

GENERAL INFORMATION Transport: No Yes Hospital _____ Primary Language: English Spanish Other: _____

Source of pt hx/info: Patient Family Hospital medical record Prenatal record Requests anonymity: Yes No
 Do you want us to notify anyone else of your hospital admission? No Yes (Name, relationship, phone) _____
 Significant Other: (Name/phone) _____ Relationship: Spouse Other (specify) _____
 Interpreter needed: No Yes If yes, for: Pt. Family Ethnicity: Caucasian Hispanic Other (specify) _____
 Baby's father involved? Yes No Plans adoption? No Yes (Social Services) If yes, arrangements made? Yes No
 Surrogate pregnancy: No Yes (SS) If yes, arrangements made? Yes No

ADVANCE DIRECTIVES Advance Directives? Yes No If **NO** Advance Directive: Information Provided
 If **YES**, copy placed on chart? Yes No Date placed in chart: _____ If **not brought in**, plan to obtain: _____

If you **DON'T** have an Advance Directive, who, other than you knows your wishes related to health care? (*surrogate*)
OR
 If you **DO** have an Advance Directive, NOT BROUGHT WITH YOU today, who did you name as your agent/decision maker?
 Name: _____ Relationship: Spouse Other: _____ Home Phone: _____ Alternate Phone: _____

OPTIONAL: Pt's healthcare wishes documented, signed, dated by patient and copy placed on chart: CHECK HERE if completed.

VALUABLES Patient/Family informed of responsibility for belongings left at bedside.

HISTORY: PERINATAL No Prenatal Care Prenatal record placed on chart If prenatal record **NOT** on file, list significant OB history (i.e., macrosomia, forceps/vacuum, precipitous delivery, preterm delivery, postpartum hemorrhage, etc.)

Ht _____ Current wt _____ kg _____ lbs. Prepregnancy wt _____ kg _____ lbs Wt gain: less than 15 lbs greater than 30 lbs.
 LMP _____ EDC: by dates _____ by u/s _____ Gest Age: _____
 Gr _____ Term _____ Preterm _____ SAB _____ TAB _____ Living _____ Stillbirth _____ Multiple Births _____
 Prev infant less than 37 weeks Prev infant less than 2500 gms Prev infant greater than 4000 gms
 Blood type: _____ Unknown Antenatal Rhogam: N/A Yes No Unknown HBsAg: Neg Pos Unknown
 VDRL/RPR: Nonreactive Reactive Unknown Rubella: Immune Nonimmune Unknown
 If prenatal lab results unavailable/not done, drawn on _____ (date)
 HIV: Neg See Chart Not done Offered Declined GBS: Neg Pos Unknown Prenatal tox screen N/A Pos Neg
 Prev C/S: No Yes If yes, plan VBAC: No Yes Current Pregnancy: IVF/Assisted Reproductive Technology No Yes
 Current pregnancy: Singleton Twins Triplets Quads Other _____
 Do you accept blood, blood products and blood fractions? Yes No If no, Refusal signed? Yes No
 Birth plan: No Yes Feeding Plan: Breast Formula Previous Breastfeeding experience: Yes No
 Childbirth Education: Techniques Breastfeeding Newborn Care VBAC Videos/Books Other (specify): _____

ALLERGIES Do you have any allergies or intolerances to ANY medications, foods, tapes, dyes or the environment? No Yes (list below):
 If yes, allergy/latex alert band on

| MEDICATION ALLERGIES | SYMPTOMS/REACTION (e.g. rash, itching, nausea, difficulty breathing, anaphylaxis) |
|----------------------|---|
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| | |
| | |

| OTHER ALLERGIES | SYMPTOMS/REACTION (e.g. rash, itching, nausea, difficulty breathing, anaphylaxis) |
|--|---|
| <input type="checkbox"/> Food: | |
| <input type="checkbox"/> Latex: <input type="checkbox"/> Sensitive <input type="checkbox"/> Allergic | |
| <input type="checkbox"/> Iodine/Contrast | |
| <input type="checkbox"/> Tape | |
| <input type="checkbox"/> Other: | |

Admission Dx _____ Date/Time Admission _____
 Attending OB _____ Pediatrician _____



PATIENT PROFILE (OB)

| MEDICATIONS <input type="checkbox"/> None (Prescription, non-prescription, eye drops, inhalers, nebulizers, vitamins, herbs, nutritional supplements, medication patches or pumps.) | | | | | | | | |
|--|-------|-----------|--|---|-------------------------------------|-------|------|--|
| Medication/Dose | Route | Frequency | Patient's Schedule (Circle Last Dose Taken) | Reason for Taking (Check if brought from home) | Disposition | | | Does anything interfere with your ability to follow health advice or your med schedule? <input type="checkbox"/> No <input type="checkbox"/> Yes |
| | | | | | Home | Pharm | Phys | |
| <input type="checkbox"/> Prenatal Vitamin | PO | Daily | | Pregnancy | <input checked="" type="checkbox"/> | | | |
| <input type="checkbox"/> Iron Sulfate | PO | Daily | | Pregnancy | | | | |
| | | | | | | | | |
| | | | | | | | | |
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| | | | | | | | | |
| | | | | | | | | |
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Important medication experience/administration information/techniques (e.g., crush pills, liquid, in food):
 No Yes

| SUBSTANCE USE (Tobacco, alcohol, caffeine, inhalants, street/recreational drugs, methadone maintenance program) <input type="checkbox"/> Denies | | | | | |
|--|---------------|----------------|---------------|-----------|---|
| SUBSTANCE | HOW MUCH USED | HOW OFTEN USED | HOW LONG USED | LAST USED | INTERVENTION |
| Smoking/Tobacco | | | | | <input type="checkbox"/> Smoking Cessation Referral Initiated (required if pt. smoked w/in last year) <input type="checkbox"/> Smoking Cessation Info Provided (required if pt. smoked w/in last year) Referrals: <input type="checkbox"/> Social Services Referral Initiated <input type="checkbox"/> Other: _____ |
| | | | | | |
| | | | | | |
| | | | | | |

Exposure to Second Hand Smoke in pt's/baby's home? No Yes If yes, education given re: effects of second hand smoke to newborn Yes No

N/A

| | | |
|---|---|--|
| TRANSFUSION HISTORY Previous Blood Transfusion: <input type="checkbox"/> Yes <input type="checkbox"/> No | Previous Reaction: <input type="checkbox"/> Yes <input type="checkbox"/> No | Pre-Medication Requirements <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|---|--|

| HEALTH HISTORY | Current Pregnancy | Past History |
|--|-------------------------------|-------------------------------|
| Reproductive / GYN Problems (e.g., PTL, PPROM, vag bleeding, post partum hemorrhage, incompetent cervix, multiple gestation, placenta previa, abruption, fetal arrhythmia, poly/oligohydramnios, cryo surgery, LEEP, isoimmunization) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Surgeries / Accidents / Injuries / Fractures (e.g., previous C/section, cerclage, other uterine surgery-specify, breast surgery) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Cardiac / Blood Pressure Problem (e.g., chronic hypertension, mild or severe pre-eclampsia, HELLP syndrome, heart disease, MVP, rheumatic fever) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Peripheral Vascular (e.g., phlebitis, varicose veins, DVT) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Respiratory (e.g., asthma, recent cold/cough, pneumonia) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Neurological / Muscular Orthopedic (e.g., seizures, migraines, stroke, developmental disability) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Endocrine (e.g., Diabetes, Gestational A1, A2; Type I, Class B, C, D, R, F, Thyroid disorder) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Ears / Nose / Throat (e.g., Meniere's, sinus infection, nose bleeds) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Immune System or Communicable Diseases (e.g., autoimmune disorders, HIV, HPV, STD, Hepatitis A, B, C) Hx of HSV? <input type="checkbox"/> No <input type="checkbox"/> Yes Last outbreak _____ | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Cancer or Blood Disorders (e.g., Sickle Cell, bleeding disorders) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| GI/GU (e.g., UTI, pyelonephritis, constipation, hemorrhoids, hyperemesis, recent change in bowel pattern) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Skin or Body Piercing (location) (e.g., rash, eczema, shingles, chicken pox) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Genetic / Congenital Abnormalities? (herself, fetal anomalies past or current pregnancies or with the patient's parents/siblings) | <input type="checkbox"/> None | <input type="checkbox"/> None |
| Mental Health (e.g., post partum blues / depression, anxiety disorder, eating disorder) | <input type="checkbox"/> None | <input type="checkbox"/> None |

HEALTH HISTORY (cont)

Previous anesthesia or sedation problems?

 Yes No

Family members with anesthesia or sedation problems?

 Yes No

Previous hospitalization (other than childbirth)

 Yes No**COGNITIVE AND PERCEPTUAL**Sensory deficits: No Yes If yes, **check** if used and **circle** if brought to hospital: Glasses Contacts Hearing AidProblems reading (comprehension / literacy): No Yes _____Preferred learning style: No Preference Reading Explanation Visual (video, photos, etc) Demo Other _____Highest grade level completed: High School Some college College or advanced degree Other _____ Special needs (i.e., dyslexia) _____**Pain:**Choice of pain control for labor: Epidural Breathing Medication Music Massage Other _____Do you have chronic (or non-labor) pain? No Yes If yes: Location _____ Intensity _____ 10, Duration _____

Description: _____

What makes the pain better or worse? _____ For chronic/non-labor pain only: _____ /10 Acceptable Comfort Level

ACTIVITY / EXERCISE / SELF-CAREHave problems related to this pregnancy required you to be on bedrest in the past month? No YesAre you physically able to walk to the bathroom and perform self care and/or baby care activities independently? Yes No (PT, Rehab) If no, describe assistance needed _____ Assistive devices used: (check if used, circle if brought to hospital) None W/C Walker Other _____Living with: Spouse Significant other Children Alone Parents Other dependents _____

Who is available to assist you at home? _____

Do you have supplies available for baby care? Yes No (SS) Do you have a car seat? Yes NoCommunity services used recently/anticipated: None Yes (SS) MediCal PHN WIC Transportation Other _____Concerns: Denies Yes (SS) Insurance Food Medications Equipment Other _____**NUTRITION / METABOLIC**Special Diet? No Yes: _____ Any removable dental work? No Yes _____ Currently in place**Nutritional Risk Screen:** Initiate Nutrition referral if any item selected: None indicated

Current diagnosis of:

 Hyperemesis Diabetes Preeclampsia Pica Multiple gestation

Currently:

 Inadequate intake (less than 75%) greater than 3 days Anticipate/actual clear liquids/NPO greater than 5 days prior/post admit Inadequate weight gain (less than 15 pounds) Unintentional weight loss of greater than 5 lbs in last month Maternal age less than 18**HEALTH PERCEPTION / HEALTH MANAGEMENT**Does anything interfere with your ability to follow the advice from your health care providers (finances, support, etc.)? No Yes**SLEEP / RELAXATION**

What equipment / aids / routines help you sleep / relax?

ROLE RELATIONSHIPS**ASK PRIVATELY (NEXT 2 QUESTIONS)**Do you have any issues of physical, emotional, sexual, or financial abuse that you would like to discuss with someone? No Yes (Social Services)Do you feel unsafe going back to the place you are living? No Yes (Social Services)**SELF PERCEPTION / SELF-CONCEPT**Have you felt depressed during this pregnancy? No Yes (Social Services)Do you have a history of anxiety, depression, postpartum blues or postpartum depression? No Yes (Social Services)Do your parents or siblings, have a history of anxiety, depression, or postpartum depression? No Yes**COPING - STRESS TOLERANCE**Have you had a major change/significant loss/stressor in your life (e.g., marital, death, birth, job change, etc)? No Yes _____**VALUES / BELIEFS / SPIRITUAL CARE**How can we help you carry out your religious, spiritual, or cultural practices while you are here? None stated _____Is there anything else we need to know to help us better care for you? None stated _____

DISCHARGE DISPOSITION

Home/No Needs Home/Needs Home with _____
 Facility Placement to: _____ Patient/Family/LRP agrees with discharge plan

INTERDISCIPLINARY DISCHARGE SUMMARY: patient's status, teaching and comprehension (meds, treatments, equipment, diet, activity)

Problems (resolved, unresolved-action)

- See Education / Outcome Record for discharge summary related to education
- Copy of Discharge Instructions given to patient
- Valuables returned to patient / family (N/A Valuables not relinquished by patient)

Discharge Date/Time: _____ Accompanied by: _____ Means of Travel: _____ Initials: _____

Discharge Planning options and process discussed with _____
 Name/Relationship _____ Phone _____

| Needs | | Resource Assessment and Referrals | Referral Complete | |
|-------|----------|--|-------------------|----------|
| Date | Initials | | Date | Initials |
| | | Health Insurance: | | |
| | | Financial Assistance: | | |
| | | Shelter: | | |
| | | Transportation: | | |
| | | Support Groups: | | |
| | | Other: | | |
| | | Other: | | |
| | | Discharge Assessment and Referrals | | |
| | | No Discharge Planning Needs | | |
| | | Reassessment Indicates Discharge Planning Needs | | |
| | | Supplies Vendor: _____ | | |
| | | <input type="checkbox"/> Diabetic <input type="checkbox"/> Wound | | |
| | | <input type="checkbox"/> Parenteral <input type="checkbox"/> Urinary | | |
| | | <input type="checkbox"/> _____ | | |
| | | <input type="checkbox"/> Dialysis Facility: | | |
| | | <input type="checkbox"/> Ability to Pay Clinic | | |
| | | <input type="checkbox"/> DME Vendor: _____ | | |
| | | <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> Walker <input type="checkbox"/> Wheelchair | | |
| | | <input type="checkbox"/> Oxygen <input type="checkbox"/> Nebulizer | | |
| | | <input type="checkbox"/> _____ | | |
| | | Non-Medical <input type="checkbox"/> _____ | | |
| | | Placement <input type="checkbox"/> Shelter <input type="checkbox"/> Board and Care | | |
| | | Interfacility <input type="checkbox"/> Refer to Interfacility Transfer Form <input type="checkbox"/> Chart Copy Requested | | |
| | | Transfer <input type="checkbox"/> Psychiatric Facility <input type="checkbox"/> _____ | | |
| | | Home Health <input type="checkbox"/> LBMMC <input type="checkbox"/> _____ | | |
| | | <input type="checkbox"/> RN <input type="checkbox"/> OT <input type="checkbox"/> PT <input type="checkbox"/> SW <input type="checkbox"/> Aid <input type="checkbox"/> Postpartum | | |
| | | <input type="checkbox"/> Parenteral Tx: _____ | | |
| | | <input type="checkbox"/> Wound Care <input type="checkbox"/> _____ | | |
| | | Outpatient <input type="checkbox"/> Sweet Success <input type="checkbox"/> Ambulatory Infusion Center | | |
| | | <input type="checkbox"/> _____ | | |

