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Contact: Clinical_Pathways_Program@health.qld.gov.au

Intrapartum Record
(without Partogram and 2nd stage observations)

Facility: ....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Model of care:		Allergies:		Skin-to-Skin contact: Importance discussed: ☐ Yes ☐ No
Gravida:	Para:	EDD: ☐ Dates ☐ Scan .... / .... /	Gestation: weeks	Placental position:
Support person(s)				
Confirmed consent		Vitamin K: ☐ IMI ☐ Oral ☐ No Hep B: ☐ Yes ☐ No Oxytocic in 3rd stage: ☐ Yes ☐ No		
Bloods / Alerts		Blood group: .... Antibodies: .... Hb: .... Date: .... / .... / .... **Serology** Hep B: ☐ Yes (◯ +ve ◯ –ve) ☐ No Hep C: ☐ Yes (◯ +ve ◯ –ve) ☐ No HIV: ☐ Yes (◯ +ve ◯ –ve) ☐ No Syphilis: ☐ Yes (◯ +ve ◯ –ve) ☐ No Rubella status: ☐ Immune ☐ Not immune Alerts:		
Birth preferences		Discussed: ☐ Yes ☐ No		

Risk Factors / Management Plan

Risk Factors	Management Plan	Initials
GBS positive: ☐ Yes ☐ No ☐ Unknown		
Weight (36 weeks): .... kg Date: .... / .... /		
Current BMI (36 weeks): .... Date: .... / .... /		
Antenatal VTE score: .... Risk identified: ☐ Yes ☐ No		
Diabetes: ☐ Yes ☐ No If *yes*, type:		
Abnormal ultrasound finding: Date: .... / .... / .... ☐ Yes *(see report)* .... ☐ No		
PPH risk: ☐ Yes ☐ No		
3rd / 4th degree tear: ☐ Yes ☐ No If *yes*, type:		
Other risks:		

☐ **Plan discussed with woman**

Risk Screen
Tick as appropriate. Implement interventions (if required). Document in medical record

Falls Risk	☐ Nil risk factors identified on admission ☐ Impaired mobility on admission ☐ History of falls during pregnancy ☐ Medications (e.g. epidural, sedation, narcotic)	☐ Environment (e.g. bath, shower, birth ball) ☐ Impaired mobility ☐ Hypotension, blood loss
Pressure Injury Risk	☐ Nil risk factors identified on admission ☐ Skin inspection completed ☐ Impaired mobility	☐ Epidural ☐ Long labour (greater than 12 hours)

Signature Log
Every person documenting in this record must provide their name, signature and initials below

Name (print)	Designation	Signature	Initials	Name (print)	Designation	Signature	Initials

DO NOT WRITE IN THIS BINDING MARGIN

v3.00 - 05/2018
Mat. No.: 10371964

SW848

INTRAPARTUM RECORD (WITHOUT PARTOGRAM AND 2ND STAGE OBSERVATIONS)

Queensland Government

Intrapartum Record
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URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Intrapartum Assessments

Date						
Time						
Indication						
Abdominal Palpation	Fundus					
	Lie					
	Attitude					
	Presentation					
	Position					
	Engagement					
Vaginal Examination	Dilatation					
	Length (cm)					
	Consistency					
	Application					
	Membranes / Liquor					
	Presenting part					
	Station					
	Caput					
	Moulding					
	Position	R L	R L	R L	R L	R L
	FHR post VE					
	MHR post VE					
Comments and plan						
Initials						

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Intrapartum Assessments

Date						
Time						
Indication						
Abdominal Palpation	Fundus					
	Lie					
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Vaginal Examination	Dilatation					
	Length (cm)					
	Consistency					
	Application					
	Membranes / Liquor					
	Presenting part					
	Station					
	Caput					
	Moulding					
	Position	R ◯ L	R ◯ L	R ◯ L	R ◯ L	R ◯ L
	FHR post VE					
	MHR post VE					
Comments and plan						
Initials						

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Given name(s):

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Birth Attendees

	Name (print)	**Designation**
Birth Accoucheur		
Midwife		
Witness		
Medical Officer		
Other		

Birth Summary

Labour	☐ Spontaneous ☐ Induced ☐ Augmented
Induction Indication / Method	
Rupture of Membranes	☐ SROM ☐ ARM Date: .... / .... / .... Time:........ : .... Total time ruptured (hrs / mins): .... / ....
Liquor	☐ Clear ☐ Meconium ☐ Blood stained ☐ Offensive
Mode of Birth / Presentation	
Length of Labour	Date / Time / Duration (hrs / mins) Onset of labour: .... / .... / .... : .... 1st stage: .... / .... Cervix fully dilated: .... / .... / .... : .... 2nd stage: .... / .... Head delivered: .... / .... / .... : .... Baby born: .... / .... / .... : .... 3rd stage: .... / .... Cord clamped: .... / .... / .... : .... Placenta delivered: .... / .... / .... : .... **Total:** .... / ....
Pain Relief	☐ Nil ☐ N_2O and O_2 ☐ Narcotic ☐ Epidural ☐ Sterile water ☐ Spinal ☐ GA ☐ Non-pharmalogical (specify): ....
Active Pushing	Time of onset: .... : .... Duration (hrs / mins): .... / ....
Maternal Position at Birth	
Perineal Care	☐ Antenatal perineal massage ☐ Perineal massage in labour ☐ Hands on (recommended) ☐ Warm compress 2nd stage ☐ Hands poised

Third Stage

Birth Mode	☐ Modified active management ☐ Active management ☐ Physiological ☐ Manual removal
Placenta	☐ Appears complete ☐ Incomplete Comments: ....
Membranes	☐ Appears complete ☐ Incomplete ☐ Ragged
Cord	Cord: ☐ Vessels .... pH: ☐ Venous .... ☐ Arterial .... Cord blood collected: ☐ Yes ☐ No BE: ☐ Venous .... ☐ Arterial .... Lactate: ☐ Venous .... ☐ Arterial ....
Blood Loss	Measured: .... mL Estimated: .... mL Total: .... mL
Oxytocic	Name / Time / Dose / Route .... : .... : .... : .... : ....

Postnatal risk factors reviewed on page 1: ☐ Yes ☐ No

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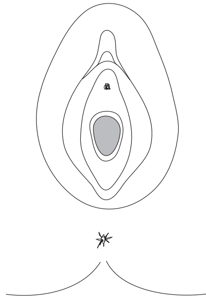
Perineal Assessment

Perineal Tears	☐ Intact ☐ 1° tear ☐ 2° tear ☐ 3° tear ☐ 4° tear Repaired in OT: ☐ Yes ☐ No
Episiotomy	Type: .... Indication: .... ☐ N/A
Perineal Repair	☐ Required ☐ Not required ☐ Declined Signature: .... Date: ...... / ...... / ......
Labia Tear	☐ Yes ☐ No
PR Examination Completed	☐ Yes ☐ No
Perineal Check	Check 1 (name): .... Check 2 (name): ....

Perineal Repair

Label trauma on diagram and include descriptions of repair. Document suture material and anaesthetic used. Document PR examination and consider PR analgesia. **Time perineal repair commenced:** ...... : ......



Name:	Signature:	Date:

Perineal Surgical Item Count	Initial Count		Additions		Final Count	
Swabs						
Needles						
Instruments						
Number of sponges						
Correct count	☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Initials (two person check)	1:	2:	1:	2:	1:	2:
⚠ **Sponges left in situ:** ☐ Yes ☐ No Sponge type: .... Number:	*If packs / sponges to remain in situ, document in Vaginal Birth Clinical Pathway*					
Removed pack / sponges Date: ...... / ...... / ...... Time: ...... :						

Newborn Summary

Baby's URN		
Identification Tag / Sex	ID checked: ☐ Yes ☐ No ID attached: ☐ Yes ☐ No Signature 1: .... Signature 2:	☐ Male ☐ Female ☐ Indeterminate
Date / Time of Birth	...... / ...... / .... :	
Born	☐ Alive ☐ Stillborn ☐ Macerated Baby to special care: ☐ Yes ☐ No	
APGAR Score	1 minute: .... 5 minutes: .... 10 minutes:	
Baby Appearance	☐ Normal ☐ Abnormal Comments:	
Measurements	Weight: .... g Length: .... cm Head circumference: .... cm	
Medication	Vitamin K given: ☐ IMI ☐ Oral ☐ Not given Hep B vaccine given: ☐ Vaccine ☐ Immunoglobulin ☐ Not given	
Skin-to-Skin Contact (recommendation ≥1 hour)	Time commenced: ...... : ...... Time discontinued: ...... : ...... ☐ Not given Comments / Variance:	
Feeding	☐ Breastfeed ☐ <1 hour ☐ EBM ☐ Formula / Artificial ☐ Nil / N/A	

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