Brigitte Rhody-Garrison, CNM
moderndaymidwife@gmail.com
585-737-0773

INFORMED DISCLOSURE and CONSENT FOR HOMEBIRTH CARE

INTRODUCTION
Thank you for considering Brigitte and her assistants for your midwifery care. We are providing this form with the hope that it will assist you in making an informed choice about homebirth. It is also meant to foster a relationship based on shared knowledge and mutual respect, and to encourage both parent responsibility and caregiver accountability.

HOMEBIRTH
For homebirth to be widely accessible, there must be a fundamental belief by the family and care provider alike that labor and birth goes smoothly the majority of the time.

Homebirth offers a woman a level of empowerment in all aspects of her care. She is surrounded by supportive people of her own choosing in a comfortable and familiar environment. At home, a woman may feel less inhibited in expressing her individual responses to labor: making sounds, adopting comfortable positions, being intimate with her partner, nursing other children. When a woman is in her domain with supportive family and friends, she can draw strength from these parts of her identity. These may include cultural and faith-based rituals which, in turn, help her cope with labor. In addition, birth at home offers less interruption with family routines. A laboring woman can, according to her own values, choose how to involve her children in the birth experience. And children, making their own adjustments to new roles in the family, are not challenged with a lengthy absence of their mothers. Staying home eliminates the decision about when to go to the hospital or birth center during labor—leaving too early can slow labor's progress, and too late can be intensely uncomfortable, even leading to giving birth enroute. Breastfeeding and family bonding are uninterrupted in their most natural setting.

SAFETY
Along with the belief that birth is a normal act that *women do,* the safety of homebirth is grounded in the careful screening of women by skilled midwives who are educated in prevention, assessment, and treatment of complications—knowing when to observe and support a woman, as well as when to intervene.

The overwhelming belief in the United States is that hospitals are the safest place to give birth, regardless of data on *planned* out-of-hospital births with skilled practitioners that suggest otherwise (see American College of Nurse Midwives Position Statement on Home Birth). This cultural belief does not speak to the risks of giving birth *in* hospitals, due to the performance of

routine episiotomies, artificial breaking of the bag of waters, frequent induction of labor, and high rate of caesarean (operative) births, as examples.

In this practice, the midwife brings certain emergency equipment to the home—IVs, oxygen, select medications—however, this does not render the home equivalent to hospital facilities that have equipment to deal with serious problems should they occur. In any birth setting, emergencies may arise. When emergencies or 'poor outcomes' occur outside the hospital setting, even if the outcome would have been the same were the birth to have occurred within the hospital, the choice of homebirth is always called into question.

We are committed to working with integrity and care. Even when practicing with the utmost attention, it is not within a midwife or physician's power to *guarantee* a normal birth or healthy outcome for mother or baby.

It is our philosophy that all decisions regarding your care will be collaborative. Situations may arise, however, in which the professional judgment of the midwife and/or consulting physician must be relied on *exclusively* for the safety of mother and baby. In emergent situations, there may not be time for lengthly discussion of management or treatment options.

OBSTETRICAL CONSULTATION/TRANSFER OF CARE

Evaluation of your and your baby's status will be ongoing through your pregnancy. If at any time signs suggest a deviation from normal, indicating that your health or the baby's would be better served in another setting, we will discuss this with you and arrangements will be made for transfer to the provider of your choice. In some circumstances we may also consult with another provider and ask you to see him or her for an evaluation during your pregnancy. If transfer becomes necessary during labor, your attendants will accompany you to the hospital, where the attending staff will continue your care. At least one member of your birth team will stay to offer labor support and serve as an advocate. On your discharge from the hospital, we will provide ongoing postpartum care. Personal preference for receiving hospital is discussed and considered when the urgency of labor transport circumstances permit. In an emergency when time is critical, transport is made to the closest hospital with appropriate services.

MATERNITY CARE PROVIDED

This practice offers prenatal care, homebirth care, and immediate newborn and postpartum care, as well as well-woman and fertility care. After the birth we usually make two home visits, the first, within the first day or two postpartum, and the second at three to seven days postpartum, followed by a six-week postpartum visit, when family planning is discussed and addressed. Our routine prenatal care covers each of the aspects normally included in the community standard, with extra time for education, discussion, and informed decision making. Women come for visits on the same basic schedule, usually every four weeks until 30 weeks, then every 2 weeks until 36 weeks, then weekly until delivery.

The first visit or two usually includes: taking maternal, family, and previous pregnancy/ obstetric history; determination of dates; a basic physical exam; PAP smear and vaginal cultures as indicated; and offering, discussing, and drawing blood work as needed. Routine initial labs currently include blood type &RH factor, antibody screen, rubella immunity titer, complete blood count with differential, syphilis screen, Hepatitis B screen, HIV screen (as required in community hospitals), urine culture with gonorrhea and chlamydia screen, and vitamin D level. Cystic fibrosis carrier screening is offered and available as desired. Other tests may be discussed, offered, and included based on history, symptoms, or request. Routine history questions include screening for genetic risks, and genetic counseling and testing referrals are offered to all women

At routine prenatal visits, women weigh themselves, check their urine for protein and glucose, and we measure and discuss blood pressure, fundal height and baby's growth, baby's heart tones (after 10-12 weeks), baby's presentation and position, activity, and maternal nutritional, exercise, and psychosocial well-being.
We document care in a chart for each woman which includes observations, lab results, records of consultations and referrals, records of labor, birth, and postpartum care and all other pertinent medical and psychosocial information. This chart is available upon request and with the client's written or verbal consent to any physician or other health care provider, who is called upon for consultation, referral or in the event of a hospital transport.

An anatomic ultrasound is offered and ordered at 18-22 weeks. Ultrasounds are discussed, offered, and ordered at other times throughout the pregnancy as needed. Glucose screening is discussed and offered at 24-28 weeks, as well as repeat antibody screening for Rh negative women. RhoGAM is discussed and offered to Rh negative women. GBS cultures are usually collected during the last month of pregnancy. Hemoglobin and hematocrit are monitored throughout pregnancy as indicated. Cord blood for baby's blood type is collected for Rh negative mothers after birth. Nutrition counseling and education is an important aspect of care throughout pregnancy and postpartum care.

As scheduling allows, Brigitte makes one prenatal home visit at 36-37 weeks gestation in order to assess facilities, supplies, adequate heat, availability of a phone and transportation readiness.

An important part of prenatal care is the informal education and discussions that take place throughout the visits. Getting to know your care providers is an important element of preparing for a safe and uninhibited homebirth. Please ask any questions you have. We may also bring up topics for you to consider and discuss, including: signs of labor, when and how to call your midwife with questions, problems, signs of labor, partner participation, preparation, plans, and adjustments for children, birth team members and roles, breastfeeding experiences, feelings and preparation, and emergency transport. Clients are to arrange pediatric care by 36 weeks of pregnancy. Childbirth classes are an excellent informational aid for parents as they take responsibility for their own pregnancy and birth. Instructors can be recommended.

Clients are asked to notify Brigitte early of signs of labor, and keep in close contact. This allows her to provide assessment, education, and anticipatory guidance as active labor develops. The laboring woman, her partner, and Brigitte share in the decision of when Brigitte and her assistant should come to the home.

At your home, Brigitte and her assistant monitor the well being of mother and baby with as little disruption to labor and coping patterns as possible. Maternal blood pressure, pulse, and temperature are assessed initially, and repeated every 4-6 hours or as needed. A portable Doppler is used to listen to baby's heartbeat intermittently. The usual schedule is every 20-30 min in active labor, and every 3-10 minutes or after every 1-3 contractions during pushing. Vaginal exams are offered and performed when they will provide helpful information for mother or midwife. Brigitte and her assistant strive to match their verbal and physical support with the mother's needs and wishes. The birth team may stay in the background, set up supplies, and assess, or they may provide more active coaching and labor support as needed. Special attention is given to maintaining good maternal hydration and nutrition throughout labor. If the mother cannot tolerate oral liquids, IV hydration may be offered.

Brigitte coaches the mother through the pushing stage as either she or the partner catches the baby with the goal of minimizing tearing and maintaining healthy baby status. Once the baby is born, Brigitte or her assistant focuses on stabilizing and assessing the newborn while the other monitors the mother's condition and watches for bleeding and signs of placental separation. Except in rare exceptions, the cord is not cut until it has finished pulsing. This helps the baby transition normally to breathing on their own.. Emergency supplies which Brigitte brings to every birth include basic resuscitation equipment and oxygen for babies in need, and medications and IV fluids for controlling and managing postpartum hemorrhage.

The midwife assists the delivery of the placenta and inspects for health and completeness. For Rh negative women, cord blood and maternal blood are drawn to assess infant blood type and need for RhoGAM. Many women find it helpful to squat for placenta delivery. After the mother and newborn are stabilized, the midwife inspects the perineum, vulva, vagina, and if indicated, the cervix for tears. Brigitte repairs first and second degree tears as needed and gives instructions for self-care for optimal healing. Rarely, severe tears (3rd or 4th degree) require transport for repair by a surgeon. Brigitte and/or her assistant remain in the home for a minimum of two hours postpartum, until both mother and infant are stable and ready to rest. Stability in the mother is defined as blood pressure at least 90/50 and not more than 140/90 and pulse between 60-100. Stability in the newborn is defined as temperature between 97.4-99.0, heart rate between 110-160 and respiratory between 30-60 at rest. If values persist outside this range without other signs of compromise and are correspondent to prenatal values, exceptions may be made after discussion and/or consultation.

During this immediate postpartum time, Brigitte provides a thorough newborn exam, offers routine newborn vitamin K and erythromycin eye ointment as required by New York State law. She assists with initiating breastfeeding, ensures that the mother drinks and eats (if possible), and assists her in getting up to void. The newborn exam includes measurement of length, head circumference, chest circumference, and weight, evaluation of heart and lung sounds, evaluation of gestational maturity, and an overview of each organ system and body area. Any abnormal or unusual findings are evaluated by a pediatrician of the parents' choice. Rarely, women are unable to void postpartum and a one-time urinary catheterization is performed. Before leaving, verbal and written postpartum care and newborn instructions are provided.

Postpartum care normally includes 2 home visits at 1-2 and 3-7 days and an office visit at 6 weeks. An extra 3 week office visit may be offered as needed. At the one day visit, the midwife assesses maternal blood pressure, pulse, temperature, bleeding, uterine condition and location, breast condition and breastfeeding progress, signs or symptoms of infection or other complications, and answers any questions. The baby is assessed for heart and lung sounds, cord condition, general signs of health, and any abnormal physical exam findings or variations. The cord clamp is removed at this visit.

The second visit reassesses mother and baby and follows up on any questions or concerns. The New York State mandated newborn screening (heel stick) is completed at this visit. Also at this visit information for the birth certificate and social security number application (which Brigitte files) is verified. If abnormalities or concerns are noted during any of the three newborn exams, the parents will need to consult with their pediatrician. When all findings are normal, the parents arrange to meet with the pediatrician at their convenience, generally some time after the second home visit.

The 6 week office visit evaluates maternal recovery with maternal vital signs, abdominal exam, pelvic exam to assess tear healing and tone, and PAP smear as needed. Blood work for hemoglobin and hematocrit or any other concerns is offered as indicated. Breastfeeding is discussed and breast health issues explored. Family planning needs are discussed and addressed at this visit, as well as questions, concerns, or discomfort related to sexual activity.

A FINAL WORD from Brigitte

Midwifery and homebirth provide an alternative to the impersonal and medically-oriented care that has become prevalent in our culture today. Birthing in one's home, attended by a midwife, is a refuge for those of us who believe that pregnancy and childbirth are normal and intimate experiences. Focusing on the normal does not mean that problems go unrecognized or unattended. Rather, they are viewed as imbalances that need to be righted, rather than expected or feared catastrophes.

If problems occur at home you will invariably be questioned by friends, family members and professionals as to the wisdom of your choice in having a homebirth. I ask that you honestly project yourselves into your worst-case scenario and examine how you would feel about your

original choices after the fact. After an honest self-evaluation, please feel free to discuss your thoughts, questions and feelings with me so that we can further clarify what would be the most appropriate birthing venue for you.

GUIDELINES FOR HOMEBIRTH MIDWIFERY CARE

General Criteria

Healthy physically and mentally
Well-nourished woman
Adequate social supports before, during and after birth
Able to accept responsibility for outcome of a homebirth
Commitment to maintaining a positive emotional environment for outcome of birth
Childbirth, homebirth and breastfeeding education secured
Commitment to breastfeeding throughout the postpartum period
Preparation of persons planning to be present for the birth
Complete records from previous provider for current and/or past pregnancies
Pediatric care arranged by 36 weeks of pregnancy
Arrangements made for emergency transport
Clean home environment- supplies orderly
Understanding there will be no intervention unless medically necessary
Understanding there will be no use of labor pain medications in the home
Agreement to use IV therapy/medication as medically indicated for the health of the mother and baby
Agreement to transfer mother and/or infant to the hospital at the discretion of the attendant at any time during labor, delivery or postpartum
Help available 24 hours a day for at least one week after the birth

Prenatal Conditions Requiring Discussion, Consultation, Collaboration, or Referral

Preexisting medical condition with documented risk to pregnancy, including, but not limited to, diabetes (not diet-controlled) uncontrolled hypertension, active tuberculosis, heart, lung, liver, or kidney disease, cancer, or significant bleeding disorders.

-Rh incompatibility with a rise in titer
-Malnutrition, poor weight gain
-Drug or alcohol addiction
-Multiple pregnancy
-Insulin dependent or gestational diabetes
-Polyhydramnios or oligohydramnios
-Intrauterine growth retardation (IUGR)
-Marked maternal anemia at term
-Preeclampsia or HEELP syndrome
-Placenta previa
-Prematurity
-Abnormal presentation (breech, transverse lie)
-Primary herpes infection in labor or active lesions in vulvar, perineal, cervical History of obstetrical problems such as uterine abnormalities, placenta acreta or abruption or incompetent cervix

-Fetus with congenital anomalies that may require immediate medical attention or vaginal area at time of birth
-Positive serology for syphilis or HIV
-Placental Abruption
-Prolonged pregnancy (beyond 42.0 weeks)
-Positive Hepatitis B
-Substance abuse
-Cigarette smoking
-Third trimester vaginal bleeding
-Ruptured membranes (with or without labor) prior to 37 weeks
-Abnormal PAP smear (Class III or greater)

Labor and Delivery Complications Requiring Discussion, Consultation, and/or Hospitalization

Fetal heart rate abnormalities (consistently over 160 or below 110—depending on labor stage; concerning decelerations)
Abnormal intrapartum bleeding
Prolonged labor with no evidence of progress and/or maternal exhaustion or dimished maternal or fetal well-being
Cord prolapse
Meconium stained amniotic fluid (depending on severity and stage of labor)
Elevated maternal temperature with ruptured membranes
Severe or persistent hemorrhage
Signs of maternal shock
Retained placenta
Newborn health status unstable
Discretion of attendant
Signs of preeclampsia
More than 2 hours of full dilation and active pushing with no progress
Maternal desire

*When a women transfers to the hospital in labor, at least one attendant remains with her if at all possible, Brigitte or her covering midwife calls ahead to the receiving hospital when possible, and records and verbal report are offered to the receiving staff.

Postpartum conditions requiring consultation, referral or transport as indicated.

Newborn complications
Apgar score of less than 7 at 10 minutes.
Baby with obvious anomaly.
Respirations with grunting, retractions, nasal flaring and tachypnea.
Cardiac irregularities.
Persistent pale, cyanotic or gray color.
Jaundice within 24 hours of birth.
Abnormal cry
Signs of prematurity or postmaturity.
No passage of meconium or urination during first 24 hours.
Lethargy or poor feeding.
Any other conditions which the parents or midwives have questions about.

Maternal Problems:
A laceration beyond the ability of the midwife to repair (generally 3rd or 4th degree)
Persistent uterine atony
Excessive bleeding.
Inability to void within 12 hours of birth.
Fever greater than 100.4.
Foul smelling lochia.
Failure of episiotomy or tear to heal properly.

Pelvic, leg or chest pain.
Signs of postpartum shock.

Insufficient involution.

For more details on emergent management of the above conditions, or management of conditions not listed, we may refer to: *Clinical Practice Guidelines for Midwifery and Women's Health*, current edition

INFORMED CONSENT

I have chosen to birth my baby at home rather than in a hospital, and have discussed with the Brigitte Rhody-Garrison, CNM her home birth practice, including the benefits and risks of both hospital delivery and birth at home.

I understand the need for complete and adequate prenatal care which may include laboratory studies, sonograms, and other tests, as necessary to ensure the normalcy of my pregnancy and appropriateness of delivering my baby at home.

While the course of childbearing is a natural process, I understand that unforeseen events during a home birth can result in a poor outcome. Brigitte has explained that if a complication arises during labor or delivery that requires a transfer to the hospital, the transfer could result in delay in the initiation of emergency treatment otherwise available in the hospital, and this delay could affect the ultimate outcome for the baby and/or the mother.

Brigitte has provided me with a copy of her practice guidelines (Guidelines for Homebirth Midwifery Care), and has answered all of my questions about them. She has also made herself available to answer/explain any question or concerns I may have during my pregnancy, labor/ birth and postpartum period.

I accept that very rarely Brigitte may not be personally able to attend my labor and delivery (due, for example, to illness, attendance at another birth) and that another Licensed Midwife covering her practice may attend my labor and deliver my baby in her absence.

I understand that birth at home cannot be guaranteed, and any number of conditions or complications that might arise during my prenatal care, labor, or postpartum care could require a transfer of care to a physician for treatment and/or hospital delivery. I understand that Brigitte will exercise her best professional judgment as to whether a transfer to a physician is in my best interest, or that of my baby.

NYS law requires that Midwives have collaborative relationships with physicians and/or hospitals to facilitate consultation, collaboration and/or transfer of care based on the health status of the client. These may include obstetricians, perinatologists, pediatricians and others. Brigitte consults and collaborates with a variety of other health care providers as dictated by patient needs. If transfer to or consultation with a physician or hospital transfer becomes necessary, this will be discussed with you and your records will be made available to the collaborating physician and/or hospital.

If I require hospital care in labor, Brigitte and/or one of her assistants or covering midwives will accompany me to facilitate my reception, and will stay with me in a supportive role if desired. Brigitte will provide postpartum care following hospital discharge.

While emergencies are rare, transfers in these cases are made to the most appropriate hospital. When time allows in labor, transfer will be made to an appropriate facility with consideration of patient and midwife preference and receiving provider availability. If transfer by ambulance becomes necessary, I understand that I will be responsible for all associated costs. All hospital, consulting physician, and laboratory expenses incurred at any time are my responsibility and are not included in the financial agreement with Brigitte Rhody-Garrison.

I fully understand that if in the future I refuse to follow Brigitte's treatment recommendations or accept a transfer of care to a physician as recommended by her, she will be free to withdraw at that time from providing further care to my baby and me.

I hereby fully and completely release Brigitte Rhody-Garrison, and covering midwives attending me and my baby in her absence, and their birth assistants, and hold each of them harmless, from any and all damages, harm, injury or death that may result to my baby or me as a result of
my refusal to follow a treatment recommendation or accept a transfer to a physician, as recommended by Brigitte or a covering midwife, at any time.

I have had a chance to thoroughly discuss all of this information and my decision to birth my baby at home with Brigitte and she has answered all of my questions. I have freely and voluntarily chosen to enter her practice and attempt to deliver my baby at home.

Physical exams and the authority to treat

I authorize Brigitte Rhody-Garrison, CNM and her designated midwives, assistants, and/or apprentices or students to perform, according to the expertise of each individual, physical exams to confirm my general health and pregnancy status, obtain lab specimens, perform diagnostic and other procedures, including but not limited to the following: **

-obtaining blood tests, as indicated
-checking vital signs
-doing internal exams, as indicated
-obtaining cervical, vaginal or rectal specimens, including PAP and/or cultures, as indicated
-providing health care and health/ pregnancy education
-beginning IV infusions, as indicated**
-giving select medication, herbs or homeopathic remedies appropriate to pregnancy, labor or birth, as indicated
-delivering my baby in my home or other out-of-hospital setting
-episiotomy and repair, as indicated**
-repair of lacerations, as indicated
-postpartum/family planning care
-immediate newborn care
-follow-up home visits

** Procedures such as episiotomies, IVs, or administering medications are **never** done routinely or for expediency.

Signature of Client	Date
Signature of Partner	Date
Signature of Midwife	Date