

INFORMED CONSENT TO MIDWIFERY TREATMENT

Direct Entry Midwife:

Name: _____

Address: _____

Telephone Number: _____

Registration Number: _____

Patient:

Name: _____

Address: _____

Telephone Number: _____

I, _____, verify that the following Informed Consent to Midwifery Treatment (“Informed Consent”) has been read to me in a language which I understand, that I understand each section of the Informed Consent, and that any questions I had have been answered by the direct-entry midwife (“Midwife.”)

I understand that the educational background and training of the Midwife is as follows:

(fill in with appropriate information)

Client’s Initials: _____

I understand that the nature and scope of the care that I will receive is as follows:

(fill in with appropriate information)

Client’s Initials: _____

- I understand that the available alternatives to direct-entry midwifery care are as follows:

Medical care by a physician or certified nurse-midwife licensed in the State of Colorado

Client's Initials: _____

- I understand that the risks of home birth are as follows:

The normal birth process is the same whether the birth takes place in a medical facility or at home. Additional risks arise in a home birth in emergency situations due to the lack of access to immediately available medical personnel, equipment and drugs.

Client's Initials: _____

- I understand that the Midwife is/is not covered under a policy of liability insurance for the practice of direct-entry midwifery.**

Client's Initials: _____

- I understand that Colorado law provides that, if I must receive medical care from a health care provider after receiving care from the Midwife because of acts or omissions of the Midwife, any physician, nurse, prehospital emergency personnel, and health care institution providing such subsequent care may not legally be sued by me for negligence. In order for me to maintain a lawsuit against a physician, nurse, prehospital emergency personnel or health care institution for subsequent medical care, I must prove that the provider engaged in gross negligence or willful and wanton conduct.

Client's Initials: _____

Client's Signature

Date

**State of Colorado, Department of Regulatory Agencies
Office of Midwifery Registration
1560 Broadway, Suite 1350, Denver, CO 80202
303-894-7429**

Mandatory Disclosure Requirements

Every direct-entry midwife is required by section 12-37-104(1), C.R.S., to provide the following information¹ in writing to each client during the initial client contact:²

- The name, business address, and business phone number of the direct-entry midwife.
- A listing of the direct-entry midwife's education, experience, degrees, membership in any professional organization whose membership includes not less than one-third of all registrants, certificates or credentials related to direct-entry midwifery awarded by any such organization, and the length of time and number of contact hours required to obtain said degrees, certificates, or credentials.
- A statement indicating whether or not the direct-entry midwife is covered under a policy of liability insurance for the practice of direct-entry midwifery.
- A listing of any license, certificate, or registration in the health care field previously or currently held by the direct-entry midwife and suspended or revoked by any local, state or national health care agency.
- A statement that the practice of direct-entry midwifery is regulated by the Department of Regulatory Agencies. The statement must provide the address and telephone number of the Office of Midwifery Registration in the Division and shall state that violation of the Midwives Practice Act may result in revocation of registration and of the authority to practice direct-entry midwifery in Colorado.
- A copy of the emergency plan as provided in section 12-37-105 (6), C.R.S.
- A list of qualified health care practitioners who can administer vitamin K to the client's newborn infant.³
- A list of qualified health care practitioners who can administer Rho(D) immune globulin to the client.⁴

¹ The layout of the form is discretionary, but the information the form contains must include the requirements listed in section 12-37-104(1), C.R.S. Any additional information on the form must not conflict with Article 37 or governing rules.

² Section 12-37-104(2), C.R.S., mandates that any changes in the information required by section 12-37-104(1), C.R.S., shall be reflected in the mandatory disclosure within five days of the change.

³ Midwives cannot administer vitamin K until such time as rules regulating the administration of vitamin K are adopted and effective.

⁴ Midwives cannot administer Rho(D) immune globulin until such time as rules regulating the administration of Rho(D) immune globulin are adopted and effective.

STATE OF COLORADO
DEPARTMENT OF REGULATORY AGENCIES
MIDWIVES REGISTRATION
EMERGENCY PLAN

Name of Patient: _____

Anticipated address at time of delivery: _____

Number of miles between patient's address and nearest health care facility: _____

Name of health care facility: _____

Telephone numbers for health care facility: _____

Telephone numbers for health care providers _____

This plan sets forth the planned referrals during the pregnancy should a risk factor occur which requires consultation with or transfer of primary responsibility for maternity neonatal/care to a licensed health care provider or which requires maternal or infant transport to a licensed health care facility capable of providing necessary or emergency services including cesarean section.

I. For any risk situation which makes it necessary for care by a licensed health care provider, but not for primary responsibility for maternity/newborn care to be transferred from the direct-entry midwife, care will be provided by _____ for the care of the mother and/or _____ for the care of the infant.

II. Conditions which indicate immediate termination of the direct-entry midwife's role as the primary provider of maternity/newborn care shall be handled by immediate referral to _____ for care of the mother or _____ for care of the infant.

III. Should immediate transport of the mother/newborn be required, transport will be to _____ with the mother's care referred to _____ and/or infant's care referred to _____

Estimated time for transport if greater than 30 minutes _____

Signature of Patient: _____

Signature of Midwife: _____

Date: _____

STATE OF COLORADO
DEPARTMENT OF REGULATORY AGENCIES
MIDWIVES REGISTRATION
RISK FACTOR ASSESSMENT FOR THE FIRST ANTEPARTUM VISIT

Patient's Name: _____ Date: _____

The registered direct-entry midwife shall not provide care to any woman whose medical history shows the following:

- | | | |
|-----|----|---|
| Yes | No | Diabetes mellitus or gestational diabetes |
| Yes | No | Hypertensive disease (BP greater than 140/90 at rest) |
| Yes | No | Pulmonary disease or cardiac disease which interferes with activities of daily living |
| Yes | No | A history of thrombophlebitis or pulmonary embolism |
| Yes | No | Blood dyscrasia, for example sickle cell anemia |
| Yes | No | Seizures controlled by medication if the woman has seized within the last year |
| Yes | No | Hepatitis B, HIV positive or AIDS |
| Yes | No | Current use of psychotropic medications if woman is not under the care and monitoring of a physician during the pregnancy |
| Yes | No | Current substance abuse of drugs or alcohol |
| Yes | No | Rh sensitization (positive antibody titre), an incompetent cervix; or previous uncontrollable postpartum hemorrhage |
| Yes | No | The midwife shall not provide care to any woman who has had a previous cesarean section whose emergency plan does not include the ability to transport, within 30 minutes, to a facility able to perform a cesarean section |
| Yes | No | Infants who were premature, stillborn, or neonatal deaths associated with maternal health or genetic anomaly without an intervening normal pregnancy |

Document referral to an appropriate licensed health care provider if any of the above are answered "yes".

Midwife's Signature: _____

STATE OF COLORADO
DEPARTMENT OF REGULATORY AGENCIES
MIDWIVES REGISTRATION
RISK FACTOR ASSESSMENT DURING LABOR AND DELIVERY

Patient's Name: _____ Date: _____

The registered direct-entry midwife shall arrange for immediate consultation and transport according to the emergency plan if the following conditions exist:

Yes	No	Bleeding other than capillary bleeding ("show") prior to delivery
Yes	No	Signs of placental abruption including continuous lower abdominal pain and tenderness
Yes	No	Prolapse of the cord
Yes	No	Any meconium staining without reassuring fetal heart tones, moderate or greater meconium staining regardless of status of fetal heart tones
Yes	No	Significant change in maternal vital signs: 1) Temperature greater than 101 ⁰ F, 2) Pulse over 100 with decrease in blood pressure, 3) Increase in blood pressure greater than 140/90 or an increase of 30 mm Hg systolic or 15 mm Hg diastolic
Yes	No	Failure to progress in labor: 1) Lack of steady progress in dilation and descent after 24 hours in the primipara or 18 hours in the multipara, 2) Second stage of labor without steady progress of descent through the mid-pelvis and/or pelvic outlet longer than two hours in the primipara or one hour in the multipara, 3) Third stage of labor longer than one hour
Yes	No	Fetal heart rate below 120 or above 160 between contractions
Yes	No	Protein or glucose in the urine
Yes	No	Seizures
Yes	No	Atonic uterus
Yes	No	Retained placental fragments
Yes	No	Vaginal or cervical lacerations requiring repair
Yes	No	Client requests transport

Document consultation and transport for any of the above risk factors.

Midwife's Signature: _____

STATE OF COLORADO
DEPARTMENT OF REGULATORY AGENCIES
MIDWIVES REGISTRATION
NEWBORN RISK FACTOR ASSESSMENT

Patient's Name: _____ Date: _____

The registered direct-entry midwife shall arrange for **immediate transport** according to the emergency plan for an infant who exhibits the following signs:

Yes	No	Apgar of 7 or less at ten minutes
Yes	No	Respiratory distress exhibited by respirations greater than 60 per minute, grunting, retractions, nasal flaring at one hour of age that is not showing consistent improvement
Yes	No	Inability to maintain body temperature
Yes	No	Medically significant anomaly
Yes	No	Seizures
Yes	No	Fontanel full and bulging
Yes	No	Suspected birth injuries
Yes	No	Cardiac irregularities
Yes	No	Pale, cyanotic, gray newborn
Yes	No	Lethargy or poor muscle tone

Documentation of referral or consultation

The registered direct-entry midwife shall arrange for **consultation and transport** according to the emergency plan for an infant who exhibits the following:

Yes	No	Signs of hypoglycemia including jitteriness
Yes	No	Abnormal cry
Yes	No	Passes no urine in 12 hours or meconium in 24 hours
Yes	No	Projectile vomiting
Yes	No	Inability to suck
Yes	No	Pulse greater than 180 or less than 80 at rest
Yes	No	Jaundice within 24 hours of birth
Yes	No	Positive Coombs test

Documentation of referral or consultation

Midwife's Signature: _____

STATE OF COLORADO
 DEPARTMENT OF REGULATORY AGENCIES
 MIDWIVES REGISTRATION
POSTPARTUM RISK FACTOR ASSESSMENT

Patient's Name: _____ Date: _____

The registered direct-entry midwife shall arrange for immediate consultation and transport according to the emergency plan if the following conditions exist:

Factors ↓	Dates →						
There is maternal blood loss of more than 500 cc							
The mother has a fever of greater than 101 ⁰ F on any of the 2 nd through 10 th days postpartum							
The mother cannot void within 6 hours after birth							
The lochia is excessive, foul smelling, or otherwise abnormal							
There are signs of clinically significant depression (not the "baby blues")							

Documentation of referral or consultation

Midwife's Signature: _____