



= YES = NO

(PLACE PATIENT LABEL HERE)

SURNAME: _____ NHI: _____

FIRST NAMES: _____

Date of Birth: ____ / ____ / ____ SEX: _____

NAUSEA & VOMITING IN PREGNANCY

Date: / / 20 Time: Clinician: NP CNS HS Reg SMO

HISTORY AND PRESENTING COMPLAINT

Gestation ____ / 40 Dates USS Unknown *No USS yet or assisted fertility: ↑ risk for ectopic*

Grav: ____ Para: ____ M: ____ TOP: ____ E: ____

Unwell for ____ Days Weeks

Nausea No Yes:

Vomiting No Yes: Number today: ____ *Abdominal pain: risk for other pathology*

Abdominal pain No Yes:

PV Bleeding No Yes:

Assisted fertility No Yes:

LMC No Yes: Name: _____

IUP confirmed by USS No Yes: Date: _____ Where: _____

Prev ED visits for Hyperemesis No Yes:

POAC treatment No Yes:

Inpatient admissions No Yes:

RELEVANT PREVIOUS MEDICAL AND SURGICAL HISTORY

Nil relevant

Prev molar pregnancy No Yes:

Gestational Diabetes No Yes:

RELEVANT MEDICATIONS / ALLERGIES

Nil regular medicines

Iodine No Yes: *MOH requirement: All pregnant women should take Folic acid & Iodine. * See link EM CeDSS site*

Folic acid No Yes:

Antiemetics

Nil known allergies **ALLERGIES:**

SOCIAL HISTORY

Smoking Hx Non smoker Smoker: *Provide smoking cessation advice*

SFV Completed *All pregnant patients must be screened*

Alcohol

Home situation



= YES = NO

(PLACE PATIENT LABEL HERE)

SURNAME: _____ NHI: _____

FIRST NAMES: _____

Date of Birth: ____ / ____ / ____ SEX: _____

VITAL SIGNS <input type="checkbox"/> Within normal limits	BP _____ mmHg	Resp Rate _____ min	Pain score ____ /10
	Pulse _____ bpm	SPO2 _____ %	Glucose ____ mmol/L
	Temp _____ °C	<input type="checkbox"/> Air <input type="checkbox"/> NP <input type="checkbox"/> Hudson: ____ l/min	
General	<input type="checkbox"/> NOT distressed		
Pain	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate <input type="checkbox"/> Severe
Dehydration	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate <input type="checkbox"/> Severe
	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Pallor	<input type="checkbox"/> Cyanosis <input type="checkbox"/> Clubbing <input type="checkbox"/> Lymphnodes <input type="checkbox"/>

EXAMINATION

CVS Warm and well perfused

Cap refill Normal

Pulses Normal

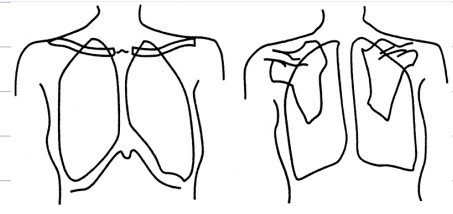
Respiratory

Breathing work Normal

Air entry Normal

Breath sounds Vesicular

Added sounds No Yes:



Abdomen *Look for signs of acute abdomen / ectopic / pyelonephritis. Ask about signs of UTI - increased risk of miscarriage*

Appearance Not distended Distended

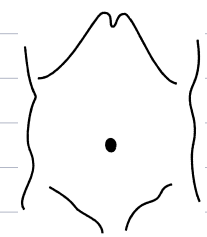
Palpation Soft

Guarding No Yes:

Rebound tender No Yes:

Bowel sounds Normal

Renal angle Not tender Tender



EMERGENCY MEDICINE NOTES



= YES = NO

(PLACE PATIENT LABEL HERE)

SURNAME: _____ NHI: _____

FIRST NAMES: _____

Date of Birth: ____ / ____ / ____ SEX: _____

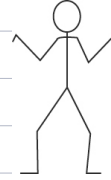
NEUROLOGICAL

GCS ____ /15 Alert and orientated

Ataxia None

Ophthalmoplegia None

Encephalopathy None



Plantar reflex ↓ ↑ ↓ ↑

Clonus - + - +

Signs of Wernicke's Encephalopathy (ophthalmoplegia, ataxia, encephalopathy). Rx Thiamine

? Eclampsia

OTHER

Blank space for other notes.

RESULTS

HAEMATOLOGY		BIOCHEMISTRY						URINE: if ? UTI	
Hb		Na ⁺						Leuc est	
WCC		K ⁺						WCC	
PL		Gluc						RCC	
		Creat						Epi's	
β-HCG		CRP						Bact	

EMERGENCY MEDICINE NOTES



= YES = NO

(PLACE PATIENT LABEL HERE)

SURNAME: _____ NHI: _____

FIRST NAMES: _____

Date of Birth: ____ / ____ / ____ SEX: _____

CLINICAL IMPRESSION / DIAGNOSIS / PLAN

Diagnosis Hyperemesis Gravidarum DDx includes:

Dehydration Mild Moderate Severe

Weight loss < 5% 5 -10% > 10% > 10% weight loss indication for inpatient admission

Other

FURTHER MANAGEMENT / NURSING INSTRUCTIONS

Nursing care Continue chosen pathway or Care as individualised below

Allied health Social Work Mental health *Some mothers find it difficult to cope with other children when they are feeling this unwell. Consider involving allied health services if concerned. See CeDDS for community support options like 'Parent Aid Waitakere'*

Location

Disposition Inpatient referral: Discussed with Dr: _____ Time: _____

Discharge *Discharge criteria and check list page 3 & 4 Best Care Bundle Pathway*

Patient info Nausea & vomiting in pregnancy *In Bundle pack or EM CeDDS. Contains diet advice and POAC information*

'Hyperemesis Nutrition Information Pack' *Under Bundle packs. 3556 if out of stock*

Referrals Dietitian referral. Indications: > 5% wt loss moderate / severe Dx > 1 admission this pregnancy
Pre-populated referral form EM CeDSS

POAC *in the community is free if mentioned it in the EDS - see 'Follow up' section page4 BCB pathway document*

Clinician Name: _____ Designation: _____ Sign: _____ Contact details: _____

For junior staff: Discussed with Reviewed by SMO Dr : _____ Sign: _____