GOVERNMENT OF MEGHALAYA
HEALTH & FAMILY WELFARE DEPARTMENT

OBSTETRIC INTRAPARTUM ADMISSION/ORDER RECORD

Hospital Name		District		
Patient's Name:		MRD No./UHID No.		
Father's/Mother's/Husband's Name				
Age:		Ward No.		
Address:		Bed No.		
		Date of Admission		
Occupation:		Time of Admission		AM/PM
Contact No:		MLC:	Yes	No
Provisional Diagnosis:				
Admitting Physician		Emergency	Outpatient	

1. Complaints:

1	History of Amenorrhoea	_____ Months _____ Day
2	Pain Abdomen, If any, since when	
3	Bleeding P.V: if any, since when	
4	Watery Discharge P.V, if any, since when	
5	Any other Complaints	

2. Menstrual History: Regular/Irregular Cycles: _____
LMP:_____
EDD:_____

3. Obstetric History:

Gravida:-	Para:-	Abortion:-	Living: Male/Female: _____

Order of Delivery	Mode of Delivery:- Normal/Instrumental/LSCS	Complications(If any)	Outcome of the Pregnancy:- Live Birth/ Still Birth
1			
2			
3			

4. Contraceptive History: _____

5. Past History: _____

6. Family History: _____

7. General Physical Examination:

Pulse:	BP:	RR:	Temp:	Oedema:

Pallor:	Icterus:	Any other findings:

8. Systemic Examination:-

Cardiovascular system:	
Respiratory system:	
Per Abdomen:	Fundal Height:-
	Presentation:-
	Uterine Contraction:-
	Foetal Heart Sound:-
	Any Other Observations:-
Other Systems(If needed):	

9. Vaginal Examination:

Cervical Effacement:-
Cervical Dilatation:-
Status of Membranes:- Absent:-_____/ Present:-_____
Station of Presenting Part:-
Colour of Liquor:-

10. Pelvic Assessment: Adequate/Not Adequate

11. Provisional Diagnosis:-

12. Laboratory Investigations:

Hb%:-	Urine:-	Blood Group & Rh typing	Blood :-R/E.	HIV & VDRL:-
Any Other Special Investigations Required:- USG Abdomen/Others :				

13. In Latent Phase [Plotting of Partograph to be initiated from 4 Cm dilatation onwards (Mandatory) Enclosed Plotted Partograph .

Date & Time	Pulse	BP	Temp	Ut. Contraction	Foetal Heart Sound	P.V. Examtn	Advice:-

14.Needs Referral to FRU for delivery (If Applicable):

15.Date and Time of Delivery:

16. Delivery Notes:

(i) Mother:-

Mode of Delivery:-	Normal		Assisted		LSCS	
Indication in case of Instrumental Delivery/ LSCS:-						
Date and time of delivery:-						

(ii) AMTSL (Active Management of the 3rd Stage of Labour):

(a)IM Oxytocin 10 unit/ or more.-Y/N
(b) CCT=[Controlled Cord Traction] in 3rd stage labour.:-Y/N
(c) Uterine Massage: Y/N
(d) Pulse: ____
(e)BP:_____
(f) Uterus:- contracted and retracted.
(g)Bleeding P.V.:- Yes/No.

(iii) Placenta & Membrane extracted: Complete ☐ **Incomplete** ☐

(iv) Baby: Sex: Male ☐ **Female** ☐

Cried Immediately / Resuscitation needed :
Colour :-Pink/Blue/Pale
Tone:-Normal / Flaccid
Weight:-
Urine:- Passed / Not Passed
Meconium:- Passed / Not Passed
Congenital Anomalies:- Yes / No; If Yes, Please specify:-

Assessment Grading:- Satisfactory ☐ **Unsatisfactory** ☐

Name of Doctor/Supervisor:_____

Signature of Doctor/Supervisor: _____

Date: _____

Time:-_____