Midwifery

Case Book I and II

FOR BASIC B.SC NURSING
SEMESTER VI AND VII NURSING STUDENTS
AS PER INC SYLLABUS

Laxmi Agnihotri Rajeshwari Kambi

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please contact:

BLUEROSE PUBLISHERS
www.BlueRoseONE.com
info@bluerosepublishers.com
+4407342408967

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PREFACE

Nursing education aims to prepare the standardised and register nurses who are capable for providing standard nursing care to sick individual. And also mothers who go through the physiological processes like conception, pregnancy, and childbirth.

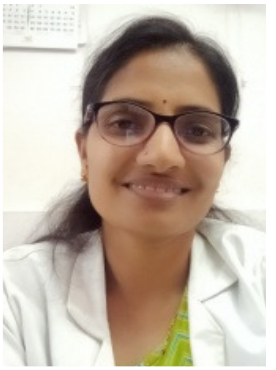
This midwifery case book is a practical record book of midwifery for 6th and 7th semester nursing students as per INC. As the theory and practical examination held on the 7th semester for the both normal and high risk cases, so this practical record book is organised to learn students from simple to complex.

SALIENT FEATURES

- ✓ It is modified and expanded according to the ***INDIAN NURSING COUNCIL (INC)SYLLABUS***
- ✓ It includes basic terminologies which aid students in clinical set up.
- ✓ It contains adequate number of cases and care plans for the antenatal, postnatal and intranatal mothers etc...
- ✓ It also helps in documenting the needs and nursing care to high risk mothers.

AUTHORS

Mrs. Laxmi Agnihotri M.sc (N) is Assistant Professor, Department Of OBG Nursing, BLDEAS Shri B.M.Patil Institute of Nursing Sciences Vijayapur. Karnataka. Earned her B.Sc Nursing in 2010 and M.Sc Nursing in 2015 in Obstetrics and Gynaecology speciality from Rajiv Gandhi University Health Sciences, with Institute and University topper. 10 years of Teaching Experience in Nursing Profession, Interested Areas Are Nursing Research, Clinical Obstetrics and Gynaecology, Nursing Education and Nursing Administration. Guided many UG AND PG students, and also published many more research articles and scientific papers in national and international Scopus indexed, UGC indexed journals. Actively Participated in Extension Activities and academic activities, presently doing PHD Nursing under RGUHS.



Mrs. Rajeshwari kambi M.sc (N) is Assistant Professor, Department Of OBG Nursing, and BLDEAS College of Nursing Jamakhandi. Completed B.Sc Nursing in 2009 and M.Sc Nursing in 2021 in Obstetrics and Gynaecology speciality from Rajiv Gandhi University Health Sciences. 3 Years of Clinical Experience and 10 years of Teaching Experience in Nursing Profession. Published many more research articles and scientific papers in national and international journals.

CLINICAL RECORD BOOK

Name of the student: _____

Registration number: _____

Age and date of birth: _____

Name of the institution: _____

Address: _____

_____

Photograph

Signature of Student

Signature of Teacher **Signature of Principal**

Signature Internal Examiner **Signature of External Examiner**

TABLE OF CONTENTS

TERMINOLOGIES

- **Gravida:** The total number of pregnancies a woman has had, regardless of their outcome.
- **Para:** The number of pregnancies that have resulted in a birth (living or dead).
- **Nulligravida:** A woman who has never been pregnant.
- **Primigravida:** A woman pregnant for the first time.
- **Multigravida:** A woman who has been pregnant more than once.
- **Fetal presentation:** The part of the fetus that is leading the way during delivery (e.g., head, breech).
- **Lie:** The position of the fetus in the uterus (e.g., longitudinal, transverse).
- **Attitude:** The position of the fetus's body (e.g., flexed, extended).
- **Engagement:** When the presenting part of the fetus enters the pelvic inlet.
- **Stations:** The position of the presenting part in relation to the pelvic ischial spines during labor.
- **Amniotic fluid:** The fluid that surrounds the fetus in the uterus.
- **Placenta:** The organ that supports fetal development during pregnancy.
- **Cesarean section (C-section):** Surgical delivery of a baby through an incision in the abdomen and uterus.
- **VBAC:** Vaginal birth after cesarean.
- **Amniocentesis (amnio):** A test used to diagnose chromosome problems and spina bifida.
- **Antepartum** (AP): Before birth.
- **Antibodies:** Proteins that protect your body from bacteria and toxins. During pregnancy and breastfeeding,
- **(AROM):** Artificial rupture of membranes
- **V/V:** Vulva/Vagina
- **BUS :**Bartholdi's glands, Urethra, Skene's gland
- **RV:** Extroverted
- **AV :** Anteverted

- **RF :** Retroflexed
- **AF :** Anteflexed
- **MP :** Midplane
- **TAH:** Total Abdominal Hysterectomy
- **TVH:** Total Vaginal Hysterectomy
- **BSO:** Bilateral Salpingo - Oophorectomy
- **IA :** Incidental Appendectomy
- **BTL/BPS** : Bilateral Tubal Ligation/Bilateral Partial Salpingectomy
- **TL:** tubal ligation
- **LTL :**laparoscopic tubal ligation
- **PID :**pelvic inflammatory disease
- **GC :**gonococcus, Gonorrhea
- **CKC :**cold knife conization of the cervix
- **D&C:** dilation and curettage of the uterus
- **Cx Bx :**cervical biopsy
- **ECC :**endocervical curettage
- **ENDO BX :**endometrial biopsy
- **LPD:** luteal phase defect
- **PMS:** premenstrual syndrome
- **CIN:** cervical intraepithelial neoplasia
- **PCO :** polycystic ovarian disease
- **ERT:** estrogen replacement therapy
- **STD :**sexual transmitted disease
- **GTN:** gestational trophoblastic neoplasia
- **SAB:** spontaneous abortion
- **EAB:** elective abortion
- **SUI :**stress urinary incontinence

ANTENATAL EXAMINATION

ANTENATAL EXAMINATION-1

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-2

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-3

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-4

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-5

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-6

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-7

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-8

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-9

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL EXAMINATION-10

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio economic history

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water facility:_____ Toilet facility:_____
- Drainage /gardening:_____ Pet animals:

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

PERSONEL HISTORY:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning :_____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

.Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
  - Height: Weight:
  - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus

- Contour of abdomen
- Linea nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Signature Of Student **Signature Of Supervisor**

ANTENATAL CARE PLAN

ANTENATAL CARE PLAN-1

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN-2

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN-3

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN -4

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN -5

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN -6

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN -7

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN -8

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN -9

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ANTENATAL CARE PLAN -10

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation : Husband

Wife:

- Income: _____ Type of house: _____
- Standard of living: _____ Lighting facility: _____
- Water Facility: _____ Toilet facility: _____
- Drainage /Gardening: _____ Pet animals: _____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT /CONDUCTION OF NORMAL DELIVERY

INTRANATAL ASSESSMENT-1

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

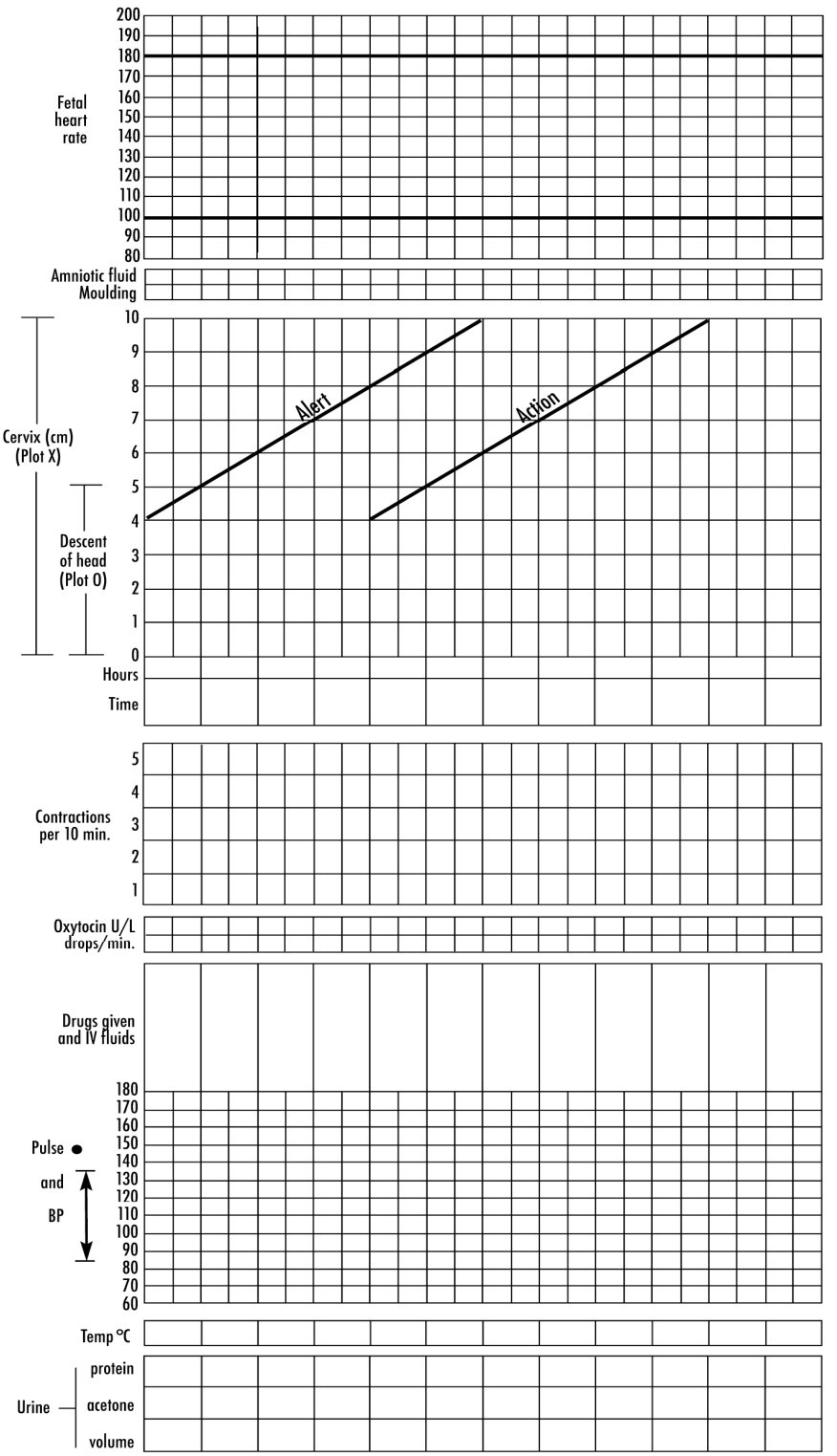
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-2

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

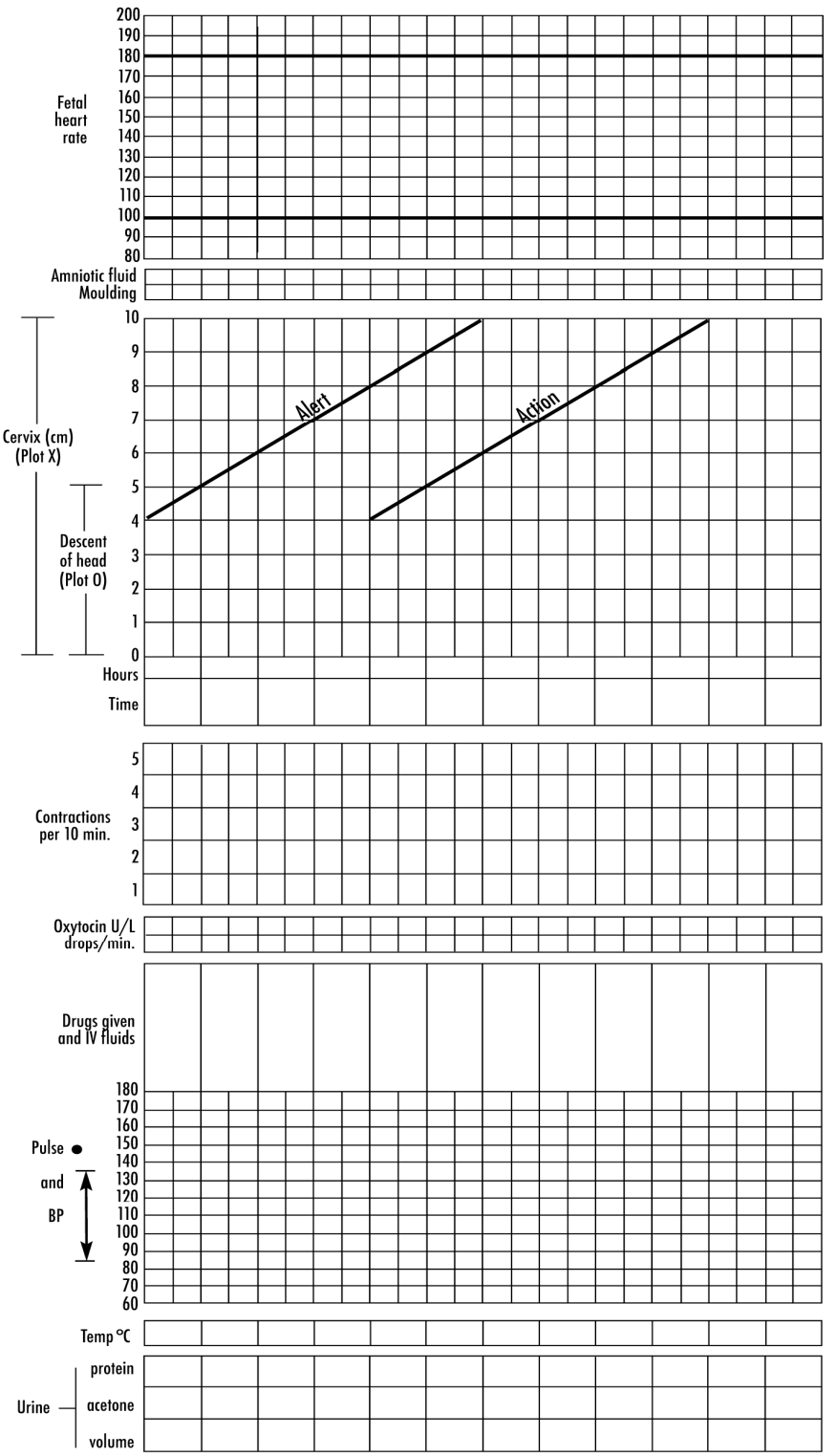
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-3

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

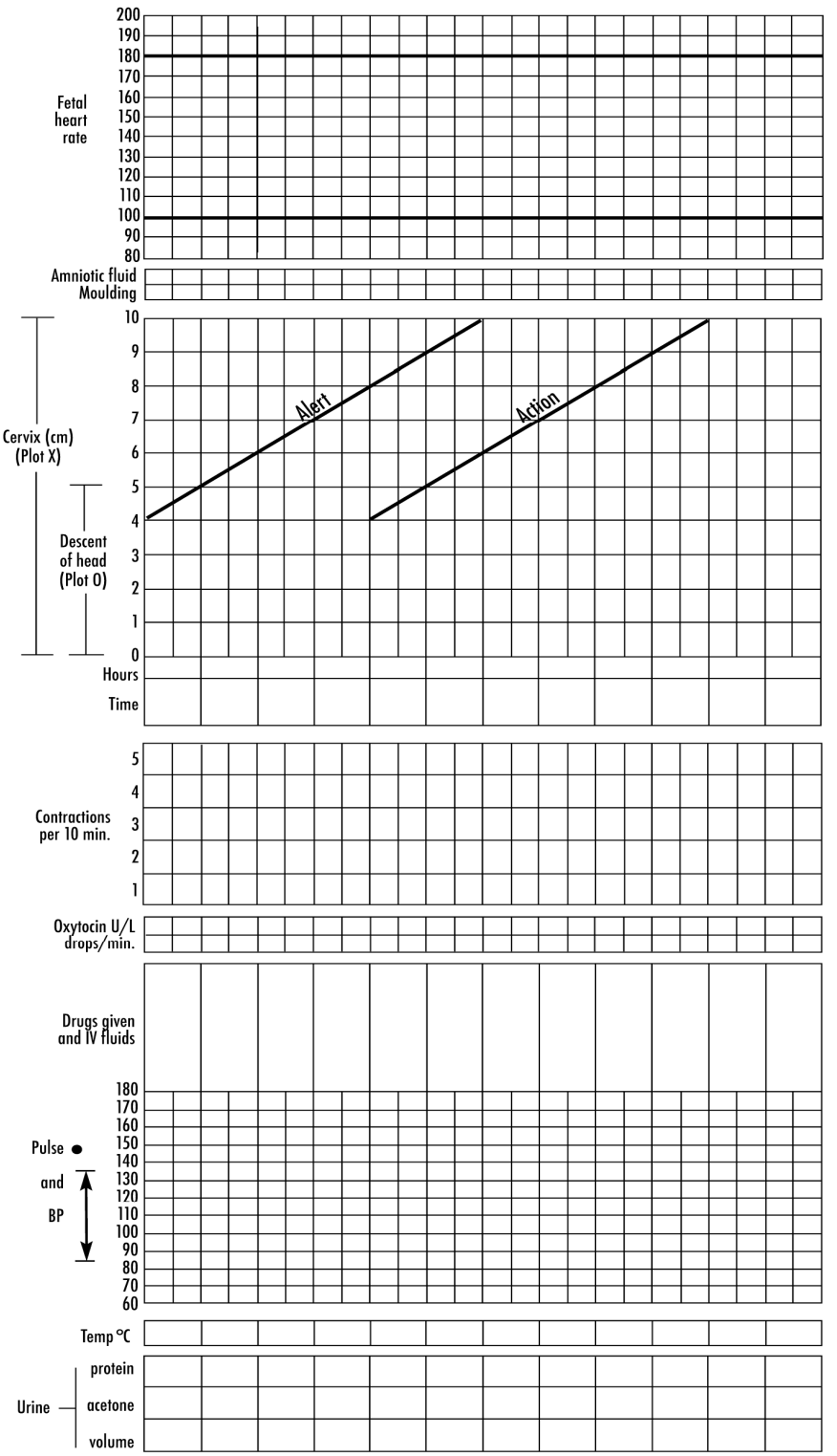
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-4

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

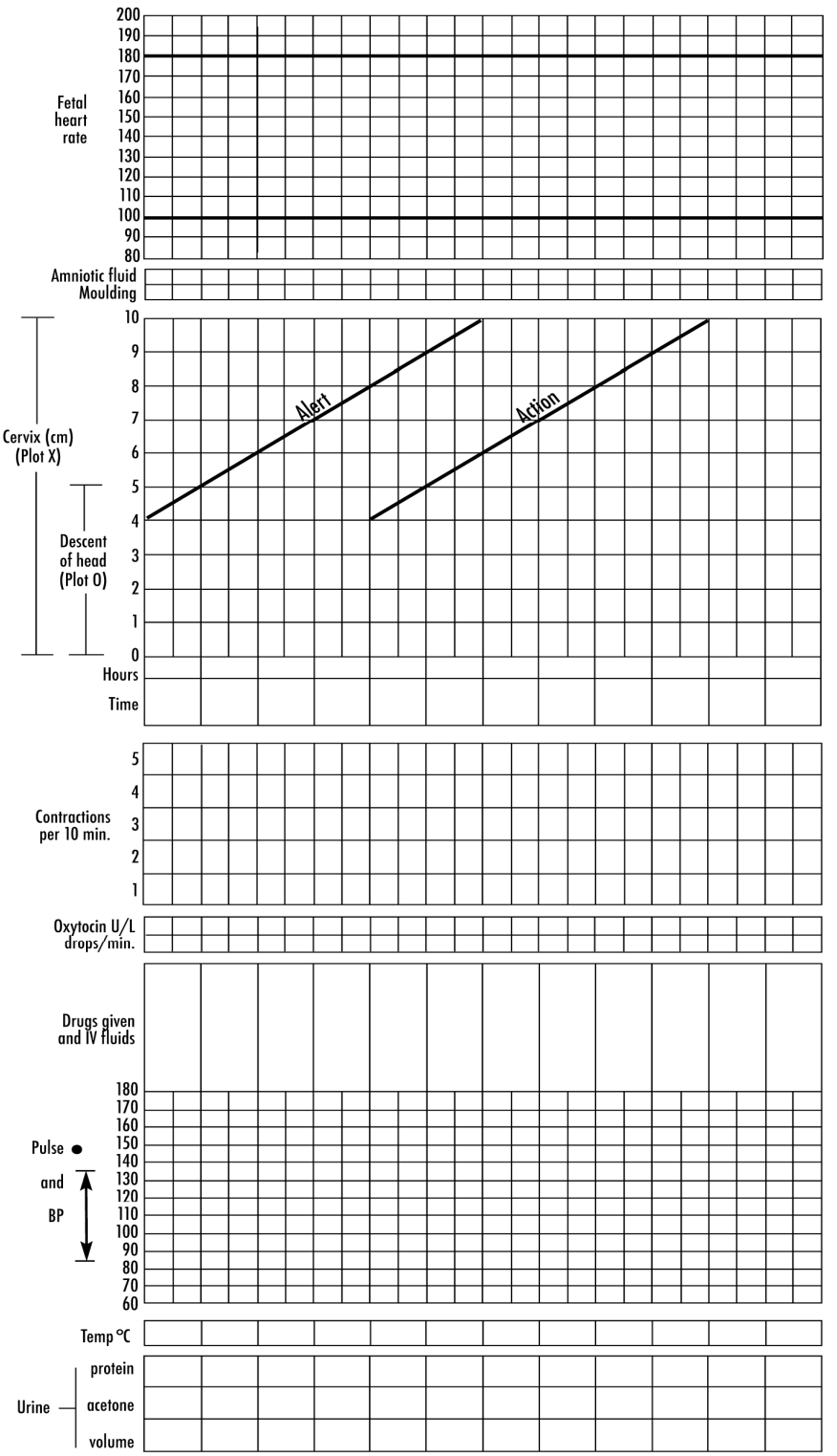
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-5

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

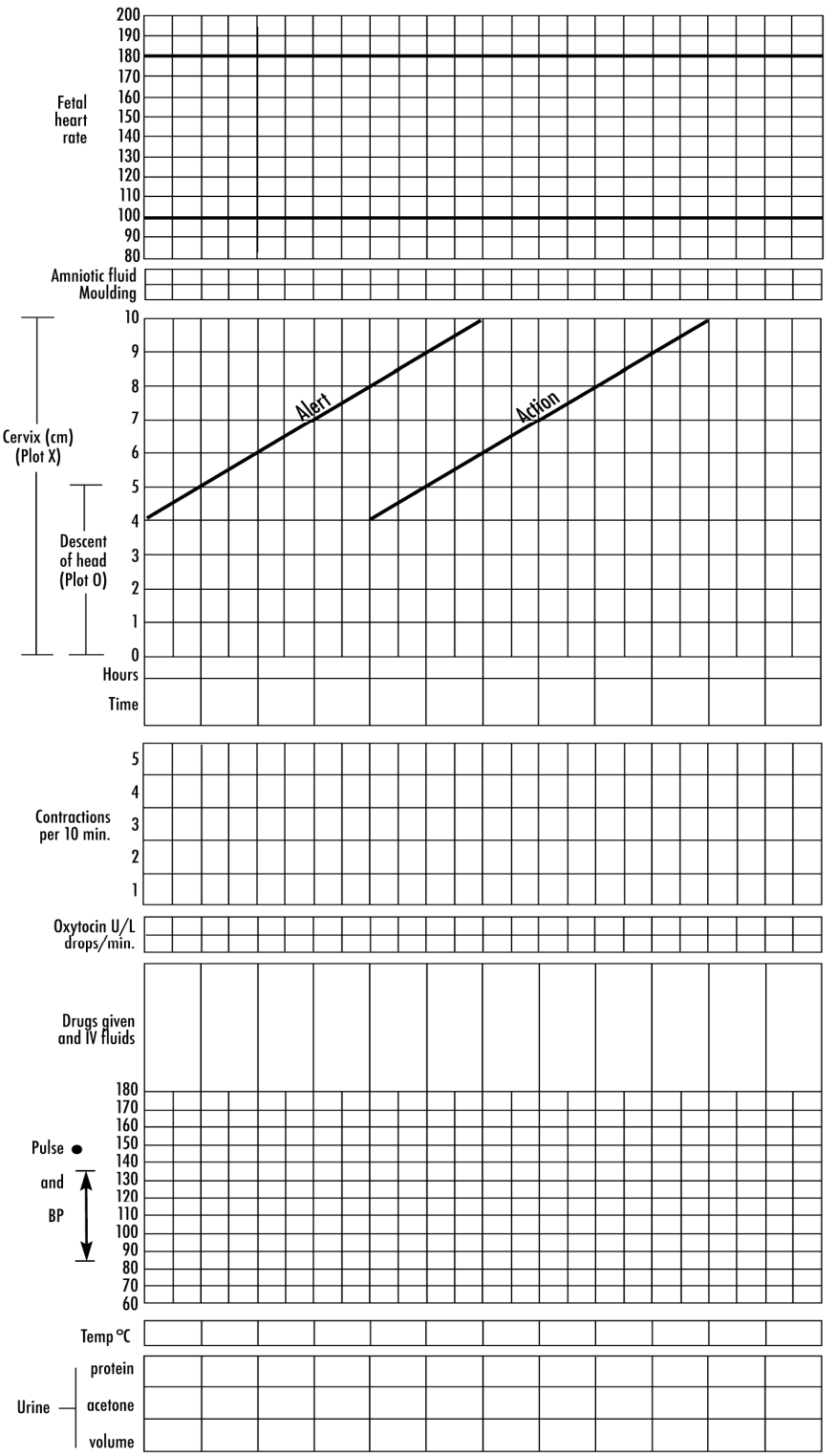
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-6

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

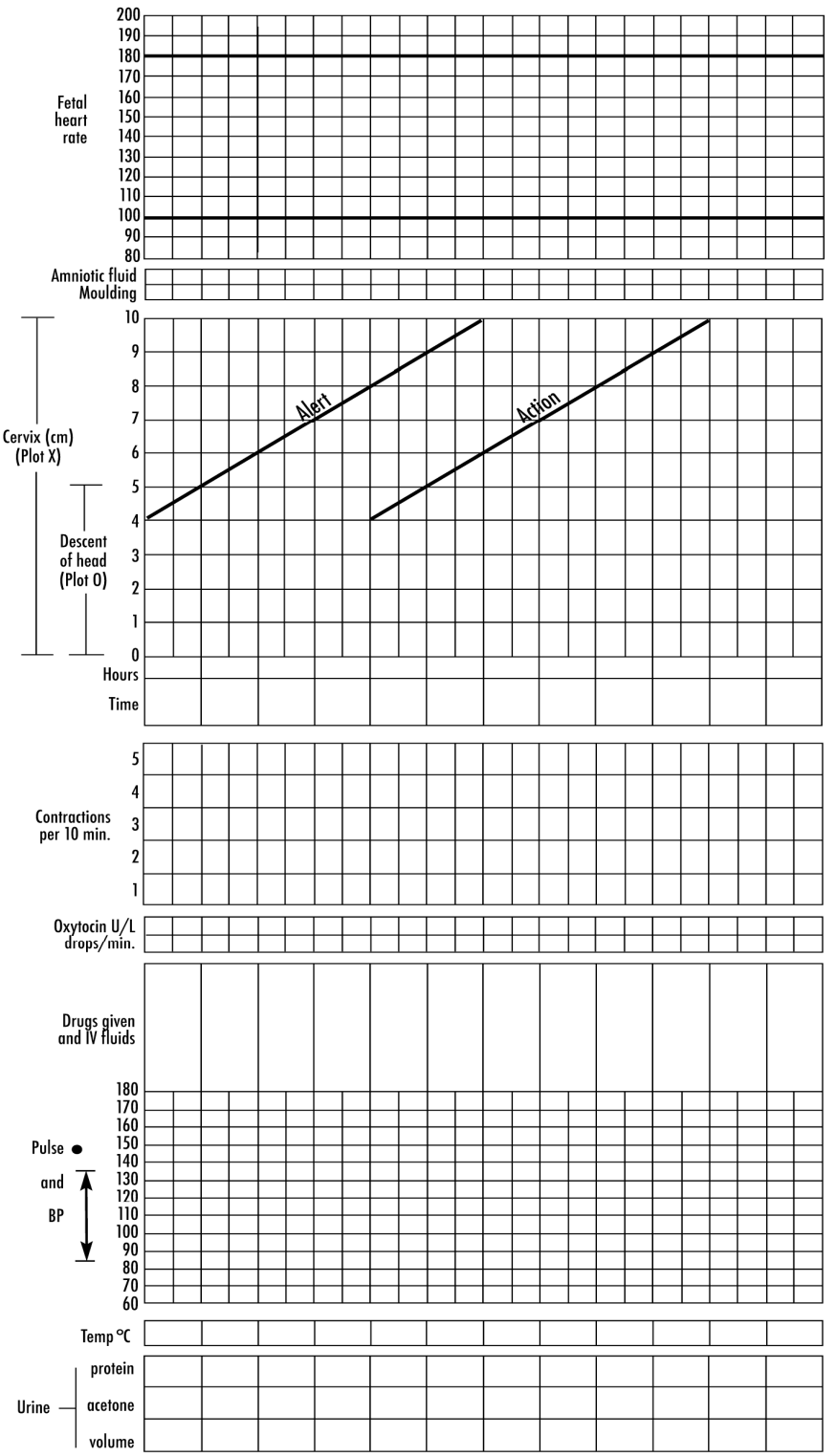
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-7

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

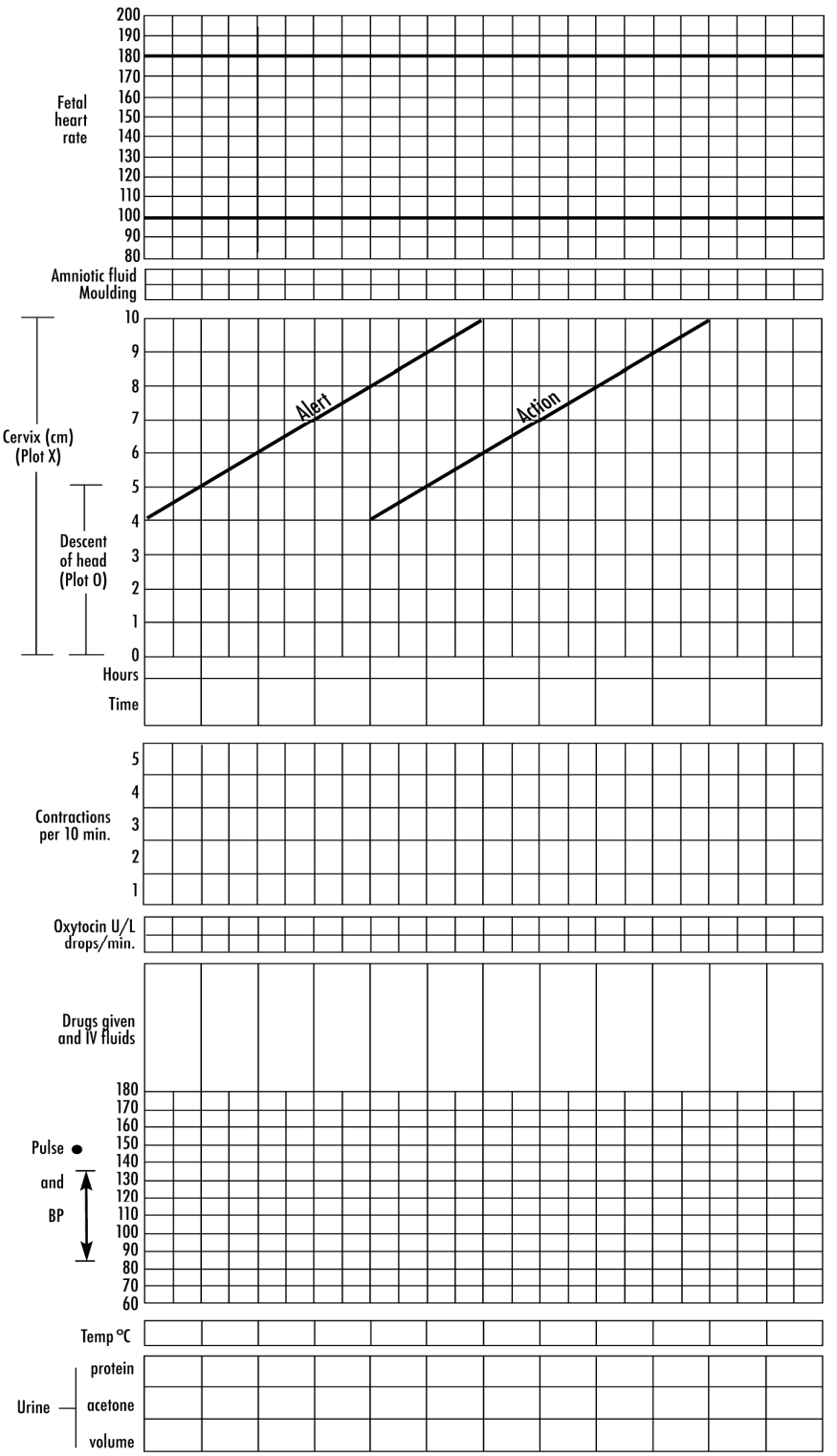
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-8

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

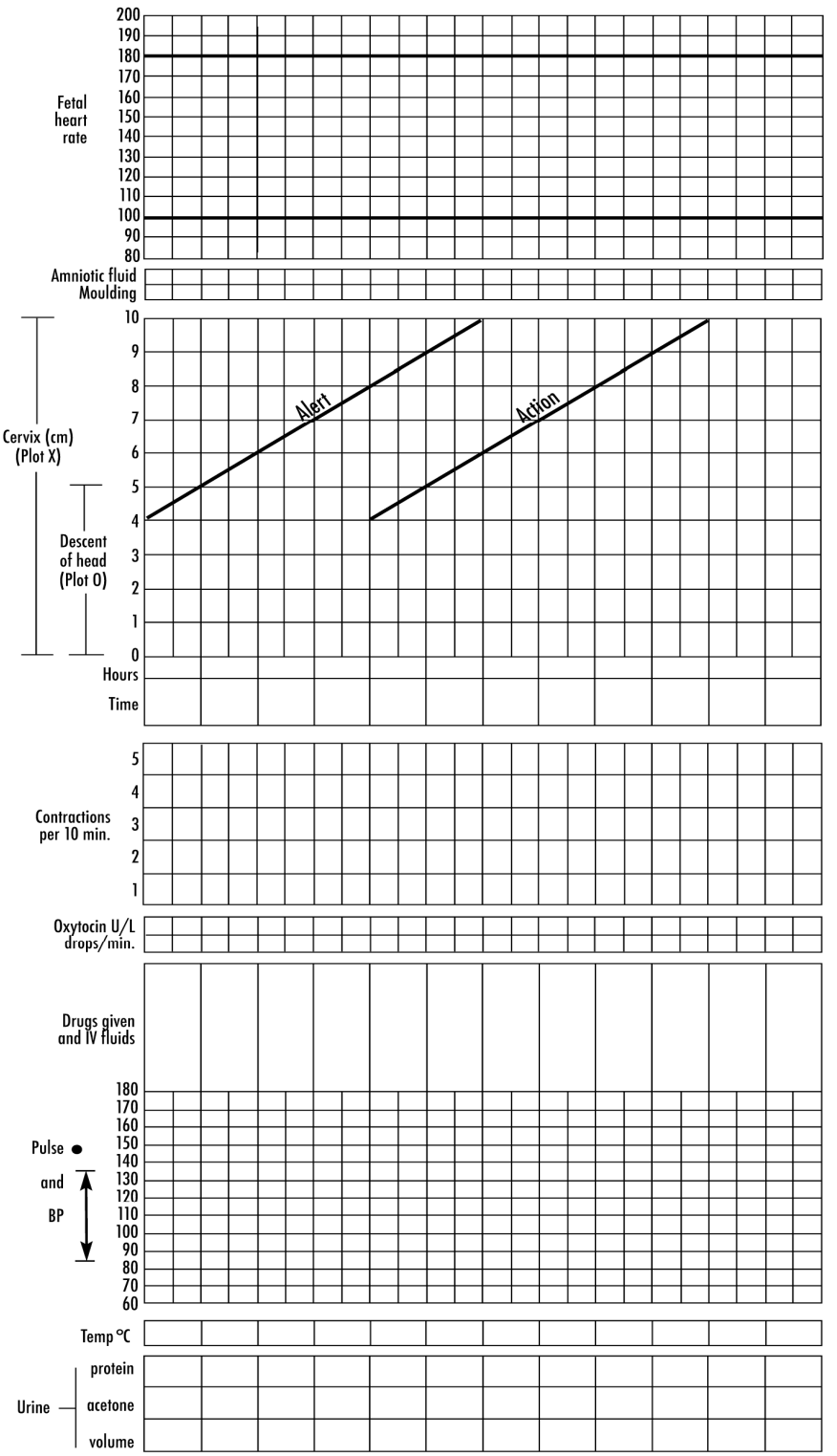
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-9

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

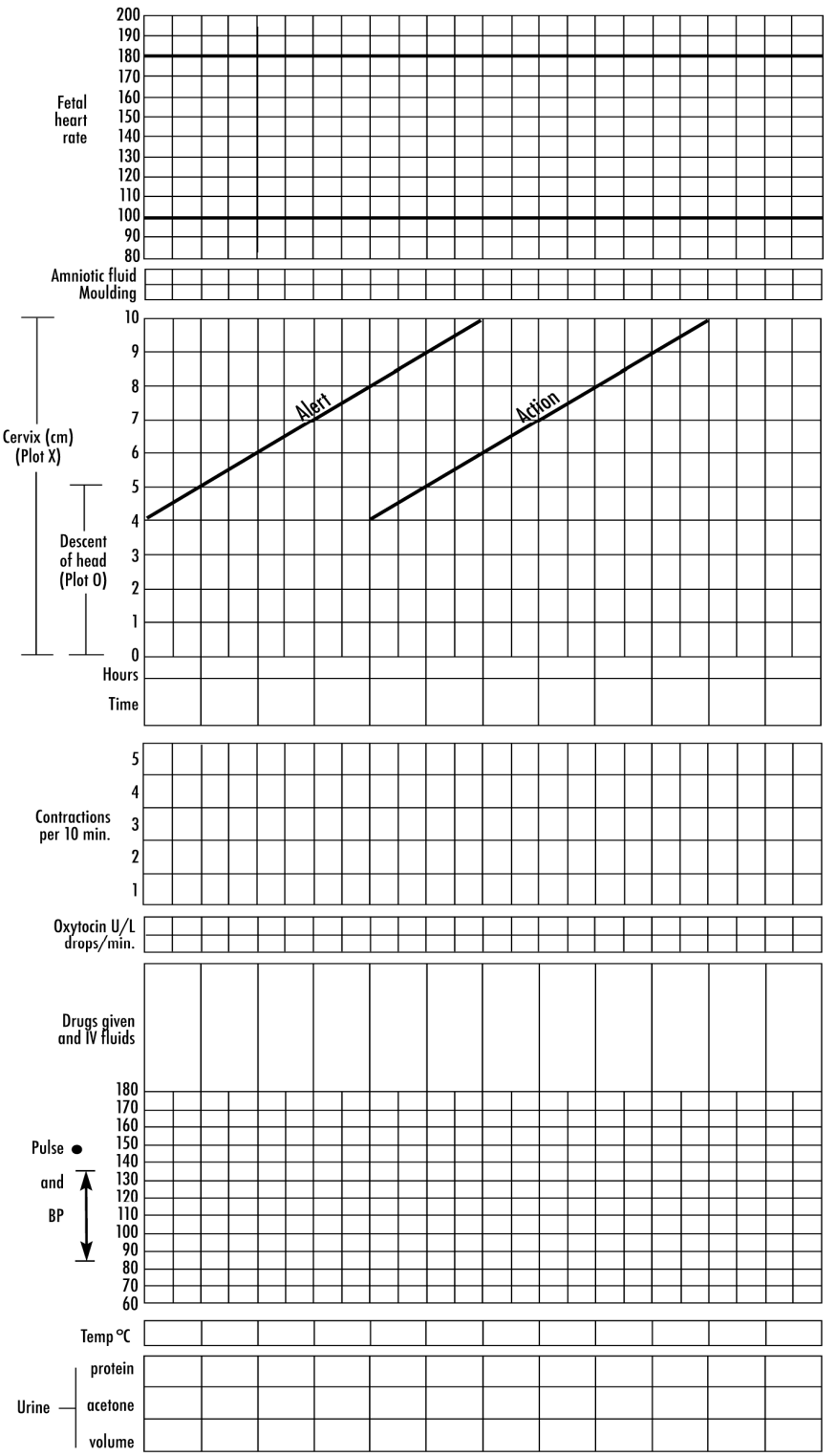
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-10

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

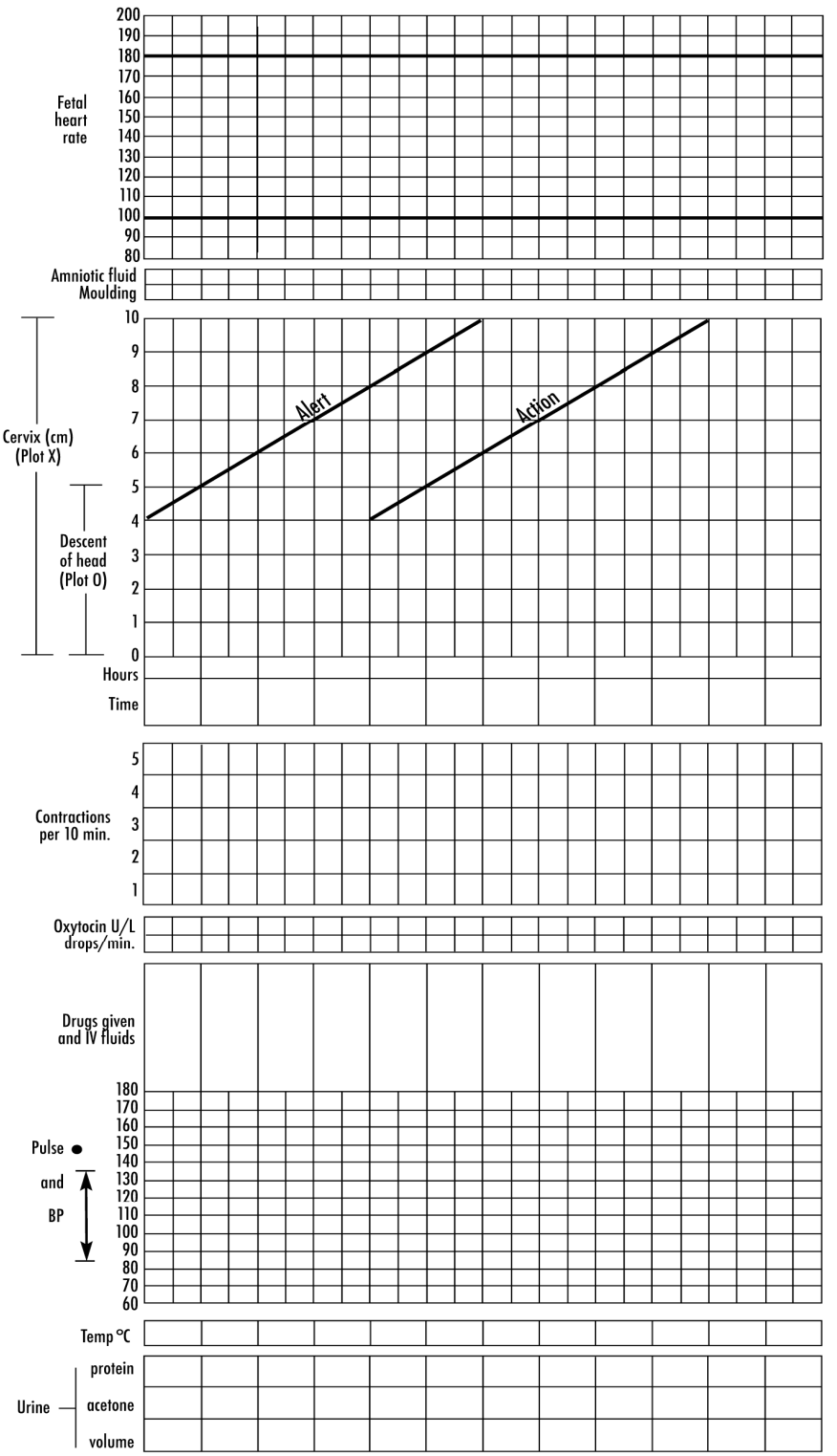
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-11

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

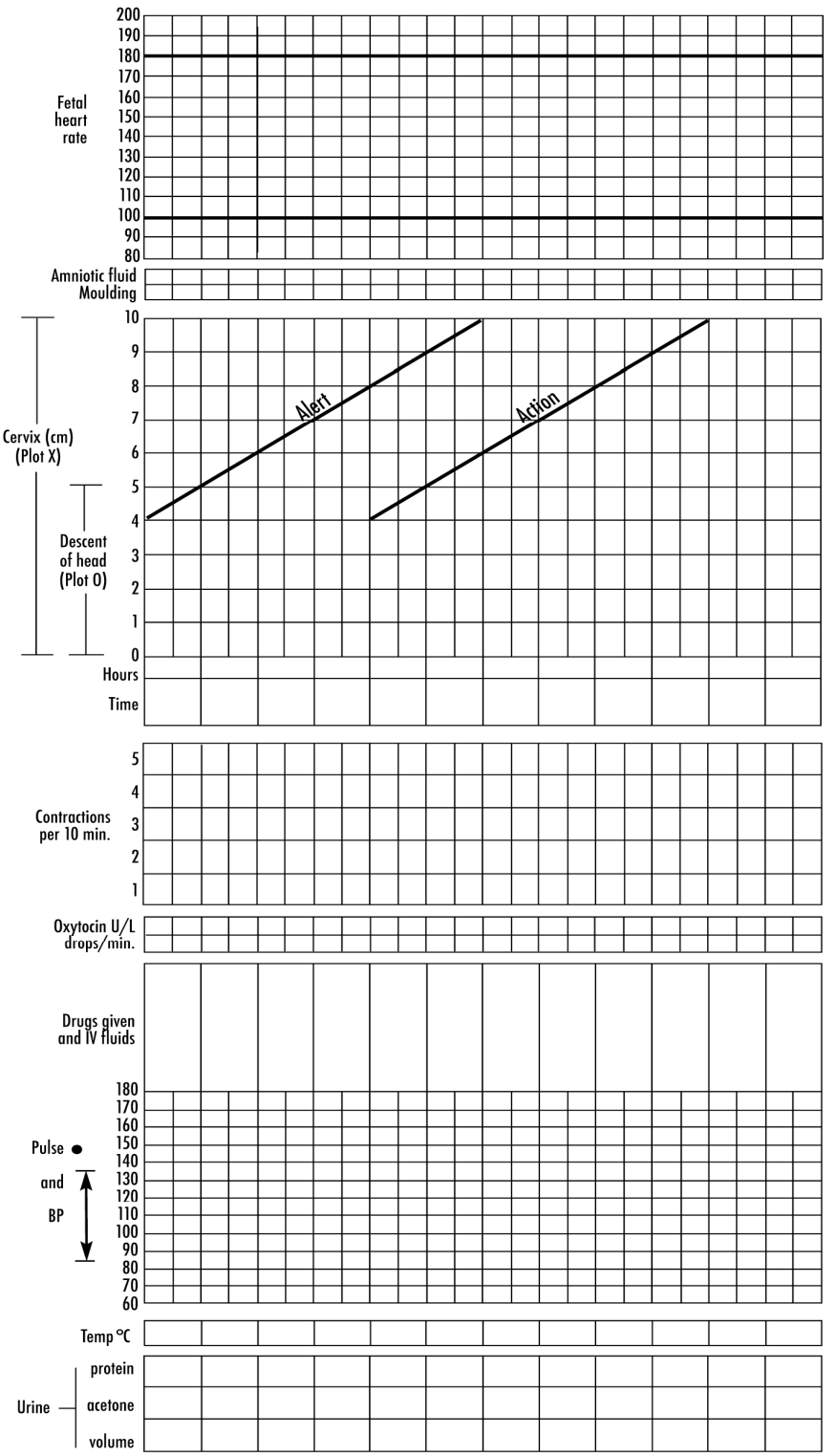
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-12

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

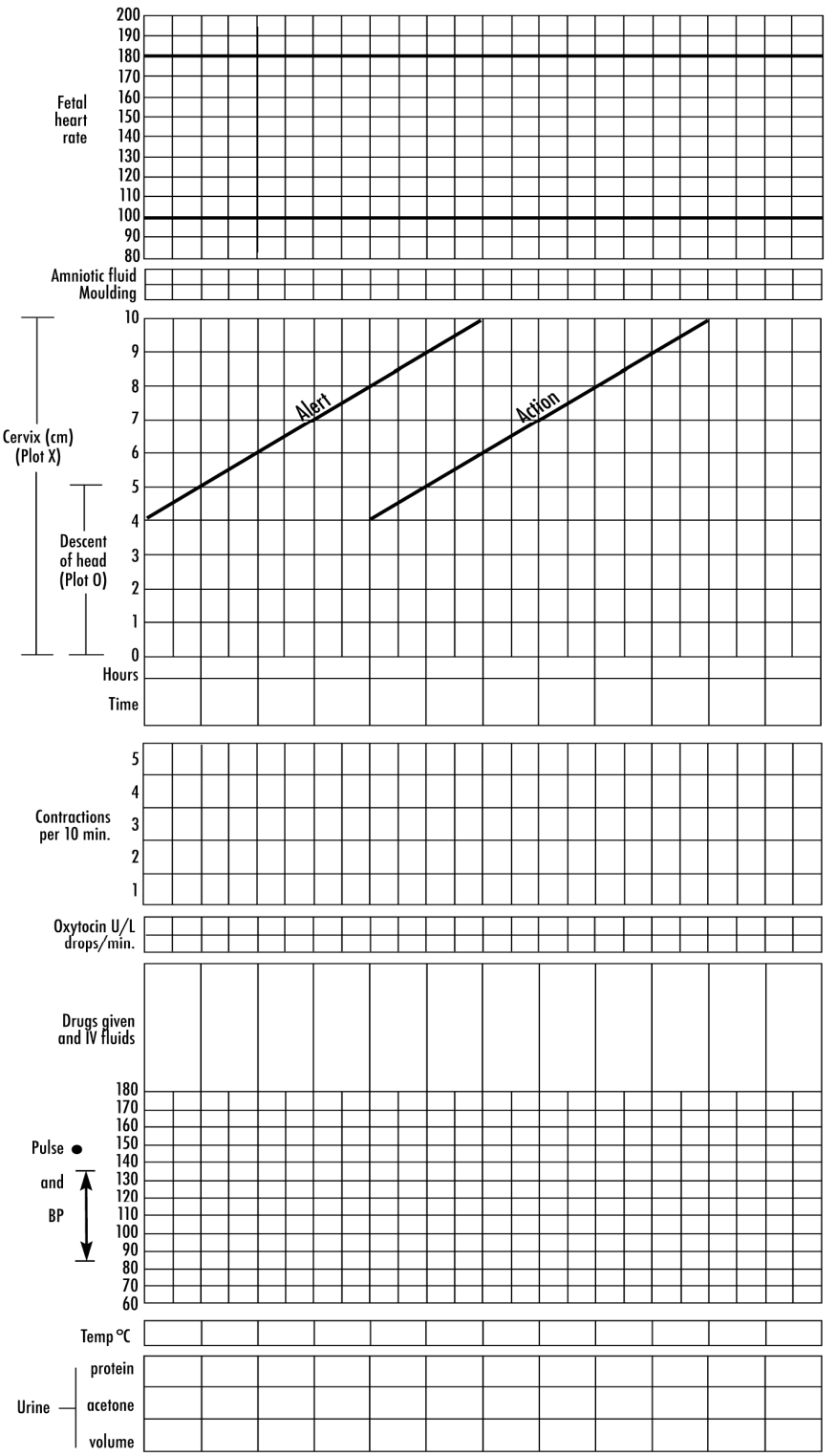
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-13

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

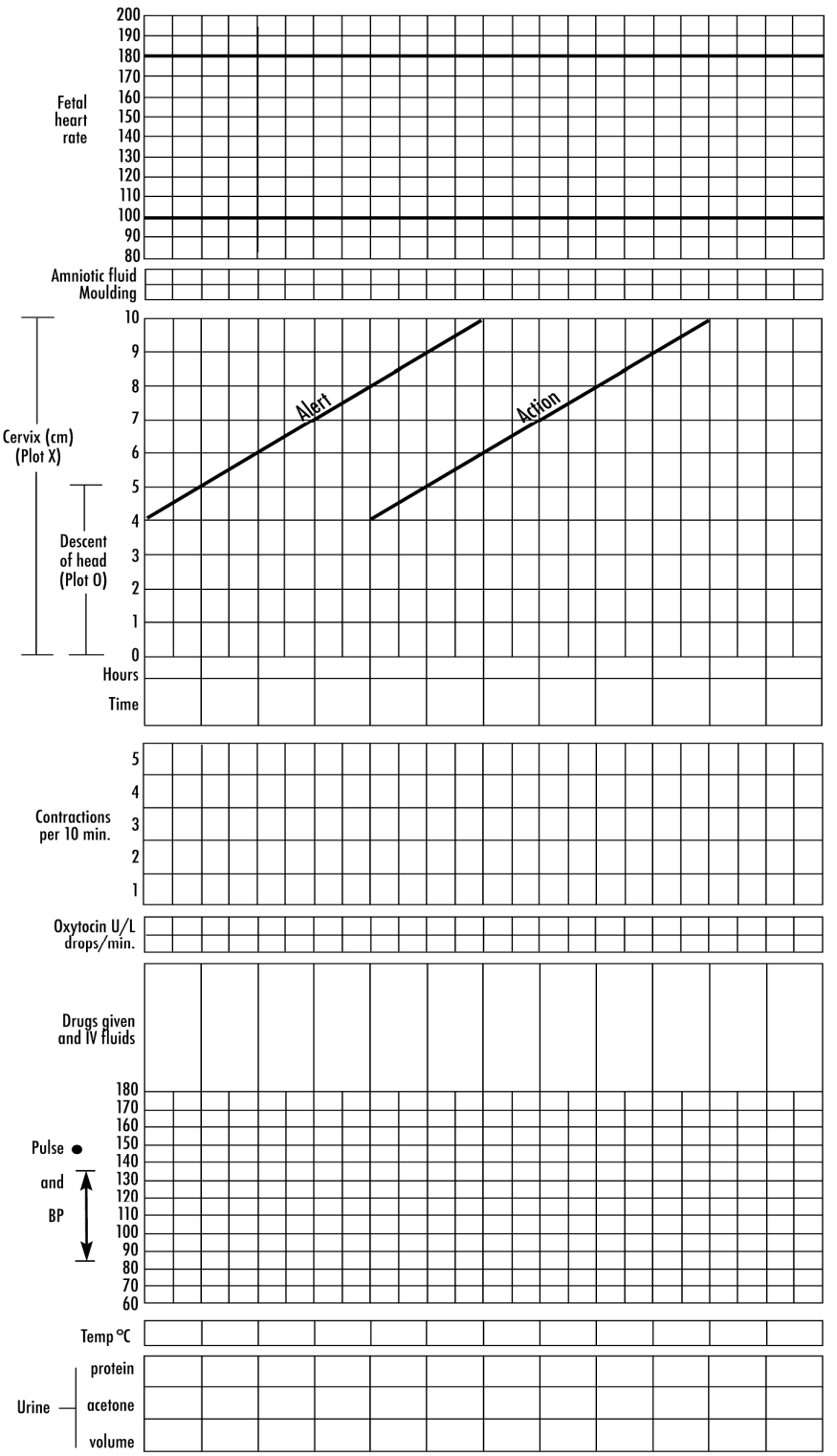
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-14

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

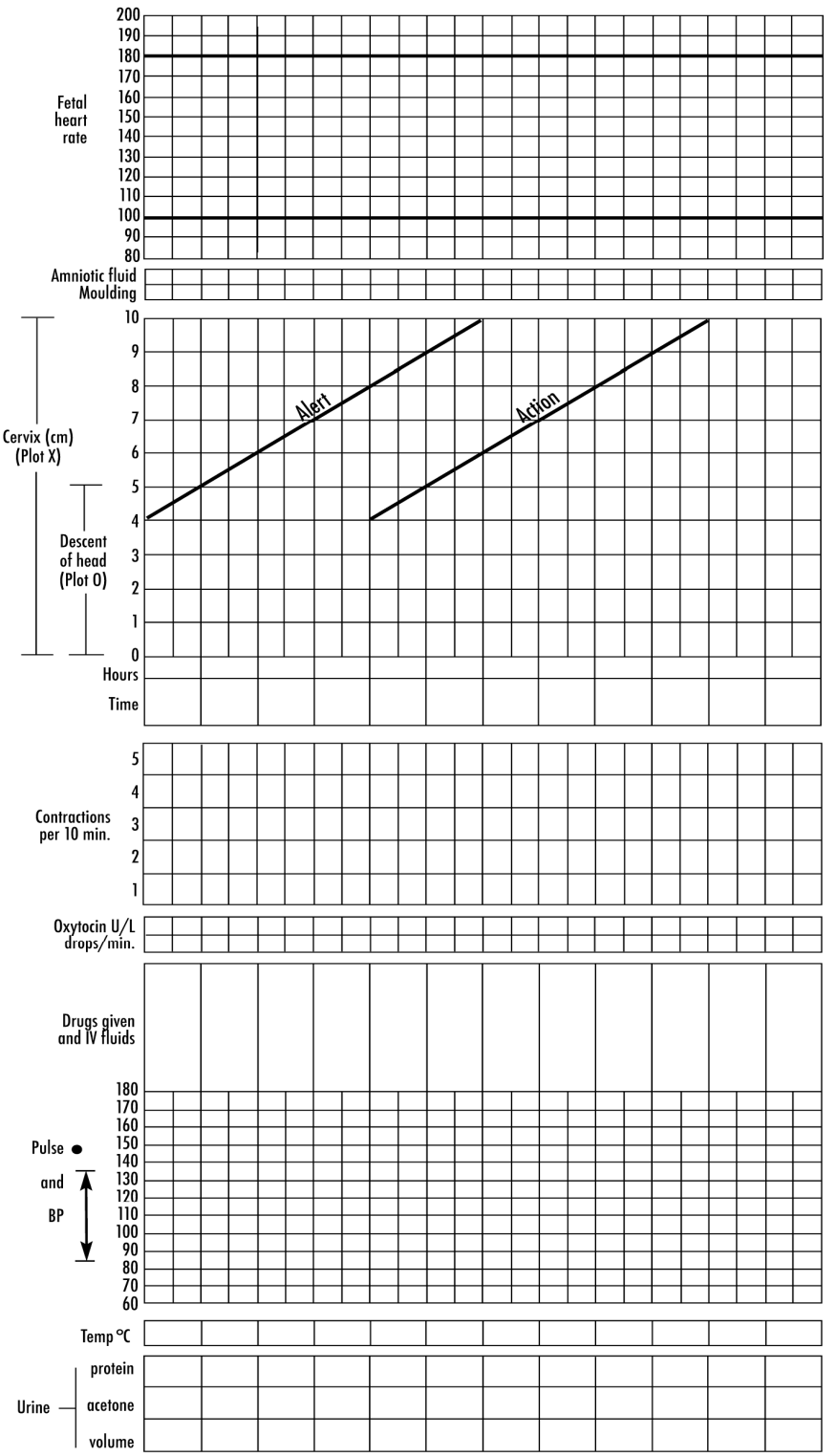
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-15

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

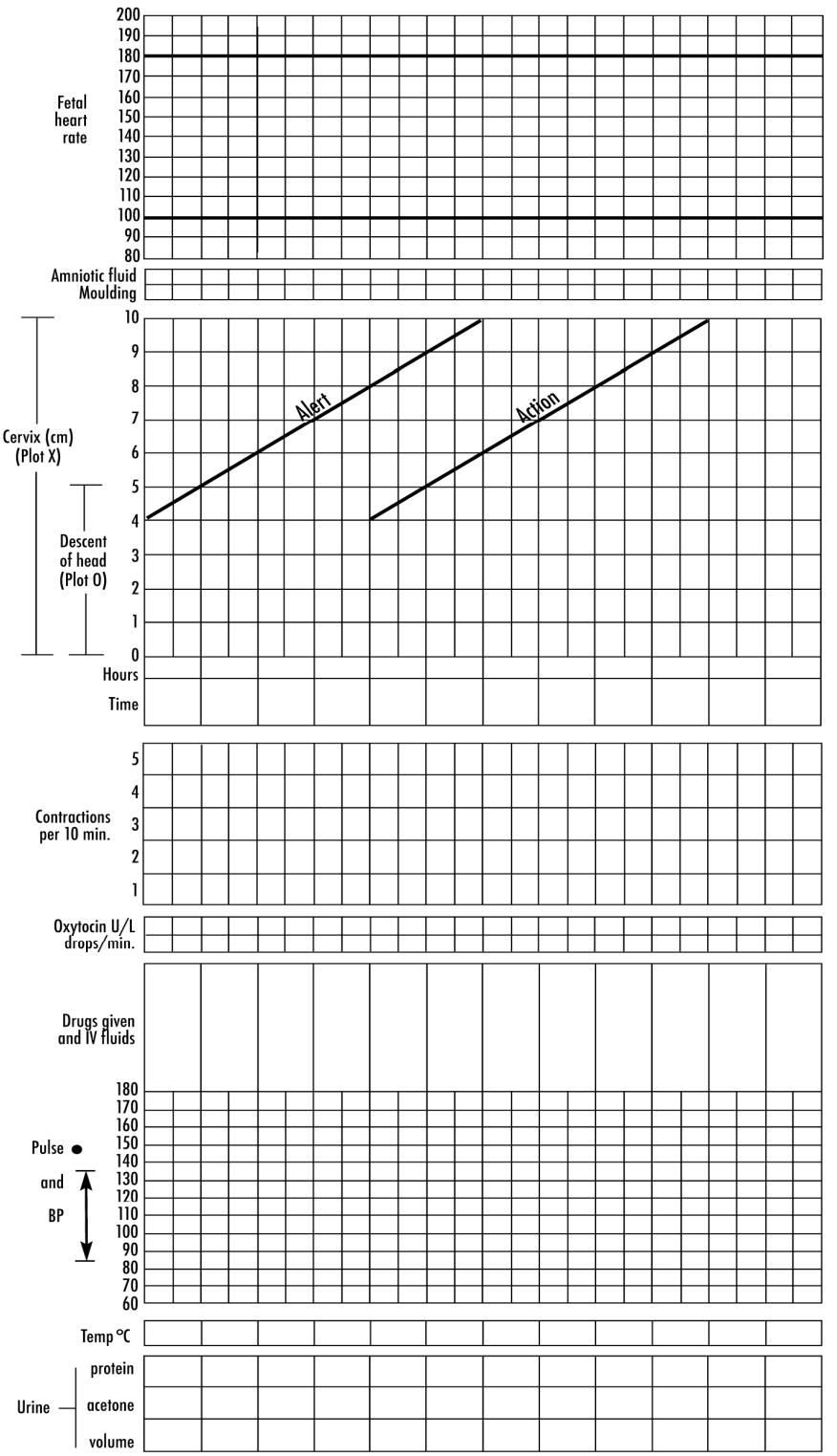
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-16

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

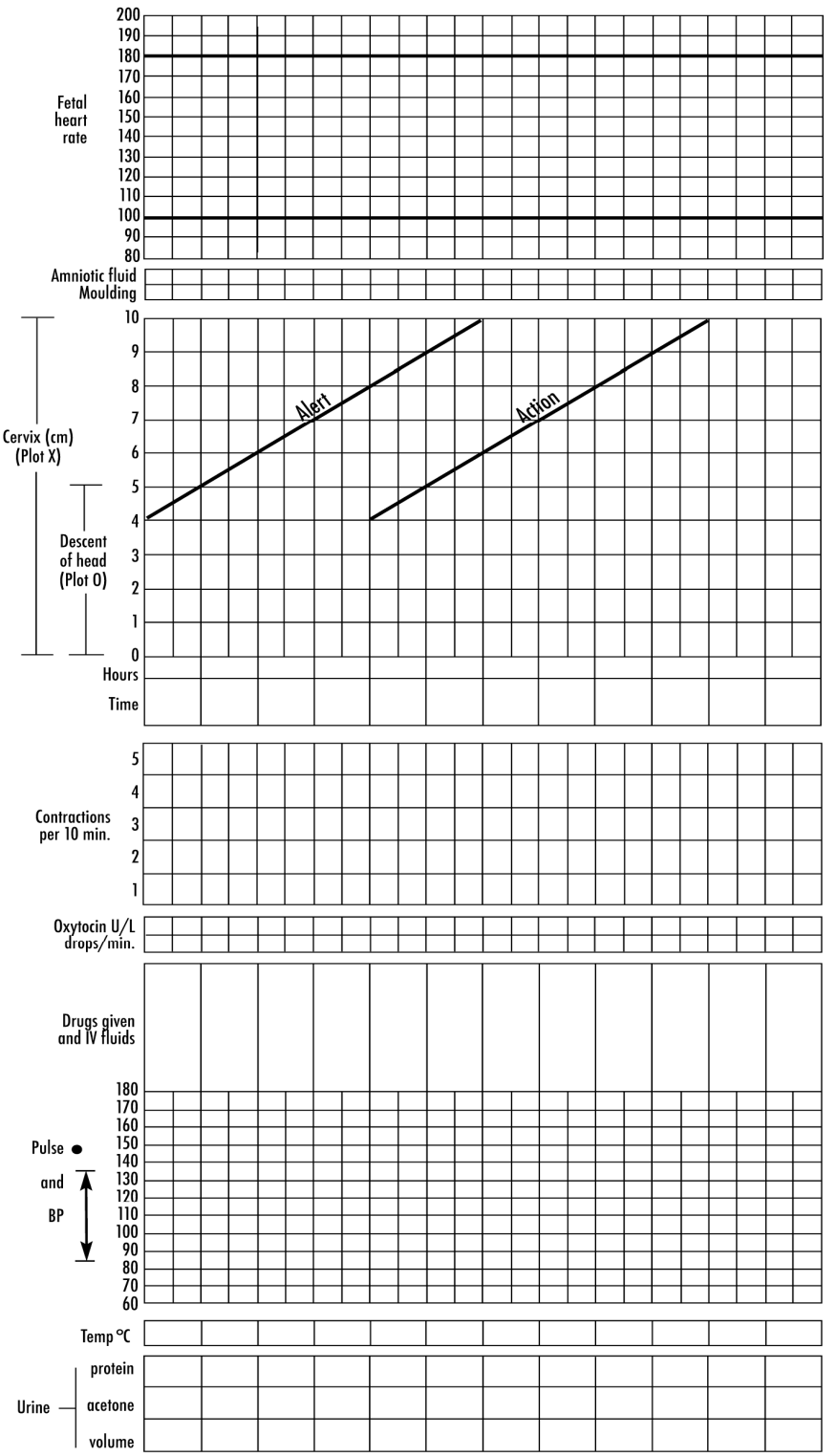
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-17

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

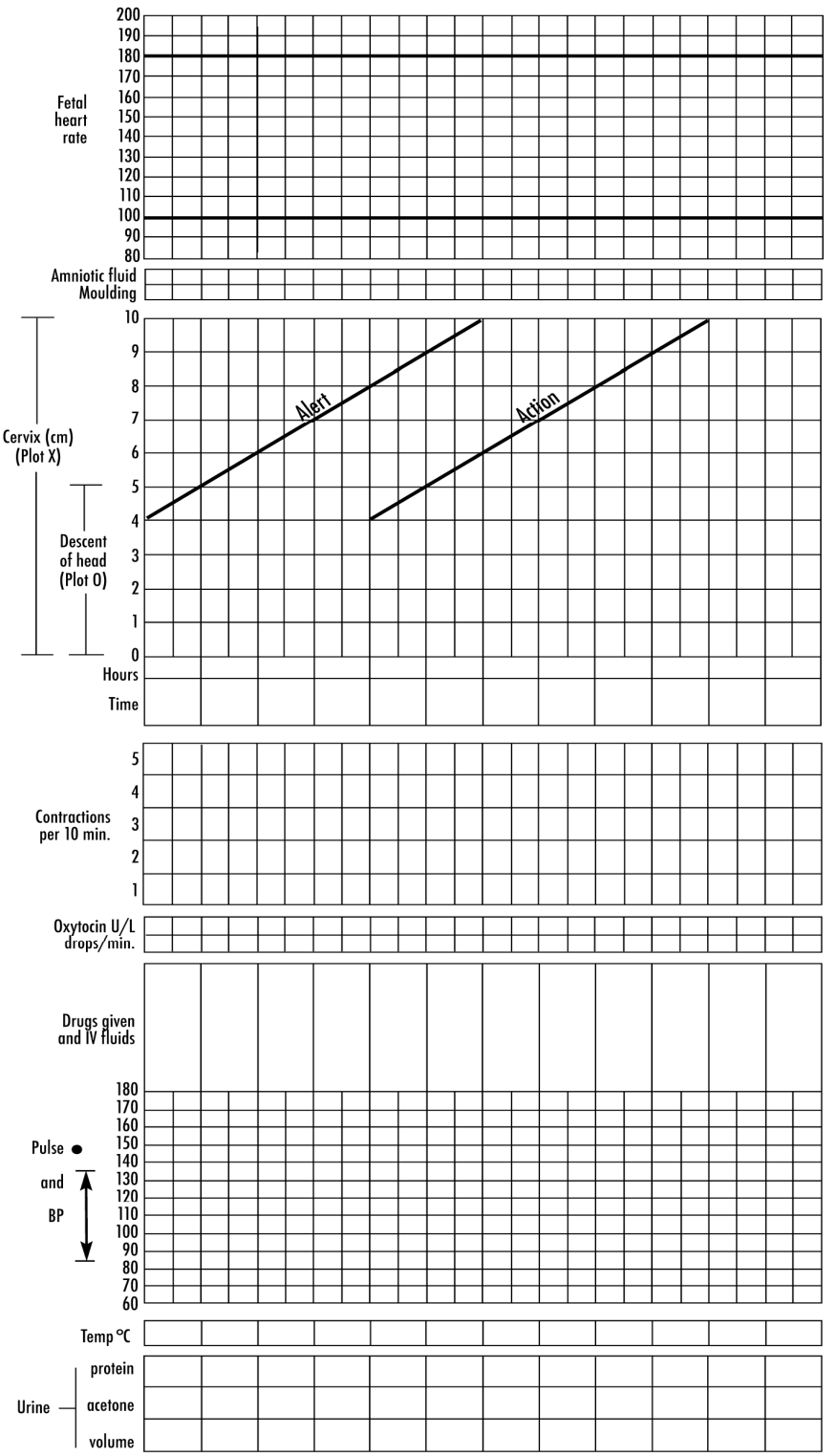
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-18

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

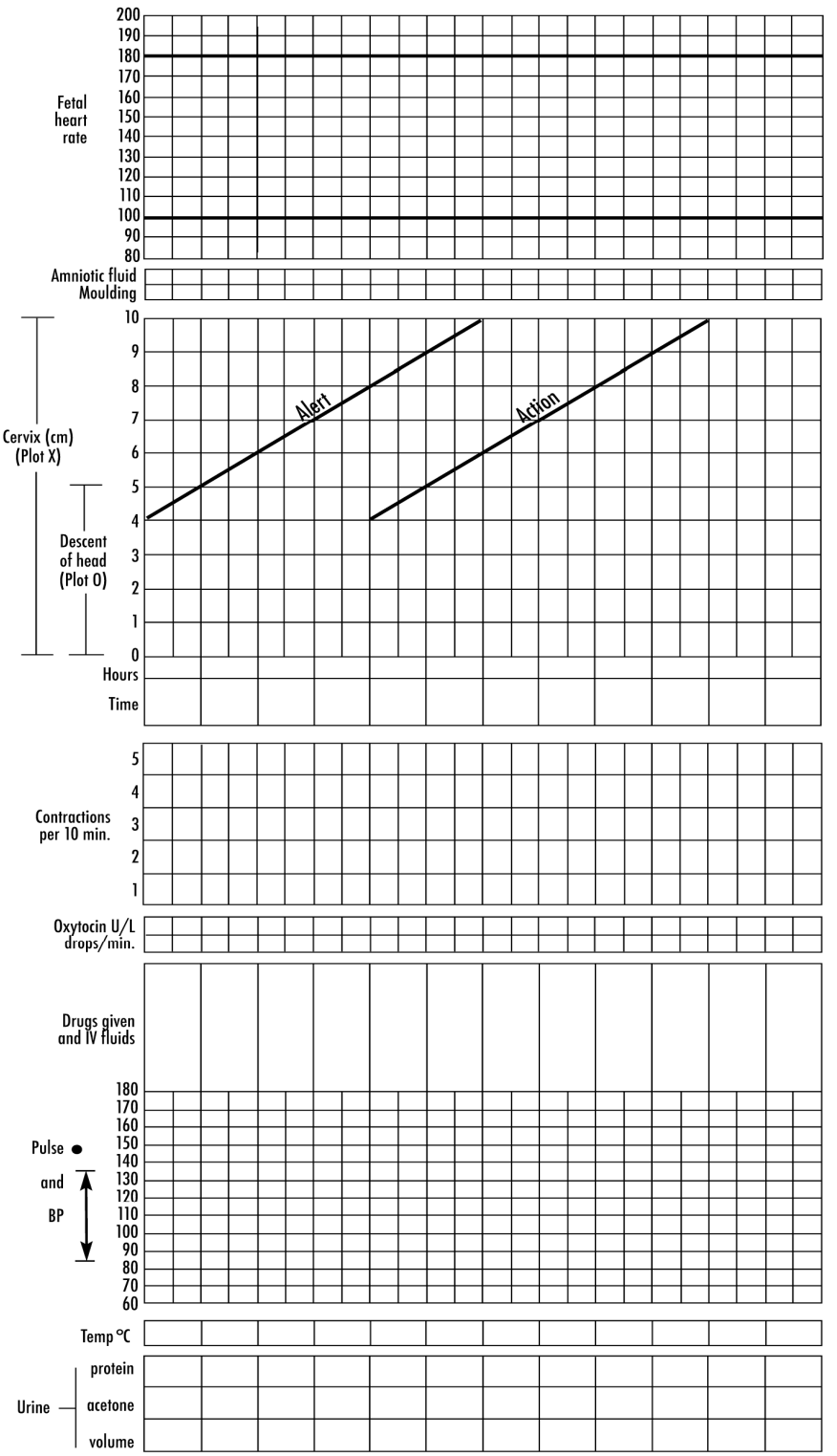
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-19

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

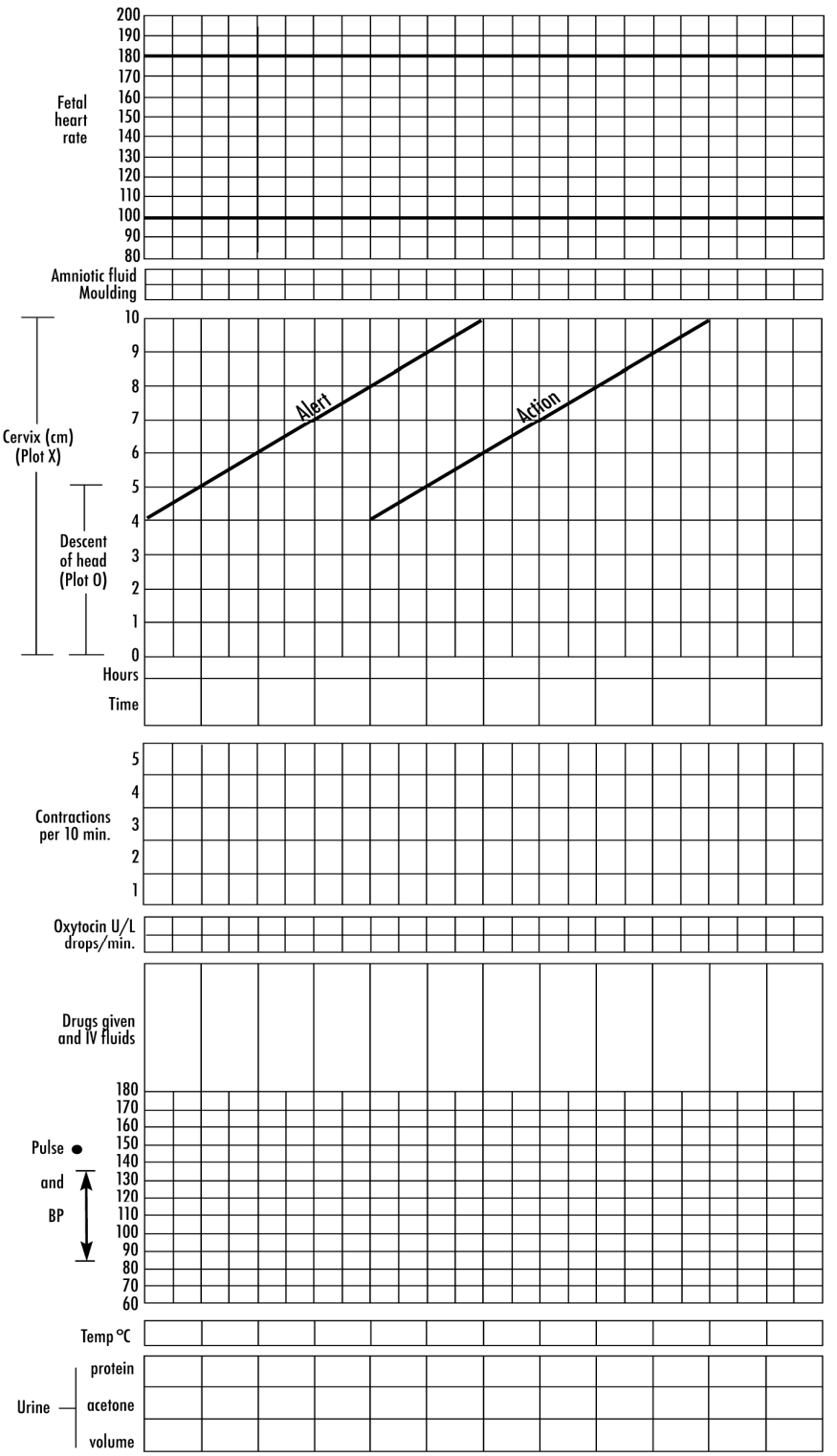
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

INTRANATAL ASSESSMENT-20

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous: _____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ Commencement of contraction:_____
- Presentation :_____ Position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____ ,
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

APGAR SCORING

Sl.No	**Sign**	**At 1 Min**			**At 5 Min**		
		0	**1**	**2**	**0**	**1**	**2**
1	Respiratory Effort						
2	Heart Rate						
3	Musle Tone						
4	Reflexes						
5	Colour						

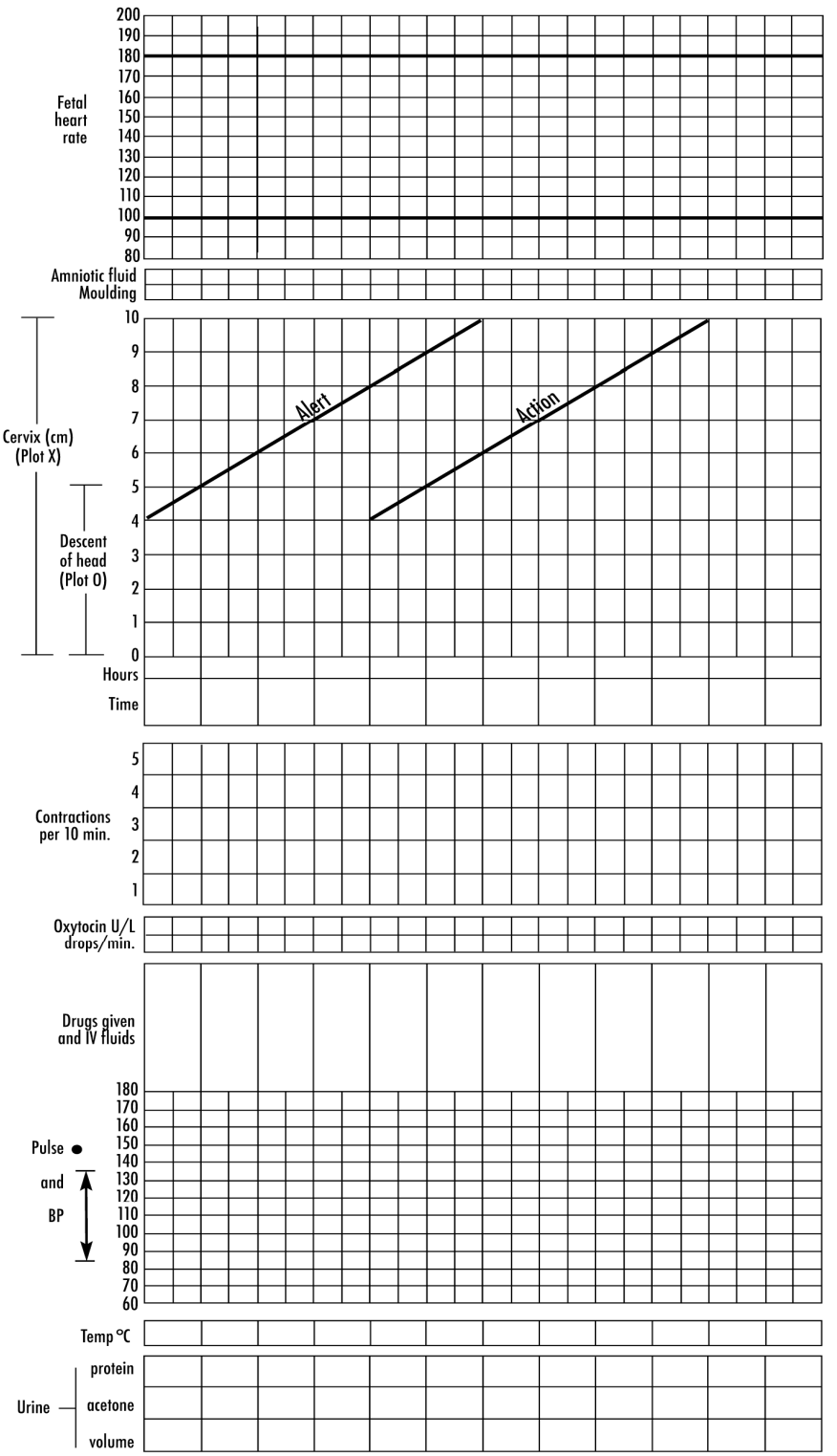
Score at 1 min: _____

Score at 5 min: _____

PARTOGRAPH

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Cord Length_____
- Weight_____ Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

Condition of mother following delivery:

- Pulse
- Respiration
- BP
- Vaginal bleeding
- Breast feeding

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN

POSTNATAL AND NEONATAL CARE PLAN -1

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -2

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -3

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -4

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -7

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -5

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -6

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -7

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -8

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -9

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -10

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -11

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -12

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -13

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -14

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -15

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -16

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -17

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -18

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -19

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

POSTNATAL AND NEONATAL CARE PLAN -20

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation: Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug
- History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK ANTENATAL EXAMINATION

HIGH RISK ANTENATAL CARE PLAN -1

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

ANTENATAL CLINICAL CHART

DATE:									
NAME :				**AGE:**					
OBSTETRICAL SCORE:				**GESTATION AGE :**					
Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight									
Any other abnormality									

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK ANTENATAL CARE PLAN -2

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

ANTENATAL CLINICAL CHART

DATE:									
NAME :				**AGE:**					
OBSTETRICAL SCORE:				**GESTATION AGE :**					
Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight									
Any other abnormality									

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK ANTENATAL CARE PLAN -3

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

ANTENATAL CLINICAL CHART

DATE:									
NAME :				**AGE:**					
OBSTETRICAL SCORE:				**GESTATION AGE :**					
Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight									
Any other abnormality									

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK ANTENATAL CARE PLAN -4

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

ANTENATAL CLINICAL CHART

DATE:									
NAME :				**AGE:**					
OBSTETRICAL SCORE:				**GESTATION AGE :**					
Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight									
Any other abnormality									

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK ANTENATAL CARE PLAN -5

Antenatal History

Baseline Data

- Name:
- Age:
- IP No:
- Date of Admission:
- LMP:
- EDD:
- Mother tongue:
- Address:
- Religion:
- Obstetrical score:
- Diagnosis:

Socio Economic History

Educational status: Husband

Wife:

Occupation: Husband

Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history

Sl.no	Name of family member	Age	Sex	Educational status	Occupation	Relationship with mother	Health status
1							
2							
3							
4							
5							
6							

Personel history:

- Dietary Pattern: _____ Bowel and Bladder Elimination Pattern:_____
- Sleeping Pattern: _____ Sexual History:_____
- Habits:_____ Drug History:_____

Menstrual History:

Age at menarche: _____ Duration of cycle in days: _____

Regularity: _____ Problems: _____

LMP: _____ EDD: _____

Marital history

Age at marriage: _____

Type Of marriage: Consanguineous/ Non Consanguineous:_____

Contraceptive history: _____

Present obstetrical history

Date of booking: _____ No of ANC visits: _____

Date of Quickening: _____ Date of Lightning: _____

Any history of disorders in Pregnancy: _____

Weight gain in Pregnancy: _____ NO of TT Inj: _____

Medications in Pregnancy: _____

Past Obstetrical history

SL.NO	Year of last pregnancy	No of Abortion	Fetal demise	Term	Mode of delivery	Living children
1						
2						
3						
4						
5						

Past medical History: _____

Past surgical History**:** _____

General Examination:

- **Appearance:**
    - Height: Weight:
    - Gait: Body built:
- Head and scalp:
- Face:
- Eyes:
- Ears:
- Nose:
- Mouth :
- Neck:
- Chest:
- Abdomen:
- Perineum :
- Limbs :
- Upper:
- Lower:

Vital signs:

- Temperature: Respiration:
- Pulse: BP:

Obstetrical Examination:

Breast examination:

- Size And Shape:
- Areola:
- Nipples:
- Secretions:

Abdominal examination:

Inspection:

- Size and shape of abdomen
- Striae gravidrum
- Umbilicus
- Contour of abdomen
- Linea Nigra
- Previous scar mark
- Fetal movements

Palpation

- Fundal height:
- Abdominal girth:
- Fundal grip:
- Lateral grip:

  Right lateral:

  Left lateral:
- Pelvic grip/Palpation:
- Pawlic Grip:

Auscultation:

- Location of FHS
- FHS/ min:

ANTENATAL CLINICAL CHART

DATE:									
NAME :				**AGE:**					
OBSTETRICAL SCORE:				**GESTATION AGE :**					
Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
BP									
Bowel									
Bladder									
Weight									
Any other abnormality									

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Medications:

Drug	Dose/Route/Time	Action	Side Effects	Nurses Responsibility

Nursing Diagnosis:

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK POSTNATAL CARE PLAN

HIGH RISK POSTNATAL CARE PLAN-1

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation : Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

TREATMENT GIVEN:_____

_____

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK POSTNATAL CARE PLAN-2

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation : Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

TREATMENT GIVEN:_____

_____

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK POSTNATAL CARE PLAN-3

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation : Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

TREATMENT GIVEN:_____

_____

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK POSTNATAL CARE PLAN-4

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation : Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

TREATMENT GIVEN:_____

_____

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK POSTNATAL CARE PLAN-5

BASELINE DATA

- Name: Age :
- IP No : Date of Admission :
- LMP : EDD :
- Mother tongue :
- Address :
- Religion :
- Obstetrical score :
- Date of Delivery:
- Diagnosis :

Socio Economic History

Educational status: Husband Occupation : Husband

Wife Wife:

- Income:_____ Type of house:_____
- Standard of living:_____ Lighting facility:_____
- Water Facility:_____ Toilet facility:_____
- Drainage /Gardening:_____ Pet animals:_____

Family history:

Type of Family: _____ No Of Family Members: _____

Personnel history:

- Dietary Pattern: _____ Sleeping Pattern: _____
- Habits:_____ Drug History:_____

Menstrual History:

- Age at menarche: _____ Duration of cycle in days: _____
- Regularity: _____ Problems: _____
- LMP: _____ EDD: _____

Marital history

- Age at marriage: _____
- Type Of marriage: Consanguineous/ Non Consanguineous:_____
- Contraceptive history: _____

Past Obstetrical history

Sl.no	Year	No of Abortion	Fetal demise	Pre Term	Full Term	Mode of delivery	Sex	Weight at birth	Health status
1									
2									
3									
4									

Past medical History: _____

Past surgical History**:** _____

PRESENT PREGNANCY:

- Admitted on:_____ commencement of contraction:_____
- Presentation :_____ position :_____
- Head engaged/not engaged _____ FHR:_____

ANTENATAL VISITS

Date of booking	Weight	Blood /urine	BP	FHR	Weeks of gestation	Fundal height	Treatment

Investigations:

Date	Investigation	Mother Value	Normal Value	Remarks

Delivery record

First Stage of Labour

- Commencement of contraction on: _____ at _____am/pm
- Vital signs T_____ P_____ R _____ BP Fetal Heart Rate _____
- Duration of Ist stage:_____ Medications given_____

Second Stage of Labour

- Membranes ruptured spontaneously at _____ / artificially Ruptured at _____
- Color of the liquor _____ Cervix fully dilated at _____
- Duration of II stage _____ Type delivery_____
- Type of Episiotomy _____
- Baby Born at _____ Sex_____
- Apgar score at 1min_____ at 5min_____
- Caput formation – yes / No
- Resuscitation details of baby_____
- Medications given _____

Third Stage of Labour

- Placenta and membranes:_____ Delivered at _____
- Duration of III stage_____ Type of placenta _____
- Cord insertion_____ Weight_____
- Approximate blood loss_____

Fourth stage:

- Condition of uterus: _____ Breast feeding initiated : _____
- Any congenital Abnormalities: _____
- Treatment at birth:_____

CLINICAL CHART OF PUEPERIUM

Date										**Fundus in cm**
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**	
^{O}F	**^{O}C**									
104	**40**									
103	**39.5**									
102	**39**									
101	**38.5**									
100	**38**									
99	**37.5**									
98	**37**									
97	**36.5**									
96	**36**									
Pulse										
Respiration										
BP										
Lochia										
Bowel										
Bladder										
Any other abnormality										

TREATMENT GIVEN:_____

_____

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK NEONATAL EXAMINATION

HIGH RISK NEONATAL CARE PLAN-1

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no APGAR score at birth:
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis Eye Discharge: Yes/ no
- Breast feeding at:_____ Passed Meconium at: _____
- Passed urine at:_____
- Congenital anomaly if any specify:_____

- Type of feed: breast/artificial, if artificial specify:_____
- Method of feeding: bottle/ Paladai/Spoon/Any Other, Specify:_____
- Sleep Pattern: Sleep Hours During Day: Hours During Night:
- Bowel Pattern: No Of Stools: /Day
- Type Of Stool: Meconium/ Transitional, Any Other, Specify

Voiding Pattern: Normal/Abnormal, If Abnormal Specify.

PHYSICAL EXAMINATION

Anthropometric measurements

- Birth weight: head to heel length:
- Head circumference chest circumference:

Vital signs

- Temperature: Heart rate:
- Respiration: General appearance:
- Posture:

Skin

- Color: Normal/ Pale/Cyanosed/Jaundiced/Any Other, Specify……
- Lanugo :Present/Absent Milia: Present/Absent
- Vernix: Present/Absent Mangolian Spots: Present/Absent
- Turgor: Normal/Lost Texture: Normal /Dry/Edematous
- Rash: Present/Absent. If Present, Specify Erythema Toxicum: Present/ Absent

Head

- Size: Normal/Microcephalus/Hydrocephalus
- Fontanelle: Flat And Soft/Depressed/Bulged/Pulsatile
- Sutures: Normal/Widened/Overlapping
- Caput Succedaneum: Present/ Absent Cephalohematoma: Present/ Absent
- Any Other:

Eyes

- Blink Reflex: Present/Absent
- Conjunctiva: Normal/Yellow/Red/Brown/Blue Tinged

- Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify……
- Any Other:

Ears

- Position: Normal/Abnormal. If Abnormal Specify:
- Recoiling Of Pinna: Slow/Instant
- If Abnormal Specify: Any Other:

Nose

- Discharge; Present/Absent Nasal Flaring: Present/Absent
- Any Other:

Mouth and throat

- Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft
- Color Of Tongue: Pink/Pale/Coated
- Palate; Normal/Cleft
- Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent

Neck: Normal /Stiff/Torricelli's

- **Chest**; Normal/ Protruded/Retractions
- Breath Sounds: Normal/Abnormal. If Abnormal Specify.
- Apnoea: Present/Absent.
- Heart Murmur: Present/ Absent

Breast

- Abdomen: Normal/Distended/Visible Peristalsis
- Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent
- Bowel Sounds: Present/ Absent
- Any Other Abnormality Specify:
- Spine :Normal/Meningocele/Meningomyocele/Spina Bifida

Extremities

- Palmer creases: well formed/single/ not formed
- Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

- Normal /Hypospadiasis/ Epispadiasis/ Hydrocele Testis: Descended/Undescended
- Ambiguous genitalia: yes /no any other:

Rectum

- Anal patency: yes/no
- Anal excoriation: present/ absent

Neurological

- Reflexes
- Moro: Tonic neck reflex:
- Stepping: Grasping:
- Glabellar: Babinski:

Feeding reflexes

- Rooting : Sucking: Swallowing: Gag:

Protective reflexes

- Blinking : cough and sneeze: yawn:
- Other neurological manifestations : absent /hypotonic/hypertonic opisthotonus/jitteriness
- Seizures: yes/no. if yes specify……

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation

MEDICATIONS

Date	Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK NEONATAL CARE PLAN-2

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no APGAR score at birth:
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis Eye Discharge: Yes/ no
- Breast feeding at:_____ Passed Meconium at: _____
- Passed urine at:_____
- Congenital anomaly if any specify:_____

- Type of feed: breast/artificial, if artificial specify:_____
- Method of feeding: bottle/ Paladai/Spoon/Any Other, Specify:_____
- Sleep Pattern: Sleep Hours During Day: Hours During Night:
- Bowel Pattern: No Of Stools: /Day
- Type Of Stool: Meconium/ Transitional, Any Other, Specify

Voiding Pattern: Normal/Abnormal, If Abnormal Specify.

PHYSICAL EXAMINATION

Anthropometric measurements

- Birth weight: head to heel length:
- Head circumference chest circumference:

Vital signs

- Temperature: Heart rate:
- Respiration: General appearance:
- Posture:

Skin

- Color: Normal/ Pale/Cyanosed/Jaundiced/Any Other, Specify……
- Lanugo :Present/Absent Milia: Present/Absent
- Vernix: Present/Absent Mangolian Spots: Present/Absent
- Turgor: Normal/Lost Texture: Normal /Dry/Edematous
- Rash: Present/Absent. If Present, Specify Erythema Toxicum: Present/ Absent

Head

- Size: Normal/Microcephalus/Hydrocephalus
- Fontanelle: Flat And Soft/Depressed/Bulged/Pulsatile
- Sutures: Normal/Widened/Overlapping
- Caput Succedaneum: Present/ Absent Cephalohematoma: Present/ Absent
- Any Other:

Eyes

- Blink Reflex: Present/Absent
- Conjunctiva: Normal/Yellow/Red/Brown/Blue Tinged

- Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify……
- Any Other:

Ears

- Position: Normal/Abnormal. If Abnormal Specify:
- Recoiling Of Pinna: Slow/Instant
- If Abnormal Specify: Any Other:

Nose

- Discharge; Present/Absent Nasal Flaring: Present/Absent
- Any Other:

Mouth and throat

- Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft
- Color Of Tongue: Pink/Pale/Coated
- Palate; Normal/Cleft
- Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent

Neck: Normal /Stiff/Torricelli's

- **Chest**; Normal/ Protruded/Retractions
- Breath Sounds: Normal/Abnormal. If Abnormal Specify.
- Apnoea: Present/Absent.
- Heart Murmur: Present/ Absent

Breast

- Abdomen: Normal/Distended/Visible Peristalsis
- Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent
- Bowel Sounds: Present/ Absent
- Any Other Abnormality Specify:
- Spine :Normal/Meningocele/Meningomyocele/Spina Bifida

Extremities

- Palmer creases: well formed/single/ not formed
- Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

- Normal /Hypospadiasis/ Epispadiasis/ Hydrocele Testis: Descended/Undescended
- Ambiguous genitalia: yes /no any other:

Rectum

- Anal patency: yes/no
- Anal excoriation: present/ absent

Neurological

- Reflexes
- Moro: Tonic neck reflex:
- Stepping: Grasping:
- Glabellar: Babinski:

Feeding reflexes

- Rooting : Sucking: Swallowing: Gag:

Protective reflexes

- Blinking : cough and sneeze: yawn:
- Other neurological manifestations : absent /hypotonic/hypertonic opisthotonus/jitteriness
- Seizures: yes/no. if yes specify……

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation

MEDICATIONS

Date	Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK NEONATAL CARE PLAN-3

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no APGAR score at birth:
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis Eye Discharge: Yes/ no
- Breast feeding at:_____ Passed Meconium at: _____
- Passed urine at:_____
- Congenital anomaly if any specify:_____

- Type of feed: breast/artificial, if artificial specify:_____
- Method of feeding: bottle/ Paladai/Spoon/Any Other, Specify:_____
- Sleep Pattern: Sleep Hours During Day: Hours During Night:
- Bowel Pattern: No Of Stools: /Day
- Type Of Stool: Meconium/ Transitional, Any Other, Specify

Voiding Pattern: Normal/Abnormal, If Abnormal Specify.

PHYSICAL EXAMINATION

Anthropometric measurements

- Birth weight: head to heel length:
- Head circumference chest circumference:

Vital signs

- Temperature: Heart rate:
- Respiration: General appearance:
- Posture:

Skin

- Color: Normal/ Pale/Cyanosed/Jaundiced/Any Other, Specify……
- Lanugo :Present/Absent Milia: Present/Absent
- Vernix: Present/Absent Mangolian Spots: Present/Absent
- Turgor: Normal/Lost Texture: Normal /Dry/Edematous
- Rash: Present/Absent. If Present, Specify Erythema Toxicum: Present/ Absent

Head

- Size: Normal/Microcephalus/Hydrocephalus
- Fontanelle: Flat And Soft/Depressed/Bulged/Pulsatile
- Sutures: Normal/Widened/Overlapping
- Caput Succedaneum: Present/ Absent Cephalohematoma: Present/ Absent
- Any Other:

Eyes

- Blink Reflex: Present/Absent
- Conjunctiva: Normal/Yellow/Red/Brown/Blue Tinged

- Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify……
- Any Other:

Ears

- Position: Normal/Abnormal. If Abnormal Specify:
- Recoiling Of Pinna: Slow/Instant
- If Abnormal Specify: Any Other:

Nose

- Discharge; Present/Absent Nasal Flaring: Present/Absent
- Any Other:

Mouth and throat

- Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft
- Color Of Tongue: Pink/Pale/Coated
- Palate; Normal/Cleft
- Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent

Neck: Normal /Stiff/Torricelli's

- **Chest**; Normal/ Protruded/Retractions
- Breath Sounds: Normal/Abnormal. If Abnormal Specify.
- Apnoea: Present/Absent.
- Heart Murmur: Present/ Absent

Breast

- Abdomen: Normal/Distended/Visible Peristalsis
- Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent
- Bowel Sounds: Present/ Absent
- Any Other Abnormality Specify:
- Spine :Normal/Meningocele/Meningomyocele/Spina Bifida

Extremities

- Palmer creases: well formed/single/ not formed
- Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

- Normal /Hypospadiasis/ Epispadiasis/ Hydrocele Testis: Descended/Undescended
- Ambiguous genitalia: yes /no any other:

Rectum

- Anal patency: yes/no
- Anal excoriation: present/ absent

Neurological

- Reflexes
- Moro: Tonic neck reflex:
- Stepping: Grasping:
- Glabellar: Babinski:

Feeding reflexes

- Rooting : Sucking: Swallowing: Gag:

Protective reflexes

- Blinking : cough and sneeze: yawn:
- Other neurological manifestations : absent /hypotonic/hypertonic opisthotonus/jitteriness
- Seizures: yes/no. if yes specify……

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation

MEDICATIONS

Date	Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
^{O}F	**^{O}C**								
104	**40**								
103	**39.5**								
102	**39**								
101	**38.5**								
100	**38**								
99	**37.5**								
98	**37**								
97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK NEONATAL CARE PLAN-4

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no APGAR score at birth:
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis Eye Discharge: Yes/ no
- Breast feeding at:_____ Passed Meconium at: _____
- Passed urine at:_____
- Congenital anomaly if any specify:_____

- Type of feed: breast/artificial, if artificial specify:_____
- Method of feeding: bottle/ Paladai/Spoon/Any Other, Specify:_____
- Sleep Pattern: Sleep Hours During Day: Hours During Night:
- Bowel Pattern: No Of Stools: /Day
- Type Of Stool: Meconium/ Transitional, Any Other, Specify

Voiding Pattern: Normal/Abnormal, If Abnormal Specify.

PHYSICAL EXAMINATION

Anthropometric measurements

- Birth weight: head to heel length:
- Head circumference chest circumference:

Vital signs

- Temperature: Heart rate:
- Respiration: General appearance:
- Posture:

Skin

- Color: Normal/ Pale/Cyanosed/Jaundiced/Any Other, Specify……
- Lanugo :Present/Absent Milia: Present/Absent
- Vernix: Present/Absent Mangolian Spots: Present/Absent
- Turgor: Normal/Lost Texture: Normal /Dry/Edematous
- Rash: Present/Absent. If Present, Specify Erythema Toxicum: Present/ Absent

Head

- Size: Normal/Microcephalus/Hydrocephalus
- Fontanelle: Flat And Soft/Depressed/Bulged/Pulsatile
- Sutures: Normal/Widened/Overlapping
- Caput Succedaneum: Present/ Absent Cephalohematoma: Present/ Absent
- Any Other:

Eyes

- Blink Reflex: Present/Absent
- Conjunctiva: Normal/Yellow/Red/Brown/Blue Tinged

- Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify……
- Any Other:

Ears

- Position: Normal/Abnormal. If Abnormal Specify:
- Recoiling Of Pinna: Slow/Instant
- If Abnormal Specify: Any Other:

Nose

- Discharge; Present/Absent Nasal Flaring: Present/Absent
- Any Other:

Mouth and throat

- Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft
- Color Of Tongue: Pink/Pale/Coated
- Palate; Normal/Cleft
- Cry: Good/Weak/Shrill/High Pitched Oral Thrush: Present/Absent

Neck: Normal /Stiff/Torricelli's

- **Chest**; Normal/ Protruded/Retractions
- Breath Sounds: Normal/Abnormal. If Abnormal Specify.
- Apnoea: Present/Absent.
- Heart Murmur: Present/ Absent

Breast

- Abdomen: Normal/Distended/Visible Peristalsis
- Umbilical Stump: Healthy/ Unhealthy Umbilical Hernia: Present/Absent
- Bowel Sounds: Present/ Absent
- Any Other Abnormality Specify:
- Spine :Normal/Meningocele/Meningomyocele/Spina Bifida

Extremities

- Palmer creases: well formed/single/ not formed
- Plantar creases; no creases/faint red marks/deeper lines

Genitourinary

Female

- Vaginal discharge: present/absent. If present, pseudo menstruation/white discharge
- Any other:

Male

- Normal /Hypospadiasis/ Epispadiasis/ Hydrocele Testis: Descended/Undescended
- Ambiguous genitalia: yes /no any other:

Rectum

- Anal patency: yes/no
- Anal excoriation: present/ absent

Neurological

- Reflexes
- Moro: Tonic neck reflex:
- Stepping: Grasping:
- Glabellar: Babinski:

Feeding reflexes

- Rooting : Sucking: Swallowing: Gag:

Protective reflexes

- Blinking : cough and sneeze: yawn:
- Other neurological manifestations : absent /hypotonic/hypertonic opisthotonus/jitteriness
- Seizures: yes/no. if yes specify……

INVESTIGATIONS

Date	Type of investigation	New born's value	Normal value	Interpretation

MEDICATIONS

Date	Name of the drug &dose	Route & frquency	Action	Side effects	Nurses responsibility

CLINICAL CHART OF NEWBORN

Date									
Temprature		**M**	**E**	**M**	**E**	**M**	**E**	**M**	**E**
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104	**40**								
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97	**36.5**								
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Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

HIGH RISK NEONATAL CARE PLAN-5

BASE LINE DATA

- Name
- Hospital IP NO
- Date of assessment
- Mother's name
- Father's name
- Address
- Date of birth
- Sex: male/ female

Antenatal history

- Age of mother
- Consanguineous marriage: yes/no if yes, relationship
- Degree of consanguinity
- Antenatal check up: yes/no. If yes specify

Intranatal history

- Place of delivery: home/ hospital/any other, specify
- Delivery conducted by: skilled/unskilled personnel. Specify
- Mode of delivery: Normal /abnormal. if abnormal, specify
- Gestational age in weeks: Birth weight:
- Cried at birth: yes/ no APGAR score at birth:
- Birth injury: yes/ no. if yes specify

Newborn history

- Color at birth: normal/ icteric/pallor/ cyanosis Eye Discharge: Yes/ no
- Breast feeding at:_____ Passed Meconium at: _____
- Passed urine at:_____
- Congenital anomaly if any specify:_____

- Type of feed: breast/artificial, if artificial specify:_____
- Method of feeding: bottle/ Paladai/Spoon/Any Other, Specify:_____
- Sleep Pattern: Sleep Hours During Day: Hours During Night:
- Bowel Pattern: No Of Stools: /Day
- Type Of Stool: Meconium/ Transitional, Any Other, Specify

Voiding Pattern: Normal/Abnormal, If Abnormal Specify.

PHYSICAL EXAMINATION

Anthropometric measurements

- Birth weight: head to heel length:
- Head circumference chest circumference:

Vital signs

- Temperature: Heart rate:
- Respiration: General appearance:
- Posture:

Skin

- Color: Normal/ Pale/Cyanosed/Jaundiced/Any Other, Specify……
- Lanugo :Present/Absent Milia: Present/Absent
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- Size: Normal/Microcephalus/Hydrocephalus
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- Any Other:

Eyes

- Blink Reflex: Present/Absent
- Conjunctiva: Normal/Yellow/Red/Brown/Blue Tinged

- Cornea: Normal/Abnormal Discharge: Present/Absent. If Present Specify……
- Any Other:

Ears

- Position: Normal/Abnormal. If Abnormal Specify:
- Recoiling Of Pinna: Slow/Instant
- If Abnormal Specify: Any Other:

Nose

- Discharge; Present/Absent Nasal Flaring: Present/Absent
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Mouth and throat

- Color Of Lips: Pink/Pale/Cyanosed Lips: Normal/Cleft
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Neck: Normal /Stiff/Torricelli's

- **Chest**; Normal/ Protruded/Retractions
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- Heart Murmur: Present/ Absent

Breast

- Abdomen: Normal/Distended/Visible Peristalsis
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97	**36.5**								
96	**36**								
Heart rate									
Respiration									
Urine									
Stool									
Jaundice									
Weight									
Any other abnormality									

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

Care plans:

Assessment	Diagnosis	Interventions	Evaluation

HEALTH EDUCATION

Draw pictures/stick images	Explanation

Signature of Student **Signature of Supervisor**

ASSESSED ABNORMAL DELIVERIES

ASSESSED FORCEPS/INSTRUMENTAL/BREECH ASSISTED DELIVERY-1

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of baby:

Sex;

Weight:

APGAR score:

Condition of mother: _____

_____

Signature of Student **Signature of Supervisor**

ASSESSED FORCEPS/INSTRUMENTAL/BREECH ASSISTED DELIVERY-2

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of baby:

Sex;

Weight:

APGAR score:

Condition of mother: _____

_____

Signature of Student **Signature of Supervisor**

ASSESSED FORCEPS/INSTRUMENTAL/BREECH ASSISTED DELIVERY-3

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of baby:

Sex;

Weight:

APGAR score:

Condition of mother: _____

_____

Signature of Student **Signature of Supervisor**

ASSESSED FORCEPS/INSTRUMENTAL/BREECH ASSISTED DELIVERY-4

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of Baby:

Sex:

Weight:

APGAR score:

Condition of Mother: _____

_____

Signature of Student **Signature of Supervisor**

ASSESSED FORCEPS/INSTRUMENTAL/BREECH ASSISTED DELIVERY-5

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of baby:

Sex;

Weight:

APGAR score:

Condition of mother: _____

_____

Signature of Student **Signature of Supervisor**

ASSESSED/WITNESSED CAESAREAN SECTION

CESAREAN SECTIONS WITNESSED/ASSISTED-1

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of Baby:

Sex:

Weight:

APGAR score:

Condition of Mother: _____

_____

Signature of Student **Signature of Supervisor**

CESAREAN SECTIONS WITNESSED/ASSISTED-2

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of Baby:

Sex:

Weight:

APGAR score:

Condition of Mother: _____

_____

Signature of Student **Signature of Supervisor**

CESAREAN SECTIONS WITNESSED/ASSISTED-3

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of Baby:

Sex:

Weight:

APGAR score:

Condition of Mother: _____

_____

Signature of Student **Signature of Supervisor**

CESAREAN SECTIONS WITNESSED/ASSISTED-4

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of Baby:

Sex:

Weight:

APGAR score:

Condition of Mother: _____

_____

Signature of Student **Signature of Supervisor**

CESAREAN SECTIONS WITNESSED/ASSISTED-5

Name of patient:

IP number:

Age:

Obstetrical score:

Gestational weeks:

LMP

EDD

Presentation

Position

Weeks of gestation

Indication

Nature of delivery:

Condition of Baby:

Sex:

Weight:

APGAR score:

Condition of Mother: _____

_____

Signature of Student **Signature of Supervisor**

EPISIOTOMY PERFORMED

EPISIOTOMY AND SUTURING PERFORMED/ASSISTED

Sl.No	Name of the patient	IP Number	Date of Delivery	Age	Obstetric Score	Indication	Type of Episiotomy	No.of Sutures	Condition	Signature of Supervisor
1										
2										
3										
4										
5										

Signature of Student **Signature of Supervisor**

VAGINAL EXAMINATION PERFORMED

VAGINAL EXAMINATIONS PERFORMED IN LABOUR

Sl. No	Name of the patient	IP Number	Date of Examination	Age	Obstetric score And GA	Cervix		Membranes	Presentation position	Station of presenting part	Remarks	Signature of supervisor
						Effacement	Dilatation					
1												
2												
3												
4												
5												

Signature of Student **Signature of Supervisor**

IUCD AND STERILIZATION PERFORMED

INTRAUTERINE CONTRACEPTIVE DEVICE (IUCD) INSERTIONS ASSISTED

Sl.No	Name of the patient	Date	IP Number	Age	Para	Date of Delivery	No of Living Children
1							
2							
3							
4							
5							

Signature of Student **Signature of Supervisor**

FEMALE STERLIZATIONS/TUBAL LIGATIONS WITNESSED/ASSISTED

Sl.No	Name of the patient	IP NO.	Age	Para	Date of Delivery	No of Living Children	Reason for tubal ligations	Contraceptive used before	LMP	Method of tubal ligation	Remarks
1											
2											
3											
4											
5											

Signature of Student **Signature of Supervisor**

PLACENTA EXAMINATION

PLACENTA EXAMINATION -1

Name of Mother

Age

Obstetrical Score

Date of Delivery

Nature of Delivery:

Condition of Mother

Condition of Baby:

Expelled Baby At:

Delivery Of Placenta At:

Complete/Incomplete:

Membranes of Placenta:

Weight of Placenta:

Type Of Placenta:

Cord Insertion:

Any Abnormality of Placenta: _____

Signature of Student **Signature of Supervisor**

PLACENTA EXAMINATION -2

Name of Mother

Age

Obstetrical Score

Date of Delivery

Nature of Delivery:

Condition of Mother

Condition of Baby:

Expelled Baby At:

Delivery Of Placenta At:

Complete/Incomplete:

Membranes of Placenta:

Weight of Placenta:

Type Of Placenta:

Cord Insertion:

Any Abnormality of Placenta: _____

Signature of Student **Signature of Supervisor**

KANGRAOO MOTHER CARE

KANGAROO MOTHER CARE -1

Name of Mother:

Age:

IP Number:

Education status:

Obstetrical Score

Date of Delivery

Nature of Delivery:

Sex of baby

Weight of baby

Apgar score at birth

Treatment at birth:

Breast feeding:

Duration of KMC:

Technique of KMC: _____

_____.

Remarks:_____

_____

Signature of Student **Signature of Supervisor**

KANGAROO MOTHER CARE -2

Name of Mother:

Age:

IP Number:

Education status:

Obstetrical Score

Date of Delivery

Nature of Delivery:

Sex of baby

Weight of baby

Apgar score at birth

Treatment at birth:

Breast feeding:

Duration of KMC:

Technique of KMC: _____

_____.

Remarks:_____

_____

Signature of Student **Signature of Supervisor**

PLANNED PARENTHOOD

PLANNED PARENTHOOD -1

Name of Mother:

Age:

IP Number:

Education status:

Name of husband:

Education status:

Obstetrical score:

AV AIDS Used:_____

_____

Remarks:_____

_____

Signature of Student **Signature of Supervisor**

PLANNED PARENTHOOD -2

Name of Mother:

Age:

IP Number:

Education status:

Name of husband:

Education status:

Obstetrical score:

AV AIDS Used:_____

_____

Remarks:_____

_____

Signature of Student **Signature of Supervisor**