



PRESCRIPTION AND ADMINISTRATION OF MISOPROSTOL FOR INDUCTION OF LABOUR (IOL) IN THE LABOUR WARD (PATIENTS THAT ARE ON CONTINUOUS CTG)

Patient sticker

- Do 10-minute antenatal fetal heart monitor strip (CTG) and interpret:
 - Normal: continue with IOL: Signature and designation: _____
 - Suspicious or pathological: Doctor informed _____ (name of Dr)
- Administer 25ml misoprostol solution (1µg/ml solution) every 2 hours, orally, until contractions start; or for a total of 24 hours: STOP if there is a suspicious or abdominal CTG and inform the doctor.

Dose nr	Time	Contractions	Dose of misoprostol solution given:	Signature
1		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
2		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
3		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
4		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
5		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
6		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
7		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
8		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
9		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
10		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
11		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	
12		Yes <input type="checkbox"/> No <input type="checkbox"/>	25 ml (1µg/ml solution) <input type="checkbox"/>	

- As soon as person reports painful contractions, STOP misoprostol and do a cervical assessment.

Signature of doctor prescribing misoprostol _____

Name and HPCSA/Persal number _____