GLWACH OBGYN

Obstetrical History Form

Obstetrics & Gynecology

Name_____ Date_____
first middle last

Age_____ Date of Birth_____ Occupation_____

Ethnicity/Race_____

Address:_____

Phone: _____ Email:_____ Relay Health: ☐ **Y** or **N** ☐

Active Duty: ☐ Army ☐ Air Force ☐ USMC ☐ Navy ☐ Other ☐ N/A

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of the father of the baby_____ His Ethnicity _____ His Age____

Spouse Active Duty: ☐ Army ☐ Air Force ☐ USMC ☐ Navy ☐ Other ☐ N/A

Emergency Contact:_____ Phone number:_____

Religious Preference: _____

What was the **FIRST** day of your last normal period?_____

Weight at that time? _____

Height? _____

Do you normally have a period every month? ☐ Yes ☐ No every _____ days

Have you had any bleeding since your last period? ☐ Yes ☐ No

What day was your pregnancy test first positive?_____

Were you on birth control when you got pregnant? ☐ Yes ☐ No

Type_____

Please list all medications that you are currently taking:_____

_____

_____

_____

_____

Please list all allergies to medications/Latex/Iodine/foods:

NAME OF ALLERGY	REACTION TO ALLERGY

PAST OBSTETRICAL HISTORY (List all pregnancies including miscarriages, abortions, tubal/ectopic)

How many times have you been pregnant? _____ Age at **FIRST** pregnancy? _____

Delivery Date	Length of Pregnancy	Length of Labor	Vaginal/ C-Section/ D&C/ Miscarriage	Anesthesia	Delivering Facility	Gender	Weight	Complications?

PAST MEDICAL HISTORY

Have you ever been diagnosed with any of the following?

- ☐ Diabetes
- ☐ Hypertension
- ☐ Heart Disease/Murmur
- ☐ Lupus/Rheumatoid Arthritis/Sjogrens
- ☐ Kidney Disease
- ☐ Recurrent urinary tract infections/pyelo/stones
- ☐ Neurologic Disorder (ex. MS)
- ☐ Epilepsy/Seizures
- ☐ Psychiatric Disorder/Anxiety/Depression/Bipolar
- ☐ Liver Disease/Hepatitis A, B, C
- ☐ Blood Clots/DVT/Pulmonary Embolus
- ☐ Bleeding Disorder (Von Willebrands/Hemophilia)
- ☐ Hypothyroid/Hyperthyroid
- ☐ Rh Isoimmunization
- ☐ Asthma/TB
- ☐ Infertility
- ☐ Uterine anomaly
- ☐ DES exposure

Have you ever had a blood transfusion? ☐ Yes ☐ No Why?_____

Would you accept a blood transfusion if needed in case of emergency? ☐ Yes ☐ No

Do you smoke? ☐Yes ☐No

How long have you smoked? _____

How much before pregnancy?_____packs/day

How much since you found out you were pregnant?_____packs/day

Do you drink alcohol? ☐Yes ☐No

How much before pregnancy?_____drinks/week

How much since you found out you were pregnant?_____drinks/week

Do you use any drugs? ☐Yes ☐No

How much before pregnancy?_____

How much since you found out you were pregnant?_____

What drugs do you regularly use?_____

Have you ever used IV drugs? ☐Yes ☐No

Do you drink caffeine? ☐Yes ☐No

_____servings/day

Do you own cats? ☐Yes ☐No

Who normally cares for the litter box?_____

Do you eat fish on a regular basis? ☐Yes ☐No

Do you plan to get an epidural during labor? ☐Yes ☐No

Do you plan to have your baby circumcised if it is a male? ☐Yes ☐No

Do you plan to breast feed? ☐Yes ☐No

Are you planning on getting your tubes tied? ☐Yes ☐No

Have you been vaccinated for HPV (Gardasil)? ☐Yes ☐No

How many shots? ☐1 ☐2 ☐3

Positive for TB (tuberculosis)? ☐Yes ☐No

Have you had your yearly flu shot? ☐Yes ☐No

Have you had the chicken pox? ☐Yes ☐No

Within the past year or since becoming pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone? ☐Yes ☐No

Are you in a relationship with someone who threatens you or physically hurts you? ☐Yes ☐No

Has anyone forced you to have sexual activities that made you feel uncomfortable? ☐Yes ☐No

SURGICAL HISTORY

Please list any surgeries or hospitalizations you have had in the past

DATE	TYPE

FAMILY HISTORY (diabetes, high blood pressure, bleeding disorders)

	Who	Age	Type
Diabetes			
High Blood Pressure			
Hypertension			
Bleeding Disorder			
Heart Attack			
Stroke			
Cancer			

Was anyone in your family or the father of the baby's family born with any birth defects?

Thalassemia: ☐ Yes ☐ No

Spina Bifida / Anencephaly: ☐ Yes ☐ No

Congenital Heart Defect: ☐ Yes ☐ No

Down Syndrome: ☐ Yes ☐ No

Tay-Sachs: ☐ Yes ☐ No

Sickle Cell Disease / Trait: ☐ Yes ☐ No

Hemophilia: ☐ Yes ☐ No

Muscular Dystrophy: ☐ Yes ☐ No

Cystic Fibrosis: ☐ Yes ☐ No

Huntington's Chorea: ☐ Yes ☐ No

Mental Retardation: ☐ Yes ☐ No

Autism: ☐ Yes ☐ No

Inherited metabolic disorder (PKU, POTS): ☐ Yes ☐ No

GYNECOLOGIC HISTORY

Have you ever had an abnormal pap smear? ☐Yes ☐No When?_____

What treatment was done?_____

_____

When was your most recent pap smear?_____Results?_____

Have you ever had:

☐Gonorrhea ☐HIV/AIDS

☐Chlamydia ☐Hepatitis A/B/C

☐Herpes ☐Syphilis

☐HPV/Genital warts ☐Pelvic inflammatory disease

Have you or anyone in your family ever had any major problems with anesthesia? ☐Yes ☐No

Explain:_____

Have you or partner been deployed in the past 2 years? ☐Yes ☐No Where?_____

When?_____ How Long?_____

Are you moving during the pregnancy? ☐Yes ☐No When?_____

Where?_____

PLEASE LIST ANY OTHER PERTINENT MEDICAL INFORMATION

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed with patient_____Date_____

MEDICAL RECORD - CONSENT FORM
Cystic Fibrosis Carrier Test
For use of this form see

I understand I am being asked to decide whether or not to have the cystic fibrosis carrier test. This test can identify if someone is a carrier of this disease.

By signing below I understand that--

1. This test is to see if I am a carrier of cystic fibrosis (CF). This means I could have the gene but not the disease.
2. The risk of being a CF carrier depends on race and ethnic background.
   a. For European Caucasian and Ashkenazi Jewish couples:
      (1) There is a 1 in 25 chance one parent is a carrier.
      (2) There is a 1 in 625 chance both parents are carriers.
   b. For Hispanic American couples:
      (1) There is a 1 in 46 chance one parent is a carrier.
      (2) There is a 1 in 2,116 chance both parents are carriers.
   c. For African American couples:
      (1) There is a 1 in 65 chance one parent is a carrier.
      (2) There is a 1 in 4,225 chance both parents are carriers.
   d. For Asian American couples:
      (1) There is a 1 in 80 chance one parent is a carrier.
      (2) There is a 1 in 8,100 chance both parents are carriers.
3. If I am a carrier of CF, testing the baby's biological father is needed to know if my baby could have CF.
4. CF carrier testing is one type of DNA testing. In the event the father is determined to be another person, a family medical history from that person will be necessary.
5. If both parents are carriers, the baby has 1 in 4 (25%) chance of having CF. If this is the case, I may have more testing to tell whether my baby has CF. This testing may be done before or after delivery.
6. I am the one to decide whether or not I am tested.
7. The test is not perfect. Some carriers are missed by the test.
8. My decision to have or not have this test wil not change my military health coverage.

I have read and understand the information provided to me about cystic fibrosis. My questions have been answered to my satisfaction. Please check one:

☐ Yes, I want to have the cystic fibrosis carrier test.

☐ No, I do not want to have the cystic fibrosis carrier test.

Patient: _____ _____ _____
(Signature) (Print Name) (Date)

Witness: _____ _____ _____
(Signature) (Print Name) (Date)

MEDICAL RECORD - CONSENT FORM
Maternal Serum Analyte Screen
For use of this form see

I understand I am being asked to decide whether or not to have the maternal serum analyte screen. The maternal serum analyte screen tests for substances made by the baby and the placenta. The amount of these substances in the blood is used to determine the risk of certain conditions in the baby. These conditions include open neural tube defects, Down syndrome (Trisomy 21), Edward's syndrome (Trisomy 18), and other related defects.

By signing below, I understand that--

1. This is a screening test only. It DOES NOT provide a diagnosis. It only predicts the chance of a certain condition occurring.
2. The maternal serum analyte screen tests for the risk of certain conditions in the baby. These conditions include open neural tube birth defects, Down syndrome, Edward's syndrome, and other related birth defects.
3. The maternal serum analyte screen is not 100% accurate. Some defects are missed. The results may be abnormal when the baby actually does not have one of these conditions. If there are abnormal results, I will need further testing to know more about my baby's health.
4. An open neural tube defect is an abnormality of the spinal cord or brain. This occurs in 1 or 2 of every 1000 births. If there is an abnormal result on the maternal serum analyte screen, my baby has a 4% to 7% risk of having an open neural tube defect.
5. Babies with Down syndrome have a distinct physical appearance, mental retardation, and an increased risk for other birth defects. About 1 in 800 babies have Down syndrome. The risk increases with maternal age. If there is an abnormal maternal serum analyte screen result, the baby has a 1% to 2% risk of having Down syndrome.
6. Babies with Edward's syndrome have serious mental and physical disabilities. Most affected babies do not live past their first year. Only 1 in 8000 babies are born with Edward's syndrome.
7. I am the one to decide whether or not I am tested.

I have read and understand the information provided to me about the maternal serum analyte screen. My questions have been answered to my satisfaction. Please check one:

☐ Yes, I want to have the maternal serum analyte screen.

☐ No, I do not want to have the maternal serum analyte screen.

Patient: _____ (Signature) _____ (Print Name) _____ (Date)

Witness: _____ (Signature) _____ (Print Name) _____ (Date)

Obstetrics and Gynecology Clinic
Presence of Children at Clinic Visits

Dear Patient,

Thank you for choosing GLWACH for your care! We are here for military families and want your visits to be safe, comfortable and productive. Visits with your health care provider will give you the opportunity to have your questions answered, address your concerns and participate in further education about your gynecological condition, pregnancy or post partum period. You and your provider are encouraged to work together effectively to address your health concerns.

A new pregnancy impacts everyone in your family. Your other child(ren) should be involved in learning more about your new baby. You may have reservations about leaving them with someone else when you attend your appointments. Discuss with your health care provider about times when your child(ren) can have the opportunity to listen to the new baby's heartbeat.

There are times during your appointments when the presence of your other child(ren) may not be appropriate. We recommend that you not bring children to visits that may be painful or embarrassing to you. These may include appointments at which you receive an injection, have a surgical procedure or an internal examination. If you are pregnant, further evaluation may be needed, such as having a Non-Stress Test (NST) or prolonged monitoring in Labor & Delivery. Since we **cannot predict** all situations, we ask that you **always** bring another adult with you to care for your child(ren) if the unexpected happens.

Examples of situations when the presence of children is not recommended:

* Gynecology Consults/Preoperative Consultation
* Colposcopy, Loop Electrosurgical Excision (LEEP) or other gynecologic procedures
* IUD Consultation and Insertions
* Receiving Injections
* Initial new OB registration class & Exams
*Non-Stress Fetal Testing (NST's)
* Post Partum Checkups/Pap Smear Procedures
* Any time you have a serious concern about your pregnancy and baby
*Around the 36th Week of your pregnancy and thereafter.

The General Leonard Wood Community Hospital Commander's policy is that children under 14 must be under adult supervision at all times. The clinic staff cannot be responsible for watching your child(ren) during your visit with your health care provider. You may be asked to ***reschedule*** your appointment if another adult is not present to supervise your child(ren) when appropriate.

Thank you for your adherence to this policy.

The Staff of the OB/GYN Clinic
GLWACH
Fort Leonard Wood, Mo

By signing this form you acknowledge our policy about children in the clinic.

Signature: _____ Date: _____

DEPARTMENT OF THE ARMY
HEADQUARTERS, USA MEDICAL DEPARTMENT ACTIVITY
126 MISSOURI AVENUE
FORT LEONARD WOOD, MISSOURI 65473-8952

REPLY TO
ATTENTION OF

MCXP-NRD-3C

AUGUST 2016

MEMORANDUM FOR RECORD

SUBJECT: Maternal Child Unit Visiting Policy

1. Thank you for choosing General Leonard Wood's Maternal Child Unit to deliver your infant. We are delighted to have the opportunity to share in your family experience.

2. Visitors are welcome at the discretion of the patient. A patient can have visitors anytime during her labor if a procedure is not taking place, after triage, and after the initial assessment is complete. For safety, we ask that you limit the number of visitors during delivery to two or three. A child of the patient aged 12 to 18 may attend the delivery if it has been discussed with the provider and the MCU nursing staff prior to admission. An adult other than the patient must chaperone the adolescent at all times.

3. The ward is locked for infant safety. Ring the doorbell at the entrance to enter the unit. A staff member at the nurses' station will be happy to open the door for your entrance and exit. Do not push the door to exit; ask a staff member at the nurses' station to open the door for you.

4. One adult may stay all night in the patient's room. We understand our patient population and understand childcare may not be readily available on rare occasions. In that instance, discuss the situation with your nurse. At all times, ensure your children are safe and are not a disturbance on the unit.

5. After recovery, please allow personal and bonding time for mom and baby. Please also allow personal time and nursing assessment time before 0900hrs. Siblings of the newborn are welcome to visit however, other children visiting must be over the age of 14. Exceptions to children can be made if they are siblings of the patient/spouse currently living in the same household. There is no strict limit on the number of visitors after recovery however, reason must be used and the nurses may impose a limit if deemed necessary. Children must stay in their mother's room and are not allowed to roam the halls.

6. Should you feel the need to prohibit certain visitors we will stop all of your visitors and will not release any of your information. The staff cannot be responsible for screening visitors for the patients.

7. We ask that you respect this policy during your stay with us. Our ultimate goal is safety for you and your family along with a wonderful experience for every patient.

Patient Signature _____

Petrina Mize
CPT / AN
OIC – Maternal Child Unit, GLWACH
4430 Missouri Avenue, Fort Leonard Wood, MO 65473
Office: (573) 596-0444

THIRD PARTY COLLECTION PROGRAM/MEDICAL SERVICES ACCOUNT/ OTHER HEALTH INSURANCE

(Read Privacy Act Statement before completing this form.)

OMB No. 0720-0055
OMB approval expires 31 Aug, 2019

PRIVACY ACT STATEMENT

AUTHORITY: Title 10 USC, Sections 1079b, Procedures for charging fees for care provided to civilian; retention and use of fees collected;1095, Health care services incurred on behalf of covered beneficiaries: collection from thirdparty payers; 42 USC. Chapter 32, Third Party Liability For Hospital and Medical Care; EO 9397 (SSN) as amended.

PURPOSE(S): Your information is collected to allow recovery from third parties for medical care provided to you in a Military Treatment FacilityROUTINE USE(S): Your records may be disclosed outside of DoD to healthcare clearinghouses, commercial insurances providers, and other third parties in order to collect amounts owed to the Department of Defense. Your records may also be used and disclosed in accordance with 5 USC 552a(b) of the Privacy Act of 1974, a amended, which incorporates the DoD Blanket Routine Uses published at: http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. Failure to provide complete and accurate information may result in disqualification for health care services from MTFs.

PATIENT INFORMATION

1. PATIENT NAME *(Last, First, Middle Initial)*	2. SSN	3. DATE OF BIRTH *(YYYY/MM/DD)*

4a. MAILING ADDRESS *(Include ZIP Code)*	b. HOME TELEPHONE NO. ( )	
	5a. FAMILY MEMBER PREFIX	b. SPONSOR SSN
6a. PATIENT'S EMPLOYER'S NAME	b. EMPLOYER TELEPHONE NUMBER	

INSURANCE INFORMATION

7. ARE YOU ELIGIBLE FOR VETERANS AFFAIRS BENEFITS?

☐ a. **YES.** *(If you have an insurance card (e.g., Veterans Health Identification Card (VHIC), Veterans Choice Card), that can be copied or scanned by the MTF representative, please provide it and proceed to Item 8; otherwise, please complete items 7.a.(1) through (5) below.)*

(1) Member ID	(2) Plan ID	(3) Expiration Date *(YYYY/MM/DD)*

(4) VA Facility Name *(e.g., primary care/specialty clinic)* that assists in coordinating your care

(5) VA Facility Address and Telephone Number ( )

☐ b. **NO.** *(Proceed to Item 8.)*

8. DO YOU HAVE OTHER HEALTH INSURANCE? *(This includes employer health insurance benefits, other commercial health insurance coverage, and Medicare Supplement.)*

☐ a. **YES.** *(Complete Item 9 and the remaining sections below.)*

☐ b. **NO,** I am a DoD beneficiary and rely solely on TRICARE, Medicare, or Medicaid. *(Proceed to Item 13.)*

☐ c. **NO,** but I am not a DoD beneficiary. *(Proceed to Item 12.)*

9. PRIMARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER

d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER	e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME

j. ENROLLMENT/PLAN CODE	k. INSURANCE TYPE	l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)*	m. POLICY END DATE *(YYYY/MM/DD)*

n.(1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number

10. SECONDARY MEDICAL INSURANCE INFORMATION. If you have an insurance card that can be copied or scanned by the MTF representative, please provide it and proceed to Item 11; otherwise, please complete the blocks below.

a. NAME OF POLICY HOLDER *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYYY/MM/DD)*	c. RELATIONSHIP TO POLICY HOLDER

d. POLICY HOLDER'S EMPLOYER'S NAME, ADDRESS AND TELEPHONE NUMBER

e. INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

f. CARD HOLDER ID	g. POLICY ID	h. GROUP POLICY ID	i. GROUP PLAN NAME
j. ENROLLMENT/PLAN CODE	**k. INSURANCE TYPE**	**l. POLICY EFFECTIVE DATE *(YYYY/MM/DD)***	**m. POLICY END DATE *(YYYY/MM/DD)***

n. (1) Pharmacy (Rx) Insurance Company Name, Address and Telephone Number

(2) Rx Policy ID	(3) Rx Bin Number	(4) Rx PCN Number

11. ARE THERE OTHER FAMILY MEMBERS COVERED UNDER THIS POLICY HOLDER?

☐ a. **YES** *(Complete 11c.-f. and proceed to Item 13.)* ☐ b. **NO** *(Proceed to Item 13.)*

c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER	c. NAME *(Last, First, Middle Initial)*	d. SSN	e. DATE OF BIRTH *(YYYY/MM/DD)*	f. RELATIONSHIP TO POLICY HOLDER

12. MEDICARE OR MEDICAID INFORMATION

a. MEDICARE PART A NUMBER	b. MEDICARE PART B NUMBER	c. MEDICARE MANAGED CARE PLAN NAME
d. MEDICARE PART D NUMBER AND PLAN NAME		**e. MEDICAID NUMBER/MANAGED CARE PLAN NAME/ISSUING STATE**

13. CERTIFICATION, RELEASE, AND ASSIGNMENT

a. I certify that the information on this form is true and accurate to the best of my knowledge. Falsification of information is covered by Title 18, United States Code, Section 1001, which provides for a maximum fine of $250,000 or imprisonment for five years, or both.

b. I acknowledge that the authority to bill third party payers has been conveyed to the medical facility within the Department of Defense by Title 10, United States Code, Sections 1095 and 1079b, and that no personal entitlement to reimbursement or payment has been granted to me by virtue of this act.

c. NON-UNIFORMED SERVICES PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided me and/or my minor dependents. ACKNOWLEDGEMENT: I hereby agree to pay for any service not covered in whole or in part by my third-party insurer.

d. NON-DoD MEDICARE, MEDICAID AND VETERANS AFFAIRS PATIENTS: I authorize and request that the proceeds of any and all benefits be paid directly to the MTF for healthcare services provided to me and/or my family member. I acknowledge I am responsible for full payment of any services not covered by Medicare, Medicaid and Veterans Affairs, including but not limited to patient copayments and deductibles.

e. UNIFORMED SERVICES BENEFICIARIES: I hereby acknowledge that the proceeds of any and all benefits shall be paid directly to the facility of the Uniformed Service for services provided to me and/or my family member.

f. ALL PATIENTS: I authorize portions of my medical records necessary to support claims for reimbursement for the cost of care rendered to be released to my insurance carriers.

14a. PATIENT OR ADULT FAMILY MEMBER SIGNATURE	b. DATE *(YYYY/MM/DD)*
15a. IF PATIENT REFUSES TO SIGN THIS FORM: MTF REPRESENTATIVE SIGNATURE	**b. DATE *(YYYY/MM/DD)***

16. ANNUAL PATIENT INSURANCE VERIFICATION

a. If any information on this form has changed, a new form must be completed and signed. Otherwise, after initial signature, verify with your initials and date at least annually.

b. I certify that the information on this form has been verified on the date(s) specified below, and that all information is true and accurate to the best of my knowledge.

17a. SIGNATURE *(Patient or Adult Family Member)*	b. DATE *(YYYY/MM/DD)*

18. VERIFICATION a. (1) Date *(YYYY/MM/DD)*	(2) Initials	b.(1) Date *(YYYY/MM/DD)*	(2) Initials	c.(1) Date *(YYYY/MM/DD)*	(2) Initials

A remedy for the common waiting room

Please invite me to secure messaging

Patient LAST NAME: _____

Patient FIRST NAME: _____

Patient DODID: _____ DOB: _____

Patient E-Mail: _____

Patient Home Zip Code: _____

My Medical Home Clinic Name: _____

With online services from Army Medicine Secure Messaging Service you can:

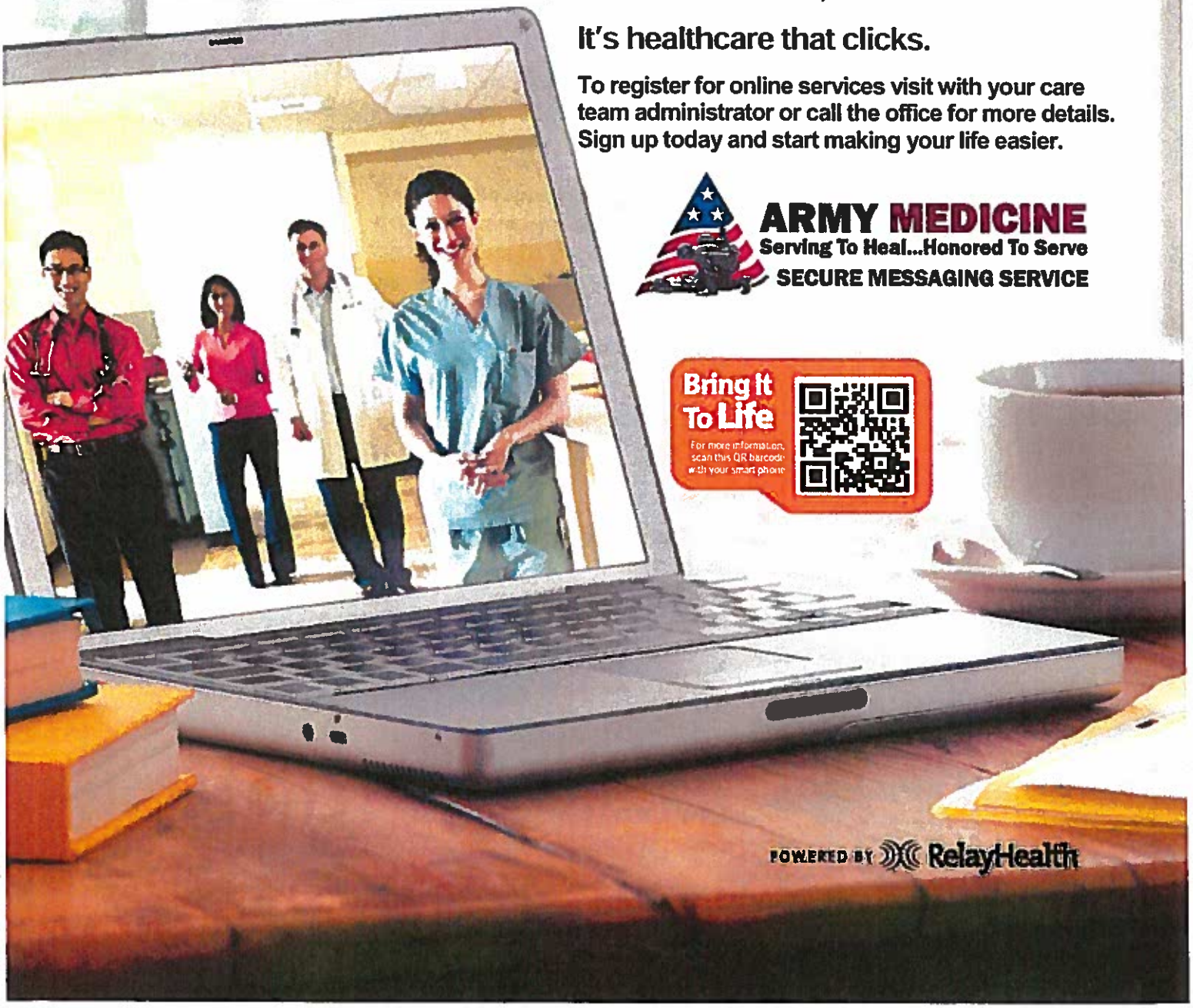
- Book appointments
- Request/review lab and test results
- Request medication refills
- Request a referral
- Request your medical records and information
- Email your doctor a question
- Schedule web visits with your doctor

It's healthcare that clicks.

To register for online services visit with your care team administrator or call the office for more details. Sign up today and start making your life easier.

ARMY MEDICINE
Serving To Heal...Honored To Serve
SECURE MESSAGING SERVICE

Bring It To Life
For more information, scan this QR barcode with your smart phone



POWERED BY RelayHealth

Maternity Care/OB Clinic
Phone #: 573-596-1770/Fax: 573-596-1797
4430 Missouri Avenue/FT. Leonard Wood, MO 65473
Welcome to General Leonard Wood Army Community Hospital OB maternity care!

1. A valid Military ID card is required for access. You must bring it with you every time you come to the hospital.

2. Husbands, significant others, or support persons are welcome to come to your appointments. Children are welcome to accompany their Mom to appointments if supervised by another adult. However, if a painful or other procedure that may expose you will occur, we recommend that you do not bring your children. The clinic staff is unable to watch your child for you. You may bring your newborn with you to your post-partum appointment.

3. **Providers** in the OB/GYN Clinic: include OB/GYN Physicians and Certified Nurse Midwives. Most of your appointments should be with the provider of your choice. All providers provide care on Mother-Child Unit (Labor & Delivery) utilizing an on call schedule. The provider on call will be managing your delivery.

4. **Scheduling Appointments:** Schedule routine OB Appointments by calling the TRICARE Appointment Line at: 1-866-299-4234, using Relay Health, or scheduling with the clerks at the OB/GYN front desk, unless told to do otherwise. OB Registration, OB Physicals and appointments after 36 weeks are scheduled through the OB Clinic front desk. After your OB Registration appointment, then you schedule and OB Physical apt. After your OB Physical, you are usually seen every 4 weeks until 36 weeks, then again at 38 weeks; then weekly until delivery. When arranging child care to cover appointments usually plan for 1-2 hours. You may bring snacks and WATER to the waiting room.

5. **Emergencies or Acute Illness:** Some symptoms which should be seen promptly: vomiting or diarrhea for more than 24 hours, urinary tract infection (burning, stinging, or blood in urine), flu symptoms(headache, nausea, vomiting, achy all over), or migraine headache NOT controlled by medications. First call the OB Clinic to speak to the triage nurse (573-596-1770) about what to do or for assistance with being seen. If directed by the staff or if you can't contact us then you should go to the

Emergency Room if you are under 20 weeks; over 20 weeks and the OB Clinic is closed, then go the Mother-Child (L&D) unit located on 3C. Come up the elevators near the emergency room to 3rd floor. OB Clinic is your Primary Care Provider for your pregnancy. If you have questions, make a list and bring it to your appointment or call the clinic and leave a message for your provider's nurse with a good phone number to return your call. A provider or nurse will return your call. If no one calls you back within 72 hours, contact the Head Nurse (see phone numbers on next page). **Be sure the phone number you leave is correct, in service and you have a voice mail.**

6. **Fetal Movement Counts:** After 28 weeks pregnancy fetal movement is a very important way to monitor your baby. If your baby is not passing the Fetal Movement Count (10 movements in 2 hours in the evening) then **Come to Mother/Child/Labor and Delivery immediately.** Contact 573-596-0444 to let the staff know you are coming in.

7. **OB Records:** Please notify the clinic if you change your name, address, or phone number as soon as possible. Verify your name and address with the OB clerk when you check in for an appointment. If you move away during this pregnancy, please come to the OB Clinic to obtain a copy of your OB Chart to take to your new provider.

8. **Medications-OVER THE COUNTER: take the following by mouth:**
   a. Do not take: Naldecon, Entex, Dimetapp or other medications containing Phenylpropanolamine (PPA). DO NOT TAKE: Motrin, Ibuprofen, Aleve, Naproxen, NSAIDS or Aspirin unless prescribed by your provider.
   b. You may take
      i. Tylenol- 2 tabs regular strength or 1 extra strength capsule/tablet every 4 hours for pain or headache.
      ii. Sudafed-30 mg 1to 2 every 8 hours for congestion.
      iii. Actifed-1 tablet every 8 hours for congestion.
      iv. Mucinex IR 400mg every 6 hours for congestion.
      v. Chlortrimeton 4mg every 8 hours for allergy.
      vi. Benadryl 25 mg every 8 hours for allergy.
      vii. Cepacol Lozenges 8 per day as needed for sore throat.
      viii. Robitussin Expectorant 2 tsp. every 6 hours for cough.
      ix. Emetrol 1 tablespoon as needed for nausea and vomiting.
      x. Vitamin B-6 3 times per day to decrease nausea.
      xi. Ginger Ale for nausea; Ginger Pops for nausea.

c. If you are taking prescribed or OTC medications regularly, please bring them to your OB Physical appointment and review all your medications with your provider.

d. **Enroll in the self-care program.** Go to Public Health Nursing, Room #111, down the hallway from pharmacy on the right, to take the test and get your over the counter self-care meds. You and your spouse are eligible to get up to 5 different over the counter medications through this program. The self-care card is good as long as you are at FLW. Get the medication list at the pharmacy, in the rack below the TV in the pharmacy waiting area. Tucks are good to put on your bottom after delivery, these are on the list.

e. Herbs: More than 2 cups of herbal tea is medicinal, discuss what you are taking with your OB provider. Some herbs should not be used during pregnancy, especially tinctures or capsules. Avoid black licorice.

9. **Phone numbers:**
   a. Appointments 1-866-299-4234
   Unit/ Labor & Delivery: 573-596-0444
   b. OB/GYN Clinic 573-596-1770
   Room 573-596-0456
   c. Community Health Nursing: (Self -Care program) 573-595-0518
   League 573-336-5281
   d. Army Community Service 573-596-0212
   Consultant/PCRMC Julie: 573-458-7353
   e. Mother/Child
   f. Emergency
   g. LaLeche
   h. Lactation

10. **BREASTFEEDING SUPPORT** is available from LaLeche League, Leader: Cathy Glick at 573-336-5281.

11. Lactation Educators are available in OB/GYN Clinic and Labor and Delivery.

12. A lactation consultant is available for FLW OB patients at Phelps County Regional Medical Center, Rolla, MO. She has available Medela supplies, to include breast pumps, breast shells, breast pump supplies, and nursing bras. She can be reached at: 573-458-7353.

13. **Pregnancy Education Classes:** Pregnancy preparation/labor and delivery classes are recommended. Topics include: Breathing Techniques, Infant Care, Infant CPR, Infant

Safety, Breastfeeding, Bottle Feeding, Shaken Baby Syndrome Prevention, Empathy Belly for the Dads, Infant Wellness and other topics.
Contact Labor and Delivery at 573-596-0444 when you are 28 weeks. Sign up your significant other but please don't bring any children. Classes are held on Wednesdays for four weeks from 1730-1930 in the MEDDAC Classroom at the hospital. A tour of the Labor and Delivery unit is held during the last class.
Other prenatal classes are held at ACS, contact 596-0212 for more information.

Traveling: Discuss when you wish to travel and how your absences from the area will affect your prenatal care before setting your plans firmly. If you plan to drive more than 2 hours, plan to get out and urinate and walk around several minutes. Drink-water, water, and more water! You fatigue more quickly, so shorter travel days-less than 8 hours per day-are better for mothers and babies. Also, the vibration from the vehicle can cause your uterus to contract. Swollen feet and legs are common with travel.

If you are PCS'ng or ETS'ng remember to carry a copy of your OB Chart to your next OB provider.

WIC: Women, Infants, and Children: A federally funded nutritional supplemental program for pregnant women, new mothers, and children age birth to 5 years. Food vouchers received through this program may be exchanged for food products and formula. WIC is located at Lincoln Square, 407 Historical Route 66, Suite 104, Waynesville, MO 65584. (They are located across the street from the Westside Baptist Church) Call 573-774-3115 or contact the Pulaski County Health Department at Crocker, MO. Appointments are required. You must take a WIC Letter from the front desk staff of the OB Clinic with your estimated date of delivery to your first appointment.

Dental Care and Cleanings are recommended every 6 months during pregnancy. A letter for the dentist with your estimated date of delivery can be obtained from the OB Clinic front desk staff to take with you for your appointment. If you have any questions, please contact Renee Minkus, RN, Head Nurse OB/GYN Clinic, at 573-596-1770.

Congratulations on your pregnancy!

Revised 07/2016/SH