Labor and Delivery Discharge Summary

DATE OF ADMISSION: 1 week ago
DATE OF DISCHARGE: 2 days after birth
DISCHARGE DIAGNOSES: Intrauterine gestation at 37 ½ weeks, in labor, multiparity, fertility, delivery of viable male infant.
PROCEDURES: Low transverse cesarean section
COMPLICATIONS: None. Level of pain at discharge, mild, 3/10.
PERTINENT FINDINGS AND HISTORY: Please refer to the detailed admission dictation as well as the written history and physical. The patient is a 39-year-old gravida 4, para 1 female with an EDC of 9 months ago who presented at 37.6 weeks gestation in labor with contractions recurring every 1-1/2 to 2 minutes of moderate intensity. Her antenatal course had been benign. She does have a GDM diagnosis. Her GDM is currently being managed with diet and insulin. On admission, examination revealed the patient was afebrile with a temperature of 97.8 degrees, blood pressure 118/78, pulse 82, and respirations 18. HEENT, neck, heart, lungs, abdomen, extremity, calf, thigh, and neurologic examinations all were within normal limits. The estimated fetal weight of the infant was over 9 pounds. The cervix was 1 cm dilated, 60% effaced, with membranes bulging with the vertex at -2 station. There was no pedal edema. The fetal heart tracing was reassuring and reactive. The contractions were recurring every 1-1/2 to 2 minutes. The patient was uncomfortable on admission.
HOSPITAL COURSE: Please refer to the admission dictation for the patient's antenatal and admission laboratory investigations. The patient's postoperative hematocrit was 30.7. The patient was admitted to labor and delivery. She had oxytocin augmentation and progressed from 3 to 5 cm over 4 hours; however, there was no change in dilation over the following four hours. The vertex was at spine at minus 1 and OP/deflexed. Following discussion of the nature of cesarean section and possible complications, consent was obtained. Informed consent was obtained. In the afternoon, under spinal anesthesia, an uncomplicated low transverse cesarean section was performed. A viable male infant with Apgars of 9 and 9 and cord pH of 7.32 was delivered. Birth weight was 9 pounds 4 ounces. There were no intraoperative or perioperative complications.
The patient's postoperative course was uneventful. She was breast-feeding. She remained afebrile with stable vital signs. She quickly returned to good ambulation and a regular diet and moved her bowels prior to discharge. By the morning of the second postoperative day, she was anxious to go home. She was having mild pain, controlled with Oxycodone. Her examination revealed clear lungs, irregular heart rate and rhythm, negative breast, abdomen incision, calf, thigh, and neurologic examination. Lochia was normal. Fundus was firm. The patient had no respiratory problems during the postoperative period. She was maintained on her home medications.

CONDITION AT DISCHARGE: Stable.
DISPOSITION: Discharged to home.
DISCHARGE INSTRUCTIONS: See Discharge Orders
DISCHARGE MEDICATIONS: See Discharge Orders
FOLLOWUP: The patient will be seen in the office 1 week post-delivery.
Prior to discharge, the patient received routine verbal and written instructions and agreed to comply. We went over all signs and symptoms of complications. The patient knows to contact immediately should she develop any issues such as fevers, chills, heavy bleeding, neurological problems such as dizziness, weakness, blurry vision, abdominal distention with nausea and vomiting, drainage from the incision, redness, tenderness, swelling of the calves or thighs or certainly chest pain, chest pressure, shortness of breath, cough, sputum, or wheeze.

Electronically Signed: K Kirst MD