Induction of Labor Checklist (May be completed prior to admission)

Yes	No	
❑	❑	1. Indication for induction noted (see below)
❑	❑	2. For elective induction, confirmation of term gestation is documented (see below)
❑	❑	3. Absence of contraindications (see below)
❑	❑	4. Risks, benefits and alternatives have been discussed by physician and patient agrees
❑	❑	5. Cervical assessment performed
❑	❑	6. Pelvis is clinically adequate
❑	❑	7. Estimated Fetal Weight $\leq$5000 gm in non-diabetic or $\leq$4500gm in diabetic mother (within past week)
❑	❑	8. Fetal presentation is known
❑	❑	9. Group B Streptococcus status known
❑	❑	10. Maternal HIV status known
❑	❑	11. If fetus is viable, documentation of fetal well being is established

If ALL the above answers are **YES**, complete the remainder of the document. Otherwise, physician to clarify.

Contraindications to Labor Induction (May be completed prior to admission)

Yes	No		Yes	No	
❑	❑	Previous non-low transverse uterine surgery	❑	❑	Umbilical cord prolapsed
❑	❑	More than 2 previous Cesarean sections	❑	❑	Complete placenta previa present
❑	❑	Active or prodromal symptoms of herpes	❑	❑	Vasa previa present

If ALL the answers to the contraindications to labor induction are **NO**, complete the remainder of the document.

Indication for Induction (May be completed prior to admission)

Yes	No		Yes	No	
❑	❑	Placental abruption	❑	❑	Chorioamnionitis
❑	❑	Fetal demise	❑	❑	Gestational hypertension
❑	❑	Premature rupture of membranes	❑	❑	Preelampsia, eclampsia
❑	❑	Postterm pregnancy			
❑	❑	Maternal/fetal compromise; specify: ______________________			

If "YES" is not documented under indication, document confirmation of term gestation for elective induction below.

Yes	No	
❑	❑	Fetal heart tones have been documented for 30 weeks by Doppler.
❑	❑	It has been 36 weeks since a positive serum or urine human chorionic gonadotropin pregnancy test was performed by a reliable laboratory.
❑	❑	An ultrasound prior to 20 weeks confirms gestation of at least 39 completed weeks.

If no indication is marked in this section, physician (resident or attending) to clarify. Proceed with induction when checklist is completed.
Document deviation from the checklist due to unexpected circumstances such as fetal intolerance to labor, tachysystole, etc., in the medical record.

______________________ ____________ ____________
Physician Signature Date Time

Fetal Assessment (minimum 30 minute tracing prior to initiation)

- ❑ Two 15 beat times 15 second accelerations (or as appropriate for gestational age) in previous 30 minutes, or BPP of 6/10 present in previous 4 hours, or adequate variability in previous 30 minutes.
- ❑ No late decelerations.
- ❑ No more than 2 variable decelerations exceeding 60 seconds, and decreasing for greater than 60 beats per minute from baseline, in the previous 30 minutes.

If not met, the provider will review Fetal Heart Rate (FHR) tracing and provide appropriate documentation.

______________________ ____________ ____________
Physician or RN Signature Date Time

WESLEY Medical Center
Induction of Labor Checklist

OBA

MR1815 (R01.14)

Patient Identification