File in 3rd spine

NHS number: _____
Name: _____
Address: _____
_____
Affix patient label
Date of birth: _____
CR number: _____

Royal Cornwall Hospitals NHS
NHS Trust

Shoulder dystocia

Mother's name:	
Date:	Person completing form:
Time:	Signature:

Called for help at:		Emergency call via switchboard at:		
Staff present at delivery of head		**Additional staff attending for delivery of the shoulders**		
Name	**Role**	**Name**	**Role**	**Time arrived**

Procedures used to assist delivery	By whom	Time	Order	Details	Reason if not performed
McRoberts' position					
Suprapubic pressure				From maternal Left ☐ Right ☐	
Episiotomy				Enough access ☐ Tear present ☐ Already performed ☐	
Delivery of posterior arm				Left ☐ Right ☐	
Internal rotational manoeuvre					
Description of rotation					

affix patient label

Procedures used to assist delivery	By whom	Time	Order	Details	Reason if not performed
Description of traction	**Routine axial** (as in normal vaginal delivery)	**Other:**		**Reason if not routine:**	
Other manoeuvres used					
Mode of delivery of the head		Time of delivery of baby		Head-to-body delivery interval	
Time of delivery of head					
Fetal position during dystocia	Head facing maternal **left**, left fetal shoulder **anterior**		Head facing maternal **right,** right fetal shoulder **anterior**		
Birth weight	kg	**Apgar score**	**1 min:**	**5 mins:**	**10 mins:**
Cord gases	**Art pH:** **Vein pH:**	**Art BE:** **Vein BE:**	**Discussed with parents**		**YES** ☐ **NO** ☐

Paediatric team called? Yes

Time paediatric team arrived: **Name:**

If not called or didn't arrive, give reason:

Baby assessment after birth (can be completed by a Midwife)
- If yes to any of the questions refer to neonatal team

Any sign of arm weakness:	Yes ☐	No ☐
Any sign of possible bony fracture:	Yes ☐	No ☐
Baby admitted to NNU:	Yes ☐	No ☐

Assessment completed by:	Sign:
Date:	Print:
Time:	Designation: