

11/09

REPORT

REPORT

PREOPERATIVE DIAGNOSIS:

1. Pregnancy at 36-1/7 weeks.
2. Preterm premature rupture of membranes.
3. Three prior cesarean sections; scheduled repeat.
4. Undesired fertility.

POSTOPERATIVE DIAGNOSIS:

1. Pregnancy at 36-1/7 weeks.
2. Preterm premature rupture of membranes.
3. Three prior cesarean sections; scheduled repeat.
4. Undesired fertility.

OPERATION: Repeat cesarean section and bilateral distal salpingectomy.

SURGEON:

ASSISTANT

ANESTHESIA: Spinal with sedation.

ANESTHESIOLOGIST:

INDICATIONS FOR PROCEDURE: The patient is a 31-year-old P3 female whose other pregnancies were all by cesarean section. She was first scheduled for repeat cesarean on 1/12. However, she presented to Labor and Delivery having spontaneously ruptured her membranes. Rupture of membranes was confirmed in triage and she was also found to be contracting. The patient was admitted and subsequently prepared for cesarean section.

The patient also requested permanent sterilization. She had been requesting this for the past month or two in the office. She is aware of the permanency of the procedure, risks of the procedure, failure rate, alternative methods of contraception and wishes to proceed. Her and her partner are in agreement.

FINDINGS: The anterior uterine wall including lower uterine segment was extremely thick. Lower uterine segment was like 2 cm. The fundal portion 4 cm thick. The amniotic fluid was clear. The uterine cavity was high. The delivery was of a viable male infant. The fetus was found in the transverse back down position with the head to the maternal right. Apgar scores following breech extraction were 3 at 1 minute, 7 at 5 minutes, 8 at 10 minutes. Weight is 7 pound 1 ounce, 19-1/4 inches in length.

The placenta was anterior and normal and the umbilical had 3 vessels. Segment of cord set side for cord gas; returned with a pH of

ORDER SHEET

ALLERGIES	ADVERSE DRUG REACTION
ALLERGIES	ADVERSE DRUG REACTION

Fill in blanks. Cross out non-applicable orders with date and initial. Use separate order sheet for additional orders.

NO KNOWN ALLERGIES

Date: 12-30-06 Time: 1100 EPIDURAL / SPINAL ANALGESIA PHYSICIAN ORDER SHEET

DRUG / DOSE: Duramorph 0.25mg EPIDURAL / INTRATHECAL SINGLE DOSE GIVEN AT: 1020

EPIDURAL CONTINUOUS INFUSION		
DRUG Morphine 0.05 mg/ml Total volume _____	DRUG Bupivacaine _____ mcg/ml Fentanyl _____ mcg/ml Total Volume _____	DRUG _____ Total Volume _____
DOSE Continuous rate _____ ml/hr PCA Bolus _____ ml q _____ min 4 Hour Limit _____	DOSE Continuous rate _____ ml/hr PCA Bolus _____ ml q _____ min 4 Hour Limit _____	DOSE Continuous rate _____ ml/hr PCA Bolus _____ ml q _____ min 4 Hour Limit _____

Mix in Preservative-free Normal Saline Only

Additional Medication Orders

Narcan 0.4 mg ampule with 1cc syringe in nurseserver until 12 hours after last bolus or discontinuation of continuous infusion.

If Respiratory rate less than 10/minute:

1. Stop epidural infusion
2. Administer Narcan 0.2 mg IV
3. Call the OB anesthesiologist in-house on pager _____ STAT
4. Start oxygen 2 - 3 litres and obtain pulse oximetry reading
5. Repeat Narcan 0.2 mg IV q 5 minutes x3 doses PRN

Reglan 10 mg IVPB q 6 hours PRN Nausea / Vomiting

Tigan 200 mg IM or PR q 6 hours PRN Nausea / Vomiting

Benadryl 25 mg PO or IM or IV q 4 hours PRN Pruritis / Sleep

Other: Toradol 30mg IV q 6 prn

Received

Review and institute Epidural / Spinal Analgesia Procedure

No PO, IV, IM or SC narcotics or sedatives are to be given during continuous infusion or within 12 hours after last bolus unless cleared by the anesthesiologist

Maintain IV access for 12 hours after last bolus or discontinuation of continuous infusion

Keep resuscitation equipment, including oral airway, ambu bag and oxygen, on unit

Provide heel protection

Notify Anesthesiologist for:

1. Respiratory rate less than 12
2. Systolic BP less than 80
3. Increasing motor or sensory block
4. Inadequate analgesia
5. Pruritis, Nausea / Vomiting not relieved using standard orders above
6. Change in mental status, sedation or confusion
7. Dressing or catheter problems
8. Extreme back pain
9. Bladder distension or no urine output in 6 hours

Contact Anesthesiologist: Home phone: _____
 Beeper: _____
 OB Anesthesiologist Pager: _____

Legible MD Name (Print)

RN Signature

Delivery Summary

Maternal Labor/Delivery Information

G/ 4 P/ 3 T/ 3 Pt/ SAB/ IAB/ L/ 3

Delivery Doctor
Anesthesiologist

OB Midlevel Provider:
Scrub Nurse:

Nursery RN:
Delivery Anesthesia: Spinal
Labor Anesthesia: None
EDC: 01/25/07
Onset of Labor: 12/30/06 07:15 EST
Complete Cerv Dilate:
ROM Method: Spontaneous
ROM Date/Time: 12/30/06 06:45 EST
Oxytocin:
EBL (ml's): 1200
Medications in Delivery: Ancef

Circulator:
Pediatric Provider:
No. of Babies in Womb: 1
Amniotic Fluid Color: Clear
Amniotic Fluid Odor:
Amniotic Fluid Amount: Copious
Cervical Ripening Agent:
Other Cerv Ripening Agent:
Stage 1: Hrs min
Stage 2: Hrs min
Stage 3: 0 Hrs 1 min
Total Time in Labor: 3 Hrs 38 min

Vaginal Delivery

Laceration Type/Ext.: /
Other Laceration:

Episiotomy:

C- Section Delivery

Primary Indication: > 2 Previous CSections
Other Primary Indicat: PPRM
Secondary Indication:
Other Second Indicat:
Labor: No Labor

Urgency: Nonemergent
Elective: N/A
Incision: Lower Uterine Transverse
Other Incision: low vertical
Incidence: Repeat

Maternal Complications

Delivery Complications:
Other Complications:

Baby A

Delivery Information

Delivery Date: 12/30/06 10:52 EST
Method of Delivery: C-Section
Born en Route: No
VBAC: N/A
Forceps: N/A
Vacuum Extraction:
Vacuum Extract # pulls:
Vacuum min-sec p/pull:
Vacuum Pressure appl:
Presentation: Other
Cephalic Position: N/A
Breech Positon: N/A
Vertex Position:
Scalp pH:
Placenta Deliv Time: 12/30/06 10:53 EST
Placenta Deliv Method: Manual Removal
Placenta Status: Delivered
ROM Date/Time: 12/30/06 06:45 EST

Baby 'A' Information

GA at Delivery/Status: 36.2 (wks) Preterm
Outcome: Liveborn
Condition: Fair
Suction: Mouth, Pharynx
Sex: Male

Birth Weight: 3215 (grams)
7 (lbs) 1 (oz)
Length: 48.9 (cm) 19.25 (in)
Cord Vessels: 3
Nuchal Cord: N/A
Other Nuchal:
True Knot:
Cord pH: (art.) 7.19 (ven.)
Cord Blood Taken: No
Bank/Donate Info:
Neonatology Called: Yes
Transferred to: SCN

Assessment

Respiratory Rate Deliv: 36
Respirations Type: Grunting, NasalFI
Physical Findings:
Other Phys Findings:

Medications

Vitamin K: Vitamin K 1 mg IM Given
Erythromycin: Given Both Eyes

Identification Information

ID Band #: 8626
ID Band Location: Right Leg, Right Arm
ID Band Read By:

Infant Security Sensor Applied: Yes
Sensor #:
Sensor Location: Other

Apgars

Time	Heart Rate	Resp Effort	Muscle Tone	Reflex	Color	Score
1 Min	<100	Irreg	Flaccid	Grimace	Blue/Pale	3
5 Min	>100	Cry	Flexion	Grimace	Body pink, extremities blue	7
10 Min	>100	Cry	Flexion	Cough or Sneeze or Pulls Away	Body pink, extremities blue	8

SIGNIFICANT MATERNAL HISTORY NO YES Explain: _____

MOTHER: Age 31 EDC 1/25/07 Gravida 4 Parity 3-4 Group/Rh A+ RPR NR
 Rubella Imm GBS unknown HbsAG neg Chlamydia _____ HIV neg Other _____

DELIVERY DATA TYPE OF DELIVERY: VAGINAL UNASSISTED FORCEPS VACUUM C-SECTION

APGAR 1 MIN 3 RESUSCITATION BAG & MASK INTUBATION
 APGAR 5 MIN 7 NO YES NO YES NO YES

IN HOSPITAL EXAMINATION DATE AND TIME OF EXAM: 12/31/06 0900 BIRTH WEIGHT 3215 GMS.

APPEARANCE (GRY, COLOR, ACTIVITY) awake alert, rooting & distress. HEAD CIRCUMFERENCE 35.5 CMS.
 LENGTH 19.4 in. CMS.

FACIES symmetrical AFOF

HEENT bilat red reflex; nose, mouth midline

HEART AND LUNGS RRR & (m), lungs CTA bilat.

ABDOMEN AND GI soft (+) BS (R) testes ↓, (L) testes @ top of scrotum

NEUROLOGICAL (MOOR, SUCK, TONE) tone wr (+) moor (+) suck.

EXTREMITIES full ROM ext. ++ pulses UE's/LE's bilat

BIRTH TRAUMA 2

MALEFORMATIONS 2

SKIN, CIRCUMCISION, CORD circ 12/31/06
skin pink warm, perfusion brisk

OTHER _____

	NO	YES
CEPHALOHEMATOMA	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HEAD MOLDING	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HIP CLICK	<input checked="" type="checkbox"/>	<input type="checkbox"/>

WEIGHT/AGE: AGA LGA
 SGA NOT DONE

DISCHARGE WEIGHT 2980 GMS.

FEEDING METHOD AT DISCHARGE BREAST BOTTLE

LENGTH OF HOSPITAL STAY 2 DAYS

DISCHARGE PLAN: FOLLOW UP BY 2 DAYS
 M.D. IN 3-4 WEEKS

DISPOSITION: HOME TRANSFER
 FOSTER CARE ADOPTION

EXAMINED BY _____ M.D.

LABORATORY DATA

MAX. TOTAL BILIRUBIN _____ MG%

TO RETURN FOR BILIRUBIN: DATE _____

HCT CAPILLARY _____ VENOUS _____

COOMBS: POS NEG NOT DONE
 REPEAT SCREEN _____

METABOLIC SCREENING DATE 1/1/07

FINAL DIAGNOSES

- Preterm infant
- Circumcision
-
-

NOTES

Passed hearing screen

COMPLICATIONS	NO	YES	THERAPY	NO	YES
HYPOGLYCEMIA (<30) X2	<input type="checkbox"/>	<input type="checkbox"/>	IN O ₂ > 24 HOURS	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HYPOCALCEMIA < 7.5	<input type="checkbox"/>	<input type="checkbox"/>	IV FLUIDS	<input type="checkbox"/>	<input type="checkbox"/>
RESP DISTRESS > 1 HR <u>but < 2°</u>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	ANTIBIOTICS GIVEN	<input type="checkbox"/>	<input type="checkbox"/>
CHOKING SPELLS	<input type="checkbox"/>	<input type="checkbox"/>	BILIRUBIN LIGHT USED	<input type="checkbox"/>	<input type="checkbox"/>
HYPOTHERMIA < 36° C X2	<input type="checkbox"/>	<input type="checkbox"/>			

HEPATITIS B VACCINE GIVEN DATE: _____
declined