MNRS
Maternal/Newborn Record System™

Obstetric Admitting Record

To order call: **1.800.247.2343** Re-order No. **5710N**

Basic Admission Data

Date____/____/____ Time_____

☐ Ambulatory ☐ Stretcher ☐ Oriented to Unit
☐ Wheelchair ☐ Transfer From _____ ☐ Safety/Security

G	T	Pt	A	L	LMP ___/___/___	EDD ___/___/___	Wks
						EDD By Fetal Assessment ___/___/___	

Prenatal Care Provider_____
Race/Ethnicity_____ Age_____
Language_____ Interpreter Needed? ☐ Yes ☐ No
Advance Directives ☐ **None** ☐ Living Will ☐ Medical Power of Attorney
☐ Patient Bill of Rights Given
Information Given ☐ Yes ☐ No (explain) _____
Organ Donor ☐ Yes ☐ No
Pain ☐ No ☐ Yes (site_____) Intensity 0 (none) _____ 10 (highest)

Type ☐ Aching ☐ Nagging ☐ Dull ☐ Heavy ☐ Crushing ☐ Sharp
☐ Stabbing ☐ Throbbing ☐ Radiating ☐ Burning ☐ Tingling
☐ Cramping ☐ Other: _____

Last Oral Intake: Fluids_____/_____/_____ Time_____
Solids_____/_____/_____ Time_____

Medications **None**

Type/Dose	Last Taken	With Patient No	With Patient Yes	Disposition
		☐	☐	
		☐	☐	
		☐	☐	

MD/CNM Tel No. | Support Person/Relationship Tel No.

Allergy/Sensitivity

☐ **None** ☐ **Latex** ☐ **Food**
☐ Other_____

Reasons for Admission

☐ **Onset of Labor** Time_____
☐ Induction of Labor
☐ Spontaneous Abortion
☐ Cesarean Section
☐ Primary ☐ Repeat
(reason for primary_____)
☐ Tubal Ligation
☐ Vaginal Bleeding
☐ ROM ☐ Premature ☐ Prolonged
☐ Preterm Labor
Detail Reasons for Admission
_____
_____

Observation Evaluation

☐ Fetal Status
☐ Ultrasound
☐ Amniocentesis
☐ NST ☐ CST
☐ Fetal Movement
_____
_____
☐ Medical Complications
_____
_____
☐ Obstetric Complications
_____
_____

Personal Effects Item	Disposition With Patient	With Support Person	Other (Describe)
☐ Clothes			
☐ Jewelry			

Patient Triage Data

☐ See Triage Record

Contractions ☐ **None** ☐ Palpation ☐ Tocotransducer
Frequency_____ Duration_____ Intensity_____
Began on____/____/____ Time_____
Pain intensity 0 (none) _____ 10 (highest)
Membranes ☐ Intact ☐ Bulging
☐ Ruptured (Date____/____/____ Time_____)
☐ Nitrazine test (☐ pos ☐ neg) ☐ Sterile Speculum Exam
☐ Fern test (☐ pos ☐ neg) (findings_____)
☐ Amnisure (☐ pos ☐ neg)

Fluid ☐ Clear ☐ Bloody ☐ Meconium Stained
☐ Foul Odor ☐ No Foul Odor ☐ None Observed
Vaginal Bleeding ☐ **None** ☐ Normal Show
☐ Bleeding (Describe _____)
Cervical Exam By_____
Station_____ Effacement_____ Dilatation___cms
Presentation ☐ Vertex ☐ Transverse Lie
☐ Face/Brow ☐ Compound
☐ Breech (type_____) ☐ Unknown

PRE-PROCEDURE CHECKLIST

(Check all that apply)

☐ History & Physical
☐ Prenatal Records
☐ X-rays and Ultrasounds
☐ Consents
☐ Patient ID
☐ Site ID / Verification
☐ No Jewelry
☐ Other _____
Timeout _____

Physical Assessment

Height	Wt Pregrav/Grav /	Temp	Pulse	Resp	BP	O_2 Sat

Detail Abnormal Findings

System	Normal	Abnormal
HEENT	☐	☐
Neurologic	☐	☐
Skin	☐	☐
Breasts	☐	☐
Extremities	☐	☐
Cardiovascular	☐	☐
Respiratory	☐	☐
Abdomen	☐	☐
Gastrointestinal	☐	☐
Urinary	☐	☐
Genitalia	☐	☐

Initial Problems Identified ☐ **None** | Plan

1. _____
2. _____
3. _____

Fetal Evaluation Data

Multiple Gestation ☐ **No** ☐ Yes

Fundal Height_____cms
Fetal Weight (est.) _____
FHR_____

	Presentation	Position
1.		
2.		
3.		

☐ Fetoscope ☐ Fetal Monitor
☐ Doppler ☐ Other_____

Specimens Obtained (Check all that apply)

Urine Test	Time	Results	Blood Test	Time	Results
☐ Urinalysis			☐ Hgb		
☐ C + S			☐ Hct		
☐ Glucose			☐ VDRL/RPR		
☐ Albumin			☐ Type/Screen		
☐ Ketones			☐		
☐ pH			Cervical Culture		
☐ Blood			☐ GBS		
☐ Toxicology			☐		

Admitting Signature Date/Time | Examiner Signature Date/Time

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Significant Prenatal Data

Prenatal Records Available on Admission
☐ No ☐ Yes Source_____
First Visit by 13 Wks ☐ Yes ☐ No
Regular Care ☐ Yes ☐ No
Prenatal Classes ☐ Yes ☐ No

Pediatric Provider

General Health ☐ **Healthy**
☐ Functional Deficit (Type_____)
☐ Recent Exposure to Communicable Disease
Type/Date_____ ____/____/____
☐ Illness (Less than or equal to 14 days prior to admission)
Type/Treatment_____
☐ Chronic Condition
Type_____

Immunizations ☐ Influenza ☐ Pneumonia ☐ Tetanus ☐ Hepatitis
☐ Other_____

Nutritional Status ☐ See Additional Nutrition Assessment
☐ Well-nourished ☐ Malnourished ☐ Obese
Plan to Breast Feed ☐ Yes ☐ No
☐ Special Diet_____
Eating Disorder ☐ None ☐ Identify_____
Nutritional Problems ☐ None ☐ Identify_____

Lab Findings

☐ **None**

Blood Type & Rh_____
Rubella Titer_____
Serology_____
HBsAg_____
HIV_____
GBS_____
_____ _____
_____ _____

Fetal Assessment Tests

☐ **None**

Date	Test	Result
/		
/		
/		
/		

Problems Identified ☐ None

	Active	Resolved
1._____	☐	☐
2._____	☐	☐
3._____	☐	☐
4._____	☐	☐

Hospitalizations ☐ **None**
1.____/____/____ Reason_____
2.____/____/____ Reason_____

Plans for Birth and Hospital Stay ☐ Birth Plan Attached

Support Person Present in L&D ☐ No ☐ Yes _____
Other Family Members in L&D ☐ No ☐ Yes _____
Anesthesia ☐ **None** ☐ Local ☐ Epidural ☐ Spinal ☐ General
Delivery Site/Position_____
Personal Requests_____
_____
Adoption ☐ No ☐ Yes Contact with Infant ☐ No ☐ Yes
Adoption Contact_____
Feeding Preference ☐ Breast ☐ Bottle
☐ Tubal Ligation Authorization Signed ☐ Yes ☐ No
☐ Circumcision Authorization Signed ☐ Yes ☐ No

Psychosocial Data

☐ See Prenatal Records

Emotional Status ☐ Happy ☐ Ambivalent ☐ Concerned
☐ Depressed ☐ Angry ☐ Other_____
Communication Barriers ☐ **None**
☐ Language ☐ Interpreter_____
☐ Vision ☐ Reading ☐ Writing ☐ Hearing
☐ Speech ☐ Other_____
Support System
Marital Status: S M Sep D W Father involved ☐ Yes ☐ No
Other Support ☐ **None** ☐ _____
Occupation_____ Education_____
Religion ☐ N/A ☐ _____
Personal/Cultural/Religious Customs Affecting Care and/or Learning
☐ **None** ☐ Identify_____
_____

Basic Needs Met	Yes	No	If No, Explain
Food	☐	☐	
Clothing	☐	☐	
Housing	☐	☐	
Transportation	☐	☐	
Finances	☐	☐	

Life Stress	Yes	No	If Yes, Explain
Physical Abuse	☐	☐	
Emotional Abuse	☐	☐	

Life Stress(Cont.)	No	Yes	If Yes, Explain
Major Change	☐	☐	
Self Care Needs	☐	☐	
Serious Illness	☐	☐	
Other_____	☐	☐	

Substance Use	No	Yes	If Yes, amt/day, last use
Tobacco	☐	☐	_____
Alcohol	☐	☐	_____
Prescribed Drugs	☐	☐	_____
Illicit Drugs	☐	☐	_____

Educational Needs	Mother	Support Person	Comments
Stages/Phases of Labor	☐	☐	
Coping Techniques	☐	☐	
Infant Feeding	☐	☐	
Infant Care	☐	☐	

_____

Preferred Learning Methods	Yes	No
One-on-One Instruction	☐	☐
Group Instruction	☐	☐
Written Information	☐	☐
Audio/Visual Information	☐	☐
Demonstration/Practice	☐	☐
Other_____	☐	☐

Discharge Planning Data

Planned Length of Stay_____Days

Home Setting

	Yes	No
Heat, running water, refrigeration	☐	☐
Infant Care Supplies/Car Seat	☐	☐
Phone in home	☐	☐
Transportation available	☐	☐
Adult assistance available	☐	☐

Referrals

☐ RN Case Manager ☐ Utilization Review ☐ Other
☐ Home Care RN ☐ Social Service _____
☐ Nutritionist/Dietician ☐ Pediatric Provider

MD/CNM notified by_____ Date____/____/____Time_____
Admitting Signature_____ Date____/____/____Time_____