

CADDRE
LABOR & DELIVERY CHART
ABSTRACTION FORM

(11/14/2005)

Study ID Number:

A. IDENTIFYING INFORMATION				<input type="checkbox"/> No Info
1. Mother's name (Last, First, Middle)		2. Study ID#		
3. Maiden Name		4. AKA		
5. Mother's Medical Record Number	6. SSN	7. Mother's DOB	8. Baby's Medical Record Number	
9. Street Address (from L&D chart)				
10. City	11. State		12. Zip Code -----	
13. Delivery Hospital Name				
14. Hospital Street Address				
15. City	16. State		17. Zip Code -----	
18. Date Abstracted ____/____/____		19. Abstractor		
20. Start Time :		21. Stop Time :		
22. Start Time :		23. Stop Time :		
24. Start Time :		25. Stop Time :		
Comments:				

B. ADMISSION THAT LED TO DELIVERY No Info

1. Admit date __/__/____ 99. <input type="checkbox"/> unknown	2. Admit time	2. Delivery date __/__/____ 99. <input type="checkbox"/> unknown	4. Delivery time 99. <input type="checkbox"/> unknown	5. Discharge date __/__/____ 99. <input type="checkbox"/> unknown	
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6. Admitting Diagnoses

Comments:

C. MATERNAL TRANSPORT BY AMBULANCE No Info

1. Transporting Facility	3. Admit date __/__/____	3. Admit time	4. Departure date __/__/____	5. Departure time	6. 1. • Med record adequate 2. • Order medical record 3. • Record not available
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7. Medical record number	8. Reason for transport
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Comments:

D. INJECTIONS/VACCINATIONS DURING CURRENT PREGNANCY THROUGH 24 HOURS POSTPARTUM No Info

Injection/vaccination	Date	Dose	Manufacturer	Product Name
Rhogam (or other RH(D)) Immunoglobulin	First __/__/____ 99. <input type="checkbox"/> unknown	First _____ 99. <input type="checkbox"/> unknown	First _____ 99. <input type="checkbox"/> unknown	First _____ 99. <input type="checkbox"/> unknown
	Second __/__/____ 99. <input type="checkbox"/> unknown	Second _____ 99. <input type="checkbox"/> unknown	Second _____ 99. <input type="checkbox"/> unknown	Second _____ 99. <input type="checkbox"/> unknown
Influenza vaccine	Date __/__/____ 99. <input type="checkbox"/> unknown	Manufacturer 99. <input type="checkbox"/> unknown		Lot # 99. <input type="checkbox"/> unknown
Other (specify): _____	Date __/__/____ 99. <input type="checkbox"/> unknown	Manufacturer 99. <input type="checkbox"/> unknown		Lot # 99. <input type="checkbox"/> unknown

Comments:

E. Cervical Exam on Admission No Info

a. Date __/__/____ 99. <input type="checkbox"/> unknown	Time 99. <input type="checkbox"/> unk	Dil (cm) 99. <input type="checkbox"/> unk	Effac (%) 99. <input type="checkbox"/> unk	Station 99. <input type="checkbox"/> unk	1. • SSE 2. • SVE 3. • US 4. • Not noted	Comments:
b. Date __/__/____ 99. <input type="checkbox"/> unknown	Time 99. <input type="checkbox"/> unk	Dil (cm) 99. <input type="checkbox"/> unk	Effac (%) 99. <input type="checkbox"/> unk	Station 99. <input type="checkbox"/> unk	1. • SSE 2. • SVE 3. • US 4. • Not noted	Comments:

Comments:

F. INDUCTION OR AUGMENTATION OF LABOR No Info

Method: 1= Prostaglandins for cervical ripening, 2= Artificial rupture of membranes (AROM), 3= Oxytocin/pitocin
4= Misoprostol 8= Other (specify), 9= Unknown

Reasons for induction/augmentation: **7= Premature ROM** **11= Mature amnio**
 1= PIH 4= Chorionamnionitis 8= Prolonged premature ROM 12= Post date
 2= Bleeding 5= Low biophysical profile 9= Prolonged ROM (term) 13= Fetal Distress
 3= Polyhydramnios 6= Low AFI or oligohydramnios 10= Prolonged labor/uterine dystocia
 88= Other (specify) 99= Unknown

a. Date initiated ___/___/_____ Date stopped ___/___/_____ _____	Time Initiated : Time Stopped : :	Method	Purpose 1. • Induction 2. • Augmentation 3. • No Info	Reason	Comments
b. Date initiated ___/___/_____ Date stopped ___/___/_____ _____	Time Initiated : Time Stopped : :	Method	Purpose 1. • Induction 2. • Augmentation 3. • No Info	Reason	Comments
c. Date initiated ___/___/_____ Date stopped ___/___/_____ _____	Time Initiated : Time Stopped : :	Method	Purpose 1. • Induction 2. • Augmentation 3. • No Info	Reason	Comments
d. Date initiated ___/___/_____ Date stopped ___/___/_____ _____	Time Initiated : Time Stopped : :	Method	Purpose 1. • Induction 2. • Augmentation 3. • No Info	Reason	Comments

Comments:

G. RUPTURE OF MEMBRANES No Info

If "yes" is indicated for medications, please fill out Section N.

1. Date ___/___/_____ _____	2. Time 1. • at delivery ___ : ___ 2. • at c-section ___ : ___ 3. • other time ___ : ___ • Unknown	3. Length of time before delivery 1. • <1 h 3. • 12-24h 2. • 1-12h 4. • >24 h • Unknown	4. Method 1. • Spontaneous 2. • Artificial 9. • Unknown	5. Confirming dx 1. • +Pooling 2. • +Nitrazine 3. • +Ferning 4. • +Indigo dye test 5. • +History 9. • Unknown	
6. Description of fluid at time of rupture 1. • Clear 3. • Bloody 5. • Foul odor 7. • Thin meconium 10. • Terminal mec 2. • Yellow 4. • Purulent 6. • Meconium NOS 8. • Thick meconium 88. • Other (specify) 9. • Moderate meconium 99. • Unknown			7. Note any changes in fluid color/odor		
8. Mother's statement (include where, when, description)				9. Medication given during ROM 1. • Yes 9. • Unknown 2. • No	

Comments:

H. DELIVERY SUMMARY						<input type="checkbox"/> No Info
11 = Singleton 20 = Twin NOS 30 = Triplet NOS 40 = Quadruplet NOS 21 = Twin A 31 = Triplet A 41 = Quadruplet A 22 = Twin B 32 = Triplet B 42 = Quadruplet B 33 = Triplet C 43 = Quadruplet C 44 = Quadruplet D						<input style="width: 150px; height: 15px;" type="text"/> ENTER 99/99/9999 when date is unknown
1. Delivery date ____/____/____	2. Delivery time :	3. Gender 1. • Male 2. • Female 3. • Ambiguous 9. • Unknown	4. Outcome 1. • Live birth 2. • Stillbirth	5. Plurality	6. Zygosity 1. • Monozygotic (MZ) 2. • Dizygotic (DZ) 3. • Unknown/No Info Zygosity determined by:	
7. Weight (gm)	8. Length (cm)	9. Head circumference (cm)	10. Apgar scores 1' 5' 10' 15'			
11. Type of delivery 1. • NSVD 2. • Operative vaginal delivery 3. • C-section 4. • Breech extraction 9. • Unknown		12. Presentation at delivery 1. • Vertex 2. • Transverse lie (shoulder presentation) 3. • Face/brow 4. • Breech 8. • Other, (specify): _____ 9. • Unknown			13. Description of delivery 1. • Normal 2. • Precipitous 3. • Prolonged 1 st stage 4. • Prolonged 2 nd stage 9. • Not Noted	
14. Meconium staining of baby's 1. • Skin 4. • Cord 2. • Nails 5. • No staining 3. • Placenta 99. • Unknown		15. Birth defects • None noted				
16. Date onset labor ____/____/____		17. Time onset :	18. If date/time unknown, mother's statement			
19. Analgesia in labor 1. • Yes 2. • No <input type="checkbox"/> Nubain <input type="checkbox"/> Stadol <input type="checkbox"/> Demerol <input type="checkbox"/> Fentanyl <input type="checkbox"/> Other: Specify: _____ _____		20. Anesthesia in labor 1. • Epidural 6. • Paracervical (saddle block) 2. • Spinal 7. • Pudendal 3. • Local 8. • Other (specify): _____ 4. • General 9. • None 5. • Perineal 99. • Unknown/Not noted List complications: Spinal/Intrathecal start time: ____:____ Date _____ Epidural start time: ____:____ Date: _____ Epidural stop time: ____:____ Date: _____ (when not stated use delivery time)			21. Estimated blood loss (EBL) 1. • <500 cc's (WNL) 2. • >500 cc's, (specify) _____ List complications Comments/Discrepancies	
22. Document any prep solutions used/where 99. <input type="checkbox"/> unknown			23. Reason for preterm delivery per MD 99. <input type="checkbox"/> unknown			
24. Newborn Screening Accession Number: <input type="checkbox"/> No Info						
Comments: 						
I. PLACENTA AND CORD						<input type="checkbox"/> No Info

1. Delivery date ____/____/____	2. Delivery time : <input type="checkbox"/> No Info	3. 1. • Spont. 2. • Assisted 3. • Manual 4. <input type="checkbox"/> No Info	4. Nuchal cord X _____ 4. <input type="checkbox"/> Other: Specify _____ 5. <input type="checkbox"/> Nuchal cord not noted	5. Cord length 1. • Long 2. • Short 3. • Not stated 4. • Stated length: _____
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6. Other cord abnormalities 1. • True knot 2. • Thin 3. • Two vessels 4. • Three vessels (normal) 5. • Velamentous/marginal insertion 6. • Cord prolapse 9. • No info	7. Infarcts noted on OB/CNM exam Size _____ 1. • Old 3. • NOS 2. • New	8. Description of placenta on OB/CNM exam • Small placenta • Fetal papyraceous • Abruption _____% <input type="checkbox"/> Placenta accreta, increta or percreta <input type="checkbox"/> Placenta previa • Complete/total • Partial/marginal • Low lying • Missing lobes • Calcification • Vascular abnormalities • Clot noted • other: specify _____ <input type="checkbox"/> No Description
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Comments:

J. PLACENTAL PATHOLOGY

No Info

- 1. • Pathology report copied
- 2. • Placenta not sent to pathology (discarded)
- 3. • Status unclear/report not in chart-contact path. Dept.

Comments:

K. DELIVERY INTERVENTIONS No Info

Codes: 1= Yes, 2= No, 9= Unknown

Code	Interventions	Comments
	Version	Date: ___/___/_____ 1. • Successful 2. • Failed
	Amnio Infusion	Specify complications:
	Vacuum	1. • Successful 2. • Failed Total time on _____min
	Forceps	1. • Successful 2. • Failed Total time on _____min 1. •Outlet 2. • Low 3. • Mid 4. • Rotation
	Cesarean Section	1. • Elective 2. • Unscheduled 3. • Emergency

Comments:

Complications of Labor and Delivery
Check all that apply

<ul style="list-style-type: none"> <input type="checkbox"/> No Complications Noted <input type="checkbox"/> Active Phase Arrest (APA) <input type="checkbox"/> Arrest of descent <input type="checkbox"/> Cephalopelvic Disproportion (CPD) <input type="checkbox"/> Cholestasis of pregnancy or intrahepatic cholestasis <input type="checkbox"/> Deep Transverse Arrest <input type="checkbox"/> Failed Trial of Labor <input type="checkbox"/> Failure to progress (FTP) <input type="checkbox"/> Failure to descend 	<ul style="list-style-type: none"> <input type="checkbox"/> Fetal distress or intolerance of labor (FIOL) <input type="checkbox"/> Herpes (genital), Active only <input type="checkbox"/> Intra-uterine Fetal Demise (IUFD)/ Stillbirth <input type="checkbox"/> Intra-uterine growth retardation (IUGR) <input type="checkbox"/> Low BPP or non-reassuring fetal testing <input type="checkbox"/> Macrosomia <input type="checkbox"/> Maternal death <input type="checkbox"/> Neonatal death <input type="checkbox"/> Oligohydramnios or Low AFI <input type="checkbox"/> Persistent OP 	<ul style="list-style-type: none"> <input type="checkbox"/> Polyhydramnios <input type="checkbox"/> Post-dates <input type="checkbox"/> Postpartum hemorrhage <input type="checkbox"/> Hemabate given <input type="checkbox"/> Methergine given <input type="checkbox"/> E&C <input type="checkbox"/> Uterine Artery Embolization <input type="checkbox"/> Prolonged latent stage <input type="checkbox"/> Retained placenta <input type="checkbox"/> Seizure <input type="checkbox"/> Shoulder dystocia <input type="checkbox"/> Slow Slope Active Phase <input type="checkbox"/> Uterine atony <input type="checkbox"/> Uterine rupture <input type="checkbox"/> Vasa previa <input type="checkbox"/> VBAC <input type="checkbox"/> Other (specify): _____
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L. MATERNAL INFECTIONS NOTED THIS ADMISSION THROUGH 24H POSTPARTUM								
								<input type="checkbox"/> No Info
Dx codes : 1=Chorioamnionitis, 2= UTI, 3= Renal, 4= Vaginal, 5= STD, 6= GI, 7= URI, 8= Other (specify), 9=Unknown								
If cultures were performed, note in Section M.								
If "yes" is indicated for medications, please fill out Section N.								
a. Dx	Date diagnosed ____/____/____ 9. <input type="checkbox"/> unknown	GA	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	Duration ____ days <input type="checkbox"/> Unk	Highest temp °C _____ °F _____ 1. <input type="checkbox"/> No temp 999. <input type="checkbox"/> unknown	Cultures 1. • Yes 2. • No 9. • Unknown	Medication Given 3. • Yes 4. • No 9. • Unknown
b. Dx	Date diagnosed ____/____/____ 9. <input type="checkbox"/> unknown	GA	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	Duration ____ days <input type="checkbox"/> Unk	Highest temp °C _____ °F _____ 1. <input type="checkbox"/> No temp 999. <input type="checkbox"/> unknown	Cultures 5. • Yes 6. • No 9. • Unknown	Medication Given 7. • Yes 8. • No 9. • Unknown
c. Dx	Date diagnosed ____/____/____ 9. <input type="checkbox"/> unknown	GA	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	Duration ____ days <input type="checkbox"/> Unk	Highest temp °C _____ °F _____ 1. <input type="checkbox"/> No temp 999. <input type="checkbox"/> unknown	Cultures 9. • Yes 10. • No 9. • Unknown	Medication Given 11. • Yes 12. • No 9. • Unknown
d. Dx	Date diagnosed ____/____/____ 9. <input type="checkbox"/> unknown	GA	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	Duration ____ days <input type="checkbox"/> Unk	Highest temp °C _____ °F _____ 1. <input type="checkbox"/> No temp 999. <input type="checkbox"/> unknown	Cultures 13. • Yes 14. • No 9. • Unknown	Medication Given 15. • Yes 16. • No 9. • Unknown
e. Dx	Date diagnosed ____/____/____ 9. <input type="checkbox"/> unknown	GA	Tri	Certainty of Dx 1. • Lab 2. • Clinical 3. • Suspect 9. • Unknown	Duration ____ days <input type="checkbox"/> Unk	Highest temp °C _____ °F _____ 1. <input type="checkbox"/> No temp 999. <input type="checkbox"/> unknown	Cultures 17. • Yes 18. • No 9. • Unknown	Medication Given 19. • Yes 20. • No 9. • Unknown
Comments:								

Codes: 1= Yes , 2= No(stated) , 3= Suspect, 9= not stated/Unknown						
S/S on admission for delivery to 24 hrs postpartum		Date first noted	Time	Fever >37.7°C or 100°F on admission to 24hrs postpartum		
			:	5 highest fevers	Date	Time
	Uterine tenderness	--/---/----	:			
	Foul vaginal discharge noted (odor)	--/---/----	:	1.	--/---/----	:
	Purulent amniotic fluid (color)	--/---/----	:	2.	--/---/----	:
	WBC count >15,000/mL	--/---/----	:	3.	--/---/----	:
	Persistent mat'l tachycardia (>100 bpm)	--/---/----	:	4.	--/---/----	:
	Persistent fetal tachycardia (>160 bpm)	--/---/----	:	5.	--/---/----	:
	Fetal Bradycardia					
	Periodic Changes					
	Other, (specify):	--/---/----				
Comments:						

**M. CULTURES OBTAINED THIS ADMISSION
(RECORD ALL CULTURES OBTAINED)** No Info

Refer: Indicate the letter of the event from Section L. Use letter code in Section L (e.g., La, Lb, Lc etc). If the culture does not correspond to an event in section L, insert "0".

Source codes: 1= amniotic fluid, 2= placenta, 3= cervix, 4= vagina, 5=urine, 6=blood, 7= sputum, 8= stool, 88= other (specify), 99= unknown

Refer	Date cultured	Source	Results	Description (organisms, etc)
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	
	___/___/_____ 99. <input type="checkbox"/> unknown		1. • No growth 3. • NL Flora 2. • Light growth 4. •Positive 5. • Growth noted, not specifed 9. •Unknown	

Comments:

N. ALL ANTI-INFECTIVES AND OTHER DRUGS TAKEN DURING THIS ADMISSION THROUGH 24 HOURS POSTPARTUM No Info

Refer: Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'.

Exclusions: laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, tylenol, methergine, labor and delivery anesthetics

Drug codes: 9= steroids (lung maturity) 10= antidiabetics, 11= steroids (other), 12= hormones, 13= thyroid, 14= antibiotics, 15= antifungals, 16= antivirals, 17= anesthetics (not labor and delivery), 18= anticonvulsants, 19= analgesics/hypnotics/sedatives/antipsychotics, 20 = antihypertensives/diuretics, 21= cardiovascular, 22= narcotic antagonists, 23= ergostrate, 24=antidepressants, 25= prenatal vitamins, 26= asthma, 27= preterm labor prevention, 88= other (specify), 99= unknown

Reason: 3 = lung maturity, 4= cervical ripening, 5= maternal disease, 6= prophylaxis 7= maternal fever 8= positive culture , 9= pain relief, 10= hyperemesis, 11= PIH, 88= other (specify), 99= unknown

Refer	Code	Drug name	Reason	Start Date	Duration (in days)	Dose	Unit	Freq	Entire pregnancy
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•

N. ALL ANTI-INFECTIVES AND OTHER DRUGS TAKEN DURING THIS ADMISSION THROUGH 24 HOURS POSTPARTUM (cont'd)

Refer: Indicate the number of the event from the corresponding section. If the medication does not correspond to a section above, enter '0'.

Exclusions: laxatives, enemas, disinfectants, topical agents, cough medicine, non-prenatal vitamins, antacids, stool softeners, benadryl, tylenol, methergine, labor and delivery anesthetics

Drug codes: 9= steroids (lung maturity) 10= antidiabetics, 11= steroids (other), 12= hormones, 13= thyroid, 14= antibiotics, 15= antifungals, 16= antivirals, 17= anesthetics (not labor and delivery), 18= anticonvulsants, 19= analgesics/hypnotics/sedatives/antipsychotics, 20 = antihypertensives/diuretics, 21= cardiovascular, 22= narcotic antagonists, 23= ergotrate, 24=antidepressants, 25= prenatal vitamins, 26= asthma, 27= preterm labor prevention, 88= other (specify), 99= unknown

Reason: 3 = lung maturity, 4= cervical ripening, 5= maternal disease, 6= prophylaxis 7= maternal fever 8= positive culture , 9= pain relief, 10= hyperemesis, 11= PIH, 88= other (specify), 99= unknown

Refer	Code	Drug name	Reason	Start Date	Duration (in days)	Dose	Unit	Freq	Entire pregnancy
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•
				____/____/_____ TIME: ____:____ 9. <input type="checkbox"/> Unknown		• variable	1. • gm 2. • mg 3. • mcg 4. • mU 5. • cc/ml 8. • other	1. <input type="checkbox"/> QD 2. <input type="checkbox"/> BID 3. <input type="checkbox"/> TID 4. <input type="checkbox"/> QID 5. <input type="checkbox"/> PRN 6. Every ____ hrs 7. <input type="checkbox"/> Per week 8. <input type="checkbox"/> Total dose 9. <input type="checkbox"/> No Info	•

Comments: