Women's
BC WOMEN'S HOSPITAL & HEALTH CENTRE
An agency of the Provincial Health Services Authority

Induction of Labour Booking Form

Fax: 875-2742 / Phone: 875-2165

Approved: YES ☐ NO ☐ By: _____

(Induction Review - Physician ☐ or Charge Nurse ☐)

Patient Name: _____

Patient Phone Number: _____

Today's Date: _____

Date Induction Requested: _____

Primary Caregiver: _____

GP/MW/OB Responsible for Induction: _____

Phone: _____ Fax: _____

Other consultant(s): _____

Cervix: Digital Exam: No ☐ Yes ☐ Date: _____

(If cervix > 2cm long and < 2 cm dilated consider ripening)

Dilation:	0 cm	☐	Position:	post	☐
	1 cm	☐		mid	☐
	2 cm	☐		ant	☐
	3 cm	☐	Consist:	firm	☐
Length:	3 cm	☐		med	☐
	2 cm	☐		soft	☐
	1 cm	☐	Station:	floating	☐
	0 cm	☐		-2 to –1	☐
				spines	☐
				+1	☐

G___ T___ P___ A___ L___ EDC: _____ Gest. Age _____ wks Induction requested PGE_2 ☐ Oxytocin ☐

Is this patient appropriate for an Outpatient Clinic Induction? YES ☐ NO ☐
(i.e. Prostin induction/able to be discharged home following insertion/not a VBAC)

**** If YES, please sign and include the Prostaglandin Inductions Physician's Orders when you fax in this booking****

LOW RISK INDUCTIONS (may be booked by family physicians without an obstetrical consultation)

☐ **TERM PROM** (not a VBAC)
Date & Time of ROM: _____ Verified by: Speculum ☐ Ferning ☐ Meconium ☐
GBS status: Positive ☐ Negative ☐ Unknown ☐

☐ **POST-DATES** (not a VBAC) $\geq 41^3$ weeks on: _____ **Attach Dating Ultrasound + Prenatal Record**
If U/S confirms dates as arrived at by LMP, accept LMP dating. If U/S result is inconsistent (>7 days variation) then redate by U/S

LMP: _____ Length of cycle (days): _____ Is cycle regular: Yes ☐ No ☐

EDC by Dates: _____ EDC By U/S: _____ Fetal Assessment done: Yes ☐ Date: _____

HIGHER RISK INDUCTIONS (patient must have obstetrical consult done prior to booking)

☐ **PIH (BP > 140/90 or increase of 30mmHg systolic or increase of 15mmHg diastolic)**
First trimester BP: _____ Present BP: _____
(Elevated BP must be recorded on at least two occasions **6 hrs.** or more apart.) **Attach prenatal record.**

☐ **Diabetes:** Type I ☐ Type II ☐ (depending on overall clinical situation) GD on insulin (>40 wks gestation) ☐

☐ **Twins ≥ 38 weeks**

☐ **IUGR** < 10 percentile *(U/S report must be attached to confirm)*

☐ **AFI Proven Oligo** < 5 percentile *(U/S report must be attached to confirm)*

☐ **Abnormal Fetal Assessment** *(Fetal Assessment form must be attached to confirm)*

☐ **Previous Uterine Scar** and Post-Dates or SROM *(U/S report must be attached to confirm)*

Other indications: _____

Additional information: _____