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Obstetric Case Record Referral and Discharge

Practical 07 / Clinical or documentation case

Aim

Prepare a complete case record, a focused referral and a patient-friendly discharge summary.

Principle

A clear record links findings to decisions and identifies responsibility. Referrals transmit the current problem and urgency. Discharge notes support follow-up and safety.

Materials and Requirements

- Fictional obstetric chart, referral and discharge forms
- Local communication and handover checklist

Procedure

1. Establish symptoms, gestation or postpartum timing, previous history, examination and observations. Enter dates and times for material events.
2. Construct a dated time line with gestation or postpartum day, symptoms, pertinent past events and changes in maternal and fetal findings. Verify entries against the case record.
3. Write a provisional impression and differential. List key investigations, treatment and response. Quote the relevant positive and negative findings.
4. Summarise the relevant findings and working assessment, including intervention, response and unresolved questions. Make clear which observations were reported and which are documented.

Continue with step 5 on the next page.

Procedure Continued

Obstetric Case Record Referral and Discharge

5. Draft the referral stating reason, acuity, essential maternal and fetal facts, actions and contact details. Confirm handover receipt in the scenario.
6. Prepare a referral with time, receiving team, reason and acuity, current status, treatments, pending results and requested action. Ask the receiver to confirm the handover.
7. Draft the discharge summary with diagnosis, procedures, medicines as verified, pending results, return precautions and follow-up dates.
8. Write the discharge summary with verified medicines, planned follow-up and specific return precautions. Allocate responsibility to review pending tests and clarify how the person will be contacted.
9. Explain the plan, invite questions and ask the patient to repeat the most important next steps.
10. Check teach-back in plain language and record next appointment, transport or access needs and contact route. Update the note when the case changes.

Precautions

- Use simulated identifiers in student records.
- Verify the final note and medication list with the supervising team.

Observations and Interpretation

Obstetric Case Record Referral and Discharge

Observations and Record

Item	What to record	What it tells you
Case timeline	Presentation, examination and intervention times	Connects findings to decisions
Referral	Acuity, current status and request	Clarifies the receiving team's role
Discharge	Plan, warnings, pending results and named follow-up	Supports continuity

Worked Example

A postpartum patient is clinically stable in the discharge case. One result remains pending. The note identifies which team will review it and how the patient will be contacted.

Result and Interpretation

A complete discharge includes both follow-up timing and ownership of unresolved results. Document that the patient understood when to return.

Viva Questions and Answers

What makes a referral specific?

It states why review is needed, how urgently and which current findings or actions affect care.

Why put pending results in the summary?

It gives the patient and teams a clear route for follow-up.

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