Southwestern Ontario
Maternal, Newborn, Child and Youth Network

NAME OF HOSPITAL: _____

OBSTETRICAL PRE-ADMISSION ASSESSMENT

Date: _____ (YYYY/MM/DD) **at** _____ **h**

This side of the form is optional, if the Ontario Antenatal Record is completed and available.

Family Physician/Midwife: _____ Obstetrician: _____

Baby's Physician/Midwife: _____ Support Person: _____ Relationship: _____

Languages spoken: ☐ English ☐ Other: _____ Name of Interpreter (if needed): _____

ALLERGIES: ☐ NKA ☐ Yes Specify (drug, food, tape, dyes, latex, other and describe reaction): _____

G_____T_____P_____A_____L_____ EDB (YYYY/MM/DD): _____

Regular Prenatal Care: ☐ Yes ☐ No If no, reason: _____ Ontario Antenatal Record: ☐ Yes ☐ No

Blood Type: _____ Rh Type: ☐ Pos ☐ Neg RhIg given: ☐ Yes ☐ No Date given (YYYY/MM/DD): _____

Previous Blood Transfusion: ☐ Yes ☐ No Comment (when, why, reaction): _____

Herpes: ☐ Yes ☐ No Last outbreak (YYYY/MM/DD): _____ Comment: _____

HIV: ☐ Yes ☐ No ☐ Not screened Comments: _____

Other STD: ☐ Yes ☐ No Type: _____ Comment: _____

Group B Strep: ☐ Pos ☐ Neg ☐ Unknown Last swab (YYYY/MM/DD): _____ Comment: _____

Hepatitis: ☐ Yes ☐ No ☐ Not screened Type: _____ Comment: _____

Rubella Immune: ☐ Yes ☐ No _____

Past Medical History (acute, chronic illness, surgeries): _____

Current Medications/Supplements	Dose & Frequency	Treatment

Street / recreational drug use: ☐ Yes ☐ No Specify: _____

Alcohol use: ☐ Yes ☐ No Quantity: _____ Smoking: ☐ Yes ☐ No Quantity: _____

Complications of Current Pregnancy	Yes	No	Date(s) of Occurrence	Treatment Given
Bleeding				
Hypertension				
Fetal Growth				
Diabetes				
Premature Ruptured Membranes				
Premature Labour				
Multiple Gestation				

Problems During Previous Pregnancy/Birth: _____

Patient's Name: _____

1. Which of the following have you attended?

☐ Prenatal Classes ☐ Sibling Tour

☐ Hospital Tour/Information Night ☐ Breastfeeding Classes

☐ Other: _____

2. What are your plans for labour?

(a) VBAC: ☐ Yes ☐ No Booked C/S: ☐ Yes ☐ No Date (YYYY/MM/DD): _____

(b) Use of comfort measures:

☐ Shower / Jacuzzi ☐ Sterile Water Injections

☐ Walking ☐ Nitronox

☐ Massage ☐ PCA Pump

☐ Birthing Ball ☐ IM Narcotic

☐ Positioning ☐ Epidural

☐ Music ☐ Other: _____

3. Breastfeeding: ☐ Yes ☐ No Previous Experience: ☐ Yes ☐ No

4. Many women experience periods of anxiety and mood swings following the birth of a baby. Are there any of the following factors that might contribute to postpartum mood or anxiety issues for you?

☐ Family history of depression (who?): _____

☐ Personal History of Depression

☐ Recent Personal or Family Stress

Comment: _____

_____

5. Who resides in the same house as you? _____

6. Who will help you after the birth of your baby? _____

7. Do you ever feel frightened by what your partner says or does? ☐ Yes ☐ No

Comment: _____

_____

_____

8. Have you ever been hit, slapped, kicked or otherwise physically hurt by someone? ☐ Yes ☐ No ☐ No opportunity to ask

If yes, see Progress Note.

9. Keeping newborn? ☐ Yes ☐ No Private Adoption: ☐ Yes ☐ No

CAS involved? ☐ Yes ☐ No Case Worker: _____

Phone: _____ Alternate Phone: _____

10. Are there any cultural/religious practices you would like to share with your health care provider to assist us in caring for you?

_____

_____

_____

11. Is there any other information that you would like to share with your health care provider? _____

_____

_____

_____

_____

DATE: _____ **NURSE'S SIGNATURE:** _____

(YYYY/MM/DD)