OB/GYN Clerkship Orientation Guide

Welcome to your OB/GYN Clerkship! We’re excited to have you here. We think this is the very best specialty of all and we want to share our love of this field with you during your time with us. This packet includes some information we think you will find helpful on your rotation, including a brief overview of our expectations of you during this rotation, sample notes, and highlights of clinical information with which we expect you to become familiar. We suggest that you use create a packet of index cards that you can carry with you on your rotation for quick reference.

OB/GYN is an often unpredictable field of medicine. Some days will be crazy and others slow. Use your down time wisely for studying. You are expected to do independent reading regarding the topics that you encounter. If you need direction, we can suggest areas where you should focus. We are here to help you learn, but much of your learning will come from your interactions with the patients and from your observation of the team as they manage the patients.

If there is anything that you feel would be a useful addition to this compilation, please let us know. We hope you find these notes helpful.

Good Luck and Enjoy!

Notes on Notes:
All notes should be titled with your POSITION, TYPE of note, and your SERVICE for easy identification.
All notes must be DATED and TIMED.
All notes should be SIGNED
You are not permitted to use templates.
Your L&D rotation is divided into one week of days and one week of nights. Students on days are expected to round on postpartum and antepartum patients and have progress notes written PRIOR TO SIGNOUT every morning. Sign-out begins at 6:00 am every day but Wednesday in the resident education room, 246, on labor and delivery. PM sign-out occurs at 5:00 pm M, T, Th, F and 6:00pm on Wednesdays. All students are expected to be on time for sign-out. You should sign-out your patients to the team that comes on after you. When you transition from one service to another, you are also responsible for passing on expectations and patient information to the next team.

L&D
Triage
Patients who present for triage should first be evaluated by the medical student. Be on the lookout for new patients. Once the nurse is finished checking in patient, you may go see them, get their history, and perform physical exam (except for pelvic).

After you have seen the patient, present them to the resident (usually the junior resident on the service). See attached OB Triage H&P note. It is helpful to look through the patient’s medical record prior to seeing them. Their prenatal record can be found under the episodes tab under chart review. Beware that the method of dating on these forms is often not correct. Radiology ultrasounds can be found under radiology, but MFM ultrasounds are scanned in under the media tab.

Labor Patients
You should divide the labor patients among the medical students present. Only one student should see each patient. Labor patients should have progress notes written every 4 hours in latent labor and every 2 hours in active labor. You are responsible for having notes written on your patients- we will not remind you. Once your note is written, please let your residents know and one will review it with you if time permits.

Deliveries
You may only attend a delivery if you have met the patient prior to the beginning of pushing. You will need to pull gloves for yourself (and sometimes a gown) to place on the delivery table. These are usually located inside the cabinet of the delivery table (or above the scrub sink at Gottlieb). Surgical caps, boots, and masks are located in drawers next to the nurses’ station (or in the room next to the OR at Gottlieb). GET DREST FAST. We can’t wait for you to get your gloves on, so if you’re not ready, you’re going to miss it. Afterward, you can help by taking the instruments back to the dirty utility room. A student should also scrub for every cesarean section. Again, make sure to meet the patient first. You should write the delivery note afterward. The resident will sign it.

Antepartum Patients
Progress notes should be written every 4 hours which review the strip, and if hospitalization is for a maternal medical indication, include a physical exam.

Mag Notes
Notes should be written every 4 hours. Patients on magnesium need special monitoring for magnesium toxicity, respiratory depression, pulmonary edema, renal failure, neurologic irritation, worsening blood pressure, or signs of fetal distress. Note should include s/sx of pre-eclampsia, vitals (including O2 sats), UOP, physical exam including reflexes, and recent labs.

Postpartum
Postpartum patients would have progress note every day. Patient’s who deliver between Midnight and 6 am are not rounded on until the next day.

Antepartum
These patients usually include women with preterm premature rupture of membranes, preterm labor, placenta previa, pre-eclampsia, or medical complications of or during pregnancy. They offer an opportunity to learn about more in-depth disease processes related to pregnancy. Please try to see antepartum patient’s in addition to postpartum patients. However, understand that the prolonged hospitalization of these women can be very stressful, so be sensitive to their needs and requests. Progress note should include questions about fetal movement, LOF, vaginal bleeding, s/sx of pre-eclampsia, sx of DVT or PE. Vitals should include fetal heart tones, which are measured every shift. Objective portion of note should include general, cardiac, pulmonary, abdomen, extremities and any new lab or ultrasound results.

The Sign-out
This is an electronic document that we keep with information regarding all of the patients on the service. It is a vital aspect in our communication with each other. Your residents may ask you to assist with keeping the sign-out updated. When you see a new patient, they should be added to the list. Just follow the form of the other patients on the list. Bold means currently pregnant.
## Labor and Delivery Pearls:

### Antenatal Testing - Know These Definitions!!!!!

<table>
<thead>
<tr>
<th>Pattern</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>• The mean FHR rounded to increments of 5 bpm during a 10 min segment</td>
</tr>
<tr>
<td></td>
<td>• Must be for a minimum of 2 min in any 10-min segment</td>
</tr>
<tr>
<td>Baseline variability</td>
<td>• Fluctuations in the FHR of two cycles per min or greater</td>
</tr>
<tr>
<td></td>
<td>• Quantitated as the amplitude of peak-to-trough in beats per min</td>
</tr>
<tr>
<td></td>
<td>o Absent—amplitude range undetectable</td>
</tr>
<tr>
<td></td>
<td>o Minimal—amplitude range detectable but ≤ 5 bpm</td>
</tr>
<tr>
<td></td>
<td>o Moderate (normal)—amplitude range 6–25 bpm</td>
</tr>
<tr>
<td></td>
<td>o Marked—amplitude range &gt; 25 bpm</td>
</tr>
<tr>
<td>Acceleration</td>
<td>• Increase in the FHR from the most recently calculated baseline</td>
</tr>
<tr>
<td></td>
<td>• Duration defined as the time from initial change in FHR from the baseline to the return to the baseline</td>
</tr>
<tr>
<td></td>
<td>• 32 weeks and beyond: acme of ≥ 15 bpm above baseline, duration of ≥ 15 sec but &lt; 2 min</td>
</tr>
<tr>
<td></td>
<td>• Before 32 weeks: 10 beats per min or more above baseline, duration ≥ 10 sec but &lt; 2 min</td>
</tr>
<tr>
<td></td>
<td>• Prolonged acceleration: ≥ 2 min but &lt; 10 min</td>
</tr>
<tr>
<td></td>
<td>• If an acceleration lasts 10 min or longer, it is a baseline change</td>
</tr>
<tr>
<td>Bradycardia</td>
<td>• Baseline FHR &lt; 110 bpm</td>
</tr>
<tr>
<td>Early deceleration</td>
<td>• Associated with a uterine contraction, gradual (onset to nadir 30 sec or more) decrease with return to baseline</td>
</tr>
<tr>
<td></td>
<td>• Nadir of the deceleration occurs at the SAME TIME as the peak of the contraction</td>
</tr>
<tr>
<td>Late deceleration</td>
<td>• Associated with a uterine contraction, gradual (onset to nadir 30 sec or more) decrease with return to baseline</td>
</tr>
<tr>
<td></td>
<td>• Onset, nadir, and recovery occur AFTER THE BEGINNING, PEAK, AND END of the contraction, respectively</td>
</tr>
<tr>
<td>Tachycardia</td>
<td>• Baseline FHR &gt; 160 beats per min</td>
</tr>
<tr>
<td>Variable deceleration</td>
<td>• Abrupt (onset to nadir less than 30 sec) decrease in the FHR below the baseline</td>
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<tr>
<td></td>
<td>• The decrease in FHR is ≥ 15 bpm, with a duration of ≥ 15 sec but &lt; 2 min</td>
</tr>
<tr>
<td>Prolonged deceleration</td>
<td>• Visually apparent decrease in the FHR below the baseline</td>
</tr>
<tr>
<td></td>
<td>• Deceleration is 15 beats per min or more, lasting 2 min or more but less than 10 min from onset to return to baseline</td>
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</tbody>
</table>

### Nonstress Test (NST)
- Reactive: 2 or more accelerations occur in 20 minutes
- Nonreactive: no accelerations noted over 40 minutes

### Contraction Stress Test:
- Pitocin or Nipple stimulation applied until 3 contractions in 10 minutes
- **Positive** (nonreassuring): late decelerations following 50 percent or more of the contractions
- **Negative** (reassuring): no late or significant variable decelerations
- **Equivocal-suspicious pattern**: intermittent late or significant variable decelerations
- **Equivocal-hyperstimulatory**: decelerations with contractions more frequent than q 2 minutes or lasting > 90 seconds.
- **Unsatisfactory test**: tracing is uninterruptable or contractions are fewer than three in 10 minutes.

### Biophysical Profile:
- 2 pts for each of the following in 30 minute period:
  - NST
  - Fetal breathing (> 1 episode of breathing lasting ≥ 30 sec)
  - Fetal movement (> 3 discrete body or limb movements)
  - Fetal tone (> 1 episode of extension of extremity with return to flexion or opening or closing of hand)
  - AFI (single vertical pocket > 2cm)
- Interpretation
  - 8-10 Reassuring
  - 6 Equivocal- deliver if mature, if not, administer steroids and repeat in 24 hrs
  - 4 or less → deliver unless extremely preterm
- Modified BPP- NST + AFI
LABOR

Phases of Labor

First: Onset of labor to complete dilatation
Second: Complete dilatation to delivery
Third: Delivery of infant to delivery of placenta

Normal Labor Progress:

<table>
<thead>
<tr>
<th></th>
<th>Nulligravida</th>
<th>Multiparous</th>
<th>Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged Latent</td>
<td>&gt; 20 hrs</td>
<td>&gt; 14 hrs</td>
<td>Rest, pitocin</td>
</tr>
<tr>
<td>Protraction</td>
<td>Dilation</td>
<td>&lt; 1.2 cm/hr</td>
<td>&lt; 1.5 cm/hr</td>
</tr>
<tr>
<td></td>
<td>Descent</td>
<td>&lt; 1 cm/hr</td>
<td>&lt; 2 cm/hr</td>
</tr>
<tr>
<td>Arrest</td>
<td>Dilation</td>
<td>&gt; 2 hrs</td>
<td>&gt; 2 hrs</td>
</tr>
<tr>
<td></td>
<td>Descent</td>
<td>&gt; 2 hrs</td>
<td>&gt; 1 hrs</td>
</tr>
<tr>
<td></td>
<td>With epidural</td>
<td>&gt; 3 hrs</td>
<td>&gt; 2 hrs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Nulligravida</th>
<th>Multiparous</th>
<th>Limit (95%)</th>
<th>Limit (95 %)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active phase</td>
<td>4.9 hrs</td>
<td>3.2 hrs</td>
<td>Avg.</td>
<td>Avg.</td>
</tr>
<tr>
<td>2nd Stage</td>
<td>50 min</td>
<td>2hr (3 with epidural)</td>
<td>20 min</td>
<td>1 hr (2 with epidural)</td>
</tr>
<tr>
<td>Total</td>
<td>9 hrs</td>
<td>18.5</td>
<td>6 hrs</td>
<td>13.5</td>
</tr>
</tbody>
</table>

Fetal Lie- axis of the fetus. Longitudinal, Transverse, or Oblique.

Presentation- the fetal part at the cervix. Cephalic, breech, shoulder

Attitude- flexed or extended

Position- named for occiput, sacrum, or mentum in relation to maternal pelvis

Leopold’s Maneuver
1. Feel top of uterus- Identification of the fetal pole in the fundus
2. Hands on either side of uterus- Location of back and small parts
3. Lower uterine segment between thumb and first finger- determines engagement
4. Fingers pointed toward patient’s feet to determine position

Cardinal Movements of Labor
1. Engagement- biparietal diameter has passed pelvic inlet, 0 station.
2. Descent- often begins with engagement in multips
3. Flexion- from resistant forces of pelvic walls, pelvic floor, etc., brings shorter AP diameter into pelvis
4. Internal rotation- fetus faces maternal spine
5. Extension- head extends under pubic bone
6. External rotation/ restitution
7. Expulsion- delivery of body

Diagnosis of Membrane Rupture
1. Pooling
2. + Nitrazine with pH > 6.5 (dark blue).
   - Amniotic fluid pH= 7.0-7.5 (normal vaginal pH 3.5-4.5)
   - False + with blood, semen, or BV
3. Ferning- due to NaCl, proteins, and carbs
4. AFI

Perineal Lacerations:
1. fourchette, perineal skin, and vaginal mucosa
2. involves fascia and muscles of perineal body
3. involves anal sphincter
4. involves rectal mucosa

Etiology of Post Partum Hemorrhage
1. Atony
2. Retained Placenta
3. Lacerations
4. Uterine inversion

Medical Agents for Postpartum Hemorrhage
Oxytocin
Methergine (Ergonovine and Methylergonovine)-CI in HTN
Hemabate (Carboprost Prostaglandin F2a)- CI in asthma
Cytotec (Misoprostol)- 1000mcg rectally

Friedman curve:
**INDUCTION OF LABOR**

**Bishop Score** - To determine if cervical ripening is needed. *Calculate this for all Inductions*

<table>
<thead>
<tr>
<th>Dilation</th>
<th>Effacement</th>
<th>Station</th>
<th>Consistency</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Closed</td>
<td>0-30</td>
<td>-3</td>
<td>Firm</td>
</tr>
<tr>
<td>1</td>
<td>1-2</td>
<td>40-50</td>
<td>-2</td>
<td>Medium</td>
</tr>
<tr>
<td>2</td>
<td>3-4</td>
<td>60-70</td>
<td>-1</td>
<td>Soft</td>
</tr>
<tr>
<td>3</td>
<td>≥ 5</td>
<td>&gt; 80</td>
<td>+1, +2</td>
<td></td>
</tr>
</tbody>
</table>

*Modified Bishop Score: Add one point for preeclampsia, and each prior vaginal delivery, Deduct one point for postdates, nulliparity, preterm or prolonged PROM*

- 0-4: 45-50% failure
- 5-9: 10% failure
- 10-13: 0% failure
- > 8: Probability of vaginal delivery similar to spontaneous labor

**Cervical Ripening Agents**
- Cervidil- (Prostaglandin E2/dinoprostone) One 10 mg Insert q 12 hrs, max 3 doses (Also available as Prepidil gel)
- Cytotec- (Prostaglandin E1/Misoprostol) 25 mcg (1/4 of 100 mcg pill) vaginally q 4 hrs
- Transcervical Catheter
- Extra-amniotic saline infusion (EASI)
- Hygroscopic dilators
- Oxytocin

*“Hyperstimulation”*
- Uterine Tetany: Single ctx > 2
- Tachysystole: more than 5 ctx in 10 minutes or 7 ctx in 15 minutes
- Correction of Tachysystole or uterine tetany with resulting FHR tracings:
  - Decrease or discontinue uterine stimulant
  - IV fluids
  - Maternal repositioning
  - Maternal oxygen
  - Consider Terbutaline if persists

**Tocolytics**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Mechanism of Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnesium Sulfate</td>
<td>Decreases calcium needed for uterine contraction</td>
</tr>
<tr>
<td>Indomethicin (Indocin)</td>
<td>Cyclooxygenase inhibitor</td>
</tr>
<tr>
<td>Nifedipine (Procardia)</td>
<td>Calcium Channel Blocker</td>
</tr>
<tr>
<td>Terbutaline (Brethine)</td>
<td>Betamimetic</td>
</tr>
<tr>
<td>Atosiban (Antocin)</td>
<td>Pitocin antagonist</td>
</tr>
</tbody>
</table>

**Pre Term Labor**

Steroids for Fetal Lung Maturity (FLM)
- Betamethasone 12mg IM q 25 hrs x 2 doses
- Dexamethasone 6 mg IM q 12 hrs x 4 doses

Tocolytic Medication to allow administration of steroids

Fetal Fibronectin (FFN)
- Used between 24 and 32 weeks to determine probability of PTL
- High negative predictive value
- Nothing per Vagina for prior 24 hrs
- Blood and Semen interfere with results → false +

**Incidences**

There are different types of skin and uterine incisions, and one has nothing to do with the other. Only women with prior low transverse uterine incisions can attempt VBAC. (Rupture rate < 1%)
Medical Student Labor and Delivery H&P

CC: Leakage of Fluid, contractions, vaginal bleeding, abdominal pain, etc
HPI: 27 yo AA G6P2123 @ 37-5 by LMP consistent with 1st TMUS (or by US alone) presents for _______. Patient reports +/- FM, no LOF, VB, or contractions. +/- HA, vision changes, RUQ pain. Pregnancy complicated by ________. Prenatal care @ ________.
LMP: ________
EDC: ________
OB Hx: G6P2123
(Year; Term or Preterm, if preterm-why; Vaginal or Cesarean, type of cesarean and why; male of female; Weight; complications. If SAB or EAB, note GA and if D&C performed)
1. 2001-41w NSVD (or FAVD or VAVD or VBAC), M, 7lb 6oz, no complications
2. 2003-36w 1LTCS, PPROM, NRFHT, F, 6lb 2oz, chorioamnionitis
3. 2005-1TM SAB with D&C
4. 2005-39w VBAC, F, 7lb 12oz, pre-eclampsia
5. 2007-6w medical EAB
6. Current, GDM-A1
GYN Hx: h/o STDs, abnormal paps, etc
PMH: Asthma, cHTN, etc
Meds: PNV
Allergies: PCN- rash (always NOTE reaction)
Family Hx: Mother-DM, Father- HTN. +/- birth defects, mental retardation, bleeding or clotting disorders
Social Hx: +/- tobacco, EtOH, drugs. Living situation. Occupation. Feels safe? +/- Depression
ROS:
Gen: +/- Fever/chills
HEENT: vision changes, sore throat, rhinorrhea
CV: papillations, chest pain
Pulm: SOB, prolonged cough
GI: abdominal pain, nausea, vomiting, diarrhea, constipation
GU: dysuria, hematuria, frequency, abnormal vaginal discharge
MS: joint pain, swelling
Neuro: severe headache, weakness
Heme: h/o anemia or blood clots
Psych: depression or anxiety
Physical Exam:
VS: BP 125/80, HR 72, RR 18, O2 Sat 99%
FHT (baby’s vitals): Baseline, variability (absent, min, moderate, marked), accels?, decels (state type-early, late, variable)
Toco: q 5 minutes (or 2 in 1hr, or none)
Gen: A/O, NAD or appears uncomfortable, etc
CV: RRR, + SEM
Pum: CTA B
Abd: gravid, NT, Fundal Height= 38cm. EFW= 7lbs. Leopolds= cephalic
Ext: no edema, calves non-tender
Neuro: DTRs 2+, no clonus (needed if any concern about pre-eclampsia)
SSE: no bleeding or pooling, Cervix visually dilated to 2-3 cm
SVE: 3cm/50%/-1
Wet Prep: - yeast, clue cells, or trich. Nitrazine and Ferning negative
Urine Dip: negative
PNL: O+/Ab-/HIV/HepB-/RPR NR/Ri/CF-/GC-/CT-/Hgb 13.2/Pap NIL/1 hr 72/GBS-
Level II US: EFW 3250g (40%), cephalic, 3VC, posterior placenta, normal anatomy, BPP 8/8, normal dopplers
A/P: 27 yo G6P2123 @ 37-5 by LMP c/w 1TMUS in labor, with SROM, PTL, etc
- FWB reassuring. Class I FHT
- Admit to L&D
- NPO, IVF
- Etc.

Your Name, MS3
**MS3 Labor Progress Note**

S: Patient comfortable after epidural  
O: BP 113/65, HR 82, RR 18, T 97.8  
FHT: 150, moderate variability, + accelerations, no decelerations  
Toco: q 3 minutes, MVUs 120  
SVE: 4/50/-1  
Pitocin @ 6 mU/minute  
A/P: 30 yo G2P1001 @ 38-4w, Labor  
  - FWB reassuring. Category I FHT  
  - Protracted labor- augmentation with Pitocin  
  - GBS +, continue pitocin  
  - Anticipate vaginal delivery

Your Name, MS3

**MS3 Mag Note**

S: + FM. Denies HA, vision changes, RUQ pain.  
O: VS: 150/96, 90, 18, 97.5, O2 98% on NC  
I/O: 4hr-600/500mL. Urine protein 3+  
FHT: 150, moderate variability, + accelerations, variable decelerations to 120 lasting 20 seconds  
Toco: q 3 minutes, MVUs 120  
Gen: a/o, NAD  
CV: RRR  
Pulm: CTA B  
Abd: gravid, NT, no epigastric or RUQ tenderness  
Ext: 2+ edema, calves non-tender, SCDs in place.  
Neuro: DTRs 3+, no clonus  
SVE: 1/50/-3  
Labs: Recent HELLP labs- CBC, LDH, Uric Acid, AST, ALT  
A/P: 19 yo G1 @ 37-0. IOL for mild pre-eclampsia  
  - FWB reassuring. Category II tracing  
  - IOL with cervidil  
  - Magnesium for seizure prophylaxis- no s/sx of toxicity  
  - UOP appropriate  
  - BP stable. Hydralazine (or Labetolol) for BP > 160/110  
  - HELLP labs negative

Your Name, MS3

**Post-Delivery Note**

Pre-op Dx: 32 yo G3P2002 @ 39-6, PPROM, Induction of labor with Pitocin  
Post-op: same, delivered, liveborn M/F infant, 2nd degree perineal laceration  
Procedure: Normal Spontaneous vaginal delivery, repair of perineal laceration (or Primary or repeat low tranverse cesarean section, or classical cesarean)  
Surgeon: Dr. Attending  
Assistants: Dr. Resident, PGY3; You, MS3  
Anesthesia: epidural and local (or spinal, or general)  
Findings: liveborn M/F infant in LOA/ROA/OP position, apgars 8/9, 3340g, placenta delivered intact, 3VC, no cervical or vaginal lacerations, 2nd degree perineal laceration (If cesarean, note normal appearing tubes and ovaries or excessive scar tissue, etc)  
EBL: 300 mL  
Specimens: placenta  
Complications: none  
Condition: Stable In LDR

Your Name, MS3
**MS3 Post Partum Note**


O: VS: 120/89, 90, 18, 97.5  
I/O: 24 hr-2350/2300mL 8hr-1234/980mL (cesarean only)  
Gen: a/o, NAD  
CV: RRR  
Pulm: CTA B

Abd: soft, appropriately tender, + BS, fundus firm below umbilicus (incision c/d/l with staples in place for cesarean)  
Ext: calves NT, no edema

Labs: Hgb 12.3 → 10.2 (Cesarean section only). Blood type: A neg. Rubella non-immune

A/P: 26 yo G3P3003 PPD#1 s/p NSVD (rLTCS, 1LTCS, VBAC, VAVD, FAVD)  
- Pain controlled with Motrin and Darvocet (Norco, T#3, Toradol)  
- Advance diet to general (clears, full liquid, etc) as tolerated (cesarean sections)  
- Urine output appropriate. Discontinue foley catheter (cesarean sections)  
- Encourage ambulation and IS (cesarean section)  
- SCDs for DVT prophylaxis (cesarean section)  
- Colace for constipation. Simethicone for gas  
- Iron for post-op anemia. MVI if breast feeding  
- Rubella Non-immune- MMR prior to discharge  
- Rh negative. Rhogam prior to discharge  
- Circ for baby boy  
- Dispo: floor. Home tomorrow

Your Name, MS3

### Routine Postpartum Care Orders- Vaginal Delivery

- General diet immediately post delivery  
- Colace for constipation  
- Motrin 600 mg q 6 hrs and Darvocet N 100 1-2 q 6 hrs prn pain  
- Discharge PPD#1-2  
- Discharge Instructions: nothing per vagina x 6 weeks (no intercourse, tampons, douching). f/u 6 weeks

### Routine Postpartum Care Orders- cesarean

- SCDs for DVT prophylaxis  
- IS 10 times per hour while awake  
- NPO x ice for 6 hrs postop, then advance to clear.  
- Bedrest x 6 hrs then OOBTC  
- PCA if no Doramorph in Epidural (Gottlieb only) or if under General Anesthesia  
- Toradol 30 mg IV q 6 hrs x 24 hrs  
- POD#1: discontinue foley, advance diet to general if + BS and no n/v, remove dressing, ambulate TID, d/c PCA and advance to PO meds if applicable, patient may shower  
- Staples out POD#3 for phannenstiel incision, PD#7 for midline (generally, always ASK first)  
- Discharge POD#2 or 3  
- Discharge Instructions: Cesarean section: nothing per vagina x 6 weeks, showers only x 2 weeks, no driving x 2 weeks, no heavy lifting x 6 weeks, f/u 2 weeks and 6 weeks

### Commonly Used Postpartum Meds:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motrin 600 mg po q 6 hrs PRN pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darvocet N-100 mg 1-2 tab q 6 hrs PRN pain (contains 650 tylenol PER TAB)</td>
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<td></td>
</tr>
<tr>
<td>Norco 5/325 1-2 tabs q 4 hours PRN pain (contains 325 mg tylenol per tab)</td>
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<td></td>
</tr>
<tr>
<td>Colace 100 mg po BID prn constipation</td>
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</tr>
<tr>
<td>Senokot-S 1 tab BD prn constipation (Gottlieb)</td>
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<tr>
<td>Simethicone 80 gm 1 tab po four times daily for gas pain</td>
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<td></td>
</tr>
<tr>
<td>Toradol 30 mg IV q 6 hours PRN pain (NSAID- do not give if also giving Motrin)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Postpartum Visit

- Cesarean sections- 2 weeks and 6 weeks  
- Vaginal deliveries- 6 weeks  
- Document using regular soap note. Special attention to 9 “Bs”: Breast, Belly, Bottom, Bleeding, Bladder, Bowels, Birth control, blues and baby. Pap and breast exam performed.  
- 2 hr glucose tolerance for all gestational diabetics
PRENATAL CARE

1st Prenatal Visit:
- Counseling on diet, exercise, weight gain, OTC meds, environmental exposure, travel, frequency or visits, ED precautions
- Routine Labs: CBC, Type and Screen, GC/CT probe, Hep B, RPR, Rubella Titer, UA and Culture, Hgb Electrophoresis if AA
- Pap smear if not done in past year
- Breast Exam
- Cystic Fibrosis Screening - optional
- HIV- opt out screening has best results
- Ultrasound for dating if uncertain LMP
11-14 wks: First Trimester screen optional
14-25 wks (usually 15-22): Quad test
18-22 wks: Anatomy US
24 wks: Rhogam for Rh Negative Patients
35wks: GBS culture

Visits q 4 weeks until 28 weeks
Q 2 weeks from 28 to 35 weeks
Weekly after 35 weeks until delivery

Prenatal Visit Progress Note
S: + FM. No LOF, VB, ctx.
O: BP 115/60, Wt 132 lbs
Urine dip- trace protein
FH: 32 cm
FHT: 145
Ext: no edema
A/P: 25 yo G2P1001 @ 32-4 by LMP c/w 1TUS
- PNL: O/-Ab/-HIV/-HepB/-RPR NR/RNI/CF-/GC-/CT-/Hgb 13.2/Pap NIL/1 hr 72
- Rh negative- s/p Rhogam at 28 weeks
- ROB 2 weeks
Your Name, MS3

Determination of Gestational Age:
1) FHT present by fetoscope > 20 weeks, or by doppler > 30 weeks
2) 36 weeks since + urine pregnancy test by reputable lab
3) US CRL @ 6-12 weeks c/w EGA > 39 weeks
4) US @ 13-20 weeks c/w GA > 39 weeks, consistent with history and physical exam

Fundal Height
Measurement in centimeters from pubic symphysis to top of fundus. After 20 weeks, should correlate with gestational age in weeks +/- 2 cm.

WELL WOMAN EXAM
- 6 “Bs”: Bleeding, Breast, Bowel, Bladder, Birth Control, Blues
- Sample GYN history:
  o Menses: LMP - _____, Menarche @ 14, cycle 28 days, 4 days flow, no severe dysmenorrheal. Age of Menopause if applicable and if any intermenstrual bleeding
  o Paps: no abnormal paps, last pap 2008- NIL
  o STDs: chlamydia at 16, treated
  o Sexual Activity: active with male partners only, 1 current partner, monogamous x 10 years, 4 partners in lifetime
  o Contraception: Condoms, OCPs, IUD, BTL, etc.
- Routine Health Maintainence: Mammogram, Colonoscopy, Dexa Scans, Lipid, Thyroid, DM, Immunizations, Calcium supplementation, Seatbelt usage
- Gardisil Vaccine for
  o Women 9-26
  o 3 shots at 0, 2, and 6 months
  o Covers types 6, 11, 16, 18 (prevents 70% cervical cancers and 90% genital warts)
ELECTIVE ROTATION SPECIFICS

WEDNESDAY
- Medical students generally are not expected to round on Wednesdays
- Be at Patient Care Conference (PCC) at 7:25. BE ON TIME and BE QUIET. This is a formal conference and is very stressful for the residents. Interruptions are VERY distracting.
- After each resident’s presentation, a student question will be asked. If you know the answer, volunteer it. Otherwise, someone will be called on.

MATERNAL FETAL MEDICINE
Clinic
- Clinic located at Loyola Outpatient Center, 2nd Floor
- Schedule located in EPIC @ LOC MATERNAL FETAL MEDICINE
- Hours usually Tuesdays 8-5pm and Thursdays 8-12pm
- Clinic responsibilities include seeing pts with resident and writing a progress note, once comfortable, student may see patients alone and present to attending before writing a note.
- Healthy Mom’s Clinic on Wed/Fri (usually half day). Schedule under @ LOC WOMEN’S HEALTH under “Healthy Mom Clinic.” There are no residents at Healthy Mom’s Clinic. Student to see all patients and then present to attending and write clinic note
- Look up pts prior to clinic to read about pts presenting problem
- Key Topics: Diabetes, HTN, and Infections in pregnancy, Preterm Delivery, Genetic Diseases, IUGR

Conference
- Tuesday morning at 7:30am in Dr. G’s conference room in main hospital on 1st floor.
- Table rounds for hospitalized antepartum patients, some housekeeping, occasional fellow lectures

History/Physical Exam
- Basic Exam Skills to be performed on OB Office Visits
  o History (including DETAILED OB and Gyne History)
    • PIH/Preeclampsia: HA/vision changes/epigastric pain/edema
    • Routine Antepartum: FM/LOF/VB/VD/CTX
    • Family History- review birth defects, mental retardation, other genetic diseases
  o CV/PULM Exam
  o Abdominal Exam
  o Uterus Fundal Measurement
  o Fetal Heart Tones with Doppler
  o Extremity Exam for edema
  o Spec exam/pap smear if indicated- Resident or attending to perform with you

Gottlieb
- Gottlieb runs slightly differently than Loyola. The main differences involve note writing rotation “assignments,” and the computer system
- Although you may be assigned to “OB” or “GYN” at Gottlieb, because of the weeknight call schedule, you may be asked to scrub a c-section or a gyn case even though you aren’t on that “service.” This is more like real life, doing both together
- Documentation: Some notes at Gottlieb are hand-written and some are typed into Epic. Patient’s of Loyola attendings (Dr. Graziano, Dr. Massey, Dr. Wagner, and Dr. Deighan) are all written in EPIC. The electronic notes then need to be printed and placed in the patient chart. This is especially important for patients in units other than L&D, because all notes automatically print in L7D.. Non-Loyola attending patient notes are written in the charts. Daily notes are placed under progress note tab, H&Ps and Dictation summaries under another tab, and procedure notes under another. There is an H&P form for non-Loyola patients. DO NOT USE THIS FORM. As with templates, this is counterproductive for the educational process and we would prefer you write your own H&P.
- Patient information: Labs, Vitals, Ins and Outs are located in the Meditech System. You should be given a username and password before starting the rotation. After logging in, press 1, then 4 to get to the patient lists, which can be searched by name, location, provider, etc.
- OR schedule: also located in Meditech. Press 1, then 1, then enter the date you would like to review. This can be tricky to review because the surgeries are listed by attending username (first four initials or last name then first initial of first).
- Signout: Located on Toughbook in L&D in Awad Documents folder.
- The Board: Most labor wards have one of these. Please keep this updated with new information throughout the day.
GYNECOLOGY Rotations

**OR Expectations**: for all services (there may be some minor variations)
- There should be a medical student at all cases when possible. Sub-Is are responsible for assigning cases. If no Sub-I, decide among your fellow rotation-mates who will attend which cases.
- You should read about the type of case you will be performing and review relevant anatomy prior to the OR
- Know your patient. Be familiar with the patient history and know why they are undergoing the procedure
- Be near patient in pre-op area and page resident (to OR number) when patient is going back
- Help wheel patient to OR and move them to OR table. You may also help by placing SCDs and helping to position patient.
- Write patient name, procedure, allergies, Hgb and BMI on white board in OR
- Write your name and position on white board
- Introduce yourself to scrub nurse and circulating nurse. Pull gloves and gown (if needed) for yourself
- Ask the scrub nurse if you can place the foley catheter.
- After case, retrieve bed and help move patient back to PACU
- Write Operative Note and review with resident
- For outpatient cases, you can help by gathering the three documents that we need to complete from the chart- H&P for, H&P Validation, and Consent. We will fill out the validation and the consent. Please complete the H&P form (this is a BRIEF H&P). We will review it with you and cosign it.

**Benign Gyn**
- Patient List under “Shared Patient Lists” - “Benign GYN
- Rounding every weekday except Wednesdays is usually between 5:30 and 6:00am. Your resident will tell you exactly what time each day, as it will vary based on number of patients on the service. Please pre-round and have notes completed by that time.
- GYN Teaching rounds occur at 6:30 every weekday except Wednesday in the back room of the cafeteria. You should review the topic ahead of time so you are prepared to answer questions. After teaching rounds, the GYN team will round with the attendings. You will be expected to present patients you rounded on.
- Mondays are primarily OR days.
- Tuesday morning is Dr. Summers’s problem GYN clinic beginning at 8:30 and usually until 1 or 1:30.
- Wednesday students do not round. Wednesday afternoon is generally Colpo clinic
- Thursday there are sometimes cases, but not always
- Fridays are primarily ambulatory surgery cases
- In House and ED consults are the responsibility of the GYN Service. You may be asked to see the patient ahead of the resident. Consult notes are detailed H&Ps similar to OB Triage notes. Make sure to get a detailed Gyn history. See WWE.
- Key Topics: Ectopic Pregnancy, Hyperemesis, Abnormal Uterine Bleeding, Fibroids, Endometriosis

**GynOnc**
- There is no “Shared Patient List” for this service. You may create a list with Dr. Smith and Dr. Potkul’s Patients.
- Rounding every weekday except Wednesdays is usually between 5:30 and 6:00am. Your resident will tell you exactly what time each day, as it will vary based on number of patients on the service. Please pre-round and have notes completed by that time.
- Monday: Dr. Potkul has OR Cases
- Tuesday: Dr. Potkul has clinic all day, Dr. Smith has clinic in AM
- Wednesday: Dr. Potkul has outpatient cases beginning around 12:30. Arrive as soon as possible after educational events
- Thursday: Dr. Potkul in OR
- Friday: Dr. Potkul clinic in AM and Dr. Smith in ambulatory cases in AM. New patient clinic in afternoon- MS3s do not attend
- Dr. Potkul’s Clinic: Briefly review chat to determine what patient has and what treatment they have undergone. Introduce yourself to patient and ask if they are having any problems. BE BRIEF. You should spend no more than 5 minutes on this process. Present patient to Dr. Potkul, then see the patient with him. Do not see new patients. The residents will see them
- You do not attend Dr. Smith’s clinic
- Key Topics: anatomy, cancer staging, tumor markers, bowel obstruction, neutropenic fever, types of hysterectomies.
**UroGyn**

You will receive a handout from the department with detailed information about expectations for this rotation. Be in clinic at 7:30 on your first day for orientation with nurses REGARDLESS of Dr. G. Lectures

**Hours:** 6am-6pm M-F

**Schedule:**
- 6:00-6:30am: Meet and round with residents and fellows.
- 6:30am: Teaching rounds in back room of cafeteria with attending doctor of the day.
- 7:00am - 5:00pm: Rounds with attending, OR cases, clinic, etc. **You will only go to OR on Tuesday.** All other days, go to clinic.
- ~5:30pm: afternoon rounds with residents or fellows, postop notes.

**Patient Lists:**
Under “Patient Lists” in Epic, open “Shared Patient Lists” and look for “Urogyne”. These are the in-patients for your service.

**Rounds:** You will typically meet for rounds in the Women’s Health on the second floor. The exact time will be determined by the fellows each day. **Make sure to ask your resident what time you will be rounding the next morning before you go home.** While you do not preround on patients, it is expected that you will **arrive before rounds to look over vital signs, labs and I/Os for the patients, and update this information on the signout.** The signout report is found in EPIC under shared list, pick Urogyne. You can update the report by clicking on Signout Report when the patient list is up. The fellows like to have the preop baseline vitals signs on the signout, so do NOT delete these. Just add urine output and any pertinent lab values. **You should have copies printed for the fellows and residents in time for rounds.** You residents may also have a specific format they’d like to follow, so ask the first day.

**Clinic:** Located on the 3rd floor of the Loyola Outpatient Center (west side of the LOC). Coats and bags are typically left at the nurses work area, although it can get crowded there at times.
- Monday - KK- all students should go to KKs clinic
- Tuesday - no clinic
- Wednesday - LB
- Thursday - MPF
- Friday - EM

Try to arrive 10-15 min before the first patient. For KKs clinic on Monday, she often has several patient’s scheduled for 8am, so she would like everyone there 15-20 min early. You will not see patients on your own in clinic, so pick a resident or fellow to follow. It can be very busy in clinic and the fellow or resident will not stop each time to invite you to follow them, so pay attention to who needs to be seen and ask if you can come in.

The Urogyns have developed a very detailed system of organization for their clinic. This consists of a whiteboard map of the clinic with magnets for the nurses, attendings, residents, students, and numbers for the order of patients. They take this very seriously, so try to learn the system and it can be helpful.

**OR Days:** **ONLY GO TO OR ON TUESDAYS UNLESS OTHERWISE DIRECTED**
- Monday - MPF
- Tuesday - KK and LB (sometimes EM or MPF will also have a case)
- Thursday - EM

You should know which cases you will be doing at least the day prior so that you can look over each patient’s history, know indications for surgery and review pertinent topics. Essentially all of the Urogyn cases are performed in the main OR, even if the patient will be going home the same day.

Prior to surgery, either you or the resident need to get the antibiotics from the OR Pharmacy prior to surgery. The Pharmacy window is located across from OR 18 - ask your resident or fellow which antibiotic the patient will need (usually cefoxitin). You just need to ask for the antibiotic and give them the patient’s name. Additionally, it is your responsibility to write up the patient’s history on the whiteboard in the OR. This needs to have patient’s name, age, diagnosis, planned procedure, PMH, PSH, Allergies, POPQ, and preop labs. It is best to do this while the patient is in preop, so that you can do other things to help out when the patient is in the room.

The Urogyns are also very focused on keeping things moving in the OR, so they do not want to see anyone just standing around. Once the patient is in the room, help with positioning, taking the bed out, getting SCDs on and whatever else may be happening. You will scrub into cases and be able to assist. Help with getting the patient out at the end of the case also.

**GRID meeting:** Weekly planning meeting on Wednesday afternoons. Typically held at 3:00pm in the 4th floor room just right out of the elevators in the Medical School. This meeting is to go over upcoming cases. There is usually a topic presented as well. It is important to go, although it is understood that sometimes you will have other teaching obligations, resident clinic, etc.

**Key Topics:** Stress, Urge, Mixed and Overflow incontinence; Pelvic Organ Prolapse
**Generic Operative Note**

Service: GYN/UroGYN/GYN Onc  
Pre-op Dx: Menorrhagia, ovarina mass, uterine prolapse, etc  
Post-op: same, delivered, liveborn M/F infant, 2nd degree perineal laceration  
Procedure: Total abdominal Hysterectomy, bilateral salpingo-oophorectomy, Lysis of adhesions  
Surgeon: Dr. Attending  
Assistants: Dr. Resident, PGY3; You, MS3  
Anesthesia: epidural and local (or spinal, or general)  
Findings: liveborn M/F infant in LOA/ROA/OP position, apgars 8/9, 3340g, placenta delivered intact, 3VC, no cervical or vaginal lacerations, 2nd degree perineal laceration (If cesarean, note normal appearing tubes and ovaries or excessive scar tissue, etc)  
EBL: 300 mL  
Specimens: placenta  
Complications: none  
Condition: Stable in LDR  

Your Name, MS3  

**MS3 Post Operative Progress Note**  
S: 26 yo female POD#1 s/p TAH, BSO. Pain controlled. Tolerating clear liquid diet. No nausea or emesis. + Flatus/BM. Voiding without difficulty (*unless catheter in place*). Ambulating without dizziness. Denies fever, chills, CP, SOB, calf pain. +/- vaginal bleeding  
O: VS: 120/89, 90, 18, 97.5  
I/O: 24 hr-2350/2300mL. 8hr-1234/980mL (cesarean only)  
Gen: a/o, NAD  
CV: RRR  
Pulm: CTA B  
Abd: soft, appropriately tender, + BS, incision c/d/I with staples  
Ext: calves NT, no edema  
Labs: *(only include most recent labs)*  
Hgb 12.3 → 10.2  
A/P: 26 yo POD#2 s/p TAH, BSO  
- Pain controlled with Motrin and Norco (PCA, T#3, Toradol)  
- Advance diet to general (clears, full liquid, etc) as tolerated  
- Urine output appropriate. Discontinue foley catheter  
- Post op Hgb appropriate (or Iron or PRBCs as appropriate for acute blood loss anemia)  
- Encourage ambulation and IS  
- SCDs for DVT prophylaxis (sometimes Heparin- especially on Onc)  
- Colace for constipation. Simethicone for gas  
- Don’t forget to mention chronic medical conditions and what we are doing for them  
- Dispo: floor.  

Your Name, MS3
Key to commonly used abbreviations:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGC</td>
<td>Atypical glanular cells</td>
</tr>
<tr>
<td>AOL</td>
<td>Augmentation of labor</td>
</tr>
<tr>
<td>AROM</td>
<td>Artificial rupture of membranes</td>
</tr>
<tr>
<td>ASCUS</td>
<td>Atypical squamous cells of undetermined significance</td>
</tr>
<tr>
<td>BMTZ</td>
<td>Betamethasone, given to promote fetal lung maturity</td>
</tr>
<tr>
<td>BME</td>
<td>Bimanual exam</td>
</tr>
<tr>
<td>AOL</td>
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<tr>
<td>BME</td>
<td>Bimanual exam</td>
</tr>
<tr>
<td>BPP</td>
<td>Biophysical profile</td>
</tr>
<tr>
<td>BSO</td>
<td>Bilateral salpingo-oophorectomy</td>
</tr>
<tr>
<td>EAB</td>
<td>Elective abortion (also sometimes called therapeutic abortion, or TAB)</td>
</tr>
<tr>
<td>EDC</td>
<td>Estimated date of confinement (due date)</td>
</tr>
<tr>
<td>EFW</td>
<td>Estimated fetal weight</td>
</tr>
<tr>
<td>EMB</td>
<td>Endometrial Biopsy</td>
</tr>
<tr>
<td>FHT</td>
<td>Fetal heart tracing</td>
</tr>
<tr>
<td>FFN</td>
<td>Fetal Fibronectin</td>
</tr>
<tr>
<td>FLM</td>
<td>Fetal Lung maturity</td>
</tr>
<tr>
<td>FM</td>
<td>Fetal Movement</td>
</tr>
<tr>
<td>FAVD</td>
<td>Forceps assisted vaginal delivery</td>
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<tr>
<td>FWB</td>
<td>Fetal well-being</td>
</tr>
<tr>
<td>FSE</td>
<td>Fetal scalp electrode</td>
</tr>
<tr>
<td>G3P1011</td>
<td>G=Times Pregnant. P=TPAL→Term (&gt;37w), Preterm (20-37w), Abortions (&lt;20w), Living</td>
</tr>
<tr>
<td>GDM</td>
<td>Gestational diabetes. Document type by White classifications</td>
</tr>
<tr>
<td>IOL</td>
<td>Induction of labor</td>
</tr>
<tr>
<td>IUPC</td>
<td>Intrauterine Pressure catheter</td>
</tr>
<tr>
<td>LDR</td>
<td>Labor, delivery, and recovery room</td>
</tr>
<tr>
<td>LOA</td>
<td>Lysis of adhesions</td>
</tr>
<tr>
<td>LOF</td>
<td>Leakage of fluid</td>
</tr>
<tr>
<td>LTCS</td>
<td>Low transverse cesarean section</td>
</tr>
<tr>
<td>MVU</td>
<td>Montevideo Units</td>
</tr>
<tr>
<td>NRFHT</td>
<td>Non-reassuring FHT</td>
</tr>
<tr>
<td>NST</td>
<td>Non-stress test</td>
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<tr>
<td>PROM</td>
<td>Premature rupture of membranes (prior to labor)</td>
</tr>
<tr>
<td>PPROM</td>
<td>Preterm premature rupture of membranes (&lt;37wks)</td>
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<tr>
<td>PTL</td>
<td>Preterm labor</td>
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<tr>
<td>PTD</td>
<td>Preterm delivery</td>
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<tr>
<td>SAB</td>
<td>Spontaneous abortion, before 20 weeks</td>
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<tr>
<td>SROM</td>
<td>Spontaneous rupture of membranes</td>
</tr>
<tr>
<td>SCH</td>
<td>Supracervical hysterectomy</td>
</tr>
<tr>
<td>SCH</td>
<td>Sterile speculum exam</td>
</tr>
<tr>
<td>SVE</td>
<td>Sterile vaginal exam (digital exam)</td>
</tr>
<tr>
<td>TAH</td>
<td>Total abdominal hysterectomy- means uterus and cervix, does NOT include ovaries</td>
</tr>
<tr>
<td>TVH</td>
<td>Total vaginal hysterectomy</td>
</tr>
<tr>
<td>VAVD</td>
<td>Vacuum assisted vaginal delivery</td>
</tr>
<tr>
<td>VB</td>
<td>Vaginal bleeding</td>
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<tr>
<td>VBAC</td>
<td>Vaginal birth after cesarean</td>
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<tr>
<td>VTE</td>
<td>Venous thromboembolism</td>
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<td>VTOL</td>
<td>Vaginal trial of labor</td>
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<td>Residents</td>
<td>Lolyola</td>
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<tr>
<td>Chuck Anderson</td>
<td>92618 L&amp;D</td>
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<tr>
<td>Michael Awad</td>
<td>92449 2 Women’s Health</td>
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<tr>
<td>Ben Barenberg</td>
<td>91899 Female Resident Call Room</td>
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<tr>
<td>Vance Broach</td>
<td>92275 Male Resident Call Room</td>
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<tr>
<td>Danielle Burkett</td>
<td>92631 Resident Office</td>
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<tr>
<td>Maryann Chimhanda</td>
<td>92375 Admitting</td>
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<tr>
<td>Lyndsey Day</td>
<td>92670 Central Scheduling</td>
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<td>Megan DeJong</td>
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<td>Suzanne Galloway</td>
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<td>91107 Fast Track ER</td>
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<tr>
<td>Vanessa Kennedy</td>
<td>91186 Gottlieb</td>
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<tr>
<td>Maike Liebermann</td>
<td>92273 Birth Center</td>
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<tr>
<td>Darby Murphy</td>
<td>91180 2 West (Postpartum)</td>
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<td>Colleen Rivard</td>
<td>10274 Med Student Call Room</td>
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<td>Jayme Sloan</td>
<td>92427 Resident Call Room</td>
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<td></td>
<td>Attending Call Room</td>
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<tr>
<td></td>
<td>Emergency Room</td>
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