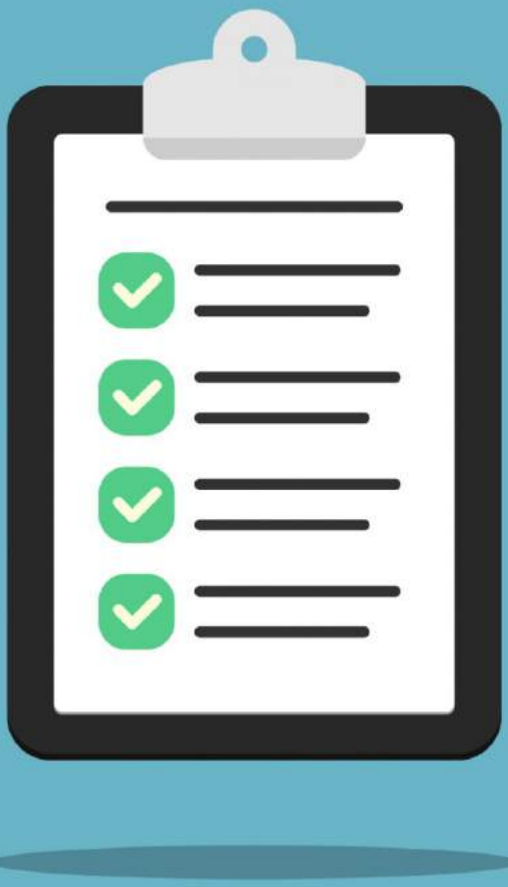
FOGSI - UNICEF PCA PARTNERSHIP

PROTOCOLS IN OB-GYN



Editors

Dr Alpesh Gandhi | Dr Prakash Mehta | Dr Girija Wagh

FOGSI - UNICEF PCA PARTNERSHIP

PROTOCOLS IN OB-GYN

EDITORS:

Dr Alpesh Gandhi
Dr Prakash Mehta
Dr Girija Wagh

PROTOCOLS IN OB-GYN - INDEX

TEAM

President: Dr. Alpesh Gandhi

Coordinators: Dr. Girija Wagh & Dr. Prakash Mehta

CONTRIBUTORS

Dr Abha Singh
Dr Abharani Sinha
Dr Aditi Nadkarni
Dr Alka Pandey
Dr Alka Sehgal
Dr Alka Sethi
Dr Alok Sharma
Dr Alpana Agrawal
Dr Ambegai Meena
Dr Anahita Chauhan
Dr Andaleep Agarwal
Dr Aniket Kakade
Dr Anil Bendre
Dr Anu Vij
Dr Anjali Siddesh
Dr Anju Soni
Dr Anu Joseph
Dr Aparna Setia
Dr Archana Verma
Dr Aruna Kumari
Dr Asha Jain
Dr Asha Rathod
Dr Ashish Mehta
Dr Ashok Kumar
Dr Ashwin Vacchani
Dr Asish Gokhale
Dr B. S. Jodha
Dr Basab Mukherjee
Dr Bhagyalaxmi Nayak
Dr Bharati Mishra
Dr Chandrakant Sanklecha
Dr Charmila
Dr Chaitra Satyanarayana
Dr Chitra T V
Dr Deepak Lawande
Dr Dipesh Dholakia
Dr Dilip Dutta
Dr Dolly Mehra
Dr Durga Sankar Das
Dr Farheen Khateeb
Dr Gaddappa Shrinivas
Dr Garima Kachawa
Dr Gayatri Rathod
Dr Geetha Balsarkar
Dr Girish Mane
Dr Gorakh Mandrupkar
Dr Hafizur Gangtok
Dr Hara Pattanaik
Dr Harini Shetty
Dr Hemant Deshpande
Dr Hemavathy Srinivasan
Dr Hina Popat
Dr Hitesh Zinzala
Dr Indrani Roy
Dr Indrani Roy
Dr Indranil Dutta
Dr Jayam Kannan
Dr Jeyarani Kamaraj
Dr JP Rath
Dr Jyoti Bindal
Dr Jyoti Jaiswal
Dr Jyothika Desai
Dr Jyotsana Suri
Dr Kalyan Barmade
Dr Kanchan Sortey
Dr Kartik Bhagat
Dr Kasturi Donimath
Dr Kavita Singh
Dr Komal Chavan
Dr Krishna Kumari
Dr Kuchalambika M
Dr Kundan Ingle
Dr Lila Vyas
Dr Madhubala Chauhan
Dr Mala Arora
Dr Mandakini Pradhan
Dr Manish Machave
Dr Manish Pandya
Dr Manisha Jhaveri
Dr Manju Puri
Dr Mary Ann
Dr Md Azam
Dr Meena Jain
Dr Meena Samanth
Dr Meenakshi Patel
Dr Meenu Agarwal
Dr Monika Gupta
Dr Mukesh Gupta
Dr Mukesh Rathi
Dr Nalini Anand
Dr Nalini Bagul
Dr Nanda Magai
Dr Narendra Gajjar
Dr Neelam Mishra
Dr Neena Gideon
Dr Neeta Thakre
Dr Nilesh Balkawade
Dr Niraj Jadav
Dr Padmaja
Dr Pragya Mishra
Dr Prarthana Shah
Dr Priti Kumar
Dr Promila Malik
Dr Ragini G
Dr Rajat Mohanti
Dr Rajendra Singh Pardesi
Dr Rajesh Darade
Dr Rajesh Mahtre
Dr Rakhi Singh
Dr Reena Srivastav
Dr Reena Wani
Dr Reeti Mehra Dutta
Dr Ritu Joshi
Dr Rushabh Dalvi
Dr Revathi Rajan
Dr Sandhya Saharan
Dr Sangita Palsania
Dr Sarita Agrawal
Dr Sasmita Dash
Dr Saswati Sanyal Choudhari
Dr Saurabh Dani
Dr Savita Kamble
Dr Sebanti Goswami
Dr Shahanaz Taing
Dr Shaswat Jani
Dr Sheela Mane
Dr Shobhana Patted
Dr Sivani
Dr Sneha Bhuyar
Dr Srividhya
Dr Sucharita Kosaraju
Dr Sucheta Kinjawadekar
Dr Suchitra Pandit
Dr Sudha TR
Dr Sujata Bhat
Dr Sujata Dalvi
Dr Sujata Sharma
Dr Sunita Patil
Dr Sunitha Mahesh
Dr Susheela rani B.S.
Dr Sushma Sharma
Dr Suyagna Joshi
Dr Suyoga Deshpande
Dr T. K. Shaanthy Guna Singh
Dr Tarakeshwari
Dr Thejavathy GV
Dr Uday Thanawala
Dr Uma Pandey
Dr Uma Ram
Dr Uma Wankhede
Dr Usha Rani
Dr Vaishali Chavan
Dr Varsha Baste
Dr Vatsala Dadhwal
Dr Vidya Prabhakar
Dr Vidya Thobbi
Dr Vijay Kansara
Dr Vijayalakshmi Gnanasekaran
Dr Virendra Kumar
Dr VP Paily
Dr Yogini Rolekar

CO ADMINISTRATOR

Dr Aparna Setia, Dr Kuchalambika M, Dr Midhuna Vinesh , Dr Ragini G, Dr Rushabh Dalvi

PRE-PREGNANCY COUNSELLING

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

HISTORY OF:

Infertility	☐ Yes ☐ No	If yes, treatment taken (ART)	☐ Yes ☐ No
Bad obstetric history:	☐ Yes ☐ No		
a) Abortions - spontaneous or induced b) Preterm delivery	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	d)Still births e) Previous Anomalous baby f) Previous neonatal death	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
c)IUD		g)Others	
Hypertensive disorders in previous pregnancy	☐ Yes ☐ No	GDM in previous pregnancy	☐ Yes ☐ No
Previous LBW/FGR/Large baby	☐ Yes ☐ No	Multiple pregnancy	☐ Yes ☐ No
Classical Cesarean delivery/ Uterine surgery	☐ Yes ☐ No	Interpregnancy interval (<18months or > 5 years)	☐ Yes ☐ No
Maternal SGA	☐ Yes ☐ No	Paternal SGA	☐ Yes ☐ No

Past menstrual history (Cycle duration, length ,regularity, amount of bleeding, associated dysmenorrhea) noted			☐ Yes ☐ No
Anti D received (if Rh negative blood group and partner Rh positive)			☐ Yes ☐ No
Medical history noted:	☐ Yes ☐ No		
1. Hypertension	☐ Yes ☐ No	9. Infections(Hep B, Hep C, Chickenpox, TB, HIV, Syphilis, Other STDs)	☐ Yes ☐ No
2. DM	☐ Yes ☐ No		
3. Thyroid disorders	☐ Yes ☐ No		
4. Heart disease	☐ Yes ☐ No	10. Psychiatric illness	☐ Yes ☐ No
5. Respiratory disease	☐ Yes ☐ No	11. Epilepsy	☐ Yes ☐ No
6. Renal disorder	☐ Yes ☐ No	12. Autoimmune	☐ Yes ☐ No
7. Anemia	☐ Yes ☐ No	disorders	☐ Yes ☐ No
8. Other hematological disorders	☐ Yes ☐ No	13. Thrombosis	☐ Yes ☐ No
		14. If any other (PCOS, Obesity, Dental problems, Cancer)	☐ Yes ☐ No
Surgical history (Abdominal surgery, Caesarean section, Bariatric surgery, Cardiac surgery, salpingectomy, ovarian cystectomy,D&C) noted:			☐ Yes ☐ No
Family history noted:	☐ Yes ☐ No		
a)Genetic disorders	☐ Yes ☐ No	d)Cancers	☐ Yes ☐ No
b)Birth defects	☐ Yes ☐ No	e)Development delay / mental subnormality	☐ Yes ☐ No
c)Haemoglobinopathies	☐ Yes ☐ No	f)Others	☐ Yes ☐ No

Medication History(*Annexure 1) noted:			☐ Yes ☐ No
Immunization history noted: ☐ Yes ☐ No			
a)TT/Tdap	☐ Yes ☐ No	d)Varicella	☐ Yes ☐ No
b)MMR/Rubella	☐ Yes ☐ No	e) Covid vaccine	☐ Yes ☐ No
c)Hepatitis B	☐ Yes ☐ No	f) Others(HPV, Influenza)	☐ Yes ☐ No
Occupational history noted: ☐ Yes ☐ No			
Type of work discussed	☐ Yes ☐ No	Exposure to teratogens / environmental toxins	☐ Yes ☐ No
Personal history noted:	☐ Yes ☐ No		
Substance use	☐ Yes ☐ No		
Alcohol	☐ Yes ☐ No	Travel History	☐ Yes ☐ No
Smoking	☐ Yes ☐ No		
Dietary history taken	☐ Yes ☐ No	History of any specific dietary intake (keto	☐ Yes ☐ No

Eating disorders	☐ Yes ☐ No	diet, fat diet) noted History of exercise taken	☐ Yes ☐ No
Excessive weight gain	☐ Yes ☐ No	Excessive weight loss	☐ Yes ☐ No
Blood transfusion	☐ Yes ☐ No	Contraceptive use	☐ Yes ☐ No
Radiotherapy	☐ Yes ☐ No	Domestic violence	☐ Yes ☐ No
		Social support	☐ Yes ☐ No
Sexual history noted:	☐ Yes ☐ No		

PARTNER HISTORY:

Occupational history noted	☐ Yes ☐ No	Work related stress present	☐ Yes ☐ No
Past medical history noted	: ☐ Yes ☐ No		
a) Chronic medical disorders (Hypertension, DM,Thyroid disorders, Hematological disorders,Autoimmune disorders)	☐ Yes ☐ No	b) Obesity c) Mumps d) Sexually transmitted diseases (HIV,Hep B, Syphilis) e) Any others	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Past surgical history noted	☐ Yes ☐ No		
Personal history noted:	☐ Yes ☐ No		
Substance use Alcohol	☐ Yes ☐ No ☐ Yes ☐ No	Smoking Any Medications	☐ Yes ☐ No ☐ Yes ☐ No
Sexual history noted:	☐ Yes ☐ No		

Vitals noted:	☐ Yes ☐ No
General physical examination including bilateral breast examination done:	☐ Yes ☐ No
Systemic examination (Orodental hygiene, CVS, RS, PA, CNS) done:	☐ Yes ☐ No
Local examination (PS, PV, Cervical cancer screening) done:	☐ Yes ☐ No

COVID vaccination(to be administered after discussion with obstetrician and counselling)	☐ Yes ☐ No

MANAGEMENT:

INVESTIGATIONS			
HBsAg	☐ Yes ☐ No	HIV	☐ Yes ☐ No
VDRL	☐ Yes ☐ No	Anti HCV	☐ Yes ☐ No
TSH	☐ Yes ☐ No	FBS/RBS/HbA1c	☐ Yes ☐ No
Others as per history	(*Annexure 2)	done	☐ Yes ☐ No
Partner's blood group and Rh typing	☐ Yes ☐ No	Partner's serology (HIV, VDRL, HBsAg)	☐ Yes ☐ No

High risk factors present If yes, mention:	☐ Yes ☐ No		
Life style modification(diet and exercise, supplements)	☐ Yes ☐ No	Fertile period explained	☐ Yes ☐ No
Advised Vaccination	☐ Yes ☐ No	Start on folic acid(if wanted pregnancy in next 3 months)	☐ Yes ☐ No
Correct anemia	☐ Yes ☐ No	Educate on handwashing and hygiene	☐ Yes ☐ No
If any specific disease, managed as per the condition	☐ Yes ☐ No	Optimize drug use	☐ Yes ☐ No
		Refer for genetic counselling (if required)	☐ Yes ☐ No

Date

Signature

Name:

ANNEXURE 1 (Medication History if present)

a) ACE inhibitors	h) Warfarin
b) ARB	i) Heparin
c) Androgens	I) Antibiotics
d) Antidepressants	j) Herbal/Native medicines
e) Antiepileptics	k) OTC Drugs
f) Immunosuppressants	i) Any others
g) Vitamin A/retinoids	

ANNEXURE 2 (Investigations if required)

a) CBC	g) APLA /ANA profile
b) LFT	h) Fundoscopy
c) RFT	I) ECG/Echocardiography
d) Urine	j) USG abdomen and pelvis
e) Hormonal workup (FSH, LH, AMH) electrophoresis/HPLC Hb	k) 3D USG for uterine anomaly
f) Immunosuppressants	l)Husband's semen analysis

VACCINATION IN PREGNANCY

PATIENT PROFILE

Patient name:	History of allergy:
Blood group:	Date of admission:
Age:	Husband's name:
Date of Birth:	Contact number
Registration number:	Weight:
ID proof:	Obstetrics Score: G P L A
Height:	Expected date of delivery:
Last menstrual period:	Corrected expected date of delivery:
Period of gestation:	Nurse's name:
Doctor's name:	Booked/ Unbooked:

PRECONCEPTION

Influenza vaccine if taken	☐ Yes ☐ No
Hepatitis B vaccination taken If not, advised	☐ Yes ☐ No
Rubella vaccination taken If not taken, advised to avoid during pregnancy	☐ Yes ☐ No
History of chicken pox If yes, date documented If no, advised vaccination	☐ Yes ☐ No
COVID vaccination(to be administered after discussion with obstetrician and counselling)	☐ Yes ☐ No

DURING PREGNANCY

Tetanus immunization within 2 year	☐ Yes ☐ No
TD / TT 1ST dose given early in pregnancy TD / TT 2ND dose given 4 weeks after 1ST dose	☐ Yes ☐ No
Alternative.... Tdap taken at 28- 32 weeks	☐ Yes ☐ No
Influenza Vaccine	☐ Yes ☐ No

Hepatitis B vaccine	☐ Yes ☐ No
Contraindicated vaccines (MMR, varicella, BCG, polio) avoided and counselled	☐ Yes ☐ No
Vaccination Counseling of Partner/Family Members	☐ Yes ☐ No
Vaccination while travelling during pregnancy (As per local guidelines)	☐ Yes ☐ No
Special Circumstances requiring Vaccination a. Rabies Vaccination b. Menigococcal Vaccination c. Typhoid Vaccination d. Any Other Vaccination Name :	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

POST NATAL PERIOD

Rubella vaccine (if susceptible)	☐ Yes ☐ No
Varicella vaccine (if susceptible)	☐ Yes ☐ No
Any other vaccine advised if required	☐ Yes ☐ No

Date

Signature

Name:

ANEMIA IN PREGNANCY

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

HISTORY

Anemia	☐ Yes ☐ No	Anemia in previous pregnancies	☐ Yes ☐ No
AUB/ puberty menorrhagia	☐ Yes ☐ No	IUGR/ SGA/ genetic anomalies in prev babies	☐ Yes ☐ No
Inadequate diet/ poor nutrition	☐ Yes ☐ No	HDP in previous pregnancies	☐ Yes ☐ No
Eating disorders/ Fad diet/dyspepsia/ APD	☐ Yes ☐ No	Hemorrhage-APH/PPH in previous pregnancies	☐ Yes ☐ No
Poor weight gain	☐ Yes ☐ No	Malaria	☐ Yes ☐ No
Chronic illness	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cooking in iron utensils Raw vet, fruits,sprouts intake	☐ Yes ☐ No	Previous blood transfusions/ iron therapy	☐ Yes ☐ No

Contraceptive usage	☐ Yes ☐ No	Transfusion reactions	☐ Yes ☐ No
Short interpregnany intervals	☐ Yes ☐ No	Bleeding diathesis	☐ Yes ☐ No
Tingling and numbness	☐ Yes ☐ No	Hereditary blood disorders in family	☐ Yes ☐ No
CURRENT PREGNANCY			
Bleeding- any trimester	☐ Yes ☐ No	Malaria	☐ Yes ☐ No
Iron Folate, B complex intake	☐ Yes ☐ No	Symptoms of COVID	☐ Yes ☐ No
Albendazole taken	☐ Yes ☐ No	Recurrent UTI/ infections	☐ Yes ☐ No
Any Iron injections taken	☐ Yes ☐ No	Worm infestation	☐ Yes ☐ No
Yellowish urine	☐ Yes ☐ No	High BP records/ HDP	☐ Yes ☐ No
Detailed diet history	☐ Yes ☐ No		☐ Yes ☐ No

HISTORY

Breathlessness	☐ Yes ☐ No	Bleeding from any sites	☐ Yes ☐ No
Palpitations	☐ Yes ☐ No	Pica	☐ Yes ☐ No
Easy fatiguability	☐ Yes ☐ No	Reduced fetal movements	☐ Yes ☐ No
Lower limbedema	☐ Yes ☐ No	Bleeding PR	☐ Yes ☐ No
Generalized edema	☐ Yes ☐ No	Bleeding PV	☐ Yes ☐ No

EXAMINATION

General Physical Examination documented			☐ Yes ☐ No
Conscious and oriented			☐ Yes ☐ No
Pallor noted (conjunctiva/nails/tongue/palm)			☐ Yes ☐ No
Icterus	☐ Yes ☐ No	Raised JVP	☐ Yes ☐ No
Angular stomatitis	☐ Yes ☐ No	Bald/ glossy tongue	☐ Yes ☐ No
Glossitis	☐ Yes ☐ No	Gingival hyperplasia	☐ Yes ☐ No

Clubbing	☐ Yes ☐ No	Cyanosis	☐ Yes ☐ No
Koilonychia	☐ Yes ☐ No	Petechiae/ purpura	☐ Yes ☐ No
Lymphadenopathy	☐ Yes ☐ No	Pedal edema	☐ Yes ☐ No
Vitals documented			
Pulse & Oxygen Saturation	☐ Yes ☐ No	Temp	☐ Yes ☐ No
Blood pressure	☐ Yes ☐ No	Respiratory rate	☐ Yes ☐ No

Systemic Examination			
RS examination done Any basal crepitations/ added sounds	☐ Yes ☐ No	PA-Uterine height Contractions Tenderness FHS	☐ Yes ☐ No
CVS examination done Cardiac / flow murmurs	☐ Yes ☐ No	Per Speculum done	☐ Yes ☐ No
CNS examination done	☐ Yes ☐ No	PV exam (if applicable)	☐ Yes ☐ No
Hepatomegaly Splenomegaly	☐ Yes ☐ No	Any other significant finding	☐ Yes ☐ No

INVESTIGATIONS (as per need and availability)

CBC/HB & PCV Platelet count Peripheral Smear	☐Yes ☐No ☐Yes ☐No ☐Yes ☐No	Urine routine Stool- ova, cysts	☐Yes ☐No ☐Yes ☐No
Blood group Rh typing Cross matching	☐Yes ☐No	RBC indices- MCV/ MCH/MCHC/RDW	☐Yes ☐No
Unresponsive Anemia	☐Yes ☐No		
Serum Ferritin	☐Yes ☐No	Mentzer index	☐Yes ☐No

sent prior to parenteral iron	☐ Yes ☐ No	(MCV/RBC count)	☐ Yes ☐ No
sTFR	☐ Yes ☐ No	ICT	☐ Yes ☐ No
TIBC	☐ Yes ☐ No	LFT/ RFT	☐ Yes ☐ No
Reticulocyte count	☐ Yes ☐ No	PT/APTT/INR, BT/CT	☐ Yes ☐ No
B12/Folic acid	☐ Yes ☐ No	Urine C&S	☐ Yes ☐ No
Hb Electrophoresis(esp if MCV<80, MCH<27)	☐ Yes ☐ No	Bone marrow examination	☐ Yes ☐ No

MANAGEMENT

Provisional Diagnosis Documented	☐ Yes ☐ No
Counseling of Patient / attenders	☐ Yes ☐ No
Stabilisation (ABC)	☐ Yes ☐ No
Admission	☐ Yes ☐ No
Patient referred to higher center if needed (follow referral checklist)	☐ Yes ☐ No
Type of Anemia documented Severity of Anemia documented	☐ Yes ☐ No

ANTEPARTUM

High risk consent (PPH, blood transfusion)	☐ Yes ☐ No
Arrangement of Blood/blood products done	☐ Yes ☐ No
PRBC / products transfusion given(as per transfusion checklist) Any transfusion reactions noted Details documented	☐ Yes ☐ No

Maternal monitoring	☐ Yes ☐ No
Fetal monitoring	☐ Yes ☐ No
Oral iron given Any side effects noted	☐ Yes ☐ No
Parenteral Iron given Details of preparation/ complications/ reactions noted	☐ Yes ☐ No
Dietary advice given at each antenatal visit	☐ Yes ☐ No
Albendazole given	☐ Yes ☐ No
B complex given	☐ Yes ☐ No
Steroid prophylaxis(if PTL)	☐ Yes ☐ No
Multidisciplinary team involved	☐ Yes ☐ No

INTRAPARTUM

Plan of Delivery documented	☐ Yes ☐ No
Mode of Delivery documented	☐ Yes ☐ No
Oxygen arranged	☐ Yes ☐ No
Blood / Products arranged	☐ Yes ☐ No
Antibiotics given	☐ Yes ☐ No
Propped up position	☐ Yes ☐ No
Intermittent chest auscultation	☐ Yes ☐ No
Input output charting (prevent fluid overload)	☐ Yes ☐ No

Intrapartum CTG monitoring/fetal monitoring	☐ Yes ☐ No
Cut short second stage of labour	☐ Yes ☐ No
Active management of third stage of labour	☐ Yes ☐ No
PPH preparedness	☐ Yes ☐ No
Baby details documented	☐ Yes ☐ No

POST NATAL

Vital monitoring done	☐ Yes ☐ No
PPH occurrence (if any)documented	☐ Yes ☐ No
Uterine contraction and retraction noted	☐ Yes ☐ No
Lactation established	☐ Yes ☐ No
Hemoglobin of mother and baby noted	☐ Yes ☐ No
Assessment of anemia & treatment done accordingly	☐ Yes ☐ No
No of Blood and Blood products transfused documented	☐ Yes ☐ No
Antibiotics given	☐ Yes ☐ No
Counseled about need for iron and folate post natally	☐ Yes ☐ No
Counseled about Exclusive Breast feeding	☐ Yes ☐ No
Counseled about pregnancy spacing and contraception	☐ Yes ☐ No
Dietary advice given	☐ Yes ☐ No

Date

Signature

Name:

PRETERM LABOUR

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

HISTORY:

Previous pregnancy

Multiple gestation	☐ Yes	☐ No
Pre term labor	☐ Yes	☐ No
PPROM	☐ Yes	☐ No
Recurrent vaginal infections	☐ Yes	☐ No
Recurrent UTI in pregnancy	☐ Yes	☐ No
Anemia	☐ Yes	☐ No
TB / STD's/ PID	☐ Yes	☐ No
Diabetes mellitus/ Hypertension	☐ Yes	☐ No
Uterine anomaly	☐ Yes	☐ No
Short cervix	☐ Yes	☐ No
Cervical stitch/ surgeries/ tears	☐ Yes	☐ No
Difficult labor/ Traumatic PPH	☐ Yes	☐ No
Bowel & bladder disturbances	☐ Yes	☐ No
Previous pelvic surgeries	☐ Yes	☐ No
Overweight or underweight before pregnancy	☐ Yes	☐ No
Smoking, alcohol or other drug abuse	☐ Yes	☐ No
Any other previous significant history	☐ Yes	☐ No

Current pregnancy

Multiple gestation	☐ Yes	☐ No
Artificial reproductive therapy	☐ Yes	☐ No
Fetal anomalies/ Intra uterine death	☐ Yes	☐ No
USG suggestive of short cervix H/O Cervical stitch Treatment received for prevention of preterm labor	☐ Yes	☐ No
Extremes of age	☐ Yes	☐ No
Overweight (BMI>23) or Underweight (BMI<18) before pregnancy	☐ Yes	☐ No
Short inter pregnancy interval (<12months)	☐ Yes	☐ No
History of bleeding per vaginum in 1st or 2nd trimester	☐ Yes	☐ No
Polyhydramnios	☐ Yes	☐ No
Recurrent UTI	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Any medical disorders (HTN/ DM/ PE/ coagulation disorders/ Autoimmune disease/ anemia/ Any Other)	☐ Yes	☐ No
Stress (Physical/Emotional)	☐ Yes	☐ No
Travelling	☐ Yes	☐ No
Intercourse	☐ Yes	☐ No
Any General and/ or abdominal trauma	☐ Yes	☐ No
Any previous Pelvic surgeries	☐ Yes	☐ No
Any other concurrent surgery in current pregnancy	☐ Yes	☐ No
Smoking ,Alcohol or drug abuse	☐ Yes	☐ No
Involved in Heavy Manual work	☐ Yes	☐ No

SYMPTOMS

Frequent uterine contractions	☐ Yes	☐ No
Increased vaginal discharge/ discomfort	☐ Yes	☐ No
Leaking PV	☐ Yes	☐ No
Perception of fetal movements	☐ Yes	☐ No
Heaviness in lower abdomen/ backache/ cramping	☐ Yes	☐ No
Any bladder symptoms Burning/ frequency/ urgency/ suprapubic pain	☐ Yes	☐ No
Any bowel symptoms	☐ Yes	☐ No

EXAMINATION

General Physical Examination documented	☐ Yes	☐ No
BMI noted (weight gain during pregnancy)	☐ Yes	☐ No
Vitals documented ☐Temperature ☐BP ☐Pallor ☐Others ☐Pulse ☐RR ☐ Edema	☐ Yes	☐ No

Systemic Examination documented (CVS,RS,CNS)	☐ Yes ☐ Yes	☐ No ☐ No
PA-Uterine height, Contractions (intensity, duration, frequency), Tenderness FHS documented	☐ Yes ☐ Yes ☐ Yes ☐ Yes	☐ No ☐ No ☐ No ☐ No
Per Speculum examination findings noted Per Vaginal examination (to be done if required)	☐ Yes ☐ Yes	☐ No ☐ No

INVESTIGATIONS (As per need and availability)

Blood group and Rh typing Cross matching	☐ Yes	☐ No
CBC	☐ Yes	☐ No
Sugars documented	☐ Yes	☐ No
Urine routine and microscopy	☐ Yes	☐ No
High vaginal swab	☐ Yes	☐ No
Fetal fibronectin test/ CRP	☐ Yes	☐ No
USG for confirmation of Gestational age , growth, liquor, anomalies	☐ Yes	☐ No
USG assessment of cervix done	☐ Yes	☐ No
Serology (HIV, HBsAg, Anti HCV)	☐ Yes	☐ No
COVID RT PCR test	☐ Yes	☐ No

MANAGEMENT

Final diagnosis documented	☐ Yes	☐ No
Counselling done	☐ Yes	☐ No
Counselling by Pediatrician/ Neonatologist (if available)	☐ Yes	☐ No
Admission(if 24/7 NICU care present)	☐ Yes	☐ No
If not admitted, referred to Centre having NICU care	☐ Yes	☐ No
Referral checklist followed	☐ Yes	☐ No
Fetal surveillance done	☐ Yes	☐ No
High risk consent (in view of preterm delivery need for NICU/Ventilatory care)	☐ Yes	☐ No
Arrangement of Blood/blood products done (if required)	☐ Yes	☐ No
Expectant management: GA <34 week	☐ Yes	☐ No
Steroid cover as per local protocol	☐ Yes	☐ No
MgSO4 for neuro protection as per local protocol	☐ Yes	☐ No
Any tocolytic therapy given If given: Reason documented	☐ Yes	☐ No
Prophylactic Anti D given in Rh Negative Cases	☐ Yes	☐ No
Antibiotics given (if applicable)	☐ Yes	☐ No
Plan of delivery documented	☐ Yes	☐ No
OT preparedness/OT staff informed	☐ Yes	☐ No
Pediatrician/Anesthetist informed	☐ Yes	☐ No
Vaginal delivery/Cesarean section	☐ Yes	☐ No
Time of Delivery documented	☐ Yes	☐ No

INTRAPARTUM

Continuous CTG monitoring done	☐ Yes	☐ No
Pediatrician informed	☐ Yes	☐ No
Intra partum details documented	☐ Yes	☐ No
APGAR noted	☐ Yes	☐ No
Completeness of placenta checked	☐ Yes	☐ No
Baby monitored	☐ Yes	☐ No

POST NATAL

Vital monitoring done	☐ Yes	☐ No
PPH monitoring done	☐ Yes	☐ No
Uterine involution noted	☐ Yes	☐ No
Neonatal sepsis screening (Optional)	☐ Yes	☐ No
Baby's blood investigations	☐ Yes	☐ No
If mother is Rh negative, Anti D injection given	☐ Yes	☐ No
Lactation established	☐ Yes	☐ No
DVT prophylaxis given	☐ Yes	☐ No
In case of neonatal death, lactation suppression done	☐ Yes	☐ No
Contraceptive advice given	☐ Yes	☐ No
Counselled about risks in future pregnancies	☐ Yes	☐ No
Follow Up advised	☐ Yes	☐ No

Date

Signature

Name:

PPROM / PROM

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

HISTORY

PPROM/ PROM in previous pregnancy	☐ Yes ☐ No	Preterm labor	☐ Yes ☐ No
Previous Antibiotics Received	☐ Yes ☐ No	Recurrent UTI	☐ Yes ☐ No
GDM	☐ Yes ☐ No	Thyroid disorders	☐ Yes ☐ No
Type 1 DM/ Type 2 DM	☐ Yes ☐ No	Koch's	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Fever	☐ Yes ☐ No	Bacterial vaginosis	☐ Yes ☐ No
Foul-smelling discharge	☐ Yes ☐ No	Persistent vaginal discharge	☐ Yes ☐ No
Surgeries in the past	☐ Yes ☐ No	BleedingPV in 1st trimester	☐ Yes ☐ No
Smoking	☐ Yes ☐ No	Steroid prophylaxis	☐ Yes ☐ No
Drug usage	☐ Yes ☐ No	Polyhydramnios	☐ Yes ☐ No
Any diagnostic / therapeutic amniocentesis	☐ Yes ☐ No	Any fetal anomalies in the scan	☐ Yes ☐ No
Multifetal gestation	☐ Yes ☐ No	Malpresentation	☐ Yes ☐ No

EXAMINATION

Vitals ☐ Pulse ☐ Temp ☐ BP ☐ RR ☐ oxygen saturation ☐			
General Examination ☐ Patient conscious and oriented ☐ ☐ Yes ☐ No			
Pallor ☐ Icterus ☐ Cyanosis ☐ Clubbing ☐ Pedal edema			
CVS- Heart sounds checked ☐		☐ Yes	☐ No
RS- Bilateral air entry checked ☐		☐ Yes	☐ No
Per Abdomen- Uterine height corresponding to gestational age Tenderness noted Contractions/tone noted ☐ FHR documented ☐			
Presentation-cephalic ☐ breech ☐ transverse ☐ oblique ☐			
Local examination			
Any vulval ulcers noted	☐ Yes ☐ No	Leaking PV noted	☐ Yes ☐ No
Foul-smelling discharge noted	☐ Yes ☐ No	Bleeding PV noted	☐ Yes ☐ No
Per speculum examination			
Leak confirmed (After coughing)		☐ Yes	☐ No
If yes, the color of liquor noted		☐ Yes	☐ No
P/V examination done (if required)		☐ Yes	☐ No
Signs and symptoms of chorioamnionitis (lower abdominal pain,		☐ Yes	☐ No
tenderness,		☐ Yes	☐ No
foul-smelling vaginal discharge,		☐ Yes	☐ No
decreased fetal movements) noted if any		☐ Yes	☐ No

Provisional diagnosis made: PROM / PPROM / ? PROM

Investigations: CBC including TC/DC ☐ Urine routine ☐ Glucose estimation ☐

Optional:

CRP ☐ Urine culture ☐ High vaginal swab for C / S ☐ NST ☐ USG ☐ RFT ☐ LFT ☐

Management

Counseling done	☐ Yes	☐ No
Consent taken	☐ Yes	☐ No
Management planned active / expectant	☐ Yes	☐ No
Maternal surveillance done (Temp,Pulse, BP,Urine output)	☐ Yes	☐ No
Fetal surveillance done (DFMR /FHS /CTG)	☐ Yes	☐ No
Antibiotics started	☐ Yes	☐ No
Steroid cover (if less than 36 weeks) given	☐ Yes	☐ No
MgSO4 for neuroprotection (if between 26 to 32 weeks) given	☐ Yes	☐ No
Fetal monitoring done	☐ Yes	☐ No
Informed to pediatrician/anesthetist/labor room staff	☐ Yes	☐ No
Plan of delivery discussed	☐ Yes	☐ No

Informed to pediatrican/anesthetist/labor room staff	☐ Yes	☐ No
Plan of delivery discussed	☐ Yes	☐ No
Timingof delivery planned	☐ Yes	☐ No
Mode of delivery planned	☐ Yes	☐ No
Postpartum vitals monitoring done	☐ Yes	☐ No
Neonatal screening for sepsis done	☐ Yes	☐ No

Patient being referred (Referral checklist to be followed)

Date:

Signature

Name:

HYPERTENSIVE DISORDERS OF PREGNANCY

PATIENT PROFILE

Patient name:	History of allergy:
Blood group:	Date of admission:
Age:	Husband's name:
Date of Birth:	Contact number
Registration number:	Weight:
ID proof:	Obstetrics Score: G P L A
Height:	Expected date of delivery:
Last menstrual period:	Corrected expected date of delivery:
Period of gestation:	Nurse's name:
Doctor's name:	Booked/ Unbooked:

HISTORY:

Hypertensive disorders in previous pregnancy: ☐ Yes ☐ No			
If yes, a) Gestational hypertension b) Preeclampsia	☐ Yes ☐ No ☐ Yes ☐ No	c)Preeclampsia with severe features d) Eclampsia	☐ Yes ☐ No ☐ Yes ☐ No
Bad obstetric history:	☐ Yes ☐ No		
If yes, a)Abortions b) Preterm delivery	☐ Yes ☐ No ☐ Yes ☐ No	c)IUD d)Still births	☐ Yes ☐ No ☐ Yes ☐ No
Known case of:			
a) Chronic hypertension b) DM/GDM c) Thyroid disorders d) Obesity e) Autoimmune disorders	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	f) PCOS g) Renal disorder h) Epilepsy I) Anemia j) Thrombophilia k) If any other	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Current pregnancy risk factors:			
a) ART conception b)Elderly gravida c)Teenage pregnancy d)Primipara e) Hypertension in current pregnancy	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	f)Multiple pregnancy g)Excessive weight gain h)Lower limb swelling i)Headache j)Visual disturbances	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Hypertension in family	☐ Yes ☐ No	Preeclampsia in family(mother/sister) Others(if any)	☐ Yes ☐ No

CLINICAL FEATURES:

Nausea/Vomiting	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No
Epigastric/Right upper quadrant pain	☐ Yes ☐ No	Urine output decreased	☐ Yes ☐ No
Rapid weight gain	☐ Yes ☐ No	New onset headache (unresponsive to medication)	☐ Yes ☐ No
Disturbed sleep	☐ Yes ☐ No	Edema(pedal edema,abdominal wall edema)	☐ Yes ☐ No
Visual changes	☐ Yes ☐ No		
Loss of consciousness	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No

EXAMINATION:

<table>
<tr><td colspan="4">Vitals :</td></tr>
<tr><td>Temperature</td><td>☐ Yes ☐ No</td><td>Pulse rate</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Oxygen Saturation</td><td>☐ Yes ☐ No</td><td rowspan="2">Blood pressure:SBP/DBP of 140/90 mm Hg or more(*Annexure 2)</td><td rowspan="2">☐ Yes ☐ No</td></tr>
<tr><td>Fundal examination done</td><td>☐ Yes ☐ No</td></tr>
<tr><td colspan="4">General physical examination :</td></tr>
<tr><td>Height</td><td>☐ Yes ☐ No</td><td>Pallor present</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Current Weight(in kg):</td><td>☐ Yes ☐ No</td><td>Cyanosis present</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Prepregnancy BMI(kg/m²)</td><td>☐ Yes ☐ No</td><td>Clubbing present</td><td>☐ Yes ☐ No</td></tr>
<tr><td rowspan="2">Excessive weight gain in pregnancy</td><td rowspan="2">☐ Yes ☐ No</td><td>Edema present</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Jaundice present</td><td>☐ Yes ☐ No</td></tr>
<tr><td colspan="4">Systemic examination:</td></tr>
<tr><td>CVS examination done (arrhythmia,murmur)</td><td>☐ Yes ☐ No</td><td rowspan="2">Per abdomen examination
Uterine height documented
FHS present
If yes, rate documented
Tenderness present
If yes,</td><td rowspan="2">☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No
☐ Yes ☐ No</td></tr>
<tr><td>RS examination done(air entry, crepitations)</td><td>☐ Yes ☐ No</td></tr>
</table>

CNS examination : Consciousness Deep tendon reflexes	☐ Yes ☐ No	Right upper quadrant tenderness present Distension present	☐ Yes ☐ No ☐ Yes ☐ No
Local examination:			
Bleeding PV present	☐ Yes ☐ No	Per speculum examination(if required)	☐ Yes ☐ No
Leaking PV present	☐ Yes ☐ No	Per vaginal examination done(if required)	☐ Yes ☐ No
Foley's insitu(If applicable)	☐ Yes ☐ No		

MANAGEMENT:

INVESTIGATIONS			
Complete blood count	☐ Yes ☐ No	Urine albumin: If yes, Dipstick 24hr urine protein Protein to creatinine ratio	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Platelet count	☐ Yes ☐ No		
Blood sugar	☐ Yes ☐ No		
If applicable,			
Serum creatinine	☐ Yes ☐ No	Extra investigations required If yes Other tests done (ECG/2-D echo/lipid profile/serum electrolytes) If done test details documented	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Total protein/serum albumin	☐ Yes ☐ No		
Liver function test	☐ Yes ☐ No		
Lactate dehydrogenase	☐ Yes ☐ No		
Uric acid	☐ Yes ☐ No		
PT INR, aPTT /BT,CT / bedside clot retraction test	☐ Yes ☐ No		

DIAGNOSIS:

Diagnosis made If yes,	☐ Yes ☐ No ☐ Preeclampsia without severe features ☐ Preeclampsia with severe features ☐ Eclampsia ☐ Gestational hypertension ☐ Chronic hypertension ☐ Superimposed preeclampsia

Patient and relatives counseled and consents taken	☐ Yes ☐ No	Admission If not admitted, referred If referred, Referral protocol followed Antihypertensives given Magnesium sulphate administered	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

TREATMENT:

HDU-ICU care needed	☐ Yes ☐ No	Maternal monitoring done	☐ Yes ☐ No
PET chart (*annexure 1)maintained	☐ Yes ☐ No	Expectant management Steroid prophylaxis for RDS	☐ Yes ☐ No ☐ Yes ☐ No
Planned for termination of pregnancy	☐ Yes ☐ No	Delivery plan documented	☐ Yes ☐ No
Pediatrician informed	☐ Yes ☐ No	Anesthetist Consultaton	☐ Yes ☐ No
Fetal monitoring: DFMC NST Ultrasound with fetal doppler as	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	In case of preeclampsia with severe features/eclampsia: Stabilized CAB done Antihypertensives given	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

per availability(Fetal growth, BPP, AFI)		MgSO4 prophylaxis given	☐ Yes ☐ No
Multi disciplinary care	☐ Yes ☐ No	Fluid restriction Catherisation	☐ Yes ☐ No
Intrapartum CTG monitoring done	☐ Yes ☐ No	done Blood or blood products arranged	☐ Yes ☐ No
Cut short second stage of labour	☐ Yes ☐ No		
POSTPARTUM MONITORING DONE: ☐ Yes ☐ No			
Weight monitoring	☐ Yes ☐ No	Blood pressure monitoring	☐ Yes ☐ No
Reflexes checked	☐ Yes ☐ No	Edema checked	☐ Yes ☐ No
Bleeding PV checked	☐ Yes ☐ No	Postpartum hemorrhage present If yes,	☐ Yes ☐ No

Urine output checked	☐ Yes ☐ No	RS examination done(crepitations)	☐ Yes ☐ No
CVS examination done	☐ Yes ☐ No	P/A examination done(uterine involution)	☐ Yes ☐ No
Discharge PV	☐ Yes ☐ No		

LONG TERM FOLLOW UP:			
BP monitoring	☐ Yes ☐ No	Contraception advised	☐ Yes ☐ No
Antihypertensive given(if applicable)	☐ Yes ☐ No	If hypertension persists after 3 months, urine albumin advised	☐ Yes ☐ No
Dietary advice and weight reduction explained	☐ Yes ☐ No	Counselling for future pregnancies done	☐ Yes ☐ No
Lipid profile advised(optional)	☐ Yes ☐ No		

Date:

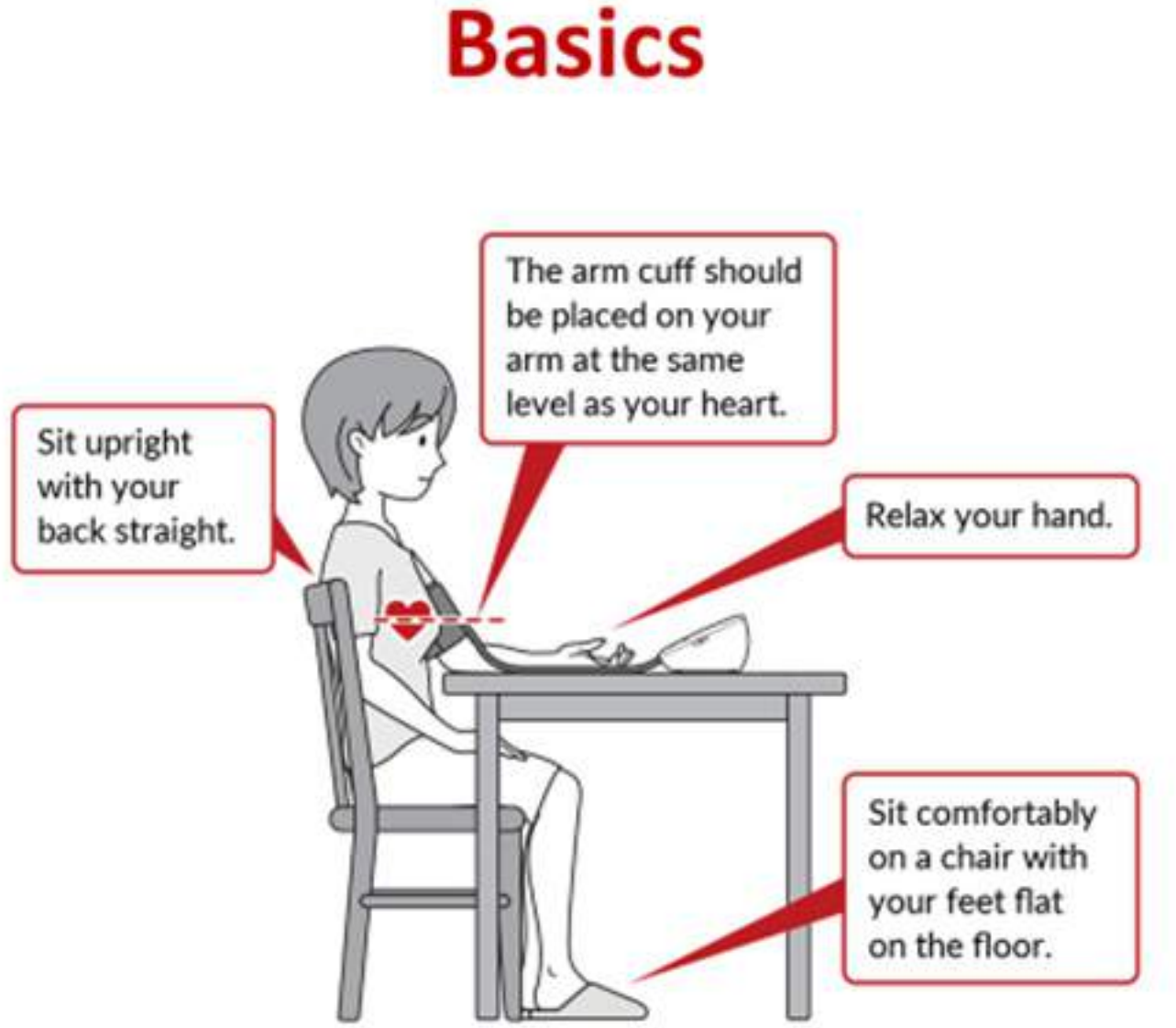
Signature

Name:

ANNEXURE-1: PET CHART
PATIENT IDENTIFICATION:
DATE:
PARITY INDEX: G P L A
DIAGNOSIS

DATE: TIME:				
WEIGHT				
PULSE				
BP				
EDEMA				
REFLEXES				
URINE OUTPUT				
URINE ALBUMIN				
CVS/RS				
PA: UTERUS HEIGHT TENDERNESS FHS				
OTHER FINDINGS				
DISCHARGE PV				
OTHER INVESTIGATIONS				

ANNEXURE-2:



(WHO)

ECLAMPSIA KIT

Confirm the following equipment in Eclampsia kit:
AIRWAY EQUIPMENTS:

ITEMS	AVAILABILITY	ITEMS	AVAILABILITY
Guedel Airways (Sizes 4, 3 and 2)	☐	Mouth gag (1)	☐
Disposable oxygen mask/ nasal prongs (1 each)	☐	Central suction/ Dedicated electrical suction machine	☐
Bag, mask and valve (1)	☐	Basic life support equipment's (ET tube, laryngoscope with batteries)	☐
Green oxygen tubing (2 meters)	☐	Others, if any	☐

OXYGEN CYLINDER:

Checked cylinder availability	☐
Checked cylinder fullness	☐
Expiry date checked	☐

VENOUS ACCESS EQUIPMENTS:

EQUIPMENT	AVAILABILITY	EQUIPMENT	AVAILABILITY
20 G Cannula (pink) (2)	☐	3-way cannula (1)	☐
18 G Cannula (green) (2)	☐	Tourniquet (1)	☐
16 G Cannula (grey) (2)	☐	Fixation tape/ surgical sticking (1)	☐

INTRAVENOUS FLUIDS

ITEMS	AVAILABILITY
Ringer lactate (1 Liter) (1)	☐
DNS (1)	☐
Normal Saline (100 ml) (1)	☐
Distilled water (10 ml) (5)	☐
IV set (2)	☐
DISPOSABLE SYRINGES	**NEEDLES**
20 CC (2) ☐	18G (5) ☐
10 CC (5) ☐	20G (5) ☐
5 CC (5) ☐	22G (5) ☐
Infusion syringe (If available) (1) ☐	

DRUGS:

Inj. MgSO4 (50%) (20 ampules)	☐	Tab. Labetalol 100mg (4)	☐
Inj. Labetalol (20mg) (2 ampules)	☐	Inj. Ondansetron (1)	☐
Inj. Hydralazine (20mg) (2 ampules)	☐	Inj. Atropine, Adrenaline, furosemide (2 each)	☐
Inj. Calcium gluconate (10%) (2 ampules)	☐	Inj. Phenergan (1 ampule)	☐
Inj. Lignocaine (1)	☐	Inj. Hydrocortisone (1 ampule)	☐
Tab. Nifedipine (2)	☐	Others, if any	☐

OTHER EQUIPMENTS:

Bed with rales	☐	Lignocaine jelly (1)	☐
Blood sample collection vials (Plain/EDTA/Fluoride) (5 each)	☐	Urine bag with uroflow meter (if available) (1)	☐
Urine albumin strip (1 bottle)	☐	Reflex hammer (1)	☐
Spirit swab bottle (1)	☐	Ampule cutter (1)	☐
Antiseptic solution (1)	☐	Surgical gloves (5)	☐
Foley's Catheter (No.14+No.16) (1+1)	☐	Others, if any	☐
Blood pressure apparatus (1)	☐	Suction catheter (1)	☐
Stethoscope (1)	☐	Checklist and patient monitoring chart (1)	☐
Ryle's tube (1)	☐	N95 mask for health personnel (1)	☐

MAINTAINENCE:

Kit kept at easily approachable place	☐
All medical and paramedical staff informed about place where the kit is kept	☐
Kit maintenance checked weekly	☐
Expiry date of the drugs checked weekly	☐
Mock drill conducted at the center every 3 monthly	☐
MgSO4 administration chart displayed at center in proper condition	☐
Battery of the laryngoscope checked monthly	☐

Date

Signature

Name:

HELLP SYNDROME

PATIENT PROFILE

Patient name:	History of allergy:
Blood group:	Date of admission:
Age:	Husband's name:
Date of Birth:	Contact number
Registration number:	Weight:
ID proof:	Obstetrics Score: G P L A
Height:	Expected date of delivery:
Last menstrual period:	Corrected expected date of delivery:
Period of gestation:	Nurse's name:
Doctor's name:	Booked/ Unbooked:

PATIENT PROFILE:

Hypertension in Pregnancy If Yes, Type:					
Gestational	☐ Yes	☐ No	Chronic	☐ Yes	☐ No
Preeclampsia	☐ Yes	☐ No	Preeclampsia superimposed	☐ Yes	☐ No
Other Medical Risk Factors:					
DM/GDM ☐			Thyroid disorders ☐		Obesity/ PCOS ☐
Autoimmune disorders (SLE, APLA) ☐			If any other: Mention		

CLINICAL FEATURES:

New onset headache (unresponsive to medication)	☐ Yes ☐ No	Visual changes / disturbances	☐ Yes ☐ No
Epigastric/Right upper quadrant pain	☐ Yes ☐ No	Nausea/Vomiting	☐ Yes ☐ No
Jaundice	☐ Yes ☐ No	Edema(pedal edema, abdominal wall edema)	☐ Yes ☐ No
Urine output adequate (100ml/ 4hr)			☐ Yes ☐ No
SBP/DBP of 140/90 mm Hg or more on two occasions 4 hours apart			☐ Yes ☐ No
Abnormal investigations			☐ Yes ☐ No

EXAMINATION:

Vitals: Temperature ☐ Pulse ☐ BP ☐ RR ☐ Oxygen saturation ☐			
General examination: Pallor ☐ Cyanosis ☐ Clubbing ☐ Icterus ☐ Pedal edema ☐			
Systemic examination:			
CVS: ☐ arrhythmia ☐ murmurs ☐		RS: ☐ air entry ☐ crepitations ☐	
CNS (deep tendon reflexes) ☐ Present ☐ Brisk ☐ Absent			
Per Abdomen: Uterine height documented If yes , ... weeks			
Contractions	☐ Yes ☐ No	Tone	☐ Yes ☐ No
Tenderness present	☐ Yes ☐ No	Abdominal Distension present	☐ Yes ☐ No
FHS	☐ Yes ☐ No	Bleeding PV present	☐ Yes ☐ No
Leaking PV present	☐ Yes ☐ No	Foley's catheter in situ	☐ Yes ☐ No
Per vaginal examination done(if required)			☐ Yes ☐ No

INVESTIGATIONS:

Complete hemogram with peripheral smear	☐ Yes ☐ No	Platelet count <1 lakh cells/cumm	☐ Yes ☐ No
Creatinine normal	☐ Yes ☐ No	LFT normal	☐ Yes ☐ No
Uric acid normal	☐ Yes ☐ No	LDH	☐ Yes ☐ No
Urine dipstick 2+			☐ Yes ☐ No
Urine protein to Serum creatinine ratio >0.3			☐ Yes ☐ No
Other tests done			☐ Yes ☐ No
If tests done- details documented			

Diagnosis of HELLP made ☐ Yes ☐ No If yes , ☐ Complete ☐ Partial

TREATMENT:

Patient stabilized	☐ Yes	☐ No
Patient and relatives counseled and consents taken	☐ Yes	☐ No
MgSO4 prophylaxis given	☐ Yes	☐ No
Antihypertensives given	☐ Yes	☐ No
Catheterization done	☐ Yes	☐ No
Steroiding done	☐ Yes	☐ No
If yes, primary dose	☐ Yes	☐ No
Rescue dose	☐ Yes	☐ No
Any other drugs given	☐ Yes	☐ No
If yes, drug details documented	☐ Yes	☐ No
Admission	☐ Yes	☐ No
If not admitted, referred	☐ Yes	☐ No
Referral protocol followed	☐ Yes	☐ No
HDU-ICU care needed	☐ Yes	☐ No
Blood transfusion required	☐ Yes	☐ No
Pediatrician/ NICU informed	☐ Yes	☐ No
Anesthesiologist informed	☐ Yes	☐ No
BP/Urine output & urine albumin monitoring done	☐ Yes	☐ No
Fetal surveillance	☐ Yes	☐ No
Ultrasound scan done	☐ Yes	☐ No
If yes, important findings (Liver hematoma/Ascites) present	☐ Yes	☐ No
Expectant management	☐ Yes	☐ No
Delivery plan documented and discussed with relatives	☐ Yes	☐ No

POSTPARTUM MONITORING:

Weight monitoring	☐ Yes	☐ No
Blood pressure monitoring	☐ Yes	☐ No
Edema checked	☐ Yes	☐ No
Urine output checked	☐ Yes	☐ No
Urine albumin done	☐ Yes	☐ No
CVS examination done	☐ Yes	☐ No
RS examination done (crepitations)	☐ Yes	☐ No
P/A examination done (Uterine height, tenderness)	☐ Yes	☐ No
Reflexes checked	☐ Yes	☐ No
Discharge Per Vaginum	☐ Yes	☐ No

Bleeding Per Vaginum	☐ Yes	☐ No
MgSO4/Anticonvulsants given	☐ Yes	☐ No
Antihypertensives given	☐ Yes	☐ No

Date

Signature

Name:

GESTATIONAL DIABETES MELLITUS IN PREGNANCY (GDM)

PATIENT PROFILE

Patient name:	History of allergy:
Blood group:	Date of admission:
Age:	Husband's name:
Date of Birth:	Contact number
Registration number:	Weight:
ID proof:	Obstetrics Score: G P L A
Height:	Expected date of delivery:
Last menstrual period:	Corrected expected date of delivery:
Period of gestation:	Nurse's name:
Doctor's name:	Booked/ Unbooked:

HISTORY:

Polyuria /polydipsia/ polyphagia	☐Yes ☐ No	Curdy/ Foul smelling discharge	☐Yes ☐ No
Repeated UTI	☐Yes ☐ No	Repeated vaginal infections	☐Yes ☐ No
Screening test for GDM If yes, 1st visit ☐ @24-28weeks ☐ @32-34 weeks ☐	☐Yes ☐ No	Screening method used DIPSI ☐ IADPSG ☐ Others ☐	☐Yes ☐ No
Diagnosed with GDM	☐Yes ☐ No	Headache/ blurring of vision /epigastric pain/ decreased urine output	☐Yes ☐ No
Abortion / still birth/ IUD / Anomalous baby	☐Yes ☐ No	GDM in past pregnancy	☐Yes ☐ No

Difficult delivery in previous pregnancy	☐Yes ☐ No	Big baby in previous pregnancy	☐Yes ☐ No
Type of previous delivery noted	☐Yes ☐ No	Puerperal sepsis in previous pregnancy	☐Yes ☐ No
History of PCOS	☐Yes ☐ No	Thyroid disorders	☐Yes ☐ No
DM in family	☐Yes ☐ No	Hypertension in patient and family	☐Yes ☐ No
Dietary history noted	☐Yes ☐ No		

EXAMINATION:

Vitals noted			
Temperature	☐Yes ☐ No	Blood pressure	☐Yes ☐ No
Pulse rate	☐Yes ☐ No	O2 Saturation	☐Yes ☐ No
General Physical Examination			
Prepregnancy BMI noted	☐Yes ☐ No	Patient conscious and oriented	☐Yes ☐ No
Pallor	☐Yes ☐ No	Fundoscopy done	☐Yes ☐ No

Icterus	☐Yes ☐ No	Pedal edema	☐Yes ☐ No
Systemic examination			
CVS checked	☐Yes ☐ No	RS checked	☐Yes ☐ No
Uterine height -	small ☐ corresponding ☐ big ☐	Polyhydramnios clinically	☐Yes ☐ No
		FHS documented	☐Yes ☐ No
Local examination done	☐Yes ☐ No	**PS/PV examination** done (if required)	☐Yes ☐ No
Provisional diagnosis made:			☐Yes ☐ No

INVESTIGATIONS DONE

1st trimester			
Complete blood count	☐Yes ☐ No	Urine routine	☐Yes ☐ No
HbA1C	☐Yes ☐ No	Urine microscopy	☐Yes ☐ No
Double marker test (as per patient acceptance)	☐Yes ☐ No	USG at 11-13+6 weeks	☐Yes ☐ No
2nd trimester			
Anomaly scan at 18-20 weeks done	☐Yes ☐ No	Fetal echo at 18-20 weeks	☐Yes ☐ No
3rd trimester			
Growth scan with 4 week interval done from 28 weeks			☐Yes ☐ No
As per case: CRP ☐Urine culture ☐High vaginal swab for Culture& Sensitivity ☐NST ☐ Renal Function Test ☐Liver Function test ☐			

MANAGEMENT
ANTENATAL

Counseling done	☐Yes ☐ No
Diet and exercise	☐Yes ☐ No
Oral antidiabetic drugs	☐Yes ☐ No
Insulin	☐Yes ☐ No
If Preeclampsia present, checklist followed	☐Yes ☐ No
Fetal surveillance done (Daily Fetal Movement Count, NST) Glucose surveillance done	☐Yes ☐ No
FBS ☐ PPBS☐ 2 point ☐ 4 point ☐ 6 point ☐ 7 point ☐	☐Yes ☐ No

INTRAPARTUM

Partograph Plotted	☐Yes ☐ No
Cardiotocography monitoring done	☐Yes ☐ No
Sugar monitoring done	☐Yes ☐ No
Pediatrician, anesthetist, OT staff informed	☐Yes ☐ No
Prepared for shoulder dystocia	☐Yes ☐ No
Prepared for PPH	☐Yes ☐ No
Difficulties encountered during delivery documented	☐Yes ☐ No

POSTPARTUM

Baby monitored for hypoglycemia	☐ Yes ☐ No
Maternal surveillance done Watched for PPH ☐ Subinvolution ☐ Infections ☐ Wound care ☐	☐ Yes ☐ No
Lactation established	☐ Yes ☐ No
Oral antidiabetic drugs/ insulin continued	☐ Yes ☐ No
Sugar monitoring done	☐ Yes ☐ No
Follow up advice given a) Diet ☐ b) Exercise ☐ c) Weight loss ☐ d) Contraception ☐ e) Breastfeeding ☐ f) OGTT after 6weeks ☐, after 6months ☐ , once in a year ☐	☐ Yes ☐ No

Date

Signature

Name:

Rh NEGATIVE PREGNANCY

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

HISTORY

Husband's Blood Group Noted		☐ Yes ☐ No
History of Previous Rh-Positive Blood transfusion		☐ Yes ☐ No
Previous pregnancies	Baby's blood group	Anti D given
I		☐ Yes ☐ No
II		☐ Yes ☐ No
III		☐ Yes ☐ No
IV		☐ Yes ☐ No
Inj. Anti D taken after previous abortions		☐ Yes ☐ No
Detailed Obstetric History taken in current pregnancy		☐ Yes ☐ No
History of any Potential Sensitizing event (Invasive Procedures, Bleeding in First Trimester, Recurrent Bleeding in Current Pregnancy) If yes Anti D taken		☐ Yes ☐ No

EXAMINATION

General Physical Examination Documented	☐ Yes ☐ No
Vitals Examined and Documented	☐ Yes ☐ No
Systemic Examination Documented	☐ Yes ☐ No
Detailed Obstetric Examination Documented	☐ Yes ☐ No

MANAGEMENT

At first contact Husband Blood group done, if not known	☐ Yes ☐ No
If Husband is Rh Positive, ICT Done	☐ Yes ☐ No
If first ICT negative, Repeat ICT if indicated	☐ Yes ☐ No
Antenatal prophylaxis of Anti D given & documented Dose of Inj. Anti D given..... Anti D given at .....weeks of Pregnancy	☐ Yes ☐ No ☐ Yes ☐ No
Counselled for serial USG monitoring	☐ Yes ☐ No
Counselled for Postnatal Anti D	☐ Yes ☐ No
If ICT positive, H/o previous affected pregnancy / Hydrops fetalis, serial MCA Doppler scan done	☐ Yes ☐ No

MANAGEMENT

If MCA PSV>1.5 MoMs, further monitoring including need for intra uterine transfusion and maternal fetal specialist opinion explained. Cordocentesis & Intra uterine transfusion planned	☐ Yes ☐ No
Mode of Delivery planned documented	☐ Yes ☐ No
Time of Delivery documented	☐ Yes ☐ No
Special care taken during delivery	☐ Yes ☐ No
Postnatal / Post abortal Anti D prophylaxis given If No, give reason.....	☐ Yes ☐ No
During delivery, vials for cord blood collection available	☐ Yes ☐ No
Neonatal Cord blood sent for Hb, Blood Grouping Rh, DCT and Bilirubin	☐ Yes ☐ No
Counselled about risks in future pregnancies	☐ Yes ☐ No

Date

Signature

Name:

HBsAg IN PREGNANCY

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

HISTORY AND CLINICAL FEATURES

Universal screening of HBsAg done	☐ Yes ☐ No
Patient documented HBsAg poitive	☐ Yes ☐ No
HBsAg status of Husband documented	☐ Yes ☐ No
Family history of HBsAg in parents and siblings	☐ Yes ☐ No
H/O IV drug abuse or Blood transfusion	☐ Yes ☐ No
H/O Tattooing	☐ Yes ☐ No
H/O Any unsafe dental procedures	☐ Yes ☐ No
H/O Antiviral drugs past or recent	☐ Yes ☐ No
H/O Previous obstetric events and outcome documented	☐ Yes ☐ No
HIV Status documented	☐ Yes ☐ No
Hepatitis C status documented	☐ Yes ☐ No

MANAGEMENT

Advised Family's HBsAg testing	☐ Yes ☐ No
If Jaundiced, Hep D/ Hep A / Hep E investigations done	☐ Yes ☐ No
Vaccination of Husband & Family advised if HBsAg negative Or Anti HBs negative (if available)	☐ Yes ☐ No
HBeAg, Anti HBe ,HBV DNA ,LFT, Coagulation profile, Liver USG advised	☐ Yes ☐ No
If HBeAg Positive & High DNA level Gastroenterology opinion taken	☐ Yes ☐ No
HBeAg Negative HBV DNA quantitative titres at 26-28 weeks done	☐ Yes ☐ No
If high viral load ,Antiviral prophylaxis given from 28 weeks	☐ Yes ☐ No
Universal precautions taken at the time of examination	☐ Yes ☐ No
Time and mode of delivery documented	☐ Yes ☐ No
Universal precautions taken during delivery	☐ Yes ☐ No
Post natal immunoglobulin and vaccination given to the child to prevent mother to child transmission	☐ Yes ☐ No
Counselled about contraception and safe sexual practice	☐ Yes ☐ No

Date

Signature

Name:

HIV IN OBSTETRICS

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

HISTORY

Details of diagnosis of HIV noted	☐ Yes ☐ No
Details of treatment taken	☐ Yes ☐ No
History of HIV in family	☐ Yes ☐ No
History of HIV in previous baby if applicable	☐ Yes ☐ No
H/o Tuberculosis HIV co-infection	☐ Yes ☐ No
History of Hepatitis/liver disorder	☐ Yes ☐ No
History of blood transfusion	☐ Yes ☐ No
Multiple sexual partners	☐ Yes ☐ No
Any other comorbidities like DM	☐ Yes ☐ No
Any immunosuppressant being taken /Other autoimmune disorders	☐ Yes ☐ No
History of any medications for coexistent medical conditions (For possible interaction)	☐ Yes ☐ No
Any other side effect or intolerance to medications	☐ Yes ☐ No

MANAGEMENT

First visit

Counselling done and informed consents taken	☐ Yes ☐ No
Partner HIV testing available If no, offered testing	☐ Yes ☐ No
Post test counselling done if positive for the first time	☐ Yes ☐ No
Ensured that vaccinations are up to date	☐ Yes ☐ No
HIV viral load checked	☐ Yes ☐ No
CD4 T lymphocyte cell count checked	☐ Yes ☐ No
Routine antenatal care given	☐ Yes ☐ No
Referral to ART Centre	☐ Yes ☐ No
If on combined antiretroviral treatment (TDF,3TC,EFV) counselled to continue	☐ Yes ☐ No
If previously not on treatment, treatment initiated	☐ Yes ☐ No
Stressed the need for follow up	☐ Yes ☐ No
Any features of AIDS present If yes, Details :_____	☐ Yes ☐ No
Coinfection ruled out	☐ Yes ☐ No
Detailed general physical examination and obstetric examination noted	☐ Yes ☐ No

Subsequent visits

Routine antenatal care	☐ Yes ☐ No
CD4 T lymphocyte cell count every 3 months rechecked	☐ Yes ☐ No
Viral load report available	☐ Yes ☐ No
Adherence and tolerance to combined antiretroviral treatment assessed	☐ Yes ☐ No
Coinfection ruled out	☐ Yes ☐ No
Treatment naive patients in labor If yes, cART started	☐ Yes ☐ No

Mode of delivery decided as per CD4/viral load	☐ Yes ☐ No
Universal precautions taken at the time of delivery	☐ Yes ☐ No
Need for neonatal follow up and prophylaxis explained	☐ Yes ☐ No
Nutrition supplement given	☐ Yes ☐ No
Discussed and Counselled for Breastfeeding	☐ Yes ☐ No
Counselled for safe sexual practice	☐ Yes ☐ No
Counselled to continue cART lifelong	☐ Yes ☐ No

Date

Signature

Name:

INDUCTION OF LABOUR

PATIENT PROFILE

Patient name: Age: Date of Birth:
Husband's name:
Registration number: Date of admission:
ID proof: Height:
Blood group: Weight:
Obstetric score: G P L A Contact number:
Last menstrual period: Expected date of delivery:
Period of gestation: Corrected Expected date of delivery:
Doctor's name: Nurse's name:
History of allergy: Booked/ unbooked:

ANTENATAL CARE

Hb at least once in every trimester done	☐Yes ☐No	Functional BP instrument and stethoscope available	☐Yes ☐No
BP recording at each ANC visit done	☐Yes ☐No	Proteinuria testing during all ANC contacts if hypertensive	☐Yes ☐No
Standard single step 75gm OGTT for screening of GDM done	☐Yes ☐No	Urine culture/urine gram staining/dipstick test for asymptomatic bacteriuria during each scheduled ANC contact done	☐Yes ☐No
HIV and Syphilis screening done	☐Yes ☐No		☐Yes ☐No
Blood group and Rh typingdone	☐Yes ☐No	Screening for malaria (only in endemic areas)	☐Yes ☐No

AT ADMISSION

Uterotonics agents available [IM/IV oxytocin (preferred), misoprostol, PPH Kit]	☐Yes ☐No	Designated new born corner is present	☐Yes ☐No
Eclampsia kits ensured	☐Yes ☐No	Radiant warmer switched ‘on’ 30 min. before childbirth	☐Yes ☐No
Functional items for newborn care and resuscitation ensured	☐Yes ☐No	Gestational age through either LMP or Fundal height or USG (previous or present is available) assessed	☐Yes ☐No
Obstetric, medical and surgical history noted	☐Yes ☐No	FHR recorded	☐Yes ☐No
Functional Doppler/ fetoscope/ stethoscope at point of use is available	☐Yes ☐No	BP and temperature recorded	☐Yes ☐No

Functional BP instrument and stethoscope and functional thermometer at point of use is available	☐Yes ☐No	Abdominal examination conducted with privacy	☐Yes ☐No

EXAMINATION AND MONITORING

PV examination done only as indicated (4 hourly or based on clinical indication)	☐Yes ☐No	Soap, running water, antiseptic solution, sterile gauze/pad available	☐Yes ☐No
Hand hygiene maintained	☐Yes ☐No	Perineum cleaned appropriately before PV examination	☐Yes ☐No
Senior obstetrician informed in case of emergency	☐Yes ☐No	Findings of PV examination recorded	☐Yes ☐No
Partograph available and charting done	☐Yes ☐No	Abnormal findings in partograph noted and managed	☐Yes ☐No
Staff trained how to interpret and manage obstructed labor	☐Yes ☐No	Prostaglandins and Oxytocin used for induction and augmentation	☐Yes ☐No
Birth companion allowed during labor	☐Yes ☐No	Provisions for privacy in LR checked	☐Yes ☐No
Privacy in LR ensured (curtains /partition between tables and non-see through windows)	☐Yes ☐No	Confidentiality of patient's records and clinical information is maintained.	☐Yes ☐No
Danger signs and important care activities explained	☐Yes ☐No	Episiotomy given under local anesthesia (only if indicated)	☐Yes ☐No
Spontaneous delivery of head allowed by maintaining flexion and giving perineal support	☐Yes ☐No	Assisted delivery conducted (if indicated)/ Consent taken	☐Yes ☐No

NEW BORN CARE

Two towels at normal room temperature or pre warmed to room temperature available	☐Yes ☐No	Baby kept on mother's abdomen	☐Yes ☐No
Baby dried immediately and wrapped in second warm towel (if normal)	☐Yes ☐No	Delayed cord clamping performed and (1-3 minutes) unless medical indication otherwise	☐Yes ☐No
Breast feeding initiated within one hour of birth	☐Yes ☐No	Immediate assessment of the newborn for any congenital anomalies done	☐Yes ☐No

Specialist care ensured if required	☐Yes☐ No	Baby weighed	☐Yes☐ No
Vitamin K given	☐Yes☐ No	OPV/BCG/Hepatitis B vaccines administered within 24 hours of birth	☐Yes☐ No

MANAGEMENT OF THIRD STAGE OF LABOR

Active Management of III Stage of Labor	☐Yes☐ No	Uterine tone and bleeding PV assessed regularly	☐Yes☐ No
Signs and symptoms of shock identified (pulse > 110 per minute, systolic BP < 90 mmHg, cold clammy skin, respiratory rate > 30 per minute, altered sensorium and scanty urine output < 30 ml per hour)	☐Yes☐ No	PPH Protocol followed if PPH occurs	☐Yes☐ No

NEW BORN RESUSCITATION

Steps of resuscitation performed within first 30 sec	☐Yes☐ No	Initiated bag and mask ventilation for 30 sec if baby still not breathing	☐Yes☐ No
Appropriate action taken after golden minute if baby doesn't respond to Ambu bag ventilation			☐Yes☐ No

POST NATAL CARE

Universal infection prevention protocols followed after delivery	☐Yes☐ No	Post partum care package offered a. Proper physical exam of Mother and Baby b. Diagnosis of Maternal & Neonatal sepsis c. Management of Postpartum psychiatric problems d. Counselling & Assistance for Exclusive breast feeding e. Family Planning discussed	☐Yes☐ No

OTHERS

24x7 labour room + diagnostic services available	☐Yes☐ No	Provided “care environment (*ANNEXURE 1)	☐Yes☐ No
Informed consent taken before treatment and procedure	☐Yes☐ No	Adequate human resources available	☐Yes☐ No
Newborn care area available	☐Yes☐ No	Rapid antigen kit available(HIV/HBsAg/Anti HCV)	☐Yes☐ No
Blood bank facility available	☐Yes☐ No	Clinical protocols for management of labour followed	☐Yes☐ No
Provision for privacy	☐Yes☐ No	Birth companion allowed during delivery	☐Yes☐ No
Freedom to choose a comfortable position during delivery	☐Yes☐ No	Stress triggers avoided (*ANNEXURE 2)	☐Yes☐ No
Allowed natural progression of labour	☐Yes☐ No	Partograph maintained	☐Yes☐ No
Delayed cord clamping done	☐Yes☐ No	Baby placed on mother’s abdomen after delivery	☐Yes☐ No
Early initiation of breastfeeding (within 1 hr)	☐Yes☐ No	RMNCHA Services provided (*ANNEXURE 3)	☐Yes☐ No
Facilities of biomedical waste	☐Yes☐ No	Proper documentation	☐Yes☐ No

Date

Signature

Name:

ANNEXURE 1:

- LDR Concept
- Avoid Bright Lights
- Avoid Noise
- Avoid unnecessary Movement of Caregivers
- Cleanliness & Hygiene
- Soothing colours and Music
- Visual Privacy

ANNEXURE 2:

- Timely arrival to avoid emergency stress
- Positive interaction with the care provider
- Proper Triaging on arrival
- Assuring Mother that Birth is a Natural Process
- Avoiding Stress triggering terms
- Sensitizing LR team to Respect the Natural Process of Labour
- Avoid Frequent Vaginal Examination

ANNEXURE 3:

- Availability of Post Partum IUD insertion services
- Availability of Vaginal Delivery services
- Management of Postpartum Haemorrhage
- Management of Retained Placenta
- Septic Delivery & Delivery of HIV positive Pregnant women
- Management of PIH/Eclampsia/ Pre eclampsia
- Availability of New born resuscitation
- Availability of Essential new born care

BASIC EQUIPMENT

Stethoscope	☐Yes ☐No	Cardiac board	☐Yes ☐No
Blood pressure apparatus	☐Yes ☐No	IV stand	☐Yes ☐No
Weighing machine	☐Yes ☐No	IV cannula(No.16,18,20,22,24)	☐Yes ☐No
Thermometer	☐Yes ☐No	IV fluids(NS,DNS,RL,dextrose)	☐Yes ☐No
Pulse oximeter	☐Yes ☐No	Blood set	☐Yes ☐No
O2 mask	☐Yes ☐No	Dynaplast	☐Yes ☐No

O2 cylinder	☐ Yes ☐ No	Sterile water	☐ Yes ☐ No
Sterile gloves(No.6,6.5,7)	☐ Yes ☐ No	Syringe(2cc,5cc,10cc,20cc, 50cc)	☐ Yes ☐ No
Labour bed	☐ Yes ☐ No	Kidney tray	☐ Yes ☐ No
Instrument trolley	☐ Yes ☐ No	Instrument tray	☐ Yes ☐ No
Handrub/Soap	☐ Yes ☐ No	Needle box	☐ Yes ☐ No
Lignocaine jel	☐ Yes ☐ No	Nasal prongs	☐ Yes ☐ No
Betadine solution	☐ Yes ☐ No	Dustbin(red, yellow, black, blue)	☐ Yes ☐ No
Ryles tube	☐ Yes ☐ No	Nebulisation mask	☐ Yes ☐ No
Stool	☐ Yes ☐ No	Dressing material- Gauze, Cotton, Betadine, Savlon	☐ Yes ☐ No
Platform to keep baby with arrangements to	☐ Yes ☐ No	Plastic sheets/ McIntosh/ Underpads	☐ Yes ☐ No
Suction machine	☐ Yes ☐ No	Sanitary pads/ Sanitary napkins	☐ Yes ☐ No
Foley's catheter (No.14/16)	☐ Yes ☐ No	Uro bag	☐ Yes ☐ No
Sink	☐ Yes ☐ No	Plain and EDTA tubes	☐ Yes ☐ No
Wheel chair/stretcher	☐ Yes ☐ No	Wall clock	☐ Yes ☐ No
Weighing machine	☐ Yes ☐ No	Refrigerator	☐ Yes ☐ No
Sterilizer/Autoc lave	☐ Yes ☐ No	Display protocols (Magnesium sulphate therapy PPH Management, Hypertensive crisis therapy, AMTSL)	☐ Yes ☐ No
Enema can/ Neotonic enema	☐ Yes ☐ No		☐ Yes ☐ No

DESIRABLE EQUIPMENT

NST machine	☐ Yes ☐ No	Ambu bag	☐ Yes ☐ No
Doppler machine	☐ Yes ☐ No	Defibrillator	☐ Yes ☐ No
Saturation probe	☐ Yes ☐ No	Ultrasound jelly for DC shock	☐ Yes ☐ No
Infusion pump	☐ Yes ☐ No	Urine dipsticks	☐ Yes ☐ No
Crash cart trolley(*Annexure 4)	☐ Yes ☐ No	Electric backup / Generator / rechargeable battery / Solar lamp	☐ Yes ☐ No
ECG strips-chest leads	☐ Yes ☐ No		

DELIVERY SET

Tray with lid	☐ Yes ☐ No	Red rubber catheter/K90 catheter	☐ Yes ☐ No	Artery forceps	☐ Yes ☐ No
Cup (galipot)	☐ Yes ☐ No			Forceps (Toothed and non toothed)	☐ Yes ☐ No
Gauze	☐ Yes ☐ No	Episiotomy Scissors	☐ Yes ☐ No	Allis forceps	☐ Yes ☐ No
Betadine solution	☐ Yes ☐ No	Cord clamps	☐ Yes ☐ No	Straight Scissors	☐ Yes ☐ No
Pads 10x10cm	☐ Yes ☐ No	Anterior vaginal wall retractor	☐ Yes ☐ No	Obstetrics Forceps	☐ Yes ☐ No
Cotton balls 3x3 cm	☐ Yes ☐ No	Sim's speculum	☐ Yes ☐ No	Vacuum cup	☐ Yes ☐ No
Kidney tray	☐ Yes ☐ No	Sponge holder	☐ Yes ☐ No	Mucous sucker	☐ Yes ☐ No
Dry cloth	☐ Yes ☐ No	Needle holder long	☐ Yes ☐ No	Infant feeding tube	☐ Yes ☐ No

Plastic apron	☐ Yes ☐ No	Suture material (Catgut/ Vicryl 1-0/1)	☐ Yes ☐ No	Medium baby sheet	☐ Yes ☐ No
Mask	☐ Yes ☐ No	Surgeon's gown	☐ Yes ☐ No	Leggings	☐ Yes ☐ No

DRUGS

Inj. Oxytocin	☐ Yes ☐ No	Inj. MgSO4(50%/20%)	☐ Yes ☐ No
Inj. Methyl Ergometrin	☐ Yes ☐ No	Antibiotics inj	☐ Yes ☐ No
Inj. Carboprost	☐ Yes ☐ No	Inj. Atropine	☐ Yes ☐ No
Tab. Nifedipine	☐ Yes ☐ No	Inj. Adrenaline	☐ Yes ☐ No
Tab. Misoprostol 200mcg	☐ Yes ☐ No	Inj. Xylocaine(2%)	☐ Yes ☐ No
Antiemetic inj	☐ Yes ☐ No	Inj. Dexamethasone/ Hydrocortisone	☐ Yes ☐ No
Inj. Vitamin K	☐ Yes ☐ No		

Checklist maintained weekly	☐ Yes ☐ No
Expiry date of the drugs checked weekly	☐ Yes ☐ No
Materials kept at easily approachable place	☐ Yes ☐ No

ANNEXURE 4:
CRASH CART TROLLEY

	Inj Atropine ☐	Inj Metoprolol ☐
Inj Dobutamine ☐	Inj Amiodarone ☐	Inj Lidocaine ☐
Inj Dopamine ☐	Inj Adrenaline ☐	Inj Digoxin ☐
Inj Pheniramine maleate ☐	Inj Adenosine ☐	Inj Sodabicarb ☐
Inj Ondansetron ☐	Inj Aminophylline ☐	Inj Nitroglycerin ☐
Inj Furosemide ☐	Inj Midazolam ☐	Budecort ☐
Duolin ☐	Inj Lorazepam ☐	Levolin ☐
Endotracheal tube(6,7,7.5) ☐	Infant feeding tube(5,6,7,8) ☐	Suction catheters(10,12,14,16) ☐

LABOUR ROOM

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

CLINICAL PROTOCOLS

ANTENATAL CARE

Hb at least once in every trimester done	☐Yes☐ No	Functional BP instrument and stethoscope available	☐Yes☐ No
BP recording at each ANC visit done	☐Yes☐ No	Proteinuria testing during all ANC contacts if hypertensive	☐Yes☐ No
Standard single step 75gm OGTT for screening of GDM done	☐Yes☐ No	Urine culture/urine gram staining/dipstick test for asymptomatic bacteriuria during each scheduled ANC contact done	☐Yes☐ No
HIV and Syphilis screening done	☐Yes☐ No		
Blood group and Rh typingdone	☐Yes☐ No	Screening for malaria (only in endemic areas)	☐Yes☐ No

AT ADMISSION

Uterotonics agents available [IM/IV oxytocin (preferred), misoprostol, PPH Kit]	☐ Yes ☐ No	Designated new born corner is present	☐ Yes ☐ No
Eclampsia kits ensured	☐ Yes ☐ No	Radiant warmer switched 'on' 30 min. before childbirth	☐ Yes ☐ No
Functional items for newborn care and resuscitation ensured	☐ Yes ☐ No	Gestational age through either LMP or Fundal height or USG (previous or present is available) assessed	☐ Yes ☐ No
Obstetric, medical and surgical history noted	☐ Yes ☐ No	FHR recorded	☐ Yes ☐ No
Functional Doppler/ fetoscope/ stethoscope at point of use is available	☐ Yes ☐ No	BP and temperature recorded	☐ Yes ☐ No
Functional BP instrument and stethoscope and functional thermometer at point of use is available	☐ Yes ☐ No	Abdominal examination conducted with privacy	☐ Yes ☐ No

EXAMINATION AND MONITORING

PV examination done only as indicated (4 hourly or based on clinical indication)	☐ Yes ☐ No	Soap, running water, antiseptic solution, sterile gauze/pad available	☐ Yes ☐ No
Hand hygiene maintained	☐ Yes ☐ No	Perineum cleaned appropriately before PV examination	☐ Yes ☐ No
Senior obstetrician informed in case of emergency	☐ Yes ☐ No	Findings of PV examination recorded	☐ Yes ☐ No
Partograph available and charting done	☐ Yes ☐ No	Abnormal findings in partograph noted and managed	☐ Yes ☐ No
Staff trained how to interpret and manage obstructed labor	☐ Yes ☐ No	Prostaglandins and Oxytocin used for induction and augmentation	☐ Yes ☐ No
Birth companion allowed during labor	☐ Yes ☐ No	Provisions for privacy in LR checked	☐ Yes ☐ No
Privacy in LR ensured (curtains /partition between tables and non-see through windows)	☐ Yes ☐ No	Confidentiality of patient's records and clinical information is maintained.	☐ Yes ☐ No
Danger signs and important care activities explained	☐ Yes ☐ No	Episiotomy given under local anesthesia (only if indicated)	☐ Yes ☐ No
Spontaneous delivery of head allowed by maintaining flexion and giving perineal support	☐ Yes ☐ No	Assisted delivery conducted (if indicated)/ Consent taken	☐ Yes ☐ No

NEW BORN CARE

Two towels at normal room temperature or pre warmed to room temperature available	☐ Yes ☐ No	Baby kept on mother's abdomen	☐ Yes ☐ No
Baby dried immediately and wrapped in second warm towel (if normal)	☐ Yes ☐ No	Delayed cord clamping performed & (1 3 minutes) unless medical indication otherwise	☐ Yes ☐ No
Breast feeding initiated within one hour of birth	☐ Yes ☐ No	Immediate assessment of the new born for any congenital anomalies done	☐ Yes ☐ No
Specialist care ensured if required	☐ Yes ☐ No	Baby weighed	☐ Yes ☐ No
Vitamin K given	☐ Yes ☐ No	OPV/BCG/Hepatitis B vaccines administered within 24 hours of birth	☐ Yes ☐ No

MANAGEMENT OF THIRD STAGE OF LABOR

Active Management of III Stage of Labor	☐ Yes ☐ No	Uterine tone and bleeding PV assessed regularly	☐ Yes ☐ No
Signs and symptoms of shock identified (pulse > 110 per minute, systolic BP < 90 mmHg, cold clammy skin, respiratory rate > 30 per minute, altered sensorium and scanty urine output < 30 ml per hour)	☐ Yes ☐ No	PPH Protocol followed if PPH occurs	☐ Yes ☐ No

NEW BORN RESUSCITATION

Steps of resuscitation performed within first 30 sec	☐ Yes ☐ No	Initiated bag and mask ventilation for 30 sec if baby still not breathing	☐ Yes ☐ No
Appropriate action taken after golden minute if baby doesn't respond to Ambu bag ventilation			☐ Yes ☐ No

POST NATAL CARE

Universal infection prevention protocols followed after delivery	☐ Yes ☐ No	Post partum care package offered a. Proper physical exam of Mother and Baby b. Diagnosis of Maternal & Neonatal sepsis c. Management of Postpartum psychiatric problems	☐ Yes ☐ No

		d. Counselling & Assistance for Exclusive breast feeding e. Family Planning discussed	

OTHERS

24x7 labour room + diagnostic services available	☐ Yes ☐ No	Provided "care environment"(*ANNEXURE 1)	☐ Yes ☐ No
Informed consent taken before treatment and procedure	☐ Yes ☐ No	Adequate human resources available	☐ Yes ☐ No
Newborn care area available	☐ Yes ☐ No	Rapid antigen kit available(HIV/HBsAg/Anti HCV)	☐ Yes ☐ No
Blood bank facility available	☐ Yes ☐ No	Clinical protocols for management of labour followed	☐ Yes ☐ No
Provision for privacy	☐ Yes ☐ No	Birth companion allowed during delivery	☐ Yes ☐ No
Freedom to choose a comfortable position during delivery	☐ Yes ☐ No	Stress triggers (*ANNEXURE 2) avoided	☐ Yes ☐ No
Allowed natural progression of labour	☐ Yes ☐ No	Partograph maintained	☐ Yes ☐ No
Delayed cord clamping done	☐ Yes ☐ No	Baby placed on mother's abdomen after delivery	☐ Yes ☐ No
Early initiation of breastfeeding (within 1 hr)	☐ Yes ☐ No	RMNCHA Services (*ANNEXURE 3) provided	☐ Yes ☐ No
Facilities of biomedical waste management available	☐ Yes ☐ No	Proper documentation and audit done	☐ Yes ☐ No

BASIC EQUIPMENT

Stethoscope	☐ Yes ☐ No	Cardiac board	☐ Yes ☐ No
Blood pressure apparatus	☐ Yes ☐ No	IV stand	☐ Yes ☐ No
Weighing machine	☐ Yes ☐ No	IV cannula(No.16,18,20,22,24)	☐ Yes ☐ No
Thermometer	☐ Yes ☐ No	IV fluids(NS,DNS,RL,dextrose)	☐ Yes ☐ No
Pulse oximeter	☐ Yes ☐ No	Blood set	☐ Yes ☐ No
O2 mask	☐ Yes ☐ No	Dynaplast	☐ Yes ☐ No
O2 cylinder	☐ Yes ☐ No	Sterile water	☐ Yes ☐ No
Sterile gloves(No.6,6.5,7)	☐ Yes ☐ No	Syringe(2cc,5cc,10cc,20cc,50cc)	☐ Yes ☐ No
Labour bed	☐ Yes ☐ No	Kidney tray	☐ Yes ☐ No
Instrument trolley	☐ Yes ☐ No	Instrument tray	☐ Yes ☐ No
Handrub/Soap	☐ Yes ☐ No	Needle box	☐ Yes ☐ No
Lignocaine jel	☐ Yes ☐ No	Nasal prongs	☐ Yes ☐ No
Betadine solution	☐ Yes ☐ No	Dustbin(red, yellow, black, blue)	☐ Yes ☐ No
Ryles tube	☐ Yes ☐ No	Nebulisation mask	☐ Yes ☐ No
Stool	☐ Yes ☐ No	Dressing material- Gauze, Cotton, Betadine, Savlon	☐ Yes ☐ No
Platform to keep baby with arrangements to keep it warm	☐ Yes ☐ No	Plastic sheets/ McIntosh/ Underpads	☐ Yes ☐ No
Suction machine	☐ Yes ☐ No	Sanitary pads/ Sanitary napkins	☐ Yes ☐ No
Foley's catheter (No.14/16)	☐ Yes ☐ No	Uro bag	☐ Yes ☐ No
Sink	☐ Yes ☐ No	Plain and EDTA tubes	☐ Yes ☐ No
Wheel chair/stretcher	☐ Yes ☐ No	Wall clock	☐ Yes ☐ No
Weighing machine	☐ Yes ☐ No	Refrigerator	☐ Yes ☐ No
Sterilizer/Autoclave	☐ Yes ☐ No	Display protocols	☐ Yes ☐ No

DESIRABLE EQUIPMENT

NST machine	☐ Yes ☐ No	Ambu bag	☐ Yes ☐ No
Doppler machine	☐ Yes ☐ No	Defibrillator	☐ Yes ☐ No
Saturation probe	☐ Yes ☐ No	Ultrasound jelly for DC shock	☐ Yes ☐ No
Infusion pump	☐ Yes ☐ No	Urine dipsticks	☐ Yes ☐ No
Crash cart trolley(*Annexure 4)	☐ Yes ☐ No	Electric backup/Generator/ rechargeable battery/Solar lamp	☐ Yes ☐ No
ECG strips-chest leads	☐ Yes ☐ No		

DELIVERY SET

Tray with lid	☐ Yes ☐ No	Red rubber catheter/K90 catheter	☐ Yes ☐ No	Artery forceps	☐ Yes ☐ No
Cup (galipot)	☐ Yes ☐ No	Kocher's forceps	☐ Yes ☐ No	Forceps (Toothed and non toothed)	☐ Yes ☐ No
Gauze	☐ Yes ☐ No	Episiotomy Scissors	☐ Yes ☐ No	Allis forceps	☐ Yes ☐ No
Betadine solution	☐ Yes ☐ No	Cord clamps	☐ Yes ☐ No	Straight Scissors	☐ Yes ☐ No
Pads 10x10cm	☐ Yes ☐ No	Anterior vaginal wall retractor	☐ Yes ☐ No	Obstetrics Forceps	☐ Yes ☐ No
Cotton balls 3x3 cm	☐ Yes ☐ No	Sim's speculum	☐ Yes ☐ No	Vacuum cup	☐ Yes ☐ No
Kidney tray	☐ Yes ☐ No	Sponge holder	☐ Yes ☐ No	Mucous sucker	☐ Yes ☐ No
Dry cloth	☐ Yes ☐ No	Needle holder long	☐ Yes ☐ No	Infant feeding tube	☐ Yes ☐ No
Plastic apron	☐ Yes ☐ No	Suture material (Catgut/ Vicryl 1-0/1)	☐ Yes ☐ No	Medium baby sheet	☐ Yes ☐ No
Mask	☐ Yes ☐ No	Surgeon's gown	☐ Yes ☐ No	Leggings	☐ Yes ☐ No

DRUGS

Inj. Oxytocin	☐ Yes ☐ No	Inj. MgSO4 (50%, 20%)	☐ Yes ☐ No
Inj. Methyl Ergometrine	☐ Yes ☐ No	Antibiotics inj	☐ Yes ☐ No
Inj. Carboprost	☐ Yes ☐ No	Inj. Atropine	☐ Yes ☐ No
Tab. Nifedipine	☐ Yes ☐ No	Inj. Adrenaline	☐ Yes ☐ No
Tab. Misoprostol 200 mcg	☐ Yes ☐ No	Inj. Xylocaine(2%)	☐ Yes ☐ No
Antiemetic inj	☐ Yes ☐ No	Inj. Dexamethasone/ Hydrocortisone	☐ Yes ☐ No
Inj. Vitamin K	☐ Yes ☐ No		

Checklist maintained weekly	☐ Yes	☐ No
Expiry date of the drugs checked weekly	☐ Yes	☐ No
Materials kept at easily approachable place	☐ Yes	☐ No

Date

Signature

Name:

ANNEXURE 4:

CRASH CART TROLLEY

Inj Noradrenaline ☐	Inj Atropine ☐	Inj Metoprolol ☐
Inj Dobutamine ☐	Inj Amiodarone ☐	Inj Lidocaine ☐
Inj Dopamine ☐	Inj Adrenaline ☐	Inj Digoxin ☐
Inj Pheniramine maleate ☐	Inj Adenosine ☐	Inj Sodabicarb ☐
Inj Ondansetron ☐	Inj Aminophylline ☐	Inj Nitroglycerin ☐
Inj Furosemide ☐	Inj Midazolam ☐	Budecort ☐
Duolin ☐	Inj Lorazepam ☐	Levolin ☐
Endotracheal tube(6,7,7.5) ☐	Infant feeding tube(5,6,7,8) ☐	Suction catheters(10,12,14,16) ☐

VAGINAL DELIVERY

PATIENT PROFILE

Patient name:	History of allergy:
Blood group:	Date of admission:
Age:	Husband's name:
Date of Birth:	Contact number
Registration number:	Weight:
ID proof:	Obstetrics Score: G P L A
Height:	Expected date of delivery:
Last menstrual period:	Corrected expected date of delivery:
Period of gestation:	Nurse's name:
Doctor's name:	Booked/ Unbooked:

HISTORY AND CLINICAL FEATURES

Antenatal records reviewed	☐ Yes ☐ No
Any associated high risk factors documented	☐ Yes ☐ No
Tetanus immunization done	☐ Yes ☐ No
Pain abdomen (Labor pain) If present, increasing in frequency and duration / regular intervals	☐ Yes ☐ No
Decreased fetal movements	☐ Yes ☐ No
Leakage per vaginum (mention duration of leakage :___ hrs ___ min) If leaking PV ,▫ Blood stained ▫ Meconium stained ▫ Other	☐ Yes ☐ No
Timing of last solid food taken noted	☐ Yes ☐ No
History of any multiple/ unclean examinations or drug intervention	☐ Yes ☐ No

HISTORY OF ANY MULTIPLE/ UNCLEAN EXAMINATIONS OR DRUG INTERVENTION

Vitals: ☐ Temperature ☐ Pulse ☐ BP ☐ RR ☐ Oxygen saturation
General examination: ☐ Pallor ☐ Cyanosis ☐ Clubbing ☐ Icterus ☐ Pedal edema
Systemic examination: ☐ CVS: ☐ Arrhythmia ☐ Murmurs ☐ RS: ☐ Air entry ☐ Crepitations ☐ CNS ☐ Reflexes

LOCAL EXAMINATION

Abdominal examination done	☐ Yes ☐ No
Presence of scar ,if any noted	☐ Yes ☐ No
Bleeding PV present	☐ Yes ☐ No
Leaking PV present	☐ Yes ☐ No
Per vaginal examination done	☐ Yes ☐ No
If leaking PV, ▫ Blood stained ▫ Meconium stained ▫ Other	☐ Yes ☐ No
Cervical dilatation documented	☐ Yes ☐ No
Effacement documented	☐ Yes ☐ No
Station documented	☐ Yes ☐ No
Membranes intact	☐ Yes ☐ No
Pelvis seems adequate	☐ Yes ☐ No
Moulding present	☐ Yes ☐ No
Caput succedaneum formed	☐ Yes ☐ No

MANAGEMENT

INVESTIGATIONS DONE	☐ Yes ☐ No
Complete hemogram (Recent)	☐ Yes ☐ No
Urine routine and microscopy (less than 1 week old)	☐ Yes ☐ No
Blood grouping and cross matching	☐ Yes ☐ No
Blood arranged if indicated	☐ Yes ☐ No
HIV/ HbS Ag/VDRL (if not done before)	☐ Yes ☐ No

FIRST STAGE OF LABOR

Referral needed (Follow referral checklist) In case of eclampsia , 1st dose of MgSO4 given before referring If not required admission documented	☐ Yes ☐ No
Informed counselling done	☐ Yes ☐ No
Partograph maintained	☐ Yes ☐ No
Any indication for antibiotics checked	☐ Yes ☐ No
Special therapy if needed (MgSo4, antihypertensives, rescue steroid)	☐ Yes ☐ No
Tocolytics given (If yes, Reason .....)	☐ Yes ☐ No
Delivery kit available	☐ Yes ☐ No
PPH kit available	☐ Yes ☐ No
Ambulation ensured	☐ Yes ☐ No
Hydration ensured	☐ Yes ☐ No
Relatives kept available	☐ Yes ☐ No
Ensured the supplies for fetal resuscitation available	☐ Yes ☐ No
Blood arranged if indicated	☐ Yes ☐ No

SECOND STAGE OF LABOR

Encouraged to bear down	☐ Yes ☐ No
Perineal support given	☐ Yes ☐ No
Episiotomy documented if given	☐ Yes ☐ No
Instrumental delivery documented if done	☐ Yes ☐ No
Informed Consent for instrumental delivery taken	☐ Yes ☐ No
Date and time of delivery noted	☐ Yes ☐ No
Baby details (weight, APGAR, Sex) noted	☐ Yes ☐ No
Second stage problems (Shoulder dystocia- Erb's palsy) documented	☐ Yes ☐ No
Obvious Conngenital malformations if any documented	☐ Yes ☐ No

THIRD STAGE OF LABOR

Placenta separated spontaneously	☐ Yes ☐ No
Active management of third stage of labor done (controlled cord traction, oxytocin, delayed cord clamping)	☐ Yes ☐ No
Placental completeness checked	☐ Yes ☐ No
Maternal vitals monitored	☐ Yes ☐ No
Post partum hemorrhage if occurred documented If yes, management documented	☐ Yes ☐ No
Skin to skin contact initiated at the earliest	☐ Yes ☐ No
Breast feeding initiated	☐ Yes ☐ No

FOURTH STAGE OF LABOR

Fourth stage protocol including vitals ,Uterus details and vaginal bleeding checked every 15 minutes for 1 hour	☐ Yes ☐ No

POST DELIVERY

Disinfection of all instruments in Hypochlorite done	☐ Yes ☐ No
Patients condition at time of transfer to ward noted	☐ Yes ☐ No
Contraception discussed	☐ Yes ☐ No

Date

Signature

Name:

PLACENTA PREVIA

PATIENT PROFILE

Patient name:

Blood group:

Age:

Date of Birth:

Registration number:

ID proof:

Height:

Last menstrual period:

Period of gestation:

Doctor's name:

History of allergy:

Date of admission:

Husband's name:

Contact number

Weight:

Obstetrics Score: G P L A

Expected date of delivery:

Corrected expected date of delivery:

Nurse's name:

Booked/ Unbooked:

HISTORY INTRAPARTUM

H/O Placenta previa in previous pregnancy	☐ Yes ☐ No
H/o previous C-Section or any other type of uterine surgery	☐ Yes ☐ No
H/O Dilatation & Curettage	☐ Yes ☐ No
H/O ART	☐ Yes ☐ No
H/O Bleeding PV in first trimester	☐ Yes ☐ No
H/O recurrent episodes of Antepartum hemorrhage	☐ Yes ☐ No
H/O Low lying placenta/Placenta previa in II trimester scan	☐ Yes ☐ No
H/O Bleeding Diathesis	☐ Yes ☐ No
After diagnosis instructions to patients -bed rest/reduced activity /avoidance of intercourse explained	☐ Yes ☐ No

CLINICAL FEATURES
SYMPTOMS

H/O Painless causeless bleeding PV	☐ Yes ☐ No
H/O Labor pain	☐ Yes ☐ No
H/O Leaking PV	☐ Yes ☐ No
Fetal movements felt	☐ Yes ☐ No
Other causes of APH ruled out	☐ Yes ☐ No

EXAMINATION

General Physical Examination documented	☐ Yes ☐ No
Vitals documented	☐ Yes ☐ No
Examination of Breast, Thyroid and Spine documented	☐ Yes ☐ No
Systemic Examination documented	☐ Yes ☐ No
Abdomen Examination -Uterine Height, Contractions, Tenderness, Station &FHS documented	☐ Yes ☐ No
Per Speculum- to be done if required	☐ Yes ☐ No
Per Vaginal examination not to be done documented	☐ Yes ☐ No
Amount of External Bleeding Assessed	☐ Yes ☐ No
Ongoing Hemorrhage	☐ Yes ☐ No

INVESTIGATION

CBC	☐ Yes ☐ No
Blood group and Rh typing	☐ Yes ☐ No
Coagulation profile	☐ Yes ☐ No
USG for confirmation of Placenta previa Features of PAS [Placenta Accreta spectrum] looked for	☐ Yes ☐ No
MRI if USG Inconclusive or to assess Invasion	☐ Yes ☐ No

MANAGEMENT

Provisional Diagnosis Documented	☐ Yes ☐ No
Arrangement of Blood/blood products done	☐ Yes ☐ No
Patient referred to higher center (follow referral checklist)	☐ Yes ☐ No

DESIGNATED DELIVERY CENTER

Informed High risk consent (PPH,massive blood transfusion, hysterectomy-if done no pregnancies or periods in future explained)	☐ Yes ☐ No
In high risk consent apart from hysterectomy other emergency procedures like internal iliac ligation /uterine artery embolization consent taken	☐ Yes ☐ No
Steroid cover / MgSO4 for neuro protection if pre-term	☐ Yes ☐ No
Prophylactic Tranexamic acid given.	☐ Yes ☐ No
Antenatal Anti D prohylaxis given for Rh negative patients	☐ Yes ☐ No
Prophylactic Antibiotics given	☐ Yes ☐ No
Multidisciplinary team involved	☐ Yes ☐ No
OT preparedness-OT staff informed	☐ Yes ☐ No
Blood and Blood Products arranged	☐ Yes ☐ No

INTRAPARTUM

Mode of delivery documented	☐ Yes ☐ No
Type of cesarean section documented	☐ Yes ☐ No
Intraoperative details documented	☐ Yes ☐ No
Cesarean Hysterectomy done	☐ Yes ☐ No
Baby delivered through placenta	☐ Yes ☐ No
Completeness of placenta checked	☐ Yes ☐ No
Placenta delivered without difficulty	☐ Yes ☐ No
Documentation of intraoperative bleeding especially following removal of placenta.	☐ Yes ☐ No
Documentation if intraoperative blood transfusions.	☐ Yes ☐ No
Intra operative management of placental site documented	☐ Yes ☐ No
Time of Delivery documented	☐ Yes ☐ No
Baby - Live with Good Apgar	☐ Yes ☐ No
Still birth	☐ Yes ☐ No
Baby - Pallor /Low Hb%	☐ Yes ☐ No

POST PARTUM

Vital monitoring done	☐ Yes ☐ No
PPH monitoring done	☐ Yes ☐ No
Uterine contraction and retraction noted	☐ Yes ☐ No
Assessment of anemia & treatment done accordingly.	☐ Yes ☐ No
No of Blood and Blood products transfused documented	☐ Yes ☐ No
Amount of PPH documented	☐ Yes ☐ No
Counselled about risk in future pregnancies	☐ Yes ☐ No

Date

Signature

Name:

CESAREAN SECTION

PATIENT PROFILE

Patient name:	History of allergy:
Blood group:	Date of admission:
Age:	Husband's name:
Date of Birth:	Contact number
Registration number:	Weight:
ID proof:	Obstetrics Score: G P L A
Height:	Expected date of delivery:
Last menstrual period:	Corrected expected date of delivery:
Period of gestation:	Nurse's name:
Doctor's name:	Booked/ Unbooked:

DETERMINE:

Preterm		☐ Yes ☐ No
High risk If yes, high risk factors documented		☐ Yes ☐ No
Indication for CS documented		☐ Yes ☐ No
Type of CS documented	☐ Elective	☐ Emergency
Modified Robson's scoring (*Appendix 1) done		☐ Yes ☐ No

PRE-OP PREPARATION:

Review of antenatal record and investigations done (Including previous intraoperative notes, if available)	☐ Yes ☐ No
Review of medications being taken by patient done	☐ Yes ☐ No
Counselling done (Indication of surgery, risks and complications, high risk factors, blood transfusion, contraception, neonatal problems, others as per case)	☐ Yes ☐ No
Consents for CS taken	☐ Yes ☐ No
High risk consent, if any	☐ Yes ☐ No
Intraoperative contraceptive planning, if any	☐ Yes ☐ No

Blood grouping and cross matching sent	☐ Yes ☐ No
Arranged blood and blood products	☐ Yes ☐ No
Additional investigations done if any as per case	☐ Yes ☐ No
Pediatrician informed	☐ Yes ☐ No
Anesthesia assessment	☐ Yes ☐ No
Informed OT team	☐ Yes ☐ No
Informed consultant/assistant	☐ Yes ☐ No
Part preparation as per local protocol done	☐ Yes ☐ No
Steroid cover (If preterm) done	☐ Yes ☐ No
MgSo4 (If <32 weeks for neuroprotection) given	☐ Yes ☐ No
FHR monitoring done	☐ Yes ☐ No
NPO for 8 hours, if no (in case of emergency) documented and necessary precautions taken	☐ Yes ☐ No
IV cannula secured (16/18G)	☐ Yes ☐ No
Antibiotic prophylaxis given (As per local protocol)	☐ Yes ☐ No
Tetanus immunization done	☐ Yes ☐ No
Antacid and antiemetic treatment given	☐ Yes ☐ No
Checked FHS prior to shifting to OT	☐ Yes ☐ No
New born corner in OT made ready	☐ Yes ☐ No
Type of anesthesia (SA/EA/CSE/GA) planned, documented	☐ Yes ☐ No
Boyle's apparatus / gases checked	☐ Yes ☐ No
Blood collection vials availability checked	☐ Yes ☐ No
Relatives kept available	☐ Yes ☐ No

INTRA-OP PREPARATION:

FHR checked on OT table	☐ Yes ☐ No
Vitals of patient checked on table	☐ Yes ☐ No
Foley's catheterization done	☐ Yes ☐ No
Sterile linen, mops and instrument check done	☐ Yes ☐ No
Skin Incision type documented	☐ Yes ☐ No
Uterine incision type documented	☐ Yes ☐ No
Adhesions documented	☐ Yes ☐ No
Liquor (Quantity and color documented)	☐ Yes ☐ No
Baby extraction details documented	☐ Yes ☐ No
Time of baby delivery documented	☐ Yes ☐ No
Immediate newborn care provided and documented	☐ Yes ☐ No
Placenta (delivery times, location, size, calcifications) documented	☐ Yes ☐ No
Inj. Oxytocin 10 IU slow iv/ im given after delivery of	☐ Yes ☐ No
Other findings, if yes documented	☐ Yes ☐ No
Types of sutures used at all steps documented	☐ Yes ☐ No
Method of uterine suturing documented	☐ Yes ☐ No
Status of uterine surface and cavity, tubes and ovaries documented	☐ Yes ☐ No
Any other finding such as fibroids, ovarian cyst documented	☐ Yes ☐ No
UV fold if sutured, documented	☐ Yes ☐ No
Parietal peritoneum if sutured, documented	☐ Yes ☐ No
Mop and instrument counts documented (*Appendix2)	☐ Yes ☐ No
Baby details (weight, sex, APGAR) documented	☐ Yes ☐ No
Drains (abdominal/subcutaneous) inserted If yes, documented	☐ Yes ☐ No
Blood loss documented	☐ Yes ☐ No
Input/ output documented	☐ Yes ☐ No
Vitals at time of shifting out of OT documented	☐ Yes ☐ No

POST- OPERATIVE CHECKLIST:

NPO minimum of 6 hours	☐ Yes ☐ No
BP / TPR checked every 15 minutes for 1 hour then every ½ hourly for 2 hour and then every 1 hourly for 24 hours	☐ Yes ☐ No
O2 given, if indicated	☐ Yes ☐ No
In high risk patients, continuous monitoring done	☐ Yes ☐ No
Post Spinal – No pillow / GA – Propped up given	☐ Yes ☐ No
Ensured IV-line patent	☐ Yes ☐ No
IV fluid with 10 units Oxytocin in first pint running at 100ml/ hour followed by plain drip (Duration as per case) given	☐ Yes ☐ No
IV antibiotics given (As per local protocol)	☐ Yes ☐ No
Analgesics given	☐ Yes ☐ No
Input output chart maintained	☐ Yes ☐ No
Sterile vulval Pad provided	☐ Yes ☐ No
Watched for Amount of bleeding PV	☐ Yes ☐ No
Catheter care done	☐ Yes ☐ No
Lactation & Breast feeding established	☐ Yes ☐ No
Specific care, if any documented	☐ Yes ☐ No
Early ambulation done	☐ Yes ☐ No

Date

Signature

Name:

APPENDIX 1:

No.	Instrument	Pre-surgical	Post-surgical
1	Gauze pieces	5	5
2	Sponge (Preferably radio opaque)	5	5
3	B.P Handles size 3 with surgical blade no. 10	1	1
4	Suction catheter No-10	1	1
5	Suction set	1	1
6	Allis forceps: 6 inches	6	6
7	Allis forceps: 8 inches	6	6
8	Artery: Curved: 6 inches	6	6
9	Sponge holding forceps	2	2
10	Dissecting toothed forceps: 6 inches	1	1
11	Dissecting non-toothed forceps: 6 inches	1	1
12	Sutures (Vicryl no.1 and 1.0 and chromic catgut no.1 and 1.0)	4	4
13	Needle holder: 6 inches	1	1
14	Needle holder: 8 inches	1	1
15	Scissors: Straight	1	1
16	Scissors: Tissue cutting –fine	1	1
17	Retractor (Doyens)	1	1
18	Outlet forceps	1	1
19	Cord clamp (long curved artery)	2	2
20	Lange Bach's Tissue retractor	1	1
21	Cautery (Monopolar) set (Cautery tip and wire) (Optional)	1	1
22	Green armytage (If available)	2	2
21	Babcock 6 inches	2	2

APPENDIX 1:

The modified Robson criteria

Table-1: The modified Robson criteria.

Group	Description
1	Nullipara, singleton cephalic, ≥ 37 weeks, spontaneous labour
2	Nullipara, singleton cephalic, ≥ 37 weeks A: Induced B: Caesarean section before labour
3	Multipara, singleton cephalic, ≥ 37 weeks, spontaneous labour
4	Multipara, singleton cephalic, ≥ 37 weeks A: Induced B: Caesarean section before labour
5	Previous Caesarean section, singleton cephalic, ≥ 37 weeks A. Spontaneous labour B. Induced labour C. Caesarean section before labour
6	All nulliparous breeches A. Spontaneous labour B. Induced labour C. Caesarean section before labour
7	All multiparous breeches (including previous Caesarean section) A. Spontaneous labour B. Induced labour C. Caesarean section before labour
8	All multiple pregnancies A. Spontaneous labour B. Induced labour C. Caesarean section before labour
9	All abnormal lies (including previous Caesarean section but excluding breech) A. Spontaneous labour B. Induced labour C. Caesarean section before labour
10	All singleton cephalic, ≤ 36 weeks (including previous Caesarean section) A. Spontaneous labour B. Induced labour C. Caesarean section before labour

PPH KIT

VENOUS ACCESS EQUIPMENTS

EQUIPMENT	AVAILABILITY	EQ UI PMENT	AVAILABILITY
20 G Cannula (pink) (2)		3-way cannula (1)	
18 G Cannula (green) (2)		Tourniquet (1)	
16 G Cannula (grey) (2)		Fixation tape (1)	

VENOUS ACCESS EQUIPMENTS

Checked cylinder availability	☐
Checked cylinder fullness	☐
Expiry date checked	☐

VENOUS ACCESS EQUIPMENTS

ITEMS	AVAILABILITY
Ringer lactate (1 unit)	☐
Normal Saline (100 ml) (1)	☐
Distilled water (10 ml) (5)	☐
Colloid Solution (1 unit)	☐
IV set (2)	☐
DISPOSABLE SYRINGES	**NEEDLES**
10 CC (4) ☐	20G (2) ☐
5 CC (5) ☐	22G (2) ☐

DRUGS

Inj. Oxytocin(5amps)	☐	Inj. Atropine, Adrenaline, furosemide (2 each)	☐
Inj. Methylergometrine (2 Amps)	☐	Inj. Phenergan (1 ampule)	☐
Inj. Prostadin (15Methyl PGF2α)(2 Amps)	☐	Inj. Hydrocortisone(1 vial)	☐
Misoprostol 200µg (3 Tab)	☐	Inj. Tranexamic acid (2Amps)	☐

OTHER EQUIPMENT

Cotton swabs	☐	Foley's Catheter (No 16)	☐
Spirit swab bottle (1)	☐	Urine bag	☐
Antiseptic solution (1)	☐	Surgical gloves (suitable size) (5)	☐
Blood sample collection vials (Plain/EDTA/Fluoride) (5 each)	☐	Blood transfusion set	☐
Suture material Vicryl no 1	☐	Suction catheter (1)	☐
Stethoscope	☐	Checklist and patient monitoring chart (1)	☐
Blood pressure apparatus (1)	☐	PPE kit/N95 mask(1)	☐
Pair of scissors	☐	Long elbow length Sterile gloves (1 pair)	

OTHER INSTRUMENTS & SUPPLIES

Large Speculums (3)	☐	Condom Tamponade	☐
Sponge holding forceps (4)	☐	Uterine Pack (6cm wide & 3 meter)2 in Number	☐
Bakri Balloon (Desirable)	☐	Non-Pneumatic Anti Shock Garment (Desirable)	☐

OTHER INSTRUMENTS & SUPPLIES

Large Speculums (3)	☐	Condom Tamponade	☐
Sponge holding forceps (4)	☐	Uterine Pack (6cm wide & 3 meter)2 in Number	☐
Bakri Balloon (Desirable)	☐	Non-Pneumatic Anti Shock Garment (Desirable)	☐

FOR CONDOM TAMPONADE

SS tray with Lid	☐	Foley's Catheter no 16	☐
Sims Speculum	☐	Condom	☐
Bowl with Swabs	☐	IV set	☐
Sponge Holder	☐	500ml NS	☐
Suture material	☐	Scissors	☐

MAINTAINENCE

Kit kept at easily approachable place	☐
All medical and paramedical staff informed about place where the kit is kept	☐
Kit maintenance checked weekly	☐
Expiry date of the drugs checked weekly	☐
Mock drill conducted at the center every 3 monthly	☐

Date

Signature

Name:

NEONATAL RESUSCITATION

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name:

Registration number: Date of admission:

ID proof: Height

Blood group: Weight:

Obstetric score: G P L A Contact number:

Last menstrual period: Expected date of delivery:

Period of gestation: Corrected Expected date of delivery:

Doctor's name: Nurse's name:

History of allergy: Booked/ Unbooked:

Required equipments kept ready	☐ Yes ☐ No	Laryngoscope	☐ Yes ☐ No
Informed Pediatrician	☐ Yes ☐ No	ET tubes	☐ Yes ☐ No
Stethoscope	☐ Yes ☐ No	Oxygen source	☐ Yes ☐ No
Sterile gloves	☐ Yes ☐ No	Type of oxygen cylinder noted	☐ Yes ☐ No
Medications – IV fluids Normal saline Epinephrine	☐ Yes ☐ No	Positive pressure device (Ambu bag, T piece resuscitator)	☐ Yes ☐ No
Suction apparatus	☐ Yes ☐ No	Scissors Adhesive tapes	☐ Yes ☐ No
Umbilical catheter	☐ Yes ☐ No	Splint for arm (to maintain IV line)	☐ Yes ☐ No
Clock with seconds hand	☐ Yes ☐ No	3 way stop cock	☐ Yes ☐ No
Shoulder roll	☐ Yes ☐ No	8 Fr Feeding tubes	☐ Yes ☐ No
Warm linen	☐ Yes ☐ No	Syringes(1, 3, 5, 10, 20 ml)	☐ Yes ☐ No

Cord clamp	☐ Yes ☐ No	Neonatal resuscitation protocol chart displayed	☐ Yes ☐ No
100 Watt overhead electric bulb/Solar light	☐ Yes ☐ No		

DESIRABLE EQUIPMENTS

Infusion pump	☐ Yes ☐ No	Humidified oxygen supply source	☐ Yes ☐ No
Radiant warmer	☐ Yes ☐ No		

DELIVERY DETAILS

Maternal high risk factors documented (if any)	☐ Yes ☐ No	Intrapartum/Intra operative findings documented	☐ Yes ☐ No
Mode of delivery documented	☐ Yes ☐ No	Anticipated neonatal resuscitation If yes, adequate preparation done	

BABY DETAILS Documentation

☐ Date of birth ☐ Birth weight ☐ Time of birth ☐ Baby sex

BABY CONDITION IMMEDIATELY AFTER BIRTH

Baby cry /respiratory efforts noted	☐ Yes ☐ No	If above features normal, r outine care (Dry, Warmth, Clear airway if required)	☐ Yes ☐ No
Baby tone noted	☐ Yes ☐ No		

IF ABOVE FEATURES ABNORMAL

Dry, warmth, clear airway done	☐ Yes ☐ No	Stimulation of baby done	☐ Yes ☐ No

REASSESSMENT AFTER 30 SEC

Heart rate <100bpm noted	☐ Yes ☐ No	If HR<100/Apnea/ gasping, PPV started	☐ Yes ☐ No
Apnea noted	☐ Yes ☐ No	PPV given by bag and mask	☐ Yes ☐ No
Baby is Gasping	☐ Yes ☐ No	Correct positioning confirmed	☐ Yes ☐ No
If all the above are absent, looked for cyanosis / labored breathing	☐ Yes ☐ No	Effective positive-pressure ventilation (Rapid rise in heart rate, Improvement in oxygenation, Improving muscle tone, Audible breath sound, Chest movement) noted	☐ Yes ☐ No
Baby is Gasping	☐ Yes ☐ No	SpO2 monitored continuously	☐ Yes ☐ No

REASSESSMENT AFTER 60 SEC

HR<100bpm			☐ Yes ☐ No
If yes, ventilation corrective steps taken			☐ Yes ☐ No
If HR>100bpm, post resuscitation care given			☐ Yes ☐ No
HR<60bpm			☐ Yes ☐ No
If yes, Intubation done	☐ Yes ☐ No	Chest compression started	☐ Yes ☐ No
Chest compression with positive-pressure ventilation at 3:1			☐ Yes ☐ No
Condition improving after above manoeuvres			☐ Yes ☐ No

HR persistently less than 60bpm			☐ Yes ☐ No
If yes, IV Epinephrine given	☐ Yes ☐ No	Colloids given	☐ Yes ☐ No
If baby stabilized, post resuscitation care given			☐ Yes ☐ No
Nearby Neonatal Resuscitation Centre kept available in case of need			☐ Yes ☐ No

Date

Signature

Name:

ANNEXURE 1
APGAR SCORE

SCORE	0 points	1 point	2 points
Appearance - Skin colour	Cyanotic/ Pale all over	Peripheral cyanosisonly	Pink
	0	<100	100-140
Grimace Reflex irritability)	No response to stimulation	Grimace (facial movement)/ weak cry when	Cry when stimulated
Activity - Tone	Floppy	Some flexion	Well flexed and resisting
Respiration	Apnoelc	Slow, Irregular breathing	Strong cry

FLUID AND ELECTROLYTES IN POSTPARTUM PERIOD

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

History Of Following Medical Conditions Noted:

Cardiac disease/failure/ Arrythmias	☐ Yes ☐ No	Renal disease	☐ Yes ☐ No
Preeclampsia/ eclampsia	☐ Yes ☐ No	Respiratory disease/ ARDS/ Pulmonary edema	☐ Yes ☐ No
Diabetes mellitus/ Thyroid disorders		Others, if any	

Clinical features noted:

Disoriented or incoherent talking	☐ Yes ☐ No	Features of Dehydration	☐ Yes ☐ No
Vomiting / diarrhea	☐ Yes ☐ No	Pallor/ jaundice	☐ Yes ☐ No
Drowsiness		Urine output of at least 30ml/hour, if decreased management planned	
Palpitations	☐ Yes ☐ No	Features of PPH	☐ Yes ☐ No

Examination findings:

Vitals monitored	☐ Yes ☐ No	IV canula in situ	☐ Yes ☐ No
Pulse rate	☐ Yes ☐ No	Temperature	☐ Yes ☐ No
BP	☐ Yes ☐ No	Input/ output	☐ Yes ☐ No
Pulse rate	☐ Yes ☐ No	Temperature	☐ Yes ☐ No
RR	☐ Yes ☐ No		☐ Yes ☐ No
Signs of dehydration (dry tongue, loss of skin turgor, tachycardia, hypotension, low volume pulse) looked for and if present, documented			☐ Yes ☐ No
Systemic examination (CVS and RS) done	☐ Yes ☐ No	If Any crepts or signs of cardiac failure, documented	☐ Yes ☐ No
Per abdomen examination done	☐ Yes ☐ No	Uterine height/tone /Ascites, if any / presence or absence of bowel sounds documented	☐ Yes ☐ No
Per vaginum bleed (Normal/ increased) documented			☐ Yes ☐ No
Provisional diagnosis (Of fluid electrolyte imbalance and condition which may be causing it) documented			☐ Yes ☐ No

Investigations done: (Relevant to diagnosis)

Urine Albumin/ ketones and sugars	☐ Yes ☐ No	Renal function tests	☐ Yes ☐ No
Blood grouping and cross matching	☐ Yes ☐ No	Coagulation profile	☐ Yes ☐ No
CBC	☐ Yes ☐ No	Desirable investigations (ECG, ABG with lactate levels, Serum magnesium levels), if available	☐ Yes ☐ No
Serum electrolytes	☐ Yes ☐ No	Other investigations, if required	☐ Yes ☐ No
Liver function tests	☐ Yes ☐ No		☐ Yes ☐ No

Management:

Reason for fluids management documented (Resuscitative or maintenance)	☐ Yes ☐ No
Type of fluid used for maintenance documented (RL/DNS)	☐ Yes ☐ No
Electrolytes correction, if given documented	☐ Yes ☐ No
Post normal Vaginal Delivery Oral fluids started as soon as possible	☐ Yes ☐ No

Post LSCS (No other co-morbidities)

IV canula confirmed	☐ Yes ☐ No	Any abnormality in examination documented	☐ Yes ☐ No
Vitals monitored	☐ Yes ☐ No	IV Fluids at 100 ml/hour given	☐ Yes ☐ No
Input output monitored	☐ Yes ☐ No	Watched for bleed per vaginum	☐ Yes ☐ No

Special Case

Signs of heart failure/ pulmonary edema (basal fine crepts) looked for	☐ Yes ☐ No
Fluid requirements adjusted as per the medical condition of the patient	☐ Yes ☐ No
Heart disease: IV Fluids given at 1- 1.5 ml/Kg BW/hour (Inclusive of all fluids) (If restriction required)	☐ Yes ☐ No
Hypertension: All dextrose containing IVF avoided	☐ Yes ☐ No
Hypertension: IV fluids given at 1 – 1.5 ml/Kg BW/hour (Inclusive of all fluids)	☐ Yes ☐ No

Hypertension: IV fluids given at 1 – 1.5 ml/Kg BW/hour (Inclusive of all fluids)			☐ Yes ☐ No
Diabetes: Dextrose containing solutions avoided unless using D5 for a neutralizing drip			
If severe PPH: Crystalloids (1 litre over 15 min) given	☐ Yes ☐ No	Blood and blood products	☐ Yes ☐ No
Crystalloids / Colloids use and amount documented	☐ Yes ☐ No	Definitive management given	☐ Yes ☐ No

Date

Signature

Name:

BLOOD TRANSFUSION IN OBSTETRICS

PATIENT PROFILE

Patient name: Blood group: Age:

Date of admission: Date of Birth:

Husband's name: Registration number:

Contact number ID proof:

Weight: Height:

Obstetrics Score: G P L A Last menstrual period:

Expected date of delivery: Period of gestation:

Corrected expected date of delivery: Doctor's name:

Nurse's name: History of allergy:

Booked/Unbooked:

INDICATION:

Severe Anaemia	☐ Yes ☐ No	Ante Partum Haemorrhage	☐ Yes ☐ No
HELLP syndrome	☐ Yes ☐ No	Post Partum Haemorrhage	☐ Yes ☐ No
DIC	☐ Yes ☐ No	Preoperative transfusion	☐ Yes ☐ No
ITP/TTP	☐ Yes ☐ No	Other indication documented (Specify)	☐ Yes ☐ No
History of transfusion previously, If yes indication specify ..... Type of Product transfused documented			☐ Yes ☐ No
Any history of transfusion reaction			☐ Yes ☐ No

Investigation

Blood grouping and cross matching	☐ Yes ☐ No	Haemoglobin	☐ Yes ☐ No
PCV	☐ Yes ☐ No	Platelet count	☐ Yes ☐ No
Peripheral smear	☐ Yes ☐ No		☐ Yes ☐ No
Any other investigation documented (For Dengue, HELLP, DIC)			☐ Yes ☐ No

TRANSFUSION:

Consent for transfusion taken (Annexure 1)	☐ Yes ☐ No	Blood product: PRBC	☐ Yes ☐ No
Crash tray with Avil / Hydrocortisone made ready	☐ Yes ☐ No	SDP	☐ Yes ☐ No
Bag number noted	☐ Yes ☐ No	RDP	☐ Yes ☐ No
Date of collection noted	☐ Yes ☐ No	FFP	☐ Yes ☐ No
Date of expiry noted	☐ Yes ☐ No	Cryoprecipitate	☐ Yes ☐ No
Blood Group of bag noted (and cross checked with patient's Blood Group)	☐ Yes ☐ No	Number of each product documented	☐ Yes ☐ No
Time and date of transfusion noted			☐ Yes ☐ No
Blood transfusion monitoring chart maintained (Annexure 2)			☐ Yes ☐ No

BLOOD TRANSFUSION REACTIONS (IF ANY)

Monitoring of transfusion done			☐ Yes ☐ No
Any reaction noted, (If Yes, please tick) ☐ Fever ☐ Rigors with chills ☐ Pain ☐ Rash ☐ Nausea ☐ Vomiting ☐ Breathlessness ☐ Swelling ☐ Urticaria ☐ Hematuria ☐ Oliguria ☐ Others _____			
Informed Blood bank in case of Blood Transfusion reactions			☐ Yes ☐ No
Monitoring in Blood Transfusion reactions (Annexure 3)			
Vitals: ☐ Temperature ☐ Pulse ☐ BP ☐ RR ☐ Oxygen saturation ☐ Chest auscultation ☐ CVS ☐ RS			
Management in Blood Transfusion reactions			
Blood Transfusion stopped	☐ Yes ☐ No	Inj. Hydrocortisone given	☐ Yes ☐ No
Inj. Avil given	☐ Yes ☐ No	Details of reaction documented	☐ Yes ☐ No
If reaction is noted, blood and urine sample sent for test within 6 hours			

Date

Signature

Name:

ANNEXURE 1

CONSENT FOR BLOOD AND BLOOD COMPONENTS TRANSFUSION

Patient name: Date:

Age: IP no:

Relationship with patient: Age: Sex:

Diagnosis:

Informed post transfusion risk factors if any:

I/we _____ the undersigned have been explained and advised by Dr._____ that patient needs transfusion of blood /blood products (fresh frozen plasma, packed red cells, platelets concentrate, platelet pheresis) for managing my condition.

I/we understand that transfusion of blood /blood products can result in adverse reactions which are fever, rashes, shortness of breath, shock and on rare occasions death.

I/we understand that inspite of careful screening according to National regulations there could be rare instances of acquiring life threatening infections such as HIV I & II, Hepatitis B & C other viruses/diseases which are yet unknown and for which screening tests do not exist and also risks of receiving transfusions of volunteer blood donors.

I/we have been explained in the language understood by us about the need of the transfusion, its benefits, costs, risk associated and other alternatives and I/we hereby give our full valid consent for the transfusion

Also explained that blood or blood products may or may not be used.

I/we also indemnify_____ hospital and its hospital staff of any liability that may arise because of transfusion.

Witness 1: Signature:

Name of patient: Signature of patient:

Name of doctor: Signature of doctor:

Patient name: Date:

Age: IP no:

Relationship with patient: Age: Sex:

Diagnosis:

Informed post transfusion risk factors if any:

I/we _____ the undersigned have been explained and advised by Dr._____ that patient needs transfusion of blood /blood products (fresh frozen plasma, packed red cells, platelets concentrate, platelet pheresis) for managing my condition.

I/we understand that transfusion of blood /blood products can result in adverse reactions which are fever, rashes, shortness of breath, shock and on rare occasions death.

ANNEXURE 2

Blood & Blood Components transfusion monitoring chart

Patient name: Age: Date:

IP no: Unique identification mark/scar:

Diagnosis:

Blood product: Blood group: Blood unit no:

Date of collection: Date of issue: Date of expiry:

Checked by: Designation: Signature:

Blood transfusion starting time:						
Time	Pulse	BP	RR	SpO2	Blood drop rate/min	remarks
0 min						
15 min						
30 min						
1hrs 30min						
2hrs						
2hrs 30min						

Blood transfusion completion time:

Post transfusion vitals - At 30 mins: At 1hr:

Blood transfusion monitored by: Signature:

ANNEXURE 3

Transfusion reaction form

Patient name: Age: Date:

IP no: Unique identification mark/scar:

Diagnosis:

Blood product: Blood group: Blood unit no:

Date of collection: Date of issue: Date of expiry:

Time of issue: Time of starting transfusion: Time of completion:

Nature of transfusion reaction:

Signs and symptoms of transfusion reaction:

Fever- rigors /chills: Nausea/vomiting:

Pain- site of pain: Allergic symptom- urticaria /rash:

Any other symptoms:

Vitals:

Temperature: SpO2: PR: BP: RR:

Samples: Blood in both EDTA and plain bulb, urine sample _____

(Within 6 hrs of suspected reactions)

Name:

Date: Signature of doctor

PAIN MANAGEMENT IN OBSTETIRCS

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

Investigation

Discussion about labour and post- delivery analgesia and evaluation by anaesthetist planned in ANC period	☐ Yes ☐ No

At pre-procedure evaluation

History taking, patient's needs, risk assessment and stratification done and documented (E.g., Comorbidities/medications history)	☐ Yes ☐ No
Examination (Including vitals, general physical and systemic examination, airway/ spine assessment) done and documented	☐ Yes ☐ No
Provisional decision and plan for mode of analgesia made and documented	

During labour:

Previous analgesia plan documented If no, plan of analgesia discussed and documented	☐ Yes ☐ No
Contraindications to any patient preferred method documented (If applicable)	☐ Yes ☐ No

Prerequisites checked according to the method chosen (Review history, Patent IV cannula, NPO status, time of last dose of heparin, etc)	☐ Yes ☐ No
Infrastructure checked as per method chosen (*Annexure 1)	☐ Yes ☐ No
Method of analgesia documented: ·Non pharmacological therapy ·Medications: IV/IM ·Central neuraxial (SA/EA/CSE) ·Programmed labour protocol Inhalational	☐ Yes ☐ No
Review of maternal and foetal condition (including FHR), stage of labour and list of medications and investigations	☐ Yes ☐ No
Time of initiation of the method documented	☐ Yes ☐ No
Drugs, dosages and route used documented (In case of Neuraxial analgesia, label and mention as ONLY FOR NEURAXIAL USE) (* Annexure 2)	☐ Yes ☐ No
Condition of mother and foetus (FHR) post procedure checked	☐ Yes ☐ No
Patient response (pain relief poor/ adequate/ good/ excellent) documented	☐ Yes ☐ No
Motor and sympathetic block monitored (SA/ EA/ CSE)	☐ Yes ☐ No
Top up dose of medications/ epidural documented	☐ Yes ☐ No
Total duration of analgesia required documented	☐ Yes ☐ No
Method of analgesia / anaesthesia during delivery (IV/IM, Local anaesthesia/ Pudendal block/ top-up EA) documented	☐ Yes ☐ No
Side effects of analgesia noted If yes, treatment given	☐ Yes ☐ No
Post Delivery review with discussion of concerns and post-delivery management documented	☐ Yes ☐ No
Method of post-delivery analgesia discussed and documented	☐ Yes ☐ No
Time of removal of epidural noted, Catheter tip checked (Caution in patients on Anticoagulants)	☐ Yes ☐ No

Date

Signature

Name:

ANNEXURE 1: EQUIPMENTS REQUIRED FOR PAIN MANAGEMENT:

Supplemental oxygen source
Suction supply and related equipment
Self-inflating bag and mask
Airway equipment (for maintaining airway patency and for intubation)
Sphygmomanometer/ pulse oximeter
Monitors (NIBP, SPO2) (As per local availability)
Intravenous cannula (in situ), with fluids, tubing, syringes, and needles
Epidural Set – 18G/ spinal set/ Combined spinal epidural sets
Labels for clear identification of epidural catheter
Aseptic solution (e.g. chlorhexidine 0.5%)/ Cotton swab/ surgical sticking
Equipment to monitor foetal heart rate (Stethoscope, doppler, fetoscope, NST) (As per local availability)
Crash cart / Crash trolley

ANNEXURE 2: DRUGS REQUIRED FOR PAIN MANAGEMENT:

FOR IV/IM analgesia:	Others:
Opioids:	Paracetamol
Tramadol	Anti-emetics like ondansetron
Morphine	Anti-spasmodic like drotaverine
Fentanyl	Antacids
Remifentanil (If available)	Narcotic antagonist like naloxone
Butorphanol (If available)	Anxiolytics
Pentazocine (if available)	Local anaesthetic like lignocaine
For neuraxial analgesia:	Vasopressor medications (ephedrine,
Bupivacaine	phenylephrine)
Ropivacaine (if available)	
Lignocaine with adrenaline	
Inhalation agents (Entonox, Sevonox)	Emergency medications (epinephrine, atropine, intralipid)

POST-OP CARE OBGYN

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

ADMISSION DETAILS

Time of Admission with Date documented	☐ Yes ☐ No
Whom to Contact in case of complication documented.	☐ Yes ☐ No
Contact number of relatives documented	☐ Yes ☐ No
H/O of any major illness documented	☐ Yes ☐ No
Complications of surgery and Anaesthesia like DIC, Embolism, Drug reactions, High spinal etc. explained	☐ Yes ☐ No

IMMEDIATE POST OP

Oxygen requirement documented	☐ Yes ☐ No
Breast feeding initiated within 30 min	☐ Yes ☐ No
Skin to skin mother and baby contact given	☐ Yes ☐ No
Type of Anaesthesia documented	☐ Yes ☐ No
Surgery details documented	☐ Yes ☐ No
Timings When the procedure started and ended	☐ Yes ☐ No
Any intra op complications	☐ Yes ☐ No
If yes, need for monitoring for the same documented	☐ Yes ☐ No
Intra op blood transfusions documented	☐ Yes ☐ No
Intra op colloids transfusions documented	☐ Yes ☐ No
Intra op fluids and medications documented	☐ Yes ☐ No
Specimen sent for Histopathological Examination	☐ Yes ☐ No
Cord blood for ABO, Rh, DCT in Rh negative pregnancy	☐ Yes ☐ No
Anti D to mother, if indicated	☐ Yes ☐ No
Any high -risk feature requiring additional monitoring documented	☐ Yes ☐ No
Time of Shift of patient to post op ward documented	☐ Yes ☐ No
Hand ov er given to post op incharge	☐ Yes ☐ No

ADDITIONAL MONITORING

VITALS AND EXAMINATION	
All Vitals checked	☐ Yes ☐ No
Urine output	☐ Yes ☐ No
Pallor	☐ Yes ☐ No
Uterine height/ tone noted	☐ Yes ☐ No
Surgical wound noted	☐ Yes ☐ No
Systemic examination (CVS and RS) done Any crep itation s noted/documented	☐ Yes ☐ No
Per vaginal bleed	☐ Yes ☐ No

Sugar monitoring (6th to 8th hourly)	☐ Yes ☐ No
Drain output monitoring (subcutaneous/intraperitoneal)	☐ Yes ☐ No
Abdominal girth charting	☐ Yes ☐ No
Continuous Pulse/SpO2/BP monitoring in high risk	☐ Yes ☐ No

MANAGEMENT

Blood / products transfusion (if indicated)	☐ Yes ☐ No
IV Fluids at 100ml/hr given for 24 hours	☐ Yes ☐ No
IV Fluids in High Risk Cases Protocol followed (if indicated)	☐ Yes ☐ No
Epidural catheter if in situ, top ups given	☐ Yes ☐ No
IV Antibiotics started	☐ Yes ☐ No
IV Analgesics started	☐ Yes ☐ No
IV Antiemetics/ antacids started	☐ Yes ☐ No
Sugar Monitoring & Insulin as per sliding scale (if indicated)	☐ Yes ☐ No
Antihypertensives (if indicated)	☐ Yes ☐ No
Any other medications (if indicated)	☐ Yes ☐ No

IMMEDIATE POST OP
LATE POST OPERATIVE PERIOD

Early Ambulation	☐ Yes ☐ No
Oral liquids followed by soft diet started If not reason documented	☐ Yes ☐ No
Urine catheter removed If delayed, reason documented	☐ Yes ☐ No
Any investigations if indicated	☐ Yes ☐ No
Drain removed (indicated cases)	☐ Yes ☐ No
Any medications to be continued in high risk cases documented	☐ Yes ☐ No

Epidural catheter (if present) removal	☐ Yes ☐ No
Bowel sounds heard	☐ Yes ☐ No
Bowel & Bladder Movements Confirmed	☐ Yes ☐ No
Features of paralytic ileus noted If yes, potassium correction given	☐ Yes ☐ No
Dressing changing on D3	☐ Yes ☐ No
Date of discharge D5 If >D5 reason documented	☐ Yes ☐ No
Dressing changing on D3	☐ Yes ☐ No
Date of discharge D5 If >D5 reason documented	☐ Yes ☐ No
DVT prophylaxis if given Duration of prophylaxis documented	☐ Yes ☐ No
Neonatal screening normal If not, abnormality documented & appropriate treatment given	☐ Yes ☐ No

DISCHARGE ADVICE

Post op discharge advice with prescribed drugs given	☐ Yes ☐ No
Stitch removal on D7	☐ Yes ☐ No
Tab. Iron and Calcium advised	☐ Yes ☐ No
Advise on breast feeding and breast care	☐ Yes ☐ No
Advice avoiding lifting of heavy weights given	☐ Yes ☐ No
Contraceptive advice given	☐ Yes ☐ No
Monitoring for high risk factor, if present, advised	☐ Yes ☐ No
Review after 6 weeks or SOS in case excessive Bleeding PV, foul smelling discharge, breast engorgement or fever	☐ Yes ☐ No
Life style Modification advice given	☐ Yes ☐ No

Date:

Signature
Name:

DVT PROPHYLAXIS

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

HISTORY

PERSONAL HISTORY			
Smoking	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
PRESENT OBSTETRC HISTORY			
Multiple pregnancy	☐ Yes ☐ No	Pre-eclampsia	☐ Yes ☐ No
Elderly Gravida	☐ Yes ☐ No	Prolonged Admission	☐ Yes ☐ No
Massive PPH	☐ Yes ☐ No	CS in labor	☐ Yes ☐ No
MEDICAL HISTORY			
Hypertension	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Thrombosis/Stroke	☐ Yes ☐ No	APLA	☐ Yes ☐ No
Surgery or Trauma	☐ Yes ☐ No	Malignancy	☐ Yes ☐ No
Varicose V eins	☐ Yes ☐ No	OHSS	☐ Yes ☐ No
Obesity	☐ Yes ☐ No	Prolonged immobility >4days	☐ Yes ☐ No

EXAMINATION

General physical examination documented	☐ Yes ☐ No
Vitals documented	☐ Yes ☐ No
Signs of Dehydration	☐ Yes ☐ No
Signs of Pelvic/Puerperal Infection	☐ Yes ☐ No
Signs of DVT	☐ Yes ☐ No

RISK ASSESSMENT

High Risk	☐ Yes ☐ No
Low Risk	☐ Yes ☐ No

DOCUMENTATION

Decision	☐ Yes ☐ No
Prophylaxis Advised	☐ Yes ☐ No
Prophylaxis Withheld Reason	☐ Yes ☐ No
Duration	☐ Yes ☐ No
Complications of Prophylaxis given	☐ Yes ☐ No

PROPHYLAXIS

Antenatal	☐ Yes ☐ No
Postnatal	☐ Yes ☐ No

METHOD

Ambulation /Leg exercise	☐ Yes ☐ No
Crepe/Elastic Stockings	☐ Yes ☐ No
Hydration	☐ Yes ☐ No
Heparin	☐ Yes ☐ No

FOLLOW UP

Next assessment	☐ Yes ☐ No
Investigations Advised	☐ Yes ☐ No
Counselling Documentation	☐ Yes ☐ No

Date

Signature

Name:

MATERNAL COLLAPSE

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

High risk informed consent taken	☐ Yes ☐ No

INITIAL MANAGEMENT

Call for help done		Secretions if present drained	☐ Yes ☐ No
Consciousness assessed	☐ Yes ☐ No	Breathing assessed	☐ Yes ☐ No
Oriented	☐ Yes ☐ No	O2 started	☐ Yes ☐ No
Glasgow Coma Scale(*Annexure 1) recorded	☐ Yes ☐ No	IV line secured	☐ Yes ☐ No
Airway examined	☐ Yes ☐ No	IV fluids started	☐ Yes ☐ No
Airway secured	☐ Yes ☐ No	SPO2	☐ Yes ☐ No
Capillary refill time	☐ Yes ☐ No	CPR required	☐ Yes ☐ No
Pulse rate ☐ Yes ☐ No Tachycardia ☐ Bradycardia ☐		If required, CPR given	☐ Yes ☐ No
BP ☐ Yes ☐ No Hypotension ☐ Hypertension ☐		Delivered	☐ Yes ☐ No
Respiratory rate	☐ Yes ☐ No	If not delivered, FHS present	☐ Yes ☐ No
Temperature recorded	☐ Yes ☐ No	Patient on MgSO4 drip If yes toxicity checked	☐ Yes ☐ No ☐ Yes ☐ No

Detailed examination done including obstetric examination	☐ Yes ☐ No	Any drugs given If given, details recorded	☐ Yes ☐ No ☐ Yes ☐ No
Detailed history taken	☐ Yes ☐ No	Urine output recorded	☐ Yes ☐ No
Samples taken	☐ Yes ☐ No	Defibrillation(If required)given	☐ Yes ☐ No
Bedside coagulation tests done	☐ Yes ☐ No	RBS done	☐ Yes ☐ No
Catheterization	☐ Yes ☐ No	If no, Catheterization done ▫ Yes ▫ No	

HISTORY

Patient handled outside ☐	Diabetes mellitus ☐	Drug intake/Injections ☐
Home delivery ☐	Obesity ☐	LSCS ☐
Instrumental delivery ☐	Asthma ☐	Uterine surgery ☐
Prolonged labour ☐	Multipara ☐	Hypertension ☐
Blood transfusion ☐	AV thrombosis ☐	Preeclampsia ☐
Trauma ☐	Group-B streptococcal infection ☐	Seizure disorder ☐
Alcohol abuse ☐	Kidney disorder ☐	Diabetes mellitus ☐
Heart disorder ☐	Liver disorder ☐	Post partum hemorrhage ☐

EXAMINATION

General physical examination			
Pallor present	☐ Yes ☐ No	Jaundice present	☐ Yes ☐ No
Pupils reactive	☐ Yes ☐ No	JVP raised	☐ Yes ☐ No
Cyanosis present	☐ Yes ☐ No	Acidotic breath present	☐ Yes ☐ No
Clubbing present	☐ Yes ☐ No	Calf tenderness present	☐ Yes ☐ No
Edema present	☐ Yes ☐ No		
Systemic examination			
CVS examination done (Arrhythmia, Murmur)	☐ Yes ☐ No	RS examination done(Air entry, Crepitations)	☐ Yes ☐ No
Per abdomen examination			

Antepartum documentation:		**Postpartum documentation:**	
Uterine height	☐Yes ☐ No	Uterine height	☐Yes ☐ No
Uterine contour	☐Yes ☐ No	Uterine tone	☐Yes ☐ No
Uterine tone	☐Yes ☐ No	Uterine contour	☐Yes ☐ No
FHR	☐Yes ☐ No	Surgical wound present	☐Yes ☐ No
Any other findings if present	☐Yes ☐ No	Distension present	☐Yes ☐ No
Intrapartum documentation:		Guarding present	☐Yes ☐ No
Uterine contour	☐Yes ☐ No	Rigidity present	☐Yes ☐ No
	☐Yes ☐ No	Any other findings if present	☐Yes ☐ No
Uterine contractions	☐Yes ☐ No		
Tenderness present	☐Yes ☐ No		
Scar dehiscence(if previous CS)	☐Yes ☐ No		
Fetal parts palpable	☐Yes ☐ No		
superficially	☐Yes ☐ No		
Any other findings if present			
Local examination			
Antepartum documentation:		**Postpartum documentation:**	
Bleeding PV present	☐Yes ☐ No	Bleeding PV present	☐Yes ☐ No
Foul smelling discharge PV present	☐Yes ☐ No	Foul smelling discharge PV present	☐Yes ☐ No
Any other findings if present	☐Yes ☐ No	Mass per vaginum present	☐Yes ☐ No
Intrapartum documentation:		Perineal wound(if present)	☐Yes ☐ No
Bleeding PV present	☐Yes ☐ No	Any other findings if present	
Foul smelling discharge PV present	☐Yes ☐ No		
Mass per vaginum present	☐Yes ☐ No		
Any other findings if present	☐Yes ☐ No		

PROVISIONAL DIAGNOSIS POSSIBLE: ☐Yes ☐ No

MEOWS SCORE(*Annexure 2): Scoring done: ☐Yes ☐ No

MANAGEMENT

INVESTIGATIONS (RELEVANT TO CASE) DONE

Blood grouping and cross matching	☐Yes☐ No	Lactate	☐Yes☐ No	Coagulation profile	☐Yes☐ No
RBS	☐Yes☐ No	Serum electrolytes	☐Yes☐ No	LFT	☐Yes☐ No
CBC	☐Yes☐ No	ECG	☐Yes☐ No	RFT	☐Yes☐ No
Special investigations including COVID if required ▫ Yes ▫ No					

DESIRABLE INVESTIGATIONS IF AVAILABLE

D-dimer	☐ Yes ☐ No	Angiography	☐ Yes ☐ No	2-D Echo	☐ Yes ☐ No
Chest X Ray	☐ Yes ☐ No	CT Scan	☐ Yes ☐ No	ABG	☐ Yes ☐ No

TREATMENT

Time of start of resuscitation noted	☐ Yes ☐ No	Neonatologist involvement	☐ Yes ☐ No
Referred	☐ Yes ☐ No	Debriefing	☐ Yes ☐ No
Followed referred protocol	☐ Yes ☐ No	ICU shift	☐ Yes ☐ No
Decision to shift to ICU/OT if required taken	☐ Yes ☐ No	Inotropic support given	☐ Yes ☐ No
Cardiology reference given	☐ Yes ☐ No	Availability of crash cart checked	☐ Yes ☐ No
Anaesthetic involvement	☐ Yes ☐ No	Neonatologist involvement	☐ Yes ☐ No

Antithrombotics given	☐	Inj. Calcium gluconate given for $MgSO_4$ toxicity	☐
Thromboprophylaxis given	☐	Blood transfusion given	☐
Antibiotics given	☐	Surgery/ Laparotomy/Uterine artery embolization done	☐
$MgSO_4$ therapy given	☐	Treatment for drug anaphylaxis given	☐
Antihypertensive given	☐	Definitive Management (As per Cause)	☐

Planned for Perimortem Cesarean Section	☐ Yes ☐ No
If yes, Done:	☐ Yes ☐ No
Within 4min:	☐ Yes ☐ No

Date:

Signature
Name:

ANNEXURE 1
GLASGOW COMA SCALE

Eye Opening		Verbal Response		Motor Response	
	Points		Points		Points
Spontaneous	4	Oriented	5	Obeys commands	6
To voice	3	Confused	4	Localizes pain	5
To pain	2	Inappropriate words	3	Withdraws	4
None	1	Incomprehensible sounds	2	Abnormal flexion	3*
		Silent	1	Abnormal extension	2**
				No movement	1

ANNEXURE 2
MEOWS SCORE

Physiological parameters	Normal values	Yellow alert	Red Alert
Respirator rate	10-20 breaths per minute	21-30 breaths per minute	< 10 or >30 breaths per minute
Oxygen saturation	96-100%		< 95 %
Temperature	36.0-37.4°C	35-36 or 37.5- 38°C	< 35 or > 38°C
Systolic blood pressure	100-139 mmHg	150 – 180 or 90 – 100 mmHg	>180 or < 90 mmHg
Diastolic blood pressure	50-89 mmHg	90–100 mmHg	>100 mmHg
Heart rate	50-99 beats per minute	100- 120 or 40 -50 beats per minute	>120 or < 40 beats per minute
Neurological response	Alert	Voice	Unresponsive, pain

OBSTETRICS REFERRAL

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

REFERRING DETAILS

Date and time of Referral mentioned	☐
Name and phone number of the Referring facility mentioned	☐
Hospital Number and name of medical Officer documented	☐
Information communicated to referral doctor	☐
Mode of transport documented	☐
Patient is sent with Nurse / Doctor / Attendant/ Paramedical staff	☐
Case summary written	☐
Medical history noted	☐ Yes ☐ No
Surgical history noted	☐ Yes ☐ No
Iv cannula in situ	☐ Yes ☐ No
Blood transfusion given If yes, indication..... Blood transfusion administered without reactions	☐ Yes ☐ No ☐ Yes ☐ No
Treatment given documented	☐ Yes ☐ No
Antihypertensives ☐ Antibiotics ☐ MgSO4 ☐ Anticoagulant / Antiplatelets ☐	

ANNEXURE
REFERRAL LETTER

Patient name: ..... Age: ..... Husband's name: .....

Date and time of admission: ..... Registration number: ..... Blood group: .....

Date and time of transfer: .....

Name of Referral hospital: .....

Telephonically informed to referral hospital: .....

Vacancy of bed enquired: ..... Mode of transport: .....Accompanied by: ....

Indication for referral: .....

Case summary:..... ....

.....

.....

Provisional diagnosis: ....

.....

Investigations REPORTS: .....

.....

Treatment given:

1) Blood transfusion details..... If given completed or not .....

2) Antihypertensives given.....

3) Antibiotics given.....

4) MgSO4 given, if yes details.....

5) Any antiplatelet/ anticoagulant treatment given .....

6) Oxygen inhalation/ ventilation.....

Condition of the patient while referring:

Vitals: ..... Oxygen saturation: ..... Urine output: ..... ml

Examination findings: .....

.....

Name of the referring doctor: Signature: Phone number:

REASONS FOR REFERRAL:
OBSTETRIC CONDITIONS

PROM ☐	Accidental Hemmorhage ☐	Placenta previa ☐
HDP/eclampsia ☐	Multiple pregnancy ☐	Malpresentation ☐
CPD ☐	Post LSCS ☐	PPH ☐
Sepsis ☐	DIC ☐	Excessive bleeding ☐
Ectopic pregnancy ☐	Abortion ☐	Acute abdomen in 1st trimester ☐

MEDICAL CONDITIONS

Severe Anaemia ☐	High grade fever/breathlessness ☐	Jaundice ☐
Seizure disorder ☐	Thyroid disorders ☐	Cardiac disease/previous ☐ Cardiac surgery
Hypertension ☐	Rh incompatibility ☐	Renal Disorders ☐

FETAL CONDITIONS

IUFD ☐	Fetal distress ☐	Fetal diseases /anomalies ☐
IUGR ☐	LBW ☐	Macrosomia ☐
Miscellaneous causes Mentioned if any ☐ Yes ☐ No		

ANESTHETIC COMPLICATIONS:

Conscious at the time of referral	☐ Yes ☐ No
Condition of patient (PR, BP, RR, O2 Saturation, Urine Output) at the time of referral was stable	☐ Yes ☐ No
If unstable, details mentioned	☐ Yes ☐ No
Examination findings of patient documented in referral letter	☐ Yes ☐ No
Presenting condition: stage of labour noted	☐ Yes ☐ No
Condition of fetus documented	☐ Yes ☐ No
Investigations with date and reports entered	☐ Yes ☐ No
Treatment given with date entered	☐ Yes ☐ No

Date:

Signature
Name:

TUBAL STERILISATION

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

Interview

Client is within eligible age >22yrs/45yrs	☐ Yes ☐ No	Client is ever married	☐ Yes ☐ No
Client and spouse has not undergone sterilization in the past	☐ Yes ☐ No	Client has at least one child more than one year of age	☐ Yes ☐ No
Investigations undertaken are within normal limits	☐ Yes ☐ No	Physical status as per clinical observation is within normal limits	☐ Yes ☐ No
Mental status as per clinical observation is normal	☐ Yes ☐ No	General examination done is normal	☐ Yes ☐ No
Informed consent given by the client	☐ Yes ☐ No	Menstrual history in case of female sterilization Date of LMP noted Cycle length in days noted Duration of flow noted Regularity Dysmennorhea	☐ Yes ☐ No

Obstetric history in case of female sterilisation Spontaneous/induced abortions Currently lactating Has amenorrhoea now Pregnant If yes MTP is needed	☐ Yes ☐ No	Contraceptive history Has spouse ever used any contraception Is client or spouse has been using any contraception during the last 6 months If yes Method- IUCD ☐ Condoms ☐ Oral pills ☐ other ☐	
Timing of procedure Post partum(24 hr to 7 days) Interval (42 days or more after delivery to <7days post menopausal) ☐ Post abortion- <12 weeks ☐ >12 weeks ☐ LMP< 08 days ☐ Contraceptive used till surgery ☐ Other ☐	☐ Yes ☐ No		☐ Yes ☐ No

Evaluation:

History of chronic and recent intake of alcohol, smoking and chronic drug intake	☐ Yes ☐ No
Recent any medical illnes	☐ Yes ☐ No
previous surgery	☐ Yes ☐ No
Allergies to medications	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No
Jaundice or liver disorder	☐ Yes ☐ No
RTI/STI/PID	☐ Yes ☐ No
Convulsive disorder	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
Malaria	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Heart disease	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No
Mental illness	☐ Yes ☐ No
Sexual problems	☐ Yes ☐ No

RTI-Prostatitis in spouse:	☐ Yes ☐ No
Epididymitis in spouse	☐ Yes ☐ No
Genital ulcer/discharge in couple	☐ Yes ☐ No
H/o blood transfusion recently	☐ Yes ☐ No
Any gynecological problems	☐ Yes ☐ No

Client Examination:

Vitals noted Pulse rate Blood pressure Respiratory rate Temperature Mental status	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Local examination Abdominal/pelvic examination done the in female are within normal limits Scar	 ☐ Yes ☐ No ☐ Yes ☐ No
Currently on medication If yes specify_____	☐ Yes ☐ No
Physical examination Lungs checked Heart checked Abdomen checked	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
Local examination 1).Female sterilization External genitalia checked PS examination done PV examination done Uterus position checked Uterus size checked Uterus mobility checked Cervical erosion checked Pap test done Adnexa checked	 ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
2).Male sterilization Skin of scrotum checked Testis checked Epididymis checked Hydrocele Hernia Vas deference checked Both vas palpable Client eligible for sterilization	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

Investigations

Hb	☐ Yes ☐ No
Urine albumin	☐ Yes ☐ No
Urine sugar	☐ Yes ☐ No
Urinary pregnancy test	☐ Yes ☐ No
Hiv test	☐ Yes ☐ No
Hbsag	☐ Yes ☐ No

Pre operative checklist:

Written consent taken on document	
Documentation of preoperative instruction	☐ Yes ☐ No
Skin preparation/cleaning with soap or antiseptic	☐ Yes ☐ No
Ornaments/denture/cosmetics/glasses/contact lenses/jewellery were removed and hair hygiene ensured	☐ Yes ☐ No
Xylocaine test dose given	☐ Yes ☐ No
Intramuscular premedication given	☐ Yes ☐ No
Shift client to OT with OT list and with one attender and hand over charge to OT staff	☐ Yes ☐ No

Operation theatre checklist:

Client identity and voluntary,written consenton sterilization form checked	☐ Yes ☐ No
Consent has the authority of a legal document explained to the client	☐ Yes ☐ No
Premedication was administered in client record/document checked	☐ Yes ☐ No
Name of the procedure checked	☐ Yes ☐ No
Availability of medication in ot , including emergency drugs checked	☐ Yes ☐ No
Availability of HLD sterile instruments in ot checked	☐ Yes ☐ No
Availability of adequate and appropriate P.P.E checked	☐ Yes ☐ No
Availability of soap,disinfectants,antiseptics,sterile gloves,sutures and clean running water in OT,client consent and incentive form checked	☐ Yes ☐ No

Operation theatre checklist:

Client is fasting since past 6 hours checked	☐ Yes ☐ No
Passed urine recently	☐ Yes ☐ No
Position of client checked	☐ Yes ☐ No
Sign of anesthetist in case of regional or general anesthesia checked	☐ Yes ☐ No
Date and time checked	☐ Yes ☐ No
Drug name,dosage and route checked	☐ Yes ☐ No

Client on Operation table during surgery checklist:

Surgeon Documentation

Skin sterilisation iodine swab two times in circles around surgical site done	☐ Yes ☐ No
Surgeon operative notes,procedure method,per operative complication/findings noted	☐ Yes ☐ No
Types of anaesthesia given noted 1.local only ☐ 2.local and analgesia ☐ 3.general anesthesia with intubation ☐ 4.spinal anesthesia ☐ 5.other_____ ☐	☐ Yes ☐ No
Surgical incision noted	☐ Yes ☐ No
Technique noted	☐ Yes ☐ No
Method of occlusion of fallopian tubes noted	☐ Yes ☐ No
Details of gas insufflations noted	☐ Yes ☐ No
Pneumoperitoneum created	☐ Yes ☐ No
Insufflators used	☐ Yes ☐ No
Per operative findings noted	☐ Yes ☐ No
Post surgery/immediately after surgery client health assessment noted	☐ Yes ☐ No
Fallopian tube specimen sent for histopatholy	☐ Yes ☐ No
Post operative instruction noted	☐ Yes ☐ No
Details of complication and management specified	☐ Yes ☐ No
Remarks with signature of surgeon noted	☐ Yes ☐ No

Anesthesiologist documentation

Details of medication noted	
Details Analgesia noted	☐ Yes ☐ No
Details of anesthesia-type,vital sign every 5 minutes noted	☐ Yes ☐ No
Complication noted	☐ Yes ☐ No
General health and vitals before shifting client out of OT with signature in notes noted	☐ Yes ☐ No

Staff nurse documentation

Name of staff nurse/assistant noted	☐ Yes ☐ No
Infection prevention protocol followed Before surgery After surgery	 ☐ Yes ☐ No ☐ Yes ☐ No
Bio medical waste management followed	☐ Yes ☐ No
Instrument and mop count taken	☐ Yes ☐ No
Decontamination of instruments in 0.5% chlorine solution for 10 minutes done	☐ Yes ☐ No
Disinfection of OT/ instrument and processing followed	☐ Yes ☐ No

Post surgery shifting and client charge handed over done	☐ Yes ☐ No
Documentation of surgery in appropriate register with date,time and signature done	☐ Yes ☐ No

Post operative checklist:

Pulse rate,blood pressure,respiration rate and type,verbal response,abdominal sweeling or wound dressig soakage if any every 15 minutes in first hour after surgery and after 2 hours,3 hours and 4 hours/continue longer if unstable general condition of client monitored	☐ Yes ☐ No

Descision protocol for discharge of client in post operative ward followed	☐ Yes ☐ No
After 4 hours of surgery client prepared for discharge	☐ Yes ☐ No
Client is awake	☐ Yes ☐ No
Comfortable	☐ Yes ☐ No
Responsive to verbal commands	☐ Yes ☐ No
Can sit on bed,walk	☐ Yes ☐ No
Drinks fluids	☐ Yes ☐ No
Passed clear urine	☐ Yes ☐ No
Vital sign stable	☐ Yes ☐ No
Presence of responsible care taker with client ensured	☐ Yes ☐ No
Written discharge order and instructions by surgeon with signature given	☐ Yes ☐ No

Discharge protocol during discharge from hospital followed	☐ Yes ☐ No
Written discharge summary sheet with details to ensure health of client	☐ Yes ☐ No

Discharge advise checklist:

Instruction to client on hygiene,wound care,diet, Ominous symptoms-fever,lower abdominal pain,wound redness,pus discharge,bloating of abdomen,urinary burning,wound disruption given	☐ Yes ☐ No
Instruction to return for suture removal on 7th say/in emergency when necessary given	☐ Yes ☐ No
Instruction to take rest for 2 days and resume to light work after 3 days and full work after 2 weeks given	☐ Yes ☐ No
Instruction to come if missed periods after surgery within 6 weeks for confirmation and diagnosis given	☐ Yes ☐ No
instruction medication to be continuedat home given	☐ Yes ☐ No
Instruction to resumption of sexual contact after 2 weeks of surgery in interval sterilization given	☐ Yes ☐ No
counselled regarding all instruction	☐ Yes ☐ No

Date:

Signature
Name:

VAGINAL HYSTERECTOMY

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

1. History:

Symptomatology Duration Trial of medical methods for relief	☐Yes ☐No	Previous surgeries: myomectomy, LSCS, endometriosis	☐Yes ☐No
Menstrual history	☐Yes ☐No	Family history of cancer/bleeding disorders	☐Yes ☐No
Obstetric history	☐Yes ☐No	Smoking/ tobacco/other addictions	☐Yes ☐No
Medical illnesses	☐Yes ☐No	Allergy to drugs if any	☐Yes ☐No

2. Examination:

General condition and vitals documented	☐Yes ☐No
Head to toe examination	☐Yes ☐No
Systemic examination	☐Yes ☐No
Vulval & perineal examinations	☐Yes ☐No
Pre op assessment for NDVH - Annexure1	☐Yes ☐No
POP – Q for vaginal hysterectomy for prolapse uterus - Annexure 2	☐Yes ☐No

3. Investigations:

All routine blood investigations	☐ Yes ☐ No
Ultrasonography / MRI/ XRay chest	☐ Yes ☐ No
Endometrial sampling for AUB/ PMB	☐ Yes ☐ No
Pap smear	☐ Yes ☐ No
Pre anaesthetic check up and related investigations	☐ Yes ☐ No

4. Pre operative preparation:

Treat any infections – UTI/ PID/ vulvovaginitis / any systemic infections	☐ Yes ☐ No
Control chronic medical disorders	☐ Yes ☐ No
Stop smoking/ tobacco use	☐ Yes ☐ No
Incentive spirometry	☐ Yes ☐ No
Counselling about complications, optional medical management, removal of ovaries &/or removal of tubes followed by informed consent	☐ Yes ☐ No
Antibiotic prophylaxis.	☐ Yes ☐ No

5. Intra operative check list

WHO surgical safety checklist- Annexure 3	☐ Yes ☐ No
All stumps checked	☐ Yes ☐ No
Status of tubes and ovaries	☐ Yes ☐ No
Uterus size and cutsection	☐ Yes ☐ No
Vault fixation	☐ Yes ☐ No
Amount of blood loss	☐ Yes ☐ No
Drain Required	☐ Yes ☐ No
P/R examination for hematoma, rectal mucosa integrity	☐ Yes ☐ No
Colour of urine	☐ Yes ☐ No
Suspicion or overt bowel or bladder injury	☐ Yes ☐ No
Documentation	☐ Yes ☐ No
Send for histopathology report	☐ Yes ☐ No

6. Post operative checklist:

Post operative vigilance (24hrs.): Pulse , BP, pallor, Urine output	☐ Yes ☐ No
Antibiotic	☐ Yes ☐ No
Thromboembolism prophylaxis	☐ Yes ☐ No
Early catheter removal	☐ Yes ☐ No
Chest physiotherapy and incentive spirometry	☐ Yes ☐ No
Early enteral feeding	
Early ambulation	☐ Yes ☐ No
Early discharge	☐ Yes ☐ No

7. Discharge advice:

Avoid tamponing/ vaginal intercourse for 4-6 wks	☐ Yes ☐ No
Report if bleeding more than spotting	☐ Yes ☐ No
Post op Histopathology	☐ Yes ☐ No
Post operative checkup	☐ Yes ☐ No

Date

Signature

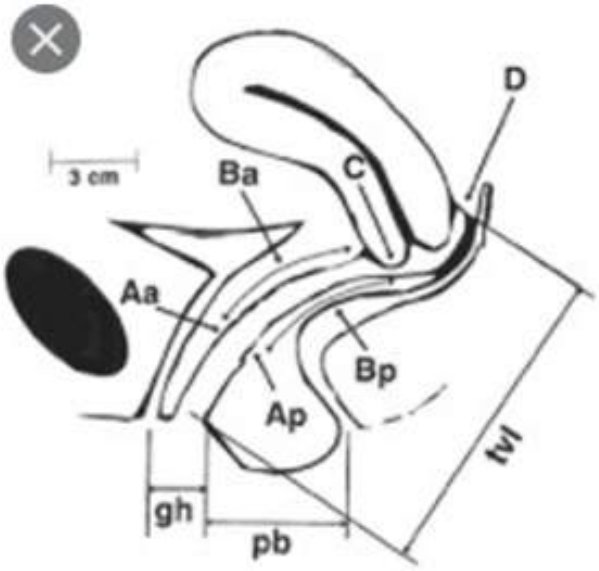
Name:

Annexure 1- Pre op assessment for NDVH(1)

Score	0	1	2
Size of uterus	<8 weeks	8–10 weeks	>10 weeks
Mobility of uterus	Good	Fair	Poor
Inter tuberous distance	>4 knuckles	4 Knuckles	<4 Knuckles
Sub pubic arch	>90°	90°	<90°
Digital exam of vagina	3 finger loose	3 finger tight	2 finger tight
Mobility of vaginal mucosa	Good	Fair	Poor
Fornix depth	>1 finger crease	1 finger crease	<1 finger crease
Descent with volsellum	>1°	1°	<1°
Surgeons experience	>10 years	5–10 years	<5 years
History of previous surgery	Nil	One	>one

Score classification: very easy (0–5), easy (6–10), difficult (11–15), and very difficult (>16)

Annexure 2 - POP – Q for Vaginal Hysterectomy for prolapse uterus (2):



anterior wall Aa	anterior wall Ba	cervix or cuff C
genital hiatus gh	perineal body pb	total vaginal length tvl
posterior wall Ap	posterior wall Bp	posterior fornix D

OR STAGING

· Stage zero- No descent.
· Stage 1.-Descent of any part, but above 1 cm from hymen.
· Stage.2. Descent of any part to a level 1 cm above or below hymen.
· Stage 3. Descent more than 1 cm below hymen but not total eversion of vagina.
· Stage 4. Total eversion of vagina (the uterus may or may not be outside the hymenal rim)

Annexure 3- Intra operative check list WHO surgical safety checklist (3):

Surgical Safety Checklist

World Health Organization | Patient Safety

Before induction of anaesthesia
(with at least nurse and anaesthetist)

Has the patient confirmed his/her identity, site, procedure, and consent?
- ☐ Yes

Is the site marked?
- ☐ Yes
- ☐ Not applicable

Is the anaesthesia machine and medication check complete?
- ☐ Yes

Is the pulse oximeter on the patient and functioning?
- ☐ Yes

Does the patient have a:

Known allergy?
- ☐ No
- ☐ Yes

Difficult airway or aspiration risk?
- ☐ No
- ☐ Yes, and equipment/assistance available

Risk of >500ml blood loss (7ml/kg in children)?
- ☐ No
- ☐ Yes, and two IVs/central access and fluids planned

Before skin incision
(with nurse, anaesthetist and surgeon)

- ☐ **Confirm all team members have introduced themselves by name and role.**
- ☐ **Confirm the patient's name, procedure, and where the incision will be made.**

Has antibiotic prophylaxis been given within the last 60 minutes?
- ☐ Yes
- ☐ Not applicable

Anticipated Critical Events

To Surgeon:
- ☐ What are the critical or non-routine steps?
- ☐ How long will the case take?
- ☐ What is the anticipated blood loss?

To Anaesthetist:
- ☐ Are there any patient-specific concerns?

To Nursing Team:
- ☐ Has sterility (including indicator results) been confirmed?
- ☐ Are there equipment issues or any concerns?

Is essential imaging displayed?
- ☐ Yes
- ☐ Not applicable

Before patient leaves operating room
(with nurse, anaesthetist and surgeon)

Nurse Verbally Confirms:
- ☐ The name of the procedure
- ☐ Completion of instrument, sponge and needle counts
- ☐ Specimen labelling (read specimen labels aloud, including patient name)
- ☐ Whether there are any equipment problems to be addressed

To Surgeon, Anaesthetist and Nurse:
- ☐ What are the key concerns for recovery and management of this patient?

This checklist is not intended to be comprehensive. Additions and modifications to fit local practice are encouraged.

Revised 1 / 2009

LAPAROSCOPY POST OP SAFETY

PATIENT PROFILE

Patient name: Age: Date of Birth:

Husband's name: Contact numbers:

Registration number: Date of admission:

ID proof:

Blood group: Hemoglobin level:

Obstetric score: P L A Last menstrual period:

Weight:

Date of delivery: Post-partum day:

Doctor's name: Nurse's name:Allergies, If any:

A. BEFORE PATIENT LEAVES OPERATION THEATER:

Staff nurse verbally confirms:	
Name of the patient	☐ Yes ☐ No
Instruments, sponges and needle count	☐ Yes ☐ No
Specimen labeling	☐ Yes ☐ No
Any equipment problems	☐ Yes ☐ No
Post - operative concerns for recovery and management of the patient	☐ Yes ☐ No

B. PATIENT IN POST-OPERATIVE RECOVERY ROOM – MONITORING:

1.Monitor Vital Signs such as Blood Pressure, Pulse Rate, Temperature and Breathing Rate	☐ Yes ☐ No
Monitor for any signs of complications	☐ Yes ☐ No
Monitor the patient's urine output	☐ Yes ☐ No
Maintain intravenous infusion rates as per instruction	☐ Yes ☐ No
Check for swallowing or gagging	☐ Yes ☐ No
Monitor the patient's level of consciousness	☐ Yes ☐ No
Check any lines, tubes or drains – Look for patency	☐ Yes ☐ No
Check the dressing over the wound – Look for soakage	☐ Yes ☐ No
Maintain the patient's comfort with analgesics and body positioning	☐ Yes ☐ No
Provide oxygen by mask at the rate of 3 -4 l/min for 1-2 post-operative hours	☐ Yes ☐ No

C. ACTIVITIES FOR PATIENT'S QUICK RECOVERY:

Deep breaths	☐ Yes	☐ No
Coughing	☐ Yes	☐ No
Incentive Spirometry	☐ Yes	☐ No
Turning	☐ Yes	☐ No
Foot and leg exercises	☐ Yes	☐ No
Stockings to be applied in patients with prolonged surgery	☐ Yes	☐ No
DVT prophylaxis	☐ Yes	☐ No

RED ALERT

If the patient is restless, look out for the following		
Airway obstruction	☐ Yes	☐ No
· Hypoxia	☐ Yes	☐ No
· Haemorrhage: Internal or External	☐ Yes	☐ No
· Hypotension and/or hypertension		
· Post-operative pain	☐ Yes	☐ No
· Shivering, hypothermia	☐ Yes	☐ No
· Vomiting, aspiration	☐ Yes	☐ No
· Falling off the bed	☐ Yes	☐ No
· Residual narcosis	☐ Yes	☐ No

SHIFTING TO WARDS – TO CHECK

· Awake or opens eyes on command	☐ Yes	☐ No
· Extubated	☐ Yes	☐ No
· Blood pressure and pulse are satisfactory	☐ Yes	☐ No
· Can lift head on command	☐ Yes	☐ No
· Not hypoxic	☐ Yes	☐ No
· Breathing quietly and comfortably	☐ Yes	☐ No
· Appropriate analgesia has been prescribed and is safely established	☐ Yes	☐ No

POST-OPERATIVE MEDICATIONS

For Pain Relief		
Opiates used	☐ Yes	☐ No
In case of opiate administration oxygen supply to the patients need to be provided.	☐ Yes	☐ No
Naloxone used	☐ Yes	☐ No
Nonsteroidal antiinflammatory drugs (NSAIDs), diclofenac (1mg/kg)/ibuprofen /paracetamol (15mg/kg).	☐ Yes	☐ No
Antibiotic Usage		
An appropriate prophylactic antibiotic used	☐ Yes	☐ No
Timing of administration documented	☐ Yes	☐ No

DISCHARGE NOTE

Diagnosis on admission and discharge	☐ Yes	☐ No
Summary of course in hospital	☐ Yes	☐ No
Instructions about further management, including prescribed drugs	☐ Yes	☐ No
Ensure that a copy of this information is given to the patient	☐ Yes	☐ No
Details of any follow up appointment	☐ Yes	☐ No
Advise to visit in case of problems	☐ Yes	☐ No

Date

Signature

Name:

INFERTILITY

Female Evaluation

Wife's name: OP number Date:

Husband's name: Contact details:

Age: Primary/secondary

infertility

Married since: Consanguinity:

Yes/No

Menstrual history: LMP: Coital history:

Contraception history:

Obstetric history: outcome of previous conception

Medical: TB / Diabetes / Hypertension / Thyroid disorders

Surgical history Drugs usage : H / O any drug

allergy

HISTORY

IUI Received	☐ Yes	☐ No
No of Ovulation induction cycles noted	☐ Yes	☐ No
Protocol followed noted	☐ Yes	☐ No
Mono/Multi follicular growth noted	☐ Yes	☐ No
Total no of cycleswith or without IUI noted	☐ Yes	☐ No
Documentation of ovulation done	☐ Yes	☐ No
Endometrial growth documented	☐ Yes	☐ No

IVF Received	☐ Yes	☐ No
No of cycles noted	☐ Yes	☐ No
Protocol followed noted	☐ Yes	☐ No
No of mature oocytes (own/donor) noted	☐ Yes	☐ No
No of oocyte fertilized noted	☐ Yes	☐ No
Cleavage / blastocyst transfer documented	☐ Yes	☐ No
No of transferred embryos documented	☐ Yes	☐ No
Details of embryo vitrification documented	☐ Yes	☐ No
Outcome of treatment documented	☐ Yes	☐ No

INVESTIGATIONS

CBC & Hb electrophoresis noted	☐ Yes	☐ No
Blood group documented	☐ Yes	☐ No
Urine routine done	☐ Yes	☐ No
TSH & FreeT4 documented	☐ Yes	☐ No
Prolactin levels documented	☐ Yes	☐ No
75gm 2 hr GTT/ HBA1C done	☐ Yes	☐ No
Day 2 FSH/ LH/ AMH documented	☐ Yes	☐ No
Serology (HBsAg/ HIV/ HCV/ VDRL) documented	☐ Yes	☐ No
Vaginal swab taken	☐ Yes	☐ No
PAP smear done	☐ Yes	☐ No
Transvaginal ultrasound done	☐ Yes	☐ No
Uterus: Malformation/ adenomyosis/fibroid/Polyp/Position documented	☐ Yes	☐ No
Endometrium: normal/thin/hyperplasia documented	☐ Yes	☐ No
Right ovary & Left ovary: reserve/cyst/adhesions documented	☐ Yes	☐ No
Cervical pathologies documented	☐ Yes	☐ No
AFC: hyper/normo/poor responder documented	☐ Yes	☐ No
Adnexal masses, pelvic adhesions, uterine cavity malformations or benign SOLs, hydrosalphinx, endometrial growth with assessment of sub endometrial blood flow noted	☐ Yes	☐ No
HSG done	☐ Yes	☐ No
Patent tubes with Normal volume cavity seen	☐ Yes	☐ No
Endometrial biopsy done	☐ Yes	☐ No
TB PCR DNA done	☐ Yes	☐ No
Laparoscopy & Hysteroscopy done	☐ Yes	☐ No
Details ofdiagnosis & management of all pathologies interfering fertility noted	☐ Yes	☐ No

MALE EVALUATION

Name: Age: Date:

Occupation:

Medical history: diabetes / hypertension / cancers / infections

Surgical history: orchidopexy / herniorrhaphy / trauma / procedures

Alcohol: yes / no Tobacco: yes / no Recreational drugs: yes / no

Smoking: yes / no

Childhood diseases:

Semen analysis:

Place	date	count	Motility (all Grades)

INVESTIGATIONS

Hb done	☐ Yes ☐ No
Blood group documented	☐ Yes ☐ No
Serology (HBsAg/ HIV/ HCV/ VDRL) documented	☐ Yes ☐ No
Blood sugar/ HbA1C documented	☐ Yes ☐ No
Urine routine done	☐ Yes ☐ No
Semen morphology documented	☐ Yes ☐ No
Semen culture in special scenario	☐ Yes ☐ No
Sperm DFI in special circumstances	☐ Yes ☐ No

Date

Signature

Name: