

## NURSING DEPARTMENT

### LABOUR AND DELIVERY NURSING ASSESSMENT

#### I. ANTENATAL ASSESSMENT

Arrival Time: \_\_\_\_\_ H

Mode of Arrival:  Ambulatory     by Wheelchair     by Stretcher     Others: \_\_\_\_\_

Admitting from:  Ward     OPD     Direct

Diagnosis: \_\_\_\_\_

Allergy/Adverse Reaction: \_\_\_\_\_

Past Medical History obtained from  Patient     Family Member     Medical Records  
 Others (Specify) \_\_\_\_\_

Medical History	Surgical History	Previous Hospital Admission

Blood Group \_\_\_\_\_

LMP: \_\_\_\_\_ EDD: \_\_\_\_\_ Gestational age during admission: \_\_\_\_\_

Obstetric History: G \_\_\_\_ P \_\_\_\_ L \_\_\_\_ A \_\_\_\_ Previous LSCS \_\_\_\_ Ectopic pregnancy \_\_\_\_

High Risk Factors: *(Please select by ticking the box as applicable)*

<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Rh Incompatibility	<input type="checkbox"/> Fertility Treatment
<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Previous LSCS 1/2	<input type="checkbox"/> Preterm Labour
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Gestational Hypertension	<input type="checkbox"/> Others : (Specify)
<input type="checkbox"/> Diabetes	<input type="checkbox"/> BOH	
<input type="checkbox"/> ET	<input type="checkbox"/> Obesity (BMI)	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Twins/Multiple Pregnancy	

#### FAMILY HISTORY

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	<input type="checkbox"/> Others : (Specify)
<input type="checkbox"/> Stroke	<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Thyroid Problems	

**INITIAL ASSESSMENT** *(Please select by ticking the box as applicable)* Key: Y (YES) N(NO)

ASSESSMENT DATA	Date	ASSESSMENT DATA	Date
	Time		Time
<b>CARDIOVASCULAR</b>		<b>INTRAVENOUS SITE</b>	
Pulse is regular	<input type="checkbox"/> / N <input type="checkbox"/>	<b>N</b> = No redness, swelling, infiltration at site	
Cyanosis	<input type="checkbox"/> / N <input type="checkbox"/>	<b>T</b> = Tubing changed	
Pallor	<input type="checkbox"/> / N <input type="checkbox"/>	<b>D</b> = Dressing changed	
Edema	<input type="checkbox"/> / N <input type="checkbox"/>	<b>R</b> = Resting (state gauge of IV needle)	
<b>CIRCULATION</b>		<b>RA</b> =Right arm <b>LA</b> =Left arm	
Extremities warm	<input type="checkbox"/> / N <input type="checkbox"/>	<b>RH</b> =Right hand <b>LH</b> = Left hand	
Pulses present	<input type="checkbox"/> / N <input type="checkbox"/>	<b>RESPIRATORY THERAPY</b>	
Color perfused to all extremities	<input type="checkbox"/> / N <input type="checkbox"/>	O <sub>2</sub> = _____ /min flow rate	
Sensation present	<input type="checkbox"/> / N <input type="checkbox"/>	<b>NC</b> = Nasal Cannula	
Good capillary refill on upper extremities	<input type="checkbox"/> / N <input type="checkbox"/>	<b>FM</b> = Face mask	
Good capillary refill on lower extremities	<input type="checkbox"/> / N <input type="checkbox"/>	<b>TC</b> = Tracheostomy	
<b>RESPIRATORY</b>		<b>UTERUS</b>	
Regular Respirations	<input type="checkbox"/> / N <input type="checkbox"/>	Fundal height	_____ cm
Dyspnea	<input type="checkbox"/> / N <input type="checkbox"/>	Presentation	
Cough or wheezing	<input type="checkbox"/> / N <input type="checkbox"/>	Position	
Lungs clear bilaterally	<input type="checkbox"/> / N <input type="checkbox"/>	FHR <input type="checkbox"/> Regular <input type="checkbox"/> Irregular	_____/min
On mechanical ventilation	<input type="checkbox"/> / N <input type="checkbox"/>	<b>BREAST</b>	
O <sub>2</sub> inhalation	<input type="checkbox"/> / N <input type="checkbox"/>	Breast	
<b>GASTROINTESTINAL</b>		Nipples	
Abdomen is soft	<input type="checkbox"/> / N <input type="checkbox"/>	<b>GENITOURINARY FUNCTION</b>	
Tenderness	<input type="checkbox"/> / N <input type="checkbox"/>	<b>FC</b> = Foley Catheter	
Nausea	<input type="checkbox"/> / N <input type="checkbox"/>	<b>CC</b> = Condom Catheter	
Vomiting	<input type="checkbox"/> / N <input type="checkbox"/>	<b>UI</b> = Urinary Incontinence	
Constipation or diarrhea	<input type="checkbox"/> / N <input type="checkbox"/>	<b>PC</b> = Perineal Care	
Bowel sound present	<input type="checkbox"/> / N <input type="checkbox"/>	<b>WOUND</b>	
<b>MUSCULOSKELETAL</b>		Location:	
Able to move upper extremities	<input type="checkbox"/> / N <input type="checkbox"/>	Clean = 1    Granulating = 2	
Able to move lower extremities	<input type="checkbox"/> / N <input type="checkbox"/>	Dry = 3      Red/In flamed = 4	
Full range of motion	<input type="checkbox"/> / N <input type="checkbox"/>	Dressing dry and intact = 5	
<b>SKIN</b>		Drainage = 6	
Warm, dry and intact		<b>S</b> = Serous <b>SS</b> = Serosanguineous	
<b>T</b> = Turned and repositioned as ordered		<b>SG</b> = Sanguineous <b>P</b> = Purulent	
<b>L</b> = Left <b>B</b> =Back <b>R</b> = Right		<b>DC</b> = Dressing changed	
<b>FOOT CARE</b>		Drain present	<input type="checkbox"/> / N <input type="checkbox"/>
<b>D</b> = Diabetic <b>R</b> = Routine		(if yes specify type) _____	

**PAIN SCREENING** (If pain score is more than 0 use the pain assessment form)



<b>FUNCTIONAL SCREENING</b>			
<input type="checkbox"/> Patient cannot position herself in bed	<input type="checkbox"/> Change in Muscle Power	<input type="checkbox"/> Restricted ROM	<input type="checkbox"/> Impaired Activities of Daily Living
Any positive response requires assessment by the physiotherapist			
<input type="checkbox"/> Referral to physiotherapist	<input type="checkbox"/> No needs identified		

**PSYCHOLOGICAL SCREENING**

Calm and Cooperative      Restless      Depressed  
 Agitated      Confused      Others \_\_\_\_\_

**NUTRITIONAL SCREENING**

<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> Needs Therapeutic diet	<input type="checkbox"/> Diarrhea more than 4 days	<input type="checkbox"/> Food Allergy
<input type="checkbox"/> Overweight <input type="checkbox"/>	<input type="checkbox"/> Psychological eating disorder	<input type="checkbox"/> Major Surgery	<input type="checkbox"/> Patient in ICU
<input type="checkbox"/> Underweight <input type="checkbox"/>	<input type="checkbox"/> Difficulty swallowing/chewing	<input type="checkbox"/> Hyperemesis Gravidarum	<input type="checkbox"/> Tube feeding
<input type="checkbox"/> Poor Appertite abo days	<input type="checkbox"/> Unplanned change in w <input type="checkbox"/>	<input type="checkbox"/> Palliative Care	
Any positive response requires nutrition assessment by a dietician			
<input type="checkbox"/> Referral to dietician	<input type="checkbox"/> No needs identified		

**SOCIAL SCREENING**

1. Marital S:      Single      Marr      Divorc      Widow

2. Living Alone       Lives with: \_\_\_\_\_

3. Numbe:      Son/s \_\_\_\_\_       Daughter/s \_\_\_\_\_

4. Number of siblings: \_\_\_\_\_      Male \_\_\_\_\_      Female \_\_\_\_\_

5. Caregiver home:       Female      Male  Family Member      Friend

6. Special Habits:      Smoker       Alcohol Abuse       Drug Abuse       Other: \_\_\_\_\_

**SAFETY**

ID band <input type="checkbox"/> <input type="checkbox"/> es    No	Call Bell i <input type="checkbox"/> ch <input type="checkbox"/> s    No	Waste Disposal Ex <input type="checkbox"/> ed <input type="checkbox"/> Yes    No
Oriented <input type="checkbox"/> it <input type="checkbox"/> es    No	Infusior <input type="checkbox"/> p <input type="checkbox"/> es    No	Hand Hygiene Ex <input type="checkbox"/> ed <input type="checkbox"/> es    No

Nurse's Name & ID \_\_\_\_\_

Date: \_\_\_\_\_ Time: (e.g. 1600H) \_\_\_\_\_

Signature: \_\_\_\_\_



O <sub>2</sub> inhalation	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
<b>GASTROINTESTINAL</b>						
Abdomen is soft	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Tenderness	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Nausea	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Vomiting	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Constipation or diarrhea	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Bowel sound present	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
<b>NEUROLOGICAL STATUS</b>						
Alert and oriented to time, place, person	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Speech clear	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Responds appropriately to commands	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Tremors	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Seizures	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Muscle weakness	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Gait steady	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
<b>MUSCULOSKELETAL</b>						
Able to move upper extremities	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Able to move lower extremities	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
VTE Initiated	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Full range of motion	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
<b>RESPIRATORY THERAPY</b>						
O <sub>2</sub> = /min flow rate						
Nasal Cannula	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Face mask	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Tracheostomy	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
<b>GENITOURINARY FUNCTION</b>						
<b>FC</b> = Foley Catheter						
<b>CC</b> = Condom Catheter						

<b>UI</b> = Urinary Incontinence						
<b>PC</b> = Perineal Care						
Urine clear	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
Urine color						
Voiding regularly in adequate amount	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
<b>SKIN</b>						
Warm, dry and intact	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>	<input type="checkbox"/> Y / N <input type="checkbox"/>
<b>T</b> = Turned and repositioned as ordered						
<b>L</b> = Left <b>B</b> =Back <b>R</b> = Right						
<b>FOOT CARE</b>						
<b>D</b> = Diabetic <b>R</b> = Routine						
<b>INTRAVENOUS SITE</b>						
<b>N</b> = No redness, swelling, infiltration at site						
<b>T</b> = Tubing changed						
<b>D</b> = Dressing changed						
<b>R</b> = Resting (state gauge of IV needle)						
<b>RA</b> =Right arm <b>LA</b> =Left arm						
<b>RH</b> =Right hand <b>LH</b> = Left hand						
<b>UTERUS</b>						
Fundal height						
Lochia/Blood loss						
<b>BREAST</b>						
<b>NIPPLES</b>						
<b>WOUND</b>						
Location:						
Clean = 1    Granulating = 2						
Dry = 3    Red/In flamed = 4						

Dressing dry and intact = 5						
Drainage = 6						
<b>S</b> = Serous <b>SS</b> =Serosanguineous						
<b>SG</b> = Sanguineous <b>P</b> = Purulent						
<b>DC</b> = Dressing changed						
Drain present						
(if yes specify type)						
BRADEN SCALE SCORE						
FALL RISK SCORE						
PAIN SCORE						
<b>Nurse's Sign</b>						
<b>License No.</b>						