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### Scheduling Form for Induction of Labor and Cesarean Sections

McLaren Boarding Phone Number: 810-342-2279 McLaren Boarding Fax Number: 810-342-2218

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

OB Provider: \_\_\_\_\_ Primary Care Provider: \_\_\_\_\_

Type of Delivery Planned:  Induction  Cesarean Section Date/Time to be admitted: \_\_\_\_\_

#### DATING

EDC: \_\_\_\_\_ Gestational Age at Date of Induction or C-Section: \_\_\_\_\_ (week+day)

EDC Based on:  US 10-20 weeks;  Doppler FHT+ for 30 weeks;  + hCG for 36 weeks

EDC by LMP  Combination of the above criteria: \_\_\_\_\_ (details)

Fetal Lung Maturity test result: \_\_\_\_\_ Date: \_\_\_\_\_

*By ACOG guidelines, women should be 39 weeks or greater before an elective (no indication) delivery. A mature fetal lung test in the absence of clinical indication is not considered an indication for delivery before 39 weeks.*

#### INDICATION

##### Obstetrical and Medical Conditions (OK if <39 weeks)

- |   |   |
|---|---|
| <input type="checkbox"/> Abnormal Fetal HR      | <input type="checkbox"/> HIV Infection                        |
| <input type="checkbox"/> Abruptio               | <input type="checkbox"/> Isoimmunization                      |
| <input type="checkbox"/> Cardiovascular Disease | <input type="checkbox"/> Liver/Biliary Tract Disorder in Preg |
| <input type="checkbox"/> Chronic HTN            | <input type="checkbox"/> Oligohydramnios                      |
| <input type="checkbox"/> Coagulation Defect     | <input type="checkbox"/> Polyhydramnios                       |
| <input type="checkbox"/> Congenital CV Disorder | <input type="checkbox"/> Poor Fetal Growth                    |
| <input type="checkbox"/> Cord Prolapse          | <input type="checkbox"/> Post Term Pregnancy                  |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Preeclampsia                         |
| <input type="checkbox"/> Fetal Distress         | <input type="checkbox"/> Previa                               |
| <input type="checkbox"/> Fetal Malformation     | <input type="checkbox"/> PROM                                 |
| <input type="checkbox"/> Gestational DM         | <input type="checkbox"/> Renal Disease in Preg                |
| <input type="checkbox"/> Gestational HTN        | <input type="checkbox"/> Twin or Triplet Delivery             |
| <input type="checkbox"/> Hemorrhage             | <input type="checkbox"/> Other: _____                         |

##### Scheduled C/S (>39 wks)

- Breech Presentation
- Other Malpresentation
- Patient Choice
- Prior C/S
- Prior Classical C/S
- Prior Myomectomy  
(may be earlier with fetal lung maturity test)
- Twin w/out Complication  
(OK ≥39 weeks)
- Other:

##### Elective Induction (> 39 weeks)

- Macrosomia
- Patient Choice/Social
- Other: \_\_\_\_\_

#### SCREENING STATUS

Group B Strep Status  Positive  Negative

Hepatitis Status  Positive  Negative

Blood Type \_\_\_\_\_ Rh Status \_\_\_\_\_ Rubella Status \_\_\_\_\_

PLAN OF CARE: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_



#### PATIENT IDENTIFICATION