Reproductive Care Program of Nova Scotia

PARTOGRAM

Gravida (G): _____ Term (T): _____ Preterm (P): _____
Abortus (A): _____ Living Children (L): _____
Stillbirth (S): _____ Gestation: _____ weeks
Blood group/Rh: _____ Antibodies: _____
Date (YYYY/MON/DD)/time active labour established: _____
Date (YYYY/MON/DD)/time of membrane rupture: _____
Group B Strep positive? ☐ Yes ☐ No ☐ Unknown

Birth Plan: _____ Support person(s): _____
Risk factors/concerns: _____

Date (YYYY/MON/DD) / Time

Hours	0	1	2	3	4	5	6	7	8	9	10	11	12
Cervical Dilatation (•) Station (X) 9													
-3 8													
-2 7													
-1 6													
0 5													
1 4													
2 3													
3 2													
1													
0													
Effacement													
Cx position													
Presenting part position													
Moulding/caput													
Amniotic fluid													
Blood/show													
Examiner													

Vaginal Examination:
Effacement: % or cm long
Cx Position: (A) anterior, (M) mid, (P) posterior
Presenting Part Position: (L) left or (R) right; (O) occiput or (Oth) other; (A) anterior, (P) posterior or (T) transverse
Moulding/Caput: (M) moulding (C) caput
Amniotic Fluid: (0) absent, (Sc) scant, (Mod) moderate, or (L) large; (Cl) clear, (Bl) bloody, or (Mec) meconium present
Blood/Show: (Sc) scant, (Mod) moderate, or (L) large

Document Medications on Medication Administration Record and Birth Record

Patient and Family Teaching

Topic	Initials	Topic	Initials	Topic	Initials
Labour Progress		Induction/Augmentation		Second Stage of Labour	
Breathing/Relaxation Techniques		Birth Plan		Cesarean Birth	
Positioning for Labour and Birth		Pain Relief Options		Preterm Birth	
Third Stage of Labour		Infant Feeding		Baby Friendly Practices	

Signatures

Print Name	Signature/Status	Initials

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Date (YYYY/MON/DD) / Time

Fetal Health Surveillance
- **Mode** (IA or EFM *indication)
- **Rate** (beats/minute)
- **Rhythm** (IA: regular or irregular)
- **Variability** (absent, min., mod., marked)
- **Accelerations** (Yes or No)
- **Decels** (no, var., early, late, prolonged)
- **Classification** (Normal, Atyp, Abn)

Contractions
- **Frequency** (number in 10 minutes)
- **Duration** (seconds)
- **Intensity** (mild, mod., strong OR mmHg)
- **Resting tone** (soft, firm OR mmHg)

Oxytocin dose (mU/minute)
☐ Augmentation ☐ Induction started at _____ h. (Init.)

- Fresh Eyes (Initial)
- Blood pressure
- Temperature, Pulse, Respirations
- Oxygen Saturation
- Somnolence Score
- Patient Position
- Other (e.g. glucose, reflexes)
- Bladder assessment

Regional Analgesia
☐ Epidural ☐ Spinal ☐ Combined ☐ PCEA Bolus at _____ h. Continuous infusion at _____ h.

Dr.													
	Infusion Rate												
	Bolus (PCEA)												
	Dermatome at or below T4	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Bromage 4-6	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
	Initials												

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Time

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Oxytocin dose (mU/minute)
☐ Augmentation ☐ Induction started at _____ h. (Init.)

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- Blood pressure
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- Somnolence Score
- Patient Position
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- Bladder assessment

Regional Analgesia

												Infusion Rate	Dr.
												Bolus (PCEA)	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Dermatome at or below T4	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	Bromage 4-6	
												Initials	

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Date (YYYY/MON/DD) & Time	Progress Notes

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Second Stage

Full Dilatation: Date ________ (YYYY/MON/DD) Time ________ h. **Active pushing started:** Date ________ (YYYY/MON/DD) Time ________ h.

	Date (YYYY/MON/DD) / Time																								
Fetal Health Surveillance	**Mode** (IA or EFM *indication)																								
	Rate (beats/minute)																								
	Rhythm (IA: regular or irregular)																								
	Variability (absent, min., mod., marked)																								
	Accelerations (Yes or No)																								
	Decels (no, var., early, late, prolonged)																								
	Classification (Normal, Atyp, Abn)																								
Contractions	**Frequency** (number in 10 minutes)																								
	Duration (seconds)																								
	Intensity (mild, mod., strong OR mmHg)																								
	Resting tone (soft, firm OR mmHg)																								
	Oxytocin dose (mU/minute) ☐ Augmentation ☐ Induction started at ________ h. (Init.)																								

Fresh Eyes (Initial)						
Blood pressure						
Temperature, Pulse, Respirations						
Oxygen Saturation						
Somnolence Score						
Patient Position						
Other (e.g. glucose, reflexes)						
Bladder assessment						
Second Stage – Regional analgesia – Bolus/Rate						
Second Stage – Regional analgesia – Bromage 4-6	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Second Stage – Patient Position						
Second Stage – Effectively Pushing (Y/N)						
Second Stage – Somnolence Score						
Initials						

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Vaginal Birth

Parturient's position for delivery: ☐ Supine ☐ Side-lying ☐ Semi-sitting ☐ Squatting ☐ Other ________
Delivery of: ☐ Male ☐ Female at ________ h by ☐ SVD ☐ Vacuum ☐ Forceps
Application time(s): ________ Traction start time(s): ________
Placenta delivery time: ________ h
Uterotonic: Oxytocin: ☐ 10 units IM ☐ 3 units IV ☐ Infusion: ________ ☐ Not given
☐ Ergonovine ☐ Misoprostol ☐ Carboprost ☐ Tranexamic Acid ☐ Describe: ________

Initial Mother-Baby Contact (all births)

☐ **Skin-to-skin contact initiated:** ________ h Duration: ________ (all babies within 5 minutes of birth, for at least 60 minutes)
☐ **Breast offered to baby**
☐ **Skin-to-skin contact with other than mother:** Reason ________

Fourth Stage: Postpartum Assessments

Time									
Blood Pressure									
Pulse									
Temperature									
Respirations									
Oxygen Saturation									
Lochia									
Perineum									
Fundus									
Dressing									
Bladder assessment									
Initials									

☐ **Epidural Catheter removed intact by:** ________ Date (YYYY/MON/DD)/Time: ________
Transferred to Room #: ________ Date (YYYY/MON/DD)/Time: ________ via: ☐ Wheelchair ☐ Stretcher ☐ Ambulating
Infant transferred to nursery: ☐ Yes ☐ No Comments: ________

Notes:

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