Moonbelly Midwifery, LLC
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INFORMED CONSENT FOR MIDWIFERY CARE AND OUT OF HOSPITAL BIRTH

I. I hereby authorize Moonbelly Midwife, LLC and/or such associates as may be selected by her to:

- Provide prenatal care, prenatal education and instruction;
- Perform physical exams to evaluate my general health and pregnancy status;
- Obtain blood, urine, vaginal, cervical or rectal samples for laboratory tests;
- Assist during my labor and the delivery of my baby;
- Provide immediate newborn and postpartum care, and any other procedures related to childbearing as needed.

II. Screening Criteria: I understand that the services of Licensed Midwives are provided for normal, healthy women who meet the definition of low-risk maternal client, and their families. Washington State defines a "low-risk maternal client" as someone who:

a. Is at term gestation, in general good health with uncomplicated prenatal course and participating in ongoing prenatal care, and prospects for a normal uncomplicated birth as defined by reasonable and generally accepted criteria of maternal and fetal health;
b. Has no previous major uterine wall surgery, cesarean section, or obstetrical complications likely to recur;
c. Has no significant signs or symptoms of anemia, active herpes genitalia, placenta praevia, known non-cephalic presentation during active labor, pregnancy-induced hypertension, persistent polyhydramnios or persistent oligohydramnios, abruptio placenta, chorioamnionitis, known multiple gestation, intrauterine growth restriction, or substance abuse;
d. Is in progressive labor; and
e. Is appropriate for a setting where methods of anesthesia are limited.

I agree to:

- Call the midwife immediately if I experience any of the warning signs listed on the "Signs and Symptoms to Immediately Report to the Midwife" form;
- Plan a natural birth without medication;
- Transfer my care or my infant's care to a hospital or physician if the midwife thinks it is necessary;
- Attend childbirth classes or read recommended books about childbirth;
- Arrange for someone to be at home with me to help after the birth of my baby;
- Establish care with a pediatrician for my baby by 2 weeks of age, or soon, if recommended;
- Notify the midwife if I cannot keep an appointment or make payments on time.

III. Services Provided: The midwife will:

- Provide normal prenatal and postpartum care;
- Be in contact and/or present during my labor, and present during delivery;
- Examine my baby at birth, 1-3 days, and 7-14 days of age;
- Provide postpartum exams at approximately 1-3 days, 2 and 6 weeks, or more if needed.

In the unlikely event that the midwife should not be available, she will arrange for another midwife to provide these services.

IV. Physician and Hospital Care: Conditions may develop during my pregnancy, labor and delivery, after delivery, or in my infant's first hours of life that may need to be evaluated and treated by a physician and may require transfer to a hospital. The midwife has explained these conditions to me and if need will arrange for a consultation with a physician, transfer of my prenatal care to a physician, or transfer of my infant or myself to a hospital. In the case of an emergency, the midwife will facilitate a transfer of my care to the closest hospital where she may or may not have an established consulting relationship with the doctor on call. In the case of a non-emergent transfer, arrangements will be made to transfer to a hospital where there is an established relationship between the midwife and hospital staff. If admitted to a hospital, the hospital medical staff will deliver care.

V. Consumer History: I understand the midwife will rely on my medical history and information about myself that I provide. I state that such information is complete, correct, and accurate, to the best of my knowledge. I also acknowledge that in midwifery care I am part of the health care team and I must into the decision making process.

VI. Student Midwives: I understand that there may be times when a student midwife may be involved in my care as an integral part of the midwifery team and that student participation occurs under the supervision of the licensed midwife. It has been explained to me that if at any time I am not comfortable with the student's participation I need only to bring it to the midwife's attention and other arrangements will be made.

I/WE, THE PARENT(S), HAVE CHOSEN TO HAVE AN OUT OF HOSPITAL BIRTH. I/WE UNDERSTAND THAT THERE ARE SPECIAL RESPONSIBILITIES AND RISKS THAT ARE ATTACHED TO SUCH A DECISION. ALTHOUGH MANY POTENTIAL PROBLEMS CAN BE FORESEEN AND/OR SCREENED FOR, THERE ARE SOME COMPLICATIONS WHICH CANNOT BE PREDICTED EITHER IN OR OUT OF THE HOSPITAL. EMERGENCY MEDICATIONS FOR THE CONTROL OF HEMORRHAGE, SHOCK AND SEIZURE ARE AVAILABLE AS WELL AS RESUSCITATIVE EQUIPMENT. NARCOTICS, EPIDURAL ANESTHESIA, BLOOD TRANSFUSION, VACUUM EXTRACTOR, FORCEPS AND CESAREAN SECTION ARE NOT AVAILABLE IN AN OUT OF HOSPITAL BIRTH SETTING. SHOULD A NEED FOR THOSE ARISE, THE CLIENT WOULD NEED TO BE TRANSPORTED TO A HOSPITAL.

I certify that the licensed midwife has informed me of the nature and character of the proposed services.

I certify that I have had the opportunity to ask questions and have had all aspects of licensed midwifery services explained to my satisfaction and I consent to midwifery care and out of hospital birth.

Client Signature: _____________________________ Date: ____________________

Partner Signature: ____________________________ Date: ____________________

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