

Name \_\_\_\_\_

Admitted to Hospital - Date \_\_\_\_\_ 20 \_\_\_\_ Time \_\_\_\_\_ A.M.  
P.M.Admitted to Delivery Room - Date \_\_\_\_\_ 20 \_\_\_\_ Time \_\_\_\_\_ A.M.  
P.M.Para \_\_\_\_\_ Age \_\_\_\_\_ Position and  
Presentation \_\_\_\_\_Membranes Ruptured: { Date \_\_\_\_\_ 20 \_\_\_\_ \_\_\_\_\_ A.M. \_\_\_\_\_ P.M.  
Artificial \_\_\_\_\_ Spontaneous \_\_\_\_\_Date of Birth \_\_\_\_\_ 20 \_\_\_\_ \_\_\_\_\_ A.M.  
P.M. Sex \_\_\_\_\_

Kind of Delivery \_\_\_\_\_

Birth of Placenta \_\_\_\_\_ A.M.  
P.M. Hemorrhage \_\_\_\_\_

Perineum \_\_\_\_\_ Sutures \_\_\_\_\_

Operations, Medicines, etc. \_\_\_\_\_

O.B. Pituitrin \_\_\_\_\_ Gestation \_\_\_\_\_

Oxytocic \_\_\_\_\_ Sedation \_\_\_\_\_

BABY - Weight \_\_\_\_\_ Temp. \_\_\_\_\_ Eyes \_\_\_\_\_ ( Ident. Number \_\_\_\_\_ )

Hosp. No. - Mother \_\_\_\_\_ Baby \_\_\_\_\_

Delv'd by Dr. \_\_\_\_\_ Intern \_\_\_\_\_

Anesthetist \_\_\_\_\_ Nurse \_\_\_\_\_

MOTHER - Temp. \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_  
(One Hour after Delivery)

## **FORM H-204**

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