Consultation Guidelines for Hospitalized Obstetrical Patients

Admitted patients

If a pregnant patient is admitted for antepartum care other than labor management, the Maternal Fetal Medicine Team will assume primary care of the patient while hospitalized. The Family Medicine Team can continue to round on the patient and discuss care plans with the MFM team.

Intrapartum Care

Family Medicine patients presenting to L&D will be evaluated by the Family Medicine Maternity Service. The Family Medicine attending physician will be responsible for the patient's care, will be available throughout labor and will be present for the delivery. If a high risk situation exists or develops or if obstetrical assistance is desired, the practitioner will then request a consultation as outlined in this agreement. If continuous attending coverage for either the FP or OB service is not anticipated, a direct attending-to-attending hand-off across services should occur, to provide ongoing resident supervision and quality patient care. Where specific obstetrical management concerns are identified, the management issue will be resolved using the existing chain of command of the obstetrics service.

Independent Management Family Medicine Maternity Service

Normal labor and SVD
AROM
Meconium stained amniotic fluid (Ob attending to consult on FHR pattern)
Monitor placement
Interpretation of intrapartum fetal monitoring
1st & 2nd degree laceration repair
Excision of vulvovaginal lesions

Intrapartum Consultation Required for:

Abnormal bleeding during labor
Active HSV
Category II tracing or persistent/recurrent abnormalities in a Category I tracing. (30minutes)
Category III tracing
Cervical, 3rd or 4th degree laceration repair
Chorioamnionitis
Estimated fetal weight <2500 gm or >4100 gm
Malpresentation
Manual removal of placenta (accretion risk)
Ongoing problems for which antepartum consultation was indicated (vide supra)
Operative vaginal delivery anticipated
Pre-eclampsia

Prior uterine surgery, including C/S
Protracted second stage: 2hours (3 hours with epidural) in a primigravida,
1 hour (1.5 hours with epidural) in parous patients.
Protracted/arrested active phase (< 1 cm/h over 2h period with documentation of adequate contractions).
Refusal of blood products
Shoulder dystocia
Unstable maternal or fetal condition during labor (transfer of care anticipated)

Puerperal Consultation

Hemorrhage
Febrile for >48 hours
Severe pre-eclampsia
Medical or surgical conditions of the mother impacting postpartum period (HTN)

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