Operative Vaginal Delivery Sheet

Date: _____ Time: _____

Parity: _____ Gestational Age: _____

BMI: _____

Labour: Spontaneous onset / IOL / Augmented

Name and addressograph

Indications: _____

Location: Room / Theatre

Operator's name: _____ Grade: _____

Senior doctor involved in decision making: Yes / No Name: _____ Grade: _____

Senior Doctor present for delivery: Yes / No Name: _____ Grade: _____

Anaesthetist present: Yes / No Name: _____ Grade: _____

Analgesia / Anaesthesia: Epidural top up / Spinal / GA / Pudendal / Local: _____

Examination Findings:

PA: ____ /5 palpable	Cervical dilatation: _____cm
Station:	Fetal position:
Caput: none / + / ++ / +++	Moulding: none / + / ++ / +++
Bladder catheterised: Yes / No	

Type of delivery

Manual rotation: Yes / No

Ventouse: Posterior metal cup / Kiwi / Other _____

Number of pulls: _____ Duration of Cup application: _____mins

Cup detachment: Yes / No; If Yes; number of times: _____

Forceps: Traction / Lift out / Rotational : _____

Number of pulls: _____ Duration of forceps application: _____mins

Second instrument used: Yes / No

If Yes; which instrument: _____Number of pulls: _____

If CS, failure of instrumental to delivery time: _____

Initial decision to delivery time: _____

Any difficulty in delivering shoulders - No / Yes

If yes, please give details _____

_____

Time of delivery of baby: _____ Time of cord clamping: _____

If cord clamped at < 60 sec, please give indication: _____

Delivery of placenta: CCT / Manual

Perineal tear - 1º / 2º / 3º / 4º Labial tear: Y / N Episiotomy: Y / N

Repair: Vagina _____ Muscle _____ Skin_____

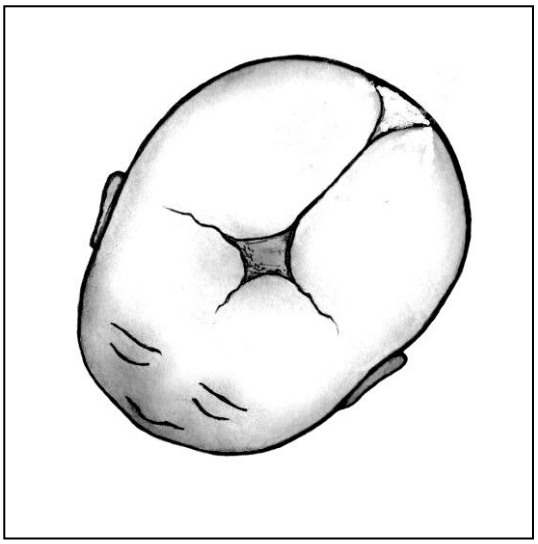
PV: _____ PR: _____ Estimated Blood loss: _____ mls.

End of procedure swabs needles and instrument check:

Swabs: _____ Needles: _____ Instruments: _____

Signatures 1 _____

2 _____



Indicate site of cup application and/or forceps marks etc. on diagram

Condition of baby

Cord blood:	Arterial	Venous
pH:	_____	_____
BE:	_____	_____

Apgars: ___[1]; ___[5]; ___[10]; Birth weight: _____

Admission to NNU: Yes / No

Trauma:

scalp abrasion / forceps mark/ facial abrasion / cuts /other

_____

Additional information:

Post- op instructions:

Thrombo-prophylaxis: **Post Natal Risk Assessment completed: Yes / No**

TEDS / LMWH for _____ days

Signature:	**Print name:**