MATERNAL ASSESSMENT

Date:_____ Time:_____
Reason for assessment:_____
G _____ P _____ A _____ NND _____ SB _____
Blood Group/Rh:_____ 28 wk Rho(D) inj. received: ☐ No ☐ Yes
Support Person(s): _____
Relationship: _____
Primary Care Provider:

LMP: _____ ☐ Known ☐ Unsure
EDD: _____ by ☐ LMP; or
☐ U/S @ _____ weeks
Gestation: _____weeks

Current Health and History:

Previous Pregnancy / Delivery:

Medical History:

Substance Use:
Smoking: ☐ No ☐ Yes Amt/day: _____
Alcohol: ☐ No ☐ Yes Amt/week: _____
Cannabis: ☐ No ☐ Yes Frequency: _____
Other: ☐ No ☐ Yes Describe: _____
Intimate Partner Violence: ☐ No ☐ Yes
Psychosocial Concerns: ☐ No ☐ Yes
Describe:

Labour and Birth Plan: ☐ Written ☐ Verbal
Key Points: _____
Pain relief choices:
☐ Non-Pharmacological: _____
☐ Pharmacological: _____
Prenatal Education:
☐ Classes ☐ Other: _____
Infant Feeding Choices:
☐ Breast ☐ Other: _____
Previous BF experiences: ☐ No ☐ Yes
Describe:

ALLERGIES: _____
Current Medications: _____

Rubella:	☐ Immune	☐ Non-immune	☐ Unknown
Varicella:	☐ Immune	☐ Non-immune	☐ Unknown
HIV:	☐ Negative	☐ Positive	☐ Unknown
Hepatitis B:	☐ Negative	☐ Positive	☐ Unknown

GC/Chlamydia Screening: Date (most recent screen): _____

Gonorrhea	☐ Negative	☐ Positive	☐ Unknown
Chlamydia	☐ Negative	☐ Positive	☐ Unknown
GBS Status:	☐ Negative	☐ Positive	☐ Unknown

Maternal Vitals TPR: _____/_____/_____ BP:_____
Pre-preg. Wt:_____ Ht:_____ BMI:_____
Current Wt: _____ Weight Gain:_____
Lab Tests: _____
Labour: ☐ No ☐ Yes ☐ N/A
Contractions started: _____
Contractions on assessment: Q _____ x _____
Palpated ☐ Mild ☐ Moderate ☐ Strong
fFN: ☐ No ☐ N/A ☐Yes: ☐ Neg. ☐ Pos.
Cervix: _____cm _____station _____%eff. _____position
Examined by: _____
Membranes:
SRM: ☐No ☐ Suspected ☐ Yes: date/time: _____
Colour and volume of fluid: _____
Ferning: ☐ No ☐ Yes ☐ Not done

Fetal: Presentation:_____ Position:_____ FH: _____cm
FM: ☐ Active (≥ 6 / 2 hours) ☐ Decreased
FHR: _____bpm ☐ IA ☐ EFM: Indication:_____
Interpretation: _____
_____
NST (if indicated): ☐ Normal ☐ Abnormal
If abnormal, plan for care: _____
BPP score: U/S:

NOTES

PLAN OF CARE Attending Care Provider: _____notified @ _____hr.

☐ Admitted to room # _____ Reason: _____
Date: _____ Time:_____
☐ Transferred to: _____ Date: _____ Time:_____
☐ Discharged home Date: _____ Time:_____
Signature/Status/Print Name: _____

☐ **For Induction**
Indication: _____
☐ **Booked C/S**
Indication: _____
Date: _____

NSRCMA