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) _____

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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) _____

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