BC Perinatal Triage and Assessment Record (PSBC 1910)

Guide for Completion

January 2020

Perinatal Services BC
Provincial Health Services Authority

Summary of Changes

WHAT'S NEW?

The updated record was developed in accordance with current clinical guidelines and best practice recommendations, and with consultation from a variety of health care providers, including midwives, physicians, and nurses.

The updated Triage and Assessment Record (PSBC 1910) replaces the 2018 version of the record (PSBC 1590).

[Note: Numbered items below correspond to the numbered sections of PSBC 1910 – Triage and Assessment Record.]

1. BACKGROUND

→ **Falls Risk Screen:** Field was moved to this section.

→ **"Purple Dot" point-of-care violence risk assessment:** Field was changed to align with the language used in the Provincial Health Services Authority Learning Hub course on Violence Prevention in health care.

2. INITIAL ASSESSMENT

→ **Triaged as:** Classifications were added based on the Obstetrical Triage Acuity Scale (OTAS).

→ **Maternal / Fetal Classification:** Section was removed. The classification tool is available as a separate form on the PSBC website.

→ **'Previous admission this pregnancy' and 'ECV attempted':** Fields were moved to Section 3 – History / Risk Factors.

3. HISTORY / RISK FACTORS

→ **RhIG:** Field was added to document the dates when RhIG was given to the mother or pregnant individual.

→ **Complementary therapy:** Field was added to document any complementary therapy that the mother or pregnant individual is using during pregnancy and / or labour and delivery.

→ **Antenatal corticosteroid administration:** Section was added to document if the mother or pregnant indiviudal received antenatal corticosteroids prior to labour and delivery.

→ **Planned mode of delivery:** Field was added to document Vaginal, Primary C / S, or Repeat C / S.

→ **VBAC eligible this delivery:** Field was added to document eligibility for a Vaginal Birth After Cesarean (VBAC) during this current delivery.

→ **GBS results:** Section was added to document Group B Streptococcus (GBS) test results.

→ **GBS swab:** Section was added to document if a GBS swab test was conducted.

→ **Postpartum hemorrhage risk assessment:** Section was added to document risk for postpartum hemorrhage. Document as "low" or "increased" risk based on institutional policy and / or best clinical judgment.

7. FOLLOW-UP / REFERRALS

→ Follow-up and referrals were combined into one section.

8. DISCHARGE STATUS

→ Field was added to include care provider authorizing the admission / discharge / transfer.

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Table of Contents

4 W'S OF TRIAGE AND ASSESSMENT DOCUMENTATION

- **WHEN?** During any antepartum hospital visits, as well as at hospital admission for labour and delivery.
- **WHO?** Health care providers (e.g., Registered Nurses, Medical Doctors, Registered Midwives, and/or Nurse Practitioners).
- **WHAT?** Document assessments, interventions, outcomes, and decisions during the hospital visit or at intake for labour and delivery.
- **WHY?** To document pregnancy care accurately and completely and to facilitate communication and continuity of care.

Introduction

Perinatal Services BC (PSBC) has the provincial mandate to develop a suite of standardized perinatal forms that are used by most health care providers in British Columbia (BC). These forms support best practice in perinatal care and act as clinical documentation tools. It is also within PSBC's mandate to collect and analyze perinatal data in an effort to evaluate provincial perinatal health outcomes and improve the health system. To meet this objective, specific fields on the perinatal forms are collected as part of a comprehensive database for the British Columbia Perinatal Data Registry (BCPDR).

The BC Perinatal Triage and Assessment Record (Form No. PSBC 1910, revised January 2020) is a standardized form that was developed for the documentation of any hospital visits during pregnancy, including during the antepartum period and hospital admission for labour and delivery. This form has been updated to ensure that it is evidence-based and aligned with current clinical guidelines, standards, and best practices. A number of guidelines from the Society of Obstetricians and Gynaecologists of Canada (SOGC) informed the content revisions of the form, along with other national, provincial and local policies and standards, and expert opinion.[1-7] Other changes in the form are intended to improve the format and flow, in an effort to make the form more user-friendly and support complete and accurate clinical documentation.

In addition, the BC Perinatal Triage and Assessment Record is a tool that facilitates communication and continuity of care between health facilities and care providers. If the pregnant individual presents to the hospital at any point during their pregnancy, documentation should include whether they are admitted to the hospital, transferred elsewhere, or discharged home. Additionally, this form should be completed at hospital intake when the pregnant individual goes into labour, prior to admission to the labour and delivery unit. The BC Triage and Assessment Record does not need to be completed for home births. Information related to the labour and birth episode of care is supplemented by other standard perinatal forms, including the Labour and Birth Record and the Labour Partogram.

A note on gender inclusion and the language of this document

This document uses gender-inclusive language. Health care providers play a critical role in creating a supportive environment for all patients, clients and families, including transgender, gender non-binary, and gender non-conforming (TGNC) people. Throughout this guide for completion, we typically refer to women, mothers, and/or pregnant individuals to recognize that not only cisgender women can and do become pregnant and seek care for their pregnancy, delivery, and postpartum care. Starting with the revised BC Antenatal Record, and throughout the continuum of care, PSBC invites providers to ask all patients and clients their preferred name and pronouns to use as part of our commitment to gender-inclusive practice.

Abbreviations and Acronyms

ARO	Antibiotic Resistant Organism
BMI	Body Mass Index
BP	Blood Pressure
C/S	Cesarean Section
C&S	Culture and Sensitivity (Urine)
Cx	Cervical
EDD	Estimated Date of Delivery
EFM	Electronic Fetal Monitoring
fFN	Fetal Fibronectin Test
FHR	Fetal Heart Rate
GA	Gestational Age
HepB	Hepatitis B
HSV	Herpes Simplex Virus
IVF	In Vitro Fertilization
LDR	Labour Delivery Recovery
LMP	Last Menstrual Period
Med. Rec.	Medications Reconciliation
MRSA	Methicillin Resistant Staphylococcus Aureus
N/A	Not Applicable
NST	Non-Stress Test
OTAS	Obstetrical Triage Acuity Scale
Pre-preg.	Pre-pregnancy
R&M	Routine and Microscopy
Rh	Rhesus
RhIG	Rh Immune Globulin
SFH	Symphysis Fundal Height
TB	Tuberculosis
Temp	Temperature
US	Ultrasound
VRE	Vancomycin Resistant Enterococcus
Wt.	Weight

Completion of the Form

Place the patient **Addressograph / Label** in the dedicated space in the upper right corner of the page, on Pages 1 and 2. If the addressograph or label is not available, record the mother's or pregnant individual's **Surname**, **Given name**, **Address**, **Phone number**, **Personal Health Number**, and the **Medical Doctor (MD) / Registered Midwife (RM)**'s name in the same space.

Section 1: Background

Item	Description
Date (dd / mm / yyyy)	Record the date of the mother's or pregnant individual's hospital visit (following the dd / mm / yyyy format).
Time (hh:mm)	Record the time of the mother's or pregnant individual's hospital visit (following the hh:mm format).
Arrived by ambulance	Specify whether the mother or pregnant individual arrived to the hospital by ambulance by selecting one of the following: ☐ **No** ☐ **Yes**
Accompanied by	If the mother or pregnant individual was accompanied to the hospital, document the person's relationship to the mother or pregnant individual (e.g., partner / spouse, parent / relative, friend, etc.). If the mother or pregnant individual was not accompanied by anyone, document '**None**'.
Language preferred	Record the language that is most readily understood by the mother or pregnant individual, which may include sign language. *Note: This information is especially important when English is not the mother's or pregnant individual's first language.*
Reason for visit	Record the reason why the mother or pregnant individual presented to the hospital. Some possible reasons may include (but are not limited to): > Labour (individual is in labour or thinks that they are in labour) > Preterm labour > Prelabour rupture of membranes (PROM) > Preterm prelabour rupture of membranes (PPROM) > Decreased fetal movement > Increased blood pressure > Bleeding > Scheduled external cephalic version > Scheduled induction > Need for medications
Gravida	Record the total number of all pregnancies, including all past and present pregnancies, regardless of gestational age, pregnancy type, and pregnancy outcome or time / method of termination. *Note: Twins or multiples should be counted as one pregnancy.* *Note: An ectopic pregnancy, a missed abortion, a blighted ovum and a hydatidiform mole are classified as a gravida and should contribute to the total number of all pregnancies.*

Completion of the Form

Item	Description
Term	Record the total number of previous pregnancies where the birth occurred at greater than or equal to 37 completed weeks gestation (i.e., gestational age ≥ 37^0 weeks). *Note: A previous multiple pregnancy delivered at term should be counted as "1 term". If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as "1 term" and "1 preterm".*
Preterm	Record the total number of previous pregnancies where the birth occurred between 20 and 36 completed weeks gestation (i.e., gestational age $20^0 – 36^6$ weeks). *Note: Late terminations should contribute to the total number of previous preterm pregnancies.* *Note: A previous multiple pregnancy delivered preterm should be counted as "1 preterm". If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as "1 term" and "1 preterm".*
Abortus	Record the total number of previous terminations of pregnancies, including spontaneous and induced terminations, ending prior to 20 completed weeks gestation and weighing less than 500 grams. *Note: An ectopic pregnancy, a missed abortion, a blighted ovum and a hydatidiform mole are classified as a gravida and should contribute to the total number of all pregnancies.*
Living	Record the total number of children that the patient has given birth to who are presently living. *Note: Do not include the current pregnancy in this count.* *Note: A previous multiple pregnancy should be counted per living child (i.e., twin pregnancy = 2, triplet pregnancy = 3, etc.)*
LMP (dd / mm / yyyy)	Record the first day of the mother's or pregnant individual's last normal menstrual period (LMP) (following the dd / mm / yyyy format).
EDD (dd / mm / yyyy)	Record the estimated date of delivery (EDD) as confirmed by ultrasound (US) or in-vitro fertilization (IVF) timing data (following the dd / mm / yyyy format). Specify the method of pregnancy dating used to confirm the EDD by selecting one of the following: ☐ **US** ☐ **IVF**
GA (wks / days)	Record the gestational age (GA) (in weeks and days) at which the mother or pregnant individual presented to the hospital based on pregnancy dating as confirmed by ultrasound or in-vitro fertilization.
Recent infectious disease / contact	Specify whether the mother or pregnant individual has had any recent infectious disease and / or contact with an infectious agent by selecting one of the following: ☐ **No** ☐ **Yes** (specify, e.g. MRSA, VRE, Varicella, HSV, HepB, TB) If '**Yes**' is selected, specify the type of infectious disease / contact that the mother or pregnant individual has had (e.g., Methicillin Resistant Staphylococcus Aureus (MRSA), Vancomycin Resistant Enterococcus (VRE), Varicella (i.e., chicken pox), Herpes Simplex Virus (HSV), Hepatitis B (HepB), Tuberculosis (TB)).

Completion of the Form

Item	Description
ARO Screen completed	Specify whether the mother or pregnant individual has had an Antibiotic Resistant Organism (ARO) screen completed, as per the institutional policy, by selecting one of the following: ☐ **No** ☐ **Yes** (initials) If '**Yes**' is selected, the care provider who confirmed that the ARO screen was completed should record their initials in the space provided. *Note: Refer to the Provincial Infection Control Network, the BC Centre for Disease Control, and institutional policies for additional information.*
ARO swab taken	If an ARO screen was completed, specify whether an ARO swab was taken, as per the institutional policy, by selecting one of the following: ☐ **Not Applicable (N / A)** (an ARO swab is not indicated). ☐ **No** (an ARO swab is indicated but it was not taken). ☐ **Yes** (dd / mm / yyyy) (an ARO swab is indicated and it was taken). If '**Yes**' is selected, record the date when the ARO swab was taken (following the dd / mm / yyyy format).
Falls Risk Screen	Specify the results of the mother's or pregnant individual's Falls Risk Screen by selecting one of the following: ☐ **Reviewed and no concerns** ☐ **At risk for falls**
At risk for falls	If '**At risk for falls**' is selected, and a falls prevention care plan, as per institutional policy, was completed, select '**Falls prevention care plan completed**'.
"Purple Dot" point-of-care violence risk assessment	Specify the results of the point-of care violence risk assessment (also known as "Purple Dot") by selecting one of the following: ☐ **Low risk** ☐ **High risk** *Note: The point-of-care violence risk assessment is a screen that is done at the point of a patient's interaction with the health care system and is meant to assess the level of risk that the patient (or anyone that may accompany them) poses to care providers (or even themselves). According to various institutional policies, this may be known as the "Purple Dot".* *Note: This is a mandatory screen that is performed in order to ensure hospital accreditation and compliance with legislation enacted for violence-prevention within the workplace.* *Note: If the patient (or anyone that may accompany them) is determined to be 'High risk', additional steps are required to be taken according to the institutional policies. Refer to* **SafeCare BC** *and institutional policies for additional information.*

Completion of the Form

Section 2: Initial Assessment

Item	Description
Contractions	Specify whether the mother or pregnant individual has experienced contractions by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**No**' is selected, skip the rest of the fields related to contractions and move on to assessing the membranes. If '**Yes**' is selected, complete the additional fields (below) related to the presence of contractions.
Start date (dd / mm / yyyy)	Record the date when the mother's or pregnant individual's contractions first started (following the dd / mm / yyyy format).
Start time (hh:mm)	Record the time when the mother's or pregnant individual's contractions first started (following the (hh:mm format).
Type	Specify the type of contractions (i.e., regular or irregular) the mother or pregnant individual is experiencing by selecting one of the following: ☐ **Regular** ☐ **Irregular**
Intensity	Specify the intensity of the mother's or pregnant individual's contractions by selecting one of the following: ☐ **Mild** ☐ **Moderate** ☐ **Strong** *Note: This can be assessed by asking the mother or pregnant individual, as well as by palpating the fundus during the contractions.*
Frequency (# / 10 min)	Record the frequency of the mother's or pregnant individual's contractions (i.e., the number of contractions per every 10 minutes).
Duration (sec)	Record the duration (in seconds) of each set of contractions, from the onset of contractions to the end of the set. *Note: This can be assessed by asking the mother or pregnant individual, as well as by palpating the fundus during the contractions.*

Completion of the Form

Item	Description
Membranes	Specify the status of the membranes by selecting one of the following: ☐ **Intact** ☐ **Query** (the status of the membranes cannot be confirmed and may require nitrazine and / or ferning tests) ☐ **Ruptured** ((specify details below)) If '**Intact**' is selected, skip the rest of the fields related to membranes and move on to determining the presence of bleeding / show. If '**Query**' is selected, skip the rest of the fields related to membranes and move on to determining the presence of bleeding / show. A nitrazine and / or ferning test may be ordered, the results of which should be recorded in section 4 under "Tests". If '**Ruptured**' is selected, complete the additional fields (below) related to ruptured membranes.
Date (dd / mm / yyyy)	Record the date when the mother's or pregnant individual's membranes ruptured (following the dd / mm / yyyy format).
Time (hh:mm)	Record the time when the mother's or pregnant individual's membranes ruptured (following the hh:mm format).
Colour	Specify the colour of the amniotic fluid from the ruptured membranes by selecting one of the following: ☐ **Clear** ☐ **Meconium stained** ☐ **Bloody**
Bleeding / show	Specify whether the mother or pregnant individual has experienced any bleeding or show by selecting one of the following: ☐ **No** ☐ **Yes** ((specify details below)) If '**No**' is selected, skip the rest of the fields related to bleeding / show and move on to assessing fetal movement. If '**Yes**' is selected, complete the additional fields (below) related to bleeding / show.
Start date (dd / mm / yyyy)	Record the date when the mother or pregnant individual first noticed bleeding / show (following the dd / mm / yyyy format).
Start time (hh:mm)	Record the time when the mother or pregnant individual first noticed bleeding / show (following the hh:mm format).
Amount	Specify the amount of bleeding that is present by selecting one of the following ☐ **Scant** ☐ **Small** ☐ **Moderate** ☐ **Large**
Colour / consistency	Record the colour and / or consistency of the blood (e.g., bright red, mucous).

Completion of the Form

Item	Description
Fetal movement	Specify the mother's or pregnant individual's awareness of fetal movement by selecting one of the following: ☐ **Normal** ☐ **Increased (↑)** ((specify details below)) ☐ **Decreased (↓)** ((specify details below)) If '**Normal**' is selected, skip the rest of the fields related to fetal movement and move on to specifying the triage level of the mother or pregnant individual. If '↑' or '↓' is selected, complete the additional fields (below) related to fetal movement.
Date (dd / mm / yyyy)	If '↑' or '↓' is selected, record the date when the mother or pregnant individual noticed increased or decreased fetal movement (following the dd / mm / yyyy format).
Time (hh:mm)	If '↑' or '↓' is selected, record the time when the mother or pregnant individual noticed increased or decreased fetal movement (following the hh:mm format).
Triaged as	Specify the triage level of the mother or pregnant individual according to the Obstetrical Triage Acuity Scale (OTAS) as confirmed by the initial assessment by selecting one of the following: ☐ **OTAS 1 – Resuscitative** ☐ **OTAS 2 – Emergent** ☐ **OTAS 3 – Urgent** ☐ **OTAS 4 – Less Urgent** ☐ **OTAS 5 – Non-Urgent** *Note: Additional information on the OTAS can be found here:* *Gratton, Robert J. et al. (February 2016). Acuity Assessment in Obstetrical Triage. Journal of Obstetrics and Gynaecology Canada , Volume 38, Issue 2, 125 – 133.*
Triaged to	Specify the location where the mother or pregnant individual was triaged to by selecting one of the following: ☐ **Labour and delivery room (LDR)** ☐ **Assessment room** ☐ **Waiting room** ☐ **Other** If '**Other**' is selected, specify the location where the mother or pregnant individual was triaged to.

Completion of the Form

Section 3: History / Risk Factors

Item	Description
Allergies (incl. reaction)	Record the mother's or pregnant individual's allergies and specify the reactions that are elicited. This section includes seafood allergies and allergies related to X-ray dyes. Do not record environmental allergens. If the mother or pregnant individual does not have any known allergies, select '**None**'.
ABO	Record the mother's or pregnant individual's ABO blood group type (i.e., A, B, AB, or O).
Rh factor	Record the mother's or pregnant individual's Rhesus (Rh) blood group type (i.e., positive or negative)
Date RhIg given (dd / mm / yyyy)	Record the date when the Rh Immunoglobulin (RhIg) was administered to the mother or pregnant individual (if applicable). *Note: Non-sensitized Rh negative mothers or pregnant individuals should receive RhIg at 28 weeks of gestation and within 72 hours after delivery of an Rh positive infant.* *Note: RhIg administration to non-sensitized Rh negative mothers or pregnant individuals may also be warranted after other potentially sensitizing events, such as miscarriage, threatened abortion, induced abortion, ectopic pregnancy, molar pregnancy, amniocentesis, chorionic villous sampling.* *Note: Non-sensitized Rh negative mothers should be offered RhIg, and verbal or written informed consent should be obtained prior to the administration of RhIg (a blood product).*
Current medications	Specify what medications the mother or pregnant individual is currently on by selecting one of the following: ☐ **None** ☐ **Vitamins only** ☐ **Medications recorded on Medications Reconciliation Form (Med. Rec. Form)** *Note: If the mother or pregnant individual is taking any medications, the details (including dose and frequency) should be recorded on the Institutional Med.Rec.Form.*
Complementary therapy	Specify whether the mother or pregnant individual is using any complementary therapies by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the type of complementary therapies that the mother or pregnant individual is using.
Previous admission this pregnancy	Specify whether the mother or pregnant individual has had a previous hospital visit / admission during this pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify reason) If '**Yes**' is selected, specify the reason why the mother or pregnant individual has previously visited / was admitted to the hospital.

Completion of the Form

Item	Description
Antenatal corticosteroid administered	Specify whether the mother or pregnant individual has had corticosteroids administered antenatally if a preterm birth is anticipated within 7 days of administration by selecting one of the following: ☐ **Not Applicable (N/A)** (corticosteroid administration is not indicated as the mother or pregnant individual is not at/has not been at risk of preterm birth) ☐ **No** ☐ **Yes** (dd/mm/yyyy) If '**Yes**' is selected, specify the date when the antenatal corticosteroids were administered (following the dd/mm/yyyy format).
External cephalic version attempted	Specify whether the mother or pregnant individual has had an external cephalic version attempted during the pregnancy in order to turn the baby from a non-vertex position to a vertex position prior to delivery by selecting one of the following: ☐ **Not Applicable (N/A)** (external cephalic version is not indicated as the baby is not in a non-vertex position) ☐ **No** ☐ **Yes** (dd/mm/yyyy) If '**Yes**' is selected, specify the date when the external cephalic version was attempted (following the dd/mm/yyyy format).
Planned mode of delivery	Specify the planned mode of delivery for this pregnancy by selecting one of the following: ☐ **Vaginal** ☐ **Primary cesarean section (Primary C/S)** ☐ **Repeat cesarean section (Repeat C/S)** If a C/S delivery is planned for this pregnancy and the patient has had a C/S for a previous pregnancy, select '**Repeat C/S**'.
VBAC eligible this delivery	If the patient has had a C/S for a previous pregnancy, indicate whether they are eligible to attempt a vaginal delivery for this pregnancy (i.e., VBAC) by selecting one of the following: ☐ **Yes** ☐ **No** (specify reason) If '**No** (specify reason)' is selected, record the reason why the patient is not eligible for a VBAC. If the patient has previously never had a C/S, select '**N/A**' (i.e., not applicable).
GBS results	Specify the results of the group B streptococcus (GBS) screening at 35–37 weeks of gestation (or at less than 35 weeks of gestation if the woman or pregnant individual is in preterm labour) by selecting one of the following: ☐ **Unknown (Unk)** (GBS status is unknown because screening is not indicated as the mother or pregnant individual is at less than 35 weeks of gestation and/or not in preterm labour, or because screening was not done [i.e., the mother or pregnant individual refused to be screened or there was no time to perform the screen prior to labour/delivery.]) ☐ **Negative (Neg)** ☐ **Positive (Pos)**

Completion of the Form

Item	Description
GBS swab taken	Specify whether an anorectal swab for GBS was taken at 35 – 37 weeks of gestation (including at the present visit if applicable) by selecting one of the following: ☐ **Not Applicable (N / A)** (anorectal swab for GBS is not indicated as the mother or pregnant individual is not at 35-37 weeks of gestation) ☐ **No** ☐ **Yes** (dd / mm / yyyy) If '**Yes**' is selected, specify the date when the most recent anorectal swab for GBS was taken (following the dd / mm / yyyy format).
Postpartum hemorrhage risk assessment	Specify the mother's or pregnant individual's risk of postpartum hemorrhage as assessed prior to delivery by selecting one of the following: ☐ **Low risk** ☐ **Increased risk** *Note: Institutional policy and clinical judgment should be used to identify risk factors at admission to categorize the pregnant individual's risk for PPH.* *Examples of "low risk" may include: no previous uterine incision, singleton pregnancy, less than 4 previous vaginal births, no known bleeding disorder, no history of PPH.* *Examples of "increased risk" may include: previous caesarean birth(s) or uterine surgery; over-distended uterus; 5 or more previous vaginal births; chorioamnionitis; abruption; history of previous PPH; uterine fibroids over 8 cm; morbid obesity (BMI > 38); thrombocytopenia (platelets < 75); hemoglobin less than 90; placenta previa, low lying placenta, suspected placenta accreta, percreta, or increta; active bleeding (greater than show) on admission; known bleeding disorder, severe Gestational Hypertension; sepsis.*
Antenatal Record Part 1 & 2	Specify whether the mother's or pregnant individual's Antenatal Record (Part 1 and 2) was available and reviewed during the hospital visit / admission by selecting one of the following: ☐ **Reviewed** (option to skip to section 4) ☐ **Not available** (complete below) If the Antenatal Record was available and reviewed, select '**Reviewed**'. Since the items that follow in this section are also included on the Antenatal Record, there is an option to skip these items if the information presented on the Antenatal Record was sufficiently detailed and described any concerns related to this pregnancy, any previous pregnancies, the mother's or pregnant individual's medical history, and any psychosocial concerns that may be present. If the Antenatal Record was not available or reviewed, select '**Not available**', and complete the items below.
Pregnancy concerns	Specify whether there are any concerns related to the mother's or pregnant individual's pregnancy by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the concerns that are present related to the mother's or pregnant individual's pregnancy.

Completion of the Form

Item	Description
Past obstetric concerns	Specify whether there are any concerns related to the mother's or pregnant individual's previous pregnancies (i.e., past obstetric concerns) by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the concerns that are present related to the mother's or pregnant individual's previous pregnancy (i.e., past obstetric concerns).
Medical / surgical / anesthetic concerns	Specify whether there are any maternal medical, surgical, and/or anesthetic concerns by selecting one of the following: ☐ **No** ☐ **Yes** (specify) If '**Yes**' is selected, specify the maternal medical, surgical, and/or anesthetic concerns that are present.
Psychosocial concerns	Specify if the mother or pregnant individual had no concerns related to their psychosocial wellbeing by selecting '**No**'. If '**No**' is not selected, specify what concerns related to the mother's or pregnant individual's psychosocial wellbeing are present by selecting all of the following that apply: ☐ **Lifestyle/social** ☐ **Substance use** ☐ **Mental health** ☐ **Other** If '**Other**' is selected, specify what other concerns related to the mother's or pregnant individual's psychosocial wellbeing are present.

Section 4: Assessment

Item	Description
Last ate (dd / mm / yyyy) (hh:mm)	Record the date and time when the mother or pregnant individual last ate a full meal (following the dd / mm / yyyy format and hh:mm format, respectively).
Last drank (dd / mm / yyyy) (hh:mm)	Record the date and time when the mother or pregnant individual last drank any fluids (following the dd / mm / yyyy format and hh:mm format, respectively).
Ht (cm)	Record the height (ht) of the mother or pregnant individual (in centimeters).
Pre-preg. Wt. (kg)	Record the pre-pregnancy weight (pre-preg. wt) of the mother or pregnant individual (in kilograms). *Note: The pre-pregnancy weight can be self-reported by the mother or pregnant individual or it can be based on the weight measured at the first antenatal visit.*

Completion of the Form

Item	Description
Pre-preg. BMI	Calculate the pre-pregnancy Body Mass Index (BMI) of the mother or the pregnant individual. *Note: The BMI is the weight (in kilograms) divided by the height (in meters) squared.* *Note: An amount of weight that the mother or pregnant individual should be gaining throughout the pregnancy can be recommended based on the pre-pregnancy BMI, with the recommendations presented on the back of Page 1 of the Antenatal Record for reference, as indicated by the asterisk.*
Current Wt (kg)	Record the current weight (wt) of the mother or pregnant individual (in kilograms) as measured during the hospital visit / admission.
Presentation	Record the presentation of the fetus as assessed during the hospital visit / admission based on the part of the baby's body that is presenting in reference to the birth canal (e.g., cephalic, breech, shoulder).
Lie	Record the lie of the fetus as assessed during the hospital visit / admission based on the relationship between the baby's long axis (i.e., spine) and the mother's or pregnant individual's long axis (e.g., longitudinal [vertical], transverse [horizontal], oblique).
Position	Record the position of the fetus as assessed during the hospital visit / admission based on the relationship between the baby's presenting body part and the mother's or pregnant individual's pelvis (e.g., Occiput – Anterior, Occiput – Posterior, Occiput – Transverse, Sacrum – Anterior, Sacrum – Posterior, Sacrum – Transverse).
Engagement	Specify whether there is fetal engagement based on whether or not the largest transverse diameter of the baby's presenting body part (usually the biparietal diameter) has passed through the maternal pelvic brim, by specifying one of the following: ☐ **No** ☐ **Yes**
Symphysis-fundal height (SHF) (cm)	Record the symphysis-fundal height (SFH) (in centimeters), from the top of the mother's or pregnant individual's fundus to the symphysis, as measured during the hospital visit / admission.
SFH consistent with GA	Specify whether the symphysis-fundal height (SFH) is consistent with the gestational age (GA) by selecting one of the following: ☐ **No** ☐ **Yes**
Fetal surveillance	Specify the methods of fetal surveillance used to assess the fetal heart rate during the hospital visit / admission by selecting all of the following that apply: ☐ **Intermittent auscultation (IA)** (specify reason) ☐ **Electronic fetal monitoring (EFM)** (specify reason) ☐ **Non-Stress Test (NST)** (specify reason) Record the indications by documenting the reasons why the method of fetal surveillance was used.

Completion of the Form

Item	Description
FHR	
Time (hh:mm)	Record the time when the fetal heart rate (FHR) was assessed (following the hh:mm format).
FHR (per min)	Record the FHR – the number of heart beats (per minute), as measured during each antenatal visit.
Rhythm / variability	Record the FHR rhythm if using IA (i.e., regular or irregular), or the variability if using EFM (i.e., absent, minimal [≤ 5 beats per min], moderate [6 – 25 beats per min], or marked [> 25 beats per min]).
Accelerations	Record the FHR accelerations (i.e., present / spontaneous, absent / not heard, or preset / scalp stimulation).
Decelerations	Record the FHR decelerations (i.e., present / spontaneous or absent / not heard). If using EFM, document also the type of decelerations (i.e., early, variable, late, prolonged). **→ Go to Section 5. Interprofessional Progress Notes** If using EFM, describe the decelerations in terms of their magnitude and duration (i.e., ↓ of __ beats per min for __ sec / min). Document also any interventions that were performed and the resulting outcomes.
Classify as	Record the classification of the fetal heart tracings as normal, atypical, or abnormal.
Initials	The care provider who performed the FHR assessment at the specified date and time should initial in the corresponding space provided.
Maternal Exam	
Time (hh:mm)	Record the time when the maternal exam was performed (following the hh:mm format).
Contractions	Record whether or not the mother or pregnant individual is experiencing contractions, and if she is, document also the frequency and intensity of the contractions.
BP	Record the mother's or pregnant individual's blood pressure (BP) as assessed during the maternal exam.
Heart rate (per min)	Record the mother's or pregnant individual's heart rate – the number of heart beats (per minute) – as assessed during the maternal exam.
Resp. rate (per min)	Record the mother's or pregnant individual's respiratory rate (resp. rate) – the number of breaths (per minute) – as assessed during the maternal exam.
Temp. (°C)	Record the mother's or pregnant individual's body temperature (in degrees Celsius) as measured during the maternal exam.
Urine	Record whether proteins and / or ketones are present in the mother's or pregnant individual's urine (e.g., negative [Neg], trace, +1, +2, +3) as assessed during the maternal exam.
Blood sugar (mmol / L)	Record the mother's or pregnant individual's blood sugar levels (in millimoles per litre) as assessed during the maternal exam using a glucometer.
Initials	The care provider who performed the maternal exam at the specified date and time should initial in the corresponding space provided.

Completion of the Form

Item	Description
Vaginal Exam	
Time (hh:mm)	Record the time when the maternal vaginal exam was performed (following the hh:mm format).
Cx dilation (cm)	Record the cervical (Cx) dilation – the distance that the cervix has opened – (in centimeters) as measured during the vaginal exam.
Cx length (cm)	Record the cervical length (in centimeters) as measured during the vaginal exam.
Fetal station	Record the fetal station – the position of the baby's head relative to the bony projections of the lower pelvis of the mother or the pregnant individual (i.e., the ischial spines) – as assessed during the vaginal exam.
Cx consistency (firm, medium, soft)	Record the consistency of the cervix – the perceived pliability of the cervix – as assessed during the vaginal exam (i.e., firm, medium, soft).
Cx position (posterior, middle, anterior)	Record the position of the cervix relative to the fetal head and maternal pelvis as assessed during the vaginal exam (i.e., posterior, middle, anterior).
Examined by (name)	The care provider who performed the maternal vaginal exam at the specified date and time should write their full name (including first name and surname) in the corresponding space provided.
Tests	
Nitrazine	If the mother or pregnant individual had a nitrazine test performed in order to confirm rupture of membranes, specify the results of the test by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)** **→Go to Section 5. Interprofessional Progress Notes** Record if a sterile speculum exam was performed.
Ferning	If the mother or pregnant individual had a ferning test performed in order to confirm rupture of membranes, specify the results of the test by selecting one of the following: ☐ **Negative (Neg)** ☐ **Positive (Pos)** **→Go to Section 5. Interprofessional Progress Notes** Record if a sterile speculum exam was performed.
Swabs	If a sterile speculum exam was performed to collect swabs, specify the reason(s) why swabs were obtained by selecting all of the following that apply: ☐ **Fetal fibronectin (fFN)** (used to test individuals with threatened preterm labour to determine risk pf premature delivery) ☐ **Culture and sensitivity (C&S)** (used to test for infection) ☐ **Other** If '**Other**' is selected, specify the reason why a vaginal swab was collected or what test was performed. Record also the results of the tests, if applicable, in the space provided.

Completion of the Form

Item	Description
[Tests continued]	
Urine	If a urine sample was collected, specify the testing that was performed by selecting all of the following that apply: ☐ **Routine and microbiology (R&M)** ☐ **Culture and sensitivity (C&S)** Record also the results of the tests, if applicable, in the space provided.
Blood (specify)	If any blood tests were performed, record which blood tests were performed. Record also the results of the tests, if applicable, in the space provided.
Sign-offs	
Care provider (name)	Record the full name (i.e., given name and surname) of the care provider responsible for the main assessment of the mother or pregnant individual and fetus during the hospital visit / admission.
Notified (hh:mm)	Record the time when the care provider responsible for the main assessment of the mother or pregnant individual and fetus during the hospital visit / admission was first notified (following the hh:mm format).
Arrived (hh:mm)	Record the time when the care provider responsible for the main assessment of the mother or pregnant individual and fetus during the hospital visit / admission arrived (following the hh:mm format).
Completed by (name) (signature)	The care provider who completed this section, who is typically the one to notify the most responsible care provider, should print their full name (including given name and surname) and sign in the space provided.

Section 5: Interprofessional Progress Notes

Item	Description
Date (dd / mm / yyyy)	Record the date when the interprofessional progress note was recorded pertaining to the mother's or pregnant individual's hospital visit / admission (following the dd / mm / yyyy format).
Time (hh:mm)	Record the time when the interprofessional progress note was recorded pertaining to the mother's or pregnant individual's hospital visit / admission (following the hh:mm format).
Focus	Record the reason / focus of the recorded interprofessional progress note.
Interprofessional Progress Notes	Record any pertinent information, including any variances in assessments / results, obtained over the course of the mother's or pregnant individual's hospital visit / admission. *Note: Interprofessional progress notes should follow a chronological order from the time of the mother's or pregnant individual's initial assessment upon presenting to the hospital to the time of admission / discharge / transfer.*

Completion of the Form

Section 6: Early Labour Discharge Teaching

Description
If the mother or pregnant individual presents to the hospital in early labour (i.e., too early for admission to the labour and delivery unit) and is being discharged home, specify which topics are discussed during the early labour discharge teaching by selecting all of the following that apply: ☐ **Progress in labour / what to expect** ☐ **Food / hydration** ☐ **Ambulation** ☐ **Comfort measures** ☐ **Labour support people** ☐ **When to call / return to hospital** ☐ **Hospital / care provider phone number to call when coming in**

Section 7: Follow-up / Referrals

Description
Record any special considerations, follow-ups, and / or referrals that are made based on the mother's or pregnant individual's assessment during the hospital visit / admission. Referrals should include information on the specific disciplines and services that are recommended (e.g., anesthesia, social work).

Section 8: Discharge Status

Item	Description
	Specify the mother's or pregnant individual's discharge status by selecting one of the following: ☐ **Admitted to** ☐ **Discharged to** ☐ **Transferred to** Record also the location where the mother or pregnant individual was admitted / discharged / transferred to in the space corresponding to the selected discharge status.
Date (dd / mm / yyyy)	Record the date when the mother or pregnant individual was admitted / discharged / transferred (following the dd / mm / yyyy format).
Time (hh:mm)	Record the time when the mother or pregnant individual was admitted / discharged / transferred (following the hh:mm format).
Care provider (name) (signature)	The care provider who authorized that the mother or pregnant individual be admitted / discharged / transferred should print their full name (including first name and surname) and sign in the space provided.

References

1. Cargill, Y.M. & MacKinnon, C.J., 2018. No. 148–Guidelines for Operative Vaginal Birth. Journal of Obstetrics and Gynaecology Canada, Volume 40, Issue 2, e74 – e80.
2. Dy, J., DeMeester, S., Lipworth, H. & Barrett, J., 2019. No. 382–Trial of Labour After Caesarean. Journal of Obstetrics and Gynaecology Canada, Volume 41, Issue 7, pp. 992 – 1011.
3. Hobson, S., Cassell, K., Windrim, R. & Cargill, Y., 2019. No. 381–Assisted Vaginal Birth. Journal of Obstetrics and Gynaecology Canada, Volume 41, Issue 6, pp. 870 – 882.
4. Kotaska, A. & Menticoglou, S., 2019. No. 384–Management of Breech Presentation at Term. Journal of Obstetrics and Gynaecology Canada, Volume 41, Issue 8, pp. 1193 – 1205.
5. Leduc, D., Senikas, V. & Lalonde, A.B., 2018. No. 235–Active Management of the Third Stage of Labour: Prevention and Treatment of Postpartum Hemorrhage. Journal of Obstetrics and Gynaecology Canada, Volume 40, Issue 12, e841 – e855.
6. Leduc, D., Biringer, A., Lee, L. & Dy, J., 2015. Induction of Labour: Review. Journal of Obstetrics and Gynaecology Canada, Volume 37, Issue 4, pp. 380 – 381.
7. Liston, R., Sawchuck, D. & Young, D., 2018. No. 197b–Fetal Health Surveillance: Intrapartum Consensus Guideline. Journal of Obstetrics and Gynaecology Canada, Volume 40, Issue 4, e298 – e322.

British Columbia Perinatal Triage and Assessment Record

1. Background

Date (dd/mm/yyyy) _____ Time (hh:mm) _____

Arrived by ambulance: ☐ No ☐ Yes Accompanied by _____

Language preferred _____

Reason for visit _____

Surname Given name

Address

Phone number

Personal Health Number Physician/midwife name

Gravida ___ **T**erm ___ **P**reterm ___ **A**bortus ___ **L**iving ___ LMP (dd/mm/yyyy) _____ EDD (dd/mm/yyyy) _____ by: ☐ US ☐ IVF GA (wks/days) _____

Recent infectious disease/contact: ☐ No ☐ Yes (specify, e.g. MRSA, VRE, Varicella, HSV, HepB, TB) _____

ARO screen completed: ☐ No ☐ Yes (initials) _____ ARO swab taken: ☐ N/A ☐ No ☐ Yes (dd/mm/yyyy) _____

Falls Risk Screen: ☐ Reviewed and no concerns ☐ At risk for falls → ☐ Falls prevention care plan completed

"Purple Dot" point-of-care violence risk assessment: ☐ Low risk ☐ High risk

2. Initial Assessment

Contractions: ☐ No ☐ Yes (specify details below)
Start date (dd/mm/yyyy) _____
Start time (hh:mm) _____
Type: ☐ Regular ☐ Irregular
Intensity: ☐ Mild ☐ Moderate ☐ Strong
Frequency (#/10 min) _____
Duration (sec) _____

Membranes: ☐ Intact ☐ Query ☐ Ruptured (specify details below)
Date (dd/mm/yyyy) _____
Time (hh:mm) _____
Colour: ☐ Clear ☐ Meconium stained ☐ Bloody

Bleeding/show: ☐ No ☐ Yes (specify details below)
Start date (dd/mm/yyyy)
Start time (hh:mm) _____
Amount: ☐ Scant ☐ Small ☐ Moderate ☐ Large
Colour/consistency _____

Fetal movement: ☐ Normal ☐ ↑ (specify details below) ☐ ↓ (specify details below)
Date (dd/mm/yyyy) _____
Time (hh:mm) _____

Triaged as: ☐ OTAS 1 – Resuscitative ☐ OTAS 2 – Emergent ☐ OTAS 3 – Urgent ☐ OTAS 4 – Less Urgent ☐ OTAS 5 – Non-Urgent
Triaged to: ☐ LDR ☐ Assessment room ☐ Waiting room ☐ Other _____

3. History/Risk Factors

Allergies (incl. reactions) ☐ None | ABO | Rh factor | Date RhIG given (dd/mm/yyyy)

Current medications: ☐ None ☐ Vitamins only ☐ Medications recorded on Med. Rec. Form
Complementary therapy: ☐ No ☐ Yes (specify) _____
Previous admission this pregnancy: ☐ No ☐ Yes (specify reason) _____
Antenatal corticosteroid administered: ☐ N/A ☐ No ☐ Yes (dd/mm/yyyy) _____
External cephalic version attempted: ☐ N/A ☐ No ☐ Yes (dd/mm/yyyy) _____
Planned mode of delivery: ☐ Vaginal ☐ Primary C/S ☐ Repeat C/S
VBAC eligible this delivery: ☐ N/A ☐ Yes ☐ No (specify reason) _____
GBS results: ☐ Unk ☐ Neg ☐ Pos
GBS swab taken: ☐ N/A ☐ No ☐ Yes (dd/mm/yyyy) _____
Postpartum hemorrhage risk assessment: ☐ Low risk ☐ Increased risk

Antenatal Record Part 1 & 2 ☐ Reviewed (option to skip to section 4) ☐ Not available (complete below)
Pregnancy concerns: ☐ No ☐ Yes (specify)
Past obstetric concerns: ☐ No ☐ Yes (specify)
Medical/surgical/anesthetic concerns: ☐ No ☐ Yes (specify)
Psychosocial concerns: ☐ No ☐ Lifestyle/social ☐ Substance use ☐ Mental health ☐ Other _____

4. Assessment

Last ate (dd/mm/yyyy) _____ (hh:mm) _____
Last drank (dd/mm/yyyy) _____ (hh:mm) _____
Height (cm) _____ Pre-preg. Wt (kg) _____ Pre-preg. BMI _____ Current Wt (kg) _____
Presentation _____ Lie _____ Position _____ Engagement: ☐ No ☐ Yes
Symphysis-fundal height (SFH) (cm) _____
SFH consistent with GA: ☐ No ☐ Yes
Fetal surveillance: ☐ IA (specify reason) _____ ☐ EFM (specify reason) _____ ☐ NST (specify reason) _____

FHR

Time (hh:mm)				
FHR (per min)				
Rhythm/variability				
Accelerations				
Decelerations				
Classify as				
Initials				

Vaginal Exam

Time (hh:mm)			
Cx dilation (cm)			
Cx length (cm)			
Fetal station			
Cx consistency (firm, medium, soft)			
Cx position (posterior, middle, anterior)			
Examined by (name)			

Maternal Exam

Time (hh:mm)				
Contractions				
BP				
Heart rate (per min)				
Resp. rate (per min)				
Temp. (°C)				
Urine				
Blood sugar (mmol/L)				
Initials				

Tests
Nitrazine: ☐ Neg ☐ Pos
Ferning: ☐ Neg ☐ Pos
Swabs: ☐ fFN ☐ C&S ☐ Other _____
Urine: ☐ R&M ☐ C&S
Blood (specify) _____

Sign-offs
Care provider (name) _____
Notified (hh:mm) _____ Arrived (hh:mm) _____
Completed by (name) _____ (signature) _____

Surname Given name

Address

Phone number

Personal Health Number Physician / midwife name

5. Date (dd/mm/yyyy)	Time (hh:mm)	Focus	Interprofessional Progress Notes

6. Early Labour Discharge Teaching

- ☐ Progress in labour / what to expect
- ☐ Food / hydration
- ☐ Ambulation
- ☐ Comfort measures
- ☐ Labour support people
- ☐ When to call / return to hospital
- ☐ Hospital / care provider phone number to call when coming in

7. Follow-up / Referrals

8. Discharge Status

☐ Admitted to _____ ☐ Discharged to _____ ☐ Transferred to _____

Date (dd/mm/yyyy) _____ Time (hh:mm) _____ Care provider (name) _____ (signature) _____

Perinatal Services BC
Provincial Health Services Authority

Obtaining Copies of the BC Perinatal Triage and Assessment Record

For sites wishing to order forms or to obtain ordering information, please refer to the PSBC website:
perinatalservicesbc.ca/health-professionals/forms

If you have any questions or feedback about any of the PSBC perinatal forms, please email **psbc@phsa.ca** or call **604-877-2121**.