northern health

Prince George Regional Hospital

INDUCTION OF LABOUR BOOKING FORM

Patient's Name: ______________________ Phone Number: ______________

Today's Date: ______________________ Date Induction Requested: ______________

Physician Name: ______________________ Phone Number: ______________ Fax: ______________

G ______ T ______ P ______ A ______ L ______ Gestational Age: ______________ weeks

Cervix: Digital Exam: Date: ______________________ Bishop Score: ______________

BISHOP SCORE LEGEND

Criteria	0	1	2
Dilation	0 cm	1 - 2 cm	3 - 4 cm
Cervical length/effacement	> 3 cm 0 - 30%	1 - 3 cm 40 - 50%	< 1 cm 60 - 70%
Position	Posterior	Midline	Anterior
Consistency	Firm	Medium	Soft
Station	- 3	- 2	-1 to ≥ 0

INDICATION

☐ **Post Dates**

Post dates on (date) ______________ (must be ≥ 41 weeks and 3 days)

** Attach dating ultrasound and prenatal record

LMP ______________ Length of cycle ______________

Is cycle regular: ☐ Yes ☐ No

EDC by LMP ______________ EDC by U/S (16 - 18 weeks) ______________

NST ☐ Yes ☐ No

☐ **PROM** Date and time of ROM ______________ Colour of amniotic fluid ______________

Confirmation of ROM ☐ Speculum Exam ☐ Ferning ☐ Nitrazine

☐ **Other:** ____

____

Signature of Physician booking induction: ______________________

Date Booked: ______________ Booked for: ______________

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Admission Bishop Score: ________________ Performed by: ________________________________

BP ______________ Proteinuria ☐ Yes ☐ No

☐ Prostin x ____________ ☐ Cervadil x ____________ ☐ Oxytocin x ____________________

Type of Delivery: ____

INFANT: APGARS: 1 __________ 5 __________ 10 __________

Weight ______________ Length ______________________

Head Circumference ________________________________

Gestational Age by exam: ____________________________