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: ……..…..

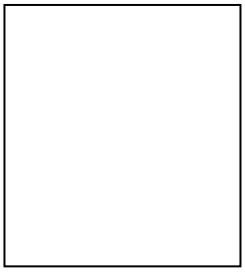
Admission Batch:……..……

University Registration number ……..

(Adapted from Undergraduate Log Book cum Portfolio by FOGSI)

INDEX

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 candidate
Mr/ Ms .....
Reg No. .....
Admitted in the year ----------
in (Medical College) ----------
has satisfactorily completed / has not completed all assignments mentioned in this logbook for MBBBS course in the subject of Obstetrics and Gynecology during the period from..... to .....
She / He is / is not eligible to appear for the summative (University) assessment.

Signature of Unit head:

(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.	Competency # addressed	Name of Activity	Date completed: 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 **Total: 5**						

3.	**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 **Total: 10**						
4.	**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**	Learner-Doctor Method of 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 allotted to						

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

21	**OG 35.17**	Write informed consent for examination / procedure						
22	**OG 35.10**	Referral note						
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						

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)					

8

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:

1. Provide peri-conceptional counselling and antenatal care
2. Identify high-risk pregnancies and refer appropriately
3. Conduct normal deliveries, using safe delivery practices in the primary and secondary care settings
4. Prescribe drugs safely and appropriately in pregnancy and lactation
5. Diagnose complications of labor, institute primary care and refer in a timely manner
6. Perform early neonatal resuscitation
7. Provide postnatal care, including education in breast-feeding
8. Counsel and support couples in the correct choice of contraception,
9. Interpret test results of laboratory and radiological investigations as they apply to the care of the obstetric patient
10. 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:

1. Elicit a gynecologic history, perform appropriate physical and pelvic examinations and PAP smear in the primary care setting,
2. Recognize, diagnose and manage common reproductive tract infections in the primary care setting,
3. 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 andpuerperal 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:

a) The logbook is a record of the academic / co-curricular activities of the designated student, who would be responsible for maintaining his/her logbook.

b) The student is responsible for getting the entries in the logbook verified by the designated faculty regularly.

c) 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.

12

Understanding the logbook activity table:

S No.	Competency # addressed	Name of Activity	Date completed: 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.								
2.								
3.								
4.								
5.								
6.								
7.								

1. **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
   b. Repeat (R) of a previously done activity
   c. Remedial activity (Re) based on the determination by the faculty

5. **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
   b. R: activity needs to be repeated without any further intervention
   c. 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

9. **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	

14

PHASE II

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)

16

Status of vaccination:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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 :

18

Investigations:

Risk factors identified:

Final diagnosis:

Summary:

Advice:

Follow up :

Plan of delivery:

Antenatal Case Record 2

Patient Identification Data and Demography:

Chief Complaints:

History of Present Complaints: (ODP)

History of present pregnancy: (Trimester-wise)

Status of vaccination:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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 :

22

Investigations:

Risk factors identified:

Final diagnosis:

Summary:

Advice:

Follow up :

Plan of delivery:

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:

24

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

26

Investigations:

Final Diagnosis:

Treatment Plan:

Follow-Up:

Case Summary:

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

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 marriage life:

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

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

Number of live children:

History of contraception usage:

Past History:

Family History:

Personal & Social History:

Medication History:

30

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:

32

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)

Date of next follow up:
When & How to obtain Urgent care

34

Learner Doctor Case Record 2

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:

Menstrual history:

Active marriage life:

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

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

Number of live children:

History of contraception usage:

Past History:

Family History:

Personal & Social History:

Medication History:

36

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 / Procedure / OT notes summary:

Condition on Discharge:

Advice on Discharge: (Pharmacological / Non-pharmacological)

Date of next follow up:

Hand washing and personal protective precautions as DOAP in simulated environment

Done –

Not done -

Phase- 3

Part - 1

42

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:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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:

46

Antenatal Case Record 4

Patient Identification Data and Demography:

Chief Complaints:

History of Present Complaints:

History of present pregnancy: (Trimester-wise)

Status of vaccination:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

Contraceptive History:

Family History:

Personal & Social History:

Drug History/ Medication History:

Past History:

48

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:

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:

52

Per Vaginal Examination:

Per-Rectal Examination (if required):

Provisional Diagnosis

Differential Diagnosis

S No.	Diagnosis	Points for	Points Against

Investigations:

Final Diagnosis:

Treatment Plan:

Follow-Up:

Case Summary:

54

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:

56

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

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:

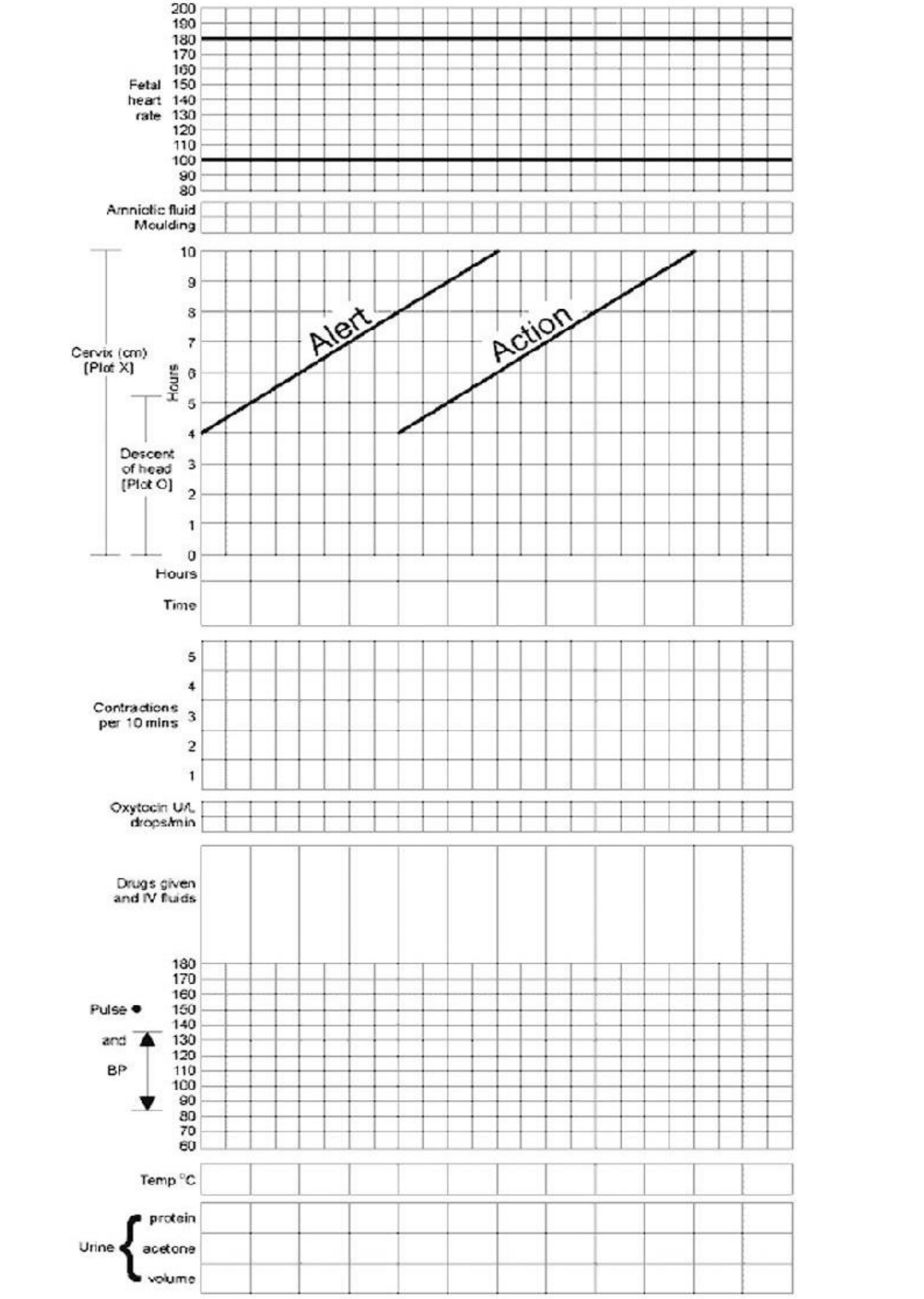
Examination of Placenta:

Intra Partum or Post Partum Maternal Complications:

Baby Notes

No. Date and Time
Sex
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



60

WHO LABOUR CARE GUIDE

Name Parity Labour onset Active labour diagnosis [Date]

Ruptured membranes [Date Time] Risk factors

			Time : : : : : : : : : : : : : : : : :
			Hours 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3
			ALERT ← ACTIVE FIRST STAGE → ← SECOND STAGE →
SUPPORTIVE CARE	Companion	N	
	Pain relief	N	
	Oral fluid	N	
	Posture	SP	
BABY	Baseline FHR	<110, ≥160	
	FHR deceleration	L	
	Amniotic fluid	M+++, B	
	Fetal position	P, T	
	Caput	+++	
	Moulding	+++	
WOMAN	Pulse	<60, ≥120	
	Systolic BP	<80, ≥140	
	Diastolic BP	≥90	
	Temperature °C	<35.0, ≥ 37.5	
	Urine	P++, A++	
LABOUR PROGRESS	Contractions per 10 min	≤2, >5	
	Duration of contractions	<20, >60	
	Cervix [Plot X] 10		
	9	≥ 2h	
	8	≥ 2.5h	
	7	≥ 3h	
	6	≥ 5h	
	5	≥ 6h	
	Descent [Plot O] 5		
	4		
	3		
	2		
	1		
	0		
MEDICATION	Oxytocin (U/L, drops/min)		
	Medicine		
	IV fluids		
SHARED DECISION-MAKING	ASSESSMENT		
	PLAN		
	INITIALS		

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

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, V – Variable, I – Intact, C – Clear, M – Meconium, B – Blood, A – Anterior, P – Posterior, T – Transverse, P+ – Protein, A+ – Acetone

Advice on Discharge : (pharmacological / Non pharmacological)

Follow Up:

Final Summary:

62

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

64

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/ Caesarean) Note in brief

AMTSL:

Date and Time:

Conducted By: Assisted By:

Supervised By:

Examination of Placenta:

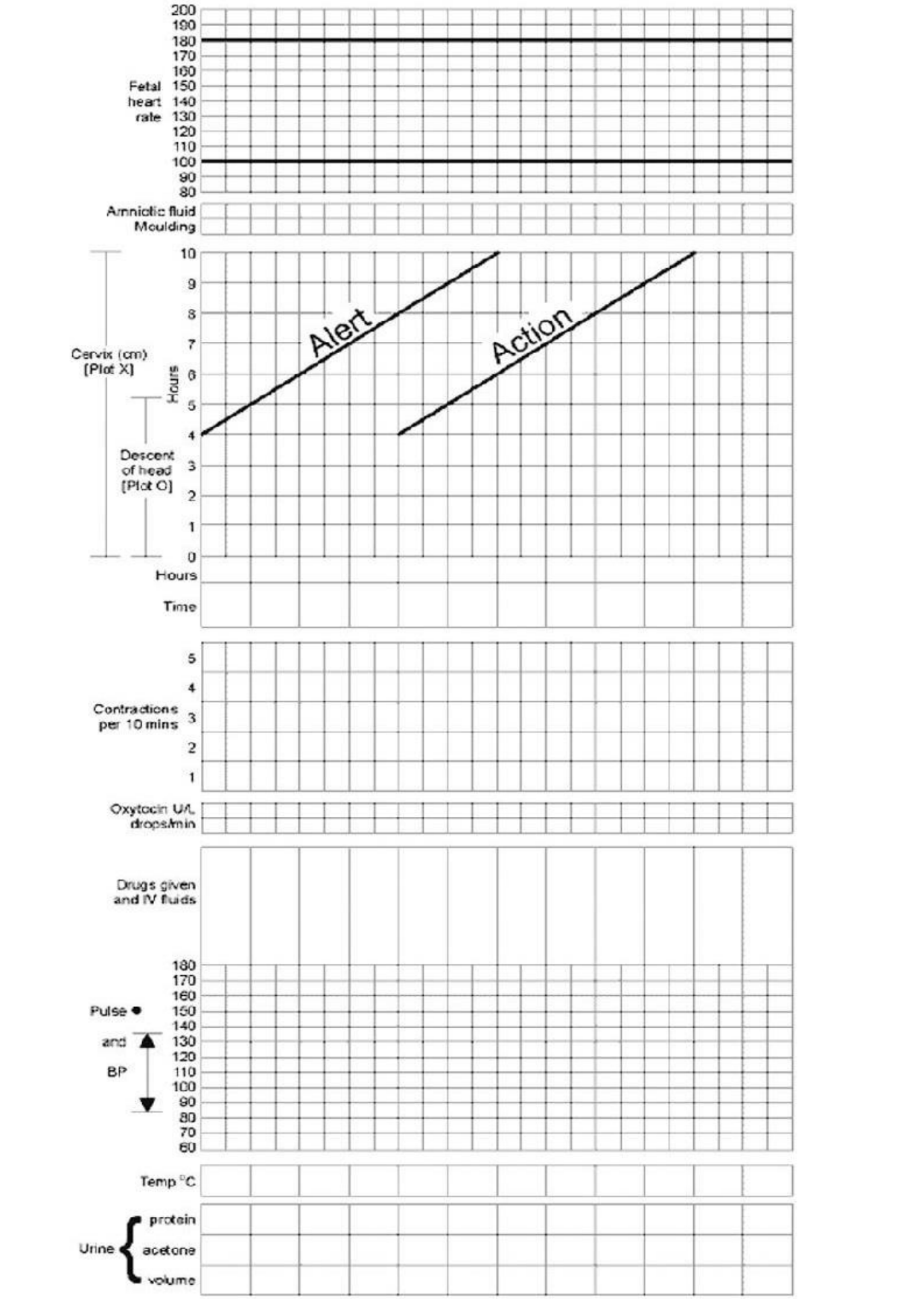
Intra Partum or Post Partum Maternal Complications:

Baby Notes

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

66

WHO modified Partograph



WHO LABOUR CARE GUIDE

Name Parity Labour onset Active labour diagnosis [Date]

Ruptured membranes [Date Time] Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →													← SECOND STAGE →		
SUPPORTIVE CARE	Companion	N																	
	Pain relief	N																	
	Oral fluid	N																	
	Posture	SP																	
BABY	Baseline FHR	<110, ≥160																	
	FHR deceleration	L																	
	Amniotic fluid	M+++, B																	
	Fetal position	P, T																	
	Caput	+++																	
	Moulding	+++																	
WOMAN	Pulse	<60, ≥120																	
	Systolic BP	<80, ≥140																	
	Diastolic BP	≥90																	
	Temperature °C	<35.0, ≥ 37.5																	
	Urine	P++, A++																	
LABOUR PROGRESS	Contractions per 10 min	≤2, >5																	
	Duration of contractions	<20, >60																	
	Cervix [Plot X]	10																	
		9	≥ 2h																
		8	≥ 2.5h																
		7	≥ 3h																
		6	≥ 5h																
		5	≥ 6h																
	Descent [Plot O]	5																	
		4																	
		3																	
		2																	
		1																	
		0																	
MEDICATION	Oxytocin (U/L, drops/min)																		
	Medicine																		
	IV fluids																		
SHARED DECISION-MAKING	ASSESSMENT																		
	PLAN																		
	INITIALS																		

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

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Abbreviations: **Y** – Yes, **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** – Posterior, **T** – Transverse, **P+** – Protein, **A+** – Acetone

68

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

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 :

Investigations

72

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:

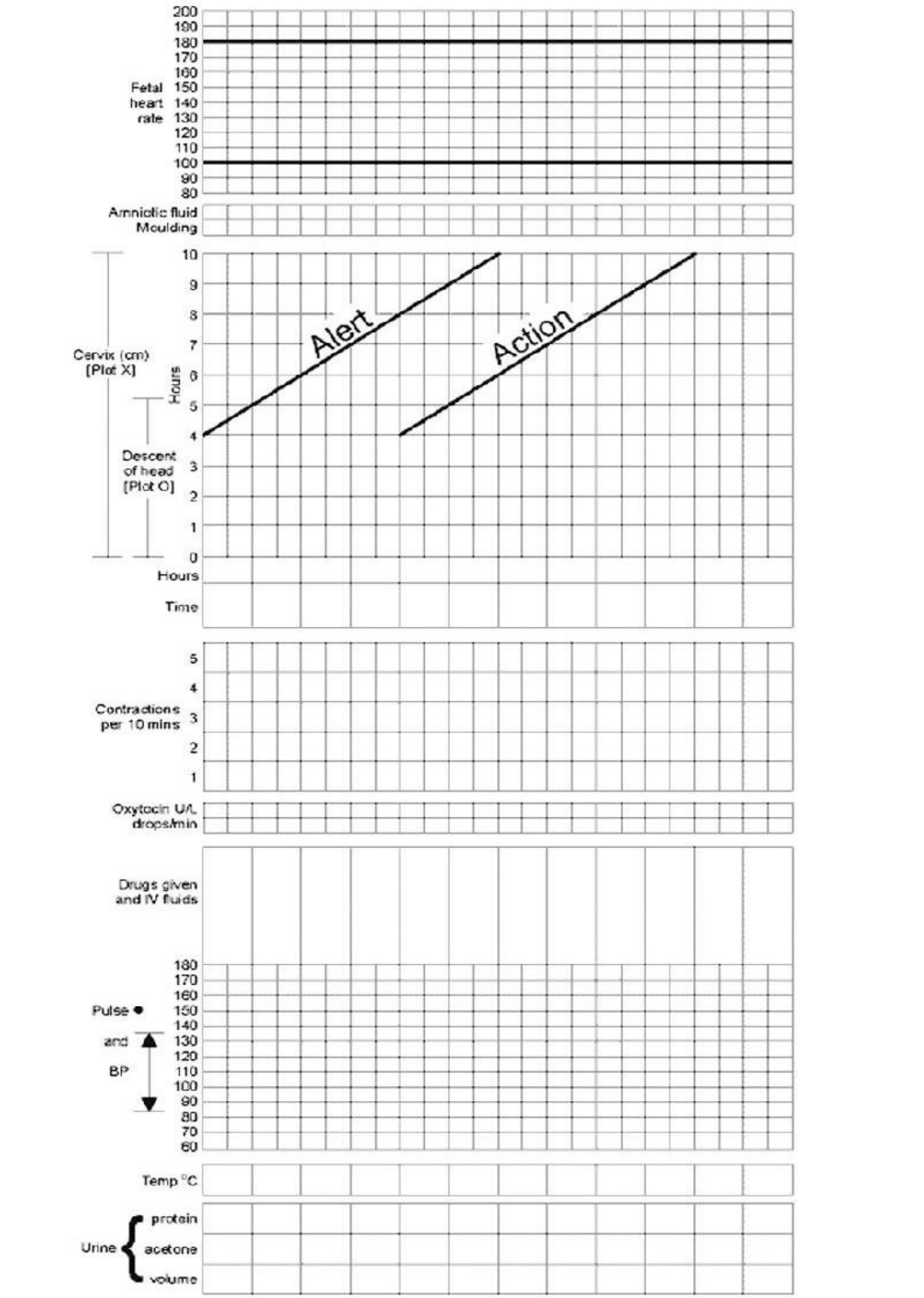
Examination of Placenta:

Intra Partum or Post Partum Maternal Complications:

Baby Notes

No. Date and Time
Sex
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



74

WHO LABOUR CARE GUIDE

Name Parity Labour onset Active labour diagnosis [Date]

Ruptured membranes [Date Time] Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →													← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N																
	Pain relief		N																
	Oral fluid		N																
	Posture		SP																
BABY	Baseline FHR		<110, ≥160																
	FHR deceleration		L																
	Amniotic fluid		M+++, B																
	Fetal position		P, T																
	Caput		+++																
	Moulding		+++																
WOMAN	Pulse		<60, ≥120																
	Systolic BP		<80, ≥140																
	Diastolic BP		≥90																
	Temperature °C		<35.0, ≥ 37.5																
	Urine		P++, A++																
LABOUR PROGRESS	Contractions per 10 min		≤2, >5																
	Duration of contractions		<20, >60																
	Cervix [Plot X]	10																	
		9	≥ 2h																
		8	≥ 2.5h																
		7	≥ 3h																
		6	≥ 5h																
		5	≥ 6h																
	Descent [Plot O]	5																	
		4																	
		3																	
		2																	
		1																	
		0																	
MEDICATION	Oxytocin (U/L, drops/min)																		
	Medicine																		
	IV fluids																		
SHARED DECISION-MAKING	ASSESSMENT																		
	PLAN																		
	INITIALS																		

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

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.

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Advice on Discharge : (pharmacological / Non pharmacological)

Follow Up:

Final Summary:

76

Normal Labour Case Record 4

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

78

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
I. Stage			
II. Stage			
III. Stage			

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

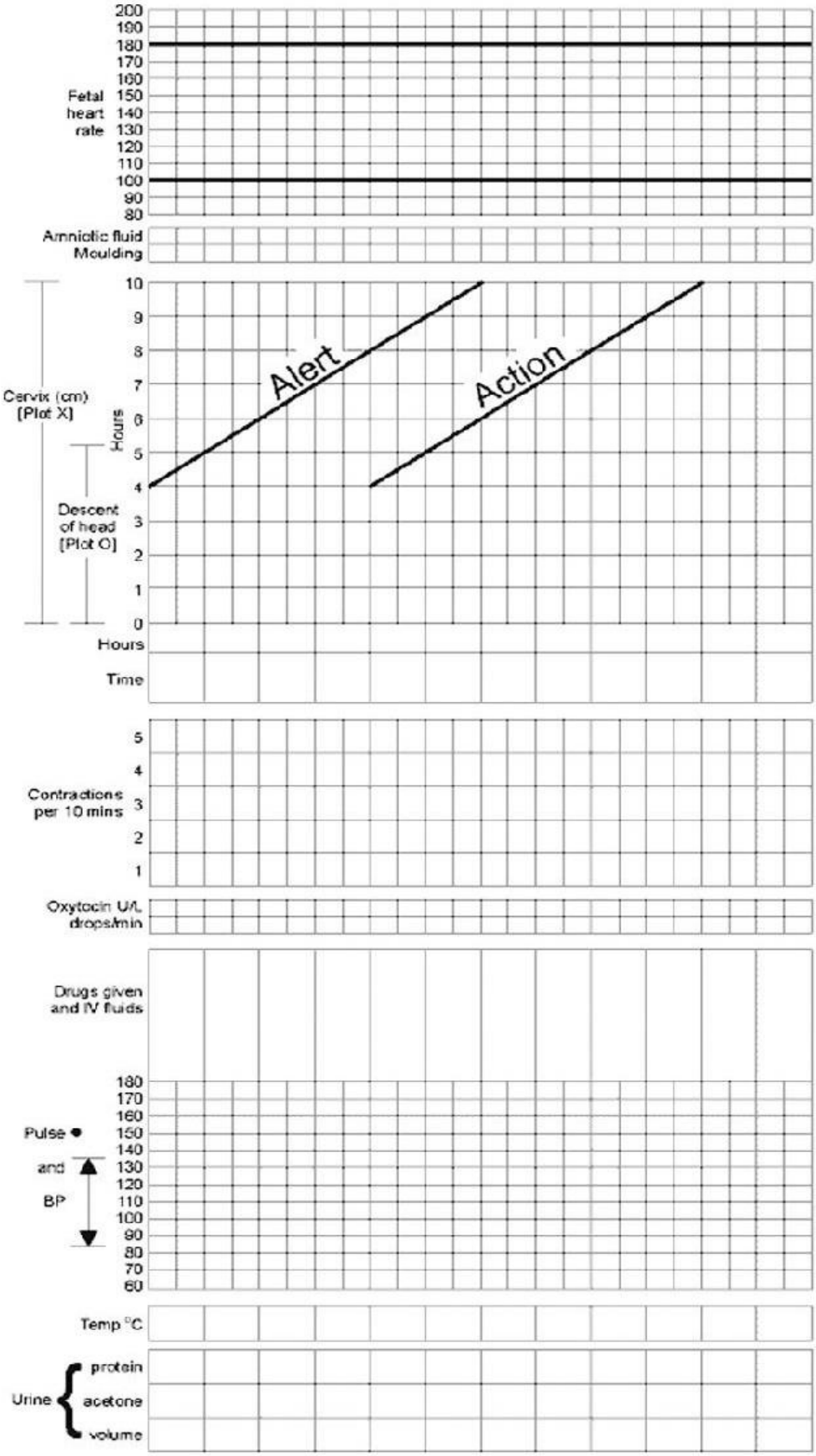
No. Date and Time
Sex
Cried Immediately after Birth- Y/N
Weight
APGAR Score at 1min
APGAR Score at 5min
NICU Admission
Duration of Stay In NICU

80

WHO Modified Partograph

Name Gravida Para Hospital number

Date of admission Time of admission Ruptured membranes hours



WHO LABOUR CARE GUIDE

Name | Parity | Labour onset | Active labour diagnosis [Date]

Ruptured membranes [Date | Time] | Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →													← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N																
	Pain relief		N																
	Oral fluid		N																
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	Fetal position		P, T																
	Caput		+++																
	Moulding		+++																
WOMAN	Pulse		<60, ≥120																
	Systolic BP		<80, ≥140																
	Diastolic BP		≥90																
	Temperature °C		<35.0, ≥ 37.5																
	Urine		P++, A++																
LABOUR PROGRESS	Contractions per 10 min		≤2, >5																
	Duration of contractions		<20, >60																
	Cervix [Plot X]	10																	
		9	≥ 2h														In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.		
		8	≥ 2.5h																
		7	≥ 3h																
		6	≥ 5h																
		5	≥ 6h																
	Descent [Plot O]	5																	
		4																	
		3																	
		2																	
		1																	
		0																	
MEDICATION	Oxytocin (U/L, drops/min)																		
	Medicine																		
	IV fluids																		
SHARED DECISION-MAKING	ASSESSMENT																		
	PLAN																		
	INITIALS																		

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.

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82

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

84

Menstrual history:

Active marriage life:

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

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

Number of live children:

History of contraception usage:

Past History:

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:

86

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)

Date of next follow up:
When & How to obtain Urgent care

Learner Doctor Case Record 4

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

90

Menstrual history:

Active marriage life:

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

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

Number of live children:

History of contraception usage:

Past History:

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:

92

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:

94

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)

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

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:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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:

Summary:

Advice:

Follow up :

Plan of delivery:

Antenatal Case Record 6

Patient Identification Data and Demography:

Chief Complaints:

History of Present Complaints:

History of present pregnancy: (Trimester-wise)

Status of vaccination:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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:

Risk factors identified:

Final diagnosis:

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 :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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:

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:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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:

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:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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:

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:

Menstrual History :

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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:

Risk factors identified:

Final diagnosis:

Summary:

Advice:

Follow up :

Plan of delivery:

Gynecological Case Record 3

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

Investigations:

Final Diagnosis:

Treatment Plan:

Follow-Up:

Case Summary:

Gynecological Case Record 4

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

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

Investigations:

Final Diagnosis:

Treatment Plan:

Follow-Up:

Case Summary:

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 :

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 / 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:

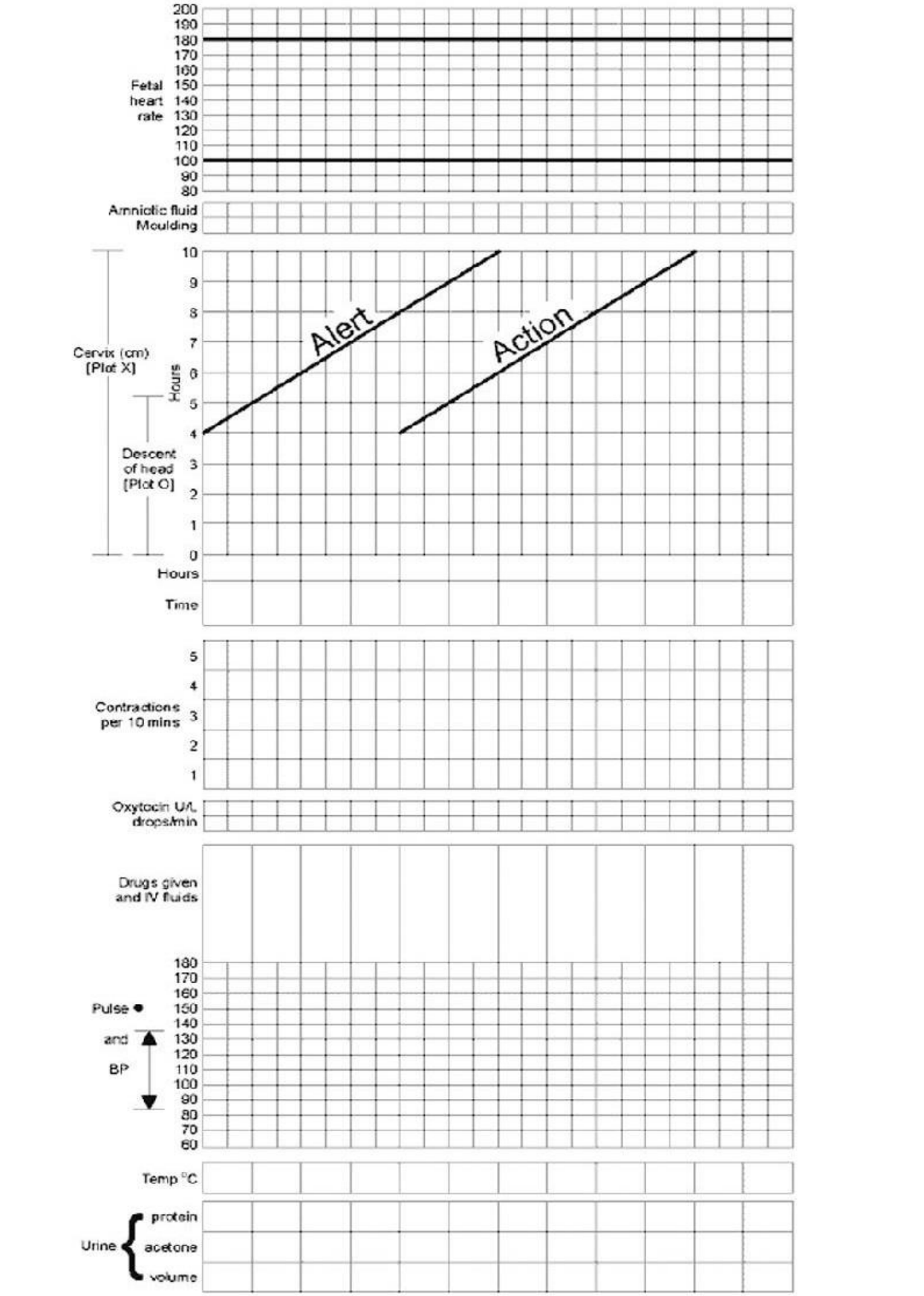
Examination of Placenta:

Intra Partum or Post Partum Maternal Complications:

Baby Notes

No. Date and Time
Sex
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

Name | Parity | Labour onset | Active labour diagnosis [Date]

Ruptured membranes [Date | Time] | Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N															
	Pain relief		N															
	Oral fluid		N															
	Posture		SP															
BABY	Baseline FHR		<110, ≥160															
	FHR deceleration		L															
	Amniotic fluid		M+++, B															
	Fetal position		P, T															
	Caput		+++															
	Moulding		+++															
WOMAN	Pulse		<60, ≥120															
	Systolic BP		<80, ≥140															
	Diastolic BP		≥90															
	Temperature °C		<35.0, ≥ 37.5															
	Urine		P++, A++															
LABOUR PROGRESS	Contractions per 10 min		≤2, >5															
	Duration of contractions		<20, >60															
	Cervix [Plot X]	10																
		9	≥ 2h													In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.		
		8	≥ 2.5h															
		7	≥ 3h															
		6	≥ 5h															
		5	≥ 6h															
	Descent [Plot O]	5																
		4																
		3																
		2																
		1																
		0																
MEDICATION	Oxytocin (U/L, drops/min)																	
	Medicine																	
	IV fluids																	
SHARED DECISION-MAKING	ASSESSMENT																	
	PLAN																	
	INITIALS																	

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, V – Variable, I – Intact, C – Clear, M – Meconium, B – Blood, A – Anterior, P – Posterior, T – Transverse, P+ – Protein, A+ – Acetone

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 :

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 / 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:

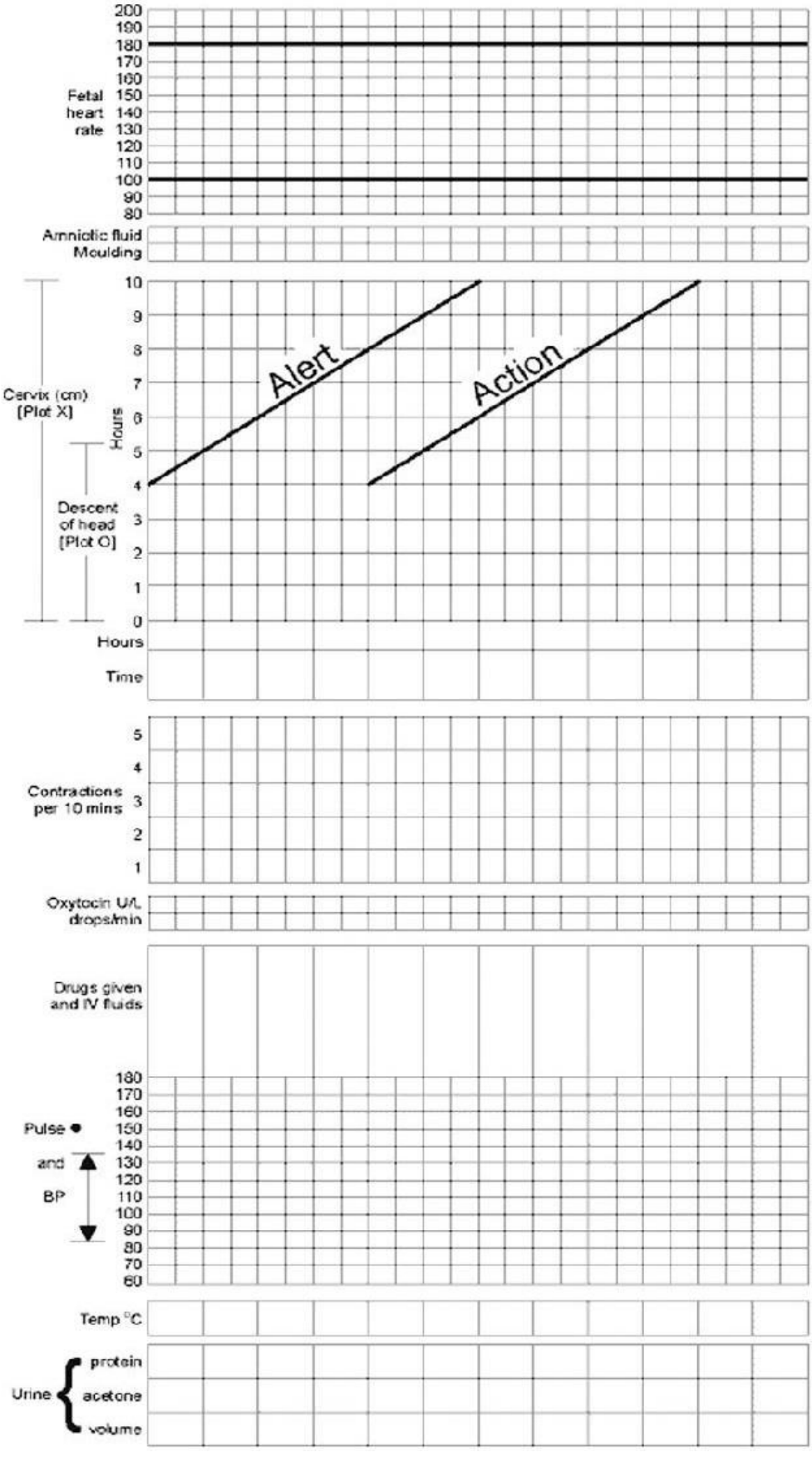
Baby Notes

No. Date and Time
Sex
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

Name | Gravida | Para | Hospital number

Date of admission | Time of admission | Ruptured membranes | hours



WHO LABOUR CARE GUIDE

Name Parity Labour onset Active labour diagnosis [Date]

Ruptured membranes [Date Time] Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N															
	Pain relief		N															
	Oral fluid		N															
	Posture		SP															
BABY	Baseline FHR		<110, ≥160															
	FHR deceleration		L															
	Amniotic fluid		M+++, B															
	Fetal position		P, T															
	Caput		+++															
	Moulding		+++															
WOMAN	Pulse		<60, ≥120															
	Systolic BP		<80, ≥140															
	Diastolic BP		≥90															
	Temperature °C		<35.0, ≥ 37.5															
	Urine		P++, A++															
LABOUR PROGRESS	Contractions per 10 min		≤2, >5															
	Duration of contractions		<20, >60															
	Cervix [Plot X]	10																
		9	≥ 2h													In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.		
		8	≥ 2.5h															
		7	≥ 3h															
		6	≥ 5h															
		5	≥ 6h															
	Descent [Plot O]	5																
		4																
		3																
		2																
		1																
		0																
MEDICATION	Oxytocin (U/L, drops/min)																	
	Medicine																	
	IV fluids																	
SHARED DECISION-MAKING	ASSESSMENT																	
	PLAN																	
	INITIALS																	

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.
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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:

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:

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:

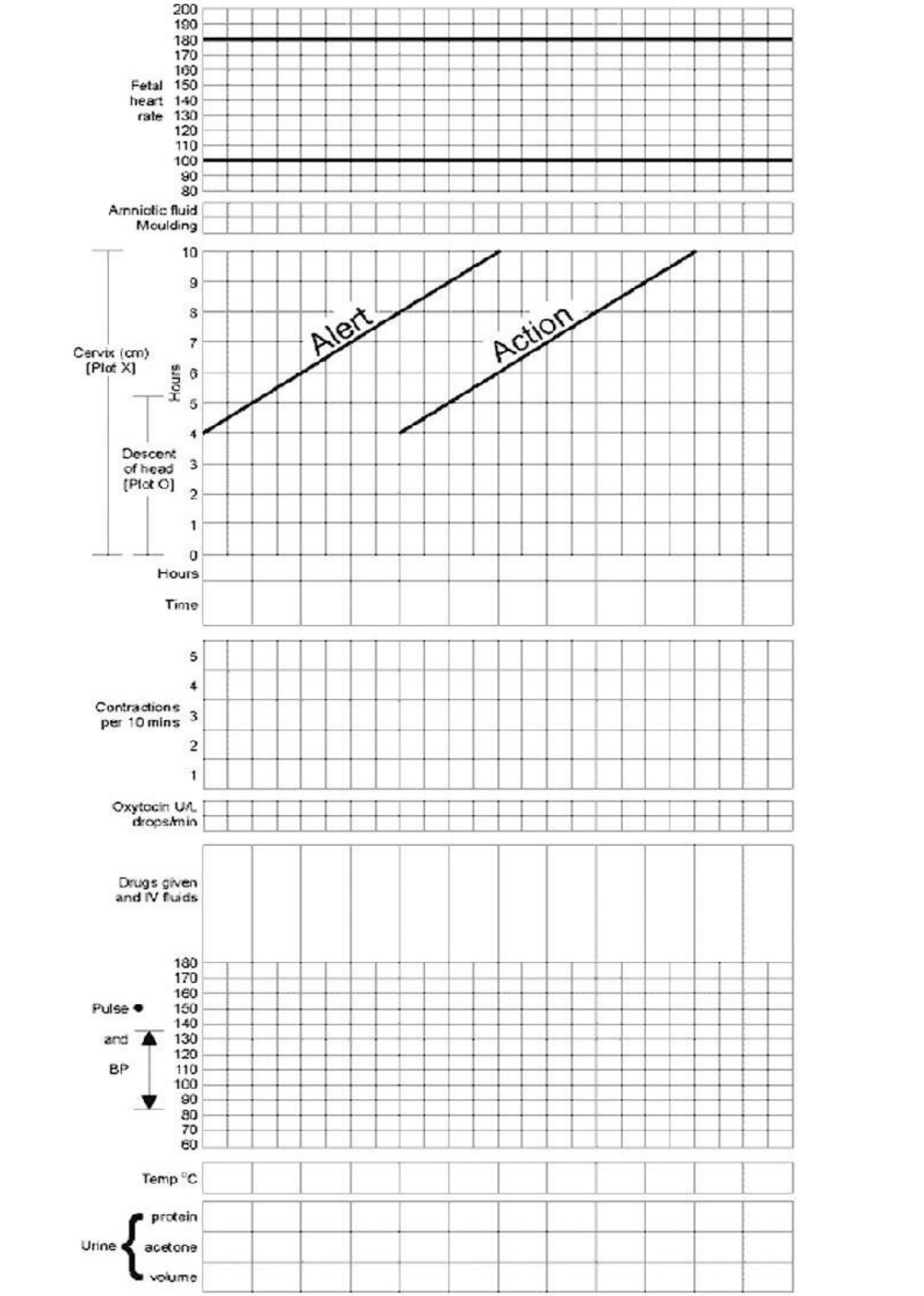
Examination of Placenta:

Intra Partum or Post Partum Maternal Complications:

Baby Notes

No. Date and Time
Sex
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

Name Parity Labour onset Active labour diagnosis [Date]

Ruptured membranes [Date Time] Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N															
	Pain relief		N															
	Oral fluid		N															
	Posture		SP															
BABY	Baseline FHR		<110, ≥160															
	FHR deceleration		L															
	Amniotic fluid		M+++, B															
	Fetal position		P, T															
	Caput		+++															
	Moulding		+++															
WOMAN	Pulse		<60, ≥120															
	Systolic BP		<80, ≥140															
	Diastolic BP		≥90															
	Temperature °C		<35.0, ≥ 37.5															
	Urine		P++, A++															
LABOUR PROGRESS	Contractions per 10 min		≤2, >5															
	Duration of contractions		<20, >60															
	Cervix [Plot X]	10																
		9	≥ 2h													In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.		
		8	≥ 2.5h															
		7	≥ 3h															
		6	≥ 5h															
		5	≥ 6h															
	Descent [Plot O]	5																
		4																
		3																
		2																
		1																
		0																
MEDICATION	Oxytocin (U/L, drops/min)																	
	Medicine																	
	IV fluids																	
SHARED DECISION-MAKING	ASSESSMENT																	
	PLAN																	
	INITIALS																	

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, **V** – Variable, **I** – Intact, **C** – Clear, **M** – Meconium, **B** – Blood, **A** – Anterior, **P** – Posterior, **T** – Transverse, **P+** – Protein, **A+** – Acetone

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:

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:

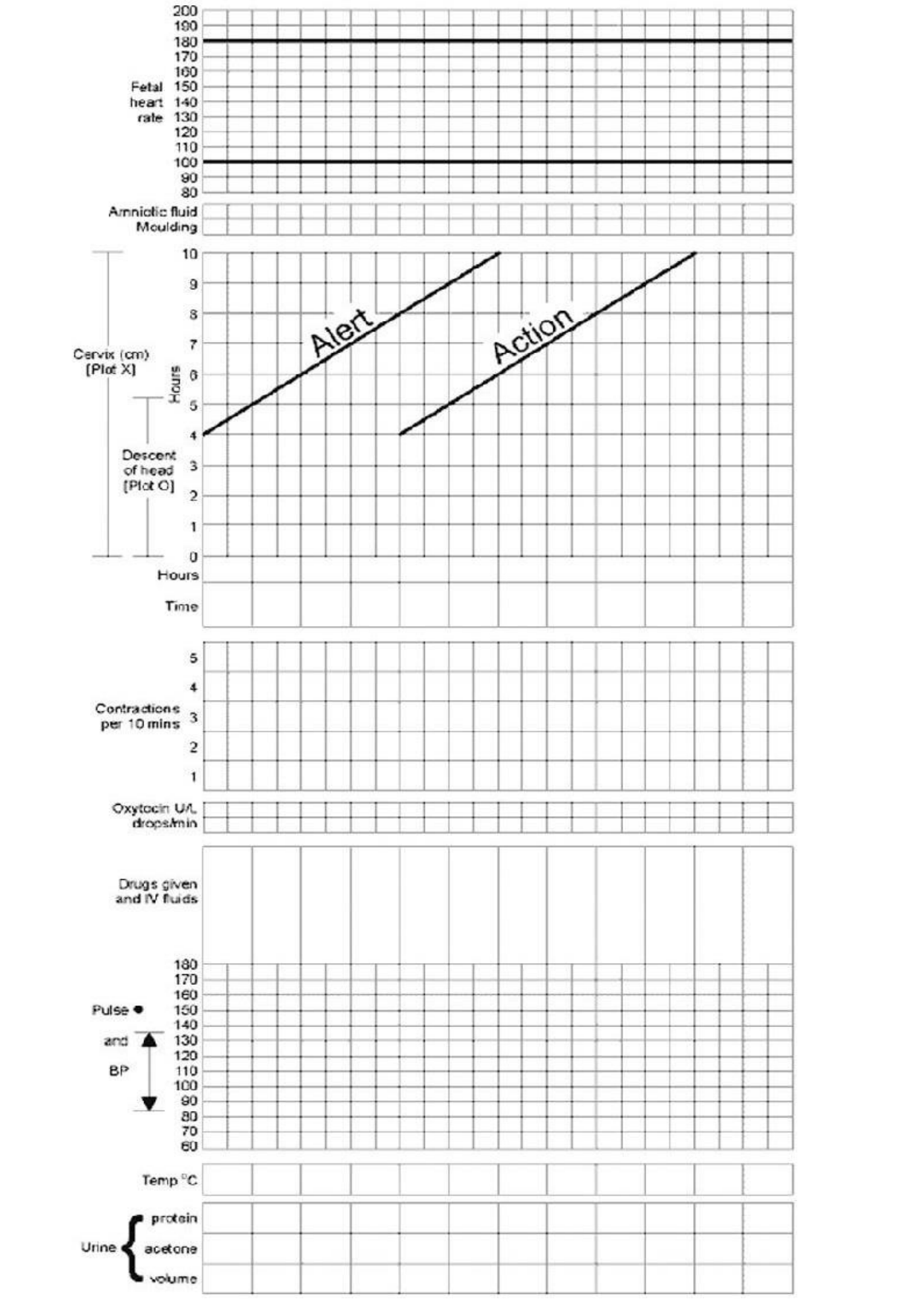
Examination of Placenta:

Intra Partum or Post Partum Maternal Complications:

Baby Notes

No. Date and Time
Sex
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

Name **Parity** **Labour onset** **Active labour diagnosis [Date]**

Ruptured membranes [Date Time] Risk factors

			ACTIVE FIRST STAGE												SECOND STAGE		
		Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
		Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
		ALERT															
SUPPORTIVE CARE	Companion	N															
	Pain relief	N															
	Oral fluid	N															
	Posture	SP															
BABY	Baseline FHR	<110, ≥160															
	FHR deceleration	L															
	Amniotic fluid	M+++, B															
	Fetal position	P, T															
	Caput	+++															
	Moulding	+++															
WOMAN	Pulse	<60, ≥120															
	Systolic BP	<80, ≥140															
	Diastolic BP	≥90															
	Temperature °C	<35.0, ≥ 37.5															
	Urine	P++, A++															
LABOUR PROGRESS	Contractions per 10 min	≤2, >5															
	Duration of contractions	<20, >60															
	Cervix [Plot X] 10																
	Cervix [Plot X] 9	≥ 2h															
	Cervix [Plot X] 8	≥ 2.5h															
	Cervix [Plot X] 7	≥ 3h															
	Cervix [Plot X] 6	≥ 5h															
	Cervix [Plot X] 5	≥ 6h															
	Descent [Plot O] 5																
	Descent [Plot O] 4																
	Descent [Plot O] 3																
	Descent [Plot O] 2																
	Descent [Plot O] 1																
	Descent [Plot O] 0																
MEDICATION	Oxytocin (U/L, drops/min)																
	Medicine																
	IV fluids																
SHARED DECISION-MAKING	ASSESSMENT																
	PLAN																
	INITIALS																

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

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.

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Advice on Discharge : (pharmacological / Non pharmacological)

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 :

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/ Caesarean) Note in brief

AMTSL:

Date and Time:

Conducted By: Assisted By:

Supervised By:

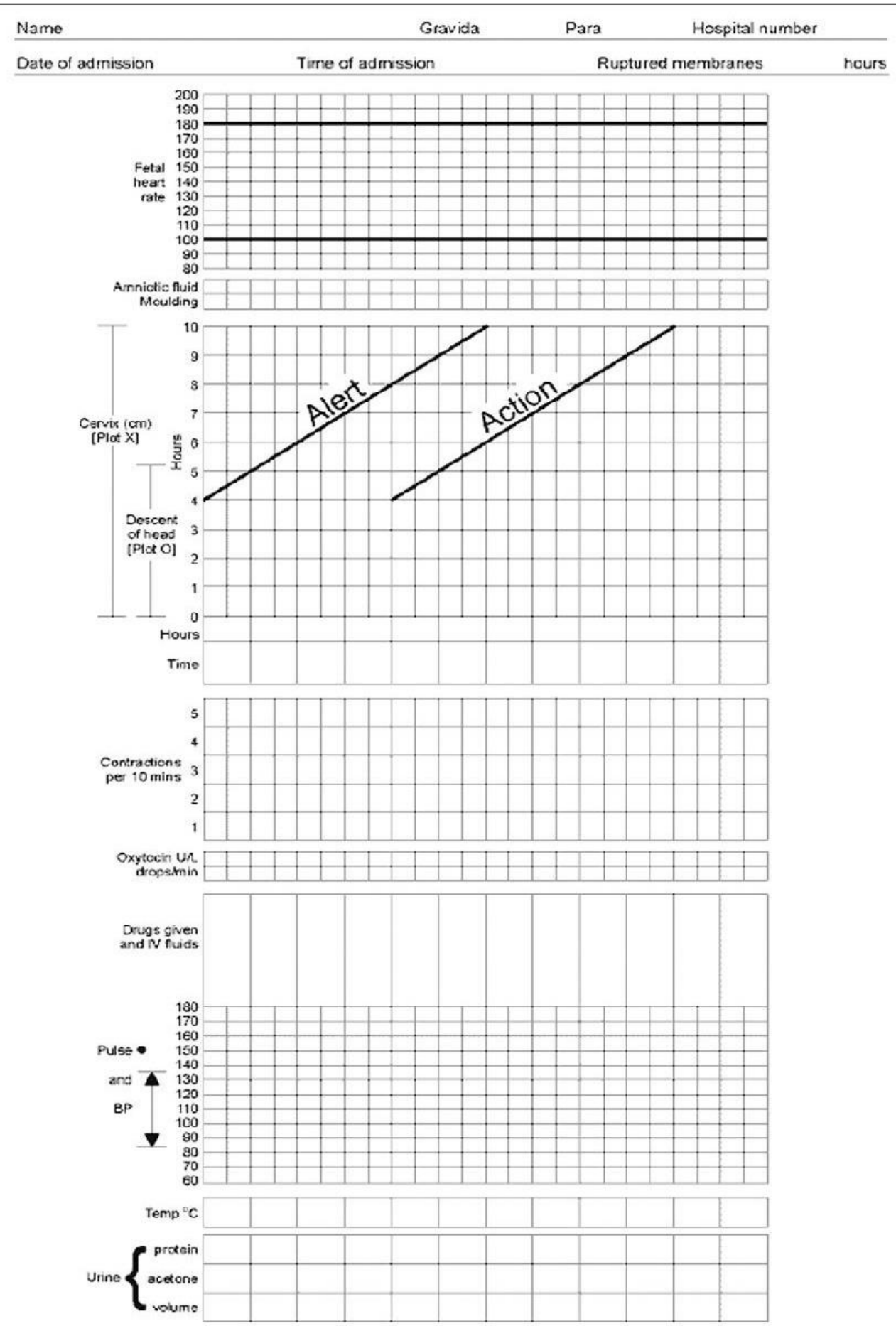
Examination of Placenta:

Intra Partum or Post Partum Maternal Complications:

Baby Notes

No. Date and Time
Sex
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

Name Parity Labour onset Active labour diagnosis [Date]

Ruptured membranes [Date Time] Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion	N																
	Pain relief	N																
	Oral fluid	N																
	Posture	SP																
BABY	Baseline FHR	<110, ≥160																
	FHR deceleration	L																
	Amniotic fluid	M+++, B																
	Fetal position	P, T																
	Caput	+++																
	Moulding	+++																
WOMAN	Pulse	<60, ≥120																
	Systolic BP	<80, ≥140																
	Diastolic BP	≥90																
	Temperature °C	<35.0, ≥ 37.5																
	Urine	P++, A++																
LABOUR PROGRESS	Contractions per 10 min	≤2, >5																
	Duration of contractions	<20, >60																
	Cervix [Plot X]	10																
		9	≥ 2h															
		8	≥ 2.5h															
		7	≥ 3h															
		6	≥ 5h															
		5	≥ 6h															
	Descent [Plot O]	5																
		4																
		3																
		2																
		1																
		0																
MEDICATION	Oxytocin (U/L, drops/min)																	
	Medicine																	
	IV fluids																	
SHARED DECISION-MAKING	ASSESSMENT																	
	PLAN																	
	INITIALS																	

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

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.
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Advice on Discharge : (pharmacological / Non pharmacological)

Follow Up:

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

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 / 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:

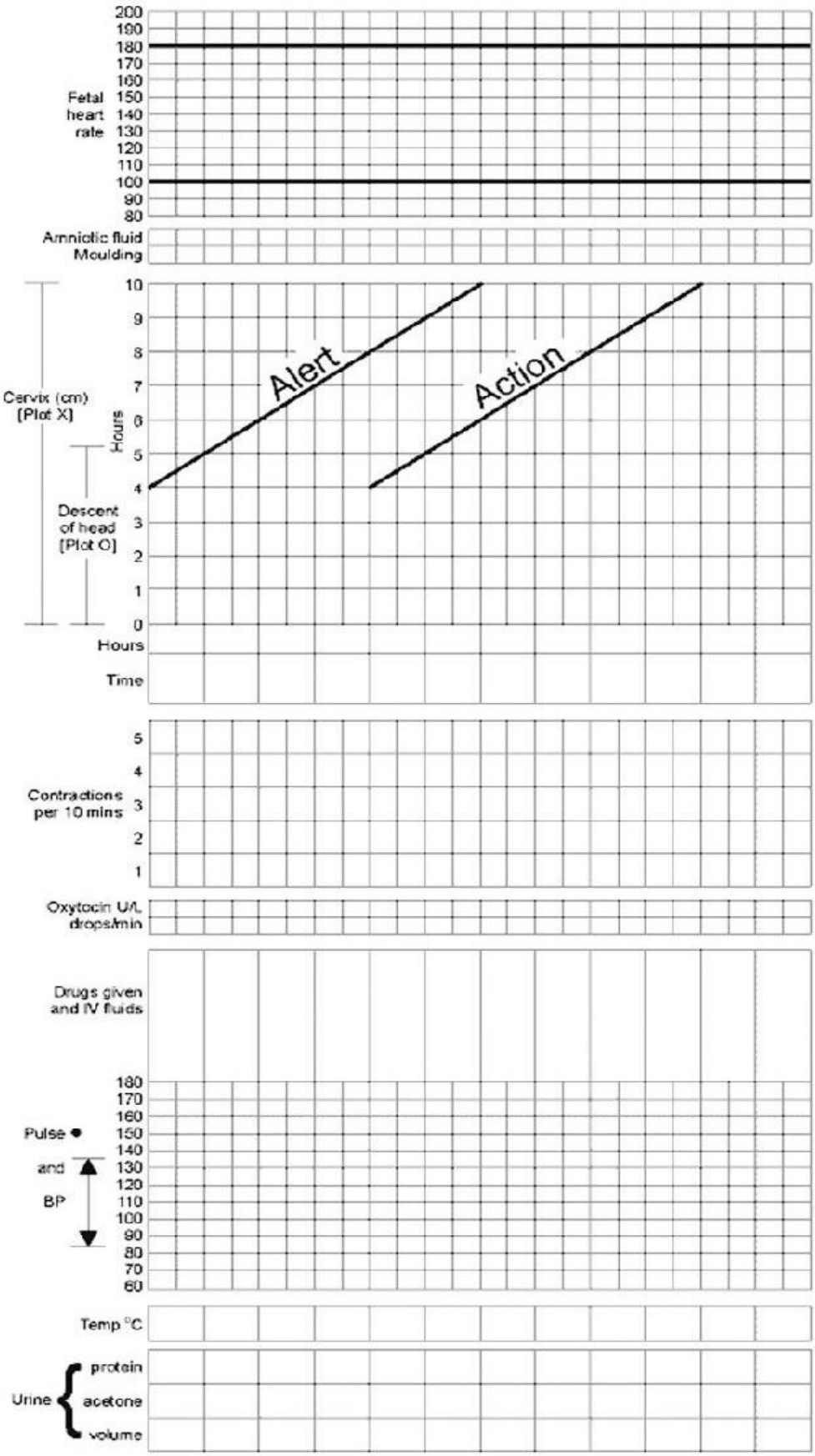
Baby Notes

No. Date and Ti me
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

Name Gravida Para Hospital number

Date of admission Time of admission Ruptured membranes hours



WHO LABOUR CARE GUIDE

Name | Parity | Labour onset | Active labour diagnosis [Date]

Ruptured membranes [Date | Time] | Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours		1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →													← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N																
	Pain relief		N																
	Oral fluid		N																
	Posture		SP																
BABY	Baseline FHR		<110, ≥160																
	FHR deceleration		L																
	Amniotic fluid		M+++, B																
	Fetal position		P, T																
	Caput		+++																
	Moulding		+++																
WOMAN	Pulse		<60, ≥120																
	Systolic BP		<80, ≥140																
	Diastolic BP		≥90																
	Temperature °C		<35.0, ≥ 37.5																
	Urine		P++, A++																
LABOUR PROGRESS	Contractions per 10 min		≤2, >5																
	Duration of contractions		<20, >60																
	Cervix [Plot X]	10																	
		9	≥ 2h																
		8	≥ 2.5h																
		7	≥ 3h																
		6	≥ 5h																
		5	≥ 6h																
	Descent [Plot O]	5																	
		4																	
		3																	
		2																	
		1																	
		0																	
MEDICATION	Oxytocin (U/L, drops/min)																		
	Medicine																		
	IV fluids																		
SHARED DECISION-MAKING	ASSESSMENT																		
	PLAN																		
	INITIALS																		

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

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Advice on Discharge : (pharmacological / Non pharmacological)

Follow Up:

Final Summary:

Learner Doctor Case Record 5

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 marriage life:

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

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

Number of live children:

History of contraception usage:

Past History:

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 / Procedure / OT notes summary:

Condition on Discharge:

Advice on Discharge: (Pharmacological / Non-pharmacological)

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 marriage life:

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

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

Number of live children:

History of contraception usage:

Past History:

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 / Procedure / OT notes summary:

Condition on Discharge:

Advice on Discharge: (Pharmacological / Non-pharmacological)

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 marriage life:

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

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

Number of live children:

History of contraception usage:

Past History:

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 / Procedure / OT notes summary:

Condition on Discharge:

Advice on Discharge: (Pharmacological / Non-pharmacological)

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 marriage life:

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

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

Number of live children:

History of contraception usage:

Past History:

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 / Procedure / OT notes summary:

Condition on Discharge:

Advice on Discharge: (Pharmacological / Non-pharmacological)

Date of next follow up:
When & How to obtain Urgent care

Learner Doctor Case Record 9: Normal Puerperium

Name & Age
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
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

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)

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 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
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

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)

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 pre-procedure 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 veins:

Any scar mark

Palpation

Fundal height in weeks:

Symphysio-Fundal Height in centimetres: _____

Abdominal Girth in inches: _____

Fundal Grip:

Right Lateral Grip:

Left Lateral Grip:

1st Pelvic Grip:

2nd Right Lateral Grip:

Uterine contractions: _____ in 10 minutes

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)

Per vaginal examination: (when indicated)

Pelvimetry: (if indicated)

Provisional Diagnosis :

Investigations:

Hb:

ABO Rh:

Urine routine, microscopic:

HIV: (both H&W) HBsAg: (both H&W) VDRL: (both H&W)

OGTT 1st 75 gm:

OGTT 2nd 75 gm:

Thyroid Profile:

Urine culture:

Imaging (USG):Date

Others :

Risk factors identified:

Final diagnosis:

Summary:

Advice:

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:

CBC:
Urine routine and microscopic examination:
Blood group:
HIV :
HBS Ag :
RFT:
LFT:
Blood Sugar :
Urine culture:
Pus culture:

Cervical swab:
Coagulation profile:
X- Ray Chest:
E.C.G:
Pap smear:
USG Abdomen and Pelvis:
CT Scan:
MRI:
Cytology/ FNAC/ Cell Block:
Any other:

Final Diagnosis:

Treatment Plan:

Follow-Up:

Case Summary:

Appendix 3
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 :

Cycles: regular/ irregular, duration, frequency,

Mention if in lactation amenorrhea or breastfeeding

LMP:

EDD:

Gestational Age :

Obstetric History :

Duration of marriage:

G_ P_ A_ L_ MTP

Obstetric History Details:

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

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

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

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 veins:

Any scar mark

Palpation

Fundal height in weeks:

Symphysio-Fundal Height in centimeters:

Abdominal Girth in inches:

Fundal Grip:

Right Lateral Grip:

Left Lateral Grip:

1st Pelvic Grip:

2nd 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, microscopic:

HIV: (both H&W) HBsAg: (both H&W) VDRL: (both H&W)

OGTT 1st 75 gm:

OGTT 2nd 75 gm:

Thyroid Profile:

Urine culture:

Imaging (USG):Date

Others :

Risk factors identified:

Labor Notes:

Labor: Spontaneous / Augmented/Induced

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

Indication of induction/augmentation:

Stages of Labour	Time Started	Time Finished	Duration Lasted
IV. Stage			
V. Stage			
VI. Stage			

Mode of Delivery:
Normal/Forceps / Ventouse/ Assisted Breech
If operative delivery then mention the indication

Date and Time:

Conducted By:

Assisted By:

Supervised By:

Examination of Placenta:

AMTSL:

Intra Partum or Post Partum Maternal Complications:

Baby Notes

No. Date and Time
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 onset | Active labour diagnosis [Date]

Ruptured membranes [Date | Time] | Risk factors

			Time	:	:	:	:	:	:	:	:	:	:	:	:	:	:	:
			Hours	1	2	3	4	5	6	7	8	9	10	11	12	1	2	3
			ALERT	← ACTIVE FIRST STAGE →												← SECOND STAGE →		
SUPPORTIVE CARE	Companion		N															
	Pain relief		N															
	Oral fluid		N															
	Posture		SP															
BABY	Baseline FHR		<110, ≥160															
	FHR deceleration		L															
	Amniotic fluid		M+++, B															
	Fetal position		P, T															
	Caput		+++															
	Moulding		+++															
WOMAN	Pulse		<60, ≥120															
	Systolic BP		<80, ≥140															
	Diastolic BP		≥90															
	Temperature °C		<35.0, ≥ 37.5															
	Urine		P++, A++															
	Contractions per 10 min		≤2, >5															
	Duration of contractions		<20, >60															
LABOUR PROGRESS	Cervix [Plot X]	10																
		9	≥ 2h															
		8	≥ 2.5h															
		7	≥ 3h															
		6	≥ 5h															
		5	≥ 6h															
	Descent [Plot O]	5																
		4																
		3																
		2																
		1																
		0																
MEDICATION	Oxytocin (U/L, drops/min)																	
	Medicine																	
	IV fluids																	
SHARED DECISION-MAKING	ASSESSMENT																	
	PLAN																	
	INITIALS																	

In active first stage, plot 'X' to record cervical dilatation. Alert triggered when lag time for current cervical dilatation is exceeded with no progress. In second stage, insert 'P' to indicate when pushing begins.

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, V – Variable, I – Intact, C – Clear, M – Meconium, B – Blood, A – Anterior, P – Posterior, T – Transverse, P+ – Protein, A+ – Acetone

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:

Menstrual history:
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
1st						
2nd						
3rd						
4th						
5th						
6th						

Number of live children:

History of contraception usage:

Past History:
Medical
Surgical
Blood transfusion

Family History:

Personal & Social History:

Medication History:
History of Allergy:
Current ongoing medications:

Examination on Admission:

General Examination:

Vitals:

Systemic Examination:

Respiratory system:

Cardiovascular system:

Nervous system:

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)

Date of next follow up:
When & How to obtain Urgent care