PRESCRIBER'S ORDERS FOR: Antepartum - Admission

DATE _____/_____/_______       TIME _________

DD      MM       YYYY

WEIGHT:_________ KG   HEIGHT______________CM

☐ ALLERGY CAUTION sheet reviewed

Diet / Intake

☐ Diet as tolerated
☐ Other (specify)_________________________________________

Activity

› Choose ONE of the following options:
  ☐ Activity as tolerated
  ☐ Significantly reduced activity (resting for most of the day, may get up to the bathroom and for meals) Source
  ☐ Review for the need for VTE prophylaxis after 7 days of significantly reduced activity

Evidence Links

› Bedrest in singleton pregnancies for preventing preterm birth (Review). The Cochrane Collaboration 2010 Althabe et al. Source
› Hospitalization and bed rest for multiple pregnancy (Review). The Cochrane Collaboration 2010 Crowther et al. Source
› Overview and assessment of risk factors for pulmonary embolism. Expert Reviews 2013 Hoo, G.W.S. Source
› Lack of evidence for prescription of antepartum bed rest 2011 Maloni, Judith Source

Vital Signs

› Choose ONE of the following options:
  ☐ Vital signs (temperature, respiratory rate, pulse and blood pressure) per guidelines for diagnosis
  ☐ Vital signs (temperature, respiratory rate, pulse and blood pressure) ____________________________

Laboratory

☐ Complete blood cell count with automated white blood cell differential
☐ Group and Screen
☐ Urinalysis ☐ Urine Culture
☐ Urine dipstick, point-of-care measurement - for protein / glucose weekly

☐ Vaginal Swab for Gram stain and Culture and Sensitivity
☐ Cervical Swab for Chlamydia and Gonorrhea
☐ Vaginal / Rectal swab for Group B Strep (GBS) ______________________________________________
☐ Other ______________________________________________________________________________

Fetal Surveillance Antepartum Nonstress Testing Frequency Ultrasound Surveillance Source

☐ Fetal movement counting daily       ☐ Fetal heart tone auscultation each shift
☐ Nonstress test per guidelines for frequency
☐ Ultrasound - AFI Doppler (specify frequency)____________________________
☐ Ultrasound - Obstetrical

Other Investigations

☐ Other ______________________________________________________________________________

Signature:_______________________________________  Print Name:____________________________________

College ID:______________________________________   Pager:________________________________________

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☐ ALLERGY CAUTION sheet reviewed

### IV Solutions
- Choose ONE of the following options:
  - Sodium Chloride 0.9% (NS) IV infuse at __________ mL/hour
  - Dextrose 5% in Water (D5W) IV infuse at __________ mL/hour
  - Dextrose 5% and Sodium Chloride 0.9% (D5NS) IV infuse at __________ mL/hour
  - Infuse____________________________at__________mL/hour
  - Saline lock

### Medications
**Self Administered Medications: After RN Assessment:**

- acetaminophen
  - ☐ 325 to 650 mg PO Q4H to Q6H PRN for pain (Max dose: 4 gram/24 h)

- ferrous gluconate
  - ☐ 300 mg PO daily (for anemia, if hemoglobin less than 110 grams/L)
  - ☐ 300 mg PO __________ times a day
  - ☐ Other iron supplement

- calcium carbonate 500 mg (eg. TUMS)
  - ☐ 1000 mg chewed daily (mineral supplement)

- multivitamin, prenatal (eg. Materna)
  - ☐ 1 tablet PO daily (nutritional supplement)
  - ☐ May use patient's own supply of prenatal vitamin 1 tablet PO daily

- Refer to constipation flow chart
  - ☐ Bowel regimen

### Consults
- ☐ Consult: _________________________________
- ☐ Consult: _________________________________

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Signature:_______________________________________  Print Name:_______________________________________
College ID:______________________________________   Pager:________________________________________
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