Obstetrical referral form

Date / /20	Name	Age
Time	Address	
Referral to :	Reason for referral:	

Obstetrical history & examination

G	P	A	Complication previous delivery: No / Yes:				
Estimated gestation: weeks			BP:	P	T°	Hb	BG
Oedema: Yes / No			Proteinuria: Pos / Neg			Conjunctiva: Normal / Pale	
Fundal height: cm			Lie:			FHR:	FM ❑ yes ❑ no
Cervix: effacement:			Consistency:			Dilatation: cm	
Presenting part:			Engagement:			P/V bleeding:	
Membranes: ❑ intact ❑ ruptured Date: / / 20 Time: ..... h							
Liquor: Clear / Meconium stained / Foul smelling / Blood stained							
Uterine contractions since (date/time): / / 20 at ...... h..... Frequency: / 10 min							

Treatment received before / during referral

Name of drug / fluid	Dose	Mode	Time	Other

Notes

Responsible for referral:	Facility:	Contact N°

Feedback

Name	Admission date: / /20	Discharge date: / /20

Performed procedures

❑ Newborn resuscitation	❑ D&C or MVA	❑ Assisted delivery
❑ Induction of labour	❑ Resuscitation of mother	❑ C- Section
❑ Augmentation of labour	❑ Blood transfusion	❑ Hysterectomy
❑ Uterine revision	❑ Episiotomy	❑ Tubal ligation
❑ Manual removal placenta	❑ Suture of cervical tear	❑ Other:

Diagnosis at exit

❑ Delivery no complications	❑ Ruptured uterus	❑ Abortion without severe complication
❑ Obstructed labour	❑ (Pre)-eclampsia	❑ Abortion with severe complication
❑ Ante-partum Haemorrhage	❑ Post-partum sepsis	❑ Extra uterine pregnancy
❑ Postpartum Haemorrhage	❑ Other:	

Mode of discharge: home / defaulter / maternal death, cause:

Newborn	alive	Stillborn,FHR		sex	Apgar			Weight	TTC	vit K	Resuscitation			
		pos	neg	M / F	1min	5min	10 min				suct	vent	chest comp	drugs
1														
2														

Treatment to continue at home:		
Post-natal consultation date: / / 20		
Family Planning received: No / Yes	Date: / / 20	Type of method:
Discharge done by:	Facility:	Contact N°