

British Columbia Perinatal Triage and Assessment Record

1 Date _____ Time _____

Arrived by ambulance Yes No

Language preferred _____

REASON FOR VISIT _____ Accompanied by _____

G _____ T _____ P _____ A _____ L _____ LMP _____ EDD dates _____ US _____ Gestational age _____

2 INITIAL ASSESSMENT

Contractions <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Time started _____ <input type="checkbox"/> Regular <input type="checkbox"/> Irregular q _____ min Intensity _____ Duration _____	Membranes <input type="checkbox"/> Intact <input type="checkbox"/> Ruptured <input type="checkbox"/> Query Date _____ Time _____ Colour _____	Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Show Date _____ Time started _____ Amount _____ Colour/consistency _____	Fetal movement <input type="checkbox"/> Normal <input type="checkbox"/> ↑ since Date _____ <input type="checkbox"/> ↓ Time _____
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Infectious history Recent infectious disease/contact No Yes, specify _____ e.g. MRSA, VRE, chickenpox, Hep B, TB, HSV

Antibiotic Resistant Organism screen completed Yes No Initials _____

Triaged as Emergent Urgent Non-urgent **Triaged to** LDR Assessment room Waiting room _____



3 HISTORY/RISK FACTORS Antenatal Record Part 1 & 2 Reviewed Not available (complete below)

ALLERGIES NKA Yes, specify/reactions _____ **ABO group** _____ **Rh** _____

GBS result Unk Neg Pos Swabs taken Last done _____

Current medications/complementary therapy Vitamins only Other meds & last dose _____

See Medication Reconciliation Form

Height _____ cm/in Pre-pregnant wt. _____ kg/lb Pre-pregnant BMI _____ Current wt. _____ kg/lb Wt. gain _____ kg/lb

Pregnancy concerns None

Past obstetric concerns None

Medical/surgical/anesthetic concerns None

Psychosocial concerns None Substance use Mental health Current tobacco use #/day _____ If quit, last use _____

Previous admission this pregnancy None Yes, reason _____

4 ASSESSMENT Last ate _____ Last drank _____ Symphysis fundal ht. consistent with gestational age Yes No _____ cm

Presentation _____ Lie _____ Position _____ Engaged Yes No

FH assessment mode AUSC EFM NST If EFM/NST, specify reason _____

		Time					Time
FHR	FHR [bpm]				VAGINAL EXAM	Cx dilatation [cm]	
	Rhythm/Variability					Cx length [cm]	
	Accelerations					Station	
	Decelerations					Cx position [Anterior, Mid, Posterior]	
	Classify as					Cx consistency [Soft, Med, Firm]	
MATERNAL		Time			TESTS	EXAMINED BY	
	Contractions					Bishop score	Urine sent <input type="checkbox"/> R&M <input type="checkbox"/> C&S
	BP					Amniotic fluid Nitrazine <input type="checkbox"/> Neg <input type="checkbox"/> Pos	Blood work:
	Pulse					Ferning <input type="checkbox"/> Neg <input type="checkbox"/> Pos	
	Temp/Resp					Swabs done <input type="checkbox"/> fFN <input type="checkbox"/> C&S <input type="checkbox"/> Other	
	Urine P/K					Provider name _____	
					Notified by _____ at _____ h		
					Provider arrived at _____ h		
					Completed by _____	Signature _____	
INITIALS							

