NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

ANTENATAL < 32 WEEKS ELECTRONIC FETAL MONITORING (EFM) TOOL

SMR110562

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

Indication for EFM:	Gestation:
Date of EFM: _____/_____/_____	EFM review period: _____:_____ to _____:_____
Fetal movements:	Maternal heart rate:
Is altered calling criteria in place? ☐ Yes ☐ No	Does the altered calling criteria require reviewing at this time? ☐ Yes ☐ No ☐ N/A

Uterine Activity	Baseline	Rate (bpm)	Baseline Variability	bpm	Reactivity	Decelerations
	☐ < 115 ☐ > 180		☐ ≤ 5 for > 90 minutes ☐ Sinusoidal/Sawtooth > 15 minutes		☐ Absent > 75 minutes	☐ Recurrent and > 30 seconds ☐ Prolonged > 3 minutes
	☐ 115 - 124 ☐ > 160 - 180		☐ ≤ 5 for > 45 minutes		☐ Absent > 45 minutes	☐ Single for > 90 seconds and ≤ 3 minutes
If there are any concerns refer to the NSW Health Management of Threatened Preterm Labour Guideline	☐ 125 - 160		☐ ≥ 6		☐ Present ☐ Rise in baseline of > 10 bpm associated with multiple fetal movements	☐ Nil ☐ Decelerations with an amplitude < 40 bpm for < 30 seconds with reactivity

Clinical Escalation Response

☐ **Normal** Review full clinical picture to determine if continued EFM is required	☐ **Abnormal** **Clinical Review within 30 minutes** 2 or more YELLOW ZONE features = **a Rapid Response** Time of call: _____:_____	☐ **Abnormal** **Call a Rapid Response** Time of call: _____:_____

Ask: Could there be fetal hypoxia?

Name:	Signature:	Date: _____/_____/_____	Time: ____:____
Name:	Signature:	Date: _____/_____/_____	Time: ____:____
Second clinician review completed and agrees with Clinical Escalation Response	☐ Yes	☐ No - Clinical Review required	

Indication for EFM:	Gestation:
Date of EFM: _____/_____/_____	EFM review period: _____:_____ to _____:_____
Fetal movements:	Maternal heart rate:
Is altered calling criteria in place? ☐ Yes ☐ No	Does the altered calling criteria require reviewing at this time? ☐ Yes ☐ No ☐ N/A

Uterine Activity	Baseline	Rate (bpm)	Baseline Variability	bpm	Reactivity	Decelerations
	☐ < 115 ☐ > 180		☐ ≤ 5 for > 90 minutes ☐ Sinusoidal/Sawtooth > 15 minutes		☐ Absent > 75 minutes	☐ Recurrent and > 30 seconds ☐ Prolonged > 3 minutes
	☐ 115 - 124 ☐ > 160 - 180		☐ ≤ 5 for > 45 minutes		☐ Absent > 45 minutes	☐ Single for > 90 seconds and ≤ 3 minutes
If there are any concerns refer to the NSW Health Management of Threatened Preterm Labour Guideline	☐ 125 - 160		☐ ≥ 6		☐ Present ☐ Rise in baseline of > 10 bpm associated with multiple fetal movements	☐ Nil ☐ Decelerations with an amplitude < 40 bpm for < 30 seconds with reactivity

Clinical Escalation Response

☐ **Normal** Review full clinical picture to determine if continued EFM is required	☐ **Abnormal** **Clinical Review within 30 minutes** 2 or more YELLOW ZONE features = **a Rapid Response** Time of call: _____:_____	☐ **Abnormal** **Call a Rapid Response** Time of call: _____:_____

Ask: Could there be fetal hypoxia?

Name:	Signature:	Date: _____/_____/_____	Time: ____:____
Name:	Signature:	Date: _____/_____/_____	Time: ____:____
Second clinician review completed and agrees with Clinical Escalation Response	☐ Yes	☐ No - Clinical Review required	

Indication for EFM:	Gestation:
Date of EFM: _____/_____/_____	EFM review period: _____:_____ to _____:_____
Fetal movements:	Maternal heart rate:
Is altered calling criteria in place? ☐ Yes ☐ No	Does the altered calling criteria require reviewing at this time? ☐ Yes ☐ No ☐ N/A

Uterine Activity	Baseline	Rate (bpm)	Baseline Variability	bpm	Reactivity	Decelerations
	☐ < 115 ☐ > 180		☐ ≤ 5 for > 90 minutes ☐ Sinusoidal/Sawtooth > 15 minutes		☐ Absent > 75 minutes	☐ Recurrent and > 30 seconds ☐ Prolonged > 3 minutes
	☐ 115 - 124 ☐ > 160 - 180		☐ ≤ 5 for > 45 minutes		☐ Absent > 45 minutes	☐ Single for > 90 seconds and ≤ 3 minutes
If there are any concerns refer to the NSW Health Management of Threatened Preterm Labour Guideline	☐ 125 - 160		☐ ≥ 6		☐ Present ☐ Rise in baseline of > 10 bpm associated with multiple fetal movements	☐ Nil ☐ Decelerations with an amplitude < 40 bpm for < 30 seconds with reactivity

Clinical Escalation Response

☐ **Normal** Review full clinical picture to determine if continued EFM is required	☐ **Abnormal** **Clinical Review within 30 minutes** 2 or more YELLOW ZONE features = **a Rapid Response** Time of call: _____:_____	☐ **Abnormal** **Call a Rapid Response** Time of call: _____:_____

Ask: Could there be fetal hypoxia?

Name:	Signature:	Date: _____/_____/_____	Time: ____:____
Name:	Signature:	Date: _____/_____/_____	Time: ____:____
Second clinician review completed and agrees with Clinical Escalation Response	☐ Yes	☐ No - Clinical Review required	

ANTENATAL < 32 WEEKS ELECTRONIC FETAL MONITORING (EFM) TOOL

SMR110.562

NH700462 201224

NO WRITING