Form 3: March of Dimes Induction/Cesarean Section Delivery Scheduling Form
(Used with permission of the March of Dimes)

Requesting Physician ___________________________ Today’s Date ________________

Patient’s Name _________________________________ Age ________ G _______ P _______

Medical Record #_______________________________ Requested Procedure Date ____________ □ AM □ PM

Gestational Age on Date of Procedure ____________

Method of Delivery Planned: □ Cesarean delivery: □ Primary or □ Repeat
□ Induction: Fetal presentation _________ EFW _________ gms Bishop Score _________

Reasons for Scheduled Delivery: Check all appropriate indications below

Level 1
□ Chorioamnionitis
□ Preeclampsia / HELLP
□ Abruptio placenta
□ Bleeding D/T marginal placenta previa
□ Non-reassuring fetal testing
□ PROM
□ Fetal hydrops / isoimmunization
□ Oligohydramnios
□ Blood group sensitization
□ Fetal compromise (severe IUGR)
□ Fetal anomaly
□ Maternal medical conditions
□ Gestational hypertension
□ Multifetal gestation

□ Other indication ______________________________________________________________________

Clinical indications (with supporting data) ______________________________________________________________________
______________________________________________________________________ _______________________________

Confirmation of gestational age:
EDC _______________ determined by: Check all that apply
□ Ultrasound obtained at < 20 weeks on _______________ @ ____________ weeks confirms gestational age

□ Known date of conception on _______________ associated with infertility treatment

For Level 3 or 4 indications, if EDC was not determined by above methods, then identify documentation of fetal maturity:
□ Amniocentesis performed on _______________ Results: ______________________

* Provide explanation if scheduling Level 3 or 4 at < 39 weeks __________________________________________

Please fax form to _________________________________

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Procedure scheduling determination:

□ Level 1 or Level 2 indication scheduled as requested
□ Medically indicated procedure necessitates delivery prior to 39 weeks gestation

□ Level 3 or Level 4 procedure scheduled as requested
□ Gestational age ≥ 39 weeks on scheduled procedure date per ACOG recommendation

□ Level 3 or Level 4 procedure scheduling request requires further review
□ Gestational age < 39 weeks on scheduled date of procedure
□ Gestational age or fetal maturity not determined using established criteria

Completed by _________________________________

March of Dimes Scheduling Form Template Adapted from the Ohio Perinatal Quality Collaborative 8/17/09
Appendix A – Other Sample Forms

This chart is provided for your convenience to assist in calculating the Bishop Score. The final score should be entered on the front of this form where indicated. Vaginal exams should have been performed at least within the last 7 days.

<table>
<thead>
<tr>
<th>Score</th>
<th>Dilation (cm)</th>
<th>Effacement (%)</th>
<th>Station* (-3 to +3)</th>
<th>Cervical Consistency</th>
<th>Cervical Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Closed</td>
<td>0-30</td>
<td>-3</td>
<td>Firm</td>
<td>Posterior</td>
</tr>
<tr>
<td>1</td>
<td>1-2</td>
<td>40-50</td>
<td>-2</td>
<td>Medium</td>
<td>Midposition</td>
</tr>
<tr>
<td>2</td>
<td>3-4</td>
<td>60-70</td>
<td>-1</td>
<td>Soft</td>
<td>Anterior</td>
</tr>
<tr>
<td>3</td>
<td>≥5</td>
<td>≥80</td>
<td>+1, +2</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

*Station reflects a -3 to +3 scale—modified from Bishop EH Pelvic Scoring for Elective Induction, Obstet Gynecol 1964, 24(267)
Please state -5 to +5 for all other purposes.

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