**BEST MEDICAL CENTER**

**SCHEDULING FORM FOR INDUCTIONS AND CESAREAN DELIVERY**

Call (XXX) XXX-XXXX or Fax (XXX) XXX-XXXX

Patient Name: ___________________ Phone: ___________________

OB Provider: ___________________ Gravida: _______ Parity: _______

Type of Delivery Planned: [ ] Induction [ ] C/S Desired Date: _______ Time: _______

**DATING**

EDC: ___________________ Gestational Age at Desired Date of Induction or C/S: _______ _______

EDC Based on: [ ] US <20 weeks [ ] Doppler FHT+ for 30 weeks [ ] +hCG for 36 weeks
[ ] Other: ___________________

By ACOG Guidelines, women should be 39 wks or greater before initiating an elective (non-medically indicated) delivery. ACOG also states that a mature fetal lung test in the absence of clinical indication is not considered an indication for delivery.

[ ] Fetal Lung Maturity test result: _______ Date: _______

**INDICATION**

**Obstetric and Medical Conditions (OK if <39 weeks)**

(The need to deliver <39 weeks is dependent on severity of condition)

[ ] Abruption [ ] Heart disease
[ ] Previa [ ] Liver disease (e.g. cholestasis of preg.)
[ ] Preeclampsia [ ] Chronic HTN
[ ] Gestational HTN [ ] Diabetes (Type I or II)
[ ] GDM with Insulin [ ] Renal disease
[ ] PROM [ ] Coag/Thrombophila
[ ] Fetal Demise (current) [ ] Pulmonary disease
[ ] Fetal Demise (prior) [ ] HIV infection
[ ] Oligohydramnios [ ] Prior classical C/S
[ ] Polyhydramnios [ ] Prior myomectomy
[ ] IUGR [ ] Other: ___________________

Perinatologist consult obtained and agrees with plan: ___________________

(consultant name)

**Scheduled Induction or C/S**

[ ] ≥41+0 weeks

**Scheduled C/S (≥39 wks)**

[ ] Prior cesarean section
[ ] Breech presentation
[ ] Other malpresentation
[ ] Patient choice
[ ] Other: ___________________

[ ] Twin w/o complication

(OK ≥38 wks)

**Elective Induction (≥39 wks)**

[ ] Patient choice/social
[ ] Macrosomia
[ ] Distance
[ ] Other: ___________________

**Description/Details:**

**CERVICAL EXAM**

(for elective inductions ≥ 39 weeks)

**Date of Exam:** _______ (within 7 days of date of induction)

**Total Score:** _______

**Bishop Score:** circle each element of the exam below and add:

<table>
<thead>
<tr>
<th>Score</th>
<th>Dilation</th>
<th>Effacement</th>
<th>Station</th>
<th>Consistency</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Closed</td>
<td>0-30%</td>
<td>-3</td>
<td>Firm</td>
<td>Posterior</td>
</tr>
<tr>
<td>1</td>
<td>1-2</td>
<td>40-50%</td>
<td>-2</td>
<td>Medium</td>
<td>Midposition</td>
</tr>
<tr>
<td>2</td>
<td>3-4</td>
<td>60-70%</td>
<td>-1, 0</td>
<td>Soft</td>
<td>Anterior</td>
</tr>
<tr>
<td>3</td>
<td>5-6</td>
<td>80%</td>
<td>+1, +2</td>
<td>-----</td>
<td>----------</td>
</tr>
</tbody>
</table>

**SCHEDULING OFFICE USE**

Procedure not scheduled: [ ]

Scheduled? [ ] by: _______ Confirmed Date: _______ Time: _______

Referred to Dept Chair / MFM Staff? [ ] Yes Prenatal Record Presented to L&D: [ ] Yes

**LABOR**

Was labor or SROM present? Choose one:

[ ] Yes, Labor
[ ] Yes, SROM
[ ] Yes, Labor & SROM
[ ] No

Labor is defined as regular uterine contractions with cervical change.

**OUTCOME AFTER DELIVERY**

Scheduled Delivery was:

[ ] Induced [ ] Not Induced

Scheduled Delivery was:

[ ] Spontaneous Vaginal
[ ] Operative Vaginal
[ ] Cesarean Section

Delivery Date: _______

Did the infant go to the special or intermediate care nursery or NICU?

[ ] Yes [ ] No

Was this delivery an intrauterine fetal demise / fetal death?

[ ] Yes [ ] No

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