AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Elective Induction of Labour (IOL) Booking Request Form

MUST ATTACH PATIENT LABEL HERE

SURNAME: _____ NHI: _____

FIRST NAMES: _____ DOB: _____

Please ensure you attach the correct patient label

ELECTIVE IOL BOOKING REQUEST FORM

For all urgent/acute IOL required within 24-48 hours, please call the L&BS SMO on call
Referring Doctor to complete and fax to DAU: int. 25905 and ext. 09-307-8904

Requested date for IOL _____/_____/_____

Requested time for IOL ☐ 07:30 ☐ 09:30 ☐ 10:30 ☐ 12:00 ☐ 16:30 ☐ other: _____
☐ anytime

Today's date _____/_____/_____

EDD _____/_____/_____

Gestational age on requested date _____ weeks _____ days

Parity _____

LMC Name:

Mobile:

☐ Self Employed Midwife
☐ Hospital Midwife
☐ Private obstetrician

Specialist responsible for IOL decision:

Guideline based indication for IOL	**Other factors (tick all that apply)**
☐ Rupture of membranes, pre-labour	☐ Maternal age 35 -39 years
☐ Multiple pregnancy	☐ Obesity: Booking BMI _____
☐ Pre-eclampsia	☐ IVF pregnancy
☐ Diabetes	☐ Slowing of growth
Detail: _____	☐ Antepartum haemorrhage (APH)
☐ Small for gestational age (SGA)	☐ Maternal request
Detail: _____	☐ Maternal medical condition
☐ Maternal age ≥ 40 years	☐ Fetal condition _____
☐ Post-dates	
☐ Hypertension, no preeclampsia	☐ Other _____
	_____

Location
☐ WAU ☐ L&BS ☐ HDU

Method
☐ PGs ☐ Balloon ☐ ARM ☐ Synto ☐ Team to decide

☐ ADHB IOL pamphlet provided ☐ Stretch and sweep offered to woman

To start IOL: ☐ LMC ☐ Hospital MW **Care in labour:** ☐ LMC ☐ Hospital MW

Interpreter needed? ☐Y ☐ N **Language:**

Staff Use only:

Confirmed IOL Date: _____/_____/_____

Confirmed IOL Time: ____:____

CR2251