Sample Delivery Note

_____ y/o now P _____ experienced (NSVD, VBAC, vacuum/forceps assisted delivery) over (intact perineum, 1° MLE, 2° MLE, etc) on (date) @ (time). The infant's head was delivered in a controlled manner. The OP and nares were then (bulb, DeLee) suctioned on the perineum. Amniotic fluid was (clear, mec stained). No nuchal cord was noted. (or a nuchal cord X # was clamped and cut or reduced). The infant's body was then delivered in the usual manner without difficulty. The cord was clamped and cut. The infant was handed to (the doctor, nurse or pediatricians) in attendance. The placenta delivered intact with 3VC followed by (30, 40) units of Pitocin IV and uterine massage for hemostasis. EBL= _____. The (1° MLE, 2° MLE, etc.) was repaired in the usual manner. The cervix and vagina were inspected for lacs and none were noted. The infant, viable (male, female) Apgars _____ and _____ and weight _____ g was taken to (Trans, Level II, Level III) in stable condition. Ms. _____ (pt's name) was taken to RR (or recovered in room) in stable condition with good hemostasis. Cord gas (if drawn): ____.

Average EBL for NSVD is 300-400cc.

Sample Vacuum Note:

_____ y/o now P _____ experienced vacuum/forceps assisted delivery) over 2° MLE on (date) @ (time). Due to (non reassuring heart rate/prolonged second stage/maternal exhaustion, etc.), the vacuum was placed at (+2) station, (ROA) position after bladder emptied and anesthesia found to be adequate. Infant was delivered within (one, two, etc) pulls without complication. The infants head/face was examined and no bruising noted. Then continue with delivery note.

Progress Note for SVD:

PPD# _____ If on antibiotics list drug(s) and day # _____
S: Pt reports _____. (Breast/Bottle) feeding without difficulty. Note what type of birth control she wants after discharge (DMPA, Foam and Condoms, or OCP's). If 3°/4° MLE note whether she has had a BM. If Hct < 25 note whether she feels dizzy or trouble ambulating.

O: VS: Tmax (over past **48 hours**, list date and time), Tc, BP (list ranges if pre-eclamptic), P, RR
Heart: RRR, no M/G/R
Lungs: CTAB
Breasts: not engorged/non-tender/no lesions
Abdomen: soft, NT, fundus firm at or ____cm below umbilicus, +BS
Lochia: scant/min/mod (ask pt to compare to period)
Labia: min edema
Extremities: no c/c/e, Homan's negative

Labs:
VDRL: _____
Type & Rh _____ If Rh neg, record baby's blood type.
PP Hct -Needs to be > 6 hours after delivery (usually pending on PPD#1)
Rubella – look in blue book/triage form/computer, (once immune, always immune) is not redrawn
HBsAg _____
List other labs (HIV, GBS +/-, culture results if drawn)

A/P: Pt is a ____ y/o G __ P _____ s/p NSVD/VBAC/vacuum/forceps assisted delivery on (date) @ (time) doing well on PPD # ___.

1. Continue PP care (if staying).
2. Pt plans to breast/bottle feed infant on discharge.
3. Pt wants DMPA/Foam & Condoms/OCP's on discharge. If pt is breast-feeding, she can have DMPA or Foam & Condoms. OCP's can cause her milk to dry up - pt can get these at FPC visit in 6 weeks. OCP's on 2/3 Sunday if not breast-feeding.
4. If *Rubella Sensitive/Unknown* - needs MMR before discharge.
5. If *Rh negative* - infant is Rh __. Does/ does not need RhoGAM prior to discharge.
6. If *Endometritis/Chorioamnionitis* - Pt Afebrile x ____ hrs or pt continues with fever - continue IV abx until afebrile x 48 hrs. Cultures pending or list results in labs section.
7. If *DM* (gestational or other class) - if GDM needs glucose testing 6 weeks post partum. If Class B or greater, Accu-Cheks should be record with vital signs. Comment on control and what meds are being used to treat it.
8. If going home: discharge home with precautions, Discontinue IV, PNV, FeSO4, Surfak, f/u FPC in 6 weeks.

Pre-Op Note for BTL:

S: no c/o, no F/C/N/V
O: VS

Heart
Lungs
Abd
Lochia
Labia

Labs- Post op Hct:
A/P: __ yo G __ P __ s/p NSVD. Check for chorio/PIH/other comps. Pt w/ satisfied parity, papers signed. Pt w/o questions. Previous surgeries include_ w// _ abdominal scar. No h/o STD's/ PID. Will proceed w/ BTL after anesthesia preop.

Progress Notes for C-section:

POD#
S: Pt reports _____. Breast/bottle feeding with/out difficulty. Flatus neg/pos, BM neg/pos, ambulating well, tolerating diet?
O: Same as for SVD except note under the line for abdomen:
Dressing clean and dry (if POD 1)
Incision: clean/dry/intact, no erythema/exudate

Lab: Post op CBC
A/P: same as SVD

1. ____ y/o G __ P ___ s/p #LTCS doing well.
2. Other pertinent factors as noted for SVDs.
3. Continue current care as per orders.

C/S Op Note:

Pre-Op Diagnosis – 1) TIUP @ ___ wks 2) Indication for procedure (arrest of dilatation/ arrest of descent/fetal distress/failed induction/repeat/ breech or malpresentation/placenta previa/multiple gestation, macrosomia, fetal anomaly)
Post-Op Diagnosis - same, add anything diagnosed during surgery
Procedure - __° LTCS via Pfannenstiel/midline inc, (classical, etc) (BTL if done)
Surgeon: _____,
Assistant _____,
Attending _____
Anesthesia: epidural, general, spinal
IVF _____,
EBL _____, Average EBL for C/S is 1000cc
Urine output _____
Drains:
Indications: __yo. G__ P__at __weeks gestation with _____indication (ie. AOD at 9cm)
Findings: viable male/female, Apgars _____, ____, wt _____, normal uterus, tubes, ovaries (note any abnormalities), cord gas (if drawn).
Complications:
Sponge count: correct x 3
Disposition: stable to RR, infant was taken to _____.
Pathology specimens: (if sent, i.e. placenta, tubals etc.)

C/S procedure and note:

The patient was taken to the operating room where her epidural/spinal anesthesia was found to be adequate. She was then prepared and draped in the normal sterile fashion in the dorsal supine position with a leftward tilt.

1. A *Pfannenstiel/midline* skin incision was then made with the scalpel and carried through to the underlying layer of fascia.
2. The fascia was incised in the midline and extended laterally with the **Mayo scissor.**
3. the incision was then grasped with the **Kocher clamps**, elevated and the underlying rectus muscles dissected off *bluntly/sharply with the **Mayo scissors***.
4. Attention was then turned to the inferior aspect of this incision which, in a similar fashion, was grasped, tented up with the Kocher clamps, and the rectus muscles dissected off *bluntly/sharply with the **Mayo scissors***.
5. The rectus muscles were then separated in the midline, and the peritoneum identified, tented up, and entered sharply with the **Metzenbaum scissors.**

6. The peritoneal incision was then extended superiorly and inferiorly with good visualization of the bladder.
7. The bladder blade was then inserted and the vesicouterine peritoneum identified, grasped with the pick-ups and entered sharply with the **Metzenbaum scissors**.
8. This incision was then extended laterally and the bladder flap created digitally.
9. The bladder blade was then reinserted and the lower uterine segmanet incised in a transverse fashion with the scalpel.
10. The uterine incision was then extended laterally with the bandage scissors.
11. The bladder blade was removed then the infant's head delivered atraumatically.
12. The nose and mouth were suctioned with the bulb suction and the cord clamped and cut.
13. The infant was handed to the waiting pediatricians.
14. The placenta was then removed, the uterus exteriorized, and cleared of all clots and debris.
15. The uterine incision was repaired with 1 chromic in a running, locked fashion.
16. A *second layer* of the same suture was used to obtain excellent hemostasis.
17. The *bladder flap* was repaired with 2.0 chromic in a running stitch and uterus returned to abdomen.
18. The gutters were cleared of all clots, irrigated and the *peritoneum* closed with 2.0 chromic in a running fashion.
19. The fascia was then reapproximated with *1 Vicryl / 1 PDS* in a running fashion.
20. The skin was closed with *staples/suture*.

The patient tolerated the procedure well. Sponge, lap and needle counts were correct times two. 3 grams of Unasyn (or Clindamycin 900mg IV) was given a cord clamp. The patient was taken to the recovery room in stable condition.

Note for Postpartum Tubal Ligation, Modified Pomeroy Method:

After ensuring informed consent, the patient was taken to the OR where spinal anesthesia was administered without complications. She was prepped and draped in the usual sterile fashion. Anesthia was found to be adequate. A small transverse infaumbilical skin incision was made. Kelley clamps were used to bluntly dissect down to the underlying level of fascia which was tented up with Alice clamps and entered sharply with the scalpel. The left Fallopian tube was identified, grasped with the Babcock clamps, and followed out distally until the fimbriae were identified. An avascular midsection of the tube was then clamped and brought into a knuckle at the skin incision. The tube was doubly ligated with 0 plain sutures and transected. The speciman was sent to pathology. Excellent hemostasis was noted and the tube was returned to the abdomen. The same procedure was performed on the right Fallopian tube. Again, excellent hemostasis was noted. The fascia was then closed with 2-0 Vicryl in a single layer. The skin was closed with 4-0 Monocryl in a subcuticular fashion. The patient tolerated the procedure well. Sponge and needle counts were correct times two. The patient was taken to the recovery room in stable condition.