Sample Notes

*****Don't forget to **date** and **time** all notes and orders*****
*****Don't forget to have **ALL** notes co-signed*****

OB Admission Note:

L&D Admit Note

26yo G3P1011, at 36W5D EGA, c/o ctx since 12 noon, getting stronger,	LMP
with ROM @ 1pm - clear fluid	EDC
(+) FM, (-) Vaginal bleeding	EGA 36W 5D

Prenatal Care (PNC)-1st visit 12/15/95, total of 15 visits, RH clinic, denies complications in this pregnancy

O+	Rubella immune	HbSag neg	VDRL NR
GC/Chlam neg	PPD neg	GCT 102	GBS (-)
MSAFP wnl	HIV neg	PAP wnl	

USG - 12/5 - 10 wks - cwd
2/15 - 20 wks - cwd, no anomalies
BP at 10 wks = 110/70, Hct 38

Ob Hx - 5/90 VTOP - 1st Trimester - no complications
7/93 FT NSVD - 7lb 8oz - RHC - no complications
Gyn Hx-denies STD/PID/Fibroids/Cysts/Abnl PAPs
Regular menses q mo x 4-5 d
PMH - Denies significant medical problems. No asthma, DM, HTN
PSH - none
Meds - PNV, FeSO4
Allergies - NKDA
Soc Hx - denies Tob/EtOH/Drugs

PE - BP 120/75 P100 R20 T 99.4
General - WD WN female in NAD
Chest - CTA-B
Heart - RRR, no M/G/R
Abd – gravid, fundus NT, FH 38cm, Leopolds - Vtx, EFW 3300 gm
SSE = + pooling - clear fluid, no blood; + nitrazine; + ferning
SVE = 4cm/80%/VTX –1 as per Dr. Smith
Ext - no C/C/E, NT

FHR - 140's, +accel, -decels, moderate variability
Toco - ctx q 4-5 min

A/ 26yo G3P1 at term, in labor with SROM
FHT reassuring
Stable

P/ Discussed with Dr. _________:
Admit to L&D
NPO with ice chips
IV--D5LR at 125 cc/hr
EFM
CBC, T&S
Anticipate NSVD

Dr. _________, attending, aware.

Labor Progress note:
S: Pt c/o strong ctx, requesting epidural
O: BP 110/70 (pit at 12mU/min)
Mod distress with ctx
SVE - 5cm / 100 % / -1 VTX, LOT
FHR - 140's, + accels, - decels, average(or moderate) variability
Toco - ctx q 3min, regular pattern
A/P - 21 yo, G2P0 at term, in active labor undergoing Pitocin augmentation
- reassuring FHT
- for epidural
- anticipate NSVD

Delivery Note:
NSVD live female 3350 gm. Apgars 9/9, no episiotomy, 2nd degree laceration
Head delivered atraumatically LOA, no nuchal cord, light meconium noted. Nose and mouth bulb suctioned at perineum, body delivered without difficulty. Cord clamped and cut. Baby handed to nurse. Cord blood and gases collected. Placenta delivered spontaneously, intact. Fundus firm, min active bleeding. Placenta inspected – appears intact with 3VC. Perineum and vagina inspected - revealed small 2nd degree perineal laceration - repaired under local anesthesia with 2-0 and 3-0 chromic suture in the usual fashion. No other lacerations noted. EBL 350cc. Dr.______________, attending.

Note: ALWAYS write which attending was at the delivery!!

Screening Room Notes (very similar to admission notes except you don't need to include prenatal labs)

28yo G2P1001, at 37W5D EGA, c/o ctx since 1pm,
(-) ROM, (+) FM, (-) Vaginal bleeding
Examined in office yesterday "2cm"

LMP:
EDC:
EGA 37W 5d

*Regardless of chief complaint, ask all patients about:
ROM (Did your water break? Are you leaking?), spotting/vaginal bleeding, FM (Is the baby moving?), contractions, and any complications in this pregnancy?

Prenatal Care (PNC)- RH clinic, denies complications in this pregnancy, GBS (-)
Ob Hx - 8/98 FT NSVD - 8lb - Haiti - no complications
Gyn Hx-denies STD/PID/Fibroids/Cysts/Abnl PAPs
PMH - none
PSH - none
Meds - PNV, FeSO4
Allergies - NKDA
Soc Hx - denies Tob/EtOH/Drugs

PE - BP 120/70 P80 R20 T 98.6
General - WD WN female in min distress with ctx
Chest - CTA-B
Heart - RRR, no M/G/R
Abd – gravid, fundus NT, Leopolds - Vtx, EFW 3600 gm
SVE = 2-3cm/80%/VTX –1 as per Dr. Lee
Ext - no C/C/E, NT

FHR - 150's, +accel, -decels, moderate variability
Toco - ctx q 3-4 min

A/ 28yo G2P1 at term, possible early labor
FHT reassuring

P/ Discussed with Dr. _________:
Ambulate for 2hrs. Return for eval in 2hrs. Routine precautions reviewed.

Screening room tips:

Pre-Term Labor (PTL):

- Notify a resident ASAP if you are seeing a preterm patient (<37wks) who may be in labor or is having contractions.
- Together with the resident you will do a speculum exam *before* digital exam (to rule out ROM, get cervical culture, possible fetal fibronectin)

Vaginal Bleeding:

- How much (relative to period flow) and when (postcoital, after crack use, trauma, etc)?
- Painful vs. painless bleeding?
- Previous episodes?
- Any contractions?
- Unusual discharge
- Any problems this pregnancy with the placenta (placenta previa) You will need to rule out placenta previa before doing any digital exams (either by sonogram either in L&D or by obtaining a recent sonogram report)

Elevated BP or Pre-eclampsia:

- Ask about symptoms of pre-eclampsia: Headache, swelling (face/hand), scotomata/visual changes, RUQ/epigastric pain, chest pain, SOB.
- Also, ask about weight gain in last week
- Pre-eclampsia in other pregnancies? H/o chronic HTN?
- Note serial BP measurements.
- Check for non-dependent edema, hyperreflexia, RUQ/epigastric tenderness
- Check urine dip for protein.

PPROM:

- Notify a resident ASAP if you are seeing a preterm patient who may have broken her water.
- Try to minimize digital exams - exams increases risk of infection. It will not be appropriate for you to examine these patients.

Post-partum notes

S: You should ask the patient

- about lochia (vaginal bleeding) - how many pads? Clots?
- pain – cramps/perineal pain? tolerating with Motrin? do they need more pain meds (Motrin is given routinely if the patient requests pain meds)
- breastfeeding – are they breastfeeding/planning to? how is it going? if they need someone to help them there is a lactation consultant and the nurses can help if they have time
- Tolerating food

O: You should check vitals and note tachycardia, elevated BP, fevers

- On exam, healthy post-partum women do not routinely need a lung or CV exam - unless they have complaints (Asthma, cough….)
- breasts: engorged? nipples – is skin intact?

- abd: soft? Fundus below umbilicus? Firm? Tender?
- perineum: assess lochia (blood on pad, how old is pad)
  visually inspect perineum - Hematoma? Edema? Sutures intact?
- extremities: edema? Cords? Tender?

A/P: PPD#_ S/P NSVD or Vacuum or Forceps (with 4th degree lac, with pre-eclampsia s/p Mg,..)
- general assessment - afeb, doing well, tol po
- contraception plans (must discuss before patient goes home)
  - -barrier/condoms
  - -Depo-Provera (given before discharge, safe in breastfeeding moms)
  - -OCP-only progesterone-only pills (Micronor) can be started immediately post-partum (secondary to hypercoagualabilty) safe for breastfeeding
  - -IUD - done at clinic/office 6 weeks post-partum or later
  - -tubal ligation usually done >6 weeks post-partum as ambulatory procedure (laparoscopic) Make sure they already have tubal papers (NY City consent form) or sign them prior to discharge.
- does pt need rubella vaccine prior to d/c - we usually write the order on L&D when we check their prenatal labs
- breastfeeding? problems?
- need for Rhogam
- needs circumcision (only necessary for service/clinic patients)
- d/c and follow-up plan
  - -patients usually go home if uncomplicated 24-48hr postpartum (baby must stay 24 hours to get heal-stick testing done in hospital unless they have made arrangements with pediatrician to do it in their office – service patients generally all stay 24hrs)
  - -follow-up 6 weeks postpartum (patients who have had postpartum BTL or operative deliveries come back in 4 weeks)
  - -patients who want a tubal ligation or IUD and will not have insurance after 6 weeks (ask patient they usually know their medicaid situation) need to come back sooner 4-5 weeks.

Post Cesarean notes

Day #1 (POD#1)

S: Ask patient about:
- pain- tol pain with PCA?
- Nausea/vomitting
- Have they had anything to drink/eat? Some patients are allowed to have clears/reg immediatlely post-op. It's up to their doctor.
- passing flatus (rare this early post-op)

O: You should check vitals and note tachycardia, elevated BP, fevers, urine output over last 8 hours
- on POD#1, listen to the patients lungs and heart
- abd: +/- bowel sounds, soft?, distended? fundus firm? below umbilicus?
- incision: take the dressing off, check for erthyema, bleeding, discharge
  the incision should stay uncovered from now on, a gauze can be place in underwear if there is any serosang discharge. Patient may shower, don't scrub incision, pat incision dry.
- extrem: tender? cords?

A/P: POD#1 S/P 1 C/S or Rpt C/S….(write why they had C/S)
- afeb, tol pain with PCA, tol po, adequate urine output (>0.5cc/kg/hr)

•routine post-op care (d/c foley, d/c PCA and po pain meds when tol po, OOB, advance diet to clears or as tolerated, IV to SL when tol po) Explain this to patient when you round so they know what to expect and can have family bring them good food if they are allowed to eat.
•check CBC

POD#2
S: pain, tolerating clears/reg diet, out of bed, passing gas, nausea/vomiting?
O: same as POD#1 except urine output will not be measured after pt voids
A/P: POD#2 S/P 1 LFT C/S….
•tol clears or reg, OOB (up out of bed), afeb, +flatus, voiding
•routine post-op care
•advance diet to reg

POD#3 and 4
same as above
discharge planning – very similar to post-partum pt
• patients can generally go home as soon as they are tol diet, walking around, afebrile - as early as POD#2, usually POD#3, as late as POD#4 - see how pt and attending or chief resident feels about d/c
•breastfeeding?
•contraception
•staple removal - look at incision to see that skin edges have re-approximated and incision is healing, apply steri-strips after staples are removed
-tell a resident if you suspect that the skin is not well healed or separating
-primary C/S can have their staples removed prior to discharge
-repeat C/S may have their staples removed prior to discharge or 1 wk post-op as an outpatient
-check with the residents if you have any questions because this is very variable
•follow-up plan
-2 week follow-up visit for a wound check in addition to a 6 week post-partum check When in doubt, review the plan with the residents.

GYN post-op notes
Day #1 (POD#1)
S: Ask patient about:
•pain- tol pain with PCA?
•Nausea/vomitting
•Have they had anything to drink/eat? Some patients are allowed to have clears/reg immediatlely post-op. It's up to their doctor.
• passing flatus (rare this early post-op)

O: You should check vitals and note tachycardia, elevated BP, fevers, urine output over last 8 hours
•on POD#1, listen to the patients lungs and heart
•abd: +/- bowel sounds, soft?, distended? fundus firm? below umbilicus?
•incision: take the dressing off, check for erthyema, bleeding, discharge
the incision should stay uncovered from now on, a gauze can be place in underwear if there is any serosang discharge. Patient may shower, don't scrub incision, pat incision dry.
•extrem: tender? cords?
A/P: POD#1 S/P ….

- afeb, tol pain with PCA, tol po, adequate urine output (>0.5cc/kg/hr)
- routine post-op care (d/c foley, d/c PCA and po pain meds when tol po, OOB, advance diet to clears or as tolerated, IV to SL when tol po) Explain this to patient when you round so they know what to expect and can have family bring them good food if they are allowed to eat.
- check CBC

POD#2

S: pain, tolerating clears/reg diet, out of bed, passing gas, nausea/vomiting?

O: same as POD#1 except urine output will not be measured after pt voids

A/P: POD#2 S/P ….

- tol clears or reg, OOB (up out of bed), afeb, +flatus, voiding
- routine post-op care
- advance diet to reg

POD#3 and 4

same as above

discharge planning

- patients can generally go home as soon as they are tol diet, walking around, afebrile - as early as POD#2, usually POD#3, as late as POD#4 - see how pt and attending or chief reident feels about d/c
- staple removal – most patients can have their staples removed prior to discharge. Check with the residents if you have any questions because this is very variable. Look at incision to see that skin edges have re-approximated and incision is healing, apply steri-strips after staples are removed
  - tell a resident if you suspect that the skin is not well healed or separating
- follow-up plan
  - 2 week follow-up visit for most patients. When in doubt, review the plan with the residents.

Orders and Results

Orders and results at Roosevelt are entirely computerized (charts are not) on the Computerized Ordering System (CCS.) Unfortunately, it is impossible for the medical students to get access to this system. You will surely help the residents with management plans and checking pathology/radiology/lab reports but you will not be able to write any orders (even if they were to be co-signed) or access results on your own.