OPERATIVE VAGINAL DELIVERY

☐ See Dictation
Delivery Date: _________________  Time: _________
Delivering Physician: __________________________________________________

PREOPERATIVE ASSESSMENT

EFW_________________________  Station:  _____________________  Position:  __________________________________
Bladder emptied: ☐ Yes ☐ No  Anesthesia Type:  ___________________________
Patient counseled on the risks/benefits and alternatives of procedures and consent given  ☐ Yes ☐ No

INDICATIONS FOR OPERATIVE DELIVERY

☐ Maternal exhaustion
☐ Prolonged 2nd stage
☐ Non-reassuring fetal heart rate pattern
☐ Other _______________________

TYPE OF INSTRUMENT USED (Check all the apply)

☐ Vacuum type: ________________________________
☐ Forceps type: _________________________________
☐ Other:  _______________________________________
Was more than one type of instrument used?  ☐ Yes  ☐ No
If yes, document all instruments used and the order in which they were used: ________________________________________

DETAILS OF DELIVERY (Fill this section out for each instrument used, use additional forms if needed)

Vacuum

Time applied: ___________  Time applied: ___________
Site applied: ____________  Application verified: ☐ Yes ☐ No
# of applications _________  # of assisted contractions used: ___________________
# of popoffs: _____________  # of assisted contractions used: ______________
Pressure release between contractions: ☐ Yes  ☐ No

Nuchal cord: ☐ None  Present x_________  ☐ Loose  ☐ Tight
Cord released by ☐ Manual reduction of cord  ☐ Clamped and cut
Placenta: ☐ Spontaneous  ☐ Manual  ☐ Intact  ☐ Other:  _____________________________
EBL: _______________________

☐ Operative vaginal delivery abandoned: proceed to cesarean section

MATERNAL OUTCOME

Episiotomy

☐ None  ☐ Median  ☐ Mediolateral
Extension:  ☐ None  ☐ 3rd degree  ☐ 4th degree
Repaired with: __________________________________________

Lacerations

Perineal  ☐ None  ☐ 1st degree  ☐ 2nd degree  ☐ 3rd degree  ☐ 4th degree
Vaginal  ☐ None  ☐ Other:  _____________________________
Cervical  ☐ None  At __________ o’clock
Repaired with __________________________________________
Other:  ____________________________________________

INFANT: Sex  ☐ Male  ☐ Female  Weight ______________  Apgars __________/__________
UApH obtained: ☐ Yes  Result___________  ☐ No

Physician Signature: _____________________________  Date_____________________  Time________