Elective Induction of Labour (IOL) Booking Request Form

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

Name of person completing form: ________________________ Mobile: ___________ Date: __/__/____

SPECIALIST RESPONSIBLE FOR DECISION: ____________________________________________

Requested date __/__/______ Requested time

EDD __/__/______

Gestational age on requested date ______ weeks ______ days

Parity ________ Previous CS? ☐ Yes ☐ No other: ________

LMC Name: _____________________________ ☐ Self Employed Midwife

Mobile: _____________________________ ☐ Hospital Midwife – Team colour: _____________

Guideline based indication for IOL

☐ Multiple pregnancy
☐ Pre-eclampsia
☐ Diabetes

Detail: ____________________________________________

☐ Small for gestational age (SGA)
☐ High Risk
☐ Low Risk

☐ Maternal age ≥ 40 years
☐ Post-dates

☐ Hypertension, no pre eclampsia

☐ PPROM

Location

☐ WAU ☐ L&B S

Complex Care requirements (attach plan)

Method (Tick all that apply)

☐ PGs ☐ Balloon ☐ ARM ☐ Any

☐ Stretch and sweep offered

☐ ADHB IOL pamphlet provided

☐ OBLIGE Study – has read info

☐ OBLIGE Study – declines to participate

If eligible please note that women may be contacted about the study by ADHB Staff / Research team

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

Interpreter needed? ☐ Yes ☐ No Language: _____________________________

Staff use only

ATTACH BOOKING STICKER HERE

Form complete? ☐ Yes ☐ No - return
Aligns with Guidelines? ☐ Yes – booked ≤ 5/7 ahead
☐ No – needs clinical review