SAMPLE DISCHARGE SUMMARY

Primary Diagnosis: 40 week IUP with delivery of a liveborn infant
Secondary Diagnosis: Advanced Maternal Age; Prolonged second stage of labor with maternal exhaustion
Procedure Performed:

1. Spontaneous Vaginal Delivery with delivery of live male infant weighing 7# 5oz at 1542 hours on January 3, 2012 with APGARS of 8 at one minute and 9 at five minutes.
2. Placement of Intrauterine Pressure Catheter.

Reason for Hospitalization: This 36yo G2P1001 presented at 40 weeks gestation by an LMP of 3/12/11 with an EDC of 1/3/12 in spontaneous labor. This pregnancy has been complicated by advanced maternal age. QS performed at 17 weeks was within normal limits and a genetic amniocentesis was offered and declined. Prenatal laboratory data showed blood type B+ with a negative antibody screen, Rubella Immune, VDRL nonreactive, HepBsAg negative, Diabetic Screen 120, HIV nonreactive. She remained normotensive throughout her pregnancy. At the time of admission she reported positive fetal movement and denied loss of fluid.
Physical Exam on Admission: Temperature 98.4. Pulse 94. Respirations 16. Blood pressure 128/78. Fetal Heart Rate 150's and reactive. Uterine contractions q 4 minutes. HEENT within normal limits. Heart regular. Lungs clear. Abdomen gravid with a fundal height appropriate for gestational age. Extremities 2+ DTR's and trace edema. Cervical exam 4 cm/80%/-1.
Lab and X-Ray Data: Predelivery H&H of 12.4 and 36.2 respectively. Platelets 221.

Hospital Course: The patient was admitted in spontaneous labor in the morning of January 3rd. FHR was reactive and reassuring throughout the course of her stay in labor and delivery. Her labor progressed well and at 0900 hours, she had spontaneous rupture of membranes with a return of clear fluid. At that time, her cervix was dilated to 6 cm/90%/0. Epidural anesthesia was requested and obtained. Her labor then quickly progressed and the patient was noted to be completely dilated at a +1 station at 1100 hours. She was then allowed to push. After pushing for 2 hours, the patient brought the vertex to the perineum, but was unable to continue her expulsive efforts. The infant was delivered by outlet forceps over a midline episiotomy. ***Please see operative report for full details.*** The patient and infant did well. She is breast-feeding the infant well, and has remained afebrile with minimal lochia since delivery. The patient was voiding and ambulating without difficulty by the evening of PPD #0. She declined any contraception at the time of discharge, and was deemed stable for discharge on PPD 2.

Instructions at Discharge: The patient was advised to remain at pelvic rest for 6 weeks. This includes no tampons, douching or intercourse. She was asked to call with any signs of symptoms of infection including fever > 100.5 degrees, pain, malodorous vaginal discharge or bleeding > 1 pad/hour. Medications at discharge include: Motrin 800 mg po q 8 hours prn pain, number 30; Tylenol #3 1-2 po q 4 hours prn pain, number 15; she was asked to continue her PNV as prescribed. She was asked to follow-up at Creighton Women's Health Center in 6 weeks for a routine postpartum checkup. Pt was rubella and varicella immune and did not need vaccination. Blood type A+ and no rhogam indicated. Pt would like and IUD for contraception that will be further discussed at the post partum visit.