Student Name: Janice Balaba

Outpatient Evaluation Orders

1. Admit as Outpatient to the OB Triage assessment center
2. Vital signs on admission as needed
3. Fetal Heart Monitor obtain 20-30 minute strip to evaluate fetal status
4. Non-Reassuring Fetal Heart Rate Patterns implement Intrauterine resuscitation and notify provider
5. Monitor uterine activity to evaluate for labor status
6. Cervical exam if no active bleeding or history of placent previa to determine Labor or SROM (no nitrazine test prior to use of lubricant)
7. Notify provided of evaluation for admission or discharge orders

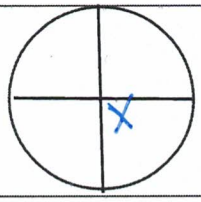
Physician Signature: *Baby Delivery, MD* **Date &Time:** **Today @ 0600**

This Section is to be completed in the Sim center- do not complete before!

Fetal Assessment: NST, US

Position determined by Leopolds _____

Place an **X** in the circle to document point or maximum impulse for FHR



Time	Temp	B/P	P	R	Uterine Activity Freq / Dur. / Str.	Dil. / Efa. / PP / Stat cm / % / /	FHR /Var. /Acel. / Decl.	Pain	Comments
0900		136/84						0	WNL

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Additional Nurses Notes:
I spoke with the provider about patient CW, and the doctor recommended scheduling an induction of labor for Wednesday. Patient agreed and is scheduled for discharge. PT infored about the upcoming appointment on wednesday

Procedure Notes:

Circle Procedure Performed: **Amino** **BPP** **(NST)** **CST** **US** **Labor Eval** **SROM Eval.** **Version**

Documentation for Invasive Procedure:

V/S prior to procedure @_____ T_____ B/P_____ P_____ R_____ FHR_____

Consent (if required) verified prior to procedure Yes (No)

Provider arrived @ N/A

Timeout @ N/A prior to procedure by _____MD _____RN

Procedure started @ N/A

Procedure performed by _____MD

Ultrasound by provided confirm:

1. **Amniotic pocket - Amniotic fluid** _____**ml obtained by provider specimen sent to lab @**_____
2. **Fetal position**
   - **Position** _____ **verified prior to version @**_____
   - **Position** _____ **verified after version @**_____

Additional Notes is needed:

Procedure ended @ _____

Nurses Signature: _____**RN**

Physician Signature _____**MD**

Student Name: Janice Balaba

Professional Communication - SBAR to Primary NURSE

Situation

- Name/age Cynthia Williams 31 F
- G 3 P 2 T PT AB L 1 M EDB / / Est. Gest. Wks.: 38 2/7 week
- Reason for admission decreased Fetal movement

Background

- Primary problem/diagnosis Pregnancy 38 2/7 weeks
- Most important obstetrical history hx of pre eclampsia 1st pregnancy, still birth 2nd pregnancy (39 weeks)
- Most important past medical history No record
- Most important background data Allergy: Morphine

Assessment

- Most important clinical data:
  - Vital signs WNL
  - Assessment NST, VS
  - Diagnostics/lab values (N/a)

Trend of most important clinical data (stable - increasing/decreasing)

- Patient/Family birthing plan? induce
- How have you advanced the plan of care?
- Patient response PT agreed to be induced on Wednesday
- Status (stable/unstable/worsening)
  Stable

Recommendation

- Suggestions for plan of care
  Follow up appointment
  Kick counts at home
  Take insulin and prenatal vitamins regularly
  Observe BP at home

O2 therapy N/a

IV site n/a IV Maintenance n/a

Pain Score - Treatment -

Medications Given -

Fall Risk/Safety -

Diet -

Last Void - Last BM -

Intake - Output: -

Notes:
The patient is stable and scheduled for discharge. Educate patient S/S of preeclampsia and the importance of adhering to Rx medication at home. Instruct PT to continue taking prenatal vitamins and regularly check blood sugar levels. Advise keeping a record of fetal kick counts and to contact provider if changes in fetal movement are noticed.