Patient Label Here

Birth Child Encounter - Birth Tab

Date of birth: dd / mmm / yyyy Time of Birth: ____________________ Sex: ☐**Female** ☐**Male** ☐**Ambiguous** ☐**Unknown**

Birth Location: √One ☐Hospital ☐Home ☐Birth Centre ☐Nursing Station ☐Other

If Birth Centre……Name:______________________________
If Birth Hospital… Name:______________________________

Type of Birth: √One ☐Spontaneous vaginal ☐Assisted vaginal (forceps/vacuum) ☐Induced or spontaneous labour - C/S ☐ No labour - C/S

Presentation Type : _____________

Birth Order: (Indicate birth order of each baby) Singleton = A Circle A B C D
*Complete separate *Birth Child Encounter* for each child

Forceps/Vacuum: ☐None ☐Vacuum ☐Vacuum and Forceps ☐Unknown

Apgar 1:______ ☐Unknown **Apgar 5**:______ ☐Unknown **Apgar 10**:______ ☐Unknown

Delayed Cord Clamping(>30 secs): ☐yes ☐no ☐unknown

Neonatal Resuscitation: ☐None ☐FFO2 ☐CPAP + Air ☐CPAP + O2 ☐PPV + air ☐PPV + O2 ☐ Intubation for tracheal suction ☐ Intubation for PPV ☐ Laryngeal Mask Airway (LMA) ☐Chest compression ☐ Epinephrine ☐ Narcan/Naloxone ☐ Volume Expander ☐Unknown

Birth Outcome: ☐Live Birth **Stillbirth at > 20 wks or > 500 gms:** ☐Termination ☐Spontaneous – occurred during antepartum period ☐Spontaneous – occurred during intrapartum period

Neonatal death: ☐No ☐Yes ☐Yes - with termination of pregnancy If yes, date: dd/mmm/yyyy Time of death: ______________ Age at neonatal death: _____Days

Birth Weight:_______________gms ☐Birth Weight Unknown GA at Birth: _____ weeks _____days ☐ Head Circumference at Birth_____

Neonatal Transfer to NICU/SCN: ☐No transfer ☐NICU/SCN other hospital ☐NICU/SCN same hospital **If NICU/SCN other hospital - Neonatal Transfer to Hospital**: Name:__________________

Reason for Neonatal Transfer: ☐Bed needed for sicker baby ☐Condition improved ☐Lack of physician coverage ☐Lack of RN coverage ☐No bed available ☐Requires further investigation ☐Requires higher level of care ☐Care closer to home ☐Other ☐Unknown

Neonatal transfer to NICU/SCN Date: dd / mmm / yyyy_ **Neonatal Transfer to NICU/SCN Time:** ______________________

Arterial cord blood test status: √One ☐Done ☐Not Done ☐Unsatisfactory Specimen ☐Unknown Arterial Cord Blood pH: ________ Arterial Cord Blood Base Excess/Deficit:_________

Venous cord blood test status: √One ☐Done ☐Not Done ☐Unsatisfactory Specimen ☐Unknown Venous Cord Blood pH: ________ Venous Cord Blood Base Excess/Deficit _________

Infant Early attachment/feeding initiation (multi-select): ☐Skin-to-skin contact uninterrupted for at least 1 hour, within the first 2 hours post-birth ☐ Skin-to-skin contact with interruptions, within the first 2 hours post-birth ☐Skin-to-skin with person other than birth mother ☐Opportunity to latch in first hour ☐Opportunity to latch in the 2nd hour ☐Latch achieved ☐Transfer to NICU/SCN ☐No attempt at breastfeeding or skin-to-skin contact within the first 2 hours post birth ☐Unknown

Neonatal Birth Complications: ☐Caput succedaneum ☐Cephalohematoma ☐Clavicular fracture ☐Facial nerve injury ☐Brachial plexus injury ☐ Birth Injury Other ☐Unknown

Newborn Congenital Anomalies Identified: ☐None ☐Suspected or Confirmed Newborn Congenital Anomalies Suspected: Specify: ____

Newborn Congenital Anomalies Confirmed: Specify:____

Midwifery Tab (Birth Child)	
Was the care of the client transferred back to midwifery: ☐yes ☐no ☐unknown	
Was there Neonatal transport to hospital during birth or immediate postpartum ☐Yes ☐No ☐Unknown **Did EMS attend in birth or the immediate postpartum** ☐ Yes ☐ No ☐Unknown **Was EMS used to transport to hospital?** ☐Yes ☐No ☐Unknown	***Reason(s) for Transport:*** ☐Respiratory Distress ☐Maternal Clinical Indication ☐Other neonatal clinical indication ☐ Other ***Primary Reason for Transport:*****_________________________ *(indicate)*** ***Barrier to Transport:*** ☐None ☐Delayed arrival time of EMS ☐Delayed Departure of EMS ☐Delay on route ☐Other
Where there any consults, transfers of care, or use of hospital/outpatient/emergency services? Yes_______ No_______	**2 consultation records provided. If additional are needed, please attach to record.**
Reason(s) for consultation/transfer of care? **Infant Consult with Physician?** Yes______ No______ **Rationale for Consult:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify___________ **Infant Transfer of Care?** Yes______ No______ **Rationale for Transfer of Care:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify___________ **Infant Transfer of Care returned?** Yes______ No______ Infant Outpatient (plus emergency) Hospital Services: Yes______ No______	**Reason(s) for consultation/transfer of care?** **Infant Consult with Physician?** Yes______ No______ **Rationale for Consult:** College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify___________ **Infant Transfer of Care?** Yes______ No______ **Rationale for Transfer of Care**: College/regulatory body___Hospital/physician protocol___Midwife discretion___Parental request___Other, specify___________ **Infant Transfer of Care returned?** Yes______ No______

Version Date: February 2017 (reflecting April 2017 enhancements)