Patient Name/I.D. Number _____ Physician Name _____

Laboratory Findings

Initial Labs	Date	Result	Reviewed	Comments / Additional Lab
Blood Type/Rh	/ /	A B AB O + / -		
Antibody Screen	/ /	+ / -		
Hct/Hgb/Platelets	/ /	_____ % _____ gm/dl _____		
Rubella	/ /	Non-Immune | Immune		
RPR	/ /	Non-Reactive | Reactive		
HB S AG	/ /	- | +		
Pap Smear	/ /	- | +		
GC/Chlamydia	/ /	- | +		
Urine Culture/Urinalysis	/ /	- | +		
Sickle Prep./Hb Elct.	/ /	AA AS SS AC SC AF		
14 - 18 Weeks				
MSAFP	/ /	WNL ___ Low ___ Elev. ___		AFP Refused ___ / ___ / ___
				Pt. Initial _____
24 - 28 Week Labs				
HCT/HGB	/ /	_____ % _____ gm/dl		
Diabetes Screen	/ /	1Hr. _____		
GTT (If Screen Abnormal)	/ /	___FBS ___1Hr. ___2Hr. ___3 Hr.		
Rh Neg. Antibody Screen	/ /	- | +		
RhG Given (28 Weeks) (if indicated)	/ /	Signature _____		
34 - 36 Week Labs				
RPR	/ /	Non-Reactive | Reactive		
GC/Chlamydia/Beta Strep	/ /	- | +		
HCT/HGB	/ /	- | +		
Ultrasound				
	/ /			
	/ /			
	/ /			
Other Labs				
HIV	/ /	Non-Reactive | Reactive		
Amnio/CVS	/ /	- | +		
HGB Electrophoresis	/ /			

Plans / Patient Education

	Date
Childbirth Classes	___/___/___
Physical Activity	___/___/___
Premature Labor Signs	___/___/___
Nutrition Counseling	___/___/___
Environmental / Work Hazards	___/___/___
Breast or Bottle Feeding	___/___/___
Travel	___/___/___
VBAC Counseling	___/___/___
Method of Anesthesia	___/___/___

Tubal Sterilization	___/___/___
Circumcision	___/___/___
Postpartum Birth Control	___/___/___
Car Seat	___/___/___
Requests	_____
	_____
Other	_____

Tubal Sterilization Consent Signed — Date ___/___/___ — Initials _____