****

WArning

Copyright Restrictions

This course content and all writings and materials provided to you at the Elson S. Floyd College of Medicine are protected by federal copyright law and Washington State University policy. The content is copyrighted by the Washington State University Board of Regents or licensed to the Elson S. Floyd College of Medicine by the copyright owner. Limited access to this content is given for personal academic study and review purposes of registered students and faculty of Elson S. Floyd College of Medicine. You shall not otherwise copy, share, distribute, modify, transmit, upload, post, republish, reuse, sell, gift, rent, lend or otherwise disseminate any portion of this course content without permission in writing, signed by an individual authorized by Washington State University.

**SAMPLE LABOR & DELIVERY ADMIT NOTE**

Referring provider:

Name: \_

Address: \_

Phone #: \_

Fax: \_

Primary OB Provider:

Name: \_

Address:\_

Phone #:\_

Fax #: \_

**IDENTIFICATION and CHIEF COMPLAINT:**

Patient \_ is a \_ year old G\_ P\_ at \_-\_/7 weeks gestational age by LMP, confirmed with \_-week ultrasound (EDD \_) who presents with \_

**REVIEW OF DATES**

**Authoritative EDD** *\_*

LMP \_/\_/\_ -> EDD \_/\_/\_

Ultrasound on \_/\_ @ \_ \_/\_ WGA by US -> EDD \_/\_/\_

Ultrasound on \_/\_ @ \_ \_/\_ WGA by US -> EDD \_/\_/\_

**PROBLEM LIST**

1. \_

2. \_

3. \_

**HISTORY OF PRESENT PREGNANCY**

Pregnancy complicated by the above problem list. She presents to L&D\_

**PRENATAL LABS**

Blood Type \_, Antibody \_, HCT \_ @ \_wks.

Rubella \_, Syphilis IgG \_, HbsAg \_, HIV \_, Hep C\_

Pap \_, GC \_, CT \_, Urine culture \_,

Quad screen \_, Integrated Screen \_, Cell free fetal DNA \_, MSAFP \_

Glucola \_, 3h GTT \_, GBS \_ on date: \_

**PRENATAL ULTRASOUND(S)**

Anatomy US on \_ at \_ wga

Placenta \_

Anatomy survey complete\_, incomplete \_

*(include additional US as necessary according to clinical situation)*

**PAST MEDICAL HISTORY**

1. \_

**PAST SURGICAL HISTORY**

1. \_

**PAST OBSTETRICAL HISTORY**

1. \_

**PAST GYNECOLOGIC HISTORY**

Abnormal paps\_, \_ history of STI's. Has used \_ for contraception in the past. GYN surgeries\_.

**MEDICATIONS**

\_

**ALLERGIES**

 \_

**SOCIAL HISTORY**

 \_ Drugs/\_tobacco/\_alcohol use. \_ screen for domestic violence.

**FAMILY HISTORY**

 Significant for \_

**REVIEW OF SYSTEMS**

 Pertinent findings are noted in the above HPI. All other systems were reviewed and are negative.

**PHYSICAL EXAMINATION**

VITAL SIGNS: BP: \_/\_ HR:\_ T: \_ RR:\_ 02 Sat:\_

GENERAL: No acute distress.

NEURO: ambulatory, gait normal

PSYCH: alert and oriented x3. Mood/affect appropriate.

HEAD/FACE: atraumatic, no visible lesions or asymmetry.

CARDIOVASCULAR: RRR, \_murmurs. Peripheral pulses 2+.

RESPIRATORY: Effort normal, \_ Clear to auscultation \_

ABDOMEN: non-tender,gravid. No palpable masses, or hernias. Scars: \_.

EXTREMITIES: \_edema, symmetrical strength and movement.

SKIN: no rashes, lesions. \_

PELVIC: External genitalia: \_ lesions. Vagina: \_ lesions, \_discharge

SSE: \_ pool, nitrizine \_, fern \_

SVE: \_ /\_ / \_

LEOPOLD's: \_ cephalic, efw \_#

FHT: baseline \_, \_ variability, \_ accels, \_ decels.

TOCO: \_

**LABORATORY ON ADMIT**

\_

**IMAGING**

Bedside US: cephalic \_, placenta \_, fetal cardiac motion \_, AFI \_

**ASSESSMENT & PLAN**

\_ y/o G\_P\_ at \_ \_/7 weeks by \_ admitted for \_.

1. \_

2. \_

3. Fetal well-being: Fetus \_reactive on monitor, vertex, efw \_#, GBS \_.

- Continuous external fetal monitoring.

4. Prenatal care:

- Postpartum contraception \_

- Immunizations: Tdap \_, Influenza \_

Disposition: patient status reviewed, inpatient \_observation \_

Note cc’d to provider/clinic: \_

**SAMPLE VAGINAL DELIVERY NOTE**

Referring Provider: \_

Primary OB provider: \_

**Physicians/Students**: \_

**Analgesia**: \_

**GBS: \_ Antibiotics: \_ Doses:** \_

**Findings**:

\_male infant at \_ \_/7 weeks gestational age in \_position, \_grams, APGARs \_ at 1 minute/\_ at 5 minutes with \_degree laceration. Cord gasses: \_.

**EBL**: \_ cc.

**Complications**: \_

**Stage I**:
\_ yo G\_P\_ at \_/7 weeks admitted for \_. Labor course: \_. Patient received \_ for analgesia. Fetal surveillance was \_. She progressed to complete in \_hours.

**Stage II**:
The patient pushed well for \_hrs to deliver a viable \_ infant. The shoulders delivered easily with the \_ shoulder anterior. The cord was clamped x 2 and cut and baby was handed to \_. A nuchal cord \_ present. Second stage duration was \_. Cord gases were \_ collected.

**Stage III**:
\_Third stage of labor was managed actively. The placenta delivered spontaneously and intact with gentle traction and fundal massage. \_The cervix was examined and found to be intact. Inspection revealed a \_degree \_ laceration, which was repaired with \_3-0 Vicryl in the usual sterile fashion. Good hemostasis was noted.

**Placenta**: \_ routine discard \_ sent to Pathology

**Infant:** \_recovering with mother \_admitted to the NICU

**SAMPLE OPERATIVE NOTE**

**DATE:**

**ATTENDING PHYSICIAN:**

**ASSISTANT(S):**

**PREOPERATIVE DIAGNOSIS(ES)**

**POSTOPERATIVE DIAGNOSIS(ES)**

**OPERATION(S):**

**ANESTHESIA:**

**COMPLICATIONS:**

**ESTIMATED BLOOD LOSS:**

**URINE OUTPUT:**

**FLUIDS**:

**SPECIMEN(S):**

**INDICATIONS:**

Patient\_ is a \_ y/o G\_P\_

**FINDINGS:**

**DESCRIPTION OF PROCEDURE**

A signed written informed consent was obtained from the patient, and they was taken to the operating room. Analgesia/Anesthesia was found to be adequate. A timeout was performed. Patient received \_ for antibiotics. The patient was prepped and draped in the normal sterile fashion in \_dorsal lithotomy position.

 **DISPOSITION**:

**SAMPLE POSTPARTUM NOTE-VAGINAL DELIVERY**

**CC/Identification**: Patient \_ is a \_ year old G\_ P\_ s/p vaginal delivery on \_ at \_ weeks GA, of \_infant.

**Problem List**:

1. \_

**Prenatal Labs**:

Blood type: \_

Rubella: \_ immune

**Subjective**: \_

* Breastfeeding/breastpumping?
* Vaginal bleeding has been\_. \_ seen large clots on pads.
* \_Dizzy/lightheaded
* Pain has been \_controlled with \_medications
* \_Tolerating diet. \_nausea/vomiting.

**Objective**:

VS: BP\_ HR \_ RR \_ O2 Sats\_

General: NAD\_

CV: RRR\_

Chest: respiratory effort normal, CTAB\_

ABD: soft, uterus firm, fundus at \_.

Perineum: \_

Extremities: no edema\_, no tenderness.

Skin: No erythema \_

I/O: \_

Admit Hct: \_

**Assessment/Plan**: Post Partum day #\_. \_afebrile. \_hemodynamically stable. \_Recovering appropriately.

1. Routine postpartum management: RN teaching on infant care.

Rhogam: \_indicated

MMR before discharge: \_

TDap:\_

Breastfeeding: \_

Perineal care: \_

Depression risk: \_

2. Planned contraception method: \_

3. Routine discharge instructions given. Follow up postpartum appointment in \_ weeks with Dr. \_ at \_ clinic.

**OB POSTPARTUM NOTE- CESAREAN DELIVERY**

**CC/Identification**: Patient \_ is a \_ year old G\_ P\_ , POD #\_, s/p \_ Cesarean delivery on \_ at \_ weeks GA, of \_male infant.

**Problem List** *(make sure to update problems resolved after delivery****)***:

1. \_

**Prenatal Labs**:

Blood type: \_

Rubella: \_ immune

**Subjective**:

* Breastfeeding/breastpumping?
* Vaginal bleeding has been\_. \_ seen large clots on pads.
* \_Dizzy/lightheaded
* Pain has been \_controlled with \_medications
* \_Tolerating diet. \_nausea/vomiting.
* \_passing flatus

**Objective**:

VS: BP\_ HR \_ RR \_ O2 Sats\_

General: NAD\_

CV: RRR\_

Chest: respiratory effort normal, CTAB\_

ABD: soft, uterus firm, fundus at \_.

Extremities: \_ edema, no tenderness.

Incision: c/d/i, no erythema or exudate. Dressing \_.

Ins/Outs: \_

Preop Hct: \_%->\_cc EBL->Postop Hct:\_%

**Assessment/Plan**: Postpartum/Postoperative day #\_. \_afebrile. \_hemodynamically stable. \_Recovering appropriately.

1. Routine postpartum management: RN teaching on infant care.

Rhogam: \_ indicated

MMR before discharge: \_

TDap:\_

Breastfeeding: \_

Depression risk: \_

2. Post-operative care: tolerating \_ diet, \_ flatus, pain \_ controlled on PO pain meds. Foley \_, Urine output \_.

- Continue routine post-operative care.

3. Planned contraception method: \_

4. Dispo: Discharge to home \_. Routine discharge instructions given. Follow up postpartum appointment in \_ weeks with Dr. \_at \_ clinic.

**SAMPLE GYNECOLOGIC HISTORY AND PHYSICAL**

GYNECOLOGY CONSULTATION: Referred by @REFPROVFLNAME@

ID/CC: Patient is a \_year old G\_P\_ \_female, who presents with \*\*\*

She has the following concerns today:

**Current Concerns:**

#. \*\*\*

#. Contraception:

#. Menses: has \_days of bleeding every \_days. Describes as \_heavy. Describes as \_painful.

#. Sexual function: \_# of sexual partners in the past 12 months. \_male/female/both. \_no pain with intercourse

#. Cervical cancer screening/prevention: Last pap smear \_ and \_result. \_Has/has not had \_doses of HPV vaccine.

#. Breast health: \_denies nipple discharge, pain, or masses. Last mammogram: \_

**GYNECOLOGIC HISTORY**

Menarche at \_ \_history of Gynecologic surgeries. \_history of STIs (gonorrhea, chlamydia, herpes, HIV, trichomonas, syphilis). \_ history of genital warts.

**OB HISTORY:**

1.

2.

3.

**MEDICAL HISTORY:**

**MEDICATIONS:**

**ALLERGIES:**

**SURGICAL HISTORY:**

**FAMILY HISTORY**

\_ family history of breast, colon, uterus, ovarian cancer. \_ family history of bleeding or blood clotting disorders.

**SOCIAL HISTORY**

\_ EtOH use. \_ tobacco use. \_ marijuana use. \_ illicit drug use. Works as \_. Lives with \_. \_ feels safe in her current living situation. \_ history of verbal, physical, or sexual abuse.

**ROS**:

 Constitutional: \_fevers \_chills

 Ears, Nose, Mouth, Throat: \_congestion \_hearing loss

 Cardiovascular: \_palpitations \_chest pain

 Respiratory: \_cough \_shortness of breath

 Gastrointestinal: \_nausea \_vomiting \_diarrhea \_constipation \_blood in stool \_abdominal pain

 Genitourinary: \_vaginal discharge that burns, itches, has odor.

 Musculoskeletal: \_joint/muscle pain

 Neurological: \_headaches *(if yes-migraine with or without aura)* \_dizzy \_weakness

 Psychiatric: \_depression \_anxiety \_suicidal ideation

Complete review of systems reviewed with patient and on intake form. Negative except as noted above.

**PHYSICAL EXAM**:

VITAL SIGNS:

CONSTITUTIONAL: Well-developed, well-nourished \_female in no apparent distress.

NEURO: ambulatory, gait normal, alert

PSYCH: oriented, mood and affect appropriate

HEAD/FACE: atraumatic, no visible lesions or asymmetry

NECK: Supple, no masses, no thyromegaly

RESPIRATORY: normal effort. Clear to auscultation bilaterally.

CARDIOVASCULAR: Peripheral pulses are 2+, no cyanosis, clubbing or edema. RRR, normal S1, S2.

BACK: No costovertebral tenderness, no flank pain

CHEST/BREASTS: Symmetric. No nipple discharge. No masses palpated.

LYMPH: No axillary or inguinal lymphadenopathy.

ABDOMEN: Soft, nontender, \_masses.

GENITOURINARY: External genitalia is within normal limits including Bartholin's, Skene's, urethral meatus, urethra, perineum, and anus. Vagina is \_rugated and \_well-estrogenized. Cervix is \_parous without lesions. \_collected. Bimanual examination reveals the bladder and urethra to be nontender. Uterus is \_position, \_ in size, mobile, \_tender. \_ adnexal masses or tenderness.

SKIN: \_ rashes, burns or other skin lesions.

**LAB RESULTS:**

**IMAGING RESULTS:**

**ASSESSMENT/PLAN:** Patient is a \_year old G\_P\_ \_female who presents with \_

#. \_

#. Contraception:

#. Health maintenance and Screening tests:

Pt seen and discussed with Dr. \_ who guided this management plan.

**SAMPLE NEW OBSTETRICS PRESENTATION IN THE CLINIC/AMBULATORY SETTING**

\_(patient name) is a \_year old G\_P\_ at \_ \_/7 week gestational age dated by last menstrual period confirmed vs not confirmed by \_ week ultrasound *or dated by \_ week ultrasound inconsistent with last menstrual period or dated by \_ week ultrasound for unknown last menstrual period*. who presents for a new obstetrics appointment. *Describe any past pregnancies, years, outcomes, complications.* She has \_been having nausea and vomiting (*indicate if able to keep liquids and any food down)*. She has \_been having any vaginal bleeding. She has \_been having any abdominal pain. Her medical history is significant for \_. Her medications and allergies are significant for\_. Her surgical history is significant for \_. Her family history is significant for \_. Her social history is significant for\_. She is \_interested in genetic screening. She has\_ had her flu *and COVID-19* vaccine*(s)* this season. My assessment for this \_ year old G\_P\_ at \_ \_/7 weeks gestation patient is \_. My plan for this patient is \_.

**SAMPLE RETURN OBSTETRICS PRESENTATION IN THE CLINIC/AMBULATORY SETTING**

\_(patient name) is a \_ year old G\_P\_ at \_ \_/7 weeks gestational age who presents for a scheduled return obstetrics appointment. She is reporting regular fetal movement *(if greater than 20 weeks gestation)*  and denies vaginal bleeding, leakage of fluid, or abdominal pain/contractions. *(If greater than 20 weeks gestation)* Her fundal height is \_. The fetal heart rate today is \_. The patient’s concerns today are \_ and they have questions about \_. They are due for \_testing today. My assessmentfor this \_ year old G\_P\_ at \_ \_/7 weeks gestation patient is \_. My plan for this patient is \_.

**SAMPLE LABOR AND DELIVERY TRIAGE PRESENTATION**

*\_Patient Name* is a year old G\_P\_ at \_ \_/7 weeks gestation who presents to labor and delivery triage complaining of \_. The patient is reporting regular fetal movement and denies vaginal bleeding, leakage of fluid, or abdominal pain/contractions. *Report relevant examination findings, labs, and imaging.* On fetal monitoring the baseline is \_s with \_variability, \_accelerations, \_decelerations. My assessment for this \_ year old G\_P\_ at \_ \_/7 weeks gestation is \_. My plan for this patient is \_.

**SAMPLE LABOR AND DELIVERY ADMISSION PRESENTATION**

*\_Patient Name* is a year old G\_P\_ at \_ \_/7 weeks gestation who presents to labor and delivery to be admitted for \_*term labor/induction of labor/scheduled cesarean delivery*. The patient is reporting regular fetal movement and denies vaginal bleeding, leakage of fluid, or abdominal pain/contractions. *Report relevant examination findings, labs, and imaging.* *If not a scheduled cesarean delivery:* The patient’s cervical examination (done by \_) is \_cm dilated, \_% effaced, \_position, \_consistency, \_station, giving a Bishop’s score of \_. On fetal monitoring the baseline is \_s with \_variability, \_accelerations, \_decelerations. My assessment for this \_ year old G\_P\_ at \_ \_/7 weeks gestation is \_. My plan for this patient is \_.

**SAMPLE INPATIENT POSTPARTUM PATIENT PRESENTATION EXAMPLE**

Patient presentations should be focused, in the format of an H&P and GOAL-DIRECTED.

**HPI:** This is \_ year old G\_P\_ Postpartum/Post operative Day #1 status post *uncomplicated Repeat vs. Primary Low-transverse cesarean delivery and bilateral tubal ligation (for history of two previous cesarean deliveries) vs. Spontaneous vaginal delivery*. \_No complaints this morning. \_Endorses passing flatus. \_Tolerating regular diet vs. ice chips vs. clear liquids. \_Breastfeeding is going \_well. \_Ambulating without difficulty. \_Voiding independently vs. foley catheter in place.

**Vital Signs**: Report all current vital signs including max temperature overnight. Report urine output (if catheter still in, hourly output with > 30 cc/hr is adequate).

**Exam**: Gen-Awake and oriented x 3; CV: RRR; Lungs: CTAB; Abd: Soft +BS; Incision: C/D/I (note if bandage intact or removed and if skin glue, steri strips or staples are in place): Firm/# centimeters at/below/above the umbilicus and if central or to one side or another; Lochia: moderate ; Ext: No clubbing/cyanosis/edema/calf tenderness.

**Labs**: Pre-delivery CBC and Postpartum CBC (if done), Blood type, RPR status, Rubella status

**Assessment:** PP/postop day #1 for *Patient name* s/p RLTCS/BTL, doing well.

**Plan:** (if resident present, can ask intern for advice).

**Common postpartum plans (vaginal delivery):**

- Continue PO pain control.

- Encourage ambulation.

- Encourage breastfeeding with support from lactation consultation.

- Anemia: Asymptomatic. Will discharge with PO iron.

- Contraception: \_

-Disposition: Follow-up in 6 weeks for postpartum visit.

**Common Post-op plans (cesarean section):**

- Follow up post op CBC.

- Post op day 1 orders: Discontinue foley catheter. Advance diet as tolerated. Encourage ambulation.

- Encourage breast feeding.

- Contraception: \_\_\_\_\_.

- Disposition: Follow up in 2 weeks for incision check. Follow-up in 6 weeks for postpartum visit.

**NEW GYNECOLOGY PATIENT/GYNECOLOGY CONSULTATION PRESENTATION**

***In clinic, emergency department, or inaptient***

*Patient name* is a \_ year old G\_P\_ presenting today (*referred by \_)* with \_symptoms. *Describe the symptoms in detail and pertinent positives and negatives in review of systems.* Her medical history is significant for \_. Her medications and allergies are significant for\_. Her surgical history is significant for \_. Her family history is significant for \_. Her social history is significant for\_. My assessment for this \_ year old G\_P\_ with *symptoms* is \_. My plan for this patient is \_.

**RETURN GYNECOLOGY PATIENT TO CLINIC/AMBULATORY SETTING**

*Patient name* is a \_ year old G\_P\_ with \_significant history presenting today with \_symptoms. *Describe the symptoms in detail and pertinent positives and negatives in review of systems.* My assessment for this \_ year old G\_P\_ with *symptoms* is \_. My plan for this patient is \_.

**SAMPLE PRESENTATION OF GYNECOLOGY POST-OPERATIVE PATIENT**

**HPI:** This is \_ year old G\_P\_ \_male on Post-operative Day #\_ from a *surgery name.* \_No complaints this morning. \_Endorses passing flatus. \_Tolerating regular diet vs. ice chips vs. clear liquids. \_Ambulating without difficulty. \_Voiding independently vs. foley catheter in place.

**Vital Signs**: Report all current vital signs including max temperature overnight. Report urine output (if catheter still in, hourly output with > 30 cc/hr is adequate).

**Exam**: Gen-Awake and oriented x 3; CV: RRR; Lungs: CTAB; Abd: Soft +BS; Incision(s): C/D/I (note if bandage intact or removed and if skin glue, steri strips or staples are in place): Ext: No clubbing/cyanosis/edema/calf tenderness.

**Labs**: Pre-operative CBC and Post-operative CBC (if done), *any other post-operative labs*

**Assessment:** Postoperative day #\_ for *Patient name* s/p *surgery name*, \_overall doing well.

**Plan:** (if resident present, can ask intern for advice).

**Common Post-op plans:**

- Follow up post-op CBC.

- Post-op day 1 orders: Discontinue foley catheter. Advance diet as tolerated. Encourage ambulation.

-Discharge to home pending normal post-operative CBC.

- Disposition: Follow up in 4-6 weeks for post-operative visit.