RPICC Obstetrical Satellite Recording Tool

EL__ IE__ UF__ HM__

_____ _____ _____
Social Security Number | Patient's Name | Medicaid Number

_____ _____ _____ ___/___/___
Patient's Birth Date | Patient's Phone# | Referring Physician/Clinic | EDD

Reasons for Referral

__Abortion, recurrent spontaneous
__Abnormal Triple Screen
__Abruptio Placenta, Chronic
__Abnormal Presentation
__ Advanced Maternal Age
__Anemia
__Antiphospholipid Syndrome
__Cardiovascular Disease
__Collagen Vascular Disease
__Diabetes (pre-gestational)
__Epilepsy/Seizure Disorders
__Gastrointestinal Disease
__Genetic Problem suspected
__Gestational Diabetes

__Hematologic Problems
__Hemoglobinopathie
__HIV Disease/AIDS
__Hyperemesis/Ketonuria
__Hypertension (140+/90+)
__Headaches
__ Incompetent Cervix
__ Infectious Disease
__ Intrauterine Fetal Demise
__Intrauterine Growth Retard
__Leoimyoma
__Liver Disease
__Malignancy-diag/susp
__Multiple Gestation

__Neurological Disease, chronic
__Oligiohydramnios
__Ovarian Mass
__Past History of Anomaly
__Placenta Previa
__Placental condition, other
__Polyhydramnios
__Possible Cong.Fetal Anomaly
__Post Term (42+weeks)
__Preeclampsia
__Pregnancy Induced Hypertension
__Premature Rupture of Membranes
__Preterm Labor Symptoms
__Previous Low Birth Weigh/Premie
__Previous Perinatal Death

__Prior Cesarean Section
__Psychological Disorders
__Psychiatric Problem
__Pulmonary dysfunc.asthma
__Renal Disease
__Rh Sensitized/Ir. Antibodies
__Sexually Transmitted Disease
__Substance Abuse
__Thyroid Disease
__Thromboembolic Disease
__Urinary Tract Infection
__Uterine Malformation
__Vaginal Bleeding
__Viral Infection, not STD

Other_____

OB Satellite Visits/Services

#1 Date of Visit_____/_____/_____
Clinic Physician:_____
Tests/Services performed
At this Clinic Visit:
___Targeted Ultrasound
___NST
___Doppler
___Transvaginal
___Amniocentesis
___Fetal Echocardiogram
___Genetic Counseling
___Preconception Counseling
___Biophysical profile (BPP)
___Other

#2 Date of Visit_____/_____/_____
Clinic Physician:_____
Tests/Services performed
At this Clinic Visit:
___Targeted Ultrasound
___NST
___Doppler
___Transvaginal
___Amniocentesis
___Fetal Echocardiogram
___Genetic Counseling
___Preconception Counseling
___Biophysical profile (BPP)
___Other

#3 Date of Visit_____/_____/_____
Clinic Physician:_____
Tests/Services performed
At this Clinic Visit:
___Targeted Ultrasound
___NST
___Doppler
___Transvaginal
___Amniocentesis
___Fetal Echocardiogram
___Genetic Counseling
___Preconception Counseling
___Biophysical profile (BPP)
___Other

#4 Date of Visit_____/_____/_____
Clinic Physician:_____
Tests/Services performed
At this Clinic Visit:
___Targeted Ultrasound
___NST
___Doppler
___Transvaginal
___Amniocentesis
___Fetal Echocardiogram
___Genetic Counseling
___Preconception Counseling
___Biophysical profile (BPP)
___Other

#5 Date of Visit_____/_____/_____
Clinic Physician_____
Tests/Services performed
At this Clinic Visit:
___Targeted Ultrasound
___NST
___Doppler
___Transvaginal
___Amniocentesis
___Fetal Echocardiogram
___Genetic counseling
___Preconception counseling
___Biophysical profile (BPP)
___Other

#6 Date of Visit_____/_____/_____
Clinic Physician:_____
Tests/Services performed
At this clinic Visit:
___Targeted Ultrasound
___NST
___Doppler
___Transvaginal
___Amniocentesis
___Fetal Echocardiogram
___Genetic counseling
___Preconception counseling
___Biophysical profile (BPP)
___Other

Total # of OB Satellite Visits_____

Infant Outcome

_____/_____/_____
Date of Delivery

Multiples
___twins
___triplets
___quads

Disposition

_____RPICC Level III
_____Non-RPICC Level III
_____Level II
_____Newborn

_____Expired Before Delivery
_____Expired After Delivery
_____Expired/Time Unknown
_____Spontaneous Abortion

Name of Hospital of Birth _____

For multiples disposition, write numbers in the blanks to indicate the disposition of each infant. For a twin example: Infant #1 went to Newborn nursery. Place #1 on line next to Newborn, infant #2 expired after delivery, write #2 on the line next to Expired After Delivery.