

Patient Label Here



## Labour - Birth Encounter

### 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

**Pre-existing Health Conditions (Outside of Pregnancy):** (List) \_\_\_\_\_  Unknown

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

**Domestic/Intimate Partner Violence:**  One  No Disclosure  Disclosure  Unable to ask

**Obstetrical History:** Gravida (G): \_\_\_\_\_ # of Previous Term Pregnancies (T): \_\_\_\_\_ # of Previous Preterm Pregnancies (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: Auto 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  Declined weight check **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

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

**Prenatal Education:**  One  Yes - In-person prenatal education only  Yes - Online prenatal education only  Yes - Combination of in-person and online prenatal education  Yes - Unknown method of education delivery  No - Patient/client did not receive prenatal education  Unknown if patient/client received prenatal education

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

**Was prenatal genetic screening offered, as indicated on the OPR?**

One  Yes, screening was offered  No, screening was not offered  Counselling and declined screening  Unknown if screening was offered – no access to the OPR  Unknown if screening was offered – other reason

**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

**Cannabis Exposure in Pregnancy:**  One  Yes  No  Unknown

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

**Antenatal Exposure to Medication:**  None

OTC/Vitamins/Homeopathic:  Prenatal Vitamins (including folic acid)  Probiotics  Anti-emetics (OTC)  Antihistamines (OTC)  Herbal or homeopathic remedies  Other over the counter medications

Prescribed Medications:  Amphetamines  Antibiotics (NOT for GBS prophylaxis)

Anticonvulsants (NOT for preeclampsia)  Anti-emetics  Antihistamines  
 Antihypertensives  Anti-inflammatory  Antiretrovirals  Anti-rheumatic  Antiviral  
 Cardiovascular  Chemotherapeutic Agents  Gastrointestinal agents /protein pump inhibitors/H2 blockers  General anaesthetic  Insulin  Metformin  Opioids  Opioid agonist therapy (Select appropriate option):  Methadone  Buprenorphine monoproduct (Subutex)  Buprenorphine – naloxone (Suboxone)  Slow-release morphine for opioid use disorder  Psychotropics  Selective Serotonin Reuptake Inhibitors  Thyroid medications  
 Other prescription  Unknown prescription or OTC exposure

**Infection & Pregnancy:**  None  C-Difficile  Chlamydia

Gonorrhea  Group B Streptococcus  Hepatitis A  
 Hepatitis B  Hepatitis C  Herpes Simplex Virus  HIV  HPV  
 Seasonal Influenza  Syphilis  Trichomonas  
 Methicillin-resistant staphylococcus aureus (MRSA)  
 Suspected Chorioamnionitis  Urinary Tract Infection (UTI)  
 Viruses-other  Other infections  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

**Progesterone** taken daily for spontaneous preterm birth prevention, any time after 16 weeks gestation  Yes  No  Unknown  
 (Do NOT include if progesterone is used only in first trimester)

**ASA (aspirin)** taken daily for preeclampsia prevention, any time after 12 weeks' gestation  Yes  No  Unknown  
 (Do NOT include if aspirin is used only in first trimester)

**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  Declined Testing  Unknown

**Hypertensive Disorders of Pregnancy:**  One  None  Gestational Hypertension  Preeclampsia  Pre-existing Hypertension with superimposed preeclampsia  Eclampsia  HELLP syndrome  Unknown

**Complications of Pregnancy, not including Hypertension or Diabetes:**  None  Unknown

Complications of Pregnancy – Fetal:  Anomaly(ies)  Isoimmunization/Alloimmunization  Intrauterine Growth Restriction (IUGR)  Oligohydramnios  
 Polyhydramnios  Other

Complications of Pregnancy - Maternal:  Anemia unresponsive to therapy  Antepartum bleeding (persistent and unexplained)  Cancer – diagnosed in this pregnancy  Haematology – Gestational Thrombocytopenia  Hyperemesis Gravidarum (Requiring Hospital Admission)  Liver/Gallbladder – Intrahepatic Cholestasis of Pregnancy  Liver/Gallbladder – Acute Fatty Liver of Pregnancy  Neurology – Epilepsy/Seizures – Seizure occurred during current pregnancy  
 Prelabour rupture of membranes(PROM)  Preterm labour prior to this admission  Preterm pre-labour rupture of membranes (PPROM)  Pulmonary – asthma occurred during current pregnancy  Other

Complications of Pregnancy – Placental:  Placenta accreta  Placenta increta  Placenta percreta  Placenta 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  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:**  Cholestasis of Pregnancy  Diabetes  Hx of precipitous delivery  Oligohydramnios  Other obstetrical complications/concerns

Polyhydramnios  Preeclampsia/Hypertension  Pre-existing maternal medical conditions  Pregnant individual age  $\geq$  40  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 0 1 2 3 4 5 6 7 8 9 10 11 12 13  Unknown

**Cervical Ripening:**  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 organization  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 Organization: Maternal Transfer to** [hospital name]: \_\_\_\_\_

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

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

No beds available  Organization evacuation  Other  Unknown

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

### **IF TRANSFERRED:**

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

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  Amniotic fluid embolism  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:** \_\_\_\_\_  Unknown

**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 indications for C/S :**

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

**Maternal:**  Cholestasis of pregnancy  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/or 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  Amniotic fluid embolism  
 Pulmonary embolism  Hysterectomy  Other  Unknown

**Intrapartum Medications Administered:**  None  Magnesium Sulfate for preeclampsia  Magnesium Sulfate for fetal neuroprotection  Antibiotics (not for GBS)  
 Antihypertensives  Anti-emetics  Antipyrexics (example: acetaminophen)  Diuretics  Insulin  Tocolytics (Mag sulfate/indomethecine/nifedipine/ritodrine etc)  Other  Unknown

**Pharmacologic Pain Management:**  None  Nitrous oxide  Opioids  Epidural  Spinal  Spinal-epidural combination  
 Pudendal  Unknown

**Supportive Care:**  None  1:1 Supportive care by clinical staff/care provider  Breathing exercises  Hypnobirthing/guided imagery  Massage  
 Shower  Sterile water/saline injections  Support partner or doula  TENS  Tub  Other  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  Clinic (midwifery)  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  Registered Nurse  
 Nurse Practitioner (CNS/NP)  Aboriginal Midwife  Midwifery Student  Unattended (None)  Other Health Care Provider  Unknown

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

**Other Care Providers Present at time of Labour and/or Birth:**  Family Physician  Obstetrician  Surgeon  Registered Midwife  Midwifery Student  
 Aboriginal Midwife  Registered Nurse  Nursing Student  Medical Student  Pediatrician  Neonatologist  Respiratory Therapist  
 Clinical Nurse Specialist/Nurse Practitioner  Doula  Other Care Provider  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: Auto-calculates*

**Maternal Birth Outcome:**  One  No Transfer  Transfer to other organization  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 Maternal Transfer To:**  One  Fetal Health Concern  Lack of Nursing Coverage  Lack of Physician Coverage  Maternal medical/obstetrical problem  No beds available  Organization evacuation  Care Closer to Home  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):** Auto-calculates

### MIDWIFERY TAB

If there was transfer of care (without return to care) in a previous encounter:

**Was care of client transferred back to Midwifery during intrapartum?**  Yes  No

### Intrapartum

**Began Intrapartum Period intending to give birth at:**  One  Hospital  
 Home  Birth Centre  Clinic  Other  Nursing Station  Undecided

**Actual Location of Labour: :**  One  Hospital  Home  Birth Centre  Clinic  
(Midwifery)  Other  Nursing Station  Undecided

**Birth Centre of Labour:**  One (select only if labour at Birth Centre)

Ottawa Birth and Wellness Centre  Toronto Birth Centre, Inc.

**Was there unplanned Maternal transport to hospital at any part of the labour?**  Yes  No  Unknown

**Reason(s) for Transport:**  Fetal well-being concerns  Pain Management  Prolonged labour  Maternal request  Provider preference  Other maternal condition/complication  Other fetal condition/complication

**Did EMS attend the labour?**  Yes  No  Unknown

**Primary Reason for Transport:** \_\_\_\_\_ (indicate)

**Barrier to Transport:**  None  Delayed arrival time of EMS  Delayed Departure of EMS  Delay on route  other

**Was EMS used to transport to hospital?**  Yes  No  Unknown

**Did midwife attend the client at home at any point during labour?**

Yes  No  Unknown

**Other care providers present at time of labour and/or birth:**  RN  OB  FP  
 Aboriginal midwife  Midwifery student  Nursing student  Medical student  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 birth or immediate postpartum?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <b>Did EMS attend any part of the birth or immediate postpartum?</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	<i>If vaginal birth: Maternal Position at Time of Birth:</i> <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  <i>If spontaneous vaginal birth: Was the baby born in the water?</i> <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
<i>If vaginal birth: Components of third stage management employed (unrelated to corrective measures for bleeding):</i> <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 labour/birth consultations or transfers of care from the onset of active labour to approximately 1 hour post-birth?</b> Yes_____ No_____	<b>2 consultation records provided. If additional are needed, please attach to record.</b>
<b>Labour/birth consultation/transfer of care reason(s):</b>  <b>Labour/birth consultation(s) with physician?</b> Yes_____ No_____  <b>Labour/birth transfer of care?</b> Yes_____ No_____  <b>Was rationale for consult due to hospital/physician protocol?</b> Yes___ No____ No____  <b>Was rationale for transfer of care due to hospital/physician protocol?</b> Yes_____ No_____  <b>Was transfer of care returned anytime from onset of active labour to approximately 1 hour post-birth?</b> Yes_____ No_____	<b>Labour/birth consultation/transfer of care reason(s):</b>  <b>Labour/birth consultation(s) with physician?</b> Yes_____ No_____  <b>Labour/birth transfer of care?</b> Yes_____ No_____  <b>Was rationale for consult due to hospital/physician protocol?</b> Yes___ No____ No____  <b>Was rationale for transfer of care due to hospital/physician protocol?</b> Yes_____ No_____  <b>Was transfer of care returned anytime from onset of active labour to approximately 1 hour post-birth?</b> Yes_____ No_____
<b>Was the client discharged from midwifery care within approximately the first hour post-birth? (Select yes to discharge client from Midwifery Care and/or bill for Course of Care)</b> Yes_____ No_____	