

Add EFW

Today's Date:

/ /

## Pomerado Hospital Birth Center

Request for Procedure

Office staff to fax (858-613-4612) to Birth Center prior to the requested procedure date.  
Prenatal chart must accompany this form or already be on the Birth Center before the procedure is initiated.

Physician: \_\_\_\_\_ Pt DOB: \_\_\_\_\_  
 Pt Name: \_\_\_\_\_ I Ht: \_\_\_\_\_ Wt: \_\_\_\_\_ BMI: \_\_\_\_\_  
 Prior PH Visits? If so, MRN: \_\_\_\_\_ Pt Type: Inpatient / Outpatient  
 Pt Address: \_\_\_\_\_  
 SS#: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 Insurance: \_\_\_\_\_  
 Subscriber #: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_  
 Subscriber DOB: \_\_\_\_\_ Group #: \_\_\_\_\_ Authorization #: \_\_\_\_\_ E Code: \_\_\_\_\_  
 Requested Appointment Date: \_\_\_\_\_ Time: \_\_\_\_\_  
 EDC: \_\_\_\_\_ EGA on Procedure Date: \_\_\_\_\_ (must be  $\geq 39$  wks for elective delivery)

## PROCEDURE REQUESTED

- 1) Induction Cesarean Section Cesarean Section w/BTL Other: \_\_\_\_\_  
 Anesthesia Type: \_\_\_\_\_ Assistant Surgeon: \_\_\_\_\_  
 Indication/Reason: \_\_\_\_\_  
 CPT Code: \_\_\_\_\_ ICD9 Code: \_\_\_\_\_
- 2) Induction Cesarean Section Cesarean Section w/BTL Other: \_\_\_\_\_  
 Anesthesia Type: \_\_\_\_\_ Assistant Surgeon: \_\_\_\_\_  
 Indication/Reason: \_\_\_\_\_  
 CPT Code: \_\_\_\_\_ ICD9 Code: \_\_\_\_\_

BISHOP SCORE: (Required for *ELECTIVE* inductions)

Factor					
Score	Dilation	Cervical Position	Effacement (%)	Station	Cervical Consistency
0	Closed	Posterior	0-30	-3	Firm
1	1 - 2	Midposition	40-50	-2	Medium
2	3 - 4	Anterior	60-70	-1, 0	Soft
3	5 - 6	-	80	+1, +2	-

\* Station reflects a -3 to a +3 scale

Please Circle: TOTAL SCORE: 1 2 3 4 5 6 7 8 9 10 11 12 13

## CRITICAL CRITERIA TO SUPPORT A TERM PREGNANCY

- ☐ Fetal heart tones documented for 20 weeks by fetoscope or for 30 weeks by Doppler.
- ☐ 36 weeks have elapsed since a serum or urine hCG pregnancy test was positive (performed at a reliable laboratory).
- ☐ Greater than or equal to 39 weeks GA by ultrasound measurement of the CRL at 6-12 weeks of gestation or BPD/FL at 13-20 weeks of gestation.

Reviewed by: \_\_\_\_\_

☐ Approved Confirmation #: \_\_\_\_\_

Fin #: \_\_\_\_\_

☐ Disapproved

Physician Notified (Date &amp; Time): \_\_\_\_\_

THIS FORM IS NOT PART OF  
THE PERMANENT MEDICAL  
RECORD.

Return to C. Sakowski after scheduling.