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

MATERNITY – INTRAPARTUM VAGINAL EXAMINATION

SMR060473

Indication: **Date:** ____ /____ / ____ **Time:** ____:____

☐ **Valid Consent** **Chaperone:** ☐ offered ☐ accepted ☐ declined

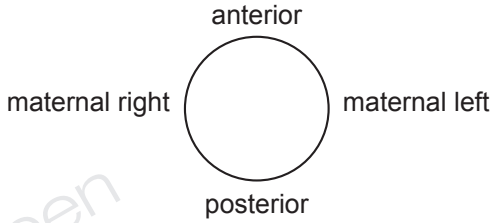
Bladder care: ☐ bladder emptied prior to vaginal examination

Abdominal palpation:

lie:_____ presentation:_____ position: _____ fifths palpable:_____

Vaginal examination:

Cervical		**Fetus**	
position	_____	presenting part	_____
consistency	_____	attitude	_____
effacement	_____	caput	_____
dilation	_____	moulding	_____
application	_____	station	_____
		position	_____



Membranes: ☐ intact ☐ spontaneous rupture ☐ artificial rupture ☐ unintended rupture

Liquor: ☐ none ☐ clear ☐ meconium ☐ blood stained ☐ purulent

Fetal heart rate after vaginal examination: _____ **(bpm)**

Print name: **Signature:** **Designation:**

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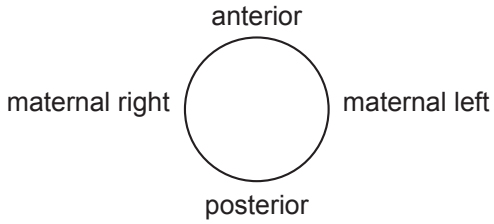

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Print name: **Signature:** **Designation:**

MATERNITY – INTRAPARTUM VAGINAL EXAMINATION

NH700961 171225

SMR060.473

NSW Health

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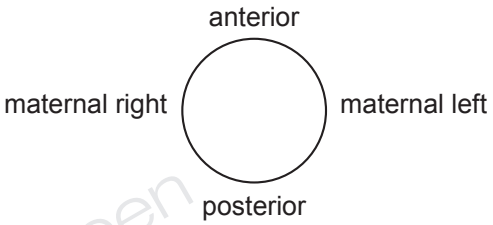

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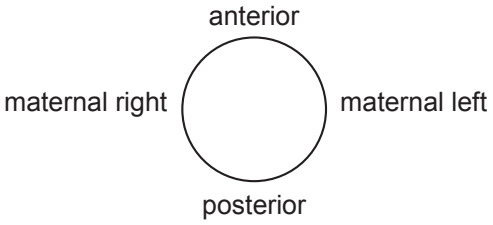

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NO WRITING