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 visit patient label

For all urgent/acute IOL required within 24 hours, please call the L&BS SMO on call and complete Acute IOL Form
For elective IOLs, referring SMO to complete this form and email to: inductions@adhb.govt.nz

Name of person completing form: ______________________ Mobile: ______________ Date: ____________

SPECIALIST RESPONSIBLE FOR DECISION: ____

Requested Date ____________________

EDD ______________________________

Gestational age on requested date _________ weeks _______ days

Parity ____________________ Previous CS? ☐ Yes ☐ No

Requested time:
- ☐ 08:30
- ☐ 10:30
- ☐ 12:30
- ☐ 16:30
- ☐ other: _______ : _______
- ☐ anytime

LMC Name: ______________________________

Mobile: ______________________________

- ☐ Self Employed Midwife
- ☐ Hospital Midwife – Team colour: ______________
- ☐ Private obstetrician

Guideline based indication for IOL	Other factor (tick all that apply)
☐ Multiple pregnancy	☐ Maternal age 35-39 years
☐ Pre-eclampsia	☐ Obesity: Booking BMI ___________
☐ Diabetes	☐ IVF pregnancy
Detail: ______________________________	☐ Slowing of growth
☐ Small for gestational age (SGA)	☐ Antepartum haemorrhage (APH)
☐ High Risk	☐ Maternal request
☐ Low Risk	☐ Maternal medical condition
☐ Maternal age ≥ 40 years	☐ Fetal condition
☐ Post-dates	______________________________
☐ Hypertension, no preeclampsia	☐ Other
☐ PPROM	______________________________

Location	Method *(Tick all that apply)*
☐ WAU ☐ L&BS	☐ PGs ☐ Balloon ☐ ARM ☐ Any
☐ Complex Care requirements (attach plan)	☐ Stretch and sweep offered

- ☐ ADHB IOL pamphlet provided
- ☐ OBLIGE Study – has read info

☐ OBLIGE Study – declines to participle
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

ELECTIVE IOL BOOKING REQUEST FORM

SINGLE SIDED FORM – Reverse not scanned
DO NOT DOCUMENT CLINICAL NOTES ON BACK