Southern Health Santé Sud

PERINATAL TRIAGE ASSESSMENT

OTAS Level ________

Initials ____________

Date________________________ Time ___________________
Gravida _________ Para _________ EDC ___________________ Gestational Age _______________
Height ___________ Weight _______________ BMI ________ Language Preferred ______________
Accompanied by ____
Signature ____ Printed name/Designation____________________________

Reason for Visit

☐ **Labour** ☐ **Preterm Labour** ☐ No ☐ Yes Date/Time Started ______________________________________

☐ Contractions ☐ Vaginal Pressure ☐ Backache Frequency __________________ Duration ____________________

Vaginal Bleeding: ☐ Yes ☐ No Date/Time Started ____________________ Amount ________________ Colour ______________
Precipitating event (if applicable) ____

Spontaneous Rupture of Membranes: ☐ No ☐ Yes Date/Time _______________________ Amount _______________________
Colour ______________________

Hypertension/Increased blood pressure: ☐ No ☐ Yes ☐ Headache ☐ Visual disturbances ☐ Upper Abdominal pain

☐ Nausea/Vomiting ☐ Other ____

Decreased Fetal Movement: ☐ No ☐ Yes **Absent Fetal Movement:** ☐ No ☐ Yes Since ______________________

☐ **Non Stress Test** ☐ Normal ☐ Atypical ☐ Abnormal ☐ See attached IPN

☐ **Other:** ☐ See attached IPN

Assessment

Pain Scale: 0 – 10 _____ Location ____ Intermittent/Constant
Describe ____

Vital Signs: T ___________________ P __________________ R _________ O_2 Sat __________ BP ______________________

If hypertensive: ☐ N/A
Reflexes: R ________ L __________ Clonus: R _________ L _________

Glucose Accucheck : ☐ N/A
Time _________ ___________
Result _________ ___________
Intervention: ____
* FHR/Contractions charted on reverse side

Urine: ☐ N/A
☐ Protein ☐ Ketones ☐ Sugar ☐ Nitrates
Sent for C&S ☐ Yes ☐ No

History

☐Drugs _________________________________ ☐ Smoking ☐ N/A

☐ Alcohol ________________________________ ☐Caffeine ______________________
Amount ___________________ Frequency _________________________ Last used ____________________________

Medications ☐ No ☐ Yes ____ ☐ See Medication reconciliation

Allergies/Reaction ____ ☐ NKA

☐ Psychosocial concerns ____

Prenatal Care: ☐Yes ☐ No | Prenatal record available: ☐ No ☐ Yes | DPIN: ☐ No ☐ Yes

GBS: ☐ Positive ☐ Negative ☐ Unknown | Fall risk form initiated: ☐ No ☐ Yes

Pregnancy Concerns: ☐ None ☐ See attached IPN

Medical Concerns: ☐ None ☐ See attached IPN

☐ ID band applied | ☐ Allergy band on, if applicable | Information Source: ☐ Patient ☐ Family ☐ Other

ORIGINAL – ATTACH TO OPD FORM COPY – OBSTETRICAL WARD UNTIL DELIVERY, THEN DESTROY COPY

Fetal Heart Rate									
	Time								
	FHR	☐ EFM ☐ IA	☐ EFM ☐ IA	☐ EFM ☐ IA	☐ EFM ☐ IA	☐ EFM ☐ IA	☐ EFM ☐ IA	☐ EFM ☐ IA	☐ EFM ☐ IA
	Rate								
	Rhythm/Variability Ø, ↑, ↓, +								
	Accelerations	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	Decelerations Ø, E, L, V, CV, P								
	Classification	☐ Normal ☐ Atypical ☐Abnormal	☐ Normal ☐ Atypical ☐Abnormal	☐ Normal ☐ Atypical ☐Abnormal	☐ Normal ☐ Atypical ☐Abnormal	☐ Normal ☐ Atypical ☐Abnormal	☐ Normal ☐ Atypical ☐Abnormal	☐ Normal ☐ Atypical ☐Abnormal	☐ Normal ☐ Atypical ☐Abnormal
Maternal	Contractions Frequency Duration Strength	____ Min ____ Sec W M S	____ Min ____ Sec W M S	____ Min ____ Sec W M S	____ Min ____ Sec W M S	____ Min ____ Sec W M S	____ Min ____ Sec W M S	____ Min ____ Sec W M S	____ Min ____ Sec W M S
	See IPN (*)								
	Initials								

√	INVESTIGATION/ COMPLETED	TIME
	CBC	
	PT, INR	
	Electrolytes	
	Hypertensive Disorders of Pregnancy (HDP)	
	Type & Screen	
	Blood Glucose	
	HIV	
	Hep B	
	Hep C	
	Rh	
	Kleihauer	
	Blood Culture	
	Urinalysis	
	Urine Culture & Sensitivity	
	GBS	
	Chlamydia	
	G.C.	
	Trichomonas	
	Ultrasound/BPP	

Membrane Assessment				
	Time			
	Membranes			
	Spec exam done	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	Pooling	☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes
	Ferning	☐ Neg ☐ Pos	☐ Neg ☐ Pos	☐ Neg ☐ Pos
	Nitrazine (+/-)			
	Initials			
Vaginal Assessment				
	Time			
	Dilation			
	Effacement (%)			
	Station			
	Position			
	Consistency			
	Presentation			
	Initials			
Vital Signs				
	Time			
	Temperature			
	Pulse			
	Respirations			
	Blood Pressure			

Modified OTAS Level ________

Initials ________________

Discharge

Discharge instructions reviewed

☐ Yes ☐ No

Patient Handouts given:

- ☐ True labour vs Pre-labour
- ☐ When to call your health care provider
- ☐ Fetal movement counts
- ☐10 great reasons to breastfeed
- ☐ Baby's Best Chance
- ☐ Group B Streptococcus

Signature

Date/Time

Initials	Signature/Designation

Physician/Midwife ____________________________ Notified at ____________ on _________________ by ________________________

☐ Admitted ☐ Observation ☐ Discharged ☐ Transferred to ___________________________via ___________________

Date/Time _____________________________ Signature ___________________________________

Re-Evaluation

Physician/Midwife ____________________________ Notified at ____________ on _________________ by ________________________

☐ Admitted ☐ Discharged ☐ Transferred to ___________________________via ___________________

Date/Time _____________________________ Signature ___________________________________