Antenatal Testing

Physician Non-Stress Test Documentation Form:

Date: _____ Time: _____ Physician signature: _____ User #: _____

☐ NST Order written by Physician/Provider Gestational Age: _____ EDC: _____

INDICATIONS FOR AN NST:

☐ Decreased Fetal Movement
☐ Oligohydramnios
☐ Hypertension (Pregnancy related)
☐ Hypertension (maternal condition)
☐ Placenta Previa/abruption
☐ Infection (pregnancy related)

☐ Preterm Labor
☐ Post Term Dates
☐ Multiple Gestation
☐ Previous Fetal Demise
☐ Polyhydramnios
☐ Fetal infection

☐ IUGR/intrauterine growth problems
☐ Current Substance Abuse
☐ Diabetes (Pregnancy related)
☐ Diabetes (type 1)
☐ Congenital anomalies
☐ Cardiac disease

☐ Hyperthyroidism (poorly controlled)
☐ Antiphospholipid Syndrome
☐ Systemic Lupus Erythematosus

☐ Chronic Renal Disease
☐ Hemoglobinopathies
☐ Isoimmunization

☐ Cardiac Arrhythmias
☐ Cyanotic Heart Disease
☐ Seizure disorder

☐ Other: _____

Baseline Rate:						
FHR Variability:	☐ Absent	☐ Minimal	☐ Moderate	☐ Marked		
Acceleration:	☐ Absent	☐ Present	☐ Prolonged	☐ Baseline Change		
Deceleration:	☐ Absent	☐ Early	☐ Late	☐ Variable	☐ Prolonged	☐ Baseline Change
Contraction Frequency / Duration/Intensity:						
Category:	☐ I	☐ II	☐ III			
Fetal Movement:	☐ Documented	☐ Absent				
Interpretation of NST:	☐ Reactive:	☐ Non- Reactive				

DISPOSITION/PLAN:

☐ Admit
☐ Follow up NST @ St. Joseph: _____ @ _____
☐ Follow –up with Physician/Provider/ Clinic:

_____

☐ Other: _____

DISCHARGE INSTRUCTION GIVEN:

☐ Kick Counts
☐ Recognizing Labor
☐ Recognizing Preterm Labor
☐ Hypertension
☐ Other: _____

Notes: _____

Patient Label