

MEDICAL RECORDS CLINICAL SUMMARY SHEET

PRINCIPAL DIAGNOSIS: (The diagnosis or condition established after study to be chiefly responsible for occasioning the patient's admission to the hospital)

Post Date Induction

SECONDARY DIAGNOSIS/COMPLICATIONS:

Multigravida

Retained Placenta

Smoker

History of LGA infants

Post Partum Hemorrhage → Anemia

PRINCIPAL PROCEDURES:

Spontaneous vaginal delivery - male
manual extraction of placenta

SECONDARY PROCEDURES:

Cytotec induction, Pitocin augmentation

Artificial rupture of membranes

FSE ; IUPC placement PRC x2

CONSULTANTS:

ICD-9-CM
645.11

666.02

649.01

648.22

280.0

V27.0

73.4

75.4

99.04

312

SIGNATURE

Admit Date / Time 01/25/2008 07:21		Account Number			Medical Record Number			Patient Type INPATIENT			
								Service Code OBSTETRICS			
PATIENT	Room/Bed		Admit By		Discharge Date / LOS 1/28/08 (3 days)		Time 13:00		Smoker		
	Patient DOB	Age 26Y	Sex F	Race W	Marital Status Married	Religion 004	County 034	FC 20	ADV DIR		
	Patient Social Security Number					Patient's Maiden Name					
Patient Employer	Admitting				Attending						
PHYSICIAN	Surgeon				Primary Care Physician						
	Office: Fax:				Fax:						
GUARANTOR	Guarantor's Name				Policy Holder's Employer				Notify in Case Of Emergency		
									Spouse		
	Plan Code 1020	Insurance Company Name BCBS COMPREHENSIVE PLUS			Certificate Number		Policy Holder Information			Group Number	
Admitting Diagnosis / Chief Complaint ANTEPARTUM						Onset Date / Time 01/24/2008 13:56		Previous Admit Date 01/23/2008 08:43			

MEDICAL RECORDS!

OB RECORD II

(2-sided form)

LABOR RECORD

Labor Began at: Date 1/25/08 Time _____ Spont? _____ Induced?
Membranes Rupt.: Date 1/25/08 Time 2:34 Spont? _____ Induced? Clear Meconium large amount

FIRST STAGE

Date	Hour	Contractions	Dilation	Cervix Effacement	Station	Fetal Heart	
1-25-08	09:00	irritability	2 cm	50%	-2-1	140-150b	cytotec
1-25-08	12:05p	irreg cix	2 cm	50-60%	-2-1	140b	cytotec
1-25-08	15:40	3-5 min	2 cm	60% soft	-2-1	140b	cytotec
1-25-08	23:45	2 min	4 cm	70%	-1	130-140b	PA ROM
1-26-08	01:30	2 min	5 cm	70%	-1 0	130-140b	pit@2

SECOND STAGE Cervix fully dilated at: Date _____ Time _____
Child born at: Date 1/26/08 Time 04:02 M? F? _____

Delivered by:

Presentation: vtx Position: LOA Apgars: 8 1 min 9 5 min _____
Delivery: Vag? Caesarean _____ Forceps - High _____ Mid _____ Low _____
Analgesia: Demerol 25 mg at: _____
Mubain 5 mg at: _____
Anesthesia: Perineal Demerol 25 mg Pudendal _____ Spinal _____ Other: General
Epiotomy: ML RML LML Other: _____
Laceration: 1 2 3 4 NA - intact perineum
repair using: _____

THIRD STAGE Placenta delivered at: Date _____ Time _____
Spont _____ Crede _____ Manual under general
Placenta normal _____ Other (describe): thickened membranes anesthesia

Cord: Normal 3-Vessel?
Other (describe): _____

SUMMARY Duration 1st Stage _____ 2nd Stage _____ 3rd Stage _____
Total: H _____ Min. _____
EBL: _____ cc. Condition: stable

Complications, Abnormalities, Emergencies: Retained placenta
EBL ≈ 700 total at least >500. Typed & crossed.
Cord Gas:
H/H pre op 13/37 ; post op crit 31 → H/H 10.8/31
Manual extraction of placenta

Obstetric Discharge Summary

<p>Reasons for Admission Admission Date: <u>1/29/08</u> Weeks Gestation <u>40^{5/7}</u></p> <p><input type="checkbox"/> Risk Pregnancy (list indicators below):</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ <p> <input type="checkbox"/> Ruptured Membranes <input type="checkbox"/> Preclampsia <input type="checkbox"/> Bloody Show <input type="checkbox"/> Pre-term <input type="checkbox"/> Free Bleeding <input checked="" type="checkbox"/> Induction for Labor <input type="checkbox"/> Contractions <input type="checkbox"/> Caesarean Section <input type="checkbox"/> Other: _____ </p> <p>Labor and Delivery: A brief description of labor, anesthesia, delivery procedures, the placenta and cord, and any resulting complications. NOTE: For more complete details refer to the <i>Labor and Delivery Summary Record</i>.</p> <p>Outcome of this Pregnancy: <input type="checkbox"/> Undelivered <input checked="" type="checkbox"/> Delivered at: <u>male 0402 - intact perineum</u> <u>returned placenta - to OR</u> <u>manual extraction - general</u> <u>10 units Rho(D) Imm Glob</u> <u>2000 IU in 500cc NS @ 150-200/min</u> </p> <p>Puerperium Surgical Procedures <input type="checkbox"/> Sterilization (define): _____ <input type="checkbox"/> Other: _____ </p> <p>Summary of Postpartum Complications: Problem List</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ <p>Additional Notes:</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Puerperium cont'd. Discharge Status of Patient: <input type="checkbox"/> Alive <input type="checkbox"/> Deceased Accompanied by: <u>infant</u> </p> <p>Social Service Referral <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> N/A WIC Forms Completed <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Public Health Nurse Referral <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A </p> <p>Patient is Discharged: <u>home</u></p> <p> <input type="checkbox"/> To a Private Physician <input type="checkbox"/> To Another Hospital: <input type="checkbox"/> Against Advice </p> <p>Plans for Follow-up Visit on: _____ <u>- 6 wks</u> </p> <p>Discharge Summary of the Newborn: Name _____ Birth Weight <u>9</u> Lbs. <u>10</u> Oz. Length <u>23 1/2</u> in. Record No. _____ <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female Gestational Age: <u>40 5/7</u> Weeks Feeding: <u>entirely</u> </p> <p>Summary of Neonatal Complications: Problem List</p> <ol style="list-style-type: none"> 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ <p>Circumcision: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A</p> <p>Discharge Weight: <u>7.2</u></p> <p> <input type="checkbox"/> Alive <input type="checkbox"/> Stillborn <input type="checkbox"/> Autopsy <input type="checkbox"/> No Autopsy <input type="checkbox"/> Neonatal Death Days _____ Hrs. Postpartum _____ </p> <p>Reasons for Death: _____</p> <p>Newborn is discharged on: <input checked="" type="checkbox"/> With Mother (or with): <u>1/29/08</u> <input type="checkbox"/> To Another Service: <input type="checkbox"/> To Another Hospital: <input type="checkbox"/> Against Advice </p> <p>Newborn's Physician: _____ Summary By: _____ Completed On: <u>1/28/08</u> Time: <u>1:30</u> </p>
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OPERATIVE REPORT

NAME: SURGEON: DATE: 1-26-2008
MED REC NO:
ASSISTANT: ANESTHESIOLOGIST:
DIAGNOSIS: Preoperative: STATUS POST SVD. RETAINED PLACENTA, POSTPARTUM
HEMORRHAGE, SMOKING IN PREGNANCY. HISTORY OF D&C X2
Postoperative: STATUS POST SVD. RETAINED PLACENTA, POSTPARTUM
HEMORRHAGE, SMOKING IN PREGNANCY. HISTORY OF D&C X2
PROCEDURE: MANUAL EXTRACTION OF PLACENTA AND UTERINE EXPLORATION

DESCRIPTION OF FINDINGS & PROCEDURE:

ANESTHESIA: General with LMA

EBL: 700cc. both pre and post op.

FINDINGS: Placenta anterior still adherent to the uterus, intact on inspection. Thickened membranes, firm fundus, empty uterus post exploration.

COMPLICATIONS: None.

MEDICATIONS: IV Pitocin and Ancef, 2grams IV.

SPECIMEN: Placenta to pathology

CONDITION: Stable

Patient is a 26-year-old G5, P3/0/2/3 and patient was admitted 1-25-2008 for induction of labor secondary to post due dates. The patient received Cytotec, 25mcg vaginally x 3 doses followed by Pitocin augmentation six hours later. The patient was artificially ruptured at 4cm at 23:45 and progressed to complete at 03:45. Patient began pushing and delivered a viable male infant with Apgars, 8:9 without incident. The perineum was intact.

On inspection infant and patient were stable. A section of cord was collected for cord gas. Cord was a three vessel cord. Cord blood was collected x 1. Attention was then turned to delivery of the placenta. There was initial lengthening of the cord followed by a gush of blood. This ceased. It was noted that the Pitocin was still running and Pitocin was placed on hold. Attempted delivery of the placenta continued. The tip of the placenta can be palpated in the upper vagina but there was no further motion. The patient was given Demerol, 25mg IV to provide more relaxation. She declined epidural in labor. Assisted manual delivery of the placenta was attempted with the patient bearing down and again there was no motion of the placenta. Appropriate delivery time for the placenta was observed. After this it was discussed with the patient of manual removal under general anesthesia. The patient was noted to have intermittent atony with intermittent gush of blood. IV Pitocin 10 units was given followed by ten units IM.

The patient was taken to the OR, anesthesia and OR team made aware. Patient consented for the procedure. Patient was typed and crossed for two units. IV Ancef ordered.

Continued: