Today's Date: ____________________

Patient Name: ____________________ Date of Birth: ________ Induction: ______ C/S: ______

OB Provider: ____________________ Date of Planned Induction/Cesarean Section: ____________

EDC: ____________________ Gestational Age on Date of Induction: ________wks ________ days

Complete This Section for All Inductions/Cesarean Sections/Deliveries With Gestation Age Less Than 39 Weeks

Medical Indication for delivery prior to 39 weeks gestation (check all that apply):

- ❑ Abruption
- ❑ Placenta Previa **US report date** ________
- ❑ Chronic HTN
- ❑ Gestational HTN
- ❑ Preeclampsia
- ❑ Diabetes (type I or II)
- ❑ Gestational Diabetes
- ❑ Oligohydramnios **AFI** ________
- ❑ Polyhydramnios **AFI** ________
- ❑ IUGR/SGA **US report date** ________
- ❑ Non-Reassuring Fetal Status **BPP** ________
- ❑ PROM
- ❑ Prior Myomectomy
- ❑ Prior Surgery with Perforation
- ❑ Isoimmunization
- ❑ Fetal Malformation
- ❑ Multiple Gestation
- ❑ Heart Disease ____________________
- ❑ Liver Disease ____________________
- ❑ Renal Disease ____________________
- ❑ Pulmonary Disease ____________________
- ❑ Coag/Thrombophilia ____________________
- ❑ HIV Infection
- ❑ Prior Classical Incision
- ❑ History of Uterine Window
- ❑ History of Uterine Rupture
- ❑ Fetal Demise Current

Scheduler / RN Signature: ____________________ Date: __________ Time: ________

Physician/CNM Signature: ____________________

Date: ____________________ **Time:** ____________________

Medical Indication for Delivery Prior to 39 Weeks Gestation

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PATIENT IDENTIFICATION