

School of Nursing Department of Community Public Health 525 N. Wolfe St. Baltimore MD 21205

BIRTH RECORD FOR BIRTH COMPANION CLIENT

Prenatal complications with this pregnancy (type X for no, yes, or unknown)	Yes	No	Unknown
Group B Strep			
Preeclampsia (PIH)			
Gestational Diabetes			
IUGR (Intrauterine Growth Restriction)			
Multiples Pregnancy (e.g. twins) ·			
Preterm Labor (labor activity <38 wks)			
STIs (including Hep C)			
Drugs (1)			
Alcohol (2)			
Drugs and Alcohol (3)			
Tobacco Smoking			
Other (describe)			

LABOR & DELIVERY

*Name of Location of Birth:			
circle one:	Hospital (0)	Home (1)	Freestanding Birth Center (2)
*Name of Care Provider:			
circle one:	OB (O)	CNM (1)	Family Practice physician (2)
*Any Previous Cesareans?	No (0)	Yes (1)	If Yes, How Many?
	TOLAC?	VBAC?	
*Gestation at delivery:	Weeks	Days	
At Admission:	Dilation:	Effacement:	Station:
*Rupture of Membranes:	Spontaneous (0)	Artificial (1)	
Location of Rupture?	Home	Hospital	Car
	Other:		
*Meconium Present?	No (O)	Yes (1)	

LABOR PROGRESSION CHART (for your information)

Time					
Dilatation					
Effacement					
Station					

MEDICAL INTERVENTIONS/PROCEDURES (type **X** for no, yes, or unknown)

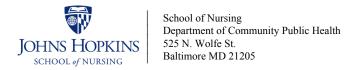
ТҮРЕ	NO	YES	UNKNOWN	
*Prostaglandin Gel/Cervidil/Cytotec				
*Pitocin Induction				cms: Time:
*Pitocin Augmentation				cms: Time:
*Epidural Anesthesia				Continuous or Bolus?
				cms:
*Episiotomy				Degree Extension:
*Cesarean Delivery				Reason:
Intermittent External EFM				
Continuous External EFM				Dilatation:
Internal Fetal Scalp Electrode				
Intrauterine Pressure Catheter				
Medlock/Heplock/IV				
Amnio-infusion				
Analgesic Medication				Drug name:
				cms:
Other Medication				Drug name: cms:
Other Anesthesia				Type:
O Inter a International				cms:
Forceps Assisted Delivery				
Vacuum Assisted Delivery				
Tears/Lacerations				Degree(s):
Other Interventions or Procedures				Explain:

BABY INFORMATION

Sex (circle)	ľ	Male	Female
*Birth Weight	lbs and	d oz	Grams
1-minute Apgar			
5-minute Apgar			
Were any resuscitative efforts required?	No	Yes	If Yes, Explain:
Immediate transfer to NICU?	No	Yes	If Yes, Explain:
Number of days in NICU			

LENGTH OF LABOR and BIRTH COMPANION(S) SUPPORT

What was the approximate time and length of (Ask client if you do not know)		
*First Stage? (onset of regular contractions-10 cm)		
*Second Stage? (pushing to birth)		
Were there any complications?	Yes*	No
*If yes, please explain:		
*Does the mother plan to breastfeed?	Yes	No
*Was she able to initiate breastfeeding after the delivery?	Yes	No
*Total time Birth Companions provided support to the client	Total time:	·
For example: student #l 9 p.m1 a.m. (4 hours)		
student #2 12 a.m 2 a.m. (2 hours)		
Total Time: hours {do not count overlap}		
[NOTE: In this example, there was 1 hour of overlap by both students.		
This counts as 1 hour spent with the client, NOT 2 hours. Do not		
"double count" overlapping hours. This is the total amount of time that support was provided-NOT the number of hours worked by each BC.]		



STUDENT SELF-EVALUATION

Client's Name:	Delivery Date:					
Birth Companion's Name(s)						
*How many prenatal classes did your clien	it attend?					
*Who else was with your client providing s		` •	u, the Birth Co	ompanion)?		
No one (O)	One or r	more (1)				
Partner/Souse/Parent of Baby	Mother	Sibling	Friend	Other:	:	
*Please check all the services that you pro	ovided as the Birt	h Companion for y	your client dur	ing the Labor	and Birth	
rease eneek an the services that you pre-	Widea as the Birth		rour chemit dur	ing the Europi	una Birtii.	
massage		d	liscussed option	s for mother		
shower/bath			old/hot packs			
water/juice		c	ounter pressure			
position/changes		b	reathing technic	ques		
eye contact						
took photos						
eased fears	_					
verbal encouragement						
continuous presence						
included other support						
helped partner/spouse/b						
reinforced birth ritual	ed birth ritual other					
*What services do you feel helped the clie	ent the most? (pic	k top three, in ord	er, from above	e list)		
1 2			3.			
		, , , , , , , , , , , , , , , , , , , 				
*Any of your services that you felt the clie	nt did not like? If	so, please explain	ı:			
Prenatal Visits:						
*****	::1 1: 40:		0	1	2 ()	
*Were you able to have a prenatal visit(s) v	with your client?	How many?	0	1	2 (more)	
Where did you meet?						
What was the major focus of the visit(s)?						

^{*}From your perspective, <u>as the Birth Companion</u>, please select the number which most closely reflects your opinion:

	More harm than good		Neither helped nor hurt		Was a big help
1. Were the techniques suggested by the Birth Companion helpful to the client in handling the physical aspects of the labor?	1	2	3	4	5
2. Were the techniques suggested by the Birth Companion helpful to the client in handling the emotional aspects of the labor?	1	2	3	4	5
3. Were the suggestions of the Birth Companion helpful for the partner and/or other family members and friends present for the labor?	1	2	3	4	5
4. Overall, how would you evaluate the usefulness of having the Birth Companion present?	1	2	3	4	5