LABOUR RECORD

Date (yyyy/mm/dd): **Time** (hh:mm):

Most responsible midwife

Languages ❑ English ❑ French ❑ Other:

Partner/Other Tel. no.

ALLERGIES / REACTIONS ❑ No ❑ Yes:

PERTINENT MEDICAL HISTORY ❑ None

Pre-pregnant weight	Present weight	Height	BMI
kg	kg	cm	

OAR 1 ❑ Reviewed ❑ Unavailable
OAR 2 ❑ Reviewed ❑ Unavailable

G	T	P	A	L	EDB - (yyyy/mm/dd)	Gest.

Previous losses
❑ stillbirth
❑ neonatal death

STREP. B :

Labour onset yyyy / mm / dd Time hh : mm
❑ Induction

MEMBRANES ❑ Intact
❑ Ruptured at Date (yyyy/mm/dd): Time (hh:mm)

❑ Clear ❑ Meconium
❑ Foul smell ❑ Bloody

P - Printed Name / S - Signature & Designation)	Init	P - Printed Name / S - Signature & Designation)	Init
P		P	
S		S	
P		P	
S		S	
P		P	
S		S	

Access Midwives

VITAL SIGNS/PROGRESS OF LABOUR RECORD

Patient

Chart no.

Date (yyyy/mm/dd)	Time (hh:mm)																						
FETAL ASSESSMENT	Mode																						
	FHR																						
	Rhythm / Variability																						
	Acceleration																						
	Deceleration																						
UTERINE ACTIVITY	Mode																						
	Frequency																						
	Duration																						
	Intensity																						
	Resting tone																						
IV	mu/min																						
MATERNAL ASSESSMENT	200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40																						
	Blood Pressure																						
	Systo ⌄																						
	Diasto ⌃																						
	Pulse X																						
	FHR •																						
	Respiration																						
	Temperature °C																						
	Vaginal exam(✓) see partogram																						
	Vaginal discharge																						
	Amount																						
	Bladder assessment																						
SUPPORTIVE CARE																							
	Activity / Position																						
INTERVENTIONS	Position change																						
	O_2 (8-10 L/min)																						
	Physician called																						
	Initials																						

Access Midwives

VITAL SIGNS/PROGRESS OF LABOUR RECORD

Patient

Chart no.

	Date (yyyy/mm/dd) / Time (hh:mm)															
FETAL ASSESSMENT	Mode															
	FHR															
	Rhythm / Variability															
	Acceleration															
	Deceleration															
UTERINE ACTIVITY	Mode															
	Frequency															
	Duration															
	Intensity															
	Resting tone															
IV	mu/min															
MATERNAL ASSESSMENT	200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40															
	Blood Pressure															
	Systo ⌄															
	Diasto ⌃															
	Pulse X															
	FHR •															
	Respiration															
	Temperature °C															
	Vaginal exam(✓) see partogram															
	Vaginal discharge															
	Amount															
	Bladder assessment															
SUPPORTIVE CARE																
	Activity / Position															
INTERVENTIONS	Position change															
	O_2 (8-10 L/min)															
	Physician called															
	Initials															

Access Midwives

VITAL SIGNS/PROGRESS OF LABOUR RECORD

Patient

Chart no.

		Date (yyyy/mm/dd) / Time (hh:mm)			
FETAL ASSESSMENT	Mode				
	FHR				
	Rhythm / Variability				
	Acceleration				
	Deceleration				
UTERINE ACTIVITY	Mode				
	Frequency				
	Duration				
	Intensity				
	Resting tone				
IV	mu/min				
MATERNAL ASSESSMENT	Blood Pressure (200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40)				
	Systo ⌄				
	Diasto ^				
	Pulse X				
	FHR •				
	Respiration				
	Temperature °C				
	Vaginal exam(✓) see partogram				
	Vaginal discharge				
	Amount				
	Bladder assessment				
SUPPORTIVE CARE					
	Activity / Position				
INTERVENTIONS	Position change				
	O_2 (8-10 L/min)				
	Physician called				
	Initials				

Access Midwives

VITAL SIGNS/PROGRESS OF LABOUR RECORD

Patient

Chart no.

		Date (yyyy/mm/dd) / Time (hh:mm)			
FETAL ASSESSMENT	Mode				
	FHR				
	Rhythm / Variability				
	Acceleration				
	Deceleration				
UTERINE ACTIVITY	Mode				
	Frequency				
	Duration				
	Intensity				
	Resting tone				
IV	mu/min				
MATERNAL ASSESSMENT	Blood Pressure Systo ⌄ Diasto ⌃ Pulse X FHR • Respiration Temperature °C (200 / 180 / 160 / 140 / 120 / 100 / 80 / 60 / 40)				
	Vaginal exam(✓) see partogram				
	Vaginal discharge				
	Amount				
	Bladder assessment				
SUPPORTIVE CARE					
	Activity / Position				
INTERVENTIONS	Position change				
	O_2 (8-10 L/min)				
	Physician called				
	Initials				

Access Midwives

Patient

Chart no.

PARTOGRAM

Initiate when in active labour

DATE (yyyy/mm/dd):

Exam:

Time (hh:mn):

2nd stage hour indicator

Hours

CERVICAL DILATION (cm) •

10 9 8 7 6 5 4 3 2 1 0

STATION X

-3 -2 -1 0 +1 +2 +3

Cervical effacement (cm / %)

Position

Moulding Caput

Membranes

Amniotic fluid | Quantity / Colour

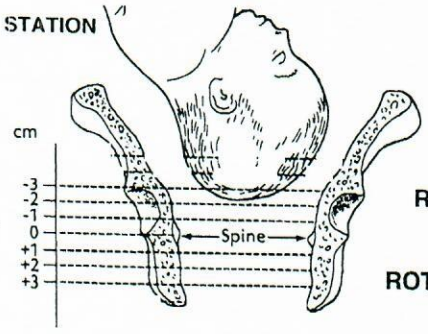
Vaginal discharge

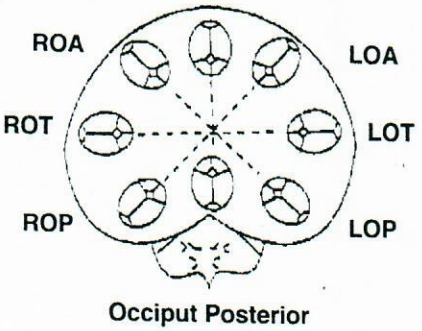
Amount

Pushing status

Examiner(s)

or INIT.





MEMBRANES:
I = Intact
SRM = Spontaneous rupture
ARM = Amniotomy

AMNIOTIC FLUID:
Ø = None **SC** = Scant **M** = Moderate
L = Large **Cl** = Clear **T** = Tinged
B = Bloody **MEC** = Meconium

VAGINAL DISCHARGE:
Cl = Clear **T** = Tinged **B** = Bloody
M = Meconium **S** = Show

AMOUNT:
Ø = None **SC** = Scant **M** = Moderate **L** = Large

PUSHING STATUS:
P = pushing **NUP** = no urge to push
NP = not pushing **IP** = involuntary pushing
UP = urge to push

Access Midwives

Patient

Chart no.

ACTIVE SECOND STAGE

SUMMARY	Date (yyyy/mm/dd)	Time (hh:mm)
Full dilatation		
Onset of pushing		

Time hh:mm	FHS (Fetal Heart Surveillance)					CONT.		Pushing Efficacy	Mat. Position	OXY mu/min	Comments	Init.
	Mode	FHR	Var. Rhythm	Acc.	Dec.	Freq.	Dur.					

	Time called hh : mn	Time arrived hh : mn

COUNT	FIRST	ADDED	FINAL	INIT.
Instruments				
Needles				
Sponges				

PUSHING EFFICACY: **E**= effective **NE**= non effective **NP**= not pushing

Access Midwives

Patient

Chart no.

ISSUE DATE (yyyy/mm/dd) **AND TIME** (hh:mm)	**INTERDISCIPLINARY PATIENT CARE NOTES**

Access Midwives

Patient

Chart no.

ISSUE DATE (yyyy/mm/dd) **AND TIME** (hh:mm)	**INTERDISCIPLINARY PATIENT CARE NOTES**

Time(hh:mm)	LAB TESTS SENT	Time (hh:mm)	LAB TESTS SENT

POST PARTUM RECOVERY ROOM RECORD

Date(yyyy/mm/dd) Time (hh:mm)	Maternal BP	HR	T	Lochia	Fundus (Location, Consistency, Height)	Bladder	Skin to skin ✓	Latch teaching initiated ✓	Infant feeding	Init.

Lochia: **R** - Rubra **L** - Large amount **M** - Moderate **C** - With clots

Fundus: **F** - Firm **B** - Boggy **M** - Massage **P** - Problem (see notes)

Bladder: **E** - Empty **D** - Distended

Infant feeding: **B** - Baby at breast **S** - Supplement

Latch: Mom instructed as follows: "Baby should have":
- Chin pressed deep into the breast
- No indrawing or dimpling of cheek
- Mouth wide open (like a yawn)
- Lower lip covering more areola than upper lip
- Mother states she is comfortable
- Lips visible and flanged outward
- No clicking or smacking sounds
- (No persistent nipple pain)

Access Midwives

BIRTH RECORD

G T P A L | EDB (yyyy/mm/dd) | Gest. | Maternal age

Primary Care Provider

TRANSFERRED FROM: ❑ N/A Reason

❑ Hospital: _____

❑ Planned Home Birth _____

EDB = Expected Date of Birth

1st trimester visit: ❑ Yes ❑ No

Antenatal care by: ❑ Family Physician ❑ Obstetrician ❑ Midwife

Prenatal classes: ❑ 20 weeks or less ❑ Over 20 weeks

Steroids: ❑ 1 dose ❑ 2 doses ❑ Less than 24 h ❑ Greater than 24 h

A MATERNAL HEALTH ISSUES

❑ NONE
❑ Smoking ❑ 20 weeks or less ❑ Over 20 weeks
❑ Substance abuse: _____
❑ Diabetes ❑ Type 1 ❑ Type 2 ❑ Insulin
❑ Chronic hypertension
❑ Asthma
❑ Social _____
❑ Other _____
_____

ANTENATAL RISK FACTORS

❑ NONE
❑ # previous cesareans: _____
❑ LGA ❑ SGA ❑ IUGR
❑ PROM ❑ PPROM
❑ Pre-eclampsia ❑ Mild ❑ Severe
❑ Gestational diabetes ❑ Insulin
❑ Gestationa hypertension
❑ Placenta abruptio ❑ Previa
❑ Preterm labour
❑ Amniotic fluid index
❑ Less than 5 cm / Less than 50 mm
❑ Greater than 25 cm / Greater than 250 mm
❑ Post dates greater than 41 weeks
❑ Multiple gestation – no. of babies: _____
❑ Fetal anomalies _____
❑ Other _____
_____

LAB RESULTS

❑ Rh:	❑ Pos	❑ Neg	❑ Unknown
❑ HBsAG:	❑ Pos	❑ Neg	❑ Unknown
❑ GBS Screening at 35-37 weeks		❑ Yes	❑ No
❑ GBS:	❑ Pos	❑ Neg	❑ Unknown
❑ HIV-VIH	❑ Pos	❑ Neg	❑ Unknown
❑ Rubella	❑ Immunized	❑ Non-immunized	❑ Equivocal

❑ Other: _____

Fetal surveillance ❑ NONE
❑ AUSC ❑ EXT ❑ INT ❑ Admission strip

Scalp pH ❑ NO ❑ YES
Last result: _____

INTRAPARTUM COMPLICATIONS

❑ NONE
❑ Suspected chorioamnionitis
❑ Meconium ❑ Thick
❑ Prolonged active phase/arrest
❑ Prolonged 2nd stage
❑ Atypical / abnormal FHR
❑ Cord proplaspe
❑ Bleeding
❑ Other: _____

MATERNAL PAIN RELIEF

❑ NON PHARMACOLOGIC SUPPORT

❑ PHARMACOLOGIC PAIN RELIEF
❑ Narcotic Last dose: _____
❑ Nitrous oxide
❑ IV PCA ❑ Local
❑ Pudendal ❑ Epidural
❑ Spinal ❑ Spinal/Epidural
❑ General
❑ Other: _____

OTHER MEDICATION
❑ NONE
❑ Antibiotics: Dose 1 at: _____
❑ Antihypertensives ❑ PO ❑ IV
❑ Magnesium Sulphate
❑ Insulin
❑ Other: _____

B LABOUR SUMMARY

Admission labour status:
❑ Latent ❑ Active ❑ N/A
❑ Admission Vag exam: _____ ❑ Cephalic
❑ Other: _____
❑ Induction ❑ In Patient ❑ Out Patient
Indication: _____
Method(s):
Cervidil ❑ 1 ❑ 2 ❑ 3 ❑ Prostin gel ❑ 1 ❑ 2 ❑ 3
❑ Misoprostol ❑ Mechanical: _____
❑ ARM ❑ Oxytocin
❑ Augmentation ❑ ARM ❑ Oxytocin

CHRONOLOGY	DATE (yyyy/mm/dd)	TIME (hh:mm)
Onset of labour		
Rupture of membranes		
Fully dilated		
Start Pushing		
Birth		
Placenta		

Patient: Chart no.:

BIRTH DATA *(BY PHYSICIAN)*

❑ **VAGINAL BIRTH**

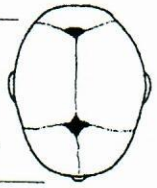
❑ Cephalic ❑ ❑ ❑ Position ❑ Breech: _____

❑ Spontaneous ❑ Operative
Indication: _____

❑ **Vacuum**
❑ Outlet ❑ Low ❑ Mild
Time applied (hh:mm) _____ removed (hh:mm)_____
contractions with traction applied: _____

❑ **Forceps**
❑ Outlet ❑ Low ❑ Mild
Time applied (hh:mm)_____ removed (hh:mm) _____
❑ Rotation: From: _____ To: _____
contractions with traction applied: _____

Cup Placement



❑ **Shoulder dystocia** (document manoeuvres)
Time head delivered: (hh:mm)_____

EPISIOTOMY: ❑ NONE ❑ Medial ❑ Medio-lateral

LACERATIONS: ❑ 1st ❑ 2nd ❑ 3rd ❑ 4th
❑ Vag. ❑ Cerv. ❑ Vulv.

Sutured by: _____

❑ **CESAREAN BIRTH**

❑ Elective ❑ Emergency ❑ Code

INDICATION(S):
❑ Previous C/S
❑ Cord prolapse
❑ Dystocia _____
❑ Non-reassuring FHR
❑ Malpresentation
❑ Failed vacuum/Forceps
❑ Maternal request
❑ Other: _____

Dilatation at C/S _____ cm

Uterine Incision: ❑ Transverse ❑ Vertical
❑ Inverted T ❑ Other: _____

CORD ❑ Nuchal X _____ # vessels: _____

PLACENTA ❑ Spontaneous ❑ Manual ❑ Expressed
❑ Normal ❑ Sent to pathology Indication _____
❑ Requested by family

BLOOD LOSS
❑ 500 mL or less ❑ Greater than 500 mL ❑ PPH Estimated volume: _____
❑ Oxytocin ❑ Carbetocin
❑ Ergot ❑ Hemabate ❑ Misoprostol
❑ Manual exploration
❑ Other: _____

INFANT ID M _____

ID BAND NO.

❑ Male ❑ Female ❑ Ambiguous
Weight: _____ g
BIRTH ORDER ❑ 1 ❑ 2 ❑ 3 ❑ ___

APGAR	1 min	5 min	10 min
Heart Rate			
Respiration			
Muscle tone			
Reflex irritability			
Skin colour			
TOTALS			

NEWBORN RESUSCITATION
❑ NONE ❑ O_2 ❑ Bag & mask
❑ Intubation: _____ ❑ Ventilation
❑ External cardiac compression
❑ Medications
_____ min. to sustained respirations

CORD BLOOD GASES:
❑ NONE
Arterial: pH _____ BE _____
Venous: pH _____ BE _____

TRANSFER TO ❑ Postpartum ❑ L2N
❑ NICU
❑ Hospital: _____

Baby care provider

Comments

PRESENT

(✔ = Delivered By)	PRINTED NAME	SIGNATURE & DESIGNATION
❑ Obstetrician		
❑ Family physician		
❑ Midwife*		
❑ Resident		
❑ Other		
❑ RN 1 / Midwife		
❑ RN 2 / Midwife		
❑ Paediatrician / APN		
❑ RT		

* ❑ Hospital * ❑ Home Midwifery Group:

Access Midwives **Immediate Newborn Care and Summary**

Baby's Name: _____ Mother's Name: _____

Date and Time of Birth: _____ Sex: _____ EGA: _____

Apgar Scores		1 min	5 min	10 min
Heart Rate	Absent 0 <100 1 >100 2			
Respiratory Effort	Absent 0 Weak Cry 1 Strong Cry 2			
Reflex Stimuli	No response 0 Grimace 1 Cough/Sneeze 2			
Muscle Tone	Limp 0 Some Flexion 1 Well Flexed 2			
Colour	Pale Blue 0 Pink/Ext Blue 1 All Pink 2			
Total				
Initials				

Newborn Physical Exam:

Date/Time: _____

HC: _____ Length: _____

Weight: _____lbs_____oz / _____ g

Erythromycin R & L: ☐ Yes ☐ No

Vitamin K 1mg IM: ☐ Yes ☐ No

Other Medication: _____

Passed Meconium: ☐ Yes ☐ No

Voided: ☐ Yes ☐ No

	Normal	Abnormal	Additional Notes
Appearance			
Reflexes			
Tone			
Skin			
Head and Neck			
Eyes / Red Reflex			
Mouth and Palate			
Ears			
Clavicle			
Heart Sounds			
Pulses			
Lungs			
Abdomen			
Umbilicus			
Genitourinary			
Anus			
Hips			
Spine			

Immediate Newborn Care and Summary

Baby's Name: _____ Mother's Name: _____

Date and Time of Birth: _____ Sex: _____ EGA: _____

Date & Time	Heart Rate	Resp. Rate	Temp.	Assessments colour / breastfeeding initiated:	Initials

Neonatal Resuscitation Record

Practice _____ Mother's Name _____

Date _____ Baby's Name _____

GENERAL INFORMATION	
Sex of Baby	☐ Male ☐ Female
Time of Birth	
Baby's Weight	

MATERNAL HISTORY	
Maternal Blood Group	Amniotic Fluid
GBS ☐ Positive ☐ Negative ☐ Unknown	☐ Clear
HB_sAg ☐ Yes ☐ No	☐ Non-Particulate Meconium
Other	☐ Particulate Meconium
	Date/Time ROM

AMBULANCE & HOSPITAL INFORMATION		
Time Ambulance Called	Time Ambulance Arrived	Time Ambulance Departed
Time Hospital Called	Name of Hospital	
Time Arrived at Hospital	Level ☐ 1 ☐ 2 ☐ 3	Paramedics Name/Level

PROCEDURES	Yes	No	By Whom?	Start	Stop	Total Time (mins)
Suction at Perineum						
Suction Oral/Nasal						
Free Flow Oxygen						
CPAP						
PPV						
Cardiac Compressions						
O / G Tube						
Intubation						
Other_____						

Cord Blood Gases	Venous____	Arterial____	pH____	PCO2_____	PO2_____	Bicarb_____	BE_____	SaO2_____

APGAR SCORES		1 Minute	5 Minutes	10 Minutes	15 Minutes	20 Minutes	25 Minutes
Heart Rate	Absent 0 <100 1 >100 2						
Respiratory Effort	Absent 0 Weak Cry 1 Strong Cry 2						
Reflex Stimuli	No Response 0 Grimace 1 Cough/Sneeze 2						
Muscle Tone	Limp 0 Some Flexion 1 Well Flexed 2						
Colour	Pale Blue 0 Body Pink/Ext.Blue 1 All Pink 2						
Total							
Initials							

See reverse for further information.

Neonatal Resuscitation Record (Page 2)

Practice ______________________________

Mother's Name ______________________

Baby's Name ______________________

Date/Time	Narrative Notes	Initials

Baby's name: _____ Mother: _____
DOB: _____ Client #: _____
Health card #: _____ Version code: ____
MPG #: _____

Neonatal Resuscitation (A)

Time of birth: _____ h

HISTORY

GA _____ Amniotic fluid at birth: ☐ Clear ☐ Meconium-stained

Labour history: _____

RESUSCITATION

Time												
Stimulation												
Suction												
Free flow O_2												
CPAP												
PPV with air												
PPV with O_2												
Chest compressions												
O_2 sat %												
Heart rate												
Respiratory rate												
Colour												
Muscle tone												
Reflex stimuli												
Indrawing/nasal flaring/grunting												
Initials												

Orogastric: 8F feeding tube Depth _____ @ _____h by: _____

LMA: Size _____@ _____h by: _____

ETT: Size _____ tip to lip _____ @ _____h by: _____

AMBULANCE AND HOSPITAL INFORMATION

	Time	Name of hospital:
Called ambulance		
Ambulance arrived		Paramedic's name:
Ambulance departed		
Called hospital		Paramedic's name:

Midwives performing resuscitation: _____

Documentation by: _____

Baby's name: _____ Mother: _____
DOB: _____ Client #: _____
Health card #: _____ Version code: ____
MPG #: _____

Neonatal Resuscitation (B)

RESUSCITATION												
Time												
Stimulation												
Suction												
Free flow O_2												
CPAP												
PPV with air												
PPV with O_2												
Chest compressions												
O_2 sat %												
Heart rate												
Respiratory rate												
Colour												
Muscle tone												
Reflex stimuli												
Indrawing/nasal flaring/grunting												
Initials												

APGAR		1 Min	5 Min	10 Min	15 Min	20 Min	25 Min	30 Min
Heart rate	Absent 0 <100 1 >100 2							
Respiratory effort	Absent 0 Weak cry 1 Strong cry 2							
Reflex stimuli	No response 0 Grimace 1 Active withdrawal 2							
Muscle tone	Limp 0 Some flexion 1 Well flexed 2							
Colour	Pale/blue 0 Acrocyanosis 1 All pink 2							
	Total							
	Initials							

HRLMP TRANSFUSION MEDICINE

SITE: Mumc **FAX#:** 905 521 2364

REQUEST FOR FRACTIONATED BLOOD PRODUCTS TO BE ADMINISTERED OUTSIDE HOSPITAL (INCLUDE EMPLOYEE HEALTH).

PATIENT INFORMATION

NAME:_____
ADDRESS:_____
_____
D.O.B.:_____
HIN:_____

ORDER INFORMATION

PRODUCT REQUIRED*:_____
IF Rh IMMUNE GLOBULIN REQUIRED A CURRENT COPY OF PRENATAL RESULTS (GROUP & SCREEN ONLY) NEEDED

DOSE REQUIRED:_____
INDICATIONS:_____
ORDERING PHYSICIAN:_____
DATE TO BE GIVEN*:_____
MUST BE GIVEN SAME DAY PRODUCT PICKED UP

LOCATION TO BE GIVEN:_____

PICKED UP BY*:_____
PERSON PICKING UP PRODUCT MUST HAVE HEALTH CARD I.D.

SIGNATURE:_____

TECHNOLOGIST:_____ DATE:_____

please fax to # above

PATIENT TRANSFER AUTHORIZATION FORM – NON-OUTBREAK

This form must be **COMPLETELY** filled out before authorization can be provided.

Please Fax this Document to 416-397-9061 **Enquiries call 416-638-7301**

REQUESTED TRANSFER DATE: _____ (Please note: Authorization #s are only valid for 24 hours)

☐ **Emergency Transfer** ☐ Non Emergency Transfer

☐ Patient requires transportation and medical supervision by a **paramedic**

☐ Patient requires transportation only, please indicate transportation provider _____

SENDING HEALTHCARE FACILITY

Patient Surname: _____ First Name: _____

Sending Healthcare Facility: _____ Unit/Room: _____

Healthcare Facility Unit Telephone (area code mandatory): ( ) _____-_____ ext: _____

Healthcare Facility Unit Fax number (area code mandatory): ( ) _____-_____

Patient sex: M ☐ F ☐ **Age or DOB is Mandatory Age _____ or DOB_____/___/___**

(YYYY/MM/DD)

Nurse/Clerk – filling out this form must provide: **Name (print)** _____

Signature _____ Sending Physician Name: _____

REASON FOR TRANSFER AND CURRENT DIAGNOSIS

_____

_____

_____

1) Is the patient admitted or being transferred for admission? Yes ☐ No ☐

2) Does the patient work for a health care agency/organization? Yes ☐ No ☐

3) Is the patient a resident of a long-term care facility? Yes ☐ No ☐

4) Does the patient have new/worse cough or SOB? Yes ☐ No ☐

5) Is the patient feeling feverish or had shakes or chills within the last 24 hours? Yes ☐ No ☐ **Temp** _____ ° C

6) Has the patient lived/visited: China, Hong Kong, Japan, South Korea, Thailand, Taiwan, or Vietnam in the last 30 days? Yes ☐ No ☐

7) Has the patient come in contact with a sick person in the last 30 days who has traveled to these same areas? Yes ☐ No ☐

Receiving Health Care Facility: _____ Unit/Room: _____

Healthcare Facility Unit Telephone (area code mandatory): (_____) _____-_____, ext: _____

Receiving Physician: _____

Initiate droplet precautions if "yes" to questions 4 and 5 these patients may potentially have Febrile Respiratory Illness (FRI).

Contact your Infection Control for patients with FRI (i.e. yes to questions 4 and 5) and answered yes to either question 2 or 3.

Initiate droplet precautions and contact your Infection Control for patients with FRI (i.e. yes to questions 4 and 5) and answered yes to either question 6 or 7. These patients may potentially have severe respiratory illness (SRI).

April 14, 2004

Emergency Information

Name_____ Phone_____ Address_____ _____ Date Due _____ Blood Type_____	Midwife #1_____ Midwife #2_____ Pager:_____
Taxi:_____	Ambulance:_____
Closest Hospital:_____ Phone # L&D_____	Backup Hospital:_____ Phone # L&D_____
Map to Hospital:	Map to Hospital:
Sibling arrangements Name of Sitter:_____ Phone Number:_____	Any other person to be contacted in case of emergency:_____ _____ _____

Ontario

Office of the
Registrar General

189 Red River Road
PO Box 4600
Thunder Bay ON P7B 6L8

Notice of Live Birth or Stillbirth

Form 1

* This form is to be sent within 2 business days. (The *Vital Statistics Act,* Sec. 8)
* This is a permanent legal record.
* Type or print plainly in blue or black ink and complete all items.

Health Card Number

Mother's Information

1. Current Legal Surname (Last Name) | First and Middle Names

2. Legal Surname at Birth (maiden name) *(optional)* | 3. Age | 4. Date of Birth — Year / Month (by name) / Day | 5. Number of Previous Births — Live Births / Stillbirths

6. Permanent Address
Number, Street name | City, Town or Village | County/District

Province | Postal Code | Telephone

Child's Information

7. Place of Birth
☐ Home ☐ Hospital ☐ Other, *specify:* _____
Full Name of Hospital
(if not hospital give exact location where birth occurred)

8. Date of Birth — Year / Month (by name) / Day | 9. Sex of Child | 10. Birthweight *(grams)* | 11. Gestation Period *(in complete weeks)*

12. Was Child Born Alive
☐ Yes ☐ No

13. Kind of Birth
☐ Single ☐ Twin ☐ Triplet ☐ Other

14. Order of Birth
(if multiple birth, state whether this child was born 1st, 2nd, 3rd, etc.)

Certification *(Name of attendant and signature of attendant at this birth must be the same)*

15. I certify that I was the attending
☐ Physician ☐ Midwife ☐ Other, *specify:* _____

16. Attendant Registration / Licence Number

17. Name of Attending Physician, Midwife or Other *(please print)*
Surname (Last Name) | First and Middle Names

18. Mailing Address
Number, Street name | City, Town or Village | County/District

Province | Postal Code | Telephone

19. Signature of Attendant | Date Signed — Year / Month (by name) / Day

