Postpartum Mother Encounter + Midwifery

BORN Ontario

Patient Label Here

SUMMARY TAB

Was this patient admitted to this organization for Postpartum Care only (the birth did not occur at the admitting hospital)? ☐ Yes ☐ No

If yes, complete all sections.
***If no, complete Admission Date and Admission Time then proceed to Section:* POSTPARTUM COMPLICATION**

Admission date: dd / mm / yyyy Admission Time: _____

Admission by Healthcare Provider: *(Select One)*

☐ Obstetrician ☐ Family Physician ☐ Midwife
☐ Nurse Practitioner (APN/CNS) ☐ Other

Maternal Transfer from: *(Select One)*

☐ No transfer ☐ Hospital ☐ Planned Home or Clinic Birth
☐ Nursing station ☐ Birthing Center
☐ Other unit same hospital ☐ Other

IF TRANSFER:

Maternal Transfer from Hospital (name):

_____

Maternal transfer from Birth Centre (name):

_____

Reason for Maternal Transfer From: *(Select One)*

☐ Fetal health concern ☐ Lack of nursing coverage
☐ Lack of physician coverage
☐ Maternal medical/obstetrical problem
☐ No beds available ☐ Organization evacuation
☐ Keeping baby and mother together ☐ Care closer to home
☐ Condition improved ☐ Other ☐ Unknown

Date of Delivery/Newborn DOB: dd / mm / yyyy

Time of Birth: _____

Type of Birth: *(Select One)* ☐ Vaginal Birth ☐ Cesarean Birth

Birth Location: *(Select One)* ☐ Hospital ☐ Home
☐ Birth Centre ☐ Clinic (Midwifery) ☐ Nursing Station
☐ Other Ontario location ☐ Outside of Ontario

Birth Hospital name: _____

Birth Centre/Clinic name: _____

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Pregnancy Outcome (Complete for each fetus if multiple pregnancy): *(Select One)*

☐ Live birth

☐ Stillbirth >= 20 wks or >= 500 gms – Spontaneous - occurred during antepartum period

☐ Stillbirth >= 20 wks or >= 500 gms – Spontaneous - occurred during intrapartum period

☐ Stillbirth >= 20 wks or > =500 gms /Termination

☐ Pregnancy loss < 20 wks and <500 gms/Spontaneous miscarriage

☐ Pregnancy loss < 20 wks and < 500 gms/Termination

Gestational age at birth: Auto-calculates

Postpartum Complication: *(Select all that apply)* ☐ None

☐ Postpartum Hemorrhage (occurring from 1hr to 24hrs after birth)

☐ Late Postpartum Hemorrhage (occurring 24hrs-6weeks after birth)

☐ Postpartum Hemorrhage Requiring Transfusion

☐ Uterine atony ☐ Fever ☐ Perineal hematoma

☐ Hysterectomy ☐ Perineal infection

☐ Abdominal incision infection

☐ Urinary Tract Infection (UTI)

☐ Methicillin-resistant Staphylococcus aureus (MRSA)

☐ Amniotic Fluid Embolism ☐ Pulmonary Embolism

☐ Thrombophlebitis ☐ Mastitis ☐ Postpartum depression

☐ Postpartum Preeclampsia ☐ Urinary Retention ☐ Other

☐ Unknown

Was Postpartum Breastfeeding Support Provided?

(Select one) ☐ Yes ☐ No ☐ Unknown

IF YES, TYPE OF BREASTFEEDING EDUCATION

(Select all that apply)

Provided information/support regarding:

☐ Hand expression ☐ Pumping ☐ Skin-to-skin

☐ Signs of effective latch

☐ Continuation of breastfeeding after discharge

☐ Sustained breastfeeding if separated from baby

☐ Community breastfeeding resources

☐ Provided assistance with breastfeeding within six hours of delivery after initial feeding

☐ Consult with a lactation consultant

☐ Referred mother to breastfeeding support services for follow-up

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IF NO, REASONS WHY POSTPARTUM BREASTFEEDING EDUCATION AND SUPPORT WAS NOT PROVIDED:

(Select one)

☐ Not applicable ☐ Early discharge home within 2 hours

☐ Mother/Parent declined ☐ Other ☐ Unknown

For Rh(D) negative patients, was Rh(D) immunoglobulin (RhIG/Rhogam/WinRho) administered postpartum?

☐ Yes ☐ No ☐ Unknown

If Yes, Date of Postpartum Rh(D) Immunoglobulin Dose:

dd / mm / yyyy

Time of Postpartum Rh(D) Immunoglobulin: _____

Maternal Outcome: *(Select one)* ☐ Discharged home

☐ Transfer to other organization

☐ Transfer to ICU/CCU

☐ Transfer to other non-obstetrical unit, same hospital

☐ Maternal death-not related to pregnancy or birth

☐ Maternal death-related to pregnancy or birth

IF TRANSFER

Maternal Transfer to Organization (name):

_____

IF TRANSFERRED TO OTHER ORGANIZATION

Maternal Transfer Date: dd / mm / yyyy

Maternal Transfer Time: _____

Reason for Transfer: *(Select One)*

☐ Fetal health concern ☐ Lack of nursing coverage

☐ Lack of physician coverage

☐ Maternal medical/obstetrical problem

☐ No beds available ☐ Organization evacuation

☐ Keeping baby and mother together ☐ Care closer to home

☐ Condition improved ☐ Other ☐ Unknown

IF MATERNAL DEATH

Maternal Death Date: dd / mm / yyyy

Maternal Time Time: _____

IF DISCHARGED HOME

Maternal Discharge Date: dd / mm / yyyy

Maternal Discharge Time: _____

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MIDWIFERY TAB

If there was a transfer of care, was care of the client transferred back to Midwifery during postpartum period?

☐ Yes ☐ No ☐ Unknown

Infant Discharged with Mother: ☐ Yes ☐ No

Was client admitted to hospital (Emergency and/or Obstetrics) in postpartum period, after approx. 1 hour post-birth (NOT in the immediate postpartum):

☐ Yes ☐ No ☐ Unknown

Was client transported to hospital in postpartum period, after approx. 1 hour post-birth (NOT in the immediate postpartum): ☐ Yes ☐ No ☐ Unknown

If yes, Reason(s) for Transport:

☐ Postpartum hemorrhage

☐ Repair of laceration

☐ Other maternal clinical indication

☐ Neonatal clinical indication

Primary Reason for Transport: *(Indicate)* _____

Did EMS attend during postpartum (not in the immediate postpartum)? ☐ Yes ☐ No ☐ Unknown

Was EMS used to transport to hospital?

☐ Yes ☐ No ☐ Unknown

Barrier to Transport: ☐ None

☐ Delayed arrival time of EMS ☐ Delayed Departure of EMS

☐ Delay on route ☐ Other

POSTPARTUM CONSULTATION/TRANSFER OF CARE

Were there any postpartum consultations or transfers of care from approximately 1 hour post-birth to discharge from midwifery care? ☐ Yes ☐ No

If YES,

Was rationale for consult only because of hospital/physician protocol, and not because of midwifery judgement or scope of practice? ☐ Yes ☐ No

Postpartum Transfer of Care: ☐ Yes ☐ No

If YES,

Was rationale for transfer of care only because of hospital/physician protocol, and not because of midwifery judgement or scope of practice? ☐ Yes ☐ No

And,

Was transfer of care returned anytime from approximately 1 hour post-birth to discharge from midwifery care?

☐ Yes ☐ No

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VISIT SUMMARY & LOCATION

 # Visits postpartum by Coordinating MW: _____

 # Visits postpartum by all other midwives: _____

 # Visits postpartum, in which a student was involved:

_____

Total # of Registered Midwives providing postpartum care:

_____

 # Postpartum visits home: _____

 # Postpartum visits hospital: _____

 # Postpartum visits clinic: _____

 # Postpartum visits virtual: _____

#Postpartum visits other location (eg. shelter, prison): _____

Was the client discharged from Midwifery care during the postpartum period? *(Select Yes to discharge client from Midwifery Care and/or bill for the Course of Care)*

☐ Yes ☐ No

Maternal OHIP coverage this pregnancy: ☐ Yes ☐ No

Discharge Date from Midwifery Care: dd / mm / yyyy

Billable Type:

☐ Yes – 12 weeks of care and/or midwife attended the birth

☐ Yes – partial payment (religious or cultural reasons)

☐ No – less than 12 weeks of care and/or midwife did not attend the birth

☐ No - care also provided and billed by another MPG

☐ No – non-resident or privately insured

Care by other MPG: ☐ Yes ☐ No ☐ Unknown

Midwife attend birth: ☐ Yes ☐ No

Midwife # - Coordinating (name and registration):

_____

Midwife # - Billing (name and registration):

_____

Midwife # - Primary Attending (name and registration):

_____

Midwife # - Second Midwife (name and registration):

_____