University of Florida Women's Southside Health Specialists

Date:_____ PCP:_____ _____

Consult: Yes___ No___ Letter Dictated: Yes___ No___

Name:_____ Age:_____ G:___ P:_____ LMP:_____ DOB:_____

Contraception/HRT:_____ Last Pap:_____ Mammo:_____ BMD:_____ Colonoscopy:_____

Allergies:_____ Medications:_____

Chief Complaint:

HPI: (Location, Quality, Severity, Duration, Timing, Context, Modifying Factors, Associated Symptoms)

Review of Systems: (check negatives, circle positives)

___ GYN(pain,abn bleed,discharge,itch,abdom disten)
___ GI(melena,nausea/vomitintg,diarrhea,constipation)
___ GU (frequency,urgency,nocturia,dysuria,incont,heme)
___ CONSTITUTIONAL (fever, weight loss/gain, fatigue)
___ HEENT (headache,sore throat,hearing/vision change)
___ INTEGUMENT(skin changes,breast changes,rash)
___ CARDIOVASCULAR (chest pain,irregular beat)
___ RESPIRATORY (SOB,cough,henoptysis)
___ HEMATOLOGIC/LYMPH (adenopathy, anemia)
___ ALLERGIC/IMMUNOLOGIC (sneeze, cough, rash)
___ MUSCULOSKELETAL(myalgia,atrophy,joint pain
___ PSYCH (depression,anxiety,sleep disturbance)
___ NEUROLOGIC (dizziness,numbness,weakness)
___ ENDOCRINE (galactorrhea, hirsuitism)
___ SEXUAL (libido changes, dyspareunia)

Physical Exam: B/P :_____ WT :_____ HT:_____ TEMP :_____ PULSE :_____

(check normals, circle/document abnormals)

_____ GENERAL (nml developed,nourished, habitus
_____ NECK (no adenopathy, thyromegaly, mass)
_____ RESP (clear bilat, nml effort, movement)
CARDIOVASCULAR:
_____ AUSCULTATION (reg rate, rhythm, w/o murmur)
_____ PERIPH VASCULAR (nml pulses w/o edema)
_____ SKIN (no rashes, lesions, ulcers)
_____ NEURO/PSYCH (nml orientation w/o anxiety, depression)
_____ LYMPH (nml nodes in neck, axillae, groin)
GI:
_____ ABDOMEN (soft w/o mass or tenderness)
_____ HERNIA (no hernia noted)
_____ LIVER/SPLEEN (nontender w/o organomegaly)
_____ GUIAC
GENITOURINARY:
_____ BREAST (symmetyric w/o tenderness, mass, discharge)

_____ EXTERNAL (nml appearance w/o lesion)
_____ UR MEATUS (nml size,color w/o prolapse)
_____ URETHRA (stable w/o mass, tenderness)
_____ BLADDER (nml support, nontender)
_____ VAGINA (nml appearance, support w/o discharge)
_____ CERVIX (nontender w/o lesion, discharge)
_____ UTERUS (nontender, nml size, shape, position)
_____ ADNEXA (nontender w/o mass)
_____ ANUS/PERINEUM (nml appearance w/o lesion, mass)
_____ RECTAL (nml tone w/o lesion, mass)

See Patient Questionaire/ Details include:

PMHX:

PSHX:

GYNHX:

OBHX:

FHX:

SOHX:

Ordered/Reviewed/Performed: UA_____ UCG_____ HGB_____ WET PREP_____ GUIAC_____ PAP_____ EMBX_____ CX_____

Lab/Radiology results_____

Assessment/Diagnosis(s): **Plan:**

Counseling Provided: ____contraception ____HRT ____diet/exercise ____self breast exam ____smoking cessation ____domestic violence ____safe sex ____Ca/vits
Orders/Consults: ____mammo ____breast sono ____DEXA ____pelvic sono ____colonoscopy/GI ____gen surgery
Follow-up: _____annual _____month(s) _____week(s) _____PRN

Total time: _____ **Face-to-Face time:** _____

_____
Bowers, Boyd, Brock, Kaunitz, McIntyre, McNeill, Seibel, Bartley, ARNP

Cervical Dilatation, cms. (0)

POSTPARTUM NOTES:'

I. Use the large stamp on a progress note .... .it will prompt you for most of the information needed for each day postpartum.
2. Always Date and time note
3. Always have a label on each note
4. Determine if patient preferences: a) breast or bottle feeding b)which clinic they go to, likely PNC clinic c) What type of birth control they want (if breast feeding, pt can only receive Micronor, Depo, IUD, BTL. .... .ie, progesterone-only methods)
5. Evaluated Vital signs found on nurses flow sheet in the graphic chart section.
    a. If patient's blood pressure is elevated (> 140/90), check # of times elevated, if urine was dipped for protein, history of HTN or Pre-eclamptic syndrome present and if 24 hours of magnesium sulfate was received on L&D. Then discuss with a resident.
    b. If a fever is present (T> I 00.4), examine the patient and pay attention for fundal tenderness, lower extremity signs of DVT, lung abnormalities, malodorous vaginal discharge, etc. Then discuss with a resident.
    c. Follow urine output. If less than 30ml/hr, discuss with resident. 6.

Always examine the patient.

    a. If you are a male medical student, you may do all of the exam by yourself EXCEPT the breast exam and the perineum evaluation of laceration. You must do this with a resident or a female chaperon (nurse, medical assistant, etc).

7. All3^{cd} and 4th degree laceration of the perineum must be examined during postpartum. Check the delivery note for this information
8. Always ask patient about her bleeding/lochia (Light/spotting, moderate, heavy).
9. Discuss any problems the patient may be having, including difficulty with voiding, eating meals, pain control, difficulty walking, and difficulty with GI function (flatus/BM).
10. Labs: The pap smear, Rubella status and Blood type should be in the chart and on the admission summary, if not check the computer. Always Check the computer for current RPR and admitting hgb and for any other pertinent labs (pre-eclampsia has a CBC and PIH panel postpartum).\

11**. IfPPD#1 -**

    a. Make sure there is a prescription written (stamp available) for prenatal vitamins, Motrin and iron sulfate. Also a prescription for the birth control of their choice like Micronor, Nuva Ring, Ortho Evra patch, etc (not needed for IUD, Depo or BTL).
    b. Add other medical problems to the problem list (AlP portion), including Chronic HTN, diabetes (with class, ex A2), Rubella NI, Dysplasia, Rh negative.
    c. Include appropriate plan for above problem list.

        Examples-

        I. Rubella NI - postpartum vaccine prior to discharge.
        II. Rh negative -Rhogam evaluation.
        III. Dysplasia (ASCUS pap with HR HPV, LGSIL, HGSIL) - 8 week postpartum colposcopy.
        IV. PPD#1 Plan always includes - continue postpartum care and patient status (doing well, etc).

12. **IfPPD#2-**

    a. Discharge on this day after total of 48 hours after delivery (ie, if delivered at 11:32am, will dlc at 11:30am on PPD#2) if there are no problems.

    b.Always make sure they have prescriptions on chart from PPD#l. c.

    Follow up visits:

        I. 6 weeks postpartum visit for everyone.
        II. 2 weeks postpartum injection clinic visit, if patient desire Depo-Provera for birth control.
        III. 8 week postpartum colposcopy visit, if patient has dysplasia (as above)
        IV. 1 week blood pressure check if patient has had chronic HTN, PreEclampsia, Eclampsia, CHTN with SIPE.

13. Always discuss any questions with the resident.
14. ALWAYS HAVE RESIDENT SIGN YOUR NOTE!

DISCHARGE ORDERS:

1. Discharge home today with infant.
2. Discontinue all lines
3. Rx (prescriptions) on chart. Write out medications given.
4. Follow up visits 6 week post partum. Other follow-up as per postpartum notes.
5. Pelvic rest for 4 to 6 weeks.
6. IfRh negative, Rhogam evaluation prior to discharge.
7. If Rubella non-immune, Rubella vaccine prior to discharge.

***"**DO NOT SIGN THESE ORDERS PLEASE! Let the resident sign them for safety purposes.

OTHER HELPFUL POINTERS:

-Always check the admission summary sheet.. .. fill in boxes if you have results.
-It is very helpful to the residents to have the discharge orders written if the patient is ppd#2 and without problems.
-Always make sure that the patient has all needed prescriptions. All patients need Motrin, prenatal vitamins, and iron sulfate to be discharge home on.

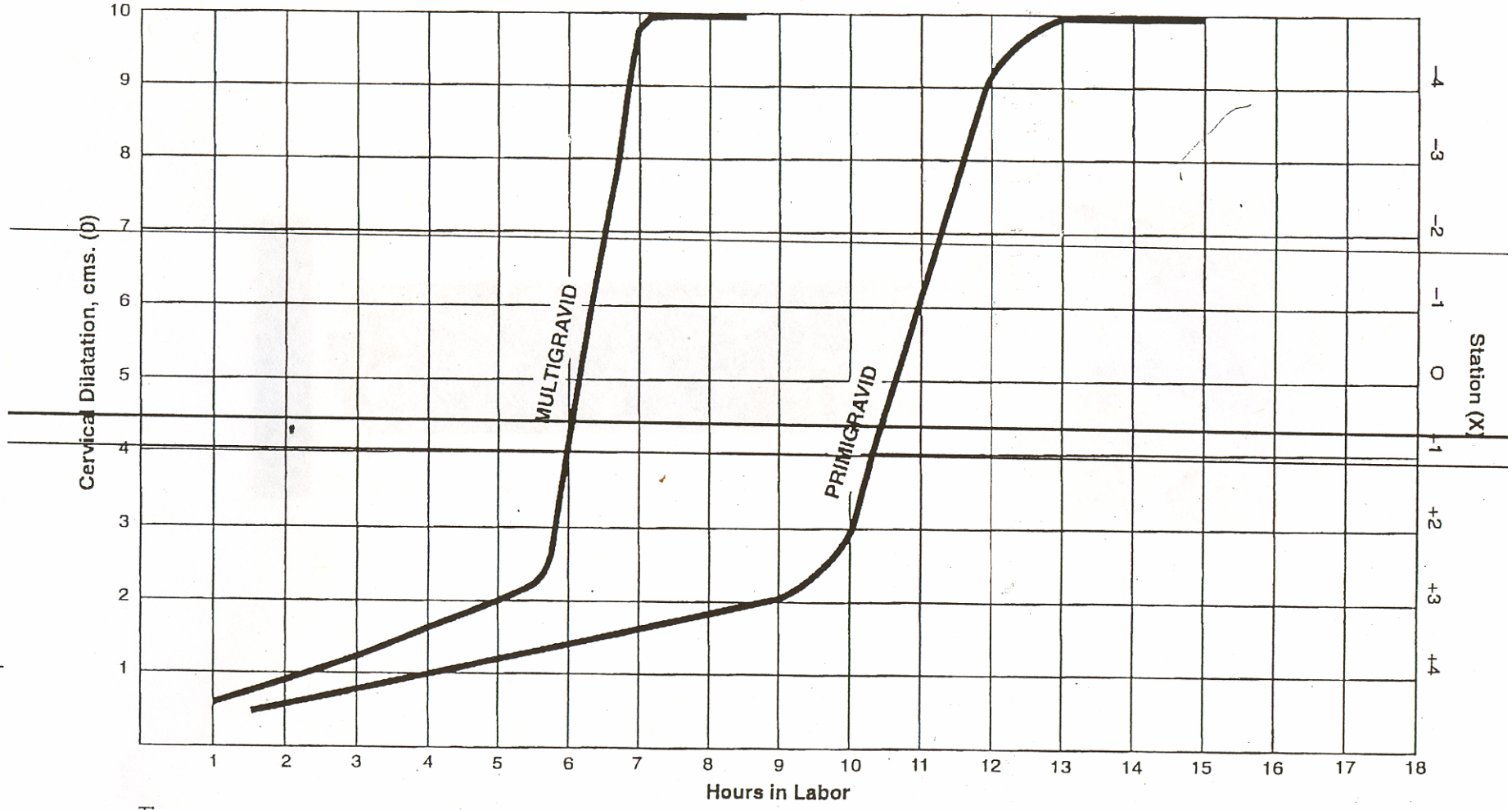
SHANDS
at the University of Florida
Gainesville, Florida 32610

Graphic Labor Record

Department of Nursing and Patient Services

Age: _____ Date: _____ Patient Name: _____ M.R. #: _____

Parity: _____ Gestational Age: _____



Time: _____