Queensland Government

Birthing Record

Facility: .....

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

- Every person documenting in this Birthing Record **must** provide their name, signature and initials in the signature log below.
- The *Assisted Vaginal Birth Clinical Pathway (SW800)* is to be used for the documentation of assisted vaginal birth and kept with the Birthing Record.

Signature Log

Print name	Designation	Signature	Initials

Birthing Assessment

Reason for presentation (or reason for induction of labour):

Arrival
Date: ... / ... / ...
Time: ... : ...

Assessment **Date:** ... / ... / ... **Time:** ... : ...	Model of care:		Allergies:		
	Gravida:	Para:	EDD: ☐ Dates ☐ Scan ... / ... / ...	Gestation: weeks	Placental location:
Support person(s)					
Birth preferences	**Discussed:** ☐ **Yes** ☐ **No**				
	Preferences:				

DO NOT WRITE IN THIS BINDING MARGIN

BIRTHING RECORD

v1.00 - 05/2024
WINC Code: 1NY43816
SW1200

Queensland Government

Birthing Record

Birthing Assessment

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Birthing Assessment *(continued)*

Bloods / alerts	Date: ... / ... / ... Hb: ... Platelets: ... Blood group: ... Antibodies: ... **Serology** Hep B: ☐ Yes (◯ +ve ◯ –ve) ☐ No Hep C: ☐ Yes (◯ +ve ◯ –ve) ☐ No HIV: ☐ Yes (◯ +ve ◯ –ve) ☐ No Syphilis: ☐ Yes (◯ +ve ◯ –ve) ☐ No Rubella status: ☐ Immune ☐ Not immune Alerts: ...
Skin-to-skin contact	Importance discussed: ☐ Yes ☐ No
Aboriginal and / or Torres Strait Islander identification	Are you of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Prefer not to say
Country of birth	☐ Australia ☐ Other: ...
Confirmed consent	Vitamin K: ☐ IMI ☐ Oral ☐ No Hep B: ☐ Yes ☐ No Oxytocic in 3rd stage: ☐ Yes ☐ No ☐ Other: ...
Obstetric history	
Antenatal corticosteroids	☐ Yes ☐ No ☐ N/A 1. Date: ... / ... / ... Time: ... : ... 2. Date: ... / ... / ... Time: ... : ... 3. Date: ... / ... / ... Time: ... : ...
Current medications	
Antenatal ACM* category on admission	☐ A ☐ B ☐ C **Australian College of Midwives*

Observations on Arrival

CTG indicated: ☐ Yes ☐ No Reason: ...		**Abdominal palpation** Fundus: ... Lie: ...		
Presentation / Attitude:	Position:	Engagement: / 5	FHR:	Fetal movements:
Urinalysis: ... MSU sent? ☐ Yes ☐ No				

Current Presentation (DOCUMENT: status on arrival, advice given, procedures / investigations undertaken)

Include the reason for presentation (signs and symptoms); acute musculoskeletal / orthopaedic symptoms; and a final assessment of maternal and fetal conditions. Record date, time, printed name, signature and staff category with all entries.

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Queensland Government

Birthing Record

Birthing Assessment

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Risk Factors / Management Plan

Risk Factors	Management Plan	Initials
GBS positive: ☐ Yes ☐ No ☐ Unknown		
Weight: ..... kg Current BMI:		
PPH risk: ☐ Yes ☐ No If *yes*, risk factors identified:		
OASI risk: ☐ Yes ☐ No If *yes*, type:		
Antenatal VTE score: ..... Risk identified: ☐ Yes ☐ No		
Diabetes: ☐ Yes ☐ No If *yes*, type:		
Abnormal ultrasound finding: Date: ... / ... / ... ☐ Yes *(see report)*: ..... ☐ No		
Falls risk: ☐ Nil risk factors identified on admission ☐ History of falls during pregnancy ☐ Medications (e.g. sedation) ☐ Environment (e.g. bath, shower, birth ball) ☐ Impaired mobility ☐ Hypotension, blood loss		
Pressure injury risk: ☐ Nil risk factors identified on admission ☐ Skin inspection completed ☐ Impaired mobility		
Psychosocial risk: ☐ Limited antenatal care ☐ Currently on mental health medication ☐ Active polysubstance use ☐ Child Protection involvement ☐ History of mental health conditions ☐ Birthing from another jurisdiction	*If any of the psychosocial risk factors are identified consider referral to a Social Worker, Perinatal Mental Health Clinician, Psychologist, Psychiatrist or Aboriginal and Torres Strait Islander Liaison Officer or seek Team Leader for further support or guidance.*	
Safety concern (flag for risk factors, i.e. DV)		
Other risks:		

☐ **Plan discussed with woman / pregnant person**

Discharge / transfer	☐ Birth Suite ☐ Ward ☐ Home ☐ Other: ..... Discharge / transfer time: ... : ...
Medical consultation / referral	☐ Required → Referred to: ..... Date: ... / ... / ... Time: ... : ... ☐ Not required

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Queensland Government

Birthing Record

Birthing Assessment

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Assessment 1

Confirmed consent for assessment 1

Verbal consent for vaginal examination obtained:

☐ Yes ☐ Declined

Examiner (name):	Designation:
Signature:	Chaperone (if present):

If there is a change in examiner, proceed to the next Assessment box.

Date: ..... / ..... / ..... Time: ..... : .....

Fundus:

Lie:

Presentation:

Attitude:

Position:

Engagement:

Pre-IOL CTG: Reviewed by (name): .....

☐ Yes Reviewed by (name): .....

Post-IOL CTG: Reviewed by (name): .....

☐ Yes Reviewed by (name): .....

Bishop score	0	1	2	3
Dilatation (cm)	☐ <1	☐ 1–2	☐ 3–4	☐ >4
Length (cm)	☐ ≥3	☐ 2	☐ 1	☐ <1
Station	☐ -3	☐ -2	☐ -1, 0	☐ +1, +2
Consistency	☐ Firm	☐ Medium	☐ Soft	
Position	☐ Posterior	☐ Mid	☐ Anterior	
Total				

Treatment:

Plan:

Comments:

Assessment 2

Confirmed consent for assessment 2

Verbal consent for vaginal examination obtained:

☐ Yes ☐ Declined

Examiner (name):	Designation:
Signature:	Chaperone (if present):

If there is a change in examiner, proceed to the next Assessment box.

Date: ..... / ..... / ..... Time: ..... : .....

Fundus:

Lie:

Presentation:

Attitude:

Position:

Engagement:

Pre-IOL CTG: Reviewed by (name): .....

☐ Yes Reviewed by (name): .....

Post-IOL CTG: Reviewed by (name): .....

☐ Yes Reviewed by (name): .....

Bishop score	0	1	2	3
Dilatation (cm)	☐ <1	☐ 1–2	☐ 3–4	☐ >4
Length (cm)	☐ ≥3	☐ 2	☐ 1	☐ <1
Station	☐ -3	☐ -2	☐ -1, 0	☐ +1, +2
Consistency	☐ Firm	☐ Medium	☐ Soft	
Position	☐ Posterior	☐ Mid	☐ Anterior	
Total				

Treatment:

Plan:

Comments:

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Birthing Record

Birthing Assessment

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

DO NOT WRITE IN THIS BINDING MARGIN

Assessment 3

Confirmed consent for assessment 3

Verbal consent for vaginal examination obtained:

☐ Yes ☐ Declined

Examiner (name):	Designation:
Signature:	Chaperone (if present):

If there is a change in examiner, proceed to the next Assessment box.

Date: ..... / ..... / ..... Time: ..... : .....

Fundus:

Lie:

Presentation:

Attitude:

Position:

Engagement:

Pre-IOL CTG: Reviewed by (name): .....

☐ Yes Reviewed by (name): .....

Post-IOL CTG: Reviewed by (name): .....

☐ Yes Reviewed by (name): .....

Bishop score	0	1	2	3
Dilatation (cm)	☐ <1	☐ 1–2	☐ 3–4	☐ >4
Length (cm)	☐ ≥3	☐ 2	☐ 1	☐ <1
Station	☐ -3	☐ -2	☐ -1, 0	☐ +1, +2
Consistency	☐ Firm	☐ Medium	☐ Soft	
Position	☐ Posterior	☐ Mid	☐ Anterior	
Total				

Treatment:

Plan:

Comments:

Assessment 4

Confirmed consent for assessment 4

Verbal consent for vaginal examination obtained:

☐ Yes ☐ Declined

Examiner (name):	Designation:
Signature:	Chaperone (if present):

If additional examinations are required, use the *Birthing Record: Birthing Assessment (Additional Page) (SW1200a).* Tick the relevant box each time a new *Additional Page* is used: ☐ **1** ☐ **2** ☐ **3** ☐ **4**

Date: ..... / ..... / ..... Time: ..... : .....

Fundus:

Lie:

Presentation:

Attitude:

Position:

Engagement:

Pre-IOL CTG: Reviewed by (name): .....

☐ Yes Reviewed by (name): .....

Post-IOL CTG: Reviewed by (name): .....

☐ Yes Reviewed by (name): .....

Bishop score	0	1	2	3
Dilatation (cm)	☐ <1	☐ 1–2	☐ 3–4	☐ >4
Length (cm)	☐ ≥3	☐ 2	☐ 1	☐ <1
Station	☐ -3	☐ -2	☐ -1, 0	☐ +1, +2
Consistency	☐ Firm	☐ Medium	☐ Soft	
Position	☐ Posterior	☐ Mid	☐ Anterior	
Total				

Treatment:

Plan:

Comments:

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Queensland Government

Birthing Record

Intrapartum Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Intrapartum Assessments

Date						
Time						
Indication						
Abdominal palpation	Fundus					
	Lie					
	Attitude					
	Presentation					
	Position					
	Engagement					
Vaginal examination	Verbal consent for vaginal examination obtained	☐ Yes ☐ Declined	☐ Yes ☐ Declined	☐ Yes ☐ Declined	☐ Yes ☐ Declined	☐ Yes ☐ Declined
	Dilatation (cm)					
	Length (cm)					
	Consistency					
	Application					
	Membranes / liquor					
	Presenting part					
	Station					
	Caput					
	Moulding					
	Position	R L	R L	R L	R L	R L
	FHR post VE					
	MHR post VE					
Comments and plan						
Initials						

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Birthing Record

Intrapartum Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Intrapartum Assessments *(continued)*

Date						
Time						
Indication						
Abdominal palpation	Fundus					
	Lie					
	Attitude					
	Presentation					
	Position					
	Engagement					
Vaginal examination	Verbal consent for vaginal examination obtained	☐ Yes ☐ Declined	☐ Yes ☐ Declined	☐ Yes ☐ Declined	☐ Yes ☐ Declined	☐ Yes ☐ Declined
	Dilatation (cm)					
	Length (cm)					
	Consistency					
	Application					
	Membranes / liquor					
	Presenting part					
	Station					
	Caput					
	Moulding					
	Position	R L	R L	R L	R L	R L
	FHR post VE					
	MHR post VE					
Comments and plan						
Initials						

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Birthing Record

2nd Stage Maternal and
Fetal Heart Rate Observations

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

DO NOT WRITE IN THIS BINDING MARGIN

Second Stage Maternal and Fetal Heart Rate Observations

Date	**Maternal Heart Rate** (beats / min)						**Fetal Heart Rate** (beats / min)						**Comments** Document when stage commenced* PS or AS, escalations, position changes, type and time of birth	**Initials**
DD / MM **Time**	≤39	40–49	50–109	110–139	≥140	MHR (bpm)	≤89	90–109	110–160	161–170	≥171	FHR (bpm)		
HH : MM														
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ACTIONS	🟪 • Emergency Call 🟧 • Notify Team Leader						🟪 • Emergency Call 🟧 • Notify Team Leader • Commence CTG monitoring • Notify Medical Officer to review within 10 mins						**MHR** Maternal Heart Rate **FHR** Fetal Heart Rate ***Stage commenced:** **PS** Passive Second Stage **AS** Active Second Stage	

Queensland Government

Birthing Record

2nd Stage Maternal and Fetal Heart Rate Observations

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Second Stage Maternal and Fetal Heart Rate Observations *(continued)*

Date	Maternal Heart Rate (beats / min)						Fetal Heart Rate (beats / min)						Comments	Initials
DD / MM Time	≤39	40–49	50–109	110–139	≥140	MHR (bpm)	≤89	90–109	110–160	161–170	≥171	FHR (bpm)	Document when stage commenced* (PS) or (AS), escalations, position changes, type and time of birth	
HH : MM														
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ACTIONS	☐ • Emergency Call ☐ • Notify Team Leader						☐ • Emergency Call ☐ • Notify Team Leader • Commence CTG monitoring • Notify Medical Officer to review within 10 mins						**MHR** Maternal Heart Rate **FHR** Fetal Heart Rate ***Stage commenced:** **PS** Passive Second Stage **AS** Active Second Stage	

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Birthing Record

Intrapartum Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Birth Attendees

	Print name	Designation
Birth Accoucheur		
Midwife		
Witness		
Medical Officer		
Other		

Birth Summary

Labour	☐ Spontaneous ☐ Induced ☐ Augmented
Induction indication	
Induction / augmentation method	
Rupture of membranes	☐ SROM ☐ ARM Date: ..... / ..... / ..... Time: ..... : ..... Total time ruptured (hrs / mins): ..... / ..... Adequate antibiotic coverage: ☐ Yes ☐ No ☐ N/A
Liquor	☐ Clear ☐ Meconium ☐ Blood stained ☐ Offensive
Mode of birth / presentation	
Water birth	☐ Yes ☐ No ☐ Planned
Length of labour	Date / Time / Duration (hrs / mins) Onset of labour: ..... / ..... / .... : ..... 1st stage: ..... / ..... Cervix fully dilated: ..... / ..... / .... : ..... 2nd stage: ..... / ..... Head birthed: ..... / ..... / .... : ..... Baby born: ..... / ..... / .... : ..... 3rd stage: ..... / ..... Cord clamped: ..... / ..... / .... : ..... Placenta birthed: ..... / ..... / .... : ..... **Total:** ..... / .....
Pain relief	☐ Nil ☐ N_2O and O_2 ☐ Narcotic ☐ Epidural ☐ Sterile water ☐ Spinal ☐ Water immersion ☐ Non-pharmacological *(specify)*: .....
Active pushing	Time of onset: ..... : ..... Duration (hrs / mins): ..... / .....
Maternal position at birth	
Perineal care	☐ Antenatal perineal massage ☐ Perineal massage in labour ☐ Warm compress in 2nd stage ☐ Hands on (recommended) ☐ Hands poised

Third Stage

Birth mode	☐ Modified active management ☐ Active management ☐ Physiological ☐ Manual removal Oxytocic: 1. ..... 2. ..... ☐ N/A
Placenta	☐ Appears complete ☐ Incomplete Comments: .....
Membranes	☐ Appears complete ☐ Incomplete ☐ Ragged
Cord	Cord: ☐ Vessels ..... Cord blood collected: ☐ Yes ☐ No pH: ☐ Venous ..... ☐ Arterial ..... BE: ☐ Venous ..... ☐ Arterial ..... Lactate: ☐ Venous ..... ☐ Arterial .....
Blood loss	Measured: ..... mL Estimated: ..... mL Total: ..... mL

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Birthing Record

Intrapartum Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Perineal Assessment

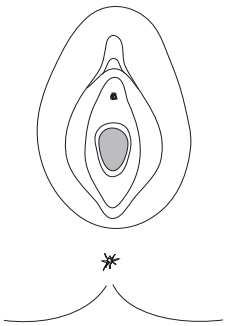
Consent confirmed	Verbal consent for vaginal examination obtained: ☐ Yes ☐ Declined Verbal consent for rectal (PR) examination obtained: ☐ Yes ☐ Declined
Perineal tears	☐ Intact ☐ 1° tear ☐ 2° tear ☐ 3° tear ☐ 4° tear Repaired in OT: ☐ Yes ☐ No
Episiotomy	Type: ..... Indication: ..... ☐ N/A ☐ Extension (document in Perineal Repairs section)
Perineal repair	☐ Recommended ☐ Not recommended ☐ Declined
Labia tear	☐ Yes ☐ No
PR examination completed	☐ Yes ☐ No
Perineal check	Check 1 (name): ..... Check 2 (name): .....

Perineal Repair

Label trauma on diagram and include descriptions of repair. Document suture material and anaesthetic used. Document PR examination and consider PR analgesia.

Time perineal repair commenced: ..... : .....

Time completed: ..... : .....



Print name:	Signature:	Date:

Perineal Surgical Item Count

	Initial count	Additions	Final count
Swabs			
Needles			
Instruments			
Number of sponges			
Correct count	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Initials (two person check)	1: 2:	1: 2:	1: 2:
Sponges left in situ: ☐ Yes ☐ No Sponge type: ..... Number:	*If packs / sponges to remain in situ, document in Vaginal Birth Clinical Pathway.*		
Removed pack / sponges Date: ... / ... / ... Time: ... : ...			

Date / Time	Comments / Notes	Initials

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Birthing Record

Intrapartum Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Newborn Summary

Baby's URN		
Identification tag / sex	ID checked: ☐ Yes ☐ No ID attached: ☐ Yes ☐ No Signature 1: ..... Signature 2:	☐ Male ☐ Female ☐ Indeterminate
Date / time of birth	..... / ..... / .... :	
Baby transferred to	☐ SCN ☐ NICU ☐ Other:	
Aboriginal and / or Torres Strait Islander identification	Is your baby of Aboriginal and/or Torres Strait Islander origin? ☐ No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐ Prefer not to say	
APGAR score	1 minute: ..... 5 minutes: ..... 10 minutes:	
Measurements	Weight: ..... g Length: ..... cm Head circumference: ..... cm	
Skin-to-skin contact (recommendation ≥1 hour)	Time commenced: ..... : ..... Time discontinued: ..... : ..... ☐ Not done Comments / variance:	
Feeding	☐ Breastfeed ☐ Within first hour ☐ EBM ☐ Formula / artificial feed ☐ Nil / N/A	

Transfer/Handover Details

Transfer from:	Transfer to:

Falls risk	☐ Nil risk factors identified on admission ☐ Impaired mobility on admission ☐ History of falls during pregnancy ☐ Medications (e.g. sedation, narcotic) ☐ Environment (e.g. shower)	☐ Impaired mobility ☐ Hypotension / blood loss ☐ Epidural ☐ Long labour (greater than 12 hours)
Pressure injury risk	☐ Nil risk factors identified on admission ☐ Skin inspection completed ☐ Impaired mobility	☐ Epidural ☐ Long labour (greater than 12 hours)
VTE	Prophylaxis required: ☐ Yes ☐ No Risk score:	
IDC	IDC during labour: ☐ Yes ☐ No IDC removed in second stage: ☐ Yes ☐ No IDC reinserted: ☐ Yes ☐ No	
Voided post-birth	☐ Yes – Volume: ..... Date: ..... / ..... / ..... Time: ..... : ..... ☐ No	
IVC	☐ Yes ☐ No Reason: ..... IVC removed – Date: ..... / ..... / ..... Time: ..... :	
Birth debrief	Debrief offered: ☐ Yes ☐ No If *yes*, debrief accepted: ☐ Yes ☐ No	
Psychosocial risk	☐ Limited antenatal care ☐ Currently on mental health medication ☐ Homeless ☐ Active polysubstance use ☐ Child Protection involvement ☐ Alerts regarding family violence	☐ History of mental health conditions ☐ Birthing from another jurisdiction ☐ Low BMI (<20) ☐ Very high BMI (>40) ☐ >12 Edinburgh Depression Scale ☐ >23 Antenatal Risk Questionnaire
Other		

Handover from (print name):	Handover to (print name):	Handover time: ..... : .....

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Queensland Government

Birthing Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date / Time	**Document all communication, including telephone communication.** Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT

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Birthing Record

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Given name(s):

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Date of birth: Sex: ☐ M ☐ F ☐ I

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Birthing Record

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Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date / Time	**Document all communication, including telephone communication.** Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT

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Birthing Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date / Time	**Document all communication, including telephone communication.** Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT

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Queensland Government

Birthing Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date / Time	**Document all communication, including telephone communication.** Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT

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Birthing Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date / Time	**Document all communication, including telephone communication.** Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT

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Queensland Government

Birthing Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date / Time	**Document all communication, including telephone communication.** Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT

DO NOT WRITE IN THIS BINDING MARGIN

Queensland Government

Birthing Record

(Affix identification label here)

URN:

Family name:

Given name(s):

Address:

Date of birth: Sex: ☐ M ☐ F ☐ I

Date / Time	**Document all communication, including telephone communication.** Add signature, printed name, staff category, date and time to all entries. MAKE ALL NOTES CONCISE AND RELEVANT

DO NOT WRITE IN THIS BINDING MARGIN