

PART II- MATERNITY CARE PACKAGE

PRENATAL CONSULTATION

1. Initial Prenatal Consultation

- -
Month Day Year

2. Clinical History and Physical Examination

a. Vital signs are normal c. Menstrual History LMP - - Age of Menarche _____
Month Day Year

b. Ascertain the present Pregnancy is low-Risk d. Obstetric History G _____ P _____ (____,____,____,____)
T P A L

3. Obstetric risk factors

- a. Multiple pregnancy
- b. Ovarian cyst
- c. Myoma uteri
- d. Placenta previa
- e. History of 3 miscarriages
- f. History of stillbirth
- g. History of pre-eclampsia
- h. History of eclampsia
- i. Premature contraction

4. Medical/Surgical risk factors

- a. Hypertension
- b. Heart Disease
- c. Diabetes
- d. Thyroid Disorder
- e. Obesity
- f. Moderate to severe asthma
- g. Epilepsy
- h. Renal disease
- i. Bleeding disorders
- j. History of previous cesarian section
- k. History of uterine myomectomy

5. Admitting Diagnosis _____

6. Delivery Plan

a. Orientation to MCP/Availment of Benefits
yes no b. Expected date of delivery - -
Month Day Year

7. Follow-up Prenatal Consultation

Prenatal Consultation No.	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
b. Date of visit (mm/ dd/ yy)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
c. AOG in weeks	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d. Weight & Vital signs:											
d.1. Weight	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d.2. Cardiac Rate	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d.3. Respiratory Rate	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d.4. Blood Pressure	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
d.5. Temperature	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DELIVERY OUTCOME

8. Date and Time of Delivery Date - - Time AM PM
Month Day Year hh-mm hh-mm

9. Maternal Outcome: _____ Pregnancy Uterine, _____
Obstetric Index AOG by LMP Manner of Delivery Presentation

10. Birth Outcome: _____
Fetal Outcome Sex Birth Weight (gm) APGAR Score

11. Scheduled Postpartum follow-up consultation 1 week after delivery - -
Month Day Year

12. Date and Time of Discharge Date - - Time AM PM
Month Day Year hh-mm hh-mm

POSTPARTUM CARE

	done	Remarks
13. Perineal wound care	<input type="checkbox"/>	_____
14. Signs of Maternal Postpartum Complications	<input type="checkbox"/>	_____
15. Counselling and Education		
a. Breastfeeding and Nutrition	<input type="checkbox"/>	_____
b. Family Planning	<input type="checkbox"/>	_____
16. Provided family planning service to patient (as requested by patient)	<input type="checkbox"/>	_____
17. Referred to partner physician for Voluntary Surgical Sterilization (as requested by pt.)	<input type="checkbox"/>	_____
18. Schedule the next postpartum follow-up	<input type="checkbox"/>	_____

19. Certification of Attending Physician/Midwife:

I certify that the above information given in this form are true and correct.

 Signature Over Printed Name of Attending Physician/Midwife

- -
Date Signed (Month / Day / Year)