MGM INSTITUTE OF HEALTH SCIENCES
SYLABUS OBSTETRICS AND GYNAECOLOGY DEPARTMENT
CBME MBBS Phase- II, Phase-III, Part-I, and Phase- III, Part- II

Annexure-60C of AC-41-2021

OBSTETRICS AND GYNECOLOGY

LOG BOOK - MBBS

AS PER COMPETENCY BASED CURRICULUM

Name of the College

Admission Year: _____

Index

BIODATA OF THE CANDIDATE

PHOTO

Name of the student: …….

Name of the course: MBBS ……

Date of birth: …….

Father's / Guardian's name: ……

Mother's name: ……

Blood group: ……..

Permanent Address: Temporary Address:

…….. ……

…….. ……. …….

…….. ……..

Student's contact no: ……..

Father's/ Guardian's contact no: …….

Student's Email id: ……

Father's/ Guardian' s Email id: …….

Candidates Signature: ……... Date: .....

LOG BOOK CERTIFICATE

This is to certify that,

Mr/Ms._____ _____

Roll No. _____ has satisfactorily attended/completed all assignments mentioned in this logbook as per the guidelines prescribed by Medical Council of India, for MBBS Competency Based Curriculum in the subject of Obstetrics and Gynecology.

Date: _____/_____/_____

Place: _____

Teacher -in-Charge

Professor and Head
Department of Obstetrics and Gynecology

Dean
MGM Medical College, Kamothe

Instructions

The undergraduate medical education program is designed with a goal to create an "Indian Medical Graduate" (IMG) possessing requisite knowledge, skills, attitudes, values and responsiveness, so that she or he may function appropriately and effectively as a physician of first contact of the community while being globally relevant.

This Logbook gives an opportunity to achieve goals pertaining to skill learning in Obstetrics and Gynecology, so that IMG becomes capable to provide respectful maternity and Gynecology care to the society.

1) Logbook is a record of the academic / co-curricular activities of the designated student, who would be responsible for maintaining his/her logbook.

2) The student is responsible for getting the entries in the logbook verified by the Faculty in charge regularly. Certifications for competencies to be taken on same day.

3) Refer to university course content for skill to ensure which competencies to be covered in which phase

4) Entries in the logbook will reflect the activities undertaken in the department & have to be scrutinized by the, teacher in charge of session, Head of the concerned unit and department.

5) The logbook is a record of various activities by the student like:

- Overall participation & performance

- Attendance

- Participation in sessions

- Record of completion of pre-determined activities.

- Acquisition of selected competencies

6) The logbook is the record of work done by the candidate in that department / specialty and should be verified by the college before submitting the application of the students for the University examination.

Record of Attendance

Phase	Duration of posting	Posting from date	Posting to date	Attended days/out of days	Signature of Unit In charge
Phase II	4 weeks				
Phase III	4 weeks				
Phase IV	12 weeks				

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Signature of Head of the Department

MGM INSTITUTE OF HEALTH SCIENCES

SYLABUS OBSTETRICS AND GYNAECOLOGY DEPARTMENT

CBME MBBS Phase- II, Phase-III, Part-I, and Phase- III, Part- II

Theory

Sr. No	Lecture Hrs	Integrated Teaching Tutorials Seminar Hrs	Self Directed Learning Hrs	Total
1.	25	--	--	25
2.	25	35	5	65
3.	70	125	15	210

Clinical Posting

1. Phase – 2 4 Weeks
2. Phase – 3 Part – 1 4 Weeks
3. Phase – 3 Part – 2 8+4 Weeks = 12 Weeks

Total 20 Weeks

Internal Examination & Assessment Format as per CBME & GME 2019

Internal Examination Format – OBGY			
Sr. No	**Particular**	**Theory**	**Practical**
	Phase II		
1	Phase II – Two Theory Exams in a professional year (40 Marks each)	80	NA
2	Post ending Examination	10	50
	Phase III (Part I)		
1	Phase III – Two Theory Exams in a professional year (40 Marks each)	80	NA
2	Post ending Examination	10	50
	Phase III (Part II)		
1	Phase IV - Term examination (Paper I)	40	NA
2	Phase IV - Prelim examination (Paper I & II)	200	200
3	Post ending Examination	10	50
Total Internal Examination Marks		**430**	**350**

Internal Assessment Calculation			
Sr. No	**Particular**	**Theory**	**Practical**
1	All internal examinations including preliminary examination (Theory And Practical)	180	180
2	Logbook Assessment (SDL, AETCOM and Logbook, competencies Etc.)	20	20
Total Internal Assessment Marks		**200**	**200**

430 Theory Internal Examination marks reduced to **200 marks**	**350** Practical Internal Examination marks reduced to **200 marks**

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Signature of Head of the Department

CLINICAL SKILLS : LIST OF COMPETENCIES

Clinical skills can be assessed by case presentation, case-based discussion, objective structured clinical assessment the checklist, MiniCex, as per the institutional preference.

Competency # addressed	Name of Activity
OG5.1	Describe, discuss and identify pre-existing medical disorders and discuss their management; discuss evidence-based intrapartum care
OG5.2	Determine maternal high risk factors and verify immunization status
OG6.1	Describe, discuss and demonstrate the clinical features of pregnancy, derive and discuss its differential diagnosis, elaborate the principles underlying and interpret pregnancy tests.
OG8.2	Elicit, document and present history in a OBGY patient including obstetric and menstrual history, last menstrual period, comorbid conditions and past medical history
OG8.3	Describe, demonstrate, document and perform a general, systemic and abdominal examination including obstetrical examinations and clinical monitoring of maternal and fetal well-being.
OG8.4	Describe and demonstrate clinical monitoring of maternal and fetal well-being
OG8.5	Describe and demonstrate pelvic assessment in a model
OG35.1	Obtain a logical sequence of history, and perform a humane and thorough clinical examination, excluding internal examinations (perrectal and per-vaginal)
OG35.2	Arrive at a logical provisional diagnosis after examination.
OG35.3	Recognize situations, which call for urgent or early treatment at secondary and tertiary centres and make a prompt referral of such patients after giving first aid or emergency treatment.
OG35.5	Determine gestational age, EDD and obstetric formula
OG36.1	Plan and institute a line of treatment, which is need based, cost effective and appropriate for common conditions taking into consideration (a) Patient (b) Disease (c) Socio-economic status (d) Institution/ Governmental guidelines.
OG36.2	Organise antenatal, postnatal, well-baby and family welfare clinics
OG38.4	Assess the need for and issue proper medical certificates to patients for various purposes

PSYCHOMOTOR / PERFORMANCE SKILLS:

Skills can be assessed by objective structured clinical assessment with checklist, Global Rating Scale, Simulated patients as per the institutional preference.

Colleges are instructed prepare modules for skill training as per NMC guidelines.

Module 5 Skill Training.

LIST OF COMPETENCIES

Competency # addressed	Name of Activity
OG9.2	Describe the steps and observe/ assist in the performance of an MTP evacuation
OG13.3	Observe/ assist in the performance of an artificial rupture of membranes
OG15.2	Observe and assist in the performance of an episiotomy and demonstrate the correct suturing technique of an episiotomy in a simulated environment. Observe/Assist in operative obstetrics cases – including - CS, Forceps, vacuum extraction, and breech delivery
OG18.2	Demonstrate the steps of neonatal resuscitation in a simulated environment
OG19.3	Observe/ assist in the performance of tubal ligation
OG19.4	Enumerate the indications for, describe the steps in and insert and remove an intrauterine device in a simulated environment
OG33.3	Describe and demonstrate the screening for cervical cancer in a simulated environment
OG34.4	Operative Gynaecology : Understand and describe the technique and complications: Dilatation & Curettage (D&C); EA-ECC, cervical biopsy; abdominal hysterectomy; myomectomy; surgery for ovarian tumours; staging laparotomy; vaginal hysterectomy including pelvic floor repair; Fothergill's operation, Laparoscopy; hysteroscopy; management of postoperative complications
OG35.7	Obtain informed consent for any examination / procedure
OG35.8	Write a complete case record with all necessary details
OG35.9	Write a proper discharge summary with all relevant information

OG35.10.	Write a proper referral note to secondary or tertiary centres or to other physicians with all necessary details
OG35.11	Demonstrate the correct use of appropriate universal precautions for self-protection against HIV and hepatitis
OG35.12	Obtain a PAP smear in a stimulated environment
OG35.13	Demonstrate the correct technique to perform artificial rupture of membranes in a simulated / supervised environment
OG35.14	Demonstrate the correct technique to perform and suture episiotomies in a simulated/ supervised environment
OG35.15	Demonstrate the correct technique to insert and remove an IUD in a simulated/ supervised environment
OG35.16	Diagnose and provide emergency management of antepartum and postpartum hemorrhage in a simulated / guided environment
OG35.17	Demonstrate the correct technique of urinary catheterisation in a simulated/ supervised environment
OG36.3	Demonstrate the correct technique of punch biopsy of uterus in a simulated/ supervised environment
OG37.1	Observe and assist in the performance of a Caesarean section
OG37.2	Observe and assist in the performance of Laparotomy
OG37.3	Observe and assist in the performance of Hysterectomy – abdominal/vaginal
OG37.4	Observe and assist in the performance of Dilatation & Curettage (D&C)
OG37.5	Observe and assist in the performance of Endometrial aspiration - endocervical curettage (EA-ECC)
OG37.6	Observe and assist in the performance of outlet forceps application of vacuum and breech delivery
OG37.7	Observe and assist in the performance of MTP in the first trimester and evacuation in incomplete abortion
OG38.1	Laparoscopy :observe
OG38.2	Hysteroscopy ;observe
OG38.3	Lap sterilization: observe

Log book record of clinical skills

Sr. no.	Phase	Competency # addressed	Name of Activity	Site Ward, skill lab, opd , casualty,	Date completed	Attempt at activity First (F) Repeat (R) Remedial (Re)	Rating Below (B)expectations Meets (M)expectations Exceeds (E) expectations OR Numerical Score	Decision of faculty Completed (C) Repeat (R) Remedial (Re)	Initial of faculty	Feedback received Initial of Learner	Method of assessment and Score
1.		OG5.1									
2.		OG5.2									
3.		OG6.1									
4.		OG8.2									
5.		OG8.3									
6.		OG8.4									
7.		OG8.5									
8.		OG35.1									
9.		OG35.2									
10.		OG35.3									
11.		OG35.5									
12.		OG36.1									
13.		OG36.2									
14.		OG38.4									

Psychomotor skills

Sr. no.	Phase	Competency # addressed	Name of Activity	Site Ward, skill lab, opd , casualty,	Date completed	Attempt at activity First (F) Repeat (R) Remedial (Re)	Rating Below (B)expectations Meets (M)expectations Exceeds (E) expectations OR Numerical Score	Decision of faculty Completed (C) Repeat (R) Remedial (Re)	Initial of faculty	Feedback received Initial of Learner	Method of assessment and Score
1.		OG9.2									
2.		OG13.3									
3.		OG13.4									
4.		OG13.5									
5.		OG15.2									
6.		OG18.2									
7.		OG19.3									
8.		OG19.4									
9.		OG33.3									
10.		OG34.4									
11.		OG35.7									
12.		OG35.8									
13.		OG35.9									

14.		OG35.10.									
15.		OG35.11									
16.		OG35.12									
17.		OG35.13									
18.		OG35.14									
19.		OG35.15									
20.		OG35.16									
21.		OG35.17									
22.		OG36.3									
23.		OG37.1									
24.		OG37.2									
25.		OG37.3									
26.		OG37.4									
27.		OG37.5									
28.		OG37.6									
29.		OG37.7									
30.		OG38.1									
31.		OG38.2									
32.		OG38.3									

CERTIFIABLE COMPETENCY

OBSTETRICS AND GYNAECOLOGY

Competency OG 13:4

To observe and assist in the conduct of normal vaginal delivery 10 Cases.

Case - 1

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

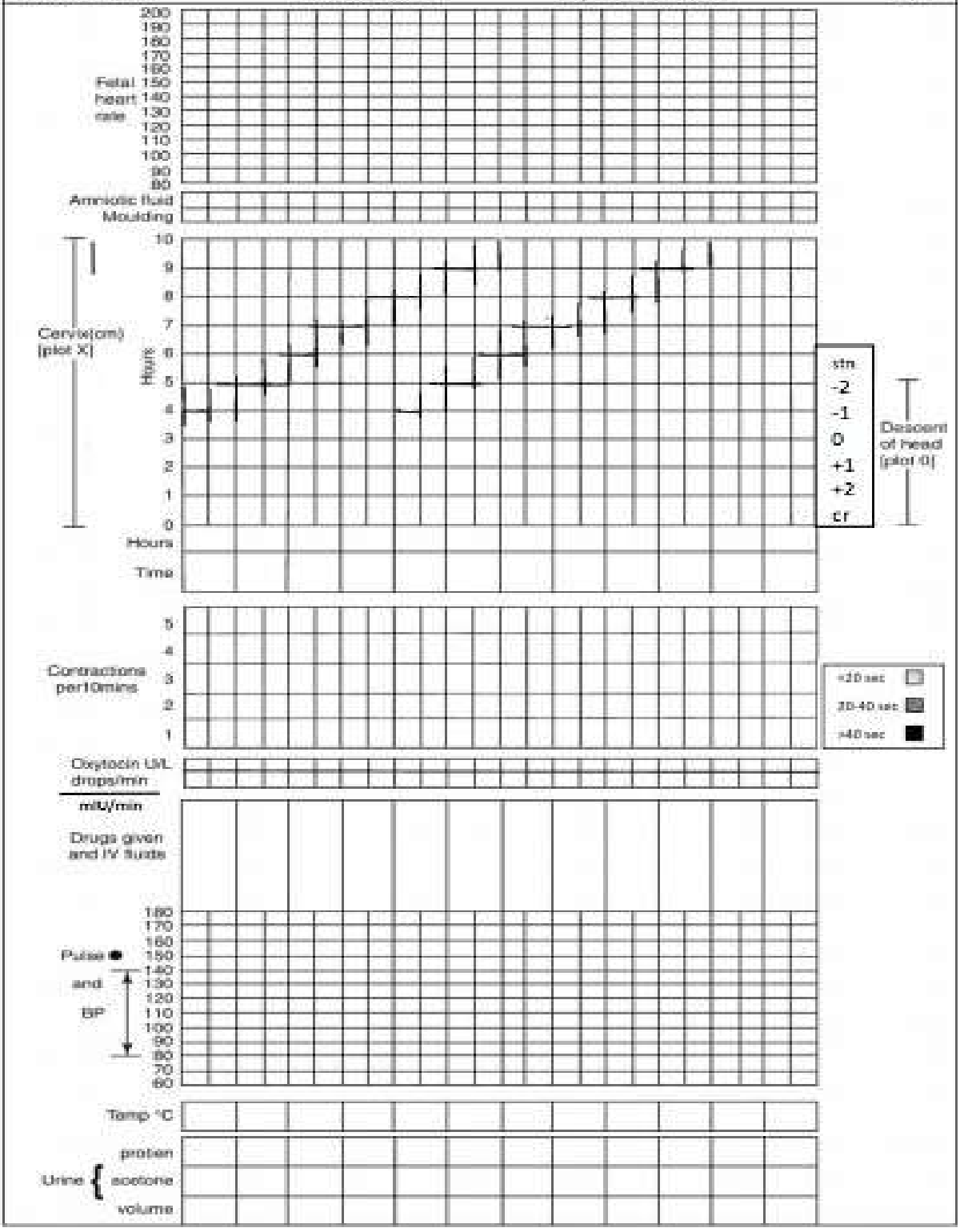
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of I st stage:_____II nd stage:_____III rd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 2

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

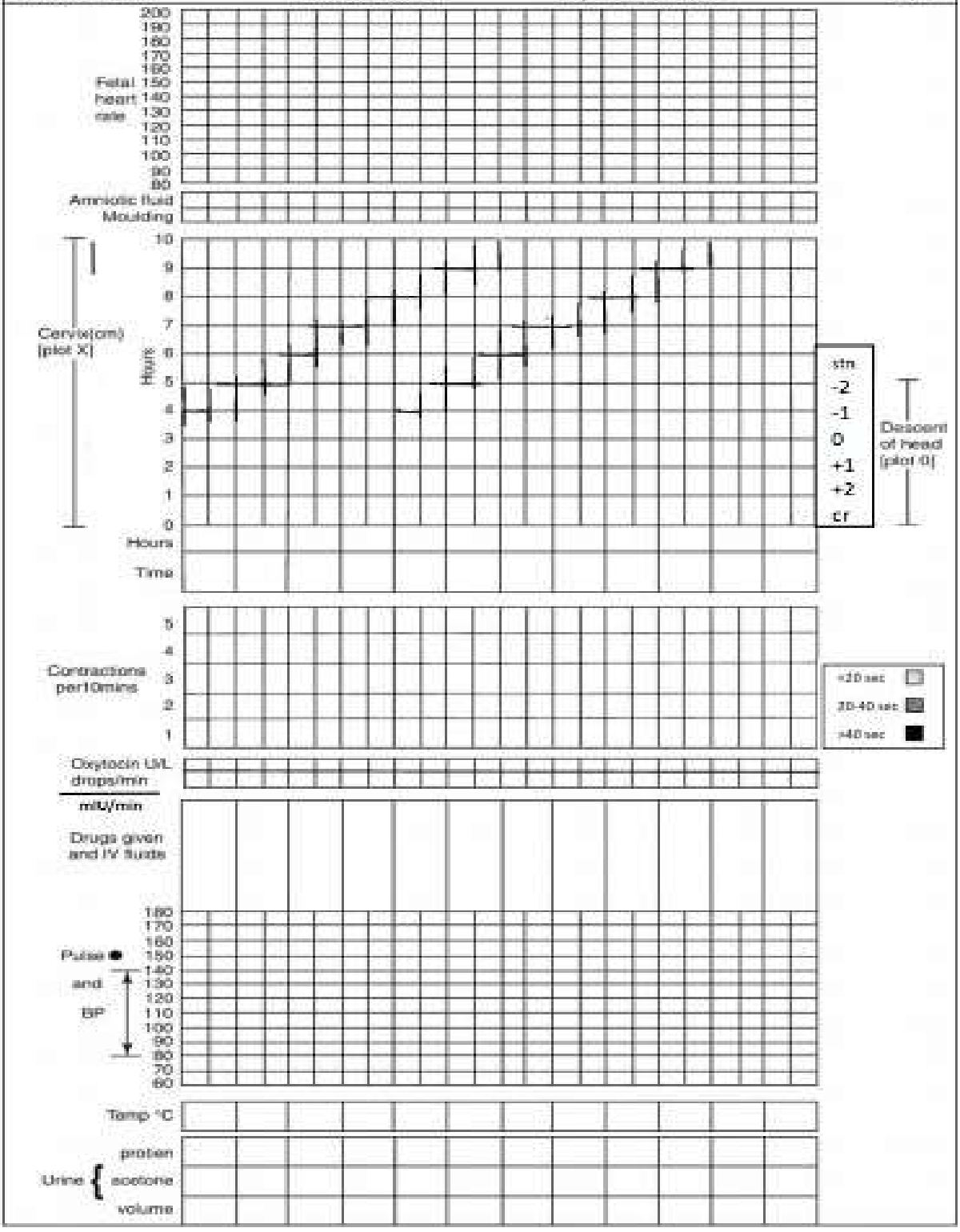
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 3

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

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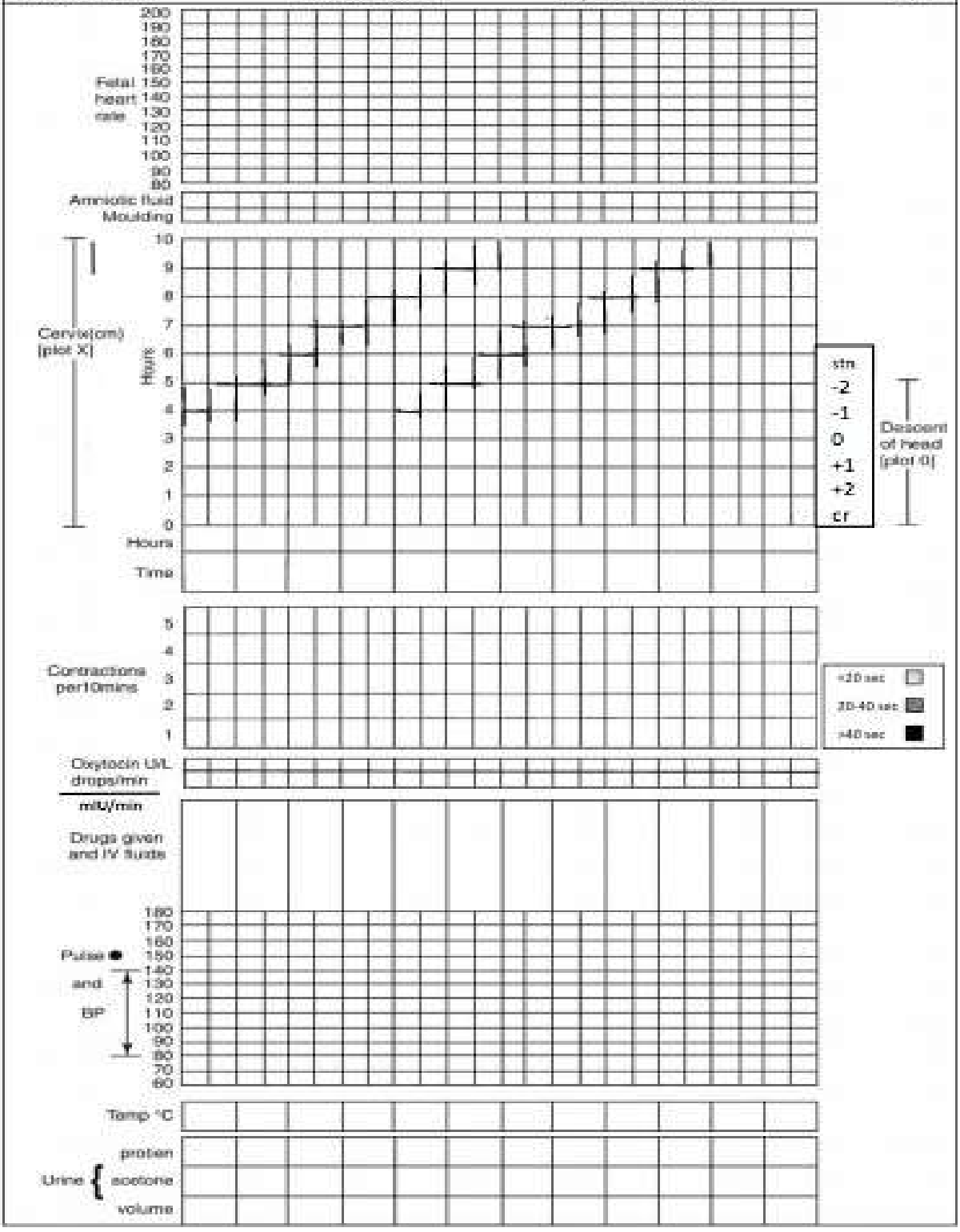
Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



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Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

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Perineal Tear: I degree II degree III degree

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Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

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Sex: Male/ Female	Alive/Stillborn–fresh/macerated
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APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 4

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
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Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

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Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

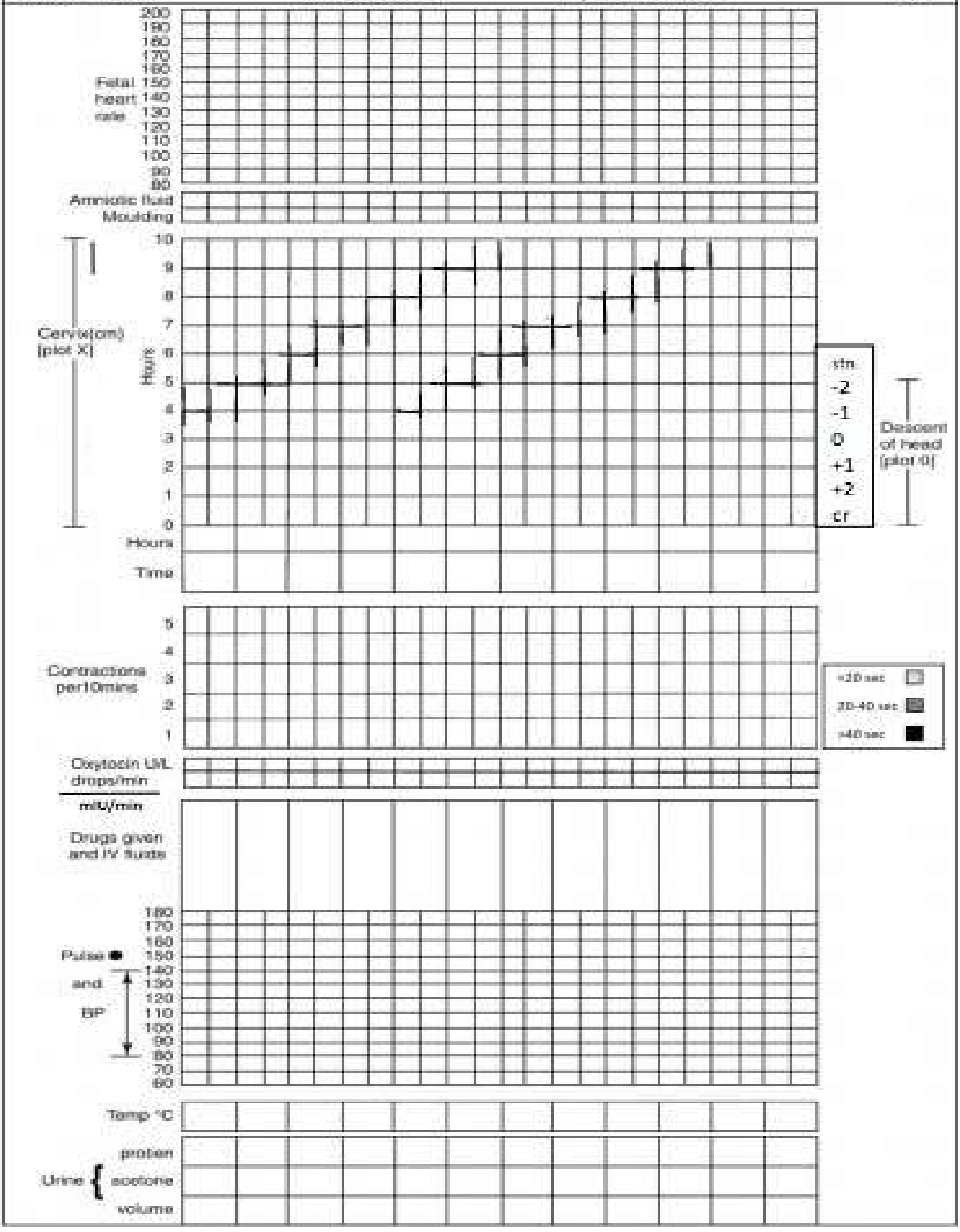
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 5

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

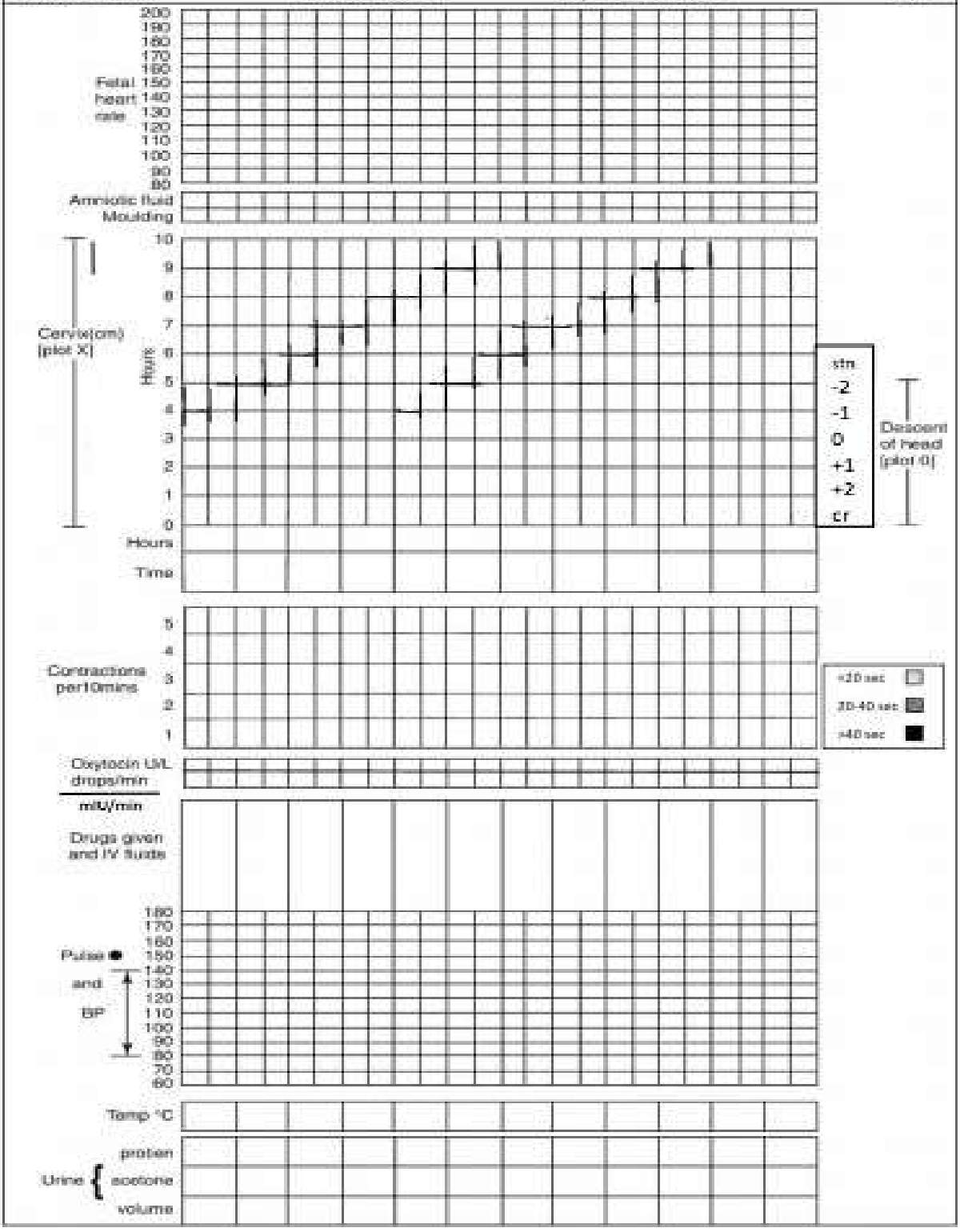
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 6

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

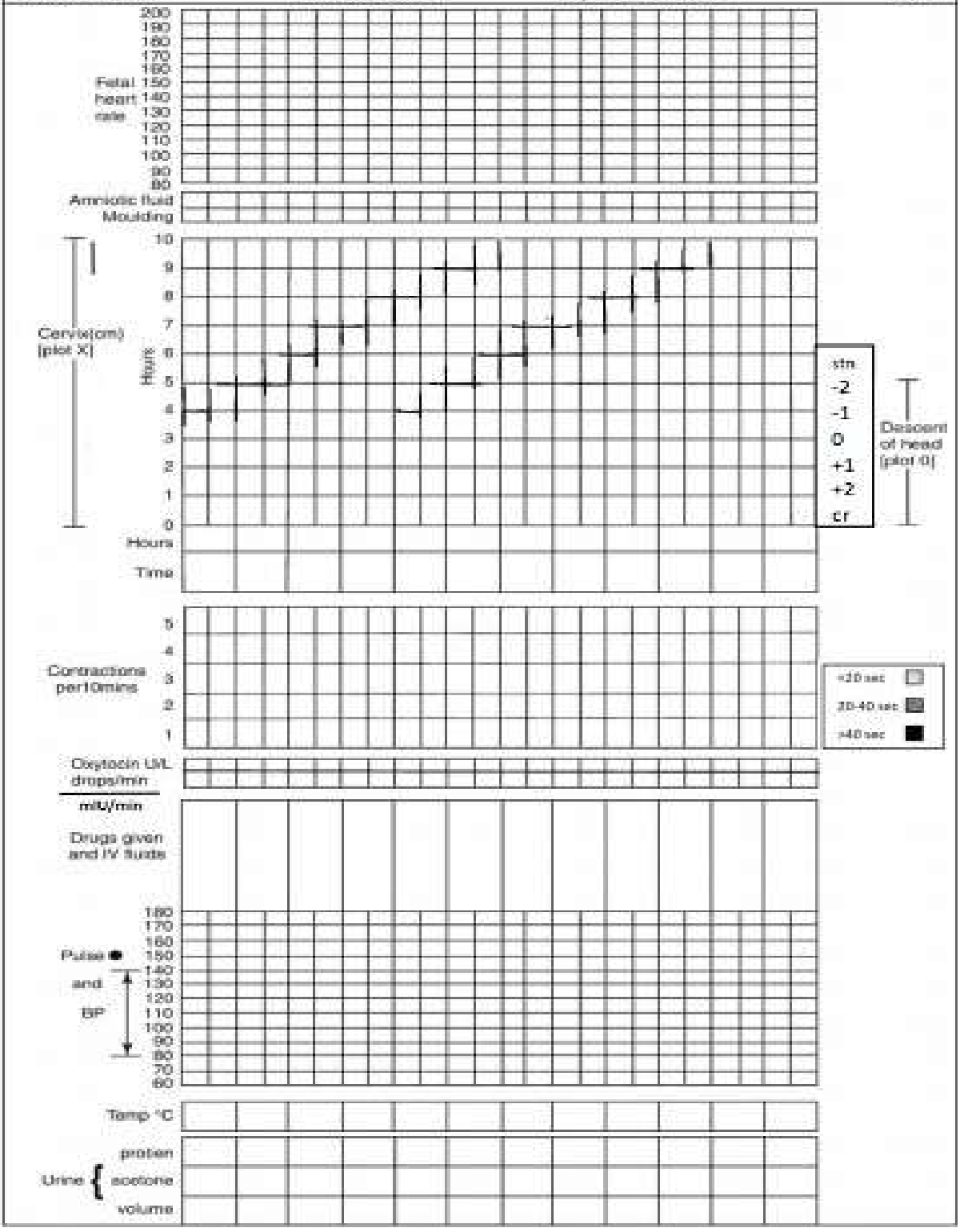
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 7

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

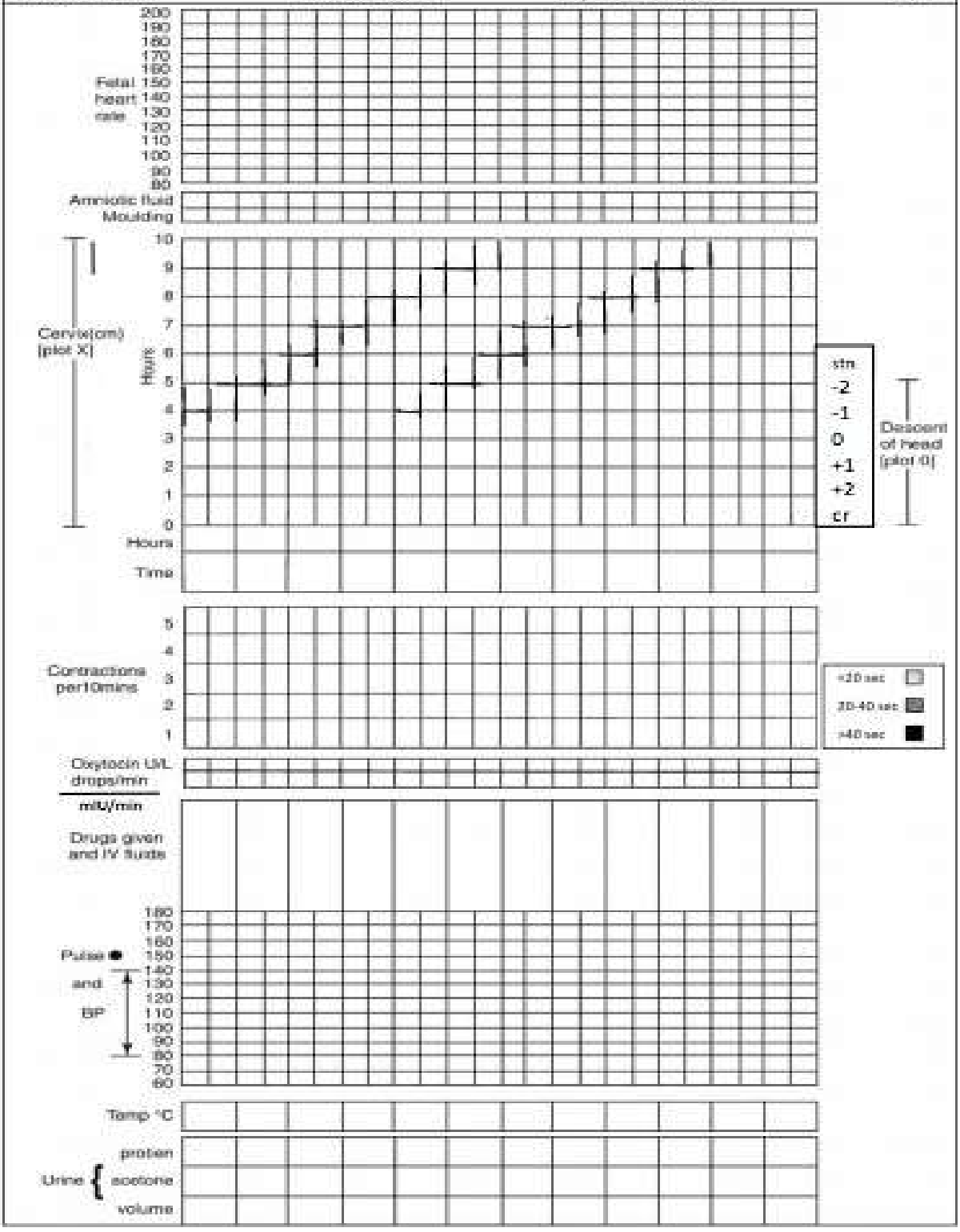
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 8

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

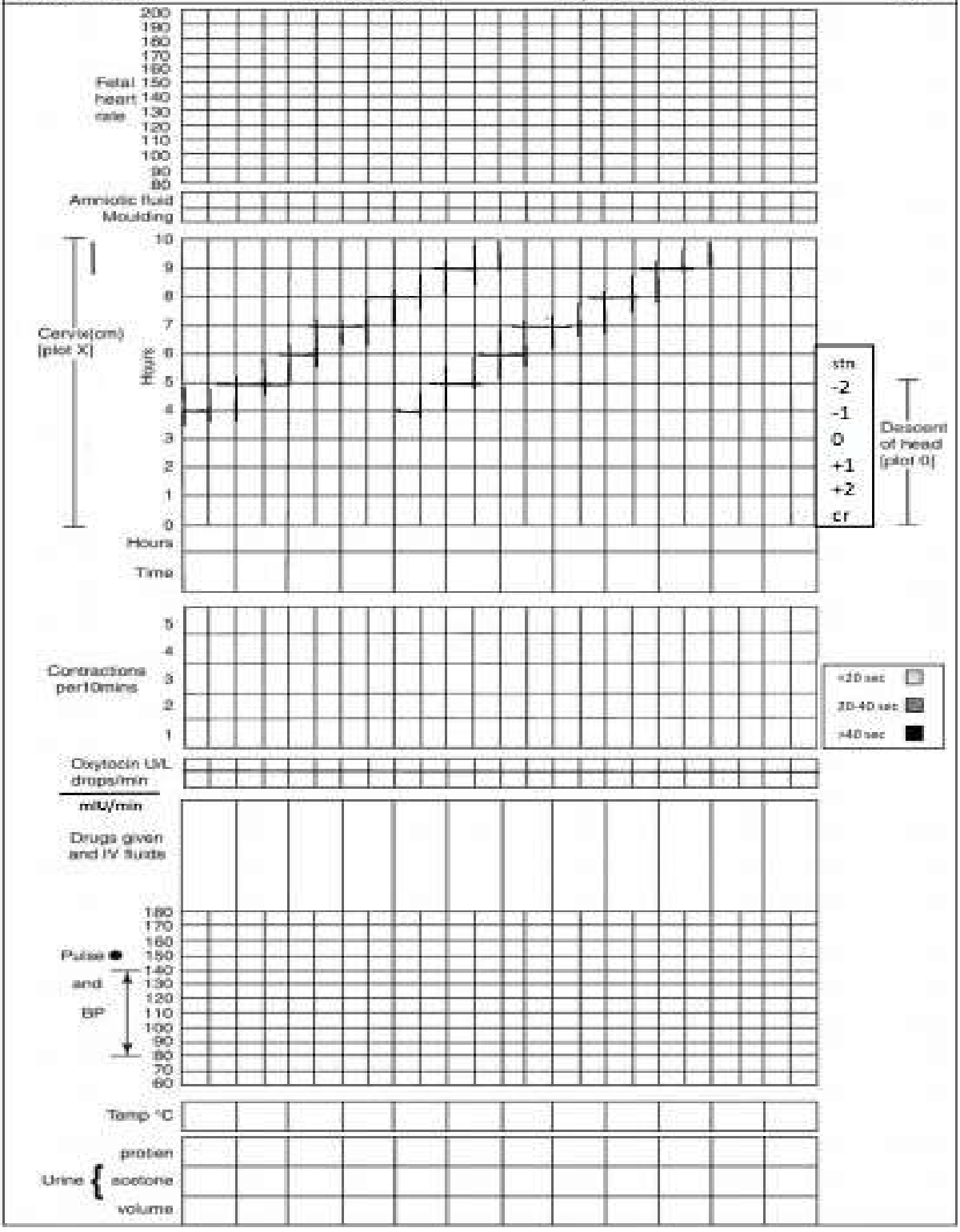
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 9

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

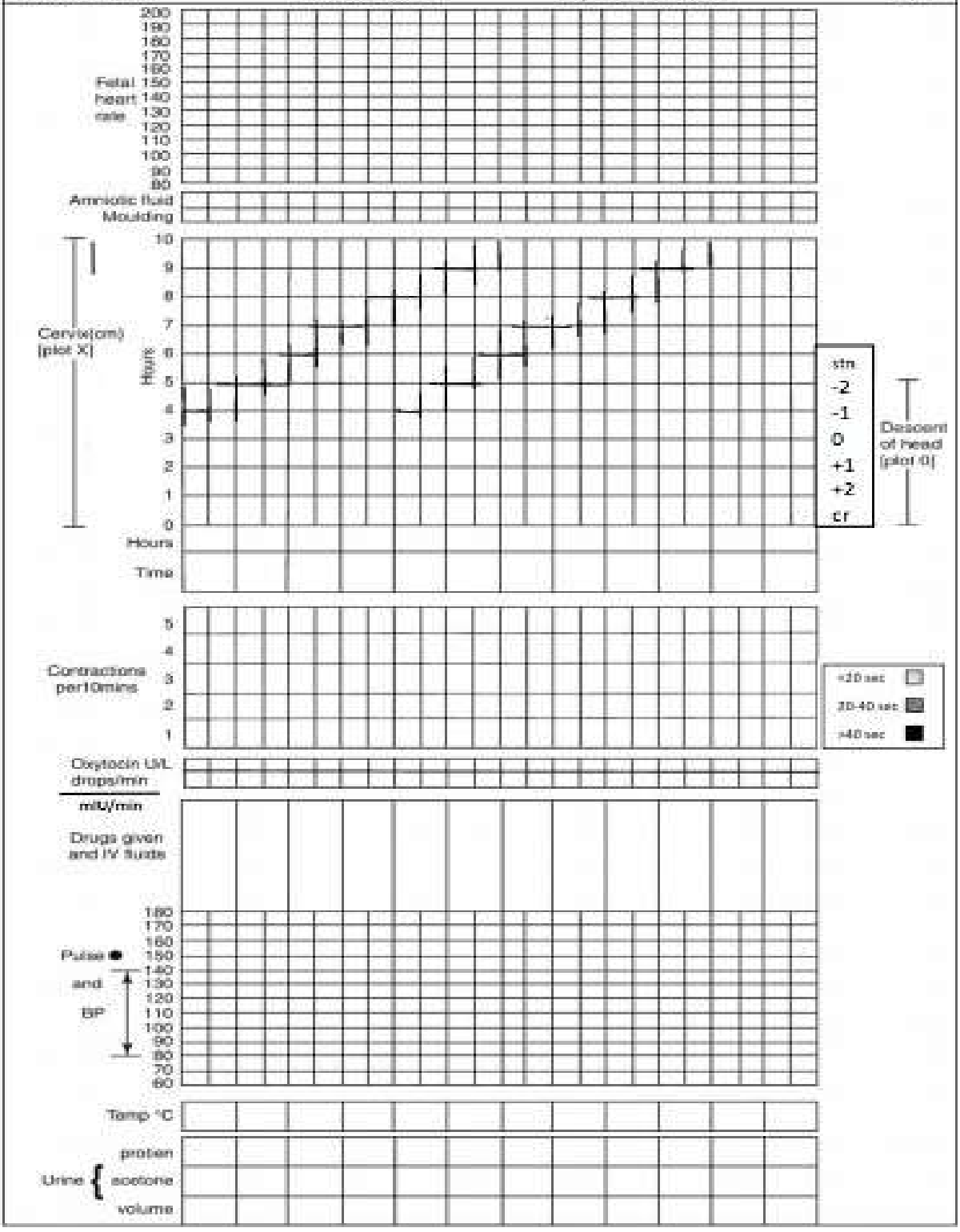
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

Case - 10

NORMAL LABOR CASE SHEET

Reg No -

Case No-

Name- Date of Admission-

Age- Married Since-

Referral–Yes /No Reason _____ Husband's Occupation-

L.M.P.- **E.D.D-**

Gestational age–_____weeks_____days

Obstetric Score: GP L A D

No. Of Antenatal Visits- Last ANC Visit on-

Presenting Complaints-

Any High Risk-

Previous obstetric History-

1. Nature of previous deliveries: Home delivery/Spontaneous /Prolonged/Instrumental
2. Abortion
3. Premature birth
4. Stillbirth

Last Conception or Delivery –How many years ago?

Past History-

Diabetes mellitus/ Hypertension/ Tuberculosis/ Bronchial Asthma/ Thyroid Disorder/ STI /Epilepsy

Family History-

Diabetes Mellitus/ Hypertension/ Twin Pregnancy/ Congenital Malformatio

Investigations done during OPD follow up-

Hb	TLC	PLT
HIV	HbsAg	VDRL
Blood Group	Urine Routine	
Last USG–Date	Placenta- Lie-	Liquor - EBW-

Findings on Antenatal Pelvic Assessment -

Treatment given –

Inj.TT_1 Inj.TT_2

Others -

Examination on admission-

General Physical Examination | Pallor | Edema

Pulse–_____/min | Blood Pressure –_____/____mmHg | Temp–_____°F

Height–_____cm | Weight–_____kg

Systemic Examination-
CVS
RS

Obstetric Examination -

Inspection: Contour of uterus- | Apparent fundal height-

Flanks–Full /Not full | Fetal movements–Seen/Not seen

Palpation: Symphysio-Fundal height–____cm | _____weeks___days

Girth of abdomen at level of umbilicus–_____cm

1st Pelvic Grip- | 2nd Pelvic Grip-

Right Lateral Grip - | Left Lateral Grip-

Fundal Grip- | Fetal Head Palpable in Fifths-

Any Abnormal Finding-

Auscultation: FHS–heard/not heard | Rate:____/min | Rhythm: Regular/ Irregular

Doppler findings:

Vaginal Examination on Arrival-

Cervix os-	Dilatation-	Effacement-
Membranes –Intact/Ruptured	Colour of Liquor-	Station-
Presenting part-	Position-	Caput-

Pelvic Assessment

Sacral Promontory	Diagonal Conjugate	Obstetric
Conjugate Sacral Curve	Sacro-sciatic Notch	Ischial Spine
Subpubic Angle		

Assessment of CPD (Head Fitting Test)

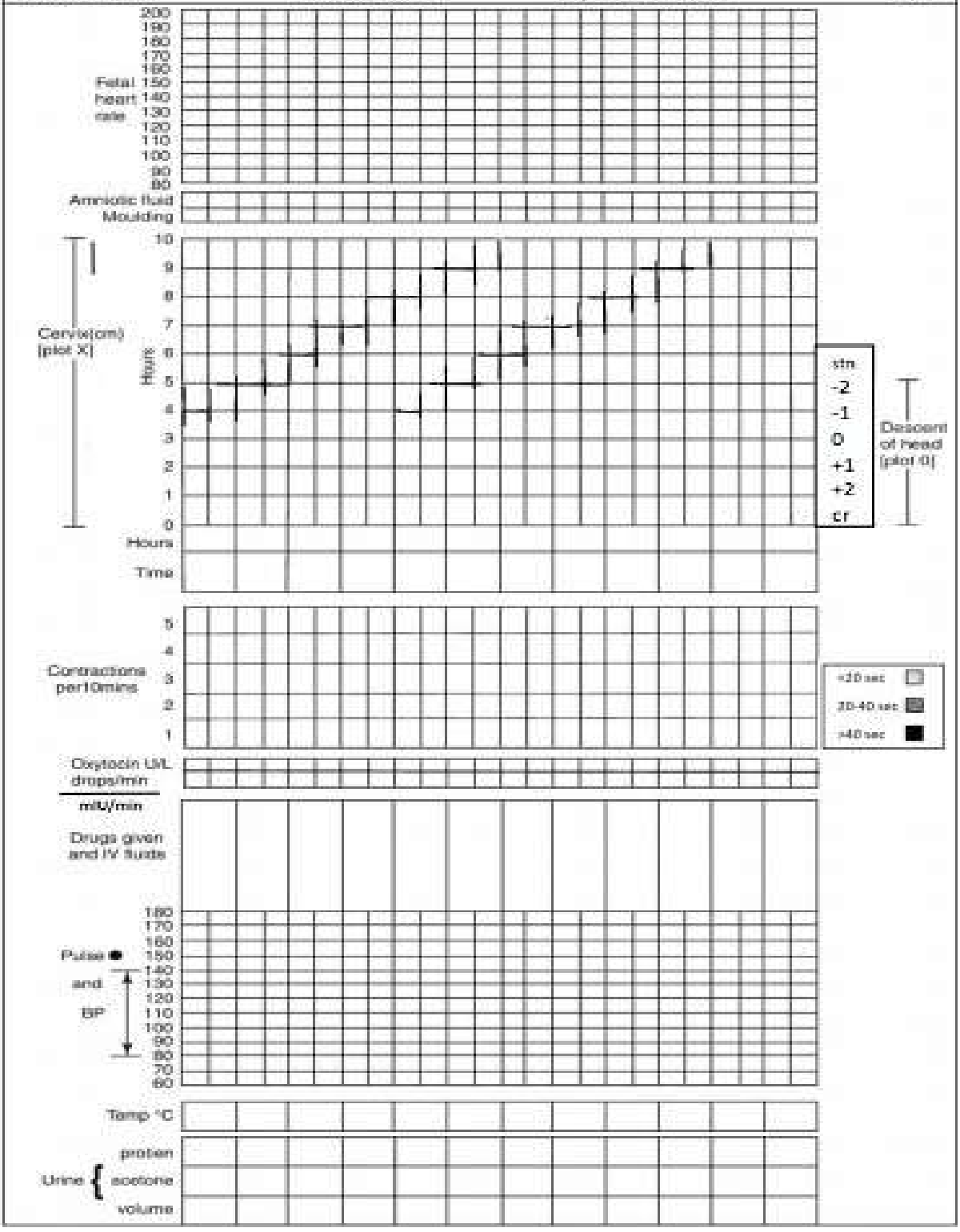
Clinical Diagnosis:

MAHATMA GANDHI MISSION HOSPITAL

Sector-4E, Kalamboli, Navi Mumbai - 410 218 Tel.: 022-2742 7104, 2742 3405 Fax : 022-2742 7104

Name | Gravida | Para | Hospital no.

Date of admission | Time of admission | Ruptured membranes | hours



Progress of Labor-

Time of rupture of membrane: Time of onset of 2nd stage:

Type of episiotomy: Anaesthesia:

Date of birth of baby_____Time of birth_____Time of Placenta Delivery _____

Mode of Placental Delivery: Blood lossin3rd stage:

Duration of Ist stage:_____IInd stage:_____IIIrd stage:_____

Oxytocin drug given: Dose and Time of Administration:

Contraction of uterus after expulsion of placenta: Well Contracted /Flabby

Perineal Tear: I degree II degree III degree

Sutured with:

Complications -

Placental Examination-

Examined/Not examined Weight: Complete/Incomplete

Membranes intact/Not Retroplacental clots: Present/Absent

Cord Length: Cord Abnormalities: PPH /No PPH

Condition of mother after IV stage of Labor-

Temp:_____°F Pulse:_____/min Blood Pressure:_____/____mmHg

Symphysio-fundal Height:_____cm Uterus: Well contracted/Flabby

Active Bleeding P/V:absent/present

Examination of New Born Infant-

Sex: Male/ Female	Alive/Stillborn–fresh/macerated
Birth weight:	Term/Pre-Term/Post-Term
APGAR Score: after 1min	After 5 mins
Congenital Malformation	Breast feeding initiated in_____hours
Passage of Meconium	Passage of Urine

Signature of Student

Signature by Resident

Signature of Head of Unit

PAP smear obtaining and filling form for same.

(2 cases so 2 similar repetitions)

Signature of teacher:

Date:

Discharge summary (as per institutional format)

1. Vaginal delivery

Signature of teacher:

Date:

Observation and Discharge summary

2. Caesarean section

Signature of teacher:
Date:

Observation and Discharge summary

3. Hysterectomy abdominal

Signature of teacher:
Date:

Observation and Discharge summary

4. Hysterectomy vaginal

Signature of teacher:
Date:

Observation and Discharge summary

5. MTP

Signature of teacher:

Date:

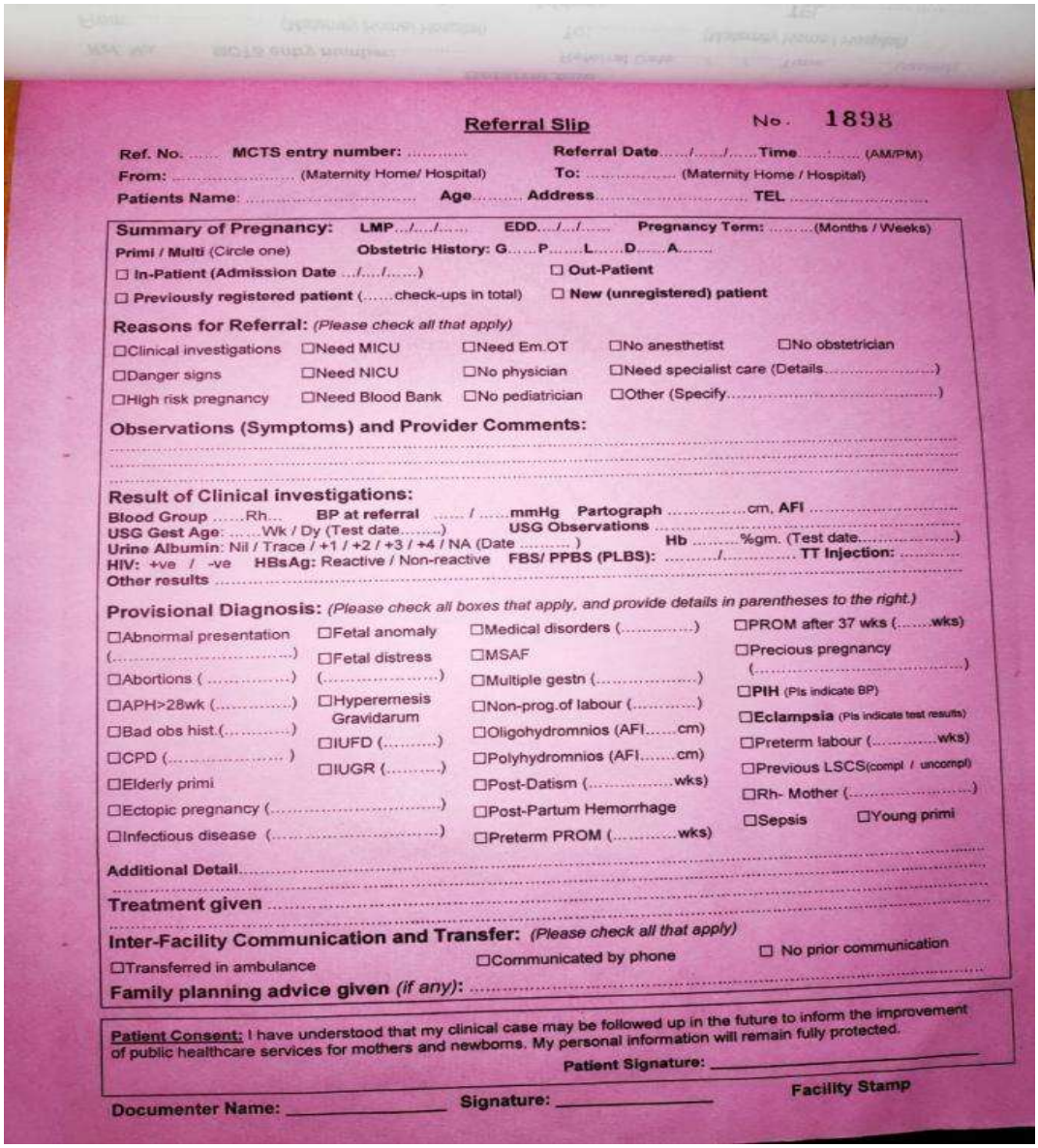
Observation and Discharge summary

6. Tubal ligation

Signature of teacher:

Date

Referral note for a higher centre for obstetric patient
(This format to be typed in journal)



Referral Slip No. 1898

Ref. No. ..... MCTS entry number: ..... Referral Date...../...../..... Time..... (AM/PM)
From: ..... (Maternity Home/ Hospital) To: ..... (Maternity Home / Hospital)
Patients Name: ..... Age..... Address..... TEL .....

Summary of Pregnancy: LMP.../..../..... EDD.../.../..... Pregnancy Term: .....(Months / Weeks)
Primi / Multi (Circle one) Obstetric History: G.....P.....L.....D.....A.....
☐ In-Patient (Admission Date .../..../.....) ☐ Out-Patient
☐ Previously registered patient (.....check-ups in total) ☐ New (unregistered) patient

Reasons for Referral: *(Please check all that apply)*

☐Clinical investigations	☐Need MICU	☐Need Em.OT	☐No anesthetist	☐No obstetrician
☐Danger signs	☐Need NICU	☐No physician	☐Need specialist care (Details.....)	
☐High risk pregnancy	☐Need Blood Bank	☐No pediatrician	☐Other (Specify.....)	

Observations (Symptoms) and Provider Comments:

Result of Clinical investigations:
Blood Group .....Rh... BP at referral ..... / .....mmHg Partograph .....cm, AFI .....
USG Gest Age: .....Wk / Dy (Test date.....) USG Observations .....
Urine Albumin: Nil / Trace / +1 / +2 / +3 / +4 / NA (Date .....) Hb .....%gm. (Test date.....)
HIV: +ve / -ve HBsAg: Reactive / Non-reactive FBS/ PPBS (PLBS): ...../..... TT Injection: .....
Other results .....

Provisional Diagnosis: *(Please check all boxes that apply, and provide details in parentheses to the right.)*

☐Abnormal presentation (.....)	☐Fetal anomaly	☐Medical disorders (.....)	☐PROM after 37 wks (.....wks)
	☐Fetal distress (.....)	☐MSAF	☐Precious pregnancy (.....)
☐Abortions (.....)		☐Multiple gestn (.....)	☐PIH (Pls indicate BP)
☐APH>28wk (.....)	☐Hyperemesis Gravidarum	☐Non-prog.of labour (.....)	☐Eclampsia (Pls indicate test results)
☐Bad obs hist.(.....)	☐IUFD (.....)	☐Oligohydromnios (AFI.....cm)	☐Preterm labour (.....wks)
☐CPD (.....)	☐IUGR (.....)	☐Polyhydromnios (AFI.....cm)	☐Previous LSCS(compl / uncompl)
☐Elderly primi		☐Post-Datism (.....wks)	☐Rh- Mother (.....)
☐Ectopic pregnancy (.....)		☐Post-Partum Hemorrhage	☐Sepsis ☐Young primi
☐Infectious disease (.....)		☐Preterm PROM (.....wks)	

Additional Detail.....
Treatment given .....

Inter-Facility Communication and Transfer: *(Please check all that apply)*
☐Transferred in ambulance ☐Communicated by phone ☐ No prior communication
Family planning advice given *(if any)*: .....

Patient Consent: I have understood that my clinical case may be followed up in the future to inform the improvement of public healthcare services for mothers and newborns. My personal information will remain fully protected.
Patient Signature: _____
Documenter Name: _____ Signature: _____ Facility Stamp

Signature of teacher:

Date:

Medical certificate (for obstetric or gynaecological condition)

Signature of teacher:

Date:

Seminars, Tutorials, Projects, Quizzes, extracurricular activities

Sr. No.	Self- directed learning (Seminars, Tutorials, Projects, Quizzes, Extracurricular activities)	Date	Phase	Signature of Teacher

Seminars, Tutorials, Projects, Quizzes, extracurricular activities

Sr. No.	Self- directed learning (Seminars, Tutorials, Projects, Quizzes, Extracurricular activities)	Date	Phase	Signature of Teacher

Reflection (minimum200words) – 1

Date:

TOPIC:

Reflection (minimum 200 words) – 2

Date:

TOPIC:

RECORDING FORM FOR MINI – CEX

EVALUATOR : DATE :

STUDENT :

YEAR :

PATIENT DIAGNOSIS :

SETTINGS : AMBULATORY NEW COMPLEXITY : LOW

IN PATIENT FOLLOW UP MODERATE

ED HIGH

OTHER :

PATIENT AGE PATIENT SEX

FOCUS : DATA GATHERING / DIAGNOSIS / THERAPY / COUNSELLING

1. **MEDICAL INTERVIEWING SKILLS** (OBSERVED / NOT OBSERVED)

1 2 3 / 4 5 6 / 7 8 9

2. **PHYSICAL INTERVIEWING SKILLS** (OBSERVED / NOT OBSERVED)

1 2 3 / 4 5 6 / 7 8 9

3. **HUMANISTIC QUALITIES** / PROFFESIONALISM (OBSERVED / NOT OBSERVED)

1 2 3 / 4 5 6 / 7 8 9

4. **CLINICAL JUDGEMENT** (OBSERVED / NOT OBSERVED)

1 2 3 / 4 5 6 / 7 8 9

5. **COUNSELLING SKILLS** (OBSERVED / NOT OBSERVED)

1 2 3 / 4 5 6 / 7 8 9

6. **ORGANIZATION / EFFICIENCY** (OBSERVED / NOT OBSERVED)

1 2 3 / 4 5 6 / 7 8 9

7. **OVERALL CLINICAL COMPETENCE** (OBSERVED / NOT OBSERVED)

1 2 3 / 4 5 6 / 7 8 9

MINI CEX TIME : OBSERVING : _____ MINS

PROVIDING FEEDBACK _____ MINS

UNSATISFACTORY 1,2,3

SATISFACTORY 4, 5, 6

SUPERIOR 7, 8, 9

EVALUATOR SATISFACTION WITH MINI CEX

LOW 1 2 3 4 4 5 6 7 8 9 HIGH

RESIDENT SATISFACTION WITH MINI CEX

LOW 1 2 3 4 4 5 6 7 8 9 HIGH

COMMENTS :

STUDENT SIGNATURE EVALUATOR SIGNATURE

Self-Directed Learning Record

Session No	Topic	Date	Signature of Teacher
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Self-Directed Learning

SDL Topic:-

Name of Facilitator:-

Summary of Concepts learnt:-

Self-Directed Learning

SDL Topic:-

Name of Facilitator:-

Summary of Concepts learnt:-

No. D-11011/500/2024-AcademicCell (e-8284443)
Government of India
National Medical Commission

Sector-8, Dwarka
New Delhi-110075
12-09-2024

Subject: Guidelines for Competency Based Medical Education (CBME) Curriculum 2024– regarding

The revised guidelines for Competency Based Medical Education (CBME) Curriculum 2024 by the Under Graduate Medical Education Board (UGMEB) is enclosed herewith. All concerned stakeholders are requested to kindly take note of the same.

Encl.: As above

Signed by B Srinivas
Date: 12-09-2024 14:52:16

DR B SRINIVAS
SECRETARY

Copy to:

i. ACS/ PS/ Secretaries/ Department/s of Medical Education in all States/ Union Territories
ii. PPS to Chairman, NMC
iii. PPS to President(UGMEB)
iv. DMMP-I System Integrator- for uploading of NMC Website
v. Guard File

Resolution No. 4.92 of Academic Council (AC-50/2024): Resolved to approve the change of Under Graduate Logbook for 2023-24 CBME Batch.

I. Record of Attendance

Phase	Duration of posting	Posting from date	Posting to date	Attended days/out of days	Signature of Unit In charge
Phase II	7 weeks				
Phase III (Part-I)	4 weeks				
Phase III (Part-II)	10 weeks				

.....

Signature of Head of the Department

MGM INSTITUTE OF HEALTH SCIENCES

SYLLABUS OBSTETRICS AND GYNAECOLOGY DEPARTMENT

CBME MBBS Phase- II, Phase-III (Part-I) and Phase- III (Part- II)

II. Theory

Sr. No	Lecture Hrs	Integrated Teaching Tutorials Seminar Hrs	Self Directed Learning Hrs	Total
1.	19	--	--	25
2.	30	50	10	90
3.	80	140	40	260

Clinical Posting

1. Phase – 2 7 Weeks
2. Phase – 3 Part – 1 4 Weeks
3. Phase – 4 Part – 2 8+2 Weeks = 10 Weeks

Total 21 Weeks

III. Electives-4 week

Proposed Internal Examination & Assessment Format as per CBME 2023

MGM Medical College Kamothe Navi Mumbai

MGM Medical College Kamothe Navi Mumbai

DEPARTMENT OF OBGY

3rd MBBS Part 2 (CBME)

Sr. No.	Roll No	Name of Student	Formative Assessment Theory			Continous Internal assessment Theory						
			1st PCT Theory	2nd PCT Theory	Prelims Theory (Paper I & II	Home Assignment	Continuous Class Test (LMS)	Semin ar	Museum Study	Library assignments	Attendance Theory	Total
								Self Directed Learning				
			100	100	200	15	30	15	15	15	10	500

Professor & Head
Department of OBGY
MGM Medical College Kamothe Navi Mumbai

3rd MBBS Part 2 (CBME)													
Faculty : Final MBBS			Year Phase - Part - II										
			Formative Assessment			Continuous Internal Assessment (Practical)							Date:-
						Log book (200)				Journal (Record book portfolio)	Attendance (Practical)	Total	
Sr. No.	Roll No	Name of Student	1st PCT Practical /First Ward Leaving Examination	2nd PCT Practical /First Ward Leaving Examination	Prelims Practical	Certifiable skill based competernciies (Through OSPL, OSCE, Sports, Exercise Other)	AETCOM Competencies	SVL Lab activity	Research				
			100	100	200	100	40	40	20	40	10	650	

Professor & Head
Department of OBGY
MGM Medical College Kamothe Navi Mumbai

CERTIFIABLE COMPETENCIES

Competency No.	Certifiable Competency
OG 2.1	Per Speculum (PS) and Per Vaginal (PV) examination
OG 33.4	Visual Inspection of cervix with Acetic Acid (VIA)
OG 35.12	Pap Smear sample collection & interpretation
OG 35.15	Intra-Uterine Contraceptive Device (IUCD) insertion & removal
OG 8.3	Obstetric examination
OG 35.14	Episiotomy
OG 13.4	OG 13.4 Normal labor and delivery (including partogram)

OG 2.1 Per Speculum (PS) and Per Vaginal (PV) examination

Signature of teacher:

Date:

OG 33.4 Visual Inspection of cervix with Acetic Acid (VIA)

Signature of teacher:

Date:

OG 35.12 Pap Smear sample collection & interpretation

Signature of teacher:

Date:

OG 35.15 Intra-Uterine Contraceptive Device (IUCD) insertion & removal

Signature of teacher:

Date:

OG 8.3 Obstetric examination

Signature of teacher:

Date:

OG 35.14 Episiotomy

Signature of teacher:

Date:

OG 13.4 Normal labor and delivery (including partogram)

Signature of teacher:

Date:

STUDENT FEEDBACK