

POST-PARTUM FILE: ADMISSION and FOLLOW-UP



Name										Number									
Delivery					Date / /				h									
NVD <input type="checkbox"/> Vacuum <input type="checkbox"/> Forceps <input type="checkbox"/> Caesarean section <input type="checkbox"/> Indication:																			
Perineum Intact <input type="checkbox"/> Episiotomy <input type="checkbox"/> Tear <input type="checkbox"/>					Newborn					Live born <input type="checkbox"/> Stillborn <input type="checkbox"/>									
Date of examination																			
Time of examination																			
Mother																			
Uterine involution (Yes/No)																			
Bleeding (0 - +++)																			
BP																			
Pulse																			
T°																			
RR																			
Breasts, normal (Yes/No)																			
Urine (Yes/No)																			
Pain (0 - +++)																			
Drugs		Dose		Route															
Newborn																			
T°																			
Cord, normal (Yes/No)																			
Urine (Yes/No)																			
Stool (Yes/No)																			
Breastfeeding (Yes/No)																			

If "NO", explain on the reverse page.

