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**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.