external anal sphincter. The degree of the involvement of the external sphincter is noted to be: ____ of the rectal sphincter. The anal sphincter was then repaired in a progressive, anatomical, and interrupted fashion, first incorporating the internal anal sphincter followed by the external anal sphincter using interrupted sutures of ___ (size) Vicryl on a ___ needle excellent hemostasis was achieved. At this point the vaginal mucosa was then reapproximated using ___ (size) Vicryl suture on a ___ needle beginning at the apex in a running fashion to the hymenal ring. Once this was accomplished the suture was transferred to the external perineum. The repair included the perirectal fascia. A crown stitch was then used to reapproximate bulbocavernosus muscles. The deep and superficial transverse perineal muscles where then reapproximated in a running fashion, and the perineal epithelium was closed in a subcuticular fashion and the knot was buried subcuticularly. The rectum was checked and was intact. Excellent hemostasis was achieved, and further inspection of the vagina showed no additional lacerations.

FOURTH DEGREE: Under appropriate lighting and analgesia the perineum and vagina were carefully evaluated. The extent of the injury and severity of bleeding were carefully evaluated and the patient was noted to have a ruptured anal sphincter complex and rectal mucosa classifying it as a fourth degree laceration. Reconstruction of the torn anal mucosa was then first accomplished by using a running suture of ___ (size) vicryl. A second layer was placed. Once this was accomplished the internal anal sphincter was properly identified and repaired in separate layers, again using a ___ (size) Vicryl on a ___ needle. The external sphincter was then identified by using Allis clamps and reapproximated by using interrupted sutures of ___ (size) vicryl. The repair was done in an end-to-end fashion showing good reapproximation and excellent hemostasis. At this point the bulbocavernosus and transverse perineal muscles were reapproximated using a sutures of ___ (size) vicryl. The vaginal mucosa was then reapproximated, including the perirectal fascia, using a ___ (size) vicryl on a ___ needle in a running fashion to the hymenal ring. Once this was accomplished the suture was then transferred to the external perineal body. The perineal skin was then closed in a subcuticular fashion. Excellent hemostasis was achieved. The anus was checked along with the rectal mucosa for any additional injury and none found.

POSTPARTUM NOTE

S: Concerns/Breastfeeding/belly pain/Bleeding/Bowels/Bladder/Activity/Diet

O: Vitals
General
Breast – for breastfeeding
Heart
Lung
Abd – fundal height, incision if c/section (remove the dressing)
Perineum – if repair
Lower Extremities

I/O: For C-section or on postpartum mag

Labs: postpartum h/h, PET labs if preeclamptic, fasting BG if GDM

A/P: age GP @ GA by LMP/US s/p SVD (complicated by second degree laceration, PPH, etc) PPD (or s/p pLTCS, POD #). Include any other maternal issues.

1) Pain
2) Boy/Girl – plan for circ
3) Feeding – lactation consult?
4) Blood type – Rhogam?
5) PPH – needs iron?
6) Contraception
7) Vaccines
8) Last pap – needs postpartum?
9) Smoking?
10) Social issues? Lack of support (teen, FOB not involved, drug use) – SW consulted, etc
11) Complications/Chronic problems
    a. DM, needs a1c at 6w check
    b. Mood disorder – needs meds now?
    c. HTN – needs meds postpartum?

OB TRIAGE EVALUATION NOTE

Chief Complaint: _

History of Present Illness: This is a __ yo G_P____ at __ weeks and __ days by (X wk US or LMP) with an EDD of _____ presenting to labor and delivery for _____ (discussion of what brought her in today).

Prenatal Care has been provided by: Dr. _____ at (Hope Drive/Camp Hill/Nyes Road/MFM/FCM Elizabethtown/FCM Palmyra/FCM Harrisburg/FCM Nyes/FCM Fishburn/Outside Institution) since ____ weeks gestational age

OB Review of Systems:
Contractions: (frequency, duration, intensity, time of onset)
Fetal Movement: (present or absent)
Leakage of fluid: (yes or no, if yes, when)
Vaginal bleeding: (yes or no, if yes, when first noticed)

Prenatal Labs:

Blood Type: (A/B/AB/O)
RH: (Neg/Pos/unknown)
Rubella: (immune/non-immune/unknown)
Treponema Ab: (NR/Pos/unknown)
HBsAg: (NR/reactive/unknown)
HepC Ab: (NR/reactive/unknown)
HIV (1st trimester): (neg/pos/unknown)
HIV (3rd trimester: (neg/pos/unknown)
GC/Chlam (1st trimester): (neg/pos/unknown)
GC/Chlam (3rd trimester): (neg/pos/unknown)
1hour glucola: ____ (fasting) _____ (1h)
GBS: (neg/pos/unknown)

Aneuploidy screening: (FTS/Quad Screen/MSAFP/Cell Free DNA/ Other (explain))

Most Recent Prenatal Ultrasound:
date, fetal position, placental location (anterior/posterior/fundal/low-lying), EFW with percentile
Abnormalities: (hypocoiled cord, uterine senechiae, succenturiate lobe of placenta, etc)

Prenatal Issues:

- List any complications (UTI, preterm labor, gestational DM, HTN/PIH, etc) and what was done for those complications including triage visits and steroid courses (with dates).
- Did the patient receive steroids during the pregnancy? (yes/no)
- If yes: How many courses? (1/2)
- If yes: Dates received: _____

Obstetrical history:
G1: (SVD/C-section) at ___ wga, (male/female) infant weighing _____ grams, analgesic (epidural/other)

Induction? (yes/no) If this was an inducation please list the indication: _____
Complications: (shoulder dystocia/post partum hemorrhage/none/other)

G2: (SVD/C-section) at ___ wga, (male/female) infant weighing _____ grams, analgesic (epidural/other)
Induction? (yes/no) If this was an inducation please list the indication: _____
Complications: (shoulder dystocia/post partum hemorrhage/none/other)

PMH:
PSH:
FH: (birth defects, CF, twins, DM)
Meds:
Allergies:
SH: (drugs, alcohol, tobacco (# of cigs/day), home situation, social supports)

Physical Exam:
Vitals:
General:
CVS:
PULM:
GI:
Leopold's, EFW
GU:
SVE: (1-10) cm/(0-100)% effaced/(-4 +4) station; Bishop Score
SSE:
TOCO: contraction pattern, frequency of contractions (e.g. q 2-3minutes)
EFM: ___ baseline, ___variability, __accelerations, ___ decelerations (early/late/variable, how long and how deep)
Bedside US:

OB Triage Course:
Labs:
Exams findings:
Etc.

Assessment:
1. This is a __ yo G__P___ @ __ weeks __ days set by LMP/US here with _____
2. Fetal heart tones Category (1/2/3) (if 2/3 state why)
3. Maternal problems/risk factors (listed)

Discharge Plan:
1. Patient is being discharged home in improved condition.
2. Patient is to follow up with her obstetric care provider within1week
3. She is to call her obstetric care provider with any concerning symptoms or signs as described in the patient instructions.
4. She is to resume her outpatient medications
5. Her questions have been answered and concerns addressed and she expressed complete understanding of this.
6. Patient seen with and case discussed in its entirety with Dr. _____ (FCM OB Attending)

CIRCUMCISION NOTE

Reference below but, there is a stamp autotext in powerchart for this already.
Open an operative report note type→ delete everything below the patient demographics→click the stamp icon→Type ci→select circumcision newborn and it will input the auto text*

Surgeon:
Assistant(s):

Informed consent obtained after discussion of risks, benefits, alternatives, and complications.
Anesthesia: 1% xylocaine dorsal penile regional nerve block _ ring block.
Prep: betadine with sterile drapes.
Procedure: circumcision using __cm Gomco clamp.
EBL: minimal.
Complications: none.
Patient tolerated procedure well. Adequate hemostasis achieved.

Procedure:
54150 Circumcision, using clamp or other device; newborn.

HOSPITAL DOOR CODES

- Boardroom: 8636#
- Call Rooms: 1234#
- L&D supply closet: 3-4-2
- Nurse's breakroom: 1160#
- 2nd floor supply room: 4-1-5
- 3rd floor patient supply room: 1-3-5
- 3rd floor supply room: 1350#
- 3rd floor conference room: 1-2-3-4 *
- EC "back door" 5-1-3
- UH ER "back door" 2451*

NOTES