

Patient Label Here



## Labour - Birth Encounter (Midwifery)

### ADMISSION TAB

**Demographics:**  Per patient label OR

Mother Family Name: \_\_\_\_\_ Given Name: \_\_\_\_\_

Maternal Date of Birth: dd/ mmm /yyyy Chart Number : \_\_\_\_\_ OHIP: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Phone: \_\_\_\_\_

No Fixed address **Estimated Date of Birth (EDB):** dd/ mmm /yyyy

**Primary Language:**  One  English  French  Other (specify): \_\_\_\_\_  Unknown

### Maternal Admission to Hospital

Admission date: dd/ mmm /yyyy Admission Time: \_\_\_\_\_

**Admission Healthcare Provider:**  One  Obstetrician  
 Family Physician  Midwife  Nurse Practitioner (APN/CNS)  
 Other

**Maternal Transfer from:**  One  No transfer  Hospital  
 Home birth/MW care  Nursing station  Birthing Center  
 Other unit same hospital  Other

### If transfer:

**Maternal Transfer from Hospital (name):** \_\_\_\_\_

**Maternal transfer from Birth Centre (name):** \_\_\_\_\_

**Reason for Maternal Transfer From:**  One  Fetal health concern  Lack of nursing coverage  
 Lack of physician coverage  Maternal medical/obstetrical problem  
 No beds available  Organization evacuation  Birth outside of hospital prior to admission  
 Care closer to home  Condition improved  Other  Unknown

### HISTORY TAB

**Maternal Health Conditions (list all health conditions):** \_\_\_\_\_  Unknown

**Mental Health Concerns:**  None  Anxiety  Depression  History of Postpartum Depression  Addiction  Bipolar  Schizophrenia  Other  Unknown

**Women Abuse :**  One  No Disclosure  Disclosure  Unable to ask

**Obstetrical History:** Gravida (G): \_\_\_\_\_ # of Previous Term Births (T): \_\_\_\_\_ # of Previous Preterm Births (P): \_\_\_\_\_ # of Previous Abortions (A): \_\_\_\_\_ # of Living Children (L): \_\_\_\_\_ # of Previous Stillbirths (S): \_\_\_\_\_ # of Previous Vaginal Births: \_\_\_\_\_ # of Previous C/S Births: \_\_\_\_\_ # of Previous VBACs: \_\_\_\_\_ Parity: *Calculates*

**PREGNANCY TAB**

**Maternal Height:** \_\_\_\_\_ (in, ft & in, cm)  Unknown **Pre-pregnancy weight:** \_\_\_\_\_ (lb/kg)  Unknown **Pre-pregnancy BMI:** *Calculates*

**Maternal Weight at end of Pregnancy:** \_\_\_\_\_ (lb/kg)  Unknown **Maternal Weight Gain at end of Pregnancy:** *Calculates*

**Number of fetuses:** \_\_\_\_\_

**Conception type:**  Spontaneous  Intrauterine Insemination alone  
 Intrauterine Insemination (IUI) with ovulation induction but no IVF  
 Ovulation induction without IVF (i.e. Clomid, FSH)  
 IVF  IVF ICSI  Surrogate  Vaginal insemination  Unknown

**Estimated Date of Birth (EDB):** dd/mmm/yyyy

**EDB determined by:**  One  Last Menstrual Period  First trimester dating ultrasound  Second trimester ultrasound  Assisted reproductive technology  
 Obstetrical clinical estimate (includes S-F height)  Unknown

**First Trimester Visit:**  One  Yes  No  Unknown

**Prenatal Classes:**  One  Yes  No  Unknown

**Antenatal Health Care Provider:**  None  Obstetrician  Family Physician  Midwife  Nurse  Nurse Practitioner (APN/CNS)  Other  Unknown

**Folic Acid Use:**  One  None  Pre-conception only  During pregnancy only  
 Pre-conception and during pregnancy  Unknown

**Intention to Breastfeed:**  One  Yes, intends to exclusively breastfeed  
 Yes, intends to combination feed (use breast milk and breast milk substitute)  
 No, does not intend to breastfeed  Mother unsure  Unknown, intent not collected

**Smoking at First Trimester Visit:**  One  None  < 10 cigarettes/day  10-20/day  >20/day  Amount unknown  Unknown

**Resides with smoker at first trimester visit:**  One  Yes  No  Unknown

**Smoking at time of labour/admission:**  One  None  < 10 cigarettes/day  10-20/day  >20/day  Amount unknown  Unknown

**Resides with smoker at time of labour/admission:**  One  Yes  No  Unknown

**Alcohol Exposure in Pregnancy:**  One  None  < 1 drink/month  1 drink/month  2-3 drinks/month  1 drink/week  More than 1 drink/week  
 Episodic excessive drinking (binging)  Exposure prior to pregnancy confirmed, amount unknown  Unknown

**Drug and Substance Exposure in Pregnancy:**  None  Cocaine  Gas/Glue  Hallucinogens  Marijuana  Opioids  Other  Unknown

**Medication Exposure in Pregnancy:**  None  Amphetamines  Antibiotics  
 Anticonvulsants  Anti-emetics  Antihistamines  Anti-inflammatory  Antiretroviral  
 Anti-rheumatic  Antiviral  Cardiovascular  Chemotherapeutic Agents  
 Contraceptives  GI agent  General Anesthetic  Herbal or homeopathic remedies  
 Insulin  Methadone/Subutex  Opioids  Other over the counter medications  
 Other prescription  Psychotropic  Selective Serotonin Reuptake Inhibitors  
 Thyroid Medication  Vitamin A & Congeners  Vitamins  Other  Unknown

**Infection & Pregnancy:**  None  C-Difficile  Chlamydia  
 Gonorrhea  Group B Streptococcus  Hepatitis A  
 Hepatitis B  Hepatitis C  Herpes Simplex Virus  HIV  
 HPV  Methicillin resistant staphylococcus aureus(MRSA)  
 Other infections  Seasonal Influenza  Suspected Chorioamnionitis  Syphilis  Trichomonas  
 Urinary Tract Infection (UTI)  Viruses – Other  Unknown

**GBS Screening Results (35-37 wks):**  One  Not Done  Done, negative result  Done, positive result  Done, result unknown  Unknown if screened

**GBS Screening Date (if done):** dd/mmm/yyyy

**Reason GBS Screening Not Done:**  One  Previous baby with GBS disease  Previous GBS screening done in this pregnancy  Urine positive for GBS  
 Declined Screening  Other  Unknown

**Diabetes and Pregnancy:**  One  None  Gestational - Insulin  Gestational - No Insulin  Gestational - Insulin status unknown  
 Type 1  Type 2 Insulin  Type 2 No Insulin  Type unknown  Unknown

**Hypertensive Disorder in Pregnancy:**  One  None  Eclampsia  Gestational Hypertension  HELLP  Preeclampsia  
 Preeclampsia requiring magnesium sulfate  Pre-existing Hypertension with superimposed preeclampsia  Unknown

**Complications of Pregnancy:**  None  Unknown

**Fetal**  Anomaly(ies)  Isoimmunization/alloimmunization  Intrauterine Growth Restriction (IUGR)  Large for Gestational Age (LGA)  
 Oligohydramnios  Polyhydramnios  Other

**Maternal:**  Anemia unresponsive to therapy  Antepartum bleeding (persistent and unexplained)  Gestational diabetes  
 Hyperemesis Gravidarum (Requiring Hospital Admission)  Hypertensive Disorder of Pregnancy  Pre-labor rupture of membranes(PROM)  
 Preterm labour prior to this admission  Preterm pre-labour rupture of membranes (PPROM)  Other

**Placental:**  Placental accreta  Placenta increta  Placenta percreta  Placental previa  Placental abruption  Other

### INTRAPARTUM TAB

**Type of Labour:**  One  Spontaneous  Induced  No Labour

**Group B Strep Antibiotics**  One

Yes  No  Declined antibiotics  Unknown

**Antenatal Steroids:**  One

None  1 dose < 24 hours (before the time of birth)  
 2 doses: Last dose < 24 hours (before the birth)  
 2 doses: Last Dose > 24 hours (from the time of the last dose to the time of birth)  
 Unknown

**Fetal Surveillance:**  Admission EFM Strip  Auscultation

Intrapartum EFM(external)  Intrapartum EFM(internal)  
 No Monitoring  Unknown

**IF SPONTANEOUS LABOUR: Augmentation:**  None  Prostaglandin  Amniotomy  Oxytocin  Unknown

**IF INDUCED LABOUR:**

**All Indications for Induction of Labour: Fetal Indications:**  Atypical or abnormal fetal surveillance  Fetal anomaly/ies  Fetal Demise  
 Isoimmunization/alloimmunization  IUGR  Macrosomia  Multiple gestation  Other fetal complication  Post dates  Termination of pregnancy

**Maternal Indications:**  Diabetes  Hx of precipitous delivery  Oligohydramnios  Other obstetrical complications/concerns  Polyhydramnios  
 Preeclampsia/Hypertension  Pre-existing maternal medical conditions  Pre-labour rupture of membranes (PROM)  Preterm Pre-labor rupture of membranes (PPROM)

**Other Indications:**  Accommodates care provider/organization  Distance from birth hospital/safety precaution  Maternal request  Unknown

**Primary Indication for Induction of Labour:** \_\_\_\_\_

**Bishop Score:** Circle 1 2 3 4 5 6 7 8 9 10 11 12 13  Unknown

**Cervical Ripening Prior to Induction:**  None  Balloon/Mechanical Method (i.e. Foley Catheter)  Laminaria/artificial tent  Prostaglandin  Unknown

**Methods of Induction:**  None  Amniotomy  Oxytocin  Prostaglandin  Sweeping Membranes  Unknown

**ALL LABOUR TYPES - SPONTANEOUS, INDUCED AND NO LABOUR**

**Maternal Outcome (prior to birth):**  One  No Transfer  Transfer to other hospital  Transfer to ICU/CCU

Transfer to other non-obstetrical unit, same hospital  Maternal Death—Not Related to Pregnancy or Birth  Maternal Death—Related to Pregnancy or Birth

**\* If Transfer to Other Hospital: Maternal Transfer to** [hospital name]: \_\_\_\_\_

**\* If Transfer to Other Hospital, ICU/CCU, or Other Non-Obstetrical Unit, same hospital:**

**Reason for Transfer:**  One  Fetal Health Concern  Lack of Nursing Coverage  Lack of Physician Coverage  Maternal medical/obstetrical problem

No beds available  Organization evacuation  Birth outside of hospital prior to admission  Care Closer to Home  Condition Improved  Other  Unknown

**Maternal Transfer Date :** dd/ mmm /yyyy **Maternal Transfer Time:** \_\_\_\_\_

**IF TRANSFERRED:**

**Intrapartum Pain Management:**  None  Nitrous oxide  Opioids  Epidural  Spinal  Spinal-epidural combination

Non-pharmacologic:  Sterile water/saline injection  TENS  Tub/Shower  Other

Local  Pudendal  Unknown

**Labour and Birth Complications:**  None  Atypical or abnormal fetal surveillance  Meconium  Cord prolapse  Shoulder dystocia  Fever >38.5 C

Non-progressive first stage of labour  Non-progressive second stage of labour  Placental abruption

Uterine rupture  Uterine dehiscence  Retained placenta-manual removal  Retained placenta-surgical removal  Postpartum hemorrhage  Uterine atony

Perineal hematoma  Pulmonary embolism  Hysterectomy  Other  Unknown

**BIRTH TAB**

**Type of Birth:**  One  Spontaneous vaginal  Assisted vaginal  Induced or spontaneous labour Caesarean Section  No labour Caesarean Section

**Presentation Type: Cephalic:**  One  Vertex  Brow  Face  Compound  Cephalic type unknown

**Breech:**  One  Frank  Complete  Footling  Compound  Breech type unknown

Transverse/Malpresentation  Unknown

**Forceps/Vacuum:**  One  None  Vacuum  Forceps  Vacuum and Forceps  Unknown

**IF TYPE OF BIRTH = SPONTANEOUS VAGINAL, ASSISTED VAGINAL, INDUCED OR SPONTANEOUS LABOUR CAESAREAN SECTION:**

**Episiotomy:**  One  None  Medio-lateral  Midline  Unknown

**Perineal Laceration:**  One  None  1<sup>st</sup> degree  2<sup>nd</sup> degree  3<sup>rd</sup> degree  4<sup>th</sup> degree  Cervical tear  Other  Unknown

**Date Fully Dilated:** dd/mmm/yyyy **Time Fully Dilated:** \_\_\_\_\_ **Date Started Pushing :** dd/ mmm/yyyy **Time Started Pushing:** \_\_\_\_\_

**FOR WOMEN WHO HAVE HAD A PREVIOUS CAESAREAN SECTION:****Vaginal Birth After Caesarean (VBAC):**

Was VBAC ever planned during this pregnancy?  One  Yes  No  Unknown

Eligible for VBAC at onset of labour:  One  Yes  No  Declined  Unknown

Attempted VBAC:  One  Yes  No  Unknown

**IF TYPE OF BIRTH = A SPONTANEOUS OR INDUCED CAESAREAN SECTION:**

**If C/S, dilatation (cm):** \_\_\_\_\_  Not Examined  Unknown

**If C/S, Type:**  One  Planned (as scheduled)  Planned (not as scheduled)  Unplanned

**If C/S, stage:**  One  First stage  Second Stage  Perimortem  No labour  Unknown

**IF TYPE OF BIRTH = SPONTANEOUS OR INDUCED CAESAREAN SECTION OR NO LABOUR – CESAREAN SECTION:****All C/S indications:**

**Fetal:**  Anomaly(ies)  Atypical or Abnormal Fetal Surveillance  Cord prolapse  Intrauterine Growth Restriction (IUGR)  Macrosomia  
 Malposition/Malpresentation  Other Fetal Indication

**Maternal:**  Failed forceps/vacuum  Failed induction  Gestational hypertension  HIV – Human immunodeficiency Virus  HSV – Herpes Simplex Virus  
 Hypertensive Disorders of Pregnancy - Eclampsia  HELLP  Preeclampsia  Maternal Health condition(s)  Multiple gestation  Non-progressive first stage of labour  Non-progressive second stage of labour  Obesity  Other Obstetrical complication  Placenta Increta/Acreta/Percreta  Placenta previa  
 Placental abruption  Prelabor rupture of membranes(PROM) in women with a planned c/section  Preterm pre-labor rupture of membranes (PPROM) in women with planned c/section  Previous C/S  Previous T incision/classical incision/uterine surgery  Previous uterine rupture  Suspected chorioamnionitis  Uterine rupture  Declined VBAC  VBAC - Failed Attempt  VBAC - Not Eligible

**Other:**  Accommodates care provider/organization  Maternal request  Unknown

**Primary indication for C/S:** \_\_\_\_\_

**Anesthesia for C/S:**  One  Epidural  Spinal  General  Unknown

**IF TYPE OF BIRTH = NO LABOUR – CESAREAN SECTION:**

**If C/S Type:**  One  Planned (as scheduled)  Planned (not as scheduled)  Unplanned

**ALL TYPES OF BIRTH – SPONTANEOUS VAGINAL, ASSISTED VAGINAL, INDUCED OR SPONTANEOUS LABOUR C/S, NO LABOUR C/S:**

**Labour and Birth Complications:**  None  Atypical or abnormal fetal surveillance  Meconium  Cord prolapse  Shoulder dystocia  Fever>38.5 C  
 Non-progressive first stage of labour  Non-progressive second stage of labour  Placental abruption  
 Uterine rupture  Uterine dehiscence  Retained placenta-manual removal  Retained placenta-surgical removal  Postpartum hemorrhage  Uterine atony  
 Perineal hematoma  Pulmonary embolism  Hysterectomy  Other  Unknown

**Intrapartum Pain Management:**  None  Nitrous oxide  Opioids  Epidural  Spinal  Spinal-epidural combination

Non-pharmacologic:  Sterile water/saline injection  TENS  Tub/Shower  Other

Local  Pudendal  Unknown

**Newborn DOB:** dd/mmm/yyyy **Time of Birth:** \_\_\_\_\_

*Time Waiting, Time Pushing, Total Second Stage and Maternal Age at time of birth: Calculates*

**Birth Location:**  One  Hospital  Home  Birth Center  Nursing Station  Other Ontario location  Outside of Ontario

**Birth Location Hospital:** \_\_\_\_\_

**Birth Centre Name:** \_\_\_\_\_

**Healthcare Provider Who Caught/Delivered Baby:**  One  Family Physician  Registered Midwife  Obstetrician  Resident  Surgeon  CNS/NP  
 Registered Nurse  Aboriginal Midwife  Midwifery Student  Other Health Care Provider  Unattended (None)  Unknown

**ID of Healthcare Provider Attending Birth (if used):** \_\_\_\_\_

**Other Care Providers Present at time of Labour and/or Birth:**  Family Physician  Registered Midwife  Obstetrician  Surgeon  CNS/NP  
 Registered Nurse  Aboriginal Midwife  Midwifery Student  Nursing Student  Medical Student  Doula  
 Other Care Provider [e.g. RT, pediatrician, neonatologist]  None  Unknown

## OUTCOME TAB

**Pregnancy Outcome** (Complete for each fetus if multiple pregnancy):  One

Live birth  Stillbirth  $\geq$  20 wks or  $\geq$  500 gms – Spontaneous - occurred during **antepartum** period  Stillbirth  $\geq$  20 wks or  $\geq$  500 gms – Spontaneous - occurred during **intrapartum** period  Stillbirth  $\geq$  20 wks or  $\geq$  500 gms /Termination  Pregnancy loss  $<$  20 wks and  $<$  500 gms/Spontaneous miscarriage  
 Pregnancy loss  $<$  20 wks and  $<$  500 gms/Termination

*Gestational age at birth: Calculates*

**Maternal Birth Outcome:**  One  No Transfer  Discharged Home  Transfer to other hospital  Transfer to ICU/CCU  
 Transfer to other non-obstetrical unit, same hospital  Maternal Death—Not Related to Pregnancy or Birth  Maternal Death—Related to Pregnancy or Birth

\* **If Transfer to Other Hospital:** Maternal Transfer to [hospital name]: \_\_\_\_\_

\* **If Transfer to Other Hospital, ICU/CCU, or Other Non-Obstetrical Unit, same hospital:**

**Reason for Transfer:**  One  Fetal Health Concern  Lack of Nursing Coverage  Lack of Physician Coverage  Maternal medical/obstetrical problem  
 No beds available  Organization evacuation  Birth outside of hospital prior to admission  Care Closer to Home  Condition Improved  Other  Unknown

**Maternal Transfer Date :** dd/mmm/yyyy  **Maternal Transfer Time:** \_\_\_\_\_ **OR** **Maternal Discharge Date:** dd/ mmm/yyyy **Discharge Time:** \_\_\_\_\_

**Admission to birth duration (Hours):** *Calculates*

<b>MIDWIFERY TAB</b>	
Was care of client transferred back to Midwifery during intrapartum? <input type="checkbox"/> Yes <input type="checkbox"/> No (only answer if there was transfer of care (w/o return to care) in a previous encounter)	
<b>Intrapartum</b>	
<b>Began Intrapartum Period intending to give birth at:</b> <input checked="" type="checkbox"/> One <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Birth Centre <input type="checkbox"/> Clinic <input type="checkbox"/> Other <input type="checkbox"/> Nursing Station <input type="checkbox"/> Undecided	<b>Actual Location of Labour:</b> <input checked="" type="checkbox"/> One <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Birth Centre <input type="checkbox"/> Clinic <input type="checkbox"/> Other <input type="checkbox"/> Nursing Station <input type="checkbox"/> Undecided Birth Centre of Labour: <input checked="" type="checkbox"/> One (select only if labour at Birth Centre) <input type="checkbox"/> Ottawa Birth and Wellness Centre <input type="checkbox"/> Toronto Birth Centre, Inc.
<b>Was there unplanned Maternal transport to hospital at any part of the labour?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Did EMS attend the labour?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Was EMS used to transport to hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Reason(s) for Transport:</b> <input type="checkbox"/> Fetal well-being concerns <input type="checkbox"/> Pain Management <input type="checkbox"/> Prolonged labour <input type="checkbox"/> Maternal request <input type="checkbox"/> Provider preference <input type="checkbox"/> Other maternal condition/complication <input type="checkbox"/> Other fetal condition/complication <b>Primary Reason for Transport:</b> _____ (indicate) <b>Barrier to Transport:</b> <input type="checkbox"/> None <input type="checkbox"/> Delayed arrival time of EMS <input type="checkbox"/> Delayed Departure of EMS <input type="checkbox"/> Delay on rout <input type="checkbox"/> other
<b>Did midwife/senior student attend client at home in early labour?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Other care providers present at time of labour and/or birth:</b> <input type="checkbox"/> RN <input type="checkbox"/> OB <input type="checkbox"/> FP <input type="checkbox"/> Aboriginal midwife <input type="checkbox"/> Midwifery student <input type="checkbox"/> Nursing student <input type="checkbox"/> Medical student <input type="checkbox"/> Other
<b>Birth and Immediate Postpartum</b>	
Was care of client transferred back to Midwifery during birth? <input type="checkbox"/> Yes <input type="checkbox"/> No (only answer if there was transfer of care (w/o return to care) in a previous encounter)	
<b>Was there unplanned Maternal transport to hospital at any part of the labour?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Did EMS attend the labour?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Was EMS used to transport to hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If vaginal birth: Maternal Position at Time of Birth:</b> <input checked="" type="checkbox"/> One <input type="checkbox"/> Supine <input type="checkbox"/> Semi-fowler's <input type="checkbox"/> Lateral <input type="checkbox"/> Standing <input type="checkbox"/> Squatting <input type="checkbox"/> Kneeling <input type="checkbox"/> All-fours <input type="checkbox"/> Lithotomy <input type="checkbox"/> McRoberts <input type="checkbox"/> Birth Stool <input type="checkbox"/> Other <input type="checkbox"/> Unknown <b>If spontaneous vaginal birth: Was the baby born in the water?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Was this a planned water birth?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>If vaginal birth: Components of third stage management employed (unrelated to corrective measures for bleeding):</b> <input type="checkbox"/> Prophylactic oxytocic <input type="checkbox"/> Early cord clamping <input type="checkbox"/> Controlled cord traction <input type="checkbox"/> Breastfeeding <input type="checkbox"/> none <input type="checkbox"/> Unknown	
<b>Were there any consults, transfers of care, or use of hospital/outpatient/emergency services?</b> Yes _____ No _____	<b>2 consultation records provided. If additional are needed, please attach to record.</b>



<p><b>Reason(s) for consultation/transfer of care?</b>  <b>In Labour Consult with Physician?</b> Yes _____ No _____  <b>Rationale for Consult:</b> College/regulatory body ___ Hospital/physician protocol ___ Midwife discretion ___ Parental request ___ Other, specify _____  <b>In Labour Transfer of Care?</b> Yes _____ No _____  <b>Rationale for Transfer of Care:</b> College/regulatory body ___ Hospital/physician protocol ___ Midwife discretion ___ Parental request ___ Other, specify _____  <b>Transfer of Care returned?</b> Yes _____ No _____</p>	<p><b>Reason(s) for consultation/transfer of care?</b>  <b>In Labour Consult with Physician?</b> Yes _____ No _____  <b>Rationale for Consult:</b> College/regulatory body ___ Hospital/physician protocol ___ Midwife discretion ___ Parental request ___ Other, specify _____  <b>In Labour Transfer of Care?</b> Yes _____ No _____  <b>Rationale for Transfer of Care:</b> College/regulatory body ___ Hospital/physician protocol ___ Midwife discretion ___ Parental request ___ Other, specify _____  <b>In Labour Transfer of Care returned?</b> Yes _____ No _____</p>
<p><b>Was the client discharged from midwifery care during intrapartum / immediate postpartum? (Select yes to discharge client from Midwifery Care and/or bill for Course of Care)</b> Yes _____ No _____</p>	

