

# 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**

<b>Contractions</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Date</b> _____ <b>Time started</b> _____ <input type="checkbox"/> Regular <input type="checkbox"/> Irregular q _____ min Intensity _____ Duration _____	<b>Membranes</b> <input type="checkbox"/> Intact <input type="checkbox"/> Ruptured <input type="checkbox"/> Query <b>Date</b> _____ <b>Time</b> _____ Colour _____	<b>Bleeding</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Show Date _____ Time started _____ Amount _____ Colour/consistency _____	<b>Fetal movement</b> <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
<b>FHR</b>	FHR [bpm]				
	Rhythm/ Variability				
	Accelerations				
	Decelerations				
	Classify as				
<b>MATERNAL</b>		Time			
	Contractions				
	BP				
	Pulse				
	Temp/Resp				
	Urine P/K				
	Blood sugar				
<b>INITIALS</b>					
			<b>VAGINAL EXAM</b>		
			Cx dilatation [cm]		
			Cx length [cm]		
			Station		
			Cx position [Anterior, Mid, Posterior]		
			Cx consistency [Soft, Med, Firm]		
			<b>EXAMINED BY</b>		
			Bishop score		Urine sent <input type="checkbox"/> R&M <input type="checkbox"/> C&S
			Amniotic fluid Nitrazine <input type="checkbox"/> Neg <input type="checkbox"/> Pos		Blood work:
			Ferning <input type="checkbox"/> Neg <input type="checkbox"/> Pos		
			Swabs done <input type="checkbox"/> fFN <input type="checkbox"/> C&S <input type="checkbox"/> Other		
			Provider name _____		
			Notified by _____ at _____ h		
			Provider arrived at _____ h		
			Completed by _____		Signature _____

