Subjective Data:

Description of Emergency: ____________________________________________________________

Time of Notification: ___________________________ Notified By: _____________________________ Time of Arrival: ___________________________

Current medication(s): ____________________________________________________________________________

Currently being treated for: __________________________________________________________________________

OB History: G: _______ P: _______ Date of LMP: ___________ EDD: ___________

Previous C section:   □ Yes   □ No Previous complications: □ Yes □ No If “Yes” describe: __________________________

Do your contractions increase in frequency, duration and intensify? □ Yes  □ No □ Comment: __________________________

Are you having contractions that stop with change in position? □ Yes  □ No □ Comment: __________________________

Is your pain relieved by walking? □ Yes  □ No □ Comment: __________________________

Are you experiencing low dull back pain that may be occasional or persistent? □ Yes  □ No □ Comment: __________________________

Are you experiencing bowel cramping-diarrhea? □ Yes  □ No □ Comment: __________________________

Are you experiencing change in color or consistency of vaginal discharge or vaginal bleeding? □ Yes  □ No □ Comment: __________________________

Are you experiencing any leakage of fluids from the vagina? □ Yes  □ No □ Comment: __________________________

Are you experiencing menstrual like cramping that feels low in the abdomen? □ Yes  □ No □ Comment: __________________________

Are you experiencing pelvic pressure-like cramping that feels low in the abdomen? □ Yes  □ No □ Comment: __________________________

Are you experiencing uterine contractions every 10 minutes or more with or without pain? □ Yes  □ No □ Comment: __________________________

Objective Data: (clinically indicated VS)

BP ___________ Pulse ___________ Resp. ___________ Temp. ___________ Wt. ___________ O2 sats. ___________ FSBS ___________

Contraction: □ Mild □ Moderate □ Strong Frequency: ___________ minutes Duration: ___________ seconds

FHT: ___________ Fetal Movement: □ + □ - Edema: □ Yes □ No If “Yes” location/description: __________________________

Urine Dipstick: Glucose: □ + □ - Protein: □ + □ - Ketones: □ + □ -

CONTACT HEALTH CARE PROVIDER FOR ALL LABORS. If preterm labor or SROM is suspect DO NOT perform digital vaginal examination. Health care provider must be called if not on site or if after clinic hours.

□ Inmate is in preterm labor (preterm labor is any labor that occurs between 20 weeks and 37 weeks of pregnancy)

□ Bloody show more than 2 tablespoons or bright red in color  □ FHT’s abnormal □ SROM □ Suspect preterm labor

□ Maternal fever greater than 100.4°C (38°C)

Emergency department/EMS notification time: ___________________________ Transport Time: ___________________________

OUMC MUST BE NOTIFIED OF TRANSPORT: Notification Time: _______ Name of person notified: __________________________

Health Care Provider: ___________________________ Time Notified: _______ Orders Received for Treatment: □ Yes □ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: (check all that apply)

□ Check in assessment only for health care providers visit.

□ Monitor uterine contractions: frequency, duration and strength

□ Maintain safe, effective care environment

□ Monitor FHT’s

□ Monitor maternal VS - q1h or as indicated

□ Obtain mid-stream urine for dipstick UA

□ Assist with frequent maternal position changes

□ Lay- in if indicated

□ Education/Intervention: Instructed on position changes, lie on left side, hydration, and frequent bladder emptying, breathing and relaxation exercises. Inmate verbalizes understanding of instructions.

Progress Note: _____________________________________________________________

__________________________________________________________

Health Care Provider Signature/Credentials: ___________________________ Date: _______ Time: _______

RN/LPN Signature/Credentials: ___________________________ Date: _______ Time: _______

Inmate Name
(Last, First)  DOC #