Student Name: Jordan Magee

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

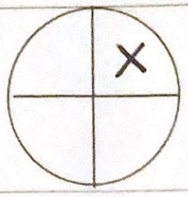
Physician Signature: *Baby Delivery, MD* **Date &Time:** Today @ 0600

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

Fetal Assessment:

Position determined by Leopolds [redacted] LSA

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
1000	99.1	138/88	—	20	6min/2min	4cm 90%	140bpm mod. Variability	0	

Student Name: Jordan Magee

Additional Nurses Notes:
Taught pt about procedure + meds
Pt does not want a C-section

Procedure Notes:

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

Documentation for Invasive Procedure:

V/S prior to procedure @ 1000 T 99.1 B/P 138/88 P — R 20 FHR 140

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

Provider arrived @ 1015

Timeout @ 1015 prior to procedure by Baby Delivery MD Jordan Magee RN

Procedure started @ 1015

Procedure performed by Baby Delivery MD

Ultrasound by provided confirm:

1. Amniotic pocket - Amniotic fluid — ml obtained by provider specimen sent to lab @ —
2. Fetal position
   - Position LSA verified prior to version @ 1000
   - Position ROA verified after version @ 1620

Additional Notes is needed:

Procedure ended @ 1017

Nurses Signature: Jordan Magee RN

Physician Signature Baby Delivery MD

Student Name: Jordan Magee

Professional Communication - SBAR to Primary NURSE

Situation

- Name/age Sarah Roger 23y/o
- G 1 P 0 T 0 PT 0 AB 0 L 0 M 0 EDB 12/08/XX Est. Gest. Wks.: 36wks
- Reason for admission Scheduled for version

Background

- Primary problem/diagnosis Breech presentation
- Most important obstetrical history None
- Most important past medical history None
- Most important background data NKDA

Assessment

- Most important clinical data:
  - Vital signs 99.1F 138/88 20RR FHR: 140bpm moderate variability
  - Assessment 4cm 90% effaced ROM
  - Diagnostics/lab values Nitrazine test +

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

- Patient/Family birthing plan? No C-section
- How have you advanced the plan of care? Administered terbutaline, flipped baby, admitted pt
- Patient response ROM after version, FHR ↑
- Status (stable/unstable/worsening) FHR ↑ 170 (average 140)

Recommendation

- Suggestions for plan of care
  Continue monitoring V/S and FHR, cervical exams. prepare to delivery baby this evening.

O2 therapy N/A

IV site (L) peripheral IV Maintenance LR 125mL/hr

Pain Score 0 Treatment —

Medications Given Terbutaline

Fall Risk/Safety Fall risk precautions

Diet —

Last Void — Last BM —

Intake — Output: —

Notes: Baby position after version was ROA.