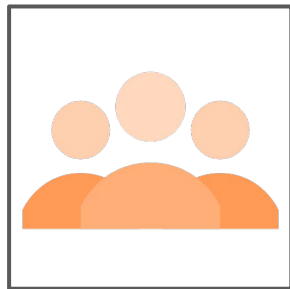


Labor and Delivery Planning Board

TEAM



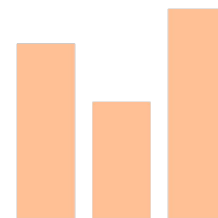
PREFERENCES



PLAN

Mom:

Baby:



Labor Progress:

NEXT ASSESSMENT



EARLY LABOR

ACTIVE LABOR

PUSHING



Labor Delivery Planning Board

Welcome: _____ Date: _____ Room #: _____

Team

Blank space for writing the team members.

Preferences

Blank space for writing preferences.

Notes

Blank space for writing notes.

Important Numbers

Emergency: Dial 88 | Free WiFi: Guest@NRHS

Plan

Mom:

Baby:

Labor Progress:


Next Huddle:




Photography Policy

Thank you in advance for not video or audio taping with still cameras, video cameras, or cell phones during labor and delivery. You may video and take pictures as soon as the baby is born at the discretion of your physician and labor/nursery nurses.

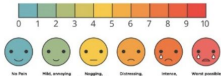
LDRP Boards



TEAMBIRTH PLANNING BOARD	TODAY'S DATE: ROOM #:	DELIVERY DATE: TIME:	BIRTH WEIGHT: LENGTH:	ROOM PHONE #:
YOUR BIRTH TEAM: Patient _____ Support _____ Nurse _____ Tech _____ Provider _____ Lactation _____ Pediatrician _____ PREFERENCES	PLAN: Mom: Baby: Progress: Next Huddle:	BABY: We are having a _____ The baby's name is _____ Breast or Bottle _____ Medications: <input type="checkbox"/> Yes or <input type="checkbox"/> No Communication Notes:		



PAIN MEASUREMENT SCALE



0 1 2 3 4 5 6 7 8 9 10

No Pain
 Mild, annoying pain
 Moderate, annoying pain
 Unpleasant pain
 Severe, unbearable pain
 Worst imaginable pain

Our goal is to provide EXCELLENT care. Questions are always encouraged.

Providence Holy Family Hospital
Know Me - Care for me - Ease my way

Room	Phone:	FMC Front Desk: 482-2229
Date		Nurse Phone:
EARLY LABOR	ACTIVE LABOR	PUSHING

My Care Team	It's a _____ !
Name:	Name:
Support Person(s):	Birthday: Time:
Nurse:	Weight: Length
Nurse Leader:	Feeding Plan: <input type="checkbox"/> Breast <input type="checkbox"/> Bottle <input type="checkbox"/> Combo
Provider:	<input type="checkbox"/> Hep B Vaccine <input type="checkbox"/> Vit K <input type="checkbox"/> Erythromycin
Newborn Provider:	My Preferences
Other:	
My Care Plan	
Mom:	
Baby:	Medications
	Next @ _____
	Next @ _____
	Next @ _____
Labor Progress:	Prepare for Discharge:
	<input type="checkbox"/> _____ <input type="checkbox"/> _____
	<input type="checkbox"/> _____ <input type="checkbox"/> _____
Last Exam: __/__/__@	GBS _____ Blood Type _____ <input type="checkbox"/> Rhogam
Next Huddle:	

Our goal is to provide exceptional care at all times.

TODAY'S DATE:

ROOM #

Portal

AllianceHealth

Welcome to Birth & Family Ponca City

Labor & Delivery Planning Board



HEALTHCARE TEAM



SUPPORT PERSON

PROVIDER

NURSE

NURSE LEADER

PEDIATRICIAN

MY CARE PLAN

MOM:

BABY:

LABOR PROGRESS:

NEXT HUDDLE:

LAST EXAM:

Congratulations!

IT'S A

NAME

BIRTHDAY

TIME

WEIGHT

LENGTH

BREAST/BOTTLE/BOTH



Infant Security Tips

- Do not give infant to anyone that does not have Red on their badge.
- Ring call bell to verify identity when in doubt.
- Do not leave baby in room or on your bed unattended.
- Do not carry baby in the hall. Transport them in your bassinet.
- You, your baby and the person you chose as your support must have their matching ID bands on. Baby must be with a banded individual at all times.
- Do not sleep with your baby in your bed.
- For SAFE sleep for your baby, remember ABC: Alone, on their Back in a Crib.



Photography Policy:

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PREFERENCES/QUESTIONS/CONCERNS



0

1

2

3

4

5

6

7

8

9

10

NO PAIN

MILD DISCOMFORT

MILD PAIN

MODERATE PAIN

SEVERE PAIN

EXTREME PAIN



Medication(s)

TODAY'S DATE:

ROOM #

Welcome to Birth & Family Ponca City

Postpartum Planning Board



HEALTHCARE TEAM



SUPPORT PERSON

PROVIDER

NURSE

NURSE LEADER

PEDIATRICIAN

MY CARE PLAN

MOM:

BABY:

NEXT HUDDLE:

Congratulations!

IT'S A

NAME

BIRTHDAY

TIME

WEIGHT

LENGTH

BREAST/BOTTLE/BOTH

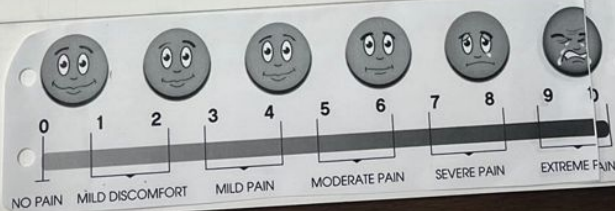
PREFERENCES/QUESTIONS/CONCERNS

Medication(s)






Preparing for Discharge

- Birth Certificate
- Newborn Screen Lab Test
- Newborn Heart Screen
- Hearing Screen
- Test For Jaundice
- Circumcision
- Safe Sleep Education
- Post-Birth Warning Signs
- Postpartum Depression



L&D and PP Board - Hillcrest Medical Center

 <small>PEGGY V. HELMERICH</small> Women's Health Center <small>@ HILLCREST MEDICAL CENTER</small>		
LABOR AND DELIVERY PLANNING BOARD	DATE: ROOM:	LAST CHECK IN: GA:
TEAM	 <small>EARLY LABOR ACTIVE LABOR PUSHING</small>	
	PLAN Mom:	
PREFERENCES	Baby:	
	Progress:	
CONSIDERATIONS	NEXT CHECK IN	

 <small>PEGGY V. HELMERICH</small> Women's Health Center <small>@ HILLCREST MEDICAL CENTER</small>			
BIRTH CARE PLANNING BOARD	DATE: ROOM:	GA:	MODE OF DELIVERY: DAYS OF POSTPARTUM:
TEAM	PLAN Mom:		
	Baby:		
PREFERENCES	NEXT CHECK IN Mom:		
CONSIDERATIONS	Baby:		

Cherokee Nation W.W. Hastings Hospital



Welcome to The Birthplace
CHEROKEE NATION

SSY
Gadugi

Date: Room #:
Room phone #:

Care Team

Name: Support people:
Nurse:
Midwife: Physician:

Preferences, Questions, Concerns



Plan

Me:
My baby:
Labor Progress:
Next Huddle:



Name: *About My* Physician
Birth Day: *Baby* Weight
Birth Time: Breast Bottle Length



Welcome to The Birthplace
CHEROKEE NATION

SSY
Gadugi

Date: Room #:
Room phone #:

Care Team

My name: Baby's name:
Nurse: Support people:
Nurse Tech Pediatrician :
OB Provider:

Preferences, Questions, Concerns

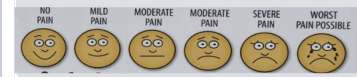


My Plan

Baby's Plan

Breast Bottle

Next Huddle:



Next Huddle:



Birthing the Nation's Future

Birth Day Weight
Birth Time: Length

Labor and Delivery

(Labor y Parto)

Date:
(Fecha)

Room Number:
(Número de cuarto)

Gestational Age:
(Edad gestacional)

Team	Plan
<i>(Equipo)</i> Me: _____ (No) Support: _____ (Apoyo)	<i>(Plan)</i> Me: _____ (No) Baby: _____ (Bebé)
Nurse: _____ (Enfermera)	Progress: _____ (Progreso)
Transition: _____ (Transición)	
OB Providers: _____ (Obstetras)	
Baby Provider: _____ (Médico del bebé)	
Lactation: _____ (Lactancia)	

Preferences/Questions/Concerns

(Preferencias/Preguntas/Preocupaciones)

Next Huddle/Check-In

(Siguiente reunión/Revisión)

Medications

(Medicamentos)

_____ next @ _____
(próximo dosis a las)

_____ next @ _____
(próximo dosis a las)

_____ next @ _____
(próximo dosis a las)

About My Baby

(Acercas de mi bebé)

Name: _____
(Nombre)

Birth Date/Time: _____
(Fecha de nacimiento/hora)

Weight: _____
(Peso)

Length: _____
(Longitud)

Feeding Plan: _____
(Plan de alimentación)

Meds: Vit K Erythromycin Hep B
(Vit K) (Eritromicina) (Hep B)

Antepartum/Postpartum

(Preparto/Posparto)

Date:
(Fecha)

Room Number:
(Número de cuarto)

Gestational Age:
(Edad gestacional)

Team	Plan
<i>(Equipo)</i> Me: _____ (No) Support: _____ (Apoyo)	<i>(Plan)</i> Me: _____ (No) Baby: _____ (Bebé)
Nurse: _____ (Enfermera)	Progress: _____ (Progreso)
Tech: _____ (Técnica)	
OB Providers: _____ (Obstetras)	
Baby Provider: _____ (Médico del bebé)	
Lactation: _____ (Lactancia)	

Preferences/Questions/Concerns

(Preferencias/Preguntas/Preocupaciones)

Next Huddle/Check-In

(Siguiente reunión/Revisión)

Medications

(Medicamentos)

_____ next @ _____
(próximo dosis a las)

_____ next @ _____
(próximo dosis a las)

_____ next @ _____
(próximo dosis a las)

_____ next @ _____
(próximo dosis a las)

_____ next @ _____
(próximo dosis a las)

About My Baby

(Acercas de mi bebé)

Name: _____
(Nombre)

Birth Date/Time: _____
(Fecha de nacimiento/hora)

Weight: _____
(Peso)

Length: _____
(Longitud)

Feeding Plan: _____
(Plan de alimentación)

Follow-Up Provider: _____
(Médico de seguimiento)

Prepare for Discharge

(Preparación para dar de alta)
