INDUCTION SCHEDULING AND INFORMED CONSENT

INDUCTION SCHEDULING:

Today's Date: _____ Date of Induction: _____

Physician: _____ Type of Induction Planned: _____

Patient Name _____ Age _____ Phone number _____ G ____ P ____ A ___ L ___

Gestational Age determined by: ☐ US less than 20 weeks ☐ US greater than 20 weeks ☐ LMP ☐ Other _____

Date of last Ultrasound:_____Gestational Age at Induction: _____ EDC _____

Reason for Induction: (Circle appropriate diagnosis below)

Level 1	**Level 2**	**Level 3 Elective**
Gestational Hypertension	Macrosomia (EFW greater than 4500 gms)	**Gestational Age greater**
Preeclampsia/Eclampsia	Postdates (41-42 weeks)	**than or equal to 39 weeks.**
Abruptio placenta	Gestational Diabetes	History of rapid delivery
Bleeding D/T Marginal Placental Previa	IUGR-reassuring testing	Distance from hospital
Non-Reassuring fetal testing	Fetal Demise	Term with a favorable cervix
Maternal Medical Conditions	History of HSV	Psychological Factors
Fetal Compromise (IUGR)	Multiples	Positive GBBS with a favorable cervix
Oligohydraminos		
Postdates greater than 42 weeks		
Blood group sensitization		
Fetal Hydrops		
Chorioamnionitis		
PROM		

Required Supporting Clinical Indications_____

_____

_____

BISHOP SCORE (Circle score for each feature and total below)

Score	**0**	**1**	**2**	**3**
Feature				
Dilatation (cm)	0	1-2	3-4	5-6
Effacement (%)	0-30	40-50	60-70	80
Station	-3	-2	-1,0	+1
Consistency	Firm	Medium	Soft	
Position	Posterior	Middle	Anterior	

Total Score: _____

With a Bishop Score of less than or equal to 8, there is an increased rate of Cesarean Section in nulliparous women. If the total score is greater than 8, the probability of vaginal delivery after labor induction is similar to that of spontaneous labor.

INDUCTION INFORMED CONSENT:

My physician has discussed the need, risks and benefits of an induction. I have been advised as to the reasonable alternative, possible consequences of remaining untreated, and risks and possible complications of each alternative. In particular, with induction, there is a potential for a longer labor and increased chance of Cesarean Section. I understand the information that has been presented to me regarding the induction of labor and all my questions about the induction have been answered.

My physician has discussed the risks, benefits and alternatives of a scheduled delivery of my baby at 36 0/7-38 6/7 weeks.

Patient Signature_____ Date _____ Time _____

Guardian Signature (if applicable)_____ Date _____ Time _____ Relationship _____

Physician Printed Name_____ Date _____ Time _____

Physician Signature _____ Date _____ Time _____

Please FAX to MCW/MCE/MCSA CPN Fax Server (614) 234-8128 Date Fax _____

Mount Carmel, Columbus, Ohio

Induction Informed Consent and Scheduling Form

Consent 106-11-08 (reorder PS)

NAME

DOB

MR #

FAN #

MOUNT CARMEL

A MEMBER OF TRINITY HEALTH

Induction Scheduling Guidelines

Purpose: To provide guidance in scheduling and prioritizing of inductions. Induction is defined as the initiation of labor in a patient in whom active labor has not been documented.

1. **To schedule an induction**, the physician/office staff will call Labor & Delivery (MCSA 898-4220, MCW 234-5089, MCE 234-6525) for an induction date and time. The physician must complete the **Induction Informed Consent and Scheduling Form** and fax it to L&D within 24 hours of the call. The induction is not considered scheduled until L&D receives the form. **Informed Consent** must also be obtained prior to the scheduled induction (available on the Induction Informed Consent and Scheduling form) and faxed to Labor and Delivery. If a consent is not obtained prior to the procedure, the physician will be notified by the Labor and Delivery staff and one will need to be completed prior to the initiation of the induction. Please fax to: **(614) 234-8128**
2. Inductions may be scheduled up to 7 days prior to the patient's planned admission. If a physician desires to add on an induction for the day, the physician must call the L&D charge nurse for a time. **No patient will be denied an induction if medically indicated**.
3. When a request is received to schedule more than the allotted number of inductions on the same day, it will be necessary to prioritize which patients need to be induced first. Medical inductions will take priority over elective inductions. If more than one patient is being induced for medical indications, the following list will be used to prioritize which patients need to be induced first:

Gestational Hypertension	Macrosomia (EFW greater than 4500 gms)	**Gestational Age greater**
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Fetal Hydrops		
Chorioamnionitis		
PROM		

4. If it is necessary to delay an induction, the following steps will be taken:
   a) The charge nurse will notify the physician of the delay and an approximate time for admission. The physician may approve a later start time for that day or elect to reschedule.
   b) The patient will be notified by the charge nurse or physician, as appropriate, of the delay.
   c) Medically indicated induction will be given priority. Elective inductions will be delayed based upon the order in which they were scheduled (last scheduled, first delayed).
   d) Elective inductions may be rescheduled or delayed, based on unit census and staffing.
5. If a concern exists about the prioritization of patients to be induced, the physician may request the L&D Unit Director or L&D Clinical Manager to review the **Induction Informed Consent and Scheduling Form** completed for each patient scheduled to be induced. In an attempt to resolve the issue the Unit Director/Clinical Manager may talk to the providers involved or the Department Chair.