

Student Name: \_\_\_\_\_ OB Simulation Scenario # \_\_\_\_\_ Patient Initials: \_\_\_\_\_ Date: \_\_\_\_\_

IM6 OB-Simulation Report Sheet

Intrapartum Report Sheet		Postpartum Report Sheet	
<p><b>1. Diagnosis</b></p> <p>Admit Date: _____ Time: _____</p> <p>Age: _____ Race: _____</p> <p>Marital Status: _____</p> <p>Allergies: _____</p> <p>Medications: _____</p> <p>LMP: _____ EDD: _____</p> <p>Estimated Gestational Age: _____</p> <p>G: _____ T: _____ PT: _____ AB: _____ L: _____ M: _____</p>	<p><b>2. Maternal Lab</b></p> <p>Blood Type &amp; Rh: _____</p> <p>Antibodies: _____</p> <p>RhoGAM @ 28-32 Weeks: _____</p> <p>Rubella: _____ GBS: _____</p> <p>HIV: _____ HBsAg: _____ VDRL/RPR: _____</p> <p>Gonorrhea: _____ Chlamydia: _____</p> <p>Glucose screen: _____</p>	<p><b>1. Diagnosis:</b></p> <p>Age: _____ Race: _____ Marital Status: _____</p> <p>Allergies: _____</p> <p>LMP: _____</p> <p>EDD: _____ Prenatal Care: _____</p> <p>Gestational Age: _____</p>	<p><b>2. Delivery Information:</b></p> <p>Delivery Date: _____ Time: _____</p> <p><input type="checkbox"/> Vaginal <input type="checkbox"/> C-section <input type="checkbox"/> BTL If C/S, reason: _____</p> <p><input type="checkbox"/> Episiotomy or Lacerations:</p> <p>Anesthesia: <input type="checkbox"/> General <input type="checkbox"/> Spinal <input type="checkbox"/> Epidural</p> <p>Analgesia in L &amp; D: _____</p> <p>Quantitative Blood Loss: _____</p>
<p><b>2. Maternal / Fetal Assessment</b></p> <p>T _____ B/P _____ P _____ R _____ O2Sat _____</p> <p>Cervix: Dili: _____ Eff: _____ Sta: _____</p> <p>PP: <input type="checkbox"/> Vtx <input type="checkbox"/> Breech <input type="checkbox"/> Other: _____</p> <p>Membranes: <input type="checkbox"/> Intact <input type="checkbox"/> SROM <input type="checkbox"/> AROM (time): _____ Color: _____ Odor: _____</p> <p>Uterine Contractions: <input type="checkbox"/> TOCO <input type="checkbox"/> IUPC Freq: _____ Dura: _____ Intens: _____</p> <p>Fetal Heart Rate: <input type="checkbox"/> US <input type="checkbox"/> FSE Baseline: _____ Variability: _____ Accelerations: <input type="checkbox"/> Present <input type="checkbox"/> Absent Decelerations: <input type="checkbox"/> Early <input type="checkbox"/> Late <input type="checkbox"/> Variable <input type="checkbox"/> Prolonged</p> <p>Interventions: <input type="checkbox"/> IUR <input type="checkbox"/> Provider Notified</p>	<p><b>5. Birth / Delivery Plan</b></p> <p>Type Delivery Desires: <input type="checkbox"/> Vaginal <input type="checkbox"/> VBAC</p> <p>C-Section: <input type="checkbox"/> Repeat <input type="checkbox"/> Primary</p> <p>Pain Control Desires: <input type="checkbox"/> Epidural <input type="checkbox"/> Spinal <input type="checkbox"/> IV medications only <input type="checkbox"/> Natural - no medication</p> <p>Special Birthing Plan Request: <input type="checkbox"/> Support person present <input type="checkbox"/> Dula present <input type="checkbox"/> Immediate Skin to Skin <input type="checkbox"/> Immediate Breastfeeding <input type="checkbox"/> Father to cut cord</p>	<p><b>3. Maternal Information:</b></p> <p>T _____ B/P _____ P _____ R _____ O2Sat _____</p> <p>Fundus: _____ @ _____ Lochia: _____</p> <p>Foley: _____ Voided @ _____</p> <p>Blood Type &amp; Rh: _____ Antibodies: _____ RhoGAM @ 28-32 Weeks: <input type="checkbox"/> Type &amp; Screen/RhoGAM needed: <input type="checkbox"/></p> <p>Rubella: <input type="checkbox"/> Immune <input type="checkbox"/> Non immune</p> <p>GBS: <input type="checkbox"/> Positive <input type="checkbox"/> Negative</p> <p>HIV: _____ HBsAg: _____ VDRL/RPR: _____</p> <p>Significant History / Complications: _____</p>	<p><b>4. Newborn Information:</b></p> <p>Sex: _____</p> <p>Apgar: 1min: _____ 5 min: _____ 10 min: _____</p> <p>Weight: _____ lbs. _____ oz. _____ or _____ gms.</p> <p>Length: _____ in. / _____ cms.</p> <p>Admitted to: <input type="checkbox"/> NNB NSY <input type="checkbox"/> NICU</p> <p>Voided: _____ Stool: _____</p> <p>Newborn Complications: _____</p> <p>Concerns: _____</p> <p>Feeding plan: <input type="checkbox"/> Breast <input type="checkbox"/> Bottle</p>

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Clinical Judgment Questions	Bow Tie - Clinical Judgement		
What matters most? (Recognize clues)	Nursing Actions (r/t Universal Competencies)	Potential Condition # 1 (Skill/Disease/Problem)	Parameters to Monitor
What could it mean? (Analyze cues)		Why it this priority # 1	
Where do I start? (Prioritize)	Nursing Actions (r/t Universal Competencies)	Potential Condition # 2 (Skill/Disease/Problem)	Parameters to Monitor
What can I do? (Generate solutions)		Why it this priority # 2	
What will I do? (Take action)	Nursing Actions (r/t Universal Competencies)	Potential Condition # 3 (Skill/Disease/Problem)	Parameters to Monitor
Did it help? (Evaluate outcomes)		Why it this priority # 3	