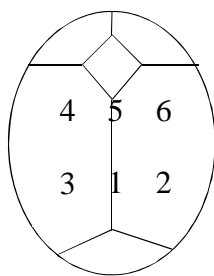



Clinical Innovations Operative Delivery Form

Provider				Date																								
Prenatal	Labor	Delivery	Complications	Newborn																								
<p>INFORMED CONSENT OBTAINED : <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MATERNAL AGE _____</p> <p>G_P _____</p> <p>EGA: _____ wks</p> <p>DIABETES <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Gestational <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Overt Diabetes</p> <p>MAX. PREVIOUS BWT _____</p> <p>PREVIOUS DELIVERY <input type="checkbox"/> None <input type="checkbox"/> Normal <input type="checkbox"/> Difficult / Shoulder dystocia <input type="checkbox"/> C/S - for dystocia <input type="checkbox"/> C/S - Other _____ <input type="checkbox"/> Previous uterine surgery <input type="checkbox"/> VBAC</p> <p>OTHER COMPS <input type="checkbox"/> None <input type="checkbox"/> IUGR <input type="checkbox"/> Oligohydramnios <input type="checkbox"/> Polyhydramnios <input type="checkbox"/> Other _____</p> <p>EFW: _____ gm/lbs</p>	<p>DECISION TIME: _____</p> <p>2nd STG DURATION: ____ mins</p> <p>UC FREQUENCY: ____ / 10 min</p> <p>OXYTOCIN: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>DURATION ROM: _____ hrs</p> <p>DILATION Complete <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>STATION (in fifths) _____</p> <p>POSITION _____</p> <p>CAPUT / MOLDING <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Marked</p> <p>DILATATION LABOR DESCENT</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Normal</td> <td style="width: 33%;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Protracted</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Arrest</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Combined</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Precipitous</td> <td><input type="checkbox"/></td> </tr> </table> <p>MATERNAL INDICATIONS <input type="checkbox"/> None <input type="checkbox"/> Prolonged 2nd Stage <input type="checkbox"/> Exhaustion <input type="checkbox"/> Elective <input type="checkbox"/> Other _____</p> <p>FETAL INDICATIONS <input type="checkbox"/> None <input type="checkbox"/> Non-reassuring – non-remed <input type="checkbox"/> Prolonged bradycardia <input type="checkbox"/> Other _____</p> <p>INTERVENTION URGENCY <input type="checkbox"/> Elective <input type="checkbox"/> Expedited <input type="checkbox"/> Emergent</p> <p>LABOR ANESTHESIA DELIVERY</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> None</td> <td style="width: 33%;"><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Parenteral</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Local/Pudendal</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Epidural</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Spinal</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> General</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other _____</td> <td><input type="checkbox"/></td> </tr> </table>	<input type="checkbox"/> Normal	<input type="checkbox"/>	<input type="checkbox"/> Protracted	<input type="checkbox"/>	<input type="checkbox"/> Arrest	<input type="checkbox"/>	<input type="checkbox"/> Combined	<input type="checkbox"/>	<input type="checkbox"/> Precipitous	<input type="checkbox"/>	<input type="checkbox"/> None	<input type="checkbox"/>	<input type="checkbox"/> Parenteral	<input type="checkbox"/>	<input type="checkbox"/> Local/Pudendal	<input type="checkbox"/>	<input type="checkbox"/> Epidural	<input type="checkbox"/>	<input type="checkbox"/> Spinal	<input type="checkbox"/>	<input type="checkbox"/> General	<input type="checkbox"/>	<input type="checkbox"/> Other _____	<input type="checkbox"/>	<p>DELIVERY DATE / TIME ____/____/____ : ____:____</p> <p>DOUBLE SET UP: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>DELIVERY <input type="checkbox"/> Spontaneous <input type="checkbox"/> Vacuum <input type="checkbox"/> Forceps <input type="checkbox"/> Sequential Vacuum / Forceps <input type="checkbox"/> Cesarean Section <input type="checkbox"/> Failed FAD/VAD to C/S</p> <p>DEVICE APPLICATION TIME _____</p> <p>APPLICATIONS: _____</p> <p>VACUUM POPOFFS: _____</p> <p>VACUUM LEVEL: _____ mmHg</p> <p>TRACTION FORCE _____ lbs.</p> <p>ROTATION AT DELIVERY Non / 0-45 / <90 / >90</p> <p>DELIVERED AS: <input type="checkbox"/> OA <input type="checkbox"/> OP</p> <p>DIFFICULTY <input type="checkbox"/> Min <input type="checkbox"/> Mod <input type="checkbox"/> Marked <input type="checkbox"/> Failed - after brief trial <input type="checkbox"/> Failed - prolonged attempt</p> <p>EPISIOTOMY <input type="checkbox"/> None <input type="checkbox"/> Median <input type="checkbox"/> Mediolateral</p> <p>PERINEAL LACERATION <input type="checkbox"/> None <input type="checkbox"/> 1st <input type="checkbox"/> 2nd <input type="checkbox"/> 3rd <input type="checkbox"/> 4th <input type="checkbox"/> Hematoma <input type="checkbox"/> Other _____</p>	<p>MATERNAL COMPLICATIONS <input type="checkbox"/> None <input type="checkbox"/> Hemorrhage <input type="checkbox"/> Fever <input type="checkbox"/> Other _____</p> <p>FETAL COMPLICATIONS (post application) <input type="checkbox"/> None <input type="checkbox"/> Tachycardia <input type="checkbox"/> Bradycardia <input type="checkbox"/> Other _____</p> <p>SH DYSTOCIA INTERVAL <input type="checkbox"/> None _____ min</p> <p>MANEUVERS <input type="checkbox"/> None <input type="checkbox"/> Suprapubic pressure <input type="checkbox"/> McRoberts <input type="checkbox"/> Rotation Woods' / Rubin <input type="checkbox"/> Posterior Arm <input type="checkbox"/> Other _____</p> <p>BRACHIAL PLEXUS INJURY <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ESTIMATED BLOOD LOSS _____</p> <p>CORD PROBLEMS <input type="checkbox"/> None <input type="checkbox"/> Nuchal <input type="checkbox"/> Around Body <input type="checkbox"/> Other _____</p> <p>MATERNAL DISPOSITION <input type="checkbox"/> Normal <input type="checkbox"/> ICU <input type="checkbox"/> Other _____</p>	<p>PEDS Notified <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>APGARS 1 ____ 5 ____ 10 ____</p> <p>CORD BLOOD GASES <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, arterial _____ venous _____</p> <p>BIRTH WT: _____ gm/lbs</p> <p>GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>MULTIPLE <input type="checkbox"/> Yes <input type="checkbox"/> No If YES: FETUS #: ____</p> <p>RESUSCITATION <input type="checkbox"/> None <input type="checkbox"/> Stimul and Suction <input type="checkbox"/> Positive Pressure <input type="checkbox"/> Extensive</p> <p>NEONATAL EXAMINATION <input type="checkbox"/> Appears normal <input type="checkbox"/> Bruising <input type="checkbox"/> Palsy (Not brachial) <input type="checkbox"/> Fracture <input type="checkbox"/> Other _____</p> <p>NEONATAL HEAD <input type="checkbox"/> Unremarkable <input type="checkbox"/> Moderate-Severe Molding <input type="checkbox"/> Bruising <input type="checkbox"/> Abrasion/Laceration <input type="checkbox"/> Other _____</p> <p>NEONATAL DISPOSITION <input type="checkbox"/> Normal <input type="checkbox"/> ICU <input type="checkbox"/> Other _____</p> <p>CUP APPLICATION SITE</p> <div style="text-align: center;">  </div> <p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6</p>
<input type="checkbox"/> Normal	<input type="checkbox"/>																											
<input type="checkbox"/> Protracted	<input type="checkbox"/>																											
<input type="checkbox"/> Arrest	<input type="checkbox"/>																											
<input type="checkbox"/> Combined	<input type="checkbox"/>																											
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<input type="checkbox"/> Spinal	<input type="checkbox"/>																											
<input type="checkbox"/> General	<input type="checkbox"/>																											
<input type="checkbox"/> Other _____	<input type="checkbox"/>																											
<p>DEVICE INFORMATION</p> <p><i>Device:</i> _____</p> <p><i>Model:</i> _____</p> <p>Serial No.: _____</p> <p>Lot #: _____</p> <div style="text-align: center; margin-top: 20px;">  <p>CLINICAL INNOVATIONS</p> </div>																												

Comments:

DICTIONATION: Yes No

Signed: _____

Date: _____

Time: _____