**Induction of Labour Referral**

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| Woman's telephone: Home ( ) Mobile: |

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  | |  | |  | Gravida: | | Parity: |
| Menstrual cycle: | Regular Cycle length: days | | | | | Irregular | |
| EDD by LMP: | ………/………/……… | | Certain  Uncertain | | | | |
| EDD by USS: | ………/………/……… | | Scan at weeks | | | | |
| LMP should agree with USS dates < 12 wks +/- 5 days; 12-20 wks +/- 7 days otherwise use USS date | | | | | | | |

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| **SUITABILITY FOR PAPER TRIAGE**  Yes  No  **Healthy woman T+8 or greater**  Age less than 40 years  BMI less than 35  AMA and IVF at term (as per CDHB guideline) | | | | **LMC/PRIVATE CONSULTANT DETAILS**  LMC name:  Consultant name:  Contact details:        Access Agreement Holder Instructions completed and signed (see over – page 2) | | |
| **TO ACCOMPANY ALL REFERRALS**  **Maternity Booking Form**  Accompanies referral  Already submitted | | | |
| **ALL OTHER REFERRALS FOR INDUCTION REQUIRE OBSTETRIC REVIEW**  Indication:      Referred by: Signature: | | | | | | |
| **BISHOP SCORE** *(if performed)*Total score: Date of Bishop Score: ………. /………. /………. | | | | | | |
| **Score** | **0** | **1** | | | **2** | **3** |
| Dilation (cm) | < 1 | 1-2 | | | 3-4 | > 4 |
| Length (cm) | > 4 | 3-4 | | | 1-2 | < 1 |
| Consistency | firm | intermediate | | | soft | - |
| Position | posterior | central | | | anterior | - |
| Level | - 3 | - 2 | | | - 1; 0 | + 1 + 2 |
| **METHOD OF IOL**  Dinoprostone  Balloon catheter | | | | | | |
| **CWH USE ONLY**  IOL booked 0730hours 1600 hours  NB: early times prioritised for women who are low risk  Date: ……../……../……..  LMC informed of IOL date  LMC to inform woman | | | **PAPER CLINIC**  Meets criteria:  Yes  No *If no, fax form to MOPD, 85301 as obstetric review required*  An ultrasound for AFI and confirmation of growth.  If IOL declined by 42/40 plus, offer of acute consultation.  MW signature:  Date: ……../………/…….. | | | |

**Suitable for paper triage:**  **Yes** – **FAX to Birthing Suite, Christchurch Women’s Hospital, (03) 364 4717**

**No** – **FAX to MOPD (03) 364 4301**

**Access Agreement Holder Instructions**

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| **Please contact me to inform me when my client is:**  Due for any review  Requesting parenteral pain relief  🗹 Contracting 3-4 in 10, at least 3 cm dilated with an increase in Bishop score since the last assessment  **AND/OR**  🗹 Requesting one-to-one midwifery care from her LMC Midwife  Thereis any change in the plan during the hours of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Overnightplan: |

**NOTE:** Please be aware that the effect of Dinoprostone on the cervix can lead to sudden changes that can result in babies being born before there is time to call the LMC or before the LMC is able to attend.

I understand that if I am contacted and informed that my client is in **labour** (by the above definition) and decline to attend, I will not be contacted again.

Signed (LMC):

OR

Completed in phone consultation with (LMC)

by

Date: ……../……../…….. Time: