DISCHARGE SUMMARY

ADMISSION DIAGNOSES
1. Intrauterine pregnancy.
2. Previous cesarean section.
3. Desire for repeat cesarean section.

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PROCEDURE DURING HOSPITALIZATION: Primary low transverse cesarean section.

DATE OF SURGERY: ___ [DATE].

HISTORY OF PRESENT ILLNESS AND PHYSICAL EXAMINATION: The history of present illness and physical examination are per the dictated history and physical.

HOSPITAL COURSE: The patient is admitted for repeat cesarean section. She presented to labor and delivery with ruptured membranes, previous cesarean section. A cesarean section was carried out without complication. The patient did well postoperatively. The baby did well postoperatively. The patient was ready for discharge to home on postoperative day 3. Her hematocrit was 37. She has an Rh+ blood type.

DISPOSITION: She goes home with the following disposition: Home: Activity as tolerated. Diet: As tolerated. Followup will be in one to six weeks with Dr. ___ [NAME].
**Urinalysis**

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Result</th>
<th>Normal Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Appearance</td>
<td>Normal</td>
<td></td>
</tr>
<tr>
<td>Specific Gravity</td>
<td>K &gt; 1.030</td>
<td>1.001-1.030</td>
</tr>
<tr>
<td>pH</td>
<td>6.0</td>
<td>5.6-6.5</td>
</tr>
<tr>
<td>Glucose</td>
<td>Negative</td>
<td>NEG mg/dL</td>
</tr>
<tr>
<td>Bilirubin</td>
<td>Negative</td>
<td>NEG mg/dL</td>
</tr>
<tr>
<td>Ketones</td>
<td>Negative</td>
<td>NEG mg/dL</td>
</tr>
<tr>
<td>Hemoglobin</td>
<td>Negative</td>
<td>NEG mg/dL</td>
</tr>
<tr>
<td>Protein</td>
<td>Negative</td>
<td>NEG mg/dL</td>
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<tr>
<td>Urobilinogen</td>
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<td>0.2-1.0 EU/dL</td>
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<tr>
<td>Nitrite</td>
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<td>NEG mg/dL</td>
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<tr>
<td>Leukocytes</td>
<td>Negative</td>
<td>NEG mg/dL</td>
</tr>
<tr>
<td>Collection Type</td>
<td>Catheterized</td>
<td></td>
</tr>
</tbody>
</table>

**Special Chemistry**

- **0944 Fetal Lung Maturity Screen**
  - FLR Range: 53.6 mg/g
  - Probability of RDS: 0.1%
  - Probability of RDS: 10%

- **0940 Fetal Lung Maturity Screen**
  - FLR Range: 40.9 mg/g
  - Probability of RDS: 0.3%
  - Probability of RDS: 10%

Result called to 1100.

**Specimens from Specific Sites**

- **1511 Fetal Fibronectin**
  - Negative

**Microbiology**

- **SCREEN, GROUP B STREP**
  - COLLECTED: 1511
  - ACCESSION NO.: 1511
  - SOURCE: Vaginal
  - REPORT STATUS: [ ]
  - CULTURE Result: 1. No beta-hemolytic streptococci group B isolated

**KEY:** H = High, L = Low, [ ] = Ref. range, * = Critical or Abnormal results
OBSTETRICAL ULTRASOUND FOLLOW-UP DATED

There is a single live intrauterine pregnancy with a vertex presentation. The amniotic fluid index has decreased measuring 8 cm. Fetal cardiac activity is identified at 137 beats per minute.

IMPRESSION: Decrease in amniotic fluid volume.
Dear Dr. [Name],

Thank you for referring your patient. As you well know, she is a 23-year-old, gravida 3, para 1-0-1-1, with a last menstrual period of [Date], and therefore at a current gestational age of 37 to 38 weeks. Her obstetric history is remarkable for prior cesarean section. She presents today for an amniocentesis to evaluate fetal lung maturity in preparation for repeat cesarean section. The patient is status post amniosentesis approximately one week ago which was consistent with fetal lung immaturity.

The risks versus benefits of amniocentesis were discussed. The informed consent was obtained. The patient’s abdomen is prepped in the usual sterile fashion with sterile Betadine. Under ultrasonic guidance a single puncture amniocentesis was performed with a #22 gauge spinal needle. Approximately 2 cc of clear amniotic fluid were obtained and sent for fetal lung maturity testing. The edge of the placenta was traversed twice. The fetal heart rate was normal both before and after the procedure. The patient tolerated the procedure well. Her blood type is O positive. She is currently undergoing a post procedure nonstress test.

Thank you very much for involving us in this patient’s care.

"I AUTHORIZE MY NAME TO BE AUTOMATICALLY AFFIXED TO THIS REPORT AS SIGNIFYING THAT I DICTION THIS REPORT."

[Signature]

[Name]

M.D.

DD/Md
DD: [Date] 10:44:04 DT: [Date] 13:53:41
VI: [Name] DOC: [Name]
cc: [Name] M.D.

ULTRASOUND
OPERATIVE REPORT

PREOPERATIVE DIAGNOSIS
1. Intrauterine pregnancy at 39 weeks.
2. Previous cesarean section.
3. Desire for repeat cesarean section.

POSTOPERATIVE DIAGNOSIS
1. Intrauterine pregnancy at 39 weeks.
2. Previous cesarean section.
3. Desire for repeat cesarean section.

OPERATION PERFORMED: Repeat low transverse cesarean section.

ESTIMATED BLOOD LOSS: 750 cc.

COMPLICATIONS: None.

FINDINGS: Viable male infant.

TECHNIQUE: After adequate anesthesia was obtained, the patient was prepped and draped in the supine position with left lateral tilt. A Pfannenstiel incision was made across the old scar. This was carried down to the anterior rectus fascia, which was incised transversely. The bellies of the rectus were separated. The peritoneal cavity was entered in the midline. A bladder flap was created. The lower uterine segment was incised transversely. The infant was noted to be in a vertex presentation. The infant was removed from the uterus using the usual maneuvers. The infant was suctioned. The cord was doubly clamped and cut between the clamps. The infant was given to respiratory therapy for further care. A cord blood sample was obtained and the placenta was manually removed from the uterus. The uterus was exteriorized. Excess membranes were cleaned from the uterine cavity. The uterus was then closed with one layer of #1 chromic suture. There was good Hemostasis at the end of this layer. There was a small 1 x 1 cm hematoma just below the incision about one-third of the way to the left angle. A figure-of-eight was placed in this region to make sure that this did not expand. The uterus was placed back in the abdominal cavity. The gutters were cleaned of clots. The incision line was inspected. It was dry. The parietal peritoneum was closed using a running stitch of #2-0 chromic. The rectus muscles were reapproximated using a running stitch of #2-0 chromic. The subfascial space was inspected and irrigated. It was dry. The fascia was closed using a running stitch of #0 Vicryl. The subcutaneous tissue was reapproximated using #3-0 plain gut after irrigation and checking for bleeding and the skin was closed using staples. The patient tolerated the procedure well and went to the recovery room in good condition.