Centralized Scheduling
713-441-6504
Please fax form to
713-790-4455

Houston Methodist
Induction / Cesarean Section Scheduling Form

Patient Information:			
Last Name	First Name	Birth Date	Prenatal Available Y/N
Home Phone	Work / Other Phone	Ht/Wt:	
Requesting physician	Requested Date/Time of Procedure:	SS# (last 4 digits only):	

Intended method of delivery:

Cesarean Delivery ☐ Primary ☐ Repeat

Induction of labor: ☐ Pitocin ☐ Misoprostol ☐ Cervidil Bishop score:_____

Grav/Para:	**Allergies:**	**GBS status:**

Anesthesia special considerations:

Obstetric and Medical Indications for Delivery:

☐ EGA ≥41 weeks	☐ PROM	☐ Gestational HTN
☐ Non-reassuring fetal status	☐ Oligohydramnios	☐ Chronic HTN
☐ Positive OCT	☐ Polyhydramnios	☐ Preeclampsia/Eclampsia
☐ IUGR	☐ Prior classical C/S	☐ GDM with insulin or medication
☐ Twins (≥ 37 weeks)	☐ Prior myomectomy	☐ Diabetes (Type I or II)
☐ Significant fetal anomaly	☐ Undocumented uterine scar	☐ Maternal anticoagulation therapy
☐ Breech presentation	☐ Placental Abruption	☐ Thombophilia
☐ Alloimmunization (Isoimmunization)	☐ Placenta previa	☐ Liver disease (incl. cholestasis of pregnancy)
☐ Fetal demise (current pregnancy)	☐ Unspecified antenatal hemorrhage	☐ Pulmonary disease
☐ Fetal demise (prior pregnancy)	☐ Vasa previa	☐ Heart disease
☐ Chorioamnionitis	☐ HIV Infection	☐ Renal disease

☐ Other(s):
_____
_____
_____

☐ Perinatology consult obtained and agrees with plan

Consultant's name: _____

Additional comments/special needs:

Confirmation of gestational age:

EDC:	GA at time of induction (weeks/days) :	EFW (g/lbs):

EDC Based on :

☐ US < 20 wks ☐ Doppler FHT + for 30 wks ☐ +HCG for 36 wks ☐ Other dating criteria: _____

By ACOG Guidelines, women should be 39 wks or greater before initiating an elective (no indication) delivery.

ACOG also states that a mature fetal lung test in the absence of clinical indication is not considered an indication for delivery

Confirmed Scheduled Date/Time of Procedure:

Procedure Date:	**Procedure Time:**	**Form Completed By:**