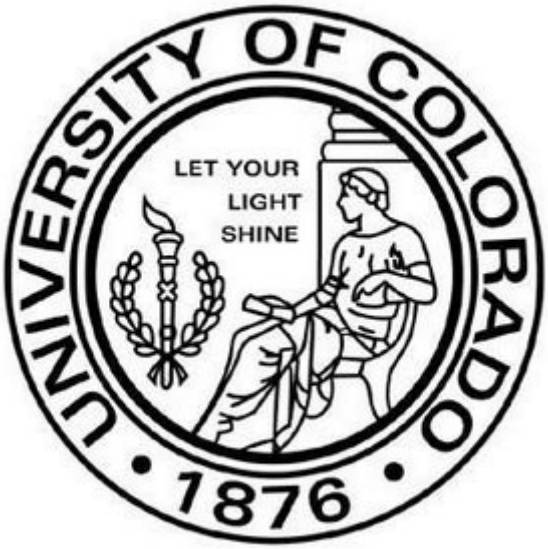
OB/GYN Clerkship



Medical Student Survival Guide
2020-2021

Contents

Ob Pearls

Prenatal Visit Schedule

0-12 weeks – one visit every 4 weeks

- First prenatal visit: prenatal profile labs (blood type/antibodies, CBC, rubella status, HIV, hepatitis B, syphilis screen), Pap (if indicated), GC/CT, urine culture, Rx for prenatal vitamins, early glucola if risk factors, hepatitis C (if risk factors)
- Every visit – gestational age, weight, blood pressure, update labs
- Flu shot as early in pregnancy as possible during flu season
- If unsure dating, may need dating ultrasound

13-24 weeks – one visit every 4 weeks (more frequently if high risk or diabetic)

- Genetic Screening: MSAFP/Quad Screen @ 15 0/7-21 6/7 weeks; if covered by insurance, may qualify for sequential screen – blood draw and U/S @ 10 – 14 weeks, second blood draw @ 15 – 22 weeks; Materni21 or cell free DNA testing if history indicated or advanced maternal age (AMA)
- Anatomy ultrasound @ 18-22 weeks
- Fetal movement @ 18-20 weeks
- Every visit – gestational age, weight, blood pressure, urine dip (at some institutions), update labs, refill PNV if needed

25-40 weeks – one visit every 4 weeks until 32 weeks, 2wk visits 32-36 weeks, weekly visits 36-40 weeks (may be more frequent if high risk &/or diabetic)

- 1 hour glucose tolerance test, CBC @ 24-28 weeks
- Tdap > 27 weeks, indicated in every pregnancy
- RhoGam @ 28 weeks for Rh negative patients (earlier if bleeding or high risk procedure)
- CBC @ 28 weeks: repeat HCT or reticulocyte count at 34 weeks to eval response to therapy if on iron
- Start once to twice weekly NSTs/weekly AFI if indication (DM, HTN, IUGR, etc.) Breastfeeding info @ 36 weeks if indicated
- GBS culture @ 36-37w6d (guidelines updated 2019); if PCN allergy add sensitivity
- Fetal kick counts BID @ 37 weeks (guidelines on kick counts varies by provider and institution)
- Every visit – gestational age, weight, blood pressure, update labs, refill PNV if needed esp. for breastfeeding moms

40+ weeks – one visit a week, or more frequently if desired by MD/NP/CNM

- NST's 2x weekly start 40 5/7, with 1x AFI
- Fetal kick counts BID
- Each visit – gestational age, weight, blood pressure, urine dip, update labs.
- Refill PNV if needed
- Schedule late term IOL after 41 0/7
- Earlier IOL may be indicated
    - 34 weeks for pre-eclampsa with severe features
    - 37 weeks for pre-eclampsia without severe features and GHTN
    - 37-39 weeks for CHTN pending BP control

- 39 weeks for well-controlled A2GDM and T2DM, earlier for poorly controlled
- Recent ARRIVE trial reports safety of elective IOL at 39 weeks in multiparous patients, data being extrapolated to primiparous patients

Three Tier Fetal Heart Rate Interpretation System FOR LABOR (not NSTs)

Category I

Cat I FHR tracings include ALL of the following

- Baseline rate: 110-160 beats per minute (bpm)
- Baseline FHR variability: moderate
- Late or variable decelerations: absent
- Early decelerations: present or absent
- Accelerations: present or absent

Category II

Cat II may represent an appreciable fraction of those encountered in clinical care. Examples of Cat II FHR tracings include ANY of the following:

- Baseline rate
  - Bradycardia not accompanied by absent baseline variability
  - Tachycardia
- Baseline FHR variability
  - o Minimal baseline variability
  - Absent baseline variability not accompanied by recurrent decelerations o
  - Marked baseline variability
- Accelerations
  - Absence of induced accelerations after fetal stimulation
- Periodic or episodic decelerations
  - Recurrent variable decelerations accompanied by minimal or moderate baseline variability
  - Prolonged deceleration ≥ 2 minutes but < 10 minutes
  - Recurrent late decelerations (>50% contractions) with moderate baseline variability
  - Variable decelerations with other characteristics, such as slow return to baseline, “overshoots”, or “shoulders”

Category III

Cat III FHR tracings include:

- Absent baseline FHR variability and any of the following:
  - Recurrent late decelerations
  - Recurrent variable decelerations
  - Bradycardia
  - Sinusoidal pattern

Note: the category system should only be used for laboring patients…not for NSTs, which should be either reactive or non-reactive. A biophysical profile (BPP) is used to evaluate fetal status if an NST is non-reactive.

The easiest way to learn FHR is to learn the strict criteria for Category I and III; then everything else is Category II!

Hypertension in Pregnancy

- **Chronic hypertension:** Blood pressure > or equal to 140/90 on two occasions > 4 hours apart
  Baseline labs: CBC, Cr, P:C (urine protein : creatinine ratio), transaminases
    - Monitor for pre-eclampsia, worsening CHTN (see below)
    - Should have antenatal testing (NSTs) and delivery between 37-39 weeks
- **Gestational hypertension:** BP > or equal to 140/90 on two occaisions > 4 hours apart after 20 weeks.
    - Weekly labs: CBC, CMP, P:C
    - Antenatal testing (NST with MVP, interval varies institutionally but at least weekly)
    - Frequent BP checks
- **Pre-Eclampsia without severe features:** Elevated "mild range" BPs as per the above in the presence of proteinuria
    - Proteinuria: P:C > 0.3 = 24-hour urine with > 300 mg protein o Urine dip stick 1+ protein (less preferable method)
    - Weekly labs to assess for severe features (see below). *Decision for delivery is not based on degree of proteinuria, once proteinuria criteria are met, do not recheck*
    - Antenatal testing (NST with MVP, interval varies institutionally but at least weekly)
    - Frequent BP checks
    - IOL at 37 weeks, sooner if develops severe features
- **Pre-Eclampsia with severe features:** dx of pre-eclampsia with one or more of the below

Severe features:

- New cerebral or visual symptoms (i.e persistent headache not relieved with meds)
- Severe range pressures (SBP > or equal 160, DBP > or equal 110)
- Thrombocytopenia (PLT < 100K)
- Hepatic Symptoms (LFT twice the upper limit of normal range, epigastric pain)
- Renal insufficiency (Cr >1.1 or twice baseline)
- Pulmonary edema

Treatment: admit for inpatient monitoring with frequent lab checks, magnesium for seizure ppx, delivery at 34 weeks or sooner if worsening clinical status, HELLP syndrome (hemolysis, elevated liver enzymes, low platelets)

Magnesium Checks

Assess signs and symptoms of worsening pre-eclampsia and magnesium toxicity

- HPI: RUQ/epigastric pain, headache, visual disturbances (scotomata) Review BP within last 2 hours (know ranges, if required any IV or PO medications)
- Know last 2 hours of I&O and know if net positive or negative
- Physical exam: Check CNS status, DTR's, clonus, lung exam to rule out pulmonary edema, cardiac exam, RUQ/epigastric TTP
- Review labs which can be Q 4-6 hours depending on presentation: CBC, BUN, Cr, LFT's, LDH, uric acid, 24- hour urine protein or P:C

- Abnormal findings may prompt magnesium serum level, additional imaging

Gyn Pearls

First Trimester Bleeding

Differential diagnosis: spontaneous abortion/miscarriage, ectopic pregnancy, molar pregnancy; less likely: implantation bleeding, cervical bleeding

- Questions to ask: LMP (allows you to estimate their GA)? Are your periods regular (allows you to assess how reliable their estimated GA really is)? Was your last period normal or abnormal? How much bleeding? Pain on one side more than other?
- Passed tissue? (if yes, send to pathology)
- Examination: Vital signs stable? Surgical abdomen? Pelvic should be performed by resident (assessing for active bleeding, uterine size, dilation of cervix, adnexal masses)
- Labs: Blood type (give Rhogam if Rh negative); CBC, BHCG level ("quant")
- +/- Ultrasound results: Does patient have an intrauterine pregnancy (IUP)? Is IUP viable? If not, consider ectopic?
- Confirmation of IUP:
    - "Discriminatory zone" when BHCG >1500-2000, should see some findings of IUP (i.e. gestational sac) though not all attendings believe in this finding
    - Double decidual sign: strong evidence of IUP, two concentric rings of echogenic tissue representing decidua capsularis and decidua parietalis. Not reliably present until GS = 10mm
    - Yolk sac (100% PPV for pregnancy)—should be visible in GS ≥ to 8 mm
    - Fetal pole—should be visible in GS ≥ to 16 mm
    - Cardiac activity—should see when fetal pole is greater than 5 mm, by 6 weeks
    - GS and fetal pole grow approx. 1mm per day

Miscarriage/Spontaneous Abortion – NEJM "Diagnostic Criteria for Nonviable Pregnancy Early in the First Trimester" is a great resource

- Definitions
    - Anembryonic pregnancy: Presence of a gestational sac larger than 25 mm without evidence of embryonic tissues (yolk sac or embryo); this term is preferable to the older and less accurate term "blighted ovum"
    - Embryonic demise or "Missed abortion": An embryo larger than 7 mm without cardiac activity, often "missed" term is used for nonviable pregnancy in which patient has no symptoms of pain or bleeding
    - Complete abortion: Complete passage of all products of conception
    - Incomplete abortion: Occurs when some, but not all, of the products of conception have passed (i.e. by exam or ultrasound)
    - Inevitable abortion: Bleeding in the presence of a dilated cervix; indicates that passage of the conceptus is unavoidable
    - Threatened abortion: vaginal bleeding <20 weeks in the presence of an embryo with cardiac activity and closed cervix
    - Management of diagnosed miscarriage:
        - Expectant: patient may opt for no treatment, more successful with incomplete abortions than missed abortions

- Surgical: can treat with D&C in OR or with manual vacuum aspiration (handheld = iPAS) in clinic/ER/procedure room.
- Medical: can induce contractions/cramping with cytotec/misoprostol 800 mcg vaginally.

Molar Pregnancy

- Definitions:
  - Complete mole: placental proliferation in the absence of a fetus; most have a 46, XX chromosomal composition; all derived from paternal source
  - Partial mole: molar tissue with fetal tissue; most are genetically triploid (69, XXY)
- Examination & lab findings: check LFT's, BUN/Cr, CXR, Rh, TSH, neuro exam (brain mets); BHCG typically high; uterus exam larger than gestational age; US with "snow storm" appearance
- Management: D&C (typically in OR due to high risk of bleeding); follow BHCG to zero for 6 months-one year due to risk of gestational trophoblastic disease; reliable birth control x1 year

Ectopic Pregnancy

- Definitions: Pregnancy outside the uterine cavity (most commonly in the fallopian tube) but may occur in the broad ligament, ovary, cervix, or elsewhere in the abdomen
  - Heterotopic pregnancy: Simultaneous intrauterine and ectopic pregnancy
- Risk factors: current IUD, history ectopic, history of PID, history of tubal surgery, IVF, smoking
- Examination & lab findings: as noted above; no IUP when above discriminatory zone, possible adnexal mass or free fluid on US; surgical abdomen; inappropriate rise in BHCG
- Can check quant in 48 hours: normal IUP should have a rise of at least 53% in 48 hours (does not rule out ectopic, esp. at early quant levels, but suspicion is lower).

Management:

- Expectant: patient may elect to have no treatment and pregnancy can resolve or tubal abort without treatment but must meet below criteria; may also have patient return in 48 hours for repeat BHCG
  - No evidence tubal rupture
  - Minimal pain/bleeding
  - Reliable follow up
- Medical: treatment with methotrexate, must meet below criteria; check day #4 & day # 7 BHCG, in general 15% decline between day 4 & 7 indicates response
  - Hemodynamically stable, RELIABLE, no evidence of ruptured ectopic
  - No medical contraindications (active liver disease, thrombocytopenia, neutropenia, renal disease)
  - HCG <6000-10,000
  - Relative contraindications: ectopic with cardiac activity, free fluid in abdomen, sac/mass >4 cm
  - Surgical: diagnostic laparoscopy with removal of pregnancy (salpingectomy typical)
    - Indications for surgical management include hemodynamically unstable, larger ectopic pregnancy, ruptured ectopic, unreliable, contraindications to MTX

Abnormal Uterine Bleeding

Definitions

You may hear a variety of terms, but ACOG recommends using the PALM-COEIN terminology:

- Normal menstrual cycle: generally, 5 days, and the normal menstrual cycle typically lasts between 21 days and 35 days
- Abnormal uterine bleeding: menstrual bleeding of abnormal quantity, duration, or schedule
- Menorrhagia: historically defined as menstrual blood loss greater than 80 mL, but use patient report of subjectively heavy periods; new term is "heavy menstrual bleeding"
- Metrorrhagia: bleeding between periods; now called "intramenstrual bleeding"
- Menometrorrhagia: heavy menses + bleeding between menses
- Polymenorrrhea: bleeding more often than every 21 days
- Oligomenorrhea: bleeding less frequently than every 35 days
- Dysmenorrhea: painful menses

PALM-COEIN

Abnormal uterine bleeding is further classified by one (or more) letter qualifiers that indicate its etiology or etiologies

- PALM = Structural causes
    - o Polyp (AUB-P)
    - o Adenomyosis (AUB-A)
    - o Leiomyoma (AUB-L)
    - o Malignancy and hyperplasia (AUB-M)
- COEIN = Nonstructural causes
    - o Coagulopathy (AUB-C)
    - o Ovulatory dysfunction (AUB-O)
    - o Endometrial (AUB-E)
    - o Iatrogentic (AUB-I)
    - o Not yet classified (AUB-N)

GYN Surgeries

- Hysterectomy o "Total" refers to removal of uterus and cervix only, does not indicate removal of ovaries or fallopian tubes
    - o "Supracervical" refers to removal of uterus only, leaves cervix in place. Does not include removal of ovaries or fallopian tubes

  If ovaries or fallopian tubes are removed, they are indicated in other terms below
    - o Total abdominal hysterectomy (TAH): via abdominal incision
    - o Total vaginal hysterectomy (TVH): removal through vaginal approach; no removal of ovaries or tubes
    - o Laparoscopic hysterectomy (TLH or LAVH): can involve only laparoscopic approach to hysterectomy (TLH) or some of procedure done with laparoscopy and some with vaginal (LAVH)
- Adnexal surgery
    - o Salpingectomy: removal of fallopian tubes
    - o Oophorectomy: removal of ovary
    - o Sometimes can combine salpingectomy and oophorectomy to be called "BSO" (bilateral) or "USO" (unilateral salpingoophorectomy)
    - o Cystectomy: removal of ovarian cyst
    - o Tubal ligation: typically, laparoscopic placement of occlusive clips (Filshie)

- Hysteroscopy
  - o Use camera through cervix to visualize inside of uterine cavity
  - o Removal of polyps or myomas or uterine adhesions or septum
  - o Essure: placing occlusive devices in tubes for sterilization

Clinic Pearls

OB Visits

- Remember the following questions to ask during routine OB visits
  - o A – amniotic fluid leakage?
  - o B – bleeding or spotting?
  - o C – contractions?
  - o D – dysuria or UTI symptoms?
  - o E – eclampsia symptoms (headache, vision changes, RUQ pain)?
  - o F – fetal movement?

- Post-partum 6-week visits: ask about the 10 B's!

  1) Breasts (Any maternal problems?) 2) Bottle or breast feeding (How is it going?) 3) Baby (How is the baby doing now?) 4) Birth control
  5) Boinking (Have you resumed intercourse?)
  6) Bleeding (Have you stopped bleeding yet?)
  7) Bottom pain (Any laceration or episiotomy problems?) 8) Bladder 9) Bowel 10) Blues (Any mood symptoms?)

- Diabetic classification (White's classification)

Class	Features
A1	Gestational, no medication
A2	Gestational, medication
B	Onset >20 yo, duration <10 yrs.
C	Onset 10-19 yo, duration 10-19 yrs.
D	Onset < 10 yo, duration >20 yrs.
R	Proliferative retinopathy
F	Nephropathy (>500 mg/day)
H	Atherosclerotic heart disease
T	Prior renal transplant

GYN Visits

- GYN history of present illness: ask LMP; how frequent menses come; how long the menses last; are they regular or irregular in frequency? How many pads/tampons do they go through in a hour/day? Do they pass clots? When they say they pass clots, ask to specify size with a fruit (e.g. grapes). Do they

have any bleeding between periods? Does the pain occur only with menses or before? When reporting dyspareunia be specific – insertional vs deep.

- OB history: ask total number of pregnancies, outcomes of pregnancies. Did the SAB require a D&C?
- Get delivery method, gestational age at delivery and any pregnancy complications. Get weight of largest infant delivered.
- Family history: specifically ask for family history of breast, uterine, ovarian, colon cancers.

Sample OB/GYN Progress Notes

Labor & Delivery/Mag Check

**If not on magnesium sulfate, do not need to include I&O, full cardiac/neuro/lung exam on every labor note. **

MS III Progress Note Example

Date: 7/14/18
Time: 2030

Subjective (S): Patient reports contractions have increased in frequency, more pelvic pressure. Comfortable with epidural. Still with clear leakage of amniotic fluid. No bleeding, active fetal movement. Denies headache, no vision changes/scotomata, and denies RUQ pain. No shortness of breath.

Objective (O):
Vital signs

- BP: 136-145/90-105 (always include ranges for BP)
- Pulse: 82
- Resp: 16
- Temp: 37.6 (we prefer Celsius)
- O2: 98% on room air

I&O 2 hours: I: 250 cc; O: 150 cc
Fetal Heart Rate: baseline 140/moderate LTV/+accels/+variables with contractions
Toco: regular Q 3 mins.
Exam:

- Awake, alert, oriented x3, no distress
- CVS: regular rate, rhythm; systolic II/VI murmur
- Chest: good air entry, clear to auscultation
- Abd: no RUQ tenderness, no fundal tenderness
- Ext: 1+ bilateral lower extremity edema
- Neuro: grossly intact, DTR 2+ lower extremity, 3+ upper extremity, no clonus
- SVE: 8/100/-1, ROP per resident exam (indicate who performed this exam if not you)

Labs: (add if there were new labs since last exam)

- Write labs with fishbone CBC, circle or highlight any abnormal labs
- Include: CBC, AST, ALT, Cr, LDH & uric acid (if drawn)

Assessment and Plan

23 y/o G3P1011 @ 36w2d (LMP, 18) (Always include age, GsPs, gestational age and dating criteria in first line of A&P)

1. Preterm IUP: category II tracing due to variable decels but overall assuring given moderate LTV and accels (the first line of your assessment should always be IUP and assessment of labor category or if not currently in labor than "reactive NST" if applicable)

2. Severe preeclampsia: diagnosis based on initial severe range BP that required IV labetalol; now normotensive without medication. Currently on magnesium sulfate for seizure prophylaxis; continue intrapartum. No symptoms preeclampsia, no signs mag toxicity. Appropriate urine output, labs Q 6 hours and last PIH set normal. (The second problem should be the main reason why admitted. For mag patients, specifically document how got diagnosis of preeclampsia, BP range and if required meds, signs toxicity or signs of preeclampsia symptoms, urine output appropriate or not, labs)

3. Induction of labor 2/2 #2: s/p cytotec, AROM and now on Pitocin. Making appropriate cervical change, continue to increase Pitocin PRN. (If they are being induced, place on third problem and how induction has gone. If they are in active labor, you can include that as a problem as well. For example: active labor and making appropriate change without augmentation, anticipate NSVD).

4. Gestational diabetes: A2, home meds of NPH/regular. Currently on diabetic protocol, POC glucose 120-130. (If diabetic, document if on insulin GTT or on scheduled insulin; document recent glucose values)

5. GBS: positive, now s/p two doses penicillin. (Always document GBS status and if getting treated)

6. Feeding/birth control: plans breast, desires Nexplanon post-partum (you do not always have to document this in each note, but should document it at least in your H&P)

7. Include any other relevant problems

Post-Partum Note

MS III Progress Note
Date: 7/14/18
Time: 2030

Subjective (S): Patient reports doing well and no acute complaints. Ambulating in room, voiding without difficulty. Passing flatus but no bowel movement. Tolerated clear diet without nausea. Pain controlled with oral medications. Moderate amount of lochia. Breastfeeding started and some trouble with latch.

Objective (O):
Vital signs

- BP: 136-145/90-105 (always include ranges for BP)
- Pulse: 82
- Resp: 16
- Temp: 37.6 (we prefer Celsius) O2: 98% on room air

Exam:

- Awake, alert, oriented x3, no distress
- CVS: regular rate, rhythm; systolic II/VI murmur
- Chest: good air entry, clear to auscultation
- Abd: active bowel sounds, small distension but no rebound or guarding; no RUQ tenderness, no fundal tenderness, fundus firm at umbilicus -1 (we always document uterine involution based on distance from umbilicus)
- Ext: 1+ bilateral lower extremity edema
- Incision: staples in place, clean/dry/intact/no erythema Peri: trace lochia on pad, no vulvar swelling

Labs: (add if there were new labs in am)

- Write labs with fishbone CBC, circle or highlight any abnormal labs

Assessment and Plan

23 y/o G3P2012 s/p primary LTCS for arrest of descent (Always include age, GsPs, type of delivery and indication in first line of A&P)

1. Post op day #1: advance diet as tolerated, foley out and voiding, PO pain medications, meeting appropriate early post op milestones (the first line of your assessment should always be postpartum or post op. Here list treatment plan based on delivery method or day post op)

2. Severe preeclampsia: diagnosis based on initial severe range BP that required IV labetalol; now normotensive with labetalol 200 BID. S/P magnesium sulfate for seizure prophylaxis. No symptoms preeclampsia; last PIH set normal @ 1800. (The second problem should be the main complications of the pregnancy if they have any. For severe preeclampsia patients, specifically document how got diagnosis of preeclampsia, BP range and if required meds, any new labs)

3. Gestational diabetes: A2, was on NPH/regular antepartum. POC glucose 120-130. Plan 2-hour GTT at 6-week visit) (If diabetic, document if on insulin GTT or on scheduled insulin; document recent glucose values)

4. Rh negative: Rhogam eval pending (document Rh status and any treatment if necessary)

5. Feeding: breast initiated some difficulty with latch. Lactation consultation (always document feeding status in postpartum visit)

6. Birth control: desires Nexplanon post-partum (you always document this in postpartum notes)

7. Include any other relevant problems

Gynecology Notes

**This includes benign Gyn, Gyn Onc, REI, UroGyn notes for inpatients. Unless told otherwise, do your GYN notes in systems-based format. **

MS III Progress Note
Date: 7/14/18
Time: 2030

Subjective (S): Patient reports doing well and no acute complaints. Ambulating in room, voiding without difficulty. Passing flatus but no bowel movement. Tolerated clear diet without nausea. Pain controlled with oral medications but overnight required IV breakthrough. Small vaginal spotting on pad. Denies shortness of breath, chest pain or nausea.

Objective (O):
Vital signs

- BP: 136-145/90-105 (always include ranges for BP)
- Pulse: 82 (many teams want ranges of pulse)
- Resp: 16
- Temp: 37.6 (we prefer Celsius)
- O2: 98% on room air (always document if on supplemental oxygen and amount)
- Intake and Output: I-2000 (500 PO, 1500 IV), O- urine 650 cc, EBL 400 cc, JP 15 cc serosanginous)
- Weight: 2 kilos up from admit, 3 L net positive
- Document I&O for all Gyn patients if available and be specific about where input/output comes from. If has drain than document amount drained x24 hours and color. GYN ONC wants to also know daily weights and net fluid status since admission.

Exam:

- Awake, alert, oriented x3, no distress
- CVS: regular rate, rhythm; systolic II/VI murmur
- Chest: decreased breath sounds in bases, no rales/rhonchi
- Abd: hypoactive bowel sounds, small distension but no rebound or guarding; tenderness along incision but no other abdominal tenderness
- Ext: 1+ bilateral lower extremity edema
- Incision: staples in place, clean/dry/intact/no erythema
- Peri: no blood on pad, no vulvar swelling (we typically do peri checks if had vaginal surgery) Labs: (add if there were new labs in am> we typically do daily CBC/BMP/mag/phos on oncology; include any relevant imaging)
- Write labs with fishbone CBC, circle or highlight any abnormal labs

Assessment and Plan
63 y/o G4P4004 s/p exploratory laparotomy, total abdominal hysterectomy, bilateral salpingoophorectomy, tumor debulking, small bowel resection with end to end reanastamosis for likely ovarian cancer (Always include age, GsPs, all surgical procedures and indication for surgery)

1. Post op day #1: clear diet and plan to advance to regular, foley out and voiding this morning, PO pain medications with IV breakthrough, buff IV fluids as good PO intake, ambulate TID, patient meeting appropriate early post op milestones (the first line of your assessment should always be post op day. Here list treatment plan based on surgery and day post op)

2. Oncology: initially with adnexal mass, Ca125 45; now s/p above surgery. Frozen consistent with ovarian carcinoma but final pathology pending.

3. Heme: EBL 800 cc. Preop Hct 43 > intraop 26 > received 2 units PRBC. Post op am Hct 30. Ambulating without symptoms of anemia. (We prefer talking about anemia in Hct)

4. CVS:
    a. Hypertension: continue home Lisinopril, BP normotensive
    b. Hyperlipidemia: continue home Lipitor

5. Pulm: no prior history, currently on 2 LNC > wean to room air today

6. GI: s/p bowel resection, no discharge until recovery of bowel function

7. Endo: type 2 diabetes, currently on insulin sliding scale with POC glucose 150s; restart home metformin today.

8. Neuro: history of epilepsy, continue home Keppra.

9. Include any other relevant problems before the last three lines.

10. Tubes/lines/drains (T/L/D): intraperitoneal JP, right PICC line

11. Fluids/electrolytes/nutrition (F/E/N): D5NS @ 125, replete magnesium and phos today, clear diet

12. Prophylaxis: SCD, ambulation, heparin TID, ranitidine

Presentation Tips

- Use your notes to help organize your presentations. We prefer presentations in systems-based order.
- You can print your note and bring it with you on rounds to help you with labs and vitals, but do not read the entire presentation directly from your paper. Some students find index cards helpful.
- Sometimes attendings or residents interrupt—we don't mean to be rude! Keep going when you can!
- Always keep SOAP format even if a short presentation, do not give the assessment/plan in the subjective part of presentation.
- Practice! Set a time to practice with your residents before rounds, do not wait until last minute!
- Read about the disease and know your patient's full medical history—rounds are when you have the most opportunity to demonstrate your preparedness to your attendings.

Rotation Specific Expectations

These are meant to be basic outlines for your rotations. They are subject to change! Please always be in contact with your residents and chief to make sure you understand MS III expectations.

Denver Health

Rotation Name:

Denver Health Clinics

Team Members & Roles:

Resident:	Role:
Chief: R4	Schedules clinic, helps organize medical students
Mid-level: R3	Clinic visits, "Chief box" (reviews clinic results)
Intern: R1	Two clinic R1s, see majority of the diabetic patients and participate in high risk clinic

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? DH R4 Clinics Chief

Schedule:

Subject to daily changes—always check with chief each day to know what your role is

- Typical start time/arrival time: 0730 Typical end time/shift change: 1730
- Where should you go on first day of rotation? Clinic Doc Box (Women's Care Pavilion C, 1st floor)
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? Yes, weekly emails. You will be assigned a clinic for every half day.

Location:

- Where are clinics located? Pavilion C – Women's Care Clinic
- If there are any associated teaching sessions, where are those located? Mondays at noon in C140 conference room; Thursdays at 7:30a High Risk Ob Conference in C140; Friday Journal Club/Teaching at noon in 3rd floor L&D Conference room. Grand Rounds on select Wednesday mornings at 7:30 in C140. See weekly schedule for final conference schedule.
- Typically, where do we go at the start of the day? Clinics' Doc Box
- If I bring a bag—where do I store it? You will get a locker during your orientation, please bring a pad lock if you have one. You can also keep your stuff in the doc box cabinets labeled for med student use.
- Is there a place for lunch storage? Yes, there are two refrigerators in the clinic kitchen.

Wardrobe and required medical equipment:

- On a typical day, what should you wear?
    - Clinic day: Business casual clothes. If you are assigned to a procedure clinic (Dysplasia or SIS), you may wear scrubs.
    - OR day: N/A
- Do you need to bring scrubs? Always good to have a pair of scrubs in your bag (or badge access to scrubs)
- Unless otherwise specified below—always have: stethoscope, white coat (you may not always wear this; some attendings like white coats while others do not), some way to calculate pregnancy

dating (either pregnancy wheel, EPIC to calculate dating, or phone app). Try to have a snack always available in case we run behind.

- Any other medical equipment: you should bring a laptop as there are not always enough computers for learners.

Medical student responsibilities:

Daily inpatient rounds: N/A

Clinic:

- In general, MS III can see patients prior to the resident evaluating the patient. See rotation specific details below on flow of clinic. Please make sure the resident you are working with knows you are seeing the patient before you go into the room. You are not expected to see every patient on the schedule. In general, it is a good idea to review the schedule the night before and have an idea of 2-3 patients you are interested in seeing.
- You should gather an HPI, OB history, GYN history, current medications, and allergies. For new patients, review PMH, PSH, FHx and SHx. Please see separate sections regarding sample clinic situations and notes.
- How can I find the clinic schedule? In EPIC use context DH Pav C Women's Care. You should be able to see the different clinic templates, i.e. GYN CL3 under schedules. Ask residents for help.
- What is the general clinic flow? Very busy clinics (9 patients in Gyn clinics vs 10-11 patients in OB clinics). You will be assigned a clinic and work with that resident. See patient, then present to resident. Do exam with resident. Resident will typically have you present to attending.
- Are medical students allowed to see patients alone? Yes, you can see the patients first and it's ok to perform a general physical exam (lungs, heart and abdomen) if needed. **Never perform a pelvic exam without a resident or attending to supervise you.**
- Do I need to document anything in the chart? No, but please keep your own notes since they can help for the completeness of the chart.
- Should I expect to present to the attending? Yes.

Operating Room: N/A

Floor Work: N/A

Pre-rotation reading topics:

- Absolute, must know information prior to showing up on first day: Components of a complete OBGYN H&P, prenatal lab tests, normal physiologic changes in pregnancy and normal menstrual cycle.
- Resources or books for reading prior to the rotation: Up-to-date, ACOG practice bulletins, CDC website. Any OBGYN textbook will be helpful.
- Subjects that are commonly "pimped" on this rotation: Normal physiologic changes of pregnancy, gestational diabetes, hypertensive disorders in pregnancy, normal menstrual cycle, sexually transmitted diseases, birth control methods, abnormal uterine bleeding.

Random information specific to this rotation:

- This is a very fun rotation. You will learn a lot from patients, residents, attending, nurses and midwives. Team work is key during this rotation!
- Once you get assigned a clinic on a daily basis, try to look at the patients' records ahead of time to understand their history and reason of the visit. You do have VPN access so you should be able to prepare your schedule the day before.

- Keep in mind these are very busy clinics. We only have 20 minutes to see each patient. Try to be focused, this is a good opportunity to work on efficiency! Be mindful of how long you are taking, it is okay to excuse yourself and explain to the patient you will be back with the resident.
- Please feel free to start the following process when appropriate:
    - If you know patient will need a pelvic exam, ask her to get undressed from the waist down after you have talked to her.
    - If pregnancy is a suspicion, have the patient give us a urine sample for a urinary pregnancy test (UPT). Same if she is complaining of dysuria, hematuria, urgency or frequency.
    - Get lab slips, consent forms, patient information pamphlets ready before you present to the resident.
    - Always keep the health care partner (HCP) in the loop of your plan of care. Make sure she is aware of the samples (CT-GC, Pap smear, biopsies, etc.) taken during the encounter so they do not get lost.
- Read about the cases you saw in clinic on a daily basis, this is key for shelf studying!
- If you have any questions, always ask any resident; we are happy to help.

Rotation Name:

Denver Health OB Days/Nights

Team Members & Roles:

Day:

- R4, OB Chief
- R2, Deck Doc
- R1, Postpartum Intern

Night:

- R3, OB Chief
- R2, Deck Doc
- R1, Family Practice Postpartum Intern

Resident:	Role:
Chief	Oversee OB care during day; OB/GYN care during night
R2	Manage laboring patients
R1	Manage postpartum patients; Gyn consults on weekends
Learners: Emergency Medicine, Family Practice, MS4, MS3	See below

We always prefer an email with the subject line “Oncoming OB/GYN MSIII” and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? OB Chief (specifically contact your night or day chief prior to starting rotation). Postpartum Intern.

Schedule:

** Subject to daily changes—always check with deck doc each day to know what your role is**

- Typical start time/arrival time:
  - Days: Sign out starts at 0700. On your first day, be at the L&D 3rd floor Pavilion C (Doc Box) a little before 0700. After your first day, you are expected to round on at least one postpartum patient daily; the goal is for you to see a patient's whose care you were involved in day before. You should round on your patient(s) and be done with rounding by 0645 to 0650 am, present to the postpartum intern and then go to L&D by 0700, so you can be at board sign out. This means you should get here at 0600 – 0630 am; depending on how much time you need. Plan to sign your postpartum patient(s) out to the attending after board sign out is complete.
  - Nights: 1800
- Typical end time/shift change:
  - Days: 1800
  - Nights: 0700 (You do not need to round on postpartum patients if you are on nights)

- Where should you go on first day of rotation? L&D (3rd floor Pavilion C). See above for timing. On Friday evening, sign out is at 1700.
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? No.
- After sign-out, the deck doc (2nd year OB resident) will assign you a patient (or a couple) to follow. You should read through this patients' H&P/progress notes and know this patient forward and backward. You will see the patient with the deck doc and will be an active member of her team (this includes delivery when appropriate).

Location:

- Where are clinics located? N/A
- Where are inpatients located? Laboring patients are on 3rd floor Pavilion C (L&D). Postpartum patients are on 4th floor Pavilion C (Postpartum).
- Where are surgeries located? Mainly cesarean sections and tubal ligation, 3rd floor Pavilion C
  If there are any associated teaching sessions, where are those located?
  - Monday afternoons in C140 conference room.
  - Friday at noon Journal Club/Teaching located on 3rd floor L&D Conference room.
- Typically, where do we go at the start of the day? L&D *See above
- If I bring a bag—where do I store it? You can put it under the desk in the doc box on L&D.
- Is there a place for lunch storage? Yes, there is a refrigerator on L&D. We can show you where. Bring a lunch (or at least a snack!) because you never know if you will have time to go to the cafeteria (and it is closed during most of the night).

Wardrobe and required medical equipment:

- On a typical day, what should you wear? Scrubs.
- Do you need to bring scrubs? There is a scrub dispenser. You should have access prior to starting your rotation. Ask to be shown where the locker room is on your first day.
- Unless otherwise specified below—always have: stethoscope, some way to calculate pregnancy dating (either pregnancy wheel, or get app on phone), shoes you can clean or that you don't mind throwing away at the end of the rotation. Try to have a snack always available and L&D is unpredictable, but exciting!
- You should bring a laptop as there are not always enough computers for learners.

Medical student responsibilities:

Daily inpatient (postpartum) rounds

- Unless otherwise specified—we expect all MSIIIs to do daily rounds on any patients they scrubbed into the OR or participated in a vaginal delivery. Pick one or two patients; you can clarify rounding assignments with the OB intern or your chief.
- We typically expect you to have seen the patient as well as completed your morning progress note before starting rounds with the attendings. This may mean you are at the hospital before the residents in order to complete your documentation in a timely manner.
- Please see separate sections on sample rounding presentations and progress notes for details on how to prepare for rounds.
  Rotation specific comments on rounding: You should write daily SOAP notes (see separate examples in survival guide).

Operating Room

- We expect you to read and know your patient's history and work up before the case.
- We also expect you to have met the patient prior to their cesarean section. This is the birth of somebody's child and one of the most important days of your patient's life! Please treat this time with the respect it deserves.
- We do not expect you to know the steps of the surgery, but you should have a basic understanding of the case before the operating room.
- The first time you are in the operating room, specifically ask your resident to show you how to prepare the OR as well as clean up at the end of the case. MSIIIs are allowed to place SCDs.
- Always put your name on the white board. Always introduce yourself to the scrub tech and RN and offer to get your gown/gloves. Expect to pull your own gloves and do so before you scrub.
- Expect to be quizzed on anatomy (pelvic and abdomen) related to the surgery of the day. Many attendings will also ask the layers of the abdominal wall (hint, hint).
- Where can I get the OR schedule? The deck doc will know if there are scheduled cesarean sections and otherwise the schedule is variable as L&D is unpredictable.
- What types of questions can I expect in the operating room? Those related to your patient's history or anatomy.
- What procedures can you expect to do in the operating room? Mostly cesarean deliveries and tubal ligations. Occasionally postpartum curettage, removal of placenta or complicated perineal repairs following deliveries. Some residents will let you suture (if you have practiced and proven to us you can do this BEFORE coming to the OR)!
- Is there something I should never do?
    - NEVER check a patient by yourself (cervical exam). You are allowed to listen to heart/lungs, palpate abdomen, etc.
    - NEVER deliver a baby without a resident present.
    - NEVER do a cesarean section without a resident.
    - NEVER do a speculum exam by yourself.
    - ALWAYS remember this is an important and sensitive time for your patient.
    - NEVER be afraid to ask questions and learn (unless in the middle of code white/hemorrhage, then ask when the work slows down)!!

Floor Work

- The majority of orders, notes and floor work is performed by residents due to legal issues with charting.
- You can often be helpful in gathering release of records forms, getting outside records or even contacting social work/consults. Be observant to see how you may help your resident – e.g. closing the loop with a patient, checking patient's chart to update the team on VS, I/O for a mag patient.

  Rotation specific expectations for floor work: You should write SOAP notes every two hours on your laboring patients (or patients on magnesium).

Pre-rotation reading topics:

- Absolute, must-know information prior to showing up on first day:

-
    - Review fetal heart rate tracings, so we can teach you as we go along.
    - Otherwise, bring a good attitude and we will learn as you go!
    - Please practice tying knots either before or early in the rotation. Ask the chief resident to teach you! We can usually get spare suture on the deck.
- Resources or books for reading prior to the rotation:
    - Beckmann, Obstetrics and Gynecology, 7th Edition
    - Hacker and Moore's, Essentials of Obstetrics and Gynecology, 4th Edition o Callahan and Caughey, Blueprints Obstetrics and Gynecology, 2008 o Gabbe Obstetrics is available online through the library o See reading list from rotation
- Subjects that are commonly "pimped" on this rotation:
    - Layers of abdominal wall
    - Blood supply of pelvis (uterine arteries, ovarian arteries)
    - Round ligament vs fallopian tube vs utero-ovarian ligament during c/s (or hysterectomy on Gyn)
    - Preeclampsia o Causes of hemorrhage
    - Differential diagnosis of postpartum fever

Rotation Name:

Denver Health Gyn

Team Members & Roles:

Resident:	Role:
Chief: R4	Oversee team, make schedules
Mid-level: R3	Pre-op conference prep, Gyn Onc
Intern: R1	Quant book, clinics, consults, MP

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? Denver Health GYN Chief (4th year)

Schedule:

** Subject to daily changes—always check with chief each day to know what your role is.**

- Typical start time/arrival time: 0630; you may be asked to arrive earlier to pick up pager.
- Typical end time/shift change: 1730
- Where should you go on first day of rotation? Gyn Chief will let you know, usually 4th floor work room or clinic doc box.
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? Yes, the GYN chief will send a weekly schedule every Sunday and a plan for the next day every night.

Location:

- Where are clinics located? Women's Care Center (1st Floor, Pavilion C)
- Where are inpatients located? Throughout the hospital!
- Where are surgeries located? Pavilion A Main OR and 4th floor in pavilion C (south side) for Minor Procedures, Pavilion M
- If there are any associated teaching sessions, where are those located? Monday afternoons at noon in C140 conference room. Friday Journal Club/Teaching at noon, 3rd floor L&D conference room. Grand Rounds on select Wednesday mornings at 7:30a in C140. The assigned resident will give a 10-minute presentation followed by discussion of interesting patients off the schedules.
- Typically, where do we go at the start of the day? 4th floor work area near colposcopy clinic If I bring a bag—where do I store it? Under the desks in our workroom.
- Is there a place for lunch storage? Yes, closest location is on L&D breakroom on 3rd floor.

Wardrobe and required medical equipment:

- On a typical day, what should you wear?
    - When you're on GYN, always wear scrubs; you never know when we'll be going to the OR (even if you are assigned clinic).
- Do you need to bring scrubs? Yes, there is a scrub machine on L&D.
- Unless otherwise specified below—always have: stethoscope, white coat (you may not always wear this; some attendings like white coats while others do not), some way to calculate pregnancy

dating (either pregnancy wheel, know how to use EPIC to calculate dating, or get app on phone). Try to have a snack always available because you may not have time to eat between OR cases.
- Any other medical equipment: None

Medical student responsibilities:

Daily inpatient rounds:
- Unless otherwise specified—we expect all MSIIIs to do daily rounds on any patients they scrubbed into the OR or helped to admit with team, or any consult that was seen.
- At the end of your shift, please confirm with your chief which patients they expect you to round on in the morning.
- We typically expect you to have seen the patient as well as completed your morning progress note (SOAP style) before starting rounds with the attendings. This may mean you are at the hospital before the residents in order to complete your documentation in a timely manner.
- Please see separate sections on sample rounding presentations and progress notes for details on how to prepare for rounds.
- Rotation specific comments on rounding: The inpatient attending changes almost daily and arrives by 0730. If we have any inpatients to round on, the chief will call the attending around 0730 to meet up for rounds before clinic starts at 0800. Sometimes due to the OR schedule, we may not round as a whole team, but one resident and student will round with the attending at some point in the morning. When time allows, we expect MSIIIs to present their patients on rounds.

Clinic:
- Please refer to the DH clinics rotation expectations (Page 16) for clinic instructions.
- Are medical students allowed to see patients alone? Yes, but you are not allowed to do a pelvic exam without a resident or attending present.
- Do I need to document anything in the chart? Discuss documentation expectations with the resident/attending you are working with.
- Should I expect to present to the attending? Yes, as often as possible. Your goal is to be able to present a patient without looking at your notes (except for vitals, labs, imaging).
- Anything specific to this rotation? Be patient in clinic because it's easy to get behind. Also, if a patient speaks a different language, please call the language line and keep the interpreter on the phone. Unless you are certified to speak Spanish or another language, you are not allowed to personally translate.

Operating Room:
- We expect you to read and know your patient's history and work up before showing up to pre-op area! It is not okay to read about the patient in the pre-op area and oftentimes is expected you read about patients the night prior to the case. The patient's MRN should be included in the daily email from the GYN chief, if you have any questions about how to look the patient up – just ask!
- We do not expect you to know the steps of the surgery, but you should have a basic understanding of the case before the operating room.
- The first time you are in the operating room, specifically ask your resident to show you how to prepare the OR as well as clean up at the end of the case. Please be ready to help place SCDs, stirrups if necessary, break down the bed as well as to help clean and put the bed back together after the case.

- Always put your name on the board in the room so people know your name. Always offer to get your gown and OR gloves—ask the scrub tech if you should get them BEFORE you leave the room to scrub.
- Expect to be quizzed on anatomy related to the surgery of the day. We recommend refreshing your knowledge of pelvic and abdominal anatomy. You may also get questions on why we are doing the surgery.
- Where can I get the OR schedule? With the weekly schedule email.
- What procedures can you expect to do in the operating room? Place Foley catheter, place speculum, and manipulate the uterus. Sometimes help close sub-q or skin.
- Rotation specific OR issues: Long turnover times!! Be nice and introduce yourself to everyone in the OR!

Floor Work:

- The majority of orders, notes and floor work is performed by residents due to legal issues with charting. But we always need help!
- You can often be helpful in gathering release of records forms, getting outside records or even contacting social work. Ask your resident how you can be helpful with the patients you are following.
- Rotation specific expectations for floor work: Write a daily progress note in the patient's chart, it's good practice for residency and we will try to give you feedback on your notes.

Pre-rotation reading topics:

- Absolute, must-know information prior to showing up on first day: GYN history taking, differential for first trimester bleeding, PALM-COEIN (see page 8).
- Subjects that are commonly "pimped" on this rotation: Surgical anatomy!! Differential diagnosis, evaluation and workup of abnormal uterine bleeding, amenorrhea, first trimester pregnancy loss, PID/TOA, pelvic masses (ovarian and uterine).

Random information specific to this rotation: We will teach you how to do speculum exams (we don't do them the way you are taught by your SPETA). You will give a 10 min informal talk with a 1-page handout (no PowerPoint) about a specific GYN topic that interests you during the last week of your rotation. We have special teaching time just for GYN every late Friday afternoon. Typically, the GYN chief will also send out an article or two that we expect you to read before our teaching time Friday afternoon. Be proactive and engaged, and we will find learning points for you even if you are not planning to join OB/GYN!

University of Colorado Hospital

Rotation Name:

UCH Gyn

Team Members & Roles:

Resident:	Role:
Chief: R4	Supervises residents/students, makes the schedule, OR cases
Baby Chief: R3	Prepares pre-op conference, OR cases
Mid-level: R2	OR cases, clinic/quant book, help with pager

Intern: R1	Pager, clinic, consults, occasionally goes to OR

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week. The students will receive the weekly plan on Sunday and the detailed plan for Monday on Sunday as well. The students should expect daily emails regarding the detailed schedule for each day.

- Who should you contact prior to starting rotation? The chief (R4) of the service.

Schedule:

** Subject to daily changes—always check with chief each day to know what your role is**
Students will get daily emails regarding their specific assignments and schedule for the next day

- Typical start time/arrival time: Typically arrive between 0600 and 0630 depending on the team census, it is often open-ended such as "You have been assigned to round on ***, meet the resident 15 minutes prior to rounding at 0700 with Attending ***." The students are expected to round and write their notes before meeting the team.
- Pager pick up is at 0630 on L&D, sometimes earlier (talk to resident who is picking it up).
- Typical end time/shift change: Sign-out to night team 1730, actual end time varies from 1730 to 1930 depending on work load and end of day consults.
- Where should you go on first day of rotation? This should be specified on daily email, if questions ask chief resident.
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? Yes, always.

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Clinic/OR	OR	Teaching	Clinic/ ?OR	Clinic/OR
PM	Clinic/OR	OR	Clinic	Clinic/ ?OR	Varies

Location:

- Where are clinics located? All are located in the resident clinic area on the 3rd floor of AOP.
- Where are inpatients located? throughout the hospital!
- Where are surgeries located? In both AIP and AOP ORs, varies from day to day and case to case
- Where is teaching? Wednesday morning teaching in Academic Office 1 7th floor.
- Typically, where do we go at the start of the day? Picking up pager = L&D. We will then pick a place to meet as a team before rounds, often outside a patient's room or clinic/sun room if rounding later. Daily emails will clarify.
- If I bring a bag—where do I store it? Best place is clinic or the sun room. We will show you!
- Is there a place for lunch storage? There are refrigerators in clinic area.

Wardrobe and required medical equipment:

- On a typical day, what should you wear? Scrubs every day, no exceptions (clinic or OR).
- Do you need to bring scrubs? Yes, always.
- Unless otherwise specified below—always have: stethoscope, no white coat necessary, some way to calculate pregnancy dating (either pregnancy wheel, know how to use EPIC to calculate dating, or get app on phone). Try to have a snack always available because you may not have time to eat between OR cases. Something to read during downtime.
- Any other medical equipment: A sense of adventure and flexibility!

Medical student responsibilities:

Daily inpatient rounds:

- Unless otherwise specified—we expect all MSIIIs to do daily rounds on any patients they scrubbed into the OR or participated in a vaginal delivery, or helped to admit with team, or any consult that was seen. Students may also be assigned to patients admitted overnight based upon the total number of patients and rounding assignments.
- At the end of your shift, please confirm with your chief which patients they expect you to round on in the morning. You will also receive an email each evening specifically detailing who you are responsible for rounding on. If you have any questions, just ask!
- We typically expect you to have seen the patient as well as completed your morning progress note before meeting with the residents and starting rounds with the attendings. This may mean you get to the hospital before the residents in order to complete your documentation.
- Please see separate sections on sample rounding presentations and progress notes for details on how to prepare for rounds.
- Rotation specific comments on rounding: GYN rounding is variable day-to-day based upon attending schedules. Be flexible and ready to present your patients at any time during the day, as rounding may be spontaneous.

Clinic:

- In general, MSIIIs can see patients prior to the resident evaluating the patient. See rotations pecific details below on flow of clinic. Please make sure the resident you are working with knows you are seeing the patient BEFORE you go into the room.
- You should gather an HPI, OBGYN history, current medications and allergies and based on the situation a PMH, PSH, family and social history. Please see separate sections regarding sample clinic situations and notes.
- How can I find the clinic schedule? All our clinic schedules can be found in EPIC (AMC OBGYN RESIDENT OP). See daily schedule for clinics the GYN team will be covering.
- What is the general clinic flow? As patients arrive, students will be assigned to see them as appropriate. There may be patients that are not appropriate for students to see alone, and the students may go with the resident to see the patient together. Students should be proactive and volunteer to see patients as clinic progresses, as well as be flexible in terms of who they are working with, as some clinics get busier more quickly than others. The students should be prepared to present clinic patients to the attending in a timely fashion. They will also typically be asked to write a note in a Word document for a patient they saw that we can review with them after clinic. Documenting in EPIC may prevent residents from closing encounters.
- Are medical students allowed to see patients alone? Yes, and perform basic physical exams, but no pelvic exams should be performed without a resident/attending.
- Do I need to document anything in the chart? See above.
- Should I expect to present to the attending? See above.
- Anything specific to this rotation? We often do procedures in clinic. Most of these are above the level of an MSIII. We will attempt to teach you pelvic exams as deemed appropriate by the residents and patient comfort level. Contraception (i.e. IUDs and Nexplanon) and endometrial biopsies are resident level procedures, but your assistance is appreciated with these. Be expected to see patients with no knowledge regarding why they are in clinic (sometimes a surprise to residents as well). It will be good practice for your history taking and efficiency skills.

Operating Room:

- Please know patient's history, work up and indication for surgery. If you are not prepared, certain attendings may ask students to leave the OR. You will be emailed the cases for each week and told the day before your specific case assignments. There are sometimes add ons or changes.
- We do not expect you to know the steps of the surgery, but you should have a basic understanding of the case before the operating room. (ACOG YouTube videos and The Atlas of Pelvic Surgery online can be helpful.)
- The first time you are in the operating room, specifically ask your resident to show you how to prepare the OR as well as clean up at the end of the case. Please be ready to help place SCDs, stirrups if necessary, break down the bed as well as help clean and put the bed back together after the case.
- Always put your name on the white board and introduce yourself. You are expected to pull your own gloves and likely gown prior to scrubbing, touch base with the scrub tech prior to the case.
- Expect to be quizzed on anatomy-related to the surgery of the day. We recommend refreshing your knowledge of pelvic and abdominal anatomy prior to the operating room.
- Where can I get the OR schedule? Will be emailed out each week and each night for the next day.
- What types of questions can I expect in the operating room? Lots of anatomy questions, expect to be asked why we have decided to take this patient to the OR. Questions about the patient's history and work-up. Questions about alternative treatments.
- What procedures can you expect to do in the operating room? Retracting, Foley placement, exams under anesthesia, cutting suture, stapling, assisting the residents in suturing/closing incisions. Practice your knot tying skills in anticipation of participating in suture closure.
- Is there something I should never do: Never examine the patient without permission. Never cut suture until told to. Never take anything off of the scrub tech's field without asking.
- Rotation specific OR issues: Help with stirrups and ask how we set them up if you are unsure. Just be overall helpful, i.e. getting the bed, moving the patient, little things help a lot and are appreciated.

Floor Work:

- Most orders, notes and floor work is performed by residents due to legal issues with charting. But we always need help!
- You can often be helpful in gathering release of records forms, getting outside records or even contacting social work. Sometimes grabbing discharge prescriptions from the printers. Ask your resident how you can be helpful with the patients you are following.
- Rotation specific expectations for floor work – we often need your help getting prescriptions/work notes to patients, talking with RNs and getting tube station numbers can save everyone a lot of leg work. Be prepared to help as needed. You may also be asked to call patients with results/appointments as appropriate.

<u>Pre-rotation reading topics:</u>

- Absolute, must know information prior to showing up on first day: Pelvic anatomy, normal menstrual cycle, differential for abnormal uterine bleeding
- Resources or books for reading prior to the rotation: whatever works best for them, any review book will have most GYN topics, Up-to-date can also be helpful for specific questions

- Subjects that are commonly "pimped" on this rotation: pelvic anatomy, abnormal uterine bleeding, contraception, STIs, post-operative complications, pregnancy of unknown location

Random information specific to this rotation: Gyn can be hectic and crazy or super slow. Be adaptable and always have something to read in case of downtime. Be prepared to help as needed, especially with floor work, as a lot is care coordination. We often have 2-3 learners at a time on the team, work with Sub-I's to improve your skills on the rotation, they are an amazing resource. Some chiefs may have students prepare a short presentation on a Gyn topic of their choice. They should be prepared to research any interesting diagnosis or patient and give short presentations as requested.

Rotation Name:

UCH OB Days

Team Members & Roles:

Resident:	Role:
Chief: R4	Oversees laboring patients, observation patients, and postpartum patients.
Mid-level /Antepartum: R3	Cares for the antepartum patients.
Intern: R1	Covers laboring patients, observation patients, and postpartum. Signs out to the OB chief.
MFM fellows:	Works with antepartum resident. Scrubs surgeries. Sees postpartum patients.
Attendings:	Boss.

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? Email the OB chief on the service. She/he will give you information about the rest of the team.

Schedule:

** Subject to daily changes—always check with chief each day to know what your role is**

- Typical start time/arrival time: Pre-rounding on your patient to have your note done by sign out at 0700.
- Typical end time/shift change: Sign out at 1800.
- Where should you go on first day of rotation? Show up at 0650 on the 4th floor Labor and Delivery.
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? No.

Location:

- Where are inpatients located? All labor rooms are now on the 4th floor of AIP 1. Postpartum is on the 5th floor (sometimes observation, GYN or antepartum patients are also on the 5th floor)

- Where are surgeries located? We have 3 L&D ORs. WCC and NICU OR on 4th floor and "birth center" OR on 5th floor.
- If there are any associated teaching sessions, where are those located? We have formal, sit-down rounds every morning at 0700. Do NOT be late to a.m. rounds. University teaching on Wednesday mornings. Discuss with your chief about presenting at board rounds.
- Typically, where do we go at the start of the day? Round on your postpartum patient, meet back in L&D workroom to be ready for 0700 sign out.
- If I bring a bag—where do I store it? In workroom.
- Is there a place for lunch storage? Yes, fridges in our workroom.

Wardrobe and required medical equipment:

- On a typical day, what should you wear? Scrubs.
- Unless otherwise specified below—always have: stethoscope, some way to calculate pregnancy dating (either pregnancy wheel, know how to use EPIC to calculate dating, or get app on phone). Try to have a snack always available because it can be busy! **You do not need to bring a white coat.**
- Any other medical equipment: Closed toe, comfortable shoes.

Medical student responsibilities:

Daily inpatient rounds:

- Unless otherwise specified—we expect all MSIIIs to do daily rounds on any patients they scrubbed into the OR or participated in a vaginal delivery.
- At the end of your shift, please confirm with your team who you will round on.
- We typically expect you to have seen the patient as well as completed your morning progress note before board rounds. Sometimes this means you are at the hospital before the residents in order to complete your documentation in a timely manner. Sign out is a hectic time for residents (prepping and printing lists), allow extra rounding time if you would like to practice your presentation with a resident prior to rounds.
- Please see separate sections on sample rounding presentations and progress notes for details on how to prepare for rounds.
- Rotation specific comments on rounding: Please do not perform any pelvic exams, examine the perineum, or do a breast exam on your post-partum patient. You should examine her abdomen to assess the uterine fundus and look at the abdominal incision of any surgical patient. Rounds in the conference room is multidisciplinary, expect to present in front of the OB team, the midwife service, the nursing staff, and the anesthesia team. This time is used for teaching. You should also expect to be asked questions about your patient, their labor course, and their postpartum course in addition to being asked clinical questions.

Operating Room:

- The first time you are in the operating room, specifically ask your resident to show you how to prepare the OR as well as clean up at the end of the case.
- Always put your name on the white board and introduce yourself. Always get your gown and OR gloves before leaving to scrub.
- Expect to be quizzed on anatomy related to the surgery of the day. We recommend refreshing your knowledge of pelvic and abdominal anatomy prior to the operating room.

- Where can I get the OR schedule? Each scheduled OR case is discussed during morning sign out in the conference room. You can also look on the L&D snapboard in EPIC. Many cases are urgent, emergent or add on.
- What types of questions can I expect in the operating room? Anatomy, physiology, maternal physiology of pregnancy, patient specific questions, management questions about the post-op period.
- What procedures can you expect to do in the operating room? Basic suturing, knot tying, and suture cutting. **Most residents will allow you to suture, so practice knot tying beforehand.**
- Is there something I should never do? In an emergency situation, you can scrub and participate if you can drop your gown/gloves on sterile field without contamination as we may not have time to help. You can always observe without scrubbing!

Floor Work:

- The majority of orders, notes and floor work is performed by residents due to legal issues with charting. But we always need help!
- You can often be helpful in gathering release of records forms, getting outside records or even contacting social work. Ask your resident how you can be helpful with the patients you are following.
- Rotation specific expectations for floor work: You will take the history of admitted patients and write an H&P. You will follow your patient from admission to discharge. Please follow your patient with electronic fetal monitoring, progress notes, and postpartum notes. Don't expect to perform cervical checks. You will deliver placentas and maybe a baby or two!

Pre-rotation reading topics:

- Absolute, must-know information prior to showing up on first day: FHT categories, stages of labor, basic anatomy of the pelvis/abdominal wall.
- Resources or books for reading prior to the rotation: ACOG practice bulletins, Up-to-Date, Clerkship text
- Subjects that are commonly "pimped" on this rotation:
    - Abdominal wall anatomy, pelvic anatomy, normal labor stages, knot tying, preterm labor, preeclampsia, postpartum hemorrhage, third trimester bleeding. We will ask you to review FHR tracings with us and expect you to know the basics.

Random information specific to this rotation: Each student's experience on the deck is different. We cannot plan the kind of cases you will see as the labor deck is unpredictable. At times, patients may request no students as part of their birth experience. Your education is very important to us and we will do our best to fill in any education gaps related to the patients we see.

Rotation Name:

UCH OB Nights

Team Members & Roles:

Resident:	Role:
Chief: R4	Oversees all services, manages CNM and FM consults.
Mid-Level: R2	Covers postpartum, Gynecology, UroGynecology, Reproductive Endocrinology & Infertility, and Gynecology Oncology. ED consults.
Intern: R1	Primary provider for triage and labor patients.
Fellows & Attendings:	Approves management plans, attends deliveries and C-sections.

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? UCH Nights Chief

Schedule:

** Subject to daily changes—always check with chief each day to know what your role is.**

- Typical start time/arrival time: 6:00 pm for board sign out
- Typical end time/shift change: 7:00 am is board sign out – expect to be there until 7:30 am
- Where should you go on first day of rotation? L&D 4th floor AIP 1, ask for resident work room.
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? No.

Location:

- Where are inpatients located? All labor rooms are now on the 4th floor of AIP 1. Postpartum is on the 5th floor (sometimes observation, GYN or antepartum patients are also on the 5th floor)
- Where are surgeries located? We have 3 L&D ORs. WCC and NICU OR on 4th floor and "birth center" OR on 5th floor.
- If there are any associated teaching sessions, where are those located? Informal teaching when time allows. Workflow on nights tend to be unpredictable. Teaching occurs adlib.
- Typically, where do we go at the start of the day? 4th floor L&D
- If I bring a bag—where do I store it? Resident work area.
- Is there a place for lunch storage? Resident workroom has a fridge.

Wardrobe and required medical equipment:

- On a typical day, what should you wear? Scrubs.
- Unless otherwise specified below—always have: stethoscope, some way to calculate pregnancy dating (either pregnancy wheel, know how to use Epic to calculate dating, or get app on phone). Try to have a snack always available. No need for white coats on L&D.
- Any other medical equipment: None.

Medical student responsibilities:

Daily inpatient rounds:

- On nights you do not typically conduct formal rounds. Discuss with your chief rounding responsibilities. There will usually be patients you can help check on before sign out.
- You will sometimes present laboring patients you followed overnight at AM board rounds.

- Please see separate sections on sample rounding presentations and progress notes for details on how to prepare for rounds.

Operating Room:

- We expect you to read and know your patient's history and work-up before participating in their C-section, postpartum D&C or other procedure (i.e. tubal ligation).
- We do not expect you to know the steps of the surgery, but you should have a basic understanding of the case before the operating room.
- The first time you are in the operating room, specifically ask your resident to show you how to prepare the OR as well as clean up at the end of the case. Please be ready to help place SCDs, stirrups if necessary, break down the bed, as well as to help clean and put the bed back together after the case.
- Always put your name on the white board and introduce yourself. Plan to get your own gloves and gown (if needed) before leaving to scrub in.
- What types of questions can I expect in the operating room? Indication for the C-section, anatomy of the anterior abdominal wall, identify the round ligament, the ovaries, tubes, and bladder. The blood supply to the ovaries, tubes and uterus.
- What procedures can you expect to do in the operating room? Help to retract in a C-section, skin staples, subcuticular suturing.
- Is there something I should never do? Try not to contaminate yourself or the field, if you think you are contaminated, say something! In general don't put or take instruments from the mayo stand.

Floor Work:

- The majority of orders, notes and floor work is performed by residents due to legal issues with charting. But we always need help! Helping the intern see triage patients is always good learning for you and super helpful for the intern. Try to be as thorough as possible in your H&P, you will help the residents immensely by gathering pertinent information!
- Rotation specific expectations for floor work: None.

<u>Pre-rotation reading topics:</u>

- Resources or books for reading prior to the rotation: Your designated textbook.
- Subjects that are commonly "pimped" on this rotation:

  Fetal heart tracing, cardinal movements, signs of placental separation, stages of labor, arrest of dilation, arrest of descent, indications for primary CS, pelvic anatomy

<u>Random information specific to this rotation:</u> Bring a computer as sometimes there are not enough workstations for all providers, especially during the day. The "Labor" summary tab under EPIC is very helpful. The workflow and acuity can be very unpredictable. Have reading materials/knot tying supplies with you.

Rotation Name:

UCH OBED – Midwifery Certified Nurse-Midwife

Team Members & Roles:

Certified Nurse-Midwife (CNM)	Role: The OBED CNM oversees the 4th floor Obstetric Emergency Department M-F 0630-1830.

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? Email amy.nacht@cuanschutz.edu.

Schedule: ** Subject to daily changes. **

- Typical start time/arrival time: 0630 Mon, Thurs, Fri |– Tues 1830
- Typical end time/shift change: 1830 – Mon, Thurs, Fri |– Tues 0630
- Does this rotation include a night shift? Yes, on Tuesday at 1830 you will work 1830- 0630 with the labor and delivery CNM. You will return to the OBED on Thursday.
- Where should you go on first day of rotation: Show up at 0630 on the 4th floor of Labor and Delivery, ask for OBED CNM Desk or call CNM at 720.848.3440.
- Is this rotation associated with weekly or daily emails from chief regarding daily plan?

Location:

- Where is it located? AIP 4th floor, OBED CNM desk next to OBED rooms.
- If there are any associated teaching sessions, where are those located? N/A
- Typically, where do we go at the start of the day? Go to Board Rounds, AIP 4th floor conference room @ 0700 after meeting with the CNM @ 0630 at the OBED desk
- If I bring a bag—where do I store it? Under OBED CNM Desk, in the OBED closet, or a locker room
- Is there a place for lunch storage? Yes, refrigerators in the staff lounge.

Wardrobe and required medical equipment:

- On a typical day, what should you wear? Scrubs.
- Unless otherwise specified below—always have: Stethoscope.

Medical student responsibilities:

- In general, MS III can see patients prior to the CNM evaluating the patient. See rotation specific details below on flow of the service. Please make sure the CNM you are working with knows you are seeing the patient BEFORE you go into the room.
- You should gather an HPI, OBGYN history, current medications and allergies and based on the situation a PMH, PSH, family and social history. Please see separate sections regarding sample notes.
- What is the general flow? The OBED RN will give report to the OBED CNM; then the CNM and MSIII will decide on plan together.
- Are medical students allowed to see patients alone? Yes.
- Do I need to document anything in the chart? Yes.
- Should I expect to present to the CNM? Yes.
- Anything specific to this rotation: Touch base with the CNM Monday AM and make a plan for the day in regard to patient care, note writing expectations.

Pre-rotation reading topics:

- Resources or books for reading prior to the rotation: http://www.midwife.org/Essential-Factsabout-Midwives
- Subjects that are commonly reviewed on this rotation: Common complications in pregnancy.

Rotation Name:

UCH GynOnc

Team Members & Roles:

Resident:	Role:
Chief: R4	Oversee service, daily and weekly schedules, patient care in clinic/OR/floor.
Mid-level: R3	Patient care in clinic/OR/floor, pathology conference.
Intern: R1	Patient care in clinic/OR/floor.
Fellow:	
Senior Fellow	Oversee patient care, OR.
Junior Fellow	Oversee patient care, OR.

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? GynOncology Chief Resident

Schedule:

** Subject to daily changes—always check with chief each day to know what your role is. **

- Typical start time/arrival time: 5:00-6:00am
- Typical end time/shift change: 1730-1830
- Where should you go on first day of rotation? 11th floor AIP 2, room 11.755 a: code 6600#: located between room 1154 and 1155 in hallway near elevator.
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? Yes, the weekly surgery/clinic schedule will be sent out the Friday prior and again Sunday night. The daily plan is contingent upon the number of patients in-house the night before and will be sent around 1800 the evening prior.
- Daily schedule is dependent on OR and clinic

Location:

- Where are clinics located? The Cancer Center on the 2nd floor.
- Where are inpatients located? AIP 2, floor 11, sometimes throughout the hospital pending bed availability. .
- Where are surgeries located? Usually AIP OR.
- If there are any associated teaching sessions, where are those located? Location varies, daily emails will have locations.
- Typically, where do we go at the start of the day? Team room on 11th floor.
- If I bring a bag—where do I store it? Team room on 11th floor, can take to clinic if in clinic for the day.
- Is there a place for lunch storage? Fridges located in floor lounge on 11th floor of AIP2.

Wardrobe and required medical equipment:

- On a typical day, what should you wear?
    - Clinic day: Clinic clothes and white coat (GynOnc LOVES white coats).
    - OR day: Green scrubs and white coat.
- Unless otherwise specified below—always have: stethoscope, white coat (you may not always wear this; some attending like white coats while others do not). Pocket snacks.
- Any other medical equipment: None.

Medical student responsibilities:

Daily inpatient rounds:

- Unless otherwise specified—we expect all MSIIIs to do daily rounds on any patients they scrubbed into the OR or helped to admit with team, or any consult that was seen.
- At the end of your shift, please confirm with your chief which patients they expect you to round on in the morning (this will also be in the daily email).
- We typically expect you to have seen the patient as well as completed your morning progress note before starting rounds with the attendings. Sometimes this means you are at the hospital before the residents in order to complete your documentation in a timely manner.
- Please see separate sections on sample rounding presentations and progress notes for details on how to prepare for rounds.
- Rotation specific comments on rounding: You should be presenting a full SOAP note in rounds on a daily basis. You should begin your presentation with a one-line introduction including the patients age, diagnosis, and reason for admission.

Clinic:

- In general, MSIIIs can see patients prior to the resident evaluating the patient. See rotation specific details below on flow of clinic. Please make sure the resident you are working with knows you are seeing the patient BEFORE you go into the room.
- You are mostly in the OR and working in the floor on this rotation, rarely you will go to clinic.
- You should gather an HPI, OBGYN history, current medications and allergies and based on the situation a PMH, PSH, family and social history. Please see separate sections regarding sample clinic situations and notes.
- How can I find the clinic schedule? Under the EPIC schedule tab, enter “AMC ONC SPEC”. The schedule will be listed under the individual Attendings. Ask one of the residents to help you set these up.
- What is the general clinic flow?
    - Student sees patient, then presents to resident, and then both present to attending.
- Are medical students allowed to see patients alone? When appropriate, check with resident first before seeing patients. Often clinics are too busy for this.
- Do I need to document anything in the chart? Update the history tab and go through the review of systems.
- Should I expect to present to the attending? Yes, as time permits and is appropriate.
- Anything specific to this rotation? Begin your presentation with a one-liner including the patient’s age, disease status, and reason for the visit.
    - Present any imaging/labs/updates since the last visit.
    - Prioritize seeing new patients.

Operating Room:

- Please know your patient's history, especially surgical history (details on routes of prior surgeries if abdominal or pelvic), presenting symptoms and workup prior to going to the operating room.
- We do not expect you to know the steps of the surgery, but you should have a basic understanding of the case before the operating room. If it is a radical hysterectomy you will get asked the types of radical hysterectomies.
- The first time you are in the operating room, specifically ask your resident to show you how to prepare the OR as well as clean up at the end of the case. Please be ready to help place SCDs, stirrups if necessary, break down the bed as well as to help clean and put the bed back together after the case.
- Always put your name on the white board and introduce yourself Always offer to get your gown and OR gloves before scrubbing.
- Expect to be quizzed on anatomy related to the surgery of the day. We recommend refreshing your knowledge of abdominal and pelvic anatomy prior to the operating room (blood flow, basic bowel anatomy)
- Where can I get the OR schedule? Under AOP/AIP OR: select individual Attendings. Schedule will also be sent out from email. You should also have access to the snapboard.
- What types of questions can I expect in the operating room? Basic pelvic and abdominal anatomy, including structures, blood supply, etc.
- What procedures can you expect to do in the operating room? Assist with retracting, holding instruments, aspirating smoke, sometimes closing sub-q or skin.
- Is there something I should never do? Don't touch the drapes during draping – attendings tend to be particular.
- Rotation specific OR issues:
    - There are often a lot of people scrubbed on surgery. You may not be actively participating, but you should still be actively watching the surgery. Don't be afraid to speak out or ask for steps if you cannot see the case.

Floor Work:

- The majority of orders, notes and floor work is performed by residents due to legal issues with charting. But we always need help!
- You can often be helpful in gathering release of records forms, getting outside records or even contacting social work.
- Rotation specific expectations for floor work o Help to prepare the daily sign out. Ask the intern how you can best with with this.

<u>Pre-rotation reading topics:</u>

- Absolute, must-know information prior to showing up on first day:
    - Basics of OBGYN history o How to present in SOAP note fashion o Basic pelvic anatomy
- Resources or books for reading prior to the rotation:
    - Practice bulletins on endometrial cancer, hereditary breast and ovarian cancer, and gestational trophoblastic disease
- Subjects that are commonly "pimped" on this rotation:
    - Pelvic anatomy
    - Routine inpatient postoperative complications e.g. postoperative fever

Random information specific to this rotation:

Like any surgical service, very specific ins and outs as well as details of bowel function are highly important. Be sure to include them in your presentation.

Rotation Name:

UCH Clinics

Team Members & Roles:

Resident:	Role:
Chief (There is no chief this rotation, but GYN chief often is in clinic.)	Runs GYN but also manages many of the clinics through the week
Mid-level (sometimes R2 or R3)	
Intern: R1 (x2)	Responsible for seeing patients during office visits in a number of clinics including OB overflow, continuity clinics, ER follow-up, high risk OB, diabetic clinic, chronic pelvic pain and colposcopy clinic
MFM fellows present on High Risk OB and Diabetes Clinic	Assist with HROB and Diabetes clinics, see patients in conjunction with interns

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? UCH Clinics Intern

Schedule: Please refer to schedule sent out by Clerkship Coordinator for clinic/resident/faculty you are assigned to work with on each day.

** Subject to daily changes. **

- Typical start time/arrival time: 0800/0745
- Typical end time/shift change: 1700
- Where should you go on first day of rotation? Resident clinic teaching room on AOP 3rd floor.
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? No.

Location:

- Where are clinics located? AOP 3rd floor.
- If there are any associated teaching sessions, where are those located? Pre-op conference is usually Wednesdays at noon (subject to change), Wednesday morning UCH teaching.
- Typically, where do we go at the start of the day? Teaching room AOP 3rd floor, unless otherwise specified
- If I bring a bag—where do I store it? Clinic work room.
- Is there a place for lunch storage? There is a staff lounge down the hall, i.e. "sun room".

Wardrobe and required medical equipment:

- On a typical day, what should you wear? Professional clothing with white coat Do you need to bring scrubs? No.
- Unless otherwise specified below—always have: stethoscope, white coat (you may not always wear this; some attending like white coats while others do not), some way to calculate pregnancy dating (either pregnancy wheel, know how to use Epic to calculate dating, or get app on phone).

Medical student responsibilities:

- In general, MSIIIs can see patients prior to the resident evaluating the patient. See rotation specific details below on flow of clinic. Please make sure the resident you are working with knows you are seeing the patient before you go into the room.
- You should gather an HPI, OBGYN history, current medications and allergies and based on the situation a PMH, PSH, family and social history. Please see separate sections regarding sample clinic situations and notes.
- How can I find the clinic schedule? If you are in a resident's continuity clinic, go to AMC OBGYN RESIDENT OP and find the specific clinic template, i.e. OB overflow, OB HIGH RISK PROVIDER, OB RESIDENT-DIABETIC, ERF1, PRE-OP CONSULT. Continuity clinics have specific names you can look up. Attending clinics can be found by going to AMC OBGYN FACULTY OP and selecting the attending.
- What is the general clinic flow? When patients are roomed, their location is changed in EPIC and on a physical schedule taped close to the door of the teaching room. Medical students may go see a patient first, and they will be expected to present to the resident, then join the resident when they go to see that patient for the first time. The medical student and resident will then staff the patient visit with the attending physician of the day. If the student is not seeing the patient first, they will join the resident for the visit and may do part of the visit with the resident present.
- Are medical students allowed to see patients alone? Yes. Clinic is a great time to see patients on your own. It works especially well if you identify a patient who is roomed but has a while to wait before being seen by a resident.
- Do I need to document anything in the chart? No. It is sometimes helpful to write your progress note on Word documents so the resident can review with you after clinic.
- Should I expect to present to the attending? Check in with the resident you are working with. For the most part, yes, be prepared to present if you were the one who took the history.
- Anything specific to this rotation? Please identify the resident you are working with as well as the MA assigned to the clinic you are on. Introduce yourself to the MA as they will be very helpful through the day. Don't shy away from details when doing your H&P, for example, get specific with patients about medication dosing, vaginal bleeding, get actual dates related to the clinical history, etc. Always try Leopold's, obtaining a fundal height and fetal heart tone on your obstetrical patients.

Pre-rotation reading topics:

- Absolute, must-know information prior to showing up on first day: How to take a detailed OBGYN history.
- Subjects that are commonly "pimped" on this rotation:
    - Routine OB care including lab tests
    - Imaging o Genetic screening

- Delivery planning: mode of delivery, timing of delivery
- Common patient concerns during pregnancy

Random information specific to this rotation: Clinic can be incredibly busy or slow due to no shows. Bring extra reading in case things are slow.

Rotation Name:

UCH REI - Reproductive Endocrinology and Infertility

Team Members & Roles:

Resident:	Role:
Chief: R2	Clinic, OR, Inpatient rounding, Contact person for MS3
Mid-level	N/A
Intern	N/A
Fellow:	
1st year Fellow	Sends out weekly schedule for R3 and MS3/4; supervises clinical team
2nd and 3rd year Fellows	Research

We always prefer an email with the subject line "Oncoming OB/GYN MSIII" and then introducing yourself, your contact info at least by Thursday prior to the oncoming week.

- Who should you contact prior to starting rotation? R2 on REI

Schedule:

** Subject to daily changes—always check with chief each day to know what your role is **

- Typical start time/arrival time: 0700 Typical end time/shift change: 1700
- Where should you go on first day of rotation?
  - Advanced Reproductive Medicine Clinic: 3055 Roslyn St # 230; Denver, CO 80238 Is this rotation associated with weekly or daily emails from chief regarding daily plan?
  - Yes, the fellow will send out the weekly schedule on Sundays.

	Monday	Tuesday	Wednesday	Thursday	Friday
AM	Clinic/OR	Clinic/OR	Teaching/IVF Meeting at 1100	Clinic/OR	Clinic/OR
PM	Clinic/OR	Clinic/OR	Clinic	Clinic/OR	Clinic/OR

Location:

- Where are clinics located? 3055 Roslyn St # 230; Denver CO 80238
- Where are inpatients located? Check with your resident, typically in AIP 1 or 2

- Where are surgeries located? AOP usually; sometimes AIP. Check with your chief on day before surgery to confirm.
- If there are any associated teaching sessions, where are those located?
    - Wednesday AM, starting at 0730, AO1, 7th floor, Conference Room 7000 o Wednesday at 1100 IVF meeting at the Advanced Reproductive Medicine Clinic Typically, where do we go at the start of the day? Clinic or OR depending on schedule.
- If I bring a bag—where do I store it? In the clinic, in the doctors' room.
- Is there a place for lunch storage? At the clinic, there is a fridge you can use. The clinic is located around the corner from Chipotle, so clinic staff will also frequently walk to Chipotle for lunch.

Wardrobe and required medical equipment:

- On a typical day, what should you wear?
    - Clinic day: Business casual clothes. Never scrubs.
    - OR day: Scrubs. No scrubs in clinic, so make sure you have scrubs to change into before going to the OR.
- Do you need to bring scrubs? Yes. Sometimes the day will start in clinic and finish in the OR or vice versa. Make sure you have the appropriate attire for each setting.
- Unless otherwise specified below—always have: stethoscope, white coat (you may not always wear this; some attending like white coats while others do not), some way to calculate pregnancy dating (either pregnancy wheel, know how to use EPIC to calculate dating, or get app on phone). Try to have a snack always available (nuts, trail mix, granola bar) because you may not have time to eat between OR cases.
- Any other medical equipment: None

Medical student responsibilities:

Daily inpatient rounds:

- Unless otherwise specified—we expect all MSIIIs to do daily rounds on any patients they scrubbed into the OR or participated in a vaginal delivery, or helped to admit with team, or any consult that was seen.
- At the end of your shift, please confirm with your chief which patients they expect you to round on in the morning.
- We typically expect you to have seen the patient as well as completed your morning progress note before starting rounds with the attendings. Sometimes this means you are at the hospital before the residents in order to complete your documentation in a timely manner.
- Please see separate sections on sample rounding presentations and progress notes for details on how to prepare for rounds.
- Rotation specific comments on rounding: Rounding can be variable, and because clinic is located outside of the hospital campus, we may not always round with the entire team (i.e. fellow/attending). You will always present and round with your resident.

Clinic:

- On REI, you will usually see patients with the resident/fellow. Other days you will work directly with an attending and the resident will be assigned to another clinic. There are several types of clinic visits:

    - New patients: If you are working directly with an attending, you may (rarely) get to see the new patients prior to the attending. You should gather an HPI, OBGYN history, current medications and allergies and based on the situation, a PMH, PSH, family and social history. If you are working with a resident, the resident will likely see the new patients, and you will observe. There is a lot of counseling in REI visits that you can listen to and learn from.
    - Return patients: Usually the resident/attending will see return patients directly, and you will be able to observe and learn from the counseling provided to the patient.
    - Ultrasound: There are a lot of ultrasounds performed in the clinic. You will usually observe these ultrasounds. Depending on the patient you may get to do an ultrasound during your week on REI with close resident/fellow/attending supervision.
    - Procedures: There are also several procedure visits in the clinic - SIS, FemVue, IUI, mock embryo transfer that you will be able to observe.
    - Other: Ask to see the lab and learn how a semen analysis is done.
- How can I find the clinic schedule? The clinic schedule is on EPIC. You must sign in under "CU ADV REPRO MED DEN". If you go to the schedule tab all the attendings' clinics are listed. In the past, med students have not always been able to access the schedule this way, however. This is likely a problem because of the way your EPIC access is set up. If you cannot see the schedule, ask the MA/nurse (Megan or Vicky) to print you a copy of the clinic schedule. They are used to doing this for medical students. The schedule will have the patient's MRNs and you can look them up.
- What is the general clinic flow? The patient gets roomed by the MA/Nurse. The patient's stickers/chart go in the door when they're ready and their status is updated to exam room in EPIC.
- Are medical students allowed to see patients alone? Not often, but you may get to do a new patient interview alone. Ask the resident/fellow/attending about their expectations prior to clinic start.
- Do I need to document anything in the chart? No.
- Should I expect to present to the attending? The resident will present. If you happen to see a new patient on your own, you will be expected to present.
- Anything specific to this rotation: REI visits are usually very high stakes/emotional visits for patients. Do not be offended if the patient does not feel comfortable having learners in the room.

Operating Room:

- Know your patient's history, work up and indication for surgery.
- We do not expect you to know the steps of the surgery, but you should have a basic understanding of the case before the operating room.
- The first time you are in the operating room, specifically ask your resident to show you how to prepare the OR as well as clean up at the end of the case. Please be ready to help place SCDs, stirrups if necessary, break down the bed as well as to help clean and put the bed back together after the case.
- Always put your name on the white board. Always offer to get your gown and OR gloves—before leaving the room to scrub.
- Expect to be quizzed on anatomy related to the surgery of the day. We recommend refreshing your knowledge of pelvic anatomy prior to the operating room.
- Where can I get the OR schedule? The fellow will email out the OR schedule with the weekly schedule on Sunday nights.

- What types of questions can I expect in the operating room? You will get quizzed about pelvic anatomy.
- What procedures can you expect to do in the operating room? Foley placement, speculum exams, help close skin incisions.
- Is there something I should never do? Never do anything in the OR without direct supervision.

Floor Work:

- The majority of orders, notes and floor work is performed by residents due to legal issues with charting, but we always need help!
- Rotation specific expectations for floor work: There is not a lot of floor work on REI. Your resident will take care of most of it. Please do write progress notes for daily rounds and make sure the resident reviews them with you.

Pre-rotation reading topics:

- Absolute, must-know information prior to showing up on first day: Understand the menstrual cycle!! Understand the HPA axis as it relates to the menstrual cycle. It is also helpful to review ovarian anatomy.
- Subjects that are commonly "pimped" on this rotation: Menstrual cycle, Primary Amenorrhea vs Secondary Amenorrhea, PCOS, Menopause, Pelvic Anatomy

Rotation Name:

UCH UroGyn

Team Members & Roles: UroGyn and GYN team are now combined into one GYN team. See UCH gyn for team structure and who to contact.

Schedule: Please refer to the Resident schedule to see who you will be working with.
**Subject to daily changes. **

- Typical start time/arrival time: 0700 Typical end time/shift change: 1700
- Where should you go on first day of rotation? UroGyn clinic, AOP 3rd floor (2/3 of the way down on the right-hand side. The punch code for the doors is 4-3-2-1.)
- Is this rotation associated with weekly or daily emails from chief regarding daily plan? Yes, daily.

Location:

- Where are clinics located? UroGynecology clinic, AOP 3rd floor (2/3 of the way down on the right. The punch code for the doors if 4-3-2-1.)
- If there are any associated teaching sessions, where are those located? Wednesdays 0730 Grand Rounds and teaching, followed by 1100 Pre-Op conference, followed by 1200 lecture or journal club.
- Typically, where do we go at the start of the day? UroGyn Clinic.
- If I bring a bag—where do I store it? UroGyn resident workroom (in clinic).
- Is there a place for lunch storage? Can store lunch in the "sunroom" or UroGyn resident workroom.

Wardrobe and required medical equipment:

- On a typical day, what should you wear? Professional clothes and white coat.
- Do you need to bring scrubs? Yes.
- Unless otherwise specified below—always have: white coat, stethoscope.

Medical student responsibilities:

Clinic:

- In general, MSIIIs can see patients prior to the resident evaluating the patient. See rotationspecific details below on flow of clinic. Please make sure the resident you are working with knows you are seeing the patient BEFORE you go into the room.
- You should gather an HPI, OBGYN history, current medications and allergies and based on the situation a PMH, PSH, family and social history. Please see separate sections regarding sample clinic situations and notes.
- How can I find the schedule? In EPIC, under "AMC UROGYN OP".
- What is the general flow? Student accompanies resident early on, but eventually you will be primary interviewer while resident charts.
- Are medical students allowed to see patients alone? Not unless specifically instructed.
- Do I need to document anything in the chart? Please write a note on any inpatient you have seen.
- Should I expect to present to the attending? Yes, sometimes in clinic and always on post-op inpatients.
- Anything specific to this rotation? We often do procedures in clinic. Most of these are above the level of a MSIII. You may be allowed to do pelvic exams as deemed appropriate by the residents. If a resident does not feel it is appropriate for you to do the pelvic exam, you should respect this decision.

Pre-rotation reading topics:

- Absolute, must-know information prior to showing up on first day: Types of incontinence and treatments, pelvic organ prolapse.
- Resources or books for reading prior to the rotation: AUGS POP Q interactive http://www.augs.org/page/pop-q
- Subjects that are commonly "pimped" on this rotation:
    - POPQ
    - Pelvic anatomy

Random information specific to this rotation:

UroGyn can be hectic and crazy or super slow. Be adaptable and always have something to read in case of downtime. Ask what you can do to help as we can often be over our heads and too busy to even think of what we actually need help with, but the MSIIIs can be vital to making the team run smoothly.

OB/GYN Acronyms

We have an unhealthy love of acronyms! Here is a basic primer to help decode what we are saying!

AROM	Artificial rupture of membranes
BBOW	Bulging bag of water
BPP	Biophysical profile
BSO	Bilateral salpingo ophorectomy

IVF	In vitro fertilization
LAVH	Laparoscopic assisted vaginal hysterectomy
LMP	Last menstrual period

BTL	Bilateral tubal ligation
CIN	Cervical intraepithelial neoplasia
COCP	Combined OCP
CPD	Cephalo-pelvic disproportion
CRL	Crown rump length
D&C	Dilation and curettage
D&E	Dilation and evacuation
EDD	Estimated date of delivery
EFM	External fetal monitor
EFW	Estimated fetal weight
EMB	Endometrial biopsy
FAVD	Forceps assisted vaginal delivery
FRH	Fetal heart rate
FSE	Fetal scalp electrode
GBS	Group B Strep
GCCT	Gonorrhea & chlamydia
GDM	Gestational diabetes
GTT	Glucose tolerance test
HRT	Hormone replacement therapy
IPAS/MVA	Manual vacuum aspirator
IUFD	Inter-uterine fetal demise
IUP	Intrauterine pregnancy
IUPC	Intrauterine pressure catheter

LMP	Last menstrual period
LTCS	Low transverse cesarean section
LTV	Long term variability
MTX	Methotrexate
NSVD	Normal spontaneous vaginal delivery
OCP	Oral contraceptive pills
PMB	Post -menopausal bleeding
POC	Products of conception
POD	Post op day
POP	Progesterone only pills
PPD	Post-partum day
PPH	Postpartum hemorrhage
PROM	Premature rupture of membranes
SAB	Spontaneous abortion
SROM	Spontaneous rupture of membranes
SSE	Sterile speculum exam
SVE	Sterile vaginal exam
TAH	Total abdominal hysterectomy
TLH	Total laparoscopic hysterectomy
TOA	Tubo-ovarian abscess
TVH	Total vaginal hysterectomy
TVUS	Trans-vaginal ultrasound
UDF	Undesired fertility

NOTES NOTES