MNRS
Maternal/Newborn Record System™

Recovery Flow Record

To order call: **1.800.247.2343** Re-order No. **5713N**

Maternal Data

Admitted___/___/___ Time_____

G	T	Pt	A	L

Pain: 0-10____ Site:_____

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

Delivered___/___/___ Time_____ Age_____ ☐ Vaginal ☐ VBAC ☐ Cesarean (☐ Scheduled ☐ Unscheduled Emergency) ☐ Tubal Ligation ☐ Vacuum ☐ Forceps ☐ Preanesthesia T_____ P_____ R_____ BP_____

Episiotomy ☐ None ☐ Midline ☐ Left Midline Lateral ☐ Right Midline Lateral

Laceration/Extension ☐ None Site:_____ ☐ 1° ☐ 2° ☐ 3° ☐ 4°

Abdominal Incision ☐ No ☐ Yes_____

Anesthesia _____

Complications _____

Mother's Physician_____ Planned LOS_____

Allergy/Sensitivity

☐ None ☐ Latex ☐ Food ☐ Other_____

Infant Data

☐ Male ☐ Female

ID/Band No._____ Name_____

Condition ☐ Live/Normal ☐ Live/Abnormalities Noted ☐ Fetal/Neonatal Death

Feeding ☐ Breast ☐ Bottle

Location ☐ With Mother ☐ Nursery ☐_____

Adoption ☐ No ☐ Yes

Problems Identified ☐ None ☐ Yes _____

Visitors Present ☐ None ☐_____

Maternal Assess

PAR Score Admission_____ Transfer_____

Time	Temperature	Pulse	Respirations/O Sat.	Blood Pressure	Level of Consciousness	Activity	Color	Fundus	Bladder	Abdomen	Lochia	Perineum	Pain	Intake (PO mL's)	Output (Urine mL's)	Response to Infant	Dermatome Level	Incision	Comments	Init

Intake (IV)

Start Date	Time	Solution	Amount mL's	Medication/Dose Added	Initials	Infused Date/Time	Amount

Medication

Time	Medication	Dose	Route/Site	Initials

Released By_____ Date___/___/___ Time_____

Transferred To_____ via _____ Time_____

Report To_____ Time_____

Signature _____

Infant Assess

☐ See Newborn Records

Time	Temperature	Pulse	Respirations	Skin Color	Muscle Tone	Behavior State	Feeding	Urine	Stool	Gastric	*NIPS on back	Comments	Init

Transferred To_____ via _____ Time_____

Report To_____ Time_____

Signature _____

Initials	Signature	Initials	Signature
Initials	Signature	Initials	Signature

See reverse side of this page for Assessment Key and PAR Score Worksheet

Assessment Key

Post Anesthesia Recovery (PAR) Score Worksheet (circle one in each category upon admission and transfer)

		Admission	Transfer
Respiration			
Able to breathe and cough	=	2	2
Dyspnea or limited breathing	=	1	1
Apnea	=	0	0
Blood Pressure			
Less than 20% of preanesthetic level	=	2	2
Plus or minus 20-50% of preanesthetic level	=	1	1
Greater than 50% of preanesthetic level	=	0	0
Level of Consciousness			
Fully awake	=	2	2
Arousable	=	1	1
Not responsive	=	0	0

		Admission	Transfer
Activity			
Able to move 4 extremities	=	2	2
Able to move 2 extremities	=	1	1
Able to move 0 extremities	=	0	0
Color			
Normal / pink	=	2	2
Pale, dusky, blotchy, jaundiced	=	1	1
Cyanotic	=	0	0

Maternal Assessment

Bladder

E	=	Empty
F	=	Filling
D	=	Distended

Perineum

R	=	Red
Ec	=	Ecchymotic
Ed	=	Edematous
NA	=	Not Approximated
WA	=	Well Approximated

Pain

0	=	None
10	=	Highest Intensity

Response to Infant

0	=	No visual contact. No verbal response, demanding or rejecting tone. No attempt to touch infant, rough handling.
1	=	Occasional glances. Single words, no inflection. Minimal touch, holding baby away from body.
2	=	Looks at infant at intervals. Short phrases, average tone. Holds infant, explores with fingertips.
3	=	Seeks en face with infant, smiles at infant. Long phrases, soft, soothing tone. Comments on infant appearance. Enfolds infant, explores with hands.
4	=	Maintains en face with infant. Speaks in rhythmic pattern, loving tone. Uses infant name or “pet” name. Enfolds infant, cuddles, strokes, rocks.

Abdomen (Dressing/Incision)

D/I	=	Dry/Intact
Dr	=	Drainage
S&C	=	Saturated and Changed
NA	=	Not Approximated
WA	=	Well Approximated

Lochia

Sc	=	Scant 0-25% pad saturation
Sm	=	Small 25-50% pad saturation
Mod	=	Moderate 50-75% pad saturation
Lg	=	Large 75-100% pad saturation
C	=	Clots

Infant Assessment

Skin Color

P	=	Pink
R	=	Ruddy
PL	=	Pale
M	=	Mottled
C	=	Cyanotic

Muscle Tone

+	or 1+	Hypotonic (Floppy; poor head control; limp extremities)
++	or 2+	Normal (Flexed; resistant to opposing flexion)
+++	or 3+	Hypertonic (Tightly flexed or stiffly extended extremities; easy startle)
++++	or 4+	Jittery (Persistent tremors, twitches; myoclonic jerks)

Behavior State

S	=	Asleep or drowsy
QA	=	Quiet, alert
C	=	Crying

NEONATAL/INFANT PAIN SCALE (NIPS) (Recommended for children less than 1 year old.) A score greater than 3 indicates pain.

PAIN ASSESSMENT			SCORE
Facial Expression	0 - Relaxed muscles 1 - Grimace	Restful face, neutral expression Tight facial muscles; furrowed brow, chin, jaw (negative facial expression - nose, mouth and brow)	
Cry	0 - No Cry 1 - Whimper 2 - Vigorous Cry	Quiet, not crying Mild moaning, intermittent Loud scream, rising, shrill, continuous (Note: Silent cry may be scored if baby is intubated as evidenced by obvious mouth and facial movement)	
Breathing Patterns	0 - Relaxed 1 - Change in Breathing	Usual pattern for this infant Indrawing, irregular, faster than usual; gagging; breath holding	

PAIN ASSESSMENT			SCORE
Arms	0 - Relaxed 1 - Flexed/Extended	No muscular rigidity; occasional random movements of arms Tense, straight legs; rigid and/or rapid extension, flexion	
Legs	0 - Relaxed/Restrained 1 - Flexed/Extended	No muscular rigidity; occasional random leg movement Tense, straight legs; rigid and/or rapid extension, flexion	
State of Arousal	0 - Sleeping/Awake 1 - Fussy	Quiet, peaceful sleeping or alert random leg movement Alert, restless, and thrashing	

*Recommended by the American Academy of Pediatrics as a pain assessment tool for newborns.