

Fetal Heart Rate Project

Prof. IV Ramakrishnan
Deven Diwakar
Maneesh Reddy

Database Details

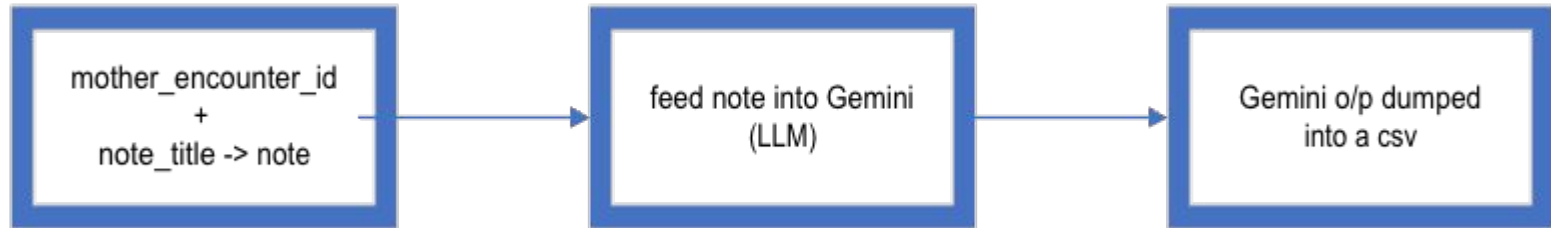
	123 row_id ▼	🕒 date_time ▼	123 mother_encounter_id ▼	123 mother_person_id ▼	ABC note ▼	ABC note_title ▼
1	463,149	2018-03-10 07:19:54.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	oblaborprogressnote
2	463,150	2018-03-10 09:38:43.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	oblaborprogressnote
3	463,151	2018-03-10 12:23:45.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	oblaborprogressnote
4	463,152	2018-03-10 15:26:02.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	oblaborprogressnote
5	463,153	2018-03-10 17:24:57.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	oblaborprogressnote
6	463,154	2018-03-10 23:25:01.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	oblaborprogressnote
7	463,155	2018-03-10 21:45:16.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	obpreprocedureverific
8	463,156	2018-03-09 19:44:08.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	obr1onservicenote
9	463,157	2018-03-10 23:25:57.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	obr3note
10	463,158	2018-03-09 17:39:20.000	54,073,291	8,274,574	OB Triage Assessment Ent	obtriageassessment-t
11	463,159	2018-03-11 11:56:23.000	54,073,291	8,274,574	OB Urgent Care Progress	oburgentcareprogres
12	463,160	2018-03-23 13:07:49.000	54,073,291	8,274,574	Patient Info: ¶Name: ¶[---	operativerreport
13	463,161	2018-03-09 16:52:03.000	54,073,291	8,274,574	Patient Factors Form Enter	patientfactors-text
14	463,162	2018-03-09 19:22:07.000	54,073,291	8,274,574	Pneumococcal Immunizati	pneumococcalimmuni
15	463,163	2018-03-11 04:42:01.000	54,073,291	8,274,574	Pneumococcal Immunizati	pneumococcalimmuni
16	463,164	2018-03-21 14:33:01.000	54,073,291	8,274,574	Post Discharge Follow Up	postdischargefollowu
17	463,165	2018-03-11 13:57:38.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	postpartumcdprogres
18	463,166	2018-03-12 15:01:54.000	54,073,291	8,274,574	Patient: [---], [---] MRN: [-	postpartumcdprogres
19	463,167	2018-03-11 06:48:00.000	54,073,291	8,274,574	PRN Response Entered On	prnresponse-text
20	463,168	2018-03-11 06:48:07.000	54,073,291	8,274,574	PRN Response Entered On	prnresponse-text

Attributes

- gestational age - delivery record
- sex of fetus- delivery record
- mother's age - delivery record
- Parity
- Ruptured Membrane
- Fever
- Meconium
- Gestational Hypertension
- Preeclampsia (mild/ w/o severe features)
- Severe Preeclampsia (with severe features)
- Intraamniotic infection
- Lupus
- Antiphospholipid Syndrome
- Asthma
- Tobacco Usage
- Oligohydramnios
- Polyhydramnios
- Cholestasis
- Chronic Kidney Disease
- IVF
- Pregestational Diabetes
- Gestational Diabetes
- Gravidity
- Fetal growth restriction/IUGR

Note identification & Gemini

- Identifying a note based on the mother_encounter_id and the note_title
- Tentatively, we ask the mother_encounter_id and the note_title to identify the note in question
- Ask Gemini to identify a single attribute from the note
- Moved on to ask Gemini to identify multiple attributes from the note



Prompt Engineering

- Tried multiple different ways of asking the LLM for the answer
 - Directly asking with a note does not give effective results
 - Couple of example notes and their expected answer does not give effective result too
 - Went with only one example note and its expected answer and fed it with the actual note.
- Current Prompt:

the list of attributes : <list of attributes> ,

<example_note> and the <example_format>

Given the above example note and format , from the following note, for all attributes in the attribute list return attribute and value along with sentence containing relevant attribute information in csv format with commas and each attribute having its own row, <actual note>

This is given every time Gemini API is called.

Example Note

Patient: [---], [---] S MRN: [---] FIN: [---] Age: 26 years Sex: Female DOB: [---] Associated Diagnoses: None Author: [---] MD, [---]
History of Present Illness 26-year-old G2P[---] at 39 weeks dated by LMP [---] c/w 7 week sono for EDD [---] Pregnancy c/b:1. Hx
of PEC with SF in prior delivery- Patient on ASA 162 mg/day - Baseline 24hr urine protein: 139mg2. Rh neg- Received Rhogam
for first trimester bleeding on [---]3. Mild intermittent asthma in childhood: one hospitalization as a child, no intubations, no inhaler
in years4. Former smoker: less than 1ppd, quit in early pregnancy5. Migraines: normal MRI, now improved 6. Obesity: BMI 37.7.
Marginal cord insertion- AGA fetus on [---]CC: Patient presents with LOF. She reports that at 2am she was awoken by a
contraction, went to the bathroom and had a large gush of yellow fluid. She reports that, at that point, she got in the car to come
to the ED, and on the drive started having ctx q5 mins. She denies VB. +FM. Currently the patient stats that she is contracting
q3mins, of moderate intensity, and is still leaking fluid. Denies HA, CP, SOB, fever, NV, RUQ pain. Prenatal labs:Blood type: A
negative, neg antibody screenH/H: 12.8/38.0Plt: 291kGC: neg[---]: negRPR: NRRubella: immuneVaricella: immuneUrine Cx:
negHepBsAg: negHep C: negHIV: negPap: NILM with BVCF screen: Genetic carrier screening: no mutationsNIPTs: 46 XYFirst
Trimester Screen: negGBS: negative Histories PMH: deniesPSH: lap cholecystectomyObHx: G2P[---]Sochx: denies smoking,
alcohol, illicit drug useAll: dilaudid- itchyMeds: Metformin 500mg qhsaspirin 81mg Pregnancy History Pregnancy History G2
[---],0,0,1 Pregnancy # 1 Baby 1Outcome Date: [---]Neonate Outcome: Live BirthOutcome or Result: VaginalGender: --[---] Age:
40 weeks 4 days Wt: [---] gHospital: --[---] Labor: --Child's Name: --Baby's Father: -- Problem list: All ProblemsAFP -
Alpha-fetoprotein raised / SNOMED [---] [---] / ConfirmedObesity / SNOMED [---] [---] / PossibleGestational hypertension /
ICD-9-CM 642.90 / ConfirmedRh negative / SNOMED [---] [---] / ConfirmedAt risk of venous thromboembolus / SNOMED [---]
[---] / ConfirmedDecreased hemoglobin or hematocrit / ICD-9-CM 285.9 /

Example Format

Example format is given below. \n denotes a new line. That tells Gemini to include new rows on a new line.

Attribute, Value, Sentence /n

Age of Mother, 32, 32 y/o G2P[---] at 37.6 wks.../n

Gestational Age, 37.6, 32 y/o G2P[---] at 37.6 wks.../n

Gravidity, 2, 32 y/o G2P[---] at 37.6 wks.../n

Oligohydramnios, Yes, Patient presents for unscheduled IOL for oligohydramnios./n

Gestational Diabetes, Yes, GDMA2: on NPH 25 units nightly \n

Input Note 1

Current Pregnancy and Risk InformationNo Data

Available-----Pregnancy History G6

[---],0,1,4 Pregnancy # 1 Baby 1Outcome Date: [---]Neonate Outcome: Live BirthOutcome or Result: C-SectionGender: Female[---] Age: 40 weeks Wt: [---] gHospital: --[---] Labor: --Child's Name: --Baby's Father: --Pregnancy # 2 Baby 1Outcome Date: [---]Neonate Outcome: Live BirthOutcome or Result: C-SectionGender: Male[---] Age: 39 weeks Wt: [---] gHospital: --[---] Labor: --Child's Name: --Baby's Father: --Pregnancy # 3 Baby 1Outcome Date: [---]Neonate Outcome: Live BirthOutcome or Result: C-SectionGender: Male[---] Age: 39 weeks Wt: [---] gHospital: --[---] Labor: --Child's Name: --Baby's Father: --Pregnancy # 4 Baby 1Outcome Date: [---] Neonate Outcome: Fetal DeathOutcome or Result: Spontaneous AbortionGender: --[---] Age: 7 weeks Wt: --Hospital: --[---] Labor: --Child's Name: --Baby's Father: --Pregnancy # 5 Baby 1Outcome Date: [---]Neonate Outcome: Live BirthOutcome or Result: C-SectionGender: Female[---] Age: 39 weeks Wt: [---] gHospital: --[---] Labor: --Child's Name: --Baby's Father: - (... continued)

Output 1

Gestational Age	Not mentioned	Current Pregnancy and Risk Infor
Gravidity	6	Pregnancy History G6 [---],0,1,4
Parity	1	Pregnancy History G6 [---],0,1,4
Ruptured membl	Not mentioned	No relevant data in provided note
Pyrexia/Severe I	Not mentioned	No relevant data in provided note
Meconium	Not mentioned	No relevant data in provided note
Gestational Hypo	Not mentioned	No relevant data in provided note
Preeclampsia	Not mentioned	No relevant data in provided note
Lupus	Not mentioned	No relevant data in provided note
Antiphospholipid	Not mentioned	No relevant data in provided note
Asthma	Not mentioned	No relevant data in provided note
Tobacco Usage	Never	Tobacco use: Never (less than 10
Oligohydramnios	Not mentioned	No relevant data in provided note
Cholestasis	Not mentioned	No relevant data in provided note
Chronic Kidney I	Not mentioned	No relevant data in provided note
IVF	Not mentioned	No relevant data in provided note
Pregestational D	Not mentioned	No relevant data in provided note
Gestational Diab	Not mentioned	No relevant data in provided note

Input Note 2

Mother of baby is a 31 year old g2p2 female, delivered a baby boy "[---]" at 38.4 weeks gestation via c/s. SW was consulted for hx of etoh/substance use. SW met with MOB alone at bedside, role of SW has been explained. MOB was breastfeeding, somewhat guarded. MOB indicated she resides in a private home in [---] with her significant other [---] [---] and their 1 yo. MOB reports she also has two stepchildren from FOB. MOB indicated she is employed as an RN at Pilgrim State Psych and will have time for maternity leave. FOB is also employed full time as per MOB. MOB does not receive WIC or any other forms of PA. MOB admits to a hx of anxiety in which she indicated is "situational." MOB denies ever being rx'ed medications to cope with anxiety. Hx of depression denied. Education provided on Postpartum Depression and baby blues. MOB verbalized an understanding and also denied hx of same. MOB reports to having an extensive support system. MOB admits to a hx of alcohol abuse at age 16 and completed an inpatient rehab. MOB reports "it is all resolved now, i am good." SW provided support and praise. MOB did not elaborate further. MOB drives, denies any barriers to follow up care for herself or newborn. Pediatrician will be Dr. [---] [---]. Infant will be added to FOB's insurance ([---]). SW provided resource packet- PPD/mental health, pregnancy postpartum, community resource list. Emotional support has been provided. No discharge needs indicated. Case discussed with team. [---] [---], LCSW S[---]beeper# [---]

Output 2

Gestational Age (weeks)	38.4	Mother of baby is a 31 year old g2p2 female, delivered a baby boy "[---]" at 38.4 weeks gestation via c/s
Sex of Fetus	Male	Mother of baby is a 31 year old g2p2 female, delivered a baby boy "[---]" at 38.4 weeks gestation via c/s
Mother's Age (years)	31	Mother of baby is a 31 year old g2p2 female, delivered a baby boy "[---]" at 38.4 weeks gestation via c/s
Liq. praecox	Not mentioned	Liq. praecox absent from excerpt.
Gravidity	2 (g2)	Mother of baby is a 31 year old g2p2 female, delivered a baby boy "[---]" at 38.4 weeks gestation via c/s
Parity	2 (p2)	Mother of baby is a 31 year old g2p2 female, delivered a baby boy "[---]" at 38.4 weeks gestation via c/s
Ruptured membrane	Not mentioned	Ruptured membrane absent from excerpt.
Pyrexia/Severe Fever	Not mentioned	Pyrexia/Severe Fever absent from excerpt.
Meconium	Not mentioned	Meconium absent from excerpt.
Gestational Hypertension	Not mentioned	Gestational Hypertension absent from excerpt.
Preeclampsia	Not mentioned	Preeclampsia absent from excerpt.
Lupus	Not mentioned	Lupus absent from excerpt.
Antiphospholipid Syndrome	Not mentioned	Antiphospholipid Syndrome absent from excerpt.
Asthma	Not mentioned	Asthma absent from excerpt.
Tobacco Usage	Not mentioned	Tobacco Usage absent from excerpt.
Oligohydramnios	Not mentioned	Oligohydramnios absent from excerpt.
Cholestasis	Not mentioned	Cholestasis absent from excerpt.
Chronic Kidney Disease	Not mentioned	Chronic Kidney Disease absent from excerpt.
IVF	Not mentioned	IVF not mentioned in excerpt.
Pregestational Diabetes	Not mentioned	Pregestational Diabetes absent from excerpt.
Gestational Diabetes	Not mentioned	Gestational Diabetes not mentioned.

Input Note 3

OB Triage Assessment Entered On: [---] EDT Performed On: [---] EDT by [---] RN, [---] General Info Arrived From : Home Arrival Mode : Ambulatory Pt Exposure to Metal Fragment or Device : No Last Menstrual Period : No qualifying data available. OB Provider Groups : [---] [---] Medicine (staff) Prenatal Care : Adequate [---] RN, [---] - [---] EDT Subjective Reason For Visit OB : Abdominal pain, Labor check, Other: Prev. C-sec. x4 Fetal Movement : Present Last Fetal Movement Date/Time : [---] EDT Contraction Frequency (min) : irreg. Urge to Push : No Contractions : Yes Contraction Onset Date/Time : [---] EDT Leaking Fluid : No Bleeding : No OB Triage Acuity : 3 [---] RN, [---] - [---] EDT Transcribed Prenatal Labs Transcribed Prenatal Blood Type : A Transcribed Prenatal RH Type : Positive Transcribed Prenatal RPR Status : Negative Transcribed Prenatal Hep B Surface Antigen : Negative Transcribed Prenatal HBsAg Date : [---] EST Maternal HepBsAG Result on Chart : Yes Transcribed Prenatal GBS Status : Negative Transcribed Prenatal GBS Status Date : [---] EDT Transcribed Prenatal HIV Status : Negative [---] RN, [---] - [---] EDT Transcribed Prenatal HIV Status Date : [---] EDT [---] RN, [---] - [---] EDT [[---] EST] - previously charted by [---] RN, [---] at [---] EDT; Prenatal Information Antepartum Risk Factors Additional Information : Reviewed with patient, document changes Antepartum Information : Current Pregnancy and Risk InformationNo Data Available-----Pregnancy History G6 [---],0,1,4 Pregnancy # 1 Baby 1 Outcome Date: [---] Neonate Outcome: Live Birth Outcome or Result: C-Section Gender: Female [---] Age: 40 weeks Wt: [---] g Hospital: -- [---] Labor: -- Child's Name: -- Baby's Father: --Pregnancy # 2 Baby 1 Outcome Date: [---] Neonate Outcome: Live Birth Outcome or Result: C-Section Gender: Male [---] Age: 39 weeks Wt: [---] g Hospital: -- [---] Labor: -- Child's Name: -- Baby's Father: --Pregnancy # 3 Baby 1 Outcome Date: [---] Neonate Outcome: Live Birth Outcome or Result: C-Section Gender: Male [---] Age: 39 weeks Wt: [---] g Hospital: -- [---] Labor: -- Child's Name: -- Baby's Father: --Pregnancy # 4 Baby 1 Outcome Date: [---] Neonate Outcome: Fetal Death Outcome or Result: Spontaneous Abortion Gender: -- [---] Age: 7 weeks Wt: -- Hospital: -- [---] Labor: -- Child's Name: -- Baby's Father: --Pregnancy # 5 Baby 1 Outcome Date: [---] Neonate Outcome: Live Birth Outcome or Result: C-Section Gender: Female [---] Age: 39 weeks Wt: [---] g Hospital: -- [---] Labor: -- Child's Name: -- Baby's Father: -----Height/WeightHeight/Length Measured (cm): (...)

continued)

Output 3

Gestational Age (weeks)	Not mentioned	No information within excerpt provided./n	
Mother's Age (years)	Not mentioned	No information within excerpt provided./n	
Gravidity		6 G6 [---],0,1,4/n	
Parity		0 G6 [---],0,1,4/n	
Liq. praecox	Not mentioned	No information within excerpt provided./n	
Ruptured membrane	Not mentioned	No information within excerpt provided./n	
Pyrexia/Severe Fever	Not mentioned	No information within excerpt provided./n	
Meconium	Not mentioned	No information within excerpt provided./n	
Gestational Hypertension	Not mentioned	No information within excerpt provided./n	
Preeclampsia	Not mentioned	No information within excerpt provided./n	
Lupus	Not mentioned	No information within excerpt provided./n	
Antiphospholipid Syndrome	Not mentioned	No information within excerpt provided./n	
Asthma	Not mentioned	No information within excerpt provided./n	
Tobacco Usage	Never (less than 100 in lifetime)	Tobacco use: Never (less than 100 in lifetime). Smokeless Tobacco use: Never./n	
Oligohydramnios	Not mentioned	No information within excerpt provided./n	
Cholestasis	Not mentioned	No information within excerpt provided./n	
Chronic Kidney Disease	Not mentioned	No information within excerpt provided./n	
IVF	Not mentioned	No information within excerpt provided./n	
Pregestational Diabetes	Not mentioned	No information within excerpt provided./n	
Gestational Diabetes	Not mentioned	No information within excerpt provided./n	
Correct			

Precision and Accuracy

Precision = 86.13%. For 14% of returned attributes, Gemini tends to extract incorrect information.

Accuracy = 95.32% i.e. High correctness rate for true negatives, but some attributes can go missing in response.

29th April - Objectives

- Attributes - Temporal and non-temporal attributes
 - Frequency analysis with 'admission' and 'h&p'
- Bert Similarity search
- LLM Used : Gemini

Attributes

- Two types of attributes
 - Attributes without Temporal aspect
 - Eg. Lupus, Asthma, Tobacco Usage
 - Attributes with Temporal aspect
 - Need them at admission and at delivery record
 - Eg. Meconium
- Started with the attributes without temporal aspect
- Scanning the notes with note titles having either 'admission' or 'h&p' in the title

Attributes - w/o temporal

- Lupus
- Antiphospholipid Syndrome
- Asthma
- Tobacco Usage
- Oligohydramnios
- Polyhydramnios
- Cholestasis
- Chronic Kidney Disease
- IVF
- Pregestational Diabetes
- Gestational Diabetes
- Gravidity
- Fetal growth restriction/IUGR
- Marginal cord insertion (MCI)
- Velamentous cord insertion (VCI)

Attributes - with temporal

- Parity
- Ruptured Membrane
- Fever
- Meconium
- Gestational Hypertension
- Preeclampsia (mild/ w/o severe features)
- Severe Preeclampsia (with severe features)
- Intraamniotic infection

Do not have temporal aspect but have to be taken from delivery record

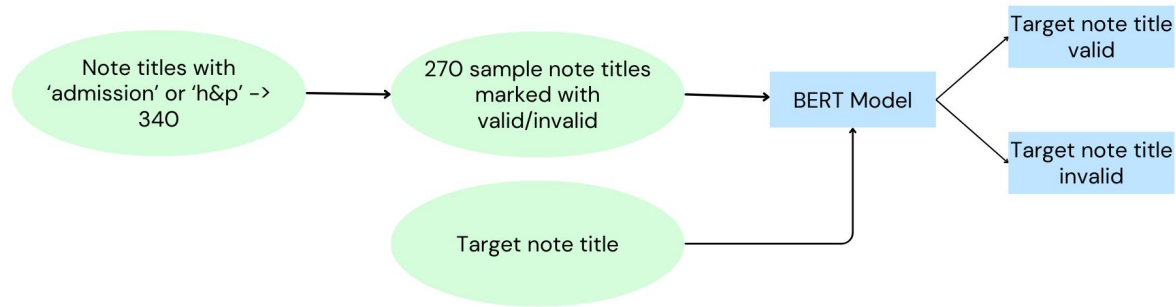
- Gestational age
- sex of fetus
- mother's age

Note titles

- Filtered the note tiles based on 'h&p' or 'admission'
- Frequency analysis of the no of notes and the titles
- The top note titles with admission or 'h&p' titles are

Note title	Count
obadmissionh&p	2477
oblaboradmission	1294
obadmissionh&pI&d	1008
obioladmissionh&p	646
obadmissionnote	584
obscheduledcdh&p*	456
obl&dadmissionh&p	138
oblaboradmissionh&p	133

BERT similarity search model



Accuracy of model is around 96%.

Note title filtering

There were a total of 340 note titles with either admission or h&p

A sample of the 270 note titles used for similarity search. Each note title has its validity - if the note is a valid admission h&p note or not - alongside

Fed remaining note titles to the BERT similarity search model and it compares the title to the closest match among the sample dataset

note_title	valid
admissionh&p	1
admissionh&pforiol	1
admissionh&piol	1
admissionh&pl&d	1
anteadmissionh&p	1
antepartumadmissionh&p	1
attendingadmissionh&p	1
cardiothorasicsurgeryadmissionh&p	0
ccucardiologyadmissionh&p	0
cesareanadmissionh&p	1
csadmissionh&p	1
icuadmissionh&p	0
ioladmissionh&p	1
iolobadmissionh&p	1
l&dadmissionh&p	1
medicineeadmissionh&p	1
midwifeadmissionh&p	1
midwifeadmissionh&pl&d	1
midwifeioladmissionh&p	1
midwiferyobioladmissionh&p	1
obactiveadmissionh&p	1
obadmissionandh&pnote	1
obadmissioncesareandeliveryh&p	1
obadmissionforoligh&n	1

Steps followed

The FHR database contains admission records for each encounter. However, the note title of the admission record varies across mothers, often including the terms 'admission' and 'h&p'. In order to filter the right note for attribute information extraction, we do the below:

- 1) We fetch notes for a particular encounter.
- 2) For each note, we check the validity of the note for information extraction, by measuring the similarity of the note title with a set of manually labelled valid note titles.
- 3) Similarity is measured with a set of parameters including presence of certain terms like 'admission' and 'h&p' and absence of certain terms like 'icu', 'ccu' etc.
- 4) Attribute information is extracted from the valid note.

Examples

Attribute	Value	Sentence		
Gestational Age (weeks)	39.4	32 y.o. G_3 P1_ at 39.4_ wks by LMP...		
Sex of Fetus	Not mentioned	Information about sex of fetus absent from excerpt.		
Mother's Age (years)	32	32 y.o. G_3 P1_ at 39.4...		
Liq. praecox	Not mentioned	Liq. praecox not mentioned.		
Gravidity	3 (G3)	32 y.o. G_3 P1_ at 39.4...		
Parity	1 (P1)	32 y.o. G_3 P1_ at 39.4...		
Ruptured membrane	Not mentioned	Ruptured membrane not mentioned.		
Pyrexia/Severe Fever	Not mentioned	Pyrexia/Severe Fever absent from excerpt.		
Meconium	Not mentioned	Meconium absent from excerpt.		
Gestational hypertension	Not mentioned	Gestational hypertension not mentioned.		
Preeclampsia	Not mentioned	Preeclampsia not mentioned.		
Lupus	Not mentioned	Lupus absent from excerpt.		
Antiphospholipid Syndrome	Not mentioned	Antiphospholipid Syndrome absent from excerpt.		
Asthma	Not mentioned	Asthma absent from excerpt.		
Tobacco Usage	Former smoker,	Tobacco: [---]; Use: Former smoker, quit more;		
Oligohydramnios	Not mentioned	Oligohydramnios absent from excerpt.		
Cholestasis	Not mentioned	Cholestasis absent from excerpt.		
Chronic Kidney Disease	Not mentioned	Chronic Kidney Disease absent from excerpt.		
IVF	Not mentioned	IVF not mentioned.		
Pregestational Diabetes	Not mentioned	Pregestational Diabetes absent from excerpt.		
Gestational Diabetes	Not mentioned	Gestational Diabetes not mentioned.		

Patient: [---], [---] K MRN: [---] FIN: [---] Age: 32 years Sex: Female DOB: [---] Associated Diagnoses: Normal labor Author: [---] [---], [---] Chief Complaint 32 y.o. G3 P1 at 39.4 wks by LMP 10 /27 /18 consistent with 8 wk ultrasound for EDD of 8 / 3 / 19 . Prenatal Care with Centering [---] office [_] uncomplicated [_] complicated by: BMI 31, hx Leep, closely spaced pregnancy Basic Information Reason for admission: Labor. Informed consent obtained for anesthesia, procedure and blood transfusion. Gestational Age: * Note: EGA calculated as of [---] EDD: [---] EGA*: 39 weeks 4 days Type: Authoritative Method Date: [---] Method: Last Menstrual Period ([---]) Confirmation: Confirmed Description: --Comments: --Entered by: [---], [---] on [---] Other EDD Calculations for this Pregnancy: No additional EDD calculations have been recorded for this pregnancy. Is the patient admitted with spontaneous labor? Yes. Patient has no history of Cesarean Birth History of Present Illness 32 y/o G3P1 39.4 weeks presents c/o regular contractions since [---], now Q2 min strong intensity Denies lof or vaginal bleeding, endorse good fetal movements Mild rectal pressure, GBS negative, closely spaced pregnancy hx LEEP. Planned unmedicated birth Presents with supportive partner Presented with _.[_] fetal movement[_ +] contractions[_ -] leakage of fluid [Date: _/_/ at _][_ -] vaginal bleeding Visit Assessments Pre-Weight Fundal term-----Cervix-----Measured-----Urine----- Presenting Fetal Date Ht(cm) S&SD ileff(%) Stak glbs BP Prot Gluc Part FHR Activity [---] 3991.6202 [---] /68140 [---] 3992.8 [---] 106/68125 [---] 3891.4202106/[---] 148 (c) [---] 89.6198120/72 [---] [---] None 89.6198 [---] /69145 [---] 3389.8198120/68146 [---] 30 None 86.7191 [---] / [---] 130 [---] 29 None 86.8191115/65128 [---] 85.1188115/67 [---] 82.9183120/62 [---] 23 None 83.5184124/[---] 148 [---] 19 None 80176106, 72140 [---] 1778.2172 [---] /60135 [---] 1276.1168100/[---] [---] 976.8169102/60 Next Visit: Review of Systems Constitutional: Negative. Respiratory: Negative. Cardiovascular: Negative. Gynecologic Negative. Psychiatric: Negative. Health Status Allergies: Allergic Reactions (All) Unknown Neosporin- No reactions were documented. Canceled/Inactive Reactions (All) NKA Current medications: Home Medications (4) Active cholecalciferol, Oral hydrocortisone topical 1 application, Per Rectum, TID; Insulin: 3 g =, TID; Multivitamin, prenatal, Oral, Once daily, Medications (2) Active Scheduled: (1) Lactated Ringers Injection intravenous solution 250 mL, Bolus IV, One Dose; Unsch Continuous: (1) Lactated Ringers 1,000 mL 1,000 mL, Continuous IV, 125 mL/hr PRN: (0), (Selected) Inpatient Medications Ordered lactated Ringers Bolus: 250 mL, Bolus IV, Infusion Rate: 1,000 mL/hr, One Dose; Unsch, First dose is STAT, [---] EDT, for non reassuring fetal status, Category 2 or 3 fetal heart tracings or heavy vaginal bleeding lactated Ringers Injection intravenous solution 1,000 mL: 1,000 mL, Continuous IV, First dose is Routine, [---] EDT, 125 mL/hr, 8 hr, Order Weight 91.6 kg, Populate Charting Weight From Order Outpatient Medications Ordered tetanus/diphth/pertuss (Tdap) adult/adol: 0.5 mL, Intramuscular, [---], First dose is Routine, [---] EDT, Stop date [---] EDT Prescriptions Prescribed Anusol-HC 2.5% rectal cream with applicator: = 1 application, Per Rectum, TID, # 30 g, 0 Refill(s), Indication: Inflammation, [---] EDT, Pharmacy: Walgreens Drug Store [---], 1 application Per Rectum TID Documented Medications Documented Fiber Choice: = 3 g, TID, 0 Refill(s), [---] EDT Prenatal Multivitamins: Oral, Once daily, 0 Refill(s), [---] Vitamin D3: Oral, 0 Refill(s), Indication: Vitamin, [---] EDT, PNV Problem list: All Problems Family history of lung cancer / SNOMED CT [---] / Confirmed Obesity / SNOMED CT [---] / Possible Pregnant / SNOMED CT [---] / Confirmed Resolved: ASCUS with positive high risk HPV cervical / SNOMED CT [---] Resolved: Cervical high risk HPV (human papillomavirus) test positive / SNOMED CT [---] Resolved: Complete miscarriage / SNOMED CT [---] Resolved: Pregnant / SNOMED CT [---] Histories Pregnancy History Pregnancy History G3 [---], 0,1,1 Pregnancy # 1 Baby 10 Outcome Date: [---] Neonate Outcome: Fetal Death Outcome or Result: Spontaneous Abortion Gender: --[---] Age: 7 weeks Wt: --Hospital: --[---] Labor: --Child's Name: --Baby's Father: --Pregnancy # 2 Baby 10 Outcome Date: [---] Neonate Outcome: Live Birth Outcome or Result: Vaginal Gender: Male [---] Age: 39 weeks 4 days Wt: [---] g Hospital: --[---] Labor: --Child's Name: --Baby's Father: -- Past Medical History: Resolved ASCUS with positive high risk HPV cervical ([---]): Onset on [---] at 32 years. Resolved. Complete miscarriage ([---]): Onset on [---] at 30 years. Resolved. Cervical high risk HPV (human papillomavirus) test positive ([---]): Onset in [---] at 21 years. Resolved. Prenatal History Prenatal labs Blood type: A, Rh positive. Rapid plasma reagin: nonreactive. Hepatitis: Hepatitis B Surface Antigen Negative, Hepatitis C Antibody Negative. Human immunodeficiency virus: negative. Group B Strep: negative. Chlamydia: negative. Gonorrhea culture: negative. Rubella: immune, Varicella: . Varicella: immune. No Data Available Current pregnancy Obesity (BMI 30-39)+. Family History: Celiac disease Aunt (paternal) Diabetes mellitus Grandfather-Maternal (Deceased) Lung Cancer Grandmother-Maternal (Deceased) Grandfather-Paternal (Deceased) Sepsis... Grandmother-Paternal (Deceased) Lymphoma, diffuse large B cell, non Hodgkins Uncle (paternal) Procedure history: Colposcopy of cervix ([---]) on [---] at 32 Years. Leep in [---] at 22 Years. BIOPSY OF CERVIX W/SCOPE ([---]) in [---] at 21 Years. Fissurectomy with sphincterotomy ([---]). Social History Social & Psychosocial Habits Alcohol: [---]; Use: Denies; Home/Environment: [---]; Lives with: Children, Spouse; Feel Unsafe At Work/Home No; Human Traffic/[---] Violence Possibility No; Substance Abuse: [---]; Use: Denies; Tobacco: [---]; Use: Former smoker, quit more; Smokeless tobacco use: Never; Screening, Brief Intervention and Referral for Treatment: [---]; In the past 12 months have you used drugs other than those r No; Over the last 2 weeks, have you been bothered by little into Not At All; Over the last 2 weeks, have you been bothered by feeling drow Not At All; In the past 12 months, how often do you have a drink contain Never; In the past 12 months, how many drinks containing alcohol do None; In the past 12 months, how often did you have 6 (Female), 8 Never; . Review / Management Results review Physical Examination Vital Signs (last [---] hrs) Last Charted Weight 91.6 kg ([---] [---]) Height 170 cm ([---] [---]) Measured Vital Signs [---] EDT Blood Pressure Systolic [---] mmHG | Blood Pressure Diastolic 68 mmHG | Mean Arterial Pressure 82 mmHG | Measurements from flowsheet : Measured Height/Weight [---] EDT Height 170 cm | Weight 91.6 kg | How Weight Measured [Stated] | Body Mass Index 31.7 kg/m2 HI | BSA 2. [---] m2 [---] EDT Height 170 cm | Weight 91.6 kg | Body Mass Index 31.7 kg/m2 HI | BSA 2. [---] m2 General: Alert and oriented. Respiratory: Lungs are clear to auscultation. Cardiovascular: Normal rate, Regular rhythm. Gastrointestinal: Soft, Normal bowel sounds. Musculoskeletal No tenderness. No swelling. SVE: 9.5/_100/_0 Membranes: [+_] intact bulging membranes EFW: _ lbs by [_] [---] [_] sono EFM: 140_bpm, mod var, + accels, variable decels Toco: [Q2] min _] none [_] Presentation: [_ +] cephalic by leopolds/SVE [_] cephalic by sono Sono: _ Impression and Plan Diagnosis Normal labor. Fetal condition: Stable. Maternal condition: Stable. Plan Admit. Consents OB labs EFM Anticipate vaginal birth

Examples

Attribute	Value	Sentence
Gestational Age(weeks)	37	30 y.o. G1 P0 at 37 wks by LMP \[---\] consistent with 8 wk ultrasound for EDD of \[---\]."
Sex of Fetus	Not mentioned	Information about sex of fetus absent from excerpt.
Mother's Age (years)	30	30 y.o. G1 P0 at 37 wks by LMP \[---\] consistent with 8 wk ultrasound for EDD of \[---\].
Liq. praecox	Yes	History of Present Illness 30 y.o. G1 P0 at 37 wks by LMP \[---\] consistent with 8 wk ultrasound for EDD of \[---\]....Presented with \[_ _ \] fetal movement[_ _ \] contractions[_ x _ \] leakage of flu
Gravidity	1 (G1)	30 y.o. G1 P0 at 37 wks by LMP \[---\] consistent with 8 wk ultrasound for EDD of \[---\].
Parity	0 (P0)	30 y.o. G1 P0 at 37 wks by LMP \[---\] consistent with 8 wk ultrasound for EDD of \[---\].
Ruptured membrane	Yes (PROM)	Reason for admission: PROM - Premature Rupture of Membranes.
Pyrexia/Severe Fever	Not mentioned	Pyrexia/Severe Fever absent from excerpt.
Meconium	Not mentioned	Meconium absent from excerpt.
Gestational hypertension	Not mentioned	Gestational hypertension absent from excerpt.
Preeclampsia	Not mentioned	Preeclampsia absent from excerpt.
Lupus	Not mentioned	Lupus absent from excerpt.
Antiphospholipid Syndrome	Not mentioned	Antiphospholipid Syndrome absent from excerpt.
Asthma	Not mentioned	Asthma absent from excerpt.
Tobacco Usage	Never smoker	Smoking History: Never (less than 100 in l Smokeless tobacco use: Never\[---\] Use: Never (less than 100 in l Smokeless tobacco use: Never
Oligohydramnios	Not mentioned	Oligohydramnios absent from excerpt.
Cholestasis	Not mentioned	Cholestasis absent from excerpt.
Chronic Kidney Disease	Not mentioned	Chronic Kidney Disease absent from excerpt.
IVF	Not mentioned	IVF absent from excerpt.
Pregestational Diabetes	Not mentioned	Pregestational Diabetes absent from excerpt.
Gestational Diabetes	Not mentioned	Gestational Diabetes absent from excerpt.

Patient: [---], [---] MRN: [---] FIN: [---] Age: 30 years Sex: Female DOB: [---] Associated Diagnoses: None Author: [---] [---], [---] Basic Information Reason for admission: PROM - Premature Rupture of Membranes. Informed consent obtained for anesthesia, procedure and blood transfusion. Gestational Age: * Note: EGA calculated as of [---] EDD: [---] EGA*: 37 weeks Type: Initial / Final Method Date: [---] Method: Last Menstrual Period ([---]) Confirmation: Confirmed Description: Normal Amount/Duration Comments: --Entered by: [---] , [---] on [---] Other EDD Calculations for this Pregnancy: Entered Method Method Date EDDEGA (At Entry) Type [---] Ultrasound [---] [---] 8 weeks Non-Authoritative [---] Ultrasound [---] [---] 12 weeks 3 days Non-Authoritative. Is the patient admitted with spontaneous labor?: No. Gestational age 37wks to 38wks and 6 days, is this elective delivery?: No. Indication for delivery: PROM. Patient has no history of Cesarean Birth Chief Complaint History of Present Illness 30 y.o. G1 P0 at 37 wks by LMP [---] consistent with 8 wk ultrasound for EDD of [---]. Prenatal Care with midwives [x] uncomplicated [_] complicated by: Presented with [_] fetal movement [_] contractions [x] leakage of fluid [Date: [---] at [---] am] [_] vaginal bleeding Visit Assessments Pre-Weight Fundal term----- Cervix----- Measured----- Urine----- Presenting Fetal Date Ht (cm) S&S Dileff (%) Stak lbs BPP Prot Gluc Part FHR Activity [---] 81.8180121/76 [---] 81.8180108/68 [---] [---] None 79.8176 [---] /68150 [---] 33 None 78.7174122/60140 [---] 30 None 76.5169122/68140 [---] 29 None 76.3168 [---] /60152 [---] [---] None 72.4160 [---] /60145 [---] 68.3151 [---] / [---] [---] 20 None [---] .9147 [---] /60148 [---] 1564.9143120/60160 [---] 63.1139100/60 [---] 62.4138 [---] /60 Next Visit: . Review of Systems Constitutional: Negative. Respiratory: Negative. Cardiovascular: Negative. Gynecologic: Negative. Health Status Allergies: Allergic Reactions (All) Mild Penicillin- No reactions were documented., Allergies (1) Active Reaction penicillin None Documented Current medications: Medications (3) Active Scheduled: (2) CefAZolin 2 g / DSW 50 mL 2 g 50 mL, IVPB, INT-Q8H Lactated Ringers 250 mL, Bolus IV, One Dose Unsch Continuous: (1) Lactated Ringers 1,000 mL 1,000 mL, Continuous IV, 125 mL/hr PRN: (0), (Selected) Inpatient Medications Ordered Lactated Ringers Bolus: 250 mL, Bolus IV, Infusion Rate: 1,000 hr, One Dose Unsch, First dose is STAT, [---] EDT, 0 mL/hr, Infuse over 0, for non reassuring fetal status, Category 2 or 3 fetal heart tracings or heavy vaginal bleeding Lactated Ringers Injection intravenous solution 1,000 mL: 1,000 mL, Continuous IV, First dose is Routine, [---] EDT, 125 mL/hr, 8 hr, Order Weight 81.8 kg, Populate Charting Weight From Order CefAZolin: 2 g, IVPB, IVPB, INT-Q8H, First dose is STAT, [---] EDT, 100 mL/hr, 0.5 hr, Antibiotic Indication Other, until delivery Documented Medications Documented multivitamin, prenatal: Oral, 0 Refill(s), Indication: Vitamin, [---], PNW Problem list: All Problems Group A beta-hemolytic streptococci / SNOMED [---] [---] / Confirmed Pregnant / SNOMED [---] [---] / Confirmed Prenatal care / SNOMED [---] [---] / Confirmed Rubella non-immune / SNOMED [---] [---] / Confirmed Histories Past Medical History: No active or resolved past medical history items have been selected or recorded. Procedure history: No active procedure history items have been selected or recorded. Pregnancy History Pregnancy History G1 P0,0,0,0 No previous pregnancies history have been recorded Family History: No family history items have been selected or recorded. Social History Social & Psychosocial Habits Alcohol [---] Use: Denies [---] Use: Denies Home/Environment [---] Lives with: Spouse Living situation: Home/Independent Feel Unsafe At Work/Home No Human Traffic/[---] Violence Possibility No Safe place to go: Yes Injuries/Abuse/Neglect in household: No Smoker in household: No Alcohol abuse in household: No Substance abuse in household: No Sexual [---] Sexually active: Yes Substance Abuse [---] Use: Denies [---] Use: Denies Tobacco [---] Use: Never (less than 100 in 1 Smokeless tobacco use: Never [---] Use: Never (less than 100 in 1 Smokeless tobacco use: Never Screening, Brief Intervention and Referral for Treatment [---] In the past 12 months have you used drugs other than those r No Over the last 2 weeks, have you been bothered by little into Not At All Over the last 2 weeks, have you been bothered by feeling down Not At All In the past 12 months, how often do you have a drink contain Never In the past 12 months, how many drinks containing alcohol do None In the past 12 months, how often did you have 6 (Female), 8 Never. Prenatal History Prenatal labs Blood type: A, Rh positive. Rapid plasma reagin: nonreactive. Hepatitis: Hepatitis B Surface Antigen Negative. Human immunodeficiency virus: negative. Group B Strep: positive. Chlamydia: negative. Gonorrhea culture: negative. Rubella: non-immune, Varicella: . Varicella: immune. No Data Available Current pregnancy No complications. Physical Examination Vital Signs (last [---] hrs) Last Charted Temp Oral 36.5 DegC ([---] [---]) SBP 121 mmHG ([---] [---]) DBP 76 mmHG ([---] [---]) Weight 81.8 kg ([---] [---]) Height 177.8 cm ([---] [---]) General: Alert and oriented. Respiratory: Respirations are non-labored. Cardiovascular: Normal rate. Gastrointestinal: Soft, Normal bowel sounds. Musculoskeletal No tenderness. No swelling. SVE: _/_ [x] deferred Appears closed on sterile speculum exam Membrane Status: [_] intact [_] gross leakage [x] positive pooling [x] positive ROM plus EFW: 7 lbs by [x] [---] [_] sonoEFM: 145 bpm, mod var, _ accel, _ decel, Toco: [_] none [x] occasionally Presentation: [x] cephalic by leopolds/SVE [_] cephalic by sono Sono: _ Neurologic: Alert, Oriented. Psychiatric: Cooperative, Appropriate mood & affect. Review / Management Results review Impression and Plan Diagnosis: IOL for PROM FHT: Category 1 Hemorrhage Risk: [x] Low [_] High Plan: Admit to L&D Consents signed OB labs IV access Cervidil to be inserted Consider cytotec and/or pitocin after cervidil Ancef 2gm IVPB q8h for GBS treatment Continue to monitor maternal/fetal status Pt plans to unmedicated methods for pain relief. Does not desire an epidural Reevaluate as needed Anticipate NSVD

Examples

Attribute	Value	Sentence		
Gestational Age	37.1	G3P[---] @ 37.1wks ...		
Sex of Fetus	Not mentioned	Information about the sex of the fetus absent from the excerpt.		
Mother's Age (years)	31	Age: 31 years		
Liq. praecox	Not mentioned	Liq. praecox not mentioned		
Gravidity	3 (G3)	G3P[---] @ 37.1wks ...		
Parity	[---]	G3P[---] @ 37.1wks ...		
Ruptured membrane	Not mentioned	Ruptured membrane not mentioned		
Pyrexia/Severe Fever	Not mentioned	Pyrexia/Severe Fever not mentioned		
Meconium	Not mentioned	Meconium not mentioned		
Gestational hypertension	Not mentioned	Gestational hypertension not mentioned		
Preeclampsia	Not mentioned	Preeclampsia not mentioned		
Lupus	Not mentioned	Lupus not mentioned		
Antiphospholipid Syndrome	Not mentioned	Antiphospholipid Syndrome not mentioned		
Asthma	Not mentioned	Asthma not mentioned		
Tobacco Usage	Never (less than 100 in lifetime)	Never (less than 100 in lifetime)		
Oligohydramnios	Not mentioned	Oligohydramnios not mentioned		
Cholestasis	Not mentioned	Cholestasis not mentioned		
Chronic Kidney Disease	Not mentioned	Chronic Kidney Disease not mentioned		
IVF	Not mentioned	IVF not mentioned		
Pregestational Diabetes	Not mentioned	Pregestational Diabetes not mentioned		
Gestational Diabetes	Not mentioned	Gestational Diabetes not mentioned		

Patient: [---], [---] MRN: [---] FIN: [---] Age: 31 years Sex: Female DOB: [---] Associated Diagnoses: None Author: [---] MD, [---] Basic Information Reason for admission: Labor. Gestational Age: * Note: EGA calculated as of [---] EDD: [---] EGA*: 37 weeks 1 day Type: AuthoritativeMethod Date: [---] Method: Unknown ([---]) Confirmation: ConfirmedDescription: --Comments: --Entered by: [---], [---] on [---] Other EDD Calculations for this Pregnancy: No additional EDD calculations have been recorded for this pregnancy. Is the patient admitted with spontaneous labor?: Yes. Gestational age 37wks to 38wks and 6 days, is this elective delivery?: No. Indication for delivery: Spontaneous Labor. Patient has a previous history of Cesarean Birth Will attempt a Trial of Labor G3P[---] @ 37.1wks by FTS for EDD [---] per patientPNC: Dr. Walker, [---] c/b: h/o C/S for fetal presentation in [---] (NSVD in [---]) History of Present Illness Pt presents feeling contractions every 15 mins since Monday. She has noticed a little bit of bright red spotting but denies heavy vaginal bleeding, LOF. +FM. She desires a TOLAC; her last deliveries were a vaginal delivery in [---] and a c/s in [---]. She denies fever, chills, headache, chest pain, SOB, nausea, vomiting, or dysuria. Health Status Allergies: Allergies (1) ActiveNo Known Medication. Type of reaction not documentedAllergie, Allergic Reactions (Selected)No Known Medication Allergies Current medications: No qualifying data available, Medications (1) ActiveScheduled: (1)Lactated Ringers 250 mL 250 mL, Bolus IV, OneDoseUnschContinuous: (0)PRN: (0), (Selected) Inpatient MedicationsOrderedLactated Ringers Bolus: 250 mL, Bolus IV, Infusion Rate: 1,000 hr, OneDoseUnsch, First dose is STAT, [---], [---] mL/hr, Infuse over 0.3, for non reassuring fetal status, Category 2 or 3 fetal heart tracings or heavy vaginal bleeding Problem list: Active Problems (1)Pregnant ([---]), All ProblemsPregnant / SNOMED CT [---] / ConfirmedResolved: Well adult / SNOMED CT [---]Resolved: Pregnant / SNOMED CT [---]Resolved: Pregnant / SNOMED CT [---] PMHx: nonePSHx: noneAll: noneSoc: denies x3Meds: none Review / Management OB Results Review Transcribed Prenatal Labs Transcribed Prenatal Blood Type : A Transcribed Prenatal RH Type : Positive Transcribed Prenatal Antibody Screen : Negative Transcribed Prenatal RPR Status : Negative Transcribed Prenatal Hep B Surface Antigen : Negative Transcribed Prenatal HBsAg Date : [---] Transcribed Prenatal GBS Status : Negative Transcribed Prenatal GBS Status Date : [---] Transcribed Prenatal HIV Status : Negative Transcribed Prenatal HIV Status Date : [---] Transcribed Prenatal Rubella Status : Immune Transcribed Prenatal Varicella Status : Immune Physical Examination No qualifying data available General: Alert and oriented. Respiratory: Respirations are non-labored. Gastrointestinal: Soft, Non-tender, Non-distended. SVE: 4/20/-3EFW: 7lbs [x][---] [] sonoSono: cephalic, posterior placentaEFM: 140 / mod var / no accels / no decels / q2-3min Histories Pregnancy History Pregnancy History G3 [---],0,0,2 Pregnancy # 1 Baby 1Outcome Date: [---] Neonate Outcome: Live BirthOutcome or Result: C-SectionGender: --[---] Age: 40 weeks Wt: --Hospital: --[---] Labor: --Child's Name: --Baby's Father: --Pregnancy # 2 Baby 1Outcome Date: [---] Neonate Outcome: Live BirthOutcome or Result: VaginalGender: --[---] Age: 40 weeks Wt: --Hospital: --[---] Labor: --Child's Name: --Baby's Father: -- Family History: No qualifying data available, No family history items have been selected or recorded. Prenatal History No Data Available Procedure history: No active procedure history items have been selected or recorded. Social History Social & Psychosocial HabitsTobacco[---] Use: Never (less than 100 in 1 Smokeless tobacco use: Never. Impression and Plan G3P[---] @ 37.1wks presenting in labor, desiring TOLAC s/p CSx1 and NSVD.1. Admit to L&D- Consents reviewed and signed in chart, all questions answered, pt expressed understanding- IV hydration, CLD, routine labs sent- Plan for expectant management- SVE every 3-4 hours or sooner for maternal/fetal indications2. FHT: category 1, continue to monitor3. Pain: pt declines epidural at this time 4. GBS: neg5. Rh+, rhogam not indicated6. Varicella immune, rubella immuned/w Dr. [---]

Sample delivery note examples

Dischargesummarystandard, encounter id: 54300142

Attribute	Value	Sentence			
Gestational Age	Not mentioned	Information about gestational age absent from excerpt.			
Sex of Fetus	Not mentioned	Information about sex of fetus absent from excerpt.			
Mother's Age (years)	32	Age: 32 years			
Parity	G1P1	2 yo G1P1			
Ruptured membrane	Not mentioned	Information about ruptured membrane absent from excerpt.			
Fever	Not mentioned	Information about fever absent from excerpt.			
Meconium	Not mentioned	Information about meconium absent from excerpt.			
Gestational hypertension	Not mentioned	Information about gestational hypertension absent from excerpt.			
Preeclampsia	Not mentioned	Information about preeclampsia absent from excerpt.			
Severe Preeclampsia	Not mentioned	Information about severe preeclampsia absent from excerpt.			
Intraamniotic Infection	Not mentioned	Information about intraamniotic infection absent from excerpt.			

Obdischargesummary, encounter id: 56209236

Attribute	Value	Sentence		
Gestational Age	39	19 y/o G1P0 presented on [---] at 39.0 wks for IOL due to oligo		
Sex of Fetus	Not mentioned	Information about sex of fetus absent from excerpt.		
Mother's Age (years)	19	19 y/o G1P0 presented on [---] at 39.0 wks for IOL due to oligo		
Parity	0	19 y/o G1P0 presented on [---] at 39.0 wks for IOL due to oligo		
Ruptured membrane	Not mentioned	Information about ruptured membrane absent from excerpt.		
Fever	Not mentioned	Fever absent from excerpt.		
Meconium	Not mentioned	Meconium absent from excerpt.		
Gestational hypertension	Not mentioned	Gestational hypertension absent from excerpt.		
Preeclampsia	Not mentioned	Preeclampsia absent from excerpt.		
Severe Preeclampsia	Not mentioned	Severe Preeclampsia absent from excerpt.		
Intraamniotic Infection	Not mentioned	Intraamniotic Infection absent from excerpt.		

Obdischargesummaryam, Encounter id: 60818246

Gestational Age	35	25 y/o G6P[---] presented on [---] at [---].5 wk with c/o ctx. PNC: Dr. [---]-->[---],25 y/o G6P[---] presented on [---] at [---].5			
Sex of Fetus	Not mentioned	Information about sex of fetus absent from excerpt.			
Mother's Age (ye	25	25 y/o G6P[---] presented on [---] at [---].5 wk with c/o ctx. PNC: Dr. [---]-->[---]			
Parity	6	25 y/o G6P[---] presented on [---] at [---].5 wk with c/o ctx. PNC: Dr. [---]-->[---]			
Ruptured memb	Not mentioned	Information about Ruptured membrane absent from excerpt.			
Fever	Not mentioned	Information about Fever absent from excerpt.			
Meconium	Not mentioned	Information about Meconium absent from excerpt.			
Gestational hype	Yes	Patient with PTL, decision made for repeat c/s with BTL. Delivered twin infants, uncomplicated. LST with Pfann, BTL pe			
Preeclampsia	Not mentioned	Information about Preeclampsia absent from excerpt.			
Severe Preeclan	Not mentioned	Information about Severe Preeclampsia absent from excerpt.			
Intraamniotic Inf	Not mentioned	Information about Intraamniotic Infection absent from excerpt.			

Backup

Prompt

Given this list of attributes: [list of attributes], example format: [example format] and example note: [example note]. From the following note, for all attributes in the above attribute list return attribute and value along with sentence containing relevant attribute information in csv format: [note]

