

May 9, 1994

STANDARD ON RECORDS CONTENT

CLIENT RECORD

- client and midwife identification
- booking date
- menstrual history
- gynecological history
- medical/surgical history
- substance use
- family history
- physical assessment
- psychosocial information

PRENATAL CARE RECORD

- pertinent factors from history and physical assessment
- results of laboratory tests and diagnostic imaging
- intended place of birth
- prenatal clinical observations and assessments of maternal-fetal well-being including discussions, advice, consultations and transfers of care
- notes of any prescription given

LABOUR RECORD

The midwife will be expected to use her clinical judgement in determining how frequently to make any of the following observations. Relevant observations should be recorded. Informed choice discussions, consultations and transfer of care must be noted.

- pertinent factors from history, physical assessment and prenatal care including relevant laboratory results
- chronology of intrapartum events, observations and assessments of maternal-fetal well-being
- narrative recordings of care provided, discussions, advice, interventions, consultations and transfers of care

THIRD STAGE AND IMMEDIATE POSTPARTUM - MATERNAL

- observation, assessment and care provided to the woman during third stage and immediate postpartum
- medications
- departure note
- observations and assessments of maternal and newborn conditions
- date and time

IMMEDIATE CARE AND ASSESSMENT OF THE NEWBORN

- observations, assessment and care given to the newborn at birth
- newborn identification
- documentation of detailed newborn examination
- medications
- feeding

POSTNATAL RECORD: BABY

- observations, assessment and care provided to the baby in the postpartum period
- date and time of birth
- birth weight
- number of days
- newborn screening dates
- laboratory results
- medications
- narrative

POSTNATAL RECORD: MOTHER

- observations, assessment and care provided to the mother in the postpartum
- date and time of delivery
- number of days
- laboratory results
- medications
- Rh immunoglobulin: date/batch number
- narrative

SIX-WEEK POSTNATAL VISIT: BABY

- final assessment and completion of care provided to the baby
- date and narrative

SIX-WEEK POSTNATAL VISIT: MOTHER

- final assessment of physical and emotional status of the mother
- completion of clinical care and contraceptive advice
- date and narrative

NEONATAL RESUSCITATION/TRANSPORT SUMMARY FOR BABY

- summary of relevant events and the actions taken in the course of a neonatal resuscitation
- record of management, consultation and transfer of care

BIRTH SUMMARY: MOTHER

- maternal age
- gravida and para
- weeks gestation
- place of birth: planned _____ actual _____
- date and time of delivery
- live birth
- still birth
- spontaneous rupture of membranes
- artificial rupture of membranes

- length of rupture of membranes
- 1st stage: latent/active
- 2nd stage
- 3rd stage
- length of labour
- placenta
- membranes
- estimated blood loss
- perineal tears
- episiotomy
- perineal repairs
- consultations
- transfer of care
- medications

BIRTH SUMMARY: BABY

- date and time of birth
- sex
- weight
- multiple
- single
- agpar - 1 minute/5 minute
- suctioning
- oxygen administration
- resuscitation: (indicate admission to level 1 or 2 hospital)

- abnormalities
- consultations
- transfer of care
- medications

Primary midwife / College registration number

*College of Midwives of Ontario
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Second midwife / College registration number

Student / College registration number

Others present