

Midwife Quarterly Report
Client Conditions/Complications

Client Name: _____

Check (✓) any of the following conditions/limitations, complications encountered. Complete a CONSULTATION/TRANSPORT SUMMARY if client or newborn required transport and/or transfer to physician care, or if you have additional information/comments to provide.

<p>Initial Workup</p> <p>1. <input type="checkbox"/> Age 15-18Yrs. 2. <input type="checkbox"/> Age >35 Yrs. 3. <input type="checkbox"/> Parity > 4 4. <input type="checkbox"/> Congenital Defects of Repro. Organs 5. <input type="checkbox"/> Abn. Findings on Physical Exam</p> <p>6. <input type="checkbox"/> Stillbirth 7. <input type="checkbox"/> Neonatal Death 8. <input type="checkbox"/> Difficult Delivery/Depressed Infant 9. <input type="checkbox"/> Birth trauma to mother/ infant 10. <input type="checkbox"/> Pre-eclampsia Eclampsia</p> <p>11. <input type="checkbox"/> Preterm or LBW infants <2500/5.5 lbs 12. <input type="checkbox"/> Infants 4500/gm or 10 lbs & greater 13. <input type="checkbox"/> Postpartum hemorrhage/transfusion. 14. <input type="checkbox"/> Other _____</p>	<p align="center">Consultation:</p> <p>Dr. _____</p> <p>Date / /</p> <p>Approved for Home birth: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Antepartum</p> <p>18. <input type="checkbox"/> Elevated BP 19. <input type="checkbox"/> Edema, Hands/face 20. <input type="checkbox"/> Persistent headaches 21. <input type="checkbox"/> Visual Disturbances 22. <input type="checkbox"/> Seizures 23. <input type="checkbox"/> Severe Abdom. Pain</p> <p>24. <input type="checkbox"/> Bleeding 1st or 2nd trimester 25. <input type="checkbox"/> Bleeding 3rd trimester 26. <input type="checkbox"/> UTI 27. <input type="checkbox"/> HGB<10gm/or HCT<30% 28. <input type="checkbox"/> Varicosities, Vulva Legs</p> <p>29. <input type="checkbox"/> Elevated Temp 30. <input type="checkbox"/> 42 wks Gestation 31. <input type="checkbox"/> Excessive Vomiting 32. <input type="checkbox"/> Persistent Ketonuria 33. <input type="checkbox"/> Wt. Gain <10 lbs. at term 34. <input type="checkbox"/> Shortness of Breath 35. <input type="checkbox"/> Chest pain 36. <input type="checkbox"/> Other _____</p>	<p align="center">Consultation:</p> <p>Dr. _____</p> <p>Date / /</p> <p>Approved for Home birth: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Fetus</p> <p>40. <input type="checkbox"/> Abn. Growth Pattern 41. <input type="checkbox"/> Expos. To Teratogens 42. <input type="checkbox"/> Excessive Activity 43. <input type="checkbox"/> Decreased Activity</p> <p>44. <input type="checkbox"/> FHR<100 45. <input type="checkbox"/> FHR>160 46. <input type="checkbox"/> Irreg FHT 47. <input type="checkbox"/> Cord Prolapse</p> <p>48. <input type="checkbox"/> Meconium Staining 49. <input type="checkbox"/> Multiple Gestation 50. <input type="checkbox"/> Other _____</p>	<p align="center">Consultation:</p> <p>Dr. _____</p> <p>Date / /</p> <p>Approved for Home birth: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Intrapartum</p> <p>54. <input type="checkbox"/> Bleeding 1st or 2nd stage 55. <input type="checkbox"/> Elevated BP 56. <input type="checkbox"/> Elevated Temp 57. <input type="checkbox"/> Pres. Not vertex 58. <input type="checkbox"/> Unengaged head 59. <input type="checkbox"/> Premature ROM 60. <input type="checkbox"/> Prolonged ROM 61. <input type="checkbox"/> Premature Labor</p> <p>62. <input type="checkbox"/> Prolonged 1st Stage 63. <input type="checkbox"/> Prolonged 2nd stage 64. <input type="checkbox"/> Persistent Ketonuria 65. <input type="checkbox"/> Difficult Delivery/Shoulder Dystocia 66. <input type="checkbox"/> Hemorrhage in 3rd stage or w/in 24 hrs. 67. <input type="checkbox"/> Retained Placenta 68. <input type="checkbox"/> Retained fragments or membranes</p> <p>69. <input type="checkbox"/> Uterine Atony 70. <input type="checkbox"/> Laceration 1^o 71. <input type="checkbox"/> Laceration 2 72. <input type="checkbox"/> Laceration 3 73. <input type="checkbox"/> Laceration 4 74. <input type="checkbox"/> Laceration periurethral 75. <input type="checkbox"/> Shock 76. <input type="checkbox"/> Other _____</p>	<p align="center">Consultation:</p> <p>Dr. _____</p> <p>Date / /</p> <p>Approved for Home birth: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Infant</p> <p>80. <input type="checkbox"/> Apgar <5 @ 1 minute 81. <input type="checkbox"/> Apgar < 7 @ 5 minute 82. <input type="checkbox"/> Respiratory Distress 83. <input type="checkbox"/> O2 given 84. <input type="checkbox"/> Assisted Ventilation 85. <input type="checkbox"/> Cardiac compression 86. <input type="checkbox"/> Pale/Cyanotic/Gray 87. <input type="checkbox"/> Meconium stained 88. <input type="checkbox"/> Foul Odor 89. <input type="checkbox"/> Abn. Head Circ.</p> <p>90. <input type="checkbox"/> Congenital Anomaly 91. <input type="checkbox"/> Preterm 92. <input type="checkbox"/> Post-Term 93. <input type="checkbox"/> < 2500 gm / 5 1/2 lbs. 94. <input type="checkbox"/> >4500 gm / 10 lbs. 95. <input type="checkbox"/> SGA 96. <input type="checkbox"/> LGA 97. <input type="checkbox"/> Flushed/Red 98. <input type="checkbox"/> Abnormal Cord 99. <input type="checkbox"/> Abnormal Cry</p> <p>100. <input type="checkbox"/> Jitteriness not resolved by feeding 101. <input type="checkbox"/> Abnormal Temp. 102. <input type="checkbox"/> Abn. Finding on PE 103. <input type="checkbox"/> No urination in 24 hrs. 104. <input type="checkbox"/> No Meconium in 24 hrs. 105. <input type="checkbox"/> Abdominal Distention 106. <input type="checkbox"/> Jaundice 107. <input type="checkbox"/> Poor Feeding 108. <input type="checkbox"/> Other _____</p>	<p align="center">Consultation:</p> <p>Dr. _____</p> <p>Date / /</p> <p>Approved for Home birth: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Postpartum</p> <p>113. <input type="checkbox"/> Hemorrhage after 24 hrs. 114. <input type="checkbox"/> Subinvolution 115. <input type="checkbox"/> Uterine infection</p> <p>116. <input type="checkbox"/> Unable to void in 6 hours 117. <input type="checkbox"/> Urinary tract infection 118. <input type="checkbox"/> Breast infection</p> <p>119. <input type="checkbox"/> Thrombophlebitis (positive Homan's sign) 120. <input type="checkbox"/> Depression 121. <input type="checkbox"/> Other _____</p>	<p align="center">Consultation:</p> <p>Dr. _____</p> <p>Date / /</p> <p>Approved for Home birth: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Narrative Summary: _____

Details on Transfer /Transport and outcome: 4. Reference Number:
Problem:

Call for Transport: 5. Date: / / 6. Time (military):

7. Paramedics 8. Ambulance

Transfer: 9. Time (military):

10. Vehicle: Private auto Ambulance other
11. Destination: Physicians office Hospital Other
12. Name of Hospital if applicable:

Arrival Disposition: 13. Date / / 14. Time (military):

15. Mother:

Evaluated/treated at phys. Office Admitted to hospital
 Evaluated/treated as outpatient at hospital and released.
 Not Applicable

16. Newborn:

Evaluated/treated at physicians office Admitted to hospital
 Evaluated/treated as outpatient at hospital and released
 Transferred to NICU at:
 Not Applicable

17. Maternal outcome: Normal Abnormal Expired

18. Newborn outcome: Normal Abnormal Expired