attach patient label here

OB Post Delivery Progress Record (Vaginal and C-Section)

* Indicates a REQUIRED field

[ ] I have reviewed home medications

* **Delivering MD:**_____

* **Assistants: (None Unless noted)** _____

* **Post Op / Final Diagnosis:** IUP (Intrauterine pregnancy) with

[ ] Full term infant (>37 wks) [ ] Preterm infant (<37 wks) [ ] Still born

Procedure Description:

* **Delivery Type: Choose delivery type**

Vaginal Delivery

[ ] SVD [ ] LF [ ] VAC [ ]VTX [ ] Breech (type)_____

C-Section

[ ] LUT [ ] LUV [ ] Classical [ ] Repeat Elective [ ] Repeat Classical

Mode of Delivery Assist

[ ] Vacuum [ ] Forceps

* **Findings (described below):**

INFANT: [ ] Male [ ] Female [ ] Single [ ] Multiple

a) _____

APGARS: _____/_____/_____b) _____

Weight _____lbs_____oz. Grams:_____

Fluid: [ ] CLEAR [ ] MEC: [ ] Thick [ ] Light

ABNORMALITIES (None unless noted):

[ ] Nuchal cord x [ ] True knot

PLACENTA: [ ] SPONTANEOUS [ ] MANUAL [ ] UTERUS EXPLORED

* **EBL:**_____

* **SPECIMENS TO PATHOLOGY: (None unless otherwise specified):**

[ ] PLACENTA [ ] OTHER _____

ANESTHESIA: [ ] NONE [ ] LOCAL [ ] PUDENDAL [ ] EPIDURAL [ ] SPINAL

EPISIOTOMY: [ ] NONE [ ]MEDIAN [ ] MEDIOLATERAL: [ ]**1** [ ] **2** [ ] **3** [ ] **4**

REPAIR: [ ] YES [ ] NO

Suture: _____

LACERATION: [ ] NONE [ ] CERVICAL [ ] VAGINAL [ ] PERIURETHRAL

[ ] PERINEAL: [ ] **1** [ ] **2** [ ] **3** [ ] **4**

REPAIR: [ ] YES [ ] NO

Suture: _____

COMMENTS:

CONDITIONS: [ ] STABLE [ ] OTHER (describe) _____

Date **Time** **Physician's Signature** **MD Number**