Labour/Birth Encounter

BORN Ontario

Patient Label Here

ADMISSION TAB

DEMOGRAPHICS: Per patient label ***or***

Family Name: _____

Given Name: _____

Maternal Date of Birth: dd / mm /yyyy

Chart Number/Client ID: _____ OHIP: _____

Address: _____

Postal Code: _____ Phone: _____

☐ No Fixed Address

Estimated Date of Birth (EDB): dd / mm / yyyy

Primary Language: *(Select One)*

☐ English ☐ French ☐ Unknown
☐ Other (specify): _____

MATERNAL ADMISSION TO HOSPITAL

Admission date: dd / mm / yyyy Admission Time: _____

Admission by Healthcare Provider: *(Select One)*

☐ Obstetrician ☐ Family Physician ☐ Midwife
☐ Nurse Practitioner (APN/CNS) ☐ Other

Maternal Transfer from: *(Select One)*

☐ No transfer ☐ Hospital ☐ Planned Home or Clinic Birth
☐ Nursing station ☐ Birthing Center
☐ Other unit same hospital ☐ Other

IF TRANSFER:

Maternal Transfer from Hospital (name):

_____

Maternal transfer from Birth Centre (name):

_____

Reason for Maternal Transfer From: *(Select One)*

☐ Fetal health concern ☐ Lack of nursing coverage
☐ Lack of physician coverage
☐ Maternal medical/obstetrical problem
☐ No beds available ☐ Organization evacuation
☐ Birth outside of hospital prior to admission
☐ Other ☐ Unknown

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HISTORY TAB

Pre-existing Health Conditions (Outside of Pregnancy):
(List All) _____

Mental Health Concerns: *(Select All That Apply)*

☐ None ☐ Anxiety ☐ Depression
☐ History of Postpartum Depression ☐ Addiction ☐ Bipolar
☐ Schizophrenia ☐ Other ☐ Unknown

Domestic/Intimate Partner Violence: *(Select One)*

☐ No Disclosure ☐ Disclosure ☐ Unable to ask

Obstetrical History: Gravida (G): _____
# of Previous Term Pregnancies (T): _____
# of Previous Preterm Pregnancies (P): _____
# of Previous Abortions (A): _____
# of Living Children (L): _____
# of Previous Stillbirths (S): _____
# of Previous Vaginal Births: _____
# of Previous C/S Births: _____
# of Previous VBACs: _____

Parity: Auto calculates

PREGNANCY TAB

Maternal Height: _____(in, ft & in, cm) ☐ Unknown
Pre-pregnancy weight: _____(lb/kg) ☐ Unknown
Pre-pregnancy BMI: *Calculates*

Maternal Weight at end of Pregnancy: _____(lb/kg)
☐ Unknown ☐ Declined weight check

Maternal Weight Gain at end of Pregnancy: *Calculates*

Number of Fetuses: _____

Is the pregnant person a gestational carrier? *(Select One)*

☐ Yes ☐ No ☐ Unknown

Estimated Date of Birth (EDB): dd / mm / yyyy

Conception type: *(Select One)*

☐ Spontaneous
☐ Intrauterine Insemination alone
☐ Intrauterine Insemination (IUI) with ovulation induction but no IVF
☐ Ovulation induction without IVF (i.e. Clomid, FSH)
☐ IVF ☐ Vaginal insemination ☐ Unknown

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EDB determined by: *(Select One)*

☐ Last Menstrual Period

☐ First trimester dating ultrasound

☐ Second trimester ultrasound

☐ Assisted reproductive technology

☐ Obstetrical clinical estimate (includes S-F height)

☐ Unknown

First Trimester Visit: *(Select One)* ☐ Yes ☐ No ☐ Unknown

Antenatal Health Care Provider: ☐ None

☐ Obstetrician ☐ Family Physician ☐ Midwife ☐ Nurse

☐ Nurse Practitioner (APN/CNS) ☐ Other ☐ Unknown

Prenatal Education: *(Select One)*

☐ Yes - In-person prenatal education only

☐ Yes - Online prenatal education only

☐ Yes - Combination of in-person and online prenatal education

☐ Yes - Unknown method of education delivery

☐ No - Patient/client did not receive prenatal education

☐ Unknown if patient/client received prenatal education

Was prenatal genetic screening offered, as indicated on the OPR?: *(Select One)*

☐ Yes, screening was offered

☐ No, screening was not offered

☐ Counselled and declined screening

☐ Unknown if screening was offered – no access to the OPR

☐ Unknown if screening was offered – other reason

Folic Acid Use: *(Select One)* ☐ None ☐ Pre-conception only

☐ During pregnancy only

☐ Pre-conception and during pregnancy ☐ Unknown

Intention to Breastfeed: *(Select One)*

☐ Yes, intends to exclusively breastfeed

☐ Yes, intends to combination feed (use breast milk and breast milk substitute)

☐ No, does not intend to breastfeed

☐ Mother unsure ☐ Unknown, intent not collected

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PRENATAL RSV VACCINE

Prenatal RSV vaccine administered: *(Select One)*

☐ Yes ☐ No ☐ Unknown

Date of prenatal RSV administration: dd/mm/yyyy

☐ Unknown

Prenatal RSV product: *(Select One)*

☐ Abrysvo ☐ Unknown

☐ Other, specify: _____

Smoking at First Trimester Visit: *(Select One)*

☐ None ☐ < 10 cigarettes/day ☐ 10-20/day

☐ >20/day ☐ Amount unknown ☐ Unknown

Resides with smoker at first trimester visit: *(Select One)*

☐ Yes ☐ No ☐ Unknown

Smoking at time of labour/admission: *(Select One)*

☐ None ☐< 10 cigarettes/day ☐ 10-20/day

☐ >20/day ☐ Amount unknown ☐ Unknown

Resides with smoker at time of labour/admission:

(Select One) ☐ Yes ☐ No ☐ Unknown

Alcohol Exposure in Pregnancy: *(Select One)*

☐ None

☐ < 1 drink/month ☐ 1 drink/month

☐ 2-3 drinks/month ☐ 1 drink/week

☐ More than 1 drink/week

☐ Episodic excessive drinking (binging)

☐ Exposure prior to pregnancy confirmed, amount unknown

☐ Unknown

Cannabis Exposure in Pregnancy: *(Select One)*

☐ Never ☐ Less than 1 day per month

☐ 1 day per month ☐ 2-3 days per month

☐ 1-2 days per week ☐ 3-4 days per week

☐ 5-6 days per week ☐ Daily

☐ Some use, but frequency unknown ☐ Usage unknown

Drug and Substance Exposure in Pregnancy:

(Select All That Apply) ☐ None ☐ Amphetamines

☐ Cocaine ☐ Gas/Glue ☐ Hallucinogens ☐ Opioids

☐ Other ☐ Unknown

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ANTENATAL EXPOSURE TO MEDICATION:

(Select All That Apply) ☐ None

OTC/Vitamins/Homeopathic:

☐ Prenatal Vitamins (including folic acid)

☐ Probiotics ☐ Iron Supplements

☐ Anti-emetics (OTC) ☐ Antihistamines (OTC)

☐ Herbal or homeopathic remedies

☐ Other over the counter medications

Prescribed Medications:

☐ Amphetamines ☐ Antibiotics (NOT for GBS prophylaxis)

☐ Anticonvulsants (NOT for preeclampsia)

☐ Anti-emetics ☐ Antihistamines ☐ Antihypertensives

☐ Anti-inflammatory ☐ Antiretrovirals

☐ Anti-rheumatic ☐ Antiviral ☐ Cardiovascular

☐ Chemotherapeutic Agents

☐ Gastrointestinal Agents / Proton Pump Inhibitors / H2 blockers

☐ General anaesthetic ☐ Insulin ☐ Metformin ☐ Opioids

Opioid Agonist Therapy:

☐ Methadone ☐ Buprenorphine monoproduct (Subutex)

☐ Buprenorphine – naloxone (Suboxone)

☐ Slow-release morphine for opioid use disorder

Other Medications:

☐ Psychotropics ☐ Selective Serotonin Reuptake Inhibitors

☐ Thyroid medications ☐ Other prescription

☐ Unknown prescription or OTC exposure

INFECTION & PREGNANCY: *(Select All That Apply)*

☐ None ☐ C-Difficile ☐ Chlamydia ☐ Covid-19 ☐ Gonorrhea

☐ Group B Streptococcus (bacteriuria) ☐ Hepatitis A

☐ Hepatitis B ☐ Hepatitis C ☐ Herpes Simplex Virus ☐ HIV

☐ HPV ☐ Seasonal Influenza ☐ Syphilis ☐ Trichomonas

☐ Methicillin-resistant staphylococcus aureus (MRSA)

☐ Suspected Chorioamnionitis ☐ Urinary Tract Infection (UTI)

☐ Viruses-other ☐ Other infections ☐ Unknown

If Yes To Covid Infection:

Date of positive COVID-19 Diagnosis: dd/mm/yyyy

Was the patient hospitalized due to COVID-19 specifically?

☐ Yes ☐ No ☐ Unknown

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GBS Screening Results (35-37 wks): *(Select One)*

☐ Not Done ☐ Done, negative result ☐ Done, positive result

☐ Done, result unknown ☐ Unknown if screened

GBS Screening Date (if done): dd/mm/yyyy

Reason GBS Screening Not Done: *(Select One)*

☐ Previous baby with GBS disease

☐ Previous GBS screening done in this pregnancy

☐ Urine positive for GBS ☐ Declined Screening

☐ Other ☐ Unknown

Progesterone taken daily for spontaneous preterm birth prevention, any time after 16 weeks gestation:

☐ Yes ☐ No ☐ Unknown

(Do NOT include if progesterone is used only in first trimester)

ASA (aspirin) taken daily for preeclampsia prevention, any time after 12 weeks' gestation: ☐ Yes ☐ No ☐ Unknown

(Do NOT include if aspirin is used only in first trimester)

BLOOD TYPING AND IMMUNOGLOBULIN

Blood group and type of pregnant individual, ABO/Rh(D):

(Select One) ☐ Not collected/unknown

☐ O+ ☐ O- ☐ A+ ☐ A- ☐ B+ ☐ B- ☐ AB+ ☐ AB-

What was the antibody screen result?:

☐ Negative ☐ Positive ☐ Unknown

For Rh(D) negative patients, was Rh(D) immunoglobulin (RhIG/Rhogam/WinRho) given in pregnancy?:

☐ No ☐ Yes, 1 dose ☐ Yes, 2 doses

☐ Yes, 3 or more doses

☐ Yes, number of doses unknown

☐ Unknown

Date of Rh(D) Immunoglobulin Dose (latest prior to birth): dd/mm/yyyy

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DIABETES AND PREGNANCY: *(Select One)*

☐ None ☐ Gestational - Insulin ☐ Gestational - No Insulin
☐ Gestational - Insulin status unknown ☐ Type 1
☐ Type 2 Insulin ☐ Type 2 No Insulin
☐ Type 2 Insulin Usage Unknown ☐ Type Unknown
☐ Declined Testing ☐ Unknown

HYPERTENSIVE DISORDERS OF PREGNANCY: *(Select One)*

☐ None ☐ Gestational Hypertension ☐ Preeclampsia
☐ Pre-existing Hypertension with superimposed preeclampsia
☐ Eclampsia ☐ HELLP syndrome ☐ Unknown

COMPLICATIONS OF PREGNANCY, NOT INCLUDING HYPERTENSION OR DIABETES: *(Select All That Apply)*

Complications of Pregnancy, not including Hypertension or Diabetes: ☐ None ☐ Unknown

Complications of Pregnancy – Fetal:

☐ Anomaly(ies) ☐ Isoimmunization/Alloimmunization
☐ Intrauterine Growth Restriction (IUGR)
☐ Oligohydramnios ☐ Polyhydramnios ☐ Other

Complications of Pregnancy - Maternal:

☐ Anemia unresponsive to therapy
☐ Antepartum bleeding (persistent and unexplained)
☐ Cancer – diagnosed in this pregnancy
☐ Haemotology – Gestational Thrombocytopenia
☐ Hyperemesis Gravidarum (Requiring Hospital Admission)
☐ Liver/Gallbladder – Intrahepatic Cholestasis of Pregnancy
☐ Liver/Gallbladder – Acute Fatty Liver of Pregnancy
☐ Neurology – Epilepsy/Seizures –
Seizure occurred during current pregnancy
☐ Prelabour rupture of membranes (PROM)
☐ Preterm labour
☐ Preterm pre-labour rupture of membranes (PPROM)
☐ Pulmonary – asthma occurred during current pregnancy
☐ Other

Complications of Pregnancy – Placental:

☐ Placenta accreta ☐ Placenta Increta ☐ Placenta percreta
☐ Placenta Previa ☐ Placental abruption ☐ Other

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INTRAPARTUM TAB

Antenatal Steroids: *(Select One)*

☐ None ☐ 1 dose < 24 hours (before the time of birth)

☐ 2 doses: Last dose < 24 hours (before the birth)

☐ 2 doses: Last Dose > 24 hours (from the time of the last dose to the time of birth)

☐ Unknown

Fetal Surveillance: *(Select All That Apply)*

☐ Admission EFM Strip ☐ Auscultation

☐ Intrapartum EFM (external) ☐ Intrapartum EFM (internal)

☐ No Monitoring ☐ Unknown

Group B Strep Antibiotics: *(Select One)*

☐ Yes ☐ No ☐ Declined antibiotics ☐ Unknown

Initial cervical dilation (cm) upon hospital admission for labour and birth:

_____

Type of Labour: *(Select One)*

☐ Active labour achieved without any intervention

☐ Induced labour in latent phase

☐ Induced labour prior to onset of contractions ("cold induction")

☐ No labour or latent phase

Cervical ripening/induction methods: *(Select All That Apply)*

☐ None ☐ Prostaglandin (PGE2)

☐ Mechanical (Foley catheter) ☐ Laminaria tents

☐ Misoprostol (PGE1) ☐ Other ☐ Unknown

Was oxytocin used any time before birth? ☐ Yes ☐ No

Cervical dilation at start of oxytocin: _____

Start date of oxytocin: _____

Start time of oxytocin: _____ ☐ Unknown

Membrane Rupture: *(Select One)*

☐ Artificial rupture of membranes

☐ Spontaneous rupture of membranes ☐ Unknown

Date of Membrane Rupture: _____

Time of Membrane Rupture: _____

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STAGES OF LABOUR

First Stage

Date of latent phase onset: _____

Time of latent phase onset: _____

☐ Unknown

Date of active phase onset: _____

Time of active phase onset: _____

☐ Unknown

Second Stage

Date fully dilated: _____

Time fully dilated: _____

☐ Unknown

Date started pushing: _____

Time started pushing: _____

☐ Unknown

IF INDUCED LABOUR:

All Indications for Induction of Labour: *(Select All That Apply)*

Fetal Indications:

☐ Atypical or abnormal fetal surveillance

☐ Fetal anomaly/ies ☐ Intrauterine Fetal Death (IUFD)

☐ Isoimmunization/alloimmunization ☐ IUGR ☐ Macrosomia

☐ Multiple gestation ☐ Other fetal complication ☐ Post dates

☐ Termination of pregnancy

Maternal Indications:

☐ Abnormal Biomarkers (eg. PAPP_A, PIGF, and HCG)

☐ Cholestasis of Pregnancy

☐ Diabetes ☐ Elevated BMI

☐ Hx of Precipitous Birth

☐ Hx of Previous of Intrauterine Fetal Death

☐ In-vitro fertilization (IVF) ☐ Oligohydramnios

☐ Other obstetrical complications/concerns

☐ Polyhydramnios ☐ Preeclampsia/Hypertension

☐ Pre-existing maternal medical conditions

☐ Pregnant individual age >= 40

☐ Pre-labour rupture of membranes (PROM)

☐ Preterm Pre-labor rupture of membranes (PPROM)

☐ Prolonged Latent Phase Labour

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Other Indications:

☐ Accommodates care provider/organization

☐ Distance from birth hospital/safety precaution

☐ Maternal request ☐ Unknown

Primary Indication for Induction of Labour: _____

Bishop Score: *Circle*

0 1 2 3 4 5 6 7 8 9 10 11 12 13

☐ Unknown

ALL LABOUR TYPES - SPONTANEOUS, INDUCED AND NO LABOUR

Maternal Outcome (prior to birth): *(Select One)*

☐ No Transfer ☐ Transfer to other organization

☐ Transfer to ICU/CCU

☐ Transfer to other non-obstetrical unit, same hospital

☐ Maternal Death—Not Related to Pregnancy or Birth

☐ Maternal Death—Related to Pregnancy or Birth

**** If Transfer to Other Organization:***

Maternal Transfer to [hospital name]: _____

**** If Transfer to Other Hospital, ICU/CCU, or Other Non-Obstetrical Unit, same hospital:***

Reason for Maternal Transfer: *(Select One)*

☐ Fetal Health Concern ☐ Lack of Nursing Coverage

☐ Lack of Physician Coverage

☐ Maternal medical/obstetrical problem ☐ No beds available

☐ Organization evacuation ☐ Other ☐ Unknown

Maternal Transfer Date: dd / mm / yyyy

Maternal Transfer Time: _____

**** If Transferred:***

Pharmacologic Pain Management: *(Select All That Apply)*

☐ None ☐ Nitrous oxide ☐ Opioids ☐ Epidural ☐ Spinal

☐ Spinal-epidural combination ☐ Pudendal ☐ Unknown

Labour and Birth Complications: *(Select All That Apply)*

☐ None ☐ Atypical or abnormal fetal surveillance

☐ Meconium ☐ Cord prolapse ☐ Shoulder dystocia

☐ Fever>38.5 C ☐ Non-progressive first stage of labour

☐ Non-progressive second stage of labour

☐ Placental abruption ☐ Uterine rupture

☐ Uterine dehiscence ☐ Retained placenta-manual removal

☐ Retained placenta-surgical removal

☐ Postpartum hemorrhage ☐ Uterine atony

☐ Perineal hematoma ☐ Amniotic fluid embolism

☐ Pulmonary embolism ☐ Hysterectomy ☐ Other ☐ Unknown

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BIRTH TAB

Type of Birth: *(Select One)* ☐ Vaginal Birth ☐ Cesarean Birth

PRESENTATION TYPE *(Select One)*

Cephalic: ☐ Vertex ☐ Brow ☐ Face
☐ Compound ☐ Cephalic type unknown

Breech: ☐ Frank ☐ Complete ☐ Incomplete
☐ Footling ☐ Compound ☐ Breech type unknown

Other: ☐ Transverse/Malpresentation ☐ Unknown

Newborn DOB: dd / mm / yyyy
Time of birth: _____

Forceps/Vacuum used vaginally: *(Select One)* ☐ None
☐ Vacuum ☐ Forceps ☐ Vacuum and Forceps ☐ Unknown

Episiotomy: *(Select One)*
☐ None ☐ Medio-lateral ☐ Midline ☐ Unknown

Perineal Laceration: *(Select All That Apply)* ☐ None
☐ 1st degree ☐ 2nd degree ☐ 3rd degree ☐ 4th degree
☐ Cervical tear ☐ Other ☐ Unknown

Birth Location: *(Select One)* ☐ Hospital ☐ Home
☐ Birth Centre ☐ Clinic (Midwifery) ☐ Nursing Station
☐ Other Ontario location ☐ Outside of Ontario

Birth Hospital name: _____

Date placenta delivered: dd / mm / yyyy

Time placenta delivered: _____

IF CESAREAN BIRTH:

Type of Cesarean birth: *(Select One)*
☐ Planned (as scheduled) ☐ Planned (not as scheduled)
☐ Unplanned

Dilation at Cesarean Birth (cm): _____

Anesthesia for Cesarean birth: *(Select One)*
☐ Epidural ☐ Spinal ☐ Spinal-Epidural Combination
☐ General ☐ Other ☐ Unknown

ALL INDICATIONS FOR CESAREAN BIRTH:

(Select All That Apply)

Fetal: ☐ Anomaly(ies)
☐ Atypical or Abnormal Fetal Surveillance ☐ Cord prolapse
☐ Intrauterine Growth Restriction (IUGR) ☐ Macrosomia
☐ Malposition/Malpresentation ☐ Other Fetal Indication

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Maternal: ☐ Cholestasis of pregnancy
☐ Failed forceps/vacuum ☐ Failed induction
☐ Gestational hypertensio
☐ HIV – Human immunodeficiency Virus
☐ HSV – Herpes Simplex Virus
☐ Hypertensive Disorders of Pregnancy - Eclampsia
☐ HELLP ☐ Preeclampsia ☐ Maternal Health condition(s)
☐ Multiple gestation ☐ Non-progressive first stage of labour
☐ Non-progressive second stage of labour ☐ Obesity
☐ Other Obstetrical complication
☐ Placenta Increta/Acreta/Percreta ☐ Placenta previa
☐ Placental abruption
☐ Prelabor rupture of membranes (PROM) in pregnant individuals with a planned cesarean birth
☐ Preterm pre-labor rupture of membrances (PPROM) in pregnant individuals with a planned cesarean birth
☐ Previous cesarean birth
☐ Previous T incision/classical incision/uterine surgery
☐ Previous uterine rupture ☐ Suspected chorioamnionitis
☐ Uterine rupture ☐ Declined VBAC ☐ VBAC - Failed Attempt
☐ VBAC - Not Eligible

Other: ☐ Accommodates care provider/organization
☐ Maternal request ☐ Unknown

Primary indication for Cesarean birth: _____

Labour and/or Birth Complications: *(Select All That Apply)*
☐ None
☐ Atypical or abnormal fetal surveillance ☐ Meconium
☐ Cord prolapse ☐ Shoulder dystocia ☐ Fever>38.5 C
☐ Non-progressive first stage of labour
☐ Non-progressive second stage of labour
☐ Placental abruption ☐ Uterine rupture
☐ Uterine dehiscence ☐ Retained placenta-manual removal
☐ Retained placenta-surgical removal
☐ Postpartum hemorrhage ☐ Uterine atony
☐ Perineal hematoma ☐ Amniotic fluid embolism
☐ Pulmonary embolism ☐ Hysterectomy ☐ Other ☐ Unknown

Intrapartum Medications Administered: *(Select All That Apply)*
☐ None
☐ Magnesium Sulfate for preeclampsia
☐ Magnesium Sulfate for fetal neuroprotection
☐ Antibiotics (not for GBS) ☐ Antihypertensives
☐ Anti-emetics ☐ Antipyrexics (example: acetaminophen)
☐ Diuretics ☐ Insulin
☐ Tocolytics (Mag sulfate/indomethecine/nifedipine/ritodrine etc)
☐ Other ☐ Unknown

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Pharmacologic Pain Management: *(Select All That Apply)*

☐ None

☐ Nitrous oxide ☐ Opioids ☐ Epidural ☐ Spinal

☐ Spinal-epidural combination ☐ Pudendal ☐ Unknown

Supportive Care: *(Select All That Apply)*

☐ None

☐ 1:1 Supportive care by clinical staff/care provider

☐ Breathing exercises ☐ Hypnobirthing/guided imagery

☐ Massage ☐ Shower ☐ Sterile water/saline injections

☐ Support partner or doula ☐ TENS ☐ Tub ☐ Other

☐ Unknown

Healthcare Provider Who Caught/Delivered Baby: *(Select One)*

☐ Family Physician ☐ Registered Midwife ☐ Obstetrician

☐ Resident ☐ Surgeon ☐ Registered Nurse

☐ Nurse Practitioner (CNS/NP) ☐ Aboriginal Midwife

☐ Midwifery Student ☐ Unattended (None)

☐ Other Health Care Provider ☐ Unknown

ID of Healthcare Provider Attending Birth: *(Optional Field)*

Other Care Providers Present at time of Labour and/or Birth: *(Select All That Apply)*

☐ Family Physician ☐ Obstetrician

☐ Surgeon ☐ Registered Midwife ☐ Resident

☐ Anesthesiologist ☐ Midwifery Student

☐ Aboriginal Midwife ☐ Registered Nurse ☐ Nursing Student

☐ Medical Student ☐ Pediatrician

☐ Neonatologist ☐ Respiratory Therapist

☐ Clinical Nurse Specialist/Nurse Practitioner ☐ Doula

☐ Other Care Provider ☐ None ☐ Unknown

OUTCOME TAB

Pregnancy Outcome (Complete for each fetus if multiple pregnancy): *(Select One)*

☐ Live birth

☐ Stillbirth >= 20 wks or >= 500 gms – Spontaneous - occurred during antepartum period

☐ Stillbirth >= 20 wks or >= 500 gms – Spontaneous - occurred during intrapartum period

☐ Stillbirth >= 20 wks or > =500 gms /Termination

☐ Pregnancy loss < 20 wks and <500 gms/Spontaneous miscarriage

☐ Pregnancy loss < 20 wks and < 500 gms/Termination

Gestational age at birth: Auto-calculates

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Maternal Birth Outcome: *(Select One)*

☐ No Transfer ☐ Transfer to other organization
☐ Transfer to ICU/CCU
☐ Transfer to other non-obstetrical unit, same hospital
☐ Maternal Death—Not Related to Pregnancy or Birth
☐ Maternal Death—Related to Pregnancy or Birth

***IF TRANSFER TO OTHER HOSPITAL:**

Maternal Transfer to [hospital name]:

_____

***IF TRANSFER TO OTHER HOSPITAL, ICU/CCU, OR OTHER NON-OBSTETRICAL UNIT, SAME HOSPITAL:**

Reason for Maternal Transfer To: *(Select One)*

☐ Fetal Health Concern ☐ Lack of Nursing Coverage
☐ Lack of Physician Coverage
☐ Maternal medical/obstetrical problem ☐ No beds available
☐ Organization evacuation ☐ Care Closer to Home
☐ Other ☐ Unknown

Maternal Transfer Date: dd / mm / yyyy

Maternal Transfer Time: _____ ***or***

Maternal Discharge Date: dd / mm / yyyy

Discharge Time: _____