
This Quick Reference Guide (QRG) reviews the workflow of an Ambulatory OBGYN Nurse.

Document an Initial Pregnancy Visit

After the patient has been checked in and roomed, follow this process to complete the initial pregnancy workflow.

➤ **From the Ambulatory Organizer:**

STEP 1: Open the patient's chart.

STEP 2: Document her Chief Complaint on the Ambulatory 2018 tab.

STEP 3: Document and sign the Antepartum Intake Form from AdHoc, including the following sections:

- Communication Needs and Preferences
- Vitals/Ht/Weight

NOTE: You must document the patient's current blood pressure and weight in order for the pregnancy card to populate.

- Obstetrical History

NOTE: Click Add to document each historical pregnancy and outcome.

- Additional Pregnancy Information
- Feeding History, Plan and Education
- Problem History
- Procedure History
- Anesthesia/Sedation
- Transfusion Reaction and Consent
- Family History
- Medications at Home
- Allergies
- ID Screening OB
- Social History
- Edinburgh Postnatal Depression Scale
- Domestic Violence/Patient Safety
- Genetic Screening

STEP 4: Add the pregnancy on the Pregnancy Workflow tab.

STEP 5: Add an ultrasound in EDD Maintenance, if appropriate.

STEP 6: Chart on the Pregnancy Visit Information in card or flowsheet view.

NOTE:

- **Pregnancy Visit Information can only be charted the day of the visit. After the visit date has passed, any additional information can be documented in IView, but this information will no longer flow into the Antepartum Record.**
- **Do not document in the Comments field; this is for the provider only.**

STEP 7: Document the patient's Birth Plans and Education in IView.

STEP 8: Place any necessary orders from WH Quick Orders.

STEP 9: Complete any tasks in the Single Patient Task List.

STEP 10: Review your documentation in the Antepartum Record.

Document a Follow-up/Established Patient Visit

After the patient has been checked in and roomed, follow this process to complete the established visit workflow.

➤ **From the Ambulatory Organizer:**

STEP 1: Open the patient's chart.

STEP 2: Document her Chief Complaint on the Ambulatory 2018 tab.

STEP 3: Chart on the Pregnancy Visit Information in card or flowsheet view, from the Pregnancy Workflow tab.

NOTE:

- **Pregnancy Visit Information can only be charted the day of the visit. After the visit date has passed, any additional information can be documented in IView, but this information will no longer flow into the Antepartum Record.**
- **Do not document in the Comments field; this is for the provider only.**

STEP 4: Review/update the patient's Home Medications and Allergies.

STEP 5: Document in IView as needed.

STEP 6: Place any necessary orders from WH Quick Orders.

STEP 7: Complete any tasks in the Single Patient Task List.

STEP 8: Review your documentation in the Antepartum Record.