Licensed Midwife Regulatory Disclosure and Consent Statements
2016

By signing below you are acknowledging that you have received, read, understand, and will comply with the following regulatory disclosure and consent statements.

Licensed Midwife Regulations	Sign/date_____
Experience and Training	Sign/date_____
Emergency Transport Plan	Sign/date_____
Complaint Procedures	Sign/date_____
Midwives Model of Care	Sign/date_____
Virginia Birth Injury Fund	Sign/date_____
Malpractice Insurance	Sign/date_____
Controlled Substances	Sign/date_____
Hospital Privileges	Sign/date_____
Client Information Practices/HIPAA	Sign/date_____
Personal Responsibility Agreement	Sign/date_____
Financial Agreement (Seal)	Sign/date_____
Warning Signs & Symptoms	Sign/date_____
Prenatal Procedure Consent/waiver	Sign/date_____
Intrapartum Risk Disclosures	Sign/date_____

Experience and Training

Misty Ward, CPM, LM, BS: I began my path to midwifery at the age of 16 after I attended the birth of my nephew. At that time I began reading whatever pregnancy related books I could get my hands on. After high school I attended Eastern Mennonite University, where I majored for a time in Nursing with the plan of becoming a Certified Nurse Midwife. Not long into that program, I realized that the CNM certification and hospital-based practice did not fit into my philosophy of normal birth. I continued to attend EMU and in 2005, 10 days before the home birth of my second child, I graduated with a degree in History and minors in Biology and Psychology.

In late 2005 I began attending home births under the supervision of licensed midwives and documenting my experience and training as part of the requirements to acquiring the CPM (Certified Professional Midwife) certification through the NARM (North American Registry of Midwives) PEP Program. To supplement my homebirth training I volunteered and interned at several high volume birthing centers around the world. I spent time in the Dominican Republic with Medical Ministry International, El Paso, Texas at Casa De Nacimiento, and Senegal West Africa with the African Birth Collective. At this time I have attended more than 400 births. I received my CPM certification in February of 2010 and my Virginia license in March of 2010.

I am certified in CPR and neonatal resuscitation. I attend continuing education courses and several workshops each year and regular peer review. I am also trained as a Postpartum Doula by DONA. For more than 5 years I was the director of Birth Matters Harrisonburg, a chapter of Birth Matters Virginia. I currently sit on the Board of Directors for the Commonwealth Midwives Alliance as Director of Professional Accountability.

I have three children, Tsion (born 2003), Jonah (born 2005), and Holden (born 2014 in Willow Suite!) all born naturally.

Maya Hawthorn, CPM, LM, CLC, BA

I have been studying midwifery since 2008 and began attending births in 2009, when I started apprenticing in Louisville, KY under Juliet Dietsch, CPM and Jennifer Woodmansee, CPM. While the majority of my training was in their small home birth practice, I also spent time in two different high volume birth centers: Better Birth in Salt Lake City, Utah, and Shiphrah Birthing Home in TayTay, Rizal, Philippines. In total I have worked and learned under 14 different midwives, attended over 200 births, and have been the primary midwife at 36 of those. In October of 2013, I sat for the North American Registry of Midwives exam, and passed, earning the title of Certified Professional Midwife. Shortly afterwards I applied for my Virginia License, and received that in December of 2013.

Along with my midwifery certification, I am also a Certified Lactation Counselor (CLC). I particularly love caring for mom and baby in the postpartum period, and place high importance on providing breastfeeding support. I maintain my certifications in CPR and neonatal resuscitation, and I am a Birthing From Within childbirth preparation mentor as well.

My own daughter, Anna, was born at home in 2010.

Kai Lyons – Senior Apprentice Midwife

Kai, having grown up in the world of midwifery has had a passion for the life since a young age. She grew up in Charlottesville, Virginia with her midwife mother and physician father teaching her the many different ways in which you can care for people, and what it means to be a respectful care provider. After she graduated from UVA with a degree in Sociology she joined the Academy of Experiential Midwifery Education in Charlottesville, and for the past year has been studying with a group of women the art of midwifery. She is thrilled to be able to share in the experience of all the miracles that take place a Brookhaven.

Savannah Fassero - Apprentice Midwife

2nd oldest of 11 children, I was my mother's last hospital birth, so I was introduced to homebirth at an early age. When I was eight and my mother was pregnant with her 7th child, I asked so many questions about the process that she knew I was ready to see the birth. Afterward I remember holding my brother, in awe of what I'd just witnessed. I couldn't get back to the normal world of being a kid and doing chores.

In 2010 I started my midwifery training through Virginia School of Traditional Midwifery. I began professionally assisting births the same year. In 2014 I started my own doula business, while looking for local opportunities to train full-time as a student midwife. In January 2016 I was accepted as a midwife apprentice at Brookhaven Natural Birth Center. I am overjoyed to be a part of their team, learning how to serve mothers and babies better.

Complaints

If you have a complaint with the care we provide, our first request is that you discuss it with us, in person or in writing. If you are not satisied with this you have the right, at any time, to file a formal complaint. This will initiate an internal investigation of our practice with the North American Registry of Midwives(our credentialing organization), the Virginia Board of Medicine (our licensing board), or both.

To file a complaint with NARM:
Formal complaints must be written and signed, and require the client to sign records release before peer-review can proceed. Written complaints are sent US Postal Mail (not email) to:

North American Registry of Midwives
Shannon Anton, CPM
PO Bo 128
Bristol, Vermont 05443-0128

For more information, please visit the NARM web site: www.narm.org. Additional questions may be sent vial email to: info@narm.org

To file a complaint with the Board of Medicine:
The department of Health Professionals recieves complaints about health care practitioners who may have violated a regulation or law. Complaints for all the licensing and regulatory boards are recieved and processed by the Enforcement Division.

The department is responsible for administering the laws and regulations pertaining to health care practitioners, which may include conducting investigations of alleged violations. In order for the department to initiate an investigations the information it recieves must relate to a law

or regulation governing a specific regulated profession or facility. While practitioners action may be considered improper, unethical, or otherwise deserving of corrective action, it may not be a violation of law

Complaints related to a Licensd Midwife's alleged violation of a regulation or law may be submitted to the Board of Medicine through Enforcement Division of the Department of Heath Professions in writing, by telephone, fax, email, or in person.

Virginia Department of Health Professions Telephone: 1-800-533-1560
6603 West Broad Street, 5th Floor Fax: 1-804-662-7079
Richmond VA, 23230-1712

Midwives Model of Care

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes
.
The MMOC includes:

- Monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle
- Providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support
- Minimizing technological interventions
- Identifying and referring women who require obstetrical attention

The application of this women-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

Virginia Birth-related Neurological Injury Compensation Fund

Every year, a small number of babies are born with serious birth-related neurological injuries. The Virginia Birth-Related Neurological Injury Compensation Fund helps parents with financial burdens associated with the life-long medical care that is needed for their child who suffered a brain injury at birth. The program covers what insurance and other programs don't, medically necessary expenses such as medical care, hospital care, rehabilitation, in-home nursing care and more. More information about this program can be found at www.vabirthinjury.com.
Physician's and hospital's that provide maternity service have the option to pay into the fund thereby making the benefits available to thier patients. Not all physician's who provide maternity services choose to participate in the fund.
Currently, Licensed Midwives do not participate in the fund due to the fact that the statute stipulates that babies who are born at home are NOT ELIGIBLE for this program.

Liablilty Insurance

We do not carry mal-practice insurance. At this time there is no liability coverage available for licensed midwives in Virginia who attend home or birth center births.

Controlled substances

Currently, Virginia law prohibits licensed midwives from carrying or administering controlled substances. This means that we are not allowed to have oxygen, pitocin, rhogam, newborn eye medication, or injectable newborn vitamin K.

Hospital Privileges

As licensed midwives we attend only out-of-hospital births. We do not have hospital privileges at any hospital. In the event of transfer of care we will accompany you to the hospital but the hospital physician will be your care provider.

Personal Responsibility

We believe that pregnancy and childbirth are natural physical processes and in most cases when a woman is in good health and eats a nutritious diet, the possibilities of complications are very low. However, like all of life, pregnancy and birth are unpredictable and occasionally emergencies or defects occur. Midwives are trained to recognize abnormal conditions and are able to treat hemorrhage, shock, and seizure, and use equipment to resuscitate if needed. Pain medications, epidurals, vacuum extractor, forceps, and Cesareans are not available in an out of hospital setting. If an abnormal condition develops or these interventions become necessary, a doctor will be consulted or I will be transported to a hospital, whichever is most appropriate, in order to protect the health and safety of the mother and baby.

I understand that my midwife will need accurate and complete information about my medical and obstetrical history in her selection of treatment offered me. I affirm that this information is and will continue to be complete and accurate to the best of my knowledge. I understand the development of certain conditions during my pregnancy could be life threatening to me and/or my baby. I acknowledge that I have responsibilities in assuring a satisfactory outcome and agree to follow through with this additional list of items that will assist my midwife in her role of monitoring and assisting me/us through this wonderful life experience.

I will:

*Call immediately if I experience any of the Signs and Symptoms to Immediately Report to Midwife as described on form by same name

*Comply with the prenatal care plan developed with the midwife, which may include but not limited to dietary changes, taking recommended herbs or supplements, exercises or tests

*Eat a nutritious diet, rest and exercise as recommended

*Participate actively in my care by telling my midwife about my problems early

*Complete childbirth education or demonstrate independent preparedness

*Prepare to go through birth without narcotics, pain medications, epidurals

*Obtain the supplies and equipment needed for the birth, baby, and postpartum

*Ask question about anything I don't understand

*Notify midwife if I can't keep an appointment or make payments on time

*Make sure my baby is seen by a pediatric practitioner as the midwife advises. Make arrangements to get the hearing test done.

*Agree to hospital transport and/or transfer to physician care should complications preclude having my baby safely at home/birth center. Prior to 37 weeks, I understand that I may need to arrange other medical care myself and my midwife does not guarantee she will be able to accompany me. My records will be faxed upon request to the attending facility.

I have chosen to have our baby at home/Brookhaven Birth Center. I understand that there are special responsibilities and risks that this decision brings. Although many problems can be foreseen and screened for, there are some problems that cannot be predicted either in or out of a hospital. I/we have been informed of conditions which our midwife may treat and are aware of others which she may need to consult with or transfer my/our care to a physician. I understand our midwife must work within standard of care protocols. If I decline to seek recommended medical care, our midwife may choose to immediately terminate care for me without other arrangements. I understand the hospital ER or the OB on call are available 24/7.

I realize that our choice of out of hospital birth is contingent upon the progress of this pregnancy, my compliance with the prenatal care plan and meeting my responsibilities as outlined above or discussed at my prenatal visits.

I have discussed the above issues with the midwife. I understand the unpredictable nature of childbirth and am/are willing to accept these.

Client Information Practices

Our practice is dedicated to maintaining the privacy of your and your babys health records. Each time we visit, a record of that visit will be recorded. We may disclose your individual identifiable health information in the following ways:

*Recommendations-We will use your health information to document your continued health status as we work toward the goal of an out of hospital birth. We may ask you to have certain tests that will help us assess your health status. This information may be used to make recommendations regarding the maintenance of that status. It also may be available to others who could assist in your care, for example, the assistant who will attend your birth.

*Payment-We may use and disclose your health information in order to bill and collect payment for services and items you received from us.

*Health Care Operation-We may use your information to improve the operation of our business. For instance we may review your records in order to assess the quality of care you receive and the accuracy of the record.

*Research- We may disclose your information to researchers if the research proposal has been properly managed for your privacy. You will be asked for specific permission if this should take place.

*Communication With Other Health Care Providers-Our practice is limited to the care of healthy pregnant women and their infants during the childbearing year. If complications should develop at any time during the course your care, we may jointly decide that a medical consultation

would be in order. If a transfer of care should arise you will need to sign a medical release form for your records to be transferred to another provider.

*By Law-We may, for various reasons, be required to disclose your health information for reasons of law.

Your Health Information Rights

Although your health record is physically property of the practice, the information therein belongs to you. As such, you have the following rights:

*You may request to be contacted by alternate means or at am alternate location. Please make your request in writing.
*You may request a copy of your health records, however is a fee of .10 per page after 20 pages. You have full access to your health records at all times through our electronic medical records system. At the beginning of your care you will be sent an email inviting you to access your records.

*If you believe there is any information in the record that is incorrect or missing, you may request that we correct the existing information or add what you believe is missing. Please make your request in writing.

*You have the right to a paper copy if this disclosure

* We must obtain a written authorization from you to disclose information for purposes other than treatment, payment, or health care operations. You have the right to revoke this authorization, except to the extent we have already used or disclosed the information.

Changes To This Policy

We may change or update this policy at any time. When changes are made you will be notified with an updated copy of our policy._

Financial

Our fee for global maternity care is $4,500.00. This fee includes all of your prenatal visits, labor & delivery, and post-partum visits. We offer an uninsured/underinsured discount based on income to our clients that do not have insurance or the client has insurance that will not cover our care. Our uninsured/underinsured price is $4,000.00. The balance is due in full by the 36th week of your pregnancy. If the fee has not been paid in full by the 36th week, the midwives cannot attend your birth, unless other arrangements have been made in writing. A non-refundable $500.00 deposit is required at your first visit along with this contract. You may pay by check, cash, or credit card. Please keep in mind that there are separate charges for ultrasounds and other additional testing (We will notify you if there is a separate charge BEFORE we run a test). We also offer water birth pool rentals for home birth for an additional $100.00, and placenta encapsulation for $150.00.

Billing Insurance: If you have insurance with maternity benefits, we will bill your insurance company. By entering into this contract, you authorize us to release health information to your

insurance company for the purpose of processing your claims. Please note that there is no guarantee that your claims will pay, as some insurance plans cover midwifery services and some do not.

We may bill your insurance company for the following services related to your care including, but not limited to: Initial visit, global fee including delivery, intra-partum care, supplies, postpartum home visits, newborn exam, subsequent newborn appointments, PKU, and facility fees for the birth center.

We will bill your insurance company for all applicable codes that represent the care we provide to you at usual and customary rates for those codes. The amount of the deposit has no bearing on the fees that we bill to the insurance company.

The deposit will be applied to the deductible and co-insurance amounts applied by your insurance company to our claims. If the insurance company pays us directly, you may be eligible for a partial refund of the deposit.

If your insurance company reimburses you directly, which is not uncommon, you agree to contact us immediately. We will determine how much is yours to keep and how much you should send to us. It is not legal for you to profit on your healthcare; therefore, any amount reimbursed by insurance that exceeds the deposit must be forwarded to us, along with applicable amounts to cover your deductible and co-insurance.

If it becomes medically necessary for you to transfer out of care before 36 weeks, we will calculate the services rendered and give you a figure for any amount still owed or will return any over payments. We will issue a check to you for any over payment within 60 days. These amounts will be calculated on the following: a $500 non-refundable deposit, $250 for your initial prenatal visit and $200 for each visit thereafter. Our care is a package that includes prenatal visits on a set schedule, the birth, and the postpartum visits, also occurring on a set schedule with more visits occurring if needed. It is not usually broken down into components.

Please call within 24 hours if you must reschedule a visit or we may bill you a $25 cancelation fee. We are certainly understanding of canceling last minute due to illness or family emergency, however if you simply do not show up you will be billed!

In case of a transport to the hospital during the labor, birth, or postpartum the entire fee is still due, and if it is already paid, there will be no refund.

I understand that by entering into this contract if my account becomes assigned to a collection agency, I agree to pay all collection fees, court costs, and attorney fees.

I _____ wish to decline the following procedure(s):

☐ Prenatal Panel**: A prenatal panel is required by Virginia State Law**, and is a blood draw that takes your Complete Blood Count, which includes information about blood type, red and white blood cells, platelets, and the oxygen carrying capacity of your blood. Our prenatal panels also include a Hemoglobin A1C, which looks at the average blood sugar level over the last 3 months, and can be used as an early risk marker for gestational diabetes. A standard prenatal panel also tests for Hepatitis B, Syphilis and immunity to Rubella. More information about the diseases tested for in the prenatal panel are below.

Rubella Antibody Titer: **This blood test, required by Virginia State Law,** measures immunity to Rubella (a virus commonly called "German Measles"). Rubella can have a devastating effect on an unborn baby should an expectant mother contract it during her pregnancy. Knowledge of a mother's immune status is helpful in determining ways to protect her and her unborn baby from Rubella.

Syphilis Testing: **This blood test, required by Virginia State law**, is for Syphilis,a bacterial infection that is usually sexually transmitted. While Syphilis may remain undetected for years, it can cause severe damage if left untreated.Paralysis, inability to coordinate movements, inability to feel pain, gradual blindness, dementia, blockage or ballooning of the heart vessels, tumors damage to the joints, deep sores and death may result from untreated Syphilis. Syphilis is extremely dangerous to unborn babies and is associated with a high rate of stillbirth and miscarriage. Unborn babies who contract Syphilis in utero may not exhibit symptoms for as long as eight months after birth. Chronic syphilis can cause extensive damage to a newborn's bones, teeth, vision, hearing, and mental development; causing brain seizures, delayed mental development and slowed physical growth. Many newborns infected with congenital syphilis eventually die from the disease. Syphilis can be effectively treated during pregnancy with antibiotics.

Hepatitis B: **This blood test, required by Virginia State law**, is for Hepatitis B, a viral infection transmitted by bodily fluids, which affects the liver. Hepatitis B causes liver inflammation, vomiting, jaundice and may lead to death. Chronic hepatitis B may cause liver cirrhosis and liver cancer. Hep. B can be passed to your newborn during delivery and may have dire consequences for him/her. If proper treatment is initiated (this requires birthing in a hospital) within 12 hours of delivery, the chances of newborn infection are greatly reduced.

☐ HIV Test: **This blood test, required by Virginia State Law**, tests for HIV (Human Immuno-deficiency Virus) the virus that causes AIDS. HIV is transmitted via bodily fluids and can be transmitted by a mother to her unborn baby during her pregnancy, during her birth or via breastmilk. The effect of HIV on an infant can be devastating and is often fatal. Medical treatments are available and can reduce transmission rates in pregnancy to less than 2% according to the March of Dimes. The HIV test can be added to the prenatal panel without having to perform a separate blood draw. ***In order to protect our midwives, HIV Testing is required for anyone who would like the option for birthing in the water.***

☐ Pap Test: A pap test (also called a Papanicolaou test) is a screening test used to detect

premalignant and malignant (cancerous) processes in the cervix. In taking a Pap smear, a speculum is used to visualize the cervix. A small, soft brush is used to gather cells from the cervix. The cells are then examined for abnormalities. The test aims to detect potentially precancerous cells which are usually caused by sexually transmitted human papillomaviruses (HPV). A pap test may cause bleeding and/ or cramping but is not associated with an increased risk of miscarriage. ACOG recommends that low risk women have a pap test every 2-3 yrs.

☐ Gonorrhea /Chlamydia Testing: These two bacterial infections are sexually transmitted and **this simple test, required by Virginia State law**, is either performed by taking a sample of cells from the cervix using a cotton swab, or *testing a urine sample*. Left untreated, Gonorrhea and Chlamydia can severely damage the female reproductive organs. Women who have Gonorrhea or Chlamydia during pregnancy have higher rates of miscarriage, infection of the amniotic sac and fluid, preterm birth, preterm premature rupture of the membranes (PPROM) and postpartum uterine infections. Babies born to mothers with an active Gonorrhea or Chlamydia infection are at risk for serious infections that can lead to blindness, pneumonia and death. Both Gonorrhea and Chlamydia can be effectively treated during pregnancy with antibiotics.

☐ Early Ultrasound Scan: An ultrasound exam is a procedure that uses high-frequency sound waves to scan a woman's abdomen and pelvic cavity, creating a picture (sonogram) of the baby and placenta. An early ultrasound scan can be used to establish dates, confirm viable pregnancy, identify uterine and pelvic abnormalities of the mother, confirm molar or ectopic pregnancy, and measure gestational age. While ultrasound is a noninvasive procedure that, when used properly, has not demonstrated fetal harm, the long term effects of repeated ultrasound exposures on the fetus are not fully known. The American Pregnancy Association recommends that ultrasound only be used if medically indicated.

☐ 20 Week Ultrasound Scan: A 20 week ultrasound is considered a “standard-of-care” in the medical establishment. It can confirm multiples, verify dates and growth, identify excessive or reduced levels of amniotic fluid, and evaluate fetal well-being. It provides useful information about factors that may negatively affect your birth like low lying placenta and fetal /congenital defects; giving families and care providers the opportunity to be proactive prior to birth should these conditions exist.

☐ AFP Quad Screen: This optional blood test is offered between 16 & 18 weeks of pregnancy. Alpha-Fetoprotein is naturally produced during all pregnancies. Testing the levels of AFP in the blood at this point in pregnancy can indicate whether the baby is more likely to have Down’s Syndrome, Trisomy -18, or open neural tube defects (i.e. spina bifida). This test is strictly a screening test, and if positive, only indicates an increased risk of the baby having one of these conditions, and indicates the need for further testing. For someone with increased risk factors for having a baby with one of these conditions, the results of a genetic screening test can provide time to prepare for a child with special needs. Please be advised that not all insurance companies cover this test or the Informaseq test under routine pregnancy care, and that choosing these tests may come with unexpected out of pocket expense.

☐ Informaseq: Another non-invasive genetic blood test, this one can be performed at any point in pregnancy after 10 weeks. While this test does not address open neural tube defects, the way the AFP does, it does screen for Down’s Syndrome, Trisomy 18, and Trisomy 13. Clients can also order a Y Analysis, to determine baby’s gender as early as 10 weeks, and the XY analysis to screen for sex chromosome aneuploides such as Klinefelter’s syndrome. This test is relatively

new, and while the lab's marketing materials advertise it with a positive predictive value of 99%, independent analysis indicates that the predictive value is closer to 33%. (*Futch, T., Spinosa, J., Bhatt, S., de Feo, E., Rava, R. P. and Sehnert, A. J. (2013), Initial clinical laboratory experience in noninvasive prenatal testing for fetal aneuploidy from maternal plasma DNA samples. Prenat. Diagn., 33: 569–574. doi: 10.1002/pd.4123)*

I have been informed by my midwife, to the best of her abilities, of the advantages and disadvantages of these procedures. I have had an opportunity to have my questions answered and need no further information in making my decision. I accept primary responsibility for the outcomes that result from my decision to waive these procedures.

Client _____ Date _____

Partner _____ Date _____

1. Intrapartum Risk Factors

Preamble:

The Midwives Model of Care® recognizes the client/patient as the primary decision maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by NARM (the *North American Registry of Midwives*).

> ***"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM***

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Conditions requiring on-going medical supervision or on-going use of medications

Clients with chronic medical conditions, on prescribed medications, or under medical care for a time-limited problem that coincides with pregnancy should be advised to consult with their treating healthcare providers regarding the impact of these conditions and medications on pregnancy, as well as any impact pregnancy may have on their other diagnosed conditions. Women who choose not to disclose information regarding any medical conditions they have or medications that they are taking may increase their risk of complications.

Current substance abuse (including alcohol and tobacco)

Obstetrical complications of cigarette smoking include:

- Growth restriction (IUGR)
- Spontaneous abortion (miscarriage)
- Sudden infant death syndrome (SIDS)

Alcohol abuse leads to:

- Nutritional deficiencies
- Fetal alcohol syndrome

In addition to increased risk of preterm labor and baby being small for gestational age, complications resulting from abusing other drugs include:

- Heroin and cocaine consumption result in medical, nutritional and social neglect
- Cocaine and amphetamine cause hypertension, placental abruption
- Intravenous abuse also increases the risk of contracting infectious disease.[1]
- Maternal substance use of opioids, benzodiazepines, barbiturates, and alcohol can cause NAS (Neonatal abstinence syndrome).[2] NAS is a set of drug withdrawal symptoms that affect the central nervous, gastrointestinal, and respiratory systems in the newborn when separated from the placenta at birth.

Documented Intrauterine growth retardation (IUGR)/small for gestational age (SGA) at term

Complications[3] for the growth-restricted fetus include:

- Prematurity
- Perinatal morbidity
- Stillbirth

"IUGR is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins."[4]

Suspected uterine rupture

Consequences of uterine rupture:

- There have been no reported maternal deaths due to uterine rupture
- Overall, 14 percent to 33 percent of women will need a hysterectomy when the uterus ruptures
- Approximately 6 percent of uterine ruptures will result in perinatal death
- This is an overall risk of intrapartum fetal death of 20 per 100,000 women undergoing trial of labor after previous cesarean section
- "For term pregnancies, the reported risk of fetal death with uterine rupture is less than 3 percent. Although the risk is similarly low, there is insufficient evidence to quantify the neonatal morbidity directly related to uterine rupture."[5]

Prolapsed cord or cord presentation

Prolapsed cord is a term describing a cord that is passing through the cervix at the same time or in advance of the fetal presenting part. This occurs in approximately 1.4-6.2 per 1000 of pregnancies. Although uncommon, it is considered a true obstetrical

[1] Pregnancy and substance abuse, G. Fischer, M. Bitschnau, A. Peternell, H. Eder, A. Topitz. Archives of Women's Mental Health. August 1999, Volume 2, Issue 2, pp 57-65.
[2] Casper, Tammy, and Megan W. Arbour. "Identification of the Pregnant Woman Who Is Using Drugs: Implications for Perinatal and Neonatal Care." Journal of Midwifery & Women's Health (2013).
[3] Lerner, Jodi P. "Fetal growth and well-being." Obstetrics and gynecology clinics of north America 31.1 (2004): 159-176.
[4] Frye, Anne, Holistic Midwifery, Volume I, Labrys Press, Portland, OR, 2006, p. 990
[5] Guise, Jeanne-Marie, et al. "Vaginal birth after cesarean: new insights." (2010).

emergency most often necessitating a caesarean delivery. Prolapsed cord is associated with other complications of pregnancy and delivery as well.

Fetal risks:

- Hypoxia
- Stillbirth/death

Suspected complete or partial placental abruption

Placental abruption results from a cascade of pathophysiologic processes ultimately leading to the separation of the placenta prior to delivery. Pregnancies complicated by abruption result in increased frequency[6] of:

- Low birth weight
- Preterm delivery
- Stillbirth
- Perinatal death

Suspected placental previa

Pregnancies complicated with placenta previa had significantly higher rates[7] of

- Second-trimester bleeding
- Pathological presentations
- Placental abruption
- Congenital malformations
- Perinatal mortality
- Cesarean delivery
- Apgar scores at 5 minutes lower than 7
- Placenta accreta
- Postpartum hemorrhage
- Postpartum anemia
- Delayed maternal and infant discharge from the hospital

Suspected chorioamnionitis

Chorioamnionitis is a potentially serious complication:[8]

- Chorioamnionitis is a major risk factor in the event of preterm birth, especially at earlier gestational ages, contributing to prematurity-associated mortality and morbidity
- Increased susceptibility of the lung for postnatal injury, which predisposes for bronchopulmonary dysplasia.

[6] Ananth, Cande V., et al. "Placental abruption and adverse perinatal outcomes." JAMA: the journal of the American Medical Association 282.17 (1999): 1646-1651.
[7] Sheiner, E., et al. "Placenta previa: obstetric risk factors and pregnancy outcome." Journal of Maternal-Fetal and Neonatal Medicine 10.6 (2001): 414-419.
[8] Thomas, Wolfgang, and Christian P. Speer. "Chorioamnionitis: important risk factor or innocent bystander for neonatal outcome?." Neonatology 99.3 (2010): 177-187.

- Chorioamnionitis is associated with cystic periventricular leukomalacia, intraventricular hemorrhage and cerebral palsy in preterm infants
- Prenatal inflammation/infection has been shown a risk factor for neonatal sepsis

Pre-eclampsia/eclampsia

Complications of preeclampsia include:

- Eclampsia
- HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome
- Liver rupture
- Pulmonary edema
- Renal failure
- Disseminated intravascular coagulopathy (DIC)
- Hypertensive emergency
- Hypertensive encephalopathy
- Cortical blindness

Maternal complications occur in up to 70% of women with eclampsia and include: [9]

- DIC
- Acute renal failure
- Hepatocellular injury
- Liver rupture
- Intracerebral hemorrhage
- Cardiopulmonary arrest
- Aspiration pneumonitis
- Acute pulmonary edema
- Postpartum hemorrhage
- Maternal death rates of 0-13.9% have been reported

Fetal complications in preeclampsia are directly related to gestational age and the severity of maternal disease and include increased rates of: [10]

- Preterm delivery
- Intrauterine growth restriction
- Placental abruption
- Perinatal death

Thick meconium stained amniotic fluid without reassuring fetal heart tones and birth is not imminent

Meconium staining of the amniotic fluid is a common occurrence during labor. Although a large proportion of these pregnancies will have a normal neonatal outcome, its presence may be an indicator of fetal hypoxia and has been linked to the development of: [11]

[9] Norwitz, Errol R., Chaur-Dong Hsu, and John T. Repke. "Acute complications of preeclampsia." Clinical obstetrics and gynecology 45.2 (2002): 308-329.
[10] de Souza Rugolo, Ligia Maria Suppo, Maria Regina Bentlin, and Cleide Enoir Petean Trindade. "Preeclampsia: effect on the fetus and newborn." Neoreviews 12.4 (2011): e198-e206.

- Cerebral palsy
- Seizures
- Meconium aspiration syndrome

Abnormal auscultated fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones

Sustained abnormal fetal heart rate patterns include bradycardia (abnormally low heart rate) and decelerations in the baby's heart rate. Additionally, tachycardia (abnormally high heart rate) is abnormal, and can also be an indication for the need for further evaluation. Historically, a 30-minute rule from decision-to-incision time for emergent cesarean delivery in the setting of abnormal FHR pattern has existed; however, the scientific evidence to support this threshold is lacking.

Excessive vomiting, dehydration, or exhaustion unresponsive to treatment

- Sufficient fluid intake during labor may prevent hemoconcentration, starvation, and activation of the thrombogenic and fibrinolytic system[12]
- With extreme exhaustion, the chances of fetal distress and non-progressive labor are greatly increased
- Bleeding during or after the placental birth, followed by shock, are much more likely to occur when the woman and her uterus are exhausted[13]
- Maternal exhaustion is diagnosed with a combination of ketonuria, elevated temperature, and elevated pulse. This condition is also known as ketoacidosis, in that the mother's blood becomes abnormally acidic and less able to carry oxygen. Unless this condition is reversed, fetal distress will result[14]

Blood pressure greater than 140/90 which persists or rises and birth is not imminent

Women with chronic hypertension are at increased risk of: [15]

- Superimposed preeclampsia (25% risk)
- Preterm delivery
- Fetal growth restriction or demise
- Placental abruption
- Congestive heart failure
- Acute renal failure
- Seizures
- Stroke
- Death

Maternal fever equal to or greater than 100.4°

Fever can indicate infection. Fever in labor is associated with: [16]

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[11] Rahman, Shimma, Jeffrey Unsworth, and Sarah Vause. "Meconium in labour." Obstetrics, Gynaecology & Reproductive Medicine 23.8 (2013): 247-252.

[12] Watanabe, Takashi, et al. "Effect of labor on maternal dehydration, starvation, coagulation, and fibrinolysis." Journal of perinatal medicine 29.6 (2001): 528-534.

[13] Frye, Anne, Holistic Midwifery, Volume II, Labrys Press, Portland, OR, 2004, p. 1055.

[14] Davis, Elizabeth, Heart and Hands: A Midwife's Guide to Pregnancy and Birth, Celestial Arts, New York, NY, 2004, p. 141.

[15] Hypertension. 2003; 41: 437-445 Published online before print February 10, 2003, doi: 10.1161/01.HYP.0000054981.03589.E9

- Early neonatal and infant death
- Hypoxia
- Infection-related death. These associations were stronger among term than preterm infants
- Meconium aspiration syndrome
- Hyaline membrane disease
- Neonatal seizures
- Assisted ventilation

Labor or premature rupture of membrane (PROM) less than 37 weeks according to due date

Premature rupture of membranes before 37 weeks' gestation (and where there is at least an hour between membrane rupture and the onset of contractions and labor) can have consequences for both the mother and the baby:

Risks to Baby:

- Neurologic injury
- Infection
- Respiratory Distress
- Death
- Increased need for neonatal intensive care services

Maternal Risks:

- Infection
- Prolonged Labor
- C-Section
- Death

Because the out-of-hospital birth setting does not provide for immediate access to medications, surgery, and consultation with a physician, there may be increased risks to mother and/or baby if any of these conditions present during the birth. In some communities, the lack of availability of a seamless, cooperative hospital transfer process adds additional risk during intrapartum transfer.

I understand that the intrapartum risks may not be apparent until labor, and my opportunity for referral to a physician, should I choose that, would be limited to hospital transfer and transfer of care to the physician on call at that facility.

I have received and read this document, discussed it with my midwife, and my midwife has answered my questions to my satisfaction.

Client _____ Date _____

Midwife_____ Date _____

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[16] PETROVA, Anna, et al. "Association of maternal fever during labor with neonatal and infant morbidity and mortality." Obstetrics and gynecology 98.1 (2001): 20-27.

MANA STATISTICS PROJECT
DATABASE CONSENT

Midwives Alliance℠
NORTH AMERICA

Dear Expectant Mother,

Your midwife is a contributor to the Statistics Project of the Midwives Alliance of North America (MANA) Division of Research. The Midwives Alliance conducts this project both to document the value of the midwifery model of care and to give midwives information that they can use to maintain and improve the quality of their practices. Will you give consent for your midwife to collect information about your pregnancy, birth, postpartum and baby to be included in this project?

The Project collects clinical data from each midwife for all maternity care provided by that midwife. Each client is registered at the beginning of care. The midwife then fills out a data form describing the particular course of care. To protect your identity, your midwife will create a distinct code for each birth rather than using your name. With your consent, your data may be used in MANA-sanctioned research studies. In addition, statistics based on your data may be used by qualified midwifery organizations to advocate for or improve midwifery practice within their region. Data that includes your information will not be released except under strict guidelines of the Division of Research, and will not be used for commercial purposes.

As a participant in the MANA Statistics Project you may be contacted in order to verify the accuracy of the data submitted by your midwife. You may also receive requests to participate in future midwifery related research studies. Any study that requires direct contact with mothers must be approved by a qualified Institutional Review Board for the protection of your privacy. Contacts, if any, would be made by phone, email or letter. If you do not wish to be contacted in any way, you may check the box indicating that.

If you choose to participate in the project, it should be because you really want to volunteer. You will not lose any benefits or rights you would normally have if you choose not to participate. You can stop at any time and still keep the benefits and rights you had before volunteering. Your decision will not affect your care or your relationship with your midwife. If at any time you have questions or wish to withdraw from the project, please contact us by telephone or in writing at the address below.

The confidentiality of your health-related information will be carefully protected. Participation in this project poses no foreseeable risks to you. We do not know if you will benefit directly from participating in this project. However, we expect that findings from the research conducted with this database will help to improve maternal and infant health and to guide the development of midwifery care policies in the United States and abroad.

To participate in this data registry, please complete the consent form on the back of this page. We appreciate your willingness to consider participation and expect that this project will benefit mothers, families and midwives.

Thank you,
The MANA Division of Research

The MANA Statistics Project
P.O. Box 6310
Charlottesville, VA 22906
Telephone 888-923-6262

MANA STATISTICS PROJECT DATABASE CONSENT

Midwives Alliance NORTH AMERICA

I have read this letter and have had any questions answered, and I have decided to permit my information to be stored and used for future research. I have received a copy of this consent/authorization form.

Name of Mother _____

Address _____

City _____ State/Province _____

Zip or Postal Code _____

Phone _____

Email _____

By signing below I give my permission to have information collected about me during this pregnancy's course of care be used for research and practice improvement.

Signature of Mother _____

Date _____

☐ I do not wish to be contacted by researchers other than my midwife.

To be completed by your midwife:

Birth Code _____ (for identifying client's record)

Midwife or Practice _____

Mail this form to:

MANA Statistics
P.O. Box 6310
Charlottesville, VA 22906

Please make sure you have logged this client online first!

Brookhaven
women's health + natural birth center

Directions and Emergency Transport Plan

Home Birth / Birth Center Birth

Name:_____Phone Number:_____

Partner:_____Work/cell number:_____

Address:_____

Directions to your home from the birth center:_____

_____

_____

Family Doctor:_____Phone:_____

Pediatrician:_____Phone:_____

Estimated EMS response time to your home:_____

Nearest hospital with maternity services:_____

Phone number:_____Estimated drive time from your home:___

Directions to hospital from client home:_____

_____

_____

_____

Directions to RMH in case of birth center transport: Take Brookhaven Drive to Port Republic Rd, turn right onto Port Rd, take U-turn at next traffic light, turn left onto Health Campus Dr. park at Emergency Dept door on the East end of RMH.

Brookhaven
women's health + natural birth center

Consent to publish Birth Announcement, Photographs, & Footprint Leaf

☐ I do hereby authorize Brookhaven Health and Natural Birth Center to announce our baby's birth in the monthly newsletter.

☐ I do by hereby authorize Misty Ward or her appointed agent to photograph our birth and/or related events. I also authorize that these photographs, as well as any I share, can be posted on Brookhaven Health and Natural Birth Center's website and Facebook unless requested otherwise. Modesty and propriety will be protected. I hereby acknowledge that these photos belong to Misty Ward and Brookhaven Health and Natural Birth Center and I understand that Misty Ward and Brookhaven Health and Natural Birth Center intend to use these photographs for the purpose of education and promotion of midwifery care. I am consenting to the publishing, exhibition, reproduction and use of the photographs by Misty Ward and Brookhaven Health and Natural Birth Center.

☐ I do by hereby authorize Brookhaven Health and Natural Birth Center to use my baby's footprint for their footprint tree.

_____ _____

Client Signature Date

I have specific requests regarding my and my child's information and/or photos:

Out of Hospital Birth Questionnaire

Please give some thought to the following questions and answers as completely as possible. You and your partner should each answer these so that we can best serve your family.

Why do you want to have this baby at home/birth center

Partner:

What do you see as the duties or responsibilities of your midwife?

Partner:

Have you faced any opposition to your plans for home birth/birth center? (if so, please describe)

There are some things that can go wrong without previous warning during labor and birth and after. If you are a low risk woman, the chances of unpredictable complications are low. However, if such complications should occur, you or your baby might be at greater risk because of being at home. There are risks involved with childbirth just as there are with driving a car. Some of these risks will probably never be eradicated no matter what our state of technology. There is a certain subset of risks involved in having you baby in a hospital as well as in your home. If you opt for the risks involved in birthing at home you need to find out what they are and how they can be dealt with. Please comment on what you know on risks and complications and how you feel about them.

Partner:

How do you feel about going to the hospital to deliver if your midwife feels that complications are arising?

Partner:

_How do you think you might deal with the problem of a baby or mother who suffered permanent injury or died at home/birth center?

Partner:

What do you think are the benefits to having your baby at home/birth center?

Partner:

Please add any comments or thoughts that you think may be important for your midwife to know about you.

Brookhaven
women's health + natural birth center

If you have a healthcare-related need or concern or believe your labor has begun you may call Misty or Maya day or night. **We use the on-call midwife number for ANY medical concerns and emergencies. Please call the on-call phone before calling the midwife's personal cell phone.** Our midwives are on call for you 24/7. If there is no answer, leave a detailed message, and she will get back to you shortly. If she has not returned your call within 10 minutes please call again. Texting the on-call phone is an option for non-urgent communication; however, **Facebook is not an appropriate form of communication for any health care concern or scheduling.**

For scheduling or billing-related issues please call our office line at 540-437-9850 during our normal business hours of Monday through Thursday 9am-5pm or you can send an email to the midwife through Maternity Neighborhood. We will return your call or email as soon as possible. Be aware that messages and email are checked by office staff members. Also note that we are closed for business Friday, Saturday, and Sunday.

Thank you.

On Call Midwife

540-476-2526

Misty Ward, CPM
Mobile: 540-830-4462

Maya Hawthorn, CPM
Mobile: 540-908-0106

Heather Brown: Office Manager
Email: brookhavenbcbilling@gmail.com (use to communicate regarding billing issues only)

Signs and Symptoms to report immediately to your midwife:

***Bleeding from the vagina, and/or cramping, especially after the first 12 weeks**

***Sudden gush or leaking of fluid from the vagina**

***Contractions before 36 weeks that are regular with or without pain that do not change with a change of activity, accompanied by a low, dull backache, pressure, or heaviness: intermittent menstrual like cramps or thigh pain, intestinal cramping with or without diarrhea or indigestion.**

***Sudden or unusual decrease in movement of the baby**

***Sharp or continuous abdominal, pelvic pain lasting longer than 20 minutes**

***Swelling, pain, redness, heat in legs, especially if just one is affected**

Signs and Symptoms to report within 24 hours to your midwife:

***severe or continuing nausea and vomiting lasting 24 hours or more**

***Unusual or sudden swelling or puffiness, especially of the hands or face**

***Blurred vision, spots before your eyes or dizziness**

***Pain or burning while urinating or a marked decrease in urination**

***Appearance of any unusual genital rash, sores. Or discharge**

***Fever or chills alone or accompanied by respiratory or gastro-intestinal symptoms**

***Continuing severe headaches**

***Any other concerns you may have**