Informed Consent for Out-of-Hospital Vaginal Birth After Cesarean

Client's Name: _____

Midwife's Name: _____

Parents planning a "Vaginal Birth after Cesarean (VBAC) with a NH Certified Midwife shall complete the following informed consent, in the presence of their NH Certified Midwife. It is the responsibility of the client to voice all questions and concerns regarding their out of hospital VBAC choice; and it is the responsibility of their midwife to address their questions and provide up to date data and research on risks of out of hospital VBAC choice.

Client initials before each of the following:

☐ I have read my midwife's informed consent for out of hospital VBAC, discussed the topic in depth, and have had all my questions and concerns addressed.

☐ I have read Med 503.04(b) and understand the requirments my midwife is required to adhere to.

☐ I am aware of the risks associated with planned Vaginal Birth after Cesarean, including the risk of uterine rupture. I understand that if my uterus were to rupture in labor this could result in serious damage to myself and my baby, and there is an increased risk that my baby could die.

☐ I understand that being a greater distance from emergency services could increase the risk to myself and my baby. I have discussed the distance from hospital of my intended place of birth with my midwife.

☐ I understand that I have the option to attempt a VBAC at a hospital or to plan a repeat Cesarean at a hospital.

☐ I agree that if my NH Certified Midwife recommends a transfer I will comply with their recommendation.

A NH Certified Midwife is required by law to confirm the following information regarding your pregnancy; please confirm:

☐ I have had only one previous Cesarean, and the scar is in the lower part of my uterus.

☐ My single previous Cesarean occurred 18 months or more before the due date of my current pregnancy.

☐ I will give permission for the release of the operative records of my previous Cesarean birth to my midwife.

☐ I agree to having at least one prenatal ultrasound in the second or third trimester of this pregnancy to determine the location of my placenta.

☐ I agree to having lab work done in this pregnancy that determines my blood group and type..

The Midwife shall complete the following:

Certified Midwife's NH Certification Number: _____

Certified Midwife's Business Address: _____

_____

Name of Freestanding Birth Center: _____

The midwife shall sign and date the form:

NH Certified Midwife's Printed Name (print legibly):

_____

NH Certified Midwife's Signature:

_____

Date Signed: _____

The client shall sign and date the form under the following affirmation:

Affirmation

I understand that these measures are required to improve the safety of my care. Given the increased risks associated with planning an out of hospital VBAC, I agree that if my midwife recommends a transfer of care or emergency transport in labor I will promptly comply with this recommendation. Having received adequate information and resources, and having had my questions addressed, I express my understanding of the risks and my desire to initiate care with the midwife.

Client's Name (print legibly): _____

Client's Signature:

_____

Date Signed: _____

A witness who is 18 years or older shall sign and date the form attesting to the fact that they witnessed both the midwife and the client signing and dating this form:

Witness Printed Name: _____

Witness Signature: _____ Date of Signing: _____