Reproductive Care Program of Nova Scotia

MATERNAL ASSESSMENT

Date _____ Time _____

Reason for assessment _____

Gravida (G) _____ Term (T) _____ Preterm(P) _____

Abortus (A) _____ Living Children (L) _____ Stillbirth (S) _____

Blood Group/Rh _____ 28 wk Pho(D) inj. received ☐ No ☐ Yes

Support Person(s) _____

Primary Care Provider _____

LMP _____ ☐ Known ☐ Unsure

EDD _____ by ☐ LMP or ☐ U/S @ _____ weeks

Gestation _____ weeks

Current Health and History

Immunizations Received in Pregnancy
(e.g.; Influenza, TDap, Hepatitis B and COVID-19)

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 _____

Initimate 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 ☐ Antenatal Colostrum collection ☐ Other _____

Previous BF experiences ☐ No ☐ Yes

Describe _____

Allergies _____

Current Medications _____

Rubella	☐ Immune	☐ Non-immune	☐ Unknown
Varicella	☐ Immune	☐ Non-immune	☐ Unknown
HIV	☐ Negative	☐ Positive	☐ Unknown
Hepatatis 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 _____

Frequency: # _____ in 10 minutes.

Palpated ☐ Mild ☐ Moderate ☐ Strong

fFN ☐ No ☐ Yes ☐ N/A ☐ 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 ☐ Decreased

FHR _____ bpm ☐ IA ☐ EFM Indication _____

Classification ☐ Normal ☐ Atypical ☐ Abnormal

Interpretation _____

NST (if indicated) ☐ Normal ☐ Atypical ☐ Abnormal

Plan of 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 _____