Electronic Encyclopaedia of Perinatal Data (EEPD)
Volume III. Datasets Relevant to Maternity Care
A. Casenotes in Dataset Format.

Hollister maternal/newborn Record System

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as personally analysed and edited

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Any Comments, Criticisms, Corrections
or Suggestions for Improvement very welcome

Hollister maternal/newborn Record System (Page 1)

PATIENT IDENTIFICATION Patient's name

1. Initial Pregnancy Profile

Date:

History since LMP

Check and detail positive findings below. Precede findings with symptom number.

1. Headaches
2. Nausea/vomiting
3. Abdominal pain
4. Urinary complaints
5. Vaginal discharge
6. Vaginal bleeding
7. Oedema (specify area
8. Febrile episode
9. Rubella exposure
10. Viral exposure
11. Drug exposure
12. Radiation exposure
13. Other
14. Last contraceptive: . . . . . None
    Type:
    Last used:
15. Nutritional Assessment: Adequate; Inadequate

Remarks.....

16. Medications Since LMP

(Rx, non-Rx, vitamins) None

Describe

Initial Physical Examination

Height

Weight

Pre-gravid weight

BP

Pulse

SYSTEM Normal Check and detail all positive findings below

17. Skin
18. EENT
19. Mouth
20. Neck
21. Chest
22. Breast
23. Heart
24. Lungs
25. Abdomen
26. Muskuloskeletal
27. Extremities
28. Neurological

Pelvic Examination

29. External genitalia
30. Vagina
31. Cervix
32. Uterus (describe)
33. Adnexa
34 Rectum
35. Other

Bony Pelvis

36. Diag. Conj.
37. Shape Sacrum
38. SS Notch
39. Ischial Spines
40. Pubic arch
41. Trans. Outlet
42. Post sag. diam.
43. Coccyx
44. Classification: Gynaecoid; Android; Anthropoid; Platypelloid
45. Estimation: Adequate; Borderline; Contracted

Exam by:

Hollister maternal/newborn Record System (Page 2)

PATIENT IDENTIFICATION Patient's name.

2. Health History Summary

Date

Age

Race

Religion

Marital Status

Years Married

Education

Occupation

Home Address

Home tel.

Work tel.

Nearest Relative

Relative's Employer

Work

Referring Physician

Attending Physician

Medical History

1. Congenital anomalies
2. Genetic diseases
3. Multiple births
4. Diabetes mellitus
5. Malignancies
6. Hypertension
7. Heart disease
8. Rheumatic fever
9. Pulmonary disease
10. GI problems
11. Renal disease
12. Other urinary tract problems
13. Genitourinary anomalies
14. Abnormal uterine bleeding
15. Infertility
16. Venereal disease
17. Phlebitis, varicosities
18. Nervous/mental disorders
19. Convulsive disorders
20. Metabol./endocrine disorders
21. Anaemia/haemoglobinopathy
22. Blood dyscrasias
23. Drug addiction
24. Smoking/alcohol
25. Infections diseases
26. Operations/accidents
27. Blood transfusions
28. Other hospitalisations
29. No known disease

Menstrual History

Onset Age

Cycle q. days

Length days

Amount

L.M.P.

Pregnancy History

Gravida

Term

Pret

Abort

Live

EDC

For each pregnancy

No

Month/Year

Sex

Weight at Birth

Weeks gestation

Hours in Labour

Type of Delivery

Details of delivery: including anaesthesia and maternal or newborn complications. Use Risk guide where applicable.

Sensitivities

(detail positive findings)

30. None known
31. Antibiotics
32. Analgesics
33. Sedatives
34. Anaesthesia
35. Other

Pre-existing Risk Guide

Indicates pregnancy/outcome at risk

36. Age <15 or > 35
37. < 8th Grade Education
38. Cardiac disease (class I or I I)
39. Tuberculosis, active
40. Chronic pulmonary disease
41. Thrombophlebitis
42. Endocrinopathy
43. Epilepsy (on medication)
44. Infertility (treated)
45. 2 Abortions
46. > 7 deliveries
47. Previous pre-term or SGA infants
48. Infants > 4,000 gms
49. Isoimmunisation (ABO etc)
50. Haemorrhage during previous preg.
51. Previous pre-eclampsia
52. Surgically scarred uterus
53. Other

Indicates pregnancy / outcome at high risk

54. Age > or = 40
55. Diabetes mellitus
56. Hypertension
57. Cardiac disease (class III or IV)
58. Chronic renal disease
59. Congenital / chromosomal anomalies
60. Haemoglobinopathies
61. Immunisation (Rh)
62. Drug addiction / alcoholism
63. Habitual abortions
64. Incompetent cervix
65. Prior fetal or neonatal death
66. Prior neurologically damaged infant
67. Other

Initial Risk Assessment

68. No Risk Factors noted
69. At risk
70. At high risk.

Signature

Hollister maternal/newborn Record System (Page 3)

PATIENT IDENTIFICATION Patient's Name

3. Prenatal Flow Record (Supplemental)

Risk Guide for Pregnancy and Outcome

Preliminary Risk Assessment (details risk factors from the HHS below)

(0) No risk factors Noted

(1) At risk

(2) High risk

Continuing Risk Guide (enter dates first noted and revisit RISK STATUS)

Month/Day

Potential risk factors

3. Preg. Without family support
4. Second pregnancy in 12 months
5. Smoking > 1 pack per day
6. Rh negative (non-sensitised)
7. Uterine/cervical malformation
8. Inadequate Pelvis
9. Venereal disease
10 Anaemia(Hct < 30%:Hgb <10%)
11 Acute pyelonephritis
12 Failure to gain weight
13 Multiple pregnancy (term)
14 Abnormal presentation
15 Post-term pregnancy
16. Other A
17. Other B

High Risk factors

18. Diabetes mellitus
19. Hypertension
20. Thrombophlebitis
21. Herpes (type 2)
22. RH sensitisation
23. Uterine bleeding
24. Hydramnios
25. Severe pre-eclampsia
26. Fetal growth retardation
27. Premature rupt.
28. Multiple pregnancy (pre-term)
29. Low/falling oestriols
30. Significant social problems
31. Other High Risk Factor A
32. Other High Risk Factor B

Initial Prenatal Screen

Month/ Day Test Result

Hct/Hgb

Patient’s Blood Type

Patient’s Rh

Father’s Blood Type

Father’s Rh

Antibody

Serology

Rubella Titre

Urinalysis Micro

Pap test

G.C.

Additional Lab Findings

Month/Day Test Result

Hct/Hgb

Hct/Hgb

G

T

P

A

L

LMP

EDC

Attends prenatal classes

Caesarean Section

For Sterilisation

Breast

Bottle Feeding

Circumcision

Anesthesia

Baby's physician

Flow Chart

Date

Year

Weight this visit:

Blood Pressure:

Urine Protein:

Urine Sugar:

Est. weeks/gestation: (dates/size)

Fundal Height:

Fetal Heart Rate:

Baby’s Physician

Edema:

Risk Status (0, 1, 2)

Physician's signature

Hollister maternal/newborn Record System (Page 4)

4. Prenatal Flow Record (Supplemental)

PATIENT IDENTIFICATION

Patient's Name.

Date:

Year

Weight this visit:

Blood Pressure:

Urine - Protein

Urine - Sugar

Est. weeks gestation: (dates/size)

Fundal height:

Fetal heart rate:

Edema:

Risk status (0,1,2):

Quickening Date: mo/day/yr

Hollister maternal/newborn Record System (Page 5)

5. Obstetric Admitting Record

Basic Admission Data

Significant Prenatal Data

G T P A L LMP: EDC. Age:

Date

Time:

Type of Admission: Direct admit; Transport; Other

Ambulatory; Wheelchair; Stretcher

Next of Kin

Tel No.

Reasons for Admission: Onset of labour; Spontaneous abortion; Observation/evaluation; Caesarean Section; Induction of Labour; Other (Detail Reason)

If Observation/evaluation:

Fetal Status;

Medical Complication;

Obstetric Complication; Other

If Caesarean Section: Primary; Repeat.

If Induction of Labour: Elective; Indicated

Patient Care Data

Contractions on admission:

None; Yes

If Yes

Frequency

Duration

Quality

Began on

Date

Time

Membranes on admission: Intact; Ruptured (date)

Fluid was clear; Meconium; Foul smelling

Vaginal bleeding: None; Normal Show; Bleeding (describe)

Patient has:

Recent URI	No / Yes
Exposure to infection	No / Yes
Been Vomiting	No / Yes
Dentures	No / Yes
Contact lenses	No / Yes
Glasses	No / Yes

Plans for anaesthesia

Yes / None planned

If “Yes”, Specify Type

Last oral intake (date/time)

Fluids	Yes / No
Solids	Yes / No

Current Medication

Yes / None

If Yes

Name / Type

Last taken

Brought in	Yes / No

Patient Plans:

Private; Semi-private

Rooming in Yes /No

Smoker; Non-smoker

Husband in delivery Yes /No

Breast; Bottle Feeding

Circumcision for boy

Other plans

Procedures:

Prep

Enema (results)

Other

Physician's name

Notified by:

Date:

Time

Significant Prenatal Data

Prenatal Lab Tests

None

Fetal assessment tests

Date, Test, Result

None

Allergies/sensitivities

None

Latest risk assessment

No risk factors noted at present; At risk; High risk

1.

2

3.

4.

5.

6.

Prenatal education

Attended Classes

Received prenatal care

Records available when admitted

Source of prenatal data:

Baby's Physician:

Tel No

Admission Physical Examination

Ht.

Wt.

BP

Temp.

Pulse

Resp.

System	WNL	Abn.	Findings
HEENT			
Breasts			
Heart and Lungs			
Abdomen			
Extremities			
Reflexes			

Fetal Evaluation

XXXXXXXXXXx

Blood sent: Time

Urine

Alb.

Glu.

HCT

Hgb

Nurse

Attending

6. Labour Progress Chart

Admission date

Admission time:

Blood type and Rh

Membranes are :

Intact

Ruptured

Bulging

Baby's Physician:

Page

Effacement

%

Examination by:

Blood Pressure:

FHR:

Oxytocin

Frequency:

Duration

Quality:

T

P

R

Medications and Key Events

7. Labour Delivery and Summary

Labour Summary

Delivery Data

Delivery Data

Infant Data

G T P A L Type

Method of Delivery

Delivery Anaesthesia

None

Medications

Presentation

Position

Cephalic

Local

Epidural

None

Spontaneous

Type

Pudendal

Spinal

Scalp care

Vertex Low forceps Paracervical
General Volume expander

Face or brow Mid-forceps No. Agent/
drug Dose Sodium bicarbonate

Breech Rotation To
Drug antagonists

Transverse lie Compound Vacuum extraction No. Agent/
Drug Dose Umbilical catheter

Unknown

Breech

Delivery Room Meds.

None

Other

Spontaneous

Complications

None

Partial extraction (assisted)

Agent/Drug

Dose

Route

Initial Newborn Exam

Total extraction

No prenatal care

Forceps to A.C. head

Time:

Sig:

No observed abnormality

Preterm labour (<37 weeks)

Caesarean (details in operation notes)

Term (>42 weeks)

Low cervical: transverse

Agent/Drug

Dose

Route

Gross congenital anomalies

Febrile (>100.4) when admitted

Low cervical: vertical

PROM (>12 hrs preadmit)

Classical

Time:

Sig.

Mec. Staining Trauma

Meconium

Caesarean

Foul smelling fluid

Placenta

Agent/Drug

Dose Route

Petechiae

Other

Hyrdamnios

Spontaneous

Abruption

Expressed

Time: Sig:

Describe_____

Placenta previa

Manual

Bleeding-site undetermined

Adherent

Chronology

Date

_____

Toxaemia (mild) (severe)

Curettage

Seizure activity

Configuration

{labour (<3hrs)

Normal

Prolonged labour (>20 hrs)

Abn.

Admitted:

Prolonged latent phase

Weighed (No) (Yes)_____gms

Prolonged active phase

Cord

Membranes Ruptured:

Prolonged 2nd stage (>2.5 hrs)

Secondary arrest of dilatation

Cord

Onset of labour:

Basic Data

Cephalopelvic disproportion

Cord prolapse
Nuchal cord
COMPLETE CERVICAL DIL.
ID Bracelet no.
Decreased FHT variability
True knot
Extended fetal bradycardia
2 3 Umbilical vessels
DELIVERY OF INFANT:
Hospital No.
Extended fetal tachycardia
Cord blood to (lab) (refrig) (discard)
Multiple late decelerations
Male
Birth order
Multiple variable decelerations
Episiotomy
DELIVERY OF PLACENTA:

Acidosis (pH<7.2)

Female

Anaesthetic complications

None

Infant Data

_____

Weight

Median

Apgar Scores

At 1 min: At 5 min:

_____

Length

Mediolateral

Heart rate

Vitamin K
Induction
None
Other
Respiration

AgNo3 1% or_____
ARM
Oxytoc
Laceration
Muscle tone
Augmentation
None
None
Sig:
ARM
Oxytoc
1 2 3 4 Degree
perineal
Reflex irritation

Vaginal

Output

Monitor

FHT UC None

Cervical

Skin colour

External

Uterine rupture

Urine

Internal

Other

Spontaneous respiration

Meconium

Gastric

Medications

Total dosage

Surgical Procedures/None

Resuscitation

Living at transfer to:

Tubal ligation

Oxygen

Other

Bag and mask

Deceased

Date

Intubation

Antepartum

Intrapartum

Neonatal

Time of last narcotic

Ext. cardiac massage

Other

Remarks

Assisting:

Attending:

Nurse

Date

8. Initial Newborn Profile

1. Basic Data (entered by nursing personnel) G T P A L

Newborn Risk Indicators - Please review these along with the prior risk

Mother's name:

LMP

information available to you, in order to arrive at your Initial risk estimate

EDC

Delivery Date:

Time: in part 3.

Apgar at: 1min. 5 min. Male Female Ambiguous

Observations at birth within 24 hrs postpartum

2. Physical Examination

(No risk factors noted

(No risk factors noted

Date of exam: Time of exam Baby's age at exam

(Abnormal presentation (Abdominal distension

Temperature

Respiration rate

Pulse rate

(Multiple birth

(Vomiting

Femoral pulse: Normal Absent Weak Delayed

(Low birth weight

(Failure to pass meconium

(Resuscitation at birth

(if skin not stained)

Code:

(= No abnormalities

(= Abnormalities present

(1 min. Apgar < 5

(Melena

(5 min. Apgar < 7

(Apneoic episodes

1. (Reflexes

6. (Thorax

11. (Genitals

(Placental abnormalities

(Tachypneoea(transient)

2. (Skin colour/lesions

7. (Lungs

12. (Anus

(Two cord vessels

(See-saw breathing

3. (Head/Neck

8. (Heart

13. (Trunk/Spine

(Difficult catheterisation

(Cyanosis

4. (Eyes

9. (Abdomen

14. (Extremities/joints

(>20ml. Of gastric aspirate

(Petechiae/Ecchymoses

5. (ENT

10. (Umbilicus

15. (Tone/Appearance

(Small mandible

(cleft palate

(Jaundice

(Grunting

(Pallor

Description of abnormal findings - please describe your findings objectively.

(Deep retractions

(Plethora

Reserve your impressions or diagnoses for part 3 below. Please begin your

(Imperforate anus

(Fever

Findings with the reference number preceding each category.

(Pallor

(Hypothermia

(Jaundice

(Arrhythmia's

(Plethora

(Murmur

(Conclusions

(Lethargy

(Decreased tone

(Tremors

(Congenital malformations

(Convulsions

4. Maturity Evaluation

Gest. age by dates

Weight

Chest circ.

Gest. age by exam

Length

Head circ.

3. Impressions and Diagnosis

This infant is	(pre-term <37 weeks	(SGA
classified as:	(term 37 - 42 weeks	(AGA
	(Post-term >42 weeks	(LGA

Initial Risk Estimate	(No risk factors noted	(Low risk
	(Medium risk	(High risk

5. Plans: diagnostic and therapeutic

9. Newborn Discharge Summary

Physical Examination

Basic Data Infant's Name: last first

Date of Exam | Time of Exam | Baby's age at Exam

Discharge weight: | Mother's record No.

Temperature: | Respiration Rate: | Pulse rate:

Tests | Results | Date | Infant's record No.

(Code: (No abnormalities (Abnormalities present)

Blood Type: | Infant's ID No.

1. (Reflexes
6. (Thorax
11. (Genitals | Coombs Serology | Sex:
2. (Skin colour, lesions
7. (Lungs
12. (Anus | PKU blood/urine | Race:
3. (Head/Neck
8. (Heart
13. (Trunk/Spine

Thyroid | T4/TSH

DoB

4. (Eyes | 9. (Abdomen | 14. (Extremities/Joints

Place of Birth: | Hospital | Home | En route | Other

5. (ENT | 10. (Umbilicus | 15. (Tone/Appearance

Description of Abnormal findings - Please describe your findings objectively.

If baby died note: | Age at death: | Autopsy: Y/N

Reserve your impressions or diagnosis for the Discharge section below. Please Begin your findings with the reference number preceding the circled category.

_____
_____
_____
_____
_____
_____

Newborn discharged on:

(With mother
(To another service
(To another hospital
(Against advice

Follow-up appointment:

(With private physician
(At clinic

Discharge Status - Use this section to summarise the baby's present condition. Describe briefly existing and resolved neonatal problems. If the baby is deceased Explain the reasons for death.

Note:

Date:

Signature:

Problem(1)_____

Course of treatment and impressions - Please refer to the Problem 1, 2, 3, or 4 in your summary. Note also your final impression of the baby at discharge.

Developed: | At birth | In nursery

Status: | Resolved | Stable | Diminished | Accelerated

Problem (2)

Developed: | At birth | In nursery

Status: | Resolved | Stable | Diminished | Accelerated

Problem (3)

Developed : At birth In nursery

Status: Resolved Stable

Diminished Accelerated

Problem (4)

Developed: At birth In nursery

Status: Resolved Stable

Diminished Accelerated

Date: Physician’s signature: