Duke University Medical Center

Obstetrics & Gynecology

Resident Handbook

2026-2027

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PHONE NUMBERS

HOSPITAL OPERATOR 684-8111 - OB EMERGENCY 115

DUKE BIRTHING CENTER

MFM Attending/(Fellow on-call)	613-2449
MFM Fellow	613-2452
Mole/Board Resident	613-1122
DWHA Attending	613-2448
APP	613-2450
Intern	613-2451
Triage RN	613-8790
5700 Charge RN	613-8788
5800 Charge RN	613-8777
Stork RN	613-1123
Anesthesia Attending	613-2121
Anesthesia Resident	613-2886
CRNA (days only)	613-2135

CLINIC NUMBERS

Duke Perinatal Workroom	668-7428
Duke Perinatal Front Desk	613-6969
OB/Gyn Appointment Line	684-2471
FDC Reading Room	668-7436
Patient RN Triage Line	684-6327
Duke Perinatal Raleigh	783-4299
Family Planning (Sally)	668-7888
Gyn (1J) Clinic Workroom	668-7416
Gyn RN Triage Line	684-6677
Gyn Onc Appointments	668-6688
Gyn Onc Clinic	684-3765
Gyn Onc Clinic Workroom	660-1272
Gyn Onc Fellow Clinic Line	613-1032
Urogyn Patterson Place	401-1000
Urogyn RNs	401-1000x6
VA WHC	286-0411

UNITS

5700 Workroom (Mole Phone)	681-1142
6300 Fax	681-8182
6300 Onc-tern Phone	681-1670
CCU	681-7241
CCU Fellow	812-5810
ER Pod A (Sr. Resident)	681-4407
ER Pod B (PA)	681-4409
ER Pod C (Sr. Resident)	681-4408
MFM Office Fax	681-4244
MICU	681-8241

SURGERY/OR

Anesthesia Attending On-Call	970-9111
Duke North OR -add-on cases	681-2255
Duke North OR Scheduling	681-5099
Duke North Pre-Op Holding	684-4718
Duke North PACU	681-3002
Duke North OR (XX=OR Rm #)	681-01XX
DMP OR	385-39XX
DMP PACU	385-3322
DRH Anesthesia	470-8169/ 3303
DRH OR Front Desk	470-6188
DRH OR Outpatient scheduling	470-8529
DRH OR (XX=OR Rm #)	470-835#
DRH OR Charge RN	470-6179
DRH PACU	470-6171
DRH ACU	470-5340
ASC Front desk	668-2000
ASC RCC (overnight stay)	668-2030
ASC Scheduling	668-2045
ASC OR (XX=OR Rm #)	668-23XX

ANCILLARY SERVICES

5700 Pharmacy	970-9916
6300 Pharmacy	681-6344/6001
9300 Pharmacy	681-2029
Bed Control	681-4300/4132
DHTS Help Desk	684-2243
Employee/Occupational Health	681-3136
Contact precautions RN	970-9721
Infection Control	684-5457
DUH Interpreter Office	681-3007
Medical Records	684-5525
OIT	684-2200
Physical Therapy	681-2030
Resp Therapy (5400 & 5700)	970-8818
Resp Therapy (6300)	970-1167
Risk Management	681-0601
Social worker On-Call	970-7419

LABS

Blood Gases	681-3223
CPED (most 5400 & 5700 labs)	681-3602
Central Lab Support	681-2620
Chemistry/Evening Lab Support	681-2545
Coagulation	684-6366
Blood Bank/Transfusion	681-2644

Patient Room (XXX=room #)	681-XXXX
DUH Unit HUC (XX=unit)	681-XX41
NICU	681-5551
NICU Fellow's Phone	877-781-
OB OR	681-5670
OB Triage	681-6070
OB Triage Workroom	681-5021
Pediatric Cardiac ICU	613-5400
SICU	681-2241
Short Stay	681-7230

CONSULTS (970-xxxx)

Acute Pain Service	8506 (epidural)
	8507 (consult)
Anesthesia – OB	9987
Anesthesia (Emergency Airway) Cardiology	9111
	1489
Dermatology	3376
Diabetes Management	6533
Dialysis Access	GORE
DVT Team	2DVT
Endocrine	6533
ENT (Otolaryngology)	1320
EP	7607
Feeding Tubes	FOOD
General Surgery	2222
GI	1858
Hematology	2414
Hyperbaric	2909
ID	GERM
Internal Medicine	7777
Interventional Pulmonology	8111
Interventional/Vascular	7930
Radiology Microbiology Fellow	8885
Neurology	4662
Oncology	7972
Ophthalmology	8040
Oral Surgery	684-2943
Orthopedics	0356
Pain Team	8506/7
Palliative Care	CARE
Pathology (FNA)	4525
Plastic Surgery	3383
Psychiatry Pulmonary	PSYC 6266
Radiation Oncology	2160
Renal	7746
Thoracic Surgery	3333
Urology	3765
Wound Management	5022

Microbiology	684-2089
Phlebotomy	681-6933
Surgical Pathology	681-3133
Frozen Pathology	681-3909
Cytology	613-9414

RADIOLOGY

Main #	684-2711
Night Radiology Jr	681-4400
Night Radiology Sr	681-4422
ED Radiology Main	684-4475
Chest Plain Film Reading	684-7252
Chest Reading	684-7419
Bone Reading	684-7247/684-7248
Breast Imaging	681-7816/684-7946
CT Body Scheduling (CT tech)	684-7221/2707
CT Body Reading	684-7224
CT Neuro Reading	684-7213
CT Head	684-7386
CT Intervention	684-7331
Interventional Coordinator	681-7281
Echo	681-5295/684-5295
EEG	681-2803
GI Reading	684-7257/684-7250
MRI Main	684-7254
MRI Inpatient	385-1381
MRI Tech	684-7254
MRI Body Reading	684-7224
MRI Neuro Reading	684-7560
Nuclear Medicine	684-7207
PET (inpatient)	684-7714
Pediatric Radiology	684-7288
Ultrasound Reading	684-7381
Ultrasound Tech	684-7431
Vascular Reading	684-7592/684-7383
X-Ray Tech	684-7312

HOSPITALS

Durham Regional Hospital	470-4000
DRH L&D	470-4220
DRH Call Room	470-4215
UNC L&D	966-3422
UNC L&D fax	966-3429

ADMINISTRATIVE

GME	684-3491
Caroline Oviedo	668- 2591

HEALTH DEPARTMENTS

Lincoln Community HC	956-4000
Durham County	560-7600

PAGER/COVERAGE INFORMATION

FUNCTIONAL PAGERS	DAY COVERAGE 7:00a – 6:00p	NIGHT COVERAGE 6:00p – 7:00a
GYN ONCOLOGY **970-7700**	PGY1 Onc	PGY2 NF
BENIGN GYN **970-4962**	Gyn PGY1 or APP	PGY2 NF
OB ANTEPARTUM **970-2233**	Antepartum PGY3	PGY2 NF
UROGYNECOLOGY **970-9976**	Urogyn PGY2 or 4	PGY2 NF
REI **970-9285**	REI PGY2	PGY2 NF
POSTPARTUM **970-0990**	PGY1 OB	PGY1 NF
OB/GYN CONSULT **970-7066**	GYN PGY 3/4 or APP	PGY4
RALEIGH **206-3918**	7:00a – 5:00p PGY 3/4	5:00p – 7:00a (PGY1*/2/3/4)

How to sign on to a functional pager: all 919-470-4636 -> press 2 -> enter the functional pager # -> press 5 -> enter your pager #

WEEKEND/HOLIDAY CALL

PGY-1
Rounds on Postpartum in the AM with post-call intern. Covers triage, deliveries, circumcisions (with supervision), Nexplanon placements (with supervision), and postpartum pager. Participates in labor management as triage and postpartum allow.

PGY-2
Rounds on GynOnc with post-call PGY-2. Signs on to Gyn Oncology, Urogyn, REI, and Benign Gyn. Covers Gyn Onc and other Gyn services. Contact Gyn Onc fellow in the afternoon for PM rounds over the phone. Assist with consults, cesarean deliveries, and add on GYN OR cases.

PGY-3
Rounds on Antepartum with APP and/or post-call PGY-3. Covers L&D active board. Covers Antepartum service Friday night – Sunday morning.

PGY-4
Rounds on Gyn Services (REI, Urogyn, Benign, VA). Signs on to Consult pager, assist with PGY-2 tasks, Postpartum tasks, and performs cesarean deliveries and add on GYN OR cases.

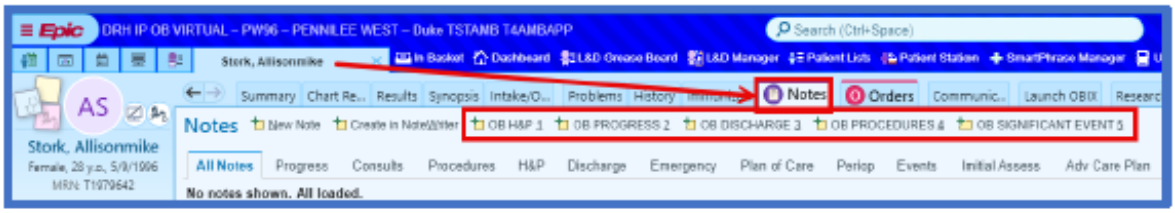
OBSTETRICS PEARLS

OB Inpatient Speed Buttons and Standard Templates

MAESTRO CARE

one patient, one record, one system

New speed buttons allow for quick, standardized documentation for OB patients admitted to the hospital. You can find the new speed buttons under the "*Notes*" tab.



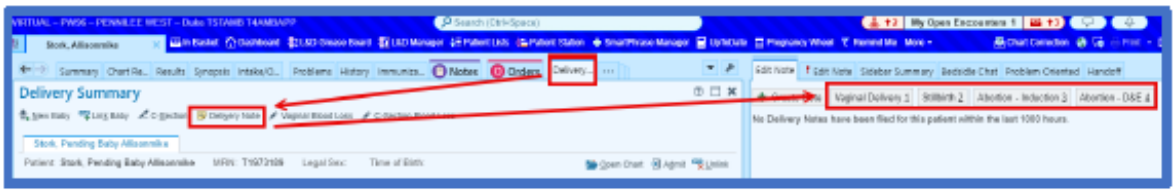
The speed buttons are categorized by "*note type*" and the following note templates are available:

1. **H&P**
2. **Progress Notes**
    a. Triage / Observation note
    b. Antepartum rounding note
    c. Labor progress note
    d. Labor magnesium check
    e. Strip review
    f. OB trauma
    g. Postpartum magnesium check
    h. Postpartum rounding note
3. **Discharge summary**
    a. Antepartum discharge
    b. Postpartum discharge
4. **Procedures**
    a. Circumcision
    b. Foley insertion for cervical ripening
    c. Nexplanon insertion
5. **Significant event**
    a. Cesarean decision note

Additionally there are speed buttons found under the **Delivery Summary** tab.

1. Vaginal Delivery
2. Stillbirth
3. Abortion-Induction
4. Abortion-D&E

Select the "*Delivery Note*" icon.



EPIC DOT PHRASES

Triage/Admission H&P: .OBHANDP (see above)

Foley balloon insertion note: .OBFOLEYINSERTION (see above

Vaginal delivery note: .OBPROCSVD (see above) located under the delivery summary tab)
Please add anything that occurred that may not auto-populate (Ritchen's maneuver, bimanual exam, etc).

Rounding note for Postpartum SVD & CS: .OBPPBETA (seeabove)

Circumcision procedure note: .2021CIRC (see above)

Rounding note for Postpartum SVD & CS: .OBPPBETA (see above)

Mag check note for PP: steal one you like, or .OBPPMAGCHECK / .OBMAGPP (see above)

OB postpartum discharge summary: .OBPPDCSUMMARY2021 (see above

Handoff – OB AP: .OBAPSIGNOUT2018
Handoff – OB ACTIVE

- 1st field: .obhandoff1summary
- 2nd field: .obhandoff2daytmnotes
- 3rd field: .obhandoff3xcover
- 4th field: .obhandoff4todo
-

Handoff – Circumcision to do list: .CIRCTODOLIST

Labs for handoff:
CBC/CMP/MG/Coags: .LABSGENERALVF
CBC/CMP/P/Cr: .PREX8 (handoff) or .PREX11 (notes).
Glucose Levels: .POCGLUCOSE8 (handoff) or .POCGLUCOSE11 (notes)
Postpartum Instructions: .PPINSTRUCTIONSSVD or .PPINSTRUCTIONSCS Spanish: .PPSPINSTRUCTIONSVD or .PPSPINSTRUCTIONCS
Add-ons: .PPINSTRUCTIONSPIH or .PPINSTRUCTIONSGDM

If a patient has a hypertensive disorder documented in the problem list, you will see a **management plan** with the new recommendations and resources as outlined.

If a patient has a 3rd or 4th degree laceration documented in the delivery summary, you will see a **management plan** with reminders for patient instructions and follow up

HELPFUL ORDER SETS
OB Labor and Delivery Admission OB Antepartum Admission
OB ERAS Pre-Op
OB ERAS Post-Op C/S
OB Labor and Delivery Magnesium OB Post Vaginal Delivery

IMAGING GUIDANCE
dukerad.radsq.com – Radiology website with numbers, contact info, and what study to order
OBSTETRIC EMERGENCIES
CALL FOR HELP – chief, fellow or 115
WHEN YOU CALL 115 (or have someone else call) indicate **what** the emergency is & **where** it is.
For example, "Ob hemorrhage 5703" or "Ob emergency to Main OB OR"

MEDICALLY INDICATED DELIVERY TIMING

Table 1. Recommendations for the Timing of Delivery When Conditions Complicate Pregnancy*

Condition	General Timing	Suggested Specific Timing
Placental/Uterine Conditions		
Placenta previa†	Late preterm/early term	36 0/7–37 6/7 weeks of gestation
Suspected accreta, increta, or percreta†	Late preterm	34 0/7–35 6/7 weeks of gestation
Vasa previa	Late preterm/early term	34 0/7–37 0/7 weeks of gestation
Prior classical cesarean delivery	Late preterm/early term	36 0/7–37 0/7 weeks of gestation
Prior myomectomy requiring cesarean delivery‡	Early term (individualize)	37 0/7–38 6/7 weeks of gestation
Previous uterine rupture	Late preterm/early term	36 0/7–37 0/7 weeks of gestation
Fetal Conditions		
Oligohydramnios (isolated or otherwise uncomplicated [deepest vertical pocket less than 2 cm])	Late preterm/early term	36 0/7–37 6/7 weeks of gestation or at diagnosis if diagnosed later
Polyhydramnios (mild, idiopathic)†	Full term (early term birth not routinely recommended)	39 0/7–40 6/7 weeks of gestation
Growth restriction (singleton)		
Otherwise uncomplicated, no concurrent findings, EFW between 3rd and 10th percentile	Early term/full term	38 0/7–39 0/7 weeks of gestation
Otherwise uncomplicated, no concurrent findings, EFW <3rd percentile	Early term	37 0/7 weeks of gestation or at diagnosis if diagnosed later
Abnormal umbilical artery Doppler studies: elevated impedance to flow (eg, S/D ratio, pulsatility index, or resistance index greater than 95th percentile for gestational age) with end-diastolic flow still present	Early term	37 0/7 weeks of gestation or at diagnosis if diagnosed later
Abnormal umbilical artery Doppler studies: absent end-diastolic flow	Preterm/late preterm	33 0/7–34 0/7 weeks of gestation or at diagnosis if diagnosed later§
Abnormal umbilical artery Doppler studies: reversed end-diastolic flow	Preterm	30 0/7–32 0/7 weeks of gestation or at diagnosis if diagnosed later§
Concurrent conditions (oligohydramnios, maternal comorbidity [eg, preeclampsia, chronic hypertension])	Late preterm/early term	34 0/7–37 6/7 weeks of gestation
Multiple gestations—uncomplicated		
Dichorionic-diamniotic twins	Early term	38 0/7–38 6/7 weeks of gestation
Monochorionic-diamniotic twins	Late preterm/early term	34 0/7–37 6/7 weeks of gestation
Monochorionic-monoamniotic twins	Preterm/late preterm	32 0/7–34 0/7 weeks of gestation
Triplet and higher order multiples	Preterm/late preterm	Individualized
Multiple gestations—complicated		
Dichorionic-diamniotic twins with isolated fetal growth restriction	Late preterm/early term	36 0/7–37 6/7 weeks of gestation
Dichorionic-diamniotic twins with concurrent condition	Late preterm	Individualized
Monochorionic-diamniotic twins with isolated fetal growth restriction	Preterm/late preterm	32 0/7–34 6/7 weeks of gestation
Alloimmunization		
At-risk pregnancy not requiring intrauterine transfusion	Early term	37 0/7–38 6/7 weeks of gestation
Requiring intrauterine transfusion	Late preterm or early term	Individualized
Maternal Conditions		
Hypertensive disorders of pregnancy		
Chronic hypertension: isolated, uncomplicated, controlled, not requiring medications	Early term/full term	38 0/7–39 6/7 weeks of gestation‖
Chronic hypertension: isolated, uncomplicated, controlled on medications	Early term/full term	37 0/7–39 6/7 weeks of gestation‖
Chronic hypertension: difficult to control (requiring frequent medication adjustments)	Late preterm/early term	36 0/7–37 6/7 weeks of gestation
Gestational hypertension, without severe-range blood pressure	Early term	37 0/7 weeks of gestation or at diagnosis if diagnosed later
Gestational hypertension with severe-range blood pressures	Late preterm	34 0/7 weeks of gestation or at diagnosis if diagnosed later
Preeclampsia without severe features	Early term	37 0/7 weeks of gestation or at diagnosis if diagnosed later

Preeclampsia with severe features, stable maternal and fetal conditions, after fetal viability (includes superimposed)	Late preterm	34 0/7 weeks of gestation or at diagnosis if diagnosed later
Preeclampsia with severe features, unstable or complicated, after fetal viability (includes superimposed and HELLP)	Soon after maternal stabilization	Soon after maternal stabilization
Preeclampsia with severe features, before viability	Soon after maternal stabilization[¶]	Soon after maternal stabilization[¶]
Diabetes		
Pregestational diabetes well-controlled[†]	Full term	39 0/7–39 6/7 weeks of gestation
Pregestational diabetes with vascular complications, poor glucose control, or prior stillbirth	Late preterm/early term	36 0/7–38 6/7 weeks of gestation
Gestational: well controlled on diet and exercise	Full term	39 0/7–40 6/7 weeks of gestation
Gestational: well controlled on medications	Full term	39 0/7–39 6/7 weeks of gestation
Gestational: poorly controlled	Late preterm/early term	Individualized
HIV		
Intact membranes and viral load >1,000 copies/mL	Early-term cesarean delivery	38 0/7 weeks of gestation
Viral load ≤1,000 copies/mL with antiretroviral therapy	Full term (early term birth not indicated)	39 0/7 weeks of gestation or later
Intrahepatic cholestasis of pregnancy: total bile acid levels <100 micromol/L	Late preterm/early term	36 0/7–39 0/7 weeks of gestation or at diagnosis if diagnosed later[#]
Intrahepatic cholestasis of pregnancy: total bile acid levels ≥100 micromol/L	Late preterm	36 0/7 weeks of gestation or at diagnosis if diagnosed later[#]
Obstetric Conditions		
Preterm PROM	Late preterm	34 0/7–36 6/7 weeks of gestation **
PROM (37 0/7 weeks of gestation and beyond)	Generally, at diagnosis	Generally, at diagnosis
Previous stillbirth	Full term (early term birth not routinely recommended)	Individualized [††]

Abbreviations: EFW, estimated fetal weight; HELLP, hemolysis, elevated liver enzymes, and low platelet count; PROM, prelabor rupture of membranes (also referred to as premature rupture of membranes); S/D, systolic/diastolic.

*In situations in which there is a wide gestational age range for acceptable delivery thresholds, the lower range is not automatically preferable, and medical decision making for the upper or lower part of a range should depend on individual patient factors and risks and benefits.

[†]Uncomplicated, thus no fetal growth restriction, superimposed preeclampsia, or other complication. If these conditions are present. then the complicating conditions take precedence and earlier delivery may be indicated.

[‡]Prior myomectomy may require earlier delivery similar to prior classical cesarean (36 0/7–37 0/7 weeks of gestation) in situations with more extensive or complicated myomectomy. Data are conflicting regarding specific timing of delivery. Furthermore, timing of delivery may be influenced by the degree and location of the prior uterine surgery, with the possibility of delivering as late as 38 6/7 weeks of gestation for a patient with a less extensive prior surgery. Timing of delivery should be individualized based on prior surgical details available and the clinical situation.

[§]Consultation with maternal-fetal medicine subspecialist is recommended.

[||]Expectant management beyond 39 0/7 weeks of gestation should only be done after careful consideration of the risks and benefits and with appropriate surveillance.

[¶]Management individualized to particulars of maternal-fetal condition and gestational age.

[#]Measurement of serum bile acid levels and liver transaminase is recommended in patients with suspected intrahepatic cholestasis of pregnancy. Delivery before 36 weeks of gestation occasionally may be indicated depending on laboratory and clinical circumstances.

**The balance between benefit and risk, from both maternal and neonatal perspectives, should be carefully considered, and patients should be counseled clearly. Although a period of expectant management may be considered for women who request additional time for the onset of spontaneous labor, the potential maternal and neonatal risks associated with prolonged expectant management should be discussed. Care should be individualized through shared decision making, and expectant management should not extend beyond 37 0/7 weeks of gestation. Outside the scenario of unknown GBS status, latency antibiotics are not appropriate in this setting. If expectant management is being considered in a patient with unknown GBS status, an initial GBS culture should be obtained, and an antibiotic regimen active against GBS should be started until results of the GBS culture return. Women with PPROM who are colonized with GBS are at an increased risk of neonatal infection with expectant management. The potential additional neonatal risks associated with prolonged expectant management in the setting of maternal GBS colonization should be discussed and the reasons for discouraging such management reviewed and documented in the medical record. Abbreviations: GBS, group B streptococcus; PPROM, preterm prelabor rupture of membranes.

[††]Deliveries before 39 weeks of gestation are associated with an increased risk of admission to neonatal special care units for respiratory complications and other neonatal morbidities; however, maternal anxiety with a history of stillbirth should be considered and may warrant an early term delivery (37 0/7 weeks to 38 6/7 weeks) in women who are educated regarding, and accept, the associated neonatal risks.

Quantitative Blood Loss for Vaginal Deliveries

QBL: A direct objective measurement of blood loss utilizing a combination of measured volume using an under buttocks drape or cannister and weighing of blood-soaked items.

Initiated immediately following the delivery of the infant and continues until 2 hours post-delivery or once bleeding is stable.

Providers

1. Assess the volume of fluid in the drape following the delivery of the infant, before the delivery of the placenta and report this volume to nursing staff.

2. At the conclusion of the delivery, or in the presence of active bleeding, reassess the drape and report volume to nursing staff

Nursing

1. Calculate V-drape volume by subtracting **pre-placenta** volume from volume at the **completion** of the delivery.

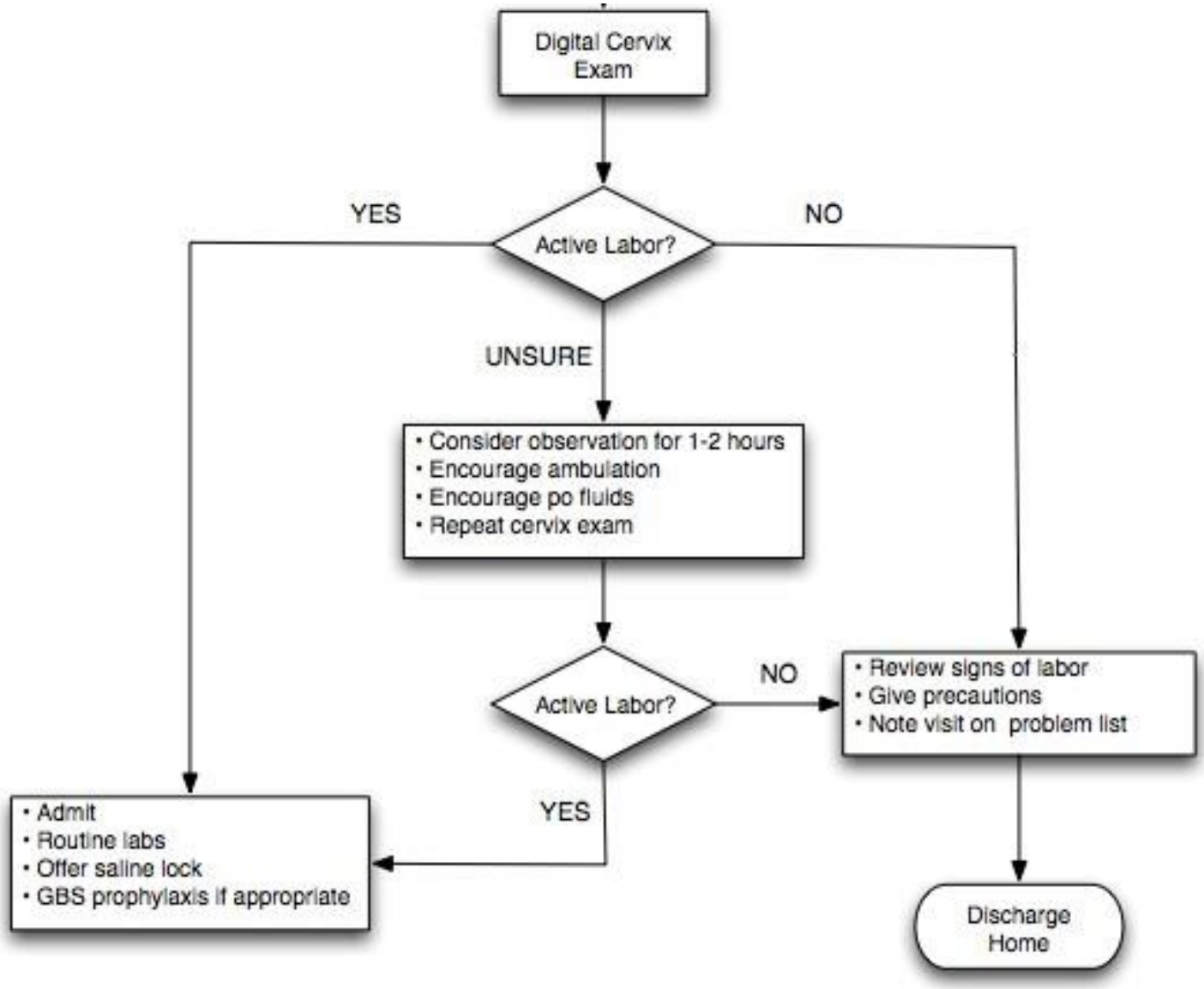
*Document this amount in the "**total wet weight**" field of the QBL calculator, in the comment box enter "v-drape"*

2. Weigh blood-soaked items and clots at the conclusion of delivery or sooner if indicated.

V-Drape + Weighed Items = Vaginal QBL

COMMON TRIAGE PRESENTATIONS

TERM EVALUATION OF LABOR



PRETERM LABOR EVALUATION

- Always confirm dating– actually look at initial ultrasound report
- Digital cervical exam (unless placenta previa)
- **LABS: Gonorrhea/chlamydia, GBS, urinalysis and urine culture, wet prep**
- IMAGING: bedside ultrasound to confirm presentation

Interventions:

- Steroids: 12mg betamethasone IM q24h x 2 doses
  - 22w5d-23w5d: situational – depends on patient and provider preference (wait for joint NICU/MFM counseling)
  - 24-34 weeks: everyone
  - 34w0d-36w6d if:
    - ALPS counseling DO NOT TOCOLYZE for steroids, but in stable PPROM, can delay augmentation x 12h.
- Antibiotics for GBS treatment/prophylaxis if GBS positive or unknown:
  - Ampicillin 2 g IV initial dose, then 1 g IV q4h until delivery
- Neuroprotection for viability up to 31w6d (for 12 hours, if delivery felt to be imminent)
  - ≥ 26 weeks Magnesium loading dose 6gm followed by 2gm/hour
  - < 26 weeks magnesium loading dose 4gm followed by 2gm/hour
- Tocolysis
  - IV fluid bolus - 1-2L over 1-4 hours.
  - 23w0d-31w6d:
    - Indomethacin tocolysis - 50mg loading dose followed by 25mg orally Q6 hours for a total of 48 hours of treatment.
  - 32w0d-33w6d:
    - Consider nifedipine tocolysis - 20mg IR PO loading dose followed by 10mg IR PO Q6 hours x48 hours
- NICU consult
- Triage bedside growth ultrasound
- Formal FDC Anatomy scan if never scanned within Duke system vs. growth ultrasound if no growth in last 3-4 weeks

TERM RUPTURE OF MEMBRANES

- HISTORY: Loss of fluid with each movement? Soaking through clothing? Recent intercourse?
- EVALUTION: sterile speculum exam with evaluation of pooling, ferning, and nitrazine (if negative -> wet prep)
    - If positive for ROM -> digital exam is indicated
- Admit to active service if positive for rupture of membranes
    - Terminology: Prelabor rupture of membranes (PROM) if not in labor vs. Spontaneous rupture of membranes (SROM) if in labor

PRETERM PRELABOR RUPTURE OF MEMBRANES (PPROM)

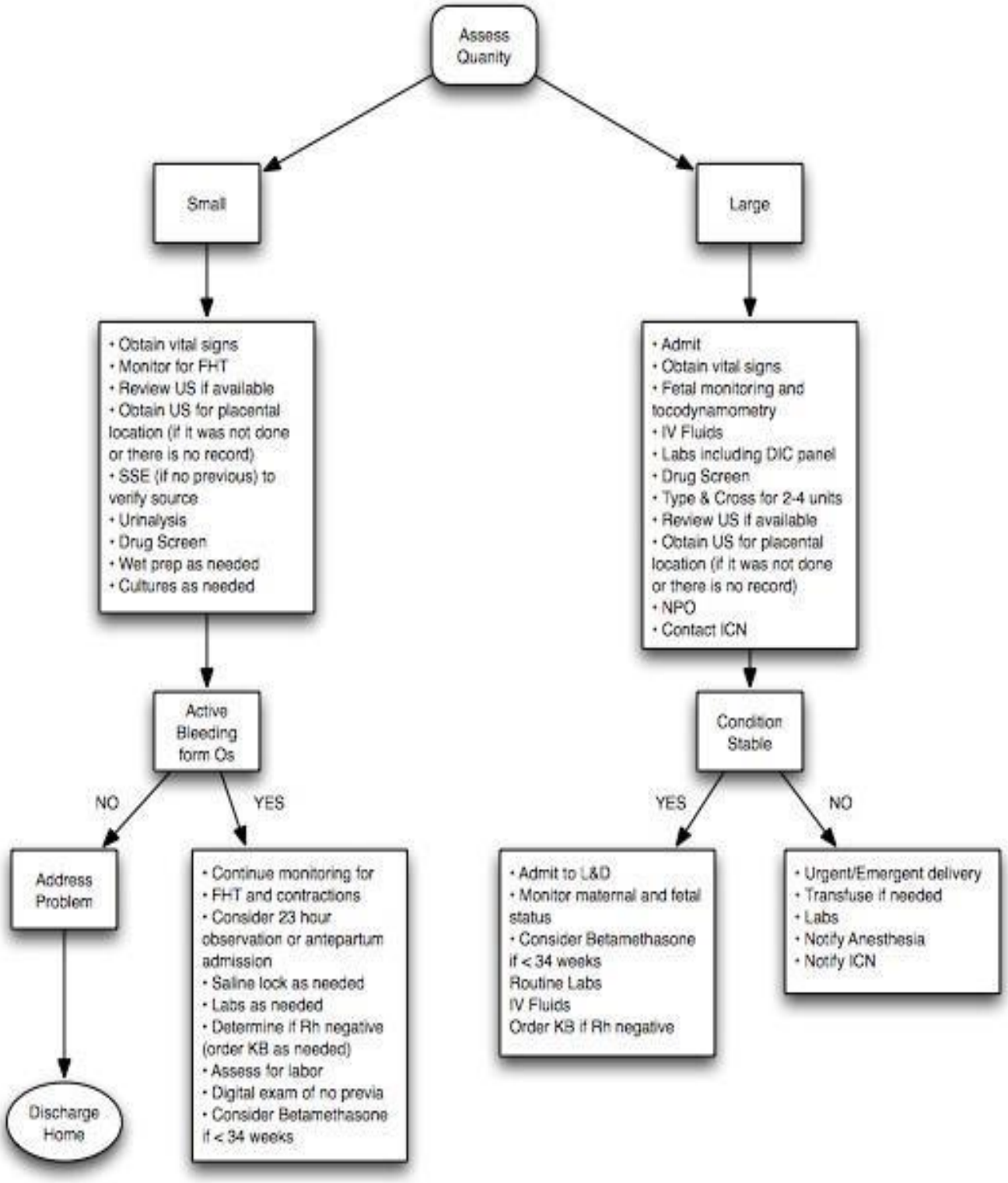
- EXAM:
    - DO NOT PERFORM DIGITAL EXAM unless >34 weeks or with strong painful contractions
    - Only perform a sterile speculum exam & estimate cervical dilation visually
- **LABS: wet prep, GCCT, GBS, CBC with diff, UA, UCx**
- IMAGING: confirm presentation with bedside scan and perform bedside growth. Order routine anatomy scan if patient has not had one at Duke vs. growth if patient has not had an ultrasound in last 3-4 weeks.

- **Counseling (with chief, fellow, or MFM)**
    - 50% of PPROM deliver in 1 week
    - 2-5% of PPROM abrupt, 15-20% PPROM develop infection

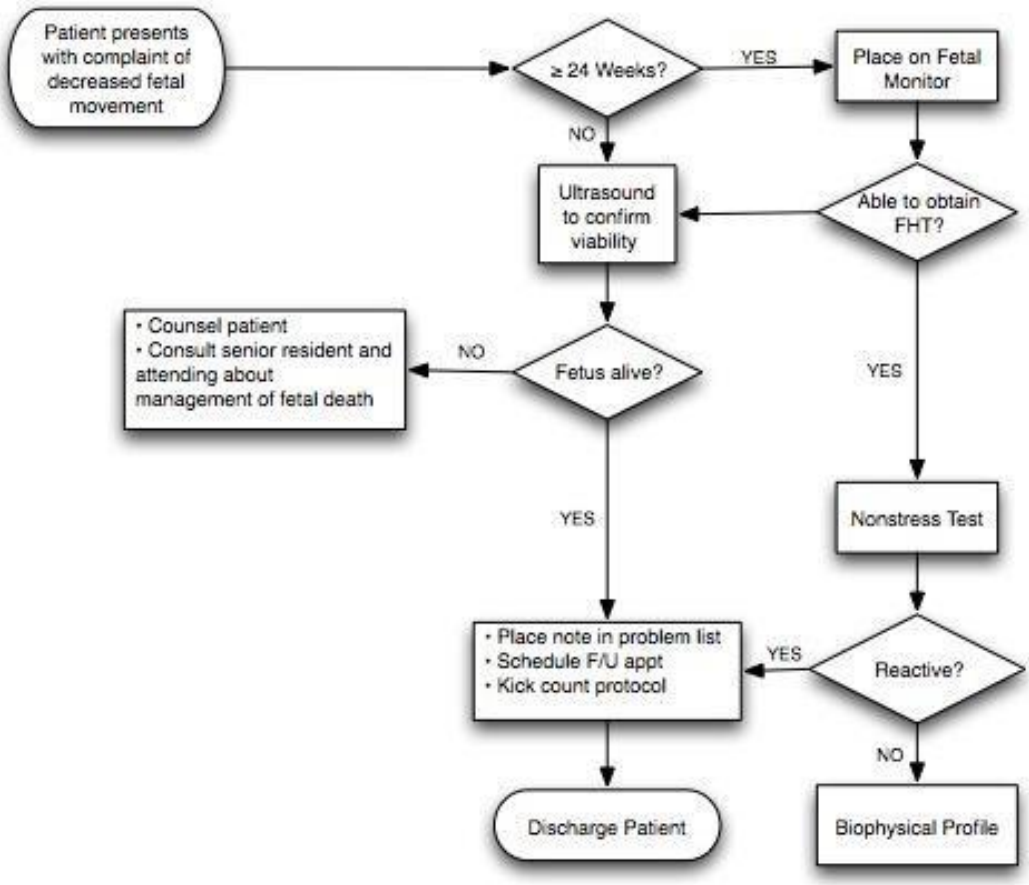
Interventions:

- DO NOT TOCOLYZE
- Steroids (viability – 37weeks) betamethasone 12 mg IM q24h x 2 doses (avoid in >34w if diabetic)
- Latency antibiotics:
    - Ampicillin 2 gm IV q6h x 48h, then amoxicillin 500 mg PO TID x 5d
    - Azithromycin 500 mg IV q24h x 2 doses, then 250 mg PO daily x 5d
- Neuroprotection viability up to 31w6d:
    - ≥ 26 weeks Magnesium loading dose 6gm followed by 2gm/hour
    - < 26 weeks magnesium loading dose 4gm followed by 2gm/hour
- Call NICU

VAGINAL BLEEDING AFTER 20 WEEKS



DECREASED FETAL MOVEMENT



NO PRENATAL CARE

- CONFIRM DATING w bedside ultrasound –PGY2-4 can help w biometry if you are unsure
- Enter OBGYN hx, medical, surgical, family, social history into epic
- Get name and phone, as well as secondary contact and phone. DOCUMENT this in your note.
    - Use OB No Prenatal Care order set to order all routine NOB labs while the pt is in triage, including: type & screen, CBC, HepB surface ANTIGEN, Hep C Antibody, Syphilis Ab, HIV L&D, Hemoglobin Electrophoresis, Rubella Antibody, Urine drug screen

PREECLAMPSIA EVALUATION

- Diagnosis
  - Labs: CBC, CMP, P/C ratio, (+/- Uric Acid in setting of cHTN to evaluated for superimposed preeclampsia)
  - Blood pressure monitoring (ensure it is every 15 minutes)

BOX E-1. Severe Features of Preeclampsia (Any of these findings) ⇦

- Systolic blood pressure of 160 mm Hg or higher, or diastolic blood pressure of 110 mm Hg or higher on two occasions at least 4 hours apart while the patient is on bed rest (unless antihypertensive therapy is initiated before this time)
- Thrombocytopenia (platelet count less than 100,000/microliter)
- Impaired liver function as indicated by abnormally elevated blood concentrations of liver enzymes (to twice normal concentration), severe persistent right upper quadrant or epigastric pain unresponsive to medication and not accounted for by alternative diagnoses, or both
- Progressive renal insufficiency (serum creatinine concentration greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease)
- Pulmonary edema
- New-onset cerebral or visual disturbances

TABLE E-1. Diagnostic Criteria for Preeclampsia ⇦

Blood pressure	• Greater than or equal to 140 mm Hg systolic or greater than or equal to 90 mm Hg diastolic on two occasions at least 4 hours apart after 20 weeks of gestation in a woman with a previously normal blood pressure • Greater than or equal to 160 mm Hg systolic or greater than or equal to 110 mm Hg diastolic, hypertension can be confirmed within a short interval (minutes) to facilitate timely antihypertensive therapy
and	
Proteinuria	• Greater than or equal to 300 mg per 24-hour urine collection (or this amount extrapolated from a timed collection) or • Protein/creatinine ratio greater than or equal to 0.3* • Dipstick reading of 1+ (used only if other quantita 300 ods not available)
Or in the absence of pro	
Thrombocytopenia	• Platelet count less than 100,000/microliter
Renal insufficiency	• Serum creatinine concentrations greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease
Impaired liver function	• Elevated blood concentrations of liver transaminases to twice normal concentration
Pulmonary edema	
Cerebral or visual symptoms	

* Each measured as mg/dL.

Management

Without severe features (new onset HTN >140/90 but <160/110, in two episodes 4h apart WITH proteinuria and NOTHING ELSE):

- >37w0d: admit for delivery – induction vs c-section
- <37 weeks: consider admit for obs

With severe features: inpatient admission until delivery at 34 weeks (or earlier depending on the situation)

- 24 hours of magnesium: 4g bolus followed by 2g/hr (OB Labor and Delivery Magnesium order set)
- CBC/CMP Q4-12 hours
- Betamethasone x 2 doses

Emergent BP management as below for BP >160/110 sustained over 15 minutes

Order set:

DUHS OB SEVERE-RANGE BLOOD PRESSURE TREATMENT PATHWAYS

DBC Guidelines: Magnesium for seizure prophylaxis
Duke Birthing Center
Updated 9/2021

Criteria for preeclampsia with severe features (and indication for magnesium)

- BP≥160/110 on 2 occasions ≥ 4 hrs apart (unless antihypertensive therapy initiated before then)

OR

- SBP ≥ 140/90 mmHg on 2 occasions ≥ 4hrs apart

AND

- Thrombocytopenia (Plt count < 100 x 10^9/L)
- LFTs > twice the upper limit of normal OR severe persistent RUQ or epigastric pain
- Creatinine > 1.1mg/dL or doubling of serum Cr without other renal disease
- Pulmonary edema
- New onset headache unresponsive to medication
- Visual disturbances

Antepartum Indication:	Postpartum Indications:
Eclampsia – to prevent recurrent seizures **Preeclampsia with severe features:** - Antepartum (>20w gestation-delivery): • New diagnosis • Prior diagnosis + new onset severe features • Ongoing workup of severe range BP (chronic hypertension vs superimposed preeclampsia with SF) • Intrapartum: during IOL / labor / CS	**Eclampsia** – to prevent recurrent seizures **Preeclampsia with severe features:** - Diagnosis prior to delivery: recommend continuation 24h PP - New diagnosis of preeclampsia with severe features up to 6 weeks postpartum

<u>Absolute contraindications to magnesium</u>

- Myasthenia gravis
- Cardiac ischemia, heart block, myocarditis

Alternatives for seizure prophylaxis / treatment: Levetiracetam (preferred) or valproic acid

Magnesium dose adjustment

Therapeutic goal: 4.8-8.4 mg/dl

	Loading dose (LD)	Maintenance	Monitor
Cr Less than 1.0	4g	2g/hr	Clinical exam
Cr 1.0-1.5 or oliguria (UOP <30ml/hr for 4 hours)	4g	1g/hr	Serum Mg q4h
Cr > 1.5	4g* Repeat 2-4g bolus if subtherapeutic**	0	Serum Mg q4h
Difficulty obtaining IV access	IM 10g total (5g, 5g)	IM 5g q4h	Clinical exam
Eclamptic seizure	IV 6g or IM 10g total (5g, 5g)	2g/hr + Additional 1x 2g bolus for recurrent seizure	Serum Mg if additional bolus

*No less than 4g LD for all patients, very likely to remain subtherapeutic if a lower LD is used

**Limited data, recommend close clinical/lab monitoring

Concerns for Magnesium Toxicity

Loss of DTRs or Serum Mg >/= 9.6 mg/dL	Stop Mg, check serum Mg q2h	Resume Mg 1g/hr when Mg <8.4 mg/dL
Respiratory depression (RR<12)	Stop Mg, obtain STAT Mg level	Give IV 10% Ca gluconate 10mL/3min Lasix to accelerate excretion
ECG changes, concern for cardiac effects	Stop Mg, obtain STAT Mg level	Give IV 10% Ca gluconate 15-30mL/5min Lasix to accelerate excretion
Pulmonary edema*	Continue Mg	Strict I/Os Stop/limit maintenance fluids <60mL/hr Lasix for diuresis O2 supplementation prn
Postpartum Hemorrhage	Continue Mg	

*Very rarely Mg side effect, more likely to be due to preeclampsia, not a Mg contraindication

MAG CHECKS:

- Vitals including O2 sats, UOP
- Note ssx worsening preX/HELLP: headache, vision changes, N/V, RUQ pain
- Note ssx magnesium toxicity: Somnolence, SOB/pulm edema, chest pain, RUQ pain
    - Loss of DTRs – reflexes are first to go! Preeclamptic patients are at baseline hyper-reflexic.

NAUSEA AND VOMITING

After Diagnosis of Nausea/Vomiting of Pregnancy

- Consider P6 acupressure wristbands (Sea-Bands, $10; remove when sleeping to prevent hand swelling)
- Consider ginger (ginger-containing foods, capsules: 250mg QID)
- Pyridoxine 25mg PO TID as single agent; OR in combination with doxylamine 12.5-25mg PO TID (just QHS if causes drowsiness)
  - Addition of doxylamine more effective for moderate sx
  - Combination tablets available as Diclegis (see to right)

Diclegis: 10m/10mg delayed release tablets

- Start 2 tab QHS; can add 1 QAM and 1Qmidday.
- May be expensive

Persistent symptoms

Add a single dopamine antagonist (phenothiazines or metoclopramide):
Common side effects include drowsiness, dizziness, dry mouth

- Promethazine (Phenergan): 12.5-25mg PO Q 4-6hr (25mg PR Q12), or
- Prochlorperazine (Compazine): 5-10mg PO Q6-8hr
- Metoclopramide (Reglan): 10mg PO Q6-8hr, before meals, or
  - Risk tardive dyskinesia with prolonged use

Red Flags
Onset after 9 wk
Abdominal pain
Headache
Fever

General outpatient precautions:
Lightheadness/dizziness
Fainting
Palpitations
Inability to tolerate PO for 12+ hr

Persistent symptoms

Consider ondansetron (Zofran) IF after 10wks and/or if dopamine antagonist side effects intolerable; see Box 2 next pg re: co-rx

- Consider initiating docusate simultaneously

If symptoms and inability to tolerate PO persist, present to triage or ED for eval, IVF, and PO challenge.
Admit for: severe dehydration, metabolic derangements, or continued inability to tolerate PO after IVF

Inpatient Management

Workup

- UA
- CMP
- Lipase
- US prn to r/o multiples, mole
- (Thyroid testing ONLY if goiter or overt sx of hyperthyroidism present)

- NPO
- IVF: 1. 2-3L bolus, NS vs LR depending on lytes
  > D5 ½ NS MIVF; 125-200mL/hr for good UOP
- Vomiting >3wks:
  Replete electrolytes prn
  Thiamine 100mg IV QD x 3d
  IV multivitamin + folate QD
- Vomiting <3wks:
  Replete electrolytes prn
  IV multivitamin + folate QD

Medications

- Famotidine 20mg IV Q12 while NPO

ALTERNATING doses of

- Promethazine IV 25mg Q6hr
- Metoclopramide IV 10mg Q6hr

Persistent symptoms

After 24hr, consider ondansetron 8mg IV Q8hr*

- Take care with co-rx's; see Box 2 next pg

Resolution of nausea/vomiting

1. Advance diet slowly
   a. Clear liquids x24hr
   b. Bland diet as tolerated
2. Once tolerating PO, transition to PO antiemetics
3. Once tolerating PO regimen, d/c home; instruct to continue regimen until 1wk followup

Persistent symptoms: consider addition of one of the below options.
Also consider if enteral nutrition is indicated (bottom box)

Corticosteroid burst/taper:
Consider for intractable sx after 10wks

- Methylprednisolone 16mg IV Q8hr 2-3d, then 2 wk taper, halving dose Q3d (PO = IV)
- If no response after 3 days, discontinue
- If sx return in taper, maintain effective dose for up to 6wks

Mirtazapine (Remeron):
Consider for intractable sx, and/or if suspect component of depression

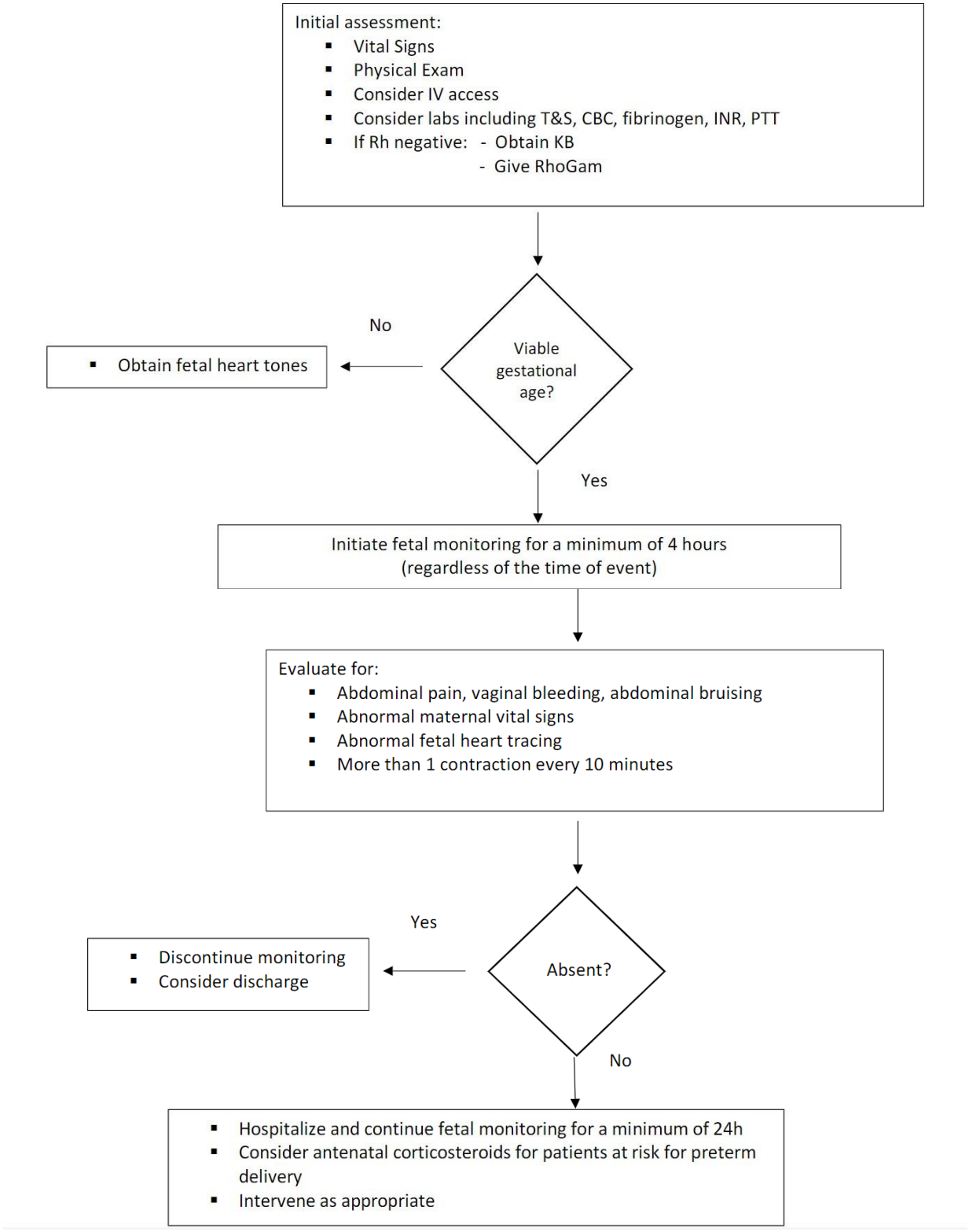
- Consult psychiatry for eval, dosing
- Response may take days
- May be able to taper later, or may need to be continued thru gestation

Diazepam (Valium):
Consider for intractable sx, and/or if suspect component of anxiety

- Add 10mg Q12hr to IVF for 48hr

GI consult:
Consider for H. pylori eval, esp if GERD/pain sx. Treat if indicated.

FETAL MONITORING AFTER OBSTETRIC TRAUMA



Recommendations for antibiotic use on Labor and Delivery (Dot phrase: .abxld)

Manual extraction of the placenta
Definition: placement of provider's hand into the uterus to remove the placenta or portions of the placenta (does not include a single bimanual exam or 'sweep' of clots x1)
Recommendation:
-No abx for bimanual exam or 'sweep'
-If there is true manual extraction or extraction of retained placenta – recommend metronidazole 500mg IV x1
**IF has not gotten antibiotics for GBS - then add Ampicillin 2g IV x1 in addition to metronidazole

PP MVA / D+C
Definition: Instrumentation of the uterus after delivery of the neonate using either metal curette or MVA device
Recommendations: metronidazole 500mg IV x1
*IF has not received antibiotics for GBS - then add Ampicillin 2g IV x1 in addition to metronidazole

Bakri Balloon / intrauterine balloon:
Recommendations: metronidazole 500mg IV x1
*IF has not received antibiotics for GBS - then add Ampicillin 2g IV x1 in addition to metronidazole

O**ASIS:**
Recommendation: Single dose of 2nd generation cephalosporin (what was used in the only RCT)

Intraamniotic infection:
Recommendations: Ceftriaxone 2g IV q24 hrs, Flagyl 500 mg IV q8hr
For Vaginal delivery: No further abx needed
For CS: Before incision: Add ancef 2g and azithromycin 500mg
Postpartum: 1 further dose of Amp 2g IV and 1 dose of flagyl 500mg IV.

**Fever within 1 hour of delivery is likely IAI and not 'new endometritis' – thus – these patients should get single dose of ceftriaxone/flagyl if had SVD and single dose of amp/gent/flagyl if had CS*

Endometritis:
Definition: NEW uterine infection >1 hour after delivery or persistent fevers >2 hours postpartum with intraamniotic infection dx
Recommendation: Ceftriaxone 2g IV q24 hrs, Flagyl 500 mg IV q8hr – until afebrile for 24 hours, then d/c all antibiotics
If continued fevers – add ampicillin 2mg IV q6hrs

ROUNDING: POSTPARTUM CARE

Rounding Limits by Block:

- First block: 6 patients
- Second block: 8 patients
- Third block: 10 patients

NOTES: This includes only OB days blocks at Duke, (DRH and Swing are not included)

- Once a block is completed, interns can round for the next level – thus, if you are on call or swing – it defers to completed (so if you have had 1 block, then swing- you can round on 8)
- APPs are there to help. Interns should see their rounding limit, if more help is needed – APPs can help, and if more help is needed, then the PGY4 should help.
- For interns on call / swing prior to OB blocks – the limit is 6
- This applies to each intern individually based on where you are in your clinical year and is independent of other interns on the rotation.

Managing Requests to Exceed Limits:

- If the number of PP patients exceeds the limit, the APPs can help during the week and the PGY4 should help on the weekends.
- It is up to the intern who is splitting the list to communicate with the team regarding need for rounding help.
- *It is problematic to round on >10 patients from a quality of care and duty hours perspective, and thus not recommended except in extenuating circumstances.

On-Call Rounding Limits:

- On call rounding limits are outlined above.
    - It is difficult to designate a release time as every night is different. Sometimes there will be deliver-

ies at 4am – it is very reasonable for interns to participate in these. Other nights, it is very slow between 3-5, but 5 triage patients come at 6am. Thus, leaving 5700 to round should be a conversation with your PGY3 and 4 based on the clinical scenarios on the labor floor – but no specific time can be set. However, if the intern has not left to round – the PGY3/4 should send them by 6am at the latest.

- Similarly, labor and delivery is a team effort; after rounding is complete, the intern should return to labor and delivery to help out if needed.
- Notes can all be pre-charted over the course of the shift.
- Split the list with the other interns & APPs the afternoon/evening prior. Unless a patient delivers after midnight on the day you are rounding, the patient needs to be rounded on. The interns should see the more complicated and high-risk patients and the APP should see the more straightforward deliveries (for example: assign APP DCHD)
- Recheck list when you arrive in the AM for any new deliveries overnight
- Round on PP pts on 5700 & 5800 including: all staff patients and all MFM patients. *Residents and APPs do NOT round on DWHA SVDs. Residents only round on DWHA c-sections on the weekends.*
- For PPD/POD#0 pts: Look over their delivery info for any complications & keep an eye out for their vitals and/or labs. Consider brief PM check-in, especially if the patient is high risk such as preeclampsia or postpartum hemorrhage.
- Non-English-speaking patients: Unless you are a Duke *certified* interpreter, use an interpreter or Blue Phone
- Important charting: overnight events, **vitals (esp BP),** meds, new labs
- During rounding: discuss postpartum milestones, contraception, VTE, circumcision, dispo planning, remove CS dressing (POD#2), etc. when seeing your patients

POSTPARTUM NOTES:

- Use .obppBETA" for *all* pp notes (see above re. radio button) if you have used the appropriate dot phrases (OBSIGNOUTBETA1, 2, and 3) and have updated the HANDOFF, the A/P of the note will essentially be written for you.
- You should aim to have daily progress notes, D/C instructions, & D/C orders completed <u>before table rounds. This becomes more and more realistic as the year progresses.</u>
- Your notes need to have a "Discussed with [insert OB chief]" and a medical student attestation. Sign the note to the PP attending and on the weekends to the DWHA attending if you round on a DWHA c-section patient.
- PP plans to steal from Hannah Kelly: start with **.PPPLA**

<u>Handoffs:</u>

- Handoff – 1st field: .obhandoff1summary
- Handoff – 2nd field: .obhandoff2daytmnotes
- Handoff – 3rd field: .obhandoff3xcover
- Handoff – 4th field: .obhandoff4todo
- Labs should be populated with **.prex8** (and **.pocglucose8** for patients with any form of diabetes)
- You can put these reminders for yourself about events, to-dos, postpartum questions (Hannahs .ppq) under Day Team Notes

VACCINATIONS: check status under "health maintenance" or "immunizations" tab

- <u>Rh neg</u>: order "RhIG Post Natal/Trauma Evaluation" with postpartum orders. F/U infant's blood type and RhIg. Order Rhophylac (Rhogam) if infant is Rh+. Order extra Rhogam if RhIg is positive
- <u>Rubella</u>: if equivocal or non-immune, order pp MMR vaccine (NOTE – This is a Live-Attenuated vaccine, it is contraindicated if patient is on immunosuppressive agent, e.g. many patients with IBD or SLE)
- <u>Tdap</u>: recommended that <u>all</u> pts get the Tdap in the 3rd trimester of each pregnancy.

If they are NOT vaccinated during the pregnancy, they should get it PP only if they haven't gotten it in the last 10 years

- Varicella: if non-immune, patient can receive inpatient or with PCP
- Flu: it's recommended that pregnant patients receive flu vaccine *during flu season*. If patient did not receive flu vaccine with prenatal care, patient can receive Flu Vaccine postpartum.
- COVID: we have COVID vaccines as well as boosters available for patients postpartum

CIRCUMCISION (Interns do not perform circs on DWHA infants, but can consent the birthing parent)

- Can ask on admission or immediately postpartum but confirm on morning rounds.
  1. Consent the MOTHER/BIRTHING PARENT. Forms are in the 5700/5800 cubbies or near HUC at 5300. You need the BABY's sticker. Be sure the name you write on form matches the sticker that is printed from the chart – most often this will be "Baby Boy" followed by the mother's last name. Mom gets yellow copy, white copy gets scanned into baby's chart and in 5800 HUC desk.
  2. Add the baby to the circumcision list and use "**.circumcisiontodolist**" to write the handoff.
  3. Order meds for baby in BABY'S CHART using the "NEO Neonatal Male Circ" order set
  4. When you call nurses to schedule circumcisions, you need to do a time-out and verify that the baby has Vitamin K, voided, and has no medical contraindications
  5. If off-service baby needs a circ, add the baby to the list, inform the 5800 charge nurse (613-8777) and remind the off-service team that they need to have their care nurse administer Tylenol to the baby prior to the circ and accompany baby with the lidocaine and Toot-Sweet.
- Each day/week the Triage intern will oversee the circumcision service and assume responsibility for getting them done. Circumcisions should be done with certified APP, upper level (PG2 and above), or faculty

POSTPARTUM CONTRACEPTION

- Options done inpatient prior to discharge = Nexplanon, Depo-Provera, postpartum BTL/BS, progesterone only pills
- Nexplanon can be placed inpatient for eligible patients – predominantly those with NC Medicaid. Patient must be consented prior to administration. There is a pre-made consent form for the Nexplanon located in triage; however, you can use a generic, blank procedure consent form and fill it out yourself.
  - Procedure: Nexplanon insertion
  - Risks: Bleeding, bruising, infection, damage to surrounding organs or structures, irregular bleeding patterns, migration with possible need for removal in an operating room, unplanned pregnancy
- Order the Nexplanon through the *Long-Acting Reversible Contraception (LARC) Program* order set
- IUDs are either placed within 10 minutes after the placenta delivers or at 6 weeks postpartum. Offer a "bridge" method (Micronor or DepoProvera; also consider emergency contraception options such as Plan B).
- Estrogen-containing contraceptives are not started until 4-6 weeks postpartum
- POPs are prescribed at discharge through the discharge tab. You can also prescribe estrogen-containing medications at discharge, will need to change the starting date.
- Bedsider.org is a patient-friendly resource for those undecided.

POSTPARTUM INPATIENT LARC CRITERIA

1. If the patient has full (but not Emergency) NC Medicaid, they are eligible for inpatient

LARC placement.

a. Use the Long-Acting Reversible Contraception (LARC) Program order set and select *Medicaid LARC*
b. Select Nexplanon. Lidocaine auto-selects.

2. If the patient does not have full NC Medicaid, see if she qualifies for the hospital-donated supply.

Does you patient meet ANY of the following criteria?

- Teenage pregnancy
- Lack of resources to come back for follow up appointment
- History of or current drug use
- Mental health disorders
- Medical condition that puts patient at significant risk with subsequent pregnancy
    - HELLP syndrome
    - Maternal cardiac disease
    - Preterm birth

If yes, order the desired contraception through the Long-Acting Reversible Contraception (LARC) Program order set, select non-Medicaid LARC, and page 970-2835 with patient information and which above criteria is met.

POSTPARTUM BTL/BS

If patient has Medicaid, they need to have the Medicaid BTL paperwork signed at least 30 days prior to delivery. If your patient meets criteria for a postpartum BTL make sure you sign BTL consents, NPO at midnight, and post case. *Ideally this is all done the day prior to the BTL, and all parties are aware.*

ANTICOAGULATION GUIDELINES – very helpful to file VTE score in the VTE tab.

	Risk Factors	Treatment Strategy
Very high risk factors	On anticoagulation treatment or prophylaxis antepartum Previous VTE Mechanical Heart Valve Thrombophilia • Antithrombin deficiency: ATIII activity is < 60% • Protein C deficiency: Protein C activity is < 60% • Protein S deficiency: Protein S activity is <35% • Presence of Factor V Leiden mutation • Presence of Prothrombin gene mutation 20210 • SLE with antiphospholipid antibody antibodies • Antiphospholipid syndrome Heart Disease with EF < 35% BMI > 50 kg/m^2 Massive transfusion (≥ 5 units) Sickle cell disease	If any risk factors: 6 weeks of LMWH Suggested dosing: Weight <100kg: 40mg QD Weight 100-150kg: 60mg QD Weight >150kg: 80mg QD May be dosed once daily or split between two doses. Alternative: subcutaneous unfractionated heparin 10,000U q12hrs
High risk (major) factors	Immobility for ≥ 1 week in the antepartum period PPH >1000 mL with need for surgery Postpartum infection BMI 40 – 50 kg/m^2 Complicated Heart Disease: congenital heart disease, cardiomyopathy, valvular heart disease, pulmonary HTN Unscheduled cesarean after labor Blood transfusion (<5 units) SLE without APLA	If 1 risk factor, mechanical prophylaxis and early ambulation If >1 risk factor OR 1 risk factor + 1 moderate risk factor: 3-6 weeks LMWH
Moderate risk (minor) factors	PPH >1000 mL Multiple gestation Cesarean delivery IUGR < 10th percentile (confirmed by birthweight) Tobacco use > 1/2ppd Preeclampsia BMI 30 – 40 kg/m2	If 3 or more: Mechanical prophylaxis and early ambulation OR 3-6 weeks of LMWH

POSTPARTUM DIABETES GUIDELINES

- **A1GDM:**
  - Fasting BG PPD1
  - If >120 (and truly fasting) – start ACHS BG checks and consider starting metformin 500 mg PO BIDCC if many >180 (and schedule PCP follow-up)
- *A2GDM (even if suspected type 2)*
  - Stop all insulin / meds and BG checks after delivery
  - Fasting BG PPD1
  - If >120 (and truly fasting) – start ACHS BG checks and consider starting metformin 500mg po BIDCC if many >180 (and schedule PCP follow-up)
- T2DM
  - if not on meds prior to pregnancy: * start ACHS BG checks and consider starting metformin 500mg po BIDCC if many >180 (and schedule PCP follow--up)
  - if on oral medications prior to pregnancy: Restart pre-pregnancy regimen. If oral agent not approved in breastfeeding – endocrine consult
  - if on insulin prior to pregnancy: decrease the pregnancy dose to ¼ dose after delivery.
- T1DM
  - Restart ¼ of pregnancy dosing or ½ of pre-pregnancy dosing initially. For breast-feeding, I always tell them to treat it like exercise and have a 15g carb snack prior to each session of BF or pumping.

**for all: Consider having patients check BG at home, and plan for 1wk BG review/check in clinic

THIRD AND FOURTH DEGREE LACERATIONS

- Dot phrase for handoff (in the X-Cover To-Do): **.OBOASISTODO**
  - Bowel regimen: Colace BID, MiraLAX Daily

- Select the appropriate management plan at discharge
- 1-2 week perineal check in clinic
- Ambulatory referral to Pelvic PT
- Exam prior to discharge

POSTPARTUM FOLLOW UP

- Case Managers assist with scheduling follow-up appointments during the weekday
- If patient doesn't have a PP visit scheduled by time of discharge or over the weekend:
  - Outlying health departments: Write HUC order to schedule follow-up in discharge tab.
  - AP/TRIAGE over the weekend: Write special follow-up requests using In-Basket messages to DUH MOTHER BABY CASE MANAGER (p 13350)
  - Scheduling Duke Perinatal follow-up on the weekends requires an internal communication to Duke Perinatal Triage, asking for patient to have the respective follow-up scheduled.
  - Can also schedule follow-up for DWHA, H&S, DOB triage
  - Dot phrase for internal communication: .internalcommunication
- Pts with diagnosis of a hypertensive disorder of pregnancy need a 3-day BP check. If the patient has a blood pressure cuff at home or is planning on receiving one through case management prior to discharge, the appointment could be telehealth. To request for a patient to be discharged with a BP cuff, order a nursing communication in the orders tab and type "please dc with BP cuff"
- Another option for BP monitoring at home is the MyChart Care Companion program. With this, patients don't need to have a televisit or in-person visit. You enroll them through the discharge tab (type in mychart BP and it'll pull up), and in their discharge instructions add .htnmanagement.
- Patients to consider in-person or virtual 3d nurse BP check for: Spanish-speaking patients, patients with high mild range BPs prior to discharge, patients who don't have MyChart set up
- Request a 1-week mood check for patients who meet criteria after being evaluated by social work. It will say in their note if they recommend a mood check. To request, send an internal communication to Duke Perinatal Durham Clerical Staff.

DISCHARGE

- Typically PPD#1-2 for SVD or POD#2-3 for C-section
- Complete "Discharge" tab in EPIC: reconcile orders, place D/C order, add D/C instructions (there are generic EPIC instructions or you can borrow a dot phrase)
- Remove normal bandages on POD2 (use adhesive remover spray if possible!)
- Tell patients to remove steri-strips on POD#7 (while in the shower). They do not fall off on their own usually, so make sure patients know to remove them!
- Spanish Dotphrases: (.ppspinstructionsvd; .ppspinstructioncs)

DISCHARGE MEDICATIONS:

- SVD
  - Ibuprofen 600 mg PO Q6H, 30 tabs
  - Acetaminophen 625 mg PO Q6H, 30 tabs
  - MiraLax daily
  - Ibuprofen 600 mg PO Q6H, 30 tabs, +/- 1 refill
  - Acetaminophen 625 mg PO Q6H, 30 tabs
  - Senokot daily x 14 days
  - Oxycodone 5 mg Q4H PRN, 15 tabs (Check NC CSRS
  - Opioid Database prior to prescribing)
    - If they have not used any or very little oxycodone while admitted you should discuss with the patient how many pills they will need at home, if any.

OTHER POSTPARTUM TIPS:

- If dressing change is needed, all the materials you need will be in the blue “dressing box” located in triage\
- If a newborn needs to stay an extra day, mom can be “discharged to the room” where she can spend the night with their newborn but not be under our care.
- DC sums must be completed at the time of discharge. The patient will automatically disappear from the postpartum list when they are discharged, so if you don’t do it before discharge (or manually add the patient to a personal list) we will not have a way of tracking them down to do their discharge summary later.
- If by the end of your shift ~6pm you notice that a patient with discharge orders has not yet been discharged, please call the nurse to inquire if the patient is still planning to go home that day.
- Share important follow-ups about specific patients with night intern.

ROUNDING: POSTPARTUM Checklist

In the room ask about:

☐ **Pain** (is it well-controlled with medications)?
- If no → ask about location, character, severity of pain
  - See if they have been taking scheduled pain medications. If not, encourage taking scheduled pain medications and check back in
  - Can offer lidocaine patches for localized (e.g. incisional, back) pain

☐ Able to **tolerate PO** without nausea/vomiting?

☐ **Ambulating?**

☐ Is **bleeding** more than, less than, or the same as a period?

☐ Have they been **urinating spontaneously** since Foley removal?
- If Foley still in, look at bag for UOP

☐ **Passing gas?**
- Don't need to have had a bowel movement
- If they have not but feel gas pain, can encourage simethicone use

☐ **Breastfeeding? Bottle Feeding?**
- Let them know lactation consultants will see them prior to discharge

☐ How is baby?
- If baby boy: do they want a **circumcision** prior to discharge?
  - If yes → sign consent, even if baby is in NICU in case they might be eligible for one later since parents might not easily be reachable then
  - Add baby to shared Circumcision list and fill out handoff with .circumcision check-list

☐ **Contraception?**
- Cannot offer IUD (only at 6-week visit d/t increased risk of expulsion PP)
- Nexplanon only for: Medicaid patients or extenuating circumstances like teen pregnancy (can see these in order set)
- Can offer basically anything else: POPs (Micronor – counsel on taking at same time every day, Slynd if higher BMI), Depo Provera, etc.

☐ Are they ready to go **home**?
- Must be at least 24 hours after SVD or 2 days after CS
- Can keep patient an extra day if baby needs to stay another night
- If yes: make sure they have a pharmacy on file to send medications

☐ **Vaccines**
- Are they okay getting these vaccines inpatient if not already up to date?
- Varicella is 2 doses so just let patient know they need a second one outpatient

☐ **Patient-specific questions** – tailor to problem list

- Ask about: symptoms currently, do they have follow-up, etc.
- Common problems:
  - HTN disorder – ask about HA, vision changes, chest pain, SOB, RUQ pain, extremity edema
    - See if they have MyChart for HTN follow up or if they prefer a tele visit
  - Anemia – lightheadedness, dizziness, chest pain, SOB
  - Depression/Anxiety – ask about mood postpartum, offer resources
  - Gestational diabetes – counsel that 30% of women with gestational diabetes develop diabetes outside of pregnancy and that they should follow up with PCP in 3 months for A1c/OGTT to check for diabetes. Make sure they don't eat before they get their fasting glucose.

☐ **Physical Exam**

- **Palpate fundus**
- If CS: POD#1 look at bandage, if POD#2 – **remove top bandage** and leave steri-strips in place, look at incision
  - Counsel: Patient can shower once top bandage is removed. Steri strips should fall off on their own in 1-2 weeks, but patients can remove if they haven't fallen off after 2 weeks. Keep the area clean and dry, avoid submerging in water (baths, pools, etc).
- Tailor exam to patient otherwise (feel for edema, etc)

Chart Review:

☐Make sure PPD (POD if CS) and G/P are updated in note

☐ **Check vitals!!!!**

- If they have an isolated mild range blood pressure look at pregnancy tab under Summary to see if they had another outpatient in addition to all inpatient blood pressures

☐ **Check recent labs**

- If they have diabetes – check blood glucose levels
  - If PPD1 fasting AM glucose <120 can discontinue meds and glucose checks
- HTN disorder- check last CBC, CMP

☐Check medications to make sure they haven't been started on anything new (important for people with HTN disorders, diabetes/insulin requirement)

☐Check Encounters tab – 'Clear Filters' to see future appointments

- Make sure they have **follow-up scheduled**
  - Everyone needs 6-week PP check (if not, mention to HUC at huddle or send an internal comm if weekend)
  - BP check in 3 days (MyChart, Telephone, In-Person) if indicated
  - 2-week mood check (CSW note will say if this is indicated at bottom)
  - Special cases
    - Preterm delivery – prematurity clinic appointment with Dr. Wheeler
    - Abnormal pap – send internal communication to 1J cervix clinic if col-

poscopy/further follow up is needed per ASCCP guidelines
- Wound check for certain patients

- Should have appropriate follow up for medical conditions (Endocrinology/PCP for diabetes, cardiology for cardiac conditions, etc)

☐Update **VTE Risk** calculator!!

- Common postpartum things that change VTE risk:
  - Endometritis
  - Receiving blood transfusion
  - New HTN disorder
- Commonly missed VTE Risk items:
  - Pre-gestational diabetes (T1DM, T2DM)
  - BMI
  - Low birthweight baby
  - PPH if final QBL is > EBL at time of delivery
  - Just always check because sometimes people forget to fill them out
- If not already ordered, make sure to order appropriate Lovenox (should be started >24hr PP, >4h after epidural removal, dosing info in handoff)

☐ **Common PP rounding orders – must be ordered as 'Urgent' in order to be collected on PP floor**

- Pain meds/lidocaine patches
- Vaccines – MMR, Varicella, flu, Tdap, etc.
- PT – for first time CS, extensive tears, etc.
- Fasting early AM glucose for gestational diabetes
- AM CBC for patient with postpartum hemorrhage, baseline anemia with significant blood loss, etc.
- CSW for maternal history of depression, anxiety, difficult social circumstances, etc.
- CBC, CMP if someone rules in for Preeclampsia/gestational hypertension

☐Check on admission H&P and last routine prenatal visit note to make sure we are not accidentally missing any problems!

☐ **Cosign note to attending**

- SDK and Dr. Kerner sign notes during rounds, so try to have notes done before then

Discharge

☐Start or take over **Discharge Summary**

☐ **Patient Instructions** (in Discharge tab) - use dotphrases from Hannah Kelly (.hckdc)

- CS or SVD in English or Spanish according to patient (.hckdcsvd, hckdccs, hckdccsspan, etc)
- My Chart Hypertension Remote Instructions
- PP Resources for all patients, especially those with history of mood disorders

☐ **Discharge orders – in Discharge 'Order Reconciliation'**

- Home medications
  - Can discontinue orders that no longer apply (e.g. gestational diabetes medications

for patients with normal postpartum fasting glucose, lancets/strips for these patients, aspirin, etc)
        - Otherwise continue home medications and 'Defer to Prescriber'
- **Meds for everyone** (continue)
    - Ibuprofen
    - Tylenol
    - Bowel medications
        - I order at least one for everyone
        - Make sure you order an aggressive bowel regimen + pelvic floor PT referral for OASIS tears
    - Oxycodone (5mg, 5 pills, 0 refills) for CS only (and OASIS tears)
        - When you hit order, it will ask you to click on a link to assess SUD risk- click on the PDMP link, make sure it looks okay, and hit 'Mark as Reviewed'
- Don't forget to order!!!!
    - **Birth control** if patient wants it
    - **Lovenox** (check how many doses they got inpatient and subtract from total length of dosing to order at discharge)
    - **New inpatient medications**
        - Make sure anti-hypertensive dosing is correct!
        - Diabetes medications
    - If they have any **hypertensive disorder** order these 3 things:
        - BP monitor
        - Nursing communication (description: Discharge with BP cuff)
        - Enroll in MyChart Hypertension Care Plan

Miscellaneous Info

- On weekends: need to send an internal communication (.internalcommunication) to schedule follow up for patients – 6 week check up, MyChart BP check, etc.
- Common Plans
    - **Anemia**
        - Admission Hb *** > QBL *** > POD1 Hb ***
            - ~300ccs blood loss = 1 Hb point drop
        - S/p IV iron on *** *(important because patients with recent IV iron don't need PO or IV iron inpatient)*
        - Patient currently asymptomatic with stable vitals
        - Plan on last line***
            - Hb < 7: transfuse pRBC
            - Hb 7-8: transfuse if symptomatic, or IV iron otherwise
                - Symptomatic = lightheaded, dizzy, tachycardic, hypotensive, etc.

        - Hb 8-9: IV iron (order: 1000g)
        - Hb 9-10: PO iron daily (can cause constipation so do every other day if Hb is higher than this)
    - **Hypertensive Disorder (gHTN, PreE, PreE with SF)**
        - Diagnosed by *** (e.g. 2 mild range blood pressures >4h apart, Cr elevation, etc)
        - Admission CBC, CMP, UPC WNL (or last labs if more recent)
            - Do not order UPC postpartum, not clinically useful
        - S/p 24 hours PP Mg (if applicable)
        - Last pathway: *** if applicable
        - Long-acting medications: *** if applicable
        - Blood pressures in *** range, currently asymptomatic
    - **Gestational diabetes**
        - If A2GDM: list out pregnancy regimen
        - PPD1 fasting glucose *** (if <120, discontinue glucose checks and medications)
            - If higher, ask patient if it was a truly fasting lab or if they ate, and if so, repeat the next day
        - Follow up with PCP in 3 months for A1c or 2h OGTT
    - **Mood (Depression, anxiety, etc)**
        - Medications ***
        - Seeing a therapist regularly ***
        - Mood is currently stable
        - CSW consulted postpartum
    - General rule of thumb for most things: patient can return to pre-pregnancy dosing (like for diabetes medications, etc) postpartum
- **Meds to Beds**
    - Order discharge meds to Duke Outpatient Pharmacy
    - Call pharmacy to enroll patient in meds to beds
- Hot tips
    - Order CBC, AM glucose prior to pre-rounding if indicated so that it comes back in time for PP rounds
    - Take notes in patient rooms! You will not remember where the fundus was, birth control, bleeding < > = period after rounding on a bunch of people
    - Bring circumcision forms with you when rounding to save time/trips
    - For patients with preeclampsia and significant extremity edema, can give Lasix 20 x 5 days if their K looks okay on CMP (can also supplement with K)
    - If they have an isolated elevated blood pressure add it/when it occurred to the plan so you don't have to hunt for it later if patient meets criteria for HTN disorder with a second one later

- Make note of things that need to be done prior to discharge for the intern going to postpartum huddle
    - E.g. if baby needs a circ prior to discharge today, if mom needs follow up scheduled

ROTATION LOGISTICS

LABOR AND DELIVERY

CLINICS	Monday	Tuesday	Wednesday	Thursday	Friday
AM	OB 1 - FP	OB 4 – HROB	Didactics	Triage or floor management	Triage or floor management
PM	OB 1 - FP	OB 4 – HROB	Triage or floor management	Triage or floor management	Triage or floor management

Epic context: DUH IP OB Departmental Virtual In-

tern logistics:

- 5:00-7:00: Pre-Rounds and Note documentation. **All discharge orders should be in and discharge Rx signed.** *This might seem unrealistic and overwhelming at the beginning of the year, but this should be a goal you work towards.*
- 7:00-7:10: 5800 safety huddle (intern on PP pager) and optional 5700 safety huddle (intern on floor) (except Wednesdays)
- 7:30: PP sign out/rounds after active sign out, inductions, and procedures (except Wednesdays when PP rounds are BEFORE at 6:45am)
- Teaching to follow postpartum rounds
- 8:00: one intern goes to triage and one goes to the floor
- 9:15: Floor intern goes to 5300 huddle (with Peds, Case management and Lactation)
- 18:00: sign out to the night team

BENIGN GYNECOLOGY

CLINICS	Monday	Tuesday	Wednesday	Thursday	Friday
AM	GYN 4/3 – CC	OR/ consults GYN 4 – CC	Didactics	OR/ consults GYN 1/3/4	OR/ consults GYN 1/3/4
PM	GYN 4/3 – CC GYN 1 – CC*	OR/ consults GYN 4 – CC	OR/ consults GYN 1/3/4	OR/ consults GYN 1/3/4	OR/ consults GYN 1/3/4

*Second half of year

Benign gyn dot phrases:

- Handoff: .BENIGNGYNHANDOFF
- Progress note: .BENIGNROUNDING
- SWU H&P: .1JSURGICALWORKUP
- Surgical schedular dot phrase: .1JSURGSCHEDULE
- SWU Pre-Op patient instructions: .GYNERASWCPHPREOP
- Post-op discharge instructions: .GYNERASWCPHDISCHARGE (If DWHA patient, use .GYNERASDWHADISCHARGE)
- 1J phone numbers: .1JPHONENUMB

Helpful order sets:

- GYN gynecology Medical Admission
- GYN gynecology Pre-Op ERAS
- GYN gynecology IP Post-Op ERAS

Pre-Op conference:

- The intern is responsible for pre-op conference on Wednesdays after didactics (~12pm)
- Prepare notes for each case (patient name and MRN, surgery, PHM, workup, etc) on an excel or word document. Will be with attendings, residents, and medical students.
    - Include: Date of surgery, Location, Attending, Planned Surgery, Indication, Prior Work-up (labs, biopsies, US, etc), PMHx, PSHx, Meds, Allergies, Issues

Surgical Work-up (SWU) Appointments: (these are now built into 1J continuity clinic)

- Purpose: Pre-op physical, surgical consent, lab work, pre-op teaching, making sure everything is taken care of so there are no surprises on day of surgery.
- To Do list:
    - Review planned procedure
    - Write H&P for Pre-Op clinic appointment
    - Pelvic exam if hysterectomy and obtain wet prep. Treat for flagyl if BG (increased risk of cuff infection if BV is present)
    - Sign consent electronically
    - Medicaid hysterectomy form or Medicaid tubal form if applicable
    - Counseling:
        - NPO after midnight. Clear liquids until 2 hours before arrival time
        - Drink the carbohydrate beverage the morning of your surgery. Complete 2 hours before scheduled time of arrival (unless diabetic)
        - Patients will want to know time of their surgery, but the final schedule isn't made until the night before. They will get a call the day prior about time of arrival. Instruct them to call the day before if they have not heard yet.
    - Check that they have an anesthesia preop visit

  - Labs if indicated. COVID test no longer required.
  - "Prep for Surgery" tab
    - Select facility
    - Preop orders for later (GYN gynecology Pre-Op ERAS)
    - Copy and paste clinic SWU H&P into prep for Surgery H&P Note
  - Follow-up visit: 4-6 weeks from day of surgery with provider on Gyn team
  - Patient instructions: .GYNERASWCPHPREOP / Alternatively, give them the ERAS booklet

Risks for ALL procedures:
- Bleeding
- Infection
- Damage to nearby organs (uterus, tubes, ovaries, bowel, bladder, ureters, major blood vessels, and nerves)
- Need for further surgery/procedure
- Anesthesia risks
- Medical risks (blood clots, pneumonia, heart attack, death)

Special considerations for counseling, consents, and risks
- **Adnexal mass**: Also consent for oophorectomy (if just planning cystectomy) & possible surgical staging if cancer found (talk to your chief about whether this is necessary for a particular case)
- **Endometrial ablation**: Specify type of endometrial ablation & also mention possibility of endometrial ablation via other modality.
- **LEEP or cone (CKC)**: Increased risk of cervical insufficiency with preterm labor & PPROM (increased from ~4-5% to 10-12%), failure to remove entire affected area of cervix with need for further surgery.
- **BTL**: 1:50 risk of failure over 10 yrs & increased risk of ectopic if pt does become pregnant. If pt has Medicaid, they need to have signed Medicaid tubal paperwork at least 30 days prior to the procedure for Medicaid to pay for it. You must confirm that this has already happened & been approved. (It should be listed somewhere in EPIC.)
- **Laparoscopy**: Possible laparotomy (open procedure)
- **Hysteroscopy or D&C**: Risk of uterine perforation (~1:500)
- **Hysterectomy**: Need to fill out separate Medicaid form for hysterectomy; this is found in 1J

Orders
- Antibiotics:
  - TVH/TAH/TLH: Ancef 3g IV if > 120kg. If <120kg, Ancef 2g IV.
  - Other laparoscopy: Not indicated as long as not entering genital tract
  - Hysteroscopy: Not indicated
  - LEEP, CKC, hysteroscopy, ablation: Not indicated
- Labs/studies (prior to day of surgery): Only get if labs are >2-3 mo out-of-date and/or clinical situation has changed (i.e. worsened VB, concern for abnormal coags, etc.)
  - CBC
  - Urine beta-hCG (only if pt pre/perimenopausal)
  - If HTN: BMP, ECG & CXR
  - If AUB: PT/INR & PTT

    - If smoker: CXR
- Call chief or attending with any questions!
- IF PT IS ON ANTICOAGULATION, THEY NEED A PLAN. Talk to your chief or attending.

Postop To-Do

- Post surgery work-flow
    - Orders
        - Admission Tab if admitted
        - Discharge Tab -> Order reconciliation -> Order sets
            - Inpatient - Gyn IP post-op eras
            - Outpatient - Gyn OP PACU
        - Oxycodone pain scale and IV dilaudid for breakthrough
        - VTE and SCDs - everyone
    - Handoff List
        - Dot phrase - .benignhandoff
        - Events put in day team notes
        - To dos
        - .cbc8 and .cmp8
    - Brief Op note (if you will not have the full op note done in <30 minutes after finishing the case) - will auto-populate w/ exception of EBL
    - Post-op check later +/- remove foley
        - Dot phrase - .gynoncpostopcheck
    - PACU handoff
        - Talk about procedure and EBL, how you closed,
        - Foley y/n, pad y/n, does the patient need to void y/n
        - Floor - usually 6300
        - Pager: 970-4962
    - Op note - need to include whether had implants (eg IUD)
        - Steal from Mellie Montoya, Vivi Meljen, Chelsea Feldman if in doubt
        - .bgynophsdc - hysteroscopy with myosure
        - .bgynophta - +HTA
        - .bgynopnovasure - +Novasure
        - .bgynopLEEP - LEEP
    - Patient instructions - see below for minors
        - .dwhamajorsurgeryinstructions
        - .dwhalapmajorinstructions

ASC (Fridays)

- Room turnover is very fast. It's a lot of fun because you get to do many procedures, but you have to move quickly.
- All patients need a Brief Op note prior to leaving the OR (unless you can get the whole Op note within 30 min of leaving the OR and absolutely before starting the next case)
- Get in the habit of writing the Op note after each case! Then, go say hi to the next pt, write the patient's rxs (usually Percocet, Motrin, Colace), fill out the patient's D/C paper-work, & put in PACU orders.
- PACU orders: continue IVF at current rate until finished, pain meds per anesthesia, ADAT, D/C from PACU when meeting criteria.
- Discharge summaries are not needed for same day surgeries

- Write patient instructions:
    - 1J: 1jpostopminorinstructions or .GYNERASWCPHDISCHARGE
    - DWHA: .dwhaminorpostopinstructions or .GYNERASDWHADISCHARGE

GYN Consults

- See patient
- Write consult note and H&P if admitted
    - There are a lot of templates out there: there are couple of commonly used ones: .chfbenignggynconsult and .kckconsultbgyn
- Call attending to discuss -> discharge vs. admit
- Call ED provider to discuss plan
- If admitted, Give ED provider Attending name and place admission Orders
    - Reconcile current and home meds
    - Order set: GYN medical admission
    - Pain: tylenol 650 mg Q6H, ibuprofen 600 mg Q6H, oxycodone pain scale 5-10 mg Q4H PRN
    - Bowel: senokot-S 2 tablets BID, miralax once daily PRN
    - PID antibiotics: cefoxitin 2 g IV Q6H, doxycycline 100 mg IV Q12H, flagyl IV 500 mg Q12H
    - Anti-nausea: Zofran or Reglan 10 mg Q8H PRN
- Handoff - .benignggynhandoff

CONTINUITY CLINIC

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	GYN 3 Urogyn 2/4 GYN 1*	GYN 4 VA/FP 3	Didactics	Onc 3/4 DRH 2/3/4 Onc 1*	Outrider 2 GYN Spec 2
PM	GYN 3 Urogyn 2/4 GYN 1*	GYN 4 VA/FP 3	Raleigh 2/4 AMB 4	Onc 3/4 DRH 2/3/4	Outrider 2 GYN Spec2 Outpatient 1*

*Second half of year

Epic context: Duke Clinic Gynecology

Dot phrases:

- New patient template: .1JNEWPT
- Return patient template: .1JRETURNPT
- Procedure note: .GYNMINORPROCEDUREOUTPATIENT
- 1J phone numbers for discharge instructions: .1JCONTACTINFO
- Present EVERY PATIENT to the attending
- Notes must be done within 48 hours of clinic. Your attending needs to close encounters within 72 hrs. If they are a Beta Book pt, the note should be finished the **same day** in case they present to the ED overnight.
- When you are done writing your note, forward chart to the attending via "Follow-up" tab.

Making the beta-book more user friendly:

1. Open the EPIC betabook
    a. Search "My Reports" in Epic within the Duke Clinic Gynecology context
    b. Search "beta" under Library – then click on "DUHS Betabook Has Active Episode" – this will bring in everyone who has an active Ectopic/Molar episode to review
    c. You can favorite this report so you can find it more quickly in the future
2. Once in the betabook, click "Options" "Edit Report Settings"
3. Click on the "Display" tab
4. Under the "Detailed Views" section add these two views:
    a. DUHS AMB SPECIALTY COMMENTS [2100070030]
    b. Episode Report [50004]
5. Click "Save as" and name it whatever you'd like. This will create a new, personalized report that you will see under your "My reports" section. Next, click "run"
6. When you're in the patient's charts, you can use the blue shared specialty comments sticky note to make quick notes and to-do's for the patient (make sure you're in the "Duke Clinic Gynecology" context!) These comments will be visible to everyone using that context
7. Now when you're on the main reports page, you can see the sticky note comments in the bottom tab so you can quickly see the next time an action is required for the patient, without having to open each patient's chart.
8. The episode report tab has information regarding visits linked to the patient's molar/ectopic episode, allowing you to quickly open notes from recent visits.

OUTPATIENT ROTATION

Clinics	Monday	Tuesday	Wednesday	Thursday	Friday
AM	L&D	DCHD	Didactics	Cervix	Early Pregnancy
PM	L&D	DCHD	HROB Postpartum	Cervix	1J US/ CC*

*Second half of year

DURHAM COUNTY HEALTH DEPARTMENT (DCHD):

- DCHD uses **UNC** EPIC; make sure you have access!
- You will be emailed the computer login from someone at the health department, but this may go to your health department email address, which can only be accessed via the HD computer

Epic context: Durham County OB

- Clinic starts at 8:30am
- Get there 30 minutes early on the first day to fill out paperwork and to ensure you have access. Also bring your laptop in case you do not have access to the desktop
- Basic prenatal care on healthy (for the most part) women
    - The visit sheet (ask nurse or MA) for each pt will spell out what needs to be done
- Clinic is fast-paced – you may see a patient every 15 minutes
- **New OB**: should already have all labs, your job is to do full H&P and review labs – get full OB history! Go through each pregnancy "what happened with your first pregnancy" Any history PPROM or preterm delivery? Postpartum hemorrhage or needing transfusion? Did they have blood pressure issues? have they been on Magnesium before? Why did they have a cesarean section?
    - SmartPhrase: .DCHDNOB
- **Return OB:**
    - Make sure appropriate labs & U/S are ordered
    - *Always* ask about LOF, VB, CTX, & FM, in addition to any other complaints
    - Measure fundal height & obtain fetal heart tones at every visit
    - SmartPhrase: .DCHDROB
- **Prenatal Visits (labs & tests, specific to DCHD):**
    - Put fetal heart tones and umbilical height into the prenatal vitals flowsheet under the OB tab
    - **Nurse visit (prior to NOB):** T&S, antibody screen, CBC, Rubella IgG, HepB surface antigen, RPR, HIV, Varicella IgG, Hgb electrophoresis, early GCT (if fam hx, personal hx of GDM, or BMI>30), PPD (only some pts need this & the nurses screen for this), UCx
    - **NOB:** GC/CT, Pap (if > 21 & no recent Pap/needs Pap documentation)
    - **11-13 wks**: 1st tri screen. Can be scheduled at NOB appt if < 13 wks
    - **16-21 wks**: AFP only (if 1st tri screen done) or MMS ("AFP Tetra") **confirm

accurate gestational age**
    - **26-28 wks**: "3rd tri labs"—CBC (if hct < 34), Glucola (GCT), HIV, RPR. Rhogam, indicated. Tdap.
    - **35-36 wks**: CBC, GC/CT, GBS
- Lunch from 12 to 1
- The last pt is scheduled at 15:45. Usually, done by 16:30–17:30

Early Pregnancy Clinic

New clinic in 1J to focus on early pregnancy ultrasound, beta-HCG trends, pregnancy of unknown location, etc.

HROB POSTPARTUM:

Epic context: Duke Perinatal Durham Clinic Progress note dot phrase:

- .MFMMASTERLIST (select postpartum for the new template we all should be using).
- Think of this as the last time this patient may have contact with the health system for a while.
- Questions to ask: Bleeding, pain, breast symptoms, urinary symptoms, bowel symptoms, resumption of sexual activity, contraception, depression
- All patients fill out an Edinburgh Postnatal Depression Scale which must be documented
- Routine gynecology follow-up: Pap screening, Immunizations, Contraceptive plan. Always ask if they have a general gynecologist they follow with. If they don't, refer them to 1J for annual gyn care.

CERVIX:

Located in the hallway next to 1J Epic context: Duke Clinic Gynecology

Dot phrases:

- New patient: .CXNEWPAT2020
- Return patient: .CXRETPT2020
- Colposcopy procedure note: .CXCOLPO2019
- LEEP procedure note: .CXLEEP2019

Great clinic to get experience with evaluation and surveillance of abnormal pap smears. Lots of colposcopy, LEEPs, and pap smears. If you are with Dr. Muasher, she will likely prep the notes for the clinic. It is helpful to prep the notes if you are with a different attending.

Get the ASCCP App – it's the best $9.99 for Ob/Gyn residency

DWHA: See section on DWHA

GYNECOLOGIC ONCOLOGY

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Tumor board Floor OR	Floor/OR	Didactics	Floor/OR 1J Onc 3/4	Floor/OR
PM	Floor OR	Floor/OR	1J Onc 2	Floor/OR 1J Onc 3/4 1J Onc 1*	Onc Clinic GYN Spec 2*

*second half of year

Dot phrases:

- Handoff: .GYNONCHANDOFFNOTES
- Progress notes: .GYNONCROUNDING* - routine chemo, med admit, routine post-op
- Admission H&P: .GYNONCADMISSION
- Discharge summary: .GYNONCDCSUMMARY or .GYNONCDCSAMEDAY
- Patient instructions: .GYNONCDCINSTPOSTOP or .GYNONCDCINSTCHEMO

Rounding

- You should be at the hospital at 5:30 AM to get sign-out from the 2nd year on nights. The overnight 2nd year will send your team a text around 4 AM regarding any new admissions, with updates in the handoff. Any important updates will have a progress note.
- Print lists (GREAT medical student task – there is a special way to print this, ask an upper level). Update: post op day #, events, labs (hit 'refresh') on the handoff. Everything size 8 font.
- Printer passcode HUCS. Auto reduce / Enlarge. 1 sided -> combo 2 orig. Sort.
- Prep rounding notes as best as you can. Look at vitals, labs, I&Os, drain/tube outputs, medications. Call the overnight nurse to get updates which will make up your subjective. Pend the note and make changes to the note after you see the patient. **Make sure you update the physical exam.**
- You will either walk-round or table-round and see the patients with the fellows. You are responsible for all floor tasks – write everything down!

Floor work

- Prioritize consults, discharges, then orders.
- First consults – Surgery ASAP; IR or procedures after 7:30am. Medicine after 8am. Gen Med procedures (e.g. paracentesis) at 10 AM (that is when that team arrives)
- While you are waiting for them to call back, supplement electrolytes, order AM labs for next day, enter other orders for the AM
- AM labs for next day: CBC, CMP or BMP, Mag (create favorites for these)
- Touch base with case manager ~ 9-10 AM. Have dispo plans and know what patients need to go home (include things like home health, SNF needs, IV antibiotics, etc)
- The handoff is a place for you to keep track of events, to-dos, and anticipatory guidance for the night team. A new thing is adding a brief Onc Hx to the handoff for this year.
- Double check everything by noon; never assume something got done because you placed an order or because your talked to/paged the consult person once
- Your team will create an EPIC Chat (secure and HIPAA compliant) with the residents and fellows – use this to ask any questions regarding floor patients/send updates
- The attending for the day will generally round with you and the fellow after first OR case
- You should plan to PM round on all the patients, the fellow will run the list with you at the end of the day. Sign out is at 6 PM in the GYN workroom.

Post-op checks

- The upper levels will update the list & sign out to you as they finish cases. Do not make yourself first call until you have received sign out. For the admits, do POC ~4 hrs after surgery. See the pt & write a quick SOAP note. (.GYNONCPOSTOPCHECKNOTE)
- Vitals, Pain, N/V, UOP.
    - Anti-HTN usually start POD1
    - Anti-coag (eg. Lovenox) starts 24 hrs post-op (usually there will be specific instructions from attending/upper levels about this)

Discharges

- The NP on service (Georgia) usually schedules the follow up appointments. If you have follow-up needs, reach out to her first rather than sending requests via epic. In general, guidelines for f/u are [Clarify with fellow on AM rounds!] Staples 10-14 days postop; benign pathology 4-6 weeks; cancer patients 2-3 weeks (with the operating surgeon)
- All Dr McNally patients f/u in Raleigh; for Drs Havrilesky/Davidson/Moss if pt was seen in Raleigh for preop, post op appt should also be Raleigh
- **Inbasket** (p Oncology Return Patient Scheduling = pool ID 10386) or call the appointment group (668-6688) to make appointments.
- Raleigh appts: EPIC request to p DCI Macon Pond Front Desk. cc Alicia Johnson, if chemo and labs needed
- Alamance appts: Epic request to Kristi Stanton
- The follow up chemo appointments are made by the nurse (Charlotte Gilbert) contact her with questions. Planned chemo admits will already have interval counts and appointments set up, you do not need to call the nurses
- If patient is going to SNF: use the “discharge to outside facility” order set when you do the med reconciliation. You will also need a d/c summary to go with them THAT DAY.

Discharge Email

- Each Sunday night you will send an email of the discharged patients from the previous week to the attendings, APP’s and resident team.
- This email needs to include an attached Excel document with the following (this should be forwarded to you by the off-going Onctern)
    - Pt name, MRN, date of admission, date of discharge, reason for admission, procedures, date of F/U appt, rounding resident & fellow.
    - People may or may not read this. If something needs follow up (i.e. still no follow up appointment), contact the resident for that patient directly, or do the task yourself
    - Update this Excel document daily to make it easier on yourself

ERAS for GYN/ONC

- Can use .SLGYNONCERASTODO for handoff checklist. It is listed below and has the basic principles of ERAS
    - [ ] ERAS

- [ ] SQH ordered w/ epidural in place to start
- [ ] foley out POD 1 - voided
- [ ] epidural removed POD2, on PO oxycodone
    - *Page Inpatient/Acute Pain Service in the AM to schedule a pause trial. And then follow-up to see if/when they remove the epidural*
    - *Patient should have Heparin discontinued and oxycodone ordered for their pause trial.*
- [ ] start Lovenox 4-6h after removal of epidural
- [ ] anticoag plan - does not*** meet criteria for lovenox on discharge

VTE Prophylaxis

- While patients have epidural in place, they will be on subQ heparin 5000u q8h
- Once the epidural is removed, Lovenox needs to be scheduled to start 4-6 hours after removal
- For patients without the epidural, they will usually receive a dose of subQ heparin POD#0 and start Lovenox on POD1. The ERAS post-op order set has all of this explained well.
- If a patient has decreased kidney function in the setting of CKD or AKI, patient may not be able to receive lovenox. In general, CrCl of <30 is contraindicated for Lovenox. If kidney damage is present, discuss with fellows on rounds.
- If a patient is deemed high-risk based on their SWU visit, they will discharge on 28 days of Lovenox. This can be found in their H&P or by following the VTE algorithm badge card. Put this in the handoff if you know a patient needs 28d at discharge.

Supplementing Electrolytes

- Check labs early & try to make sure supplement orders are in before noon. There is an order set called Electrolyte Replacement
- **Potassium** (Supplement to 4):
    - [Potassium chloride IV (Adult Peripheral)] KCl 10 mEq IV = 0.1 increase in K+
    - KCl given IV can burn. PO KCL can make patient nauseous/vomit. Use Potassium chloride (KLOR-CON) for PO
- **Magnesium** (Supplement to 2.0)
    - mag sulfate 1-4 g IV ***or*** magnesium oxide 400 mg PO
    - If needing to supplement daily, start oral mag ox (can cause diarrhea)
- **Calcium** (If low albumin, will need to calculate corrected calcium)
    - Calcium carbonate 1250mg PO or calcium gluconate 1g IV

Radiology Studies and Procedures:

- When ordering studies, always include reason for study (i.e. evaluate for PE, pneumonia, bowel obstruction).
- **CXR: '**chest xray PA and lateral'
- KUB: '**abdomen xray flat and upright'**
- Chest CTA: '**chest CT PE protocol**' - ** Pts with an allergy to contrast need a steroid prep.
- **Small bowel follow-through**: you have to place order AND call GI radiology (see #s)
- Contrast agent: **Gastrograffin** NOT BARIUM.
- **Interventional Pulm:** Will eval thoracic PleurX catheters. Place the consult, they will call you.
- **Gen Med Procedures:** Do paracentesis, thoracentesis. Place the consult, they will

call you.

- **CT body:** Do other kind of drains (i.e. intraperitoneal abscesses). Call CT intervention (see phone #s) to evaluate imaging with you; they will let you know if drainable and what orders (coags, etc)
- **Interventional Radiology (IR)**: For PCNs, abdominal pleurXs as well as Port-a-caths.
- **Prior to having anything done by IR**, the pt needs recent coags & to be NPO after MN. You MUST PAGE the Vascular IR resident (970-7930) to give more context. DO THIS EARLY – Non-emergent slots fill quickly.

NGT Orders:

- Type in **'NGT'** to orders & select what you want.
- Placement or removal – RNs can do this but it is a GREAT med student task – RN can teach them
- **'Abd xray portable'** to ensure accurate placement.
- **'NGT settings'** – continuous wall suction
- **Also order:** Pepcid 20mg IV BID. NPO. Replacement Fluids.
- **REPLACEMENT FLUIDS:** every 1ml Gastric (NGT) output : ½ ml D5 NS + 40mEq KCl. Q8hours. Go to order sets and type in **'replacement fluid'**. Select appropriate order.
- **CLAMP TRIALS:** 'NGT clamp' - clamp for 4 hours. Then hook back up to suction and measure output ('residual'). In free text section, instruct RN to page *7700 with residual. If no nausea and vomiting and <100ml residual, they passed!

Called to see patient (CTSP):

- **Fever** (≥ 38.3 or > 100.4) needs an evaluation & full written note in chart
- Use the Duke CustomID webpage if you have questions about which abx to use for treatment. Notify upper level that you are starting abx!
- Neutropenic pts with fever: Always check an ANC with CBC with differential. Tx with cefepime. If spiking through cefepime, talk with Fellow (may add Vanc, fungal coverage)
- **Chest pain**: has multiple causes including reflux, MI, PE, pneumonia
    - See the pt & perform an exam
    - Order cardiac enzymes (CK, CK-MB, troponin) & ECG, 3 sets 6-8 hrs apart via "CAR Acute MI Rule-Out" order set
    - If there is concern for PE → CT PE protocol. Call radiology to actually have it done STAT
- **Pain control**:
    - Many Onc pts have a very high pain tolerance OR opioid tolerance – don't be stingy
    - If tolerating PO, "**oxycodone PAIN SCALE**". Oxycodone preferred to Percocet to avoid Tylenol toxicity.
    - **Dilaudid 0.5-1.0 mg IV PRN** for breakthrough
    - *Schedule* **Motrin** & **Tylenol** if oxycodone per pain scale is not completely

covering pain
    - If the pt is not tolerating PO & is in severe pain, or if the pt was on large amounts of narcotics at home, **Dilaudid PCA** is a good option. Order via the **PCA order set** & select either opioid-naïve or -tolerant. If you need help with PCA orders, call pharmacy & have them talk you through it the first few times. They are an awesome resource!

- **Bowel Regimen/Constipation:**
    - Stool softener: **Colace** (100 mg BID) does nothing; generally order Senna-S (2 tabs BID)
    - Laxative: **Miralax** 17g PO daily if needed
    - Suppository: **Dulcolax** PRN
    - **Enema**: FLEET or SMOG or Molasses
    - For gas: **simethicone**
- **Post-op ileus/Small bowel obstruction:** (SBO): Sxs include significant n/v &/or abdominal pain.
    - order a 3-view of the abdomen (XR) to eval for bowel dilation & air/fluid levels
    - make pt NPO & consider placing an NGT
    - order GI prophylaxis (Pepcid 20 mg IV BID)

DUKE REGIONAL HOSPITAL

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	DRH Floor/OR	DRH Floor/OR	DRH Floor/OR	DRH Floor/OR DRH 2/3/4 - CC	DRH Floor/OR
PM	DRH Floor/OR	DRH Floor/OR	DRH Floor/OR	DRH Floor/OR DRH 2/3/4 – CC	DRH Floor/OR

*second half of year

Epic context: DRH IP OB VIRTUAL

Getting Situated

- First Floor: Cafeteria
- Second Floor: ER, Medical Records, Medical Staff Services, Staff Entrance
- Third Floor: OR, Main Lobby
- Fourth Floor: Labor and Delivery, Women's Unit (43)

Emergency Room

- Before you see the patient, always ask who their OB/GYN provider is:
  - If it is a CHOB/DWC private patient, the ER MD needs to contact the private MD. Residents see the H&S/DOB private patient ED consults.
  - Have staff patients follow-up in your continuity clinic whenever possible
- EVERY consult should be staffed with the attending… ***no matter what time!***
- If you're unsure of the exam, don't hesitate to ask the attending to come down to the ED

C-sections

- You will be expected to scrub into C-sections for H&S (Harris & Smith, Durham OB, HROB), and no prenatal care/out of town patients. As interns, this is where your c-section experience starts.
- DWC (Durham Women's Clinic) and CHOB (Chapel Hill OB) attendings may ask for your help in a c-section if their midwife is unavailable. Some residents have historically asked attendings if they could help out, but this is not expected.

Triage, Labor, Postpartum patients

- During this rotation, you will start getting experience with c-sections! This is your primary responsibility. You will also have experience managing labor, but this is not your primary focus.
- Triage
  - You will only see the health department patients, those without prenatal care, or HROB patients. If any of these patients are admitted to L&D, you and the resident team will be responsible for managing their labor.
  - The midwife/family medicine resident will see the Harris & Smith, Durham OB, and Duke Family Medicine patients. They will also manage these patients' labor courses.
  - Discuss management of all patient with the attending on-call before admitting or D/C

- You may be asked to help with the CHOB/DWC c-sections, but we typically do not round on CHOB/DWC C-section patients
- Answering pages on non-resident patients (H&S/DOB SVDs not delivered by the Family Med resident; or CHOB/DWC patients):
    - If is ok to give simple medication orders (i.e. Phenergan, Simethicone). It is also okay to say this is not your patient and they can call the patient's attending.
    - Acute situations (PPH, unresponsive patient), evaluate the patient and call the attending
    - Otherwise, defer management to private attendings

ULTRASOUND

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Off	1J with Irene	Didactics	DBC with JoAnne	MFM Raleigh or Cary
PM	Off	1J with Irene	HROB Postpartum	DBC with JoAnne	MFM Raleigh or Cary

MFM Raleigh
11001 Durant Road
Raleigh NC 27614
Phone: 919-684-6327 (front desk)

MFM Cary
600 New Waverly Place
Cary NC 27518

DBC sonographer number (JoAnne): (984) 327-5131

Description:

- The goals of this rotation are to learn how to perform a biophysical profile, accurately measure fetal biometry, acquire an AFI, determine fetal position, and interpret fetal anatomy images.
- Once per week, be sure to sit in on a genetic counseling visit with Amanda (Raleigh) or Erin (Cary). The sonographers can help you preview the schedule if needed.

Requirements/Guidance:

- Dr. Kuller will schedule times to go over a few practice bulletins with you that discuss genetic screening. It is helpful to read these ahead as he will informally ask you questions about the article. The goal is to have 3-4 meetings throughout the rotation.
- On the last Thursday of the rotation, you will give a mandatory presentation to the Cary staff. We will encourage, but not require you to write the project up as a review article with supervision by Drs. Kuller and Rhee.
- At the beginning of the rotation, please be sure to introduce yourself to sonographers in the workroom and the attending MFM (usually Kuller). You will discuss expectations with the attending MFM in the first week. Maggie, or one of the other Raleigh sonographers, will familiarize you with the ultrasound machines and transducers. Throughout the day, you will sit in the sonographer workroom. When a patient arrives, take the initiative to look into their indications and OB history and ask to go in on the scan. After the scan, follow the sonographer to present the case to the MFM, discuss the case with the MFM, and accompany the MFM to discuss findings with the patient. You may wear scrubs or business casual with a lab coat. Please arrive at 8 am and if you are not going to be there, please let one of the sonographers know.
- Week 1:
  - Understand clinic workflow
  - Introduction to probe orientation, basic principles of instrumentation and ultrasound physics.
  - Ask for someone to orient you to the knobs and know-how of an ultrasound. Preferably after the end of the day has finished so your learning is protected.
  - Shadow sonographers during ultrasound and Attending MFM during consultations
- Week 2:
  - Hands on practice with fetal presentation, situs, M-mode heart rate, and AFI
  - Introduction to biometry measurements and fetal anatomy
  - Introduction to BPP
- Week 3:
  - Continue to practice Presentation, AFI, BPP, and Growth independently
  - Introduction to Umbilical Artery Doppler
- Week 4 -6
  - Begin to work independently on ultrasounds (eg. BPP's are a great place to start). Sonographers will scan at the end and give feedback on your images.

DWHA

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	DWHA	DWHA	Didactics	DWHA (Pelvic floor PT)	DWHA
PM	DWHA	DWHA	DWHA	DWHA (Pelvic floor PT)	DWHA

Dr. Barret (megan.barrett@duke.edu) makes the schedule and will email you 1-2 weeks before you start – she will tell you what your schedule is for each week.

Epic context: PATTERSON PLACE WOMEN'S HEALTH or BRIER CREEK WOMEN'S HEALTH CLINIC or DUKE WOMEN'S HEALTH ARRINGDON

Patterson Place (11m from hospital)

5324 McFarland Drive

Durham, NC 27707
Hours: Mon-Fri,
8 am-5 pm
Office: 919-687-4688

Brier Creek (17m from hospital):

10207 Cerny Street, Suite 302

Raleigh, NC 27617
Hours: Mon-Fri,
8 am-5 pm
Office: 919-206-4880

Arringdon (17m from hospital):

5601 Arringdon Park Dr Suite

Morrisville, NC 27560
Hours: Mon-Fri,
8 am-5 pm

- Your main priority is to learn. However, some attendings will have you write notes for practice. Clarify expectations each day with a new attending.
- You will be assigned an attending each morning and afternoon; follow their schedule, and they will suggest patients for you to see and present. The format is similar to medical school where you will chart on the patient, see the patient and collect FHTs and fundal height, then report back to the attending and present the patient with a plan. You will both go see the patient together.
- Both low-risk OB and benign gynecology patients are on the schedule
- Absorb as much about Benign Gyn as you can, particularly postmenopausal pts, as we do not see much of this in continuity clinic
- One Thursday during the rotation you will shadow pelvic PT. There are two separate clinics: Brook Orvis at Duke PT/OT at Arrington and Jennifer Thornton-Jones at Duke PT/OT at Brier Creek.
- You'll typically get at least 30 minutes for lunch each day. Food places close to all locations (walking distance at Patterson Place)
- There is a self-guided curriculum during this rotation https://canvas.duke.edu/courses/42362

EMERGENCY MEDICINE

The rotation schedule will be made by ED chief residents prior to each block, who will often accommodate requests for specific individual days off if emailed in advance. Plan on working every weekend/holiday if you don't make requests. 2 months before your rotation, put in any shift requests you may have in https://www.shiftadmin.com/login.php There, you can access your schedule and see which E.D. upper level you will be working with on that shift.

- You'll alternate working in Pod A, Pod B, & Pod C/Psych
  - Pod A and C has an attending, upper level, and intern
  - Pod B is staffed by a P.A. with an intern and typically has lower acuity patients
- Shifts are 8 **hrs** on weekdays & **12 hrs** on weekends.
  - Mon-Fri: 07:00-15:00, 15:00-23:00, 23:00-07:00
  - Sat-Sun: 07:00-19:00 or 19:00-07:00
- **EPIC context**: DUH EMERGENCY DEPT
- First "sign in" using the button on the toolbar, otherwise EPIC won't let you assign yourself to pts. When patients are placed in rooms, their name appears in the ED flow sheet. As new patients pop up the board, the next resident signs up to care for the pt. Do this in the Track Board view by right-clicking in the "MID" (mid-level provider) column & choosing "Assign me." Pt status is color-coordinated.
- Be sure to see non-gynecologic cases. Use the time to see postop patients, pulmonary, gastrointestinal and cardiac complaints.
- After you see a pt, enter orders and labs, and then present to the attending. There are many different order sets under the Order Sets button (e.g. ED Chest Pain).
- Documentation:
  - For new patients, you are expected to gather an HPI, complete a ROS, complete a full physical exam, and then enter in your assessment and plan under "MDM" or Medical Decision Making in the patient note. Here, explain your differential, why you ordered particular labs or imaging. As the labs/imaging return, show your thought process has evolved and consider a disposition (hospital vs. outpatient)
  - For patients whose care you are assuming, write a brief sign out note. Pend a note that says something about receiving sign out on the patient and taking over the patient's care. The template I had basically said "At XX:XXpm, patient was signed out from the off-going treatment team with communication of patient's care plan. In brief, this is a XXyo M/F with X, Y, Z presenting with …. For full details, see the patient's H&P from the previous care team"
  - This note will be where you can put all the updates that happen over the shift. It helps to keep a running, temporal list of events that happened to stay organized.

    - Steal dotphrases for the ED H&P and ED Sign out note. Your residents may have other helpful dotphrases to use
    - There are certain components that the ED H&P has to have in order for the chart to be complete. The computers have a little laminated card that shows what components need to be present. If you're struggling with this, have one fo the ED residents walk you through this.
- If you need to call a consult, first staff with an attending, and then write & sign an order for "Consult to X" where you can enter your one-liner & a call-back number.
- ED social workers are available for D/C needs
- Continue to pick up pts **as you feel comfortable.** Most of us started with 2-3 pts at a time. You can expect to see approximately 3-6 patients per shift
- The expectations of us are simply to show up & work as hard as we can—there's nothing wrong with letting the ED upper level pick up more pts if you feel that your hands are full with what you have. You can ask to be involved in traumas or seriously ill patient care as you desire, but it is not expected of you at all.
- Food breaks are just when you find a spare minute. Often times the attendings would go eat for 15-20 minutes at a time and fully expected you to take some time to eat as well
- You are still expected to attend Wednesday Ob/Gyn Grand Rounds and should include this in your requested time off.

	Block 1	Block 2	Block 3	Block 4	Block 5	Block 6	Block 7	Block 8	Block 9
	5 weeks	6 weeks	6 weeks	6 weeks	6 weeks	6 weeks	6 weeks	6 weeks	5 weeks
	7/1-8/2	8/3-9/13	9/14-10/25	10/26-12/6	12/7-1/17	1/18-2/28	3/1-4/11	4/12-5/23	5/24-6/30
PGY3 only	*7/1-8/16 (~6 weeks)*	*8/17-9/27 (6 weeks)*	*9/28-11/8 (6 weeks)*	*11/9-12/20 (6 weeks)*	*12/21-2/7 (7 weeks)*	*2/8-3/28 (7 weeks)*	*3/29-5/16 (7 weeks)*	*5/17-6/30 (6.4 weeks)*	
PGY4									
Jasmine Arrington	Elective (Admin)	OB Chief	Benign (swing) (9/14-9/18)	Urogyn	NF/ AMB (12/21-12/25)	Gyn Onc	DRAH (4/5-4/9)	AMB / NF	DRH (6/7-6/11)
Aya Bashi	DRH	Elective (Admin)	OB Chief (10/5-10/9)	Benign (swing)	Urogyn	NF/ AMB	Gyn Onc	DRAH (5/10-5/21)	AMB / NF (6/24-6/30)
Shelby Davis-Coope	DRAH (7/6-7/10)	AMB / NF	DRH (10/16, 10/19)	Elective (Admin) (11/23-11/27)	OB Chief	Benign (swing)	Urogyn (3/10-3/14)	NF/ AMB	Gyn Onc
Shakira Harding	NF/ AMB	Gyn Onc (8/10-8/14)	DRAH	AMB / NF	DRH (12/21-12/25)	Elective (Admin) (2/8-2/12)	OB Chief	Benign (swing) (4/19-4/23)	Urogyn
Isabel Josephs	OB Chief	Benign (swing)	Urogyn (10/12-10/16)	NF/ AMB	Gyn Onc || Elective	DRAH	AMB / NF (3/1-3/5)	DRH	Float
Hannah Kelly	Urogyn	NF/ AMB	Gyn Onc (9/28-10/2)	DRAH	AMB / NF (12/14-12/18)	DRH	Elective (Admin)	OB Chief (4/26-4/30)	Benign (swing) (6/24-6/3
Tara Markert	AMB / NF	DRH (9/7-9/11)	Elective (Admin)	OB Chief	Benign (swing) (12/28-1/1)	Urogyn	NF/ AMB (3/29-4/2)	Gyn Onc	DRAH (6/14-6/18)
Kelsey McNew	Benign (swing)	Urogyn (8/31-9/4)	NF/ AMB	Gyn Onc	DRAH (12/7-12/11)	AMB / NF	DRH (3/22-3/26)	Elective (Admin)	OB Chief (6/24-6/30)
Nat Wickenheisser	Gyn Onc (7/13-7/17)	DRAH	AMB / NF	DRH	Elective (Admin) (12/21-12/25)	OB Chief (2/22-2/26)	Benign (swing)	Urogyn (5/17-5/21)	NF/ AMB
Isa Del Canto	DRH	Elective (Co-Admin)	MIGS (9/21-9/25)	REI	Onc float (half block only) (12/28-1/1)				
PGY3									
Ghazal Aghagoli	Gyn Onc (7/20-24)	Elective	AP/NF (9/28-10/2)	Float (swing)	DRH (1/4-8)	Benign	NF/AP (3/29-4/2)	MIGS	
Edith Amponsah	DRH	Benign	NF/AP (10/26-30)	MIGS	Gyn Onc	Elective (2/15-19)	AP/NF	Float (swing) (5/24-28)	
Dana Hazimeh	Benign	NF/AP (8/31-9/4)	MIGS	Gyn Onc (12/13-18)	Elective	AP/NF	Float (swing) (3/22-3	DRH (5/31-6/4)	
Ben Jacobs	Float (swing)	DRH (9/21-25)	Benign	NF/AP	MIGS (12/21-25)	Gyn Onc	Elective (3/29-4/2)	AP/NF (5/24-28)	
Maya Nitecki	NF/AP	MIGS (8/31-9/4)	Gyn Onc	Elective (MD Anderson 11/2-1	AP/NF (1/11-15)	Float (swing)	DRH (4/19-23)	Benign (6/7-11)	
Katie Penvose	MIGS	Gyn Onc	Elective	AP/NF (11/9-13)	Float (swing)	DRH (2/15-19)	Benign (4/12-16)	NF/AP (6/21-25)	
Allie Piselli	AP/NF	Float (swing) (9/7-11)	DRH	Benign	NF/AP (12/21-25)	MIGS (2/22-26)	Gyn Onc	Elective (6/7-11)	
Maddie Thornton	Elective (8/3-7)	AP/NF	Float (swing)	DRH (11/16-21)	Benign (12/21-25)	NF/AP	MIGS (4/5-9)	Gyn Onc	
PGY2									
Mikayla Bowen	Urogyn	REI/Swing	Outrider (10/19-10/23)	NF/Procedures	Gyn Specialties (12/28-1/1)	DRH (2/1-2/5)	DRAH (4/12-4/16)	FP	Procedures/NF
Elana Brotkin	REI/Swing	Outrider	NF/Procedures	Gyn Specialties	DRH	DRAH	FP (3/15-3/19)	Procedures/NF	Urogyn (6/21-6/25)
Kelby Hunt	Procedures/NF (7/1	Gyn Specialties	DRH (10/12-10/16)	DRAH	FP (12/14-12/18)	Procedures/NF	Urogyn	REI/Swing	Outrider (5/24-5/28)
Spoorthi Kamepalli	DRAH	FP (9/7-9/11)	Procedures/NF	Urogyn	REI/Swing (12/21-12/25)	Outrider	NF/Procedures (3/24	Gyn Specialties (5/17-5/21)	DRH
Dionna Thomas	FP (7/20-7/24)	Procedures/NF	Urogyn (9/14-9/18)	REI/Swing	Outrider (12/21-12/25)	NF/Procedures	Gyn Specialties (3/8-	DRH	DRAH
Siera Lunn	NF/Procedures	Urogyn	REI/Swing	Outrider (10/26-10/30)	NF/Procedures (12/21-12/25)	Gyn Specialties (2/8-2/12)	DRH	DRAH	FP (5/24-5/28)
Jada Phillips	DRH	DRAH	FP (9/21-9/25)	Procedures/NF (11/2-11/6)	Urogyn	REI/Swing (2/23-2/26)	Outrider	NF/Procedures	Gyn Specialties (6/7-6/11
Nishita Pondugula	Gyn specialties	DRH	DRAH (9/28-10/2)	FP	Procedures/NF (12/28-1/1)	Urogyn	REI/Swing	Outrider (4/12-4/16)	NF/Procedures (6/21-6/2
Angela Rutkowski	Outrider	NF/Procedures	Gyn Specialties (10/5-10/9)	DRH	DRAH (12/28-1/1)	FP (2/15-2/19)	Procedures/NF	Urogyn	REI/Swing (5/31-6/4)
Canice Dancel	DRH (8/3-8/7)	DRAH | DUH NF [last wk]	DUH NF [1st wk] | Benign (10/	DRH	TBD	TBD	TBD	TBD	TBD
PGY1									
Morgan Bou Zerdar	DWHA/ED	US (Swing)	OB Days (9/14-18)	Outpatient	Benign (12/28-1/1)	NF/OB	Gyn Onc (3/1-5)	DRH (5/17-21)	OB/NF
Allison Chu	Benign (7/20-24)	NF/OB	Gyn Onc (10/12-16)	DRH	OB/NF	DWHA/ED (1/25-29)	US (Swing)	OB Days	Outpatient (5/31-6/4)
Tetiana Korzun	NF/OB	Gyn Onc (9/6-10)	DRH	OB/NF	DWHA/ED (12/28-1/1)	US (Swing)	OB Days	Outpatient (4/19-23)	Benign (6/7-11)
Sally Kuehn	Outpatient	Benign (8/31-9/4)	NF/OB	Gyn Onc	DRH (12/21-25)	OB/NF (2/1-5)	DWHA/ED	US (Swing) (4/26-30)	OB Days
Alana Lanser	OB/NF	DWHA/ED (9/6-10)	US (Swing)	OB Days (11/2-8)	Outpatient	Benign (1/18-24)	NF/OB (4/5-9)	Gyn Onc	DRH
Addy McFarland	DRH	OB/NF	DWHA/ED (9/20-24)	US (Swing)	OB Days (12/28-1/1)	Outpatient (2/22-26)	Benign	NF/OB	Gyn Onc (5/24-5/28)
Julian Moran	US (Swing)	OB Days (8/10-14)	Outpatient (10/12-16)	Benign	NF/OB	Gyn Onc (1/25-1/29)	DRH (3/29-4/2)	OB/NF	DWHA/ED
Christy Ray	Gyn Onc	DRH	OB/NF (9/27-10/1)	DWHA/ED	US (Swing) (12/21-25)	OB Days	Outpatient (3/15-19)	Benign (5/10-14)	NF/OB
Brooke Schroeder	OB Days	Outpatient	Benign (10/12-18)	NF/OB	Gyn Onc (12/21-25)	DRH	OB/NF (3/8-12)	DWHA/ED (5/17-21)	US (Swing)

NOTES

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