

SURNAME: _____ NHI: _____
 FIRST NAMES: _____
 DATE OF BIRTH: ____ / ____ / ____ SEX: _____
 Please attach patient label here

Risk Factors:

G: _____ P: _____	Blood Group: _____	Cord bloods: Yes / No	Membranes SRM <input type="checkbox"/>
EDD: Dates: _____ Scan: _____	Antibodies: _____	Hb: _____ Date: ____ / ____ / ____	Colour ARM <input type="checkbox"/>
Date: ____ / ____ / ____	Hep B: _____	Plat: _____ Date: ____ / ____ / ____	Date: ____ / ____ / ____ Time: _____

Fetal heart rate ●	Time	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30	00	30		
	→																																		
Blood pressure	200																																		
	190																																		
Maternal heart rate x	180																																		
	170																																		
	160																																		
	150																																		
	140																																		
	130																																		
	120																																		
	110																																		
	100																																		
	90																																		
	80																																		
	70																																		
	60																																		
	50																																		

Temperature																																			
Liquor / Show																																			

CERVICAL DILATATION X	10																																		
	9																																		
ABDOMINAL DESCENT ◦	8																																		
	7																																		
	6																																		
	5																																		
	4																																		
	3																																		
	2																																		
	1																																		
	0																																		

Syntocinon: (mu / min)																																			
Start time:																																			
Contractions:	5																																		
<input type="checkbox"/> Mild	4																																		
<input type="checkbox"/> Mod	3																																		
<input type="checkbox"/> Strong	2																																		
	1																																		

Drugs:																																			
--------	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Urine output																																			
Urinalysis																																			
Signature																																			

SURNAME: _____ NHI: _____

FIRST NAMES: _____

DATE OF BIRTH: _____ / _____ / _____ SEX: _____

Please attach patient label here

1. ABDOMINAL PALPATION

Date _____ Time _____

Cx dilatation _____

Effacement _____

Consistency _____

Station _____

Application _____

Position _____

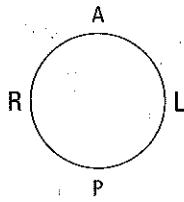
Caput / moulding _____

F.H. _____

Membranes _____

Comments _____

Signature & Designation _____



2. ABDOMINAL PALPATION

Date _____ Time _____

Cx dilatation _____

Effacement _____

Consistency _____

Station _____

Application _____

Position _____

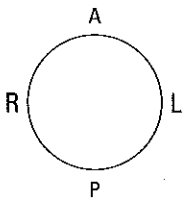
Caput / moulding _____

F.H. _____

Membranes _____

Comments _____

Signature & Designation _____



3. ABDOMINAL PALPATION

Date _____ Time _____

Cx dilatation _____

Effacement _____

Consistency _____

Station _____

Application _____

Position _____

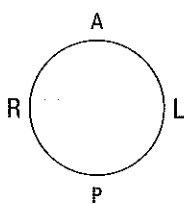
Caput / moulding _____

F.H. _____

Membranes _____

Comments _____

Signature & Designation _____



4. ABDOMINAL PALPATION

Date _____ Time _____

Cx dilatation _____

Effacement _____

Consistency _____

Station _____

Application _____

Position _____

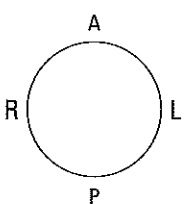
Caput / moulding _____

F.H. _____

Membranes _____

Comments _____

Signature & Designation _____



5. ABDOMINAL PALPATION

Date _____ Time _____

Cx dilatation _____

Effacement _____

Consistency _____

Station _____

Application _____

Position _____

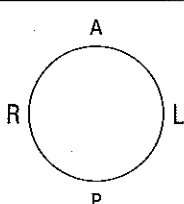
Caput / moulding _____

F.H. _____

Membranes _____

Comments _____

Signature & Designation _____



HIGHLIGHTS OF BIRTHPLAN

Signature & Designation _____