Logbook-2021

(Undergraduate Competency Based Curriculum)

Department of Obstetrics and Gynaecology

Maulana Azad Medical College,
New Delhi

Logbook-2021

Department of Obstetrics and Gynaecology

Maulana Azad Medical College, New Delhi

(Competency Based Curriculum)



Name of student:
Admission Batch:
University Registration number

(Adapted from Undergraduate Log Book cum Portfolio by FOGSI)

INDEX

S no.	Topic	Page No.
1	Personal Details	4
2	Logbook Certificate	5
3	Attendance Record	6
4	Assessment Record	7
5	Competencies in Obstetrics & Gynaecology	8
6	List of competencies requiring DOAP Sessions/Logbook documentation as per NMC	9-10
7	Glossary and General Instructions	11-12
8	Phase-wise distribution of activities	13
9	Activity 1: Antenatal Case Record	15-22, 41-48, 96-119
10	Activity 2: Gynaecological Case Record	23-26, 49-52, 120-131
11	Activity 3: Learner Doctor Case Record & Discharge Summary Postpartum case	27-39, 82-93, 174-197, 198-207
12	Activity 4: Labour Case Record	53-81, 132- 173
13	Activity 5: Pap smear collection	94
14	Activity 6:Eclampsia drill & referral note	208
15	Activity 7:PPH drill	209
16	Activity 8: Integrated session on Counselling for Breastfeeding	210
17	Activity 9: Counselling for Contraception	211
18	Activity 10: Caesarean section and Informed Consent	212-213
19	Activity 11: Insertion & removal of IUCD	214

20	Activity 12: Urinary Catheterisation	215
21	Activity 13 : Neoborn care	216
22	Record and Assessment of Competencies	217-223
23	Appendix 1	224-227
24	Appendix 2	228-232
25	Appendix 3	233-240
26	Appendix 4	241-246

PERSONAL DETAILS

Name:	
Roll No. & Batch	
Date of Admission to MBBS Course:	
Registration No.(College/University ID):	
Present Address:	
Permanent Address:	
Student's Contact No:	_
Student's Email-id:	

Logbook Certificate

This is to certify that the cand	lidate	
Mr/ Ms		
Reg No		
Admitted in the year		
in (Medical College)		
, ,	has not completed all assignme	ents mentioned in
	se in the subject of Obstetrics an	
during the period from	,	
She / He is / is not eligible to a assessment. Signature of Unit head:	appear for the summative (Univ	ersity)
Signature of Omt nead:		
(Date)		
Countersigned by		
Head of the department:		
Dean :		

Record of Completion and Assessment of Competencies*

*These can be integrated with the case presentations/ demonstrations/ seminars or may be undertaken as standalone activities.

S No.	Competen cy # addressed	Name of Activity	Date complete d: dd-mm- yyyy	Attempt at activity: First (F) Repeat (R) Remedial (Re)	Rating: Below (B) expectations Meets (M) expectations Exceeds (E) expectations OR Numerical Score	Decision of faculty: Completed (C) Repeat (R) Remedial (Re)	Initial of faculty and date	Feedback Received: Initial of Learner and date
1.	OG 5.2 OG 8.2 OG 8.3 OG 8.4 OG 8.6 OG 35.1 OG 35.2 OG 35.3 OG 35.5 OG 35.8 OG 36.1 OG 36.2 PE 18.3	Write a complete case record of an antenatal case with all necessary details Total: 10						
2.	OG 35.1 OG 35.2 OG 35.8 OG 36.1	Write a complete case record of a gynecology case with all necessary details						

_			 			
3.	OG 8.4	Observe				
	OG 13.3	and assist				
	OG 13.5	the conduct				
	OG 15.1	of a normal				
	OG 15.2	vaginal				
	OG 18.2	delivery	 			
	OG 19.2					
	OG 19.4					
	OG 35.5	Total: 10				
	OG 35.8					
	OG 35.13					
	OG 35.14					
	PE 18.4					
	PE 18.5					
4.	OG 17.2	Learner-				
	OG 19.2	Doctor				
	OG 36.1	Method of			l	
1	00 30.1	Wicklind Of				
	OG 35.1	Clinical				
	ı	1				
	OG 35.1	Clinical				
	OG 35.1 OG 35.5	Clinical Training:				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4	Clinical Training: Elicit history, conduct a				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8	Clinical Training: Elicit history, conduct a physical				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination,				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8	Clinical Training: Elicit history, conduct a physical examination, make a				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a differential				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a differential diagnosis,				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a differential diagnosis, formulate a				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a differential diagnosis, formulate a treatment				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a differential diagnosis, formulate a treatment plan and				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a differential diagnosis, formulate a treatment plan and follow up				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a differential diagnosis, formulate a treatment plan and follow up the patient				
	OG 35.1 OG 35.5 OG 35.2 OG 35.3 OG 35.4 OG 35.8 OG 35.9	Clinical Training: Elicit history, conduct a physical examination, make a provisional diagnosis and a differential diagnosis, formulate a treatment plan and follow up				

		you daily monitoring their progress & make a discharge summary of the patient. Total: 10			
5.	OG 35.7 OG 35.11 OG 37.1	Observe and assist in the performance of a Caesarean section with use of SIPP & Informed Consent Total: 1			
6.	OG 35.11	Handwashing and personal protective precautions as DOAP in simulated environment			
7.	OG 13.5 OG 14.1 OG 14.2	Mechanism of labor as DOAP in simulated environment			
8.	OG 8.5 OG 13.4	Conduct of delivery as DOAP in simulated environment			
9.	OG 15.2 a	Instrumenta I delivery vaccum, as DOAP in simulated			

		environment			
10.	OG 15.2 b	Instrumental delivery forceps as DOAP in simulated environment			
11.	OG 15.2 c	Mechanism and conduct of breech delivery as DOAP in simulated environment			
12.	OG 35.4 OG 35.10	Eclampsia Drill followed by a proper referral note Total:1			
13.	OG 35.16	PPH Drill Total: 1			
14.	OG 17.2 PE 7.8 PE 7.9 PE 20.6	Counsel in a simulated environment care of the breast, importance and the technique of breast feeding Total: 1			
15.	OG19.2	Counsel in a simulated environment, contraception and puerperal Sterilisation Total: 1			

16.	OG 33.3	Obtain a						
16.	OG 33.3 OG35.12							
	0033.12	PAP smear						
		in a stimulated						
		environment						
		environment						
		Total: 1						
		Total. 1						
17.	OG 35.15							
	00 33.13	Demonstrate						
		the						
		correct						
		technique						
		to insert						
		and remove an IUD in a						
		simulated/						
		supervised environment						
		environment						
		Total: 1						
18.		Demonstrate						
	OG 35.17	the						
		correct						
		technique						
		of urinary						
		catheterisation						
		in a						
		simulated/						
		supervised						
		environment						
		Total: 1						
19	OG	Demonstrate						
15	35.13	technique of						
	33.13	ARM in						
		simulated						
		environment						
		and observe						
		in labour						
		room					1	
20	OG	Observe						
	35.14	episiotomy,						
		Demonstrate						
		correct						
		technique of						
		episiotomy in						
		simulated						
		environment						
	1		1	ı	1	1	1	1

	T	T .	I		T	I	
21	OG	Write					
	35.17	informed					
		consent for					
		examination /					
		procedure					
22	OG	Referral note					
	35.10						
23	OG 37.2	Observe and					
		assist in					
		performance					
		of					
		laparotomy					
24	OG 37.3	Observe and					
		assist in					
		performance					
		of					
		hysterectomy					
		(abdominal /					
		Vaginal)					
25	OG 37.4	Observe and					
		assist in					
		performance					
		of Dilatation					
		and curettage					
26	OG 37.5	Observe and					
		assist in					
		performance					
		of EA /ECC					
27	OG 37.6	Observe and					
		assist in					
		performance					
		of Outlet					
		forceps					
		application					
		/Vacuum /					
		Breech					
		Delivery					
28	OG 37.7	Observe and					
		assist in					
		performance					
		of MTP in					
		first trimester					
		and					
		Evacuation in					
		incomplete					
		Abortion					
		1 . 1001 (1011	l				

29	OG 38.1	Observe			
		laparoscopy			
30	OG 38.2	Observe			
		Hysteroscopy			
31	OG 38.3	Observe			
		Lap			
		sterilization			
32	OG 38.4	Assess the			
		need and			
		issue proper			
		medical			
		certificate			
33	OG 36.3	Observe			
		punch biopsy			
		and			
		demonstrate			
		in simulated			
		environment			
34	OG 18.2	Demonstrate			
		the steps of			
		neonatal			
		resuscitation			
		in a			
		simulated			
		environment			
35	OG 8.5	Demonstrate			
		Pelvic			
		assessment in			
		a model			
36	OG 14.1	Describe			
		diameter of			
		fetal skull &			
		maternal			
		pelvis			

ATTENDANCE RECORD- CLINICAL POSTING

Phase	Duration	From	To	Remarks	Faculty Signature
Phase-II					
Phase-III,					
Part 1					
Elective					
Phase-III Part-2					
Repeat posting (ifany)					

Competencies in Obstetrics and Gynaecology

There are 10 broad competencies in Obstetrics and 3 in Gynecology which have been divided into 38 topics and 126 outcomes for OBGYN that you need to acquire as per the NMC document for CBME as follows.

(a) Competencies in Obstetrics:

The student must demonstrate ability to:

- Provide peri-conceptional counselling and antenatal care
- Identify high-risk pregnancies and refer appropriately
- Conduct normal deliveries, using safe delivery practices in the primary and secondary care settings
- Prescribe drugs safely and appropriately in pregnancy and lactation
- Diagnose complications of labor, institute primary care and refer in a timely manner
- Perform early neonatal resuscitation
- Provide postnatal care, including education in breast-feeding
- Counsel and support couples in the correct choice of contraception,
- Interpret test results of laboratory and radiological investigations as they apply to the care of the obstetric patient
- Apply medico-legal principles as they apply to tubectomy, Medical Termination of Pregnancy (MTP), Pre-conception and Prenatal Diagnostic Techniques (PC PNDT Act) and other related Acts.

(b) Competencies in Gynecology:

The student must demonstrate ability to:

- Elicit a gynecologic history, perform appropriate physical and pelvic examinations and PAP smear in the primary care setting,
- Recognize, diagnose and manage common reproductive tract infections in the primary care setting,
- Recognize and diagnose common genital cancers and refer them appropriately.

List of competencies requiring DOAP Sessions as per NMC

This is a comprehensive list of competencies requiring DOAP session extracted from NMC document. These can be integrated with the case presentations / demonstrations / seminars or may be undertaken as standalone activities.

	Number	Competency
1.	OG 8.3	Describe, demonstrate, document and perform an obstetrical examination including a general and abdominal examination and clinical monitoring of maternal and fetal well-being
2.	OG 8.4	Describe and demonstrate clinicalmonitoring of maternal and fetal well being
3.	OG 8.5	Describe and demonstrate pelvic assessment in a model
4.	OG 8.6	Assess and counsel a patient in a simulated environment regarding appropriate nutrition in pregnancy
5.	OG 9.2	Describe the steps and observe/ assist in the performance of an MTP evacuation
6.	OG 13.3	Observe/ assist in the performance of an artificial rupture of Membranes
7.	OG 13.4	Demonstrate the stages of normal labor in a simulated environment/mannikin
8.	OG 13.5	Observe and assist the conduct of a normal vaginal delivery
9	OG 14.1	Enumerate and discuss the diameters of maternal pelvis and types
10	OG 14.2	Discuss the mechanism of normal labor, define describe obstructed labor, clinical features prevention and management
11	OG 14.3	Describe and discuss rupture uterus, causes, diagnosis and management
12	OG 15.2	Observe and assist in performance of episiotomy, demonstrate correct suturing technique of episiotomyin a simulated environment. Forceps, CS, vaccum, breech delivery
13	OG 17.2	Counsel in a simulated environment care of the breast, importance and technique of breast feeding
14	OG 18.2	Demonstrate the steps of new-borncare in a simulated environment

15	OG 19.2	Counsel in a simulated environment contraception and puerperal sterilisation
16	OG 19.3	Observe assist in performance of tubal ligation
17	OG 19.4	Enumerate the indications, describe the stepsin insertion and removal of IUCD
18	OG 20.2	In a simulated environmentadminister informed consent to a person wishing to undergo MTP
19	OG 33.3	Describe and demonstrate the screening of cervical cancer in a simulated environment
20	OG 35.11	Demonstrate the correct use of appropriate universal precautions for self-protection against HIV and hepatitis and counsel patients
21	OG 35.12	Obtain a PAP smear in a stimulated environment
22	OG 35.13	Demonstrate the correct technique to perform artificial rupture of membranes in a simulated / supervised environment
23	OG 35.14	Demonstrate the correct technique to perform and suture episiotomies in a simulated/ supervised environment
24	OG 35.15	Demonstrate the correct technique to insert and remove an IUD in a simulated/ supervised environment
25	OG 35.16	Diagnose and provide emergency management of antepartum and postpartum hemorrhage in a simulated / guided environment
25	OG 35.17	Demonstrate the correct technique of urinary catheterisation in a simulated/ supervised environment
26	OG 37.1	Observe and assist in the performance of a Caesarean section
27	OG 37.6	Observe and assist in the performance of outlet forceps application of vacuum and breech delivery
28	OG 37.7	Observe and assist in the performance of MTP in the first trimester and evacuation in incomplete abortion

Glossary & General Instructions

Log Book:

Logbook is defined as a verified record of the progression of the learner documenting the acquisition of the requisite knowledge, skills, attitude and/ or competencies. Log book is the most important tool that will help us achieve successful implementation of the key aspects of the new Competency Based UG Curriculum—we hope you understand the importance of maintaining it meticulously. It is a record of all your learning that takes place and the competencies acquired by you. It also forms an integral part of your internal assessment /formative assessment and your eligibility for appearing in the final summative assessment. Successful documentation and submission of the logbook is a prerequisite for being allowed to take the final summative examination (GMER 11.1.1.b.7).

Portfolio:

A portfolio is an evidence of events documented in the logbook along with selected assignments, self-assessment, feedback, work-based and in-training formative assessments, reflections and learnings from planned activity in the curriculum.

Students please note:

- The logbook is a record of the academic / co-curricular activities of the designated student, who would be responsible for maintaining his/her logbook.
- The student is responsible for getting the entries in the logbook verified by the designated faculty regularly.
- Entries in the logbook will reflect the activities undertaken in the department & have to be scrutinized by the Head of the concerned department.
- d) The logbook should be verified by the college before submitting the application of the students for the University examination.

Activity:

This term refers to a predefined task performed by learners that contributes to the achievement of stated objectives or competencies.

Remedial:

Remedial is a planned activity aimed at correcting deficits that prevent a learner from achieving an intended outcome.

Feedback:

Feedback is a formal active interaction performed at the completion of an observed activity (or activities) intended to facilitate positive change, growth and improvement of the learner through guided reflection of activities performed.

Understanding the logbook activity table:

S No.	Competency	Name	Date	Attempt	Rating:	Decision	Initial	Feedback
	# addressed	of	completed:	at	Below (B)	of faculty:	of	Received:
		Activity	dd-mm-	activity:	expectations	Completed	faculty	Initial of
			уууу	First	Meets (M)	(C)	and	Learner
				(F)	expectations	Repeat	date	and date
				Repeat	Exceeds (E)	(R)		
				(R)	expectations	Remedial		
				Remedial	OR	(Re)		
				(Re)	Numerical			
					Score			
1.								
2.								
3.								
4.								
5.								
6.								
7.			·					

- The number of the competency addressed, includes the subject initial and number (from Volume III of the UG Curriculum) e.g. OG 2.1
- 2. Name of activity: Seminar / Small Group Discussion/ Skills Lab / Drill / Role Play
- 3. Date the activity gets completed
- 4. Attempt at activity by learner, indicate if:
 - a. First attempt (or) only attempt
 - Repeat (R) of a previously done activity
 - Remedial activity (Re) based on the determination by the faculty
- Rating, use one of the following three grades:
 - a. Below expectations (B)
 - b. Meets expectations (M)
 - c. Exceeds expectations (E)
- 6. Decision of faculty
 - a. C: activity is completed, therefore closed and can be certified, if needed
 - R: activity needs to be repeated without any further intervention
 - Re: activity needs remedial action (usually done after repetition did not lead to satisfactory completion)
- 8. Initial (Signature) of faculty indicating the completion or other determination
- Initial (Signature) of the learner if feedback has been received.

Phase wise distribution of activities

PHASE	ACTIVITY	NUMBER
Phase II	Antenatal case history record	2
	Gynaecological case history	1
	Learner doctor history record	2
	Hand washing and personal protective precautions as DOAP in simulated environment	1
Phase III, part 1	Antenatal case history record	2
	Gynaecological case history	1
	Learner doctor history record	2
	Labour record	4
	Obtain a pap's smear in simulated environment	1
Phase III, part 2	Antenatal case history record	6
	Gynaecological case history	3
	Learner doctor history record {postpartum cases- 2(PNC& Peurperium)}	6
	Labour record	6
	Mock Drill Eclampsia	1
	Mock Drill PPH	1
	Counseling for breast feeding as DOAP in simulated environment	1
	Counseling for contraception as DOAP in simulated environment	1
	Cesarean section record with informed consent with documentation	1
	IUCD insertion and removal	1
	Urinary catheterization as DOAP in a simulated environment	1
	Neoborn resuscitation	1
	Mechanism of conduct of normal delivery and assisted breech vaginal delivery in a simulated environment	



Activity 1: Antenatal Case Record

Competencies addressed: OG 5.2, OG 8.2, OG 8.3, OG 8.4, OG 8.6, OG 35.1, OG 35.2, OG 35.3, OG 35.5, OG 35.8, OG 36.1, OG 36.2

Write a complete case record of an antenatal case with all necessary details

You are required to use the basic format as given in appendix 1 to elicit and document case histories of antenatal patients as given in phase-wise distribution table.

Antenatal Case Record 1

Patient Identification Data and Demography:
Chief Complaints:
History of Present Complaints: (ODP)
History of present pregnancy: (Trimester-wise)

Status	Ot.	vaccu	nat	ion.
Julius	•	Vacci	ma.	

Menstrual History:

G_ P_ A_ L_MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum/	Baby
	Year,	factor in	Delivery/	operative delivery	(Sex/Apgar/	post abortal	vaccina-
	gestational	pregnancy	Abortion		Weight)	complications	tion
	age at					If any	
	delivery						

Contraceptive History:							
Famil	y History:						
Personal & Social History:							
Drug	History/ Me	edication Hist	ory / Aller	rgy:			
Past I	listory:						

General Examination:	
Systemic Examination:	
Cardiovascular system:	
Respiratory system:	
Nervous system:	
Obstetrical Examination :	
Interpretation based on palpation	
Per speculum examination: (if indicated)	
Per vaginal examination: (when indicated)	
Delivior at the Africa disease di	
Pelvimetry: (if indicated)	
Provisional Diagnosis :	

Plan of delivery:

Investigations:		
Risk factors identified:		
Final diagnosis:		
Summary:		
Advice:		
Follow up :		

Antenatal Case Record 2

Patient Identification Data and Demography:	
Chief Complaints:	
ciner complaints.	
History of Present Complaints: (ODP)	
History of present pregnancy: (Trimester-wise)	
The second programme, (The second programme)	

Status of vaccination:

Menstrual	History	<i>i</i> :
-----------	---------	------------

G_ P_ A_ L_ MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum/	Baby
	Year,	factor in	Delivery/	operative delivery	(Sex/Apgar/	post abortal	vaccina-
	gestational	pregnancy	Abortion		Weight)	complications	tion
	age at					If any	
	delivery						

Cont	raceptive Hi	story:				
Fami	ly History:					
Perso	onal & Socia	l History:				
Drug	History/ Me	edication Hist	tory / Aller	rgy:		
Past	History:					

General Examination:
Systemic Examination:
Cardiovascular system:
Respiratory system:
Nervous system:
Obstetrical Examination :
Interpretation based on palpation
Per speculum examination: (if indicated)
Per varinal evaminations (when indicated)
Per vaginal examination: (when indicated)
Pelvimetry: (if indicated)
Provisional Diagnosis :

Plan of delivery:

Investigations:
Risk factors identified:
Final diagnosis:
Summary:
Advice:
Follow up :

Activity 2: Gynecological Case Record

Write a complete case record of a gynecological case with all necessary details Competencies addressed: OG 35.1,OG 35.2, OG 35.8, OG 36.1 You are required to use this basic format to elicit and document case histories of gynecological patients
Gynecological Case Record 1
Patient identification data & demography:
Chief Complaints:
History of Presenting Illness: (ODP)
Past History:
Personal History:

Medication History / Allergies :
Family History:
Menstrual History:
Obstetrical History:
General Examination:
Systemic Examination: Respiratory System:
Cardiovascular System:
Central Nervous System:
Per Abdomen Examination:

Local Genital Examination:
Per Speculum Examination:
Per Vaginal Examination:
Per-Rectal Examination (if required):
Provisional Diagnosis
Differential Diagnosis

S No.	Diagnosis	Points for	Points Against

Case Summary:

Investigations:	
Final Diagnosis:	
Treatment Plan:	
Follow-Up:	

Activity 3: Learner Doctor Case Record

Competencies addressed: OG 17.2, OG 19.2, OG 36.1, OG 35.1, OG 35.5, OG 35.2, OG 35.3, OG 35.4, OG 35.8, OG 35.9, OG 35.10,

The student is expected to elicit history, conduct a physical examination, make a provisional diagnosis and a differential diagnosis, formulate a treatment plan and follow up the patient allotted to them daily monitoring their progress. All this activity has to be documented in the logbook including the discharge summary of the patient. You have to document 10 such cases.

Learner Doctor Case Record 1

Name of the patient :
Type of admission : OPD / emergency / referral / Booked / Unbooked
Date of Admission:
Date of Discharge:
Date of Delivery/ Surgery:
Outcome of patient:
Chief Complaints:
History of present illness in detail:

Menstrual history:							
Active ma	rriage life:						
Obstetric	History: GF	PAMTP	L				
	Type of Delivery	Gestational Age	Live birth/	Current age of	Breast- feeding	Vaccination	
			stillbirth/ neonatal	child			
			death		+		
1 st							
2 nd							
3 rd							
4 th					1		
5 th							
6 th							
Number	of live children:	:					
History of	f contraception	usage:					
Past Histo	orv:						
	1.						
Family History:							
Personal & Social History:							
Medication History:							

Examination

General Examination:
Vitals:
Systemic Examination:
Per abdomen examination:
Per Speculum examination:
Per vaginal examination:
Provisional Diagnosis:
Investigations suggested:

Treatment Plan: (Pharmacological and Non-Pharmacological including special nursing care)	
Differential Diagnosis:	
Treatment Received:	

Daily Monitoring Chart: (to be filled by student -doctor on daily basis)

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice modified (if any)

Final Appraisal:

Discharge Summary

Patient Name:	Hospital indoor no.:
Age:	
Address:	
Final Diagnosis	
DOA:	
DOD:	
Date of Procedure/ Operation:	
Indication of Procedure/ Operation	
Patient's condition on admission:	
Treatment Provided:	
Delivery / Breedure / OT notes summers	
Delivery / Procedure / OT notes summary:	
Condition on Discharge:	
• · · · · · · · · · · · · · · · · · · ·	
Advice on Discharge: (Pharmacological / Non-pharmacological /	ogical)
Date of next follow up:	
When & How to obtain Urgent care	
The state of the s	

Learner Doctor Case Record 2

Name of the patient :
Type of admission : OPD / emergency / referral / Booked / Unbooked
Date of Admission:
Date of Discharge:
Date of Delivery/ Surgery:
Outcome of patient:
Chief Complaints:
History of present illness in details:

Patient Identification Data & Demography

Menstrua	l history:					
Active ma	rriage life:					
Obstetric	: History: GF	PAMTP	L			
	Type of	Gestational	Live	Current	Breast-	Vaccination
	Delivery	Age	birth/	age of	feeding	Vaccination
	,		stillbirth/	child		
			neonatal			
			death			
1 st						
2 nd					+	
3 rd						
4 th						
5 th						
6 th						
Number	of live children:					
History o	f contraception	usage.				
1113101 y 0	r contraception	usage.				
Past Hist	ory:					
Family Hi	story:					
Personal	& Social History	y:				
	!!!-					
iviedicati	on History:					

Examination

General Examination:
Vitals:
Systemic Examination:
Per abdomen examination:
Per Speculum examination:
Per vaginal examination:
Provisional Diagnosis:
Investigations suggested:

Treatment Plan: (Pharmacological and Non-Pharmacological including special nursing care)
Differential Diagnosis:
Treatment Received:

Daily Monitoring Chart: (to be filled by student -doctor on daily basis)

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice modified (if any)

Final Appraisal:

Discharge Summary

Patient Name: Age:	Hospital indoor no.:
Address:	
Final Diagnosis	
DOA:	
DOD: Date of Procedure/ Operation:	
Indication of Procedure/ Operation	
Patient's condition on admission:	
Treatment Provided:	
Delivery / Procedure / OT notes summary:	
Condition on Discharge:	
Advice on Discharge: (Pharmacological / Non-pharmacolo	ogical)
Date of next follow up:	

Hand washing and personal protective precautions as DOAP in simulated

environment

Done –

Not done -

Phase-3

Part - 1

Antenatal Case Record 3

Patient Identification Data and Demography:					
Chief Complaints:					
History of Present Complaints: (ODP)					
History of present pregnancy: (Trimester-wise)					

Status of vaccination:

	_			
Mens		1111-4		
IVIER	STP II S	HIST		۰
I VII CITE		1113	~ .	

G_ P_ A_ L_MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-
	gestational	pregnancy			Weight)	If any	tion
	age at						
	delivery						

Contraceptive History:
Family History:
Personal & Social History:
Drug History/ Medication History / Allergy:
Past History:

General Examination:	
Systemic Examination:	
Cardiovascular system:	
,	
Respiratory system:	
Nervous system:	
Obstetrical Examination :	
Interpretation based on palpation	
Per speculum examination: (if indicated)	
Per vaginal examination: (when indicated)	
Pelvimetry: (if indicated)	
Provisional Diagnosis :	

Investigations:	
Risk factors identified:	
Final diagnosis:	
Summary:	
Advice:	
Follow up :	
Plan of delivery:	

Antenatal Case Record 4

Patient Identification Data and Demography:
Chief Complaints:
Chief Complaints.
History of Present Complaints:
History of present pregnancy: (Trimester-wise)

Status of vaccination:

	-		 		
MAG	net	2113	 cto	-	
Me	II S L	ua	 310	·v	

G_ P_ A_ L_ MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-
	gestational	pregnancy			Weight)	If any	tion
	age at						
	delivery						

Contraceptive History:	
amily History:	
Personal & Social History:	
Orug History/ Medication History:	
Past History:	

General Examination:
Systemic Examination:
Cardiovascular system:
Respiratory system:
Nervous system:
Obstetrical Examination :
Interpretation based on palpation
Per speculum examination: (if indicated)
Per vaginal examination: (when indicated)
rei vaginai examinationi (when maleatea)
Pelvimetry: (if indicated)
Provisional Diagnosis :

Investigations:		
Risk factors identified:		
Final diagnosis:		
Summary:		
Advice:		
Follow up :		

Plan of delivery:

Gynecological Case Record 2

Patient identification data & demography:
Chief Complaints:
History of Presenting Illness: (ODP)
Past History:
Personal History:
Drug History/ Medication History / Allergy:
Family History:
Menstrual History:

Obstetrical History:
General Examination:
Systemic Examination: Respiratory System:
Cardiovascular System:
Central Nervous System:
Per Abdomen Examination:
Local Genital Examination:
Per Speculum Examination:

Per Vaginal Examination:
Per-Rectal Examination (if required):
Provisional Diagnosis
Flovisional Diagnosis
Differential Diagnosis

S No.	Diagnosis	Points for	Points Against
-+			

Investigations:

Final Diagnosis:		
Treatment Plan:		
Follow-Up:		
Case Summary:		

Activity 4: Normal labour Case Record

Competencies addressed: OG 8.4, OG 13.3, OG 13.5, OG 15.1, OG 15.2, OG 18.2, OG 19.2, OG 19.4, OG 35.5, OG 35.8, OG 35.13, OG 35.14, PE 18.4, PE 18.5

Observe and assist the conduct of a normal vaginal delivery

You are required to observe/assist in the management of 10 cases of normal labour using the following format including the WHO labor care guide. The labor care guide is available in the labor room and is to be filled and attached to the logbook.

The following format maybe used: Antenatal case history, labor management, conduct of second and third stages, postnatal advice and follow up for each patient.

Normal Labor Case Record 1

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Menstrual History:

Past Obstetrical History:

Gestational Age(GA) By L.M.P: By U.S.G :
Past History
Family History
Social and Personal History
Medication History , Allergies :
Contraceptive History:

General Examination

Systemic Examination
Abdominal Examination
Local Examination of Genitalia
Per-Speculum Examination (if required):
Per-Vaginal Examination and Pelvimetry :
Investigations

58 58

Labour notes:

Spontaneous / augmented
If induced: ARM / Syntocinon / PG/ Foley's
Indication of induction/augmentation

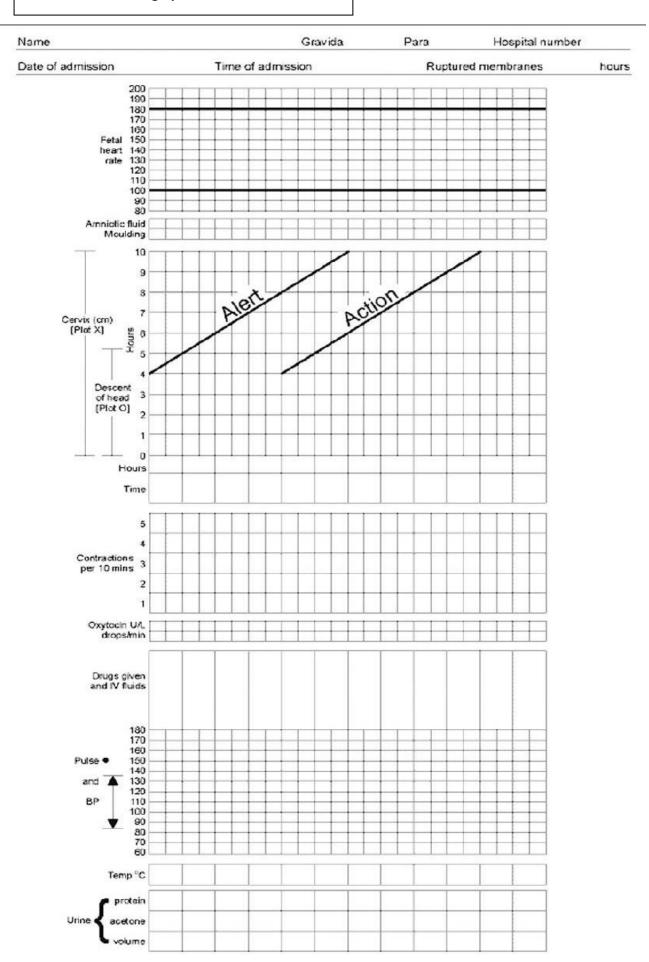
Stages of Labour	Time Started	Time Finished	Duration Lasted
Stage I			
Stage II			
Stage III			
Mode of Delivery (Normal	/Forceps / Assisted	Breech/ Caesarean) Note in brief
AMTSL:			
Date and Time:			
Conducted By:		Assisted By:	
Supervised By:			
Examination of Placenta:			
Intra Partum or Post Part	um Maternal Comp	lications:	

Date and Time

Baby Notes

No.
Sex
Cried Immediately after Birth- Y/N
Weight
APGAR Score at 1min
APGAR Score at 5min
NICU Admission
Duration of Stay In NICU

WHO Modified Partograph



WHO LABOUR CARE GUIDE

Nam							Parity	, I	abour ons	et				Active labo	ur diagr	osis [Date			
Rup	tured membra	Time	10	Time] Risk	factors	1	10	7	3	10	12			:		:		
		Hours		1	2	3					8	9 1	10	11 12			1		2	
_		ALERT	-	_			A	CTIVE FI	RST STA	GE —			1			- SE	CONI) STA	GE -	-
CARE	Companion	N																		
LIVE	Pain relief	N																		
SUPPORTIVE CARE	Oral fluid	N													15		100			
SUF	Posture	SP													3					
	Baseline FHR	<110, ≥160																		
	FHR	L														Ħ				
_	deceleration Amniotic fluid	1		+	-	-	-	-				-		+ +	- 1	H		-	-	
BABY	Fetal position															-		- Y Y		
	Caput	+++												1	0.				-	
	Moulding	+++		1 = -																
=	170	_		1																_
	Pulse	<60, ≥120													_	-				<u> </u>
IAN	Systolic BP	<80, ≥140		-		-	-								-				_	<u> </u>
WOMAN	Diastolic BP	≥90		-																<u> </u>
	Temperature °	231.3												-	-	<u>_</u>				_
_	Urine	P++, A++		<u> </u>																
	Contractions per 10 min	≤2, >5																		
	Duration of contractions	<20,>60																		
	10			Ħ												Ħ	Ħ	Ħ		Ħ
	9	_													ln -	active	first s	tage,	plot ')	K' to
ESS	Cervix 8 [Plot X]	600000000									In active first stag record cervical dil triggered when l								tion. A	Alert for
ROGR	6			ļ .										1	CI	ırrent	cervic	al dila	tatior	n is
LABOUR PROGRESS	5	3		-											seco	nd sta whe	ge, ins n push	ert P	to in	s. In dicate
AB0	5															T	Pus		9	
_	4														-		77			
	Descent 3																			
	[Plot O] 2																			
	1													-						
	0															_			_	_
N	Oxytocin (U/	L, drops/min)																		
MEDICATION	Medicine																			
/EDI	Wedicine														, E					
	IV fluids																			
SNI	ASSESSMEN	T																		
-MAK																				
SION																				
DECI																				
SHARED DECISION-MAKING																				
SHA	PLAN																			
_																			<u>_</u>	
	INITIALS																			

INSTRUCTIONS: CRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE "ALERT" COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF DABOUR EXTENDS BEYOND 12H, PLASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y - Vis, N - No, D - Decland, U - Unknown, SP - Supine, MO - Mobile, E - Early, L - Late, V - Variable, I - Intact, C - Clear, M - Meconium, B - Bood, A - Anterior, P - Proteiner, T - Transverse, P - Protein, A - - Accisione

C - World Health Organization, 2021. Some rights reserved. Likence (CC BY-NC-SA 3, 0 IGO). The WHO Labour Care guide should be used in conjunction with the User's Manual, Responsibility for the inserpretation and use of the material lies with the reader in no event shall the WHO be liable for damages artising from its use.

Advice on Discharge : (pharmacological / Non pharmacological)	
Follow Up:	
Final Summary:	

Normal Labor Case Record 2

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Menstrual History:

Past Obstetrical History:
Gestational Age(GA) By L.M.P: By U.S.G:
Past History
Family History
Social and Personal History
Medication History / Allergy :
Contraceptive History:
General Examination

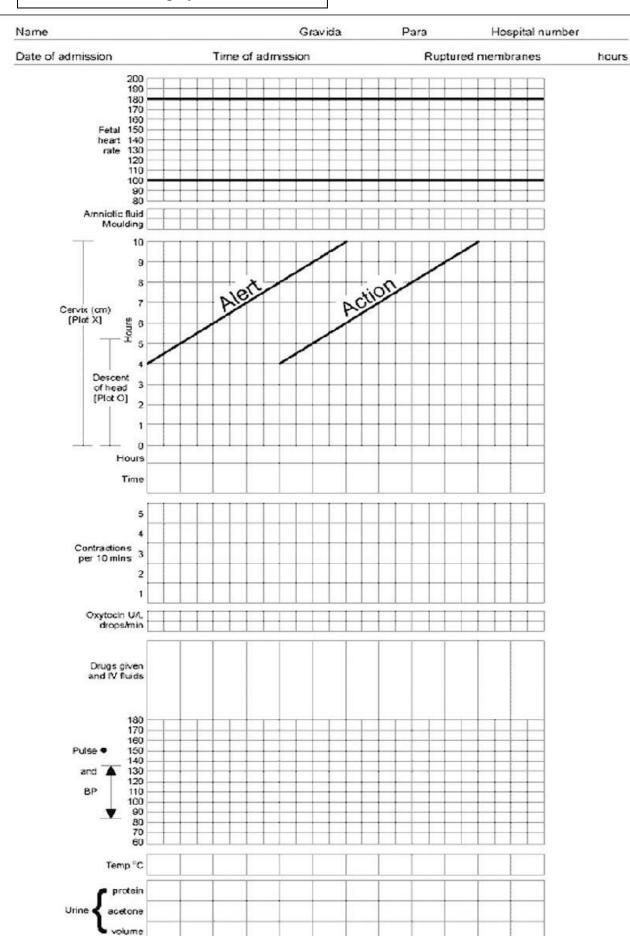
Systemic Examination
Abdominal Examination
Local Examination of Genitalia
Per-Speculum Examination (if required):
Per-Vaginal Examination and Pelvimetry :
rei-vaginal examination and reivinietry.
Investigations

Labour notes:

Spontaneous / augmented If induced: ARM / Syntocinon / PG/ Foley's Indication of induction/augmentation

Stages of Labour	Time Started	Time Finished	Duration Lasted
Stage I			
Stage II			
Stage III			
Mode of Delivery (Normal/Forceps / Assisted Breech/ Caesarean) Note in brief			
AMTSL:			
Date and Time:			
Conducted By:		Assisted By:	
Supervised By:			
Examination of Placenta:			
Intra Partum or Post Partum Maternal Complications:			
mita i artam of i ost i artam maternal complications.			
Baby Notes			
No.		Date	and Time
Sex			
Cried Immediately after Bir	rtn- Y/N		
Weight APGAR Score at 1min			
APGAR Score at 5min			
NICU Admission			
Duration of Stay In NICU			

WHO modified Partograph



WHO LABOUR CARE GUIDE

Nam	P						Parit	v I	Labour ons	et				Active labo	ur diann	nsis [[)ate			
		ranes [Date		Time] Risk		у .	Labour Oils					Active labe	ui uiugii	טון נונט	Jacc			
nup	ureu memi	ianes [Date		s i i i i i	• 12	1 1113K	iactors													
		Time	1 11	- 1	- 0	1		- 10	10	- 1	- 10	- 2		1						
		Hours		1	2	3	4	5	6	7	8	9	10 1	1 1	1		1		2	
		ALERT	•	4			A	CTIVE FI	RST STA	GE		i i j		<u> </u>	_	- SEC	CONE) STA	GE -	-
ARE	Companio	n N																		
INE (Pain relief	f N																		
PORT	Oral fluid	N															2			
SUPPORTIVE CARE	Posture	SP													5		z.			
7-	Baseline FHR	<110, ≥16																		
	FHR FHR deceleration	(200)														Н		H		
>	Amniotic flu	- 2	1		++		<u> </u>	-					H	_		H	-	Н		1
BABY	Fetal position	-			-															
	275	7	-													\vdash				
	Caput	+++																		
_	Moulding		1	<u> </u>	_	1										닏		<u> </u>		
	Pulse	<60, ≥120			2													<u> </u>		
AN	Systolic B	- 100 			-											Ш				
WOMAN	Diastolic B				1															
_	Temperature	°C <35.0, ≥37.5														Ш				
	Urine	P++, A++													L					
	Contraction per 10 min	ns ≤2, >5																		
	Duration c	of _20 >60																		
		10	+	+	+-	+	+ -			-					Ħ	Ħ	Ħ	Ħ		\vdash
		9 ≥ 2h													ln a	ctive	first s	tage	olot ')	C' to
SS	Cervix	8 ≥ 2.5h													reco	ord cer	rvical	dilata	tion.	Alert
OGRE	[Plot X]	7 ≥ 3h													cu	rrent	cervic	al dila	tation	is .
R PR	-	6 ≥ 5h 5 ≥ 6h		-	-										In a reco tri cu exc secor	id stag	ge, ins	ert P	to in	s. in dicate
LABOUR PROGRESS		0000000	_		+											wner	n pusn	ning be	egins.	
_	1	5 4	-	7	+	-	1							-	-		-	-		_
	Descent	3			_	-									-		-			
	[Dlot O] -	2																		
	1 SE	1																		
		0																		
z	Oxytocin (U/L, drops/min																		
MEDICATION																				
Œ	Medicine																			
_	IV fluids																			
																-				
NG	ASSESSME	NT														-				
MAK																-				
-NOI																				
SHARED DECISION-MAKING			1		1								1				0			
RED [
SHA	PLAN																			
_												-0								
	INITIALS																			

INSTRUCTIONS: CRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE "ALERT" COLUMNI, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKENLIF LABOUR EXTENDS BE YORD 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y - Yes, N - No, D - Decidined, U - Unknown, SP - Supine, MO - Mobile, E - Early, L - Late, V - Variable, I - Intact, C - Clear, M - Meconium, B - Blood, A - Anterior, P - Posterior, T - Transverse, P - Protein, A - - Actenine

Of World Health Granization, 2021, Some rights reserved. Likence (CC BY-NC-SA 3.0 (GO), The WHO Labour Care guide should be used in conjunction with the User's Manual, Responsibility for the Interpretation and use of the material lies with the reader in no event shall the WHO be liable for damages arising from its use.

Advice on Discharge: (pharmacological / Non pharmacological)

Follow Up:

Final Summary:

Normal Labor Case Record 3

Patient identification data:

Chief Presenting Complaints:	
History of Present Illness:	
History of Presenting Pregnancy:	
Menstrual History:	

70 70

Past Obstetrical History:

Gestational Age(GA) By L.M.P: By U.S.G:
Past History
Family History
Social and Personal History
Medication History / Allergy :
Contraceptive History:

General Examination

Systemic Examination	
Abdominal Examination	
Local Examination of Genitalia Per-Speculum Examination (if required):	
rer-speculati examination (ii required).	
Per-Vaginal Examination and Pelvimetry :	
Investigations	

Labour notes:

Spontaneous / augmented

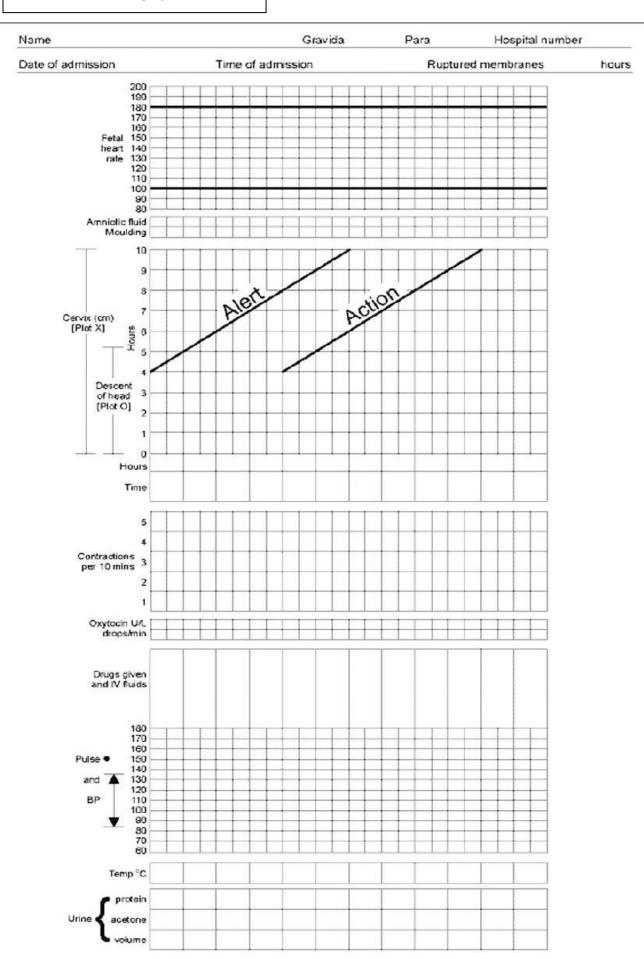
APGAR Score at 1min APGAR Score at 5min NICU Admission

Duration of Stay In NICU

If induced: ARM / Syntocinon / PG/ Foley's Indication of induction/augmentation

Stages of Labour	Time Started	Time Finished	Duration Lasted
Stage I			
Stage II			
Stage III			
Mode of Delivery (Norma	al/Forceps / Assiste	d Breech/ Caesarea	n) Note in brief
AMTSL:			
Date and Time:			
Conducted By:		Assisted By:	
Supervised By:			
Examination of Placenta:			
Intra Partum or Post Par	tum Maternal Com	plications:	
Baby Notes			
No. Sex		Date	e and Time
Cried Immediately after Weight	Birth- Y/N		

WHO Modified Partograph



WHO LABOUR CARE GUIDE

Nam	ie											1	Parity	y	ļ	Labou	ir ons	et							Acti	ve la	bour	diagn	osis [Date]
Rup	tured memb	ranes	[Date			Ti	ime			1	Risk f	actor	s																					
			Time	80	-	-	-						:		80			٠	-	4		•	1	10		0					-	_		
			Hours		1		2		-	3	-	1	_	5		6		7	8		9		10		11	•	12			1	÷	2	9	
			ALERT	•					_						VE FI											-	-	•	- SE	COI	ND !			→
RE	Companio	n	N		Т		Ī						-	Γ							Ť		Ī		T					T			LOA-OL	
/E CA	Pain relie		N		+									\vdash																\vdash	_	\forall		
ORTIV	Oral fluid		N		\top									\vdash					-													\top		- 3
SUPPORTIVE CARE	Posture		SP				*				- 3																	8						
	Baseline FHR	<1	10, ≥160																															
	FHR deceleration	n	E																															
ВУ	Amniotic flu	uid M	l+++, B																												Τ			
BABY	Fetal position	on	P, T						- 3								,		- 53	7	3		- 3	9	3	0"				80				
	Caput	7	+++		1									Т									T					1.			T			
	Moulding		+++		- 6									Г					- 6								-			30				9 - 1
	Pulse	-6	50, ≥120		Ť		T							H							1		+		4		7		\equiv	T	Ť	寸		H
	Systolic Bl	-	30, ≥120		+						_			\vdash			_		7		:-		+				-	-		+	+	+		_
MAN	Diastolic B		177		+		-		-		_		_	\vdash			_		-		-				+		+	-		+	+	+		_
WOMAN	16000000000000000000000000000000000000	8: 11	≥90 <35.0.		+		-		-					╁			-		- 1				+		-		-	-		+	+	+		-
	Temperature	Tilesea	<35.0, ≥ 37.5		+		+		_		-		_	⊢					-		-		+		+		-	-		+	+	+		-
_	Urine		++, A++		+	-	_	_						H	,		,			- 7		-	+	-	+	-	4	H	H	Ļ	+	\perp	-	H
	Contraction per 10 min		≤2, >5																												Ш	Ш		
	Duration of contraction	of ns <	20,>60																															
		10		- 10	T	305								Г								03,	Ī		Ī	20.		П	П	П	Т	П		
	I		≥ 2h																									In a	ictive	firs	t sta	ge, p	lot ')	í to
ESS	[Plot Y] -	100	≥ 2.5h		+					_				L									+		-			reco	ord ce igger irrent	rvice ed w	al dil /hen	atati lag t	ion. /	Vert for
ROG			≥ 3h ≥ 5h		+		-		-					╁				1	11		9		,		50		-	exc	rrent	cerv d wi	ical th no	dilat o pro	ation	is s. In
UR P	1 3-		≥ 6h		+						-			\vdash					-				-					secon	id sta whe	ge, i	nseri	t 'P' i g beg	to in	dicate
LABOUR PROGRESS		5			十		1				_			H			_						t		Ť		1			T	1	T		
Second .	l de	4			+									t	_		_													+	$^{+}$	7		
	Descent	3																																
	I 1	2			4									L									1							L	1	4		
	1	1					-		-					L							-		-		-			_		_	+	4		
=		0			+		_	_	_		_			_					_				+		1		4		<u> </u>	<u> </u>	_	4		Щ
NO	Oxytocin (U/L, dro	ops/min)																															
MEDICATION	Medicine																																	
M	IV fluids				1																													
SHARED DECISION-MAKING	ASSESSME	NT																																
_	INITIALS				<u> </u>																<u> </u>				<u> </u>						_	<u> </u>		

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE. Abbreviations: Y - Yes, N - No, D - Declined, U - Unknown, SP - Supine, MO - Mobile, E - Early, L - Late, Y - Variable, I - Intact, C - Clear, M - Meconium, B - Blood, A - Anterior, P - Posterior, T - Transverse, P+ - Protein, A+ - Acetone

© World Health Organization, 2021. Some rights reserved. Licence (CC BY-NC-SA 3.0 IGO). The WHO Labour Care guide should be used in conjunction with the User's Manual. Responsibility for the interpretation and use of the material lies with the reader. In no event shall the WHO be liable for damages arising from its use.

Advice on Discharge : (pharmacological / Non pharmacological)
Follow Up:
Final Summary:

Normal Labour Case Record 4

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Menstrual History:

Past Obstetrical History:
Contational Academy
Gestational Age(GA) By L.M.P: By U.S.G:
Past History
Family History
Social and Personal History
Medication History , Allergies :
Contraceptive History:
General Examination

Systemic Examination
Abdominal Examination
Local Examination of Genitalia
Per-Speculum Examination (if required):
Per-Vaginal Examination and Pelvimetry :
Investigations

Labour notes:

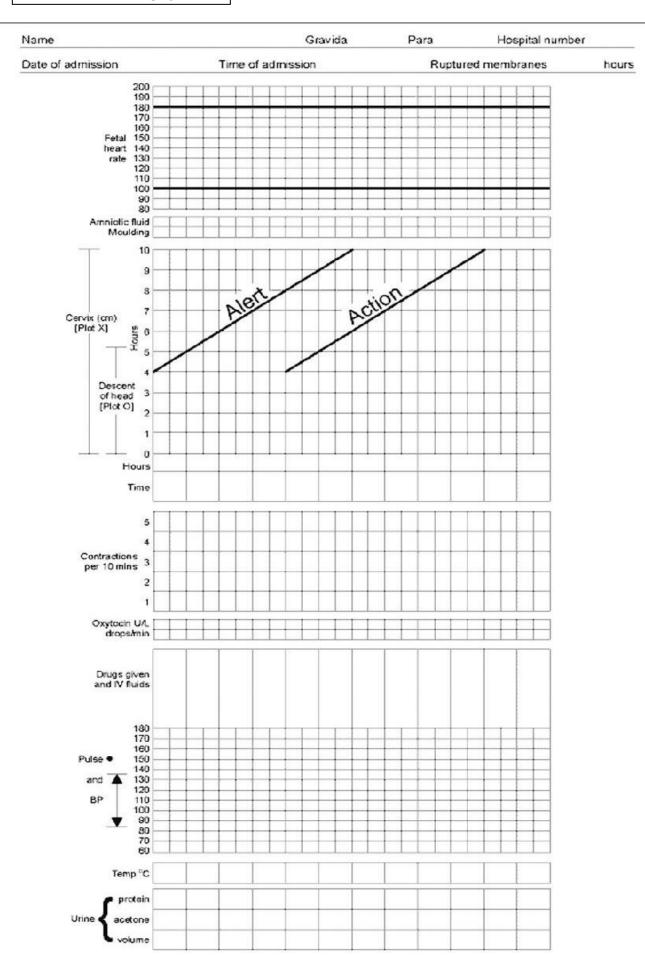
Spontaneous / augmented If induced: ARM / Syntocinon

Duration of Stay In NICU

If induced: ARM / Syntocinon / PG/ Foley's Indication of induction/augmentation

Stag	es of Labour	Time Started	Time Finished	Duration Lasted
I.	Stage			
II.	Stage			
III.	Stage			
Mode	e of Delivery (Norr	mal/Forceps / Assisted	d Breech/ Caesarea	n) Note in brief
AMTS	iL:			
Date	and Time:			
Cond	ucted By:		Assisted By	:
Super	vised By:			
Exam	ination of Placent	a:		
Intra	Partum or Post P	artum Maternal Com	plications:	
Baby	Notes			
No.			Date	and Time
Sex	I	- Pi-st- W/N		
Cried Weigh	Immediately afte	r Birth- Y/N		
_	R Score at 1min			
	R Score at 5min			
NICU	Admission			

WHO Modified Partograph



WHO LABOUR CARE GUIDE

Time	
ACTIVE FIRST STAGE SECOND SECOND	2
Bascline	
Bascline	
Basedine	
Basedine	
First Comparison First	
FIFE	
Note	
Fetal position P,T	1111
Caput	
Moulding	+
Pulse	-
Systolic BP	
Distolic BP 290	
Urine P++, A++	
Urine P++, A++	+
Contractions 22, >5	+
Duration <20,>60	
Duration <20,>60	
Cervix	
Section Page Page	
Descent	t 'P' to indica
Descent 3 2 1 1 1 1 1 1 1 1 1	
Plot O 2	
O	
Oxytocin (U/L, drops/min)	+
Medicine	+
IV fluids	
IV fluids	
ASSESSMENT PLAN	
BO BLAN PLAN	
INITIALS	

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMIN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BYOND 124, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y - Vs, N - No, D - Declined, U - Unknown, SP - Supine, MO - Mobile, E - Early, L - Late, V - Variable, I - Intact, C - Clear, M - Meconium, B - Blood, A - Anterior, P - Poterior, T - Transverse, P a - Protein, A - - Actenine

V World Health Organization, 2021. Some rights reserved. Likence (CC BY-NC-SA 3, 01GO). The WHO Labour Care guide should be used in conjunction with the Uzer's Manual. Responsibility for the inserpretation and use of the material lies with the reader in no event shall the WHO be liable for damages artising from its use.

Advice on Discharge: (pharmacological / Non pharmacological)

Follow Up:

Final Summary:

Learner Doctor Case Record 3

Patient Identification Data & Demography
Name of the patient :
Type of admission: OPD / emergency / referral / Booked / Unbooked
Date of Admission:
Date of Discharge:
Date of Delivery/ Surgery:
Outcome of patient:
Chief Complaints:
History of present illness in details

Menstrua	al history:					
Active ma	arriage life:					
Obstetri	c History: G	PAMTP	L			
	Type of Delivery	Gestational Age	Live birth/ stillbirth/ neonatal death	Current age of child	Breast- feeding	Vaccination
1 st						
2 nd	+	+				
3 rd	1					_
4 th						
5 th						
6 th						
	of live children					
Past Hist						
Family H	istory:					
Personal	& Social Histor	ry:				
Medicati	ion History:					

Examination: General Examination: Vitals: Systemic Examination: Per abdomen examination: Per Speculum examination: Per vaginal examination: **Provisional Diagnosis:**

Investigations suggested:

Treatment Received:

(Pharmacological and Non-Pharmacological including special nursing care	:)
Differential Diagnosis:	

Daily Monitoring Chart: (to be filled by student -doctor on daily basis)

Date &	Response to treatment	Any new	Results of	Treatment
Time	in chief complaints	complaints	investigations	/advice
				modified (if
				any)
		-		

Final Appraisal:

Discharge Summary

Patient Name: Age: Address:	Hospital indoor no.:
Final Diagnosis	
DOA: DOD: Date of Procedure/ Operation: Indication of Procedure/ Operation Patient's condition on admission:	
Treatment Provided:	
Delivery / Procedure / OT notes summary:	
Condition on Discharge:	
Advice on Discharge: (Pharmacological / Non-pharmacolo	ogical)
Date of next follow up: When & How to obtain Urgent care	

Learner Doctor Case Record 4

Name of the patient :
Type of admission : OPD / emergency / referral / Booked / Unbooked
Date of Admission:
Date of Discharge:
Date of Delivery/ Surgery:
Outcome of patient:
Chief Complaints:
History of present illness in details

Patient Identification Data & Demography

Menstrual history:							
Active ma	rriage life:						
Obstetric	History: GP-	AMTP	L				
	Type of	Gestational	Live	Current	Breast-	Vaccination	
	Delivery	Age	birth/	age of	feeding		
			stillbirth/	child			
			neonatal				
			death				
1 st							
2 nd							
3 rd							
4 th							
5 th							
6 th							
Number	of live children:						
Watania	£tt						
History o	f contraception u	isage:					
Past Hist	orv:						
Family H	istory:						
Dancasal	O Coolel Webser						
Personal	& Social History:						
Medicati	on History:						
	Medication History:						

Examination General Examination: Vitals: Systemic Examination: Per abdomen examination: Per Speculum examination: Per vaginal examination: **Provisional Diagnosis:** Investigations suggested:

Treatment Received:

Treatment Plan: (Pharmacological and Non-Pharmacological including special nursing care)
Differential Diagnosis:

Daily Monitoring Chart: (to be filled by student -doctor on daily basis)

Treatmen /advice modified	Results of investigations	Any new complaints	Response to treatment in chief complaints	Date & Time
any)				

Final Appraisal:

Discharge Summary

Patient Name:	Hospital indoor no.:
Age:	
Address:	
Final Diagnosis	
DOA:	
DOD:	
Date of Procedure/ Operation:	
Indication of Procedure/ Operation	
Patient's condition on admission:	
Treatment Provided:	
Delivery / Procedure / OT notes summary:	
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Condition on Biochesses	
Condition on Discharge:	
Advice on Discharge: (Pharmacological / Non-pharmacological /	gical)
Date of next follow up:	
When & How to obtain Urgent care	

Activity 5: Obtaining a Pap smear in a simulated environment

OG 35.12

Steps of taking Pap Smear

96

Phase -3

Part-2

Antenatal Case Record 5

Patient Identification Data and Demography:
Chief Complaints:
History of Present Complaints:
History of present pregnancy: (Trimester-wise)
Status of vaccination:

	-		 		
MAG	net	2113	 cto	-	
Me	II S L	ua	 310	·v	

G_ P_ A_ L_ MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-
	gestational	pregnancy			Weight)	If any	tion
	age at						
	delivery						

Contraceptive History:
Family History:
Personal & Social History:
Drug History/ Medication History:
Past History:

Systemic Examination:
Cardiovascular system:
Respiratory system:
Nervous system:
Obstetrical Examination :
Interpretation based on palpation
Per speculum examination: (if indicated)
Per vaginal examination: (when indicated)
Doluinatou (if indicated)
Pelvimetry: (if indicated)
Provisional Diagnosis :
Provisional Diagnosis:
Investigations:
mvestigations.

Risk factors identified:		
Final diagnosis:		
Summary:		
Advice:		
Follow up :		
Plan of delivery:		

Antenatal Case Record 6

Patient Identification Data and Demography:
Chief Complaints:
History of Brosont Completents
History of Present Complaints:
History of present pregnancy: (Trimester-wise)

General Examination:

Status of vaccination: Menstrual History: G_ P_ A_ L_ MTP Obstetric History Details:									
Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby		
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-		
	gestational	pregnancy			Weight)	If any	tion		
	age at								
	delivery								
Contraceptive History:									
Family History:									
Personal & Social History:									
Drug History/ Medication History:									
Past History:									

Systemic Examination:
Cardiovascular system:
Respiratory system:
Nervous system:
Obstetrical Examination :
Interpretation based on palpation
Per speculum examination: (if indicated)
Per vaginal examination: (when indicated)
Pelvimetry: (if indicated)
Provisional Diagnosis:
Investigations:

Risk factors identified:	
Final diagnosis:	
Summon.	
Summary:	
Advice:	
Follow up :	
Plan of delivery:	

Antenatal Case Record 7

Patient Identification Data and Demography:
Chief Complaints:
History of Present Complaints:
History of present pregnancy: (Trimester-wise)
Status of vaccination:

Menstrual History :	Men:	strual	History	ı:
---------------------	------	--------	---------	----

G_ P_ A_ L_MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-
	gestational	pregnancy			Weight)	If any	tion
	age at						
	delivery						

Contraceptive History:
Family History:
Personal & Social History:
Drug History/ Medication History:
Past History:
General Examination:

Systemic Examination:
Cardiovascular system:
Respiratory system:
Nervous system:
Obstetrical Examination :
Interpretation based on palpation
Per speculum examination: (if indicated)
Per vaginal examination: (when indicated)
Pelvimetry: (if indicated)
Provisional Diagnosis :
Investigations:
mvesugations:

Risk factors identified:	
Final diagnosis:	
Summary:	
Advice:	
Follow up :	
Plan of delivery:	

Antenatal Case Record 8

Patient Identification Data and Demography:
Chief Complaints:
History of Present Complaints:
History of present pregnancy: (Trimester-wise)
Status of vaccination:

Mens		111-4	
Mone	rriial	HICT	nn, .
MICHS	пчан	HIS	υν.

G_ P_ A_ L_ MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-
	gestational	pregnancy			Weight)	If any	tion
	age at						
	delivery						

Contraceptive History:
Family History:
Personal & Social History:
Drug History/ Medication History:
Past History:
General Examination:

Systemic Examination:
Cardiovascular system:
Respiratory system:
Nervous system:
Obstetrical Examination :
Interpretation based on palpation
Per speculum examination: (if indicated)
•
Per vaginal examination: (when indicated)
Pelvimetry: (if indicated)
Provisional Diagnosis :
Investigations:
mrestigations.

Risk factors identified:
Final diagnosis:
Summary:
Advice:
Follow up :
Plan of delivery:

Antenatal Case Record 9

Patient Identification Data and Demography:
Chief Complaints:
History of Present Complaints:
History of present pregnancy: (Trimester-wise)
Status of vaccination:

			_	
Man	netrus	al His	story:	
IVIC	เเวเนเน		SCOLV.	

G_ P_ A_ L_MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-
	gestational	pregnancy			Weight)	If any	tion
	age at						
	delivery						
							·

Contraceptive History:
Family History:
Personal & Social History:
Drug History/ Medication History:
Past History:
General Examination:

Systemic Examination:
Cardiovascular system:
Respiratory system:
Nervous system:
Obstetrical Examination :
Interpretation based on palpation
Per speculum examination: (if indicated)
Per vaginal examination: (when indicated)
rei vaginai examinacion: (when indicated)
Pelvimetry: (if indicated)
, , ,
Provisional Diagnosis :
Investigations:

Risk factors identified:
Final diagnosis:
Summary:
Advice:
Follow up :
Plan of delivery:

Antenatal Case Record 10

Patient Identification Data and Demography:
Chief Complaints:
History of Present Complaints:
History of present pregnancy: (Trimester-wise)

Status of vaccination:

Monet	runal	Histor	
MEHS	ичан	111310	ν.

G_ P_ A_ L_ MTP

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-
	gestational	pregnancy			Weight)	If any	tion
	age at						
	delivery						

Contraceptive History:							
Famil	Family History:						
Personal & Social History:							
Drug History/ Medication History:							
Past I	History:						
Gene	ral Examina	tion:					

Systemic Examination:
Cardiovascular system:
Respiratory system:
Nervous system:
Obstetrical Examination :
Interpretation based on palpation
Per speculum examination: (if indicated)
Per vaginal examination: (when indicated)
Pelvimetry: (if indicated)
Provide law of Pita amounts a
Provisional Diagnosis :
Investigations
Investigations:

Risk factors identified:		
Final diagnosis:		
Summary:		
(a)		
Advice:		
Follow up :		
Plan of delivery:		

Gynecological Case Record 3

Patient identification data & demography:	
Chief Complaints:	
History of Presenting Illness: (ODP)	
Part Wistons	
Past History:	
Personal History:	
Medication History / Allergy :	
Formily History	
Family History:	
NA	
Menstrual History:	

Obstetrical History:

General Examination:
Systemic Examination: Respiratory System:
Cardiovascular System:
Central Nervous System:
Per Abdomen Examination:
Local Genital Examination:
Per Speculum Examination:

Per Vaginal Examination:				
Per-Red	ctal Examination (i	f required):		
Provisio	onal Diagnosis			
Difforo	ntial Diagnosis			
Differe	ntial Diagnosis			
S No.	Diagnosis	Points for	Points Against	
Investi	gations:			

Final Diagnosis:	
Treatment Plan:	

Case Summary:

Follow-Up:

Gynecological Case Record 4

Patient identification data & demography:
Chief Complaints:
History of Presenting Illness: (ODP)
mistory of Fresenting Inness. (OSF)
Past History:
Personal History:
reisonal history.
Medication History / Allergy :
Family History:
Menstrual History:

Obstetrical History:

General Examination:	G
Systemic Examination: Respiratory System:	
Cardiovascular System:	C
Central Nervous System:	C
Per Abdomen Examination:	P
Local Genital Examination:	L
Per Speculum Examination:	P
Per Vaginal Examination:	Р

Per-Rectal Examination (if required):					
Provisional Diagnosis					
Differen	itial Diagnosis				
S No.	Diagnosis	Points for	Points Against		
Investig	Investigations:				

Final Diagnosis:		
Treatment Plan:		
Follow-Up:		
Case Summary:		

Gynecological Case Record 5

Patient identification data & demography:
Chief Complaints:
History of Presenting Illness: (ODP)
Past History:
Personal History:
Medication History / Allergy :
Family History:
Menstrual History:

Obstetrical History:

General Examination:
Systemic Examination:
Respiratory System:
Cardiovascular System:
Central Nervous System:
Per Abdomen Examination:
Local Genital Examination:
Per Speculum Examination:
Per Vaginal Examination:

Per-Rectal Examination (if required):							
Provisional Diagnosis							
Differential Diagnosis							
S No.	Diagnosis	Points for	Points Against				
		'	-				
Investig	rations:						

Final Diagnosis:	
Treatment Plan:	

Case Summary:

Follow-Up:

Normal Labor Case Record 5

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Menstrual History:

Past Obstetrical History:
Gestational Age(GA)
By L.M.P: By U.S.G:
ву 0.3.0 .
Past History
Family History
running rinstory
Social and Personal History
oodar ana r oroonar motor,
Medication History , Allergies :
Contraceptive History:
General Examination

Abdominal Examination
Local Examination of Genitalia
Per-Speculum Examination (if required):
Per-Vaginal Examination and Pelvimetry :
Investigations

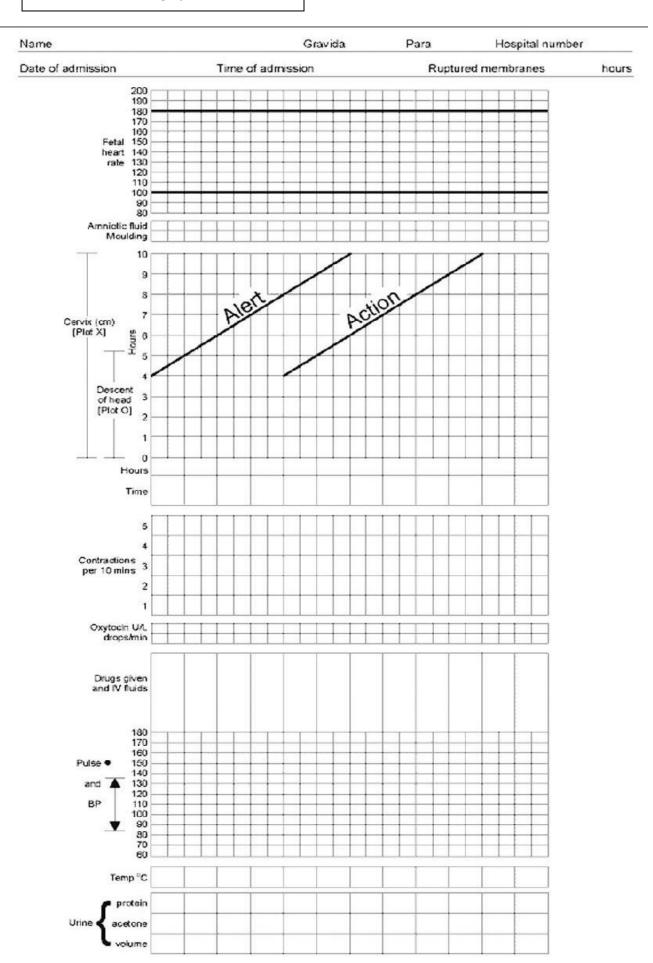
Systemic Examination

Labour notes:

Spontaneous / augmented

If induced: ARM / Syntocinon / PG/ Foley's Indication of induction/augmentation

Stages of Labour	Time Started	Time Finished	Duration Lasted		
Stage I					
Stage II					
Stage III					
Mode of Delivery (Normal/Forceps / Assisted Breech/ Caesarean) Note in brief					
AMTSL:					
Date and Time:					
Conducted By:		Assisted By:			
Supervised By:					
Examination of Placenta:					
Intra Partum or Post Partum Maternal Complications:					
Baby Notes					
No.		Date	and Time		
Sex	rth V/N				
Cried Immediately after Bir Weight	I UI - T/IN				
APGAR Score at 1min					
APGAR Score at 5min					
NICU Admission					
Duration of Stay In NICU					



Nam	ne									Parit	у	abour ons	et				Active labou	ur diagr	nosis	Date]
Rup	tured mem	brane	es [Date			Time] Risk f	factors													
			Time	10		9		1	0	- 10		- 1	1	- 1	1	1			:		:		
			Hours		1		2		3	4	5	6	7	8	9 .	10	11 12		1	1	2		3
			ALERT	-					W.	<u> </u>	CTIVE FI	RST STA	GE			100	→	4	– SE	CONI) STA	GE -	-
ARE	Companio	on	N																				
VE C	Pain relie	ef	N																				
ORTI	Oral flui	d	N																	T			
SUPPORTIVE CARE	Posture		SP																				
	Baseline FHR	е .	<110, ≥160																				
	FHR decelerati		L																				
BABY	Amniotic fl	luid	M+++, B																				
BA	Fetal posit	tion	P, T			17															- Van 1		
	Caput	1	+++															12					
	Moulding	3	+++																				
=	Pulse	-	<60, ≥120		÷		+	_			 										H		H
	Systolic B		<80, ≥120		+		\vdash						,							+			\vdash
WOMAN	Diastolic I		≥90		+		1	_			_								+	+			
WO	Temperatur	200	<35.0, ≥ 37.5		+		-				+							-		+			
	Urine	1	≥ 37.5 P++, A++		+		+				+					1				+			
=	Contraction per 10 mi		≤2, >5		t	1	H	<u> </u>							\vdash		$\overline{\Box}$	Н				T	
	per 10 mi				7.0	+	-	-									\vdash		H	H	Н	-	H
	contraction	ons	<20,>60				_	<u> </u>		<u> </u>	<u> </u>		<u> </u>	<u> </u>	<u> </u>		Щ		Ш	11	Щ		Щ
		10			+		-				-								Ш		Ш		
		8	≥ 2h ≥ 2.5h		13		-											In .	active	e first s	tage, p	olot ')	('to Nert
SRES		7	≥ 3h		+		+	_										tr	igger	ed whe	en lag	time i	for
PROC		6	≥ 5h		1						1							ex	ceede	d with	no pro	gres	s. In
LABOUR PROGRESS	33	5	≥ 6h															seco	whe	e first s ervical red whe t cerviced with age, ins	ing be	gins.	uicate
LAB		5	ĺ		T															Т			
		4																					
	Descent [Plot O]	3			- 2											,			_				
		2									-												Щ
	-	0					\vdash				+							-	\vdash	+-	\vdash		\vdash
=	500 E XX		W. W. W. W. W.		+		\vdash		_		+					1			_	+	_		닉
No	Oxytocin	(U/L,	drops/min)		_	_	_																_
MEDICATION	Medicine																						
Σ	IV fluids				Ť		T																\neg
					Ť													01					一
ON-MAKING	ASSESSM	IENT																					
SHARED DECISION-MAKING	PLAN																						
	INUTUALC				1						1					1							

INSTRUCTIONS: CRCLE ANY OBSERVATION METING THE CRITERIA IN THE ALERTY COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAXEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y - Ve, N - No, D - Decland, U - Unknown, SP - Supine, MO - Mobile, E - Early, L - Late, V - Variable, I - Intact, C - Clear, M - Meconium, 8 - Blood, A - Anterior, P - Posterior, T - Transverse, P - - Protein, A - - Actions

(V word Health Organization, 2021, Some rights reserved. Likence (CC BY-NC-SA 3.0 IGO). The WHO Labour Care guide should be used in conjunction with the User's Manual, Responsibility for the interpretation and use of the material lies with the reader in no event shall the WHO be liable for damages artising from its use.

Advice on Discharge : (pharmacological / Non pharmacological)
Follow Up:
Final Summary:

Normal Labor Case Record 6

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Menstrual History:

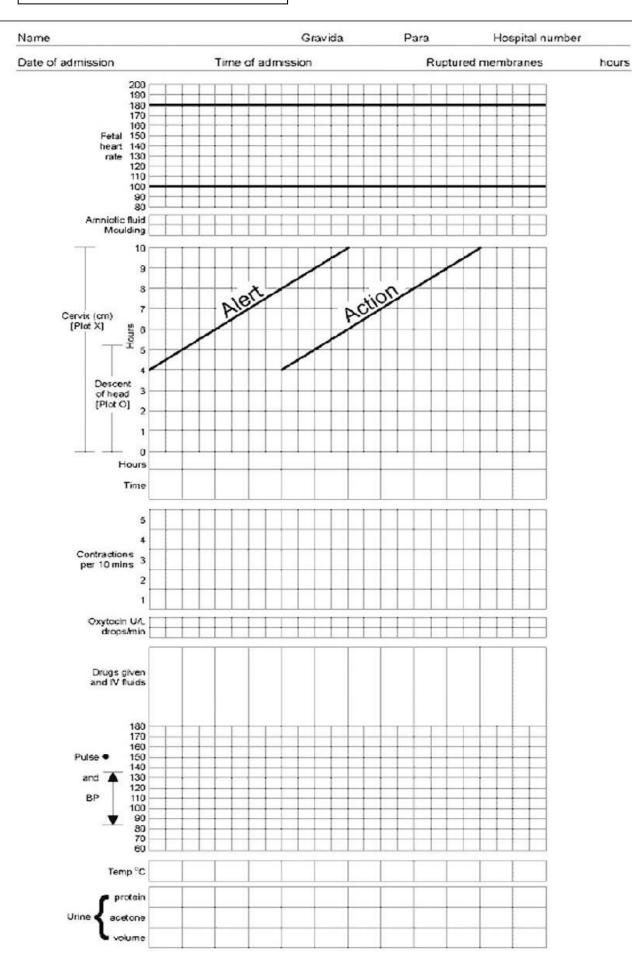
Past Obstetrical History:
Gestational Age(GA)
By L.M.P: By U.S.G :
by 0.3.G :
Past History
Family History
Social and Personal History
Social and Personal Instally
Medication History , Allergies :
Contraceptive History:
General Examination

Systemic Examination
Abdominal Examination
Local Examination of Genitalia
Per-Speculum Examination (if required):
Per-Vaginal Examination and Pelvimetry :
Investigations

Labour notes:

Spontaneous / augmented
If induced: ARM / Syntocinon / PG/ Foley's
Indication of induction/augmentation

Stages of Labour	Time Started	Time Finished	Duration Lasted						
Stage I									
Stage II									
Stage III									
Mode of Delivery (Norma	l/Forceps / Assiste	d Breech/ Caesarea	n) Note in brief						
AMTSL:									
Date and Time:									
Conducted By:		Assisted By:							
Supervised By:									
Examination of Placenta:									
Intra Partum or Post Partum Maternal Complications:									
Baby Notes									
No. Sex		Date	and Time						
Cried Immediately after E Weight APGAR Score at 1min APGAR Score at 5min NICU Admission	Birth- Y/N								
Duration of Stay In NICU									



Nam	ne						Parity		Labour ons	et				Active labou	r diagn	osis [I	Date]
Rup	tured mem	branes [Date		Tim	ie] Risk	factors													
		Time	- 1		1	1	1	iş.	- 1	1		10	- 0	1						6
		Hours		i	2	3	4 5				8 9	9	10 1	11 12	20/0	• 6	1		2	
		ALERT	•	4	Ť	Ť	— AC	TIVE F	IRST STAC	GE	· ·	ì	1		_	- SEC	CONE) STA	GE -	-
SUPPORTIVE CARE	Companio	on N	-	-	-															
TIVE	Pain relie	ef N																		
PPOR	Oral flui														5	-			_	
SOI	Posture	SP													5		2			
	Baseline FHR	<110, ≥160																		
	FHR decelerati	on L																		
BABY	Amniotic fl	uid M+++, B																		
BA	Fetal posit	ion P, T		3													0	- Y		1
	Caput	+++													0.					
	Moulding	g +++		3											33		~			
	Pulse	<60, ≥120																		
_	Systolic B	- 100 march - 100 march			1															
WOMAN	Diastolic I			1	1															
MO	Temperatur	-25.0		1	1															
	Urine	≥ 37.3 P++, A++											-							
	Contraction	ns ≤2, >5		İ											П			П		
	Duration	of <20, >60														П				
	501141444	10				+									Ħ	H	Ħ	Ħ		Ħ
	3	9 ≥ 2h		1	1										ln a	ctive	first s	tage	nlot ')	K' to
SS	Cervix [Plot X]	8 ≥ 2.5h													rec	ord ce	rvical	tage, ¡ dilata en lag al dila	tion.	Alert
OGR		7 ≥ 3h				1									CL	rrent	cervic	al dila	tation	n is
JR PR	S	6 ≥ 5h 5 ≥ 6h		-	+	-									secor	nd stag	ge, ins	ert P	to in	s. In dicate
LABOUR PROGRESS		5 201			+	+										Wilei	pusii	ilig be	giis.	
_		4		7	+	+			-						_		77 - 1			
	Descent	3																		
	[Plot O]	2																		
		1			1	1														
		0			<u> </u>															
z	Oxytocin	(U/L, drops/min)																		
MEDICATION	Medicine																			
ME	IV fluids							-							ā		9	-		
				1	+	+										- 7		_	\equiv	
N-MAKING	ASSESSM	ENT																		
SHARED DECISION-MAKING	PLAN																			
	ΙΝΙΤΙΔΙ S		1	1	1	1	1 1		1				1							-

INSTRUCTIONS: CRCLE ANY OBSERVATION METING THE CRITERIA IN THE ALERTY COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAXEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y - Ve, N - No, D - Decland, U - Unknown, SP - Supine, MO - Mobile, E - Early, L - Late, V - Variable, I - Intact, C - Clear, M - Meconium, 8 - Blood, A - Anterior, P - Posterior, T - Transverse, P - - Protein, A - - Actions

(V word Health Organization, 2021, Some rights reserved. Likence (CC BY-NC-SA 3.0 IGO). The WHO Labour Care guide should be used in conjunction with the User's Manual, Responsibility for the interpretation and use of the material lies with the reader in no event shall the WHO be liable for damages artising from its use.

Advice on Discharge : (pharmacological / Non pharmacological)
Follow Up:	

Final Summary:

Normal Labor Case Record 7

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Monetweel History
Menstrual History:

Gestational Age(GA) By L.M.P:
By U.S.G : Past History
Family History
Social and Personal History
Medication History , Allergies : Contraceptive History:

General Examination

Past Obstetrical History:

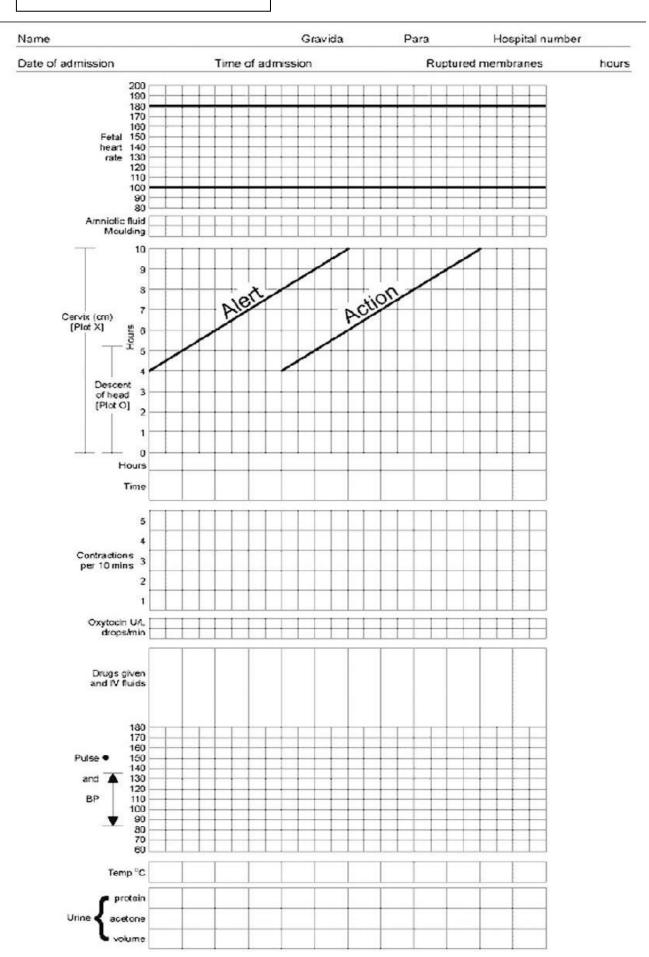
Systemic Examination
Abdominal Examination
Local Examination of Genitalia
Per-Speculum Examination (if required):
Per-Vaginal Examination and Pelvimetry :
Investigations

Labour notes:

Spontaneous / augmented
If induced: ARM / Syntocinon / PG/ Foley's
Indication of induction/augmentation

Stages of Labour	Time Started	Time Finished	Duration Lasted
Stage I			
Stage II			
Stage III			
Mode of Delivery (Norma	l/Forceps / Assisted	d Breech/ Caesarear	n) Note in brief
AMTSL:			
Date and Time:			
Conducted By:		Assisted By:	
Supervised By:			
Examination of Placenta:			
Intra Partum or Post Part	tum Maternal Com	plications:	
Baby Notes			
No.		Date	and Time
Sex			
Cried Immediately after B	Birth- Y/N		
Weight			
APGAR Score at 1min			
APGAR Score at 5min			
NICU Admission			
Duration of Stay In NICU			

WHO Modified Partograph



Nam							Parit	у	Labour ons	et				Acti	ve labo	ur diag	nosis	[Date			
Rup	tured membi	ranes [Date		Time] Risk	factors	1 .						_							
		Hours	_	3	1		4	5	: 6	7	8		10	11	12	-	1	1	Ť	2	i
		ALERT	—					ACTIVE FI							-	4	— SE	CON	ID ST		
ARE	Companion	n N												T				T			
VE C	Pain relief	N																			
SUPPORTIVE CARE	Oral fluid	N																			
SUPF	Posture	SP																			
	Baseline	<110, ≥160													$\overline{}$	П	T	T	T		$\overline{\Box}$
	FHR FHR	(a) (210)						+						+	\vdash	H	+	+	+		+
	deceleration	1	-	-	<u> </u>	-	-	++	-	-		-	-	+	4	1	H		+	H	╨
BABY	Amniotic flu			3				1					1		-		+				+
		7 2225						-					-	+	-	1.7	+		+		+
	Caput	+++												+	-	8				-	-
_	Moulding	+++						1						+	_	H	+	_	+	_	+
	Pulse	<60, ≥120				-		-						\perp			+		+	1	1
AN	Systolic BP			-				-						-	_		+	4	+	-	₩
WOMAN	Diastolic BF			-	-			1		-		-	-	-			+	+	-	-	1
	Temperature	231.3			-			+					-	+		-	+	+	+	-	\vdash
_	Urine	P++, A++		<u> </u>				<u> </u>					<u> </u>	+	\blacksquare	L	<u> </u>	<u> </u>	<u> </u>	<u> </u>	<u> </u>
	Contraction per 10 min																				
	Duration of contractions	<20,>60																			
	1	10															\prod	П	П		
		9 ≥ 2h														In	activ	e first	stage, I dilat	plot '	X' to
RESS	Cervix [Plot X]	200000000		-				-					-	+	-	t	rigge	red w	hen la	time	for
ROG		7 ≥ 5h			1			1					4	+		e	cceed	t cerv	ical dil h no p	rogre	on is ss. In ndicate
LABOUR PROGRESS		5 ≥ 6h														seco	ona st wh	age, II en pu	shing b	egins	naicate
LAB		5											Î				T				
	1 P	4																			
	[Diet O]	3						2	,		,		2	-			-		-	-	\vdash
	I	1												+	-		+		+	\vdash	+
	I	0															+				+
	Oxytocin (U	I/L, drops/min)												Ť						Ī	
MEDICATION	- ON Y LOCALITY CO	re, an opsimin,		-				1						+				-		+	_
DICA	Medicine																				
ME	IV fluids													+						\vdash	
								+						+				+			_
NG	ASSESSME	NT																			
AAKII																					
SHARED DECISION-MAKING																					
ECIS.						-			1		1	<u> </u>	1	-						T	
RED C																					
SHA	PLAN																				
_																					
	INITIALS																				

INSTRUCTIONS: CRICLE ANY OBSERVATION MEETING THE CRITERIA IN THE YALERT'COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAXENLIF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y - Yes, N - No, D - Declined, U - Unknown, SP - Supine, MO - Mobile, E - Early, L - Late, V - V ariable, I - Intact, C - Clex, M - Merconium, B - Blood, A - Anterior, P - Posterior, T - Transverse, P - Protein, A - - Actione

O World Health Organization, 2021. Some rights reserved. Likence (CC BY-NC-SA 3.0 IGO). The WHO Labour Care guide should be used in conjunction with the User's Manual, Responsibility for the interpretation and use of the material lifes with the reader in no event shall the WHO be liable for damager artising from its size.

Advice on Discharge : (pharmacological / Non pharmacological)						
Follow Up:						
Final Summary:						

Normal Labor Case Record 8

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Menstrual History:

Past Obstetrical History:
Gestational Age(GA)
By L.M.P: By U.S.G):
Past History
Family History
Social and Personal History
•
Medication History , Allergies :
Contraceptive History:
•
General Examination

Systemic Examination
Abdominal Examination
Local Examination of Genitalia
Per-Speculum Examination (if required):
Per-Vaginal Examination and Pelvimetry :
Investigations

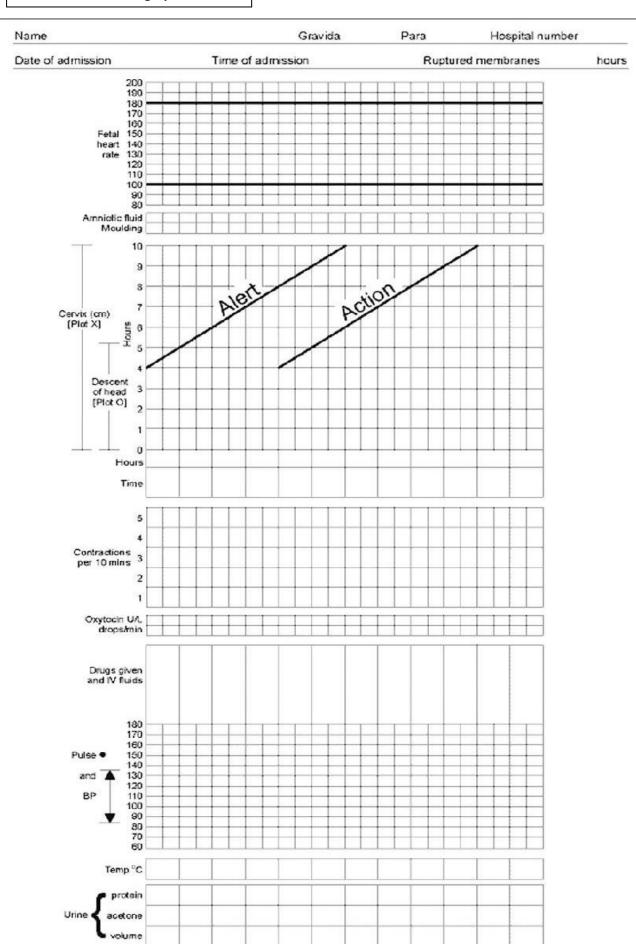
Labour notes:

Duration of Stay In NICU

Spontaneous / augmented If induced: ARM / Syntocinon / PG/ Foley's Indication of induction/augmentation

Stages of Labour	Time Started	Time Finished	Duration Lasted
Stage I			
Stage II			
Stage III			
Mode of Delivery (Norma	al/Forceps / Assiste	d Breech/ Caesarea	n) Note in brief
AMTSL:			
Date and Time:			
Conducted By:		Assisted By	:
Supervised By:			
Examination of Placenta:			
lata Bartana an Bart Bar	\$4	- North-	
Intra Partum or Post Par	tum Maternai Com	plications:	
Baby Notes			
No.		Date	and Time
Sex			
Cried Immediately after	Birth- Y/N		
Weight APGAR Score at 1min			
APGAR Score at 1min APGAR Score at 5min			
NICU Admission			

WHO Modified Partograph



Man								Davita		ahaur ans					Active labor	n disan	oeie II) nto			
Nan Rup	tured mem	bran	es [Date		Time] Risk f	Parity factors		abour ons	et				Active labor	ır diagr	iosis įt	Jate			
		[Time	10	1		0	10	10	1	1	10	10	10			:		:		E .
			Hours		1	2	3	4 5	5	5 7	,	8 9	9 1	0	11 12			1		2	
		[ALERT	-		N.	W	—— A	CTIVE FI	rst stac	GE					4	- SEC	COND) STA	GE .	
4RE	Companio	on	N																		
/E C	Pain relie	ef	N																		
JKI	Oral fluid	-	N														-		_		
SUPPORTIVE CARE	Posture	-	SP													15	- 2	2			
7		- 21	31															2			_
	Baseline FHR	~ [<110, ≥160																		
	FHR decelerati	on	L														П		П		
_	Amniotic fl	- 2	M+++, B						-	3				-					Ė	- 15	Н
BABY												_									+
	Fetal posit	IOII	P, T			-										2					⊬
	Caput		+++		3																L
	Moulding	g	+++														Ш		\Box		
	Pulse		<60, ≥120																		
	Systolic B	Р	<80, ≥140																		t
MAN	Diastolic I		≥90								-						\vdash				╁
WOMAN	(6) (6) (6) (6) (6) (6) (6)				1	2					-	-			4						1
	Temperatur	e °C	<35.0, ≥ 37.5			-										-	_	_			┡
	Urine		P++, A++																		
	Contraction per 10 mi	ns	≤2, >5																		
	Duration of	of	<20,>60														H		т		
	contraction		120,700			1		Hi							$\vdash\vdash\vdash$				+		
		10	241		-	1					-						Ш	Ш	Ш		
		9	≥ 2h					-								In a	In active first stage, record cervical dilata triggered when lag current cervical dila exceeded with no pr second stage, insert 'P' when pushing be				X' to
RESS	Cervix [Plot X]	7	≥ 2.5h ≥ 3h													tr	iggere	d whe	n lag	time	for
ROG		6	≥ 5h			+					-	-				exi	irrent ceeded	cervic with	al dila no pr	itatioi ogres	n is s. In
LABOUR PROGRESS		5	≥ 6h													seco	nd stag	ge, ins	ert P	to in	dica
ABOI			2 011			1											VVIICI	pusii	ilig b	giiis.	_
_		5				-										_	-				╀
	Descent	3			-	-									-	-		-			╀
	[Plot O]	2																X :			-
		1														-					+
		0				_											\vdash				H
=	20040 EV 10040		Tarri de sour		1												_		=		_
NO	Oxytocin	(U/L,	drops/min)																		
Š	Medicine																				
MEDICATION	ivieurane																				
2	IV fluids																				
	5				1																
5																					
Z	ASSESSM	ENI																			
-W																					
5																					
DEC						1					Ž.							Q			
ED																					
SHARED DECISION-MAKING	PLAN																				
S																					
-	100,000,000				1	1													_		_
	INITIALS																				

INSTRUCTIONS: CRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE "ALERT" COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAXEN. IF LABOUR EXTENDS BEYOND 12.H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE. Abbreviations: Y - Yes, N - No, D - Decidined, U - Unknown, SP - Supine, MO - Mobile, E - Early, L - Late, V - Variable, I - Intact, C - Clear, M - Meconium, B - Blood, A - Anterior, P - Posterior, T - Transverse, P - - Protein, A - - Actende

O'World Health Grand Proteins (C BY-NC-SA 3.0 IGO). The WHO Labour Care guide should be used in conjunction with the User's Manual, Responsibility for the interpretation and use of the material lies with the reader in no event shall the WHO be liable for damages arising from its use.

Advice on Discharge :	(pharmaco	logical / No	n pharmacol	logical)
-----------------------	-----------	--------------	-------------	----------

Follow Up:

Final Summary:

Normal Labor Case Record 9

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Menstrual History:

Past Obstetrical History:
Gestational Age(GA) By L.M.P: By U.S.G:
Past History
,
Family History
Social and Personal History
Medication History / Allergy :
medication mistory / Allergy .
Contraceptive History:

General Examination

Systemic Examination	
Abdominal Examination	
Local Examination of Genitalia	
Eccal Examination of Gentalia	
Per-Speculum Examination (if required):	
Per-Vaginal Examination and Pelvimetry :	
Investigations	

Labour notes:

Spontaneous / augmented If induced: ARM / Syntocinon / PG/ Foley's Indication of induction/augmentation

Stages of Labour	Time Started	Time Finished	Duration Lasted
Stage I			
Stage II			
Stage III			
Mode of Delivery (Normal/	Forceps / Assisted	Breech/ Caesarean)	Note in brief
AMTSL:			
Date and Time:			
Conducted By:		Assisted By:	
Supervised By:			
Examination of Placenta:			
Intra Partum or Post Partu	m Maternal Comp	lications:	

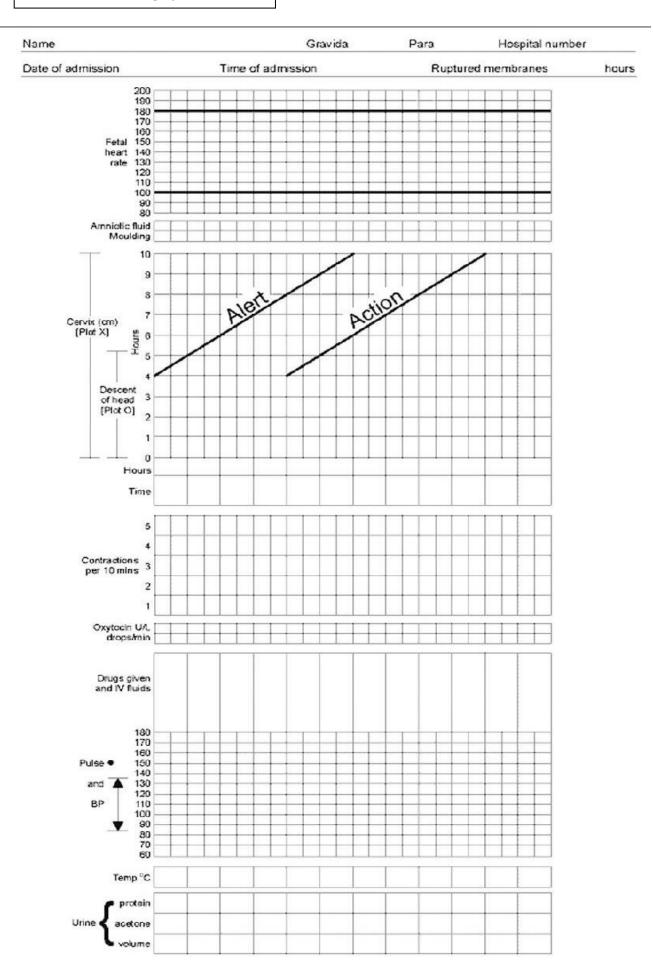
Date and Time

No. Sex Cried Immediately after Birth- Y/N Weight

APGAR Score at 1min APGAR Score at 5min NICU Admission

Baby Notes

Duration of Stay In NICU



Nam	ie						Parit	ty	Labour ons	et				Active labo	ur diagn	osis [Date]
Rup	tured membi			Time] Risk														
		Time Hours	- 0	1	1	1	1	1	6	1	8	1	1	1						1
		ALERT		1	2	3		S ACTIVE F			8	9	10	11 12			1 CONI		2 NGE -	
ш.	C			1	Ť			ACTIVE II	INSI SIA	UL	Î	T T	1			JL	COM))	IGL -	
SUPPORTIVE CARE	Companion			-	-	-	-	+	-			-		+ -	-	_				
	Pain relief	N		-	-								1	+						_
	Oral fluid	N					-					-		-	ls		8	_		
S	Posture	SP									0				15		8	2		
	Baseline FHR	<110, ≥160																		
	FHR deceleration															Т				
_	Amniotic flu		-		+	-	-	-			-	<u> </u>	-		-			-		H
BABY	Fetal positio						1	1									0.75	V. 3		
	Caput	+++					_					_	_	1	1.7				-	
	Moulding	3						-	8					8 2 8	8 = 8		8	===		
=	ivioulality	+++																	\vdash	
	Pulse	<60, ≥120												1						
N	Systolic BP	<80, ≥140																		
WOMAN	Diastolic BF	1.0																		
\$	Temperature	°C <35.0, ≥ 37.5																		
	Urine	P++, A++																		
=	Contraction per 10 min	s ≤2, >5				Ħ								TI	П	П				T
	Duration of	-20 >60														H	H	H		H
	contractions	5 \20,700		1	1	1	1	1	<u> </u>			<u> </u>	1	$+$ \square	H	Ш		Щ		1
	10			-	-		-	-				-	+	-	LL	Ш	LL	LL		
s		9 ≥ 2h 8 ≥ 2.5h											1		In a	ctive ord ce	first s	tage, dilata	plot ')	(' to Alert
SRES	[Plot X] 7	ec ecc.coss.			1		1	1				1		+	tr	ggere	ed who	en lag	time i	for n is
PRO		W. CONTON													In active first stage, plot 'X' to record cervical dilatation. Alen triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indica-				s. In	
LABOUR PROGRESS		5 ≥ 6h													secoi	whe	n push	ing be	egins.	uicate
LAB		5																		
	DE	4																		
	Descent [7] [Plot O] 2 1 0																X.			
							-					-	-			_				-
					1	-	+	1				-	1	+	-		-		\vdash	\vdash
=			l	1		1	_	1	1			1	1	+		_			=	
No	Oxytocin (U	/L, drops/min)												4			-			
MEDICATION	Medicine																			
MED	Wiculding																			
	IV fluids																			
_								1					T							
SHARED DECISION-MAKING	ASSESSMENT																			
ECIS				*	Î		Ì		İ		Ì	•	i				Ú.		$\overline{}$	
ED D																				
SHAR	PLAN																			
•1																				
_	INITIALS			1	1	T	†	1		1		1	1	$\overline{}$					$\overline{}$	
				1	1		1	1					1							

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE ALBERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN. IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE.
Abbreviations: Y - Yes, N. - No, D - Declined, U - Unknown, SP - Supline, Mo - Mibile, E - Early, L - Late, V - Variable, I - Intact, C - Clex, M - Micronium, 8 - Blood, A - Anterior, P - Posterior, T - Transverse, P + - Protein, A - - Action

(© World Health Organization, 2021, Some rights reserved, Likence (ICE BY-NC-SA 3, 01GO). The WHO Labour Care guide should be used in conjunction with the User's Manual, Responsibility for the interpretation and use of the material lies with the reader. In no event shall the WHO be liable for damages arising from its use.

Advice on Discharge: (pharmacological / Non pharmacological)
Follow Up:
Final Commons
Final Summary:

Normal Labor Case Record 10

Patient identification data:
Chief Presenting Complaints:
History of Present Illness:
History of Presenting Pregnancy:
Menstrual History:

Past Obstetrical History:
Gestational Age(GA) By L.M.P:
By U.S.G :
Past History
Family History
Family History
Social and Bounce of Winters
Social and Personal History
Medication History , Allergies :
Contro contino Uistamu
Contraceptive History:
General Examination

Systemic Examination **Abdominal Examination** Local Examination of Genitalia Per-Speculum Examination (if required): Per-Vaginal Examination and Pelvimetry:

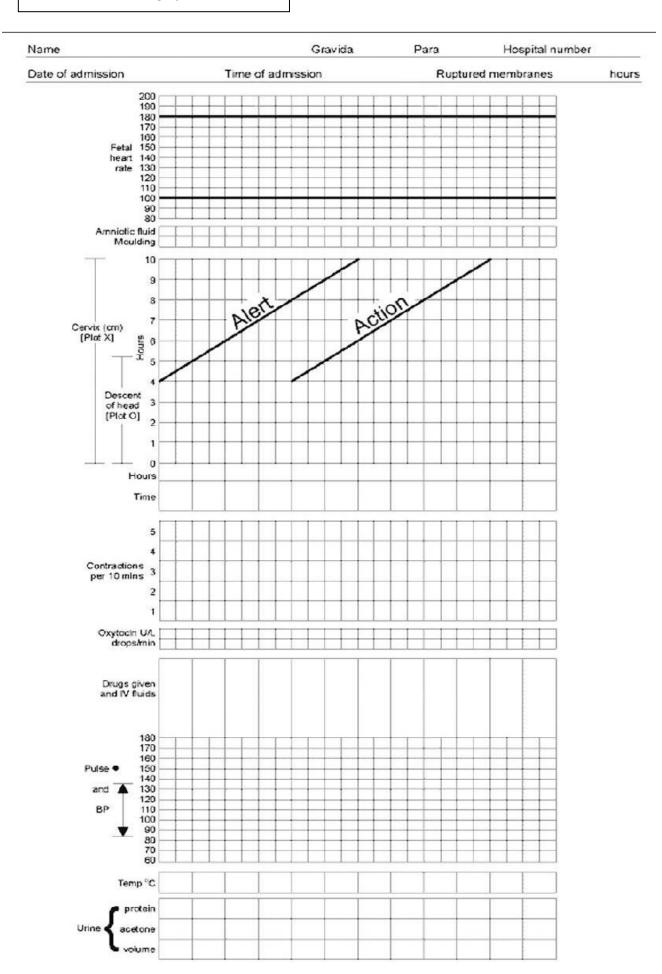
Investigations

Labour notes:

Spontaneous / augmented

If induced: ARM / Syntocinon / PG/ Foley's Indication of induction/augmentation

Stages of Labour	Time Started	Time Finished	Duration Lasted
Stage I			
Stage II			
Stage III			
Mode of Delivery (Normal	/Forceps / Assisted	Breech/ Caesarear	ı) Note in brief
AMTSL:			
Date and Time:			
		Assistant Day	
Conducted By:		Assisted By:	
Supervised By:			
Examination of Placenta:			
Intra Partum or Post Parti	um Maternal Comp	lications:	
Baby Notes			
No.		Date	and Ti me
Sex	al selec		
Cried Immediately after Bi	rth- Y/N		
Weight APGAR Score at 1min			
APGAR Score at 5min			
NICU Admission			
Duration of Stay In NICU			



WHO LABOUR CARE GUIDE

Nam		ones (Date		Ti		1 Biolo	Parit	у	Labour ons	et				Acti	ive labo	ur dia	igno	sis (C	ate			
кир	tured membi	Time		Time] Risk		5	6 :	14		10			4		1			0		1
		Hours		1	2	3					8	9	10	11	1	2	- 4			1	2	1
_		ALERT	-			4	A	CTIVE F	RST STA	GE				-	-	_	\vdash	SEC	ONI	D STA	\GE	→
CARE	Companion	N																				
INE	Pain relief	N																				
SUPPORTIVE CARE	Oral fluid	N																				
SUP	Posture	SP																	S.			
	Baseline	<110, ≥160															П					П
	FHR FHR deceleration	(200) (200)																				
BABY	Amniotic flu	d M+++, B																				
BA	Fetal positio	n P, T													9					1-77		
	Caput	+++															T					
	Moulding	+++											8	-					8	8 = 8		
	Pulse	<60, ≥120												Ť			Ť					\top
z	Systolic BP	<80, ≥140															7				Т	T
WOMAN	Diastolic BF	≥90												\top			\top					
×	Temper at ure	°C <35.0, ≥ 37.5															T					Т
	Urine	P++, A++															\top				П	Т
=	Contraction	≤2, >5												Ť	П		T	П	T	Т	П	$\overline{\Box}$
	per 10 min Duration of	-20 > 60						+							+		+	Н	+	+		+
	contractions).		<u> </u>	+ +			 				 	+	+	4	L	ᆜ	\perp	+	#		+
	Cervix 8 [Plot X] 7			-	1	-		1	1			1	+	+	-	L	Ш	Ш		LL		11
SS																r	In active first stage, plot 'X' to record cervical dilatation. Alert			X' to Alert		
GRE																	trig	gere rent o	d whe	en lag cal dila	time atatio	for in is
PRO		-														se	exceeded with no progress second stage, insert 'P' to inc			ss. In ndicate		
LABOUR PROGRESS		5 ≥ 6h			<u> </u>								<u> </u>	_				wher	push	ning be	egins.	
LA	I	5												_			4				L	\perp
	Descent :	4		-		-							-	-	_	-	+	-	-	_	-	\vdash
	[Diet O]	2															+		W		\vdash	\vdash
	I	1															†		-		\vdash	\vdash
		0																				
_	Oxytocin (U	/L, drops/min)																	6			
MEDICATION	Medicine																					
ME	IV fluids	-										-	+	+					ä		\vdash	
	11.11.50.5					_		_					+	+			_	- 7			\vdash	
S G	ASSESSME	JT.																				
IAKII	713523311121																					
ON-N																						
ECISI													1	_		F	_		Ú.	_	T	
ED D																						
SHARED DECISION-MAKING	PLAN																					
unië.																						
																L						
	INITIALS												1	1								

INSTRUCTIONS: CRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERT' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN. IF LABOUR EXTENDS BEYOND 124, "REASE CONTINUE ON A NEW LABOUR CARE GUIDE. Abbreviations: "Y - Vs, N - No, D - Docisined, U - Unknown, SP - Supline, MO - Mobilit, E - Early, L - Late, V - Variable, I - Intact, C - Clear, M - Meconium, 8 - Blood, A - Anterior, P - Proteinor, T - Transverse, P - - Protein, A - - Actenine

C Word Health Organization, 2021. Some rights reserved. Likence (CC BY-NC-SA 3, 0 (GO). The WHO Labour Care guide should be used in conjunction with the User's Manual. Responsibility for the interpretation and use of the material lies with the reader in no event shall the WHO De liable for damages arising from its use.

Advice on Discharge : (pharmacological / Non pharmacological)							
Follow Up:							
Final Summary:							

Learner Doctor Case Record 5

Menstrual history:										
Active ma	Active marriage life:									
Obstetric	History: GP-	AMTP	L							
	Type of Delivery	Gestational Age	Live birth/ stillbirth/ neonatal death	Current age of child	Breast- feeding	Vaccination				
1 st		1								
2 nd										
3 rd										
4 th										
5 th										
6 th										
Number of live children: History of contraception usage:										
Past Histo	Past History:									
Family Hi	story:									
Personal	& Social History:									
Medicati	on History:									

Examination

General Examination:
Vitals:
Systemic Examination:
Per abdomen examination:
Per Speculum examination:
Per vaginal examination:
Provisional Diagnosis:
Investigations suggested:

Treatment Plan:						
(Pharmacological and Non-Pharmacological including special nursing care)						
Differential Diagnosis:						
Treatment Received:						

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice modified (if any)

Final Appraisal:

Discharge Summary

Patient Name:	Hospital indoor no.:
Age:	
Address:	
Final Diagnosis	
DOA:	
DOD:	
Date of Procedure/ Operation:	
Indication of Procedure/ Operation	
Patient's condition on admission:	
Treatment Provided:	
Delivery / Procedure / OT notes summary:	
Condition on Discharge:	
Advice on Discharge: (Pharmacological / Non-pharmacol	ogical)
Date of next follow up:	
When & How to obtain Urgent care	

Learner Doctor Case Record 6

Patient Identification Data & Demography
Name of the patient :
Type of admission: OPD / emergency / referral / Booked / Unbooked
Date of Admission:
Date of Discharge:
Date of Delivery/ Surgery:
Outcome of patient:
Chief Complaints:
History of present illness in detail

Menstrual history:								
Active ma	rriage life:							
Obstetric	: History: GP-	AMTP	L					
	Type of	Gestational	Live	Current	Breast-	Vaccination		
	Delivery	Age	birth/ stillbirth/	age of child	feeding			
			neonatal					
	-		death					
1 st		1						
2 nd								
3 rd								
4 th								
5 th								
6 th								
Number	of live children:							
History o	f contraception (ısage:						
Past Hist	orv:							
r dot mot	.,.							
Family U								
Family H	istory:							
Personal	& Social History:							
Medicati	on History:							
Medicati	on matory.							

Examination

General Examination:
Vitals:
Systemic Examination:
Per abdomen examination:
Per Speculum examination:
Per vaginal examination:
Provisional Diagnosis:
Investigations suggested:

Treatment Plan: (Pharmacological and Non-Pharmacological including special nursing care)	
Differential Diagnosis:	

Treatment Received:

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice modified (if any)

Final Appraisal:

Discharge Summary

Patient Name:	Hospital indoor no.:
Age:	
Address:	
Final Diagnosis	
rillai Diagnosis	
DOA:	
DOD:	
Date of Procedure/ Operation:	
Indication of Procedure/ Operation	
Patient's condition on admission:	
Treatment Provided:	
Treatment Provided:	
Delivery / Procedure / OT notes summary:	
,	
Condition on Discharge:	
Advice on Discharge: (Pharmacological / Non-pharmacological /	ngical)
ratice on bischarge. (Finantiacological / Hori pharmacol	o Bicary
Date of west follows:	
Date of next follow up:	
When & How to obtain Urgent care	

Learner Doctor Case Record 7

Patient Identification Data & Demography
Name of the patient :
Type of admission: OPD / emergency / referral / Booked / Unbooked
Date of Admission:
Date of Discharge:
Date of Delivery/ Surgery:
Outcome of patient:
Chief Complaints:
History of present illness in detail

Menstrual history:						
Active ma	rriage life:					
Obstetric	History: GP	AMTP	ι			
	Type of Delivery	Gestational Age	Live birth/ stillbirth/ neonatal death	Current age of child	Breast- feeding	Vaccination
1 st						
2 nd						
3 rd						
4 th						
5 th						
6 th						
Number of live children: History of contraception usage:						
Past Histo	ory:					
Family History:						
Personal & Social History:						
Medication History:						

Examination

General Examination:
Vitals:
Systemic Examination:
Per abdomen examination:
Per Speculum examination:
Per vaginal examination:
Provisional Diagnosis:
Investigations suggested:

Treatment Plan: (Pharmacological and Non-Pharmacological including special nursing care)
Differential Diagnosis:
Treatment Received:

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice modified (if any)

Final Appraisal:

Discharge Summary

Patient Name:	Hospital indoor no.:
Age:	
Address:	
Final Diagnosis	
DOA:	
DOD:	
Date of Procedure/ Operation:	
Indication of Procedure/ Operation	
Patient's condition on admission:	
Treatment Provided:	
Treatment From Co.	
Delivery / Deserving / OT notes summany	
Delivery / Procedure / OT notes summary:	
a. Het	
Condition on Discharge:	
Advice on Discharge: (Pharmacological / Non-pharmacological /	ogical)
Date of next follow up:	
When & How to obtain Urgent care	

Learner Doctor Case Record 8

Patient Identification Data & Demography
Name of the patient :
Type of admission: OPD / emergency / referral / Booked / Unbooked
Date of Admission:
Date of Discharge:
Date of Delivery/ Surgery:
Outcome of patient:
Chief Complaints:
History of present illness in detail

Menstrual history:						
Active ma	rriage life:					
	History: GP	AMTP	ι			
	Type of Delivery	Gestational Age	Live birth/ stillbirth/ neonatal death	Current age of child	Breast- feeding	Vaccination
1 st						
2 nd						
3 rd						
4 th						
5 th						
6 th						
Number of live children:						
1113101 4 0	History of contraception usage:					
Past Histo	ory:					
Family Hi	story:					
Personal & Social History:						
Medication History:						

Examination

Treatment Plan: (Pharmacological and Non-Pharmacological including special nursing care)
Differential Diagnosis:
Treatment Received:

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice modified (if any)

Final Appraisal:

Discharge Summary

Patient Name:	Hospital indoor no.:
Age:	
Address:	
Final Diagnosis	
DOA:	
DOD:	
Date of Procedure/ Operation:	
Indication of Procedure/ Operation	
Patient's condition on admission:	
ration of admission.	
Treatment Provided:	
Treatment Formed	
Delivery / Procedure / OT notes summary:	
benvery, rescedure, or notes summary.	
Condition on Discharge:	
Advice on Discharge: (Pharmacological / Non-pharmac	cological)
, , , , , , , ,	,
Date of next follow up:	
When & How to obtain Urgent care	

Learner Doctor Case Record 9: Normal Puerperium

Wife of					
Resident of					
Occupation/Education/Religion					
Parity Live Issue Abortion					
Postnatal Day					
Mode of Delivery					
Post natal complaints					
History of Present Illness					
Course of Management Before Delivery & Delivery Details with Postnatal recovery					

Antenatal History
Menstrual History
Obstetrical History
Past History
Developed History.
Personal History

Family History	
General Physical Examination	
Breast and Thyroid	
Respiratory	
CVS	
Abdominal Examination	
Local Examination	
Baby Examination	
Diagnosis	

Treatment Plan	
Postpartum Contraceptive Counselling	
Treatment Received	
Treatment Received	

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice modified (if any)

Advice on Discharge:

Learner Doctor Case Record 10:

Puerperium (Post Cesarean)

Name & Age				
Wife of				
Resident of				
Occupation/Education/Religion				
Parity	Live Issue	Abortion		
Postnatal Day				
Mode of Deliver	ry			
Post natal comp	laints			
History of Prese	nt Illness			
Course of Mana	gement Before Deli	very & Delivery Details with Postnatal recovery		

Antenatal History	
Monetrual History	
Menstrual History	
Obstetrical History	
,	
Deat History.	
Past History	
Personal History	

Family History
Congral Dhysical Evamination
General Physical Examination
Donast and Thomasid
Breast and Thyroid Respiratory
CVS
Abdominal Examination
Local Examination
Baby Examination
Duby Examination
Diagnosis

Treatment Plan	
Postpartum Contraceptive Counselling	
Treatment Received	

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice
		_		modified (if any)
				,,

Advice on Discharge:

Activity 6: Eclampsia Drill & Referring a Patient

OG 35.4 Demonstrate interpersonal and communication skills befitting a physician in order to discuss illness and its outcome with patient and family.

OG 35.10 Write a proper referral note to secondary or tertiary centres or to other physicians with all necessary details.

Case Scenario:

You are posted at a CHC. Mrs X, Primi gravida with 36 weeks pregnancy is brought to the CHC with history of convulsions for last 2 hours. Her BP is recorded as 170/100 mmHg and she has 3+ albuminuria. Respond to the emergency and provide initial management. As there is no anesthetist available at your CHC write a referral note for the nearest tertiary care center.

Activity 7: PPH Drill

OG 35.16

Diagnose and provide emergency management of postpartum hemorrhage in a simulated / guided environment

Case scenario:

Mrs AS is brought to the triage with history of massive bleeding after delivery of twins at home by a traditional birth attendant 2 hours back. Her pulse is 140, weak, low volume, BP is 70 systolic, respiratory rate is 32 per minute. Respond to the emergency.

Activity 8: Counselling for Breastfeeding

OG 17.2, PE 7.8, PE 7.9

Counsel in a simulated environment, care of the breast, importance and the technique of breast feeding

Mrs B primi delivered a live, healthy baby 2 hours back. She requests prescription for formula milk as she is too tired to feed her baby and says she tried but the baby keeps on falling asleep. How will you counsel her?

Activity 9: Counselling for Contraception

OG19.2 Counsel in a simulated environment, contraception and puerperal Sterilisation Total: 1

Case scenario: Mrs A, 37 year old lady, G4 P3+0 with 3 living children reports for routine antenatal care. . She says she wants to discuss post partum contraception. She plans to breastfeed her baby.

Details of activity

Activity 10: Caesarean Section and informed consent

OG 35.7
Obtain informed consent for any examination / procedure
OG35.11
Demonstrate the correct use of appropriate universal precautions for self-protection
against HIV and hepatitis and counsel patients
OG:37.1
Observe and assist in the performance of a Caesarean section
The student has to observe/ assist in one case undergoing CS and document the preprocedure tasks including informed consent, steps of the procedure and the post procedure
tasks.

Patient details and case summary:

Indication of the operation:

Anesthesia given:

Pre procedure tasks including informed consent (see appendix)

Steps of the procedure:
Post operative tasks:
Post operative assessment:
Post operative advice:

Activity 11: Insertion and Removal of IUCD

OG 35.15

Demonstrate the correct technique to insert and remove an IUD in a simulated/ supervised environment

Total: 1

Steps of procedures:

Activity 12: Urinary Catheterisation

OG 35.17

Demonstrate the correct technique of urinary catheterisation in a simulated/ supervised environment

Total: 1

Steps of procedure -

Activity 13: Newborn Care

OG 18.2: -Demonstrate the steps of neonatal resuscitation in a simulated environment

Total 1

Steps of Neonatal Resuscitation

Appendix 1

Antenatal Case Record

Patient Identification Data and Demography:	
Date:	ANC Reg no:
Name	Husband's name :
Age	Husband's Age
Educational status :	Educational status
Occupation:	Occupation:
Address :	
Socioeconomic status:	
Booked/Un-booked:	
Chief Complaints:	
History of Present Complaints:	
History of present pregnancy: (Trimester-wise)

Status of vaccination:

Daily Calorie intake:	
Deficit, if any:	
Appetite	
Bladder	
Bowel	
Addiction	
Domestic Violence	
Drug History/ Medication History:	
Any Allergies:	
Past History:	
Medical : Tuberculosis/Epilepsy/Any Other	Chronic Illness ; Blood transfusion
History of any Surgery:	
General Examination:	
Built: Average/Poor/Well	
Height: Cms	BMI:
Weight: Kgs	
PR:	
RR:	
BP:	
Pallor:	
Edema:	
Icterus:	
Thyroid:	
Breast Examination:	
Lymphadenopathy:	
Systemic Examination:	
Cardiovascular system:	
Respiratory system:	
Nervous system:	
Obstetrical Examination :	
Inspection:	
Contour of abdomen	Flanks : full/not full

Umbilicus:	Central/Displaced	Inverted/Everted/Flat
Linea nigra:		Stria gravidarum:
Any abnormal v	veins:	
Any scar mark		
<u>Palpation</u>		
Fundal height i	n weeks:	
Symphysio-Fun	dal Height in centimetres:	
Abdominal Girt	th in inches:	
Fundal Grip:		
Right Lateral G	rip:	
Left Lateral Gri	p:	
1 st Pelvic Grip:		
2 nd Right Latera	al Grip:	
Uterine contra	ctions: in 10 minute:	5
Auscultation:		
Location, Rate,	Rhythm of Fetal Heart Sound	
Interpretation	based on palpation	
Number of fetu	ises	
Lie		
Presentation		
Liquor: increase	ed/average/reduced	
Uterus: relaxed	I/ contractions if present descr	ibe frequency, duration and intensity
Per speculum e	examination: (if indicated)	
Per vaginal exa	mination: (when indicated)	
Pelvimetry: (if	indicated)	
Provisional Dia	gnosis:	

Investigations:		
Hb:		
ABO Rh:		
Urine routine, microscopic:		
HIV: (both H&W)	HBsAg: (both H&W)	VDRL: (both H&W)
OGTT 1st 75 gm:		
OGTT 2 nd 75 gm:		
Thyroid Profile:		
Urine culture:		
Imaging (USG):Date		
Others:		
Risk factors identified:		
Final diagnosis:		
Summary:		
Advice:		
Language of the second		
Follow up :		
Plan of delivery:		

Appendix 2

Gynecology Case Record

Patient identification data & demography:	
Name:	Date:
Age:	
Address:	
Mobile Number:	
Consultant Incharge:	
Occupation:	
Educational status	
Income:	
Registration Number:	
Chief Complaints:	
History of Presenting Illness:	

History of Past Illness:

Tuberculosis / Hypertension/ Diabetes Any other relevant Medical History Any other relevant Surgical History

Personal History:

Diet

Sleep

Appetite

Bladder and Bowel

Addiction

Family History:

Tuberculosis / Hypertension/ Diabetes Malignancy Hereditary disease Others:

Menstrual History:

Cycles: regular/irregular

Age of Menarche Frequency of cycle

Amount and duration of flow

Dysmenorrhoea Other complaints Last Menstrual Period:

Obstetrical History:

General Examination

General condition:

Pulse:

Temperature: Blood Pressure: Respiratory Rate:

Pallor:

Icterus:

Lymphadenopathy:

Cyanosis: Clubbing:

Pedal Edema:

Thyroid Examination: Breast Examination:

Spine and gait

Systemic Examination

Respiratory System:
Cardiovascular System:
Central Nervous System:
Per Abdomen Examination Inspection:
Palpation:
Percussion:
Auscultation:
Local Genital Examination
Per Speculum Examination Vagina:
Cervix:
Discharge:
If any evidence of utero-vaginal descent perform relevant examintion:
Per Vaginal Examination
Uterus
Size: Normal/ Enlarged, Symmetrical/ Asymmetrical
Direction: Anteverted/ Retroverted
Mobility: Freely Mobile/ Restricted / Fixed
Cervix:
Fornices: free /fullness, tender/ non tender
Right Adnexa: If any mass is felt through the fornices, describe the mass
Left Adnexa:
Pouch of Douglas:

Uterosacral	ligaments:
-------------	------------

Per-Rectal Examination (if required):

Provisional Diagnosis

Differential Daignosis

S No.	Diagnosis	Points for	Points Against

Investigations:

r	•	D	ø	٠	
١,	,	D	۲,	,	i

Urine routine and microscopic examination:

Blood group:

HIV : HBS Ag : RFT: LFT:

Blood Sugar : Urine culture: Pus culture:

Follow-Up:

Case Summary:

Appendix 3 Labor Case Record

Labor Case Record Patient Identification Data and Demography: Date: A NC Reg no: Name Husband's name: Age Age Educational status: Educational status: Occupation: Occupation: Address: Socioeconomic status: Booked/Un-booked: **Chief Complaints: History of Present Complaints:** History of present pregnancy: (Trimester-wise)

Status of vaccination: Menstrual History : Age at Menarche :

G_ P_ A_ L_MTP
Duration of marriage:
Obstetric History :
Gestational Age :
EDD:
LMP:
Mention if in lactation amenorrhea or breastfeeding
Cycles: regular/ irregular, duration, frequency,

Obstetric History Details:

Number	Month &	Any high risk	Mode of	Indication if CS or	Baby Details	Post partum	Baby
	Year,	factor in	Delivery	operative delivery	(Sex/Apgar/	complications	vaccina-
	gestational	pregnancy			Weight)	If any	tion
	age at						
	delivery						

Contraceptive History:

Family History:

Twin/Congenital Malformation/ Hypertension/Diabetes Mellitus/Any Other Chronic Illness

Personal History:

Vegetarian/Non-Vegetarian

Daily Calorie intake:

Deficit, if any:

Appetite								
Bladder								
Bowel	Bowel							
Addiction	Addiction							
Domestic Viol	ence							
Drug History/	Medication History:							
Any Allergies:								
Past History:								
Medical : Tube	erculosis/Epilepsy/Any Othe	r Chronic Illness ; Blood transfusion						
History of any	Surgery:							
General Exam	ination:							
Built: Average	/Poor/Well							
Height:	Cms							
Weight:	Kgs							
PR:								
RR:								
BP:								
Pallor:								
Edema:								
Icterus:								
Thyroid:								
Breast Examin	ation:							
Lymphadenop	eathy:							
Systemic Exar	nination:							
Cardiovascula	r system:							
Respiratory sy	stem:							
Nervous system:								
Obstetrical Ex	amination :							
Inspection:								
Contour of ab	domen	Flanks : full/not full						
Umbilicus:	Central/Displaced	Inverted/Everted/Flat						
Linea nigra:		Stria gravidarum:						

Any abnormal veins:
Any scar mark
<u>Palpation</u>
Fundal height in weeks:
Symphysio-Fundal Height in centimeters:
Abdominal Girth in inches:
Fundal Grip:
Right Lateral Grip:
Left Lateral Grip:
1st Pelvic Grip:
2 nd Right Lateral Grip:
Superficial Pelvic Grip:
Deep Pelvic Grip:
Uterine contractions:
Auscultation:
Location, Rate, Rhythm of Fetal Heart Sound
Interpretation based on palpation
Number of fetuses
Lie
Presentation
Liquor: increased/average/reduced
Uterus: relaxed/ contractions if present describe frequency, duration and intensity
Per speculum examination: (if indicated)
Mention any swelling/ulcer/skin changes/vesicles
Per vaginal examination: (when indicated)

Cervix: length/dilatation/bag of membranes/discharge/leaking from cervical os/position of the cervix/consistency of cervix/ Status of membranes intact or ruptured

Station of head Color of liqour if ruptured membranes Presenting Part and station

Vagina: septum/growth/cyst/tag/dilated varcose veins

Discharge: color/smell/ amount/watery /blood mixed/purulent

Pelvimetry: (if indicated)

Sacral promontory
Anterior surface of sacrum and sacral curve
Side walls paralell or convergent
Sacrosciatic notches
Interischial diameter
Sub pubic angle
Transverse diameter of outlet
Any other finding

Provisional Diagnosis:		
Investigations:		
Hb:		
ABO Rh:		
Urine routine, microsco	pic:	
HIV: (both H&W)	HBsAg: (both H&W)	VDRL: (both H&W)
OGTT 1st 75 gm:		
OGTT 2 nd 75 gm:		
Thyroid Profile:		
Urine culture:		
Imaging (USG):Date		
Others :		
Risk factors identified:		
Labor Notes:		
Labor: Spontaneous / Au	gmented/Induced	

If induced: ARM / Syntocinon / PG/ Foley's/ Prostaglandins

Indication of induction/augmentation:

Stag	es of Labour	Time Started	Time Finished	Duration Lasted
IV.	Stage			
٧.	Stage			
VI.	Stage			
Mode	of Delivery:			
Norm	al/Forceps / Vent	ouse/ Assisted Breed	:h	
If ope	rative delivery the	en mention the indic	ation	
Date	and Time:			
Cond	ucted By:			
Assist	ed By:			
Super	vised By:			
Exam	ination of Placent	a:		
AMTS	L:			
Intra	Partum or Post Pa	artum Maternal Com	plications:	

Date and Time

Baby Notes

No.
Sex
Cried Immediately after Birth- Y/N
Weight
APGAR Score at 1min
APGAR Score at 5min
NICU Admission
Duration of Stay In NICU

WHO LABOUR CARE GUIDE

Name							Parity	/	Labour ons	et				Active labo	ur diagr	nosis [l	Date			
Ruptured	membran	es [Date		Time	tir] Risk	factors													
		Time Hours	84		1	1		- 0	1	- 1		- 1	1	: 12		:	1	:	_	1
	1	ALERT	←	1	2	3			6 RST STAC		8 !	9 1	10 1	11 12			1 CONI	STA	2 AGE •	_
Z Com	mpanion	N	9/43							0.002					2000	0000		60m100g	26.504-01	
Pai	in relief	N													-					_
Ora	ral fluid	N																		_
Compositive Care	osture	SP													s					
Ba	aseline	<110, ≥160														П	П		$\overline{\Box}$	
	FHR FHR eleration	L																		
	iotic fluid	M+++, B																		
Amni Fetal	position	P, T								7 - 3	77									
C	Caput	+++													il.					
Mo	oulding	+++								22-6										
F	Pulse	<60, ≥120		Ì	Ĭ	Î	Î													
Syst	stolic BP	<80, ≥140																		
Dias	stolic BP	≥90																		T
ĭempe	erature °C	<35.0, ≥ 37.5													ii)					
ι	Urine	P++, A++																		T
Cont	tractions r 10 min	≤2, >5													П		П	Т	П	T
Dur	ration of	<20, >60														H	H	H	Н	H
cont	tractions 10													\vdash	\pm	H	H	H		H
LABOUR PROGRESS [blo.]	9 8 7 6 5	≥ 2h ≥ 2.5h ≥ 3h ≥ 5h ≥ 6h													In rec tr cu ex seco	active ord ce iggere urrent ceede nd sta whe	first s rvical ed who cervic d with ge, ins n push	tage, p dilata en lag al dila no pr ert P ing be	olot ') tion. I time tation ogres to in egins.	(' to Alert for n is s. In dicat
[A	5																			
D	4														-		_			_
[Plot	ot 0] 2																			-
	1																			\vdash
	0																			
Оху	ytocin (U/L,	drops/min)			1															
Medication Med	dicine																			
E IV fl	luids											-			-					_
	SESSMENT																			
INIT	TIALS																			

INSTRUCTIONS: CIRCLE ANY OBSERVATION MEETING THE CRITERIA IN THE 'ALERI' COLUMN, ALERT THE SENIOR MIDWIFE OR DOCTOR AND RECORD THE ASSESSMENT AND ACTION TAKEN.IF LABOUR EXTENDS BEYOND 12H, PLEASE CONTINUE ON A NEW LABOUR CARE GUIDE. Abbreviations: Y – Yes, N – No, D – Declined, U – Unknown, SP – Supine, MO – Mobile, E – Early, L – Lair, V – Variable, I – Intact, C – Clear, M – Meconium, B – Blood, A – Anterior, P – Posterior, T – Transverse, P + – Protein, A + – Acetone

© World Health Organization, 2021, Some rights reserved, Licence (CC BY-NC-SA 2.0 IGO). The WHO Labour Care guide should be used in conjunction with the User's Manual, Responsibility for the interpretation and use of the material lies with the reader. In no event shall the WHO be liable for damages arising from its use.

Advice on Discharge		
Follow Up:		

Final Summary:

Appendix 4

Learner Doctor Case Record

Patient Identification Data
Name of the patient :
Age:
Education :
Wife
Husband Residence: Urban / Semi urban / Rural / City Slum / Occupation: Wife Husband Socio-economic class:
Religion: (Hindu / Muslim / Christian / Sikh/any other) Type of family: Joint / nuclear Contact person's name: Telephone: Type of admission: OPD / emergency / referral / Booked / Unbooked
Date of Admission:
Date of Discharge:
Date of Delivery/ Surgery:
Outcome of patient: Cured / Controlled / Referred / LAMA/ Death
Chief Complaints:

Mens	trual	histo	rv:

Age of menarche:

L.M.P:

Past menstrual history : Regular/irregular

Frequency of cycle: Duration of cycle:

Present menstrual history:

Other associated ailments: pain / clots / systemic complains

Active marriage life:

Obstetric History: G-----P-----A----MTP----

	Type of Delivery	Gestational Age	Live birth/ stillbirth/ neonatal death	Current age of child	Breast- feeding	Vaccination
1 st						
2 nd						
3 rd						
4 th						
5 th						
6 th						

Number of live children:

History of contraception usage:

Past History:

Medical

Surgical

Blood transfusion

Family History:	
Personal & Social History:	
Modication History	
Medication History: History of Allergy: Current ongoing medications:	
current origonia medications.	Examination on Admission:
General Examination:	<u> </u>
Vitals:	
Systemic Examination:	
Respiratory system:	
Cardiovascular system:	
caraiorascaiai systemi	
Nervous system:	
B	
Per abdomen examination:	
Per Speculum examination:	
Per vaginal examination:	
Provisional Diagnosis:	

Investigations suggested:
Treatment Plan: (Pharmacological and Non-Pharmacological including special nursing care)
Differential Diagnosis:
Treatment Received:

Daily Monitoring Chart: (to be filled by student -doctor on daily basis)

Date & Time	Response to treatment in chief complaints	Any new complaints	Results of investigations	Treatment /advice modified (if any)

Final Appraisal:

Discharge Summary

Patient Name:	Hospital indoor no.:
Age:	
Address:	
Final Diagnosis	
DOA:	
DOD:	
Date of Procedure/ Operation:	
Indication of Procedure/ Operation	
Patient's condition on admission:	
Treatment Provided:	
Delivery / Procedure / OT notes summary:	
Condition on Discharge:	
Advice on Discharge: (Pharmacological / Non-pharmacological /	gical)
Date of part follow up:	
Date of next follow up:	
When & How to obtain Urgent care	