INDUCTION OF LABOR (IOL) SCHEDULING REQUEST
HOAG MEMORIAL HOSPITAL PRESBYTERIAN

The Prenatal Record MUST be on file in Labor and Delivery **or** Faxed with this completed form.

LDR Scheduling: (949) 764-8484 **LDR Scheduling Fax: (949) 764-5735**

☐ Check if this is an update to a currently scheduled case

☐ Elective ☐ Non-Elective Date Submitted:

Requested Induction Date:	
Requesting OB:	Alternate time availabilities:
Pediatrician:	

Dating: EDC (month/day/year): Gestational age at desired date of IOL: _____weeks _____days

IOL Diagnosis: Latex Allergy: ☐ Yes ☐ No

PATIENT DEMOGRAPHIC INFORMATION:

Patient Name:

DOB:	SSN:	MR#:

Address:	Home #:	Work #:
	Cell #:	Other #:

Office contact: Phone #: Fax #:

☐ Induction Order in CPOE (Sign & Hold)

Special instructions:

_____ _____ A.M./P.M. _____ _____

[Date] [Time] [Physician Signature – Required] ID#

To Be Completed by Physician Office Staff

INSURANCE CARD INFORMATION Primary Subscriber's Name: _____

ID#; _____ Group#: _____

To Be Completed By Hoag Hospital LDR Scheduling

Confirmation Code:	IOL Date:	IOL Time:

FAX FORM TO LDR (949) 764-5735

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PS 5529 Rev 09/14/15

[2201]

Name Label:

Induction of Labor: Gravity: _____ Parity: _____

Indication: *(check all appropriate indications below)*

Level 1
- ☐ Chorioamnionitis
- ☐ Diabetes Uncontrolled
- ☐ Fetal Anomaly
- ☐ Fetal hydrops/isoimmunization
- ☐ Gestational/Chronic hypertension
- ☐ IUGR less than 5%
- ☐ Maternal medical conditions (specify): _____
- ☐ Multiple gestation: ☐ twins ☐ di/di ☐ mo/di
- ☐ Non-reassuring fetal testing
- ☐ Oligohydramnios
- ☐ Preeclampsia/HELLP
- ☐ PROM

Level 2
- ☐ ≥ 41 weeks gestation / Post-term pregnancy
- ☐ Gestational diabetes
- ☐ IUGR – reassuring testing
- ☐ Fetal demise

Level 3
- ☐ Distance from hospital
- ☐ History of rapid labor
- ☐ Maternal request
- ☐ Prior C/S
  - ● Patient desires VBAC
- ☐ Psychological factors (specify): _____
- ☐ > 39 weeks with a favorable cervix
- ☐ Other indication: _____

Confirmation of gestational age:

LMP: _____

EDC: _____ determined by: *(check all that apply)*

- ☐ Ultrasound obtained at < 20 weeks on (date): _____@ (gestational age): _____ weeks confirms gestational age
- ☐ Known date of conception on (date): _____ associated with infertility treatment

If EDC was not determined by above methods, then identify documentation of fetal maturity:

☐ Amniocentesis performed on: _____ Results: _____

*Provide explanation if scheduling at < 39 weeks : _____

Bishop Score

	0	1	2	3	Score
Dilation (cm)	closed	1-2	3-4	≥ 5	
Effacement (%)	0-30	40-50	60-70	≥ 80	
Station (cm)	-3	-2	-1	≥ 0	
Cervical Consistency	Firm	Medium	Soft	----------	
Cervical Position	Posterior	Midline	Anterior	----------	
				Total:	

A Bishop Score ≥ 6 is required for elective induction of multiparous patients.

Physician Signature: _____ **Date/Time:** _____

To be completed by Chief of Maternal Fetal Medicine or OB Hospitalist

Procedure Scheduling Determination:

- ☐ Schedule: Medically indicated and necessitates delivery < 39 weeks gestation
- ☐ Schedule: Gestation age ≥ 39 weeks on scheduled date

Completed by: _____ Date/Time: _____

[Chief of Maternal Fetal Medicine/OB Hospitalist]

Bishop Score on Admission

	0	1	2	3	Score	Repeat Score
Dilation (cm)	closed	1-2	3-4	≥ 5		
Effacement (%)	0-30	40-50	60-70	≥ 80		
Station (cm)	-3	-2	-1	≥ 0		
Cervical Consistency	Firm	Medium	Soft	----------		
Cervical Position	Posterior	Midline	Anterior	----------		
				Total:		
Exam done By:						

- ☐ Difference in Bishop score greater than or equal to 4
- ☐ Cervical ripening ordered
- ☐ Patient discharged and rescheduled

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