

**THE SURVIVAL GUIDE
FOR
MEDICAL STUDENTS
V13**

Survival Guide for the Spectrum Butterworth OB/GYN Rotation

Obstetrics and Gynecology is a world of its own which has its own language and unique features. This rotation will offer exposure to a field that spans the healthcare for women across a lifetime and often includes two patients instead of one!

The key to any rotation is to remember that as you take this journey you are NEVER alone. As the medical student, you can always ask for help and IT IS NEVER YOUR FAULT. If you have a question or a doubt, ASK! You've heard it all before, but just so we all know – THERE IS NO SUCH THING AS A DUMB QUESTION! Hopefully, this guide will help you along.

Helpful Hints

- First, **DON'T PANIC**. The material may be overwhelming, but you CAN learn it all! Make every moment a learning opportunity.
- You have a unique role as a medical student that permits you to see and be exposed to whatever you like. Don't forget that! You may only see that certain scenario once.
- Don't be afraid to ask questions! However, timing is key in this field. Often, the patient presents with a sensitive concern – a question can wait to the discussion outside of the patient room amongst the residents and attendings.
- If you are involved in a patient's care, you should be letting the attending know WHO you are and WHAT your role is. They expect medical students and many enjoy teaching, but they do not appreciate a student or resident for that matter who does not know the patient, who isn't following the patient, and who has not made themselves present. You will be kicked out of the OR or delivery if you expect to be involved even though you disappeared for hours.
- Never let a situation go bad without calling your resident. If you notice something concerning or if the patient you are following has a complication, let the resident know.
- Never disrespect the nursing staff. Nothing will make your rotation worse. They are your friend. You will not survive if you treat them like dirt. Introduce yourself, be polite, don't act as though you are entitled as they can make or break your experience. If you keep them informed, they will often return the favor.
- Never be caught unprepared. Whenever you do something, ask yourself, "How can this go wrong and how am I prepared to handle it?" If you always anticipate a complication, then you won't look dumb when it happens. Prepare for a case the night before. Know your patients front and back.
- Never "check" a pt alone. Always have a chaperone for breast and pelvic exams without exception. Always ASK a nurse/resident/attending/patient for permission to do so. You should learn how to do these exams, but remember that they are NEVER comfortable for the patient.
- If you need help, page your PG1/2/3/4. They may not do your work for you, but they may be able to help you triage it.
- Lastly, **DON'T PANIC!** There is always help available.

Helpful Websites and General Information

NPI: DEA:	ACOG #: ASCCP: username: Password:
www.globalrph.com – medical calculations and general reference tool	www.icsi.org – clinic guidelines
www.MIGeneticsConnecting.org – Information about genetics testing	www.fgmnetwork.org – information about female circumcision
www.ACGME.org – Log procedures:	www.new-innov.com/suite - Log hours: GRMEP/ login:first initial last name/password
www.myairmail.com – Send alpha pages: obgyn/obgyn	www.med623.org – Information about ventilators, medicine topics
www.brightfutures.org – Information about immunizations.	Login: genob; password: genob SMM: Obix
www.vaccineinformation.org	DermLectures.com www.pelvicpain.org
Library Numbers	www.nichd.nih.gov/about/org/cdbpm/pp/prog_epbo/epbo_caseestimates.cfm – Preterm survivability

MSU Library – Great source for accessing Practice Bulletins and other medical books.

Books – Beckman, Blue Prints, Case Files

Questions – Uwise questions, USMLE World

DAILY SCHEDULES AND EXPECTATIONS:

LABOR AND DELIVERY (General OB – days and nights)

- Team –
 - One or 2 on-service (OB) interns and 1 or 2 off-service (ER, FP) interns
 - 2nd year
 - 3rd year
 - 4th year – the chief
 - Do not expect to be assigned to a specific resident – we work as a unit and coverage of patients will be divided during morning sign out.

- Rounding – To be completed by 6:45am, but not to be started any earlier than 5:30 am.
 - You are expected to round on patients that you deliver regardless of if you have a continuity clinic that day.
 - Your goal is to get to the chart before the resident does.
 - Each patient has a unique postpartum progress note, which is what we use in general OB. Vitals will be in OBTV and all lab data will be in Cerner.
 - Codes to chart racks are 1-2-3-4.
 - Sample Postpartum Note: *Use the preprinted Rounding Notes in the chart – a copy of this is provided at the end of this packet*

S: Pain controlled? Tolerating PO? Ambulating? Urinating? Bleeding? Flatus or BM?
 **Remember to ask about the 5 Bs

 1. **Baby** How is the baby doing?
 2. **Bottle/Breast** Are you breast or bottle feeding (find out which formula if bottle)
 3. **Bleeding** Are you having any bleeding and how much?
 4. **Bottom** Are you having any vaginal, rectal, perineal pain?

O: Vitals (include T max date and time), Abdomen (check uterus, ex. Fundus firm at umbilicus), incision/episiotomy (as the medical student, you should NOT be looking at perineal lacerations – if the patient has a concern regarding their laceration, let the resident know)
 Labs: Hgb, rubella status, blood type

A: __ yo G_P__ PPD#, uncomplicated NSVD and doing well (or if complications, address here) (or POD# s/p LTCS)

P: Continue current care, treatment of complications, need for follow-up, need for teaching; Breastfeeding?

- Morning report – Begins at 6:45am in the OB Classroom Monday through Friday, 7 am in Resident Lounge Saturday/Sunday
 - Grab breakfast before, but be on time.
 - The night team will run this.
 - Each morning will have some form of education –
 - Monday/Thursday – assigned practice bulletin with questions – your chief should provide this reading for you. Let him/her know if you do not know what should be read.
 - Tuesday – Neonatal Rounds – This is presented by the MFM 2nd year and the Neonatologist. Often great discussions!
 - Wednesday – Resident lectures/M&M.
 - Friday – Strip rounds presented and ran by one of the nurse managers.

- During the day –
 - Attire – scrubs!
 - Your Team and their Roles:
 - The **OB INTERN** on the board is responsible for following all clinic patients and high risk or complicated patients >36 weeks gestation. Often, they will be your go-to person.
 - The **2nd YEAR RESIDENT** on the board (the 2nd year) is responsible for everything that happens on labor and delivery. They oversee it all and focus more attention on preterm patients (<36 weeks, high risk term patients, clinic patients).
 - The **3RD YEAR RESIDENT** will also oversee the board. Clinic patients are the priority. He/she will act as the Chief when necessary.
 - The **4TH YEAR RESIDENT/CHIEF** will be the leader. He/she will give you instructions on the day and oversees all OB patients.
 - The **CORE FACULTY** are the clinic attendings – they are Drs. Caldwell, Johnson, Backus, and Oldenberg.
 - Patients to See:
 - After morning report, the residents will split up the board.
 - You should try to follow at least 2 patients. If you feel you can handle more, then go for it! At times, there are more residents than patients, which makes it a bit crowded. If the patient and attending is OK with more than 1 learner, then it is reasonable to follow a patient that is already covered by a resident.
 - Clinic patients, for the most part, should not be followed by medical students. Often there are multiple people already involved in their care and adding a 4th learner makes it crowded.
 - Watch triage! Butterworth has roughly 9,000 deliveries a year – there are constantly women being admitted for labor. If you need a new patient, then “pick the patient up”. You have to be proactive!
 - MFM patients will be covered by the MFM team. You can avoid these patients.
 - It is OK to pick up midwife or FP patients, but it is best to check with the nurses and providers before meeting these patients. These patients may be more hesitant to allow medical students to be involved.
 - Documentation:
 - If you are going to meet a patient and the H&P is not complete, then do it. There should be no blank H&Ps in charts. *A sample history and physical form is provided at the end of this packet.*
 - H&Ps are fill in the blank forms – ask the questions according to the form
 - Sample Assessment and Plan:
 - A: ___ yo G__P___ @ ___ GA with SOL/IOL/SROM, etc (also list any complications or reason for induction)
 - P:
 1. Admit and expectant management? Augmentation? Comment on what’s next
 2. Plan for Pain Control
 3. Rh status/GBS status and/or need for Abx
 4. Comment on how to manage any complications – e.g. HTN? preE? GDM? Maternal med issue?

- **Basic Soap Note –**
 - You should be checking on patients every 1-2 hours and DOCUMENTING what you see/discuss.
 - Example of Note:
 - S – How does the pt feel? Any complaints? Comfortable, uncomfortable, unusual abd pain, tetanic ctx, LOF, VB, HA, vision change, N/V, epigastric/RUQ pain, fever/chills, etc.
 - O – VS if pertinent
 - FHT baseline, variability, acels, decels
 - Ctx q # minutes, palp mild/mod/strong, ?MVU if IUPC
 - SVE dil/station/effacement, position?, caput?, cvx swelling?
 - A/P - __ yo G_P____ at GA with SOL/IOL/SROM
 1. Labor – how is she progressing? Need for augmentation? Moving forward or is the labor protracted?
 2. FWB (fetal well-being) – Cat I/II/III
 3. Pertinent Labs – Rh status, Rubella status, GBS status
 4. Pain Control
 5. Any other complications of her pregnancy?
 - If there is a change, often the nurse will update the attending. As a way to meet the attending and introduce yourself, it is a good idea to call then yourself so you can appropriately let them know you will be following their patient.
- **At a Delivery:**
 - Prior to the delivery, push with the patient! This is good to be a part of this stage of labor too.
 - You can and will be able to put on a gown and gloves during the delivery. The more present you are, the more likely you will be able to have a more active role at the time of delivery.
 - After the delivery, you can write the delivery note which is helpful! Here is an example:
 - **Delivery note** (sample)
 - IUP @ __ weeks, delivered by (C/S, NSVD, vacuum, VBAC, ...etc)
 - Labor—spontaneous/induced/augmented (include max rate of pitocin if used)
 - ROM—spontaneous vs AROM, meconium stained?, date/time, length of rupture
 - Anesthesia — epidural, pudendal, ITM, local – what kind and how much?
 - Episiotomy-- mention any extensions and repair; over intact membranes?
 - Infant—weight, sex, position, Apgars, time of birth, also mention nuchal cords and the use of DeLee suction
 - Placenta—spontaneous, manual extraction, time of delivery, intactness, # of vessels, was pitocin given
 - Lacerations—cervical, vaginal vault, perineum (discuss degree and repair)—Lidocaine w/Epi 1%
 - Complications
 - EBL
 - Duration of labor: 1st stage, 2nd stage, 3rd stage and total
 - Postpartum condition
 - In attendance: staff, residents, and med student

- Cesareans – you will be assigned c-sections and/or you should go to all sections that happen off the board for patients you are following
 - Sample Op Note:
 - **Preop Dx:** 1. IUP@ __ 2. Reason for cesarean (Repeat? Arrest of active phase? Arrest of descent? Cat II FHT?)
 - **Postop Dx:** Same as above + any new findings/issues with surgery
 - **Procedure:** Primary or Repeat LTCS (low transverse cesarean section) or Classical (if this happened)
 - **Surgeon Name**
 - **Assistants**
 - **Anesthesia:** Epidural vs. Spinal
 - **EBL/IV Fluid Total/Urine Output**
 - **Complications**
 - **Pathology**
 - **Findings:** 1. Liveborn male/female @time, weight ____, APGARs of __ & __ at 1 and 5 minutes 2. Normal uterus/tubes/ovaries (any other finding noted) 3. Intact placenta, 3 vessel cord (or other variations)
- Each patient needs a discharge summary and for the vaginal deliveries, there is a pink form at the back of the chart that can be filled out. *A sample of this is provided at the end of this packet.* The resident will take care of most discharge summaries.
- For deliveries – if there is a complication or if there is an operative delivery, be sure the residents are involved. Here is who to call:
 - Clinic patient – 1st year, 2nd year and clinic attending
 - Private patient – Private attending
 - 3rd or 4th degree repairs – Offer to OB chief (have nurse page OB chief)
 - Vacuum or forceps – Offer to 3rd year during the night (this will be your OB chief) and OB Chief during the day (have nurse page appropriate resident)
- P.M. Sign Out:
 - 5:00 pm on Monday and Friday; Tuesday through Thursday will be at 5:30 pm – always will be in the resident lounge.
 - You should be prepared to present your patient:
 - **PURPOSE:** Convey pertinent information from the OB team coming off call to the OB team coming on call. The diagnosis is already made; just communicate what has been done and what needs to be followed up on/managed. Be concise. People can always ask for more details.
 - **WHO TO PRESENT** at sign-out: You are expected to present any patient you have been following.
 - **EXAMPLE:** “This is a ____ yo G __ P ____ patient @ ____ wks who presented with SOL/ ROL (still in triage)/ IOL for xxx/ PROM/ SROM. Her pregnancy has been uncomplicated / complicated by _____. Her labor is progressing / not progressing. She currently is _____ (dilation). She *does / does not* have internals (IUPC and FSE) and her contractions *are/ are not* adequate. She *is / is not* on pitocin. She is GBS *positive / negative/ unknown.*”
 - Has the patient been progressing? Comment on this if she is moving fast, if she has not had any descent, if she has been stuck at a certain dilation, etc.

- Do not report blood type or rubella status. This will be something that is easy to find and will not be pertinent to her progress.
 - Mention details such as blood sugars, blood pressures, estimated fetal weight if she has diabetes, HTN, etc
- If your patient is delivering/close to delivering, it's best to stay and you will not be expected to be at sign out.
- Triage –
 - Located on the A level and can get there by the C elevators
 - First year resident and Triage Specialist will be seeing patients
 - Use this as an opportunity to perform pelvic exams and to see patients in early labor.
 - You are welcome at any point in the day to follow the resident and see patients in triage. You will see common complaints during pregnancy and see interesting pathology – any where from rule out preeclampsia, ROL, ROR, rule out PTL, to 3rd trimester bleeding, etc.
- Down Time –
 - We always encourage self-learning and know that a lot of patience is requiring while managing a laboring patient. During these down times, it's OK to take the time to read! Make yourself visible though – do not hide in the lounge or disappear to the library – you will never be called to a delivery if you are not actively involved in the patient's care.
 - Where to go?
 - Read at the nurse's stations near your patients. This allows you to be involved and hear of changes that may occur.
 - Be mindful of nurses' and doctors' need for computers – if you sitting at one and not looking up something pertinent to your patient, then please move to allow charting.
- Night Float –
 - You will be working Sunday night through Thursday night (7p-7a on Sunday, 5p -7a on Monday, and 5:30 p-7a on Tues through Thurs) alongside the residents
 - Nights operate with a smaller team – who you will be working with:
 - Intern – will cover all term patients (>36 weeks) with clinic and high risk being greater priority – he/she will assign patients
 - 2nd Year – will cover all preterm patients (<36 weeks), clinic patients, and any high risk transfers – also always being aware of the whole board – will do all c-sections
 - 3rd Year – holds day call and covers any ER hits, consults, or floor calls – will do all GYN procedures – also will be aware and chief all OB clinic patients
 - As during the day, you will be expected to follow patients. There are often more inductions that are admitted through the night and these can be patients that you see as well as a way to see why we do inductions. Also, always be mindful of triage of laboring patients that are being admitted.
 - Your chances of participating during a delivery are much higher given the smaller team, but just as during the day, if you are not visible and active, you will miss the delivery.

MATERNAL FETAL MEDICINE

- Your team will include an Intern, 2nd year resident, and 3rd year resident (chief) – occasionally there will be a visiting resident.
- Attire:
 - Dress attire is expected with a clean white coat
 - Occasional instances will require scrubs – be sure to bring appropriate footwear just in case
- PRIOR TO YOUR WEEK – e.g. the THURSDAY or FRIDAY before the week you start – page the 3rd year resident and discuss when and where to meet your team on Monday morning
- You will be expected to round on patients – most patients are on the antepartum floor on 4 Center, occasionally there are patients being induced or as high risk transfers that are on labor and delivery
- Average Week:
 - Each day we round on all of the patients between 5:30 am and 6 am – your chief will let you know when to come to start rounding
 - Monday Morning – Group sign out with attendings at 25 Michigan on the 5th floor – this will start at 7:30 am
 - Each morning, rounding should be done by 6:45 am to be present at the general OB sign out in the OB classroom on the 2nd floor
 - After sign out, we will then be rounding with whichever attending is on during the week
 - Rounds vary from a sit down sign out with discussion of each patient followed by seeing the patients to normal walking rounds – will be based on attending preference
 - Following rounds, afternoons will be filled with education, consults, high risk transfers/admissions
 - Do not be surprised if you are asked to look up a topic and present
 - Occasionally, we will have the medical student go to the office – this will be your ONLY opportunity to see ultrasounds – use it.
 - High Risk Clinic is the residency clinic’s time to see high risk patients with the MFM docs – this is on Monday and Friday mornings typically
- Documentation:
 - Due to billing reasons, all medical student notes need to be cosigned
 - Your morning notes will need to be fully written soap notes and should include a full basic exam (general, CV, Lungs, Abd, Ext) and should include information on the fetal status

GYNECOLOGY

- Team will be made of a 4th year, 3rd year, 2nd year, and 1st year residents –
 - 3rd and 4th years will likely be performing the “Major” cases
 - 1st and 2nd years will likely be performing the “Minor” cases
 - 2nd year will be holding the Day Call pager
- “Major” Cases –
 - Include all hysterectomies and Prolapse repair surgeries
- “Minor” Cases –
 - Include hysteroscopies, D&C’s, diagnostic laparoscopies
- Day Call –
 - Will answer all floor calls and do all ER consults and floor consults
- Sign Out –
 - At 6:45 am in the resident lounge on the 3rd floor of labor and delivery
 - Will discuss over night GYN events and divide cases

- Average Day –
 - You will be assigned cases with specific residents
 - After your cases are complete, you will then need to check in with the chief for direction
 - Day Call is an excellent experience as well and you should try to follow the resident who is holding this pager as well – you will see ER GYN care and consults
- Attire –
 - Scrubs and your white coat
- Rounding –
 - Often our patients go home on the same day of their surgery
 - Major cases that lead to the patient staying will require a postoperative check on the day of their surgery
 - If your patient stays overnight, you are expected to see the patient in the morning before the resident does – this requires you to be here by at least 6 am to round.

GYNECOLOGIC ONCOLOGY

- Team –
 - Includes a 3rd and a 4th year resident
 - Attendings – Dr. Charles Harrison and Dr. Gordon Downey
- Prior to beginning the week, you need to contact the 3rd or 4th year resident for details – page the 4th year resident on service and they will let you know where to go
- All patients are on 5 North (Oncology unit)
- Your week will be filled mostly with OR exposure some days will be with Dr. Harrison, some will be with Dr. Downey – the residents will guide you on where to be and with who
- Rounding –
 - Rounding will start around 5:30 or 6 – again your resident will tell you when
 - We do both a.m. and p.m. rounds – you are expected to participate in both
 - Every patient requires a postoperative check after their procedure on the day of the surgery
 - You are expected to write notes on patients which will be cosigned -
 - Notes are System's based – Example:
 - **Subjective** – pain controlled? Diet? Voiding? Flatus or BMs? Ambulating? Any N/V, CP, SOB, fevers/chills, etc?
 - **Objective** – Vital signs, I's and O's, any drain output
 - General
 - CV/Pulm
 - Abd and comment on incision
 - Extremities
 - Labs
 - **Assessment** - __ yo F POD#__ s/p *_(Procedure)_ for (state cancer or reason for procedure)_*
 - **Plan** – will be laid out in system's based manner
 - Cardiovascular
 - Pulmonary
 - GI/FEN
 - GU
 - Heme/Onc
 - Infectious Disease (if appropriate)
 - Pain
 - Prophylaxis

- NEVER TELL A PATIENT PATHOLOGY RESULTS EVEN IF YOU HAVE ALREADY SEEN THEM!! This will be discussed in detail with the patient by the attending.
- Education –
 - Review pelvic anatomy before your week – you will definitely be pimped during cases by the attendings – they like you to know vessels, spaces, etc.
 - Tumor Board – every Friday morning at 7:30 am at the Lemmon-Holton Cancer Center
 - Multidisciplinary with review of cases by GYN ONC, pathology, and radiation oncology
 - Learn staging and be prepared to answer questions
- Attire –
 - You are expected to be in dress attire with a clean white coat EVERY morning regardless of OR schedule – after rounding, you will then change into scrubs

UROGYNECOLOGY

- Team –
 - Includes a 3rd year resident and Dr. Christine Heisler – she also has PA's that work with her as well
 - Contact the 3rd year resident on the THURSDAY before your assigned week by paging that resident. He/she will let you know where to meet on Monday.
- Schedule –
 - Monday, Tuesday, occasional Thursdays
 - Office through out week – Wednesday will be lecture only, but discuss with Dr. Heisler if she would like you to go there
 - Fridays are Dr. Heisler's day off – often you will round then the day will be spent studying
- Attire –
 - Dress clothes with a clean white coat is expected in the office
 - Scrubs for OR days with white coat
- Education –
 - Know your pelvic anatomy from the perineum up – all of her cases are by a vaginal approach

RESIDENT CLINIC

- Location –
 - 330 Barclay Ave, suite 304 (across the street from hospital)
- Schedule –
 - A.M. clinic starts at 8 am, P.M. clinic starts at 12:45 pm
- You will be assigned to a 3rd or 4th year resident, occasionally a 2nd year
- Your day will be filled with seeing various patients – a general mix of OB and GYN patients is expected – best to review normal initial prenatal care, genetic screening, pap smear guidelines, etc
 - We get very little menopausal care so this is a topic that you should review on your own and can be discussed with the resident
 - Bring study material as you may have down time if there are no shows or your resident is charting
- Attire –
 - Dress clothes and a clean white coat

SAINT MARY'S

- As a whole, Saint Mary's is a bit more laid back than Butterworth – It can be absolutely busy and crazy one minute to the next be completely dead. Best thing is to be around and be visible. Be eager and be involved.
- Team –
 - Intern
 - 2nd Year – one on nights, one on days – runs the board and cares for all obstetrical patients, will go to ED and do consults
 - 3rd Year – mostly performs scheduled gyn surgeries, present for back up and/or assistance when needed on L&D; will be chief if 4th year is absent
 - 4th Year – the Chief – performs gyn surgeries, makes the daily schedule and will be the go to boss essentially
- Codes –
 - All doors = 4135
 - Chart Racks = 13579 (press all buttons in order)
- Day Time -
 - During the day, often folks are spread out doing various activities – each day you will be assigned where to go, what to do, and who to be with
- Nights –
 - Only one resident is in house through the night and during your nights rotation, you will be with them
 - Often it is more hectic with one resident so it is best to always be available and around to help
 - If it does get to be slower, your resident may let you sleep – you should use to the call rooms on the 9th floor as the resident will be in the lounge.
- Labor & Delivery –
 - We cover all obstetrical patients – two main OB groups:
 - “GTABZ” – Drs. Gorsuch, Turke, Anderson, Bennett, and Zylstra
 - Advantage Health – Drs. Leahy, Hartmann, Mathis, Avery, Born, and Burns (Gyn only)
 - MFM –
 - If preterm, will be followed by the 2nd year; if term, will be followed by the OB intern
 - Drs. Balaskas and Cummiskey
 - Family Practice –
 - Large amount of delivery FP docs here
 - You are free to follow any of these patients – just be sure to let the doc know!
 - At times, you will be the only other person following the patient so be in contact with the nurse and discuss plans with the doc
 - Occasionally there will be a FP resident on service and he/she may also be following these patients
 - OB residents will only follow these patients if a consult is requested – needs to have a physician to physician conversation
 - Any patient in labor should be followed by a resident and/or medical student. The labor and delivery unit is smaller here and the volume is a little less, but there are plenty of opportunities to be involved and see interesting obstetrical cases.
 - Documentation will be similar to Butterworth General L&D guidelines as discussed above – expect progress noted every 1-2 hours, all info will be the GE QPM system

- Rounding –
 - Postpartum patients will be on 9 N – every person should be rounded on
 - Given smaller volume, even if you did not see a delivery and were not involved, it is helpful to have you see the patient!
 - Postpartum notes are discussed above (see example postpartum note) but the difference here is that there are no fill-in-the-blank forms
 - If you participated in a GYN case where the patient stayed, be sure to round on that person.
- GYN –
 - We will cover all Minor/Major GYN cases and will always ensure a medical student comes with us. These will be assigned at morning report that morning.
 - We DO NOT cover Drs. Michael and Jason Bennett as they generally have visiting residents with them – occasionally you can participate and watch.
 - Robots will rarely be covered by residents but are ALWAYS a good opportunity to see a good hysterectomy. Go watch these if you have no other cases to be a part of!
- GYN ONC –
 - You will be assigned a week with Drs. Hoskins and Brader
 - We do not cover these patients as they often have visiting residents
 - You will need to contact the attending the week before your rotation to discuss when/where to be that Monday
- Clinic –
 - Monday P.M. Colposcopy/ER follow up clinic with 3rd or 4th year resident
 - Tuesday A.M. – MFM clinic with Drs. B & C
 - Tuesday P.M. – resident clinic at Wege center
 - Wednesday – none
 - Thursday A.M. – MFM clinic with Drs. B & C
 - Thursday P.M. – none
 - Friday A.M. – resident clinic at Wege center
 - Friday P.M. – none
- Education –
 - Be sure to always have study material with you – there will be times when you can be productive – take advantage!
 - Mondays/Thursdays – will discuss a practice bulletin which should be given to you beforehand and will go over questions
 - Fridays – there are various conferences we are expected to be at – your resident will tell you where to go

EDUCATIONAL MATERIAL:

COMMON ACRONYMS USED

SOL- spontaneous onset of labor
 ROL – rule out labor
 ROR – rule out rupture
 AROM- artificial rupture of membranes
 SRM- spontaneous rupture of membranes
 PROM – premature rupture of membranes
 PPROM – preterm premature rupture of membranes
 IOL- induction of labor
 PEDC- post EDC
 SVE – sterile vaginal exam (CE- cervical exam)
 SSE – sterile speculum exam
 VB – vaginal bleeding
 LOF – leakage of fluid
 FM – fetal movement
 FF – Fundus firm
 PPS- post-partum sterilization
 PTL – preterm labor
 gHTN – gestational hypertension
 cHTN – chronic hypertension
 preE – preeclampsia
 GDM – gestational diabetes mellitus
 Di/di – dichorionic, diamniotic (twins)
 Mono/di – monochorionic, diamniotic (twins)
 Mono/mono – monochorionic, monoamniotic (twins)

Dating a Pregnancy

from ACOG practice bulletin Number 10, November 1999 "Induction of Labor"

At least one of the criteria below should be met or fetal lung maturity should be established before induction.

- Fetal Heart tones documented for 30 weeks by Doppler (this means heard FHTs @ 9-10 weeks).
- It has been 36 weeks since a positive pregnancy test performed by a reliable lab (this means a documented pregnancy test @ 3-4 weeks).
- An ultrasound measurement of the crown-rump length, obtained at 6-11 weeks, supports a gestational age of > 39 weeks.
- An ultrasound obtained at 13-20 weeks confirms the gestational age of at least 39 weeks determined by clinical history and physical exam.

This translates into if you haven't seen the patient until week 10-12, get a first trimester ultrasound in case you need to induce at the end of the pregnancy (because you already missed the first two on the list). If you don't see the patient until weeks 13-20, also get an ultrasound and document physical exam well.

OB Dates

- Calculate due date: Subtract 3 months and add 7 days from LMP.
- Date fetal heart tones heard with doppler (7-12 weeks.)
- Date fetal heart tones heard with fetoscope or stethoscope (18-21 weeks.)
- Quickening felt ~ 20 weeks for primagravida, as early as 16-17 weeks in a multigravida.)
- Fundal height (distance from symphysis pubis to the top of the fundus) at each visit. After 20 weeks, fundal height should grow approximately 1 cm per week.
 - Six - Eight wk uterus = orange
 - Ten wk uterus = grapefruit
 - Twelve wk uterus = pineapple at symphysis (out of pelvis)
 - Twenty wk uterus = at umbilicus
- First trimester ultrasound is most reliable for dating with +/- 1 week. Second trimester may be off by two weeks, third by three weeks. Rule of thumb: Accuracy of ultrasound is $\pm 8\%$ of ultrasound date (ie 20 week US is accurate ± 2 wks).
- Can use transcerebellar size in mm 15-21 wks = gestational age (not affected by IUGR). See page 104 of red book.

Normal Labs in pregnancy

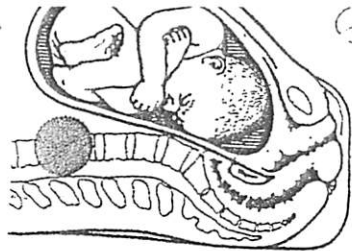
HCG levels tend to rise 50-66 every 48 hours (doubling) early in pregnancy. If it is not, something may be wrong (molar pregnancy, ectopic, miscarriage, etc).

Lab	Normal pregnancy range	Δ from non-pregnancy
Alk phos (produced by placenta)		Less than 4x normal
WBC	5-15 x 10 ³ /mm ³	↑
Hemoglobin	11-14 gm/dL	↓
Hematocrit	33-42%	↓
Uric acid		↓ (2-3%)
Arterial pH	7.4-7.45	↑
PCO ₂	27-32 mm Hg	↓
HCO ₃	19-25 mEq/L	↓
Creatinine	<1.0 mg/dL	↓
BUN	4-12 mg/dL	↓
Fibrinogen	400-500 mg/dL	↑
Thyroid	↑ T ₄ & TBG, ↓ T ₃ uptake, normal FTI	
EKG	May have flat or inverted T-waves or Q waves in inferior leads	

Bishop Scoring

Used to assess cervical "ripening" for labor induction. Total score >7~8 is favorable.

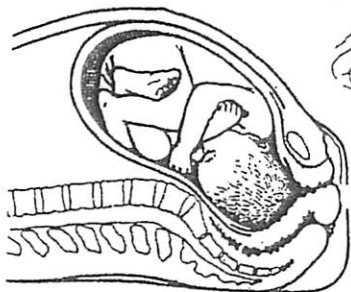
Points given:	0	1	2	<ul style="list-style-type: none"> ▪ Predictive Value for Success – Score 0-4 50-55% success; Score 5-9 90% success; Score 10-13 0% fail. ▪ Add 1 point for preeclampsia and each prior vaginal delivery. ▪ Subtract 1 point for post dates, nulliparity, preterm or prolonged ROM
Dilation (cm)	0	1-2	3-4	
Effacement	0-30%	40-50%	60-70%	
Station	-3	-2	-1 to 0	
Consistency	Firm	Medium	Soft	
Position	Posterior	Mid	Anterior	



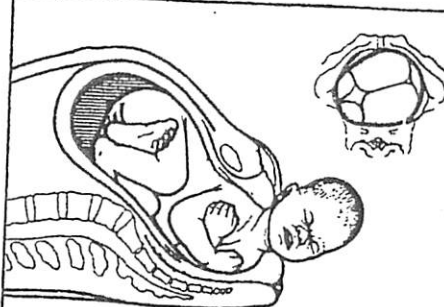
1. Head floating, before engagement



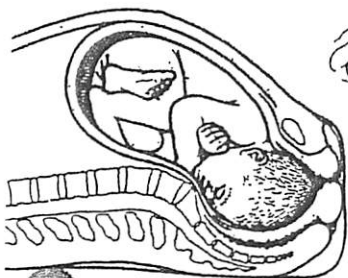
5. Complete extension



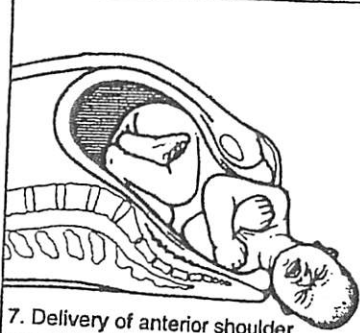
2. Engagement; descent, flexion



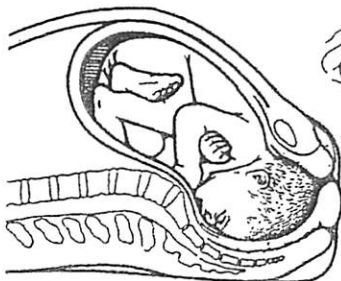
6. Restitution (external rotation)



3. Near descent, internal rotation



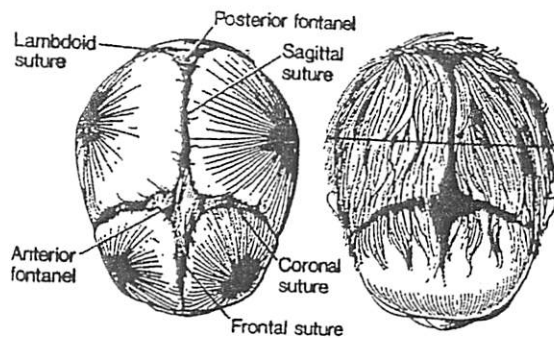
7. Delivery of anterior shoulder



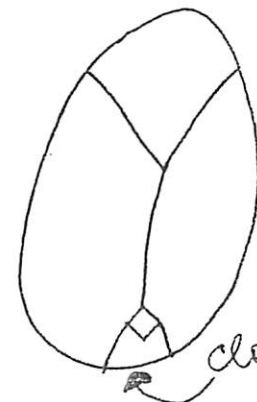
4. Complete rotation, beginning extension



8. Delivery of posterior shoulder



p. 96 willi



closer together

p. 549

p. 418 williams

Cardinal Movements occur during second stage of labor

1. Engagement (BPD passes through the pelvic inlet)
2. Descent
3. Flexion
4. Internal Rotation
5. Extension
6. Restitution
- External rotation.

TABLE 23-1 Classification of Forceps and Vacuum Delivery According to Station and Rotation

Procedure	Criteria
Outlet	<ol style="list-style-type: none"> 1. Scalp is visible at introitus without separating the labia 2. Fetal skull has reached pelvic floor 3. Sagittal suture is in anteroposterior diameter or right or left occiput anterior or posterior position 4. Fetal head is at or on the perineum 5. Rotation does not exceed 45 degrees
Low	Leading point of fetal skull is at station $\geq +2$ cm, and not on pelvic floor Rotation is 45 degrees or less (left or right occiput anterior to occiput anterior, or left or right occiput posterior to occiput posterior)
Midpelvic	Rotation is greater than 45 degrees
High	Station above +2 cm but head is engaged
	Not included in classification

Abortion Definitions and Treatment

Abortion	Definition	Treatment
Complete abortion	Less than 20 wks gestation. All products of conception expelled. Internal cervical os is closed. Uterine bleeding is present	
Incomplete abortion	Less than 20 wks gestation. Some products of conception expelled. Internal cervical os is open. Uterine bleeding is present	Dilation and curettage* Cytotec
Threatened abortion	Less than 20 wks gestation. NO products of conception expelled. Membranes intact. Internal cervical os is closed. Uterine bleeding is present. Abdominal pain may be present. Fetus still viable.	Avoid heavy activity. Pelvic rest. Bed rest.
Inevitable abortion	Less than 20 wks gestation. No products of conception expelled. Membranes are ruptured. Internal cervical os is open. Uterine bleeding and cramps are present.	Emergent D&C* or Cytotec
Missed abortion	No cardiac activity No products of conception expelled Retained fetal tissue Uterus not growing Internal cervical os is closed No uterine bleeding Nonviable tissue not expelled in 4 wks	Evacuate uterus via either D&C* or cytotec
Septic abortion	Infection associated w/ abortion Endometritis leading to septicemia Maternal mortality of 10-50%	Complete uterine evacuation via D&C IV abx

- Use either Doxy 100mg before D&C and 200mg after PO or Doxy 100mg PO BID x7days
- **Cytotec:** 600mcg PO q6hrs up to 8 doses OR 400mcg PO and PV q4-6hrs

AnteNatal Testing

Non Stress Test / Contraction Stress Test

The **negative predictive value** that fetus will be stillbirth within 1 week of NST/CST/BPP is 99.8% for a reactive NST and 99.9% all others.

NST—Non-Stress Test – Measures fetal heart tones continuously. At 24-28 weeks only 50% of NST's are reactive. By 30 weeks, 80% are reactive and by 32 weeks 85% are reactive. Once a fetus has a reactive NST, they should always be reactive.

- Reactive - Two accelerations (increase of fetal heart rate by 15 bpm above baseline lasting 15 seconds) in 20 minutes. This is very reassuring that the fetus is doing well. Use 10x10 rule for 24-28 wks.
- Non-reactive—absence of two accelerations in 20 minutes over 40 minutes. Attempt acoustic stimulation (to "wake" baby before calling the strip non-reactive.

CST—Contraction Stress Test – Generally performed after a non-reactive NST and late in pregnancy to determine if fetus can handle the stress of labor. Contractions are usually induced with pitocin. Do NOT do with PPRM, classical incision, previa, or prematurity. **Adequate test has 3 contractions lasting > 40 sec in 10 minutes.**

- Negative – No late decelerations with contractions (there must be at least three contractions per ten minutes.) Note: **negative is good.**
- Positive – Persistent late decelerations without hyperstimulation of uterus. Note: **positive is bad.**

BPP—Biophysical Profile

The granddaddy of testing. Most accurate for determining fetal well-being. The BPP uses the NST and ultrasound. The fetus is given 0 or 2 points in each of five categories. Note this is an all or nothing scoring mechanism. A **modified BPP** is NST and AFI. Normally start antenatal testing at 32-34 weeks or 26-28 weeks for severe disease. You have **30 minutes** to get this information.

- Reactive NST = 2 points
- Fetal tone (extends and flexes) = 2 points (*this is the last to go*)
- Movement = 2 points (≥ 3 discrete movts)
- Breathing = 2 points (≥ 4 episodes of breathing lasting at least 30 sec)
- Amniotic fluid = 2 points. ** This is a very important value. Amniotic fluid is measured with U/S in four quadrants. Would like at least one pocket of amniotic fluid > 2cm in 2 perpendicular planes. Would like AFI>8, <5 is considered oligohydramnios. AFI>20 is consistent with polyhydramnios.

Consider delivery if

- BPP is 6 or less
- Oligohydramnios is present
- NST is non-reactive.
- BPP of 8, consider delivery or repeat BPP in 24 hours depending upon clinical picture.

Score of 8-10 is normal; 6 is equivocal; 4 is abnormal.

Fetal Heart Tones – Interpreting the Strip

Accelerations – Mean placenta is good. BP > 160 for > 10 min is tachycardic (and usually means baby is stressed). Again, ≥ 32 wks 15x15; 24-28 wks 10x10 rule.

Decelerations in FHT should cause you to take note. They come in three flavors.

- **Early**—the baby's baseline heart tone decreases then increases with the onset and resolution of the contraction (**peaks with the contraction**). These are due to compression of baby's head (vagal stimulation).
- **Variable**—baseline decreases (**sharp decline**) unrelated in time to contractions. Usually < 30 seconds to nadir. Needs to decrease by 15 bpm x 15 sec (like accel). Due to cord compression. Consider doing amnioinfusion for repeat severe variable decels.
- **Late—gradual** baseline decreases after start of contraction and persists after its resolution (**peaks after contraction peaks**). Starts late, peaks late, ends late (compared to uterine contractions). Usually > 30 seconds to nadir. Frequently due to placental insufficiency or other kinds of badness.

Baseline – Two minutes. Doesn't have to be continuous. Can be 20-30 sec parts x 4.

Recurrent – Occurs with at least 50% of contractions.

Persistent – Not defined but consensus is late decels that do not resolve with interventions.

Prolonged – Lasts ≥ 2 minutes but ≤ 10 minutes (after 10 minutes it is a baseline change)

Variability – Fluctuations of baseline over 2 minutes. Choices are absent; minimal (1-5); moderate (6-25 *this is normal*); or marked (> 25).

Tachysystole – 6 or more contractions / 10 minutes

Commonly Prescribed Meds

- **Agitation** (do not use in the elderly) – Called a “B52” Haldol 5 mg IV and Ativan 2 mg IV and Benadryl 50 mg IV
- **Amnioinfusion** – warm NS or LR 300cc bolus then 100cc/° to gravity. D/C if no return.
- **Buffered Lidocaine** – Mix Lidocaine 1% w/ epi 30 mL with NaBicarb 5 mL. Inject SLOWLY!
- **Cytotec** – 200 micrograms PO the night before or morning of procedure where need to dilate cervix. Or 25 mcg q 4 hrs for cervical ripening.
- **Dom Burrows** – OTC drying agent (can buy at Mejer)
- **Dysrhythmias**
 - Amiodorone drip – 150 mg IV push loading dose, then 1 mg/min for 6 hrs, then 0.5 mg/min for 18 hrs. Start amiodorone PO couple hours before turn off or continue 0.5 mg/min IV until can take PO.
 - **Bradycardia** – Give Atropine 0.5mg IV bolus. Repeat q3-5 minutes prn to max of 2 mg.
 - **Vtach w/ pulse** lasting > 10 seconds – Give Lidocaine 1 mg/kg IV bolus over 1-2 min.
- **Epifoam**
- **Fenugreek** – Two to three capsule TID. Increases milk production within 2-3 days. Can stop medication once supply stimulated to appropriate level.
- **Floseal** – Need fibrinogen to work. Apply pressure for 3 minutes.
- **Hemabate** 0.25mg IM q15” (max 8 doses) (do NOT give if ASTHMA)
- **Hydralazine** 5-10mg IV q20” for BP >160/105-110
- **Indocin**: Initial dose 50mg PO, then 25 mg q6° for 48° (<32 weeks) – *Works faster than sulindac but more effect on the ductus.*
- **Labetalol** 20/40/80/80mg IV q5-10” for BP >160/105-110 (need cardiac monitoring)
- **Lovenox**
 - In pregnancy: Dose 30-80mg q12hrs in pregnancy for anticoagulation. Check factor XA level 4 hours after 4th dose. Therapeutic level 0.6-1; prophylaxis 0.2-0.5
 - Non pregnant: Therapeutic 1mg/kg BID; Prophylaxis 40mg daily
- **Lupron** only prescribe for up to 6 months
 - Can use of laparoscopy x 6 months to help relieve pain x 2 years (70% vs 58%)
 - Prescribe **Norethindrone** 5mg daily while on Lupron. Adding this reduces bone loss from 3.2 → 0.3% and hotflashes by 67%. Have patient take calcium/vit D while on lupron.
- **Magic Nipple Cream** – Bactroban ointment 2%; Nystatin ointment; Lotrimosole cream; Betamethasone Balenatione 0.1% → 15 grams each for a total of 60 grams.
- **Magnesium Sulfate** 4-6g IV bolus then run @ 2g/° OR 10g IM (5g each buttock for eclampsia, no IV)
- **Meclofenamate** 100mg PO TID x 3 days with first bleed (helps reduce amount bleeding w/ menses)

- **Mercer protocol**
 - Ampicillin 2g IV q6° × 48° then amoxicillin 250mg po q8° × 5 days, PLUS
 - Erythromycin 250 mg IV q6° × 48° then erythromycin 333mg po q8° × 5 days
 - Pharmacy may substitute Zithromax 1 gm IV x 1 or 250 mg PO qd x 5 days for Erythromycin
- **Methergine** 0.2mg IM q8° (do NOT give if HTN)
- **Methotrexate** 50mg/m² IM × 1
- **Migraine Treatment** – RAT (Reglan 10mgIV/PO; Ativan 0.5-1mgIV; Toradol 60mg IM/IV); CAT (Compazine 10mg IV slow push, Ativan and Toradol)
 - No IV access – Morphine 4mg IM and Vistaril 50mg IM
- **Morphine Sleep** 10-20 mg IM or 2-5 mg IV and mix with Vistaril 100 mg PO or Phenergan 25 mg IM.
- **Nubain** 10 – 20 mg IV push – analgesic for labor management. Lasts about 2 hours.
- **Omipaque** – Use for HSG 10mL
- **PCA**
 - MSO4 – 1mg/ml q10" with 30mg max q4°
 - Dilaudid – 0.2mg/ml q15" with 6mg max q4°
 - Demerol – 10mg q8" with 80-100mg max q4°
- 17 alpha hydroxyprogesterone caproate 250mg/moL → 250 mg IM wkly (16-36 wks). Call 800-331-8272 to order.
- **Pitocin** 10U/1000cc LR to run @ 1 mU/min for 30 minutes then increase by 1-2 mU/min q20-30 minutes until adequate labor or maximum of 20mU/min. Call if d/c'd for hyperstimulation.
 - **Aggressive pitocin** – Increase by 2mU/min q 20 min until at 20 mu/min
 - **High dose pitocin** – Start at 6mU/min and increase by 6 q 15 minutes to max 40mu/min
- To **replace potassium**: 10 meq KCL in 100 mL NS each over 1 hr x 4. Mix with Lidocaine 2% 10 mg with boluses. **10 meq IV = 20 meq PO → Will increase K+ by 0.1 meq.** Can only replace 10 meq IV per hour.
- **Procardia** 10-20mg PO q4-6°
- **Pruitis** – hydroxyzine 25-50 mg IM/PO q4 hrs prn itching; Can also use Doxepin 50 mg PO qhs, 25 mg PO daily (do not exceed 75 mg/day)
- **Rhogam** 1 amp (300mU) IM × 1 – *covers 30mL of blood. Most bleeds about 15mL*
- **Stadol** 1 mg IV q 1 hr x 3 – analgesic for labor management
- **Stress Dose Steroids** Solumedrol 30 mg q8h or Hydrocortisone 100mg q8h
- **Sulindac** 200mg PO q12° for 48° (<32 weeks) – *Works slower than indocin but less effect on the ductus*
- **Terbutaline** 0.25mg SQ q1-4° × 24°
- **Trigger Point Injections**: Use 3mL 1% Lidocaine (can add Triamcinolone 20mg if incisional/surgical pain).

- **Magic Nipple Cream** – Mix Bactroban oint 2%, nystatin oint, lotrimin cream 1% and betamethasone cream 0.1%. 15 grams each for a total of 60 grams.

NSAIDS – Inhibit platelets for 6-8 hrs (length of drug)

Aspirin – Inhibit platelets for the life of the platelet

Postpartum Hemorrhage

Defined as a **> 500cc blood loss** or **> 10% drop in Hgb** (2 grams) in the 24 hours after delivery.

Primary if w/in 24 hrs of delivery. Secondary 24 hrs – 6 wks.

Risk factors include uterine atony (grand multiparity, uterine over-distention, prolonged labor with pitocin, chorioamnionitis, general anesthesia, rapid labor, magnesium treatment), retained placental products (usually delayed bleeding; seen in placenta accreta, preterm delivery, cord avulsion), genital tract laceration, and uterine inversion (don't pull on the cord).

Causes are the 4 Ts –

1. **Tone**
2. **Tissue** (retained placenta)
3. **Trauma** (genital tract)
4. **Thrombosis** (coaguability pre-eclampsia or HELLP)

Treatment includes laceration repair and removal of placental products. Treatment of atony includes bimanual uterine massage and medications below. If these measures do not work, must consider uterine/hypogastric artery ligation or embolization, uterine packing, curettage for retained products, O'Leary stitch, or hysterectomy.

- **Pitocin** Max dose is 80 units / 24 hours and 40 units / 1L bag fluid (pitocin IV causes hypotension)
- **Cytotec** 1000 mcg PR
- **Methergine** 0.20 mg IM—repeat in five minutes. Max is 5 doses. **Use with Asthma.** Works on the lower uterine segment.
- **Hemabate** 0.25 mg IM (15-methyl-prost-F2 (a prostaglandin)) May inject into myometrium—Max 8 doses q15 minutes. **Use when patient has Hypertension** (H goes with H). Can cause explosive diarrhea.

Labs to get are CBC w/ platelets, coags (PTT, INR, fibrinogen), type and cross, and an U/S to rule out clots.

Table 1 Carcinoma of the Cervix Uteri

Stage I	The carcinoma is strictly confined to the cervix (extension to the corpus would be disregarded).
IA	Invasive carcinoma which can be diagnosed only by microscopy, with deepest invasion ≤ 5 mm and largest extension ≤ 7 mm
IA1	Measured stromal invasion of ≤ 3.0 mm in depth and extension of ≤ 7.0 mm
IA2	Measured stromal invasion of > 3.0 mm and not > 5.0 mm with an extension of not > 7.0 mm.
IB	Clinically visible lesions limited to the cervix uteri or pre-clinical cancers greater than stage IA*
IB1	Clinically visible lesion ≤ 4.0 cm in greatest dimension
IB2	Clinically visible lesion > 4.0 cm in greatest dimension
Stage II	Cervical carcinoma invades beyond the uterus, but not to the pelvic wall or to the lower third of the vagina
IIA	Without parametrial invasion
IIA1	Clinically visible lesion ≤ 4.0 cm in greatest dimension
IIA2	Clinically visible lesion > 4 cm in greatest dimension
IIB	With obvious parametrial invasion
Stage III	The tumor extends to the pelvic wall and/or involves lower third of the vagina and/or causes hydronephrosis or non-functioning kidney**
IIIA	Tumor involves lower third of the vagina, with no extension to the pelvic wall
IIIB	Extension to the pelvic wall and/or hydronephrosis or non-functioning kidney.
Stage IV	The carcinoma has extended beyond the true pelvis or has involved (biopsy proven) the mucosa of the bladder or rectum. A bullous edema, as such, does not permit a case to be allotted to Stage IV.

IVA	Spread of the growth to adjacent organs.
IVB	Spread to distant organs.

- * All macroscopically visible lesions—even with superficial invasion—are allotted to stage IB carcinomas. Invasion is limited to a measured stromal invasion with a maximal depth of 5.0 mm and a horizontal extension of not > 7.0 mm. Depth of invasion should not be > 5.0 mm taken from the base of the epithelium of the original tissue—superficial or glandular. The depth of invasion should always be reported in mm, even in those cases with "early (minimal) stromal invasion" (~ 1 mm). The involvement of vascular/lymphatic spaces should not change the stage allotment.
- ** On rectal examination, there is no cancer-free space between the tumor and the pelvic wall. All cases with hydronephrosis or non-functioning kidney are included, unless they are known to be due to another cause.

Table 1 Carcinoma of the Endometrium

Stage I*	Tumor confined to the corpus uteri
IA*	No or less than half myometrial invasion
IB*	Invasion equal to or more than half of the myometrium
Stage II*	Tumor invades cervical stroma, but does not extend beyond the uterus**
Stage III*	Local and/or regional spread of the tumor
IIIA*	Tumor invades the serosa of the corpus uteri and/or adnexae*
IIIB*	Vaginal and/or parametrial involvement*
IIIC*	Metastases to pelvic and/or para-aortic lymph nodes*
IIIC1*	Positive pelvic nodes
IIIC2*	Positive para-aortic lymph nodes with or without positive pelvic lymph nodes
Stage IV*	Tumor invades bladder and/or bowel mucosa, and/or distant metastases
IVA*	Tumor invasion of bladder and/or bowel mucosa
IVB*	Distant metastases, including intra-abdominal metastases and/or inguinal lymph nodes

* Either G1, G2, or G3

** Endocervical glandular involvement only should be considered as Stage I and no longer Stage II.

* Positive cytology has to be reported separately without changing the stage.

Table 1 FIGO Staging for Fallopian Tube Cancer

Stage 0	No evidence of primary tumor.
Stage I	Tumor confined to the fallopian tube.
Stage Ia	Tumor limited to one tube without penetrating the serosal surface, no ascites.
Stage Ib	Tumor limited to both tubes without penetrating the serosal surface, no ascites.
Stage Ic	Tumor limited to one or both tubes with extension onto/through the serosal surface, or with positive malignant cells in the ascites or positive peritoneal washings.
Stage II	Tumor involves one or both fallopian tubes with pelvic extension.
Stage IIa	extension and/or metastasis to uterus and/or ovaries.
Stage IIb	extension to other pelvic organs.
Stage IIc	IIb/c with positive malignant cells in the ascites or positive peritoneal washings.
Stage III	Tumor involves one or both fallopian tubes with peritoneal implants outside the pelvis and/or positive regional lymph nodes.
Stage IIIa	Microscopic peritoneal metastasis outside the pelvis.
Stage IIIb	Macroscopic peritoneal metastasis outside the pelvis 2cm or less in greatest dimension.
Stage IIIc	Peritoneal metastasis more than 2cm in greatest dimension and/or positive regional lymph nodes.
Stage IV	Distant metastasis beyond the peritoneal cavity.

http://www.igo.org/docs/staging_booklet.pdf

Table 1. FIGO Anatomical Staging of Gestational Trophoblastic Neoplasia

- Stage I Disease confined to the uterus.
 Stage II GTN extends outside of the uterus, but is limited to the genital structures (adnexa, vagina, broad ligament).
 Stage III GTN extends to the lungs, with or without known genital tract involvement.
 Stage IV All other metastatic sites.

From FIGO committee report Int J Gynecol Obstet 77, 285-287, 2002.

Table 2. FIGO Risk Factor Score for Gestational Trophoblastic Neoplasia

Score	0	1	2	4
Age	<40	≥40	-	-
Antecedent Pregnancy	mole	abortion	term	-
Interval months from index pregnancy	<4	4-6	7-12	>12
Pretreatment serum hCG (IU/L)	<10 ³	10 ³ -<10 ⁴	10 ⁴ -<10 ⁵	≥10 ⁵
Largest tumor size (including uterus)	<3 cm	3-4 cm	≥5 cm	-
Site of metastases	lung	spleen, kidney	GI tract	liver, brain
Number of metastases	-	1-4	5-8	>8
Previous failed chemotherapy	-	-	single agent	two or more drugs

To stage and allot a risk factor score, a patient's diagnosis is allocated to a stage as represented by a Roman number I, II, III, and IV. This is then separated by a colon from the sum of all the actual risk factor scores expressed in Arabic numerals, e.g. Stage II:4, Stage IV:9. This stage and score will be allotted for each patient.

Table 1 FIGO Staging for Carcinoma of the Ovary

Staging of ovarian carcinoma is based on findings at clinical examination and by surgical exploration. The histologic findings are to be considered in the staging, as are the cytologic findings as far as effusions are concerned. It is desirable that a biopsy be taken from suspicious areas outside of the pelvis.

- Stage I Growth limited to the ovaries.
- Stage IA Growth limited to one ovary; no ascites present containing malignant cells. No tumor on the external surface; capsule intact.
- Stage IB Growth limited to both ovaries; no ascites present containing malignant cells. No tumor on the external surface; capsule intact.
- Stage IC* Tumor classified as either Stage IA or IB but with tumor on the surface of one or both ovaries; or with ruptured capsule(s); or with ascites containing malignant cells or with positive peritoneal washings.
- Stage II Growth involving one or both ovaries, with pelvic extension.
- Stage IIA Extension and/or metastases to the uterus and/or tubes.
- Stage IIB Extension to other pelvic tissues.
- Stage IIC* Tumor either Stage IIA or IIB but with tumor on the surface of one or both ovaries; or with capsule(s) ruptured; or with ascites containing malignant cells or with positive peritoneal washings.

- Stage III Tumor involving one or both ovaries with peritoneal implants outside the pelvis and/or positive retroperitoneal or inguinal nodes. Surface liver capsule metastases equals Stage III. Tumor is limited to the true pelvis but with histologically proven malignant extension to small bowel or omentum.
- Stage IIIA Tumor grossly limited to the true pelvis with negative nodes but with histologically-confirmed microscopic seeding of abdominal peritoneal surfaces.
- Stage IIIB Tumor of one or both ovaries with histologically-confirmed implants of abdominal peritoneal surfaces none exceeding 2 cm in diameter; nodes are negative.
- Stage IIIC Abdominal implants greater than 2 cm in diameter and/or positive retroperitoneal or inguinal nodes.
- Stage IV Growth involving one or both ovaries, with distant metastases. If pleural effusion is present, there must be positive cytologic findings to allot a case to Stage IV. Parenchymal liver metastasis equals Stage IV.

**Notes about staging:*

To evaluate the impact on prognosis of the different criteria for allotting cases to Stage IC or IIC, it would be of value to know whether the rupture of the capsule was spontaneous or caused by the surgeon and if the source of malignant cells detected was peritoneal washings or ascites.

Table 1 Staging for uterine sarcomas

Leiomyosarcomas and Endometrial Stromal Sarcomas (ESS)*

Stage Definition

- I Tumor limited to uterus
 - IA ≤ 5 cm
 - IB > 5 cm
- II Tumor extends beyond the uterus, within the pelvis
 - IIA Adnexal involvement
 - IIB Involvement of other pelvic tissue
- III Tumor invades abdominal tissues (not just protruding into the abdomen).
 - IIIA One site
 - IIIB $>$ one site
 - IIIC Metastasis to pelvic and/or para-aortic lymph nodes
- IV Tumor with
 - IVA Bladder and/or rectum invasion
 - IVB Distant metastasis

Adenosarcomas

Stage Definition

- I Tumor limited to uterus
 - IA Tumor limited to endometrium/endocervix with no myometrial invasion
 - IB \leq to half myometrial invasion
 - IC $>$ half myometrial invasion
- II Tumor extends beyond the uterus, within the pelvis
 - IIA Adnexal involvement
 - IIB Involvement of other pelvic tissues
- III Tumor invades abdominal tissues (not just protruding into the abdomen).
 - IIIA One site
 - IIIB $>$ one site
 - IIIC Metastasis to pelvic and/or para-aortic lymph nodes
- IV Tumor with
 - IVA Bladder and/or rectum invasion
 - IVB Distant metastasis

Carcinosarcomas

Carcinosarcomas should be staged as carcinomas of the endometrium.

*Note:

Simultaneous endometrial stromal sarcomas of the uterine corpus and ovary/pelvis in association with ovarian/pelvic endometriosis should be classified as independent primary tumors.

FIGO Staging System for Carcinoma of the Vagina

Stage 0	Carcinoma in situ, intraepithelial neoplasia.
Stage I	Limited to the vaginal wall.
Stage II	Involvement of the subvaginal tissue without extension to the pelvic sidewall.
Stage III	Extension to the pelvic sidewall.
Stage IV	Extension beyond the true pelvis or involvement of the mucosa of the bladder or rectum. Bullous edema as such does not permit a case to be allotted to Stage IV.
Stage IVA	Spread to adjacent organs and/or direct extension beyond the true pelvis.
Stage IVB	Spread to distant organs.

Table 1 Carcinoma of the Vulva

Stage I	Tumor confined to the vulva
IA	Lesions ≤ 2 cm in size, confined to the vulva or perineum and with stromal invasion ≤ 1.0 mm*, no nodal metastasis
IB	Lesions > 2 cm in size or with stromal invasion > 1.0 mm*, confined to the vulva or perineum, with negative nodes
Stage II	Tumor of any size with extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with negative nodes
Stage III	Tumor of any size with or without extension to adjacent perineal structures (1/3 lower urethra, 1/3 lower vagina, anus) with positive inguino-femoral lymph nodes
IIIA	(i) With 1 lymph node metastasis (≥ 5 mm), or (ii) 1-2 lymph node metastasis(es) (< 5 mm)
IIIB	(i) With 2 or more lymph node metastases (≥ 5 mm), or (ii) 3 or more lymph node metastases (< 5 mm)
IIIC	With positive nodes with extracapsular spread
Stage IV	Tumor invades other regional (2/3 upper urethra, 2/3 upper vagina), or distant structures.
IVA	Tumor invades any of the following: (i) upper urethral and or vaginal mucosa, bladder mucosa, rectal mucosa, or fixed to pelvic bone, or (ii) fixed or ulcerated inguino-femoral lymph nodes
IVB	Any distant metastasis including pelvic lymph nodes

*The depth of invasion is defined as the measurements of the tumor from the epithelial-stromal junction of the adjacent most superficial dermal papilla to the deepest point of invasion.

Dictating Instructions

Butterworth / Blodgett	St. Marys
391-4300 BWH / 774-7441 BL / 774-7443 Ambulatory	685-6172 / 752-6366 (752-6005 for assistance)
5-digit dictator ID xxxxx 2-digit facility 00-BW or 01-BL	5-digit dictator ID xxxxx
<u>Work Types</u>	<u>Work Types</u>
00 Preadmit H&P/Annual	02 Procedure Note
01 Inpatient H&P	03 Operative Report
02 Inpatient Procedure	07 Discharge Summary
03 Discharge Summary	11 Preadmit H&P
07 Clinic Note	12 Inpatient H&P
08 Clinic Letter	17 Consult Report
14 Outpatient Procedure	
19 Consult Report	# - Rewind to where want to insert, touch #6 and dictate (St. Mary's system only).
23 ER Consult	
<u>To Listen to a Dictation</u>	<u>To Listen to a Dictation</u>
Dial 14340	Dial 6172 or 6366
Enter 16178#	Dial 1
Enter patient's DOB mm/dd/yyyy	Dial 01000 → #1 → 1
	Enter patient's DOB mm/dd/yyyy

Touch Tone Controls

- | | |
|-------------------|---------------------|
| 1 – Listen | 6 – Go To End |
| 2 – Dictate | 7 – Fast Forward |
| 3 – Short Reverse | 8 – Go to Beginning |
| 4 – Pause | 9 – Disconnect |
| 5 – End Report | |

Important Phone Numbers

Ob/Gyn residency office:

391-1929 (Cathie)
391-2100 (Anne)
391-3174 (fax)

BWH (391 prefix):

391-1774 (Main)
391-3999 (Physician operator)
1-1580 (2C L&D) Sch Inductions
1-1751 (OB Triage)
1-1280 (3C L&D) Sch C/S
1-2013 (fax 2C)
1-3821 (fax 3C)
1-1500 (4C OBSC)
1-1490 (5N)
1-9995 (ER Mod I)
1-1447 (ER Mod E/P)
1-2680 (ER Mod A)
1-1510, 1-1504 (Surg Sch)
1-1252 (South Holding)
1-1510 (North Holding)
1-1517 (PACU)
2-67__ (Direct to OR rooms)
2-6299 Doctors Sleep Room
1-1660, 0 (Med Records)
1-3702 (Chart Room)
Tanya Anderson (OR scheduling):
340-7581 ext: 12436
Surgery Scheduling: 11510
L&D -11751
3rd Floor Lounge 1-3053, 1-3263
4th MFM Floor Lounge 2-4908
OB Classroom/AM report: 1-2840

Spectrum Dictation:

1-4300
02 Inpt Op
03 D/C summary
07 Clinic note
08 Clinic letter
13 Counsults
14 Outpt Op
Resident Copier Code 1-1774 (in library)
Copier in Med Records 78110

BWH Resident Clinic:

330 Barclay Ste 304 49503
391-2160 (Public #, press 1 to leave a message)
391-2138 (back line)
391-2152 (to leave a message)
391-2683 (fax)
391-3531 (phone room)
2-6431

Clinic Back Door Code #1716

St. Mary's Hospital (685 prefix):

685-6090 (Main)
6488 (9S L&D)
685-3052 (fax)
6470 (9N)
6261 (8S)
6789 (ER)
6440 (Surgery Main Desk)
6166 (Med Records)
6429 (Resident Room)
6005 (Transcription)

St. Mary's Dictation: 685-6172

03 Op Note
07 Discharge summary

St. Mary's Clinic:

685-6920 (Public #)
685-5122, 5043 (back line)
685-5110 (fax)
685-5276 (front desk)

St. Mary Door Codes

4135 (everything but OR)

BWH Door Codes

1751# L&D Locker Room
1351 OB classroom-Rm 2751
512 OR South locker room
1309 3rd floor L&D Locker Rm
531 3rd floor lounge
215 4th floor MFM study
1751 Men's locker room

Important Phone Numbers

Attending	Pager	Attending	Pager
Anderson	397-1849	Kreuze	480-7646
Andersson-Zetye	339-7440	LaGrand	680-7879
Avery	680-6164	Lalley	397-3388
Backus	479-4710	Leahy	680-6076
S. Bennett	397-1202	Leary (no FSE/IUPC)	397-3387
Bitner	397-3385	Leazenby	479-0119
Blickley	444-4192	Ligon	270-1559
Bollin-Richards	444-0396	Lim	444-0254
Bowes	444-1628	Luce	444-0378
Brader	397-1764	Mathis	680-0012
Bradley	479-7295 (11707 office)	Menapace	397-3384
R. Brandt	230-4191	Oldenberg (cell)	648-2514
Brown		Olson	479-7171
Caldwell	479-3047	Rechner	480-7605
Cottingham	680-0497	Rinzler	478-4481
Craig	479-4367	Roberts	351-4841
Dalm	262-4975 (cell phone)	Rohn	680-5955
Dietrich	564-0022	Seamon	479-4401
Dood	480-0258	Steensma	480-7614
Edverson	444-0346	Taber	444-0463
Elderkin	472-4603	Tanner	479-8172
Federico	397-3382	Turke	397-2298
Freeburger	479-0998	Ulstad	351-9434
Gary		VanDeBurg	444-0875
Gorsuch	397-4084	VandenBosch	564-2205
Hartmann	680-2410	VanSlooten	480-7656
Hicks	480-1437	VanValkenburg	230-0442
Hoekstra	444-0043	VanWingen (cell)	616-402-5455
Hubbard	444-4187	Werkema	680-0122
Irving	444-0448	Wisebaker	478-8342
Johnson	479-2738	Wittingen	479-5051
Klyn	479-5487	Wolfe	479-3494
Knudsen	397-3383	Zylstra	397-3034
Kowalczyk	479-6369		

<p><u>McAuley Clinic (HIV clinic)</u></p> <p><u>Cherry Street – main number</u> Dr. Nancy Pranger</p> <p>pager nancypranger@cherryhealth.com Fax: Med Records: 454-8611/Triage: 235-0739</p> <p><u>Clinic Numbers</u> Westside Booth Baxter Community Center Dental Clinic (\$30-40)</p>	<p>913-8200 (main number) 913-8208 (new patient referral) 913-8238 (medicine consult) 685-9301 (fax)</p> <p>235-7272 Ext: 2065 – Dr. P Ext: 2066- Dr. P nurse Ext: 2117 Catherine B (nurse)</p> <p>444-0195 (M – Th 8-5pm)</p> <p>776-2215 (to leave message) 454-1385 (to leave message) 456-5310</p>
<p><u>Advanced OB/Gyn</u> LaGrand</p>	<p>Office: 971-0060</p>
<p><u>Advantage Health OB/GYN</u> Avery, Born, Burke, Burns, Hartmann, Leahy, Mathis</p>	<p>Office: 685-8750</p>
<p><u>Areawide OB/GYN</u> Ligon, Lim, VanValkenburg, Andersson-Zetye, Brown</p>	<p>Office: 458-7591 / 532-1410 Private: 532-3285 / 257-1450</p>
<p><u>Female Pelvic Medicine and Urogynecology</u> M. Bennett, J. Bennett, VanDrie</p>	<p>Office: 588-1800 Private: 588-1814</p>
<p><u>Grand Rapids Women’s Health</u> Blickley, Bollin-Richards, Bowes, Brandt, Edvenson, Gary, Hoekstra, Hubbard, Luce, Taber, VanDeBurg</p>	<p>Office: 588-1200 Private: 588-1295</p>
<p><u>Gynecologic Oncology of West Michigan</u> Downey, Harrison</p>	<p>Office: 957-3398 957-1948 voice mail</p>
<p><u>Maternal Fetal Medicine Associates PC</u> Balaskas, Cumiskey</p>	<p>Office: 285-3310</p>
<p><u>Michigan Reproductive & IVF Center</u> Dodds, Leach, Shavell, Young</p>	<p>Office: 988-2229 988-2007 (back line)</p>
<p><u>Spectrum Health Medical Group: Female Pelvic Medicine & Reconstructive Surgery</u> Heisler</p>	<p>Office: 391-3323 Pager: 479-9362</p>
<p><u>Spectrum Health Medical Group-OB/GYN</u> Bitner, Federico, Knudson, Kowalczyk, Menapace, Lalley, Leary, Rinzler, West, Wisebaker</p>	<p>Lk MI: 453-8225 Private: 453-7038 E.Belt: 363-9069 Private: 363-2536</p>
<p><u>Spectrum Health OB/GYN</u> Klyn, Leazenby, Tanner, Ulstad, Wittingen, Wolfe</p>	<p>Office: 391-3315 Private: 391-3323</p>
<p><u>St. Mary’s OB/GYN Specialists</u> Anderson, S. Bennett, Gorsuch, Turke, Zylstra</p>	<p>Office: 685-8600 Private:</p>
<p><u>West Michigan OB/GYN</u> Cottingham, Dietrich, Dood, Elderkin, Hicks, Jelsema, Kreuze, Rechner, Rohn, Steensma, VandenBosch, VanSlooten, Werkema</p>	<p>Office: 774-7035 Private: 774-8410 Jelsema: 774-8410</p>
<p><u>West Michigan Perinatal Diagnostics (MFM)</u> Fee, Romero, Sheikh, Zuidema</p>	<p>Office: 391-3681 Private: 391-8668</p>

SUBSPECIALISTS PAGER NUMBERS

Attending	Pager
Balaskas	480-4413
J. Bennett	444-0387
M. Bennett	444-0374
Brader	397-1764
Cummiskey	480-4401
Dodds	479-7289
Downey	339-1199/676-2976 (cell)
Fee	479-1924
Harrison	630-0880 /485-8479 cell
Heisler	479-2615
Jelsema	480-7631
Romero	479-8483
Sheikh	479-5566
VanDrie	444-0311
Young	479-7385
Zuidema	479-2009



History/Physical OBSTETRIC - ADMISSION

Patient Name _____

DOB _____

MRN _____

Physician _____

FIN _____

Date _____ Admission time _____

HISTORY

Age _____ Gravida _____ Para _____ with expected date of confinement _____

Ultrasound _____ Last menstrual period _____

Is admitted to OB delivery with complaints of _____

FETAL HEART RATE

- Category I Category II
- Category III

CONTRACTIONS

Frequency _____
 Duration _____
 Intensity _____
 Onset _____

PRENATAL PROBLEMS

Hypertension _____
 Diabetes mellitus _____
 Other _____

MEMBRANES

- Intact
- Spontaneous rupture of membranes confirmation by
 - Sterile speculum exam Positive ferning
 - Gross leaking of fluid Amnionic Fluid Volume

Time of rupture _____ Color of fluid _____

VAGINAL BLEEDING

No Yes Amount _____
 Characteristics _____

PRE-ECLAMPSIA SYMPTOM

Headache _____ Visual changes _____
 Right upper quadrant pain _____
 Edema _____ Other _____

SIGNIFICANT PAST AND FAMILY HISTORY

PAST OBSTETRICAL HISTORY _____

PAST MEDICAL HISTORY

Prior transfusions? No Yes

Last oral intake:
Time _____

REVIEW OF SYSTEMS

Smokes _____ packs per day

Alcohol _____

Drugs _____

Steroids _____

List hospitalizations/surgeries _____

ALLERGIES? No Yes If yes, list _____

MEDICATIONS

Current _____

During pregnancy _____

OVER →

DO NOT MARK BELOW THIS LINE

BARCODE ZONE

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* X 0 1 5 7 9 *

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

PHYSICAL

VITAL SIGNS: Temperature _____ Heart Rate _____ Respiratory rate _____ Height _____

Weight _____ Blood pressure _____ / _____ Repeat blood pressure _____ / _____

GENERAL APPEARANCE _____

SKIN _____

HEET _____

GENITALIA _____

NECK _____

PELVIC EXAM _____ / _____ / _____
dilation station effacement

BREAST _____

BISHOP SCORE _____

CHEST _____

	0	1	2	3
Dilation	<input type="checkbox"/> Closed	<input type="checkbox"/> 1 - 2	<input type="checkbox"/> 3 - 4	<input type="checkbox"/> 5+
Effacement	<input type="checkbox"/> 0 - 30	<input type="checkbox"/> 40 - 50	<input type="checkbox"/> 60 - 70	<input type="checkbox"/> 80+
Station	<input type="checkbox"/> -3	<input type="checkbox"/> -2	<input type="checkbox"/> -1	<input type="checkbox"/> 1, +2
Consistency	<input type="checkbox"/> Firm	<input type="checkbox"/> Medium	<input type="checkbox"/> Soft	
Position	<input type="checkbox"/> Posterior	<input type="checkbox"/> Mid	<input type="checkbox"/> Anterior	

CARDIAC _____

EDEMA

ABDOMEN

Upper extremities _____

Lower extremities _____

Presentation _____

NEUROLOGIC

Tenderness _____

Reflexes _____

Clonus _____

LAB RESULTS

INFORMAL ULTRASOUND

Urine (dipstick): Blood type _____

Performed _____ Not performed _____

Glu _____ Hgb/Hct _____

Position _____

Pro _____ Rubella titer _____

Fluid index _____

Ketones _____ VDRL _____

Placental location _____

Other _____ Hepatitis _____

Estimated fetal weight _____

HIV _____

Estimated gestational age _____

Antibody screen _____

Cardiac motion _____

Group B strep _____

Other _____

Other _____

IMPRESSION

PLAN

TIME _____ DATE _____ Resident Physician signature _____

TIME _____ DATE _____ Attending Physician signature _____

**Progress Notes
VAGINAL DELIVERY/CESAREAN SECTION -
POST PARTUM, OBSTETRIC**

Patient Name _____
DOB _____
MRN _____
Physician _____
FIN _____

Date _____ Time _____

Post Partum Day _____ Post Procedure Day _____

S: SUBJECTIVE

- Tolerating oral intake/Voiding/Ambulating/Flatus
- Normal Lochia flow
- Pain controlled
- Denies headache/Right upper quadrant pain/Visual changes
- Other/Complaints _____

O: OBSERVATION

Vitals: Temperature _____ BP _____ Pulse _____ Respirations _____ Intake/Output _____
Postpartum hemoglobin _____

EXPLAIN ANY ABNORMALITIES

GENERAL No abnormalities
(i.e. alert/no acute distress)

CARDIOVASCULAR/RESPIRATORY No abnormalities
(i.e. regular rate and rhythm, no murmur)

ABDOMEN/UTERUS: No abnormalities
(i.e. soft, non distended, non tender)

LOWER EXTREMITIES: No abnormalities
(i.e. no edema, non tender)

Incision _____
Uterus _____

A: ASSESSMENT

Age _____ Gravida _____ Para _____
 Status post (s/p): Vaginal delivery, no abnormalities Forceps/Vacuum Cesarean section
 Patient doing well
 Breastfeeding Bottle feeding Both
 Immunizations needed before discharge: Rubella immune MMR Tdap Varicella
 Blood type _____ Rhogam protocol ordered
 Contraception: Birth control pills Depo Provera Condoms Patch IUD Other _____

P: PLAN

TIME _____ DATE _____ Resident Physician signature _____

TIME _____ DATE _____ Physician signature _____

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BARCODE ZONE

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OVER →



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Form to be filled out after vaginal delivery.

* Pink Tab *

Summary NEWBORN CONDITIONS AND POSTPARTUM DISCHARGE

NEW BORN CONDITIONS

ABNORMAL CONDITIONS OF THE NEWBORN

- None
Anemia (Hgb. less than 13 or Hct. greater than 39)
Birth injury
Fetal alcohol syndrome
IRDS/Hyaline membrane disease
Meconium aspiration syndrome
Assisted ventilation less than 30 minutes
Assisted ventilation greater than 30 minutes
Seizures
Other

OTHER NEONATAL COMPLICATIONS

- None
Resuscitation
Prematurity
Dysmaturity
Infection
Other
Other

CONGENITAL ANOMALIES OF THE NEWBORN

- None
Anencephaly
Spina bifida/meningocele
Hydrocephaly
Microcephaly
Other CNS anomalies
Cardiac malformations
Other circulatory/respiratory anomalies
Rectal stenosis/atresia
Tracheoesophageal fistula/esophageal atresia
Omphalocele/Gastroschisis
Other gastrointestinal anomalies
Abnormal genitalia
Renal agenesis
Other urogenital anomalies
Cleft lip/palate
Polydactyly/Syndactyly/Adactyly
Club foot
Other musculoskeletal anomalies
Diaphragmatic hernia
Other

POSTPARTUM DISCHARGE SUMMARY

TREATMENT OR OPERATIONS

- None
Antibiotics
Transfusion units
Tubal Ligation
Other

SPECIAL MEDICATIONS/IMMUNIZATIONS

- None
Rhogam Blood type
Rubella immunization Immune

HOSPITAL COURSE

- Uneventful
Complication/Other

LABORATORY RESULTS

Discharge Hgb. / Hct.
Other

DISCHARGE CONDITION AND DIAGNOSES

- Uncomplicated term pregnancy, labor, and vaginal delivery with normal postpartum course
Other diagnoses

DISCHARGE MEDICATIONS/CONTRACEPTION

Discharge date

Discharge date

TIME DATE Physician signature

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KEY

- CNS = Central nervous system
Hct = Hematocrit
Hgb = Hemoglobin
IRDS = Infant respiratory distress syndrome

White - Chart Yellow - Physician

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