

CERTIFICATION IN ELECTRONIC FETAL MONITORING (CEFM) PRACTICE TEST (SAMPLE) STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE**

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Fetal heart block may present with which primary finding on the fetal tracing?**
 - A. Bradycardia
 - B. Minimal Variability
 - C. Sinusoidal Pattern
 - D. Tachycardia
- 2. What is the recommended action regarding electronic fetal monitoring documentation when a nonreassuring tracing is identified?**
 - A. Document only the fetal heart rate
 - B. Document at delivery only
 - C. Document only if interventions occur
 - D. Document baseline FHR, variability, accelerations, decelerations, contractions, and all interventions with times; maintain continuous monitoring and communication
- 3. What effect can epidural analgesia have on fetal monitoring interpretation?**
 - A. Causes maternal hypertension and increased variability
 - B. Causes maternal hypotension, reduced fetal variability, and sedation
 - C. Improves fetal variability
 - D. Has no effect on fetal monitoring
- 4. What is the NICHD definition of baseline rate?**
 - A. Approximate mean FHR rounded to increments of 5 bpm during a 10-minute window excluding accelerations and decelerations and periods of marked variability. There must be ≥ 2 minutes of identifiable baseline segments (not necessarily contiguous) in any 10-minute window, or the baseline for that period is indeterminate. In such cases, one may need to refer to the previous 10-minute window for determination of the baseline.
 - B. Average FHR over a 5-minute window.
 - C. Mean FHR during a 5-minute window including accelerations.
 - D. Peak FHR within any 10-minute window.

- 5. According to ACOG, in a patient without complications, the fetal heart rate tracing during the first stage of labor should be reviewed approximately every:**
- A. 5 minutes
 - B. 15 minutes
 - C. 30 minutes
 - D. 60 minutes
- 6. How is NICHD uterine activity defined?**
- A. Uterine activity is assessed by the number of contractions in a 10 minute segment, averaged over a 30 minute period.
 - B. Uterine activity is assessed by fetal heart rate variability.
 - C. Uterine activity is assessed by contraction intensity alone.
 - D. Uterine activity is assessed by the time between contractions.
- 7. Maternal fever influence on fetal heart rate?**
- A. Tachycardia
 - B. Accelerations
 - C. Increase in baseline rate, minimal variability
 - D. Prolonged decelerations
- 8. What is the NICHD definition of normal uterine activity?**
- A. Five or fewer contractions in a 10 minute segment, averaged over 30 minutes.
 - B. More than five contractions in 10 minutes.
 - C. Exactly seven contractions in 10 minutes.
 - D. Contractions per hour.
- 9. Which noninvasive device is used to monitor uterine activity?**
- A. Intrauterine pressure catheter
 - B. Manual palpation
 - C. Tocodynamometer
 - D. Fetal scalp electrode

10. Which of the following deceleration types is most consistent with a contraction-associated pattern?

- A. Variable
- B. Early
- C. Late
- D. Prolonged

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Answers

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1. B
2. D
3. D
4. A
5. C
6. B
7. C
8. C
9. C
10. A

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Explanations

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1. Fetal heart block may present with which primary finding on the fetal tracing?

- A. Bradycardia
- B. Minimal Variability**
- C. Sinusoidal Pattern
- D. Tachycardia

Fetal heart block disrupts conduction between the atria and ventricles, so the ventricles pace themselves at a slow, independent rate. On the tracing, this often appears as a bradycardic rhythm that is unusually regular with little beat-to-beat fluctuation in the baseline—minimal variability. The reduced variability occurs because the ventricular rhythm is driven by an intrinsic pacemaker rather than the normal, autonomic-influenced atrial-ventricular conduction. Sinusoidal patterns point to severe anemia or hypoxia, tachycardia to a tachyarrhythmia, and pure bradycardia can occur for other reasons, but the combination of slow rate with minimal variability is characteristic of heart block.

2. What is the recommended action regarding electronic fetal monitoring documentation when a nonreassuring tracing is identified?

- A. Document only the fetal heart rate
- B. Document at delivery only
- C. Document only if interventions occur
- D. Document baseline FHR, variability, accelerations, decelerations, contractions, and all interventions with times; maintain continuous monitoring and communication**

When a tracing is nonreassuring, you need a complete, time-stamped record of the entire tracing and every action taken. Documenting baseline fetal heart rate, variability, accelerations, decelerations, contractions, and all interventions with precise times provides a full chronology of the fetal status and the care response. This not only guides ongoing clinical decisions—such as whether to escalate care or pursue delivery—but also supports clear communication among the care team and serves as a thorough record for review. Keeping the tracing under continuous monitoring and maintaining open, documented communication ensures that anyone involved can see how the fetus is responding over time and what steps were taken. Incomplete documentation—focusing only on heart rate, recording at delivery, or noting documentation only when interventions occur—misses critical context and the sequence of events, which can impede timely decision-making and accountability.

3. What effect can epidural analgesia have on fetal monitoring interpretation?

- A. Causes maternal hypertension and increased variability
- B. Causes maternal hypotension, reduced fetal variability, and sedation
- C. Improves fetal variability
- D. Has no effect on fetal monitoring**

Epidural analgesia does not directly change the fetal heart rate patterns you see on a monitor. Fetal monitoring interpretation focuses on the fetus's oxygenation and autonomic response, reflected in baseline rate, variability, accelerations, and decelerations. The drug in the epidural acts on maternal nerves and does not inherently alter these fetal patterns. Any effect you might observe would come from indirect consequences, most notably maternal hypotension from the regional block, which can reduce uteroplacental perfusion and potentially cause changes in the tracing if not managed. With appropriate fluid management, positioning, and, if needed, vasopressors, these indirect effects are minimized, so the epidural itself does not necessitate a change in how you interpret fetal monitoring.

4. What is the NICHD definition of baseline rate?

- A. Approximate mean FHR rounded to increments of 5 bpm during a 10-minute window excluding accelerations and decelerations and periods of marked variability. There must be ≥ 2 minutes of identifiable baseline segments (not necessarily contiguous) in any 10-minute window, or the baseline for that period is indeterminate. In such cases, one may need to refer to the previous 10-minute window for determination of the baseline.
- B. Average FHR over a 5-minute window.
- C. Mean FHR during a 5-minute window including accelerations.
- D. Peak FHR within any 10-minute window.

Baseline rate is the approximate mean fetal heart rate over a 10-minute period, excluding accelerations, decelerations, and periods of marked variability, and it is rounded to the nearest 5 bpm. There must be at least 2 minutes of identifiable baseline within that 10-minute window; if not, the baseline for that period is indeterminate and you may refer to the previous 10-minute window. This is why the first option is the correct definition: it captures the 10-minute window, the exclusion of transient events, and the rounding rule. The other options differ because a simple 5-minute average (without excluding accelerations/decelerations), including accelerations, or focusing on peak FHR do not reflect how NICHD defines baseline.

5. According to ACOG, in a patient without complications, the fetal heart rate tracing during the first stage of labor should be reviewed approximately every:

- A. 5 minutes
- B. 15 minutes
- C. 30 minutes
- D. 60 minutes

Intermittent fetal heart rate assessment in low-risk labor uses a longer interval in the first stage. According to ACOG guidelines, for patients without complications, the fetal heart rate tracing should be reviewed about every 30 minutes during the first stage of labor when using intermittent auscultation. This strikes a balance between monitoring safety and practicality, since fetal status is less likely to change rapidly early in labor and continuous monitoring isn't necessary for all low-risk cases. Shorter intervals, such as every 15 minutes, are typically reserved for the second stage or for higher-risk situations where the fetus may be more susceptible to distress. Extremely frequent checks (every 5 minutes) would be unnecessarily burdensome in the first stage of a low-risk pregnancy, while waiting 60 minutes could miss important changes in fetal status. So, the 30-minute interval is the recommended approach for reviewing the fetal heart rate tracing in a patient without complications during the first stage of labor.

6. How is NICHD uterine activity defined?

- A. Uterine activity is assessed by the number of contractions in a 10 minute segment, averaged over a 30 minute period.
- B. Uterine activity is assessed by fetal heart rate variability.**
- C. Uterine activity is assessed by contraction intensity alone.
- D. Uterine activity is assessed by the time between contractions.

Uterine activity is evaluated by how often contractions occur, not by fetal heart patterns. NICHD defines it using the number of contractions in a 10-minute window, averaged over 30 minutes. This frequency-based measurement lets clinicians identify tachysystole, typically more than five contractions in 10 minutes over a 30-minute period. Contraction intensity alone isn't the primary way we assess uterine activity, and the time between contractions isn't used by itself to define it. Fetal heart rate variability is a separate parameter used to gauge fetal well-being, not uterine activity.

7. Maternal fever influence on fetal heart rate?

- A. Tachycardia
- B. Accelerations
- C. Increase in baseline rate, minimal variability**
- D. Prolonged decelerations

Maternal fever tends to raise the fetal heart rate baseline. When the mother has a fever, the fetus experiences increased metabolic demand and sympathetic stimulation, which commonly manifests as an elevated baseline fetal heart rate (tachycardia). If the fever is significant or sustained, the fetus may also show reduced variability, which can indicate evolving distress or compromised oxygenation. So the pattern you'd expect with fever is an increased baseline rate accompanied by minimal variability, reflecting both the tachycardia and a potential shift toward less variability. Accelerations are brief, temporary increases in rate tied to fetal movement and are not specific to fever. Prolonged decelerations indicate sustained drops in rate usually related to uteroplacental insufficiency or cord compression, not just fever. A simple tachycardia describes the higher rate but doesn't convey what variability might do, whereas fever commonly alters both baseline rate and variability, making the combined description the best fit.

8. What is the NICHD definition of normal uterine activity?

- A. Five or fewer contractions in a 10 minute segment, averaged over 30 minutes.
- B. More than five contractions in 10 minutes.
- C. Exactly seven contractions in 10 minutes.**
- D. Contractions per hour.

Normal uterine activity, per NICHD, is five or fewer contractions in a 10-minute period, averaged over 30 minutes. This windowing smooths out short spikes and represents the typical contraction frequency during labor. More than five contractions in any 10-minute window over 30 minutes is tachysystole, meaning contractions are occurring too frequently and can compromise uteroplacental blood flow. So seven contractions in 10 minutes would be tachysystole, not normal. Describing contractions per hour isn't the NICHD standard for defining normal activity.

9. Which noninvasive device is used to monitor uterine activity?

- A. Intrauterine pressure catheter
- B. Manual palpation
- C. Tocodynamometer**
- D. Fetal scalp electrode

Noninvasive monitoring of uterine activity is done with a tocodynamometer. It sits on the abdomen and senses the changes in abdominal wall tension caused by uterine contractions, producing a tracing that shows how often contractions occur, how long they last, and, to a limited extent, their strength. This method is noninvasive and commonly used during labor to track activity and correlate it with fetal monitoring. The other options are not noninvasive tools for monitoring uterine activity: an intrauterine pressure catheter requires inserting a catheter through the cervix into the uterus to measure actual intrauterine pressure, which is invasive; manual palpation relies on the clinician feeling contractions by hand, which is subjective and less precise; a fetal scalp electrode monitors fetal heart rate, not uterine contractions.

10. Which of the following deceleration types is most consistent with a contraction-associated pattern?

- A. Variable**
- B. Early
- C. Late
- D. Prolonged

When fetal heart rate changes are tied to what the uterus is doing during labor, it's describing a contraction-associated pattern. Variable decelerations fit this idea because they are abrupt drops in heart rate that can occur at any time during or after contractions and are influenced by changes in the fetal environment (often due to cord compression) that accompany labor. This makes them the pattern most closely linked to the activity of contractions themselves. In contrast, early decelerations are time-locked to the peak of contractions and reflect head compression, late decelerations reflect uteroplacental insufficiency, and prolonged decelerations are extended drops.

Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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