

Labour Room Register

Year SN	Month SN	Client Detail	Obstetric History	Admission Details	Detail of interventions for Delivery	Details of Delivery	Information about Baby	Complications	In case of referral	Condition of the mother and baby at discharge	Postpartum Family planning	Addition Info./ Follow up details
1	2	3	4	5	6	7	8	9	10	11	12	13
		Registration No. _____ MCTS No. _____ Name and age _____ Husband's/Fathers/Guardians Name _____ Address _____ Mobile No. _____ BPL/MBS reg: Y/ N _____ Aadhar No. _____ Bank details _____ ASHA's name & contact no. _____	LMP/EDD _____ Gravida _____ Parity _____ Abortion _____ Living children _____ Previous LSCS (Y/N) _____ Other previous complications: _____	Date _____ Time _____ Direct in labour <input type="checkbox"/> Gestational age (in weeks) _____ BP _____ Temp _____ FHR _____ Proteinuria _____ Hb gms % _____ Blood Group _____ HIV _____ Syphilis _____ Malaria _____ Hep B _____ Hep C _____ Referred From _____ Identified as High Risk <input type="checkbox"/> Specify: _____	Partograph Filled Inducted* <input type="checkbox"/> Augmented* <input type="checkbox"/> Inj. Dexamethasone <input type="checkbox"/> Inj. Magnesium Sulfate <input type="checkbox"/> Episiotomy <input type="checkbox"/> AMTSL <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type of Uterotonic Oxytocin IM <input type="checkbox"/> If others, then specify: _____ Delayed cord <input type="checkbox"/> Clamping (1-3 min) _____ Antibiotics <input type="checkbox"/> Blood transfusion <input type="checkbox"/>	Date _____ Time _____ Type: Normal <input type="checkbox"/> Assisted Delivery <input type="checkbox"/> (Instrumental, Vacuum, etc.) Caesarean <input type="checkbox"/> If caesarean, Indication: _____ Conducted By: _____ Mother: Alive <input type="checkbox"/> Maternal Death <input type="checkbox"/> Baby: Single <input type="checkbox"/> Multiple <input type="checkbox"/> Term <input type="checkbox"/> Preterm <input type="checkbox"/> Alive <input type="checkbox"/> Still birth: <input type="checkbox"/> Fresh <input type="checkbox"/> Macerated <input type="checkbox"/> New born death <input type="checkbox"/>	Identification No _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Weight (Kgs): _____ Dried immediately after birth Yes <input type="checkbox"/> No <input type="checkbox"/> Resuscitation required** Yes <input type="checkbox"/> No <input type="checkbox"/> Breast feed within 1 hour Yes <input type="checkbox"/> No <input type="checkbox"/> If not, mention time: _____ Vitamin K1 given Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccination done BCG <input type="checkbox"/> OPV <input type="checkbox"/> Hep B <input type="checkbox"/>	Mother: APH <input type="checkbox"/> PPH <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Sepsis <input type="checkbox"/> Obs. labour <input type="checkbox"/> Prolonged labour <input type="checkbox"/> Others (specify): _____ Baby: Sepsis <input type="checkbox"/> Asphyxia <input type="checkbox"/> LBW <input type="checkbox"/> Pre Maturity <input type="checkbox"/> Others <input type="checkbox"/> (specify): _____	Mother: Reason _____ Referred to _____ Baby: Reason _____ Referred to _____	Date and time of Discharge _____ Mother: BP _____ Temp _____ Bleeding PV _____ Baby: Temp _____ Feeding _____ Respiratory Rate _____	Counselling Yes <input type="checkbox"/> No <input type="checkbox"/> Method chosen: LAM <input type="checkbox"/> Condoms <input type="checkbox"/> Injectable <input type="checkbox"/> PPIUCD <input type="checkbox"/> Male Sterilization <input type="checkbox"/> PPS <input type="checkbox"/> Others <input type="checkbox"/> Date of method adopted _____	Signature of LR I/C
		Registration No. _____ MCTS No. _____ Name and age _____ Husband's/Fathers/Guardians Name _____ Address _____ Mobile No. _____ BPL/MBS reg: Y/ N _____ Aadhar No. _____ Bank details _____ ASHA's name & contact no. _____	LMP/EDD _____ Gravida _____ Parity _____ Abortion _____ Living children _____ Previous LSCS (Y/N) _____ Other previous complications: _____	Date _____ Time _____ Direct in labour <input type="checkbox"/> Gestational age (in weeks) _____ BP _____ Temp _____ FHR _____ Proteinuria _____ Hb gms % _____ Blood Group _____ HIV _____ Syphilis _____ Malaria _____ Hep B _____ Hep C _____ Referred From _____ Identified as High Risk <input type="checkbox"/> Specify: _____	Partograph Filled Inducted* <input type="checkbox"/> Augmented* <input type="checkbox"/> Inj. Dexamethasone <input type="checkbox"/> Inj. Magnesium Sulfate <input type="checkbox"/> Episiotomy <input type="checkbox"/> AMTSL <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Type of Uterotonic Oxytocin IM <input type="checkbox"/> If others, then specify: _____ Delayed cord <input type="checkbox"/> Clamping (1-3 min) _____ Antibiotics <input type="checkbox"/> Blood transfusion <input type="checkbox"/>	Date _____ Time _____ Type: Normal <input type="checkbox"/> Assisted Delivery <input type="checkbox"/> (Instrumental, Vacuum, etc.) Caesarean <input type="checkbox"/> If caesarean, Indication: _____ Conducted By: _____ Mother: Alive <input type="checkbox"/> Maternal Death <input type="checkbox"/> Baby: Single <input type="checkbox"/> Multiple <input type="checkbox"/> Term <input type="checkbox"/> Preterm <input type="checkbox"/> Alive <input type="checkbox"/> Still birth: <input type="checkbox"/> Fresh <input type="checkbox"/> Macerated <input type="checkbox"/> New born death <input type="checkbox"/>	Identification No _____ Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Weight (Kgs): _____ Dried immediately after birth Yes <input type="checkbox"/> No <input type="checkbox"/> Resuscitation required** Yes <input type="checkbox"/> No <input type="checkbox"/> Breast feed within 1 hour Yes <input type="checkbox"/> No <input type="checkbox"/> If not, mention time: _____ Vitamin K1 given Yes <input type="checkbox"/> No <input type="checkbox"/> Vaccination done BCG <input type="checkbox"/> OPV <input type="checkbox"/> Hep B <input type="checkbox"/>	Mother: APH <input type="checkbox"/> PPH <input type="checkbox"/> Pre-eclampsia <input type="checkbox"/> Eclampsia <input type="checkbox"/> Sepsis <input type="checkbox"/> Obs. labour <input type="checkbox"/> Prolonged labour <input type="checkbox"/> Others (specify): _____ Baby: Sepsis <input type="checkbox"/> Asphyxia <input type="checkbox"/> LBW <input type="checkbox"/> Pre Maturity <input type="checkbox"/> Others <input type="checkbox"/> (specify): _____	Mother: Reason _____ Referred to _____ Baby: Reason _____ Referred to _____	Date and time of Discharge _____ Mother: BP _____ Temp _____ Bleeding PV _____ Baby: Temp _____ Feeding _____ Respiratory Rate _____	Counselling Yes <input type="checkbox"/> No <input type="checkbox"/> Method chosen: LAM <input type="checkbox"/> Condoms <input type="checkbox"/> Injectable <input type="checkbox"/> PPIUCD <input type="checkbox"/> Male Sterilization <input type="checkbox"/> PPS <input type="checkbox"/> Others <input type="checkbox"/> Date of method adopted _____	Signature of LR I/C

*Induction and Augmentation to be done only at FRUs with C-section facility (Unnecessary Induction and Augmentation should not be done).

**States may consider including steps of newborn resuscitation: Position, Suction, Stimulation, Reposition, Bag & Mask Ventilation.