

Student Name: _____

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 placenta 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 transverse

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
					every 10 min mild	3 1/2 cm 80%	moderate variability	3	VS WNL

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Additional Nurses Notes:

Reported early labor, contractions every 10 mins, Braxton Hicks

Educated true vs. false

Provide financial resources

Cervical Exam: 3cm - 3 1/2 cm, 75% - 80% effacement

Procedure Notes:

Circle Procedure Performed: Amino BPP NST CST US Labor Eval. SRM 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 @ _____

Timeout @ _____ prior to procedure by _____ MD _____ RN _____

Procedure started @ _____

Procedure performed by _____ MD _____

Ultrasound by provided confirm:

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

Additional Notes is needed:

Procedure ended @ _____

Nurses Signature: _____ RN _____

Physician Signature _____ MD _____

Student Name: _____

Professional Communication - SBAR to Primary NURSE

Situation
<ul style="list-style-type: none">Name/age Alice JONES , 24 y.o.G2 P1 T PT AB L1 M EDB 3/27/XX Est. Gest. Wks.: 38 5/7 weeksReason for admission UC every 10mins
Background
<ul style="list-style-type: none">Primary problem/diagnosis reported early labor - Braxton HicksMost important obstetrical historyMost important past medical history asthmaMost important background data GBS positive
Assessment
<ul style="list-style-type: none">Most important clinical data:<ul style="list-style-type: none">Vital signs ABP - left lateralAssessment 3 - 3 1/2 cm, 75 - 80% effacedDiagnostics/lab valuesTrend of most important clinical data (stable - increasing/decreasing)Patient/Family birthing plan?How have you advanced the plan of care?Patient responseStatus (stable/unstable/worsening)
Recommendation
<ul style="list-style-type: none">Suggestions for plan of careMore teaching - left lat, contractionsdiscuss birth plan

O2 therapy _____
IV site _____ IV Maintenance _____
Pain Score _____ Treatment _____
Medications Given _____
Fall Risk/Safety _____
Diet _____
Last Void _____ Last BM _____
Intake _____ Output: _____

Notes: financial support - give resources