

OHIO DEPARTMENT OF HEALTH
MATERNITY LICENSURE
HOSPITAL REPORT FORM – PART I

Please complete and return to surveyors at the beginning of your maternity licensure inspection.

Hospital: _____ OB/Nursery Beds _____/_____

Level Classification: _____

Address: _____

City: _____ County: _____

Telephone No: (____) _____ Fax No: (____) _____

Deliveries Per Annum For The Last Five (5) Years:

1. ADMINISTRATOR

A. Name: _____ Title: _____

B. Tenure In Position: _____

2. MEDICAL STAFF

A. OB/GYN SERVICES:

1. Chief/Co-Director of Obstetrics: _____

Ohio License Number: _____

a. Education: _____

b. Board of Certification – Year: OB/GYN _____

Family Practice _____ Subspecialty: _____

c. Experience:

i. OB/GYN _____

ii. High-Risk Obstetrics _____

B. Neonatal/Infant Services:

1. Chief/Co-Director of Newborn: _____

Ohio License Number: _____

a. Education: _____

b. Board of Certification – Year: Pediatrics _____

Family Practice _____ Subspecialty: _____

C. Anesthesia Services:

1. Director of Anesthesia: _____

Director of OB Anesthesia (Level III): _____

Ohio License Number: _____

a. Education: _____

b. Board Certified – Year: _____

c. Experience:

i. Anesthesia _____

ii. OB/Newborn Anesthesia _____

D. Physicians/Advanced Practice Staff (totals of those providing services in the perinatal units)

1. Anesthesiologists _____ CRNAs _____ Anesthesia Assistants _____

Board Certification/Eligible (total number): _____

Coverage (per 24-hour period):

Anesthesiologists	CRNAs
Hours In-House:	Hours In-House:
Hours On-Call:	Hours On-Call:

2. Obstetricians (total number): _____

Board Certification/Eligible (total number): _____

Attending or House Officer	Resident
Hours In-House:	Hours In-House:
Hours On-Call:	Hours On-Call:

3. Perinatologists/Maternal-Fetal Subspecialists (total number): _____

Attending or House Officer	Fellow
Hours In-House:	Hours In-House:
Hours On-Call:	Hours On-Call:

4. Pediatricians (total number): _____

Board Certification/Eligible (total number): _____

Attending or House Officer	Resident
Hours In-House:	Hours In-House:
Hours On-Call:	Hours On-Call:

5. Neonatologists (total number): _____

Board Certification/Eligible (total number): _____

Attending or House Officer	Resident
Hours In-House:	Hours In-House:
Hours On-Call:	Hours On-Call:

6. Family Practice Physicians (total number): _____

Board Certification/Eligible (total number): _____

Attending or House Officer	Resident
Hours In-House:	Hours In-House:
Hours On-Call:	Hours On-Call:

7. Nursing (nurses practicing in advanced practice roles in the perinatal program):

a. Nurse Practitioners (total number): _____

	Certified	Master's Level	Other
Neonatal			
Pediatric			
OB/GYN			
Other: _____			

b. Clinical Nurse Specialists (total number): _____

	Certified	Master's Level	Other
Neonatal			
Pediatric			
OB/GYN			
Other: _____			

c. Certified Nurse Midwives (total number): _____

	Certified	Master's Level	Other
Employed by the Hospital/Clinic			
Self-Employed			
Employed by Physician			

3. DIRECTOR OF OB/NEWBORN SERVICES:

A. Name: _____ Title: _____

Ohio Licensure Number: _____

B. Tenure In Position: _____

C. Experience, Formal Education and Training: _____

4. NURSING STAFF:

A. Nurse Manager of Obstetrical Services:

1. Name: _____ Title: _____

Ohio Licensure Number: _____

2. Education: _____

3. Tenure In Position: _____

4. Experience: _____

B. Nurse Manager of Newborn Services:

1. Name: _____ Title: _____

Ohio Licensure Number: _____

2. Education: _____

3. Tenure In Position: _____

4. Experience: _____

5. SUPPORTIVE SERVICES:

A. Pharmacy:

1. Hospital Pharmacist: _____

Ohio Registration Number: _____

Consultant _____ Full-Time _____

Hours In-House	Hours On-Call

B. Nutritional Services:

1. Hospital and/or Perinatal Dietician: _____

Registered: _____ License Number: _____

Continuing Education And Perinatal Background: _____

Date Of Current Food Service License: _____

Hours In-House	Hours On-Call

C. Social Services:

1. Hospital and/or Social Worker: _____

Registered: _____ License Number: _____

Continuing Education and Perinatal Background: _____

Hours In-House	Hours On-Call

D. Lactation Consultant:

Lactation Consultant(s)	Certified By:

Hours In-House	Hours On-Call

6. OTHER

A. Infection Control:

1. Chairperson of Infection Committee: _____

2. Epidemiology Person: _____

B. Renovation/Construction:

1. Is new renovation/construction to the maternity unit requiring building permits being done within the current year?

C. Ethics/Bioethics Committee:

1. Do you utilize a Ethics/Bioethics Committee in OB/Newborn?

_____ YES _____ NO

D. Morbidity and Mortality:

1. Do you conduct or participate in multidisciplinary morbidity and mortality conferences/reviews?

	Participate	Conduct
Department (OB newborn)		
Hospital		
Regional		

E. Waivers And Variances:

1. Has your facility ever made application: _____ YES _____ NO IF, yes, WHEN _____
2. If yes, please have available any requests you have submitted or replies that you have received at the time of survey.

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HOSPITAL REPORT FORM – PART II

Please complete and return to surveyors at the beginning of your maternity licensure inspection.

Surveyor: _____ Survey Date: _____

Hospital: _____ City: _____

Level Classification: _____

NEONATAL UNIT

1. Physical Facilities – Nurseries:

A. Number of Newborn Nurseries: _____
Number of Bassinets/Isolettes in each Nursery: _____

B. Number of Special Care Nurseries: _____
Number of Bassinets/Isolettes in each Nursery: _____

C. Number of Neonatal Intensive Care Nurseries: _____
Number of Bassinets/Isolettes in each Nursery: _____

D. Does Facility Provide a Developmental/Stepdown Unit? _____ Yes _____ No
If Yes, Number of Bassinets/Isolettes: _____

E. Does Facility Provide Mother/Infant Care? _____ Yes _____ N/A

2. Staff Continuing Education:

A. NRP Certified:

1. Nursing	_____ Yes	_____ No
2. Medicine	_____ Yes	_____ No
3. Anesthesia	_____ Yes	_____ No
4. Respiratory Therapy	_____ Yes	_____ No

4. Nurseries:

A. Vital Signs Routine for Newborn in Transition (first 4-6 hours of life) is?

B. What type of gestational age assessment is done:

1. Dubowitz

2. Ballard

3. Other: _____

5. Teaching/Discharge Instructions:

A. Infant Teaching Sheet Signed on Discharge by Mother?

_____ Yes _____ No

B. Infant Discharge/Summary Sheet?

_____ Yes _____ No

6. Surgery:

A. Where is Neonatal Surgery performed?

B. What types of Surgeries are being performed?

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Surveyor: _____ Survey Date: _____

Hospital: _____ City: _____

Level Classification: _____

ANTEPARTUM/POSTPARTUM UNIT

1. Physical Facilities:

A. Labor and Delivery (Indicate Number of Beds):

L.R. _____ L.D.R. _____ C/S – D.R. _____ R.R. _____

B. Antepartum/Postpartum (Indicate Number of Beds):

1. AP/PP: _____ P.R. _____ S.P. _____ L.D.R.P. _____

2. Antepartum Unit (If Applicable): P.R. _____ S.P. _____

2. Support Services:

A. Laboratory – 24 hours _____ Yes _____ Other

B. X-Ray – 24 hours _____ Yes _____ Other

C. Anesthesia – 24 hours _____ Yes _____ Other _____ On Call (Level I)

3. Prenatal Clinic:

A. List the name(s) of the prenatal clinic(s) where clients receive care prior to their admission to your hospital at the time of birth:

1. Hospital _____
2. Health Department _____
3. Community _____
4. Other _____

4. What unit are your high-risk patients admitted to? (e.g. L & D, antepartum) _____

Where do they go following delivery if still high risk? _____

OB? 5. Do you have a collaborative policy for patients with medical/surgical condition admitted to services other than

_____ Yes _____ No

6. C/S Deliveries:

A. Location for Planned C/S:

_____ Delivery Room/C-Section Room _____ Operating Room (Surgical)

B. Location for Emergency C/S:

_____ Delivery Room/C-Section Room _____ Operating Room (Surgical)

C. Scrub Team:

_____ Perinatal Staff _____ O.R. Staff

Circulating: _____ R.N./OB _____ R.N./O.R

D. Attendance at Delivery for the Newborn:

_____ Pediatrician _____ Neonatologist _____ Respiratory Therapist

OB/R.N. (specify specialty): _____

8. Recovery Period

A. Length of Recovery Period:

_____ C/S _____ Vaginal Delivery

B. Vital Signs Routine for C/S Patient: _____

9. Postpartum Period

A. Teaching Sheet/Discharge Instructions Signed by Patient: _____ Yes _____ No

B. Patient Given Copy of Signed Instructions: _____ Yes _____ No

PERINATAL PERSONNEL LIST

HOSPITAL NAME: _____

DATE OF INSPECTION: _____

EMPLOYEE NAME	DATE OF HIRE	DISCIPLINE(RN,LPN,MD,ETC) LICENSURE VERIFICATION	CERTIFICATION SPECIALTY	NRP CERTIFIED EXP. DATE	AREA OF WORK	SHIFT	TOTAL HOURS WORKED WEEKLY
PHYSICIANS/RESIDENTS/INTERNS:							
:							

(USE ADDITIONAL SHEETS AS NEEDED)

PERINATAL PERSONNEL LIST

HOSPITAL NAME: _____

DATE OF SURVEY: _____

EMPLOYEE NAME	DATE OF HIRE	DISCIPLINE(RN,LPN,MD,ETC) LICENSURE VERIFICATION	CERTIFICATION SPECIALTY	NRP CERTIFIED EXP. DATE	AREA OF WORK	SHIFT	TOTAL HOURS WORKED WEEKLY
NURSE MIDWIVES:							
ANESTHESIOLOGISTS/ CRNA'S:							
RESPIRATORY THERAPISTS:							
RADIOLOGY:							

(USE ADDITIONAL SHEETS AS NEEDED)

PERINATAL PERSONNEL LIST

HOSPITAL NAME: _____ *DATE OF SURVEY:* _____

DATE OF SURVEY: _____

EMPLOYEE NAME	DATE OF HIRE	DISCIPLINE(RN,LPN,MD,ETC) LICENSURE VERIFICATION	CERTIFICATION SPECIALTY	NRP CERTIFIED EXP. DATE	AREA OF WORK	SHIFT	TOTAL HOURS WORKED WEEKLY
SUPERVISORY PERSONNEL:							
STAFF NURSES:							
:							

(USE ADDITIONAL SHEETS AS NEEDED)

PERINATAL PERSONNEL LIST

HOSPITAL NAME: _____

DATE OF SURVEY: _____

EMPLOYEE NAME	DATE OF HIRE	DISCIPLINE(RN,LPN,MD,ETC) LICENSURE VERIFICATION	CERTIFICATION SPECIALTY	NRP CERTIFIED EXP. DATE	AREA OF WORK	SHIFT	TOTAL HOURS WORKED WEEKLY
NURSE AIDES/TECHS/PCAs/UNLICENSED							
DIETICIANS:							
LACTATION CONSULTANTS/IBCLC:							

(USE ADDITIONAL SHEETS AS NEEDED)

PERINATAL PERSONNEL LIST

HOSPITAL NAME: _____ *DATE OF SURVEY:* _____

DATE OF SURVEY: _____

(USE ADDITIONAL SHEETS AS NEEDED)