

Induction of Labor Checklist

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Indication for Induction listed below |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Pelvis is clinically adequate |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Estimated Fetal Weight \leq 5000 gm in non-diabetic or \leq 4500gm in diabetic mother (within past week) |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Gestational age documented |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Physician with cesarean privileges is aware of the induction and readily available |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Status of cervix is assessed and documented |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Fetal presentation is known (and addressed in documentation if non-cephalic) |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Maternal HIV and Group B Streptococcus status known |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Risks, benefits and alternatives have been discussed by physician and patient consents |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Absence of contraindications (see below) |

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

Contraindications to Labor Induction

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Previous non-low transverse uterine surgery | <input type="checkbox"/> | <input type="checkbox"/> | Umbilical cord prolapsed |
| <input type="checkbox"/> | <input type="checkbox"/> | More than 2 previous Cesarean sections | <input type="checkbox"/> | <input type="checkbox"/> | Complete placenta previa present |
| <input type="checkbox"/> | <input type="checkbox"/> | Active or prodromal symptoms of herpes | <input type="checkbox"/> | <input type="checkbox"/> | Vasa previa present |

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

Indication for Induction

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Placental abruption | <input type="checkbox"/> | <input type="checkbox"/> | Chorioamnionitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Fetal demise | <input type="checkbox"/> | <input type="checkbox"/> | Gestational hypertension |
| <input type="checkbox"/> | <input type="checkbox"/> | Premature rupture of membranes | <input type="checkbox"/> | <input type="checkbox"/> | Pre-eclampsia, eclampsia |
| <input type="checkbox"/> | <input type="checkbox"/> | Postterm pregnancy | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Maternal/fetal compromise; specify: _____ | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | For inductions not medically indicated, confirmation of gestation of at least 39 weeks is documented. | | | |

If no box is marked **YES** 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.

All portions of this document may be completed by the physician prior to admission

Physician Signature

Date

Time

