



**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

**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: \_\_\_\_\_  Self Employed Midwife  
 Hospital Midwife

Mobile: \_\_\_\_\_  Private obstetrician

**SPECIALIST RESPONSIBLE FOR IOL DECISION:**

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

**Location**  WAU  L&BS  HDU **Method**  PGs  Balloon  ARM  Synto  Team to decide

ADHB IOL pamphlet provided  Stretch and sweep offered to woman

Interested in OBLIGE trial and willing to be contacted by research team

**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: \_\_\_\_\_:\_\_\_\_\_



ELECTIVE IOL BOOKING REQUEST FORM CR2251