

Form Title **Cervical Ripening Order Set**

Form Number **20864**

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Cervical Ripening Orders Set

Select orders by placing a (✓) in the associated box

Last Name	
First Name	
PHN#	MRN#
Birthdate (dd-Mon-yyyy)	Physician

Patient Care		
Diet		
<input type="checkbox"/> Maternal Diet <input type="checkbox"/> NPO – when in active labour <input type="checkbox"/> NPO – may take oral medications <input type="checkbox"/> Clear Fluids – when in active labour <input type="checkbox"/> Other _____		
Activity		
<input type="checkbox"/> Bedrest <input type="checkbox"/> Bedrest with Bathroom privileges <input type="checkbox"/> Ambulate with assist <input type="checkbox"/> Activity as tolerated		
Monitoring (<i>Vital signs are indicated at a minimum of every hour in the initial 1-4 hours</i>)		
<input type="checkbox"/> Vital signs: These orders need to be re-evaluated based on progression of labour. Vital signs to include: temperature (T), pulse rate (P), respiratory rate (RR), blood pressure (BP) and oxygen saturation (O2 sat) with options to include: <ul style="list-style-type: none"> <input type="checkbox"/> As per local standards <input type="checkbox"/> Every _____ minutes <input type="checkbox"/> Every _____ hour 		
<input type="checkbox"/> External Fetal Monitoring <ul style="list-style-type: none"> <input type="checkbox"/> Nonstress test (NST) immediately prior to dinoprostone or balloon catheter insertion to determine fetal well being <input type="checkbox"/> Notify the primary clinician based on the Electronic Fetal Heart Rate Guidelines <input type="checkbox"/> Monitor fetal heart rate for at least 60 minutes post dinoprostone gel or dinoprostone vaginal insertion 		
Laboratory Investigations		
<i>Ensure completed prior to decision to proceed with cervical ripening and induction of labour.</i>		
Hematology		
<input type="checkbox"/> Complete Blood Count (CBC) with differential		
Microbiology		
<input type="checkbox"/> Group B Strep Vaginal/Rectal Swab (<i>if status unknown</i>)		
Prescriber Signature	Date (dd-Mon-yyyy)	Time (hh:mm)

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Last Name	
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Laboratory Investigations <i>continued</i>			
Urine Tests			
<input type="checkbox"/> Urine Dipstick Testing - Point of Care Test			
<input type="checkbox"/> Urinalysis Random			
Intravenous Therapy			
<input type="checkbox"/> Intravenous Cannula – Insert: Initiate IV			
<input type="checkbox"/> IV Peripheral Saline Flush/Lock: Insert: Saline Lock			
<input type="checkbox"/> sodium chloride 0.9% infusion IV at _____ mL/hour			
<input type="checkbox"/> lactated ringers infusion IV at _____ mL/hour			
Medications			
<input type="checkbox"/> dinoprostone vaginal insert 10 mg INTRA VAGINALLY once. (<i>dinoprostone may be left insitu for up to 24 hours</i>)			
<input type="checkbox"/> Remove dinoprostone vaginal insert upon onset of active labour, rupture of membranes, or 24 hours after insertion			
<input type="checkbox"/> dinoprostone vaginal gel _____ mg INTRA VAGINALLY once			
<input type="checkbox"/> May repeat dinoprostone vaginal gel _____ mg INTRA VAGINALLY after 6 hours			
<input type="checkbox"/> Other: _____ Dose _____ mg Route _____ Frequency _____ hours			
PRN Analgesics			
<input type="checkbox"/> morphine _____ mg IM every 3 hours PRN			
<input type="checkbox"/> morphine 2.5 mg DIRECT IV every 10 minutes PRN. Maximum Dosage 10 mg.			
<input type="checkbox"/> fentaNYL _____ mcg DIRECT IV every 10 minutes PRN, (<i>Recommended fentaNYL dose: 0.5 mcg/kg</i>). Maximum 50 mcg per dose. Maximum cumulative dose of 2 mcg/kg in 1 hour. Maximum total cumulative dose of 4 mcg/kg.			
<input type="checkbox"/> Entonox® Inhalation PRN during contractions			
PRN Antinauseants			
<input type="checkbox"/> dimenhyDRINATE _____ mg IVPB every _____ hours PRN			
<input type="checkbox"/> dimenhyDRINATE _____ mg IM every _____ hours PRN			
Transitions and Referrals			
<input type="checkbox"/> Consult Anesthesia	Consultant Contacted	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Required
<input type="checkbox"/> Consult Obstetrician on call	Consultant Contacted	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Required
<input type="checkbox"/> Consult Endocrinology	Consultant Contacted	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Required
<input type="checkbox"/> Consult Neonatology	Consultant Contacted	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Required
<input type="checkbox"/> Consult _____	Consultant Contacted	<input type="checkbox"/> Yes	<input type="checkbox"/> Not Required
Prescriber Signature	Date (dd-Mon-yyyy)	Time (hh:mm)	